

**DEPARTMENT OF HEALTH AND SENIOR SERVICES  
DIVISION OF AGING AND COMMUNITY SERVICES**

**GLOBAL OPTIONS (GO) FOR LONG TERM CARE FOR NURSING FACILITY  
TRANSITIONS (NFT)**

**SUBJECT: Care Management Monitoring of Services**

**PURPOSE:** Care Management, for Global Options, is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a participant's health and welfare. It is characterized by advocacy, communication and resource management and promotes quality and cost-effective interventions and outcomes.

The Monitoring of GO Services by Care Managers, and the oversight provided by the State, ensure that a participant's continued enrollment in the Global Options (GO) program is justified; and that assessed services are provided as agreed upon and authorized in the Plan of Care and delivered by qualified approved providers.

**IMPACT:** If monitoring oversight is not provided to measure performance of the Global Options program, standards may not be met and participant satisfaction and safety may be compromised.

Moreover, the State will not be able to provide evidence-based information to demonstrate quality assurance and improvement efforts related to Home and Community Based Services (HCBS) Medicaid Waivers and thereby justification for continued Federal funding.

With regards to Monitoring of Services, the Care Manager serves dual roles – one as the primary service coordinator, assessing, evaluating and authorizing services for participants; and the other as a local administrator of State and Federal funding to operate Home and Community Based Service programs statewide.

**PROCEDURE:**

**ROLES AND RESPONSIBILITIES**

**1. Participant or his or her Representative:**

- Verifies that authorized services are in place.
- Expresses concerns when the program or services are not meeting expectations.

- Acknowledges and actively engages in defined participants' responsibilities

## 2. **Service Providers:**

- Render services that have been authorized by the Care Manger.
- Submit invoices to the Fiscal Billing Agent(s) only for services that have been authorized and provided.

## 3. **Care Manager:**

- Secures a complete Referral Packet from OCCO which includes the Transition Plan.
- Completes preliminary data entry and documents for enrollment such as the Client Profile and CP-5 (Enrollment Letter).
- Contacts the GO participant as soon as possible following his or her discharge from the nursing facility to plan an initial home visit.
- Conducts the initial home visit within two weeks, if possible, of the GO participant's discharge from the nursing facility.
- Completes the Plan of Care (WPA-2) within 30 days of the GO participant's discharge from the nursing facility. The POC:
  - A. Ensures that the health and related needs of the participant are clearly identified, addressed, and reassessed.
  - B. Is developed with the assistance of the participant and includes personal goals, informal supports, formal service providers, risk factors, back up plans, and unmet needs.
  - C. Addresses the needs identified in the assessment tool.
  - D. Is signed and dated by all parties.
  - E. Is updated as needed, to identify participant needs, and the services that will address those needs.

\* NOTE: The Division of Aging and Community Services (DACS) has developed a Policy and Procedure Guideline that should be referenced and adhered to when Care Managers complete the Plan of Care.

\* For GO participants residing in an Assisted Living setting, the 'Care Plan Process for Assisted Living Participants' remains the same - see Policy Memorandum, 2004-8, IX-1, August 6, 2004.

- Arranges for and secures approved Providers to render services identified in the POC. These include Traditional Medicaid-enrolled Providers, Non-traditional DACS-approved Providers, or Participant-Employed Providers.
- Executes the Individual Service Agreement (ISA) authorizing services when necessary.
- Monthly Contacts with the GO participant. The contact must be made directly with the participant -- or the participant's representative if the participant is cognitively impaired or non-responsive -- either by telephone or face-to-face, and documented in the Monitoring Record. Messages left on voice mail, through a note left on the door, or indirectly through communication with providers does not satisfy this requirement.
- Quarterly Visits with the participant every three months. At least every six months, the visit must occur in the participant's home.
- Documents care management activities in the Monitoring Record. The documentation should be brief but comprehensive and legible, and include:
  - A. updated information about the participant's well-being;
  - B. any changes in supports or health condition;
  - C. significant happenings since the previous contact;
  - D. verification of the delivery of services or unmet needs; and
  - E. client satisfaction.
- Service Verification. Communicates with Service Providers at least quarterly to verify that the services being delivered as authorized and continue to be appropriate, and to determine if the provider has concerns about the participant's status.
 

\*The DACS 'Assisted Living Verification of Services' policy remains the same and is still to be adhered to by the CM when a GO participant resides in an Assisted Living setting.
- Completes the Level of Care Re-evaluation at least annually. However, the Care Manager is responsible for continually assessing the participant's needs to determine whether he or she continues to meet clinical eligibility criteria for GO. If the participant is no longer eligible, the CM will pursue the steps for voluntary withdrawal from the program, and if necessary request a Pre-Admission Screening assessment from the Office of Community Choice Options (OCCO) to determine clinical eligibility.
- Develops the Service Cost Record which identifies service costs not to exceed the cost cap for each participant. Exceptions based on need must

be authorized accordingly. Authorized services are intended to supplement rather than supplant informal supports.

- Maintains other documentation in the case file such as:
  - A. Inter- and Intra-agency communications
  - B. Fax remission forms
  - C. Agency required documents

### **Forms Associated with Monitoring**

1. Pre-Admission Screen (MDS-HC or MI-CHOICE tool) – proof of clinical eligibility.
  2. Long Term Care Referral (SINQ, CP-2, PA-3L) – proof of financial eligibility
  3. Transition Plan (Choice of Care)
  4. Notification of Program Enrollment (CP-5)
  5. Release of Information
  6. Agreement of Understanding (CP-28)
  7. Plan of Care (WPA-2) or Resident Service Plan for Assisted Living Residents along with the Care Plan Approval Form
  8. Level of Care Reevaluation
  9. Service Cost Record
  10. Monitoring Record
  11. If applicable, the following forms or documentation, should also be filed:
    - Cost Share (signed, dated and proof of reviewed every six months, updated annually)
    - Room and Board Supplementation for Assisted Living residents
    - Proof of Verification of Services as performed by Assisted Living facility
    - Withdrawal Form (CP-18)
    - Notification of Program Disenrollment (CP-23)
- Data Entered onto HCBS Website –
- Client Profile (WPA-6)
  - Individual Service Agreement (ISA) for services identified in POC, signed by participant if Participant Employed Provider is used)

## **Administrative Responsibilities**

- The NJ Department of Health and Senior Services' Division of Aging and Community Services (DACS) has developed monitoring protocols, new survey tools and an on-site review schedule - all with the intention of discovering and quantifying findings with regard to program administration in areas such as:
  - Eligibility and level of care determination;
  - Plans of care;
  - Provider qualifications;
  - Participant health and well-being, including whether they are afforded choice and the ability to direct their own care;
  - Administrative authority and responsibility; and
  - Fiscal accountability
  
- The most significant method currently utilized by DACS staff, to ensure that all quality assurance standards are being met, is the statewide on-site monitoring reviews of all care management agencies.
  
- Upon the conclusion of the on-site review, a **Summary Report / Follow-up Letter** is sent by DACS to the care management agency within 30 business days of the visit to outline the conclusions of the quality assurance survey. If a **Corrective Action Plan** is warranted, the care management agency has 30 days from the date of the letter to respond.