Living Choice Case Management Guidelines

Disclaimer: This guide is not all-inclusive. When in doubt please contact Living Choice personnel.

Case manager's (CM) or transitional coordinator's (TC) role in the Living Choice Demonstration: Case management involves developing a rapport with the member. This includes assisting the Living Choice (LC) member with securing identification (e.g., birth certificate, or driver's license); housing or household essentials needed for transition; identifying a primary care doctor; and continuous monitoring of the member's acute and/or chronic health issues, mental health status, social needs and overall well-being while in the Living Choice Demonstration.

Step 1: When you receive an initial LC case:

- ✓ Review all case documents (UCAT I and III, etc.) to familiarize yourself with the case and the needs for the member.
- ✓ Make phone contact with the member to introduce self as CM. Discuss your role in assisting the member and explain the expectations regarding the member's involvement with transition.
    - o Discuss member's housing preferences and options (apartment, assisted living, residing with family members, etc.). Let him or her know what informal supports available.
    - o Identify if the member has proper identification (such as a driver's license, birth certificate or social security card). Make sure identification reflects the legal name the member uses.

If member needs help to secure proper identification:

Example: Jane Doe (maiden name) is married. The legal name she goes by is Jane Smith, but all of her identifying documents refer to her as Doe. In this scenario, the member would need a copy of the marriage certificate in order to obtain proper documentation. It is the responsibility of the CM to assist the member with this task. A CM can provide copies of the birth certificate request form for the member to complete and send back, if possible.

Costs associated with obtaining documentation can be reimbursed from the transitional funds that are available to the member. Each member is eligible for up to $2,400 in transitional funds to assist with their return back into the community.

The Oklahoma Health Care Authority (OHCA) receives a reimbursement of these funds after the member transitions to the community and all necessary paperwork is submitted. Nursing facility social services workers may help facilitate this task if they are available.

There may be additional expenses for which the member requires financial assistance and these may be covered.

If the member has proper identification, move to the next step.

Step 2: Schedule a visit to have a face-to-face meeting with the member.

- ✓ Address concerns, questions or issues, as well as bring any outstanding paperwork for the member to complete, if needed (such as birth certificate forms, or housing applications).
- ✓ Develop a timeline for assisting member with his or her transition.
- ✓ Identify potential housing preferences and/or gather apartment applications if there is time to do so.
    - The goal is to involve the member and/or informal supports as much as possible; however, your priority is to ensure the member's needs are met.

Step 3: Identify potential housing for member.

- ✓ Secure affordable and accessible housing for the member. This step can involve the use of various resources.
    - Examples of such resources include: Applications for the Oklahoma Housing Finance Agency (OFHA) or other Section 8/local income-based properties; apartment magazines with housing options; and **OHCA LC staff** who may have knowledge of potential resources for the area in which member would like to reside. Lastly, don't overlook disabled housing options, assisted living or privately-owned properties.
    - Make member involvement a priority! This is very important to the process.

If you encounter problems securing affordable, accessible housing:

Sometimes housing is identified, but the member must be placed on a waiting list. Other times there just aren't feasible options, even after exhausting all available resources. When this happens:

- OHCA will suspend the case so that the member does not use up the 180 days allowed for community transition.
    - The TC must submit a provider communication with the effective suspend date during this period.
    - When the member is contacted for vacant housing, then another provider communication must be submitted with the effective resume date.
    - The TC may continue with community transition activities when the case is back in active status.

Step 4: Confirm appropriate residence for the member.

- ✓ TC should view the property to inspect the condition of residence and verify safety (property is free from hazards or barriers). This is to ensure that the housing is a feasible option for the member and his or her health needs.
- ✓ Please notify LC research analyst (RA) with the name and location of the property as well as the management or personnel contact.
    - o OHCA LC staff will conduct a housing inspection on every residence prior to a member's transition.
    - o Members cannot transition without a complete and approved housing inspection by LC staff.

When Appropriate Housing is Identified:

For Example: Member utilizes a wheelchair for mobility. The housing option is a lower-level apartment, and the owner is able to make some modifications to unit for accessibility. You do not identify any hazards or barriers of which safety is a concern.

