Options Counseling Policy and Procedure

Policy: CC.1.1	**Effective Date: 08.22.05**
Approved by: Tom Curtis **,CEO**	**Revised: 4.19.16** **Reviewed: 4.19.16**

SCOPE: Options Counselors will assist callers and visitors to navigate and access older adult benefits and services.

POLICY: Anyone contacting Senior Resources inquiring information on long term care will be directed to an Options Counselor. Counselors will listen to the person's unique life situation, present options, help develop a plan and guide individuals to information and resources to allow for extended opportunity to remain in the environment of their choice. Counselors will help in pairing personal resources with community resources for a variety of long term care needs. All appropriate service options will be discussed including but not limited to; caregiver support services, in home care, respite care, housing options, legal resources, wellness and nutritional services, durable medical equipment, transportation, medical assistance etc. Options Counselors create a plan with the individual and then assist in making referrals to appropriate resources in the community. They will assist the participant or their designee to screen for eligibility, complete necessary applications for programs and resources available in the community.

PROCEDURE: Every contact is logged in the Harmony Database according to Intake Guidelines for tracking and reporting purposes. If a participant is referred to a Senior Resources Program, information is also logged into the COMPASS database system.

REFERENCES:

CC.1.2 Screening and Intake Policy and Procedure
CC.1.3 Waitlist Policy and Procedure
AASA Waitlist Priority Guidelines
Intake Guidelines for COMPASS
Intake Guidelines for Harmony
Intake Guidelines for Referrals

SeniorResources
Our Name. Our Focus.

Screening and Intake Policy and Procedure

Policy: CC.1.2	**Effective Date: 08.22.05**
Approved by: Pam Cintis, **CEO**	**Revised: 4.19.16** **Reviewed: 4.19.16**

SCOPE: Aging and Adult Services Agency (AASA) and the Michigan Department of Health and Human Services (MDHHS) contracts with Senior Resources to screen individuals residing in Muskegon, Oceana or Ottawa Counties for services. Others will be referred to their appropriate Area Agency on Aging or service provider.

POLICY: Telephone or in-person screens for Care Connections programs will be conducted by Options Counseling staff. Any person who expresses interest in the MI Choice Waiver Program or the Care Management/Targeted Care Management Program must be evaluated using the MI Choice Intake Guidelines (MIG) at the time of his or her request.

PROCEDURE: Persons that wish to receive services will be screened using the MI Choice Intake Guideline (MIG) to determine whether the person may be eligible for the service requested. If the caller is seeking services for another person a screen is attempted within 2 business days of referral. There will be two attempts made to reach the participant or legally appointed representative or their designee. If contact is not made the referral source is notified.

The prescreening process identifies the person's health, social, emotional and environmental needs as well as financial status and possible Medicaid eligibility. It identifies the person's abilities and needs in performing activities of daily living. Prescreen may be conducted with the caregiver or a third party in order to get all the needed information and complete the pre-screen. Screening may involve a proxy and/or a referral source to confirm the applicant's need and willingness to receive Supports Coordination and in-home services. Home, nursing home, or hospital visit may be needed to complete the screen if requested or deemed appropriate by the Options Counselor. Referral source and prescreening proxies can be informed of pre-screening disposition according to the wishes of the participant.

Specific information recorded in the COMPASS intake are:

1) Name, address, telephone number
2) Date of birth
3) County of residence
4) Social Security Number (MI Choice Waiver only)
5) Contact information
6) Start/MIG date
7) Priority category
8) Referral date/source
9) Diagnosed medical problems
10) Service needs
11) Financial information

Participants who are deemed ineligible for the MI Choice Waiver Program, based on telephonic screen information, may request a face-to-face evaluation using the Michigan Medicaid Nursing Facility Level of Care Determination.

Participant is then advised of his or her appeal rights when the applicant has been determined ineligible. An adequate action notice is sent to the applicant or their designee at the time they are determined medically ineligible.

Participants who do not meet screening criteria for a MI Choice Waiver assessment, either financially or medically, are referred to AASA funded Supports Coordination or provided additional information and assistance.

The Options Counselor will document in COMPASS the results of the screen or if screen cannot be completed and the reason. The Options Counselor will document all attempts to do appropriate pre-screen and screening. Paper intake forms are filed either as waiting for service, screened not eligible or not assessed. All participants that are being referred for a program are entered on the appropriate waitlist.

Those who are able and willing to private pay for services are referred for Senior Resources Private Pay program, private agencies or facilities as appropriate.

REFERENCES:
CC.1.1 Options Counseling Policy and Procedure
CC.1.3 Waitlist Policy and Procedure
AASA Waitlist Priority Guidelines
Intake Guidelines for COMPASS
Intake Guidelines for Harmony
Intake Guidelines for Referrals

Waiting List Policy and Procedure

Policy: CC.1.3	**Effective Date: 08.22.05**
Approved: Pam Curtis, **CEO**	**Revised: 4.19.16** **Reviewed: 4.19.16**

SCOPE: This policy applies to all participants in the Muskegon, Oceana and Ottawa County areas who have been screened as possibly eligible for a Supports Coordination program at Senior Resources.

POLICY: Participants, who are determined presumptively eligible for any supports coordination program through use of either the MI Choice Intake Guideline (MIG) or face-to-face Level of Care Determination (LOCD) screen, and using financial information, are placed on the appropriate waitlist. Waitlists are used for tracking purposes; therefore, every participant is placed on a waitlist regardless of whether the program is or is not accepting new participants. New participants are placed on the COMPASS Waiting List by program, priority category and chronological date of completion of the MIG/LOCD.

For Access Services, a waitlist of persons who seek an assessment through Case Coordination and Support, Care Management, or Targeted Care Management programs is maintained. Additionally a waitlist for in-home service and respite care is kept when funds are not available to provide the services immediately or to increase services. The in home services waitlist is prioritized by participant income and asset as well as functional score using the COMPASS assessment.

PROCEDURE: If a person appears to be eligible, she/he will be placed on the appropriate COMPASS waitlist and prioritized according to Michigan Department of Health and Human Services (MDHHS) guidelines and Adult and Aging Services Agency (AASA) standards. If placed on the MI Choice Waiver waiting list, a Capacity Action Notice will be sent.

The waitlist/s must contain the following information:
1) Name, address, telephone number
2) Date of Birth
3) County of residence
4) Social Security Number (MI Choice Waiver only)
5) Contact information
6) Start/MIG date
7) Priority category
8) Referral date/source
9) Diagnosed medical problems
10) Service needs
11) Financial information
12) Date enrolled or removed from wait list (list reason).

If the applicant appears to be eligible for the MI Choice Program based on the MIG, but does not appear to meet financial eligibility requirements, the applicant will be placed on the waiting list if it appears that he/she may become financially eligible within 60 days. DHHS contact information is provided if the participant/designee requests guidance to become asset eligible for the MI Choice Waiver program.

A quarterly contact must be made to the participant or their representative to ensure a continued interest to wait for the program and if there is a change in their living condition or health. At the time a person is assessed and

placed on a program or deemed ineligible at assessment, their name is removed from the wait list and archived with the information on the program.

Options Counselors may place a participant on multiple program waitlists according to screening results.

If demand exceeds program capacity, participants or their referral source will be informed that they may:
1. Be screened by telephone and placed on the appropriate wait list. Persons will be re-screened and assessed in order of referral;
2. Purchase care management services through Senior Resources as private pay and pay for desired services;
3. Be referred to home health agencies that provide in-home services for a fee;
4. Inquire periodically as to the availability of service.

Participants, who have an established place on the MI Choice waiting list and want to move or apply to another MI Choice Waiver agent, may transfer to the new agency waiting list using the original MIG/Start date. Senior Resources staff will give waiting list information to transfer agency. Senior Resources will also honor waitlist transfers from other Waiver Agents.

Waiting list reports are submitted quarterly to MDHHS Long Term Care Program Development Section staff using the required format as well as AASA through submission on the reporting database FIRST.

PRIORITY: If a program is open to new participants but placement is being made from a wait list, priority clients are placed at the top of the waitlist to be assessed by priority, then by date of referral.

When placing people on the COMPASS waitlist for the MI Choice program, priority is given as follows:
1) Persons no longer eligible for Children's Special Health Care Services (CSHCS) because of age. This category includes only persons who continue to need Private Duty Nursing care at the time coverage ended under CSHCS.
2) Nursing Facility Transition participants.
3) Current Adult Protective Services (APS) clients and those approved for Imminent Risk when appropriate.
4) Chronological Order by date services were requested. This category includes potential participants who do not meet any of the above priority categories and those for whom prioritizing information is not known.

When placing people on the COMPASS wait list for Access programs or in home services, priority is given as follows:
1) Single persons with income less than $1,010 per month and assets less than $2,000. Married persons with income less than $1355 per month and assets less than $3,000.
2) Single persons with income between $1,011 and $1,478 and assets less than $7,280. Married persons with income between $1,356 and $1,823 and assets below $10,930.
3) Single person with income between $1,479 and $1,957 and assets below $15,000. Married persons with income between $1,824 and $2,640 and assets under $30,000.
4) All others.

Priority 1 and 2 Care Management participants will have priority over Case Coordination & Support priority 1 and 2 participants. Further Priority 3 Care Management participants will have priority over priority 3 Case Coordination and support participants. Finally, priority 4 Care Management participants will have priority over priority 4 Case Coordination and Support participants. Participants will further be prioritized by functional and social need criteria when being assigned.

REFERENCES:
MI Choice Waiver Contract
AASA Standards Manual

CC.1.1 Options Counseling Policy and Procedure
CC.1.2 Screening and Intake Policy and Procedure
Intake Guidelines for COMPASS
Intake Guidelines for Harmony
Intake Guidelines for Referrals
AASA Waitlist Priority Guidelines
ACCESS Guidelines for Supports Coordination

SeniorResources
Our Name. Our Focus.

Initial Assessment and Program Eligibility Policy and Procedure

Policy: CC.1.4	**Effective Date: 10.01.05**
Approved: Pam Curtis **,CEO**	**Revised: 10.9.15; 4.7.16**

PURPOSE: The purpose of the initial assessment meeting is to explain the program in detail, determine eligibility, discuss and complete the Freedom of Choice, Notice of Privacy Practices, review the intake folder and the Waiver handbook as appropriate, gain signature on consent and acknowledgement forms, share information on providers, devise a person-centered plan, discuss the complaint procedure, record verifications needed to achieve eligibility, complete an asset declaration as appropriate, conduct a nutrition screen, complete a Nursing Facility Level of Care Determination NFLOC, and complete the entire iHC assessment.

POLICY: Participants of the MI Choice Program must be offered a face-to-face evaluation within seven days if the MI Choice Program is accepting new participants, based on slot allocations dispersed by Michigan Department of Health and Human Services (MDHHS). The assessment for MI Choice Waiver Nursing Facility Transition (NFT) participants must occur within 5 days of intake or within 5 days of the participant being put in process on the COMPASS waitlist. The assessment must be conducted by a Registered Nurse (RN) and Licensed Social Worker (SW) Supports Coordination Team as outlined in the MDHHS operating standards.

Participants of Access Programs will be assessed by a Supports Coordinator who has a minimum of a bachelor's degree in a human service field or who by training or experience has the ability to effectively determine an older person's needs. The initial assessment will be offered within 10 working days of intake according to Adult and Aging Services Agency (AASA) Standards. The COMPASS assessment is utilized for all programs.

It shall be verified that a participant has functional, physical, or mental characteristics preventing them from providing a needed service for themselves and that an informal support network (family, friends, neighbors, etc.) capable of meeting the identified need is unavailable or insufficient.

PRODEDURE: Supports Coordinators, using the iHC assessment form in COMPASS, assess the health, welfare and safety of the participant. Any abnormal findings are to be addressed, and if appropriate, reported to the relevant entity.

