Chapter V: CARE MANAGEMENT

Overview

Care Management is a service provided by the Area Agencies on Aging (AAAs) to assist individuals in need of resources, services, or supports. Care Management supports OPTIONS consumers to remain in their home or community. This service is also provided to Caregivers enrolled in the Caregiver Support Program (CSP) to assist with alleviating stress associated with caregiving and support the caregiving relationship. For purposes of this Chapter, the Caregiver is the identified consumer for the CSP. Care Management may be offered as a stand-alone service to individuals who need the support and assistance of a Care Manager and are not receiving other services.

The Care Manager works with the consumer and/or designated representative to develop and implement a plan to address unmet needs identified in the Needs Assessment Tool (NAT), Needs Assessment Tool Express (NAT-E), or Caregiver Assessment Tool (CAT).

The Care Manager will consider all available formal and informal supports including community resources. To ensure the delivery of person-centered services, the Care Manager will consider an individual's lifestyle, preferences, and cultural needs.

Care Management assists individuals to achieve an optimal level of wellness and functioning through:

- Communication and relationship building
- Education and advocacy
- Assessment and person-centered care planning
- Identification and coordination of resources, services, and supports
- Ongoing follow-up and support

Care Management requires an understanding of the aging process, knowledge of human service programs, and awareness of social issues impacting the older population.

The Pennsylvania Department of Aging (hereafter referred to as "the Department") requires Care Management to be provided as an active service to individuals enrolled in the OPTIONS Program (see Chapter IV: OPTIONS Program) or the Caregiver Support Program (see Chapter VI: Caregiver Support Program), including individuals placed on a wait list. Care Management is also required for individuals served in the Domiciliary Care (Dom Care) Program.

Chapter V: CARE MANAGEMENT

I. ADMINISTRATIVE REQUIREMENTS

A. Minimum Experience and Training Requirements

Staff providing Care Management to consumers will meet the Minimum Experience and Training (MET) requirements as outlined in Chapter I: Administration and can be found here:

- Aging Case Aides
- Aging Care Managers
- Aging Care Management Supervisors

B. Staff Training Requirements

Care Managers, under the direction of a Care Management Supervisor, will receive an orientation using the Department's policies and procedures. The following materials, at a minimum, will be used to train Care Managers:

Aging Services Policy & Procedure Manual

- Chapter II: Hearings and Appeals
- Chapter III: Assessment
- Chapter IV: OPTIONS Program
- Chapter V: Care Management
- Chapter VI: Caregiver Support Program

Pennsylvania Department of Aging Learning Management System (LMS)

- Assessments Webinars
- Care Management Webinars
- Caregiver Support Program (CSP) Webinars
- Data Entry Webinars for Social Assistance Management Software (SAMS), also known as WellSky Aging and Disability
- Mandatory Care Manager Training Modules
- OPTIONS Program Webinars

NOTE: Care Managers may be required to attend additional trainings as mandated by the Department or the local AAA.

Chapter V: CARE MANAGEMENT

II. STAFF RESPONSIBILITIES

A. Care Manager

The primary focus of Care Management will be to support the health, safety, and well-being of consumers. Care Managers will support consumer choice and preference whenever possible. Care Manager responsibilities include, but are not limited to:

- Conducting Comprehensive Assessments
  - Identifying a consumer's unmet needs
  - Identifying available supports
  - Collecting appropriate financial information and discussing OPTIONS cost share or the CSP caregiver reimbursement percentage with the consumer
  - Identifying a consumer's functional ability for OPTIONS
  - Collecting information pertaining to a consumer's health status and medical conditions
  - Identifying needs of the Caregiver to support the Caregiving relationship and Caregiver's wellbeing for CSP
  - Determining program eligibility
  - Identifying the need to refer individuals to additional programs

- Developing Person-Centered Care Plans
  - Ensuring the care plan is developed based on unmet needs identified during the assessment
  - Ensuring the care plan developed with the consumer integrates the individual's lifestyle, preferences, and cultural needs
  - Offering the consumer choice of service providers when available
  - Ensuring the Department is the payer of last resort by:
    - Identifying potential informal supports, third-party payers, or available resources, e.g., senior centers, PA MEDI, Veterans benefits, PACE, LIHEAP, SNAP, etc. to address the consumer's needs (See Appendix F)
    - Discussing available financial resources, including income and assets, to explore how these resources may enhance their care plan
  - Following up on recommendations, interventions, and referrals

- Completing On-Going Activities
  - Ensuring services are being provided as authorized and directed by the care plan
  - Maintaining on-going contact with the consumer as required and as needed
  - Adjusting a care plan/service plan based on functional changes and/or available supports
  - Assisting the consumer with issues related to services and supports
  - Making referrals to resources (as agreed upon by the consumer)
  - Making a referral to Protective Services as appropriate under the Older Adult Protective Services Act
  - Ensuring cases are transferred appropriately to other Care Managers and AAAs
  - Ensuring the AAA follows the OPTIONS to Medical Assistance Long-Term Services and Supports (MA LTSS) Transfer Process (Refer to Chapter IV: OPTIONS Program Appendix F.2)

- Entering Data
  - Adhering to all SAMS documentation and data entry requirements

B. Care Management Supervisor

The Care Management Supervisor is responsible for the direct oversight of Care Managers. The supervisor will possess all knowledge and competencies required of Care Managers. Care Management Supervisor responsibilities include, but are not limited to:

- Providing Training and Quality Assurance
  - Providing information and training to Care Management staff including:
    - Policies and procedures required by the Department as related to their position within the agency
    - Internal Care Management procedures that directly impact the provision of services
    - Community resources
    - SAMS data entry
  - Making home visits, as determined necessary, to:
    - Evaluate staff performance

