Oklahoma HealthCare Authority

OKLAHOMA
Medically Fragile

Oklahoma's Medically Fragile Waiver

- A medically fragile condition is defined as a chronic physical condition which results in prolonged dependency on medical care:
  - Oklahoma Health Care Authority & ADvantage collaborated to create the Medically Fragile Waiver to address the needs of members whose care could not be managed in another waiver program.
  - Medically Fragile was approved in July 2010 and the first member was enrolled in August 2010.
  - In 2010, 31 slots were approved for the first year. Currently, the waiver is approved for 155 slots.

How To Make a Referral

- A referral form can be completed by anyone via phone, fax, email or on the OHCA website
  - Phone: 1-888-287-2443
  - Fax: 405-530-7265
  - Website: www.okhca.org/ltc

Staff

- Program coordinator
- Senior research analyst (2)
- Administrative assistant
- Clinical nurse supervisor
- Senior clinical nurse

Who We Serve

EPSDT	ADvantage	Community members
• Early, Periodic, Screening, Diagnostic Treatment (EPSDT) • Age out	• Unmet needs	• No services

Eligibility Requirements

19 years of age or older

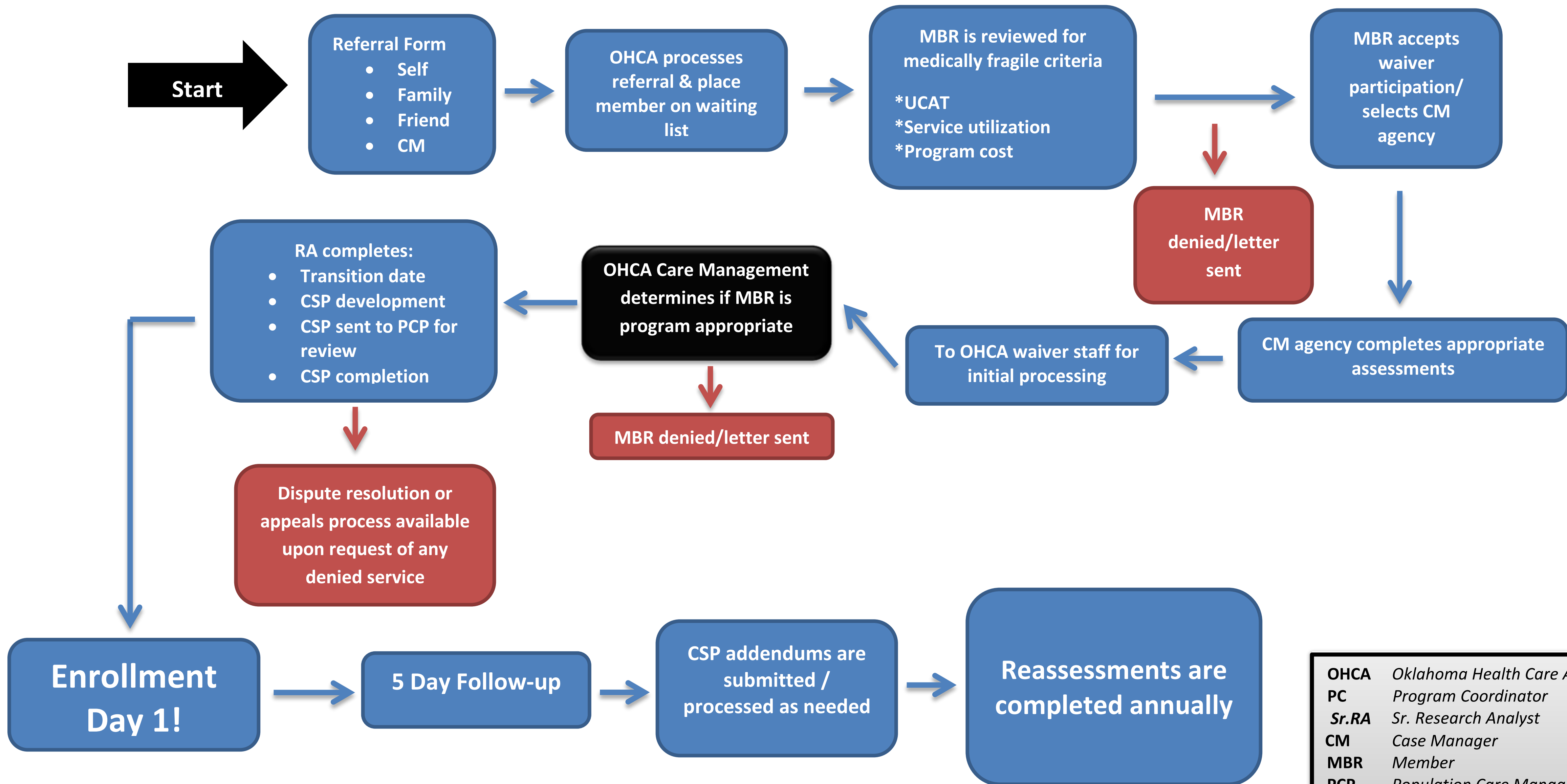
Financial eligibility determined through DHS county offices

Currently reside in a community setting of their choosing

Program Criteria

- Meet hospital or skilled nursing facility level of care AND
- A life threatening condition; requires frequent medical supervision OR
- Frequent administration of specialized treatment OR
- Dependent on medical technology

Medically Fragile Enrollment Process



OHCA	*Oklahoma Health Care Authority*
PC	*Program Coordinator*
Sr.RA	*Sr. Research Analyst*
CM	*Case Manager*
MBR	*Member*
PCP	*Population Care Management*
ROI	*Release of Information*
UCAT	*Uniform Comprehensive Assessment Tool*
CSP	*Community Service Plan*
IDT	*Inter-Disciplinary Team*

Medically Fragile Services

Advanced supportive/restorative assistance
Case management
- Institutional transition case management
- Transitional case management

Environmental modifications
Home-delivered meals
Hospice care
Personal care
Prescription drugs
Personal emergency response system (PERS)
Respite care
Skilled nursing
Private duty nursing
Self-Direction Services:
- Personal Care
- Advanced Supportive/Restorative
- Respite
- Self-Directed Goods and Services (SD-GS)

Specialized medical equipment and supplies
Therapy services: Occupational
Therapy services: Physical
Therapy services: Respiratory
Therapy services: Speech

Reimbursement Rates for Services
Medically Fragile Waiver Program

Medically Fragile					
Waiver Services	**Unit of Service**	**Unit Rate**	**Service Code**	**Modifier 1**	**Modifier 2**
Advanced Supportive/Restorative	15 minutes	$4.35	T1019	**TF**	-
Case Management S	15 minutes	$14.68	T1016	-	-
Case Management VR	15 minutes	$21.01	T1016	**TN**	-
Institutional Transition Case Management S	15 minutes	$14.68	T1016	**U3**	-
Institutional Transition Case Management VR	15 minutes	$21.01	T1016	**U3**	**TN**
Transition Case Management S	15 minutes	$14.68	T1016	**U3**	-
Transition Case Management VR	15 minutes	$21.01	T1016	**U3**	**TN**
Environmental Modifications	As Billed	As Prior Authorized	S5165	-	-
Home Delivered Meals	1 Meal	$5.15	S5170	-	-
Hospice Care	1 Day	$122.67	S9126	-	-
In-home Extended Respite (8+hrs)	1 Day	$170.86	S9125	-	-
In-home Respite (2-7 hours)	15 minutes	$4.04	T1005	-	-
NF Extended Respite (8+ hours)	1 day	Varies	UB120	-	-
Personal Care	15 minutes	$4.04	T1019	-	-
Personal Emergency Response *Install*	1 Time	As Prior Authorized	S5160	-	-
Personal Emergency Response *Monthly*	Monthly	As Prior Authorized	S5161	-	-
Prescriptions (maximum of 7 units only)	As Ordered	Avg. $76.40 each	W1111	-	-
Private Duty Nursing	15 minutes	$7.78	T1000	-	-
RN Assessment/Evaluation	15 minutes	$13.91	T1002	-	-
RN Assessment/Evaluation - Transitional	15 minutes	$13.91	T1002	**U3**	-
Skilled Nursing – Home Health Setting (LPN)	15 minutes	$13.91	G0300	-	-
Skilled Nursing – Home Health Setting (RN)	15 minutes	$13.91	G0299	-	-
Specialized Medical Equipment and Supplies	As Billed	As Prior Authorized	HCPCS	-	-
Therapy Services					
Therapy – Occupational	15 minutes	$20.60	G0152	-	-
Therapy – Physical	15 minutes	$20.60	G0151	-	-
Therapy – Respiratory	15 minutes	$14.16	G0237	-	-
Therapy – Speech/Language	15 minutes	$20.60	G0153	-	-

