Diversion and Transition Coordinator guide

Fall 2025 – Updated Sept. 29, 2025

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Purpose

This manual consolidates guidelines, policies, and processes affecting Diversion/Transition (DT) Coordinators, providing an up-to-date guide on best practices, definitions, and program information. It serves as a quick reference or supplement to Case Management Tools. Teams should adapt its use based on regional needs and workflows.

Mission and Focus

The mission of the Office of Aging and People with Disabilities (APD) is to help consumers:

- Remain as independent as possible
- Sustain the supports needed to maintain quality lives in their home communities
- Honor choices made by them about their own lives
- By promoting value-driven commitments in statute and policy; and
- By partnering with advocacy groups, commission and councils, local government partners, and community organizations.

Definitions

ACS – Acute Care Setting, also refers to the benefit available to eligible consumers to access OSIPM coverage while receiving skilled services under their Medicare benefit. See OAR 461-135-0745 for eligibility details.

Acute Inpatient Care Facility - A licensed hospital with an organized medical staff, permanent facilities that include inpatient beds, and comprehensive medical services, including physician services and continuous nursing services under the supervision of registered nurses. These facilities provide diagnosis and medical or surgical treatment primarily for, but not limited to, acutely ill patients and trauma patients.

Bariatric - Relating to providing services or supports such as durable medical equipment for people who are obese, which are necessary for the safety or comfort of the individual.

Community Based Care (CBC) - Waivered services that include In-Home (Live-In, Hourly, Spousal Pay, ICP), Adult Foster Home (AFH), Assisted Living Facility (ALF), Resident Care Facility (RCF), Endorsed Memory Care Communities, Specialized Living and Specific Need Contracted placements.

Community Based Facilities (CBF) – Includes AFH, RCF, ALF, Specialized Living, Group Care Homes.

Collaborative Care Organizations (CCO) - Managed health agencies that contract with the Oregon Health Authority to manage the medical benefits for Medicaid recipients. CCO also manage dental and mental health benefits as well as transportation for medical services. Currently, there are 16 CCO's operating in Oregon. The Coordinated Care Support Unit Assignment List provides local office with a representative from each CCO. The contact person can be helpful if you are having challenges.

Complex Case Team (CCC) – A team of Central Office policy analysts that support local office's need for assisting in finding placement for consumers with little or no options for receiving services. An appropriate referral would be if the individual has had a series of failed placements, or they are between placements and have been refused by multiple providers; and if the manager approves the referral; and if the CM/DT has exhausted all local resources. A referral form (Form 2841) is requested, to be sent to APDComplexCase.ConsultationTeam@odhsoha.oregon.gov . If you have questions about this program, please refer to the CCC section of this manual.

Diversion - The process of developing a service plan that offers an alternative to an institutional setting (long term care placement).

Diversion cases shall be monitored to ensure the stability of the move for a minimum of 30, and up to 90 days (please see Transmittal APD-IM-25-048 for the full monitoring practice). A person may be a patient in an acute care setting (inpatient in a hospital) or diverting from a failed placement where there was risk for nursing facility placement.

Diversion/Transition Coordinator (D/T) - The position designed to focus on assisting individuals in the process of moving out of a hospital or nursing facility and securing community placement for individuals with high risk for entering long term care services. Also referred to as Transition Coordinator (TC) or Diversion Coordinator (DC) depending on the team.

Diversion/Transition Special Needs – OARs 461-155-0526 and 461-155-0710. A one-time special needs payment that can be used, as a last financial option, for Medicaid individuals qualifying for long term services and supports (LTSS) (allowed for OSPIM individuals in Long Term Care or K Plan, but not MAGI or SPPC). To potentially qualify for this special need, the case first must qualify for diversion or transition. Funding is used when no other community resource or natural support funds are available, and the individual cannot afford item.

Durable Medical Equipment (DME) - equipment provided by durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) providers or home health agencies that is designed for medical use, durable, and suitable for home use. Examples include wheelchairs, crutches, and hospital beds, along with necessary supplies and accessories for effective use.

Intellectual or Developmental Disability (IDD) - Any mental and/or physical disability manifested before the age of 22 that may continue indefinitely and result in substantial limitations in three or more of the following life activities: self-care, mobility, independent living, receptive and expressive language, learning, self-direction and economic sufficiency.

Interdisciplinary Team (IDT) - Provides comprehensive information to provide information and helps create an ideal service plan, often meeting individually or via phone/email or during formal care conferences. Care conferences at a hospital could include hospital or NF staff, the case manager, or receiving staff. In a nursing facility. The TC plays a key role in offering resources, coordination, advocacy, and service plan authorization.

Home and Community-Based Services (HCBS) - services provided in the home or community of an individual. HCBS are authorized under the following Medicaid authorities:

- 1915(c) - HCBS Waivers;
- 1915(i) - State Plan HCBS; or
- 1915(k) - Community First Choice (K State Plan Option).
- HCBS are delivered through the following program areas:
    - DHS, Aging and People with Disabilities;
    - DHS, Office of Developmental Disabilities Services; and
    - OHA.

Holistic Assessment - The consideration of several components that impact the individuals' physical, psychological, social, cultural, environmental, spiritual and

financial wellbeing. These components can be brought together to develop a higher quality service plan.

Institutional Settings - An establishment designed to provide targeted services. Institutional settings are highly regulated and are considered the costliest service model. Institutions include the Oregon State Hospital (Oregon's primary state-run psychiatric facility for adults), Nursing Facilities – Skilled Care (SNF), Nursing Facilities- Intermediate Care Facility (ICF) and Acute Care Hospitals (In-Patients).

Intermediate Care Facility (ICF) - Refers to a long-term care nursing facility. A nursing facility will not have a room & board payment because the rate is "all inclusive". Consumers need to meet SPL 1-13 to qualify for Medicaid paid services in ICFs. Sometimes, ICF is referred to as "long term care" or "institutional" living. It is a non-skilled stay in a nursing home. There are two different rates for Medicaid under ICF; a basic NF rate and a Complex Medical rate. The Medicaid resident will pay a liability to the NF and the Personal Incidental Fund.

Long Term Care Community Nursing Services (LTCCN) – A service that can be requested by the DT/CM for Medicaid clients living in an AFH or in-home setting. DT/CM will request services when approved nursing services are needed to help support the individual living independently in the community. Services include assessing and delegation of insulin injections, for example. See OAR 411-048-0160-23.

Medications at Discharge - NF discharge medication to accompany the resident must be on the written order of a physician. See OAR 411-086-0260, (3) (e).

Monitoring - D/T cases require the Diversion/Transition Coordinator to ensure that the post transitional services are adequate to meet the service needs. Cases should be held for typically 90 days, but in certain scenarios D/T coordinators can transfer the case earlier. If a case is to be transferred to a different D/T Coordinator or an ongoing Case Manager prior to the end of the 90-day monitoring time, best practice is to take appropriate communication steps to ensure a warm hand off to the new worker. Please see Transmittal APD-IM-25-048 for more information about the 90-day hold practice.

To be considered a successful transition or diversion, the individual would need to be living in HCBC for at least 90 days. It is also considered a successful D/T in cases where the consumer's death occurs due to natural causes, not neglect or abuse, prior to the 90-day post-discharge period.

Nursing Facility (NF) – An institutional setting designed for both rehabilitation skilled (SNF) and/or long-term care (ICF) services. Some nursing facilities do not serve both populations, for example a NF may be just for ICF services only. Generally, medical insurance will have benefits to cover the skilled stay but not the long-term care. For long term care, a Medicaid individual would need to qualify for Medicaid service eligibility (SPL 1-13). For SNF services, the Medicaid individual does not have to meet SPL 1-13.

Person Centered Care Plan - A care planning process directed by the individual who is transitioning. The focus of the service plan involves empowering the individual regarding preferences, needs and strengths.

Post Hospital Extended Care (PHEC) – Up to a 20-day stay in a nursing facility for non-Medicare clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre- admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO. See specific section below for OAR and further information on this topic.

Pre-Admission Screening (PAS) – The assessment and determination of a potential Medicaid-eligible individual's need for nursing facility services, including the identification of individuals who can transition to community- based service settings and the provision of information about community- based alternatives. This assessment and determination are required when potentially Medicaid-eligible individuals are at risk for admission to nursing facility services. PAS may include the completion of the federal PASRR Level I requirement (42 CFR, Part 483, (C)-(E)), to identify individuals with mental illness or intellectual or developmental disabilities. See specific section below for OAR and further information on this topic.

Pre-Admission Screening/Resident Review (PASRR) – The federal requirement, (42 CFR, Part 483, (C)-(E)), to identify individuals who have serious mental illness or developmental disabilities and determine if nursing facility service is required and if specialized services are required. PASRR includes Level I and Level II functions. See specific section below for OAR and further information on this topic.

Prior Authorization - The local APD or AAA office participates in the development of proposed nursing facility care plans to assure the facility is the most suitable service setting for the individual. Nursing facility reimbursement is contingent upon prior authorization.

Private Admission Assessment (PAA) - The assessment that is conducted for non-Medicaid residents as established by OAR 411-071, who are potential admissions to a Medicaid- certified nursing facility. Service needs are evaluated, and information is provided about long-term service choices. See specific section below for OAR and further information on this topic.

Skilled Care – A medical benefit health insurances, such as private insurance and Medicare/Medicaid can cover. The service is provided in nursing facilities that are approved to provide skilled care (not all NF have skilled services, some NF are ICF only). Skilled care is typically rehabilitation services that follow an inpatient hospitalization of at least 3 nights in the hospital; include physician's orders for admission to the skilled care unit and the patient has some need for the service, such as physical therapy, occupational therapy or speech therapy or nursing.

Skilled Nursing Facility (SNF) – A nursing facility that is approved to provide skilled care.

Special Needs Payment - OAR 461-155-0526, 0600, 0630, 0660 and 0710. Special needs funds are used to help support preserving community living situations or assisting the individual with financial coverage of equipment or services that create a barrier to discharge, if not purchased.

Specialized Living Services - A home-like environment for a specific target group who are eligible for a live-in attendant but because of special needs, are unable to live independently or receive services in other community- based care facilities and who would otherwise require nursing facility care. Admissions to these settings require prior approval from central office.

Specific Needs Contract (SNC) – A contractual agreement between a provider and DHS to deliver Medicaid services specifically at one location for a certain reimbursement rate that requires that provider to deliver a distinct number of services and goods, as outlined in the contract's Statement of Work.

Admission requires approval through central office through the 494 form and process.

"Touring" or "Shopping" Facilities - The process of visiting the potential CBF, prior to moving in. If there is no available transportation, the KPlan Transition services may be utilized.

Transition - The process of developing a HCBC service plan designed to assist a Medicaid client who is currently receiving services in an institutional setting (long

term care). The transition process includes completing an updated assessment; interviewing the individual and determining where they would like to receive their services; meeting with the interdisciplinary team as needed (this may include individual, their representative or family, discharge planner, RN, new providers, mental health), touring potential facilities, a home visit to see what home modifications are needed; gathering bids for modifications, arranging for household items and DME products. The D/T would verify that the transition day itself goes smoothly and is typically present for the actual move. All transitional cases shall be entered into the D/T Database.

Training Guidelines

Required Training

Please discuss all required DHS and locally required trainings with your leadership team. Regularly scheduled required case management trainings are also required for Diversion/Transition staff.

Recommended Training

Workday has a training on PointClickCare that is useful for tracking consumers in facilities.

Requests for local trainings or submission of training topics are encouraged and can be sent to the Transition Services Analyst at DT.Policy@odhsoha.oregon.gov.

Roles and Responsibilities

Diversion and Transition Focus

D/T coordinators should concentrate efforts on the following target populations:

- Longstanding Nursing Facility (NF) residents.
- “Spend down” NF residents.
- NF residents receiving skilled nursing services.
- Consumers who need increased support in their current Home or Community Based Care setting (HCBC) to avert a NF placement.

    - Note: this is up to local office management to determine if the specific circumstances where the situation and consumer's needs justify DT involvement in the case.
- Consumers who are in a hospital and require supports to return to their existing HCBC setting.

Diversion and Transition Services

There are three main types of services provided by the D/T Coordinator:

1) Diversion: services to help a person discharge out of a hospital into a CBC or in-home, rather than a NF.
2) Transition: services provided to move a person out of a NF or hospital.
3) Nursing Facility Authorization: Also referred to as a Pre-Admission Screening, this authorizes a NF placement for a Medicaid-funded client in a long-term care setting. Ultimately, the goal is to eventually move the consumer out of the NF, but sometimes consumers do need placement there for time to rehabilitate.
    a. Note: this depends on local office procedures and determination.

Specific Roles and Responsibilities

The following roles and responsibilities are often identified as a priority for a local Diversion/Transition Coordinator:

- Be familiar with the information and resources found within this guide and D/T SharePoint site.
- Complete Pre-Admission Screenings for the local service area, depending on local area policies.
- Authorize nursing facility placement for Medicaid-funded clients going into long-term care.
- Identify all current Nursing Facility residents that could transition to a lower acuity setting.
- Monitor clients that are either Post Hospital Extended Care (PHEC) or Medicare Skilled for transition potential prior to going long-term care.
- Create a relationship of trust with the client and discuss placement options for them in the community.
- Identify family, friends, and legal representatives that are involved with the client and communicate with them as appropriate.

