OPTIONS Program – Appendix D.1
SAMS DATA ENTRY REQUIREMENTS

OPTIONS consumer information and transactions are recorded in SAMS. This information includes consumer details and National Aging Program Information System (NAPIS) data, Care Enrollments, Care Plans, Service Plans, Service Orders/Deliveries, Journal Notes, Assessments and Actions.

The table below provides details about OPTIONS program data collection in SAMS.

Registering a New Consumer	• When registering a consumer, the following fields at minimum will be entered in the consumer details field in SAMS:
	  o First and Last Name
	  ▪ This will be their Legal Name, not a nickname.
	  o Social Security Number (SSN)
	  ▪ Enter the complete 9-digit SSN if known.
	  ▪ If the full SSN is unknown, leave the field blank. Do not enter a partial SSN.
	  o Default Agency
	  ▪ This is the AAA for county where older adult permanently resides.
	  o Default provider
	  ▪ This will be your AAA/Provider.
	
	• For additional information on how to search for and/or register a consumer in SAMS, please refer to and review the following training modules which are available on WellSky's Training site (accessed via the WellSky Portal).
	  o A_D Consumer Records - Part 1.mpg
	  o A_D Consumer Records - Part 2.mpg

Level of Care	• Not Applicable – Level of care is not applicable in OPTIONS care enrollment. All OPTIONS consumers are treated the same with respect to enrollment, regardless of level of care. • Needs are initially assessed using the NAT (Needs Assessment Tool) or NAT-E (Express). These tools do not provide a level of care determination. • If a consumer has had a level of care determination, the level of care is entered into the NAT, Question 19. A.1. This will automatically transfer the answer into SAMS Consumer Details. The data is recorded in a custom field "Assessed and Determined NFCE", in the Care Management section.

NAT and NAT-E	• Consumer needs are assessed using the NAT or NAT-E as part of the OPTIONS enrollment process and reassessment process. • Prior to enrollment in OPTIONS, the NAT or NAT-E is service delivered under the consumer's non-care managed Care Enrollment. • Upon enrollment in OPTIONS, follow-up NAT or NAT-E reassessments are service delivered under the consumer's OPTIONS Care Enrollment. • The NAT or NAT-E service delivery date will be the date the face-to-face interview was completed by the Care Manager (NAT question 1.A.1.).
Care Enrollment	• OPTIONS – Care Enrollment used for all OPTIONS consumers. • Emergent Services – Care Enrollment used for Emergent Services delivered to consumers **NOT** currently enrolled in OPTIONS.
Care Enrollment: Status <u>Active Care Enrollment:</u> <u>Terminated Care Enrollment</u>:	• Active – All OPTIONS consumers will have an active OPTIONS Care Enrollment regardless of placement on the Wait List. When applicable, use the following Reason Codes for Active Care Enrollment status: o Referred by AmeriHealth Caritas o Referred by Independent Enrollment Broker o Referred by PA Health & Wellness o Referred by UPMC CHC • Terminated – When Care Enrollment is terminated, identify reason for termination by using one of the following Reason Codes: o Consumer Refused Services o Deceased o Moved out of PSA Area o Placement/NF o Terminated - Enrolled in MA LTSS o Transfer to another PSA o Voluntary closure by consumer o Other/Unknown (Journal entry required)

Care Enrollment: Start Date	• The Care Enrollment Start Date will be on or after the date the Care Management Supervisor signs the initial assessment and approves the care plan
	  o NAT question 20.B.6
	  o NAT-E question 12.A.9

Care Plan	• The OPTIONS Care Plan will be created upon enrollment into the program.

Care Plan: Status
 	
<u>Active Care Plan</u>**:**
 	
<u>Expiring Care Plan:</u>
 	
<u>Terminated Care Plan</u>*:*
	• All OPTIONS consumers will have an active OPTIONS Care Plan regardless of Wait List placement.
	
	• All OPTIONS consumers will be care managed, even if on the Wait List for other services.
	
