Comments and DAS Responses – DAS Operations Manual Chapter 112
The Statewide Access System
August 2005

1. Comment re General Summary §112.1: "No mention of Gateway."

DAS Response: We have added a reference to Gateway to this section.

2. Comment re§112.1(a): "does not reference persons with disabilities."

DAS Response: *The text has been amended to add "persons with disabilities."*

3. Comment/Question re §112.5 "Integration of Access Service System Functions"

"Recommend ESP is spelled out fully" and "Should ESP be introduced as a requirement?"

DAS Response: We have used the full name, Elderly Services Program, as suggested. Yes, we do want to standardize our processes to take full advantage of the ESP database's capabilities.

4. Comment re §112.5.1(d) Access System Components: suggested wording change "…determine eligibility and **priority** for all aging network programs and services.

DAS Response: We reworded this to read, '…those contacts with applicants to determine their eligibility and priority for services and appropriate service options available through all aging network programs and services

5. Comment/Question: The AAA would like to clarify addressing CCSP within this guideline. Is this basically addressing HCBS applicants and in the case where a CCSP client comes into play will CCSP requirements take precedence? We will further address/clarify some discrepancies between HCBS and CCSP within the content of the comments.

DAS Response: The guidelines are promulgated as relates to the Area Agencies' functional and administrative role as the single point of entry for applicants for all aging program services, regardless of the funding that pays for the service. AAAs use both HCBS and CCSP funds to support the administrative function. The programmatic policies, however, do not influence Gateway functioning, except for establishing eligibility for any/all services that may be available in the planning and service area. CCSP program policies which establish "Level of Care," plus Medicaid criteria for establishing financial eligibility, would appear to be those that would apply to the Gateway process.

6. Question re §112.5(b): funding for client assessment and care coordination: "Will a list of allowable fund sources be provided? Would like more specific allowable fund sources addressed."

DAS Response: This is an administrative issue which AAA directors must address in the budget planning process. Comprehensive case management services, including the assessment component, are supported by both HCBS and CCSP funds. Of the HCBS fund sources, Older Americans Act Title III-B and Title III-E, Social Service Block Grant, and State CBS funds may be used to pay for case management services, including client assessment.

7. Question re §112.5(d) "Reference to IR&A Services and Screening being met by a single staff person; this policy contradicts Appendix 112-F Gateway Model 2 and Gateway Model 3 in the aspect [that] the flow chart does not reflect a single staff carrying a client all the way through."

DAS Response: The terms "Intake Specialist" and "Screener" as used in the models could be interpreted to be one and the same person. It is our intent that AAAs make the attempt to implement a service delivery model which assures that one person follows an inquirer/applicant through the entire process of obtaining information and applying for services, if at all possible. We recognize that to accomplish this goal, a phased approach to implementation may be necessary and we will work with each agency to determine the best approach, considering current circumstances. We do acknowledge that the third model does represent a departure from this approach.

8. Question re §112.5(h) "Is the model used at the discretion of the AAA?"

DAS Response: See response to item 6. This is a management decision of the AAA Director and senior management staff. The AAA may elect to implement one of the three models, with the first being considered the most effective at eliminating barriers to consumers' access to information and services. We will be working with each Area Agency to assess current status and design implementation or improvement plans, as needed.

9. Comment re §112.5.1(b)(4): "Advocacy, in a sense, appears to be geared more toward case management rather than I&A, I&R, and I&S. Request added footnote with definition/clarification for advocacy in this instance."

DAS Response: These guidelines and standards apply to a system of access services, comprising several components, which include Information, Assistance and Referral services and the administrative function of intake and screening. Information, Assistance and Referral staff often engage in time-limited advocacy on behalf of the people they assist, as do case managers in an ongoing relationship with consumers. Case management is also a component of a comprehensive access system. Advocacy is a core function of Area Agencies on Aging, according to the Older Americans Act. The advocacy may occur on behalf of groups of individuals, focused on an issue that impacts older people or at the individual level, at both the Gateway and case management levels. These guidelines are designed to instruct and facilitate the development of a statewide comprehensive system of access.

