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600 - CARE COORDINATION

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POLICY STATEMENT	Care coordination facilitates the process of screening, assessing, planning, arranging, coordinating, delivering and evaluating service delivery for all applicants/clients in the CCSP. Unless otherwise indicated, a registered nurse or social services worker may conduct these processes.
POLICY BASICS	Every CCSP client enters the program through the care coordination process. The care coordinator's primary responsibility is to the client. Care coordinators are either registered nurses or social services workers. Area Agencies on Aging (AAA), or lead agencies, are responsible for the administration of the care coordination process. The care coordinator serves as a single source of information regarding service options. In addition, the care coordinator also arranges and authorizes service(s) provided by enrolled providers. Care coordinators must be available 24 hours a day, seven days a week. During non-business hours a contact person (not an answering machine) must be available by telephone. If action is required, the contact person calls a RN for consultation. The contact person must have available a data set which includes clients names, addresses, and telephone numbers of clients, service providers and emergency contacts. Care coordination agencies establish and maintain written policies and procedures for clients and staff to follow in the event of an emergency or disaster. Only qualified individuals may function as care coordinators. Responsibilities of care coordinator include: ▪ Collaborating with client to determine service needs and outcomes ▪ Planning, arranging, coordinating, and evaluating service delivery
POLICY BASICS	▪ Brokering services with provider agencies

(contd.)

- When a provider agency is unable to deliver services as ordered in the client's care plan, reporting these situations to the AAA
- Coordinating with provider agencies to assure comprehensive service delivery and thorough communication
- Communicating with client's physician regarding status changes and health issues
- Assisting the client with obtaining ancillary services such as transportation and durable medical equipment.
- Completing Comprehensive Care Plan (CCP) reviews
- Monitoring client health changes and the care provided to assure that services are rendered by the service provider as ordered in the CCP
- Identifying, resolving and monitoring issues related to quality of care and timely delivery of services
- Assuring that clients are free from abuse, neglect of care and exploitation by provider's agents
- Initiating actions to address events which may adversely affect the client's health status
- Initiating discharge planning
- Working closely with clients to be familiar with their needs and preferences
- Being accountable to a client and the direct service delivery system
- Acting as an advocate for a client in the human service bureaucracy and brokering services
- Assisting clients with appeals.

POLICY BASICS (contd.)

Activities *not appropriate* for care coordinators include, but are

	not limited to the following: ▪ Instructing providers which funding source, such as Medicare, to bill for service(s)` ▪ Providing direct services, such as Medical Social Services, to a client ▪ Changing the initial CCP without consulting the RN who completed the initial assessment ▪ Updating a diagnosis without requesting a reassessment ▪ Making a major change in service without a reassessment, except when regulations permit ▪ Soliciting clients on behalf of providers.
REFERENCES	Chapter 300, Administrative Organization; Chapter 700, Care Management; Appendix 320, Care Coordination Registered Nurse; Appendix 330, Care Coordination Social Services Worker; Georgia DHR Administrative Policy and Procedures Manual, Part IV.L., Section II; Rules and Regulations for Disaster Preparedness Plans; Rules of Georgia Department of Human Resources Public Health

610 -TELEPHONE SCREENING ASSESSMENT

POLICY STATEMENT	AAA telephone screening specialist completes a telephone screening to determine a referral's eligibility for CCSP and to establish priority for face-to-face assessment for the initial care plan.
POLICY BASICS	CCSP referrals come from a variety of sources, including the following: ▪ Applicant and/or family member /care giver /applicant representative ▪ Hospitals ▪ Physicians ▪ Nursing homes ▪ Home health agencies ▪ Programs/Providers for the elderly ▪ Other community agencies. Once an applicant has been telephone screened, the individual is: ▪ Referred for a face- to-face assessment for the initial care plan OR ▪ Determined ineligible for CCSP services OR ▪ Placed on a waiting list. To be eligible for CCSP, an applicant must meet all eligibility criteria. If an individual lives in another PSA, the applicant needs to be screened and placed on the waiting list in the area where the client will receive service. An applicant does not have to be a resident of Georgia to be telephone screened. When placed on a waiting list, an applicant will be re-screened every four months until removed from the list. Re-screening
POLICY BASICS (contd.)	determines if applicant's priority or need for service has changed

	in the past four months.
PROCEDURES	During telephone screening, complete the following activities: ▪ Discuss the eligibility criteria with applicants ▪ Use the DON-R to determine functional eligibility ▪ Determine if applicants meet Level of Care (LOC) ▪ Use Medicaid criteria to assess financial eligibility Advise applicants of all available community resources that may meet their needs. Use the Client Health Assessment Tool (CHAT) to gather the following client information during telephone screening: ▪ Demographic information ▪ Personal contacts ▪ DON-R score that determines applicant's priority for initial assessment. Use the Notice of Status of Request for Services From the Community Care Services Program form to notify applicants of their CCSP eligibility and waiting list status. Use Form 5382, Notice of Denial, Termination, or Reduction in Service from the CCSP to advise applicants of denial at telephone screening. Use Level of Care denial letters to advise applicants who do not meet LOC criteria. Send a copy of the CCSP information handout to all applicants.
PROCEDURES (contd.)	When having difficulty reaching referrals to complete the

	telephone screening assessment, use the procedures in Chart 610.1 to contact referrals:

610.1 - Telephone Screening Contact Procedures

IF	THEN
Unable to reach client for telephone screening/re-screening	Contact person indicated on the referral.
Unable to reach the contact person	Send letters to the client and/or contact person asking them to contact the AAA for a telephone screening/re-screening
Client/contact makes no attempt to contact telephone screening specialist	▪ Document attempts to contact referral in case notes. ▪ After receiving no response to letters sent to client and/or contact person, send Form 5382.