- Supports Coordinators will explore the participant's needs and desires through discussion.
- Assessment should be supportive of the functional/medical eligibility as determined by the Nursing Facility Level of Care determination for required programs.
- For Access programs, a cost-sharing agreement must be completed for all participants who receive services. Cost sharing will be discussed and implemented at the time of assessment.

Assessments will be conducted honoring the applicant's preferences in regards to the time and location of the assessment as well as who is to attend. Assessments should be conducted in the applicant's place of residence if possible. In the case where an assessment is completed in a nursing home or hospital, a home visit will be made once the participant transitions back into a community setting.

The Supports Coordinator is to call to arrange an assessment within 5 days of the case being assigned. Supports Coordinators must document in COMPASS each attempt to contact a participant or their representative and the outcome.

The assessment requires direct questioning of the applicant and the primary caregiver, if available; observation of the applicant in the home environment; and a review of secondary documents. The applicant is the primary source of information when possible. With the applicant's permission, input is elicited from family members and caregivers as part of the assessment whenever possible. In instances where a guardian is appointed to make decisions on behalf of an individual, the guardian must be included in the assessment process to make decisions over which he/she has authority.

All individuals who wish to apply for Medicaid (MA) financial assistance for MI Choice Waiver services must be assessed to determine medical eligibility using the Michigan Medicaid Nursing Facility Level of Care Determination (NFLOC) process prior enrollment and service provision.

PROGRAM ELIGIBILITY: Medical eligibility, according to the appropriate program criteria, is confirmed at time of a face to face visit with participant.

When determining MI Choice waiver eligibility, Supports Coordinators must look at medical, financial, and ongoing service needs. Medical eligibility is determined by using the Michigan Medicaid Nursing Facility Level of Care Determination.

If unsure regarding eligibility, or if participant is ineligible, Supports Coordinators are to confer with the in-house MDHHS eligibility specialist regarding financial eligibility or the RN or SW supervisor regarding medical eligibility or service need within one (1) business day.

FREEDOM OF CHOICE: If during the course of the determination process, the applicant is deemed medically and financially eligible for the MI Choice program, a Freedom of Choice is completed with the participant, and participant is offered a choice for receiving services and supports through:

1. MI Choice Program,
    a. Senior Resources of West Michigan
    b. Reliance Community Care Partners, or
2. Nursing facility care, or
3. PACE Program.

If participant chooses to receive services and supports through the MI Choice Program, an assessment is completed and participant is offered options for receiving care in the least restrictive setting of their choice allowable under the MI Choice program.

If during the course of the determination process, the applicant is deemed medically ineligible for the MI Choice program through Doors 1-7, but it is believed the participant may meet the criteria for an exception, the Supports Coordinator will discuss this option with the participant and if participant is in agreement, a Freedom of Choice is completed and the Supports Coordinator will initiate the process for an exception request.

If during the course of the determination process, the applicant is deemed medically or financially ineligible for the MI Choice program, does not meet the ongoing service need requirement and an exception will not be requested, a Freedom of Choice is completed with participant and:

1. A written notice of denial must be sent with grievance/appeal instructions.
2. The participant is referred to other appropriate community services and the case is not opened to MI Choice.

Participants who do not meet eligibility for the MI Choice Waiver may be assessed using the appropriate assessment tool and opened to Care Management if 60 years of age or over. DHHS eligibility specialist contact information is provided if participant/designee request guidance to become asset eligible for the MI Choice Waiver program. Others may be referred to Case Coordination and Support if over 60 years of age or to Private Pay or other community programs that may be appropriate to meet their needs.

REFRENCES:

ACCESS Guidelines for Supports Coordination
FC.1.15 Cost Share Policy and Procedure
MI Choice Waiver Guidelines for Supports Coordination

Plan of Care Policy

Policy: CC.1.5	**Effective Date: 09/30/05**
Approved by: Pam Curtis **,CEO**	**Revised: 10.9.15; 4.7.16**

POLICY: The Plan of Care will be developed, updated and revised as the participant's needs change. The Plan of Care will maximize the participant's strengths, stated goals, cultural and ethnic needs, stated preferences, available resources, personal control and independent living, taking into consideration the whole person. There will be active involvement of the participant, family members, caregivers, and others as deemed appropriate by the participant.

The Plan of Care development and/or Person Centered Plan of Care will be initiated at the assessment and completed within 7 business days upon applicant eligibility and enrollment in the any program.

Care planning activities will include the issues identified in the CAPS and Triggers report created on COMPASS, participant needs and the assessment process.

The participant will approve the Plan of Care prior to implementation of services. If a signature cannot be obtained, verbal approval may be obtained from participant/representative for initiating services. Verbal approval and date of approval shall be documented. Signature will be obtained at next visit.

Services from informal caregivers and community agencies are maximized prior to purchasing services. For State Care Management and Case Coordination & Support participants, Senior Resources cost sharing policies will be followed.

The Plan of Care must be reviewed at each assessment for progress toward meeting specified goals.

REFERENCES:
CC.1.19 Person Centered Planning Policy and Procedure
CC.1.25 Private Pay Policy and Procedure
ACCESS Guidelines for Supports Coordination
MI Choice Waiver Guidelines for Supports Coordination

Service Planning and Continued Coordination of Services Policy and Procedure

Policy: CC.1.6	**Effective Date: 09.30.05**
Approved by: Pam Curtis, **CEO**	**Revised: 10.25.15**

POLICY: Before initiating a home-based service, it shall be determined whether a participant is eligible to receive the respective service(s) or any component support service(s) by conducting an assessment or reassessment and participant must demonstrate a need for the service(s).

Using a Person Centered Planning (PCP) approach, participant/ representative and supports coordinator will identify and discuss appropriate services, availability, and participant cost when appropriate. The Plan of Care will be used as the basis for service planning purposes and services are arranged according to participant request. The Supports Coordinator will assist the participant or their appointed representative in finding the agency of their choice for provision of services.

Waiver Supervisors approve all purchase of service for MI Choice Waiver participants. Access programs Supports Coordinators approve all purchase of service within the Service Provision Guidelines. Additional services must be approved by the Quality and Education Coordinator or Access Programs Supervisors.

PROCEDURE: When initiating a new service, Supports Coordinators contact the contracted provider agency as chosen by the participant or their representative to arrange for service provision on the day(s) and time(s) identified by the participant/representative. Once it has been established that the provider is able to staff the service being requested, the Supports Coordinator completes the internal confirmation of services (ICOS) and submits to a supervisor for approval or directly to data department for entry.

The Supports Coordinator communicates with the participant/representative regarding the anticipated start of services, and follows-up with the participant/representative within the first 2 weeks of service provision to inquire if services started as ordered and the satisfaction of the participant/representative with ordered services.

The Supports Coordinator communicates with the service provider to address unsuccessful delivery of services and appropriateness of the service or product. The Supports Coordinator communicates findings to the participant to determine if a change is required to the service or product to ensure participant satisfaction.

Continued coordination of services requires the Supports Coordinator to periodically inquire as to satisfaction with services, in accordance with service standards, and making changes to the Plan of Care and ICOS as needs and request for service change.

REFERENCES:
ACCESS Guidelines for Supports Coordination
CC.1.5 Plan of Care Policy and Procedure
CC.1.19 Person Centered Planning Policy and Procedure
CC.1.4 Initial Assessment Policy and Procedure
CC.1.7 Reassessment Policy and Procedure
MI Choice Waiver Guidelines for Supports Coordination

SeniorResources
Our Name. Our Focus.

Reassessment and Continued Eligibility Policy and Procedure

Policy: CC.1.7	**Effective Date: 09.30.05**
Approved by: Pam Curtis, **CEO**	**Revised: 10.13.15; 4.6.16**

PURPOSE: Reassessment (hereinafter "REA") provides for a periodic in-person examination of participant functioning for the purpose of identifying changes that may have occurred since the initial assessment or most recent REA.

POLICY: A complete REA is provided to all participants classified as 'active' within 90 days of assessment or previous REA. Participant classified as 'maintenance' require a REA at a minimum of every 180 days. If the REA is not completed within 90/180 days, a reason why is to be documented in the participant's progress notes and documented in the SW section of the next REA.

The REA is completed by a team consisting of a registered nurse and a licensed social worker for MI Choice Waiver program participants. If both disciplines are not available to do the REA, one discipline may complete the entire REA with the participant and/or representative. The discipline that completes the REA solo is responsible to review the REA with a member of the opposite discipline within 10 business days and document said review in the progress notes of participant's file. The REA for Access program participants is completed by an Access Supports Coordinator or a Waiver Initial Assessment can substitute for an REA when a participant is not found eligible for Waiver and remains an Access participant.

All reassessments are documented in COMPASS and included in the participant case file.

A participant may refuse a REA; this shall be noted in the case record.

PROCEDURE: The REA process is comprehensive and includes review of participant functioning. REA findings are reviewed with the participant and others as determined appropriate by the participant.

The Supports Coordinators using the COMPASS system will download necessary, most recent, information prior to appointment with the participant. The Supports Coordinators assess the health, welfare and safety of the participant using the iHC assessment. Any abnormal findings are to be addressed, and if appropriate, reported to the relevant entity.

ELIGIBILITY: MI Choice Waiver participants are reevaluated by their Supports Coordinator at each REA, as well as at their phone contact every 30 days, to determine participant continues to meet the Nursing Facility Level of Care determination (NFLOC). If a REA is completed, verification of ongoing eligibility is documented in both the REA, as well as a Progress Note entry. If verification is determined at a 30 day contact, the determination is documented in a Progress Note entry. If at a REA, the determination is made that participant no longer continues to meet the NFLOC, the Supports Coordinator will initiate and follow the discharge procedures as set out by the MI Choice program. If at a 30 day contact the determination is made that participant no longer continues to meet the NFLOC, the Supports Coordinator will initiate the discharge procedure and request to schedule a face-to-face visit with the participant to verify ineligibility.

Access Supports coordinators determine continued eligibility for programs through reassessment. The basis for eligibility for Access programs is the support of the assessment that a service need exists.

REFERENCES:
CC.1.9 Case Classification Policy and Procedure
ACCESS Guidelines for Supports Coordination
MI Choice Waiver Guidelines for Supports Coordination

Out of Home Placement Policy for Hospitalization or Nursing Home	
Policy: CC.1.8	**Effective Date: 09.30.05**
Approved by: Pam Curtis**, CEO**	**Revised: 7.15.15; 4.7.16**

SCOPE: All current participants and possibly eligible applicants.

POLICY: Senior Resources will provide Supports Coordination (AASA or MI Choice) to persons hospitalized or temporarily residing in nursing homes. These services are in anticipation of discharge. Out-of-home respite may be provided at a nursing home or foster care home if appropriate for the participant and if the home is under contract with Senior Resources to provide such care.

REFERENCES:
ACCESS Guidelines for Supports Coordination
MI Choice Waiver Guidelines for Supports Coordination

Case Classification Policy and Procedure

Policy: CC.1.9	**Effective Date: 09.30.05**
Approved by: Tom Cuntis, **CEO**	**Revised: 10.12.15; 4.7.16**

POLICY: Case status shall be designated for each participant. Supports Coordinators designate a case status when determining the level of intervention necessary to meet participant needs.

A COMPASS Status Report will be maintained on each participant, placed in each participant chart and updated as needed by the supports coordinator. Case will be classified according to program by dates of service.

PROCEDURE: A case classification will be determined at the time of care plan development. The Waiver Supervisor will complete the program status form following initial assessment and eligibility determination as well as any time the status of a participant changes for MI Choice Waiver participants. Access Supports Coordinators assign a status using the data cover sheet with the paper chart or submitting a vendor view message requesting a status. Data Entry will enter information.

Case classification will be changed when a participant transfers from one program to another within the agency. Documentation will be maintained in the participant progress notes or contact log as to the reason for the change in participant status. Case Classification may only be changed at the expressed approval of the participant or their legal representative.