10. Question re §112.5.1(b)(4)(A) , permission to share information: "Can AAA policy state permission acquisition obtained verbally and noted in client file? If written documentation is required, does the HIPAA form suffice? If so, can the DHR HIPAA form be added to the appendix?"

DAS Response: Documentation of a person's verbal permission for staff to share information regarding his/her need for assistance with a community resource would appear to be appropriate in most instances. For example, if someone requests assistance with housing and a Gateway staff member offers to make inquiries on her behalf, verbal consent would be appropriate and could be noted in the client record (paper or electronic form). If the Gateway staff is handling health-related issues on behalf of an inquirer, necessitating the exchange of personal health information, it would appear that execution of the HIPAA release form would be in order.

11. Question re §112.5.1(b)(5)(C) , follow-up contacts: Should permission to follow up be obtained in initial contact?

DAS Response: Yes, if, as the guideline states, the situation is such that the staff believes that the follow-up contacts/activity would "clearly benefit the inquirer."

Example 1: An elderly inquirer requests information about how to get into subsidized housing and indicates that she can no longer stay where she is currently living. Staff give her information about housing resources, but has concerns about her ability (functionally and/or cognitively) to follow through, and that she may be at risk of homelessness, self-neglect or other endangerment. Staff does not believe that the caller is a victim of abuse, neglect or exploitation, which could result in a referral to Adult Protective Services. However, follow-up does appear to be indicated, to assure that the inquirer was able to get the services/assistance she needs.

Example 2: A caller requests information about assisted living resources for her mother, who lives with her. Staff determines that this is the only resource of interest to the caller and that she is willing and able to follow through on her own to contact the assisted living facilities in the area. Staff does not believe that either the caller or her mother are at risk in any way, based on the interaction with the caller. Follow-up, except for sampling for consumer satisfaction, probably is not necessary.

Staff must use their judgment and knowledge to determine when follow-up is indicated.

12. Comment: §112.5.1(c) Note: there is no §112.5.1(c) in the document, skipped from (b) to (d).

DAS Response: Noted and corrected. Thanks.

13. Question/Comment re§112.5.1(d) "Staff are not to screen applicants for a specific service." Clarify, does this mean all screeners screen for HCBS and CCSP and will not be assigned to screen for specific programs? (Example: Screener A screens for HCBS only and Screener B screens for CCSP only.) Paragraph may need to be expanded to include screening for CCSP due to the differences in program protocol. (Example: CCSP clients must meet NH LOC where HCBS clients do not.)

DAS Response: *Yes. The Division's intent through these guidelines is to create a system through which barriers to access to services are removed to the greatest extent possible. We believe that productivity and efficiency suffer when certain core functions are compartmentalized by program "silos." We acknowledge that applicants for services who appear to be appropriate for CCSP services must meet additional criteria for nursing home level of care, but we believe that properly qualified and well-trained staff can learn to assess and assign "level of care" in compliance with CCSP criteria. Again, although these guidelines are disseminated through the Home and Community Based Services Manual, it should be understood that the Gateway system is implemented to provide access to all aging network services and other community resources, regardless of the funds that are used to pay for them.*

14. Comment re §112.6(f)(5) Service Availability and Access: Suggested rewording to read, "make all or a portion of its **resource** database available on an Internet Webpage.

DAS Response: *Reworded as suggested.*

15. Comments re §112.7(a), facilities: "Expand last sentence to allow staff with private office space option to use other methods such as handset or speaker."

and "Real privacy not available here in a cubicle environment – all staff have been trained on HIPAA guidelines and have signed a confidentiality agreement. All staff are directed to turn computers off when away from their desks for long periods of time and to minimize (the screen) when away for a few moments."

DAS Response: *The text has been revised to read, " AAAs are encouraged to provide headsets to staff who desire to use them when actively handling calls. When staff must work in communal or open office environments, the agency shall develop, implement and train staff on appropriate privacy protocols, including HIPAA guidelines."*

16. Comments/Question re §112.8(a): "Could a MOU/A example be provided?" and "May be challenging to get a formal MOU with all entities. The 'Care Options' program at ARC is assisting with coordination."

