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Introduction

Purpose of this Diversion/Transition Manual

The purpose of this manual is to pull from historical program guidelines and current policies and processes that impact the work of local Diversion/Transition Coordinators to create an up-to-date guide of best practices, definitions and program applicable information. It can be used as a quick reference or supplemental tool to all the items found on Case Management Tools. Each team should determine the most appropriate way to implement this tool, as needed, based on the inter-workings of their region.

Missions That Drive Diversion/Transition work:

Department of Human Services (DHS) Mission: To help Oregonians in their own communities achieve wellbeing and independence through opportunities that protect, empower, respect choice and preserve dignity.

Aging and People with Disabilities (APD) Mission: The Department of Human Services Aging and People with Disabilities program assists seniors and people with disabilities of all ages to achieve well-being through opportunities for community living, employment, family support and services that promote independence, choice and dignity.

APD Goals: We help aging and people with disabilities:

- Remain as independent as possible
- Sustain the supports needed to maintain quality lives in their home communities
- Honor choices made by them about their own lives
- By promoting value-driven commitments in statute and policy; and
- By partnering with advocacy groups, commission and councils, local government partners, and community organizations.

Implementation and History of Diversion/Transition

- 1981: ORS 410.050 found that:
 - the needs of the elderly population can best be served and planned for at the local community level.
 - Oregon believes that people have a right of free choice about long-term care.
- Over the next several years relocation positions were funded across the state to perform Diversion and Transition duties.
- 2008: On The Move (OTM) program started utilizing Money Follows the Person funding to pay for accommodations to meet consumers specific needs out of Nursing Facilities into the community. New state positions were funded through this program separately from the relocation positions.
- 2011: On The Move was dissolved and many of the OTM positions were absorbed into the relocation teams across the state.
- Diversion/Transition teams continue working diligently to honor Oregon's mission to offer free choice about long-term care through education, support and services to the residents of the State.
- Diversion and Diversion/Transition Coordinators currently use the following funding sources to provide services consumers need in order to avoid institutionalization and live the most independent lives possible:
 - K State Plan (OAR 411-035)
 - Community-Based Care Transition Services (OAR 411-037)
 - OSIPM Special Needs Payments: (OSIP Program Manual and OAR 461-155)

Definitions

ACS – Acute Care Setting, also refers to the benefit available to eligible consumers to access OSIPM coverage while receiving skilled services under their Medicare benefit. See OAR [461-135-0745](#) for eligibility details.

Acute Inpatient Care Facility - A licensed hospital with an organized medical staff, with permanent facilities that include inpatient beds, and with comprehensive medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment primarily for but not limited to acutely ill patients and accident victims.

Bariatric - Relating to or specializing in the treatment of obesity. Specialized services and heavy duty DME will be necessary for the safety of the individual.

BMI- (body mass index) - A standardized estimate of an individual's relating body fat calculated from his or her height and weight. The formula for calculating BMI is weight divided by height.

CBC (Community Based Care) - Waivered services that include In-Home (Live-In, Hourly, Spousal Pay, ICP), Adult Foster Home (AFH), Assisted Living Facility (ALF), Resident Care Facility (RCF), Endorsed Memory Care Communities, Specialized Living and Specific Need Contracted placements.

Community Based Facilities (CBF) - AFH, RCF, ALF, Specialized Living, Group Care Homes

Centers for Medicare & Medicaid Services (CMS) - The federal government branch that sets policy for both Medicare and Medicaid. CMS provides funding for both Medicare and matching state funds for Medicaid.

Collaborative Care Organizations (CCO) - Managed health agencies that contract with the Oregon Health Authority to manage the medical benefits for Medicaid recipients. Additionally, CCO's will manage dental and mental health benefits as well as transportation for medical services. Currently, there is 17 CCO's operating in Oregon. The Coordinated Care Support Unit Assignment List provides local office with a representative from each CCO. The contact person can be helpful if you are having challenges.

Complex Case Team (CCC) – A team of Central Office policy analysts that support the field's need for assisting in finding placement for consumers with little or no options for receiving services. An appropriate referral would be if the individual has had a series of failed placements, or they are between placements and have been refused by multiple providers; and if they manager approves the referral; and if the CM/DT has exhausted all local resources. A referral form with associated guidelines is requested (see AR 13-064). If you have questions about this program, please refer to the CCC section of this manual

Diversion - The process of developing a service plan that offers an alternative to an institution setting (long term care placement). The HCBC service plan is implemented prior to long term care placement. Mitigating the barriers to put an individual at high risk for losing their community-based plan is required. Diversion cases shall be entered in to the Diversion/Transition Data Base and be monitored to ensure the stability of the move for 90 days. A person may be a patient in an acute care setting (inpatient in a hospital) or diverting from a failed placement where there was risk for nursing facility placement.

Diversion/Transition Coordinator (D/T) - The position designed to focus on assisting individuals in the process of moving out of an institutional setting and securing community placement for individuals' high risk for entering in to long term care services. Also referred to as Transition Coordinator (TC) or Diversion Coordinator (DC) depending on the team.

Diversion/Transition Database - The DT Database is currently an application found within the Transition-Diversion SharePoint site that is designed to capture details regarding diversion or transition cases as well as other work that D/T Coordinators do to support their community. Each case should be data entered in to the data base timely. Trends and success of D/T services can be queried from the D/T data base. See section titled “Tracking in Diversion/Transition Database” for instructions on how to record your work. Or you can find additional information in the DT Document Library found on the SharePoint Site.

Diversion/Transition Special Needs – OARs [461-155-0526](#) and [461-155-0710](#). A one-time special needs payment that can be used, as a last financial option, for Medicaid individuals qualifying for LTSS (allowed for OSPIM individuals in Long Term Care or K Plan, but not MAGI or SPPC). Review K Plan ancillary services OAR 411-035 first. To potentially qualify for this special need, the case first must qualify for diversion or transition. Funding is used when no other community resource or natural support funds are available and the individual cannot afford item.

Durable Medical Equipment (DME): Equipment, furnished by durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or home health agency that can withstand reported use, is primarily and customarily used to serve a medical purpose, generally not useful to a client in the absence of an illness or injury and is appropriate for use in the home. Some examples include wheelchairs, crutches and hospital beds. Durable medical equipment extends to supplies and accessories that are necessary for the effective use of covered durable medical equipment.

Intellectual or Developmental Disability (IDD) - Any mental and/or physical disability manifested before the age of 22 that may continue indefinitely and result in substantial limitations in three or more of the following life activities: self-care, mobility, independent living, receptive and expressive language, learning, self-direction and economic sufficiency.

Interdisciplinary Team (IDT) - A group of individuals that together provide holistic information that aide the individual in determining the ideal service plan; sometimes referred to as a multi-disciplinary team. The Interdisciplinary Team sometimes meets formally in care conference, but more common may meet individually or through phone and email communication. The TC plays a vital role on the IT as he/she will bring available resources, coordination and advocacy as well as authorization of the service plan.

Home and Community-Based Services (HCBS) - services provided in the home or community of an individual. HCBS are authorized under the following Medicaid authorities:

- 1915(c) - HCBS Waivers;
- 1915(i) - State Plan HCBS; or
- 1915(k) - Community First Choice (K State Plan Option).
- HCBS are delivered through the following program areas:
 - DHS, Aging and People with Disabilities;
 - DHS, Office of Developmental Disabilities Services; and
 - OHA.

Holistic Assessment - The consideration of several components that impact the individuals life including physical, psychological, social, cultural, environmental, spiritual and financial. Together, a higher quality service plan can be developed.

Institutional Settings - An establishment designed to provide targeted services. Residents living in institutions may have limited choices regarding their decision-making process and options available in the community are not readily available. Institutional settings are highly regulated and are considered the costliest service model. Institutions include Oregon State Hospital (Oregon’s primary state-run psychiatric facility for adults), Nursing Facilities – Skilled Care (SNF), Nursing Facilities- Intermediate Care Facility (ICF) and Acute Care Hospitals (In-Patients).

Intermediate Care Facility (ICF) - Refers to the long-term care nursing facility. A nursing facility will not have a room & board payment due to the rate is “all inclusive”. The Medicaid individual will need to meet the SPL 1-13 in order to qualify for Medicaid paid services. Sometimes, ICF is referred to as “long term care” or “institutional” living. It is a non-skilled stay in a nursing home. There are two different rates for Medicaid under ICF. One is basic NF rate and Complex Medical rate. The Medicaid resident will pay a liability to the NF and the Personal Incidental Fund.

Long Term Care Community Nursing Services (LTCCN) – A service that can be requested by the DT/CM for Medicaid clients living in an AFH or in-home setting. DT/CM will request services when approved nursing services are needed to help support the individual living independently in the community. Services include assessing and delegation of insulin injections, for example. See rule 411-048-0160-80.

Medications at Discharge - NF discharge medication to accompany the resident must be on the written order of a physician (411-086-0260, (3) (e))

Monitoring - D/T cases require the Diversion/Transition Coordinator to ensure that the post transitional services are adequate to meet the service needs. If a case is to be transferred to a different D/T Coordinator or an ongoing Case Manager prior to the end of the 90-day monitoring time, best practice is to take appropriate communication steps to ensure a warm hand off to the new worker. This step shall be recorded in the comments section of the D/T database for that case. To be considered a successful transition or diversion, the individual would need to be living in HCBC for at least 90 days. It is also considered a successful transition or diversion in cases where the consumer’s death occurs due to natural causes, not neglect or abuse, prior to the 90 days.

Neurological Disorders: Refers to diagnoses related to disorders of the body's nervous system. Symptoms may include paralysis, muscle weakness, poor coordination, and loss of sensation, seizures, confusion or pain. Examples of neurological diagnoses include Parkinson's, Huntington's disease, Multiple Sclerosis, Traumatic Brain Injuries and Cerebrovascular diseases.

Nursing Facility (NF) – An institutional setting designed for both rehabilitation skilled (SNF) and/or long-term care (ICF) services. Some nursing facilities do not serve both populations, for example a NF may be just for ICF services only. Generally, medical insurance will have benefits to cover the skilled stay but not the long-term care. For long term care, a Medicaid individual would need to qualify for Medicaid service eligibility (SPL 1-13). For SNF services, the Medicaid individual does not have to meet SPL 1-13.

Person Centered Care Plan - A care planning process directed by the individual who is transitioning. The TC recognizes this can be a difficult process for those who have lived in nursing facilities for a long period of time. The individual may look for guidance from others for decision making. The focus of the service plan involves empowering the individual regarding preferences, needs and strengths.

Post Hospital Extended Care (PHEC) – Up to a 20-day stay in a nursing facility for non-Medicare clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO. *See specific section below for OAR and further information on this topic.*

Pre-Admission Screening (PAS) – The assessment and determination of a potential Medicaid-eligible individual's need for nursing facility services, including the identification of individuals who can transition to community-based service settings and the provision of information about community-based alternatives. This assessment and determination are required when

potentially Medicaid-eligible individuals are at risk for admission to nursing facility services. PAS may include the completion of the federal PASRR Level I requirement (42 CFR, Part 483, (C)-(E)), to identify individuals with mental illness or intellectual or developmental disabilities. *See specific section below for OAR and further information on this topic.*

Pre-Admission Screening/Resident Review (PASRR) – The federal requirement, (42 CFR, Part 483, (C)-(E)), to identify individuals who have mental illness or developmental disabilities and determine if nursing facility service is required and if specialized services are required. PASRR includes Level I and Level II functions. *See specific section below for OAR and further information on this topic.*

Prior Authorization - The local Aging and People with Disabilities or Area Agency on Aging office participates in the development of proposed nursing facility care plans to assure the facility is the most suitable service setting for the individual. Nursing facility reimbursement is contingent upon prior-authorization.

Private Admission Assessment (PAA) - The assessment that is conducted for non-Medicaid residents as established by ORS 410.505 to 410.545 and OAR chapter 411, division 071, who are potential admissions to a Medicaid-certified nursing facility. Service needs are evaluated, and information is provided about long-term service choices. *See specific section below for OAR and further information on this topic.*

Skilled Care – A medical benefit health insurances, such as private insurance and Medicare/Medicaid can cover. The service is provided in nursing facilities that are approved to provide skilled care (not all NF have skilled services, some NF are ICF only). Skilled care is typically rehabilitation services that follow an inpatient hospitalization of at least 3 nights in the hospital; include physician’s orders for admission to the skilled care unit and the patient has

some need for the service, such as physical therapy, occupational therapy or speech therapy or nursing.

Skilled Nursing Facility (SNF) – A nursing facility that is approved to provide skilled care.

Special Needs Payment - OAR 461-155-0526, 0551, 0600, 0630, 0660 and 0710. Special needs funds are used to help support preserving community living situations or assisting the individual with financial coverage of equipment or services that create a barrier to discharge, if not purchased.

Specialized Living Services - A home-like environment for a specific target group who are eligible for a live-in attendant but because of special needs, are unable to live independently or receive services in other community-based care facilities and who would otherwise require nursing facility care. Admissions to these settings require prior approval from central office.

Specific Needs Contract (SNC) – A contractual agreement between a provider and DHS to deliver Medicaid services specifically at one location for a certain reimbursement rate that requires that provider to deliver a distinct amount of services and goods, as outlined in the contract’s Statement of Work. Admission requires approval through central office through the 494 form and process.

“Touring” or “Shopping” Facilities - The process of visiting the potential CBF, prior to moving in. If there is no available transportation, the KPlan Transition services may be utilized.

Transition - The process of developing a HCBC service plan designed to assist a Medicaid client who is currently receiving services in an institutional setting (long term care). The transition process includes completing an updated assessment; interviewing the individual and determining where they would like to receive their services; meeting with the interdisciplinary team as

needed (this may include individual, their rep or family, discharge planner, RN, new providers, mental health), touring potential facilities, a home visit to see what home modifications are needed; gathering bids for modifications, arranging for household items and DME products. The D/T would verify that the transition day itself goes smoothly and is typically present for the actual move. All transitional cases shall be entered in to the D/T Database and be monitored to ensure the stability of the move for 90 days

Training Guidelines

Required Training

Please discuss all required DHS and locally required trainings with your leadership team. Regularly scheduled required case management trainings are also required for Diversion/Transition staff.

Recommended Training

- The Office of Continuous Improvement offers many courses on communication skills that have shown to be very helpful for Diversion/Transition teams.
- Aspiring Leaders is a training course for those who are interested in expanding their leadership skills. Interested staff can apply for this opportunity with management approval.
- Ongoing Diversion/Transition calls will be scheduled based on need.
- Requests for local trainings or submission of training topics are encouraged and can be sent to the Transition Services Analyst.

Roles and Responsibilities

Diversion and Transition Focus

Local Diversion/Transition teams should focus on the following target populations while performing their diversion/transition activities as it best aligns with the local goals of the district and leadership:

- Clients who are longstanding Nursing Facility (NF) residents.
- Applicants who are “spend down” NF residents.
- Clients/Applicants who are in a NF receiving skilled nursing services.
- Clients/Applicants who need increased support in their current Home or Community Based Care setting (HCBC) to avert a NF placement.
- Clients/Applicants who in a hospital and require supports to return to their existing HCBC setting.

Diversion and Transition Services

There are three types of services in relationship to the roles and responsibilities of a Diversion/Transition Coordinator, these include:

- Diversion- services provided to prevent a person from becoming a long-term resident of a Nursing Facility or other institution such as the Oregon State Hospital.
- Transition- services provided to an individual who currently resides in a Nursing Facility (skilled or ICF level of care) or other institutions.
- Nursing Facility Authorization- service which authorizes Nursing Facility placement for a Medicaid-funded client in a long-term care setting also referred to as a Pre-Admission Screening (PAS).