PROCEDURES (contd.)	When adding an applicant with income below the SSI limit to the waiting list, use procedures in Chart 610.2:

Chart 610.2 - Applicants with Incomes Below SSI Limit

IF	THEN
Applicant's monthly income from all sources is less than SSI monthly limit	Individual may be a potential SSI recipient. Refer the applicant to the Social Security Administration for SSI eligibility determination. Do not refer a potential SSI client to care coordination for assessment for initial care plan until SSI eligibility is determined.
Applicant is not eligible for SSI due to applicant or spouse's income or resources AND Receives social security disability benefits	Determine applicant's PMAO eligibility. When funds are available, refer applicant for assessment for initial care plan.

IF (contd.)	THEN (contd.)
NOTE: Individuals may receive widow's and early retirement benefits from social security without disability being established.	
Applicant is not eligible for SSI due to applicant or spouse's income and resources AND Applicant is 65 years of age or older	Determine applicant's PMAO eligibility. When funds are available, refer applicant for assessment for initial care plan.
Applicant is not eligible for SSI due to applicant or spouse's income and resources AND Applicant is under 65 years of age AND Does not receive social security disability benefits	Refer the applicant to DFCS to apply for Adult Medically Needy (AMN) Medicaid. DFCS will establish disability when processing the AMN application. Do not refer the applicant for initial assessment until DFCS approves the AMN application.
Applicant is not eligible for SSI for any reason other than income or resources	Refer the applicant to DFCS. Do not refer the applicant for assessment for initial care plan until DFCS determines AMN Medicaid eligibility or potential eligibility for CCSP Medicaid.

PROCEDURES (contd.)	**NOTE:** If a client needs to be admitted before the SSI or AMN Application is approved, consult with the Division of Aging Services before admitting the client.
REFERENCES	Appendix 100, Telephone Screening, Instructions; Appendix 700, Medicaid Classes of Assistance; Chapter 500, Eligibility Criteria Section 510, CCSP Medicaid Eligibility

612 - WAITING LIST

POLICY STATEMENT	Depending upon availability of CCSP benefit funds, applicants who have been telephone screened and determined eligible for CCSP may have to be placed on a waiting list for full assessment.
POLICY BASICS	Cost factors and the number of individuals participating in the CCSP affect the availability of funds. If no waiting list exists in the area, clients are admitted to the CCSP in the order they are referred to care coordination for full assessments. The Division of Aging Services allocates CCSP funds to each AAA. The AAA manages the PSA's service benefit allocation that supports a specific number of CCSP clients for a given fiscal year. The AAA may delegate to the care coordination agency the responsibility for managing the allocation and tracking authorizations. The AAA requests care coordinators complete assessments in order to properly expend the area's allocation. Before sending referrals to care coordination for face-to-face assessments, AAA's contact waiting list clients to determine if their living arrangements and need for services have changed. If CCSP clients receiving services transfer from one PSA to another, they are not placed on a waiting list in the receiving area, but are admitted immediately. After coordinating with appropriate Division of Aging Services staff, sometimes AAAs admit emergency clients to the CCSP when other admissions are restricted. AAA and care coordinators use Chart 612.1 to manage waiting lists for CCSP services:

Chart 612.1 - Waiting List Procedures

IF	THEN AFTER COMPLETING TELEPHONE SCREENING
There are not budget constraints	Refer applicants on a first-come, first-served basis.
Budget constraints prevent new admissions	▪ Place names of applicants who appear eligible based on the DON-R scores for level of impairment and unmet need for care on a waiting list for assessment.
Budget constraints limit the number of admissions	▪ Refer applicants with the highest DON-R scores and the most days on the **THEN (contd.)**

IF (contd.)	
	waiting list for initial assessments.
Budget allows new admissions	▪ Refer clients for initial assessment. Remove the names of clients who have the highest DON-R scores and who have been on the waiting list the longest.

REFERENCES	Section 714, Brokering Emergency Admissions; Chapter 900, Ongoing Activities; Appendix 100, Telephone Screening, Instructions

620 - INITIAL ASSESSMENT

POLICY STATEMENT	Before being admitted to CCSP, each applicant receives a face-to-face assessment from a care coordinator (RN).
POLICY BASICS	The initial assessment of a client enables the care coordinator (RN) to: ▪ Evaluate the client's medical and health status; functional ability; social, emotional, and financial factors related to illness; home situation; and available resources ▪ Identify services needed to restore or preserve client health ▪ Identify desirable outcomes for a client ▪ Certify client level of care (LOC). At initial assessments, RN uses Client Health Assessment Tool (CHAT) to complete the following: 1. Minimum Data Set- Home Care (MDS-HC) 2. Comprehensive Care Plan (CCP) 3. Case notes 4. Verification of spelling of client's name, SSN, and Medicare and Medicaid numbers. 5. DON-R. The DON-R questions are incorporated into the MDS-HC. 6. Nutritional Screening Initiative (NSI) At initial assessments, RN uses forms to complete the following: 1. LOC page 2. Authorization for Release of Information and Informed Consent (signature page) 3. Notice of Right to Appeal Decisions Regarding CCSP, Form 5381
POLICY BASICS	4. PMAO Financial Worksheet, if applicable

(contd.)