- Create, review, and update CA/PS assessments to provide for a comprehensive placement plan, depending on local area policies and available staffing.
- Identify and address all barriers to placement in a community-based setting or in-home.
- Locate qualified provider and placement options for a client.
- Arrange visits; verify supports and additional needs to create a safe placement.
- Identify and facilitate provider/caregiver training.
- Assist clients in preparation for the move.
- Follow county to county best practices if applicable.
- Monitor and follow up with client, provider, family, and legal representatives for up to 90 days after the move, or fewer days if a case manager hand-off is appropriate.
- Ensure an orderly and timely transfer of case to ongoing case manager.
- Provide training and case consultation to case managers and other staff.
- Update OR ACCESS and D/T databases with client information and outcomes as appropriate.
- Enter direct and in-direct contacts into OR ACCESS as completed.

D/T Coordinator Competencies

Diversion/Transition Coordinators need to be knowledgeable, experienced, trusted, and compassionate individuals. A highly skilled D/T Coordinator listens to individuals to identify their needs and goals, supports them as they weigh their options, connects them with the right type of care in the right setting, and anticipates and prevents problems with care delivery. D/T Coordinators have knowledge about:

- Issues confronting older adults and individuals with disabilities;
- The full range of long-term service and support options available in a community;
- Eligibility requirements of Medicaid services, potential placements, and wrap arounds services including but not limited to contracted placements, K-Plan Ancillary Services, local community programs, Long Term Care Community Nurse, etc.
- Related and relevant public policies and programs including exceptions, behavioral supports, programs offered through the local county.

Diversion/Transition Coordinators are responsible for using all resources available to them to initiate wrap-around services and supports including but not limited to:

- Transportation of consumer and their belongings
- Behaviors Supports Services
- Long Term Care Community Nursing
- Adult Day Services
- Durable Medical Equipment
- Assistive Devices
- Chore Services
- Home Modifications or Repairs
- Transition Services such as household items, furniture, personal items, moving costs, ID replacement
- Diversion purchases that are not covered under other payment options
- Connection to community resources

Pre-Admissions Screening

Pre-Admission Screening – (PAS). The process of evaluating the individual who is nearing admission to ICF Medicaid paid service and includes a face-to-face visit, verifying the individual qualifies for Medicaid services (SPL 1-13). Because a representative of the division is the only person who can approve a Medicaid payment, the PAS process can only be completed by a Medicaid staff (unlike the completion of the PASRR level 1 screening, using 460 form, which can be completed by "non-Medicaid personnel" such as a discharge planner at the hospital).

The PAS process should be completed in a timely manner and allow the D/T team to schedule a visit, complete a determination of qualification for Medicaid services (SPL 1-13), placement choice counseling and a development of a diversion or transition plan before approving the person for admission to ICF Medicaid payment. The Medicaid office has the right to deny the Medicaid payment if this process is not followed.

PAS includes:

- An assessment;
- The determination of an individual's service eligibility for Medicaid-paid long-term care or post-hospital extended care services in a nursing facility;

- The identification of individuals who can transition to community-based service settings;
- The provision of information about community-based services and resources to meet the individual's needs; and
- Transition planning assistance as needed.

For more information, refer to OAR 411-070-0040.

The PAS assessment can be conducted by a case manager or other qualified APD or AAA representative using APD's Client Assessment and Planning System (CA/PS) tool, and other standardized assessment tools and forms approved by APD.

A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a nursing facility when short-term nursing facility services are needed. A face- to-face assessment including the discussion of alternative community- based services and resources shall be completed within seven days of the initial, short term nursing facility service approval.

Payment for nursing facility services may not be authorized by APD until PAS has established that nursing facility services are required based on the individual's service needs and Medicaid financial eligibility has been established.

Any facility that admits an individual for nursing facility level of care that has not had a Pre-Admission Screening (PAS) will not be reimbursed by Medicaid for the days not prior authorized.

Individuals that qualify under our current assessment for long-term care services, who have had the appropriate PAS work completed, and have had community options provided to them and still choose to admit to the nursing facility have a right to that level of care and may be reimbursed for this level of care once the Department has completed the prior authorization.

Individuals should exhaust their PHEC or other skilled benefits before accessing long-term care nursing facility services.

Implementation/transition instructions: Any facility requesting Medicaid payment for days without prior authorization will not be authorized in the Plan of Care to bill for those days.

Pre-Admission Screening and Resident Review

Pre-Admission Screening/Resident Review (PASRR) - Level 1 (form 460). This process is required by the federal government and is designed to ensure that all potential NF admissions have been screened for indicators of Intellectual/Developmental Disability (I/DD) or Serious Mental Illness (SMI). The information is captured on the 460 form. This form can be completed by Medicaid staff as well as non- Medicaid staff and is most commonly completed by the hospital discharge planner. The form should be forwarded to the NF prior to admission. The 460 form is not an approval for Medicaid payment for nursing home stay.

If there are indicators of I/DD or SMI, a PASRR Level 2 will be required prior to NF admission. The PASRR Level 2 is completed by central office staff. Individuals with I/DD or SMI indicators (without a PASRR Level 2) may enter a NF if the conditions of categorical determinations are met. See SDS 460 INS for instructions. The SDS 460 form can be filled out by hospital discharge planners, Medicaid staff including a D/T or CM.

- PASRR is required for individuals, regardless of payment source, with either mental illness or developmental disabilities who need nursing facility services. The purpose is to prevent placing individuals with mental illness or intellectual or developmental disabilities in a nursing facility, unless their medical needs clearly indicate that they require nursing facility level of service.
- Federal regulations (Title XIX) require utilization review and quality assurance reviews of Medicaid residents in nursing facilities. The reviews must meet these requirements:
    - Staff associated with APD are required to maintain service plans on all APD residents in nursing facilities. The frequency of their service plan update shall vary depending on such factors as the resident's potential for transition to home or community-based care and federal or state requirements for resident review.
    - Authorized representatives of APD or the authorized utilization review organization must have immediate access to APD residents and to facility records. APD or the authorized utilization review organization representative must be able to make and remove copies of charts and records from the facility's property as required to carry out the above responsibilities.

- APD or the authorized utilization review organization representatives must have the right to privately interview any APD residents and any facility staff in carrying out the above responsibilities.
- APD or the authorized utilization review organization representatives must have the right to participate in facility staffing on APD residents.

PASRR Central Office Contacts

PASRR Policy:

- Policy specific questions: Kathryn Nunley, 503-947-2309, Kathryn.M.Nunley@odhs.oregon.gov
- General PASRR questions: OR.PASRR@odhsoha.oregon.gov

Intellectual and developmental disabilities (I/DD):

- Rachel Olson, PASRR Level II Coordinator, Rachel.Olson@odhs.oregon.gov

Serious Mental Illness:

- Nirmala Dhar, 503-945-9715, Nirmala.Dhar@oha.oregon.gov. Please contact Nirmala to request a current copy of mental health contacts.

Placement Choice Counseling

Introduction

Individuals in need of LTSS often face a complicated patchwork of service options and need assistance exploring the public and private programs available to them, navigating eligibility and enrollment requirements and weighing other factors that affect their ability to live independently.

Placement Counseling Overview and Functions

The placement options counseling process is designed to educate individuals about the range of long-term services and supports available and to assist them in selecting the LTSS option that will best meet their needs. This process is directed by the individual (and may include others that the person chooses), and is centered on the individual's preferences, strengths, needs, values and individual circumstances. Placement options counseling should be offered to any individual

who seeks long- term services and supports, irrespective of their age, socioeconomic status or need.

Options counseling leads to the development of a unique, person-centered plan of care, enrollment in a Managed Long-Term Services and Supports Plan, enrollment in a PACE program, or selection of other LTSS options. Given the unique needs of each individual, there is no single “correct” approach to options counseling. The following components, however, ensure that individuals receive comprehensive, timely, conflict-free counseling that results in a robust, person-centered plan of care.

Placement Options Counseling

Either a case manager or DT Coordinator will conduct options counseling, depending on local management policies and priorities. An individual may need options counseling if they:

- Request or indicates an interest in receiving information or advice concerning long-term support options;
- Are referred by a hospital, nursing home, assisted living home or other long-term residential setting, home and community-based waiver services provider or another agency;
- Has had a recent change in life situation, resulting in a greater need for LTSS;
- Has had a recent change in health status, resulting in a greater need for LTSS;
- Needs assistance coordinating their LTSS and health care needs across many services and systems;
- Has LTSS needs but is unsure about the process of accessing services or what services will best meet their preferences or needs;
- Is requesting assistance in transitioning from one living situation to another;
- Is admitted to the hospital and needs to know what they should be planning for once discharged;
- Was denied eligibility for Medicaid or another public program and needs decision support about other options (likely performed by ADRC);
- Lacks awareness of existing community resources and supports and could benefit from decision support and education around their options;
- Has cognitive impairment and could benefit from support about early intervention, caregiver support, or LTSS related to dementia;

- Has behavioral health needs and would like support on options related to their specific needs or situation;
- Has family or caregivers who request or require additional information.

Even if an individual has received options counseling in the past, they may require additional options counseling as personal needs and circumstances change.

Options Counseling Step 1: Assessment of goals, values and needs

Placement options counseling begins with a preliminary interview where the D/T can assess an individual's need for long-term services and supports, assess their existing supports, and explore individual strengths, values and goals. To ensure timely delivery of long-term services and supports, D/T should determine an individual's clinical/financial eligibility for public programs early in the process. During the initial assessment, D/T will evaluate an individual's short and near-term risk for long-term nursing home placement.

Options Counseling Step 2: Exploring Options/Planning

Based on the individual's needs, strengths and goals, as identified in the preliminary interview, D/T Coordinators should support individuals in considering the full range of services available to them. During the exploration phase, D/T should offer comprehensive, accurate, unbiased information about all available services. D/T will help participants weigh the pros/cons of various options, explore potential costs and benefits of services, and offer other decision supports. A D/T Coordinator should not make judgments on behalf of the individual or withhold information about appropriate options.

Long-Term Care Placement Options in Oregon

- Adult Foster Home (AFH)
    - Capacity of 5 or less
    - Home-like environment
    - Provider and family often live in the home
    - Providers can obtain a designation as a ventilator home
    - Specific Needs Contracted options for consumers with higher needs
- Residential Care Facility (RCF)
    - Can have private or shared rooms
    - Community meals
    - Can be endorsed as Memory Care Community (MCC)

        - Consumer must have a dementia type diagnosis
        - Only Medicaid LTSS option that can be locked
- Assisted Living Facilities (ALF)
    - Apartment-like setting
    - Often private rooms
    - Many have policies requiring the consumer to be a certain age
    - Community Meals
    - Specific Need Contract options available for consumers with higher needs
- Specific Needs Contracted Options for consumers with higher needs

Options Counseling Step 3: Develop a long-term support plan

After an individual has developed a plan to meet their LTSS needs, the D/T Coordinator should assist the individual in connecting with appropriate service providers. This may include facilitating enrollment in public programs, identifying appropriate providers, employing a fiscal intermediary such as money management program or rep payee and other services. If there is a delay in finding placement, inability to access skilled care benefits or that crisis situations call for immediate intervention, the D/T Coordinator may authorize short term Nursing Facility (ICF level) stay while continuing to seek Home or Community Based placement options for the consumer.

Options Counseling Step 4: Follow-up

D/T Coordinators should monitor consumers for up to 90 days after their placement which includes periodic follow-up to ensure that individual needs are being met, to modify the transition plan as necessary to adapt as circumstances change or other wrap-around service needs are identified.

County to County Moves

Statewide, each AAA and APD Diversion/Transition team has different processes and resources available. When given the opportunity to connect with a different team, it may be helpful to take time to share common practices of your area and to learn about the other team's processes, strengths and needs.

County to County Diversion/Transition Guidelines

County to County coordination is a part of the person-centered planning process, which includes the CMS waiver requirement to identify risks and interventions. This process will identify available resources to meet identified risks/needs and seek to mitigate transfer stress for the client. The goal is for successful placement and transfer of cases between branches. Coordination between counties will ensure a safe, smooth transition for clients from one setting to another.

County-to-County Definitions

Receiving D/T Coordinator: The member of the Diversion/Transition team who will coordinate transition services with the sending D/T Coordinator and assist with monitoring duties after the consumer has moved into the receiving worker's county.

Receiving CM: The worker the sending D/T Coordinator connects with if the receiving county wishes the ongoing Case Manager to assume coordination and monitoring duties.

Sending D/T Coordinator: The member of the D/T team who is coordinating the transition or diversion for the consumer who is moving to a different county.

Placement: It is the expectation for all transitions and diversions from one county to another that the consumer is moving into a CBC setting in the new county. However, this may not always be the case.

Prior to Transition or Diversion:

- Sending D/T will open the Transition Team Contact List located on the Diversion/Transition SharePoint site and identify the contact person(s).
- Sending D/T will call one of the receiving county's identified persons found on the D/T contact list:
    - To ask the receiving county to identify a receiving D/T or CM and their manager who will be responsible for staffing the case.
    - This should be done at least 3 days prior to discharge date.

- Receiving office will respond to these requests within 2 business days providing the name of a D/T or CM and their manager who the sending D/T can coordinate the transition or diversion with.

Sending D/T will coordinate a call with receiving D/T or CM to discuss the following:

- Date of Move
- Placement information
- Reason for out of county move
- Transportation
- Durable Medical Equipment/Assistive Devices
- Household and personal items a consumer may need
    - In-Home items including furniture, clothing, cleaning supplies, basic food necessities, locks, etc.
    - AFH, ALF, RCF items that the provider is not required to provide
- Wrap-around services
    - Behavioral Support Services and mental health needs
    - LTCCN
    - Exceptions
- Insurance/Primary Care Provider/Health Care Provider Concerns
- Medication supplies

The receiving office will share the following information:

- APS or Licensing concerns about provider
- Coordination questions
- Any resources they think would make the transition/diversion successful

Both parties will agree on who will be responsible for required in-person visits and follow up actions that must be taken within the first 90 days.