The participant and/or proxy shall be informed of case closure or transfer to another program in writing except when the reason for case closure is death. The participant and/or proxy shall be informed of procedures to be followed to re-enter the program if the need for intervention changes.

Open Active - Reassessments are required at least every 90 days.
Open/Active cases are new or those with the most difficult, unstable or complex need which require intensive and/or regular care manager involvement.

Open Maintenance - Reassessments are required at least every 180 days.
Open/Maintenance cases are more physically stable and less complex. Supports Coordinator monitoring is required less frequently. Participants may be moved to maintenance if documentation in the case file shows the participant:

1. Is stable, but he/she requires continued services and monitoring to assure stability and remain at home.
2. Has refused needed services, but Supports Coordinators perceive services may be accepted within the next four to six months
3. Is institutionalized and is expected to return home with Supports Coordination assistance within the next six months.

Closed - Closed cases are those which no longer require supports coordinator intervention
Closed status will be designated for the following reasons:

1. The participant moves from the service area but does not transfer to another Waiver Agent.
2. The participant is institutionalized on a permanent basis.
3. The participant terminates involvement with the program (e.g. refuses service.)
4. The participant transfers to another provider agency
5. The participant stabilizes to a point that case management is no longer required as participant is no longer

eligible.
6. The participant transfers to PACE or another Long Term Care Program
7. Death
8. Other

REFRENCES:
Data Cover Sheet
CC.1.10 Case Closure - Termination Policy and Procedure
Procedure Grid for Closing or Changing Status of a Waiver Participant
CC.1.18 Grievance/Appeals Policy and Procedure
ACCESS Guidelines for Supports Coordination
MI Choice Waiver Guidelines for Supports Coordination

Case Closure/Termination Policy and Procedure

Policy: CC.1.10	**Effective Date: 12.20.05**
Approved: Pam Cintas, **CEO**	**Revised: 10.20.15**

POLICY: Participant cases will be closed for rationale that is case specific. Closed status will be designated by the Supports Coordinators for the following reasons:

- Participant moves from the service area
- Participant is institutionalized on a permanent basis
- Participant terminates involvement with the program
- Participant stabilizes to a point that the services are no longer required and participant is no longer eligible or appropriate for the program.
- Death of participant
- Participant transfers to another community based program
- Participant is determined financially ineligible
- Participant is determined medically ineligible
- For cause
- Other

PROCEDURE: The Supports Coordinator completes the following steps to close a participant's case:

- Supports Coordinator determines closing reason and discusses with supervisor if necessary.
- Supports Coordinator documents in participant record date of close and reason.
- If applicable, the Supports Coordinator follows the Procedure Grid for Closing or Changing a Status of a participant. The MI-Choice Waiver disenrollment notification is provided to DHHS within 5 days.
- Appropriate action notice (if applicable) is sent to participant/guardian.
- Supports coordinator informs contracted service providers of case closure date.
- Supervisor routes participant chart with closure information to the data department for entry.
- Copy of status change filed in chart.
- Closed chart filed in participant records room.

TERMINATION FOR CAUSE: Participants who have a complaint regarding a provider or Senior Resources shall follow the Senior Resources Participant Complaint Procedure and/or the Senior Resources Grievance/Appeals Procedure. When there is identified conflict between the supports coordinator and the participant, the supports coordinator will notify a supervisor to attempt to reach a resolution. The participant will be given the option of being assigned to another supports coordinator within Senior Resources if the conflict cannot be resolved.

The participant will be reminded of the Participant Rights and Responsibilities and Grievance Procedures.

When the conflict is due to non-compliance on the part of the participant, the supports coordinator will work with the participant and caregivers to attempt to resolve the problem. Competency of the participant will be documented and APS or other appropriate referrals will be made as warranted.

If the supports coordinator cannot find resolution, the actions of the participant will be brought to the attention of the supervisor and program director. A case conference will be held with the participant, caregivers, allies, agencies involved, Supports Coordinators and supervisors. A case conference report will be submitted and will address any agreements that are made. Attending parties will receive a copy of the report.

If resolution is found, documentation will be made in the participant record of case conference, of the corrective change to be made and services will continue as scheduled. Resolution may include change of Supports Coordinator, change of provider agency, adjustment of type or amount of services, referral to appropriate community agency, referral to family or individual counseling services, behavior modification, a written agreement regarding problem behavior, etc.

If the problematic behavior continues following a case conference, the appropriate parties will be notified. A letter will be sent to the participant and appropriate representatives/allies stating the responsibilities of the participant, the agreement and the possibility of terminating the services due to non-compliance.

If the non-compliant behavior continues beyond the participant receiving the above letter, a written notification of termination will be sent to the appropriate parties stating services will be terminated/ The grievance/appeals procedures will also be provided to the participant.

The participant may follow the complaint procedure or MDHHS appeals procedure as appropriate.

Critical Incident reports will be completed in the Critical Incident Portal as appropriate.

REFERENCES:
CC.1.20 Critical Incident Policy and Procedure
ACCESS Guidelines for Supports Coordination

Medication Management Policy and Procedures	
Policy: CC.1.11	**Effective Date: 10.31.13**
Approved by: Pam Curtis, **CEO**	**Revised: 10.15.15; 4.7.16**

POLICY: In compliance with MDHHS standards, participants are assessed for risk in managing medications. Effective risk management is built upon the service planning and monitoring process. At-risk planning is contingent on the participant and families agreeing with the Supports Coordinator's assessment and recommendations for care.

Senior Resources respects the participant's right to make choices as long as the participant appears capable of understanding the consequences and risks of those choices and the choices do not place the participant in jeopardy.

Supports Coordinators are not authorized to handle or administer a participant's medication. Supports Coordinators are only authorized to handle the containers the medications are stored in. This is to gather information to create a medication list in COMPASS.

PROCEDURES: Supports Coordinator (SC) creates a medication list for each participant in COMPASS. SC documents the purpose for each medication, medication allergies, side effects, drug interactions and implications of abrupt discontinuation of medications.

SC provides education to participants and allies regarding actions to take in an emergency, administration, indications and contraindication, dispensing, storage/disposal, medication errors and medication expiration dates.

Supports Coordinator (SC), utilizing the iHC Assessment System, will review with the participant and his/her family or representative(s) the capacity as well as the performance of the participant to obtain and manage his/her medications. If the SC and participant and/or family or representative(s) agree assistance is needed, SC will develop a Plan of Care with the participant following the person centered process.

The SC will arrange or purchase in home health services approved in the Plan of Care. All services purchased through the MI Choice Waiver for managing the medications of the participant will follow the Minimum Operating Standards for MI Choice Waiver Program Services for the service being provided and adhere to program service definitions.

The SC will follow-up with the participant and provider agency to ensure that the Plan of Care is implemented as written. The Plan of Care will, at a minimum, address the issue identified with the management of participant's medications, the goal, planned intervention, desired outcome, participant agreement to the intervention and review of outcomes.

SC will review medication adherence on a periodic basis, through thirty (30) day phone contacts and periodic in person reassessments. If participant is noncompliant with medication adherence, SC will consider health education, counseling, or training as possible solutions. SC will also communicate with provider and participant's physician or other appropriate health care professional(s) as needed to prevent additional decline, illness or injury to participant.

At Risk Participants Policy and Procedure
(Abuse, Neglect, Exploitation, Use of Restraints, Seclusion)

Policy: CC.1.12	**Effective Date: 04.01.2006**
Approved: Pam Curtis, **CEO**	**Revised: 10.14.15; 4.7.16**

PURPOSE: Abuse, neglect, and exploitation must be reported to MDHHS Adult Protective Services(APS) as specified in P.A. 519 of 1982 (as amended) which mandates that all human service providers and health care professionals make referrals to the MDHHS Adult Protective Services unit when an adult is suspected of being, or believed to be, abused, neglected, and/or exploited. The Vulnerable Adult Abuse Act (P.A. 149 of 1994) creates a criminal charge of adult abuse for vulnerable adults harmed by a caregiver. The requirements also apply for suspected financial abuse per the Financial Abuse Act (MI S.B. 378 of 1999).

DEFINITIONS:
CMS Regulation regarding restraints: The participant has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the participant's medical symptoms. Restraint use may constitute an accident hazard and professional standards of practice have eliminated the need for physical restraints except under limited medical circumstances.

Seclusion: is the act of placing or keeping someone away from other people; isolating.

Physical restraints: are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, vests, lap cushions and lap trays the participant cannot remove. Also included, as restraints are provider/caregiver practices that meet the definition of a restraint, such as:

- Using bed rails to keep a participant from voluntarily getting out of bed as opposed to enhancing mobility while in bed;
- Tucking in a sheet so tightly that a bed bound participant cannot move:
- Using wheel chair safety bars to prevent a participant from rising out of a chair:
- Placing a participant in a chair that prevents rising; and
- Placing a participant who uses a wheelchair so close to a wall that prevents the participant from rising.

Chemical Restraints: is defined as a psychopharmacological drug that is used for discipline or convenience and not required to treat medical symptoms.

Discipline: is defined as any action taken for the purpose of punishing or penalizing.

Convenience: is defined as any action taken to control behavior or maintain participant with a lesser amount of effort by the provider/caregiver and not in the participant's best interest.

Physical: e.g. hitting, punching, slapping, burning, pushing, kicking, restraining, false imprisonment / confinement, or giving excessive or improper medication as well as withholding treatment and medication.

Psychological/Emotional: e.g. humiliating a person. A common theme is a perpetrator who identifies something that matters to an older person and then uses it to coerce an older person into a particular action. It may take verbal forms such as yelling, name-calling, ridiculing, constantly criticizing, accusations, blaming, or non-verbal forms such as ignoring, silence, shunning or withdrawing affection.

Financial abuse: also known as financial exploitation. e.g. illegal or unauthorized use of a person's property, money, pension book or other valuables (including changing the person's will to name the abuser as heir). It may be obtained by deception, coercion, misrepresentation, undue influence, or theft. This includes fraudulently obtaining guardianship or use of a power of attorney. Other forms include deprivation of money or other property, or by eviction / removal from their own home

Scam by strangers: e.g. worthless "sweepstakes" that elderly persons must pay in order to collect winnings, fraudulent investment schemes, predatory lending, and lottery scams. [7]

Sexual: e.g. forcing a person to take part in any sexual activity without his or her consent, including forcing them to participate in conversations of a sexual nature against their will; may also include situations where person is no longer able to give consent (dementia)

Neglect: e.g. depriving a person of proper medical treatment, food, heat, clothing or comfort or essential medication and depriving a person of needed services to force certain kinds of actions, financial and otherwise. Neglect can include leaving an at-risk (i.e fall risk) elder person unattended. The deprivation may be intentional (active neglect) or happen out of lack of knowledge or resources (passive neglect).

Hybrid financial exploitation (HFE): e.g. financial exploitation that co-occurs with physical abuse and/or neglect. HFE victims are more likely to be co-habiting with abusive individual, to have fair/poor health, to fear the abusive individual, to perceive abusive individual as caretaker, and to have a longer duration of abuse.[8]

In addition, some U.S. state laws [9] also recognize the following as elder abuse:

Abandonment: deserting a dependent person with the intent to abandon them or leave them unattended at a place for such a time period as may be likely to endanger their health or welfare.[10] Elder abuse includes deserting an elderly, dependent person with the intent to abandon them or leave them unattended at a place for such a time period as may be likely to endanger their health or welfare.[10]

Rights abuse: denying the civil and constitutional rights of a person who is old, but not declared by court to be mentally incapacitated. This is an aspect of elder abuse that is increasingly being recognized and adopted by nations

Self-neglect: any persons neglecting themselves by not caring about their own health, well-being or safety. Self-neglect (harm by self) is treated more conceptually different than abuse (harm by others). Elder self-neglect can lead to illness, injury, or even death. Common needs that older adults may deny themselves, or ignore are the following: Sustenance (food or water); cleanliness (bathing and personal hygiene); adequate clothing for climate protection; proper shelter; adequate safety; clean and healthy surroundings; medical attention for serious illness; essential medications.[11] Self-neglect is often created by an individual's declining mental awareness or capability. Some older adults may choose to deny themselves some health or safety benefits, which may not be self-neglect. This may simply be their personal choice. Caregivers and other responsible individuals must honor these choices if the older adult is sound of mind. In other instances, the older adult may lack the needed resources, as a result of poverty, or other social condition. This is also not considered as "self-neglect". [12]

Institutional abuse refers to physical or psychological harms, as well as rights violations in settings where care and assistance is provided to dependent older adults or others.

