KIPDA IN-HOME SERVICES POLICIES AND PROCEDURES FY 2023

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THE GUIDE TO THE GUIDE FOR IN-HOME SERVICES

This document is a comprehensive guide to KIPDA's In-Home Services. It is applicable to KIPDA staff, providers, potential clients, and anyone else who wants to learn the details about this service. It is a fluid document that has been designed to be updated and changed as needed. If changes are made that apply to providers, they will be notified and given an updated copy. It also exists as both a printed binder and an electronic document.

This program is also guided by the other policies and procedures in the Aging Services Policies and Procedures manual as well as contracts, standard operating procedures, regulatory language, and other applicable guidance.

Electronic Document:

-On KIPDA's drive, it is found in Aging: Policy and Procedure FY 2023: Social Services and Providers Policies: In-Home Services

-It consists of a PDF version of the printed guide

-It consists of all topics in electronic formats in an electronic file

-Changes should go through Quality Management to prevent the problem of numerous working manuals in several places on the drive (there are still some spacing issues due to importing)

What You Will Find in this Guide:

-The flexibility to add and subtract topics as the situation requires

-A section for three audiences within each policy and procedure topic. These policies and procedures are written for clients, KIPDA staff, and agencies and providers. They can also be utilized when requested at monitoring time, and as a guide for agencies and providers. Within each topic, one will find specifics on how the policies and procedures r relate to each of these groups. They are delineated after the section by the following icons so they can be identified:

For clients 

For KIPDA staff 

For Agencies/Provider 

This policy manual is intended to be a guide for all parties who assisted in the provision of KIPDA's In-Home Services or who are interested in the details of the program. Each policy is presented for three audiences, and with the below icons designating their intended audience.

Clients

KIPDA's Staff

Agencies/Providers/Contractors

INTRODUCTION TO KIPDA'S IN-HOME SERVICES

It is well documented that our communities are aging, but dramatic increases in life expectancy have occurred over the past half-century. It is reported that about four out of five individuals can expect to reach age 80, (Hooyman and Kiyak) About 95% of Americans over age 65 and 80% of those over age 85 live at home. (Institute of Medicine for the Elderly and Functional Dependency) With increasing age comes an increase in chronic illness that affects functioning. Planning for the future of older adults requires a continuum of care option. The combination of an aging society and increased life expectancy lend itself to the need of continuing to develop, expand, and maintain a long-term service and supports infrastructural than can facilitate aging in place, quality care, and dignity in aging, as well as facilitate cost effective and efficient services. The National Institute on Aging (a subsection of the National Institutes of Health) conducts ongoing studies demonstrating the need for a variety of in-home services to be available for our aging population.

In the past ten years, rising costs of nursing home care and the psychological effects of nursing home placement have prompted the government and health care professionals to search for alternative methods of providing long term care. (Long term care includes various levels of care such as nursing facilities, assisted living communities, adult day care, as well as community-based home care services.) The trend to- ward having services in the home, or homecare, has increased since 1989. There continues to be an in- creasing demand for long term care services to maintain the physical, social and mental functioning of old- er adults. The focus of the long- term care system is projected toward the older person with a functional disability who needs assistance with activities of daily living, such as personal care and housekeeping. Per a comprehensive survey completed by AARP in November of 2021 , 77 percent of those 50 and older wish to age in their homes.

Title III of the Older Americans Act, Medicaid and Kentucky State General Funds, and other local funds and grants has provided opportunities for developing community services. Case management is a means of ensuring that services, which are allocated from a pool of limited resources, are used effectively and distributed equitably.

Kentuckiana Regional Planning and Development Agency **(KIPDA),** through its In-Home Services Support Services Program, provide services in the following Kentucky counties : Bullitt , Henry, Jefferson, Oldham, Shelby, Spencer and Trimble.

THE MISSION OF KIPDA'S IN-HOME SERVICES

The mission of KIPDA's In-Home Support Services Program, utilizing the case management process, is to provide quality services to assist persons with disabilities and older adults with limited functioning, to remain independent in their homes and communities. In coordination with community resources, a variety of funding sources, and area providers, services are targeted to eligible community members in greatest economic and social need that are consistent with the scope and funding limitations for each service . The In-Home Services Support Program emphasizes each person's right to self-determination, dignity and quality of life through the provision of assessment and case management, homemaker/home management, personal care, home delivered meals, respite, escort, chore and home repair services.

THE NEED FOR IN-HOME SERVICES, MISSION AND REGULATOR SUPPORT

As communities in America and particularly the communities in Kentucky and within the KIPDA Region continue to age, population projections reflect an increase in the older adult population (60+) of more than 13% since 2009. (Profile of Older Americans: 2020; Administration on Aging Report) The Administration on Community Living (AoA) state projection data indicates that the 60 and older population in the U.S. will increase by approximately 25% from 2005 to 2030. The same report estimates Kentucky's 60

and older population Increasing by approximately 25% during the same time period.