- If errors occur or wrap-around services are not completed both parties should work together as a team to resolve them.
- The sending office is responsible for taking the lead on resolution
- Unless there is a restriction of admission or other sanctions limiting admissions on the potential provider, the receiving office cannot prevent the move as it is the consumer’s right to choose where they receive services.

- If the receiving office does not respond to the request for the conference call by the 3rd business day, the sending D/T will summarize the information in #4 and email it to the identified persons at the local office and move forward with the diversion/transition.
- The sending D/T worker will continue to send follow up emails as needed.

The sending TC is responsible for up to 90 days remote monitoring as follows:

- Minimum phone check-in and narration review at 7th, 30th, 60th, 90th day
- If in-person visit is needed, negotiate with receiving office
- Ensuring wrap-around supports are in place
- Trouble shooting that can be done remotely
    - If a move out notice is issued during the 90 days both parties will work together on a plan to stabilize or divert the consumer.

Specific Need Contracted Placement – Additional Responsibilities

- Identifying an ongoing CM or receiving CM or DT (for out of county moves) is an essential part of the contract case coordination.
    - If the case is staying within your district or county you need to identify the ongoing CM or ongoing CM leadership who will be available to staff the case and be part of Care Planning Team meetings once the placement is approved by Central Office.
    - If the case is leaving your county or district, please follow the guidelines referenced suggested in the county-to-county transition section above.
- Most contracts state that the transition or diversion cannot occur until a Care Planning Team meeting, also referred to as the Transition Care Conference, has occurred.
    - Contracted placements are not meant to be emergency placements, and Central Office understands that health and safety needs are an integral part of person-centered care.
    - If there is an identified and documented health or safety need requiring a quick placement, please staff with your leadership or Complex Case Team in Central Office.
    - The Care Planning Team meeting shall include the following participants:
        - What is required by the providers contract; or

- If the provider's contract does not define who is required to be there the minimum in attendance shall include:
    - Current provider or member of their caregiving team familiar with the consumers' care needs
    - New provider
    - Sending D/T
    - Consumer or consumer's representative

If at any time a CM or D/T worker has a concern about a contracted provider please contact the appropriate entities such as APS or Licensing and then the contract team at specific-needs.contract-team@odhs.oregon.gov

- The SNC team will forward any RCF or ALF concerns to the SOQ licensors at Central Office if they are sent to the email above
- If a contracted provider approves 2 or more consumers for only one available placement – please contact the contract team.

Courtesy Pre-Admission Screening:

Each county has a different process for how PAS are assigned to consumers within their county as well as how a courtesy PAS is assigned. Please follow these best practices to ensure as smooth as possible interaction between all parties. In this situation we will refer to the office where the case is housed as the "home office".

Best practices include:

- Often the NFs and hospitals will forget that they won't be working with the staff from the office in their area.
    - Communication between offices helps provide a consistent message to the NF or hospital regarding who is responsible for what actions on the case.
- If you are the county (home office) requesting the courtesy PAS, follow up with worker assigned to discuss the case and preferred communication approach.
- If you are the county performing the courtesy PAS, keep the home office up to date on your actions on the case.
    - If the nursing facility or hospital contacts you to act on the case other than the PAS – please refer them to the contact at the home office.

County to County Move FAQs

Is a case staffing with the receiving office required prior to placement?

- For standard CBC or in-home placement this is a best practice and is not required to happen prior to placement.
- For contracted CBC placement it is a required part of the 494 process.

What do I do if I have been referred to an ongoing Case Manager to staff the case and am not getting a response, or they do not seem to understand the purpose of my call?

- If they do not understand the purpose of your call – explain your role as D/T Coordinators and that you need to ensure a successful transition or diversion for your mutual consumer.
- If you are not getting a response, be sure to include your leadership and their leadership in your next follow up email.
- Local office leadership contact information is found on the DT/TC SharePoint database.
- If that is not successful, notify the Diversion/Transition Services Analyst to assist with coordination.

What information should the receiving office provide when the placement is denied or blocked?

- Concerns they have regarding provider's ability to serve the consumer, including APS or Licensing issues.
- Additional wrap-around services they think is necessary for a well-planned person-centered transition or diversion

Any other helpful information that would benefit the sending D/T and the consumer?

- A receiving office cannot "deny" a placement unless there is a restriction of admissions or sanctions on the CBC facility or AFH. The provider has the right and responsibility to screen and accept consumers into their facilities and consumers have the right to choose their placement.

Why do we staff transfers?

- Even for easy placements, moving is stressful for consumers as well as staff. Coordination between the receiving and originating office supports a person-centered approach and smooth transition.
    - Contracted placement staffing between sending and receiving staff is required as part of the 494 process.

Providers are soliciting new placements even when their AFH or facility is under investigation for APS allegations, licensing violations, prior to their contract being executed, or when they do not have vacancies. How do we share this information with other counties?

- Contact local AFH licensing or Central Offices CBC licensing team to inform them of the concerns.
- Additional information found on the LTC licensing webpage can be helpful to review when looking at placement options for consumers.
- Review this resource: https://ltclicensing.oregon.gov/
- Post substantiated or verified information on the Announcement section of SharePoint
- Discuss concerns when you are contacted for a case staffing
- Contact the Specific Needs Contract team at specific-needs.contract-team@odhsoha.oregon.gov

How do we follow these guidelines when a hospital or other facility places a consumer that a Diversion/Transition Coordinator is actively working without notifying the D/T Coordinator?

- Narrate that this happened.
- Email the receiving local office D/T contact as soon as possible and request a staffing.
- If the consumer is placed into an ICF setting and authorization was not given through the PAS process, the NF could potentially face non- payment until the PAS is complete and authorization is given.
- Check in with the new provider to see if consumer's needs are being met and if any additional wrap around services are needed.
- Contact the relevant party with additional questions:
    - D/T Services Analyst at dt.policy@odhsoha.oregon.gov

- Complex Case Coordinator: apdcomplexcase.consultationteam@odhsoha.oregon.gov
- Specific Needs Contract team: specific-needs.contract-team@odhs.oha.oregon.gov.

County to County Transition Best Practice Checklist

Please refer to D/T webpage on Case Management staff tools or SharePoint's DT document library for interactive or printable copies.

- Standard Placement: Sending D/T
  - Provider accepted consumer
  - At least 3 days prior to discharge – identify receiving D/T or ongoing CM contact
  - Staff case with receiving CM or D/T contact
  - Discuss wrap around service
  - Negotiate monitoring duties
  - Send recap email to receiving D/T or CM and their manager
  - Monitor consumer for up to 90 days
- Receiving Office
  - Respond to initial request within 2 business days
  - Identify the D/T Coordinator on Ongoing CM and their manager who will be responsible for the case
  - Coordinate and staff case with sending D/T or CM
- Staffing Topics
  - Anticipated Diversion or Transition Date
  - Placement Information
  - Reason for out of county move
  - APS or Licensing or other concerns about provider
  - Transportation arrangements
  - CCO or medical provider concerns
  - Durable Medical Equipment/Assistive Devices
  - Behavior Support Services (Referral recommended for every move)
  - Long Term Care Community Nurse (if applicable)
  - Exception details and in-person visit requirements of exception
  - Mental Health Services (if applicable)
  - Doctor's Orders and Medication
  - Any other applicable information

    - Monitoring visits – what in-person visits are needed (receiving D/T or CM) and what monitoring can be done remotely (sending D/T)
- Communication Barriers
    - 1st attempt via phone and email follow up – requesting staffing
    - 2nd attempt via email – requesting staffing, include managers/supervisors
    - 3rd attempt via email – summarizing case, include managers/supervisors
    - If no response after 3rd attempt, notify leadership and Transition Services Analyst
- Specific Needs Contract Placements
    - Includes offices within your own county or district
    - Identify receiving D/T or CM
    - Submit 494 for approval
    - Follow steps above under Standard Placement
    - Work with provider to plan Transition Care Conference
    - Sending D/T in attendance at Care Conference
    - Receiving D/T or CM or alternate at Care Conference
    - Cover staffing topics listed above during Care Conference
    - Consumer admits after Transition Care Conference

Specific Need Contracted Placements

Webpage on CM Tools: Specialized Services/Specific Needs Contracts

The APD 0494 form is used by local office staff to seek approval from Central Office prior to the placement of a consumer into a Specific Needs Contracted AFH, ALF or RCF.

Before completing the 494, document the following in OR Access:

- Past failed placements and attempts at finding placement including the date, provider name and reason for refusal. Or any extenuating circumstances that indicate the consumer cannot access care in a standard in-home or CBC placement.
- Date the contracted provider with a current contracted vacancy screened and accepted the consumer.

- Describe how the consumer meets the Target Group of potential provider's contract type. Email contract team for narration examples.
- Complete Section 1 of 494 in its entirety.
- CAPS must be completed within the last 3 months or with change of condition – whichever is more recent.
    - If a new CAPS is needed to meet this requirement, Buckley Bill process must still be followed or waived by consumer or the consumer's representative.
    - For in-district transitions the D/T will identify the ongoing CM who will be assigned to the case and enter their contact information under receiving DT/CM
    - For out-of-district transitions the D/T will contact the receiving D/T or CM team to identify the best contact for coordinating transition details within their district and enter the identified contact information under receiving DT/CM.
- Complete Section 2 of 494 in its entirety
    - Check boxes to confirm actions in this section are complete.
        - If you are being asked to submit a 494 by a provider or other sources and you cannot confirm one of these actions within the section have been completed, please do not check the box. Explain the situation in the body of the email when you submit the 494 so the reviewer knows it was left unchecked intentionally and why.
        - It is best practice to have verified all actions have occurred and that the boxes are checked to reflect that – otherwise the form may be returned as incomplete.
- Verify documentation can be found in OR Access Narration, CAPS and Client Details which support the consumer's eligibility for admission into the SNC placement.
- Submission of 494:
    - Best practice for workers new to the process is to have a member of local leadership team review for the following information:
        - Appropriateness of and reasoning behind the placement.
        - Verify the required information can be found in OR Access.
        - 494 is completed in its entirety.
    - Diversion/Transition Coordinator shall email request to APD.Admissions@odhsoha.oregon.gov with 494 attached.
    - Email should be sent securely using "494 request" in the subject line.

- Urgent requests should be flagged and have the word URGENT in the subject line
- Central Office strives to respond within 2 business days
    - If approved, D/T to assist with the completion the care planning team meeting, appropriate transition planning and admission of consumer.
    - If denied due to error, 494 can be resubmitted once corrected.

County to County best practices (located on the SharePoint site) are also a good resource to ensure that the consumer's wrap around services are in place and that the placement is stable.

512 Instructions: to be completed upon admission

These apply to all AFHs and the following CBC facilities: The Bridge, MacDonald Res, Orchards, and Fircrest. All other CBC facilities have the rate set up already.

After the 512 payment has been set up the DT/CM will:

- Email: APD.Admissions@odhsoha.oregon.gov with Consumer's name, consumer's prime, provider name, provider number and effective date.
    - In the email subject line, type "rate adjustment request".
- The DT/CM will receive an email back stating that the specific need rate has been added with instructions to "touch" the 512
- If the request is not sent during the same month as admission, an underpayment will need to be completed for the months that the provider did not get the contracted rate. The local office will be responsible for completing all underpayments.

Contact the following with questions:

- Admission questions or payment issues: APD.Admissions@odhsoha.oregon.gov
- Concerns about a SNC provider: specific-needs.contract-team@odhsoha.oregon.gov
- Providers interested in SNC: APD.SpecificNeedContractApplications@odhsoha.oregon.gov

Specific Need Contract Admission/Discharge/Target Group Reference Sheet for Adult Foster Homes

Adult Foster Home Contracts are negotiated by collective bargaining agreement. All other types of contracts (RCF, ALF, ECF) are negotiated individually without union representation. The below information is standardized information for all Adult Foster Homes.

Eligibility & Admission Process:

The Adult Foster Home must:

- Notify DHS of referrals, screen potential placements, and (if needed) obtain nursing consultation to determine appropriateness of placement.
- All people eligible for Specific Needs Services must meet the Target Group.
- All Medicaid placements must be prior approved by DHS, through the "494 process". Payment not prior-approved will not be reimbursed.

Discharge Process:

To discharge a consumer, Adult Foster homes must:

- Have the DHS Designee and the consumer's Care Planning Team prior review and approve the move.
- Ensure that the Care Planning Team has been convened in a timely manner, and documents that the Care Planning Team helped the consumer move and provided supports needed to help sustain a person in-home.
- Contractor shall complete a Form 492 "Resident Discharge Report Specific Need Contract" documenting all discharges.

Target Groups

Basic SNC AFH Target Group

- Eligible for Medicaid Long-Term Care Services per OAR 411-015.
- Currently residing a nursing facility or are being diverted from nursing facility placement.

- Documentation verifying that there is no access to a home or community care located in the community or unsuccessful placement in standard APD CBC settings.
- Requires full assist in mobility, toileting, eating, or cognition; and
- Daily, requires more than one direct staff for mobility, transfer, toileting or other ADL care; or
- Behavioral management requiring daily staff interventions, redirection or cuing and establishment of Behavior Support Services.