Specific Roles and Responsibilities

The following roles and responsibilities are often identified as a priority for a local Diversion/Transition Coordinator:

- Be familiar with the information and resources found within this guide and the Diversion/Transition webpage found on Case Management tools.
- Complete Pre-Admission Screenings for the local service area.
- Authorize nursing facility placement for Medicaid-funded clients going into long-term care.
- Identify all current Nursing Facility residents that have a potential for Transition.
- Monitor clients that are either Post Hospital Extended Care (PHEC) or Medicare Skilled for Transition potential prior to going long-term care.
- Create a relationship of trust with the client and discuss placement options for them in the community.
- Identify family, friends, and legal representatives that are involved with the client and communicate with them as appropriate.
- Create, review, and update CA/PS assessments to provide for a comprehensive placement plan.
- Identify and address all barriers to placement.
- Locate qualified provider and placement options for a client.
- Arrange visits; verify supports and additional needs to create a safe placement.
- Identify and facilitate provider/caregiver training.

-
- Assist clients in preparation for the move.
 - Follow county to county best practices if applicable.
 - Monitor and follow up with client, provider, family, and legal representatives for 90 days after the move.
 - Ensure an orderly and timely transfer of case to ongoing case manager.
 - Provide training and case consultation to case managers and other staff.
 - Update OR ACCESS and D/T databases with client information and outcomes as appropriate.
 - Enter direct and in-direct contacts into OR ACCESS as completed.

Pre-Admissions Screening

Pre-Admission Screening – (PAS). The process of evaluating the individual who is nearing admission to ICF Medicaid paid service and includes a face to face visit, verifying the individual qualifies for Medicaid services (SPL 1-13). Because a representative of the division is the only person who can approve a Medicaid payment, the PAS process, can only be completed by a Medicaid staff (unlike the completion of the PASRR level 1 screening, using 460 form, which can be completed by “non-Medicaid personnel” such as a discharge planner at the hospital). The PAS process should be completed timely and allowing D/T team to schedule visit, complete a determination of qualification for Medicaid services (SPL 1-13), placement choice counseling and a development of a diversion or transition plan before approving the person for admission to ICF Medicaid payment. The Medicaid office has the right to deny the Medicaid payment if this process is not followed.

PAS OAR 411-070-0040

- INTRODUCTION. All individuals who are candidates for admission to a Medicaid-certified nursing facility must be assessed to evaluate their service needs and preferences and must receive information about community-based, alternative services, and resources that can meet the individual’s service needs and are safe, least restrictive, and potentially less costly than comparable nursing facility services.
- PRE-ADMISSION SCREENING. A pre-admission screening (PAS) as defined in OAR 411-070-0005 is required for potentially Medicaid eligible individuals who are at risk for nursing facility services.
 - PAS includes:
 - An assessment;
 - The determination of an individual’s service eligibility for Medicaid-paid long-term care or post-hospital extended care services in a nursing facility;
 - The identification of individuals who can transition to community-based service settings;

-
- The provision of information about community-based services and resources to meet the individual’s needs; and
 - Transition planning assistance as needed.
 - PAS is conducted in conjunction with the individual and any representative designated by the individual.
 - The PAS assessment shall be conducted by a case manager or other qualified SPD or AAA representative using SPD’s Client Assessment and Planning System (CA/PS) tool, and other standardized assessment tools and forms approved by SPD.
 - A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a nursing facility when short-term nursing facility services are needed. A face-to-face assessment including the discussion of alternative community-based services and resources shall be completed within seven days of the initial, short term nursing facility service approval.
 - Payment for nursing facility services may not be authorized by SPD until PAS has established that nursing facility services are required based on the individual’s service needs and Medicaid financial eligibility has been established.



Aging and People with Disabilities

Policy Transmittal

Mike McCormick

Number: APD-PT-14-016

Authorized Signature

Issue Date: 6/10/2014

Topic: Long Term Care

Transmitting (check the box that best applies):

- New policy Policy change Policy clarification Executive letter
 Administrative Rule Manual update Other: _____

Applies to (check all that apply):

- All DHS and Health Directors
 Area Agencies on Aging Health
 Services Office of Developmental
 Aging and People with Disabilities Disabilities Services
 Children, Adults and Families

(ODDS)

County DD Program Managers Other (*please specify*):

Policy/rule title:	PAS prior approval required for payment	
Policy/rule number(s):	OAR 411-070-0040 through OAR 411-070-0045	Release no:
Effective date:		Expiration:
References:		
Web Address:	http://www.dhs.state.or.us/policy/spd/rules/411_070	

Discussion/interpretation:

The purpose of this transmittal is to provide clarification concerning the responsibility of the APD or AAA offices to prior authorize nursing facility services for Medicaid individuals. OAR 411-070-0040 and 411-070-0045 require that payment for nursing facility services may not be authorized until the APD or AAA office has completed a PAS and prior authorized the payment.

PAS includes:

- An assessment;
- The determination of an individual’s service eligibility for Medicaid-paid long-term care or post-hospital extended care services in a nursing facility;

-
- The identification of individuals who can transition to community-based service settings;
 - The provision of information about community-based services and resources to meet the individual's needs; and
 - Transition planning assistance as needed.

Any facility that admits an individual for nursing facility level of care that has not had a Pre-Admission Screening (PAS) will not be reimbursed by Medicaid for the days not prior authorized.

Individuals that qualify under our current assessment for long-term care services, who have had the appropriate PAS work completed, and have had community options provided to them and still choose to admit to the nursing facility have a right to that level of care and may be reimbursed for this level of care once the Department has completed the prior authorization.

Please remember that individuals should exhaust their PHEC or other skilled benefits before accessing long-term care nursing facility services.

A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a nursing facility when short-term nursing facility services are needed. A face-to-face assessment including the discussion of alternative community-based services and resources shall be completed within seven days of the initial, short term nursing facility service approval OAR 411-070-0040(2)(d). All other PAS authorizations should be done face-to-face.

When an individual is transitioning into another county or across offices, it is the expectation that the APD or AAA office placing the individual in the other office or county nursing facility will notify the receiving local APD or AAA office prior to placement.

Implementation/transition instructions: Effective immediately any facility requesting Medicaid payment for days without prior authorization will not be authorized in the Plan of Care to bill for those days.

Pre-Admission Screening and Resident Review

Pre-Admission Screening/Resident Review (PASRR) - Level 1 (form 460). The process required by the federal government is designed to ensure that all potential NF admissions have been screened for indicators of Intellectual/Developmental Disability (I/DD) or Serious Mental Illness (SMI). The information is captured on the 460 form. This form can be completed by Medicaid staff as well as non-Medicaid staff and is most commonly completed by the hospital discharge planner. The form should be forwarded to the NF prior to admission. The 460 form is not an approval for Medicaid payment for nursing home stay.

If there are indicators of I/DD or SMI, the PASRR Level 2 will be required prior to NF admission. The PASRR Level 2 is completed by central office staff. Individuals with I/DD or SMI indicators (without a PASRR Level 2) may enter a NF if the conditions of categorical determinations are met. Both the 460 and the 460 Instructions can be found on APD's Form Server. See SDS 460 INS for instructions. The SDS460 can be filled out by hospital discharge planners, Medicaid staff including a D/t or CM. A PASRR- Level 1 is not authorizing Medicaid payment.

PASRR as described in OAR 411-070-0040: Screening, Assessment and Resident Review:

- A pre-admission screening and resident review (PASRR) as described in OAR 411-070-0043 is required for individuals, regardless of payment source, with either mental illness or developmental disabilities who need nursing facility services.
- RESIDENT REVIEW. Title XIX regulations require utilization review and quality assurance reviews of Medicaid residents in nursing facilities. The reviews carried out by the authorized utilization review organization must meet these requirements:

-
- Staff associated with SPD are required to maintain service plans on all SPD residents in nursing facilities. The frequency of their service plan update shall vary depending on such factors as the resident's potential for transition to home or community-based care and federal or state requirements for resident review.
 - Authorized representatives of SPD or the authorized utilization review organization must have immediate access to SPD residents and to facility records. "Access" to facility records means the right to personally read charts and records to document continuing eligibility for payment, quality of care, or alleged abuse. SPD or the authorized utilization review organization representative must be able to make and remove copies of charts and records from the facility's property as required to carry out the above responsibilities
 - SPD or the authorized utilization review organization representatives must have the right to privately interview any SPD residents and any facility staff in carrying out the above responsibilities.
 - SPD or the authorized utilization review organization representatives must have the right to participate in facility staffing on SPD residents.

PASRR OAR 411-070-0043

- INTRODUCTION. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, subparts C through E. The purpose of PASRR is to prevent the placement of individuals with mental illness or intellectual or developmental disabilities in a nursing facility unless their medical needs clearly indicate that they require the level of service provided by a nursing facility. Categorical determination, as described in section (2) of this rule, are groupings of individuals with mental illness or intellectual or developmental disabilities who may be admitted to a nursing facility without a PASRR Level II evaluation.
- CATEGORICAL DETERMINATIONS.
 - Exempted hospital discharge:

-
- The individual is admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; or
 - The individual is admitted to the nursing facility directly from a hospital after receiving care as an observation-status; and
 - The individual requires nursing facility services for the condition for which he or she received care in the hospital; and
 - The individual's attending physician has certified before admission to the facility that the individual is likely to require nursing facility services for 30 days or less.
 - End of life care for terminal illness. The individual is admitted to the nursing facility to receive end of life care and the individual has a life expectancy of six months or less.
 - Emergency situations with nursing facility admission not to exceed seven days unless authorized by AAA or APD staff.
 - The individual requires nursing facility level of service; and
 - The emergency is due to unscheduled absence or illness of the regular caregiver; or
 - Nursing facility admission is the result of protective services action.
 - PASRR includes three components.
 - PASRR LEVEL I. PASRR Level I is a screening process that is conducted prior to nursing facility admission for all individuals applying as new admissions to a Medicaid certified nursing facility regardless of the individual's source of payment. The purpose of the screening is to identify indicators of mental illness or intellectual or developmental disabilities that may require further evaluation {42 CFR 483.128} or if categorical determinations, as described in section (2) of this rule, which verify that the nursing facility service is required.
 - PASRR Level I screening is performed by AAA or APD authorized staff, private admission assessment (PAA) programs, professional medical staff working directly under the supervision of the attending physician, or by organizations designated by DHS.

-
- Documentation of PASRR Level I screening is completed using a APD-designated form.
 - If there are no indicators of mental illness or intellectual or developmental disabilities or if the individual belongs to a categorically determined group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.
 - If PASRR Level I screening determines that an individual has indicators of mental illness and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact AMH and request a PASRR Level II evaluation.
 - If PASRR Level I screening determines that an individual has indicators of intellectual or developmental disabilities and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact APD and request a PASRR Level II evaluation.
 - Except as provided in section (3)(a)(F)(ii) of this rule, nursing facilities must not admit an individual without a completed and signed PASRR Level I screening form in the individual's resident record.
 - Completion of the PASRR Level I form under sections (3)(a)(A) through (3)(a)(F) of this rule does not constitute prior authorization of payment. Nursing facilities must still obtain prior authorization from the local AAA or APD office as required in OAR 411-070-0035.
 - A nursing facility may admit an individual without a completed and signed PASRR Level I form in the resident record provided the facility has received verbal confirmation from the Level I assessor that the screening has been completed and a copy of the PASRR Level I form will be sent to the facility as soon as is reasonably possible.

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- The original or a copy of the PASRR Level I form must be retained as a permanent part of the resident's clinical record and must accompany the individual if he or she transfers to another nursing facility.
 - PASRR LEVEL II. PASRR Level II is an evaluation and determination of whether nursing facility service and specialized services are needed for an individual who has been identified through the PASRR Level I screening process with indicators of mental illness or intellectual or developmental disabilities who does not meet categorical determination criteria (42 CFR 483.128).
 - Individual's identified with indicators or mental illness or intellectual or developmental disabilities as a result of PASRR Level I screening are referred for PASRR Level II evaluation and determination.
 - PASRR Level II evaluations and determinations are conducted by AMH for individuals with mental illness or by APD for individuals with intellectual or developmental disabilities.
 - PASRR Level II evaluations result in a determination of an individual's need for nursing facility services and specialized services (42 CFR 483.128-136) consistent with federal regulations established by the Social Security Act, Section 1919(e)(7)(C).
 - Pursuant to 42 CFR 483.130(l), the written determination must include the following findings:
 - Whether a nursing facility level of services is needed;
 - Whether specialized services are needed;
 - The placement options that are available to the individual consistent with these determinations; and
 - The rights of the individual to appeal the determination.
 - The PASRR Level II evaluation report must be sent to the individual or their legal representative, the individuals attending physician, and the admitting or retaining nursing facility. In the case of an individual being discharged from the

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- hospital, the discharging hospital must receive a copy of the PASRR evaluation report as well {42 CFR 483.128 (l)(1)-(3)}.
- Denials of nursing facility service are subject to appeal {OAR 137-003, OAR 461-025 & 42 CFR Subpart E}.
- RESIDENT REVIEW. Resident reviews are conducted by AMH for individuals with indicators of mental illness or APD for individuals with intellectual or developmental disabilities who are residents of nursing facilities. Based on the findings of the resident review, a PASRR Level II may be requested. {42 CFR 483.114}.
- All residents of a Medicaid certified nursing facility may be referred for resident review when symptoms of mental illness develop.
 - Resident review for individuals with indicators of mental illness that require further evaluation must be referred to the local Community Mental Health Program who shall determine eligibility for PASRR Level II evaluations.
 - The resident review form, part A, must be completed by the nursing facility. The resident review must be performed in conjunction with the comprehensive assessment specified by the AMH, in accordance with OAR 411-086-0060.
 - All individuals identified as having intellectual or developmental disabilities through the PASRR Level I screening process that are admitted to a nursing facility must receive a resident review. A resident review must be conducted within seven days if the nursing facility admission is due to an emergency situation {OAR 411-070-0043(2)(c)(A)-(C)}, within 20 days if the nursing facility admission is due to other categorical determinations {OAR 411-070-0043(2)(a)-(b)}, and annually, or as dictated by changes in resident's needs or desires
 - The resident review must be completed by APD or designee.

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- The resident review must be completed using forms designated by APD.

PASRR Central Office Contacts

- PASRR Policy:
 - Kathryn Nunley, 503-947-2309, Kathryn.m.nunley@state.or.us
- Intellectual and developmental disabilities (I/DD):
 - Rachel Olson, PASRR Level II Coordinator, Rachel.olson@state.or.us
- Serious Mental Illness:
 - Nirmala Dhar, 503-945-9715, Nirmala.dhar@state.or.us

PASRR Level II Mental Health Contacts

See Transition and Diversion SharePoint site or DT Webpage on CM tools for link to most recent contact list

Or contact Nirmala Dhar to request a current copy

Post Hospital Extended Care Benefit

411-070-0033 Post Hospital Extended Care Benefit (*Amended 12/15/2013*)

- The post hospital extended care benefit (OAR 410-120-1210(4)) is an Oregon Health Plan benefit that consists of a stay of up to 20 days in a nursing facility to allow discharge from hospitals.
- The post hospital extended care benefit must be prior authorized by pre-admission screening for individuals not enrolled in managed care.
- To be eligible for the post hospital extended care benefit, the individual must meet all of the following:
 - Be receiving Oregon Health Plan Plus or Standard, Fee-for- Service benefits;
 - Not be Medicare eligible;
 - Have a medically-necessary, qualifying hospital stay consisting of:

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- A DMAP-paid admission to an acute-care hospital bed, not including a hold bed, observation bed, or emergency room bed.
 - The stay must consist of three or more consecutive days, not counting the day of discharge.
 - Transfer to a nursing facility within 30 days of discharge from the hospital;
 - Need skilled nursing or rehabilitation services on a daily basis for a hospitalized condition meeting Medicare skilled criteria that may be provided only in a nursing facility meaning:
 - The individual is at risk of further injury from falls, dehydration, or nutrition because of insufficient supervision or assistance at home;
 - The individual's condition requires daily transportation to a hospital or rehabilitation facility by ambulance; or
 - It is too far to travel to provide daily nursing or rehabilitation services in the individual's home.
 - The individual may qualify for another 20-day post-hospital extended care benefit only if the individual has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in this rule.
 - Individuals eligible for the 20-day post-hospital extended care benefit are not eligible for long term care nursing facility or Medicaid home and community-based services unless the individual meets the eligibility criteria in OAR 411-015-0100 or OAR 411-320-0080.