        - Provide insight and support to the Care Manager to assist in care plan development or intervention strategies
    - Participating in random record reviews as part of an agency's plan of continuous quality improvement which includes identifying staff training needs

- Completing Ongoing Activities
    - Reviewing assessments for completeness and accuracy
    - Reviewing care plans to ensure they are person-centered and recommended services correspond to unmet needs identified in the assessment (CAT, NAT, and NAT-E)
    - Providing input and guidance in the development of the care plan, including intervention strategies for complex cases
    - Approving and signing assessments and care plans
    - Reviewing and authorizing care plan cost cap exceptions according to local AAA policy
    - Reviewing financial information for accuracy
    - Ensuring policies and procedures are followed

- Providing Supervisory Oversight
    - Assigning and/or reassigning cases to ensure compliance with program requirements
    - Confirming cases are transferred to other AAAs
    - Ensuring the AAA follows the OPTIONS to MA LTSS Transfer Process. Refer to Chapter IV: OPTIONS Program, Appendix F.2
    - Responding to consumer complaints and issues
    - Evaluating staff performance

- Ensuring Data Integrity
    - Checking SAMS data entry for completeness and accuracy per Appendix D
    - Verifying required forms are complete, accurate, and file attached
    - Confirming cases have been closed in SAMS per Appendix D
    - Retrieving and reviewing applicable SAMS Maintenance Reports to ensure the correction of data entry errors

III. SAMS DATA ENTRY

SAMS is the database the AAAs utilize for collecting, managing, and reporting consumer information for the Department's programs. The Care Manager is responsible for entering timely, complete, and accurate information into the consumer's record in SAMS. When using SAMS, staff are required to log in using their individually assigned user ID and password.

A case record will be maintained in SAMS for each consumer. The SAMS record will include:

- Registration
- Care Enrollment
- Assessments (CAT, NAT, NAT-E)
- Care Plan
- Service Plans (Service Allocations)
- Journal Entries
- Service Orders
- Service Deliveries
- File Attachments
- Activities and Referrals

NOTE: Detailed SAMS data entry requirements are found in the Aging Services Policy & Procedure Manual, Chapter IV: OPTIONS Program, Appendix D and Chapter VI: Caregiver Support Program, Appendix D.

IV. CARE MANAGEMENT PROCESS

The Care Management process consists of:

- Assessment and Identification of Needs
- Identification of Available Supports and Resources
- Care Plan Development
- Initial Care Plan Approval and Implementation
- Reassessment
- Monitoring and Follow-Up
- Case Closure

In instances when the AAA serves an individual with limited English proficiency, the AAA will provide an interpreter at no cost to the individual. When using the Department's designated interpreter service, the Care Manager will follow the process outlined in Appendix F.3. In the event interpreter services are unavailable, an alternative interpreter may be utilized. The Care Manager will document in a journal entry the reason for the use of an alternative interpreter and the interpreter's relationship to the consumer.

A. OPTIONS Program

1. Assessment and Identification of Needs

Upon receipt of the referral for OPTIONS services, the Care Manager will contact the consumer to schedule a home visit. For the purpose of this chapter, the date the Care Manager receives the referral will be documented in a journal entry titled, "OPTIONS – Initial Referral". The home visit will be completed within 10 business days of the initial referral to the Care Manager. The home visit begins the Care Management process. The Care Manager will strive to build rapport with the consumer during the home visit and complete an assessment to identify the individual's need for services.

During the home visit, the Care Manager will complete a NAT or NAT-E to identify the consumer's unmet needs. The assessment (NAT or NAT-E) collects information about the individual and is the foundation for developing the care plan. It is imperative the Care Manager engage the individual in conversation, ask open-ended questions, and request clarification as necessary. The information collected provides insight into an individual's functional needs, preferences, supports, and resources to determine program eligibility. Details of the home visit will be documented in a journal entry in SAMS.

A thorough assessment is critical to the development and implementation of an individual's care plan. The Care Manager will ensure all assessment questions are answered and financial information has been provided (for the NAT). The consumer will be encouraged to provide financial information during the home visit. In rare instances when the consumer is unable to provide financial information during the home visit, the consumer is permitted to provide financial information at a later date. The assessment is

not considered complete until financial information is received and recorded in the NAT.

Consumers receiving Care Management or In-Home Meal service, alone or in combination, may be care managed by a Case Aide or trained intern. In these instances, a Case Aide or trained intern is permitted to complete the home visit and the NAT-E.

2. Identification of Available Supports and Resources

During the home visit, the Care Manager will work with the consumer and/or their representative to identify the consumer's current formal and/or informal supports. Formal supports consist of private pay services or third-party providers such as paid caregivers, home health agencies, medical services, or transportation providers. Examples of informal supports include friends, family members, neighbors, and others who assist the consumer without compensation.

All available resources must be explored and utilized prior to the authorization of the Department-funded services. The Care Manager will engage the consumer in a conversation about using their existing assets and resources to meet their needs. The Older Americans Act mandates services be provided to those with the greatest social or economic need. The Department-funded services should never replace existing supports; however, these services may be used as a supplement to enhance a consumer's ability to remain safely and independently in the community.

3. Initial Care Plan Development

The information collected in the NAT or NAT-E provides a foundation for the development of the care plan. The Care Manager will work closely with the consumer to ensure the plan is person-centered, culturally sensitive, and addresses the needs of the consumer to remain in the community. Developing a person-centered care plan with the consumer encourages choice and independence. A consumer's preference for days of the week and time of day will be considered in developing the care plan. The Care Manager will consider personal preferences and provide the consumer a choice of service providers when available.

The care plan will appropriately address the needs of the consumer and the Department-funded services will be provided in a fiscally responsible

manner. The Care Manger will coordinate services with all third-party payers (TPP) (Medicare, Medicaid, private insurance), formal and informal supports, and other community resources. This ensures there is no duplication of services as the Department is the payer of last resort.