5. Client Referral Form- Home Delivered Meals, if applicable

6. Nutrition Screening Initiative Checklist

7. Clients Rights and Responsibilities

8. Authorization for Release of Information, Form 5459, if needed.

Only a RN may complete initial assessments.

PROCEDURES

Use the LOC page, MDS-HC, DON-R, and CCP to complete a comprehensive, standardized assessment which:

- Determines applicant's degree of functional impairment and need for therapeutic services
- Qualitatively documents the presence or absence of illness, problems, and/or needs to support that an applicant meets the intermediate level of care (LOC) criteria for nursing facility care
- Compiles pertinent information about the applicant's social and functional status, physical and mental condition, nutritional status, and adequacy/inadequacy of support system and physical environment
- Functions as the initial care plan for the care coordinator, records initial service brokering, and enables the care coordinator to assure the appropriateness of care
- Serves as a Medical Plan of Treatment for all CCSP providers except Medicaid home health agencies.

Each care coordination agency designs a CCSP folder to be left in an easily accessible location in the client's home during initial assessment. The contents include, but are not limited to:

1. Information the client may need to contact CCSP staff.

   - Care coordination agency's number for 24 hour availability
   - Care coordinator's name, address, and phone number

PROCEDURES (contd.)

- AAA name, address and telephone number
- 911 or emergency number.

NOTE: Type these numbers in a large font on a single sheet of paper for the client's use. Explain to the client when to call these numbers.

2. CCSP Fact Sheet that includes CCSP process, financial eligibility criteria, and available services.

3. Notice of Right to Appeal Decisions, Form 5381.

4. CCSP brochure, Understanding Medicaid booklet, and Home and Community Services booklet.

5. Client Rights and Responsibilities form.

6. Cost share brochure, if applicable.

The RN uses the following steps to conduct the initial assessment and LOC determination:

1. Contact client to schedule the home visit for initial assessment.

   - For emergency situations, use Chart 620.3
   - If a client lives in one PSA but will receive services in another area, the PSA where the client resides may complete the initial assessment for the other area. The care coordination agencies communicate to determine which PSA completes the initial assessment.

2. Conduct a comprehensive, face-to-face interview with a prospective client/representative at the applicant's residence, hospital, long-term care facility or other appropriate site, using the Level of Care page, MDS-HC and CCP.

   - Explain the CCSP to applicant/representative.
   - Obtain client's signature on the LOC page and Authorization for Release of Information and Informed Consent.

PROCEDURES (contd.)

   - If applicable, complete and explain the Authorization for Release of Information, Form

5459 to the client and obtain client's signature.
- Use the Notice of Right to Appeal Decisions regarding CCSP, Form 5381 to inform applicant of appeal rights and responsibilities.
- Discuss the information on the Client Rights and Responsibilities form.

3. If client is already a Medicaid recipient, examine the Medicaid card to determine the following:

   - Spelling of applicant's name, date of birth, and Medicaid number exactly as shown on the card Use information as indicated on the Medicaid card

4. Determine MAO/PMAO eligibility status, using procedures in Chart 620.2 for MAO and PMAO applicants:

Chart 620.1 - Assessment Procedures for MAO and PMAO Applicants

IF	THEN
Applicant is MAO or PMAO	Follow above assessment procedures. In addition, take the following steps: ▪ Use cost share brochure to inform applicant of cost share potential and maximum estimated cost share. ▪ Discuss the Medicaid eligibility process with the client and/or family member. ▪ Advise applicant that DFCS determines Medicaid eligibility and exact cost share amount. ▪ Complete the Potential CCSP Medicaid MAO Financial Worksheet. Have applicant sign the Statement of Intent: Cost Responsibility, with the estimated cost share indicated.
IF (contd.)	**THEN (contd.)**
Applicant is neither eligible for Medicaid nor	

PMAO	▪ Complete Notice of Denial, Termination or Reduction in Services, Form 5382 to deny the application. ▪ Do not complete the assessment. Document client's decision in case notes.

NOTE: Complete the Potential CCSP Medicaid MAO Financial Worksheet for applicants not already receiving Medicaid benefits who are seeking CCSP admission. Use the worksheet to determine potential MAO clients and to determine whether applicant resources are within the appropriate limit.

PROCEDURES (contd.)

5. Using all information, determine applicant's status as follows:
   - Is not financially eligible for CCSP
   - Requires immediate institutional care without further assessment
   - Chooses nursing facility placement over admission to CCSP and does not require further assessment.

6. If applicant is determined ineligible at initial assessment:
   - Discontinue the assessment
   - Refer the applicant to other community services or nursing facility
   - Complete Notice of Denial, Termination or Reduction in Services, Form 5382 and advise the applicant of appeal rights and responsibilities.

7. If applicant is determined eligible for the CCSP:
   - Use the MDS-HC to complete a comprehensive evaluation of applicant's medical status and health functional ability, and available resources.

     Analyze and interpret medical and social information as compiled. Obtain additional information as needed.

   - Determine appropriate services and setting necessary to maintain or improve applicant health and functional status.

PROCEDURES (contd.)

   - Determine if the client has or can obtain supplies-soap, water, or others -necessary to benefit from

CCSP services ordered. If necessary, ask client and/or family to arrange for obtaining needed supplies.

- Develop a realistic, cost-effective, individualized, CCP. Encourage the client/family to assume an active role in the development of the CCP. Consult with applicant's physician for medical information and recommended treatment for the CCP.

  NOTE: Applicant's physician reviews LOC page and CCP of the assessment and signs LOC page before RN certifies a LOC.