- ✓ TC completes the community plan after OHCA approves the housing.
    - o CM drafts the community plan.
        - ▪ Submit a completed community plan to the RA at least two weeks before the anticipated transition. This allows time for review and corrections, if needed.
        - ▪ Please contact the RA should questions arise while developing the community plan. This helps to prevent delays in the approval process that may cause a delay in the transition period.
    - o Contact OHCA LC staff to let us know you have identified housing and that it needs an inspection.
        - ▪ We perform housing inspections on EVERY UNIT prior to transition.
        - ▪ LC staff MUST approve the unit before the member can transition from the nursing home.
    - o OHCA LC staff notifies you regarding the outcome of the inspection.
        - ▪ If notified that the property did not pass inspection, **continue** to assist member with his/her housing search. (See more instructions below.)

When Inappropriate Housing is Identified:

For Example: Member utilizes a wheelchair for mobility, but the housing choice is not ADA (Americans with Disabilities Act) compliant and is located on the 2nd floor. This scenario is a safety concern, and the housing considered an inappropriate option for the member. In such a case, the CM and member would need to continue the search for suitable housing.

When Housing FAILS Inspection:

- OHCA may suspend the case so that the member does not use up the 180 days allowed for community transition.
    - The TC must submit a provider communication with the effective suspend date during this period.
    - When the member is contacted for vacant housing, then another provider communication must be submitted with the effective resume date.
    - The TC may continue with community transition activities when the case is back in active status.

Step 5: Prepare the Community Plan

- Customize each community plan to meet the member's specific medical and safety needs.
    - The Uniform Comprehensive Assessment Tool (UCAT) III is an excellent resource that may assist you.
        - The member's medical approval for the Living Choice Demonstration includes suggested recommendations from the nurse who performed the initial UCAT assessment. Please review these records when developing the community plan services for member.
        - **UPDATE the UCAT documents as needed.** This may be necessary if, after visiting with the member, you identify additional needs or believe the needs are no longer valid. Please submit the revised UCAT documents along with community plan.
- Secure home health services or supplies for the member. (Examples include catheter supplies, diabetic supplies and nutritional supplements.)
    - To do this, you must obtain orders from the nursing facility doctor. The home health agency can usually acquire this documentation but needs advanced notice of the transition.
    - This information goes to the durable medical equipment (DME) provider in charge of providing equipment and supplies for the member.
    - **Delaying this task can hinder the transition and safety of the member** because services will not be in place by his/her date of transition.
- Locate a primary care provider (PCP).
    - The member must get a new PCP if his or her nursing home medical doctor does not see patients outside of the facility.
        - Home health agencies have provider resources who conduct home visits, or the member may have a PCP in mind.
        - Whichever is the case, make sure the member selects a new PCP, or the same PCP from the nursing home, to resume care after his/her transition to community.

- Utilize AbleTech's DME Reuse Program (www.ok.gov/abletech/DME_Reuse/index.html) as a resource to obtain medical equipment for the member. AbleTech will deliver equipment to the member's home.

A few items are essential to all initial community plans, such as:

- Code T1016 - Allowable varies for each plan
- Code T1019 - Units will vary depending on the needs of the member
- Code T1002 - Allowable 15 units
- Codes S5160 and S5161 - Almost all members receive the PERS ear monitoring system for safety (when medically necessary)
- Code G0200 - If member has only Medicaid, the first 36 visits are covered by State Plan, and then LC covers additional visits thereafter; if the member has Medicare and Medicaid (dually eligible), then this service is billed to Medicare.
- **Obtaining orders** from the nursing facility medical provider in regard to home health, supplements, prescriptions, medical equipment and/or supplies, and any other pertinent services is **very important.**
    - The home health agency can usually acquire this documentation but needs advanced notice of the transition to ensure timeliness of services.
    - The director of nursing (DON) and social services worker (SSW) at the nursing homes can help coordinate this so please establish contact and rapport with these individuals.
- A list of informal supports
- Completing a back-up plan with the appropriate people. Include contact numbers for each company or person listed.
- Customization - Services needed on the plan will vary from member to member.
- The signature of the CM/TC and the member. <u>This is required</u> for each plan.
- Help is available should you have concerns or questions. Contact the RA or clinical nurse supervisor for guidance at any time during your community plan preparation.

<u>Step 6: Complete and send community plans to the assigned RA for submission to the clinical nurse supervisor to review. Do this at least two weeks prior to the tentative transition.</u>

- In circumstances when this is not be feasible, LC staff will work with the TC/CM to coordinate completion of the plan.
- ALL community plans MUST BE APPROVED prior to transition.
    - Once approved, the RA sends the 6g and 6gSP (confirming approved status).
    - It is the TC's responsibility to fax or email a copy of approved 6gSP to all providers listed on the plan.
- Work with the clinical nurse supervisor to make any necessary revisions. Adjust, add or remove items as quickly as possible.
- Schedule the planned interdisciplinary team (IDT) meeting if you have a target transition date.