Advanced SNC AFH Target Group

- Eligible for Medicaid Long-Term Care Services per OAR 411-015.
- Currently residing in a nursing facility or is being diverted from nursing facility placement.
- Documentation verifying that there is no access to a home or community care located in the community or unsuccessful placement in standard APD CBC settings.
- Requires full assist in mobility, toileting, eating, or cognition;
- Daily, requires more than one direct staff for mobility, transfer toileting or other ADL care 24/7; and
- Meet at least one of the following:
    - Dangerous behavior which has resulted in hospitalization, criminal charges or caused injuries to self or others;
    - Physical or sexual aggression to staff or individuals;
    - Disruptive or agitated behaviors which occur several times a week;
    - Verbally abusive behaviors to staff or individuals which occur several times a week;
    - Refuses medications or health care services creating legal or healthcare risks to themselves or other individuals;
    - Has a Rehabilitation Plan developed and reviewed on a twice a year basis by licensed therapists and which requires daily interventions by trained caregivers;
    - Has complex medical, rehabilitation or psycho pharmacy regime requiring On-Site RN services more than once a week.

Complex Activities of Daily Living (ADL) SNC AFH Target Group

- Currently is residing in a nursing facility or is being diverted from nursing facility placement and;
- Eligible for Medicaid Long-Term Care Services per OAR 411-015 and;
- Require full assistance in one or more of the following ADL tasks mobility, transfer, toileting or eating and;
- Requires multi–person "hands on" ADL care or 2 person transfers on a daily
- basis and;
- Requires weekly onsite monitoring or assessment by a RN and
- One or more of the following:
    - has a Rehabilitation Plan which requires daily interventions by trained caregiver(s) or
    - requires weekly contact with primary care provider for an unstable medical condition or
    - is enrolled in Palliative or Hospice Care with a terminal diagnosis

Bariatric SNC AFH Target Group

- Currently residing in a nursing facility or is being diverted from nursing facility placement;
- Eligible for Medicaid Long-Term Care Services per OAR 411-015, at the time of admission;
- Require full assist in mobility, toileting, eating, or cognition;
- Has an ADL, medical or behavioral need requiring an Available, on-site second staff 24/7;
- Cannot be served in another home or community-based care Setting; and
- Has at least one of the following:
    - A physician's diagnosis of obesity with a body mass index calculation of 38 or greater on the date of admission
    - A deteriorating medical condition requiring weekly contact with a physician on a continuing basis e.g. Hospice Care
    - Have a health condition such as Tracheotomy, Ventilator Dependence, Renal Failure or uncontrolled Methicillin-resistant Staphylococcus Aureus (MRSA) type infection which requires:
        - Complex care coordination;
        - Durable Medical Equipment;
        - Onsite RN services of more than once a week; and
        - Interdisciplinary health team supports.

RCF, ALF contracts have been negotiated ion an individual basis. Their criteria can be found within their individual statement of work on the Specialized Services/Specific Needs Contract section of the APD Case Management Tools and Resources webpage.

Care Planning Team & Transition Care Conference

Care Planning Team: the team made up of the following persons: Diversion/Transition Coordinator, Contractor's Registered Nurse (RN), the Client and/or the Client's designated representative, and the Contractor. The Care Planning Team may expand the list of invitees as deemed necessary to include other parties; however, these additional parties are not mandated to attend under this Contract. Attendance may be done in person or by phone.

In most contracts the Care Planning Team is required to meet prior to admission to ensure safe and comprehensive transition plan is in place this is referred to as the Transition Care Conference. A Transition Care conference is best practice for any transition or diversion.

In all contracts the Care Planning Team is required to meet prior to a contracted provider or any staff employed by the provider issuing a move out notice or states the consumer cannot return to the AFH under the contract.

Unexpected Consumer Moves

The goal in these situations is to work collaboratively with offices throughout the state to make a transition as seamless as possible for our consumers. Cases that cross county lines will involve more collaboration and communication between offices to ensure that the consumer is being served in the most effective way.

In many situations, this means that a case will be transferred to the county where the client is physically residing regardless of where they would like to move to. The reason for the case transfer is continuity of care for the resident and better communication with the facility who already has a working relationship with a local TC. These situations may include: if it is going to be more than a couple of months before the client is ready to transition, if there are no feasible options for the client

to return, or if there are things that need to be done that would be difficult to do from a distance, like an exception.

Funding Streams and Purchases

Refer to information on the OFS website to find all OFS policy and procedural information.

DT Coordinators use the following funding sources to provide services consumers need to avoid being hospitalized or placed in a nursing facility, and live the most independent lives possible:

- K State Plan (OAR 411-035-0015)
- Community-Based Care Transition Services (OAR 411-037)
- Crisis Support: (Crisis Support Program Outline)
- OSIPM Special Needs Payments: (OSIP Program Manual and OAR 461- 155-0500 through 461-155-0660)

Please refer to this coding document on the CM Tools page for a guide to coding and eligibility for the various funding streams.

Below is a summary of the four main purchasing options:

K-Plan Ancillary Services	Community-Based Transition Services	Special Needs Medical Related Payments	Crisis Support
•Enhanced federal match + state funds •For helping people live independently; also for leaving the NF or state hospital into in-home and CBC •To increase independence, reduce the need for human assistance, and/or maintain health or safety •Link to K-Plan Policy	•Federal match + state funds •For consumers transitioning from CBC or acute care hospital to in-home setting •Helps people establish a home •Offers more flexibility compared to Special Needs rule •Link to OAR 411-037	•State funds •Supports people in all settings to maintain independence, dignity, and health/safety •Link to OAR 461-155-0610	•State funds •For those assessed with a **high** or **medium** risk •Funding is to mitigate or prevent a crisis •Only for people living in-home •Link to Crisis Support Program Outline

DME and Assistive Technology Purchases

Payor source by situation type. These are listed in the order they should be pursued (for instance, have insurance to cover a service before K-Plan, if possible).

If the consumer is NOT transitioning or diverting

1. Insurance (MAGI and OSIPM)
    - Durable Medical Equipment
    - Medical Supplies
    - Flex Funds
    - Intensive Case Management Services
    -
2. K Plan services not related to transitioning (MAGI and OSIPM)
    - Assistive Technology
        i. Alarms
        ii. Sensors
        iii. DME
        iv. Lift Chairs
    - Chore Services
    - Environmental modifications
    - Extended Emergency Response System (ERS)
    -
3. Special Needs Funding (OSIPM Only)
    - Food for guide dogs/assistance animals
    - Laundry allowance
    - Home Repairs
    - Moving Costs
    - Property taxes
    - Community Based Care
    - Accommodation Allowance
    - Special diet allowance
    - Supplemental communication allowance
    - Personal incidentals and room/board
    - Prescription drug and co-pay coverage
    - In-home supplemental

For consumers transitioning from Skilled Nursing Facility or the Oregon State Hospital

1. Insurance (MAGI and OSIPM)
    - DME
    - Medical supplies
    - Flex funds
    - Intensive Case Management Services
2. K-Plan Services (MAGI and OSIPM)
    - Assistive Technology
        - Alarms
        - Sensors
        - DME
        - Lift Chairs
    - Chore services
    - Environmental modifications
    - Extended Emergency Response System
    - Transition services
        - Move-in
        - Household purchases
        - Moving costs
        - CBC and In-Home visits (tours)
    - Transition services that require approval by central office:
        - Purchases above monetary limits
        - Approval for expenses that occur more than 30 days after the transition period
        - Items required to re-establish a home not identified in this rule.
        - Other necessities to help someone move from a Nursing Facility or Oregon State Hospital
        - Transportation to a community-based service setting tour that requires overnight travel
        - Payment of past rent or utility bills, when a consumer is more than one month behind.
        - Transportation costs for the individual to transition from a nursing facility or the state hospital to a home or community-based care setting. This may include attendant services and transportation out of state.
3. Special Needs funding (OSIPM)
    - Food for guide dog/assistance animals
    - Laundry Allowance
    - Home Repairs
    - Moving Costs

- Property Taxes
- Community Based Care
- Accommodation Allowance
- Special Diet Allowance
- Supplemental Communication Allowance
- Personal Incidentals and Room and Board
- Prescription Drug Co-Pay Coverage
- In-Home supplement

4. Special needs funding (OSIPM) for Community Transition Services, use code 49 when the item is not covered by one of the 3 options above

Diversion consumers: those being diverted from an institution into the community. For example: currently in a hospital, failed placement, or experiencing homelessness where ICF or other institutional placement is a potential risk.

1. Insurance (MAGI and OSIPM)
2. K-Plan Services other than transition services
    a. Assistive technology
        i. Alarms
        ii. Sensors
        iii. DME
        iv. Lift chairs
    b. Chore services
    c. Environmental modifications
    d. ERS
3. Special needs funding (OSIPM only)
    a. Food for guide dog/assistance animals
    b. Laundry Allowance
    c. Home Repairs
    d. Moving Costs
    e. Property Taxes
    f. Community Based Care
    g. Accommodation Allowance
    h. Special Diet Allowance
    i. Supplemental Communication Allowance
    j. Personal Incidentals and Room and Board
    k. Prescription Drug Co-Pay Coverage
    l. In-Home supplement

Submitting payment-related questions

- KPlan Payment or provider enrollment questions – send to KPlan.Requests@odhsoha.oregon.gov
    - Mark the e-mail as "urgent"
- KPlan Policy questions – send to Margaret.May@odhs.oregon.gov
- Community Transitions questions and approval: inhome.transitionservices@odhsoha.oregon.gov
- Special Needs Transition or Diversion questions – send to DT.Policy@odhsoha.oregon.gov
- Other Special Needs questions – send to APD.MedicaidPolicy@odhs.oregon.gov
- CCO/DME/OHA questions or concerns – send to DT.Policy@odhsoha.oregon.gov to facilitate discussion with OHA

Durable Medical Equipment (DME)

- DME Pre-discharge planning:
    - Attend care conferences with NF or Hospital to help plan discharge
    - Identify with care team what DME is required for the consumer to return home or go to new community placement.
    - Nursing Facility or hospital staff are responsible for obtaining doctors' orders
    - The D/T Coordinator is responsible for ensuring consumer has all DME needed to return home, or contingency plan if returning before all DME is delivered.
- For consumers enrolled with a CCO:
    - Close communication may be necessary to allow for approval for items in anticipation for discharge.
    - If the CCO refused to provide necessary DME because consumer is discharging to another area contact the Transition Services Analyst (DT.Policy@odhsoha.oregon.gov) to staff the case.
- For fee-for-service consumers:
    - Health Services Division (HSD – formally known as DMAP) has an exceptions process. Request for exceptions should come from the consumer's provider. A DME supplier or prescribing practitioner can ask for an individual medical appropriateness review (exception) who will need to provide documentation from the client's doctor, the

prescriber of the device or supply, that supports criteria in OAR 410-122-0080(20) have been met for an exception.

- If item has been denied by insurance, unavailable through local DME vendor, or consumer does not meet coverage criteria then the D/T Coordinator can complete a K-Plan request under Assistive Devices.
    - Transition and Diversion funds through K-Plan or OSIPM Special Needs are only available if the insurance will not cover the item.
- Monitoring best practices for consumers with new DME or Assistive Technology:
    - D/T Coordinator is responsible to complete an in-person monitoring visit within the first week after discharge and should look for the following:
        - All items have been delivered to consumer
        - All items are in working order
        - All items are set up and installed properly
        - Identify and coordinate acquisition any additional DME or Assistive Devices that could further improve the consumer's safety and independence:
            - Weighted utensils
            - Transfer devices
            - Movement detectors
            - Plate switch
            - See Assistive Technology Guide for additional examples

K-Plan Home Modification Process and Best Practices

- Home Modifications are covered through K-Plan Ancillary Services for both MAGI and OSPIM consumers who meet the criteria of the OAR.
    - Home modifications are only available for homes and rentals with landlord's permission; they are not available for AFH or ALFs.
- When home modifications are required for a client to return to their home or a family member's home or a rental unit, the D/T coordinator will complete the K-Plan request according to the instructions found in the K-Plan Ancillary Services Guidance.
- Best practice is for the D/T Coordinator to, as soon as possible, arrange a visit to the home and take photos and measurements. D/Ts will need to know the DME participants will use when returned to home (wheelchair, walker, scooter, bath chair/commode etc.) measurements.
- Additional guidance for different parts of the home:

- Ramps
    - In consultation with participant and others in the home as appropriate
    - Determine which entry would be best
    - Measure threshold height
    - Ramp length is usually 1 foot for every 1-inch height of threshold
    - Take photos of exterior area where ramp would be constructed; note any challenges such as sprinkler heads, property lines, etc.
- Doorways:
    - In consultation with participant and others in the home as appropriate
    - Photos of both sides of doorways
    - Photos of adjacent walls to doorways
    - Note adjacent electrical plugs or switches
    - Consider the off-set door hinge solution (2" clearance can be gained by using off-set hinges, if swing room allows)
- Bathrooms:
    - In consultation with participant and others in the home as appropriate
    - Photos of existing bathroom
    - Floor space measurements
    - Anticipated bathroom usage (abilities, barriers, 1 or 2 person assist, DME)

Please note: This information is good to obtain for your KPlan request and in your initial discussions with the contractor. The contractor will still complete their own professional assessment of the modification needs. It gives you the opportunity to explore what additional Assistive Devices may be appropriate to meet the consumer's needs and identify any unforeseen barriers that may be left out if coordinated remotely.