Stat. Auth.: ORS 410.070, 414.065 Stats. Implemented: ORS 410.070, 414.065

Placement Choice Counseling

Introduction

Individuals in need of long-term services and supports (LTSS) often face a complicated patchwork of service options and need assistance exploring the public and private programs available to them, navigating eligibility and enrollment

requirements and weighing other factors that affect their ability to live independently.

These concepts are adapted from a range of sources, including the Administration for Community Living's *Draft National Options Counseling Standards*, various states' options counseling standards, Financial Alignment Demonstration Memoranda of Understanding and other sources. This document is not intended to be all-encompassing. As states and programs grow and evolve, additional guidance on options counseling and enrollment may be necessary.

Overview

Placement options counseling is an interactive process to help individuals make informed choices about how to access health care benefits and long-term services and supports. This process is directed by the individual (and may include others that the person chooses), and is centered on the individual's preferences, strengths, needs, values and individual circumstances.

Placement options counseling should be offered to any individual who seeks long-term services and supports, irrespective of their age, socioeconomic status or need. Priority should be given to individuals at high-risk for near-term nursing home placement.

Accessing Placement Options Counseling

An individual may need options counseling if he or she:

- Requests or indicates an interest in receiving information or advice concerning long-term support options;
- Is referred by a hospital, nursing home, assisted living home or other long-term residential setting, home and community-based waiver services provider or another agency;
- Has had a recent change in life situation, resulting in a greater need for LTSS;
- Has had a recent change in health status, resulting in a greater need for LTSS;

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- Needs assistance coordinating their LTSS and health care needs across many services and systems;
 - Has LTSS needs but is unsure about the process of accessing services or what services will best meet their preferences or needs;
 - Is requesting assistance in transitioning from one living situation to another;
 - Is admitted to the hospital and needs to know what they should be planning for once discharged;
 - Was denied eligibility for Medicaid or another public program and needs decision support about other options;
 - Lacks awareness of existing community resources and supports and could benefit from decision support and education around their options;
 - Has cognitive impairment and could benefit from support about early intervention, caregiver support, or LTSS related to dementia;
 - Has behavioral health needs and would like support on options related to their specific needs or situation;
 - Has family or caregivers who request or require additional information;

Even if an individual has received options counseling in the past, s/he may require additional options counseling as personal needs and circumstances change.

Placement Counseling Functions

The placement options counseling process is designed to educate individuals about the range of long-term services and supports available and to assist them in selecting the LTSS option that will best meet their needs. The final product of options counseling may be the development of a unique, person-centered plan of care, enrollment in a Managed Long-Term Services and Supports Plan, enrollment in a PACE program, or selection of other LTSS options. Given the unique needs of each individual, there is no single “correct” approach to options counseling. The following components, however, ensure that individuals receive comprehensive, timely, conflict-free counseling that results in a robust, person-centered plan of care.

Step 1: Assessment of goals, values and needs

Placement options counseling begins with a preliminary interview where the Diversion/Transition Coordinator can assess an individual's need for long-term services and supports, assess his/her existing supports, and explore individual strengths, values and goals. To ensure timely delivery of long-term services and supports, Diversion/Transition Coordinators should determine an individual's clinical/financial eligibility for public programs early in the process. During the initial assessment, a Diversion/Transition Coordinator will evaluate an individual's short and near-term risk for long-term nursing home placement.

Step 2: Exploring Options/Planning

Based on the individual's needs, strengths and goals, as identified in the preliminary interview, Diversion/Transition Coordinators should support individuals in considering the full range of services available to them. During the exploration phase, Diversion/Transition Coordinator should offer comprehensive, accurate, unbiased information about *all* available services. During this phase, Diversion/Transition Coordinators help participants weigh the pros/cons of various options, explore potential costs and benefits of services, and offer other decision supports. A Diversion/Transition Coordinator should not make judgments on behalf of the individual or withhold information about appropriate options.

Long-Term Care Placement Options in Oregon

- Adult Foster Home (AFH)
 - Capacity of 5 or less
 - Home-like environment
 - Provider and family often live in the home
 - Providers can obtain a designation as a ventilator home
 - Specific Needs Contracted options for consumers with higher needs

- Residential Care Facility (RCF)
 - Can have private or shared rooms
 - Community meals
 - Can be endorsed as Memory Care Community (MCC)
 - Consumer must have a dementia type diagnosis
 - Only Medicaid LTSS option that can be locked

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- Specific Needs Contracted Options for consumers with higher needs
 - Assisted Living Facilities (ALF)
 - Apartment Like setting
 - Often Private Rooms
 - Many have policies requiring the consumer to be a certain age
 - Community Meals
 - Specific Need Contract options available for consumers with higher needs

Step 3: Develop a long-term support plan

After an individual has developed a plan to meet their LTSS needs, the Diversion/Transition Coordinator should assist the individual in connecting with appropriate service providers. This may include facilitating enrollment in public programs, identifying appropriate providers, employing a fiscal intermediary such as money management program or rep payee and other services. If there is a delay in finding placement, inability to access skilled care benefits or that crisis situations call for immediate intervention, Diversion /Transition Coordinator may authorize short term Nursing Facility (ICF level) stay while continuing to seek Home or Community Based placement options for the consumer.

Step 4: Follow-up

Diversion/Transition Coordinators should monitor consumers for 90 days after their placement which includes periodic follow-up to ensure that individual needs are being met, to modify the transition plan as necessary and to ensure quality. Follow-up should take place soon after an individual's plan is activated, but also consistently over the 90day monitoring period as an individual's needs and circumstances may change or as other wrap-around service needs are identified.

Diversion/Transition Coordinator Competencies

Diversion/Transition Coordinators shall be knowledgeable, experienced, trusted, and compassionate individuals. A highly skilled Diversion/Transition Coordinator listens to individuals to identify their needs and goals, supports them as they weigh their options, connects them with the right type of care in the right setting,

and anticipates and prevents problems with care delivery. Individual Diversion/Transition Coordinators should have knowledge about:

- Issues confronting older adults and individuals with disabilities;
- The full range of long-term service and support options available in a community;
- Eligibility requirements of Medicaid services, potential placements, and wrap arounds services including but not limited to contracted placements, KPlan Ancillary Services, local community programs, Long Term Care Community Nurse, etc.
- Related and relevant public policies and programs including exceptions, behavioral supports, programs offered through the local county.

Adopted from the: National PACE Association

Care Coordination

Diversion/Transition Coordinators shall work with the consumer, Nursing Facility staff, HCBS providers, key medical professionals, authorized individuals who the consumer has identified as a natural support, rep-payees, authorized reps, guardians, and other key members of the consumers care team to develop a sound discharge plan into an in-home or community-based care placement.

OAR's which support your worker and for you to reference:

- 411-070-0040: APD/AAA staff must have immediate access to APD consumers and their facility records, right to interview APD consumers, and to participate in facility staffing.
- 411-086-0060: NF responsibility to assess consumer's discharge potential and develop a care plan to include discharge planning.
- 411-086-0240: NF Social Services staff must education the consumer and their significant others about the potential for discharge and availability of alternate living situations. The facility must coordinate services required for consumer discharge

Diversion/Transition Coordinators are responsible for using all resources available to them to initiate wrap-around services and supports including but not limited to:

- Transportation of consumer and their belongings
- Behaviors Supports Services
- Long Term Care Community Nursing
- Adult Day Services
- Durable Medical Equipment
- Assistive Devices
- Chore Services
- Home Modifications or Repairs
- Transition Services such as household items, furniture, personal items, moving costs, ID replacement
- Diversion purchases that are not covered under other payment options
- Connection to community resources

Durable Medical Equipment (DME) Best Practice Resource

- Review Transmittal IM-08-055 titled:
Guidelines for SPD Transition Coordinators and Case Managers In Facilitating Authorization of Durable Medical Equipment for Clients
- DME Pre-discharge planning:
 - Attend care conferences with NF or Hospital to help plan discharge
 - Identify with care team what DME is required for the consumer to return home or go to new community placement.
 - Nursing Facility or hospital staff are responsible for obtaining doctors' orders
 - Diversion-Diversion/Transition Coordinator is responsible for ensuring consumer has all DME needed to return home, or contingency plan if returning before all DME is delivered.
- For consumers enrolled with CCO:
 - Close communication maybe necessary to allow for approval for items in anticipations for discharge.

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- If the CCO refused to provide necessary DME because consumer is discharging to another area contact the Transition Services Analyst to staff the case.
 - For fee-for-service consumers:
 - Health Services Division (HSD – formally known as DMAP) has an exceptions process. Request for exceptions should come from the consumer’s provider. A DME supplier or prescribing practitioner can ask for an individual medical appropriateness review (exception) who will need to provide documentation from the client’s doctor, the prescriber of the device or supply, that supports criteria in OAR 410-122-0080(20) have been met for an exception.
 - If item has been denied by insurance, unavailable through local DME vendor, is uncovered by insurance or consumer does not meet coverage criteria then Diversion/Transition Coordinator can complete a KPlan request under Assistive Devices.
 - Transition and Diversion funds through KPlan or OSIPM Special Needs are only available if the above resources cannot meet the need.
 - Monitoring best practices for consumers with new DME or Assistive Technology:
 - D/T Coordinator is responsible to complete an in-person monitoring visit within the first week after discharge and should look for the following:
 - All items have been delivered to consumer
 - All items are in working order
 - All items are set up and installed properly
 - Identify and coordinate acquisition any additional DME or Assistive Devices that could further improve the consumer’s safety and independence:
 - Weighted utensils
 - Transfer devices
 - Movement detectors
 - Plate switch
 - See Assistive Technology Guide for additional examples

Tracking in Diversion/Transition Database

- Tracking is mandatory for both AAA and APD D/T teams.
- Enter every case you work on – the database will sort type of move it was.
- The new database will supply necessary information for Central Office staff to monitor the barriers and trends across the State allowing Central Office staff to propose changes to ongoing policies and procedures and increase the probability of successful outcomes.
- Every office may request reports from the Transition Services Analyst to assist with local goals, QA purposes or for funding proposals.
- Enter consumer information as soon as you are assigned a case.
- To do so go to the DATABASE tab on the Transition – Diversion SharePoint webpage.
 - If you do not have access to SharePoint please refer to the SharePoint section of this manual to obtain access.
- Enter all the information you have available about the consumer initially.
- Best practice is to update information on cases every week, as applicable.
- There will no longer be an approval or denial of each case – this information will be obtained through sorting options available to Central Office through the database.

Entry Instructions:

Please refer to the DT Document Library on Share Point to access the most recent versions of the following documents coon database entries:

- DT Database Specific Instructions: provides step by step explanation of each question asked in the database.
- DT Database FAQ: answers commonly asked questions about the DT Database.
- DT Database Views Instructions: provides instructions on how to set up personal views for management of local entries.

Various Types of Moves

Statewide each AAA and APD Diversion/Transition team has a different process, geographical setting, a wide variance in number of hospitals, nursing facilities and capacity for placement in community-based care or in-home settings. Each team continually evaluates their processes and resources to discover new and innovative ways to meet the specific needs of their area. When given the opportunity to connect with a different team, it may be helpful to take time to share common practices of your area and to learn about the other team's processes, strengths and needs.

***“Trust, assume positive intent, live believing in yourself and other people.
Positive energy is contagious” – Mary-Frances Winters***

County to County Diversion/Transition Guidelines

Please refer to Transmittal PT 03-035 titled: Case Transfer Protocols for Service and Financial Cases. While some of the references are outdated – the protocol remains relevant and is considered standard operating policy.

In addition to the protocols referenced above there are statewide best practices developed by the D/T Best Practice team comprised of both AAA and APD local leadership and Diversion Transition Coordinators for all county to county diversions or transitions

PURPOSE

County to County coordination is a part of the person-centered planning process, which includes the CMS waiver requirement to identify risks and interventions. This process will identify available resources to meet identified risks/needs and seek to mitigate transfer stress for the client. The goal is for successful placement and transfer of cases between branches. Coordination

between counties will ensure a safe, smooth transition for clients from one setting to another.

Definitions:

Best Practice: Actions that create the best results for all parties involved, with a focus on person-centered planning for the Oregonians we serve as a team.

Expectations: Actions that are expected of the identified position

Receiving D/T Coordinator: The member of the Diversion/Transition team who will coordinate transition services with the sending D/T Coordinator and assist with monitoring duties after the consumer has moved into the receiving worker's county.

Receiving CM worker: The worker the sending D/T Coordinator connects with if the receiving county wishes the ongoing Case Manager to assume coordination and monitoring duties.

Sending D/T Coordinator: The member of the D/T team who is coordinating the transition or diversion for the consumer who is moving to a different county.

Standard CBC Placement:

This is the expectation for all transitions and diversions from one county to another:

Prior to Transition or Diversion:

- Sending D/T will open the Transition Team Contact List located on the [Diversion/Transition webpage](#) and identify the person(s), highlighted in yellow, to contact.
- Sending D/T will call one of the receiving county's identified persons found on the D/T contact list
 - To request that they identify a receiving D/T or CM and their manager who will be responsible for staffing the case.
 - This should be done at least 3 days prior to discharge date.
 - If no answer, leave message and send an email with the same request.
- Receiving office will respond to these requests within 2 business days providing the name of a D/T or CM and their manager who the sending D/T can coordinate the transition or diversion with.

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- Sending D/T will coordinate a call with receiving D/T or CM to discuss the following:
 - Date of Move
 - Placement information
 - Reason for out of county move
 - Transportation
 - Durable Medical Equipment/Assistive Devices
 - Household and personal items a consumer may need
 - In-Home items including furniture, clothing, cleaning supplies, basic food necessities, locks, etc.
 - AFH, ALF, RCF items that the provider is not required to provide
 - Wrap-around services
 - BSS
 - LTCCN
 - Exceptions
 - MH
 - Insurance/PCP/Health Care Provider Concerns
 - Medication supplies
 - The receiving office will share the following information:
 - APS or Licensing concerns about provider
 - Coordination questions
 - Any resources they think would make the transition/diversion successful
 - Both parties will agree on who will be responsible for required in-person visits that and follow up actions that must be taken within the first 90 days.
 - If errors occur or wrap-around services are not completed both parties should work together as a team to resolve.
 - The sending office is responsible for taking the lead on resolution
 - Unless there is a restriction of admission or other sanctions limiting admissions on the potential provider the receiving office cannot prevent the move as it is the consumer's right to choose where they receive services.
 - If the receiving office does not respond to the request for the conference call by the 3rd business day, the sending D/T will summarize the information in #4 and email it to the identified persons at the local office and move forward with the diversion/transition.
 - The sending D/T worker will continue to send follow up emails as needed.

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- The sending TC is responsible for 90 days remote monitoring as follows:
 - Minimum phone check-in and narration review at 7th, 30th, 60th, 90th day
 - If in-person visit is needed, negotiate with receiving office
 - Ensuring wrap-around supports are in place
 - Trouble shooting that can be done remotely
 - If a move out notice is issued during the 90 days both parties will work together on a plan to stabilize or divert the consumer.