DAS Response: *We will try to identify or develop a template for a MOU/A. We understand that not every entity may be willing to participate in such an agreement, but believe that it is worthwhile to try to establish as many relationships through agreements as possible. Perhaps ARC can share its learnings with us.*

17. Question re §112.9 Staffing. "Can all areas dedicate one FTE staff person, or at least assign the function of resource development as a core responsibility to one person?"

DAS Response: *That is the intention of item (e) in this section. We will work with each agency to assure that resource development and database management are core duties of at least one specified staff member.*

18. Comment re §112.10 Staff Certification and Training (a): "Should refer to Appendix 112-D instead of Appendix 112-C."
and

(b) §112.10(a)(2): Suggested rewording to read, "The lead staff persons for the access service system, at a minimum, will seek Certified Information and Referral Specialist – Aging (CIRS-A), or Certified Resource Specialist (CRS) status, through the Alliance of Information and Referral Systems (AIRS) Certification Program."

DAS Response: *Appendix reference corrected and item reworded as suggested. Thanks.*

19. Comment re §112.10,: suggested rewording "**to refer and assist** difficult callers,**" "to assist** populations not typically reached through the aging network.

and

20. Question re the same section: "Should there be mention of HIPAA here?"

DAS Response: *Reworded as suggested and the following text was added to this section: "Staff will be knowledgeable of and comply with HIPAA guidelines, as applicable, in providing Information, Referral and Assistance services."*

21. Comment re §112.10(a)(1): "Be more specific. "Staff will be crosstrained…." Should possibly state appropriate number of staff or all staff. (Example: We have one primary staff to manage waiting list to eliminate communication duplication, problems, and/or issues. Other staff are already trained and can handle referrals during absence of primary staff person. Another example, we have one primary staff person to provide I&A with other staff trained in times of absence.)

DAS Response: *This has been reworded to read, "Staff whose primary function is to assist inquirers by providing information, assistance and referrals, and screening to determine program eligibility shall be cross trained in the provision of all components of the access service system. Staff whose primary responsibilities are related to resource development and/or administrative in nature are encouraged, but not required, to be cross-trained."*

Please note that this entire section was reorganized and re-numbered for consistency in formatting.

22. §112.11(b) re HIPAA: "With this being a privacy issue (HIPAA), previous training was interpreted as requiring written consent from client utilizing the HIPAA form. Here, verbal consent can be obtained and documented in electronic file. Clarify with certainty verbal consent can be obtained and documented."

DAS Response: There are several issues involved. First the AAA is supposed to have conducted its own self assessment and determination as to whether it is a "covered entity" or not. If the AAA has determined that it is a covered entity or a business associate of a covered entity and that HIPAA and the Privacy Rule apply, it must assure that staff are safeguarding Protected Health Information . For contacts made as a part of the initial screening process or the provision of information and assistance, we would interpret those as not requiring staff to read HIPAA notices to callers. However, if the contact is for the purpose of re-screening for the CCSP, staff would be advised to provide brief, oral notice, followed by sending a more complete written notice and the opportunity for the applicant to make acknowledgement. In general, screening applicants for program eligibility or directing inquirers to services would not fall into the category of "providing treatment" by a "health care provider," thus the information shared would not be subject to this rule.