Self-Directed Services					
Advanced Supportive/Restorative	15 minutes	$4.35	S5125	**TF**	-
Personal Care	15 minutes	$4.04	S5125	-	-
In-home Respite (2-7 hours)	15 minutes	$4.04	T1005	**U4**	-
In-home Extended Respite (8+hrs)	1 day	$170.86	S9125	**U4**	-
Incontinence Supplies					
Adult Small Brief	Each	$.80	T4521	-	-
Adult Medium Brief	Each	$.88	T4522	-	-
Adult Large Brief	Each	$.99	T4523	-	-
Adult Extra Large Brief	Each	$1.16	T4524	-	-
Adult Small Underwear	Each	$.89	T4525	-	-
Adult Medium Underwear	Each	$1.04	T4526	-	-
Adult Large Underwear	Each	$1.13	T4527	-	-
Adult Extra Large Underwear	Each	$1.29	T4528	-	-
Disposable/Guard Liner	Each	$.61	T4535	-	-
Any Size Reusable Underpad	Each	$13.91	T4537	-	-
Chair Size Reusable Underpad	Each	$14.83	T4540	-	-
Large Disposable Underpad	Each	$.60	T4541	-	-
Small Disposable Underpad	Each	$.39	T4542	-	-

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Uniform Comprehensive Assessment, Part III
Medical (Level of Care) Assessment

Assessment information.

(Assessor) Attach completed Form 02HM001E, Uniform Comprehensive Assessment, Part I, Intake and Referral. Numbers in parenthesis refer to item numbers in the Oklahoma Long-Term Care Authority (OLTCA) Manual.

(1) Consumer name		Date
Social Security number (2)	Case number	Unique ID number

(3) Location of: ☐ assessment ☐ reassessment
☐ consumer's residence ☐ relative's home ☐ nursing home
☐ hospital ☐ other, specify ______________

Mental status questionnaire (MSQ)

(Assessor) Write responses to questions. Do not score until section is completed. Count one error for each incorrect response up to the maximum errors for the item. No response is counted as an incorrect response.

(4) **(Say)** I'm going to read you a list of questions. These are questions often asked in interviews like this and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with the current year.

Question	Answer	Maximum errors	Score	Weight		Weighted score
What year is it now?	________	1	________	X 4	=	________
What month is it now?	________	1	________	X 3	=	________

(Say) I'm going to give you a man's name and address to memorize and you will be asked to repeat the phrase later.

Memory phrase: **John Brown, 42 Market Street, Chicago**

Elicit three correct repetitions from the consumer, phrase by phrase or word by word, if necessary, before continuing.

(Ask) Without looking at a clock, what time is it? (within one hour)

Time is: ________ Response: ________ 1 ________ X 3 = ________

(Say) Count backwards from 20 to 1.

Indicate missed or out of order numbers in boxes. Mark **/** for correct and **x** for incorrect.

2 ________ X 2 = ________

20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

(Ask) Say the months in reverse order.
For ease in scoring, start with the month of December. Indicate missed or out of order months in boxes. Mark **/** for correct and **x** for incorrect.

2 ________ X 2 = ________

Dec	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	Mar	Feb	Jan

(Ask) Now, repeat the memory phrase.
Prompt the consumer if necessary: **It was John Brown…**
Write consumer's response on the line below to score.

Error points	John	Brown	42	Market Street	Chicago
	(1)	(1)	(1)	(1)	(1)

Response:

5 ________ X 2 = ________

Maximum weighted error score = 28

Total weighted error score ☐

Health assessment.

(1) Check source of information used for Health assessment:
☐ Consumer ☐ Record review ☐ Other, specify ________________________

Health conditions.

(2) **(Ask)** Do you have any health conditions, and how do they affect you?
Has a doctor told you that you have any of the following health problems or symptoms of health problems?

Read health conditions to consumer.

Reviewed	Health conditions	Present	Interferes with living	Condition is not under treatment	Number of years had condition
☐	**Allergies** (drug/skin/etc.), type: ________	☐	☐	☐	
☐	Amputation, site: ________	☐	☐	☐	
☐	**Anemia,** type: ________	☐	☐	☐	
☐	Arthritis, type: ________	☐	☐	☐	

Reviewed	Health conditions	Present	Interferes with living	Condition is not under treatment	Number of years had condition
☐	**Asthma,** type: ______________________	☐	☐	☐	
☐	Autism	☐	☐	☐	
☐	**Bed sore(s),** decubitus stage: _________	☐	☐	☐	
☐	Bladder/kidney problems (UTI, etc.)	☐	☐	☐	
☐	**Blood disorder,** type: ________________	☐	☐	☐	
☐	Brain injury	☐	☐	☐	
☐	**Broken bones,** type, site: _____________	☐	☐	☐	
☐	Cancer, type: _______________________	☐	☐	☐	
☐	**Cerebral palsy**	☐	☐	☐	
☐	Cognitive learning disability	☐	☐	☐	
☐	**Cystic Fibrosis**	☐	☐	☐	
☐	Dehydration	☐	☐	☐	
☐	**Dementia** (ALZ, OBS, etc.), type: ______	☐	☐	☐	
☐	Dialysis, type: ______________________	☐	☐	☐	
☐	**Diabetes,** type: _____________________	☐	☐	☐	
☐	Dizziness	☐	☐	☐	
☐	**Eating disorder,** type: ______________	☐	☐	☐	
☐	Emphysema (COPD, etc.)	☐	☐	☐	
☐	**Falls** (past year): ___________________	☐	☐	☐	
☐	Gall bladder problems (gallstones, etc.)	☐	☐	☐	
☐	**Hearing problems**	☐	☐	☐	
☐	Heart problems (CHF, MI, etc.), type: ____________________________	☐	☐	☐	
☐	**High blood pressure** (hypertension), type:______________________________	☐	☐	☐	
☐	HIV/AIDS	☐	☐	☐	
☐	**Hormonal disorder,** type: ____________	☐	☐	☐	
☐	Intestinal disorder, specify _____________	☐	☐	☐	
☐	**Liver problems** (cirrhosis, hepatitis, etc.), type: ____________________________	☐	☐	☐	
☐	Lupus	☐	☐	☐	
☐	**Mental illness,** type: ________________	☐	☐	☐	
☐	Mental retardation	☐	☐	☐	
☐	**Migraine headaches**	☐	☐	☐	
☐	Mood or behavior problems	☐	☐	☐	
☐	**Multiple sclerosis**	☐	☐	☐	