Home Repairs

Home repairs are allowable for consumers receiving OSIPM only – it is not a covered benefit under KPlan – who meet the criteria under OAR 461-155- 0600

APD can help pay for home repairs if they're necessary to fix health and safety hazards. This is a one-time payment with the following rules:

- The repairs must be the least expensive option available.
- The payment can't exceed $1000 in 24 months.
- If the home is jointly owned, the payment amount is based on how much of the home the client owns. If the client is married, there may be an exception to this rule.
- The cost of the repairs must be less than the cost of moving to a new home.
- The repairs must be less than the cost of moving to another home.
- To qualify for the payment, the client must get three bids from contractors, unless there aren't three contractors available in the area.
    - The repairs make sense based on the client's care plan and whether the repairs will help the client stay in the home.
- Contractors must follow building codes, and only licensed, bonded contractors can do the work.
- The types of repairs that may be covered include:
    - Electrical work needed to prevent a fire or shock hazard.
    - Plumbing repairs or installations, like fixing toilets or sinks, cleaning septic tanks, or connecting to a new sewer system.
    - Repairing or replacing a pump for a well, but not drilling a new well.
    - Heating equipment repairs or replacements, such as stoves, furnaces, and water heaters.
    - Roof repairs.
    - Repairing or replacing steps and floors.
- People with life estates (a right to live in the home for life) are not eligible for this help. After the person passes away, the person who inherits the property is responsible for the repairs.

Payment Instructions:

- Issue payments by DHS 437 using pay reason 40. Also enter an N/R code on CMS of SHR with an end date of 24 months in the future, to indicate that the client's total home repair payments cannot exceed $1000 during that time.

Special Needs Payments

Special Needs payments are listed in OAR 461-155-0010 through 461-155-0710.

Special Needs Overview

- Special needs may be one-time needs or ongoing needs at a consistent cost.
- To be eligible for a special need item, clients must have no other available resources in the community or in their natural support system, and their insurance will not cover the item or mee the need.
- The Department will authorize payment for one-time and ongoing special needs for the following:
- One-time needs for:
    - Home repairs (up to $1,000 in any 24-month period)
    - Moving costs, up to $1,000 in a 12-month period if the consumer is either:
        - Moving to provide nonhazardous housing
        - Evicted for reasons beyond neglect or failure to make rent or house payments
        - Protect the safety of the client because the client is a victim of domestic violence
        - For a client in nonstandard living arrangement, the move is because the level of client services increases or decreases
        - The consumer is moving out of state
    - Property taxes under certain circumstances
    - Community transition services for consumers leaving a psychiatric hospital or nursing facility
    - Community based care room and board
    - Community transition services for consumers leaving a psychiatric hospital or a nursing facility, and includes:
        - Moving belongings, housing security deposits, essential furnishings, eating utensils, food preparation items, and deposits for utility hook-ups for heat, electricity and telephone.
        - Also includes health and safety measures such as pest eradication or allergen control
    - Diversion services to keep individuals who might otherwise be served in nursing facilities to community-based care.
- Ongoing needs for the following:
    - Laundry allowance if they have proven and excessive costs for laundry, with coin-operated laundry machines

- Personal incidentals, and room/board allowance to help a consumer reside in a community-based care facility to avoid placement in NF, or to leave a NF or hospital
- Special diet allowance
- Supplemental communication allowance, which could include covering broadband internet, telephone service, adaptive equipment for a phone. These are limited to $25 per month per consumer.
- Accommodation allowance for accommodation needs related to:
    - Temporary absences from the home and plans to return within 6 months, and would be unable to afford the house without the allowance
    - Disability-related housing costs for consumers with increased shelter costs due to a disability
- Accommodation of an additional bedroom for a service provider
- Food for guide dogs and special assistance animals
- Supplemental assistance of $22 monthly for consumers who only receive SSI for income and are in home or CBC settings, or State Plan Personal Care services
- Prescription Drug Co-pay Coverage
    - Payment for financial assistance for all Medicare Part D or Veteran's Administration Health Care prescription co-pays if a client's co-pays exceed $10 per month
    - If copays exceed $30 per month, it must be approved by APD Central Office
    - Payment for Medicare Part D co-pays is limited to the current Low-Income Subsidy (LIS) program amounts for a fully dual eligible individual under 100 percent of the Federal Poverty Limit.

Payor Source Best Practices

Payor Source by Situation Type

Below are 3 scenarios and the payment options (in order) the local office can use to obtain items or services for consumers. Please use this as a best practice tool to guide your decision-making process when making purchases for consumers. The items and services listed are applicable only if the consumer meets the eligibility criteria described in OARs and program manuals/guides.

New or ongoing LTSS consumer NOT transitioning or diverting

1. Insurance (MAGI & OSIPM)
    a. Durable Medical Equipment
    b. Medical Supplies
    c. Flex Funds
    d. Intensive Case Management Services

2. KPlan Services not related to transition services (MAGI & OSIPM)
    a. Assistive Technology W1 - local limit $500
        i. Alarms
        ii. Sensors
        iii. DME
        iv. Lift chairs
    b. Chore Services (Central office approval)
    c. Environmental modification (Central office approval)
    d. Extended emergency response system (see K Plan guide)

3. Special Needs funding (OSIPM only) – See OSIPM manual for coding instructions and funding limits
    a. Food for guide dog/assistance animals
    b. Laundry Allowance
    c. Home Repairs
    d. Moving Costs
    e. Property Taxes
    f. Community Based Care
    g. Accommodation Allowance
    h. Special Diet Allowance
    i. Supplemental Communication Allowance
    j. Personal Incidentals and Room and Board
    k. Prescription Drug Co-Pay Coverage
    l. In-Home supplement

Transition consumers: those moving from an institution (Examples: Oregon State Hospital, Skilled Nursing Facility, Intermediate Care Facility) into the community

1. Insurance (MAGI & OSIPM)
    b. Durable Medical Equipment

c. Medical Supplies
d. Flex Funds
e. Intensive Case Management Services

2. KPlan Services (MAGI & OSIPM)
    a. Assistive Technology less than $500: Code W1
        i. Alarms
        ii. Sensors
        iii. Durable Medical Equipment
        iv. Lift Chairs
    b. Chore Services: Central Office approval always required
    c. Environmental Modification: Central Office approval
    d. Extended Emergency Response System
    e. Transition Services
        i. Move-In: Code W3
        ii. Household Purchases: Code W4
        iii. Moving Costs ($1,000 local limit): Code W5
        iv. CBC & In-Home visits (tours): Code W6
    f. Transition Services requiring CO Approval not listed in the guide

4. Special Needs funding (OSIPM only) - See OSIPM manual for coding instructions
    a. Food for guide dog/assistance animals
    b. Laundry Allowance
    c. Home Repairs
    d. Moving Costs
    e. Property Taxes
    f. Community Based Care
    g. Accommodation Allowance
    h. Special Diet Allowance
    i. Supplemental Communication Allowance
    j. Personal Incidentals and Room and Board
    k. Prescription Drug Co-Pay Coverage
    l. In-Home supplement

5. Special Needs funding (OSIPM only) - Community Transition Services – code 49 only

a. Use only when the item is not covered by one of the 3 options above
b. OAR 461-155-0526 describes this in more detail.

Diversion consumers: those being diverted from an institution into the community. For example: currently in a hospital, failed placement, or experiencing homelessness where ICF or other institutional placement is a potential risk

1. Insurance (MAGI & OSIPM)
2. K-Plan Services other than transition services (MAGI & OSIPM)
    g. Assistive Technology: local limit $500
        i. Alarms
        ii. Sensors
        iii. Durable Medical Equipment
        iv. Lift Chairs
    h. Chore Services: Central Office approval
    i. Environmental Modifications: Central Office approval
    j. Extended Emergency Response System: See KPlan guide
3. Special Needs funding (OSIPM only) - See OSIPM guide for coding instructions
    a. Food for guide dog/assistance animals
    b. Laundry Allowance
    c. Home Repairs
    d. Moving Costs
    e. Property Taxes
    f. Community Based Care
    g. Accommodation Allowance
    h. Special Diet Allowance
    i. Supplemental Communication Allowance
    j. Personal Incidentals and Room and Board
    k. Prescription Drug Co-Pay Coverage
    l. In-Home supplement
4. Special Needs funding (OSIPM only) - Diversion Services – code 59 only
    a. Use only when the item is not covered by one of the 3 options above
    b. OAR 461-155-0710

Submitting payment-related questions

- KPlan Payment or provider enrollment questions – send to KPlan.Requests@odhsoha.oregon.gov
    - Mark the e-mail as "urgent"
- KPlan Policy questions – send to Margaret.May@odhs.oregon.gov
- Community Transitions questions and approval: inhome.transitionservices@odhsoha.oregon.gov
- Special Needs Transition or Diversion questions – send to DT.Policy@odhsoha.oregon.gov
- Other Special Needs questions – send to APD.MedicaidPolicy@odhs.oregon.gov
- CCO/DME/OHA questions or concerns – send to DT.Policy@odhsoha.oregon.gov to facilitate discussion with OHA

Choosing the Best Payor Source Cheat Sheet

Please follow this to determine the best payor source to obtain the items your consumer needs for a safe move. Underlined items are linked to online guides or OARs.

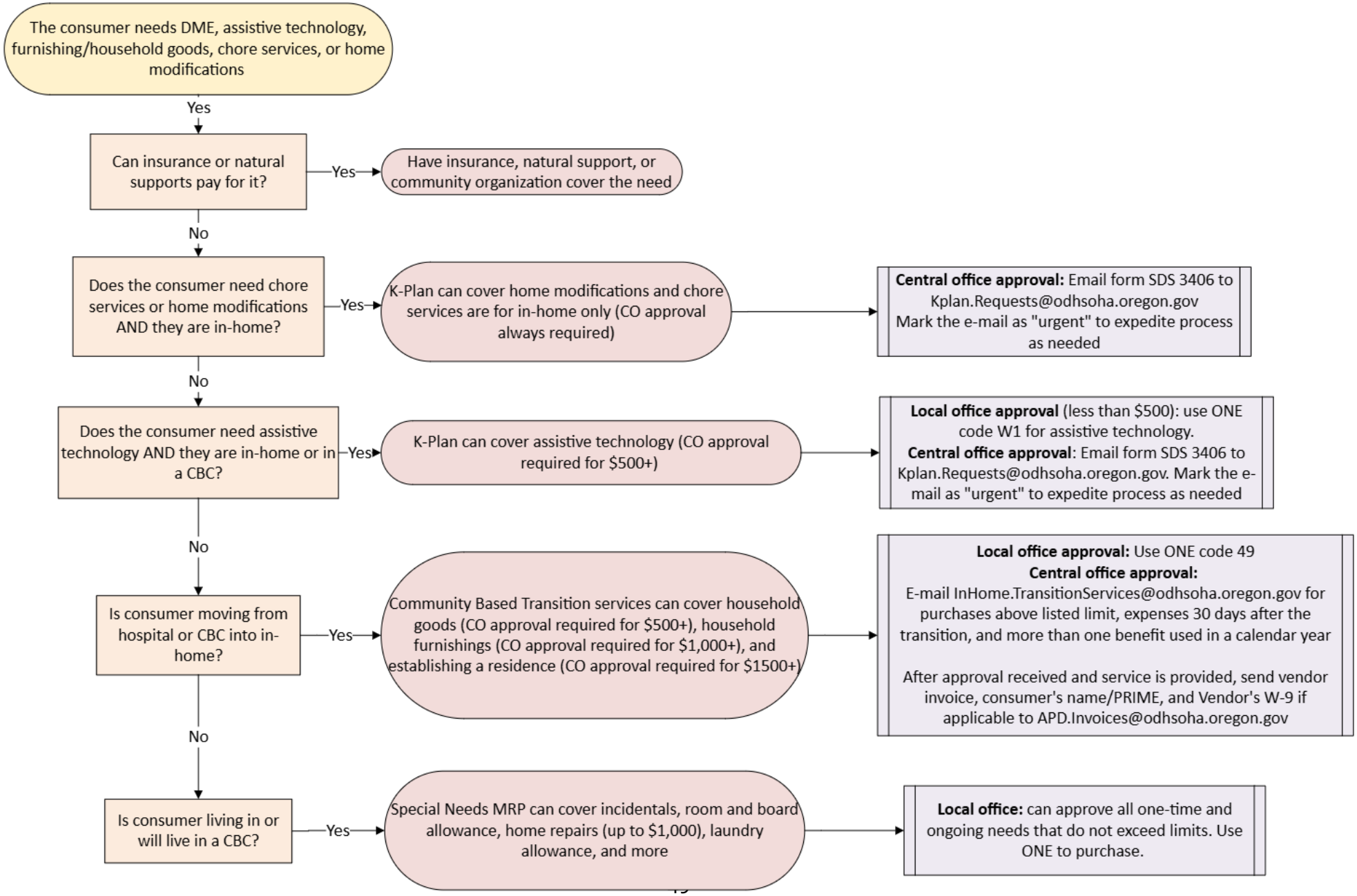
Please review these OARs or Guides to ensure consumer eligibility before using.