Also see this excerpt from U.S. Department of Health and Human Services regarding non face-to-face contacts:

> "The HIPAA Privacy Rule is intended to be flexible enough to address the various types of relationships that covered health care providers may have with the individuals they treat, including those treatment situations that are not face-to-face. For example, a health care provider who first treats a patient over the phone satisfies the notice provision requirements of the Privacy Rule by mailing the notice to the individual the same day, if possible. To satisfy the requirement that the provider also make a good faith effort to obtain the individual's acknowledgment of the notice, the provider may include a tear-off sheet or other document with the notice that requests that the acknowledgment be mailed back to the provider. The health care provider is not in violation of the Rule if the individual chooses not to mail back an acknowledgment; and a file copy of the form sent to the patient would be adequate documentation of the provider's good faith effort to obtain the acknowledgment.
>
> Where a health care provider's initial contact with the patient is simply to schedule an appointment or a procedure, the notice provision and acknowledgment requirements may be satisfied at the time the individual arrives at the provider's facility for his or her appointment.
>
> For service provided electronically, the notice must be sent electronically automatically and contemporaneously in response to the individual's first request for service. In this situation, an electronic return receipt or other return transmission from the individual is considered a valid written acknowledgment of the notice."

23. Comment/Question re §112.14: "Standards of Promptness (SOP) are established for I&A but are not established for I&S. Will SOP be established for I&S? Based on previous policies, I&S was to take place within 5 working days of being received. If SOP include I&S, the AAA would like the opportunity to further respond to this issue to address I&S elements."

DAS Response: Please review the guideline: "Access service staff will respond to inquiries and requests for information, assistance and services as follows:…" Once again, we are attempting to create a comprehensive system of access, rather than continuing with a siloed approach. Compartmentalization reduces efficiency. Staff cannot know with certainty whether any given call or inquiry will result in an application or request for services until they interview the inquirer. Similarly, not every request for services necessarily will result in screening and eligibility determination. These SOPs are established to assure that the processes begin in a timely fashion. We don't expect that all contacts and activities will be completed within the SOP. This guideline is designed to provide parameters by which management can measure the impact of volume of contacts and evaluate staff productivity.

24. Comment: §112.14(a) "Consider expanding with statement to include inquiries received by postal mail or drop off."

DAS Response: We believe item (c) in this section covers that category of correspondence, but have re-written it to read: "provide a response to written inquiries received by postal mail or delivered personally within ten (10) calendar days of the receipt of the request. The exception to this is if an applicant or his/her representative is submitting application materials in person at the agency, staff are to review the material in the person's presence at the time s/he visits the agency. The agency may provide the final decision regarding eligibility or admission to service at a later time within the standard of promptness."

25. Question re §112.14(a b, and c): Why are SOPs different for phone, fax, email, mail, etc.? Is an inquiry not an inquiry regardless of source?

DAS Response: Yes, an inquiry is an inquiry, but when someone is seeking assistance by telephone, there is a possibility that s/he may perceive the situation to be more urgent than someone who registers an inquiry by a letter or faxed request. Each communication must be evaluated on its own merit. The nature and content of the inquiry ultimately will influence the priority given to the issue, regardless of the form in which the information is received.

26. Comment re §112.15(c): "Should refer to Appendix 112-E instead of Appendix 112-D."

DAS Response: Noted and corrected. Thanks.

27. Comment re §112.16 Coordination with Community Information and Assistance Agencies: Suggestion that disaster and emergency planning be referenced.

DAS Response: The following has been added: "Coordination of access services should also extend to address disaster and emergency planning, preparedness, and access system operations during such events."

28. Comment/Question re consumer satisfaction survey: "Can the AAA utilize a portion of the recommended satisfaction survey tool and scorecard rather than the entire card? AAA feels this survey is lengthy and burdensome for the client/caregiver to complete. Can the AAA continue to utilize current AAA survey developed specifically for each program/service instead of the recommended survey?"

DAS Response: The selected survey currently is being developed through the Aging and Disabilities Resource Center Grant and is being refined and probably will be shortened. We anticipate that the refined instrument will be available within the next month or two. We will update this appendix with the revised survey when it is available. We would like all AAAs to use a common survey tool and do not expect that every consumer will receive a survey. An adequate sampling of consumers should produce meaningful data for evaluation purposes.

29. Appendix 112-F re organizational models: "XYZ AAA Gateway Staff has a consensus to utilize Model 3. Again, are we understanding correctly, we have the discretion to use either of the three models?"

DAS Response: Please see response to question 8, preceding. Model A aligns most closely with the intent of with the written standards and should be the goal that each AAA works toward.