Reviewed	Health conditions	Present	Interferes with living	Condition is not under treatment	Number of years had condition
☐	Muscular dystrophy	☐	☐	☐	
☐	**Osteoporosis**	☐	☐	☐	
☐	Paralysis, site: ______________________	☐	☐	☐	
☐	**Parkinson's disease**	☐	☐	☐	
☐	Pneumonia	☐	☐	☐	
☐	**Polio/post-polio syndrome**	☐	☐	☐	
☐	Potassium/sodium imbalance (electrolytes)	☐	☐	☐	
☐	**Seizure disorders** (epilepsy, etc.)	☐	☐	☐	
☐	Shingles (herpes zoster)	☐	☐	☐	
☐	**Skin disease,** specify: _______________	☐	☐	☐	
☐	Sleep problems	☐	☐	☐	
☐	**Spina bifida**	☐	☐	☐	
☐	Spinal cord injury	☐	☐	☐	
☐	**Stroke**	☐	☐	☐	
☐	**Thyroid problems** (Graves, myxedema, etc.), type: ____________________________	☐	☐	☐	
☐	Tuberculosis	☐	☐	☐	
☐	**Ulcers,** type and site _____	☐	☐	☐	
☐	Vision problems (cataracts, glaucoma, etc., Type: ____________________________	☐	☐	☐	
☐	**Other,** specify: ______________________	☐	☐	☐	
☐	Substance abuse, type: _______________	☐	☐	☐	

Notes:

Drug, alcohol, and tobacco use.

(3) **(Ask)** Do you use a recreational substance? For example, marijuana, LSD, crack cocaine, barbiturates, designer drugs, or inhalants.

- ☐ Uses. Specify frequency: ____
- ☐ Does not use.
- ☐ Used in the past. Specify when quit: _____________________________________

(4) **(Ask)** Do you drink any alcoholic beverages, including beer and wine?

☐ Drinks alcohol. **(Ask)** On average, how much beer, wine, and other alcoholic beverages do you drink?
Specify frequency:_________

☐ Never drinks alcohol.
☐ Used alcohol in the past. Specify when quit: ______________________________

(5) **(Ask)** Do you smoke, chew, or dip tobacco?
☐ Yes **(Ask)** How much do you use per day? ___________________
☐ No
☐ Used tobacco in the past. Specify when quit: ______________________________

(6) **(Assessor)** Are you concerned about consumer's drug, alcohol, and tobacco use? ☐ Yes ☐ No
Describe why:

Comments and conditions unique to consumer pertaining to health conditions through drug, alcohol, and tobacco use sections:

(7) **Medication use.** Current medicines, refrigerated medicines, and non-prescription drugs, such as aspirin, vitamins, laxatives, home remedies, herbal products, and birth control.

Name	Dosage	Frequency	Physician	Date filled

(8) Pharmacy used by consumer. If more than one, note others in comments.

Name	Phone
Address	

(9) **(Ask)** How do you remember to take your medications? **Do not read list. Check answer and specify who gives or fills.**

☐ Caregiver gives _________
☐ Follow directions on label or doctor order _________
☐ Plastic pill minder _________
☐ Calendar or log _________

- ☐ Egg carton, envelopes _________
- ☐ Other, specify: _________

(10) **(Assessor)** Check if yes. I am concerned consumer is:

- ☐ not taking meds on time
- ☐ not taking proper number of meds
- ☐ taking meds prescribed for others
- ☐ not getting Rx properly filled
- ☐ not getting med needs re-evaluated
- ☐ not getting meds due to cost
- ☐ affected by drug side effects
- ☐ taking prescriptions from too many physicians
- ☐ using outdated meds
- ☐ refusing to take meds
- ☐ having other medication problems, specify: _____

Comments and service plan implications:

Medical utilization.

(11) **(Ask)** In the PAST SIX MONTHS have you seen a doctor (physician's assistant or nurse practitioner, eye doctor, foot doctor, dentist, or hearing exam), been admitted to a hospital, or gone to an emergency room? ☐ Yes, complete below ☐ No ☐ Don't know

Name of physician/hospital/ER	Date	How long?	Reason for visit/admission

(12) Were you ever a resident of a nursing home, RCF, or similar place? ☐ Yes, complete below ☐ No ☐ Don't know

Admit date	Discharge date	Name of facility (RCF, NF, SNF, ICF-MR)	Reason for admission

Special equipment and assistive devices.

(13) **(Ask)** Do you have or need any of the following special equipment or aids?

Equipment/ assistive device	Has and uses	Has, but doesn't use	Needs but doesn't have
Prosthesis, type:_______________	☐	☐	☐
Cane	☐	☐	☐
Walker	☐	☐	☐
Wheelchair**,** type: _______________	☐	☐	☐
Brace, leg/back: _______________	☐	☐	☐
Hearing aid(s)	☐	☐	☐
Glasses	☐	☐	☐
Contact lenses	☐	☐	☐
Dentures	☐	☐	☐
Emergency alert response (EAR)	☐	☐	☐
Hospital bed	☐	☐	☐
Bedside commode	☐	☐	☐
Bathing equipment	☐	☐	☐
Transfer equipment	☐	☐	☐
Adaptive eating equipment	☐	☐	☐
Disposable medical supplies	☐	☐	☐
Other, specify: _______________	☐	☐	☐

Comments and service plan implications:

Medical treatments and therapies

(14) **(Ask)** Do you regularly receive any of the following medical treatments?

Medical treatment	Yes	No	Frequency
Aseptic dressing	☐	☐	
Bedsores treatment	☐	☐	
Bowel/bladder rehab	☐	☐	
Bowel impaction therapy	☐	☐	
Catheter care, type: _______	☐	☐	
Dialysis (type): ____________	☐	☐	
IV fluids	☐	☐	
IV medicines	☐	☐	
Insulin therapy	☐	☐	
Lesion irrigation	☐	☐	
Ostomy care, type: ________	☐	☐	

Medical treatment	Yes	No	Frequency
Oxygen	☐	☐	
Resp. treatment, type: ______	☐	☐	
Suctioning	☐	☐	
Tube feeding, type: _______	☐	☐	
Physical therapy	☐	☐	
Occupational therapy	☐	☐	
Speech therapy	☐	☐	
Respiratory therapy	☐	☐	
Other, specify: ____________	☐	☐	

Comments on medical treatment and therapies and service plan implications:

(15) **(Assessor)** Record consumer's diagnosis.

Diagnosis	DRG-code
Primary :	
Secondary:	

Nutrition.

(16) **(Ask)** Would you say that your appetite is good, fair, or poor?

Good (0) Fair (2) Poor (6) Score: ________

(17) Current weight and height? Weight _________ Height ___________ ☐

(18) **(Ask)** Have you gained or lost a significant amount of weight in the last six months? **10% unintentional change is significant.**

Yes (4) ☐ Gain: ______ pounds
No (0) ☐ Loss: ______ pounds

Score: ________ ☐

(19) Do you have any problems that make it difficult to eat?

List score. For example, do you have:	Yes	No
tooth or mouth problems	______ (4)	______ (0)
swallowing problems	______ (4)	______ (0)
nausea/vomiting	______ (4)	______ (0)
taste problems	______ (0)	______ (0)
problems eating certain foods	______ (0)	______ (0)
food allergies	______ (0)	______ (0)
any other problems eating **Describe:**	______ (0)	______ (0)
Total:		

Comments and service plan implications:

(20) Are you on a special diet that the doctor told you to follow?

None (0) ________ 1 Diet (4) _______ 2 or more diets (6) _______

Are you following the diet? ☐ Yes ☐ No

Check if you are on one of the diets below:

- ☐ Low sodium (salt)
- ☐ Low fat/cholesterol
- ☐ Low sugar
- ☐ Calorie supplement
- ☐ Other prescribed special diet, specify: ______________________________________

Comments and service plan implications:

(21) **(Assessor)** Does consumer take three or more prescribed or over-the-counter drugs daily?