	• The Active Care Plan will include:
	  o Status Code: Active
	  o Reason Code: Current
	
	• Care Plans with monthly costs exceeding $765 will include:
	  o Status Code: Active
	  o Reason Code: Cap Exception Approved
	
	• When a consumer has a reassessment, the <u>Expiring Care Plan</u> will include:
	  o Status Code: Inactive
	  o Reason Code:
	  ▪ CP Complete; <u>or</u>
	  ▪ CP Complete-Cap Exception Approved
	
	• When the consumer's Care Enrollment and Care Plan are terminated, the Care Plan will include:
	  o Status Code: Terminated
	  o Reason Code:
	  ▪ Terminated Cap Exception Approved; <u>or</u>
	  ▪ Terminated Current
	
	• *This preserves the reason the Care Plan was Active*

Service Plans (also known as Service Allocations)	• Service Plans will be entered for each service in the OPTIONS Care Plan. • All OPTIONS Care Plans will include a Service Plan for Care Management.

Health and Safety Plans:	• Each Service Plan will include "Special Instructions" which outline details about the provision of the service (i.e. 2 hours of Home Support provided on Wednesdays for grocery shopping). Special Instructions will transfer to service orders when orders are generated.
	
	• If health and safety concerns are identified, a Health and Safety Service Plan will be created
	
	• If consumer refuses to address the identified health and safety concerns, the Care Manager will document this refusal in a journal entry.
	
	• When entering the Health and Safety Service Plan:
	  o Service Category: Care Management
	  o Service: Health and Safety
	  o Unit Price: $0.00
	  o Schedule Allocation Type: Care Plan
	  o Special Instructions: Related health and safety concerns and measures to address the concerns will be documented.

Service Plan (Allocation): Status
 	
Active Service Plans:
 	
Wait List Service Plans:
	• The Status of the Care Management and the Health and Safety Service Plans will be Active, regardless of Wait List placement for other OPTIONS services.
	
	• Service Plans that are able to start immediately will be placed in Active Status.
	
	• Each Service Plan will have a Reason Code that identifies the payment model for that specific service:
	  o Status Code: Active
	  o Reason Code: (One of three choices)
	  ▪ Agency
	  ▪ Consumer Reimbursement
	  ▪ Fiscal Agent
	
	• Service Plans for which the consumer is on a Wait List are placed in one of three "Waiting" statuses. (See Wait List/Wait List Status below)
	
	A status of "Waiting" will only be indicated in the Status Code for the Service Plan, not in the Care Enrollment or Care Plan.

Expiring Service Plans:	• When a consumer is reassessed, the Status and Reason Codes for the Expiring Service Plans do not need to be changed.
Terminated Service Plan:	• Terminated Service Plan – When a Service Plan is terminated due to a change in provider or service is no longer needed, the Status Code of the terminated Service Plan will be changed to one of the three Status Codes below to preserve the original payment model: o Status Code: Terminated - Agency o Status Code: Terminated - Consumer Reimbursement o Status Code: Terminated - Fiscal Agent o No Reason Code
Terminated Service Plan with Waiting List Status Code:	• If the Terminated Service Plan has a Waiting List Status Codes: o Status Code: Waiting List Terminated – Other o Reason Code: Other – Required Journal Entry Status
Wait List / Wait List Status	• Wait List status is entered within each individual Service Plan in the Care Plan. • The Care Management Service Plan is always active for a consumer with an active OPTIONS Care Enrollment. • Identification of a provider is not required when consumer is waiting for a service.
Wait List Service Plan Status Code:	• When a consumer is waiting for services, each individual Service Plan will be assigned one of the three following Status Codes: o Waiting – No Funding (no Reason Code required) o Waiting – No Provider (no Reason Code required) o Waiting – Other (select appropriate Reason Code below) • When “Waiting – Other” is selected as the waiting status, select one of the following Reason Codes: o Consumer away or out of town o Consumer hospitalized o Short-term nursing facility o Other – Journal Entry Required