Specific Need Contracted Placement – Additional Responsibilities

- Identifying an ongoing CM or receiving CM or DT (for out of county moves) is an essential part of the contract case coordination.
 - If the case is staying within your district or county you need to identify the ongoing CM or ongoing CM leadership who will be available to staff the case and be part of Care Planning Team meetings once the placement is approved by Central Office.
 - If the case is leaving your county or district, please follow the guidelines referenced suggested in the county to county transition section above.
- Most contracts state that the transition or diversion cannot occur until a Care Planning Team meeting, also referred to as the Transition Care Conference, has occurred.
 - Contracted placements are not meant to be emergency placements and Central Office understands that health and safety needs are an integral part of person-centered care.
 - If there is an identified and documented health or safety need requiring a quick placement, please staff with your leadership or Complex Case Team in Central Office.
 - The Care Planning Team meeting shall include the following participants:
 - What is required by the providers contract; or
 - If the provider’s contract does not define who is required to be there the minimum in attendance shall include:
 - Current provider or member of their caregiving team familiar with the consumers’ care needs
 - New provider
 - Sending D/T
 - Consumer or consumer’s representative

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- If at any time a CM or D/T worker has a concern about a contracted provider please contact the appropriate entities such as APS or Licensing and then the contract team at specific-needs.contract-team@dhsosha.state.or.us
 - The SNC team will forward any RCF or ALF concerns to the SOQ licensors at Central Office if they are sent to the email above.
 - If a contracted provider approves 2 or more consumers for only one available placement – please contact the contract team.

Specific Need Contracted Placements

Webpage on CM Tools: [Specialized Services/Specific Needs Contracts](#)

The SPD 0494 form is used by field staff to seek approval from Central Office prior to the placement of a consumer into a Specific Needs Contracted AFH, ALF or RCF.

- Before completing the 494, document the following in OR Access:
 - Past failed placements and attempts at finding placement including the date, provider name and reason for refusal. Or any extenuating circumstances that indicate the consumer cannot access care in a standard in-home or CBC placements
 - Date the contracted provider with a current contracted vacancy screened and accepted the consumer.
 - Describe how the consumer meets the Target Group of potential provider's contract type. Email contract team for narration examples.
- Complete Section 1 of 494 in its entirety.
 - CAPS must be completed within the last 3 months or with change of condition – whichever is more recent.
 - If a new CAPS is needed to meet this requirement, Buckley Bill process must still be followed or waived by consumer or the consumer's representative.
 - For in-district transitions the D/T will identify the ongoing CM who will be assigned to the case and enter their contact information under receiving DT/CM
 - For out-of-district transitions the D/T will contact the receiving D/T or CM team to identify the best contact for coordinating transition details

within their district and enter the identified contact information under receiving DT/CM.

- Complete Section 2 of 494 in its entirety

- Check boxes to confirm actions in this section are complete.

If you are being asked to submit a 494 by a provider or other sources and you cannot confirm one of these actions within the section have been completed, please do not check the box. Explain the situation in the body of the email when you submit the 494 so the reviewer knows it was left unchecked intentionally and why.

In situations without extenuating circumstances listed above, it is best practice to have verified all actions have occurred and that the boxes are checked to reflect that – otherwise the form may be returned as incomplete.

- Verify documentation can be found in OR Access Narration, CAPs and Client Details which support the consumer’s eligibility for admission into the SNC placement.

- Submission of 494:

- Best practice for workers new to the process is to have a member of local leadership team to review for the following information:

- Appropriateness of and reasoning behind the placement.

- Verify the required information can be found in OR Access.

- 494 is completed in its entirety.

- Diversion/Transition Coordinator shall email request to APD.Admissions@state.or.us with 494 attached.

- Email should be sent securely using “494 request” in the subject line.

- Urgent requests should be flagged and have the word URGENT in the subject line

- Central Office strives to respond within 2 business days

- If approved, D/T to assist with the completion the care planning team meeting, appropriate transition planning and admission of consumer.

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- If denied due to error, 494 can be resubmitted once corrected.
 - Case Transfer Protocol per PT 03-035 shall be followed. County to County best practices are also a good resource to ensure that the consumer's wrap around services are in place and that the placement is stable.

512 Instructions: to be completed upon admission

These apply to all AFHs and the following CBC facilities: The Bridge, MacDonald Res, Orchards, and Fircrest. All other CBC facilities have the rate set up already.

- After the 512 payment has been set up the DT/CM will:
 - email: APD.Admissions@state.or.us with
 - Consumer's name, consumer's prime, provider name, provider number and effective date.
 - In the email subject line, type "rate adjustment request".
- The DT/CM will receive an email back stating that the specific need rate has been added with instructions to "touch" the 512.
- If the request is not sent during the same month as admission, an underpayment will need to be completed for the months that the provider did not get the contracted rate. The local office will be responsible for completing all underpayments.

Resources:

- Specialized Services/Specific Needs Contract webpage – found in Case Management Tools
- Flow chart reference for new admits and renewals.
- Questions contact the following:
 - Admission questions or payment issues: apd.admissions@dhsoha.state.or.us
 - Concerns about a SNC provider: specific-needs.contract-team@dhsoha.state.or.us
 - Providers interested in SNC: APD.SpecificNeedContractApplications@dhsoha.state.or.us

Specific Need Contract Admission/Discharge/Target Group Reference Sheet For Adult Foster Homes

The following information is pulled directly from the standard templates for Adult Foster Home Contracts negotiated by the Collective Bargaining Agreement. All other types of contracts (RCF, ALF, ECF) are negotiated individually without representation of a union.

Eligibility & Admission Process:

- (a) Contractor shall notify the DHS Designee of all inquiries or referrals of potential placements and provide the DHS Designee with sufficient time for assessment and determination of approval for admission.
- (b) Contractor shall screen all potential placements and obtain nursing consultation, as needed, to determine appropriateness of placement.
- (c) All persons eligible for Specific Needs Services must meet the Target Group definition and be eligible for DHS services under the currently funded service priority levels in Long-Term Care Service Priorities for Clients served under OAR 411-015-0000 through 411-015-0100.
- (d) All Medicaid placements must be prior approved by DHS, through the “494 process.” Placements not prior approved will not be reimbursed under this Contract.

Discharge Process:

- (a) No Client served under this Contract may be discharged from the home without the prior review and approval by the DHS Designee and the Client’s Care Planning Team.
- (b) Contractor shall ensure that the Care Planning Team has been convened in a timely manner and has documented attempts to provide supports needed to maintain the Client’s placement in the home. If the Client’s needs cannot be addressed or if the Client wants to move voluntarily, then the Care Planning Team must develop a discharge or transition plan to support the Client. Documentation of Care Planning Team efforts must be completed prior to and attached to any move out notice required under licensing rules.

(c) Clients approved for admission under this Contract do not have to be discharged if they no longer meet Target Group criteria. As long as they continue to receive comparable services, they may remain in the home at the specific needs contracted rate under this Contract.

(d) Involuntary moves, transfers and discharges must be in accordance with the DHS Adult Foster Homes Administrative Rules OAR 411-050-0645.

(e) Contractor shall complete a Form 492 “Resident Discharge Report Specific Need Contract” documenting all discharges.

Target Group: for purposes of AFH Contracts, means the population of Individuals who meet the following documented criteria, upon admission:

Basic SNC AFH Target Group:

- Eligible for Medicaid Long-Term Care Services per OAR 411-015.
- Currently residing a nursing facility or is being diverted from nursing facility placement.
- Documentation verifying that there is no access to a home or community care located in the community or unsuccessful placement in standard APD Community Based Care (CBC) settings.
- Requires full assist in mobility, toileting, eating, or cognition; and
- On a daily basis, requires more than one direct staff for mobility, transfer, toileting or other ADL care; or
- Behavioral management requiring daily staff interventions, redirection or cuing and establishment of Behavior Support Services (BSS).

Advanced SNC AFH Target Group:

- Eligible for Medicaid Long-Term Care Services per OAR 411-015.
- Currently residing a nursing facility or is being diverted from nursing facility placement.
- Documentation verifying that there is no access to a home or community care located in the community or unsuccessful placement in standard APD Community Based Care (CBC) settings.
- Requires full assist in mobility, toileting, eating, or cognition;
- On a daily basis, requires more than one direct staff for mobility, transfer toileting or other ADL care 24/7; and

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- Meet at least one of the following:
 - Dangerous behavior which has resulted in hospitalization, criminal charges or caused injuries to self or others;
 - Physical or sexual aggression to staff or individuals;
 - Disruptive or agitated behaviors which occur several times a week;
 - Verbally abusive behaviors to staff or individuals which occur several times a week;
 - Refuses medications or health care services creating legal or healthcare risks to themselves or other individuals;
 - Has a Rehabilitation Plan developed and reviewed on a twice a year basis by licensed therapists and which requires daily interventions by trained caregivers;
 - Has complex medical, rehabilitation or psycho pharmacy regime requiring On-Site RN services more than once a week.

Complex Activities of Daily Living (ADL) SNC AFH Target Group

- Currently is residing in a nursing facility or is being diverted from nursing facility placement and;
- Eligible for Medicaid Long-Term Care Services per OAR 411-015 and;
- Require full assistance in one or more of the following ADL tasks mobility, transfer, toileting or eating and;
- Requires multi-person “hands on” ADL care or 2 person transfers on a daily basis and;
- Requires weekly onsite monitoring or assessment by a RN and
- One or more of the following:
 - has a Rehabilitation Plan which requires daily interventions by trained caregiver(s) or
 - requires weekly contact with primary care provider for an unstable medical condition or
 - is enrolled in Palliative or Hospice Care with a terminal diagnoses

Bariatric SNC AFH Target Group

- Currently residing in a nursing facility or is being diverted from nursing facility placement;

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- Eligible for Medicaid Long-Term Care Services per OAR 411-015, at the time of admission;
 - Require full assist in mobility, toileting, eating, or cognition;
 - Has an ADL, medical or behavioral need requiring an Available, On-Site second staff 24/7;
 - Cannot be served in another home or community-based care Setting; and
 - Has at least one of the following:
 - A physician’s diagnosis of obesity with a body mass index calculation of 38 or greater on the date of admission: or
 - A deteriorating medical condition requiring weekly contact with a physician on a continuing basis e.g. Hospice Care; or
 - Have a health condition such as Tracheotomy, Ventilator Dependence, Renal Failure or uncontrolled Methicillin-resistant Staphylococcus Aureus (MRSA) type infection which requires:
 - Complex care coordination;
 - Durable Medical Equipment (DME);
 - Onsite RN services of more than once a week; and
 - Interdisciplinary health team supports.

RCF, ALF, and 3 older AFH contracts have been negotiated on an individual basis. Their criteria can be found within their individual statement of work on the [Specialized Services/Specific Needs Contract](#) webpage.

After 12/31/2019 – all Neurological AFH Contracts will be transitioned to “Basic” or “Advanced”.

Care Planning Team & Transition Care Conference

Care Planning Team: the team made up of the following persons:

Diversion/Transition Coordinator, Contractor’s Registered Nurse (RN), the Client and/or the Client’s designated representative, and the Contractor. The Care Planning Team may expand the list of invitees as deemed necessary to include other parties; however, these additional parties are not mandated to attend under this Contract. Attendance may be done in person or by phone.

In most contracts the Care Planning Team is required to meet prior to admission to ensure safe and comprehensive transition plan is in place this is referred to as the Transition Care Conference. A transition Care conference is best practice for any transition or diversion.

In all contracts the Care Planning Team is required to meet prior to a contracted provider or any staff employed by the provider issuing a move out notice or states the consumer cannot return to the AFH under the contract.

Unexpected Consumer Moves

Unplanned Consumer Move/Case Transfer:

The goal in these situations is to work collaboratively with offices throughout the state to make a transition as seamless as possible for our consumers. Cases that cross county lines will involve more collaboration and communication between offices to ensure that the consumer is being served in the most effective way. In many situations, this means that a case will be transferred to the county where the client is physically residing regardless of where they would like to move to. The reason for the case transfer is continuity of care for the resident and better communication with the facility who already has a working relationship with a local TC. These situations may include: if it is going to be more than a couple of months before the client is ready to transition, if there are no feasible options for the client to return, or if there are things that need to be done that would be difficult to do from a distance, like an exception.

Courtesy Pre-Admission Screening:

Each county has a varying process to how PAS are assigned to consumers within their county as well as how a courtesy PAS is assigned. Please follow these best practices to ensure as smooth as possible interaction between all parties. In this situation we will refer to the office where the case is housed as the “home office”.

- Often the NFs and Hospitals will forget that they won't be working with the staff from the office in their area.

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- communication between offices helps provide a consistent message to the NF or Hospital regarding who is responsible for what actions on the case.
 - If you are the county (home office) requesting the courtesy PAS please follow up with worker assigned to discuss the case and preferred communication approach.
 - If you are the county performing the courtesy PAS please keep the home office up to date on your actions on the case.
 - If the nursing facility or hospital contacts you to take action on the case other than the PAS – please refer them to the contact at the home office.

FAQs on county to county moves and contracted placements

- Is a case staffing with the receiving office required prior to placement?
 - For standard CBC or in-home placement this is a best practice and is not required to happen prior to placement.
 - For contracted CBC placement it is a required part of the 494 process.
- I have been referred to an ongoing Case Manager to staff the case and am not getting a response or they do not seem to understand the purpose of my call.
 - If they do not understand the purpose of your call – explain your role as D/T Coordinators and that you need to ensure a successful transition or diversion for your mutual consumer.
 - If you are not getting a response be sure to include your leadership and their leadership in your next follow up email.
 - If you do not know who their manager or supervisor is please contact the local leadership in that area from the D/T contact list or ask your leadership for assistance.
 - If that is not successful, notify the Transition Services Analyst to assist with coordination.
- After I staffed the case with the receiving office prior to admission and then the placement was denied or blocked.
 - Important information that the receiving office could share includes: :

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- Concerns they have regarding provider's ability to serve the consumer, including APS or Licensing issues.
 - Additional wrap-around services they think is necessary for a well-planned person-centered transition or diversion
 - Any other helpful information that would benefit the sending D/T and the consumer.
 - A receiving office cannot "deny" a placement unless there is a restriction of admissions or sanctions on the CBC facility or AFH. The provider has the right and responsibility to screen and accept consumers into their facilities and consumers have the right to choose their placement.
 - Often the office has experience with the incoming case and is just wishing to express their concerns in order to promote a successful placement based on their past experiences.
 - This seems like an excessive step in some of our easier placements.
 - Even for easy placements, moving is stressful for consumers as well as staff. Connecting with the receiving office to ensure they are aware of the move is important for a smooth transition and supports a person-centered approach.
 - Feedback from receiving offices indicates that, even with easy placements, the transition will be smoother for both the consumer and the 2 offices when it is staffed, compared to cases that have not been staffed.
 - Contracted placement staffing between sending and receiving staff is required as part of the 494 process.
 - Providers are soliciting new placements even when their AFH or facility is under investigation for APS allegations or Licensing violations or prior to their contract being executed, or when they do not have vacancies. How do we share this information with other counties?
 - Contact local AFH licensing or Central Offices CBC licensing team to inform them of the concerns.
 - Additional information found on the LTC licensing webpage can be helpful to review when looking at placement options for consumers.
 - <https://ltclicensing.oregon.gov/>

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- Post substantiated or verified information on the Announcement section of SharePoint
 - Discuss concerns when you are contacted for a case staffing
 - Contact the Specific Needs Contract team at specific-needs.contract-team@dhsosha.state.or.us
 - How do we follow these guidelines when a hospital or other facility places a consumer that a Diversion/Transition Coordinator is actively working without notifying the D/T Coordinator?
 - Narrate that this happened.
 - Email the receiving local office D/T contact as soon as possible and request a staffing.
 - If the consumer is placed into an ICF setting and authorization was not given through the PAS process, the NF could potentially face non-payment until the PAS is complete and authorization is given.
 - Check in with the new provider to see if consumer's needs are being met and if any additional wrap around services are needed.
 - Additional Questions: contact the current Transition Services Analyst, Complex Case Coordinator, or Specific Needs Contract Team.