Yes (2) ______ No (0) _______

Briefly describe what the consumer usually eats and drinks during a typical day, including weekends. Enter one mark for each serving the consumer eats and drinks in a typical day. **Do NOT add these scores into nutrition total score.**

Type of food or drink	Breakfast	Lunch	Dinner	Snack	Total
Fluids					
Fats, oils, sweets					
Milk, yogurt, cheese					
Fruit					

Type of food or drink	Breakfast	Lunch	Dinner	Snack	Total
Meat, poultry, fish, dry beans, eggs, nuts					
Vegetables					
Bread, cereal, rice, pasta					

Specify any religious or self-imposed diets practiced:

Nutrition total score ☐

(22) **Subjective evaluation of health.**

(Ask) Overall, do you consider your health excellent, good, fair, or poor?
(Assessor) Enter score: Excellent (0) _________ Good (5) ________
Fair (15) _________ Poor (25) ________

(Ask) What makes you feel that way? **(Document answer)**

Subjective evaluation of health total score ☐

(23) **(Assessor)** Rate consumer's speaking and communication ability based on performance in the interview:

Speaking.

- ☐ Speaks clearly with others of the same language
- ☐ Some defect in speech/usually gets message across
- ☐ Unable to speak clearly/does not speak

Communication.

- ☐ Transmits/receives information
- ☐ Limited ability
- ☐ Nearly or totally unable to speak

(24) **Health assessment.** Clinical judgment, pertaining to Health assessment.

Check risk level and document why.

☐ low risk ☐ moderate risk ☐ high risk

Comments and service plan implications - Summary:

Functional assessment – ADLs.

(1) Check sources of information used for Functional assessment section.
☐ Consumer ☐ Other, specify: ______________________________

For initial assessment: List in the last column assistance needed in addition to what is already in place. Be specific about tasks needed and frequency.

For reassessment: Indicate in the last column if services need to be increased, decreased, or remain at the same level.

Read all choices before taking answer.

Assistant codes: 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church 7 = Volunteer 8 = Private pay
Level of help needed codes: 0 = no assistance 2 = Some assistance/supervision 3 = Can't do at all

ACTIVITIES OF DAILY LIVING (ADLs) Would you say that you need help with:	No assistance	Some assistance/ supervision	Can't do at all	Comments, required to justify score of 2 or more	Name and phone number of assistant	Assistant code	Frequency, hours, etc	Assistance needed
(2) **dressing.** Includes getting out clothes, putting them on, fastening them, and putting on shoes.	___	___	___					
(3) **grooming.** Includes combing hair, washing face, shaving, and brushing teeth.	___	___	___					
(4) **bathing.** Includes running the water, taking the bath or shower, and washing all parts of the body, including hair.	___	___	___					
(5) **eating.** Includes eating, drinking from a cup, and cutting foods.	___	___	___					

ACTIVITIES OF DAILY LIVING (ADLs) Would you say that you need help with:	No assistance	Some assistance/ supervision	Can't do at all	Comments, required to justify score of 2 or more	Name and phone number of assistant	Assistant code	Frequency, hours, etc	Assistance needed
ca(6) **transferring.** Includes getting in and out of a tub, bed, chair, sofa, vehicle, etc.	___	___	___					
(7) **mobility.** Moving about, even with a cane or walker or using a wheelchair. Independence refers to the ability to walk or move yourself short distances. Does not include using stairs; may refer to history of falling.	___	___	___					
(8) **stairs.** Ability to use any stairs that affect your daily activities three or more times per week, both in your home and community.	___	___	___					
(9) **toileting.** How well can you manage using the toilet? Independence includes adjusting clothing, getting to and on/off the toilet, and keeping yourself clean and dry. If accidents occur and consumer manages it alone, count as **NO** assistance. If reminders are needed, count as **some** assistance/supervision.	___	___	___					

ACTIVITIES OF DAILY LIVING (ADLs) **Would you say that you need help with:**	**No assistance**	**Some assistance/ supervision**	**Can't do at all**	**Comments, required to justify score of 2 or more**	**Name and phone number of assistant**	**Assistant code**	**Frequency, hours, etc**	**Assistance needed**
(10) **bladder/bowel control.** How often do you have bladder or bowel accidents? ______ Never (0) ______ Occasionally (2) ______ Often (3) ______ Always (4)	enter one score: _________							
(11) **incontinence.** Do you wear incontinence pads or use appliances or training programs? ☐ Yes (Ask question below) ☐ No (Skip next question) ☐ pad/brief ☐ urinal/bedpan ☐ catheter ☐ training programs ☐ ostomy	Specify type appliance/training:							
(12) Do you need assistance to change pads or appliances or manage training programs?	___	___	___					
Totals								

ADL total score ☐

ADL impairment count ☐

Functional Assessment – IADLs.

For initial assessment: List assistance needed in the last column in addition to what is already in place. Be specific about tasks needed and frequency.

For reassessment: Indicate in the last column if services need to be increased, decreased, or remain at the same level.

Read all choices before taking answer.

Assistant codes: 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church 7 = Volunteer 8 = Private pay
Level of help needed codes: 0 = no assistance 2 = Some assistance/supervision 3 = Can't do at all

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) Would you say that you need help to:	No assistance	Some assistance/ supervision	Can't do at all	Comments, required to justify score of 2 or more	Name and phone number of assistant	Assistant code	Frequency, hours, etc	Assistance needed
(13) **answer the telephone.** Identify the signal and use the equipment to respond effectively to caller, etc. Includes the use of an amplifier or special equipment.	___	___	___					
(14) **make a telephone call.** Select and dial numbers to connect with desired parties. Use the equipment to effectively communicate purpose of call. Includes programmed calling systems.	___	___	___					
(15) **go shopping or run errands.** Shopping for food and other things you need. Does not include getting to and from store. Includes making lists, selecting needed items, reading labels, reaching shelves, completing the purchase, etc.	___	___	___					

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) **Would you say that you need help to:**	**No assistance**	**Some assistance/ supervision**	**Can't do at all**	**Comments, required to justify score of 2 or more**	**Name and phone number of assistant**	**Assistant code**	**Frequency, hours, etc**	**Assistance needed**
(16) **go places.** Arranging and using local transportation or driving to places beyond walking distance, to get to places you need to go.	___	___	___					
(17) **prepare meals.** Making sandwiches, cold or cooked meals, TV dinners, etc., so that you won't go hungry. Does not refer to quality of nutritional content.	___	___	___					
(18) **do laundry.** Using detergent, getting items in/out of washer or dryer, starting and stopping the machine, or otherwise washing and drying, sorting, folding, putting away, etc.	___	___	___					
(19) **do light housekeeping.** Includes dusting, vacuuming, sweeping, etc. Does not include laundry.	___	___	___					
(20) **do heavy chores.** Windows, moving furniture, general home maintenance, yardwork. Does not include laundry.	___	___	___					
(21) **take medication.** Ability to set up, remember, and take your own medication in correct doses and methods.	___	___	___					

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) **Would you say that you need help to:**	**No assistance**	**Some assistance/ supervision**	**Can't do at all**	**Comments, required to justify score of 2 or more**	**Name and phone number of assistant**	**Assistant code**	**Frequency, hours, etc**	**Assistance needed**
(22) **manage money.** Refers to only your own money. Paying bills, balancing checkbook, counting change, staying within available financial resources, etc.	___	___	___					
Totals								

IADL total score [ ]

IADL impairment count [ ]

Consumer support and social resources.

(1) Check source of information used for Consumer support and social resources.