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This program has been authorized by the following legislation: KRS 205.010(6), 205.201, 205.203, 205.455-465, 42USC 3001 et seq. 910KAR 1:180

STATUTORY AUTHORITY: KRS 194.050 , 205.204(2)

This policy manual is intended to be a guide for all parties who assisted in the provision of KIPDA's In-Home Services or who are interested in the details of the program. Each policy is presented for three audiences, and with the below icons designating their intended audience.

Clients

KIPDA's Staff

Agencies/Providers/Contractors

ABUSE, NEGLECT AND EXPLOITATION OF VULNERABLE INDIVIDUALS

For Clients: Abuse of any type is not tolerated. Clients should report any suspected abuse (including concerns about themselves as victims) to their case manager, and to the Kentucky Abuse Reporting Hotline 1- 877 - 597- 2331.

For KIPDA Staff:

Policy: KY State Law, KRS 209, requires all persons to report any suspected cases and/or situations of neglect or abuse of any vulnerable individuals including older adults.

Procedures:

- KIPDA ICC/Case manager and/or Social Service Assistants are to notify Adult Protective Services to report concerns of suspected neglect or abuse.
- KIPDA ICC/Case manager and Social Service Assistant are to indicate suspected neglect or abuse in a progress note indicating the nature of the situation and the date and time Adult Protective Services was contacted.
- Home care aides are to report concerns of suspected neglect or abuse to the KIPDA In-Home Services provider. Providers, either the aide or provider supervisor, shall notify Adult Protective Services. Providers are to contact the KIPDA case manager and note the concern/report in the client database.

QUALITY ASSURANCE:

- The In-Home Services Coordinator and/or Quality Management Planner are to be made aware of the suspected neglect or abuse report.
- The In-Home Services Coordinator, Quality Management Planner, ICC/Case manager or Social Service Assistant will follow-up with Adult Protective Services case worker as to outcome of the possible investigation.
- The In-Home Services Coordinator or Quality Management Planner is to review all documentation related to suspected neglect or abuse situations.

For Providers/Agencies/Contractors:

- All suspected cases of abuse and neglect should be reported to the Kentucky Abuse Hotline 1-877- 597-2331.
- All suspected cases of abuse and neglect should be reported to **KIPDA** as well.

- Agencies should review other abuse, neglect and exploitation guidance in this section as well as in **KIPDA's** other policies and procedures

ADVOCACY

For Clients:

Within regulations, KIPDA staff (specifically ICCs) can and should function as advocates for clients.

For KIPDA Staff:

KIPDA staff is expected to act as advocates for clients in daily operations and when appropriate. KIPDA staff should pay close attention to advocating for those who are more likely to be overlooked in the community. This includes vulnerable adults in rural areas, racial minorities , and other minority populations.

For Agencies/Contractors:

Agencies and contractors should also act as advocates when appropriate for older adults and vulnerable individuals in rural areas, who are minorities, and for those who are members of special populations.

POLICY: KIPDA staff is to serve as advocates on behalf of individuals 60 years of age or older, especially the vulnerable elderly and others as appropriate. The case manager is the advocate for the client who receives case management services.

PROCEDURES:

- An essential direct advocacy role of the case manager is to implement care plans and to assure that the client receives the most appropriate services.

- The case manager advocates for the best interest of the client when communicating with each provider.

- The case manager strives to assist the older person in maintaining autonomy consistent with their functional capacity.

- The case manager is to assist clients in understanding and exercising their rights.

- The case manager supports clients in exercising choices through informed decision-making.

- The case manager identifies gaps in services.

- The case manager identifies the services that are in the greatest demand.

- The case manager shall make referrals to other community agencies for appropriate programs and services. Referrals are to be indicated in a case management note or in the summary/judgment. A follow-up, either with the client or referred agency, shall be made on all referrals by the case manager prior to the next monthly contact.

- The case manager educates the client, family and friends, as to community resources.

QUALITY ASSURANCE:

- Sample case records are reviewed every six months by the In-Home Services Coordinator and/or the Quality Management Planner to determine if referrals are made to other agencies as needed.

- Unmet needs, when there are no available resources, are monitored by review of the client summary on all initial assessments within three days of completion.

- Sample case records will be reviewed every six months by means of an audit checklist as to completion of release of information forms, quality of assurance agreement and client's right to a fair hearing form.

- Efforts to empower/educate client and/or family to make informed decisions will be noted in case reviews as needed .

- Caregiver stress assessments and dementia checklists are monitored on every initial assessment to see if respite care or referral to the KIPDA Caregiver program as needed.

ARRANGING SERVICES

For Clients:

- After the client is approved through intake and assessments, a provider must be identified.
- Depending on what service the client's plan of care identifies, these providers will include an aid for personal care and homemaking, a provider for lawn and chore services, a provider for transportation and a provider for meals.
- **KIPDA's** case manager will make referrals to **KIPDA's** provider network when possible.
- If no provider is available to provide services, sometimes clients will be placed on a waiting list until a provider becomes available.