County to County Transition Best Practice Checklist

Please refer to D/T webpage on Case Management staff tools or SharePoint's DT document library for interactive or printable copies.

- **Standard Placement: Sending D/T**

- Provider accepted consumer
- At least 3 days prior to discharge – identify receiving D/T or ongoing CM contact
- Staff case with receiving CM or D/T contact
- Discuss wrap around service
- Negotiate monitoring duties
- Send recap email to receiving D/T or CM and their manager
- Monitor consumer for 90 days

- **Receiving Office**

- Respond to initial request within 2 business days

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- Identify the D/T Coordinator on Ongoing CM and their manager who will be responsible for the case
 - Coordinate and staff case with sending D/T or CM

- **Staffing Topics**

- Anticipated Diversion or Transition Date
- Placement Information
- Reason for out of county move
- APS or Licensing or other concerns about provider
- Transportation arrangements
- CCO or medical provider concerns
- Durable Medical Equipment/Assistive Devices
- Behaviour Support Services (REFERRAL RECOMMENDED FOR EVERY MOVE)
- Long Term Care Community Nurse (if applicable)
- Exception details and in-person visit requirements of exception
- Mental Health Services (if applicable)
- Doctor's Orders and Medication
- Any other applicable information
- Monitoring visits – what in-person visits are needed (receiving D/T or CM) and what monitoring can be done remotely (sending D/T)

- **Communication Barriers**

- 1st attempt via phone and email follow up – requesting staffing
- 2nd attempt via email – requesting staffing, include managers/supervisors
- 3rd attempt via email – summarizing case, include managers/supervisors
- If no response after 3rd attempt notify leadership and Transition Services Analyst

- **Specific Needs Contract Placements**

- Includes offices within your own county or district
- Identify receiving D/T or CM
- Submit 494 for approval
- Follow steps above under Standard Placement
- Work with provider to plan Transition Care Conference

- Sending D/T in attendance at Care Conference
- Receiving D/T or CM or alternate at Care Conference
- Cover staffing topics listed above during Care Conference
- Consumer admits after Transition Care Conference

Payor Source Best Practices

Payor Source by Situation Type:

Below are 3 scenarios and the payment options (in order) the field can use to obtain items or services for consumers. Please use this as a best practice tool to guide your decision-making process when making purchases for consumers.

The items and services listed are applicable only if the consumer meets the eligibility criteria described in OARs and program manuals/guides.

New or ongoing LTSS consumer NOT transitioning or diverting

1. Insurance (MAGI & OSIPM)
 - a. Durable Medical Equipment
 - b. Medical Supplies
 - c. Flex Funds
 - d. Intensive Case Management Services

2. KPlan Services not related to transition services (MAGI & OSIPM)
 - a. Assistive Technology W1 - local limit \$500
 - i. Alarms
 - ii. Sensors
 - iii. Durable Medical Equipment
 - iv. Lift Chairs
 - b. Chore Services CO Approval
 - c. Environmental Mod CO Approval
 - d. Extended Emergency Response System See KPlan guide

3. Special Needs funding (OSIPM only) – See OSIPM manual for coding instructions and funding limits

- a. Food for guide dog/assistance animals
- b. Laundry Allowance
- c. Home Repairs
- d. Moving Costs
- e. Property Taxes
- f. Community Based Care
- g. Accommodation Allowance
- h. Special Diet Allowance
- i. Supplemental Communication Allowance
- j. Personal Incidentals and Room and Board
- k. Prescription Drug Co-Pay Coverage
- l. In-Home supplement

Transition consumers: those moving from an institution (Examples: Oregon State Hospital, Skilled Nursing Facility, Intermediate Care Facility) into the community

1. Insurance (MAGI & OSIPM)

- a. Durable Medical Equipment
- b. Medical Supplies
- c. Flex Funds
- d. Intensive Case Management Services

2. KPlan Services (MAGI & OSIPM)

- a. Assistive Technology Code W1 - \$500
 - i. Alarms
 - ii. Sensors
 - iii. Durable Medical Equipment
 - iv. Lift Chairs
- b. Chore Services CO Approval
- c. Environmental Mod CO Approval
- d. Extended Emergency Response System See KPlan guide
- e. Transition Services
 - i. Move-In Code W3
 - ii. Household Purchases Code W4
 - 1. see KPlan guide for limits

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- iii. Moving Costs Code W5
 - 1. \$1000 local limit
 - iv. CBC & In-Home visits (tours) Code W6

f. Transition Services requiring CO Approval not listed in the guide

i. OAR: 411-035-0075 Section 7: The following services and expenses must be pre-authorized by the Department's Central Office:

1. Purchases that exceed the monetary limits described in this rule.
2. Approval for expenses that occur greater than 30 days after the transition period.
3. Items required to re-establish a home not identified in this rule.
4. Other necessities not identified in this rule that are required for a consumer to transition from a nursing facility or the Oregon State Hospital.
5. Transportation for community-based service setting tours that require overnight travel.
6. Payment of past rent or utility bills in which a consumer was more than one month behind.
7. Transportation costs for the individual to transition from a nursing facility or the state hospital to a home or community-based care setting. This may include attendant services and transportation out of state.

3. Special Needs funding (OSIPM only) - See OSIPM manual for coding instructions

- a. Food for guide dog/assistance animals
- b. Laundry Allowance
- c. Home Repairs
- d. Moving Costs
- e. Property Taxes
- f. Community Based Care
- g. Accommodation Allowance
- h. Special Diet Allowance
- i. Supplemental Communication Allowance
- j. Personal Incidentals and Room and Board

-
- k. Prescription Drug Co-Pay Coverage
 - l. In-Home supplement
4. Special Needs funding (OSIPM only) - Community Transition Services – code 49 only
- a. Use only when the item is not covered by one of the 3 options above
 - b. OAR 461-155-0526

Diversion consumers: those being diverted from an institution into the community. For example: currently in a hospital, failed placement, or experiencing homelessness where ICF or other institutional placement is a potential risk

1. Insurance (MAGI & OSIPM)
2. KPlan Services other than transition services (MAGI & OSIPM)
 - a. Assistive Technology local limit \$500
 - i. Alarms
 - ii. Sensors
 - iii. Durable Medical Equipment
 - iv. Lift Chairs
 - b. Chore Services CO Approval
 - c. Environmental Mod CO Approval
 - d. Extended Emergency Response System See KPlan guide
3. Special Needs funding (OSIPM only) - See OSIPM guide for coding instructions
 - a. Food for guide dog/assistance animals
 - b. Laundry Allowance
 - c. Home Repairs
 - d. Moving Costs
 - e. Property Taxes
 - f. Community Based Care
 - g. Accommodation Allowance
 - h. Special Diet Allowance
 - i. Supplemental Communication Allowance
 - j. Personal Incidentals and Room and Board
 - k. Prescription Drug Co-Pay Coverage
 - l. In-Home supplement

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4. Special Needs funding (OSIPM only) - Diversion Services – code 59 only
 - a. Use only when the item is not covered by one of the 3 options above
 - b. OAR 461-155-0710

- Submitting questions
 - KPlan Payment or provider enrollment questions – send to KPlan.Requests@dhs.ohastate.or.us
 - KPlan Policy questions – send to Margaret.May@dhs.ohastate.or.us
 - Special Needs Transition or Diversion questions – send to Amy.Gordin@dhs.ohastate.or.us
 - Other Special Needs questions – send to APD.MedicaidPolicy@dhs.ohastate.or.us
 - CCO/DME/OHA questions or concerns – send to Amy to facilitate discussion with OHA
 - Supervisor for Transition Services – send to Sandra.J.Yoro@dhs.ohastate.or.us

Choosing the Best Payor Source Cheat Sheet

Please follow this in order to determine the best payor source to obtain the items your consumer needs for a safe move. Underlined items are linked to online guides or OARs.

Please review these OARs or Guides to ensure consumer eligibility before using.

1. Is it covered by insurance?
 - a. Yes – use this payor source
 - b. Yes – but denied. Reach out to CCO and find out reasons why and re-submit if consumer meets criteria
 - c. Yes – but DME company can't or won't provide it. Reach out to CCO for assistance
 - i. Email Amy Gordin name of DME company and item trying to buy and reason for refusal – attach any correspondence or documentation you may have.
 - d. No – Go to #2
2. Is there a community resources or natural support that can cover this cost?

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- a. Yes – use this payor source
 - b. No – Go to #3
 3. Is it covered by KPlan? (MAGI and OSIPM consumers)
 - a. Review KPlan Guidance or OAR 411-035 for eligibility information
 - b. Yes – use appropriate section (I – v are for any situation, vi – vii are for transition only)
 - i. DME = Assistive Tech, other
 - ii. Alarms or Sensors = Assistive Tech
 - iii. Chore Services
 - iv. Environmental Mod
 - v. Emergency Response
 - vi. Transition Services (Move In, Household, Moving, Tours)
 - vii. Other services including out of state move or attendant services: 411-035.0075.7.g
 - c. No – go to #4
 4. Is it a diversion to an in-home plan that meets Community Based Care Transition Services OAR 411-037? (OSIPM & MAGI)
 - a. Yes – use this payor source – Same W Codes you use for KPlan Transitions
 - b. No – go to #5
 5. Is it covered by Special Needs other than Transition/Diversion funds? (OSIPM only)
 - a. Yes – use that payor source
 - b. No – go to #6
 6. Is it covered by Special Needs under Transition or Diversion rule? (OSIPM only)
 - a. Yes – use appropriate code
 - i. Transition = 49
 - ii. Diversion = 59
 7. No – staff with your local leadership or Transition Services Analyst for other options.

Medical Insurance – CCO Concerns

If you are struggling to effectively connect with the consumer's CCO consider making a referral for CCO Intensive Case Management services.

If you are unable to resolve your concern please refer the case for Complex Case Coordination. The CC team is able to collaborate with other CCO entities and can be used for issues other than placement searches.

Consider posing your question or concern as a discussion on SharePoint to gather input from other workers.

KPlan

KPlan Ancillary Services Guide

Follow [link](#) for copy of the guide (9/27/18)

KPlan OAR: 411-035: Additional information not found in the Guide.

411-035-0075 – Section 7:

The following services and expenses must be pre-authorized by the Department's Central Office:

- Purchases that exceed the monetary limits described in this rule.
- Approval for expenses that occur greater than 30 days after the transition period.
- Items required to re-establish a home not identified in this rule.
- Other necessities not identified in this rule that are required for a consumer to transition from a nursing facility or the Oregon State Hospital.
- Transportation for community-based service setting tours that require overnight travel.
- Payment of past rent or utility bills in which a consumer was more than one month behind.

-
- Transportation costs for the individual to transition from a nursing facility or the state hospital to a home or community-based care setting. This may include attendant services and transportation out of state.

Special Needs Payments

[OSIP Program Manual](#) - H. Special Needs - Updated 7/1/18

Please follow link above to manual for most updated information

Overview

- Special needs are needs not included in the basic standard. They may be one-time needs or ongoing needs.
- Ongoing special needs are needs that last several months at a consistent cost. Examples are special diets and accommodation allowances. [461-155-0010](#) is used to determine how special needs are considered for each program.
- To be eligible for a special need item, clients must have no other available resources in the community or in their natural support system to meet the need.
- To be eligible for a special need item, clients must not be eligible for the item through Medicare, Medicaid or any other medical coverage.
- Clients may be eligible for an ongoing special need item if providing the ongoing special need item is authorized in lieu of additional provider service hours pursuant to [411-030-0002](#) through [411-030-0090](#) and is more cost-effective.
- The Department will authorize payment for one-time and ongoing special needs for the following, in accordance with the policies in this section:
- One-time needs for the following:
 - [Home repairs](#)
 - [Moving costs](#)
 - [Property taxes](#)
 - [Community transition services](#)
 - [Community based care room and board](#)
 - [Community transition services](#)

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- Ongoing needs for the following:
 - Food for guide dogs and special assistance animals
 - Laundry allowance
 - Personal Incidentals and Room and Board Allowance
 - Accommodation allowance
 - Special diet allowance
 - Supplemental Communication allowance
 - Prescription Drug Co-pay Coverage
 - In-Home Supplement
 - Special needs are items that are not included in the basic standard for each program. They may be one-time needs or ongoing needs. 461-155-0500

Spots Card Purchases

Refer to information on SharePoint Site for APD consumer purchasing process information

Refer to information on the OFS website to find all OFS policy and procedural information.

DME and Assistive Technology Purchases

Transmittal IM-08-055 is currently being updated and contains useful information about obtaining DME for consumers through their OHP benefits.

Please follow the payor source tools to determine the best source to obtain the items your consumer needs for a safe move.

Oregon Health Authority's OAR on Durable Medical Equipment, Prosthetics, Orthodontics and Supplies is 410-122-0000.

Here are some helpful excerpts from the OARs:

Please note: Due to potential OAR changes the information below should be used as helpful reference. For current OAR language please follow links embedded in the text (often underlined) or refer to CM tools for most updated information.

Doctor's Order OAR

A written order must be legible and contain the following elements:

- Client's name;
 - Detailed description of the item that can either be a narrative description (e.g., lightweight wheelchair base) or a brand name/model number including medically appropriate options or additional features;
 - The detailed description of the item may be completed by someone other than the practitioner. However, the prescribing practitioner must review the detailed description and personally indicate agreement by his signature and the date that the order is signed:
 - Practitioners shall sign for services they order;
 - This signature must be handwritten or electronic, and it must be in the client's medical record;
 - The ordering practitioner shall ensure the authenticity of the signature;
 - Primary ICD-10 diagnosis code for the equipment and supplies requested.
- Use of signature stamps may not be used on any medical record.

410-122-0375: Walkers

- Indications and Limitations of Coverage:
 - A standard walker (E0130, E0135, E0141, E0143) and related accessories are covered if both of the following criteria are met:
 - When prescribed by a treating practitioner for a client with a medical condition impairing ambulation and there is a potential for increasing ambulation; and
 - When there is a need for greater stability and security than provided by a cane or crutches;

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- For an adult gait trainer, use the appropriate walker code. If a gait trainer has a feature described by one of the walker attachment codes (E0154-E0157), that code may be separately billed;
 - A heavy duty walker (E0148, E0149) is covered for clients who meet coverage criteria for a standard walker and who weigh more than 300 pounds
 - A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for clients who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand;
 - When a walker with an enclosed frame (E0144) is dispensed to a client, documentation must support why a standard folding wheeled walker, E0143, was not provided as the least costly medically appropriate alternative;
 - Enhancement accessories of walkers are non-covered;
 - Leg extensions (E0158) are covered only for patients six feet tall or more

410-122-0380 – Hospital Beds

- Indications and limitations of coverage and medical appropriateness: The Division may cover some hospital beds for a covered condition including:
 - A fixed height hospital bed (E0250, E0251, E0290 and E0291) when the client meets at least one of the following criteria:
 - Has a medical condition that requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed;
 - Requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain;
 - Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure,

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- chronic pulmonary disease, or problems with aspiration. Pillows or wedges shall have been considered and ruled out;
 - Requires traction equipment that can only be attached to a hospital bed;
 - A variable height hospital bed (E0255, E0256, E0292 and E0293) when all of the following criteria are met:
 - Criteria for a fixed height hospital bed are met;
 - A bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position is required;
 - A semi-electric hospital bed (E0260, E0261, E0294 and E0295) when all of the following criteria are met:
 - Criteria for a fixed height hospital bed are met;
 - Frequent changes or an immediate need for a change in body position are required;
 - The client is capable of safely and effectively operating the bed controls;
 - A heavy duty extra wide hospital bed (E0301, E0303) when all of the following criteria are met:
 - Criteria for a fixed height hospital bed are met;
 - The client weighs more than 350 pounds but less than 600 pounds;
 - The client is capable of safely and effectively operating the bed controls;
 - An extra heavy duty hospital bed (E0302, E0304) when all of the following are met:
 - Criteria for one of the hospital beds described in (1)(a)-(d) are met;
 - The client weighs more than 600 pounds;
 - The client is capable of safely and effectively operating the bed controls;
 - When provided for a nursing facility client, the bed shall be rated for institutional use;

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- Total electric hospital beds (E0265, E0266, E0296 and E0297) are not covered since the height adjustment feature is considered a convenience feature;

410-122-0590 – Patient Lifts (Hoyer)

- Indications and coverage — A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the client would be bed confined.
- The areas within the client’s residence where the lift will be utilized must be able to accommodate and allow for the effective use of the lift. The Division of Medical Assistance Programs (Division) does not reimburse for adapting the living quarters.
- A sling or seat for a client lift may be covered as an accessory when ordered as a replacement for the original equipment item.
- E0621 is included in the allowance for E0630 when provided at the same time.
- E0635 may be covered only when a client weighs 450 pounds or more;

ADRC Assistive Device Resource Guide – follow embedded link for a detailed guide including pictures and descriptions of items that may help improve your consumer’s level of independence

Home Modifications VS Home Repairs

Policy references:

Transmittal: APD-PT 17-040

Home Modification OAR: 411-035-0060

Home Repair OAR: 461-155-0600

KPlan Home Modification Process and Best Practices

- Home Modifications are covered through the KPlan under Ancillary Services for both MAGI and OSPIM consumers who meet the criteria of the OAR.