☐ Consumer ☐ Other, specify ______________________________

For initial assessment: List in the last column assistance needed in addition to what is already in place. Be specific about tasks needed and frequency.

For reassessment: Indicate in the last column if services need to be increased, decreased, or remain at the same level.

Assistant codes: 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 6 = Church 7 = Volunteer 8 = Private pay
Level of help needed codes: 0 = no assistance 2 = Some assistance/supervision 3 = Can't do at all

(2) **CONSUMER SUPPORT** **Do you receive assistance from:**	**Yes**	**No**	**Name and phone number of assistant**	**Assistant code**	**Frequency, hours, etc.**	**Assistance needed**
a health professional, such as RN, therapist, hospice, specify:	☐	☐				
adult day care.	☐	☐				
home-delivered meals.	☐	☐				
any other kind of assistance, such as respite, specify:	☐	☐				

Social resources.

(3) Does consumer live alone? ___ Yes (6) ___ No (0)

(4) **(Ask)** Is there someone who could stay with you if you needed it or if you were sick? ___ Yes (0), complete below ___ No (6)

Name	Relationship to consumer	Phone
		( )

(5) If you could not continue to live in your present location, do you have any ideas about where you would live?

- ☐ Home
- ☐ Smaller home (apartment, mobile home)
- ☐ Relative's home, specify: ____________
- ☐ Residential care facility or group home
- ☐ Assisted living
- ☐ Adult foster home
- ☐ Nursing home
- ☐ Other, specify ______________
- ☐ Don't know

(6) Is there a person you can talk to when you have a problem?
___ Yes (0), complete below ___ No (4)

Name	Relationship to consumer

(7) Do you have a pet? ☐ Yes, specify: _________ ☐ No

(8) How often do you talk to friends, relatives, or others on the phone, they call you or you call them?

___ Once a day or more (0)
___ 2 - 6 times a week (1)
___ Once a week (2)
___ 1 - 3 times a month (3)
___ Less than once a month (4)
___ No phone (4)

Name	**Phone number**

Comments: ______________________________

(9) How often do you spend time with someone who does not live with you? You go to see them or they come to visit you, or you do things together, in the home or out of the home?

___ Once a day or more (0)
___ 2 - 6 times a week (1)
___ Once a week (2)
___ 1 - 3 times a month (3)
___ Less than once a month (4)

Name	**Phone number**

Comments: ______________________________

(10) What activities or interests do you enjoy?

(11) Are you able to attend services or practice your religion as often as you like? ☐ Yes ☐ No ☐ N/A

Name of church/synagogue: ______________________

Contact person: ______________________

Notes:

Social resources total score ☐

Comments and service plan implications:

Mental health.

(1) Check source of information used for Mental health.

☐ Consumer ☐ Other, specify: ______________________

(2) Is there any indication that the consumer has a current mental health problem? ☐ Yes ☐ No

If yes, describe:

(3) **(Ask)** Are you currently, or have you previously, received mental health services or counseling? ☐ Yes, complete below ☐ No

Provider name	Phone

Comments:

Emotional well-being.

(4) **(Ask)** I have some questions about how you have been feeling during the **past month.**

- Are you satisfied with your life? ☐ Yes ☐ No
- Have you been feeling in good spirits? ☐ Yes ☐ No
- Have you been depressed or very unhappy? ☐ Yes ☐ No
- Have you been very anxious or nervous? ☐ Yes ☐ No
- Have you had difficulty sleeping? ☐ Yes ☐ No
- Have you seen or heard things that other people didn't see or hear? ☐ Yes ☐ No
- Have you had serious thoughts about harming anyone? ☐ Yes ☐ No
- Have you had serious thoughts about harming or killing yourself? ☐ Yes ☐ No
- Is anyone plotting against you? ☐ Yes ☐ No

Comments and service plan implications:

Memory assessment.

(5) **(Ask)** I'd like to ask you some questions about your memory and ability to find things. In the **past month** have you:

- had any problems with your memory?
  Specify: ____ ☐ Yes ☐ No
- frequently lost items, such as your purse, wallet, or glasses? ☐ Yes ☐ No
- failed to recognize family members/friends? ☐ Yes ☐ No
- lost your way around the house. For example, can't find the bedroom or bathroom? ☐ Yes ☐ No
- forgotten to turn the stove off? ☐ Yes ☐ No

Comments/service plan implications:

(6) **(Assessor)** In your judgment, does the consumer:

- appear to be depressed, lonely or dangerously isolated? ☐ Yes ☐ No
- wander away from home or other places for no apparent reason? ☐ Yes ☐ No
- need supervision? If yes, specify how much, such as constant, at night only. ____ ☐ Yes ☐ No
- pose a danger to self or others? ☐ Yes ☐ No
- show suicidal ideation? ☐ Yes ☐ No
- demonstrate significant memory problems? ☐ Yes ☐ No
- exhibit other behavior problems, specify: ____________________

Comments and service plan implications:

(7) Does the consumer require:

☐ Immediate intervention
☐ Mental health referral
☐ Neither

Document why or who, if immediate intervention is needed:

Environmental assessment.

Subjective evaluation of environment.

(1) **(Ask consumer only)** Are you concerned about your safety in your home or neighborhood? ☐ Yes ☐ No If yes, comment required:

(2) **(Assessor)** Indicate specific area(s) in which there are potential safety or accessibility problems for the consumer.

- ☐ Structural damage/dangerous floors
- ☐ Barriers to access, including steps and stairs
- ☐ Electrical hazards
- ☐ Fire hazards/safety equipment
- ☐ Unsanitary conditions/odors
- ☐ Insects or other pests
- ☐ Poor lighting
- ☐ Insufficient water/hot water
- ☐ Insufficient heat/air conditioning
- ☐ Shopping
- ☐ Transportation
- ☐ Telephone
- ☐ Neighborhood unsafe
- ☐ Unable to evacuate in emergency

Problem area:

Environmental - clinical judgment.

No risk (0) _____ Low risk (5) _____ Moderate risk (15) _____ High risk (25) _____

Environmental total score ☐

Document why:

Comments:

Landlord name	Phone
Yardwork/home repairs name	Phone

Caregiver assessment

(1) Does an informal caregiver help the consumer on a regular basis?

☐ **Yes**, complete this section. ☐ **No,** go to Recommendations.

Name	Relationship
Address	Phone

Address to caregiver alone:

(2) **(Ask)** How long have you assisted **(name of consumer)**? _____ years _____ months

(3) How often do you assist **(name of consumer)**? Would you say you assist:

☐ every day ☐ less than once a week
☐ several times a week ☐ never
☐ at least once a week ☐ don't know

(4) What kind of assistance do you give **(name of consumer)**?
If caregiver gave information in Sections ADLs/IADLs and Consumer Support and Social Resources, verify and note here and go to the next question.

You help the consumer with:	Yes	No	Comments
Personal care - assistance with bathing, dressing, using the toilet, getting in and out of the bath, and feeding	☐	☐	___
Housekeeping - assistance with meal preparation, cleaning, and laundry	☐	☐	___
Transportation	☐	☐	___
Shopping and errands	☐	☐	___
Supervision for safety	☐	☐	___
Money management	☐	☐	___
Other, specify: ____________________	☐	☐	___

(5) Are you employed? ☐ Full-time ☐ Part-time ☐ Not working at all

(6) If you were suddenly unable to provide care, who would take your place?
☐ No one ☐ Other, specify: ______

(7) Would you say your own health is: ☐ excellent ☐ good, ☐ fair ☐ poor

(8) Considering the assistance you provide for **(name of consumer)**, I would like to ask you if various aspects of your life have become better, stayed the same, or become worse since you began providing care. Let's start with….