Wait List Service Plan Termination:	• Upon removal from the Wait List, individual Service Plans will be assigned one of three Status Codes:
	  ○ Waiting Terminated – Funding Available (no Reason Code required)
	  ○ Waiting Terminated – Provider Available (no Reason Code required)
	  ○ Waiting Terminated – Other (select appropriate Reason Code below)
	
	• When "Waiting Terminated – Other" is selected, select one of the following Reason Codes:
	  ○ Consumer Enrolled In Another Program
	  ○ Consumer No Longer In Hospital
	  ○ Consumer No Longer In Rehab/Short-Term Facility
	  ○ Consumer Passed
	  ○ Consumer Returned Home
	  ○ Consumer Refused Service
	  ○ Other – Required Journal Entry
	
	• The consumer already has an Active OPTIONS Care Enrollment, Care Plan and Service Plan for Care Management. When the service becomes available and waiting status is terminated, only that Service Plan Status will be updated.
	
	• Upon termination of Service Plans in waiting status, new Service Plans for those services will be created with a Status of Active.
	
	• If there is no Wait List, the Service Plan Status is Active for all services in the Care Plan.

Service Order / Service Delivery	• Service orders will be generated for all services, except for Care Management, Informal Supports, Health and Safety, third-party payers (TPP), and services in "waiting" status. • Service orders will include "Special Instructions" which outline details about the provision of the service (i.e. 2 hours of Home Support provided on Wednesdays for grocery shopping). • Service orders will have a completed Service Allocation Schedule that details days and units of service per day. • Service orders **will be** generated for Agency payment model services and **sent** to the service provider.

	• Service orders **will be** generated for Consumer Reimbursement and Fiscal Agent payment model services but **not sent** to a provider. • Service Deliveries including Daily Unit Details will be entered for all OPTIONS services rendered.
Service Delivery of Care Management	• Every contact with an OPTIONS consumer or on a consumer's behalf will be documented in a journal entry and included in a Care Management Service Delivery. • There will be one Care Management Service Delivery entered for each calendar month that a Care Manager has contact with, or on behalf of an OPTIONS consumer. • Each contact with a consumer, or on their behalf, during that calendar month will be entered into the Daily Unit Details of the Service Delivery for Care Management. • Units of Care Management are counted in hours or fifteen-minute increments of an hour: ▪ 15 minutes = 0.25 ▪ 30 minutes = 0.50 ▪ 45 minutes = 0.75 ▪ 60 minutes = 1.0 • Care Management Service Deliveries will be entered with a unit price of $0.00.
Journal Entries	• Journal entries will be entered for each contact with or related to the Care Management of an OPTIONS consumer. • Indicate the date the activity occurred in the body of the narrative if this date is different than the entry date o Example: A voicemail came in on Sunday, 6/19/22, but the Care Manager was not able to input the related Journal into SAMS until the afternoon of Monday, 6/20/22. ▪ Journal Entry Date: 6/20/2022 ▪ Journal Entry Time: 12:53 PM ▪ The Journal Comments contain the actual date of activity; Cons called on Sunday, 6/19/2022 and left a voicemail. • In addition to regular journal entries for each contact related to a consumer, the following Journal Entry Types will be used as indicated below for these specific activities:

	○ 3 months-Telephone Contact ○ 6 months-Home Visit ○ 9 months-Telephone Contact ○ 12 months-Annual Reassessment ○ Back-Up Plan ○ MA Eligibility-IEB App Status-30 days ○ MA Eligibility-IEB App Status-60 days ○ MA Eligibility-IEB App Status-Home Visit-90 days ○ MA Eligibility-Referral to IEB ○ OPTIONS-90 Day Extension ○ OPTIONS-Authorization for Emergent Svcs ○ OPTIONS-Average Care Plan Cost Determination ○ OPTIONS-Bid Solicitation ○ OPTIONS-Cost Cap Exception ○ OPTIONS-Cost Cap Exception-Provider Rate Increase ○ OPTIONS-Income Calculation Exception ○ OPTIONS-Initial Referral ○ OPTIONS-Insurance Denial Home Health Svcs ○ OPTIONS-Insurance Denial Medical Equip/Supp/AA Devices ○ Timeframe Extension ○ Two-Week Follow-Up
Activities and Referrals (Actions)	• Activities and Referrals are required for the following: ○ OPTIONS Cost Cap Exception Process ▪ One of the following Status Codes will be used: • Submitted ○ Care Manager has entered the activity • Completed ○ Supervisor has reviewed and approved the exception • Denied ○ Supervisor has reviewed and denied the exception
File Attachments	• The Care Manager will scan and attach any relevant documents to the OPTIONS consumer record in SAMS. Examples of documents to be scanned include, but are not limited to: ○ Accepted bid(s) for Home Modification(s) ○ Consumer Reimbursement Form(s) ○ Draft Care Plan ○ Financial information ○ Insurance denials, if available ○ Landlord approval agreement for Home Modification ○ Powers of Attorney ○ Release of Information form ○ Self-Employed/Independent Contractor Declaration Form