POLICY: Referral to Adult Protective Services (APS) is required when a vulnerable adult is suspected of being abused, neglected, and/or exploited. A vulnerable adult is one who is unable to take action to protect oneself from harm. When assessing the safety and security of the participant's living arrangement, the supports coordinator will identify risk factors and offer modification to promote independence and safety in the home.

Participants may be considered to be in at risk situations that are created by the absence of scheduled services, living in structurally damaged or unsanitary environments, noncompliance with medical care, use of restraints, living in seclusion, etc. These situations place the participant in a vulnerable state by compromising his/her health and welfare.

Supports coordinators do not encourage the use of restraints or seclusion.

Senior Resources respects the participant's right to make choices as long as the participant appears capable of understanding the consequences and risks of those choices and the choices do not place others in jeopardy.

The participant has a right to participate in care planning and the right to refuse treatment, which includes the right to accept or refuse restraints. For the participant to make an informed choice about the use of restraints, the supports coordinator should explain the risks involved if any.

Restraints are not to be used strictly for the convenience of the caregiver. Medical symptoms that would warrant the use of restraints must be reflected in the comprehensive assessment and care planning.

PROCEDURES*:* When there is suspicion of abuse, neglect, or financial exploitation, the Senior Resources staff person who has witnessed or been told of the situation will make a referral to the APS and will notify their supervisor. Referral to law enforcement is required when a situation involves imminent and immediate danger to the safety and well-being of anyone involved in a situation**.**

If a referral to APS results in unsatisfactory action or no action, the primary supports coordinator will consult with a supervisor to determine next steps.

Programs that require the COMPASS Plan of Care to be completed will identify in Participant Plan of Care Topic section that the participant is "At Risk" and document appropriately in progress notes.

Critical Incident Reports will be completed, filed in the participant's chart and a copy routed to the appropriate supervisory staff.

Documentation of the situation will be made in the progress notes including APS response, all activity and referrals involved the outcome and resolution.

Service Providers will be informed of a participant's risk status when services are ordered or when situation presents itself.

Services will be continued and reviewed for need for additional or increased services.

ABUSE AND NEGLECT INTERVENTIONS: The participant will be informed by the supports coordinator of the risks being taken. The supports coordinator will document the participant's informed choice in the case record progress notes, assessment comments and COMPASS Plan of Care.

When a participant makes decisions that are self-injurious and/or create jeopardy for others, supports coordinators will discuss with the participant and their allies regarding the possibility of the need for

family/caregiver intervention.

If participant is noncompliant with medical care, supports coordinator will make a referral for physician involvement, health education, counseling, or training.

ENVIRONMENTAL INTERVENTIONS: Participants may be offered home modifications, heavy duty chore, or increased services when resources are available.

Supports coordinators will discuss relocating to a safer environment when appropriate to the situation.

EXPLOITATION INTERVENTIONS: Supports coordinator must provide education to the participant or their representative about the suspected exploitation and make a report to local law enforcement and/or the prosecutor's office.

Supports Coordinator can make a referral to a third party payer if the participant is in agreement.

RESTRAINTS AND SECLUSION INTERVENTIONS:
The participant and caregiver will be informed by the supports coordinator of the risks being taken. The supports coordinator will document the participant's informed choice in the case record progress notes, assessment comments and plan of care.

Supports coordinator will discuss alternative solutions with participant and caregiver(s).

Supports coordinator will review the COMPASS Plan of Care and/or the Person Centered Plan of Care and assess the need for increased respite or other community services to relieve caregiver stress.

Other interventions that might be incorporated in care planning include:
- Providing restorative care to enhance abilities to stand safely and to walk;
- A trapeze to increase bed mobility;
- Placing the bed lower to the floor and surrounding the bed with a soft mat;
- Equipping the participant with a device that monitors attempts to arise;
- Encouraging frequent caregiver monitoring at night with periodic assisted toileting

TRAINING: Supports coordinators will receive in-service trainings regarding the following:
- Requirements for reporting cases of abuse, neglect, or exploitation.
- Social Welfare Act and "Vulnerable Adult Abuse Act",
- Definition of "vulnerable adult",
- Definition of "competency",
- Procedures for making referrals to APS, law enforcement, and legal services,
- Proper use of and requirements for restraints with participants
- Critical incident reporting
- Working effectively with MDHHS, Law Enforcement agencies, and legal services.

REFERENCES:
CC.1.20 Critical Incident Policy
Senior Resources Critical Incident Database
ACCESS Guidelines for Supports Coordination
MI Choice Waiver Guidelines for Supports Coordination

Guardianship for Participants Policy and Procedure

Policy: CC.1.13	**Effective Date: 10.31.13**
Approved: Pam Curtis, **CEO**	**Revised: 10.14.15; 4.7.16**

POLICY: When a participant makes decisions that are self-injurious and/or jeopardize the safety of others, the Supports Coordinator will seek input from informal supports and/or participant representatives. If no informal support is available the Supports Coordinator will seek a third party vendor to pursue a possible guardianship/conservatorship to protect the participant. The Supports Coordinator will make every effort to secure the least restrictive legal arrangement necessary for successful community living. The following options will be evaluated for their appropriateness:

- Patient advocate
- Conservatorship
- Limited guardianship

PROCEDURES: The Supports Coordinator will evaluate the participant situation and a case conference will be held between the participant, whomever the participant wishes to be present, the Supports Coordinator, a supervisor, and/or the Program Director to determine the appropriate action to be taken. The outcome of this case conference will be documented in the participant case file as a progress note.

All informal supports, including family/caregiver intervention, will be reviewed for their possible appropriateness as a substitute decision-maker for the participant.

If the participant is unable to afford the fees associated with legal intervention, the Supports Coordinator will seek free legal assistance from reputable organizations before requesting funding from the MI Choice Waiver Program.

REFERENCES:
CC.1.20 Critical Incident Policy and Procedure
CC.1.12 At-Risk Participant Policy and Procedure

SeniorResources
Our Name. Our Focus.

Case Record Maintenance Policy and Procedure

Policy: CC.1.14	**Effective Date: 04.01.06**
Approved by: Tom Curtis, **CEO**	**Revised: 11.16.15**

POLICY: Case records will be maintained in a manner that conforms to positive professional practice, permits effective professional review and audit and facilitates an adequate system for follow up. Files may be kept electronically or in paper form. All electronic documentation will be entered into the electronic data system. All electronic initial assessments will be entered within 48 hours (two business days), all electronic reassessments will be entered within 10 business days and all electronic progress notes will be entered within one business day (24 hours).

A file will be established for each participant served. Paper charts will include at a minimum the following:

1. Referral and Prescreen or MIG information
2. NFLOC Determination results for MI Choice applicants
3. Participant approved Plan of Care and/or Person-Centered Plan of Care
4. Service order forms/Internal Confirmation of Service (ICOS)
5. Correspondence
6. Consent for Release of Information
7. Acknowledgement of Program Participation and Receipt of Notice of Privacy Practices
8. Financial verification as appropriate and required
9. Status documentation
10. Other pertinent information.

Files that are kept electronically are:

1. Online LOCD
2. Online Freedom of Choice
3. Action Notices (when applicable)
4. MI Choice Waiver enrollment notification
5. Scanned Documents
6. Internal Confirmation of Service forms

PROCEDURE: Paper Recordkeeping:

1. All permanent participant case record information must be written in ink or printed from a computer.
2. Case record entries must be signed or initialed by each employee making the case record entry.
3. All contacts must include the person/agency contacted, date of contact, and type of contact.
4. Corrections to case record entries must be made by drawing a single line through the information to be changed and entering the corrected information above, below or beside. The employee making the correction must initial and date each corrected entry.
5. The participant/representative must also date and initial any corrections made to paper documents.

PROCEDURE: Electronic Recordkeeping:

1. Initial assessments will be entered into the electronic charting system within 2 business days. Supervisor reviews will occur with an additional 2 business days.
2. Corrections regarding initial assessments will be emailed to the supports coordinator.
3. Primary Supports coordinator will mark the assessment as complete once corrections are made.

4. Reassessments will be entered into the electronic participant record within 10 business days.
5. Primary supports coordinator is responsible to mark the assessment as complete.
6. Progress note entries not entered into the electronic participant record with 24 hours will be entered based on the following:

   Late entry procedure regarding progress note entries:

   - Use the pull down calendar and select the date and time that the contact (visit/monthly contact) actually occurred. The narrative part of the entry MUST contain the following statement:

     LATE ENTRY MADE ON 'TODAY'S DATE' FOR VISIT/CALL MADE ON 'ACTUAL DATE OF VISIT/CALL.

   - This entry/line must be in ALL capital letters.

     Example: LATE ENTRY MADE ON 6/10/17 FOR MONTHLY CONTACT MADE ON 6/5/15. Participant reports that she had no falls or hospitalizations during the past month. Participant did see her primary care physician on 5-14-15. Etc.

RETENTION:
Participant files are retained for four years for Access Programs and seven years for MI Choice HCBS program.

REFERENCES:
See Records Retention Schedule
ACCESS Guidelines for Supports Coordination
MI Choice Waiver Guidelines for Supports Coordination

SeniorResources
Our Name. Our Focus.

Nursing Facility Transition Incentive (NFTI) Policy and Procedures

Policy: CC.1.15	**Effective Date: 4.1.06**
Approved: Tom Curtis, **CEO**	**Revised: 11.15.15; 4.7.16**

SCOPE: This policy applies to participants who meet eligibility for the MI Choice Waiver Program and who desire to transition from a skilled nursing facility to either home or a community-based setting that meets CMS criteria.

POLICY: Senior Resources will adhere to the Nursing Facility Transition Program Requirements and Guidelines published by MDHHS as part of its annual contract. Senior Resources will make every attempt to achieve each fiscal year's NFTI benchmarks as determined by MDHHS.

PROCEDURES: A transition agent other than Senior Resources may identify potential nursing facility residents for transition and assist in transitional activities as appropriate. Senior Resources will maintain a positive working relationship with the Center for Independent Living agencies that share the same program service areas.

When reviewing and evaluating a nursing facility resident for transition, there will be reasonable assurance that the person will successfully transition to a community setting. To be considered a NFT priority 2, the candidate must be in a Skilled Nursing Facility, have a barrier to transitioning, and active or pending Medicaid.

When anticipating a nursing facility transition to MI Choice, a waiver slot will be held in reserve for that transition to ensure sufficient funding is available in the current MI Choice contract to absorb the service costs. NFT participants are a priority 2 on the MI Choice Waiver waitlist.

A person-centered planning process will be used in developing a transition plan that includes projected costs, participant needs and participant goals. Senior Resources shall follow person-centered planning in accordance with MDHHS's Person-Centered Planning Guideline.

NFT services shall begin no more than six months before the expected date of discharge from the nursing facility and shall be completed no later than 60 days after the transition to the community takes place. As NFT candidates are assessed, Supports Coordinators will enter the required information into the Compass NFT portal.

NFT services will be billed according to the MDHHS Operating Standards for MI Choice Waiver Program Nursing Facility Transition service.

For billing purposes, all NFT services provided before MI Choice enrollment will have a date of service equal to the first date of MI Choice enrollment. The MI Choice case record shall accurately reflect dates of service provision.

If the NFT participant does not enroll in the MI Choice Waiver program, service costs incurred during the NFT process shall be billed on the actual date of service.