	Better	Same	Worse	Don't know
Relationship with (name of consumer)	☐	☐	☐	☐
Relationships with other family members	☐	☐	☐	☐
Relationships with friends	☐	☐	☐	☐
Your health	☐	☐	☐	☐
Your work, if applicable	☐	☐	☐	☐
Your emotional well-being	☐	☐	☐	☐

(9) Is there anything that makes it difficult for you to manage care? ☐ Yes ☐ No
If yes, describe:

(10) Do you **(caregiver)** need training or services? ☐ Yes ☐ No
If yes, describe:

Comments:

(11) **(Assessor)** Has providing care to the consumer become a problem for the caregiver?
☐ Very much a problem ☐ Somewhat a problem ☐ Not at all a problem

(12) How likely is it that **(caregiver)** will continue to provide the care to the consumer?
☐ Very likely ☐ Somewhat likely ☐ Unlikely

Comments on caregiver and service plan implications:

(13) **Consumer support - clinical judgment.**

Check the consumer's level of need for additional services.
☐ Very low ☐ Low ☐ Moderate ☐ High

Justify informal supports:

Justify formal supports:

Recommendations.

Scoring matrix

Domain	Range	Score	Range	Score	Range	Score
Cognitive functioning (MSQ)	(0 - 6)		(7 - 11)		(12 - 28)	
Health assessment - clinical judgment	(5)		(15)		(25)	
Nutrition	(0 - 8)		(9 - 11)		(12 - 30)	
Subjective evaluation of health	(0, 5)		(15)		(25)	
Functional - ADL (count: _____)	(0 - 2)		(3 - 9)		(10 - 31)	
Functional - IADL (count:_____)	(0 - 2)		(3 - 11)		(12 - 30)	
Consumer support - clinical judgment	(0, 5)		(15)		(25)	
Social resources	(0 - 6)		(7 - 14)		(15 - 24)	
Environmental - clinical judgment	(0, 5)		(15)		(25)	
Subtotals						

Total score ☐

Overall risk score ranges, check one:

☐ Low (0 - 44) ☐ Moderate (45 - 116) ☐ High (117 - 243)

☐ Meets expanded criteria for ADvantage

Is consumer homebound? Refer to Form 02HM001E, Uniform Comprehensive Assessment, Part 1. ☐ Yes ☐ No

Should consumer be referred for:

- physical health assessment/services? ☐ Yes ☐ No
- mental health assessment/services? ☐ Yes ☐ No

Was assessor override used for any of the domains? ☐ Yes ☐ No

If yes, provide written justification.

(1) **Alternatives.**

Check all alternatives that were discussed with the consumer and caregiver.

a. ☐ Home with services
b. ☐ Home without services
c. ☐ Assisted living, RCF, or adult foster home with services
d. ☐ Assisted living, RCF, or adult foster home without additional services
e. ☐ Mental health residential facility
f. ☐ Nursing home
g. ☐ Short-term respite care
h. ☐ Short-term nursing home stay with intent to return home with services
i. ☐ Developmental services facility (ICF/MR)/waiver
j. ☐ Consumer refuses service - place in NF, SNF, ICF/MR
k. ☐ Consumer refuses service - remains in community
l. ☐ Adult day care
m. ☐ ADvantage
n. ☐ Other: ______________________________
o. ☐ Undecided

(2) **Recommendations.**

In your judgment, the consumer:

☐ has community potential:
  ☐ low
  ☐ moderate
  ☐ high
☐ requires care in a nursing home on a temporary basis but community potential exists.
☐ requires care in a nursing home.

Recommend, choose code from the Alternatives list above:

Consumer's choice: ______ Family/caregiver's choice: ______________
Assessor's recommendation: ______

Assessor name	Agency/program	Date

Area nurse recommendations.

Document why approved service/service setting is not what the OKDHS nurse assessor recommended:

Area nurse signature Date

LONG TERM CARE ADMINISTRATION

☐ Living Choice ☒ Medically Fragile

COMMUNITY SERVICE PLAN AUTHORIZATION REQUEST CHECKLIST

Participant Name				SoonerCare ID
	Last	*First*	*Middle*	

☐ A. INITIAL ASSESSMENT

Pre-assessment

_____ Participant Consents and Rights
_____ Release of Information
_____ UCAT I & III
_____ Quality of Life Survey (QOL)

Post-assessment

_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan

STOP
This Section only pertains to The Living Choice Demonstration Program

☐ B. INITIAL COMMUNITY SERVICE PLAN

_____ Participant Consents & Rights
_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan
_____ UCAT (Parts I & III)
_____ Other, only if necessary for this plan (i.e. Nutritional Supplement, Environmental Mods)

☐ C. REASSESSMENT

_____ Participant Consents & Rights
_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan
_____ UCAT (Parts I & III)
_____ Other, only if necessary for this plan (i.e. Nutritional Supplement, Environmental Mods)

☑ D. ADDENDUM

2____ Community Service Plan Addendum
2____ Revised Goal(s)
1____ Other, only if necessary for this plan

SIGNATURES

Documentation marked above was sent:

TC/CM Agency	TC/CM Signature	Date

REQUEST FOR NUTRITIONAL SUPPLEMENT

☐ Living Choice ☒ Medically Fragile

Participant Name				
	Last	*First*	*M.I.*	*SoonerCare ID*

A. DESCRIPTION

Oral Nutritional Supplements provide medically necessary nutrient intake for individuals with special nutritional needs related to a specific medical condition for which the use of oral nutritional supplements is an accepted treatment. The participant must either have a medical condition requiring special nutrients or preventing him/her from obtaining sufficient nutrients with food alone, have a Body Mass Index below 21, or have experienced a significant weight loss.

B. TYPE OF REQUEST

☐ New Request ☒ Request for extension ☐ Request for change in authorized product and/or quantity

C. PRESCRIPTION

Physician's prescription must include specific product name, amount, frequency and related diagnosis.

☒ **Physician's prescription attached (required)** Product Name: ______

Amount & Frequency: 4- cans per day per peg with 500ML of water Related Diagnosis: 787.20/783.41

D. CURRENT RELATED MEDICAL CONDITIONS (Please check all that apply and indicate date of onset.)

Condition	Date of Onset	Condition	Date of Onset
☐ Renal Dialysis		☒ Other Shaken Baby	01/01/1991
☐ Chemotherapy Frequency: ______		☒ Other Cerebral Palsy	01/01/1991
☐ Radiation Frequency: ______		**Wounds**	**Date of Onset**
☐ Burns (within past 3 months) Location/Degree: ______		☐ Location: ______ Stage/Type: ______	
☐ Sepsis (within past 3 months) Type: ______		☐ Location: ______ Stage/Type: ______	
☐ Major Surgery (within past 3 months) Type/Location: ______		☐ Location: ______ Stage/Type: ______	
☐ Major Trauma (within past 3 months) Type: ______		☐ Location: ______ Stage/Type: ______	

LONG TERM CARE ADMINISTRATION

☐ Living Choice ☒ Medically Fragile

COMMUNITY SERVICE PLAN ADDENDUM

Participant Name				SoonerCare ID	
	Last	First	M.I.		