The care plan will include the services necessary to address the functional needs of the consumer. In the special instructions within each service plan, the Care Manager will document services ordered, duration and frequency, and specific details of how the services will be delivered.
Identification of informal supports and TPP is necessary to develop a person-centered care plan. At a minimum, the Care Manager will document informal supports and TPP in a journal entry. The AAA may choose to include informal supports and TPP service plans within the care plan.

An initial care plan cost will not exceed $765 monthly, as averaged over a 12-month care plan period. In the rare instance when services above this amount are needed, the care plan may be increased to a maximum of $1900 per month. The Care Manager will be familiar with their local AAA Cost Cap Exception Policy and apply the policy consistently to all cases.

In instances where care plans have exceeded the cost cap due to the renegotiation of contracts or the provider service rate increase, services will not be adversely affected. This only applies to existing consumers. This will be documented in a journal entry titled, “OPTIONS-Cost Cap Exception-Provider Rate Increase”. New consumers or consumers in need of an increase in service will be subject to the cost cap.

In the event a consumer is transitioning from OPTIONS to MA LTSS, the Care Manager will encourage the consumer to select OPTIONS providers which are also MA enrolled. This ensures services will be provided seamlessly. The Care Manager will offer the consumer a choice of MA providers and update the care plan.

If the consumer chooses providers which are not MA enrolled, there will be a gap in services. Services provided through the Consumer Reimbursement and Fiscal Agent payment models do not transfer as MA LTSS utilizes Financial Management Services. The Care Manager will inform the consumer of the gap in services and document in a journal entry.

Chapter V: CARE MANAGEMENT

During care plan development, a Care Manager may identify health and safety concerns related to the consumer or their living environment. These concerns may be related to a lack of services, refusal to accept services, or environmental or safety issues. The Care Manager will discuss any identified concerns with the consumer and/or their designated representative and work together to develop appropriate measures to address those concerns. The concerns and appropriate measures will be documented in the special instructions of a “Health and Safety” service plan. In instances when the consumer chooses not to address the identified concerns, the refusal will be documented in a journal entry. Refusal to address the concerns will not exclude the consumer from receiving services.

If the Care Manager identifies an imminent risk situation that involves abuse, neglect, exploitation or abandonment, the Care Manager will make a referral to Protective Services.

The discussion of emergency information and planning during the assessment may indicate the need to develop a back-up plan with the consumer and/or their designated representative. The purpose of a back-up plan is to assist with planning for a disruption of service or emergency. When a back-up plan is developed, the Care Manager will document the plan in a journal entry titled, “Back-Up Plan”.

The Care Manager will review the draft care plan with the consumer to ensure the plan adequately addresses their needs and explain the plan must be approved by the Care Management Supervisor prior to implementation. The Consumer Care Plan Report will be used to document the draft care plan. The Care Manager will ensure the consumer’s understanding of the program, review the ongoing contact schedule, and gain the signature of the consumer to show their agreement with the draft care plan and their cost share obligation. If the consumer is not able to sign due to mental and/or physical impairment, there will be documentation on the signature line explaining why the consumer was not able to sign. A representative designated by the consumer may sign the care plan if the consumer is unable to do so. In the event a consumer refuses to sign the care plan, the Care Manager will explain that the consumer is not eligible to receive AAA-funded services other than Care Management.

4. Initial Care Plan Approval and Implementation

The Care Management Supervisor will review and sign-off on the initial assessment and draft care plan within 10 business days of the home visit. The Care Management Supervisor will document their approval by signing and dating the NAT or NAT-E. An assessment is complete when all questions are answered, financial information has been provided (for the NAT), and the supervisor has reviewed and signed-off on the assessment tool (refer to Chapter III: Assessment). In the event a NAT-E is completed by a Case Aide or trained intern, the Care Manager supervising the Case Aide or trained intern may sign-off on the NAT-E and approve the care plan for Care Management and In-Home Meal services.

NOTE: In rare instances where a timeframe is exceeded, a journal entry documenting the reason for the exception will be entered in SAMS. Workload and staffing issues are not considered valid reasons. The journal entry will be titled, “Timeframe Extension”.

Once the Care Management Supervisor has approved the care plan, the Care Manager will create the Care Enrollment and enter the care plan in SAMS per Chapter IV: OPTIONS Program, Appendix D. The initial care plan will have a start date on or after the date the Care Management Supervisor signs off on the NAT or NAT-E and approves the care plan.

NOTE: The care plan will cover a 12-month period. For example, if an initial care plan has a start date of May 16, 2022, the end date will be April 30, 2023. Upon reassessment, the next care plan will have a start date of May 1, 2023.

Service orders will be generated for all services, except for Care Management, Informal Supports, Health and Safety, TPP, and services in “waiting” status. The Care Manager will submit service orders to agency model service providers.

Upon approval of the care plan, the Care Manager will contact the consumer by telephone to provide notification of care plan approval, answer any questions, and provide further clarification about the program. A copy of the approved care plan will be provided to the consumer. If the approved care plan differs from the draft care plan, changes will be explained to the

consumer. In these instances, the approved care plan will be sent to the consumer for signature and returned to the Care Manager.

In instances where the initial units of service are not sufficient to complete the tasks identified in the care plan and there has not been a change in the consumer's condition, a new NAT is not required. The Care Manager will document the request for the increase in service in a journal entry in SAMS. The Care Management Supervisor will review this request within 10 business days and approve the increase before the Care Manager adds the increased units to the care plan. The Care Management Supervisor approval will be documented in a journal entry. A copy of the updated care plan will be mailed to the consumer for signature.