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- When home modifications are required for a client to return to their home or a family member's home or a rental unit, the Diversion /Transition Coordinator (D/T) will complete the KPlan request according to the instructions found in the KPlan Ancillary Services Guidance.
 - Best practice is for the Diversion/Transition Coordinator to, as soon as possible, arrange a visit to the home and take photos and measurements. TCs will need to know the Durable Medical Equipment (DME) participants will use when returned to home (wheelchair, walker, scooter, bath chair/commode etc.) measurements.
 - Additional guidance for different parts of the home:
 - Ramps
 - In consultation with participant and others in the home as appropriate
 - Determine which entry would be best
 - Measure threshold height
 - Length is usually 1 foot for every 1 inch height of threshold
 - Take photos of exterior area where ramp would be constructed; note any challenges such as sprinkler heads, property lines, etc.
 - Doorways:
 - In consultation with participant and others in the home as appropriate
 - Photos of both sides of doorways
 - Photos of adjacent walls to doorways
 - Note adjacent electrical plugs or switches
 - Consider the off-set door hinge solution (2" clearance can be gained by using off-set hinges, if swing room allows)
 - Bathrooms:
 - In consultation with participant and others in the home as appropriate
 - Photos of existing bathroom
 - Floor space measurements
 - Anticipated bathroom usage (abilities, barriers, 1 or 2 person assist, DME)

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- Please note: This information is good to obtain for your KPlan request and in your initial discussions with the contractor. The contractor will still complete their own professional assessment of the modification needs. It gives you the opportunity to explore what additional Assistive Devices may be appropriate to meet the consumer's needs and identify any unforeseen barriers that may be left out if coordinated remotely.

Home Repairs:

- Home repairs are allowable for consumers receiving OSIPM only – it is not a covered benefit under KPlan – who meet the criteria under OAR 461-155-0600
- Additional information listed below can also be found in the OSIP Program Manual, Section H.5
- The Department will authorize a special-need payment for home repairs for homeowners or buyers as a one-time special need within the following limits:
- The repairs must be needed to remove a physical hazard to the health and safety of the client.
- Payment for repairs authorized by this rule:
 - Is limited to the least expensive means possible;
 - Cannot exceed \$1000 in any 24-month period; and
 - When the home is jointly owned, is limited to a percentage of the cost of the repairs equal to the percentage of client ownership. An OSIPM in-home service client who is married to a community spouse may qualify for a waiver of this criterion. See APD-PT 17-040.
- The repairs must cost less than moving to another home.
- Payment is limited to the lowest possible cost that will provide adequate facilities. The client must provide three competitive bids for the repairs, unless there are not three providers of the service in the local area.

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- Before approving payment for repairs or new installations, the Department will consider the use value and will determine whether it is consistent with the care plan for the client to remain in the house.
 - Contractors who complete the repairs or new installations must ensure that the work being completed meets current building codes. Payment is only made for home repairs performed by a licensed and bonded construction contractor.
 - Repairs or replacements include, but are not limited to:
 - Electrical wiring that does not constitute conversion to electrical space heating but that is needed:
 - To avoid condemnation; or
 - To remove a definite fire or shock hazard as documented by appropriate public officials.
 - Plumbing—but not including the costs of plumbing items with which the house is not already equipped except that a toilet may be paid for when newly required by the creation or extension of a sewer district. Examples of what plumbing-related items may be covered include:
 - Toilets and sinks.
 - Cleaning or replacing septic tanks or cesspools.
 - Installing sewer connections from house to street—but not sewer installation — if required by the creation of a new sewer district or the extension of an existing district.
 - Repair or replacement of existing electric pumps for wells needed to continue the water supply. This does not include drilling a new well.
 - Heating equipment:
 - repair of heating stoves, furnaces and water heaters and,
 - if repair is not possible, replacement with the least expensive adequate equipment.
 - Repair of roofs.
 - Repair or replacement of steps and repair of floors.
 - Clients with life estates are not eligible for this special need allowance. The person who will benefit from the life estate, following the death of the client, is considered responsible for the home repairs.
 - Payment Instructions:

- Issue payments by DHS 437 using pay reason 40. Also enter an N/R code on CMS of SHR with an end date of 24 months in the future, to indicate that the client's total home repair payments cannot exceed \$1000 during that time.



Aging and People with Disabilities

Policy Transmittal

Mike McCormick

Number: APD-PT-17-040

Authorized Signature

Issue date: 9/27/2017

Topic: Cash Payments

Transmitting (check the box that best applies):

- New policy
 Policy change
 Policy clarification
 Executive Letter
 Administrative Rule
 Manual update
 Other: _____

Applies to (check all that apply):

- | | | |
|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> | | <input checked="" type="checkbox"/> All DHS employees |
| <input checked="" type="checkbox"/> | Area | <input type="checkbox"/> Agencies on Aging Health |
| <input checked="" type="checkbox"/> | Services | <input type="checkbox"/> Aging and People with |
| <input type="checkbox"/> | | <input type="checkbox"/> Self Sufficiency Programs |
| <input type="checkbox"/> | Disabilities Office of Developmental | |
| <input type="checkbox"/> | Disabilities Services(ODDS) | |

County DD Program Managers ODDS Children's Intensive

ODDS Children's In Home Services

Residential Services Stabilization and Crisis Unit (SACU) Child Welfare

Programs Other (please specify):

Policy/rule title:	Special Need: Home Repairs, OSIPM		
Policy/rule number(s):	OAR 461-155-0600	Release no:	
Effective date:	10/01/17	Expiration:	
References:			
Web address:	https://apps.state.or.us/cf1/caf/arm/B/461-155-0600.htm		

Discussion/interpretation:

OAR 461-155-00600 establishes that Special Needs payments for necessary household repairs may be made to OSIPM clients who own their own home.

Under OAR 461-155-0600(2)(c), when an OSIPM client’s home is jointly owned, payment for repairs to the client’s home is limited to the percentage of the cost of the needed repairs equal to the percentage of the client’s ownership in the home.

Beginning 10/01/17, OAR 461-155-0600(10) will permit APD Central Office Staff to waive the provisions of OAR 461-155-0600(2)(c) in in-home service cases where an institutionalized spouse and a community spouse both live in the home.

DHS 0079 (12/14)

OAR 461-155-0600(10) reads:

When a home is jointly owned by an institutionalized spouse (see OAR 461-001 0030(6) receiving in-home services under OAR chapter 411 division 030 and a community spouse (see OAR 461-001-0030(1)), section (2)(c) of this rule may be waived by the Department if requiring the community spouse to pay a percentage of the costs of the repairs would impose an undue hardship on the client.

Even where OAR 461-155-0600(2)(c) is waived, payment for repairs is limited to \$1000 in any 24-month period.

Implementation/transition instructions: N/A

Training/communication plan: N/A

Local/branch action required:

Refer requests to waive the provisions of OAR 461-155-0600(2)(c) to Chris Ellis at Christopher.m.ellis@state.or.us. Include in the e-mail any available information concerning the community spouse's monthly income, resources and expenses.

Central office action required:

Determine whether or not to waive the provisions of OAR 461-155-0600(2)(c) when determining the amount of the Home Repair payment to be made, and inform the originating APD or AAA office of the decision.

If you have any questions about this policy, contact:

Contact(s):	Chris Ellis		
Phone:	503-373-2305	Fax:	
Email:	Christopher.m.ellis@state.or.us		

Wrap-Around Services and Resources

SharePoint

- SharePoint is an interactive site where D/T Teams can go to post announcements, start discussions , find program materials, and enter information into the D/T database.
- To gain access please email the Transition Services analyst. If a worker leaves the D/T team please notify the Transition Services Analyst to have their name and information removed from access to the site.

Acute Care Settings Coverage

Consumers receiving skilled care should not be coded NFC.

ACS is an insurance benefit that can assist with the uncovered costs Medicare consumers may have during a skilled nursing stay.

OSIP Program Manual: D. Nonfinancial Requirements, Section 12

An individual in an acute care hospital or nursing facility is evaluated for OSIPM under the Acute Care Setting rule as follows:

- The individual must meet all non-financial eligibility requirements for OSIPM;
- The individual is considered in his/her own household and filing group;
- The financial group consists of only the individual applying for benefits, except the spousal impoverishment guidelines apply, so a resource assessment must be completed;
- The individual must have countable income at or below 300 percent of the full SSI standard or has established a qualifying trust as specified in 461-145-0540(9)(c); and
- The individual must require a continuous period of care, which basically means the individual must be expected to stay in the hospital, nursing facility, or another service setting for at least 30 days or until death - you do need to have evidence of the expectation, but you do not have to wait until the 31st day to determine if he/she met the requirements

Please note that you do not have to refer to this rule if the individual would qualify for OSIPM under a standard living arrangement, this rule is here for those who would otherwise be over income or resources. It establishes that these individuals are treated as if they were receiving or applying for services.

For more information on coding and liability for clients in NF acute care settings, [click here](#) or see Appendix A.

If a client needs a long-term care payment (not post-hospital extended care) and does not have Medicare, see section D.11 above.

- *Note: A client in an acute care hospital may accumulate resources. If they are above the resource limit, they will need to spend-down or become ineligible.*
- OAR 461-135-0745

Aging and Disabilities Resource Center (ADRC)

The ADRC of Oregon provides access to a [searchable database of resources and services available across the state](#). Search by keyword, by need/service, or complete a needs assessment for a list of service offerings in your area.

[Planning for your future – A toolkit for long-term services and supports](#)

The ADRC of Oregon offers a downloadable [planning toolkit](#) with information about long-term services and supports options, facility types, service costs, worksheets to help consumers plan for service costs, and checklists to support their decision process. The ADRC of Oregon also has a limited supply of printed hard copy toolkits available upon request.

[Long-term services costs – tools to prepare for future care costs](#)

The ADRC of Oregon includes interactive worksheets to help consumers [estimate how much money they may need for long-term care expenses](#) and to help plan for [how to pay for service costs](#) in the future.

[Legal resources of older adults and people with disabilities](#)

The ADRC of Oregon includes many legal resources including the following guides:

- [Legal Issues for Older Adults: An Oregon Information and Reference Guide](#)
- [Help for agents under a power of attorney](#)
- [Help for court appointed guardians of property and conservators](#)
- [Help for trustees under a revocable living trust](#)
- [Help for representative payees and VA fiduciaries](#)

[Checklists to support decision process](#)

The ADRC of Oregon offers a number of checklists to support a consumer's decision process:

- [Home care services checklist](#)
- [Facility comparison checklist](#)

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- [Adult day services checklist](#)
 - [Activity/senior center checklist](#)
 - [Transportation services checklist](#)

[Put a plan in place for when you may not be able to determine your own medical treatment](#)

The ADRC of Oregon offers information about [putting a plan in place for when you may not be able to determine your own medical treatment](#) including information on creating an advance directive for health care decisions, the physician's orders for life-sustaining treatment (POLST), financial power of attorney, representative payee, and trusts.

[Alzheimer's disease and related dementias](#)

The ADRC of Oregon provides access to many resources and information on [Alzheimer's disease and related dementias](#).

[Caregiver supports resources](#)

The ADRC of Oregon includes caregiver supports resources, including access to a downloadable version of the [Family caregiver supports guide](#). Printed copies are also available upon request.

[Assistive technology](#)

The ADRC of Oregon includes assistive technology resources and educational information on the [assistive technology section of the ADRC website](#).

See Appendix B for ADRC's illustrated guide

Behavior Support Services

[When to request:](#)

- Eligible for home and community-based care services provided through APD
- Receiving services through either State Plan K Community First Choice or Independent Choice
- An individual is moving into a new care setting

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- An individual at risk of requiring behavior interventions
 - An individual whose caregiver requests assistance in developing person-centered interventions
 - An individual with a placement failure related to their behavior
 - An individual at risk of involuntary move out or who has received an eviction notice
 - An individual receiving Medicaid service payments to support behavior interventions, such as a behavior add-on or an exception
 - An individual whose provider receives a payment for costs associated with interventions needed to address the individual's challenging behaviors

Limitations: may not be provided to Individuals who are receiving:

- Specific needs setting contracted rate for "enhanced care services"
- Services through Developmental Disabilities per OAR chapter 411, division 308, OAR chapter 411, division 330, or OAR chapter 411, division 325.
- Individuals receiving services in a nursing facility or hospital

Authorizations

- D/T makes referral to BSS
- Service hours are authorized on the date the BSS accepts the referral
- D/T can authorize 40 hours for initial assessment, service planning and follow up. Local management can authorize an additional 40 hours. Additional hours can be authorized by Central Office.
- Authorizations are valid for 12 months from acceptance by BSS

Communication

- Diversion/Transition Coordinators or Case Managers and behavior consultants are required to exchange information regarding changes in the individual's eligibility status, service location, or service needs during the duration of the Behavior Support Service
- Follow up best practice includes reviewing of BSS recommendations and comparing them to the provider's care plans and notes.

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- If recommendations have not been implemented discuss timeline with provider for implementation
 - If the provider continually fails to implement BSS recommendations, please staff the case with the provider or the provider's licensor per the following OAR:
 - 411-050-0655 Standards and Practices for Care and Services (4) CARE PLAN. (f) The licensee is responsible for ensuring implementation of the resident's care plan and, if applicable, the behavioral support plan with suggested interventions.
 - Failure to implementation of the consumer's care plan can result in a licensing citation.
 - If a move out notice is given to the consumer and BSS has not been implemented, staff case with your Local Licensing Authority (LLA)
 - Mandatory forms must be sent to the D/T Coordinator or case manager before or at the time of submission of invoices or before receipt of the monthly Medicaid service rate

CCO Intensive Case Management

Defined in OAR 410-141-3000.40:

"Intensive Case Management (ICM)" means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency or with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports.

ICM Duties as defined in OHA's contracts with CCOs:

r. Intensive Case Management

- Contractor is responsible for Intensive Case Management services. This section sets forth the elements and requirements for Intensive Case Management.