30. Comments regarding the various models: One AAA offered comments in detail about the model process flows.

DAS Response: The process flow charts were developed to display the access system at a very high level. Steps in processing certain forms and information were intentionally omitted. Following are responses to certain excerpted questions.

30(a) Appendix 112-F, Model 1: "Screener enters data into ESP/CHAT; should this possibly read ESP and/or CHAT? If call does not turn into a screening, it would only be entered into ESP and not into CHAT."

DAS Response: Please interpret the slash [/] in ESP/CHAT to mean "and/or."

30(b)1. re Appendix 112-F, Model 2: "1. Appears to be a step missing to the effect there is no I&A provided by the Intake Specialist. Should the Intake Specialist provide I&A at initial contact rather than waiting for a Screening Specialist to contact the caller for screening? Not all calls require a referral for CHAT screening."

DAS Response: Our purpose in reissuing these guidelines is to standardize the access systems processes to the greatest extent possible. This includes implement ing processes through which as few people as possible at the AAA are involved in meeting all the needs of inquirers, whether they need only information or they are requesting services and need to be screened. As mentioned previously, the term "Intake Specialist" could be interpreted to mean someone who provides both I&A services and who is trained to screen applicants for service.

30(b) 2. "Once a caller is referred for screening and contact is attempted and not made, should the note go into CHAT and ESP?"

DAS Response: *Again: Start in ESP by entering basic client data. If screening is indicated, open CHAT and the client information will populate the CHAT record. Record attempted contacts for screening in CHAT.*

30(b)3. "Could DAS provide MS Access training for AAA staff?"

DAS Response: *We will work to identify resources from within DAS to provide some training.*

31. Comments/Questions re Rescreening: "If a client is receiving an HCBS services, such as homemaker or personal care, but also remains on the HCBS waiting list for additional services, i.e. meals or ERS, etc., is it necessary to conduct 120 day re-screenings? If so, why? The purpose of re-screening, (as I thought it to be), is to determine if the applicant's priority or need for service has changed in the past 4 months. If you have a client receiving services on a continuous basis, then why is it necessary to contact the client for changes through the telephone? Changes should be identified through the direct provider who has the capability of observing the client or through the face-to face assessment process required on an annually basis for each active HCBS client. "

DAS Response: *These are good points. We have added a footnote to §112.5(d)(2) which reads, "To reduce the impact of rescreenings of applicants wait listed for HCBS, AAAs may establish protocols with Case Management Organizations and direct service providers to provide that the CMOs/providers advise the agency of changes in condition for active service consumers who are wait listed for additional services. The protocol should include a process by which the CMO/provider informs the AAA of changes which would increase the consumers' priority status for admission to the services for which they are wait-listed, based on an increase in DON-R score."*

32. Multi-part Comments/Questions re HCBS Case Management: "I would also like the manual to address case management policies for HCBS clients. In my opinion, if a client is receiving structured case management through a care coordination agency, then telephone re-screening should not be required. Additionally, duplicate case management should not occur."

DAS Response: *We agree that Case Management assistance as a part of the overall access system is very important. We have developed separate policies and standards in draft form for case management for non-Medicaid HCBS. However, thus far we have not issued them for review and comment. In those policies and standards we have established "levels" of case management which could be implemented based on the needs of the consumers. We agree that telephone re-screening by the AAA probably can be forgone, if, as suggested the AAA establishes a protocol with the CMO to share information regarding client status, if the person is still wait listed for additional services, while actively receiving others. We agree that there is no need to duplicate case management interventions. We can provide the draft standards for Case Management upon request.*

33. Multi-part Comment/Question continued: "For example, a hospice client may enroll in HCBS to receive a meal. It is understandable that the initial assessment is required to enter the client into AIMS; however, is on-going contact necessary? Is a follow-up NSI and Level 1 screening necessary for a hospice client? The client is already receiving some medical oversight through hospice? How can HCBS coordinate with hospice providers so as not to duplicate services? CCSP has addressed this issue with hospice clients, but HCBS really hasn't in my opinion."