5. Reassessment

The purpose of the reassessment is to determine ongoing program eligibility, reevaluate the consumer's needs and level of functioning, and review the appropriateness of the current care plan. The Care Manager will reassess a consumer annually or when the consumer has a change in condition, income and/or assets, or living environment. The Care Manager will complete the reassessment during a home visit with the consumer and/or their designated representative.

During the home visit, the Care Manager will complete the NAT or NAT-E to ensure the collected information accurately reflects the consumer's current functional needs, preferences, supports, and resources. For specific information, please refer to Chapter III: Assessment. The care plan will also be developed for the next 12-month care plan period.

The annual reassessment will occur by the end of the last month of the 12-month care plan period. Specific details of the home visit will be documented in a journal entry titled, "12 months – Annual Reassessment".

In instances when the current care plan remains the same for the next care plan period, the Care Management Supervisor will review and sign-off on the assessment tool and approve the care plan within the first month of the new care plan period.

Example: If the reassessment is completed in July, the next care plan period will have a start date of August 1st. The Care Management Supervisor review and approval will occur by August 31st.

In the event a reassessment is completed due to a change in the consumer's circumstances, the Care Manager will document in a journal entry the details of the home visit, change in circumstances, and any updates to the care plan. In instances when changes to the care plan are necessary, the Care Management Supervisor will review and sign-off on the assessment tool and approve the increased or additional service(s) within 10 business days of the home visit. To align the assessment date and care plan period, the Care Manager will enter the increased or additional service(s) to the existing care plan for the remainder of the month in which the change in service occurred and end date the care plan as of the last day of the month. The updated care plan will be copied in SAMS for the next 12-month care plan period. A decrease in services will not occur until the Care Management Supervisor approves the changes unless the consumer has requested a decrease in service(s) or termination of service(s). When the AAA determines the units of service in a care plan need to be reduced or the service be terminated, the Care Manager will follow the guidance outlined in Chapter II: Hearings and Appeals.

NOTE: In the event a reassessment NAT-E is completed by a Case Aide or trained intern, the Care Manager supervising the Case Aide or trained intern may sign-off on the NAT-E and approve the care plan according to the procedures outlined within Section 5. Reassessment.

6. Monitoring and Follow-Up

Monitoring and follow-up activities are required to ensure the care plan is administered and adequately addresses the needs of the consumer. Activities may involve the consumer, informal supports, providers, and others involved in care and service delivery. These activities determine and/or confirm:

- Services are being provided in accordance with the consumer's care plan
- Services in the consumer's care plan are appropriate and effective
- Changes in the consumer's circumstances which may impact their care plan

Contact Plan Time Frames and Requirements:

- Two-Week Follow-Up

  Consumers receiving services will have a telephone contact two weeks after the service is ordered. The purpose of this contact is to ensure the service has started, is provided in accordance with the care plan, and the consumer is satisfied with the service. The Care Manager will take necessary steps to ensure any concerns are addressed.

  The two-week follow-up is required for every service ordered during the duration of the consumer's case. This contact will be documented in a journal entry titled, "Two-Week Follow-Up".

- Consumer Contact Plan

  Regular contact with consumers receiving Care Management will occur, at a minimum, as follows:

  - 3 months – Telephone Contact
  - 6 months – Home Visit
  - 9 months – Telephone Contact
  - 12 months – Annual Reassessment

In rare instances when the Care Manager is unable to make contact with the consumer after three attempts, additional follow-up is warranted in order to complete the required consumer contacts. The Care Manager will contact the consumer's emergency contact, a family member, or a service provider of the consumer to seek assistance in contacting the consumer. The Care Manager will complete a home visit in instances when previous contact attempts failed. In the event the Care Manager has exhausted all efforts to contact the consumer, the Care Manager will send written notice of the contact attempts to the consumer and request the consumer contact the Care Manager within 10 business days or services will be terminated. Each attempt to contact the consumer will be documented in a journal entry.

NOTE: Case Aides or trained interns may complete the required telephone contacts and home visits with consumers.

- Mandatory Medical Assistance (MA) Eligibility Determination Process

  Upon referral to the Independent Enrollment Broker (IEB), the Care Manager will document the date of referral and any relevant information in a journal entry titled, “MA Eligibility–Referral to IEB”. Once a referral is made to the IEB, the Care Manager will closely monitor the case (refer to Chapter IV: OPTIONS Program for detailed information). The Care Manager will contact the consumer and document in a journal entry as follows:
  - 30 days – Telephone Contact with journal entry titled: “MA Eligibility–IEB App Status–30 days”
  - 60 days – Telephone Contact with journal entry titled: “MA Eligibility–IEB App Status–60 days”
  - 90 days – Home Visit with journal entry titled: “MA Eligibility–IEB App Status–Home Visit–90 days”

  If the consumer is not cooperating with the MA Eligibility Determination Process at the time of the home visit, the Care Manager will provide the consumer the option to receive services at 100% of the care plan cost or terminate OPTIONS services. Consumers who terminate services may continue to receive Care Management and In-Home Meals, if eligible. If the consumer is cooperating with the IEB and the County Assistance Office (CAO), a 90-day extension may be granted. This will be documented in a journal entry titled “OPTIONS–90 Day Extension”.

  NOTE: Care Managers are not required to follow any other contact plan when the Mandatory MA Eligibility Determination Process Contact Plan is being followed.

7. Case Transfer

- Intra-agency

  When a case is transferred from one Care Manager to another, the receiving Care Manager will contact the consumer within 30 calendar days. This contact will be used to introduce the new Care Manager and address any concerns which may exist.

- Inter-agency

  When a case is transferred from one AAA to another, the losing AAA will, at a minimum, contact the gaining AAA to make a referral for services and coordinate the transfer of relevant file attachments. The losing AAA will terminate the case per SAMS Data Entry Requirements as outlined in Chapter IV: OPTIONS Program, Appendix D. The gaining AAA will complete a new NAT or NAT-E and follow the enrollment procedures as outlined in Chapter IV: OPTIONS Program.