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- Contractor shall make culturally and linguistically appropriate Intensive Case Management Services available to Members identified as aged, blind, or disabled, Members with Special Health Care Needs, Members who have complex medical needs, high health care needs, multiple chronic conditions or Behavioral Health issues, and for Members with severe and persistent mental illness receiving home and community-based services under the State's 1915(i) State Plan Amendment. Intensive Case Management services may be requested by the Member, the Member Representative, Physician, other medical personnel serving the Member, or the Member's agency case manager.
 - Contractor shall respond to requests for Intensive Case Management services with an initial response by the next Business Day following the request.
 - Contractor shall periodically inform all Participating Providers of the availability of Intensive Case Management services, provide training for PCPCHs and other PCP's staff on intensive Case Management Services and other support services available for Members.
 - Contractor shall assure that the case manager's name and telephone number are available to agency staff and Members or Member Representatives when Intensive Case Management services are provided to the Member.
 - Contractor shall make intensive case management services available to coordinate the provision of all Covered Services to Members who exhibit inappropriate, disruptive, or threatening behaviors in a Practitioner's office or clinic or other health care setting.

Additional CCO Services found in OAR 410.141.3015:

- (17) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patient-centered primary care homes and individualized care:

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- Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans particularly for members with intensive care coordination needs, and screen for all other issues including mental health;
 - Applicants shall describe how its implementation of individualized care plans reflects member or family and caregiver preferences and goals to ensure engagement and satisfaction.
 - (18) CCOs shall assure that members receive comprehensive transitional health care including appropriate follow-up care when entering or leaving an acute care facility or long-term care setting. Applicants shall:
 - Describe their strategy for improved transitions in care so that members receive comprehensive transitional care, and members' experience of care and outcomes are improved;
 - Demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes;
 - Describe their arrangements, including memorandum of understanding, with Type B Area Agencies on Aging or the Department's offices of Aging and People with Disabilities concerning care coordination and transition strategies for members.
 - (19) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, community health workers, and personal health navigators. The applicant shall describe its planned policies for informing members about access to personal health navigators, peer wellness specialists where appropriate, and community health workers.
 - (20) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:

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- Delivery system elements that respond to member needs for access to coordinated care services and supports;
 - Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;
 - Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long term psychiatric care settings.
 - (21) Each CCO shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with severe and persistent mental illness covered under the State’s 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:
 - Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;
 - Reflect member or family and caregiver preferences and goals to ensure engagement and satisfaction.

Contact List for CCO’s Intensive Case Manager:

[https://inside.dhsoha.state.or.us/images/stories/HSD/Intensive Case Managers List.pdf](https://inside.dhsoha.state.or.us/images/stories/HSD/Intensive_Case_Managers_List.pdf)

Complex Case Consultation

CRITERIA FOR REFERRALS TO THE COMPLEX CASE CONSULTATION (CCC)

Introduction:

Complex Case Consultation is a process to advise and offer technical assistance to case managers who have difficulty finding services for clients with complex needs. The criteria for referrals have been revised and are in effect as of September 1, 2018.

Referral Guidelines:

- Referrals are accepted for open APD Medicaid service cases only, but clients can be in any care setting. Clients with pending eligibility may be referred for complex case consultation when lack of placement is the reason for the pended status.
- Referrals are accepted only from local APD/AAA office staff after receiving approval from their supervisor.
- Clients who have difficulty maintaining service providers are appropriate for referral.
- CAPS assessments must be completed or updated within the last 3 months prior to referral, or the CAPS reflects the current needs of the client AND narration clearly describes the recent complexities relative to the need for placement.
- The case manager must have contacted local providers and county resources and been unable to locate appropriate service providers.
- Referrals may be sent to the Complex Case Consultation team using the Referral Form and sending to:
APDComplexCase.ConsultationTeam@state.or.us.
- All referral materials should be scanned and sent electronically. Referral materials should include supporting documentation such as clinical records, recent facility care plan, copy of the BSS or behavioral plan, CMHP provider notes, and/or other applicable information.
- The Complex Case Consultation team will meet each Wednesday from 11am- 12pm to review cases. After staffing with or referring to the Complex

Case Consultation team, case managers will be responsible for following up on suggestions. Additionally, the case manager will be responsible for relevant narration and service planning and coordination as well as coordinating with the receiving county in the event of a case transfer.

Complex Case Consultation FAQ's

- Who is the Complex Case Team?
 - The Complex Case Team at APD Central Office is made up of the Complex Case Coordinator, the Exceptions Coordinator, the Enhanced Care Coordinator, the Diversion and Transition Policy Analyst, and the Behavior Support Services Coordinator. We also sometimes reach out to other areas within Central Office including the LTC Policy Unit, the MED team, and Health Systems Division (mental health)

- What will the Complex Case Team really do?
 - Upon receiving a referral, the Complex Case Coordinator will review all documentation and case information including CAPS and narrative to determine what options have already been tried and to attempt to determine what might be some additional appropriate options.
 - If appropriate placement options are not clear from the documentation and case information, we may request additional information or to have a conference call with the case manager.
 - We then will send suggestions for placement options for you and your team to try.
 - *We do not make the referrals ourselves or take over the case.* The case manager is still responsible for contacting potential providers, scheduling screenings, coordinating moves, etc.

- What should I do before I make a Complex Case Referral?
 - It is appropriate for the field to make a Complex Case Consultation (CCC) referral when all local resources and tools have been exhausted. This will be a different level and time for all local offices due to

-
- differing local resources in the extremely different regions of our state.
- Resources and tools to attempt prior to making a CCC Referral include but are not limited to:
 - Staffing with your team locally including: supervisors; Diversion/Transition or Intensive Case Management workers; placement specialists; other case managers; licensors; etc.
 - Referring to money management or rep payee programs if appropriate
 - Referring to Behavior Support Services; Long-Term Community Care Nursing; Home Health; local Mental Health services
 - Referring to Enhanced Care Services or Special Need Contract homes if appropriate
 - Referring to public guardianship programs if appropriate
 - Working with the provider to request exceptions if appropriate
 - Do I have to staff the case with my supervisor before I make a referral?
 - While a signature from your supervisor is not required on the referral form, it is best to staff all Complex Case referrals with your supervisor for many reasons. Your supervisor may have information on resources you are unaware of, they may have additional history or information on this case, or they may have a reason a Complex Case referral would not be appropriate. While it is not required, it is best practice to staff all referrals with your supervisor.
 - When will I get a response?
 - The Complex Case Team strives to respond to all referrals within *one business day* with a minimum of a notification of receipt.
 - Following the initial notification of receipt, you will receive a secondary email with suggestions for possible placement options or a request for additional information which may include things like additional documentation, a conference call with the case manager, etc. The goal for these secondary responses is within *3 business days* following receipt of a referral.

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- The Complex Case Team meets once per week on Wednesdays from 11am – noon. At this time, we will staff exceptionally challenging cases. If your referral falls into this category, you will be notified because it may cause a delay in suggestions for placement.
 - Does the consumer have to agree to a Complex Case Consultation?
 - No, a Complex Case Consultation is meant to be a tool for the case manager in attempting to find appropriate placement. Consumers may not even know that you have made a Complex Case referral or have had a consultation.
 - Can Complex Case Team help if the consumer has pending legal charges?
 - This is something that we discuss on a case by case basis. Depending upon the charges, status of the case, and potential outcomes we may be able to assist in finding placement anyway. Please make a referral and specify in the referral that this is one of the presenting issues.
 - What do we do if the consumer is refusing to leave their current placement or area?
 - This is a choice that the consumer can make, assuming they do not have a guardian. However, what we must make sure they understand is that providers can, over time, take legal action to evict and/or trespass someone in which case local law enforcement would require the person to leave their placement.
 - As for moving to another region or area, this is another time you would need to have a very clear conversation regarding the fact that in certain areas there are very limited resources for placement and moving to a different town or area might open up a lot of opportunities. Also, explain that if they chose to stay in the area they are in, with very few options they may be actively choosing a less appropriate placement or no placement at all dependent upon the options available.

-
- Is making a referral even going to help?
 - Again, yes! We strive to respond as quickly as possible to all referrals and present you with at least a couple more options than you had before. We understand that sending a referral to someone who is not actively working in the field can feel hopeless or like you are not going to get a useful answer but our team has experience and access to resources across the state that you may not know about or how to utilize. Please, if you ever are feeling at a loss when it comes to a case, reach out to the Complex Case Team, we will always do our best to give you some extra resources and support as best we can.
 - Can I reach out with questions or for advice without making a full referral?
 - Yes! We always welcome questions or requests for information and technical assistance. Please feel free to send questions or scenarios to the APDComplexCase.ConsultationTeam@state.or.us inbox anytime. We will let you know if we need further information or would like a full referral to be made at any time.

[Link to CCC Referral Form](#)

Enhanced Care Services

Enhanced Care Services (ECS) was developed to enable individuals to leave, or reduce risk of admission to, the Oregon State Hospital (OSH). The program was designed to support individuals who need additional behavioral health resources in order to live successfully in the community. Treatment is focused on teaching skills and coping strategies to enable individuals to live with greater autonomy in less restrictive settings.

Individuals referred to ECS must be eligible for APD long-term care services and require rehabilitative mental health treatment. The ECS program provides mental health support services through joint funding between APD and OHA, in collaboration with licensed APD providers and Community Mental Health Programs.

Enhanced Care Facilities (ECF)

ECF's are dedicated APD Residential Care Facilities or units within Nursing Facilities with Enhanced Care Services program staff based at the facility. Mental health supports are provided on-site daily for a minimum of 4 hours per day. There are currently 9 ECFs located in the following counties: Hood River, Multnomah, Washington, Yamhill, Marion, and Lane.

Enhanced Care Outreach Services (ECOS)

Mental health services are provided to residents of any APD licensed setting. Based on individual needs, behavioral health services typically are delivered at the individual's residence or in the community, but can include clinic based services. ECOS services are currently only provided in the following counties: Hood River, Multnomah, Washington, Polk, Yamhill, Marion, Lane, and Coos.

ECS program goals

- To assist the individual in stabilizing and managing their psychiatric symptoms and support them in achieving their desired quality of life.
- Treatment services focused on supporting individuals as they develop skills and coping strategies, enabling individuals to live with greater autonomy in the least restrictive settings.
- Increased supports to reduce the risk of psychiatric hospitalizations.

Consumers must meet the following criteria:

- APD eligible (financial *and* service eligible)
- Qualifying Mental Health Diagnosis and complex symptoms
- Requires intensive community mental health services to transition to a lower level of care
- Has difficulty maintaining APD placements due to complex symptoms secondary to a mental illness
- Has been denied admission to, and cannot be supported in any other APD community setting
- Can benefit and engage in mental health treatment services
- Currently exhibits two or more of the following:
 - Self-endangering behavior

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- Aggressive behavior
 - Intrusive behavior
 - Intractable psychiatric symptoms
 - Complex psychiatric medication needs
 - Sexually inappropriate behaviors
 - Risk to health and safety without intensive supervision.

Services

Enhanced Care Service program includes the following:

- Increased facility services around direct care and nursing
- Qualified mental health staff to provide client centered treatment services;
- Licensed Medical Providers who provide psychiatric medication management;
- Crisis services; and
- Coordination of services through an Inter-disciplinary Treatment (IDT) Team.

Referrals

Referrals may be sent to the Enhanced Care Services team, using the [Referral Form](#) and attaching requested clinical documentation, at the following email:

EnhancedCare.Team@dhsosha.state.or.us

The Referral Form and other ECS resources can be found at:

<http://www.dhs.state.or.us/spd/tools/cm/enhanced/index.htm>

In addition, the ECS Team is available to staff cases or answer questions regarding eligibility for this program.

Exceptions

[Link to Case Management Tools Webpage on Exceptions](#)

Adult Foster Home

Purpose of an exception:

Exceptions stem from OAR 411-027-0050:

- Service payment exceptions may only be granted if the Department determines:
 - The individual has service needs, documented in the service plan, that warrant a service payment exception; and
 - The provider actually provides the exceptional service.
- Service payment exceptions shall be based on the additional hours of services required to meet the individual's assessed and verified ADL and IADL service needs. Exceptional hours are not allowed based solely on choice of the individual. The Department and AAA local office staff must monitor the individual service needs and recommend adjustments to the plan when appropriate.
- Service payment exceptions in Adult Foster Homes and Residential Care Facilities may be authorized only for individual service needs that are not paid for by the base rate or any of the three available add-on payments.
- In short, exceptions are written for ADL's requiring 2 caregivers to complete, extensive 1:1 interaction by a caregiver for behavioral needs, or other critical needs. Night needs that do not require 2 caregivers will also be considered.

Needs that do not qualify (included in base rate):

- Bladder and Bowel needs (unless this requires two people, which is rare and would need to be verified)
- Grooming/Hygiene tasks (almost never requires 2 caregivers)
- Medication management (even at night)

CAPS Assessment:

- MUST support the request – requests are based on the assessed and verified needs. If an ADL task requires 2 caregivers, it must be noted in the assessment. Frequency and duration are also preferable but can be included in the 514.

Behavioral Requests:

-
- Is BSS engaged?
 - If so, attach the BSS plan and any documentation from the provider showing implementation of the BSS recommendations.
 - If not, exception will be temporary (90 days).
 - Try to quantify the behavioral episode: How long it lasts, how many times per day, is there a pattern, what are the caregivers doing, how does the consumer respond.
 - Exception hours can be used to implement caregiver engagement strategies from the BSS plan.
 - Make unannounced visits – try to witness the behaviors as they are happening to verify what the caregivers are doing and how long it takes.

Pre-placement approvals:

- Can be done – staff with Exceptions Coordinator first.
- Typically done with crisis situations, or when transitioning from acute care settings.

Questions to ask before submitting:

- For night needs and/or behaviors – request a log or notes from the provider. Ensure that the notes are reflecting the needs.
- Collect the BSS plan, if applicable.
- Send a referral for BSS if not already.
- If Adult Day Services are in play or being requested – please note this on the 514.

Follow up/monitoring:

- Staffing should always be verified if visiting the home.
- Visit with the consumer – verify (where applicable) if the care is being given.
- Large exceptions will come with a mandate to make unannounced visits to verify staffing and care being provided.

Multiple exceptions in the same home:

- Under heightened scrutiny at Central Office.

- Request a staffing plan, then verify through unannounced visit.
- May be denied if there is evidence of “overlap” of the exceptional caregivers.

Exceptions in Specific Needs Contract homes:

- Residents that were in the home prior to execution, and don’t meet the SOW.
- New placements that don’t meet the SOW.
- If the exception request is large – need to determine if the consumer will be better served by the contract rate. Also, the contract already requires elevated staffing, and this will be taken into account when determining exceptional needs.

Adult Foster Home Exceptions Checklist

(All exceptional rate requests must be submitted by a manager in the local office to [Exceptions, SPD@state.or.us.](mailto:Exceptions_SPD@state.or.us))

	Yes	No	N/A	Notes
Are the 514 and 514A complete? Is client and provider information correct?				
Does the CA/PS assessment reflect current care needs <u>and</u> is no more than 6 months old?				
Is there clear narration, comments or synopsis regarding client’s needs and justification for the exceptional rate being requested?				
Has the rate been calculated correctly? (Number of hours per week x 4.3 weeks x \$13.11) This is the cost the provider will incur for additional staff necessary to meet client’s care needs.				
Does the 514A include tasks or services not covered under the waiver (ROM, RN, PT/OT, respite/relief, smoking, standby)? If so, task/service and associated hours should be removed.				

Does the provider have a resident manager? (prv8,provider #) (A resident manager can not be paid for exceptional hours and should not be listed as a caregiver on the 514A.)				
Does the AFH have the correct classification level to meet the care needs of the client? If not, has your licensor granted a classification exception to the provider? (Submit copy with request.)				
Are there other clients with exceptional rates in the AFH? (pasm,p,provider #) If so, do needs/hours overlap?				
Is the client under 65 years with care needs related to a mental health diagnosis? Should the case be referred to the MED review team?				
Do you support the request? If not, include an explanation regarding why. Was it denied locally? Is there an alternate plan?				

This check list is provided as technical support for local office staff when an exceptional rate request is being prepared. It is not necessary to send this form with the request but we strongly encourage you to use it as a tool to ensure that all issues are explored and documented prior to submission.