- The transition date may change for various reasons. If this happens, please communicate this information to RA or clinical nurse to adjust the dates of services. The RA/clinical nurse will notify DHS as to when to turn the member's eligibility over to LC.
    - LC cannot assist the member in the community if the transition occurs without an approved community plan and/or the Living Choice Demonstration process is not completed. Other resources must be explored at such time.
    - **Please make every effort to discuss this with the member** and the importance of completing the process prior to leaving the nursing home.

At this point, you have identification; housing has been selected and passed inspection; the community plan is approved; and the IDT is scheduled. Please go to next step.

Step 7: Conduct IDT on date of transition at a mutual location determined by the member and TC.

- ✓ The IDT can be held at the member's new residence, the nursing home or other mutually agreeable setting.
- ✓ Once the member successfully transitions, the TC/CM sends a provider communication to the RA at the OHCA. The RA then updates the member's new address and contact number (cell phone or home phone) as well as the effective date of the change (which is typically the transition date).

Step 8: Complete and submit a five-day follow-up with the member after transition has occurred. This follow-up helps to ensure the member adjusts at home and has all needed resources in place.

- ✓ We want to confirm that all services are being delivered in the type, scope and frequency as stated on the community service plan.

Step 9: Submit an addendum for the reimbursement of transitional funds (T2038) within 30 days of transition. Include receipts and any transitional units (T1016-U3) with case notes. Reimbursement of transitional funds and units pay to the TC's agency through a prior authorization.

- ✓ We want to ensure that the case management agency is paid (reimbursed) for services provided during pre-transition.
    - This also includes all expenses paid from the one-time allotment of up to $2,400 per member. Receipts serve as proof of purchase for reimbursement. You must provide them.
- ✓ **IMPORTANT:** There may be times when Steps 1-6 are completed but, for some reason, the member does not transition. Or, maybe you have worked with the member and neither of you have been successful in locating affordable housing. In these scenarios you would contact the RA to discuss closure or suspension options for the case.
    - If the case closes, please complete the above steps (retain receipts, calculate units spent working the case, and submit an Alternative Funds Request form for reimbursement).

***Additional information applicable to the 365-day Living Choice Demonstration:**

- ✓ The TC must submit monthly case notes to the RA the following month. These notes are due by the fifth day of each month.
  - Please include the member's RID number on all case notes.
  - The monthly case notes assist with our quality and reporting measures as well as help us recognize and mitigate potential risk factors that would could adversely affect the member's health and welfare.
- ✓ Submit a provider communication to the RA as notice of a TC change; change in provider, case suspensions; updated phone numbers and addresses for the member; hospitalizations; temporary nursing facility placements; etc. These efforts help keep our charts/database up-to-date.
- ✓ Turn in a Critical Incident Report (CIR) for the Levels I, II and III within the required reporting timeline to the RA assigned over the case. (Please reference CIR for each specific incident that requires report.) Call the RA for guidance if you have any questions or concerns.
- ✓ Please notify the LC staff immediately if any problems or concerns arise prior to or after the member transitions. We are here to help you and ensure the safety of our members.
- ✓ Please type out information on all LC documents, if possible. This helps to eliminate any processing delays due to illegible handwriting.
- ✓ All LC documents are available online at www.okhca.org/ltc.
- ✓ **Please fax all correspondences to the main fax number (405-530-3497), addressed to the RA assigned to the case. You may also contact us toll free at 888-287-2443.**
- ✓ **Living Choice Research Analysts (RA):**
  - **Essence McKnight** Phone: 405-522-7682
  - **Patricia Harrison** Phone: 405-522-7367
  - **Shakina Johnson** Phone: 405-522-7402

- ✓ <u>For clinical questions regarding community plans</u> - In addition to contacting the RA, you can also contact the Living Choice clinical nurse supervisor. The clinical nurse supervisor reviews all community plans and addendums.

  Anataya Rucker, Living Choice clinical nurse supervisor
  Phone: 405-522-7307

Most members transition to ADvantage, State Plan or other private assistance after their 365 days in the Living Choice Demonstration.

The ADvantage Waiver process starts when a nurse with the Oklahoma Department of Human Services (DHS) contacts the member and/or CM approximately 30-60 days prior to the end of the Living Choice Demonstration. This is to schedule an assessment.

If the member meets the criteria, then he/she will transition to the ADvantage Waiver. This occurs by day 366 at the latest.