8. OPTIONS to MA LTSS

   Refer to Chapter IV: OPTIONS Program, Appendix F.2 for details outlining the transition to MA LTSS.

9. Case Closure

   When a Care Manager becomes aware a consumer no longer requires services, the following actions will be completed within 30 calendar days:

   - Document the reason for the termination in a journal entry
   - Complete SAMS data entry requirements (Refer to Chapter IV: OPTIONS Program, Appendix D)
   - Care Management Supervisor review to ensure the case has been closed appropriately, and SAMS data entry has been completed correctly

B. Caregiver Support Program

1. Assessment and Identification of Needs

   Upon receipt of the referral for the CSP, the Care Manager will contact the consumer to schedule a home visit. For the purpose of this chapter, the date the Care Manager receives the referral will be documented in a journal entry titled, “CSP–Initial Referral”. The home visit will be completed within 10 business days of the initial referral to the Care Manager. This visit will begin the Care Management process and set the tone for establishing the relationship between the Care Manager, the Caregiver, and Care Receiver. The Care Manager will strive to build rapport with the Caregiver and Care Receiver during the home visit. The Care Manager is encouraged to discuss

sensitive information with the Caregiver outside of the presence of the Care Receiver, as appropriate and necessary.

During the home visit, the Care Manager will complete the CAT to provide an overview of the caregiving relationship and identify areas where support is needed. It is critical the Care Manager engages both individuals in conversation, asks open-ended questions, and requests clarification as necessary. In addition to the caregiving relationship, the CAT addresses Caregiver well-being, caregiving expenditures, and the Care Receiver's household composition and income. Details of the home visit will be documented in a journal entry in SAMS.

Assessment of each of these areas provides insight into the Caregiver's strengths, coping skills, goals, existing supports, resources, and eligibility for formal services. The Care Manager will ensure all assessment questions are answered and financial information has been provided (for the CAT). The Caregiver will be encouraged to provide financial information during the home visit. In rare instances when the Caregiver is unable to provide financial information during the home visit, the Caregiver is permitted to provide financial information at a later date. The assessment is not considered complete until financial information is received and recorded in the CAT. Information collected in the CAT is critical to the development and implementation of a Caregiver's care plan.

NOTE: For Grandparents/Older Relative Caregivers of children, a new CAT will be completed with the Caregiver when a Care Receiver turns age 18 if other Care Receivers who are children remain in the home.

If the Care Receiver has an unmet need and may qualify for OPTIONS services, the Care Manager will complete an assessment with the Care Receiver during the initial home visit or at a later date, if necessary. The Care Receiver is subject to all eligibility requirements outlined in Chapter IV: OPTIONS Program.

2. Identification of Available Supports and Resources

The Care Manager will assist the Caregiver in identifying available formal and informal supports and caregiving resources. Formal supports consist of paid providers such as home health agencies, medical or transportation providers, and caregivers including friends and neighbors. Informal

supports assist the Caregiver without compensation. Informal supports may include friends, family members, neighbors, and support groups. The Care Manager will encourage the Caregiver to build upon and utilize informal supports in the development of their care plan.

NOTE: The Caregiver will not be reimbursed for caregiving expenses paid to a relative.

The Older Americans Act mandates services be provided to those with the greatest social or economic need. All resources and assets must be explored and utilized prior to the authorization of the Department-funded services. The Department-funded services will never replace existing supports, however, may be used as a supplement to enhance the Caregiver's ability to maintain the Care Receiver safely in the community.

Caregivers of children will be informed of additional benefits that may be available to them. For a list of resources for Caregivers of children, refer to Chapter VI: Caregiver Support Program, Appendix F.3.

3. Initial Care Plan Development

The information collected in the CAT provides a foundation for the development of the care plan. The Care Manager will work closely with the Caregiver to ensure the plan is person-centered, culturally sensitive, supports the caregiving relationship, and addresses the needs of the Caregiver to maintain the Care Receiver in the community. The primary goal of care planning is to establish a plan that encourages and supports the Caregiver in their caregiving role. The documentation in the care plan will identify items and services that have been approved by the AAA for reimbursement. Specific instructions relating to the items and services for reimbursement will be clearly identified in SAMS. In the special instructions within each service plan, the Care Manager will document the approved caregiving-related items and/or services purchased by the caregiver for which a reimbursement is issued. The AAA may choose to include informal supports within the care plan.

The Care Manager will encourage the Caregiver to utilize respite as a service to decrease stress and prevent Caregiver burnout. Additionally, the Care Manager will discuss the option for the Caregiver to accumulate benefits. Accumulating benefits allows a Caregiver the opportunity to be away for several days of respite, vacation, hospitalization, or an emergency

absence. Accumulated benefits may be used to purchase extended respite care or other supportive services for a Care Receiver, such as summer camp for a grandchild or disabled adult. The Care Manager will work with the Caregiver to develop a plan for accumulating benefits within their care plan as appropriate.

The Care Manager will determine an appropriate CSP monthly care plan cost cap, taking into consideration the Caregiver's needs and actual caregiving expenditures. The Caregiver's care plan cost cap will not exceed the maximum care plan cost cap established by the Department. Please refer to Chapter VI: Caregiver Support Program. Consideration must be taken to ensure the care plan is appropriate and fiscally justified.

During care plan development, a Care Manager may identify health and safety concerns which may affect the caregiving relationship or the Caregiver's ability to provide care. The Care Manager will discuss any identified concerns with the Caregiver and work together to develop appropriate measures to address those concerns. The concerns and appropriate measures will be documented in the special instructions of a "Health and Safety" service plan. Should the Caregiver choose not to address the identified concerns, the refusal will be documented in a journal entry. Refusal to address the concerns will not exclude the Caregiver from receiving services.