- Develop the initial discharge plan in consultation with the client/family, the client's physician, other involved service agencies, and other available local resources, considering the following factors:
  - problem identification
  - anticipated progress
  - evaluation of progress to date
  - target date for discharge (difficult to assess)
  - identification of alternative resources for care after discharge
  - client's preference in discharge options.

  Document the discharge plan in comments section of CCP.

- Complete the NSI. If necessary, consult with a registered dietitian when assessing the client's nutritional needs. Refer to appropriate resources.

- For clients who will receive CCSP HDM, with client's permission, conduct refrigerator/freezer check to assure that units are able to maintain the proper food temperature.

PROCEDURES (contd.)

- Note diet type on LOC page of the assessment and if ordering HDM, complete the Client Referral

	Form-Home Delivered Meals. ▪ If applicant chooses CCSP admission, document on the CCP whether applicant selects a particular CCSP provider or whether the care coordinator uses the rotation system to select the CCSP provider. ▪ Determine if the applicant meets the Intermediate LOC criteria for nursing facility admissions. Use the LOC chart to document which LOC criteria client meets. 8. Use procedures in Chart 620.3 for applicants in emergency situations.

EXAMPLES OF APPROPRIATE EMERGENCY ASSESSMENTS for CCSP ADMISSION:

- Impending discharge from an acute care facility with no caretaker, home health services, or other community services available
- Need for immediate relocation of a person who resides in a nursing facility, personal care home, or family home due to natural disaster, or other crisis
- Adult Protective Services client
- Caretaker incapacity or unavailability.

CHART 620.2 - Assessment Procedures for Emergency Cases

IF	THEN
No other service options are available to applicant OR Immediate institutional placement is the only alternative other than CCSP	Consider an emergency placement. The applicant must, however, meet CCSP eligibility criteria for emergency placement.
The PSA has a waiting list for CCSP admissions	Work with the AAA to determine availability of funds for emergency placement.
The AAA agrees to admit the applicant and the care coordinator determines that applicant is eligible for emergency placement	1. Review available medical and social information from hospital discharge planner, nursing home, or other institution, private physician, health care providers, family or friend. 2. Set up an appointment to complete the initial assessment within two working days from date on Telephone Screening.
IF (contd.)	**THEN (contd.)**

	3. Complete initial assessment. 4. Discuss with appropriate parties, the client's need for emergency services (e.g., client's physician, hospital discharge planner, DFCS, the provider with whom services are being brokered).
Emergency placement occurs	Determine and document in applicant case notes the criteria used to determine the need for emergency placement.
	NOTE: The AAA maintains a log of emergency admissions that includes name, date of placement, and Medicaid number, if applicable.

REFERENCES	Appendix 500, Level of Care Criteria; Section 510, CCSP Medicaid Eligibility; Appendix 700, Medicaid Classes of Assistance; Chapter 800, Reassessment; Appendix 100, Forms and Instructions; Section 340, Area Agencies on Aging; Appendix 300, Job Descriptions

622 -COMPREHENSIVE CARE PLAN

POLICY STATEMENT	The Comprehensive Care Plan (CCP) is the care coordinator's order for CCSP services.
POLICY BASICS	The CCP provides the following: • Directions for the agency or person who will provide needed services • Client focused goals • Expected changes in client capabilities at a specific future time. The care coordinator (RN) develops the initial CCP but involves the client/caregiver in decisions to the extent possible. The RN uses input from the SSW, physician, provider(s) and client/family to develop the initial care plan. Care coordinators develop subsequent CCPs at reassessments and reviews. Each CCP includes the following: • Statement of client problems and needs • List of services needed by the client to remain in the community • A monthly total of needed service units • Estimate of duration of services • The CCP includes other formal services such as Medicare home health and services provided by informal caregivers and community resources. Care coordinators may <u>not</u>: • Order services on an "as needed" (PRN) basis • Admit applicants whose needs are <u>fully</u> met by Medicare home health services or hospice care
PROCEDURES(contd.)	

PROCEDURES (contd.)

During CCP development, conduct the following activities:

1. Determine client needs based on observations of individual functional capabilities and information obtained during assessment. Discuss client problems and needs with client and appropriate family members. If it is obvious that the client does not understand the CCSP or may not remember what the care coordinator says during an interview, include the caregiver.

   NOTE: If a client does not want the caregiver present during the interview, or the caregiver refuses to allow a client to be interviewed alone, the care coordinator must judge whether these requests can be honored and discuss them with those involved before sharing information.

2. Explore existing client support system and informal services. Investigate with caregiver what services care giver or others might provide that they do not presently provide. The caregiver may be very willing to give more help but may lack necessary knowledge or skill. If appropriate, assist caregiver in obtaining training needed to provide additional assistance. Determine if caregiver is able/willing to continue providing caregiver level of service.

   EXAMPLE: The provider may need to teach a care giver to fill insulin syringes to give injections to a client.

   Obtain client permission to investigate informal services. Care coordinators may discover people who have been providing support services or who are willing to help meet care plan goals.

3. Include client in decision about services needed. Consider all services needed by a client.

4. With the client, set specific goals in the CCP. Measurable goals and objectives can help motivate a client and/or caregiver and can help provide a sense of accomplishment and increased competence when they are met. It is important that everyone involved understands what is expected.