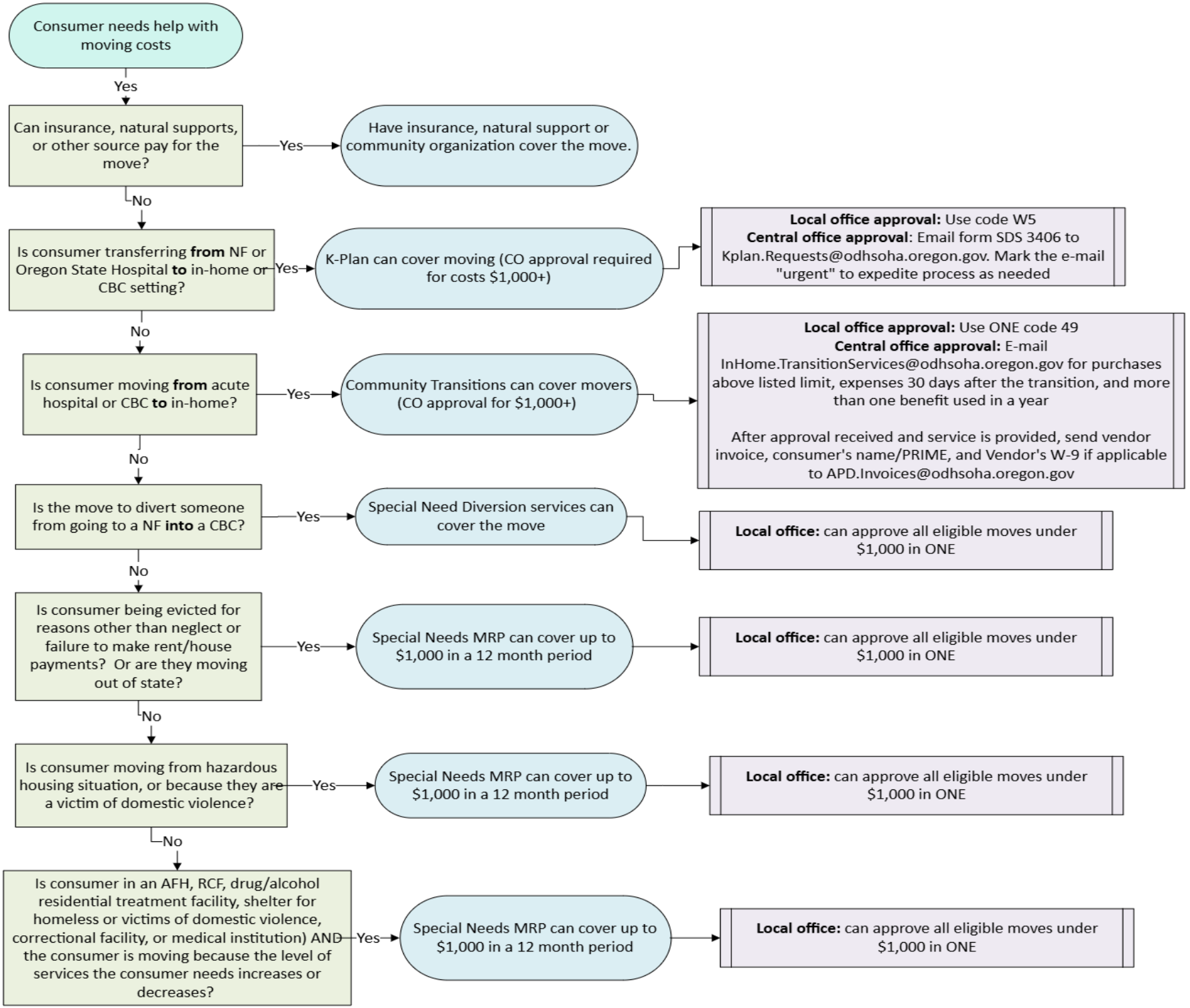
1. Is it covered by insurance?
    a. Yes – use this payor source
    b. Yes – but denied. Reach out to CCO and find out reasons why and re-submit if consumer meets criteria
    c. Yes – but DME company can't or won't provide it. Reach out to CCO for assistance
        i. Email DT.Policy@odhsoha.oregon.gov name of DME company and item trying to buy and reason for refusal – attach any correspondence or documentation you may have.
    d. No – Go to #2
2. Is there a community resources or natural support that can cover this cost?

    a. Yes – use this payor source
    b. No – Go to #3
3. Is it covered by KPlan? (MAGI and OSIPM consumers)
    a. Review KPlan Guidance or OAR 411-035 for eligibility information

    b. Yes – use appropriate section (I – v are for any situation, vi – vii are for transition only)
        i. DME = Assistive Tech, other
        ii. Alarms or Sensors = Assistive Tech
        iii. Chore Services
        iv. Environmental Mod
        v. Emergency Response
        vi. Transition Services (Move In, Household, Moving, Tours)
        vii. Other services including out of state move or attendant services: 411-035.0075.7.g
    c. No – go to #4
4. Is it a diversion to an in-home plan that meets Community Based Care Transition Services OAR 411-037? (OSIPM & MAGI)
    a. Yes – use this payor source – Same W Codes you use for KPlan Transitions
    b. No – go to #5
5. Is it covered by Special Needs other than Transition/Diversion funds? (OSIPM only)
    a. Yes – use that payor source
    b. No – go to #6
6. Is it covered by Special Needs under Transition or Diversion rule? (OSIPM only)
    a. Yes – use appropriate code
        i. Transition = 49
        ii. Diversion = 59
    b. No – staff with your local leadership or Transition Services Analyst for other options.

Below are two flow-charts to guide funding eligibility determination, using the information listed in this section.


The consumer needs DME, assistive technology, furnishing/household goods, chore services, or home modifications
Yes
Can insurance or natural supports pay for it?
Yes
Have insurance, natural support, or community organization cover the need
No
Does the consumer need chore services or home modifications AND they are in-home?
Yes
K-Plan can cover home modifications and chore services are for in-home only (CO approval always required)
Central office approval: Email form SDS 3406 to Kplan.Requests@odhsoha.oregon.gov Mark the e-mail as "urgent" to expedite process as needed
No
Does the consumer need assistive technology AND they are in-home or in a CBC?
Yes
K-Plan can cover assistive technology (CO approval required for $500+)
Local office approval (less than $500): use ONE code W1 for assistive technology. Central office approval: Email form SDS 3406 to Kplan.Requests@odhsoha.oregon.gov. Mark the e-mail as "urgent" to expedite process as needed
No
Is consumer moving from hospital or CBC into in-home?
Yes
Community Based Transition services can cover household goods (CO approval required for $500+), household furnishings (CO approval required for $1,000+), and establishing a residence (CO approval required for $1500+)
Local office approval: Use ONE code 49 Central office approval: E-mail InHome.TransitionServices@odhsoha.oregon.gov for purchases above listed limit, expenses 30 days after the transition, and more than one benefit used in a calendar year
After approval received and service is provided, send vendor invoice, consumer's name/PRIME, and Vendor's W-9 if applicable to APD.Invoices@odhsoha.oregon.gov
No
Is consumer living in or will live in a CBC?
Yes
Special Needs MRP can cover incidentals, room and board allowance, home repairs (up to $1,000), laundry allowance, and more
Local office: can approve all one-time and ongoing needs that do not exceed limits. Use ONE to purchase.


Consumer needs help with moving costs
Yes
Can insurance, natural supports, or other source pay for the move?
Yes
Have insurance, natural support or community organization cover the move.
No
Is consumer transferring **from** NF or Oregon State Hospital **to** in-home or CBC setting?
Yes
K-Plan can cover moving (CO approval required for costs $1,000+)
Local office approval: Use code W5
Central office approval: Email form SDS 3406 to Kplan.Requests@odhsoha.oregon.gov. Mark the e-mail "urgent" to expedite process as needed
No
Is consumer moving **from** acute hospital or CBC **to** in-home?
Yes
Community Transitions can cover movers (CO approval for $1,000+)
Local office approval: Use ONE code 49
Central office approval: E-mail InHome.TransitionServices@odhsoha.oregon.gov for purchases above listed limit, expenses 30 days after the transition, and more than one benefit used in a year
After approval received and service is provided, send vendor invoice, consumer's name/PRIME, and Vendor's W-9 if applicable to APD.Invoices@odhsoha.oregon.gov
No
Is the move to divert someone from going to a NF **into** a CBC?
Yes
Special Need Diversion services can cover the move
Local office: can approve all eligible moves under $1,000 in ONE
No
Is consumer being evicted for reasons other than neglect or failure to make rent/house payments? Or are they moving out of state?
Yes
Special Needs MRP can cover up to $1,000 in a 12 month period
Local office: can approve all eligible moves under $1,000 in ONE
No
Is consumer moving from hazardous housing situation, or because they are a victim of domestic violence?
Yes
Special Needs MRP can cover up to $1,000 in a 12 month period
Local office: can approve all eligible moves under $1,000 in ONE
No
Is consumer in an AFH, RCF, drug/alcohol residential treatment facility, shelter for homeless or victims of domestic violence, correctional facility, or medical institution) AND the consumer is moving because the level of services the consumer needs increases or decreases?
Yes
Special Needs MRP can cover up to $1,000 in a 12 month period
Local office: can approve all eligible moves under $1,000 in ONE

Acute Care Settings Coverage

ACS is an insurance benefit that can assist with the uncovered costs Medicare consumers may have during a skilled nursing stay. OAR 461-135-0745 describes eligibility.

An individual in an acute care hospital or nursing facility is evaluated for OSIPM under the Acute Care Setting rule as follows:

- The individual must meet all non-financial eligibility requirements for OSIPM;
- The individual is considered in their own household and filing group;
- The financial group consists of only the individual applying for benefits, except the spousal impoverishment guidelines apply, so a resource assessment must be completed;
- The individual must have a countable income at or below 300 percent of the full SSI standard or has established a qualifying trust as specified in 461-145- 0540(9)(c); and
- The individual must require a continuous period of care, which basically means the individual must be expected to stay in the hospital, nursing facility, or another service setting for at least 30 days or until death - you do need to have evidence of the expectation, but you do not have to wait until the 31st day to determine if he/she met the requirements

Please note that you do not have to refer to this rule if the individual would qualify for OSIPM under a standard living arrangement, this rule is here for those who would otherwise be over income or resources. It establishes that these individuals are treated as if they were receiving or applying for services.

- If a client needs a long-term care payment (not post-hospital extended care) and does not have Medicare, see section D.11 above.
- *Note: A client in an acute care hospital may accumulate resources. If they are above the resource limit, they will need to spend-down or become ineligible.*

Aging and Disabilities Resource Center (ADRC)

The ADRC of Oregon provides access to a searchable database of resources and services available across the state. Search by keyword, by need/service, or complete a needs assessment for a list of service offerings in your area.

ADRC Planning for your future toolkit

The ADRC of Oregon offers a downloadable planning toolkit with information about long-term services and supports options, facility types, service costs, worksheets to help consumers plan

for service costs, and checklists to support their decision process. The ADRC of Oregon also has a limited supply of printed hard copy toolkits available upon request.

ADRC Long-term services costs tools

The ADRC of Oregon includes interactive worksheets to help consumers estimate how much money they may need for long-term care expenses and to help plan for how to pay for service costs in the future.

Legal resources of older adults and people with disabilities

The ADRC of Oregon includes many legal resources including the following guides:

- Legal Issues for Older Adults: An Oregon Information and Reference Guide
- Help for agents under a power of attorney
- Help for court appointed guardians of property and conservators
- Help for trustees under a revocable living trust
- Help for representative payees and VA fiduciaries

ADRC Checklists

The ADRC of Oregon offers several checklists to support a consumer's decision process:

- Home care services checklist
- Facility comparison checklist
- Adult day services checklist
- Activity/senior center checklist
- Transportation services checklist

The ADRC of Oregon offers information about putting a plan in place for when you may not be able to determine your own medical treatment including information on creating an advance directive for health care decisions, the physician's orders for life-sustaining treatment (POLST), financial power of attorney, representative payee, and trusts.

Alzheimer's disease and related dementias

The ADRC of Oregon provides access to many resources and information on Alzheimer's disease and related dementias.

Caregiver supports resources

The ADRC of Oregon includes caregiver supports resources, including access to a downloadable version of the Family caregiver supports guide. Printed copies are also available upon request.

Assistive technology

The ADRC of Oregon includes assistive technology resources and educational information on the assistive technology section of the ADRC website.

Behavior Support Services

When to request:

- Eligible for home and community-based care services provided through APD
- Receiving services through either State Plan K Community First Choice or Independent Choice
- An individual is moving into a new care setting
- An individual at risk of requiring behavior interventions
- An individual whose caregiver requests assistance in developing person- centered interventions
- An individual with a placement failure related to their behavior
- An individual at risk of involuntary move out or who has received an eviction notice
- An individual receiving Medicaid service payments to support behavior interventions, such as a behavior add-on or an exception
- An individual whose provider receives a payment for costs associated with
- interventions needed to address the individual's challenging behaviors

Behavior Support Services may not be provided to Individuals who are receiving:

- Specific needs setting contracted rate for "enhanced care services"
- Services through Developmental Disabilities per OAR 411-308; OAR 411-330; or 411-325.
- Individuals receiving services in a nursing facility or hospital

Authorizations

- D/T makes referral to BSS
- Service hours are authorized on the date the BSS accepts the referral
- D/T can authorize 40 hours for initial assessment, service planning and follow up. Local management can authorize an additional 40 hours. Additional hours can be authorized by Central Office.
- Authorizations are valid for 12 months from acceptance by BSS

Communication

- Diversion/Transition Coordinators or Case Managers and behavior consultants are required to exchange information regarding changes in the individual's eligibility status, service location, or service needs during the duration of the Behavior Support Service
- Follow up best practice includes reviewing of BSS recommendations and
- comparing them to the provider's care plans and notes.
    - If recommendations have not been implemented discuss timeline with provider for implementation
    - If the provider continually fails to implement BSS recommendations, please staff the case with the provider or the provider's licensor per the following OAR:
        - 411-050-0655 Standards and Practices for Care and Services (4) CARE PLAN. (f) The licensee is responsible for ensuring implementation of the resident's care plan and, if applicable, the behavioral support plan with suggested interventions.
- Failure to implementation of the consumer's care plan can result in a licensing citation.
    - If a move out notice is given to the consumer and BSS has not been implemented, staff case with your Local Licensing Authority (LLA)
- Mandatory forms must be sent to the D/T Coordinator or case manager before or at the time of submission of invoices or before receipt of the monthly Medicaid service rate

Coordinated Care Organizations

In Oregon, Coordinated Care Organizations (CCOs) are community-based, integrated healthcare entities established to coordinate and deliver services to Medicaid recipients under the Oregon Health Plan. CCOs aim to improve health outcomes, enhance member satisfaction, and reduce health inequities by focusing on prevention, early intervention, and the integration of physical, behavioral, and social services.