Senior Resources will use MDHHS approved (Non-Waiver) Nursing Facility Transition Services Expenditure Report as appropriate.

A NFT portal case record begins a case record for the potential NFT participant. All NFT participants will be tracked using COMPASS status tables. This includes participants who transition as NFT participants and

transitions who enroll in the MI Choice Waiver program.

The MI Choice iHC assessment will be completed in the nursing facility. MI Choice assessments will be conducted by a Registered Nurse (RN) and Licensed Social Worker (SW) Care Management Team as outlined in the MDHHS Performance Standards.

Care Setting Status will be "Nursing Home" or "Hospital" as appropriate when the transition work begins. Original Nursing Home Care Setting Status will remain through the day before another program such as Waiver begins.

Using a person-centered planning process and the MDHHS Person Centered Transition Plan form, a transition plan will be developed that includes all barriers to transition, projected transition costs, and participant goals, based on the individual's needs. The transition Plan will minimally include:

1. Nursing facility resident name
2. Nursing facility resident identifying information including Social Security Number and Medicaid ID number.
3. Name and address of nursing facility
4. Date of initial contact
5. Barriers to transitioning
6. Estimated date of transition to MI Choice and/or community
7. Needed or anticipated NFT services
8. Projected costs and total cost of transition plan
9. Participant goals and expected outcomes of transition

Supports Coordination staff will assist the participant in completing the Quality of Life questionnaire and notify MDHHS of results in a timely manner.

The Supports Coordinator will meet in person with the participant prior to the transition date to complete the Nursing Facility Level of Care document to determine medical eligibility for the MI Choice Waiver program.

The Supports Coordinator will contact (preferably in person) the NFT participant within one business day of transition. The Supports Coordinator will ensure that the participant's services are in place and meeting the participant's needs. The Supports Coordinator will provide more intensive follow-up to the participant in the first month following discharge from the nursing home).

REFERENCES:

Nursing Facility Transition Program Requirements and Guidelines - Attachment L to FY2016 MDHHS/Senior Resources Grant Agreement

NFT Transition Plan

MI Choice Waiver Guidelines for Supports Coordination

Money Follows the Person Program Policy and Procedure

Policy: CC.1.16	**Effective Date: 01.01.11**
Approved: Tom Cintis, **CEO**	**Revised: 11.15.15; 4.7.16**

SCOPE: This policy applies to participants who meet eligibility criteria for the MI Choice Waiver Program, who desire to transition from a skilled nursing facility to either home or a community-based setting that meets CMS criteria, and additionally meet the State of Michigan criteria for the Money Follows the Person Program (MFP).

POLICY: MI Choice Home and Community Based Services (HCBS) Money Follows the Person (MFP) will be delivered in accordance with the most recent MDHHS Operating Standards for Money Follows the Person. Senior Resources will make every attempt to achieve NFTI benchmarks as determined by MDHHS.

PROCEDURES:
Senior Resources staff will evaluate all Nursing Facility Transitionees to determine if they qualify for to be a Money Follows the Person Participant. Requirements to be a MFP participant are that the individual:

- Must be a senior or adult with a disability.
- Must have resided in a nursing facility/hospital for at least 3 months prior to transitioning.
- Must have been Medicaid eligible for at least one day prior to transitioning.
- Must be enrolled in MI Choice immediately upon discharge from the nursing facility.
- Must move into qualified housing:
    - Home owned or leased by the individual or a family member.
    - Apartment rented by the individual or a family member.
    - Community based home with less than 4 unrelated persons

When anticipating a Money Follows the Person to MI Choice, a waiver slot will be held in reserve for that transition to ensure sufficient funding is available in the current MI Choice contract to absorb the service costs. MFP participants are placed as priority 2 on the MI Choice Waiver waiting list.

A person-centered planning process will be used in developing a transition plan that includes projected costs, participant needs and participant goals. Senior Resources shall follow person-centered planning in accordance with MDHHS's Person-Centered Planning Guidelines.

MFP services will be billed according to the MDHHS Operating Standards for MI Choice Waiver Program Money Follows the Person service.

MFP requirements:

- An MFP participant must sign an "Informed Consent for Participation in Michigan Money Follows the Person Rebalancing Demonstration" form developed specifically for the MFP initiative. A copy will be kept in the participant case record.
- Prior to signing consent for enrollment in the MFP program, the Senior Resources supports coordinator will review the MFP withdrawal form with the participant. The participant will be informed that participation in the MFP program is voluntary and they may withdraw at any time.

- Senior Resource will have a "Michigan Money Follows the Person Demonstration Program Withdrawal Confirmation" form available to be signed if an individual does not wish to participate in the MFP program.

- Senior Resources will notify MDHHS of a participant's enrollment in the MFP program.

- Senior Resources will notify MDHHS expeditiously of change in address of all MFP participants.

- Each MFP participant without a PERS must have at least one 24-hour designated contact person (participants can choose to have more than one 24-hour contact person) to call in case of an emergency or a need for service assistance 24-hours a day. The 24-hour contact person(s) will be responsible for assisting the participant in activating his/her back up service when needed, particularly during off hours when a supports coordinator may not be available. The contact person may be a family member, a friend, an ally, neighbor, acquaintance or a worker who agrees to help the participant 24-hours/day when the participant has a critical need that cannot wait. This contact person must be identified during person centered planning and in the participant's care plan. If the participant doesn't have a contact person, the supports coordinator must work with the participant to identify a person or ally who can fulfill the role of contact person for purposes of activating 24-hour assistance, as needed for all MFP participants without a PERS. The supports coordinator must ensure that the contact person has a copy of the participant's current care plan with after-hours telephone numbers to call for help with transportation, equipment repair or no-show. Phone number shall include the service agency's 24-hour telephone numbers per the approved care plan. (DME and service providers maintain 24-hour call systems for participants to use for this purpose.) The supports coordinator must review the participant's care plan with the contact person(s) and train them as to the agency or service to call for potential service need situations and in emergencies. The contact person will be trained by the supports coordinator (SC) to report 24-hour crisis activation to the SC within 48-hours of occurrence, describing what occurred, and who the contact person called to activate service to assist the participant to initiate back up services or emergency services. The supports coordinator will complete a written crisis activation incident report as described to them by the designated contact. This incident report will be sent to the NFT/MFP project director by the SC within two working days.

- Service providers will be required to report missed visits for MFP participants to the waiver agents as they occur. Crisis activation incident reports will be matched with service provider no show reports by waiver agents, thus providing an additional match in the service delivery system to ensure that participants are receiving services as planned. This additional mechanism for MFP participants provides extra support to the MI Choice Quality Improvement Project for reducing provider no shows. The supports coordinators, with participant consent, are responsible for ensuring that interventions are implemented to reduce or ameliorate future back up failures from re-occurring.

- Per CMS guidance, an MFP participant who has been re-institutionalized for at least 30 days is dis-enrolled from the MFP program, but may re-enroll in MFP without being a SNF resident for an additional 3months.

REFERENCES:

MDHHS/Senior Resources Grant Agreement, Attachment E (MFP Demonstration Grant)

MI Choice Waiver Guidelines for Supports Coordination

Advance Directives Policy and Procedure

Policy: CC.1.17	**Effective Date: 10.15.15**
Approved: Pam Curtis, **CEO**	**Revised: 10.15.15; 4.7.16**

SCOPE: This policy applies to all participants of Senior Resources services.

POLICY: Senior Resources will inform all participants of their rights under state law to make decision concerning their medical care, including the right to accept or refuse medical or surgical treatment, and of their right to formulate an advanced directive, such as a living will or durable power of attorney for health care, relating to the provision of care when the participant is incapacitated.

Information about advance directives is verbally given to each participant and/or their identified support system. Information will be shared taking into account any impairment, education level, language/cultural differences.

Senior Resources honors participant choices regarding advance directives, including the choice to refuse resuscitation.

Senior Resources procedures address documenting when participants have an advance directive, DPOA for health care, and/or a do not resuscitate declaration. This information is included in the COMPASS assessment and is included in the person centered plan.

Senior Resources staff does not sign/witness advanced directive documents.

Participants wishing to formulate an advance directive shall receive support through Supports Coordination and may be referred for external assistance.

PROCEDURE: Upon initial assessment and at reassessments, Supports Coordinators will inquire about the status of any Advanced Directives (AD), Power of Attorney (POA), Durable Power of Attorney (DPOA), and Guardianship. If a participant does not have these in place, information, written and/or verbal, will be provided to the participant and their care team by the Supports Coordinator. The Five Wishes booklet is located in both the MI Choice and the Targeted Care Management/Case Coordination and Support/Care Management (TCM/CCS/CM) Initial Assessment folders.

REFERENCES:
AD.2.14 Witnessing Documents Policy
ACCESS Guidelines for Supports Coordination
MI Choice Waiver Guidelines for Supports Coordination

SeniorResources
Our Name. Our Focus.

Grievance / Appeals Policy and Procedure

Policy: CC.1.18	**Effective Date: 4.15.2006**
Approved: Tom Curtis**, CEO**	**Revised: 10.15.15**

POLICY: Participants or their caregivers may comment about service provision or appeal termination of services. Participants have the right to express dissatisfaction and suggest changes in services without fear of coercion, discrimination, reprisal, or unreasonable interruption of services. Attempts will be made to resolve problems or complaints informally through the care management staff.

PROCEDURES: Participants are encouraged to first discuss the problem or complaint with the supports coordinator. The supports coordinator is expected to attempt to resolve the problem, if with a provider, by contacting the provider. If the problem is with the type or amount of services, the supports coordinator will discuss the issues with a supervisor to attempt to resolve. All attempts will be made to satisfy participant need.

If the supports coordinator is unable to satisfy the participant, the issue will be brought to the attention of the supervisors and/or the Waiver or Community Services Director. If needed, a case conference will be held with all parties to attempt to resolve the issues. The case conference will be held within 7 days from the participant request. This may include participant, family members, caregivers, provider agency, supports coordinators, supervisors and contracts manager. Participants will be provided with a copy of their rights and responsibilities during the case conference. Participants will also be provided with a list of advocates and community resources. Complaints about a provider will be documented on the appropriate grievance form.

If issues are not resolved through these informal methods, a written complaint must be filed within 30 days, and the Formal Grievance/Appeals Procedure is followed.

If the participant is appealing a decision concerning eligibility for, reduction, suspension or termination of services under the Michigan Medicaid Home and Community Based Services Waiver (MI Choice Waiver) an administrative hearing may be requested. Participants have the right to initiate an appeal through Senior Resources and the Michigan Department of Health and Human Services at the same time. The Hearings and Appeals Process for an Administrative Hearing will be followed.

Participant complaints/problems are to be noted in the participant case file and a complaint form completed by either the participant, their appointed representative or by the Supports Coordinator. The completed form is to be given to the supervisor of the program. All complaints are kept in a central location and are referenced as a tool for quality assurance and performance improvement. On an annual basis, the Quality Improvement Coordinator will prepare a report of all complaints received. The findings and improvement plan will be presented to the management team and supports coordinators as appropriate.

REFERENCES:
Appeals Process for Administrative Hearing
Participant Complaint Form

Person Centered Planning Policy and Procedure

Policy: CC.1.19	**Effective Date: 4.29.14**
Approved: Tom Curtis, **CEO**	**Revised: 10.25.15**

SCOPE: This policy applies to all Senior Resources employees and volunteers including those who are part time, temporary and contractual, hereby referred to as "staff". This policy applies to all individuals while under the care of any Senior Resources staff and/or contractual agencies within the provider network.

POLICY: Senior Resources supports Person-Centered Thinking Process (PCT), which includes assessing, planning, implementing, and evaluating. This process must have an individualized focus and incorporate the principles of Person-Centered Thinking, self-determination, informed choice, and equity. Input from the person and their Person-Centered Thinking Team will guide and direct this process.