5. Develop and use community resources to meet client

	needs. Maintain a list of available resources. Coordinate with available Information and Assistance systems. In areas where resources are unavailable, coordinate with the AAA to help develop services and resources to meet client needs. 6. Order units of service on a monthly basis. Use frequency to specify the weekly schedule for service delivery. 7. Determine if client requires Medicaid home health services. If the physician writes orders for the provider to include occupational, physical, and speech therapies, the order must be time-limited. **NOTE:** If Medicaid home health services are ordered, specify the service(s). 8. As necessary, confer with mental health professionals to complete the initial CCP for any CCSP client with a secondary mental health, mental retardation, or developmental disability diagnosis. Incorporate recommendations from a psychiatric or psychological report into the CCP. 9. Use reimbursement rates provided by DMA to determine the cost of client services. 10. Coordinate CCSP services with informal and other formal services that the client receives.
REFERENCES	Appendix 100, Forms and Instructions

624 - COST LIMIT GUIDELINES

POLICY STATEMENT	The cost of CCSP services provided must be less than the established cost guideline.
POLICY BASICS	Costs include waivered services reimbursed by Medicaid. The calculation of cost limits excludes: • Service costs covered by the MAO client's cost share • First 50 visits from Medicaid home health. There is a set monthly cost limit per individual in the CCSP. Individual cases may exceed this amount only with approval from the Division of Aging Services.
PROCEDURES	Use reimbursement rates provided by DMA to estimate the cost of the client's CCSP services on the CCP. Use the Chart 624.1 to assist in determining the cost-effectiveness of services:

Chart 624.1 - Cost Limit Guideline Procedures

IF	THEN
Applicant appears to be eligible, services are below cost edit, and applicant chooses to enter the CCSP	Inform applicant of potential CCSP eligibility and arrange for CCSP and, if ordered, Medicaid home health services to begin.
Applicant chooses to enter CCSP service AND Costs exceed cost edit for a specified time, 2 months to 3 months	Inform applicant of potential CCSP eligibility. Arrange for CCSP service and, if ordered, Medicaid home health services to begin for applicant. Arrange for prior authorization and complete DMA-80 for applicant.
Applicant chooses to remain in community and chooses CCSP AND Services on CCP indefinitely exceed cost edit.	Discuss situation with AAA and care coordination team members to determine if applicant is appropriate for the CCSP, nursing home placement or other community-based services. If CCSP admission is indicated, arrange for prior authorization and complete DMA-80.

IF (contd.)	THEN (contd.)
CCSP services would be less than or more than the cost edit AND Applicant chooses to enter a nursing facility	Do not complete application process for CCSP.

REFERENCES	Chapter 500, Eligibility Criteria; Section 964, Prior Authorization/Prepayment Review

626 - CLIENT CHOICE OF CCSP PROVIDER

POLICY STATEMENT	CCSP clients may choose their CCSP service providers.
POLICY BASICS	Care coordinators give clients an opportunity to choose their CCSP service providers when they enter the program, change service providers, or when a new service is added. Factors affecting client choice are as follows: • Doctor's recommendation for services • Specific client needs which affect service availability (e.g., need for week-end or evening service) • Availability of services • Provider chosen is not enrolled as a CCSP provider.
PROCEDURES	The care coordinator (RN) uses these procedures to offer and document client's choice of CCSP provider: 1. Ask client to select the provider for each service recommended in the CCP. Consider whether recommended service is available in client's county. Indicate on the CCP that client selected a provider and list name(s) of provider(s) selected. 2. If the client's physician specifies a preference for a particular CCSP provider for CCSP services, inform the client of the recommendation. Advise the client whether the recommended provider delivers services included on the care plan. Ask the client to make the final choice regarding the service provider. 3. If a provider referred the client to CCSP, ask the individual if the referring provider is the provider of choice. 4. If a client has no provider preference, indicate on the CCP that rotation is the selection method. The care coordination team then uses the rotation method to assign a service provider.
REFERENCES	Section 710, Brokering Services

628 - LEVEL OF CARE

POLICY STATEMENT	The Intermediate Level Of Care (LOC) determination for CCSP is based on the medical criteria used by Department of Community Health (DCH), Division of Medical Assistance (DMA) to establish an individual's LOC certification for nursing facility placement.
POLICY BASICS	LOC determination is a function of the initial assessment and the reassessment processes. A change in the client's situation, however, may require a reassessment at any time. CCSP eligibility requires an applicant/client to have a current approved LOC assigned by the care coordinator RN on a LOC page. Since DCH/DMA recovers Medicaid funds paid to a provider for a client without a certified LOC, a new LOC must be secured prior to the expiration of the previous LOC. A LOC length of stay may be approved for less than 12 months but no LOC length of stay may be approved for more than 12 months. The LOC length of stay is certified through the last day of the month in which the LOC expires. The RN bases the LOC decision on information collected during the home visit and from other sources.
PROCEDURES	The RN determines the LOC within 2 months of the initial assessment. The RN completes a re-determination of LOC within 12 months. The care coordinator begins the LOC process at least 2 months prior to the expiration of the current LOC. The RN uses the Intermediate Level of Care Criteria (Appendix 500) to determine the LOC for an applicant/client and documents the LOC decision on the LOC page of the CCSP assessment. Use Chart 628.1 to determine if a situation requires a new LOC and full assessment:

628.1 - Level of Care Special Considerations

IF	THEN
Client enters a nursing facility or certain hospital units, (e.g., hospital swing beds, transitional care units, sub-acute units, and extended care units)	DMA-6 is completed by NH and physician. **NOTE:** Care coordinators contact facilities to determine if the client received a level of care for admission.