DAS Response: We can't say that we've been aware of the phenomenon of consumers receiving both hospice care and non-Medicaid HCB services, but can see that some modification of requirements on the HCBS side could be in order. With regard to the NSI and Level 1 screenings, because the consumer presumably does receive a meal which is reported to AoA/NAPIS as eligible to include in the NSIP meal count, the NSI-D checklist information is required. We would hope that a hospice patient's nutritional status and special dietary needs have been assessed and addressed by the hospice provider, but we would still need to have the meal provider obtain the required NSI-D data. If the patient is a high risk, at a minimum the significance of this status should be discussed with the hospice agency, if there is concern that all needs are not being met. We would interpret that consultation as "referral to a health care professional," which can be recorded on the client registration form, and subsequently extracted through a report.

34. Multi-part Comment/Question continued: "How can we get better collaboration at the state level regarding CCSP and HCBS polices and procedures? In many cases, the clients' profiles are the same. This is becoming more and more evident as potential CCSP clients decline CCSP due to cost shares and elect to use one of the various discount cards to save medication costs and receive HCBS services and little or no costs. I am starting to look at the number of HCBS clients terminating the program to enter the nursing homes. This past month, I had 5 out of 18 terminations for March that entered the nursing home on a permanent basis. I know HCBS was not initially designed for this population, but it appears that we are having to address the needs of these clients often with only one or two HCBS. The levels of care has helped to identify these clients at admission so that we can increase oversight and prioritize services to make sure they don't have to wait a long time for needed services. This is just a thought I wanted to put out there."

DAS Response: We work constantly at keeping communications open at all levels of the network, including within DAS. To the extent that we have implemented a common screening tool, the DON-R, we believe that this does signify that we our understanding that there is sharing and "crossover" of consumers. We appreciate the documentation of the admission rate of HCBS consumers to nursing homes. While the HCBS program, as mentioned, was not originally envisioned as serving persons at risk of admission to institutional care, the Administration on Aging now acknowledges that the home and community based services do contribute to people's independence and length of stay in the community. And, we agree that levels of care for case management and targeting certain populations are strategies for making the best use of limited case management and other service resources. Thank you for sharing these thoughts.

35. Comment: "We no longer conduct telephone re-screens (through a waiver request) on active case management clients; however, there is no way to identify this in CHAT. For example, if you pulled the CHAT waiting list for HCBS clients, it would look as if many clients had not been re-screened in sometime. This would be correct. The clients were not re-screened because they are in active case management; however, an outside auditor would not be able to initially detect that by just looking at the report. They would have to further investigate the case to determine if the client is receiving an HCBS. We need better report features in CHAT for HCBS clients.

DAS Response: We will pass this along to the people who manage and develop the CHAT database.

36. Comment: "Additionally, because clients are often on multiple service lists, it is hard to determine the actual number of clients waiting for HCBS services without spending several hours cross-referencing the lists to get an accurate count of individuals waiting for one or more HCBS service."

DAS Response: Again, we will share with the CHAT developers.

37. Comment re 112.14(c), Standards of Promptness: "10 days seems like an awful long time. I know that we may be trying to make standard of promptness in line with CCSP – however, I believe most people who call may not be CCSP eligible, and as stated above need information sooner than 10 days."

DAS Response: The standards of promptness were adapted from the AIRS operating standards for their own offices, rather than from CCSP. We are trying to build in some flexibility for response times. Also see response to C/Q 23.

38. Comment: "My only feedback relates to the Appendix 112-D on "Training Content". While it may be 'a given,' (I) would like to see some reference to: understanding of APS criteria, which (types) of cases go to APS Central Intake and which ones go to ORS and/or the Ombudsman - when abuse, neglect or exploitation is alleged."

DAS Response: Thank you for the suggestion. We have amended the appendix to specifically include these content areas. Also, with the help of the network, we will continue to develop, implement and improve our protocols to address the referral process.