If the Care Manager identifies an imminent risk situation that involves abuse, neglect, exploitation, or abandonment, the Care Manager will make a referral to Protective Services.

A Caregiver may benefit from a back-up plan to assist with planning for a disruption of service or emergency. When a Care Manager recognizes the need to develop a back-up plan with the Caregiver, the Care Manager will document the plan in a journal entry titled, "Back-Up Plan".

The Consumer Care Plan Report will be used to document the draft care plan. The Care Manager will explain the plan must be approved by the Care Management Supervisor prior to implementation. Discussion with the Caregiver will clearly outline the process for completing and submitting required monthly documentation, ensure the Caregiver's understanding of the program including reimbursement for approved services and supplies, the monthly care plan cost cap, and their determined reimbursement percentage. The Care Manager will also review the ongoing contact

schedule with the Caregiver and gain the signature of the Caregiver to show agreement with their draft care plan. In the event a Caregiver refuses to sign the care plan, the Care Manager will explain the Caregiver is not eligible to receive AAA-funded services other than Care Management.

4. Initial Care Plan Approval and Implementation

The Care Management Supervisor will review and sign-off on the initial assessment and draft care plan within 10 business days of the home visit. The Care Management Supervisor will document their approval by signing and dating the CAT. An assessment is complete when all questions are answered, financial information has been provided, and the supervisor has reviewed and signed-off on the assessment tool (refer to Chapter III: Assessment).

NOTE: In rare instances where a timeframe is exceeded, a journal entry documenting the reason for the exception will be entered in SAMS. Workload and staffing issues are not considered valid reasons. The journal entry will be titled, “Timeframe Extension”.

Once the Care Management Supervisor has approved the care plan, the Care Manager will create the Care Enrollment and enter the care plan in SAMS per Chapter VI: Caregiver Support Program, Appendix D. The initial care plan will have a start date on or after the date the Care Management Supervisor signs off on the CAT and approves the care plan.

NOTE: The care plan will cover a six-month period. For example, if an initial care plan has a start date of May 17, 2022, the end date will be October 31, 2022. Upon reassessment, the next care plan will have a start date of November 1, 2022.

Upon approval of the care plan, the Care Manager will contact the Caregiver by telephone to provide notification of care plan approval, answer any questions, and provide further clarification about the program. A copy of the approved care plan will be provided to the Caregiver. If the approved care plan differs from the draft care plan, changes will be explained to the Caregiver. In these instances, the approved care plan will be sent to the Caregiver for signature and returned to the Care Manager.

The Care Manager will explain any additional items or services will only be reimbursed if the Caregiver receives prior approval from the AAA. Any

changes to the care plan will be documented in a journal entry in SAMS. Any changes specific to a service plan will be detailed in the special instructions.

5. Reassessment

The purpose of the reassessment is to determine ongoing program eligibility, reevaluate the Caregiver's needs, and review the appropriateness of the current care plan. The Care Manager will reassess the Caregiver every six months or anytime there is a significant change in the caregiving relationship or a change in household income/composition. A Care Manager will complete the reassessment during a home visit with the Caregiver and Care Receiver in the caregiving environment.

During the home visit, the Care Manager will complete the CAT to ensure the collected information accurately reflects the caregiving relationship and identifies areas where support is needed. The care plan will be developed for the next six-month care plan period.

The six-month reassessment will occur within the last month of the six-month care plan period. Specific details of the home visit will be documented in a journal entry titled, "6 months–Home Visit–Reassessment".

While reassessment for the CSP is required every six months, financial information is only required to be provided on an annual basis or when there has been a significant change in countable income or household composition that may affect the Caregiver's reimbursement percentage. Specific details of the home visit will be documented in a journal entry titled, "12 months-Home Visit-Reassessment." Please refer to Chapter III: Assessment.

In instances when the current care plan remains the same for the next care plan period, the Care Management Supervisor will review and sign-off on the assessment tool and approve the care plan within the first month of the new care plan period.

Example: If the reassessment is completed in July, the next care plan period will have a start date of August 1st. The Care Management Supervisor review and approval will occur by August 31st.

In the event a reassessment is completed due to a significant change in the caregiving relationship or Care Receiver's household income/composition, the Care Manager will document in a journal entry the details of the home visit, change in circumstances, and any updates to the care plan. In instances when changes to the care plan are necessary, the Care Management Supervisor will review and sign-off on the assessment tool and approve the increased or additional service(s) within 10 business days of the home visit. To align the assessment date and care plan period, the Care Manager will enter the increased or additional service(s) to the existing care plan for the remainder of the month in which the change in service occurred and end date the care plan as of the last day of the month. The updated care plan will be copied in SAMS for the next 6-month care plan period. A decrease in the Caregiver's monthly care plan cost cap will not occur until the Care Management Supervisor approves the changes unless the Caregiver has requested a decrease or termination. In cases where the AAA has taken action to reduce a Caregiver's monthly care plan cost cap or terminate services, the Care Manager will follow the guidance outlined in Chapter II: Hearings and Appeals.