REVISED SERVICES AND GOALS

Put Appropriate Amount for the Pay/Support Source: I=Informal; P=Private Pay; O=Other; M=Medicare; SP=State Plan; SC=Self Care

SERVICE/SUPPORT

Service line to be ended:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

Service line to be added:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program
B4150	Jevity	Preferred Pediatrics	360	Y	360	$ 2.02	10/30/2017	01/30/2018							2351.52

GOALS

Expected Outcome	Action Steps	Monitoring of Expected Outcome
has all nutritional needs met.	1. is NPO, All Nutrition Is received through peg tube (Jevity). has no PO potential . 2. Preferred Pediatrics will deliver Jevity monthly paid for by Med-Frag. 3.Preferred Pediatrics will administer Jevity per Dr. orders. 4 cans per day per peg w/500ML of water. 4.. will maintain a healthy weight and receive all needed nutrition. 5.CM/MD will assess weight, nutrition, and need for changes monthly and as needed.	How will outcome be monitored? RN/CM HOW OFTEN will monitoring occur? RN 2xyrly/CM monthly HOW LONG will monitoring continue? ☒ Plan Year ☐ Until Expected Outcome is met

Participant/Legal Representative Initials___________

NOTE: Full signature required on final page only. Initials required for all other pages.

OKHCA Revised 10-27-2015

E. HEIGHT/WEIGHT INFORMATION

1. Participant's current height/weight: 4'8 / 117 Date weighed: 09/01/2017
2. Participant's Body Mass Index (BMI): ____________
   BMI below 21: ☐ Yes (skip to Section F – authorization guideline met) ☐ No (continue to #3 below)
3. Previously documented weight: 119 From: ☐ UCAT ☒ RN Eval ☐ Other ____________
4. Date of previous weight: 06/28/2017 Total pounds lost: 2 % body weight lost: ________
5. Documented weight loss: ☐ 10% loss past 6 months ☐ 5% loss past 30 days ☒ Neither

F. CORRESPONDING GOALS

☒ **Corresponding goals attached (required)**

Corresponding goals must include the following information:

1) The nutritional outcome of the request (wound healing, increased weight, etc.);
2) What steps are to be taken to meet nutritional goals and by whom; and
3) How, how often, and by whom progress toward outcome will be assessed.

G. ADDITIONAL SUPPORTING DOCUMENTATION (Optional)

Member is NPO, All nutrition from peg tube (Jevity). Member has no po potential and will not change , most recent weight was from hospital stay.

Signature of Participant or Legal Agent (If Participant signs with a mark, two witnesses are required.)	Date	Signature of TCCM	Date
Signature of Witness	Date	Signature of Witness	Date

AUTHORIZATION GUIDELINES

Authorization for payment of oral nutritional supplement products requires documentation of medical necessity by the TC/CM. An Orally Administered Nutritional Supplement – Documentation of Need must be completed and signed by the Participant and the TC/CM. The TC/CM must document the medical need for which oral nutritional supplement is an accepted treatment, the nutritional outcome, action steps and monitoring plan. The TC/CM must submit:

1. a completed and signed Request for Nutritional Supplement form
2. a copy of physician's prescription The prescription must include specific product, amount, frequency, and related diagnosis for which the nutritional supplement is being prescribed)
3. the Plan or Plan Addendum for authorization (please indicate amount requested in monthly quantity).

COMMUNITY SERVICE PLAN ADDENDUM

Participant Name				SoonerCare ID #	
	Last	*First*	*M.I.*		

SERVICE/SUPPORT

Service line to be ended:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

Service line to be added:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

GOALS

Expected Outcome	Action Steps	Monitoring of Expected Outcome
		How will outcome be monitored?
		HOW OFTEN will monitoring occur?
		HOW LONG will monitoring continue? ☐ Plan Year ☐ Until Expected Outcome is met

Participant Agrees to Addendum: ☑ Yes ☐ No

Signature of Participant or Legal Agent — Date

(If Participant signs with a mark, two witnesses are required.)

Witness Signature and Date:

Witness Signature and Date:

Supporting Documentation:

Date Submitted:

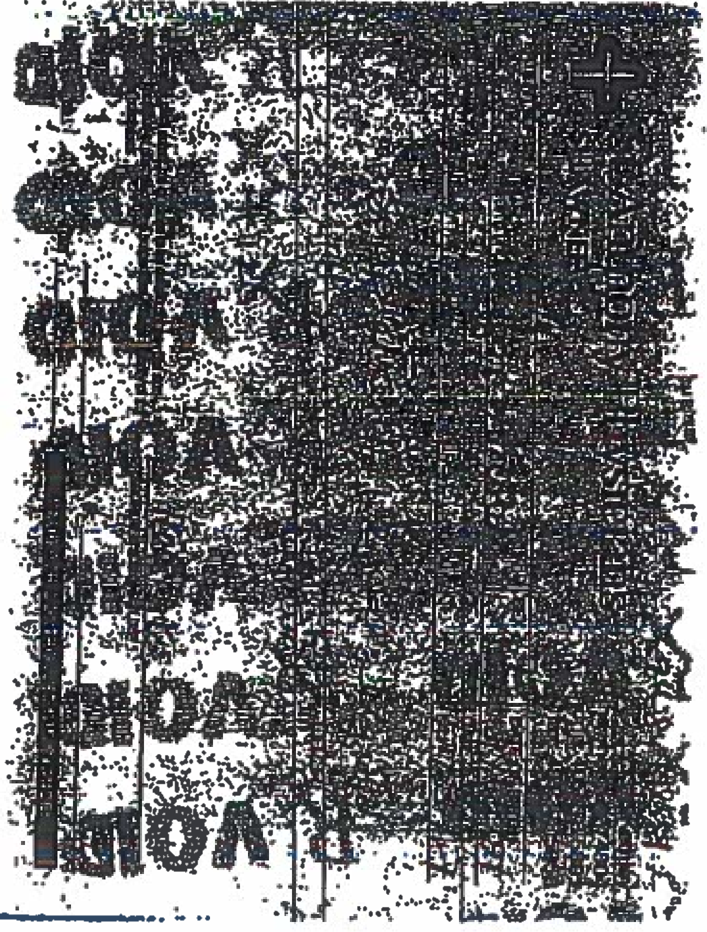
TC/CM Name (Print or Type):

TC/CM Signature:

TC/CM Supervisor Signature:

TC/CM Agency:

Program – Administrative Use Only



COMMUNITY SERVICE PLAN

C. SERVICES AND GOALS - #1

SERVICE/SUPPORT

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Informal	Private Pay	Other	Medicare	State Plan	Self Care	Program
							Put Appropriate Amount for the Payer Source						
T1016	Case Mgt	Case Management Agency	250	Y	250	$ 14.25							$ 3,562.50

GOAL #1

Expected Outcome	Action Steps	Monitoring of Expected Outcome
Sooner is managing her health, environment and safety needs and is directing all assistance to maintain a safe and supportive environment	Transition Coordination/Case Management will visit monthly, at a minimum, to monitor Sooner's community plan and goals and determine the need for change in services, level of assistance, supplies or education. TCCM will amend the community plan as needed. TCCM will collaborate with Beth and all team members, through the use of IDT, meeting, to address changes in Sooner's health and social status	HOW will outcome be monitored? Home Visits HOW OFTEN will monitoring occur? Monthly and PRN HOW LONG will monitoring continue? ■ Plan Year ☐ Until Expected Outcome is met

SERVICES AND GOALS - #2

SERVICE/SUPPORT

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Informal	Private Pay	Other	Medicare	State Plan	Self Care	Program
							Put Appropriate Amount for the Payer Source						
T1019	Personal Care	Home Health Agency	56	W	2912	$ 3.92							$ 11,415.04

GOAL #2

Expected Outcome	Action Steps	Monitoring of Expected Outcome
See Supplemental Goal and Outcome	See Supplemental Goal and Outcome	HOW will outcome be monitored? Home Visits HOW OFTEN will monitoring occur? Monthly HOW LONG will monitoring continue? ■ Plan Year ☐ Until Expected Outcome is met

Participant/Legal Representative Initials_______________

NOTE: Full signature required on final page only. Initials required for all other pages.