39. Comment re 112.5 Integration of Access Service System Functions, page 4: (d) Inquirers will have their needs . . . met by a single trained staff person who will manage all aspects of service provision.

"While having fewer individuals working on behalf of a client helps to ensure continuity in service delivery, it is not always feasible. Staff absences due to illness or annual leave will have an impact on who will provide a client services in the most time effective manner. Likewise, some staff in our AAA are assigned specific I&A duties, especially in terms of making client referrals and following up on service dispositions. We find that this allows us to maintain a higher level of productivity while assuring standards of promptness for client screenings and re-screenings.

We recommend that this section allow AAAs flexibility as to how many staff may serve an individual client, but that internal policies and procedures reflect the desire to use as few staff as possible in the delivery of services."

DAS Response: *You make good points. We do provide models that deviate from the unified approach and will work with AAAs individually to assist with designing and implementing the best, most feasible approach to providing access, considering available resources.*

40. Comment re 112.5.1 Access System Components, page 6 "Please define "supported access."

DAS Response: *We use the term to describe situations in which staff actually make contacts on behalf of an inquirer/applicant for services, because the person would have difficulty or would not be able to do so on her own, or would have extreme difficulty in understanding or making herself understood. The applicant could have cognitive and/or sensory impairments, or language limitations, that affect ability to effectively communicate with yet another entity, to obtain the help s/he needs.*

41. Comment/Question re "Staff are not to screen applicants 'for' a specific program or service."

"The eligibility criteria for certain aging programs requires that we not screen applicants for every service. Not every applicant qualifies for HCBS services, CCSP services, or Title IIIE programs. Client age, county of residence (not all services are available in all counties), and income may preclude them from applying for certain programs. For example, a caregiver may only be eligible for Title IIIE services. It makes perfect sense to only screen this individual for caregiver services and for nothing else.

Can you explain the intent of this specific guideline?"

DAS Response: *This statement alludes to the current state of the access system in some areas which results in certain staff screening only for CCSP and others only for HCBS, creating silos in staffing and creating the potential for even greater limitations on productivity and staff efficiency and effectiveness. It does make sense that if someone requests a service as specific as caregiver support, and staff know that services are immediately available through*

Title III-E, it may not be necessary or appropriate to explore the core non-Medicaid services and the CCSP at that time. However, in a holistic system, staff would want to consider all needs and available resources and should be mindful of the potential for arranging for services from a number of programs. Continuing the example of Title III-E services, if a person requests respite care and the III-E program is full, it would be appropriate to determine whether the applicant is eligible for a similar service, such as HCBS respite care and personal care, or CCSP extended personal support services (XPSS), rather than merely wait listing the person pending an opening in the III-E program. Also please see our response at C/Q 13.

42. Comment/Question re 112.6(f)(2) Service Availability and Access, "establish a presence at community facilities where consumers are helped face-to-face."

"Does this require that a permanent presence be established? Or does it pertain to community health fairs, conferences, and occasional meetings throughout the year? Establishing a permanent presence in community facilities would require more resources and staff time than the budget permits. Please clarify."

DAS Response: *We are not requiring permanent co-location of services, with such entities as a DFACS or CAP agency office, but would suggest that staff establish a working relationship and plan to visit those sites on a regular basis, perhaps monthly or quarterly. Staffing health fairs, conferences and professional meetings also goes toward meeting this guideline. We also will be working with the network, as mentioned previously, to develop consistent approaches for Gateway and APS staff to interact and share information.*

43. Comment re 112.6(a), Facility Requirements , "Staff will use headsets when actively handling calls."

"Not all staff are comfortable using headsets, and for those who work in private offices, this is not always necessary. We would prefer to see some language here that allows for closed off office areas where passers-by would not be able to overhear conversations between I&A staff and the client. Is this possible?"