PROCEDURE:

1. Staff shall use a Person-Centered approach along with other formal and informal assessments to develop the service plan.
2. The person's team will work with the person to identify goals.
    a. The person receiving supports or the person's representative determines the membership of the PCT Team (hereafter referred to as the Team), which will include the Supports Coordinator.
    b. The membership of the team (as determined by the person or persons representative) will meet at least every one hundred eighty (180) days or more often as the person or other members of the team determine necessary.
3. The Supports Coordinator ensures that the Person-Centered Plan is completed in the planning meeting. Members of the team who are not present during the planning meeting will be contacted within 7 business days by the supports coordinator. The Supports Coordinator will communicate the Person-Centered Plan to the absent team member(s). The Supports Coordinator will make accommodations if necessary to ensure the information provided to the member(s) is easily understood.
4. The Team will assess, plan, implement and evaluate goals and supports for which they are responsible, as agreed upon and listed on the Person-Centered Plan in the planning meeting.
5. Persons are provided with opportunities to provide ongoing feedback regarding their individual supports and services. These mechanisms include both informal feedback through persons providing or monitoring supports, formal satisfaction and outcome measurement processes, and problem resolution/complaint processes.
6. Planning is an ongoing process. Services are tailored or adjusted over time based on changes in needs or preferences. The plan shall be updated and refined as frequently as needed. The person will be provided the opportunity for a person centered planning meeting no less than every one hundred eighty (180) days.
7. If any interested party believes that Person-Centered Planning is not being implemented as outlined or receives a request from the Person/Representative, they should immediately contact the Supports Coordinator to resolve the issue by following the informal and, if necessary, the formal resolution process outlined in the Grievance/Appeals Procedure.

Dispute Resolution/Appeal Mechanisms

Persons have the right to access the Senior Resources Grievance/Appeals Procedure processes if they believe that:

a. They have not received the opportunity for person centered planning
b. They have been inappropriately denied a requested service
c. Limitations have been placed on their choice or preference for perceived health and safety reasons.

Employee Training:

1. Within thirty (30) days of employment with Senior Resources, new hires will have successfully completed the online Person Centered Thinking training module. Certificate of completion will be filed in employee file.
2. Within one hundred eighty (180) days of hire, all employees will attend a two (2) day Person Centered Thinking Training led by master level trainers in the MI Office of Services to the Aging Person Centered Thinking Training Curriculum.

Employee/Stakeholder Training

Senior Resources offers Person Centered Process Training twice yearly to all new organizational staff, focal points, purchase of service and grant providers, members of the Aging & Disability Resource Collaboration of the Lakeshore and advisory and executive board members. This training may be a PCT full training or components of PCT training curriculum.

REFERENCES:

Person Centered Planning Modules 1-4
Person Centered Planning Person Workbook
Person Centered Planning Training CD's 1-2
Person-Centered Plan
Client Quality Survey Results
Formal Assessment
Participant Rights and Responsibilities

Critical Incidence Reporting Policy and Procedures

Policy: CC.1.20	**Effective Date: 7.1.2006**
Approved by: Pam Cintis, **CEO**	**Revised: 10.12.15**

POLICY: Senior Resources employees are responsible to provide interventions, services and support to participants to attempt to resolve any incidents about which the employees become aware. It is Senior Resources employees' responsibility to report any incident to the appropriate authorities. All incidents must be reported into the Senior Resource Incident Database. A Critical Incident must additionally be reported via the Critical Incident online portal per Michigan Department of Health and Human Services (MDHHS) requirements.

DEFINITION: An "Incident" is any actual, alleged or suspected event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a participant.

A "Critical Incident" is any incident that occurs with a Senior Resources participant, as defined by the Michigan Department of Health and Human Services (MDHHS).
Types of incidents may include:

- Communicable disease
- Elopement
- Exploitation
- Hospital and ER visits within 30 days of a previous hospitalization
- Humiliation
- Illegal activity in the home with potential to cause serious or major negative activity
- Infection control concerns/ bio hazardous accidents
- Medication errors
- Neglect
- Physical Abuse or injury
- Provider no shows, particularly when the participant is bed bound all day or has critical needs
- Reports of vehicular accidents
- Sexual Abuse
- Suicide or attempts of suicide
- Suspicious or unexpected death
- Theft
- Unauthorized possession of a weapon
- Unauthorized use and/or possession of legal or illegal substances
- Use of restraints or seclusion
- Verbal Abuse
- Wandering
- Worker consuming drugs/alcohol on the job
- Other

PROCEDURES: Participants will be informed regarding their responsibility to report any incident to the Supports Coordinator. Any instances of abuse, neglect, or exploitation must be reported to MDHHS/Adult Protective Services (APS). This information will be given at the time of assessment, reassessment and as needed.

Identifying an Incident
When an employee becomes aware of a potential incident or suspects that an incident has occurred, it is the Senior Resources employee's responsibility to gather accurate and credible information within two days of the incident. Questions about a particular incident or suspected incident should be discussed with their immediate supervisor for clarification.

Actions taken
When an employee determines that an incident has occurred or is about to occur they must inform their immediate supervisor of the incident. Staff will then work with the participant to resolve the incident or mitigate further harm. Follow-up action, which could include reporting to Adult Protective Services (APS) and law enforcement, will be taken immediately. If a provider agency is involved in an incident, information will be forwarded to the Contracted Services Coordinator.

Reporting
All such incidents, as well as follow-up actions taken, the outcome and resolution of the event, will be documented in the progress notes as well as in the Senior Resources incident database. COMPASS progress notes must include documentation of case conferences, all referrals to APS, law enforcement, dispute resolution, counseling, etc.

Supports Coordinators will document the incident in the participant's progress notes as appropriate but will not refer to it as a "Critical Incident".

Initial incident will be reported in the Senior Resources Incident Database within 2 business days of the incident discovery. Follow up reporting including debriefing with involved staff and/or participant is entered as needed.

Procedures Specific to MI Choice Waiver
Critical Incident reports for MI Choice participants will be completed on the web portal developed by the Center for Information Management (CIM) with MDHHS. Supports Coordinators will use the Critical Incident User Guide for direction. After supervisory review, the Critical Incident will be approved for review by MDHHS as required.

Suspicious or unexpected death that is related to providing services, supports or caregiving will be reported to MDHHS contract managers as soon as reasonably possible, i.e. within two (2) business days of identification that this event occurred.

Senior Resources staff will submit a report in the Critical Incidents Portal and in the Senior Resources Incident Database within 2 business days of the incident discovery. Follow up reporting is entered as needed.

Quality Review
The Quality Improvement Coordinator will be responsible to develop a written analysis and present it to the Quality Improvement Committee annually to evaluate compliance with guidelines, identify causes, identify trends and develop actions for performance improvement. The Quality Improvement Coordinator will review results of performance improvement plans and determine in coordination with the Staff Educator the necessary training of personnel to prevent recurrence. The Quality Improvement Coordinator will review results with the

full management team annually.

REFERENCES:

Michigan Department of Health and Human Services (MDHHS) Critical Incident User Guide
CC.1.28 MiChoice Quality Management and Improvement Policy and Procedure
Senior Resources Incident Database
CIM Web Portal https://webapp.ciminc.com/compassci/login.seam
MDHHS Definition of Critical Incident

MI Choice Self Determination Policy and Procedures

Policy: CC. 1.21	**Effective Date: 03.01.08**
Approved: Tom Cintis **,CEO**	**Date Revised: 10.9.15**

PURPOSE: Senior Resources' Self-Determination program allows participants to direct and manage their services through an individual budget that is accessible, flexible and portable. The participant and their allies work with the Supports Coordinator (SC) to determine the type of services and level of services to be allocated in their budget, based on the person centered plan

DEFINITION: Through Self-Determination, participants directly employ workers or directly contract with chosen providers. The budget authorized by the SC provides a defined amount of resources sufficient to pursue the participant's plans, goals and outcomes. Service and support arrangements directly controlled by the participant may range from one specific service to all of those in the care plan. It is the participant's choice whether to manage some or all of their services.

A fiscal intermediary (FI) is an independent legal entity that acts as the fiscal agent of the waiver agent for the purpose of assuring financial accountability for the funds in the participant's individual budget. The FI:

- Receives the funds comprising the participant's budget;
- Makes payments as authorized by the participant, and approved in the budget, to providers of services, supports or equipment;
- Acts as an employer agent when the individual directly employs workers;
- Minimizes and eliminates conflicts of interest.
- Cannot be a direct provider of services.
- Ensures eligibility of all providers of service prior to releasing budgeted funds.

POLICY: The Self Determination program option shall be offered to all participants enrolled in the MI Choice Waiver program. Senior Resources, the Fiscal Intermediary (FI), and Self-Determination Participants will adhere to the Waiver contract for Self-Determination in Long-Term Care, which lists the functions of the waiver agent, the FI and the participants.

PROCEDURE: MI Choice Waiver Supports Coordinators review the Self-Determination program with the participant or their representative to confirm their understanding of the program and their responsibilities.

REFERENCES:
Senior Resources Conditions of Participation – Appendix A, Criminal History Screening- Exclusion from Employment

Application for a Right to Hire Waiver Policy and Procedure

Policy: CC.1.22	**Effective Date: 10.26.15**
Approved: Tom Cintas, **CEO**	**Revised: 10.26.15**

SCOPE: When a participant requests that a family member be hired by a contracted agency and it is found that the family member has a positive criminal history screening. This finding would normally result in preventing the family member from providing services reimbursed by Senior Resources.

POLICY: Senior Resources may consider, in limited circumstances, waiving the adverse employment action requirements relating to positive criminal history screening results as stated in the Purchase of Service contract with the third party fiscal intermediary (FI) under the following conditions:

1. The results of the criminal history screening do not include convictions for the following:
    a. Abuse or violence against a minor, patient, or vulnerable adult
    b. Fraud against a minor, vulnerable adult, or state or federally funded health care program
    c. Felony related to manufacture, distribution, prescription or dispensing of a controlled substance if felony occurred on or prior to August 21, 1996.
2. The Participant requests that the Caregiver provide services to them
3. The Participant's Person Centered Planning Team determines a Right to Hire Waiver is in the best interest of the Participant.
4. The Caregiver meets all other applicable conditions of employment of the FI
5. A signed Right to Hire Waiver form is completed, signed by all applicable parties, and is kept on file by the FI and Senior Resources.

PROCEDURE: At any point during this procedure any party to the agreement may terminate the procedure which will result in a Waiver not being granted.

1. The FI notifies the Participant's Supports Coordinator that a Caregiver has a positive criminal history screening that would normally preclude them from employment providing services reimbursed by Senior Resources.
2. The Supports Coordinator notifies the participant and/or their representative of the results of the criminal history and the procedure and request process approval of the Waiver.
3. The Participant and/or their legal representative decide whether they are interested in a Waiver. If the Participant no longer desires the Waiver they must inform the Supports Coordinator. The Supports Coordinator must inform their supervisor and the FI and the procedure terminates.
4. If pursuing a Waiver the Supports Coordinator discusses the request for Waiver, the Participant's case, and reviews the criminal history screening results with their supervisor who confers with the Senior Resources Conditions of Participation Criminal History Screening – Exclusion for Employment. If criminal history report does not contain exclusionary elements the waiver is granted.
5. The Right to Hire Waiver is completed and signed by the Participant or their legal representative, the Supports Coordinator, the Supervisor, the FI and a final copy sent to the Supports Coordinator
6. A copy must be maintained in the Caregiver's personnel record maintained by the FI.
7. A copy of the Right to Hire Waiver is placed in the Participant's chart.
8. Once the FI has sent the final copy of the Waiver to the Supports Coordinator the FI may proceed with their regular staffing procedures.