IF (contd.)	THEN (contd.)
	RN assesses and determines LOC**.**
Client is terminated from the CCSP and later re-enters the program	RN assesses and determines LOC before services may resume.
Client's condition shows significant change, or medical diagnosis changes	RN reassesses and re-determines LOC**.**
Client does not receive a waivered service within 2 months after assessment.	RN reassesses and re-determines LOC.

REFERENCES	Chapter 800, Reassessment; Appendix 100, Forms and Instructions; Appendix 500, Level of Care Criteria; Section 605.1, Provider General Manual

630 – TRIAGE

POLICY STATEMENT	Care coordinators make provisions for continuing client service at a safe level in the event of an emergency or disaster that would result in interruption of client service(s).
POLICY BASICS	Care coordination agencies establish and maintain policies and procedures for assuring that a system of contingency plans for emergencies or disasters are in place. These plans assure back-up care when usual care is unavailable and the lack of immediate care would pose a serious threat to health, safety, and welfare of clients enrolled in the Community Care Services Program (CCSP). These policies and procedures include: • Delivery of service to clients • Assignment of responsibilities to staff • Names and phone numbers of care coordinators • Notification to attending physicians and others responsible for residents/clients • Arrangement for transportation and hospitalization • Availability of appropriate records • Alternatives to current living arrangements • Emergency energy sources. Emergencies include, but are not limited to, the following: • Inclement weather (i.e., heavy rains and snow storms) • Natural disasters (i.e., flood, tornado, hurricane, and ice storms) • Major industrial or community disaster (i.e., power outage, fire, explosion, and roadblocks) • Agency employee illness or staffing shortage affecting significant number of employees or clients • Damage, destruction or fire at the agency's location • Remote areas where transportation would be limited

POLICY BASICS (contd.)	• Suspected abuse, neglect or exploitation. A registered nurse or social services worker may assign a triage level.
PROCEDURES	Use the following guidelines to assign triage levels. Level one clients meet the following criteria: • Require only minimal amount of care • Require less complex treatments, and/or observation, and/or instruction • Provide self-care, ADLs or has a willing and capable caregiver • Do not exhibit any unusual behavior problems. Level two clients meet the following criteria: • Require an average amount of care • No longer experience acute symptoms • Require periodic treatments, and/or observation, and/or instruction • Require some assistance with ADLs, up and about with help for limited periods; or have willing and capable caregivers • Exhibit some psychological or social problems. Level three clients meet the following criteria: • Require an above average amount of care • Require daily treatment, and/or observation, and/or instruction • Have willing caregivers whose capabilities are limited • Require assistance with ADLs • Ambulate with the assistance of two people • Exhibits disorientation or confusion. Level four clients meet the following criteria: • Require a maximum amount of care and have no caregivers in the home • Exhibit acute symptoms
PROCEDURES (contd.)	• Confined to bed

	• Require complete care • Require treatment and/or procedures necessary to sustain life. **NOTE:** Guidelines for triage levels include but are not limited to the above criteria. Evaluate each client and assign a triage level at initial assessment, Comprehensive Care Plan (CCP) review, and reassessment. Document triage level in the comment section of the CCP. **NOTE**: Waivers for desk reviews are not appropriate for triage levels three and four. If needed, consult with providers to assign or change triage levels.
REFERENCES	Section 608, Provider General Manual

640 - CONFIDENTIALITY

POLICY STATEMENT	Any information related to a client is confidential. Release of this information to unauthorized persons or agencies is strictly prohibited.
POLICY BASICS	CCSP case records contain both social and medical information of a sensitive nature and by definition are highly confidential. The *DHR Administrative Policy and Procedures Manual, Volume II*, Section II(A)(2) states: "Records which contain confidential information must be specifically labeled, handled, and stored in such a way as to guard against accidental disclosure." This policy on confidentiality of records is applicable to DHR employees, the AAA and its subcontractors, and all others involved in CCSP service delivery under paragraph number 303 of the DHR contract "Confidentiality - Individual Information". There are some situations, however, in which the confidentiality of client information cannot be honored. Any information indicating that a client is a danger to self or others does not fall, by law, under confidentiality (see references below). For example, if a client threatens suicide, the professional is bound by law and by ethics to communicate this information to the proper authorities. Cases in which a client indicates harm to self or others are difficult to deal with, and discussing such situations with a supervisor is a necessity.
PROCEDURES PROCEDURES (contd.)	The AAA staff and care coordination agencies assure confidentiality of case records by requiring that: • Care coordinators do not remove case records from the office for any reason except when required by the Administrative Law Judge, Office of State Administrative Hearings, or by subpoena • Care coordinators file and lock case records at the close of business each day • Care coordinators do not share case record information with any other agency or person without a signed Authorization for Release of Information, Form 5459

	from the client. In the case of a deceased CCSP client, information is not shared without a written release from the executor of the estate, attorney, etc., stipulating who may obtain information and includes a copy of the letter of administration issued by the probate court. If the person requesting information is not representing the estate and cannot provide the appropriate release and letter of administration, no information may be released without a subpoena.
REFERENCE	Chapter 600, Care Coordination; Chapter 700, Care Management; Chapter 1000, CCSP Appeals; Appendix 100, Forms and Instructions; DHR Administrative Policy and Procedures Manual, Volume II, Section II(A)(2) and Section II(A)(3c); Legal References: Code Section 50-18-90, et seq., O.C.G.A. and 50-18-120 & 121 O.C.G.A.