Long Term Care Waiver Operations

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Supplemental Community Service Plan Goals & Outcomes

Participant Name	Boomer	Sooner	O	123456789
	Last	*First*	*M.I.*	*SoonerCare ID*

Challenges	Strengths
Risk for infection due to ventilator dependence	Able to direct own care
Immobility	Able to express needs
History of Falls	Strong informal support system in place
	Alert

ANTICIPATED OUTCOMES	ACTION STEPS
Goal # 2 Boomer is managing his personal care and homemaking needs with assistance. He is directing all aspects of his ADLs and IADLS. He is clean, groomed and free of odors and is apartment is clean. Odis has transportation needed to keep his appointments and for socialization.	A) Boomer will have assistance with homemaking and chores under self-directed services. B) Odis will recruit, hire and train his PSA under self-direction and will monitor hours to remain within authorized # of hours per plan year. C) PCA will assist Boomer 14 hours a week with the following as directed by Boomer: 1. Personal Care - 3 hours/week: Boomer will perform as much of his own personal care as he is able and PCA will provide transfer assistance, safety supervision and assist Boomer with reaching areas that he unable to safely reach. PCA to clean and sanitize bathroom following personal care. 2. General homemaking - 2 hours/week: PCA to dust, sweep, mop and vacuum living area and bedroom. Take out trash. 3. Meal Prep - 3 hours/week: PCA to prepare meals for member, clean and sanitize kitchen and wash dishes following meal prep. Clean out refrigerator weekly. Wipe out and sanitize microwave and clean coffee pot.

ANTICIPATED OUTCOMES	ACTION STEPS
Goal # 2	4. Laundry - 2 hours/week: PCA to sort, wash, dry, fold and put away linens and clothing. Change bed linens weekly. 5. Shopping and Errands - 2 hours/week: PCA to assist Boomer with preparing a list, shop for items, bring back and put away. Pick up prescription upon request. 6. Transportation - 2 hours/week: PCA to provide transportation to appointments, errands and socialization activities.

LONG TERM CARE WAIVER OPERATIONS

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COMMUNITY SERVICE BACK-UP PLAN

Participant Name	Boomer	Sooner	O	SoonerCare ID #	123456789
	Last	*First*	*M.I.*		

REQUIRED DOMAINS				
NOTE: Disaster-preparedness is not addressed in this document – See Disaster Preparedness Plan for actions related to disaster planning.				
List Specific Risks	**Tier I** Formal Support	**Tier II** Informal Support	**Tier III** Back-Up Support	**Tier IV** Extreme Emergency
Direct Care Assistance Potential for risk of injury and illness if Personal Care needs not met and apartment kept clean & free of clutter	Home Health Agency Staffing Coordinator Case Management Agency/Case Manager	Family or Friends	PCP After Hours: Case Management Agency After Hours:	☒ 911 ☐ Other
Critical Health - Supportive Services Potential for deterioration of health & function if skilled nurse not available for health monitoring & medication management	PCP Information goes here Case Management Agency	Family or Friends	PCP After Hours: Case Management Agency After Hours:	☒ 911 ☐ Other

LONG TERM CARE WAIVER OPERATIONS
COMMUNITY SERVICE BACK-UP PLAN

REQUIRED DOMAINS				
NOTE: Disaster-preparedness is not addressed in this document – See Disaster Preparedness Plan for actions related to disaster planning.				
List Specific Risks	**Tier I** Formal Support	**Tier II** Informal Support	**Tier III** Back-Up Support	**Tier IV** Extreme Emergency
Equipment – Maintenance Options Potential risk for injury if equipment malfunctions or breaks	All DME Providers goes here	Family or Friends	Case Management Agency After Hours:	☒ 911 ☐ Other
Transportation Potential risk for isolation and deterioration of health if transportation is not available to physician appointments or socialization activities.	SoonerRide or any other transit system in that area	Family or Friends	Case Management Agency After Hours:	☒ 911 ☐ Other

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

CRITICAL INCIDENT REPORT: EVALUATION

Participant Name	Sooner	Boomer	O	SoonerCare ID	123456789
	Last	First	MI		
Name of Person Reporting	Case Manager/Home Health Provider/Support System				

A. CRITICAL INCIDENT LEVELS AND EVENTS

Critical Incident Level	INCIDENT Please check box that describes incident.	Reporting Time Lines	Follow-Up Requirements
Level I – Urgent	☐ Sexual abuse ☐ Lost or missing person ☐ Questionable, unexpected or preventable death ☐ Suicide attempt ■ Neglect* ☐ Physical abuse* ☐ Exploitation*	Within 1 working day	***Investigation Required.*** Report on investigation required.
Level II – Serious	☐ Involvement with the criminal justice system ☐ Restraint use ☐ Medication error with adverse effects ☐ Falls with injury	Within 2 working days	Evaluation required. ***May require investigation.*** If investigated, report on investigation required.
Level III – Significant	☐ Verbal abuse* ☐ Hospitalizations ☐ Emergency room visits	Within 2 working days	Evaluation required. ***May require investigation.*** If investigated, report on investigation required.

*** OKDHS/APS is the lead investigative authority in the event of critical events regarding abuse, neglect or exploitation.**

B. DETAILS OF INCIDENT

Date and Time of Incident:	03/23/2015	Date Agency Aware of Incident:	03/24/2015
Witnesses to Incident:	Neighbor Friend	Location of Incident:	Okie Apartments

Description of Incident: Brief description

Action Taken and Outcome: As an Agency, what actions were taken and what was the outcome

Did the Incident result in a change in the agency's Continuous Quality Improvement Plan? ☐ Yes ■ No
If 'Yes' – has the change been implemented? Please comment:

Agency Investigation Required? ☐ No ■ Yes ****If Yes: <u>Submit Critical Incident Investigation Report</u>**

Who was notified about this incident? ■ Supervisor/TC/CM ☐ APS ☐ Other (list)
☐ OKHCA or Designee ☐ Law Enforcement ■ Legal Guardian

C. SUPERVISORY REVIEW

Agency Supervisor has reviewed Critical Incident Report Evaluation: ■ Yes ☐ No

Date Critical Incident Report Evaluation was reviewed? 03/23/2015 TC/CM Supervisor Signature:

Was Critical Incident a result of Back Up Plan failure? ☐ Yes ■ No

LONG TERM CARE WAIVER OPERATIONS

☐ Living Choice ☐ My Life; My Choice ☐ Sooner Seniors ☐ Medically Fragile

CRITICAL INCIDENT REPORT: INVESTIGATION

Participant Name	Sooner	Boomer	O	SoonerCare ID	123456789
	Last	*First*	*MI*		
Name of Person Reporting	Case Manager/Home Health Provider/Support System				

A. CRITICAL INCIDENT

(Describe Critical Incident)

Detailed Information as best as you can

B. EVIDENCE COLLECTED

(Describe evidence collected – Types of evidence include: testimonial; documentary; demonstrative, and physical)

Statements and/or Tangible evidence

C. ASSESSMENT OF EVIDENCE

(What is the root cause of the Critical Incident?)

Was this preventable?

D. C ONCLUSIONS AND RECOMMENDATIONS

(What are your conclusions? What are your recommendations to resolve this issue and assure the Participant's future health and welfare?)

What did you conclude and what did you implement to avoid future risks

E. QUALITY IMPROVEMENT IMPLICATIONS

(How will the conclusions and recommendations from Section D enhance your organization's continuous quality improvement system?)

How will you strengthen your current strategy to further prevent this incident from happening again

F. SUPERVISORY REVIEW

TC/CM Supervisor has reviewed Critical Incident Report Investigation: ☒ Yes ☐ No

Date Critical Incident Report Investigation was reviewed? 03/23/2014 TC/CM Supervisor Signature:

Comments: For the Case Manager's Supervisor use