6. Monitoring and Follow-Up

Monitoring and follow-up activities are required to ensure the care plan is administered and effectively addresses the needs of the Caregiver. Activities include:

- Reviewing and reconciling monthly receipts to ensure that services and supplies are provided in accordance with the care plan
- Verifying there is no duplication of services, and the Department is the payer of last resort prior to monthly authorization of reimbursement
- Contacting the Caregiver regarding discrepancies with receipts
- Identifying significant changes in caregiving expenses and discussing the changes with the Caregiver to ensure the care plan adequately addresses their needs
- Updating the care plan as needed
- Providing on-going contacts as required by the CSP

Contact Plan Time Frames and Requirements

- Caregiver Contact Plan

  All Caregivers, including those on a wait list for the CSP will have Care Management as an active service in their care plan. At a minimum, Caregivers will receive the following ongoing contacts during the care plan period:

  - 3 months – Telephone Contact
  - 6 months – Home Visit – Reassessment
  - 9 months – Telephone Contact
  - 12 months – Home Visit – Reassessment – Annual Financial Redetermination

- Additional Caregiver Contact:

  For Grandparents/Older Relative Caregivers of Children, a new CAT will be completed when a Care Receiver turns age 18 if other Care Receivers who are children remain in the home:

  - Age 18 – Home Visit – Reassessment

In rare instances when the Care Manager is unable to make contact with the Caregiver after three attempts, additional follow-up is warranted in order to complete the required Caregiver contacts. The Care Manager will contact the Caregiver's emergency contact to seek assistance in contacting the Caregiver. The Care Manager will complete a home visit in instances when previous contact attempts failed. In the event the Care Manager has exhausted all efforts to contact the Caregiver, the Care Manager will send written notice of the contact attempts to the Caregiver and request the Caregiver contact the Care Manager within 10 business days or services will be terminated. Each attempt to contact the Caregiver will be documented in a journal entry.

7. Case Transfer

- Intra-agency
  When a case is transferred from one Care Manager to another, the receiving Care Manager will contact the Caregiver within 30 calendar days. This contact will be used for the Care Manager to introduce

themselves, answer Caregiver questions, and gain updates from the Caregiver.

- Inter-agency

  When a case is transferred from one AAA to another, the losing AAA will, at a minimum, contact the gaining AAA to make a referral for services and coordinate the transfer of relevant file attachments. The losing AAA will terminate the case per SAMS Data Entry Requirements as outlined in Chapter VI: Caregiver Support Program, Appendix D. The SAMS case record will remain open until the last day of the month of transfer in order for services to be reimbursed. The gaining AAA will complete a new CAT and follow the enrollment procedures as outlined in the CSP Chapter.

8. Case Closure

   When a Care Manager becomes aware a Caregiver no longer needs CSP-related services, the following actions will be completed within 30 calendar days:

   - Document the reason for the termination in a journal entry
   - Complete SAMS data entry requirements (Refer to Chapter VI: Caregiver Support Program, Appendix D)
   - Care Management Supervisor review to ensure the case has been closed appropriately, and SAMS data entry has been completed correctly

C. Domiciliary Care Program

The AAA will follow the Domiciliary Care Services for Adults regulations cited in 6 Pa. Code § 21.54 (relating to AAA care plan responsibilities).

V. CASE DOCUMENTATION

Care Managers will provide accurate, clear, and concise documentation of each activity and contact with the consumer, their informal or formal supports, and any activity occurring in relation to the case. Case documentation includes, but is not limited to, journal entries, activities and referrals, mandatory forms, and

attachments to the SAMS record. The Care Manager will enter journal entries into SAMS within 3 business days of the event or contact. Any forms mandated by the Department will not be altered unless prior approval has been received from the Bureau of Aging Services.

Journal entries will provide a complete and accurate history of the Care Manager's involvement with the consumer during the life of the case. Journal entries will be objective and free of subjective or judgmental language. At a minimum, journal entries will:

- Document each on-going contact and interaction with, for, or about a consumer
- Use language that is concise, accurate, and based on facts and observations
- Refrain from using locally developed acronyms or abbreviations (refer to Appendix B for the Department-approved list)
- Indicate the date the activity occurred in the body of the narrative if this date is different than the entry date

A. OPTIONS

1. Mandatory Journal Entries

    - Back-Up Plan
    - OPTIONS–90 Day Extension
    - OPTIONS–Authorization for Emergent Services
    - 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 Services
    - OPTIONS–Insurance Denial Medical Equipment, Supplies, Assistive/Adaptive Devices
    - Timeframe Extension

2. Mandatory Journal Entries for Consumer Contacts

    - 3 months–Telephone Contact
    - 6 months–Home Visit
    - 9 months–Telephone Contact
    - 12 months–Annual Reassessment
    - 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
    - Two-Week Follow-Up

    Care Managers are encouraged to use activities and referrals and dashboards for scheduling, time management, and reporting as needed. AAAs have local discretion in requiring the use of activities and referrals and dashboards for Care Management, except for those required by the OPTIONS Chapter.

3. Mandatory Activities and Referrals

    - OPTIONS Cost Cap Exception Process

4. Mandatory Forms

    At the time of enrollment and reassessment, the following forms will be explained, signed, and retained as a file attachment in the consumer's SAMS record:

    - Consumer Care Plan
    - Notice of Appeal Rights
    - Voter Preference Form (English, Spanish)

    The following forms will be reviewed, signed, and retained as file attachments in the consumer's SAMS record, if applicable:

    - Consumer Reimbursement Self-Employed/Independent Contractor Declaration
    - OPTIONS Program Consumer Reimbursement for Personal Care or Home Support Services
    - OPTIONS Program Consumer Reimbursement Request

B. Caregiver Support Program

1. Mandatory Journal Entries

- Back-Up Plan
- CSP–Authorization for Agency Model
- CSP–Bid Solicitation
- CSP–Care Plan Cost Cap Justification
- CSP–Income Calculation Exception
- CSP–Initial Referral
- CSP–Insurance Denial Med/Eq/Sup/Adapt Dev
- CSP–Late Receipt Submission
- CSP–Out-of-State Caregiver Verification
- CSP–Planned Accumulation of Benefits
- Grandchild–Age 18–Reassessment
- Timeframe Extension

2. Mandatory Journal Entries for Consumer Contacts

- 3 months–Telephone Contact
- 6 months–Home Visit–Reassessment
- 9 months–Telephone Contact
- 12 months–Home Visit–Reassessment

Care Managers are encouraged to use activities and referrals for scheduling, time management, and reporting as needed. AAAs have local discretion in requiring the use of activities and referrals for Care Management.