650 - CLIENT PROTECTION ASSURANCE

POLICY STATEMENT	Each care coordination agency has established procedures for reporting, investigating and following up on allegations of mistreatment, neglect, abuse, or financial exploitation of CCSP clients.
POLICY BASICS	Each policy will at a minimum: • Ensure that all allegations of mistreatment, neglect, abuse or financial exploitation, as well as injuries of unknown source are reported immediately to Adult Protective Services (APS) Central Intake. If the client resides in ALS, the report is made to the Office of Regulatory Services (ORS) and Long Term Care Ombudsman (LTCO). • Require documentation that all allegations of mistreatment, neglect, abuse or financial exploitation, as well as injuries of unknown source, are thoroughly investigated and procedures are in place to prevent further potential abuse while the investigation is in progress. • Require prompt reporting of the results of the investigation to the administrator or designated representative or to other officials in accordance with State law, within five business days of the incident. • Require appropriate corrective action if the alleged violation is substantiated.
PROCEDURES	The care coordinator agency: • Reports the following to DAS APS Central Intake, CCSP Section Manager (or designee) immediately upon receipt of any such report, or no later than the next business day: Section Manager (or designee) immediately upon receipt of any such report, or no later than the close of the next business day: • A client's death is sudden and from other than natural causes

PROCEDURES (contd.)	• A client experiences serious injury from physical abuse, neglect, rape, assault, or any maltreatment that is excessive or bizarre, regardless of the identity of the alleged perpetrator (caregiver or others) • There is media contact regarding the occurrence • Reports allegations of mistreatment, neglect, abuse, financial exploitation, and injuries of unknown source to the proper authorities and follows up. • Assists in the investigation by providing evidence of alleged mistreatment, neglect, abuse, financial exploitation, and injuries of unknown source. • Has procedures in place to prevent further potential abuse while the investigation is in progress. • Reports the results of the investigation to the administrator or designated representative or to other officials in accordance with State law within five business days of the incident. • Documents in the client record the results of the investigation. • Takes appropriate corrective action if alleged violation is verified.
REFERENCES	DHR Adult Abuse Reporting and Prevention Guide (1997)

660 - DOCUMENTATION

POLICY STATEMENT	The care coordinator documents in case notes all program activity related to a client.
POLICY BASICS	Each AAA may determine the format for organizing case records but the format should be uniform within the PSA and ensures that: • Case notes are not shared with other agencies without written consent. • Closed case records are retained for six years after closure. • Case records are confidential.

PROCEDURES
 	
PROCEDURES (contd.)
	Use the following procedures for documentation of new admissions:
	
	1. Complete an initial summary for each client using case notes in CHAT. Describe the situation and explain how the care plan goals and objectives will be met.
	
	2. Include documentation of the following activities in case notes:
	
	• Discussion with a client regarding the right to appeal
	• Discussion with a client regarding the potential for cost share (PMAO and MAO only), if applicable including estimated cost share
	• Discussion with client and/or care giver regarding his or her responsibility to apply for Medicaid benefits, if necessary (PMAO and MAO only).
	
	3. Include the following documents in the client case record:
	
	• Original LOC page
	• MDS-HC and CCP generated from CHAT, including the following:
	  • Client detail
	  • Assessment questions short
	  • DON- R
	  • Assessment detail
	
	• Case notes

- Triggers and Client Assessment Protocols (CAPs)
- Care plan.

- Copy of the Notice of Right to Appeal Decisions Regarding CCSP, Form 5381
- Copy of the Authorization for Release of Information and Informed Consent
- Copy of the Client Rights and Responsibilities form
- Original Potential CCSP MAO Financial Worksheet, which contains client signed Statement of Intent: Cost Responsibility (PMAO and MAO clients only), if applicable
- Other appropriate medical information
- Community Care Communicator, Form 5590 (PMAO and MAO clients only)
- Original SAFs
- Community Care Notification Form, Form 6500
- A copy of Community Care Services Program Participation Form, Form 5389
- Any other information appropriate to the case, (e.g., DMA-80, Authorization For Release of Information, Form 5459, etc.).

NOTE: A completed form in a case record serves as documentation that the care coordinator received or completed it.

4. Document the following items in the case notes in order of occurrence for applicants and active clients:

- Communication with provider(s) regarding a client
- Communication with a client/client representative/caregiver, including home visits and telephone contacts
- Follow-up activities including referrals to other agencies, problem identification and resolution, case conferences and other related activities
- Significant information necessary for completing a CCP review
- Reasons for changes in the case conferences
- Transfer information
- Termination information

PROCEDURES (contd.)

- Significant information regarding changes in client condition, environment, support system, or

	other issues. **NOTE:** Do not share case notes with other agencies or persons other than the client unless the client gives written permission. The Office of State Administrative Hearings may request any part of a case record to assist with a hearing decision. 5. Include the following in CCP Review documentation for active clients: • Feedback from client regarding services • Information regarding changes in the frequency or delivery of the services required or requested by client • Changes in client's physical, emotional or mental status • Changes in client's physician or medications • Comments regarding changes in client's home environment. • Changes in client's informal support network • Verification of client emergency contact person • Comments regarding problems or concerns the care coordinator identified during the last care plan review • Follow-up activities • Recommendations for continued services if client needs are sufficiently met • Recommendations for other needed services and plans for securing them • Information from providers pertinent to client CCP review • Date that a care coordinator completes a reassessment • Date the next CCP review is due and the reasons for the time interval selected. • Client Satisfaction Provide report data regarding program activities to the AAA.
REFERENCES	Section 730, CCP Review; Section 740, Follow-Up Activity; Section 1140, AIMS Reports; Appendix 100, Forms and Instructions