DAS Response: *Please see response to C/Q 15.*

44. Comment/Question 112.8(b) Crisis Intervention and Emergency Services,
"AAAs shall establish linkages with emergency response organizations . . . as appropriate to provide necessary coverage. . . "

"Can you clarify this portion of the guidelines? Are these to be formal linkages via memoranda of understanding? What is meant by 'necessary coverage?' "

DAS Response: *Memoranda of Understanding make for a clearer understanding of roles, responsibilities and expectations of all parties, but we will not require them. This particular guideline is an attempt to assure that Gateway staff are able to obtain the desired involvement of emergency response providers in a timely way, when attempting to assist people who manage to reach the AAA's access system in a state of crisis or emergency. Prior knowledge and understanding of the Gateway system and staff by the emergency response*

organizations should result in urgent calls being handled in a timely, expeditious, and appropriate manner. "Necessary coverage" refers to instances in which the Gateway staff may be called upon to expand the hours of operation to deal with a weather-related emergency or other disaster situation.

45. Comment re 112.10 Staff Training and Certification:

"It is virtually impossible to hire new employees already skilled and knowledgeable in I&A/R and the aging services network. Further, new staff must also learn to use software unique to the Georgia Gateway system.

We would very much like to see the division develop training modules for all elements under section (3) (A, B, C, and D) and the training topics listed in Appendix 112-D to ensure that the quality of services being delivered across the state is both adequate and consistent. Well-documented and comprehensive training modules would allow AAAs to train new staff as they come on board with the reassurance that the materials and methods being employed for training are the most current and meet the minimum requirements established by the Division of Aging Services. We recommend that a workgroup be established to identify training needs across the state and to create training materials for use by each AAA."

DAS Response: We acknowledge that recruitment of personnel experienced in providing I&A services and knowledgeable of aging-specific systems is challenging. We understand that it takes time for new staff to learn aging program applications and systems. We agree that a standardized set of training modules would be very beneficial and will be glad to charter a work group per this suggestion. Thank you!

46. Comment re Appendix 112-C, Waiting List Management

This section describes the manner in which the waiting lists are to be managed and the admission criteria for client referrals to contracted providers. These admission criteria stress the need to take into account information about the applicant in order to determine priority for services. For example, clients who live alone would have greater social need than an individual living with extended family. Likewise, clients who don't have the resources to purchase their food (as indicated in the NSI), are at a greater economical disadvantage, and should be referred for nutrition services ahead of others with higher DON scores and whose income needs are not as great.

Our current waiting list procedure is to refer clients based on the highest score as determined by the total DON score. Currently, this score does not take into account the client's current living environment or their income, factors which, according to the draft guidelines, must be considered. Section 112.4 (c) requires AAA staff remain neutral and objective when assessing applicants and making referrals for services. Further, section 112.5 (g) states that staff shall manage the waiting list using the CHAT application. The waiting list available in CHAT is currently insufficient for staff to remain neutral and objective when factoring in criteria outside the DON score. It will be virtually impossible to remain neutral and objective in the referral process unless CHAT is upgraded to take into consideration the various elements that establishes an "appropriate referral."

DAS Response: *We are not certain how considering additional assessment data, such as living situation and income status, negatively affects neutrality and objectivity. It would seem that such additional data combined with the other hard data, obtained from the DON-R and NSI-D Checklist assessments, would support decision-making. Certainly considering the additional data would influence decisions about admissions, but it doesn't seem to us to create a lack objectivity. And, we don't believe it is a given that a person living alone necessarily would have greater social need that someone living with a large extended family, if the family relationships are neglectful or abusive. We do agree in general that people at higher nutritional risk per the NSI-D score should receive priority for admission to nutrition services. It is correct that the DON-R impairment level score does not reflect the social and economic need, but information you obtain regarding unmet need for care does reflect those issues and could be factored into the decision-making process. As always, judgment is involved in making a good decision, and the more data one has, the better the outcome.*

We will discuss the need for additional data with the CHAT developers.

47. Comment re Appendix 112-E, Consumer Satisfaction Survey, page 34:

"The survey is well-structured and comprehensive. However, we fear it may be too long and the wording too complicated for most respondents, and will result in a small number of surveys actually returned. Suggest a shortened format with simpler language be used."

DAS Response: *See response to C/Q #28. It is a work in progress.*