In-Home Services – Links to resources:

[In-Home Support Services webpage](#)

[Exceptions webpage](#)

[In-Home Care Agencies](#)

[HomeCare Worker webpage](#)

Long-Term Community Care Nursing (LTCCN)

LTCCN Webpage can be found here: <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/PROVIDERS-PARTNERS/LTCCN/Pages/index.aspx>

Overview

a nursing program that is designed to help individuals, their caregivers, foster home providers and case managers develop the supports needed to help a

Medicaid eligible person with chronic health care needs live in their own home or foster home.

Referrals and authorization for the service are made by each persons case manager. These ongoing services can be provided in conjunction with short-term home health services which are a different type of community nursing authorized by a physician and funded through the persons medical insurance plan.

The service can only be provided by either self-employed RNs or RNs employed by In-Home/Home Health agencies. Both types of providers must have a contract with the Oregon Department of Human Services Seniors and be enrolled as a Medicaid Provider. Registered Nurses (RN) in the LTC Community Nursing program provide:

- A nursing assessment, medication review and service plan for the person
- Health education for the person, caregivers, foster home providers and/or family members
- Teaching for the individual who self directs their care or family members on how to perform tasks of nursing
- RN delegation of nursing care tasks provided by a non-family or paid care provider
- Technical assistance and progress summaries to the case manager regarding the person's healthcare needs
- Care coordination with the persons medical and ancillary health providers

Frequently Asked Questions:

The LTCCN webpage has a large FAQ section for both provider and D/T Coordinators to refer to. Here are some that may be most helpful – consider any reference to a Case Manager to be applicable to D/T Coordinators:

- When should I make a referral?
 - The following section identifies reasons why a referral may be made to a nurse. Services are expected to be provided in a person centered manner including the individual with a focus on promoting self-management of the health condition(s) whenever possible. Items marked with an * indicate situations where the physician should be

informed by the nurse, foster home provider or case manager of the change in health status.

- Need for consumer, family member or care provider education
- Delegation is needed for a nursing care task. Nursing care tasks are defined as tasks that are taught in Schools of Nursing and not performed by the general population. After an assessment, the nurse would be expected to either ‘teach’ family members or the individual to perform the nursing task or ‘delegate’ the task to a paid care provider. The nurse will need to follow this case as long as the delegation is in effect.
- Medication safety issues or concerns.
- Unexpected increased use of emergency care, physician visits or hospitalizations. RNs can help the caregivers and case manager evaluate the placement and ensure that the caregivers have the skills they need to meet the individual’s needs. When this situation occurs with an individual who already has a nurse, the nurse may need to do a Reassessment and provide an updated Nurse Service Plan.
- Changes in behavior or cognition. A RN can help the caregivers or individual communicate in a manner to ensure the primary care physician receives relevant information, PRN parameters are clearly understood and that medications are not used as chemical restraints or for caregiver convenience. The nurse can assist the caregivers in developing a positive behavior support plan if the person does not have a Behavior Consultant or a mental health provider. Individuals who are assessed as a full assist in cognition may need this type of referral.
- Nutrition, weight, or dehydration issues. RNs can help the caregivers or individual communicate effectively to ensure that physicians and registered dietitians receive relevant information. The nurse can assist the caregiver and individual with identification of strategies to help promote adherence to a therapeutic lifestyle and dietary orders.

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- Pain Issues. The RN can help the caregivers or individual communicate effectively to ensure the primary care provider has all relevant information related to the underlying potential causes of the pain. The RN can provide teaching on the basics of pain management, including administration of pain medications, use of PRN medications, safe management of narcotics, assessment of interventions, use of pain severity scales and how to report pain related issues/concerns.
 - History of recent, frequent falls. The RN would be expected to examine the reason for the falls, provide a safety assessment of the home, educate the individual and/or caregivers about mobility safety, fall prevention, when to access medical care and when to access 911 services. The RN can help the caregivers or individual communicate effectively to ensure the primary care provider has all relevant information related to the falls.
 - Potential for skin breakdown or recently resolved skin breakdown. LTCCN RNs would not be used to manage complex wound care or deteriorating skin conditions, such as advanced pressure ulcers. A LTCCN referral may be done if the caregivers or individual need help with ongoing interventions designed to prevent future problems or maintain a stabilized skin condition.
 - Not following medical advice. If an individual refuses ordered treatments, medications or therapies, all parties (nurse, caregiver, foster home provider, case manager and primary care provider) need to closely coordinate and ensure the individual understands the risks. A LTCCN referral may be helpful in these situations, as a nurse may help the individual identify and communicate what is preventing him or her from following through with the needed interventions. Through teaching, the nurse can help identify solutions to provide the individual with more acceptable interventions. Nurses may

refuse to accept or continue with the case unless there is a strong team approach and it's clear that the individual can provide informed consent.

- How do I know if a person is eligible to receive Long Term Care Community Nursing services?
 - Individuals must be eligible for either an APD or DD waiver and receive services in the following settings or programs: In-Home Services; Comprehensive In-Home Support for Adults with Developmental Disabilities; Adult Foster Homes for Person with Developmental Disabilities; Foster Homes for Children with Developmental Disabilities, Adult Foster Homes for Aging or Persons with Physical Disabilities, Independent Choices, or State Plan Personal Care Services. Settings such as ventilator homes where persons receive nursing as part of a contracted or enhanced rate would not be eligible.
 - SPPC participants are eligible to receive LTCCN services, if they meet the other eligibility requirements in OAR 411-048-0170.

- What type of documentation should I expect from a RN after I authorize Long Term Care RN services?
 - There are two required forms that the nurse completes: The APD Long Term Care Community Nursing Service Plan (SDS 0754) and the APD Long Term Care Community Nursing Services Summary (SDS 0752). The purpose of these forms is to ensure that the RN communicates information to you. The documentation entered on each form is required to be legible and easily understood. The RN is not to use medical abbreviations, medical terminology or jargon. If you find that the RN is not willing to document in a manner that helps you understand their services, immediately let your manager or the LTCCN Program Coordinator know of the communication problems. The nurse must also complete SDS 4102 as part of the authorization process.

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- You should expect to receive a current Nursing Service Plan each and every time a RN makes updates to the Service Plan and when there is a request for Prior Authorized services.
 - The APD Long Term Care Community Nursing Service Plan (SDS 0754) is a required form and is intended to communicate the individual's health issue, the desired outcomes for that issue and the specific activities that the nurse will be providing for your individual to help the individual get to these outcomes, and needs to be individualized to the individual's needs. The LTCCN RN also uses the nursing service plan (SDS 0754) to communicate to the CM:
 - If delegation is needed, and the estimated service units for delegation.
 - The frequency of monitoring visits
 - The APD Long Term Care Community Nursing Services Summary (SDS 0752) is a required form and is to be completed by the RN for all individual encounters; i.e., a professional services visit to your individual's home, attendance at individual care team or individual support plan meetings, for any telephone consultation with the individual, the CM or another care team member concerning the individual. The summary should address:
 - Individual's current health status
 - A summary of the services provided to your individual on that date of service
 - Any proposed actions that the RN and/or you should take as a result of the services provided that day
 - Copies of reassessment and updated service plan if these activities were performed.
- What should a RN Nursing Assessment tell me?
 - The nursing assessment is the nursing process used to collect information about your individual and their living environment. At a minimum the nursing assessment should review:

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- The individual's health support needs related to both the reason and other known health conditions.
 - Any environmental concerns that prevent challenges to health or safety
 - The individual's key health beliefs and health behaviors including behaviors that create potential and current risk to the individual.
 - Any teaching or delegation needs that need to be addressed.
- How often should the LTCCN RN and CM communicate?
 - At a minimum the LTCCN RN and CM must communicate every six months before the CM authorizes the next six months of service. The best practice is to use the information on the Nursing Service Summary (SDS 0752) as a guide for checking in with the nurse. If the CM wants more information on an event the CM should contact the nurse. Guidelines for communication include:
 - Both the case manager and the nurse will contact each other in a timely manner whenever they become aware of a change of condition (see the referral list) or the individual needs more intensive medical supports such as hospitalization, a referral to specialist or a change in physician services.
 - Frequent communication by email is encouraged as the case manager can easily add these information to the ACCESS narrative.
 - Scheduling of face-to-face meetings must factor in the case manager's workload, schedule and the fact that nurses do not get paid for travel time.
 - Problems or concerns that either the nurse or case manager has regarding communication must be immediately brought to management attention
- What if the RN stops communicating with me or stops providing me with documentation concerning my individual?

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- If a LTCCN RN stops communicating with you or stops providing you with documentation at the visitation frequency identified on the Nursing Service Plan, contact the RN directly and ask why there has been no documentation or communication concerning your individual. Long Term Care RNs are required to submit a completed RN Services Summary to you for every individual encounter. If you cannot reach the LTCCN RN alert local management.
 - What Is Delegation?
 - Delegation of a nursing task is a legal procedure overseen by the Board of Nursing (OAR 851-047). Delegation means the nurse provides training and supervision to ensure that the individual receives safe ongoing provision of a specific nursing task by a qualified caregiver. ‘Nursing’ tasks are activities that must be delegated if performed by non- family members without a nursing license. Tasks might include subcutaneous insulin injection, tracheotomy care and suctioning, and the administration of nutritional supplements, medications and hydration through a gastrostomy tube. Nurses have sole authority whether to perform delegation or not and it must be limited to individuals with stable health conditions. Each delegation is performed by a specific nurse and is focused on a specific task, delivered by a specific caregiver to a specific individual. The delegation process must be restarted if any of these components changes (the task, the caregiver, the individual or the nurse). Nurses are expected to use forms of their choice to document delegation and teaching activities.

Mental and Emotional Disorders Review

For most current information use link to [MED – Mental or Emotional Disorders Review Team webpage](#)

Recent MED Updates 9/27/18 – per LTSS Leadership

- We cannot open a service plan for APD LTSS while waiting for MED. They are not eligible until a decision is made. If we opened them we would be violating OARs.

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- Familiarize yourself with the information and checklist on the MED webpage
 - There is a transmittal in process to cover MED updates
 - Oregon's state plan states that APD will serve all eligible consumers over 65
 - APD can provide services in a MH setting that is not secure – requires an extensive process and needs CO approval.
 - It is the hospital's and other healthcare providers' responsibility to provide adequate documentation for the D/T Coordinator to submit to MED
 - TBI and dementia severity is on a spectrum like most diagnosis. Documentation is need showing TBI or abnormal aging is the cause of care needs.
 - Any observations that you think are imperative for the MED team to know and understand about the consumer and their care needs should be included on the front page of the referral.
 - The 5 day timeline for an answer from MED is outdated and the expectation is approximately 30 days from date all the documentation has been submitted.
 - Best practice is to wait to submit until you have all the documentation you are waiting for.
 - If new documentation comes to you unexpected, please submit quickly with information about which referral it is in reference to. Be sure to indicate it is not a new referral.
 - If you have questions about a specific scenario staff with your leadership– email MED directly
 - If you are being questioned by a hospital or other facility about the process after you have completed your responsibilities, please refer them to:
 - Your leadership team, then
 - MED Team, then
 - Executive Leadership – via your local leadership team's process.

Older Adult Behavioral Specialist

THREE PRIMARY FUNCTIONS

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- Interagency/multi-system planning for better coordination between systems
 - Complex case consultation
 - Workforce development and community health and wellness promotion

FUNCTION #1 -COORDINATION

- Promote partnerships and linkages
- Promote value of collaboration
- Build shared common culture and values
- This process would result in –
 - Removal of silos
 - Elimination of barriers
 - Creation of synergies
 - Alignment of priorities and goals
 - Finding better solutions

FUNCTION #2 -CONSULTATION

- Complex Case Consultation –
 - Multi-disciplinary team approach
 - Multi-morbidity lens
 - Individuals with cross-system needs
 - Social factors
 - Clinical data
 - Solution focused

FUNCTION #3 –Workforce Development and Community Education and Awareness

- Workforce development –increase the human capital infrastructure through a range of activities that -
 - CREATE
 - SUSTAIN
 - RETAIN
- A viable and competent workforce

Older Adult Behavioral Health Specialists Contact List can be found on ShaprePoint DT Document Library or you can email the OHA Coordinator

Statewide Older Adult Behavioral Health Coordinator

- Nirmala Dhar, nirmala.dhar@state.or.us, 503-945-9715

Oregon Project Independence (OPI)

Link to OPI page from CM tools

Program of All-Inclusive Care for the Elderly (PACE)

Link to PACE page on CME tools

PROGRAM DESCRIPTION

PACE is a Medicare and Medicaid national program that offers an array of health and social services in a consolidated all-inclusive service model. Medicare and Medicaid funds cover all medically necessary services. There are no co-pays or deductibles. Recipients can also pay privately for the PACE program if they do not qualify for Medicare or Medicaid. Currently, 31 states offer the PACE program serving approximately 23,000 people nationwide and approximately 1,100 people in Oregon. Oregon's PACE program is one of the first and largest in the country.

PACE services are coordinated with the service recipient and their team of healthcare professionals referred to as an interdisciplinary team. Together the service recipient and their interdisciplinary team develop a plan of care that is comprehensive and responsive to the individual's health and social service needs.

PACE SERVICES

- Long-term Care
- Primary Care
- Laboratory Tests & Procedures

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- Emergency Medical Services
 - Hospital Care
 - Nursing Home Care
 - Hospice/Palliative Care
 - Specialty Medical Care: Audiology/Optical/Podiatry
 - Therapeutic Services: Physical/Occupational/Speech/Recreational
 - Dental Services
 - Mental Health Services
 - Social Services
 - Medication: Prescription & Over the Counter
 - Medical Supplies
 - Medical Equipment
 - Adult Day Services
 - Transportation

PACE ELIGIBILITY

- 55 years old or older;
- Living in a PACE service area;
- Able to reside safely in the community;
- Nursing Home Level of Care (SPL 1-13).

PACE SERVICE AREAS

Currently the PACE program is offered in the following locations in the state of Oregon:

- Multnomah County
- Clatsop County: Arch Cape, Astoria, Cannon Beach, Hammond, Seaside, Tolovana Park
- Tillamook County: Manzanita, Nehalem, Wheeler
- Washington County: Beaverton, Tualatin, Cornelius, Forest Grove, Hillsboro, Sherwood, Portland

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- Clackamas County: Clackamas, Gladstone, Happy Valley, Marylhurst, Oregon City, Tualatin, West Linn, Lake Oswego, Portland

The Oregon Department of Human Services supports a statewide expansion of the PACE program and additional PACE provider organizations.

PACE PROVIDER ORGANIZATIONS

PACE provider organizations are responsible for meeting all of the health and social service needs identified in the service recipient's plan of care. APD currently contracts with Providence Health & Services to provide PACE program services in the current PACE service areas in Oregon. Providence Health & Services is a not-for-profit health system providing a comprehensive array of services in Oregon, Washington, Alaska, Montana and California.

Providence brands the PACE program in Oregon as *Providence ElderPlace Portland*. Providence ElderPlace Portland operates nine Health and Social Centers, two licensed Residential Care Facilities and one Assisted Living Facility in Oregon. Services are delivered by Providence ElderPlace staff and/or contractors that make up a network of hundreds of healthcare and residential providers.

Referrals to the Providence ElderPlace PACE program can be made on-line at <http://appsor.providence.org/oregonemailforms/for-more-information/> or by calling Providence ElderPlace directly at 503-215-6556.

RESOURCES

DHS APD Contact

Cindy Susee, PACE Policy Analyst

Direct Line: 503-945-6448

PACE Toll-free: 1-844-224-7223

cynthia.susee@dhsosha.state.or.us

Providence ElderPlace <http://oregon.providence.org/our-services/p/providence-elderplace/>

Medicare.gov PACE Overview

<http://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html>

State-Planned Personal Care

Link to SPPC webpage on CM tools

Other Tools

“It always seems impossible until it’s done.”