CCOs are responsible for facilitating and overseeing care coordination, collaborating with other service providers, and ensuring that services are person-centered, trauma-informed, and culturally responsive. This collaboration helps to identify and address unmet needs, reduce duplication of services, and support individuals in managing chronic conditions or disabilities.

By working closely with CCOs, case managers can ensure that individuals receive comprehensive, coordinated care that aligns with their unique needs and circumstances.

CCO Coverage of DME

CCOs contract with DME vendors, and covered items are only available through those vendors. These items do not require prior authorization, so if the DME vendors are in-network for the CCO, the CCO will pay for the DME.

This link shares OHA's Medicaid rules for DME coverage (Division 122). It includes charts specific to toileting supplies and other DME. Sometimes consumers want, or a physical therapist or facility recommends, DME that is above the basic model that a CCO is contracted with a DME vendor to cover. In that situation, the facility might report that the DME they tried to order was denied. In that scenario, it would be reasonable to use K Plan transition funding to purchase the specific shower chair needed.

If you are struggling to effectively connect with the consumer's CCO, or the CCO is refusing to pay for DME or other services that they should pay for and instead are suggesting K-Plan cover a service, e-mail margaret.may@odhs.oregon.gov and DT.Policy@odhsoha.oregon.gov for additional guidance and coordination with the CCO.

CCO Intensive Case Coordination

Defined in OAR 410-141-3870:

Intensive Case Coordination (ICC) means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency or with severe and persistent behavioral health issues, or those receiving Medicaid- funded long-term care or long-term services and supports.

Additional information about Intensive Care Coordination and requirements for CCOs include:

- CCOs must coordinate ICC services, in addition to other care coordination tasks.
- Some groups of people are considered to have higher care needs, including:
    - Older adults or those with disabilities.
    - People with complex health issues or who use long-term care services.
    - Individuals in medication-assisted treatment for substance use.
    - People with conditions like HIV/AIDS, tuberculosis, or those in need of substance use treatment.
    - Veterans, and others facing certain health challenges.
- Individuals in the populations listed above should automatically be assessed by the CCO for ICC services within 10 days of their health risk screening..
- The Intensive Care Coordinator is the CCO's person who helps manage ICC services for individuals.

- The Intensive Care Coordination Plan is a detailed plan created for individuals receiving ICC services that outlines goals, needed resources, and the roles of each team member. The plan is created by the CCO.
- CCOs must reassess individuals receiving ICC services if certain events occur (like hospital visits or new diagnoses). They also need to check the plan annually or when otherwise necessary.
- The ICC care coordinator is responsible for managing care, including making contact with the member, their healthcare providers, and coordinating treatment plans. The coordinator must meet with the member regularly and follow up on any changes or needs.
    - The ICC care coordinator must organize regular team meetings to discuss the member's care, make adjustments, and ensure everyone involved in the care is on the same page.
- CCOs must share relevant information about the care plan with the member's healthcare team, while ensuring privacy laws are followed.
- Services may include helping individuals access medical care, coordinating with various healthcare providers, and connecting members with community and social support services.
- CCOs must ensure their staff is properly trained in care coordination and working with vulnerable populations.
- CCOs must ensure individuals with special healthcare needs get timely access to specialists and other necessary services.

Complex Case Consultation

Complex Case Consultation is a process to advise and offer technical assistance to case managers who have difficulty finding services for clients with complex needs.

Referral Guidelines:

- Referrals are accepted for open APD Medicaid service cases only, but consumers can be in any care setting. Consumers with pending eligibility may be referred for complex case consultation when lack of placement is the reason for the pended status.
- Referrals are accepted only from local APD/AAA office staff after receiving approval from their supervisor.
- Consumers who have difficulty maintaining service providers are appropriate for referral.
- CAPS assessments must be accurate to the consumer's care needs, and narration clearly describes the recent complexities relative to the need for placement.

- The case manager and/or TC must have contacted local providers, county resources and been unable to locate appropriate service providers. Denials must be documented in narration in Oregon Access. If possible, please get a reason for the denial.
- Referral materials should include supporting documentation such as clinical records, recent facility care plan, copy of the BSS or behavioral plan, CMHP provider notes, and/or other applicable information.
- The Complex Case Consultation team meets each Wednesday from 9:05-10:00 to review cases. After staffing with or referring to the Complex Case Consultation team, local office staff will be responsible for following up on suggestions. Additionally, the local office will be responsible for creating relevant narration and service planning and coordination as well as coordinating with the receiving county in the event of a case transfer.
- Referrals may be sent to the Complex Case Consultation team using the Referral Form and sending to: APDComplexCase.ConsultationTeam@odhsoha.oregon.gov

Complex Case Consultation FAQ's

Who is the Complex Case Team?

- The Complex Case Team at APD Central Office is made up of the Complex Case Coordinator, the in-home and CBC Exceptions Coordinators, the Enhanced Care Coordinators, the Diversion and Transition Policy Analyst, Policy Analysts, Adult Protective Services Policy Analyst, and the Behavior Support Services Coordinator. The team also sometimes reaches out to other areas within Central Office including the LTC Policy Unit, the MED team, and Health Systems Division (mental health).

What will the Complex Case Team really do?

- The Complex Case team provides guidance and technical support to local office staff on Complex Cases who are either looking for placement or need assistance to sustain their placement in their current care setting.
- Upon receiving a referral, the Complex Case Coordinator will review all documentation and case information including CAPS and narrative to determine what options have already been tried and to attempt to determine what might be some additional appropriate options.
- If appropriate placement options are not clear from the documentation and case information, we may request additional information or to have a conference call with the local office.
- The Complex Case Coordinator then will send suggestions for placement options for local office to try. Local office staff is invited to join Complex Case to staff cases on Wednesday mornings.
- Cases referred to the Complex Case team will be held by the local office. The local office is responsible for contacting potential providers, scheduling screenings, coordinating moves, etc.

What should I do before I make a Complex Case Referral?

- It is appropriate for the local office to make a Complex Case Consultation (CCC) referral when all local resources and tools have been exhausted and the local office feels that they need support and/or guidance.
- Resources and tools to attempt prior to making a CCC Referral include but are not limited to:
    - Staffing with your team locally including supervisors, Diversion/Transition coordinators, lead workers, housing placement specialists, other case managers, licensors, etc.
    - Referring to money management or rep payee programs if appropriate.
    - Referring to community partners such as Behavior Support Services, Long-Term Community Care Nursing, Home Health, local Mental Health services and so on.
    - Referring to Enhanced Care Services or Special Need Contract homes if appropriate.
    - Referring to public guardianship programs if appropriate.
    - Working with the provider to request exceptions if appropriate.
    - Submitting K-Plan request for durable medical equipment, home modifications, etc.

Do I have to staff the case with my supervisor before I make a referral?

- While a signature from your supervisor is not required on the referral form, it is best to staff all Complex Case referrals with your supervisor for many reasons. Your supervisor may have information on resources you are unaware of, they may have additional history or information on this case, or they may have a reason a Complex Case referral would not be appropriate. While it is not required, it is best practice to staff all referrals with your supervisor.

Does the consumer have to agree to a Complex Case Consultation?

- No, a Complex Case Consultation is meant to be a tool for the D/T or case manager in attempting to find appropriate placement. Consumers may not even know that you have made a Complex Case referral or have had a consultation.

Can Complex Case Team help if the consumer has pending legal charges?

- This is something that we discuss on a case-by-case basis. Depending upon the charges, status of the case, and potential outcomes we may be able to assist in finding placement anyway. Please make a referral and specify in the referral that this is one of the presenting issues

What do we do if the consumer is refusing to leave their current placement or area?

- This is a choice that the consumer can make, assuming they do not have a guardian. However, what we must make sure that the consumer understands providers can, over

time, take legal action to evict and/or trespass someone from the facility in which case local law enforcement would require the person to leave their placement.

- The Case Manager or TC's responsibility is to present the consumer and/or their legal guardian with alternative placement options State-wide. This may include options that are outside of the consumer's preferred location. The LO staff should have a conversation with the consumer to ensure that they fully understand the situation and brainstorm ways to keep the consumer safe. LO staff should have a candid conversation with the consumer to discuss where they will go next and how will they get their basic needs (shelter, food & water, medication, care needs, etc..) met. The local office staff should also discuss with the consumer what the barriers are to finding new placement and suggest ways to resolve/reduce those barriers. This conversation may need to happen several times until the consumer is ready to accept alternative placement options or solutions to resolve the barriers. Every conversation must be narrated in Oregon Access.

Is making a referral even going to help?

- Yes! We strive to respond as quickly as possible to all referrals and present you with at least a couple more options than you had before. We understand that sending a referral to someone who is not actively working in the local office can feel hopeless or like you are not going to get a useful answer, but our team has experience and access to resources across the state that you may not know about or how to utilize. Please, if you ever are feeling at a loss when it comes to a case, reach out to the Complex Case Team, we will always do our best to give you some extra resources and support as best we can.

Can I reach out with questions or for advice without making a full referral?

- Yes! We always welcome questions or requests for information and technical assistance. Please feel free to send questions or scenarios to the APDComplexCase.ConsultationTeam@odhsoha.oregon.gov inbox anytime. We will let you know if we need further information or would like a full referral to be made at any time.

Link to Complex Case Referral Form DHS 2841

Enhanced Care Services

Enhanced Care Services (ECS) was developed to enable individuals to leave, or reduce risk of admission to, the Oregon State Hospital (OSH). The program was designed to support individuals who need additional behavioral health resources to live successfully in the community. Treatment is focused on teaching skills and coping strategies to enable individuals to live with greater autonomy in less restrictive settings.

Individuals referred to ECS must be eligible for APD long- term care services and require rehabilitative mental health treatment. The ECS program provides mental health support services through joint funding between APD and OHA, in collaboration with licensed APD providers and Community Mental Health Programs.

Enhanced Care Facilities (ECF)

ECFs are dedicated APD Residential Care Facilities or units within Nursing Facilities with Enhanced Care Services program staff based at the facility. Mental health supports are provided on-site daily for a minimum of 4 hours per day. There are currently 9 ECFs located in the following counties: Hood River, Multnomah, Washington, Yamhill, Marion, and Lane.

Enhanced Care Outreach Services (ECOS)

Mental health services are provided to residents of any APD licensed setting. Based on individual needs, behavioral health services typically are delivered at the individual's residence or in the community but can include clinic-based services.

ECOS services are currently only provided in the following counties: Hood River, Multnomah, Washington, Polk, Yamhill, Marion, Lane, and Coos.

ECS Program Goals

- To assist the individual in stabilizing and managing their psychiatric symptoms and support them in achieving their desired quality of life.
- Treatment services focused on supporting individuals as they develop skills and coping strategies, enabling individuals to live with greater autonomy in the least restrictive settings.
- Increased supports to reduce the risk of psychiatric hospitalizations.

Consumers must meet the following criteria:

- APD eligible (financial and service eligible)
- Qualifying Mental Health Diagnosis and complex symptoms
- Requires intensive community mental health services to transition to a lower level of care
- Has difficulty maintaining APD placements due to complex symptoms secondary to a mental illness
- Has been denied admission to, and cannot be supported in any other APD community setting
- Can benefit and engage in mental health treatment services
- Currently exhibits two or more of the following:
    - Self-endangering behavior
    - Aggressive behavior
    - Intrusive behavior

- Intractable psychiatric symptoms
- Complex psychiatric medication needs
- Sexually inappropriate behaviors
- Risk to health and safety without intensive supervision.

Enhanced Care Service program includes the following:

- Increased facility services around direct care and nursing
- Qualified mental health staff to provide client centered treatment services;
- Licensed Medical Providers who provide psychiatric medication management;
- Crisis services; and
- Coordination of services through an Inter-disciplinary Treatment (IDT) Team.

Referrals

Referrals may be sent to the Enhanced Care Services team, using the Referral Form and attaching requested clinical documentation, at the following email: EnhancedCare.Team@odhsoha.oregon.gov

The Referral Form and other ECS resources can be found at: https://www.oregon.gov/odhs/providers-partners/seniors-disabilities/Documents/ecs-fact-sheet.pdf

In addition, the ECS Team is available to staff cases or answer questions regarding eligibility for this program.

Adult Foster Home Exceptions

Exceptions stem from OAR 411-027-0050:

- Service payment exceptions may only be granted if the Department determines:
  - The individual has service needs, documented in the service plan, that warrant a service payment exception; and
  - The provider actually provides the exceptional service.
- Service payment exceptions shall be based on the additional hours of services required to meet the individual's assessed and verified ADL and IADL service needs. Exceptional hours are not allowed based solely on choice of the individual. The Department and AAA local office staff must monitor the individual service needs and recommend adjustments to the plan when appropriate.
- Service payment exceptions in Adult Foster Homes and Residential Care Facilities may be authorized only for individual service needs that are not paid for by the base rate or any of the three available add-on payments.