REFERENCES:

Right to Hire Waiver
Conditions of Participation Criminal History Screening

Payer Source Policy and Procedure

Policy: CC.1.23	**Effective Date: 10.25.15**
Approved: Tom Curtis**, CEO**	**Revised: 10.25.15**

POLICY: Senior Resources shall pursue and secure all available third-party funding including Medicare benefits, Medicaid State Plan benefits, Veteran's benefits, insurance benefits, and other available sources including private pay where unused monthly income may result in excess assets. Third-party funding, when available, shall be utilized prior to any MI Choice Waiver funding. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access Waiver services.

Neither Senior Resources nor any service provider under contract to provide MI Choice services will require monetary donations from participants of the MI Choice waiver program as a condition of participation. No paid or volunteer staff person may solicit contributions from MI Choice program participants, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

PROCEDURE: During the initial assessment of a potential participant, the Primary Supports Coordinator shall obtain copies of all insurance policy information and determine if the potential participant is financially able to contribute toward their service needs. The Supports Coordinator compares the insurance information provided during the initial assessment to CHAMPS data to ensure consistency. Discrepancies will be reported to MDHHS within 10 business days of the initial assessment. Medicaid Liaison will send a form letter to attempt to identify possible coverage of any Waiver services by the third party payer sources. The collaboration between the Medicaid Liaison and potential payer sources will be documented in the participant record.

Orientation and Trainings Policy and Procedure	
Policy: CC.1.24	**Effective Date: 01/02/03**
Approved by: Tom Cintas, **CEO**	**Revised:7.20.15; 4.7.16**

POLICY: Supports Coordination staff will receive training for quality performance in order to best service the needs of the participants of the Senior Resources Supports Coordination programs. New supports coordinators will receive training in all areas that are covered on the Supports Coordinator Competency Checklist. This Checklist must be completed between the 90 day and 180 day probationary period.

PROCEDURE: At hire, supports coordinator will receive orientation to the policies and procedures of Senior Resources, the Care Connections Programs, availability of services, and other information as outlined in the orientation procedures.

Supports coordinators will receive in-service on at least a monthly basis regarding community resources such as DHHS, in-home services, Social Security, food pantries, etc.

When funds are available, supports coordinators will be allowed/encouraged to register for conferences and workshops that are available and applicable to the program, especially when applicable CEUs are available. When feasible, Senior Resources will cover the costs involved including registration, mileage, and meals within the guidelines of the Senior Resources Personnel Policy.

A list will be maintained by the Staff Educator of in-service trainings offered throughout each fiscal year.

REFERENCES:
Orientation Schedule
Mentoring Schedule
Master Training Log
Supports Coordinator Competency Checklist

SeniorResources
Our Name. Our Focus.

Private Pay Supports Coordination

Policy: CC.1.25	**Effective Date: 10.16.15**
Approved: Tom Cintis**, CEO**	**Revised: 10.16.15**

POLICY: Senior Resources offers a Private Pay Program in which Supports Coordination services are offered on a fee for service basis.

PROCEDURE: A Private Pay classification will be determined at the time of Options Counseling following the guidelines below.

Private Pay Guidelines: If upon intake the participant and or family member reports over $25,000 for a single person or $50,000 for a married couple in assets, they will be informed that there is an initial assessment fee of $75.00. Should the participant and/or family desire ongoing supports coordination it will cost $75.00/month.

Case classification can be changed from Private Pay to other program classification if at initial assessment new or additional assets information is discovered. Documentation will be maintained in the client progress notes or contact log as to the reason for the change in participant program status.

The participant and/or care team can decide to seek in-home services through a local provider or pay for a Support Coordination assessment through Senior Resources to assist them in determining their in-home needs and/or ongoing needs and access to services.

Private Pay Supports Coordination services will be billed directly to the participant and or family member. All other agencies providing direct in-home services for the participant will be billed by the rendering provider to the participant/responsible party.

Under the Private Pay Program the Support Coordinator can provide information and coordination for the following:

- Home assistance with light housekeeping, laundry, lawn care, and minor home repairs.
- Prescription and health insurance assistance.
- Respite care options.
- Support groups, including caregiver support.
- Resources to address elder abuse and neglect.
- Recreational, socialization, and volunteer programs.
- For on-going supports coordination a home visit will be made once every 3 months
- For on-going supports coordination the case manager will make one contact per month to participant and/or family member or as needed. An in-person assessment will be conducted once every six months.
- All contact and subsequent follow up will be recorded in participant notes.

Supports Coordinator will:
Make initial contact with participant within 5 working days of referral
Complete comprehensive in-person assessment and document in COMPASS database
Make referrals to in-home providers as appropriate and approved by participant and/or responsible party

Forward the bill routing form and Senior Resources Private Pay Agreement form to the appropriate Senior Resources employee by 10th of the month following the client contact.

Client Files Private Pay client files should include at a minimum:

- Comprehensive Assessment
- Bill Routing Form
- Consent Form
- Release of Information form
- Private Pay Agreement

REFERENCES

Bill routing form

CC.1.9 Case Classification Policy

Performance Measure, Management and Improvement Policy and Procedure

Policy: CC.1.26	**Effective Date: 07.01.06**
Approved: Pam Curtis, **CEO**	**Revised: 10.16.2015**

MISSION: To provide a comprehensive and coordinated system of services designed to promote the independence and dignity of older persons and their families in Muskegon, Oceana and Ottawa counties - a mission compelling us to focus on older persons in greatest need and to advocate for all.

POLICY: Senior Resources will have a Performance Measurement and Management Committee (PMMC) to oversee the quality of Case Management and Home and Community Based Services as well as the continuous improvement of the Aging Services Network. The objectives of these programs and services are to; expand access, increase effectiveness and efficiencies, improve on the health and safety of participants as well as staff, address issues within human resources and technology, increase satisfaction of the consumer and other stakeholders, enhance service planning and delivery and focus on risk management. Members of the committee will include at minimum: Community Services and the MI Choice Waiver Program Director, Access Services Supervisor, Registered Nurse Supervisor, Social Work Supervisor, Contract and Grant Services Managers, Human Resources and Quality Improvement Coordinator (QI). A subcommittee of the PMMC, the Waiver Quality Improvement Committee, meets biweekly and is comprised of the QI Coordinator, WA Director, SW Supervisor, RN Supervisor, Contracted Services Coordinator, Data Manager and Staff Educator.

PROCEDURES: Senior Resources will develop measurable quality improvement plans. The Quality Improvement Committee will review the plan on a quarterly basis. Progress will be gauged based on determined indicators. The committee will review relevance of the objectives and if objectives have been met. New objectives will be created based on data collection or by the direction of fiduciaries. The data collected is used to set written business and service delivery objectives and must allow for comparative analysis. The Performance Measurement and Management/Improvement Matrix/Scorecard will be used for planning.

Performance Improvement Activities are those which are state mandated or agency defined goals. Data collection focuses on:

- Integrity of data
  - Reliability
  - Validity
  - Completeness
  - Accuracy
- Time intervals for collection at the beginning and end of services as well as appropriate intervals during services and points in time following services.
- Characteristics of the persons served
- The current MI Choice Quality Management Plan as determined by Michigan Department of Health and Human Services (MDHHS).
  - The seven focus areas of the Center for Medicare/Medicaid Home and Community Based (CMS HCBS) Quality Framework: Participant Access, Participant Centered Service Planning and Service Delivery, Participant Provider Capacity and Capabilities, Participant Safeguards, Participant Rights/Responsibilities, Participant Outcomes and Satisfaction and System Performance

Data collected by the agency will address the needs of persons served and other stakeholders as well as the needs of the organization. The data will include:

- Financial information

- Accessibility status reports
- Resource allocation
- Surveys
- Risk management
- Governance reports
- Human resources reports
- Technology
- Health and safety reports
- Strategic planning information
- Field trends
- Service Delivery

Responsibilities of the QI Coordinator include but are not limited to:
- Overseeing audits: preparation and follow-up
- Chart reviews as defined by MDHHS and AASA program standards
- Monthly and random audits, and assigning/reviewing peer and self-audits
- Participant Satisfaction Surveys
- Running of quality reports as determined by QI Committee
- Feedback on audits, surveys, and reviews to RN and SW supervisors and to QI Committee
- Quality Indicator Drill-Downs when need identified

The Quality Improvement Committee will have the following responsibilities:
- Review participant complaints and follow-up activities
- Review Critical Incidents and follow-up
- Review appeals and results
- Review staffing complaints
- Suggest policy and procedure changes as a result of the above activities.
- Review and revise Performance Improvement Plan

REFERENCES:
Performance Measure Matrix/Scorecard
CO.1.2 Purchase of Service Provider Quality Policy and Procedure

Access Quality Management and Improvement Policy and Procedure

Policy: CC.1.27	**Effective Date: 07.01.06**
Approved: Pam Curtis, **CEO**	**Revised: 10.12.15**

SCOPE: This policy applies to all quality monitoring and improvement activities associated with the Aging and Adult Services Agency (AASA) Access Services Programs.

POLICY: Senior Resources' will monitor participant records, including electronic and paper charts, for quality. The Quality Coordinator will conduct annual satisfaction surveys for the purpose of gauging participant/caregiver satisfaction and analyzing areas of opportunity for improvement.

PROCEDURES: The Quality and Education Coordinator under the direct supervision of the Access Supervisor is responsible for conducting quality improvement activities that assure the program meets or exceeds all standards set for Access Services.

Responsibilities of the Quality and Education Coordinator include but are not limited to:

- Chart reviews of new and existing participants, random audits, and assigning/reviewing peer and self-audits
- Person Centered Plan of Care reviews
- Participant Satisfaction Surveys
- Analysis of quality summaries reported to and as determined by Performance Measure and Management Committee, Access Supervisor, and Community Services Director
- Quality Indicator Drill-Downs when need identified

REFERENCES

CC.1.26 Performance Measure, Management and Improvement Policy and Procedure
Quality and Education Coordinator Job Description

MI Choice Waiver Quality Management and Improvement Policy and Procedure

Policy: CC.1.28	**Effective Date: 07.01.06**
Approved: Tom Cintis, *CEO*	**Revised: 10.22.15; 4.7.16**

SCOPE: This policy applies to all quality management and improvement activities associated with the MI Choice Waiver Program.

POLICY: Senior Resources' MI Choice Waiver Program quality management and improvement activities will be conducted in accordance with the current Senior Resources' contract with the Michigan Department of Health and Human Services (MDHHS).

PROCEDURES: Quality Management Activities are included as part of regular business operations and focus on:

A. Waiver Staff
- Qualified staff
- Orientation and ongoing training
- Performance evaluations
- Regularly scheduled and random audits
- Supervisor/Manager oversight

B. **Providers**
- High quality providers
- Adequate capacity for service area
- Response to participant provider complaints
- Oversight, contract management and surveys by Contacted Services Coordinator

C. Participants
- Comprehensive and ongoing assessment of needs and eligibility
- Person-centered planning based on individual needs, goals and preferences
- Access to services and informed choice regarding services, care settings and providers
- Participant input including (minimum of) monthly contacts, participant surveys, grievance process, Consumer Quality Council
- Participant rights, responsibilities and safeguards
- Supports Coordination with Supervisor and Waiver Director oversight

Quality Improvement Activities are based on a feedback loop of design, discovery, remediation and continuous quality improvement. The focus is on:
- Senior Resources' MI Choice Waiver Quality Management Plan devised from Quality Improvement interventions determined by MDHHS and agency-specific goals.
- The seven focus areas of the CMS HCBS Quality Framework: Participant Access, Participant Centered Service Planning and Service Delivery, Participant Provider Capacity and Capabilities, Participant Safeguards, Participant Rights/Responsibilities, Participant Outcomes and Satisfaction and System Performance

The **Quality Improvement Coordinator** under the direct supervision of the Waiver Director is responsible for conducting quality improvement activities that assure the Waiver program meets or exceeds all standards set for Home and Community-Based Waiver agents.