3. Mandatory Forms

At the time of enrollment and reassessment, the following forms will be explained, signed, and retained as file attachments in the Caregiver's SAMS record:

- Conditions of Participation/Certificate of Accountability
- Notice of Appeal Rights
- Consumer Care Plan
- Voter Preference Form (English, Spanish)

The following forms will be reviewed, signed, and retained as file attachments in the Caregiver's SAMS record, if applicable:

- Caregiver Reimbursement for Services and Supplies
- Caregiver Reimbursement for Personal Care and In-Home Respite Services
- Caregiver Support Program Self-Employed Independent Contractor Declaration

C. Domiciliary Care Program

The AAA will follow the Domiciliary Care Services for Adults regulations cited in 6 Pa. Code § 21.60 (related to Recordkeeping).

VI. CONFIDENTIALITY

Any information about a consumer and their situation will be held in strict confidence and may not be released without the consumer's or legal representative's written consent. AAAs will have written confidentiality procedures within their agencies addressing:

- General Policy
- Release of Information Forms
- HIPAA Policy

For purposes of sharing information with service providers, only relevant consumer information will be communicated. Examples of this include hearing loss which impacts use of the telephone or ability to hear knocking on the door, home environment issues, or relevant information the provider would need to know to provide services effectively.

Protective Service Situations

Care Managers are voluntary reporters of elder abuse, neglect, exploitation, and/or abandonment. Under the voluntary reporting provisions of the Older Adults Protective Services Act (OAPSA), a person who has reasonable cause to believe that an older adult needs protective services may report this to the local provider

of protective services. A Report of Need (RON) will be made immediately and documented in a journal entry in SAMS. Documentation may only reflect that a referral was made to another service program due to the confidentiality provisions in OAPSA. There will not be any language that specifically states that a referral was made to Protective Services or exactly what risk(s) were identified. In addition, no information leading to the need for Protective Services will be documented.

If Protective Services is investigating a case in which the older adult is already receiving services from another care program, the Care Manager will likely be contacted as part of the investigation. The Care Manager and Protective Services caseworker may share information in accordance with protective services regulation §15.105(3). In addition, both programs are required to maintain confidentiality. The Care Manager and the Protective Services caseworker will work together to ensure the older adult is free from abuse, neglect, exploitation, and/or abandonment and receiving adequate care and services to maintain health and safety.

VII. QUALITY ASSURANCE

Quality assurance is critical in measuring the effectiveness and consistency of Care Management to ensure quality standards are being met.

AAA

The AAAs must establish and implement written quality assurance measures to ensure Care Management is meeting standards in accordance with this chapter. This is accomplished through various activities such as:

- Developing local procedures and policies
- Overseeing Care Management activities
- Utilizing SAMS reports for monitoring purposes including the scheduling of assessments, caseload management, time management, time frames, etc.
- Applying benchmark reports for statistical purposes and monitoring of any outliers against statewide average
- Distributing and analyzing Consumer Satisfaction Surveys
- Training of Care Management staff
- Monitoring of sub-contracted service providers

Chapter V: CARE MANAGEMENT

The Department

The Department is responsible for the monitoring of Care Management in all AAAs through various activities such as:

- Reviewing selected cases electronically to verify the AAA is operating within the Department policy
- Conducting reviews to include, but not limited to, confidentiality compliance, completion of required forms, adherence to local and the Department policy, and fiscal reporting requirements
- Reviewing benchmark reports for statistical purposes and identifying AAA outliers against statewide averages
- Utilizing SAMS reports to evaluate data entry to assure accuracy and compliance with policy

The Bureau of Aging Services is available to provide technical assistance related to policy. The Bureau of Quality Assurance is available to provide technical assistance related to SAMS.

Chapter V: CARE MANAGEMENT

Resources:

Appendix A – Definitions and Service Standards

- Refer to Chapter IV: OPTIONS Program Appendix A
- Refer to Chapter VI: Caregiver Support Program Appendix A

Appendix B – Documentation Requirements

- Appendix B.1 The Department-Approved Acronyms and Abbreviations

Appendix C – Forms

- Appendix C.1 Voter Preference Form – English
- Appendix C.2 Voter Preference Form – Spanish
- Refer to Chapter IV: OPTIONS Program Appendix C
- Refer to Chapter VI: Caregiver Support Program Appendix C
- Refer to Chapter II: Hearings and Appeals

Appendix D – SAMS Data Entry Requirements

- Refer to Chapter IV: OPTIONS Program Appendix D
- Refer to Chapter VI: Caregiver Support Program Appendix D

Appendix E – Regulations and Citations

- Appendix E.1 6 Pa. Code Chapter 21 – Domiciliary Care Services for Adults
- Refer to Chapter VI: Caregiver Support Program Appendix E

Appendix F – Other Resources

- Appendix F.1 Benefits and Services for Veterans and Their Beneficiaries in Pennsylvania
- Appendix F.2 Benefits & Rights for Older Pennsylvanians
- Appendix F.3 Limited English Proficiency Service
- Appendix F.4 Introduction to Dashboards & Widgets in Aging & Disability (SAMS)
- Appendix F.5 OPTIONS Program Consumer Contact Plan Schedule
- Appendix F.6 Caregiver Support Program Caregiver Contact Plan Schedule
- Refer to Chapter IV: OPTIONS Program Appendix F
- Refer to Chapter VI: Caregiver Support Program Appendix F

Appendix G – Training Materials