In short, exceptions are written for ADL's requiring 2 caregivers to complete, extensive 1:1 interaction by a caregiver for behavioral needs, or other critical needs. Night needs that do not require 2 caregivers will also be considered.

Needs that do not qualify for an exception, as they are already included in base rate:

- Bladder and Bowel needs (unless this requires two people, which is rare and would need to be verified)
- Grooming/Hygiene tasks (almost never requires 2 caregivers)
- Medication management (even at night)

CAPS Assessment:

- MUST support the request – requests are based on the assessed and verified needs. If an ADL task requires 2 caregivers, it must be noted in the assessment. Frequency and duration are also preferable but can be included in the 514.

Behavioral Requests:

- Is BSS engaged?
    - If so, attach the BSS plan and any documentation from the provider showing implementation of the BSS recommendations.
    - If not, exception will be temporary (90 days).
- Try to quantify the behavioral episode: How long it lasts, how many times per day, is there a pattern, what are the caregivers doing, how does the consumer respond.
- Exception hours can be used to implement caregiver engagement strategies from the BSS plan.
- Make unannounced visits – try to witness the behaviors as they are happening to verify what the caregivers are doing and how long it takes.

Pre-placement approvals:

- Can be done – staff with Exceptions Coordinator first.
- Typically done with crisis situations, or when transitioning from acute care settings.

Questions to ask before submitting:

- For night needs and/or behaviors – request a log or notes from the provider. Ensure that the notes are reflecting the needs.
- Collect the BSS plan, if applicable.
- Send a referral for BSS if not already.
- If Adult Day Services are in play or being requested – please note this on the 514.

Follow up/monitoring:

- Staffing should always be verified if visiting the home.
- Visit with the consumer – verify (where applicable) if the care is being given.

- Large exceptions will come with a mandate to make unannounced visits to verify staffing and care being provided.

Multiple exceptions in the same home:

- Under heightened scrutiny at Central Office.
- Request a staffing plan, then verify through unannounced visit.
- May be denied if there is evidence of "overlap" of the exceptional
- caregivers.

Exceptions in Specific Needs Contract homes:

- Residents that were in the home prior to execution, and don't meet the SOW.
- New placements that don't meet the SOW.
- If the exception request is large – need to determine if the consumer will be better served by the contract rate. Also, the contract already requires elevated staffing, and this will be considered when determining exceptional needs.

Adult Foster Home Exceptions Checklist

All exceptional rate requests must be submitted by a manager in the local office via this form.

- ☐ Are the 514 and 514A complete? Is client and provider information correct?
- ☐ Does the CA/PS assessment reflect current care needs and is no more than 6 months old?
- ☐ Is there clear narration, comments or synopsis regarding client's needs and justification for the exceptional rate being requested?
- ☐ Has the rate been calculated correctly? (Number of hours per week x 4.3 weeks x $13.11) This is the cost the provider will incur for additional staff necessary to meet client's care needs.
- ☐ Does the 514A include tasks or services not covered under the waiver (ROM, RN, PT/OT, respite/relief, smoking, standby)? If so, task/service and associated hours should be removed.
- ☐ Does the provider have a resident manager? (A resident manager cannot be paid for exceptional hours and should not be listed as a caregiver on the 514A.)

- ☐ Does the AFH have the correct classification level to meet the care needs of the client? If not, has your licensor granted a classification exception to the provider? (Submit copy with request.)
- ☐ Are there other clients with exceptional rates in the AFH? If so, do needs/hours overlap?

- ☐ Is the client under 65 years with care needs related to a mental health diagnosis? Should the case be referred to the MED review team?
- ☐ Do you support the request? If not, include an explanation regarding why. Was it denied locally? Is there an alternate plan?

This check list is provided as technical support for local office staff when an exceptional rate request is being prepared. It is not necessary to send this form with the request, but we strongly encourage you to use it as a tool to ensure that all issues are explored and documented prior to submission.

For questions about Adult Foster Home exceptions, contact Erin Drake at erin.l.drake@odhs.oregon.gov.

Long-Term Community Care Nursing (LTCCN)

LTCCN Webpage is linked here:

Overview

LTCCN is a nursing program that is designed to help individuals, their caregivers, foster home providers and case managers develop the supports needed to help a Medicaid eligible person with chronic health care needs live in their own home or foster home.

Referrals and authorization for the service are made by each consumer's case manager. These ongoing services can be provided in conjunction with short-term home health services which are a different type of community nursing authorized by a physician and funded through the persons medical insurance plan.

The service can only be provided by either self-employed RNs or RNs employed by In-Home/Home Health agencies. Both types of providers must have a contract with the Oregon Department of Human Services Seniors and be enrolled as a Medicaid Provider. Registered Nurses (RN) in the LTC Community Nursing program provide:

- A nursing assessment, medication review and service plan for the person
- Health education for the person, caregivers, foster home providers and/or family members
- Teaching for the individual who self directs their care or family members on how to perform tasks of nursing
- RN delegation of nursing care tasks provided by a non-family or paid care provider

- Technical assistance and progress summaries to the case manager regarding the person's healthcare needs
- Care coordination with the persons medical and ancillary health providers

Frequently Asked Questions:

The LTCCN webpage has a large FAQ section for both provider and D/T Coordinators to refer to. Below are some that may be most helpful.

When should I make a referral?

- A referral should be made when there is a change in the individual's health or care needs that requires nursing involvement. Services should always be person-centered and support the individual's ability to manage their own health when possible. Items marked with an asterisk (*) also require the physician to be informed.
- Referral reasons include:
  - Education needed for the individual, family, or care providers.
  - Delegation required for nursing tasks (those not typically done by the general population).
  - Medication safety concerns.
  - *Unexpected increase in ER visits, doctor visits, or hospitalizations.
  - *Changes in behavior or cognition.
  - *Issues related to nutrition, weight, or dehydration.
  - *Pain management concerns.
  - Recent or frequent falls.
  - *Potential or resolved skin breakdown (not for complex wound care).
  - Non-compliance with medical advice (treatments, meds, or therapies).

How do I know if a person is eligible to receive Long Term Care Community Nursing services?

- Individuals must be eligible for either an APD or DD waiver and receive services in the following settings or programs: In-Home Services; Comprehensive In-Home Support for Adults with Developmental Disabilities; Adult Foster Homes for Person with Developmental Disabilities; Foster Homes for Children with Developmental Disabilities, Adult Foster Homes for Aging or Persons with Physical Disabilities, Independent Choices, or State Plan Personal Care Services. Settings such as ventilator homes where persons receive nursing as part of a contracted or enhanced rate would not be eligible.

Is an individual who receives State Plan Personal Care (SPPC) services eligible for LTCCN RN services?

- Yes, SPPC participants are eligible to receive LTCCN services, if they meet the other eligibility requirements in OAR 411-048-0170.

What type of documentation should I expect from a RN after I authorize Long Term Care RN services?

- There are two required forms that the nurse completes: The APD Long Term Care Community Nursing Service Plan (SDS 0754) and the APD Long Term Care Community Nursing Services Summary (SDS 0752). The purpose of these forms is to ensure that the RN communicates information to you. The documentation entered on each form is required to be legible and easily understood. The RN is not to use medical abbreviations, medical terminology or jargon. If you find that the RN is not willing to document in a manner that helps you understand their services, immediately let your manager or the LTCCN Program Coordinator know of the communication problems. The nurse must also complete SDS 4102 as part of the authorization process.
    - You should expect to receive a current Nursing Service Plan every time a RN makes updates to the Service Plan and when there is a request for Prior Authorized services.

Older Adult Behavioral Specialist

Three primary functions to this role:

1. Interagency/multi-system planning for better coordination between systems
2. Complex case consultation
3. Workforce development and community health and wellness promotion

Function #1 – Coordination

- Promote partnerships and linkages
- Promote value of collaboration
- Build shared common culture and values
- This process would result in –
    - Removal of silos
    - Elimination of barriers
    - Creation of synergies
    - Alignment of priorities and goals
    - Finding better solutions

Function #2 - Consultation

- Complex Case Consultation –

- Multi-disciplinary team approach
- Multi-morbidity lens
- Individuals with cross-system needs
- Social factors
- Clinical data
- Solution focused

Function #3 –Workforce Development and Community Education and Awareness

- Workforce development –increase the human capital infrastructure through a range of activities that create, sustain, and retain a viable and competent workforce.

Older Adult Behavioral Health Specialists Contact List can be found on SharePoint DT Document Library, or you can email the OHA Coordinator:

- Statewide Older Adult Behavioral Health Coordinator
  - Nirmala Dhar, Nirmala.Dhar@oha.oregon.gov, 503-945-9715

Post Hospital Extended Care Benefit

OAR 411-070-0033 Post Hospital Extended Care Benefit

- The post hospital extended care benefit is an Oregon Health Plan benefit that consists of a stay of up to 20 days in a nursing facility to allow discharge from hospitals.
- The post hospital extended care benefit must be prior authorized by pre- admission screening for individuals not enrolled in managed care.
- To be eligible for the post hospital extended care benefit, the individual must meet all the following:
  - Be receiving Oregon Health Plan Plus or Standard, Fee-for- Service benefits;
  - Not be Medicare eligible;
  - Have a medically necessary, qualifying hospital stay consisting of
- A DMAP-paid admission to an acute-care hospital bed, not including a hold bed, observation bed, or emergency room bed.
- The stay must consist of three or more consecutive days, not counting the day of discharge.
- Transfer to a nursing facility within 30 days of discharge from the hospital;
- Need skilled nursing or rehabilitation services daily for a hospitalized condition meeting Medicare skilled criterion that may be provided only in a nursing facility meaning:
  - The individual is at risk of further injury from falls, dehydration, or nutrition because of insufficient supervision or assistance at home;

    - The individual's condition requires daily transportation to a hospital or rehabilitation facility by ambulance; or
    - It is too far to travel to provide daily nursing or rehabilitation services in the individual's home.
- The individual may qualify for another 20-day post-hospital extended care benefit only if the individual has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in this rule.
- Individuals eligible for the 20-day post-hospital extended care benefit are not eligible for long term care nursing facility or Medicaid home and community-based services unless the individual meets the eligibility criteria in OAR 411-015-0100 or OAR 411-320-0080.

Program of All-Inclusive Care for the Elderly (PACE)

Link to PACE page on CM tools

PACE Program Description

PACE is a Medicare and Medicaid national program that offers an array of health and social services in a consolidated all-inclusive service model. Medicare and Medicaid funds cover all medically necessary services. There are no co-pays or deductibles. Recipients can also pay privately for the PACE program if they do not qualify for Medicare or Medicaid. Currently, 31 states offer the PACE program serving approximately 23,000 people nationwide and approximately 1,100 people in Oregon. Oregon’s PACE program is one of the first and largest in the country.

PACE services are coordinated with the service recipient and their team of healthcare professionals referred to as an interdisciplinary team. Together the service recipient and their interdisciplinary team develop a plan of care that is comprehensive and responsive to the individual’s health and social service needs.PACE Services

- Long-term Care
- Primary Care
- Laboratory Tests & Procedures
- Emergency Medical Services
- Hospital Care
- Nursing Home Care
- Hospice/Palliative Care
- Specialty Medical Care: Audiology/Optical/Podiatry
- Therapeutic Services: Physical/Occupational/Speech/Recreational
- Dental Services

- Mental Health Services
- Social Services
- Medication: Prescription & Over the Counter
- Medical Supplies
- Medical Equipment
- Adult Day Services
- Transportation

PACE Eligibility

- 55 years old or older;
- Living in a PACE service area;
- Able to reside safely in the community;
- Nursing Home Level of Care (SPL 1-13).

PACE Service Areas

Currently the PACE program is offered in the following locations in the state of Oregon:

- Multnomah County
- Clatsop County: Arch Cape, Astoria, Cannon Beach, Hammond, Seaside, Tolovana Park
- Tillamook County: Manzanita, Nehalem, Wheeler
- Washington County: Beaverton, Tualatin, Cornelius, Forest Grove, Hillsboro, Sherwood, Portland
- Clackamas County: Clackamas, Gladstone, Happy Valley, Marylhurst, Oregon City, Tualatin, West Linn, Lake Oswego, Portland

The Oregon Department of Human Services supports a statewide expansion of the PACE program and additional PACE provider organizations.

PACE Provider Organizations

PACE provider organizations are responsible for meeting all the health and social service needs identified in the service recipient's plan of care. APD currently contracts with Providence Health & Services to provide PACE program services in the current PACE service areas in Oregon. Providence Health & Services is a not- for-profit health system providing a comprehensive array of services in Oregon, Washington, Alaska, Montana and California.

Providence brands the PACE program in Oregon as Providence ElderPlace Portland. Providence ElderPlace Portland operates nine Health and Social Centers, two licensed Residential Care Facilities and one Assisted Living Facility in Oregon.

Services are delivered by Providence ElderPlace staff and/or contractors that make up a network of hundreds of healthcare and residential providers.

Referrals to the Providence ElderPlace PACE program can be made on-line at http://appsor.providence.org/oregonemailforms/for-more-information/ or by calling Providence ElderPlace directly at 503-215-6556.

PACE Resources

- DHS APD Contact
    - Cindy Susee, PACE Policy Analyst
        - Direct Line: 503-945-6448
        - cynthia.susee@dhsoha.state.or.us
- PACE Toll-free: 1-844-224-7223
- Federal PACE Overview
- https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/other-medicare-health-plans/PACE

If you have any edits or policy-related questions, contact Paige Organick-Lee at paige.w.organick-lee@odhs.oregon.gov, or DT.Policy@odhs.oregon.gov

Thank you for all that you do!