Responsibilities of the QI Coordinator include but are not limited to:

- Oversight of CQAR audits: preparation and follow-up
- Prepares and submits the annual Quality Management Plan to DHHS
- MPRO audits
- Oversight of Critical Incidence Reporting
- Chart reviews including: a minimum of 20 per calendar year utilizing the Statewide Clinical Peer Review Tool and reported to DHHS; charts of new and re-enrollees, charts for Supports Coordinator Performance evaluations; Plan of Care reviews; and assigning/reviewing of Supports Coordinator peer and self-audits.
- Monthly audits for compliance with Senior Resources' internal and contract standards, including but not limited to 30 day contacts and COMPASS assessment completion timeframes.
- Oversight of Participant Satisfaction Surveys
- Generating and distributing Quality Indicator reports as determined by QI Committee
- Providing feedback on audits, surveys, and reviews to management staff and QI Committee
- Co-leadership of local quarterly MI Choice Waiver Quality Council meetings

The **Quality Improvement Committee** meets no less frequently than twice each month. The committee consists of the QI Coordinator, WA Director, SW Supervisor, RN Supervisor, Contracted Services Coordinator, Data Manager and Staff Educator.

Responsibilities of the QI Committee include but are not limited to:

- Develop, review and revise policies and procedures in order to improve quality
- Review, evaluate and make recommendations re: the following:
    - Participant grievances
    - Provider complaints/concerns
    - Critical incidents
    - Participant survey results
    - NFT and MFP benchmarks
    - Quality Indicator Reports
    - Chart review findings
    - CQAR and AQAR audit results and recommendations
- Identify staff development needs

REFERENCES:
Participant Satisfaction Survey by calendar year
HR.1.8 Employee Job Performance Evaluation Policy
CO.1.2 Purchase of Service Provider Quality Policy
QI Coordinator Job Description
Minutes of QI Committee meetings

Agency Disaster and Emergency Response Policy and Procedure

Policy: CC.1.29	**Effective Date: 11.16.15**
Approved: Tom Curtis**, CEO**	**Revised: 11.16.15; 4.5.16**

SCOPE: Senior Resources' Emergency Plan guides preparedness, response, and recovery actions. The Emergency Plan may be activated during a community or regional crisis. It applies to a broad range of emergency incidents. These emergency incidents include, but are not limited to:

- Extended Power Outages
- Fires and Explosions
- Hazardous Material Releases
- Insufficient or unsafe water
- Snow Emergencies

POLICY: In an emergency situation, Senior Resources shall take all appropriate actions to protect life and property and alleviate human suffering and hardship. Senior Resources' agency response shall be prioritized to address the immediate health and safety needs of those individuals at highest risk due to isolation, frailty, and disability. Senior Resources shall also ensure effective communication with the population served and their families, community disaster responders and staff to promote a timely response to an emergency. The Emergency Preparedness Coordinator shall assume primary responsibility for communication with staff related to the emergency, and implementation of agency response.

PROCEDURE:

Emergency Plan

1. Emergency Preparedness Coordinator shall communicate with Emergency County Operation Centers' (EOC) contact point in the event of an emergency. Emergency information to include type of emergency, current response action, suggested response action and identify methods to provide help to high risk individuals.

2. Emergency Preparedness Coordinator shall notify key agency management staff of emergency. These individuals will notify other individuals as outlined in the Senior Resources Visual Command Tree ~ CM All Counties. Information on emergency, directions to staff and participants, and available services to participants to be provided.

3. Emergency Preparedness Coordinator to gather information regarding available emergency services and resources by contacting the Red Cross Disaster Preparedness Director and Human Services Annex contact. Red Cross may provide information on available crisis services namely food and shelter. *Red Cross Emergency Response - (231) 726-3555.*

4. Emergency Preparedness Coordinator to:
   a. Maintain communication with other human service agencies and coordinate emergency responses within the three-county area.
   b. Provide agency staff as well as Community Access Line of the Lakeshore (C.A.L.L.) Resources Manager with local numbers to access service availability in the event of an emergency. Information to also be distributed following the Senior Resources Visual Command Tree.
   c. Assign Senior Resources staff to contact senior residences (nursing homes, assisted living, senior housing units, etc.) to determine needed assistance in the event of an emergency.
   d. Provide all other tasks as outlined in the Emergency Preparedness Coordinator job description.

5. Support Coordinators are responsible for:
    a. For participants enrolled in the MI Choice Waiver program, the primary supports coordinator provides a Service/Emergency Plan and Back-Up Plan upon the initial implementation of purchased and arranged services and when changes occur. For ACCESS programs the Back-up Plan with supporting information is sent to the participant following the Initial Assessment and as changes occur.
    b. When changes occur to the frequency/duration of the service, provider of the service or termination of the service occurs, an updated Service/Emergency Plan and Back-Up Plan are provided to the participant.
    c. The Service/Emergency and Back-Up Plans consist of vital information specific to each individual participant.
    d. Maintain in their possession the most current Participant Service Need Level Classification, both at work and in a sealed envelope at all times (home, work bag, etc.)
    e. Remain accessible via telephone or cellular phone for the duration of an emergent situation.
    f. Contact supervisor or manager of personal availability during identified emergency if not first contacted.
    g. Get information on emergency and verify what their responsibilities are.
    h. Contact those participants/caregivers in affected area via phone or have someone visit their residence if necessary. Assist in accessing emergency services such as food, shelter, medication, and other as needed. ER Participant Service Need Level Classification shall be used to determine contact priorities.
    i. Inform participant and their informal supports of available services and assist is accessing services if needed.
    j. If necessary, contact C.A.L.L. for list of open shelters and comfort centers as needed.
    k. Follow appropriate emergency evacuation procedures for frail and vulnerable participants as needed.
    l. Complete miscellaneous tasks as assigned based on the actual emergency.
    m. Inform participant of known risks and document the participant's informed choice in the Case Record Progress Notes, in assessment comments, and the Plan of Care.
    n. Discuss with supervisor the possibility of an Adult Protective Service referral when participant is choosing to make decisions that are self- injurious and /or is harmful to others.
    o. Will discuss relocating a participant to a safer environment if appropriate.

6. Staff supervisors along with Emergency Preparedness Coordinator to assure that all tasks are completed.

Shelter and Evacuation Procedures for Persons Served

1. American Red Cross:
    a. Will contact human service agencies with available shelters that will be open during emergency. Will also inform agencies if evacuation is needed.
2. Senior Resources:
    a. Emergency Preparedness Coordinator shall inform key staff in order indicated on Command Tree of shelter availability and/or evacuation notice for distribution to staff as needed.
    b. Support Coordinators will inform participants in need of shelter, availability, and ensure transportation through caregivers, neighbors, volunteers, or working transportation systems.
    c. Support Coordinators will assist in evacuation by alerting evacuation teams of location and condition of elderly/disabled in need of evacuation assistance.
    d. Senior Resources to identify alternative shelters if American Red Cross has no availability. These possibly include area Nursing Homes and Assisted Living Centers.
    e. Emergency Preparedness Coordinator or supervisory staff will alert shelters if/when participants are being evacuated.

REFERENCES:

Senior Resources Visual Command Tree ~ All Counties
Emergency Preparedness Coordinator Job Description
Service/Emergency Plan
Participant Service Need Level Classification
ACCESS Guidelines for Supports Coordination

MI Choice Waiver Guidelines for Supports Coordination

Copyrighted Materials/Michigan Department of Health and Human Services Policy and Procedure

Policy: CC.1.30	**Effective Date: 1.1.11**
Approved by: Pam Curtis**, CEO**	**Revised: 10.12.15**

POLICY: Copyrighted materials will acknowledge that Michigan Department of Health and Human Services (MDHHS) reserves a royalty-free, non-exclusive and irrevocable license to reproduce, publish and use such materials.

Copyrighted materials or modifications bear acknowledgement or MDHHS's name are approved by MDHHS prior to reproduction.

PROCEDURE: Senior Resources will include acknowledgement of funding sources in all printed materials. Senior Resources will include acknowledgement of funding sources in all public presentations.

Senior Resources will seek approval from MDHHS prior to printing any copyrighted materials bearing MDHHS's name.

Program Transfer Policy and Procedure

Policy: CC. 1.31	**Effective Date: 10.25.15**
Approved: Pam Curtis**, CEO**	**Revised: 10.25.15; 4.7.16**

SCOPE: This policy applies to all current participants and potential participants involved with Senior Resources.

POLICY: To ensure person's needs are being met in the community, Senior Resources staff will make referrals and assist in program transfers as appropriate internally and externally.

PROCEDURE: Senior Resources programs are structured to meet the needs of participants on a continuum from low to high need. When it is determined through assessment and person centered discussion with the participant and/or their representative that their needs may be better met through a different program (internal or external), the referral and program transfer is completed by the Supports Coordinator. Depending on the program that the participant is transitioning from or to, the process is outlined in the Guidelines for Program Transfer.

The Supports Coordinator determines possible eligibility for alternative programs and after discussion with the participant and supervisor follows the appropriate process. The Supports Coordinator making the referral continues to manage the case until the transfer is completed. The Supports Coordinator assigned to the case post transfer is responsible to introduce themselves to the participant through a phone call and letter.

REFERENCES:
ACCESS Guidelines for Supports Coordination
MI Choice Waiver Guidelines for Supports Coordination

Services in a Residential Setting Policy and Procedure

Policy: CC.1.32	**Effective Date: 10.25.15**
Approved: Pam Cintis, **CEO**	**Revised: 10.25.15**

POLICY: Through the assessment process, using a person-centered approach, the participant, allies and Supports Coordinator review the services available through the MI-Choice Waiver program to determine the type, quantity and intensity of services needed. Once the services needed are determined, the Supports Coordinator uses the appropriate tool, the Residential Settings Agreement, to generate the authorization of service. The Supports Coordinator utilizes the data collected during the assessment process that has been entered into the interRAI Home Care (iHC) assessment to complete the Residential Settings Agreement

PROCEDURE: The Residential Settings Agreement (RSA) is used solely for the purpose of determining the provider reimbursement rate for MI Choice Waiver participants who reside in, or request to reside in a licensed Adult Foster Care (AFC) home or a licensed Home for the Aged (HFA) and receive Community Living Supports. The RSA is completed regardless of individual contracted AFCs or HFAs, ensuring a reimbursement mechanism that is equitable to all such contracted agencies. This tool is completed based on information gathered during the most recent Assessment in conjunction with the services identified in the Person Centered Planning process. Specific services that are obligations of the provider's licensure, such as the opportunity to bathe, the provision of three meals and snacks, clean linens, and general supervision are not items for which compensation is provided within the form. These licensure-mandated services are considered standard services. All services for which provision is not a requirement of licensure are available as services to be authorized and therefore compensated for. Once executed by the Supports Coordinator and contracted provider, the RSA becomes a component of the service authorization and therefore part of the participant record. The Worksheet only contains the input used to determine the reimbursement rate for service and is not part of the participant record.

Additional MI Choice Waiver services allowable in residential settings and identified in a participant's plan of service will be authorized directly with appropriate contracted provider agencies with a separate plan of care. These may include durable medical equipment, adult day care, counseling and other appropriate services.

REFERENCES:
Request to Access Protected Health Information (PHI)
MI Choice Waiver Guidelines for Supports Coordination

MI Choice Waiver Reporting Requirements Policy and Procedure

Policy: CC.1.33	**Effective Date: 7.21.15**
Approved: Tom Curtis**, CEO**	**Revised: 11.15.15**

SCOPE: This policy applies to the MI Choice Waiver program and the reporting requirements implemented by MDHHS.

POLICY: Senior Resources will submit timely required reports to MDHHS that:

- Accurately reflect the information required by contract
- Are in compliance with MDHHS's terms, standards and conditions.

Achieving compliance with this policy is a responsibility shared by the Chief Executive Officer (CEO) and the MI Choice Waiver Director.

PROCEDURE: See attached grid for list of required reports, who is to receive them at MDHHS, and who is responsible to complete the report on behalf of Senior Resources.

REFERENCES:

MI Choice Waiver Agency Report Schedule