670 - HELP AND DEADLINES

POLICY STATEMENT	Care coordinators and providers first contact the AAA which is the lead agency to discuss problems or questions about the CCSP.
PROCEDURES	Chart 670.1 below indicates whom to ask for assistance:

Chart 670.1 - Whom to Ask for Help

IF YOUR QUESTION IS ABOUT ...	AND YOU ARE A...	THEN ASK THE...
CCSP	Care coordinator	Local AAA
CCSP	AAA	Division of Aging Services (404) 657-5258
CCSP	Medicaid provider	Primary AAA
CCSP Subsystem	Care coordinator	AAA
CCSP Subsystem problem	AAA	DHR Help Desk 1-800-764-1017
Enrollment application packages	Medicaid provider	Provider Enrollment Unit, DMA 1-800-766-4456 or (404) 298-1228
Enrollment approvals	Medicaid provider	Division of Aging Services (404) 657-5258
Reimbursements and claims	Medicaid provider	Billing Inquiry Unit, DMA (404) 657-9324
Reimbursements and claims	ACS- a Billing Inquiry Unit member	Waivered Services Unit, DMA (404)657-9324

REFERENCES	Chapter 600, Care Coordination; Chapter 700, Care Management; Chapter 1100, CCSP AIMS; Appendix 300, Job Descriptions; CCSP service provider manuals

672 - STANDARDS OF PROMPTNESS

POLICY STATEMENT	Care coordinators complete CCSP activities within the standards of promptness guidelines determined by the Division of Aging Services and DMA.
PROCEDURES	The following Chart 672.1 gives standards of promptness:

Chart 672.1 - Standard of Promptness for Care Coordination

IF ACTIVITY IS	THEN STANDARD OF PROMPTNESS IS WITHIN
Responding to telephone inquiry regarding CCSP service	24 hours after telephone inquiry
Screening a referral	5 business days after receiving referral
Notifying client referral source of client denial/ineligibility after telephone screening	Immediately
RN completion of initial assessments	5 business days after receiving referral from AAA/intake and screening unit
Advising applicant of denial during screening	Immediate verbal notice
Notifying applicant of non-entry into CCSP due to ineligibility, i.e. financial ineligibility or ineligible for services	3 business days after screening completed
Determining initial level of care	2 months from date of initial assessment visit **NOTE:** A RN assigns the LOC within 24 hours of receipt of the LOC page signed by the physician.
Sending level of care denial (first notice)	10 working days after LOC denial
Applicant sending additional medical information	10 calendar days after receipt of LOC denial notice
Sending level of care denial (second notice)	10 working days after second LOC denial
Beginning level of care re-determination	2 months before expiration of the level of care **NOTE:** May begin as early as 3 months prior to expiration of LOC.

IF ACTIVITY IS (contd.)	THEN STANDARD OF PROMPTNESS IS WITHIN (contd.)
Assigning LOC at reassessment	2 months from date of reassessment home visit
Completing reassessments when client situations change for the following reasons:	
• Emergency	2 business days after reassessment request
• Major change in client condition or situation	5 business days after reassessment request
• Adding skilled service(s)	5 business days after reassessment request
• Adding another skilled service	10 business days after reassessment request
• Terminating a skilled service	As needed
• Adding non-skilled service	5 business days after reassessment request
• Moved to another PSA	5 business days if client needs a change in service.
Completing reassessments when requested by: • CCSP service provider • Utilization Review analyst • Legal Services Office • Administrative Law Judge • Client	10 business days after reassessment request
Admitting an emergency client	2 business days after referral received
Brokering services for an emergency client	24 hours after LOC assigned
Brokering services for new client	3 business days after LOC assigned
Registering client in AIMS	3 business days of brokering services for new client
	THEN STANDARD OF PROMPTNESS

IF ACTIVITY IS (contd.)	IS WITHIN (contd.)
Telephone follow-up with a client after service brokered to assess service compliance, client satisfaction	10 business days after service brokered
Sending client a Participation Form	3 business days after brokering services
Sending referral packet to provider **NOTE:** If referral packet is faxed to provider, a hard copy is mailed the same day. The provider's SOP begins the day they receive the faxed referral.	24 hours of brokering services
Completing and returning Community Care Notification Form (CCNF), Form 6500, to provider	3 business days after receipt from provider
Sending CCC and LOC to DFCS	3 business days from receipt of first CCNF
Initial Comprehensive Care Plan Review	60 days of admission
Subsequent Comprehensive Care Plan reviews	Every 4 months
Completing a new Comprehensive Care Plan that includes exact service orders using only standardized abbreviations. "No change" notation may not be used.	At care plan review time and when client services change
Sending completed Comprehensive Care Plan to provider	Three days to the expiration date of the current care plan
Notifying Adult Protective Services (APS) and Division of Aging Services (DAS) Section Manager(or designee) of serious injury, death suspected abuse, neglect, or exploitation **NOTE:** If the client is in an ALS, notify ORS and LTCO instead of APS.	Immediately
Sending initial SAFs for PMAO client to provider(s)	3 business days from receipt of eligibility notice or CCC.
Sending initial Service Authorization Forms (SAFs) for SSI client to provider(s)	3 business days from receipt of first CCNF

IF ACTIVITY IS (contd.)	THEN STANDARD OF PROMPTNESS IS WITHIN (contd.)
Sending SAF for active client to provider(s)	5 business days prior to the month for which services are authorized
Transfer of electronic record when client moves to another PSA	2 business days after notification of transfer
Transfer of original client record when client moves to another PSA	5 business days after notification of transfer

REFERENCES	Chapter 600, Care Coordination; Chapter 700, Care Management