Consumer Details/Custom Fields	• Needs Assessment Score (NAS) – This field self-populates based upon results of decision logic embedded in the Needs Assessment Tool (NAT), and is used for placement on the Wait List, if applicable.
	  ○ This score is calculated in question 20.A.4. The Care Manager will manually enter the score in question 20.A.5. to allow the score to display in the NAS field on the consumer's details screen.
	
	• Cost Share Amount (%) – The consumer's calculated cost share (see Appendix F.3 OPTIONS Cost Share Scale) is populated directly from the NAT.
	  ○ The cost share amount is calculated in question 19.D.1. The Care Manager will manually enter this percentage in question 19.D.2 to populate the OPTIONS Cost Share Percent field on the consumer's details screen.
	
	• Assessed and Determined NFCE – field self-populates based upon assessment results, if applicable.
	
	• OPTIONS Lifetime Home Mod Amount – Care Manager will calculate and manually enter the updated amount of **all** OPTIONS Home Modification expenditures, not to exceed the $15,000 lifetime maximum.

SAMS Reports
 	
<u>Wait List Report:</u>
 	
<u>Consumer Care Plan Report:</u>
	• The following steps will help you run your local AAA Wait List Report:
	  ○ In SAMS, go to the menu bar and select "Reports".
	  ○ Navigate to the report entitled:
	  ○ **OPTIONS WL-1 Waiting List**
	  ○ Click to open the report.
	  ○ Enter the following information
	  ▪ Title (not required unless report definition is saved)
	  ▪ Your agency
	  ▪ Select Summary or Detail.
	  ○ Click preview to view report (and print if desired).
	
	• The following steps will help you run Consumer Care Plan Report:
	  ○ In SAMS, go to the menu bar and select "Reports".
	  ○ Navigate to the report entitled:
	  ○ **Consumer Care Plan**
	  ○ Click to open the report.
	  ○ If running report for an **initial assessment / initial care plan**:
	  ▪ Date of Report = Today's date

	▪ Program = OPTIONS ▪ Click preview to view report and print ▪ Please note this will produce a blank report you can print, complete during the assessment visit, and obtain the consumer's signature. o If running report for **reassessment**: ▪ Title = Not required unless report definition is saved ▪ Consumer ID = ID of consumer ▪ Date of Report = Today's date ▪ Program = OPTIONS ▪ Enter Your AAA Number (AAA##) = Your AAA number in AAA## format ▪ Click preview to view report and print ▪ This will produce a report you can print containing the current care plan details, update as needed during the reassessment visit, and obtain the consumer's signature. • Please note that the consumer's Co-Pay must be populated on the Consumer Details screen for the report to display correctly.
Additional Resources	• Official Pennsylvania Department of Aging website o https://www.pa.gov/agencies/aging ▪ Contains extensive sources of information and access to PDA's policies and procedures. ▪ Includes official chapters, manuals, appendices and regulations that can be viewed or downloaded for offline use. • PDA-LMS training website o https://www.pda-lms.org/ ▪ Contains numerous SAMS/A&D and OPTIONS trainings, documents, and webinars that can be viewed and downloaded for offline use.