For KIPDA's Staff:

Policy: ICC shall negotiate with informal and formal service providers for the delivery of needed services to the client. This policy and procedure shall apply to KIPDA staff on a daily basis .

Policy : The Case manager shall make referrals as appropriate to providers/agencies for services not offered through Homecare or additional services where needed (i.e. hot home-delivered meals).

For Agencies/Contractors

- This applies to agencies as they provide services on a daily basis
- Agencies will provide adequate staff to meet the needs of clients
- Agencies will not accept clients when they do not have adequate staff to provide services
- Agencies will communicate effectively and according to policy with clients
- Agencies will become familiar with KIPDA's processes as they relate to arranging services

Procedures:

- The case manager develops a cooperative relationship with providers and knowledge of the provider's capacity to serve the particular client.
- Formal services are arranged to supplement rather than replace informal services (friends, family, etc.)
- By arranging for services, the case manager retains some control over the delivery of services.

- The case manager will be familiar with available resources.
- In circumstances that constitute an emergency, the case manager will determine the emergency status and initiate the appropriate actions to meet the client's immediate needs.
- The case manager takes into account the characteristics of the client, client's family or other informal support system.
- The case manager arranges services that build on identified strengths, compensate for weaknesses and acknowledge the client's uniqueness.
- The case manager shares information that will assist the provider to understand and meet the client's needs.
- The case manager makes use of client's entitlements and other eligible program benefits.
- Services are initiated by a referral with follow-up service orders as appropriate.
- The case manager will thoroughly review clients' file to familiarize themselves on clients' situations, for completeness and to activate clients' services in data system. Case manager should engage client within **48** hours of assignment when possible. In emergency situations a 24 hour turnaround is expected,
- Referrals are not to be accepted verbally.
- Referrals are made through the client database system.
- Service units are not to be verified by case managers in the client data based system, or guaranteed to the client or family, until the file is reviewed by the Program Coordinator or Quality Assurance Planner, entered in the client data base by support staff and assigned to the case manager to input data and activate services.
- The case manager follows up with the provider and/or client to assure that service delivery has been initiated and continues as planned.
- The case manager will document the role and/or tasks of all informal providers to ensure the client's needs are being met.

Quality Assurance:

Utilizing a record audit checklist, the following will be monitored via sample client files and case manager logs with each initial assessment and every six-month review:

1. Informal support utilized (family, neighbors, church, etc.)
2. Chosen provider delivered services that matched client needs
3. Other referrals made on behalf of client, if applicable
4. Case manager follow-up to confirm that services were in place

ASSESSMENT

For Clients:

- An initial comprehensive assessment will be completed for every person seeking in-home services. Every client will be reassessed annually.
- All persons will be assessed and reassessed in person in their place of residence at the time of engagement including home, nursing facility, or hospital; or other facility where the person resides.
- The initial assessment is the collection and evaluation of a person's information and data about their situation and functioning. This information is used to determine the person's service Level and to develop an Individualized Plan of Care.
- Clients should answer assessment questions as thoroughly as possible .

For KIPDA's Staff:

- This policy and procedure applies to KIPDA staff on a daily basis.

For Agencies/Contractors:

- Agencies are not directly involved in assessments, however, the Plan of Care that agencies follow is created during the assessment process.
- Agencies should review assessment processes for situational awareness and to ensure communication between KIPDA case management and subcontracted in-home services.

Policy: KIPDA will utilize the assessments required by DAIL or other regulatory bodies as they apply.

Policy: An initial comprehensive assessment will be completed for every person seeking in- home services . Every client will be reassessed annually. Assessments and reassessments will be completed in the format prescribed by the Department for Aging and Independent Living DAIL) and KIPDA.

Policy: All persons will be assessed and reassessed in person in their place of residence at the time of engagement including home, nursing facility, hospital; or other facility where the person resides.

Policy: Pers n-centered principles and strategies for conducting assessments and reassessments will be utilized by the ICC, Case Managers. Social Service Assistants, In-Home Service Coordinator, the Quality Management Planner, and any other professional engaged in the assessment and reassessment process.

Policy: The initial assessment is the collection and evaluation of a person's information and data about their situation and functioning. This information Is used to determine the person's service Level and to develop an Individualized Plan of Care . The reassessment is the annual (or sooner if deemed necessary due to significant change in status or functioning) reevaluation of the client's situation and functioning.

Policy: The initial assessment and reassessment shall include data and information that will be submitted electronically to the DAIL in formats as required.

Procedures:

The ICC will be responsible for the following during the initial assessment process:

- Based on priority scores, contact the potential client based on receipt of referral to arrange for the initial assessment.
- Utilize person-centered principles and strategies in conducting the assessment .

  Gather information about the client's situation which will allow for identification of the client's problems and care needs in major functional areas.
- Encourage clients to answer all appropriate questions.
- Complete assessment instrument at the time of the interview in the format as determined by the Department for Aging and Independent Living and KIPDA Area Agency on Aging and Independent Living.
- In completing the assessme l lt, a client's failure or refusal to respond should be noted in the assessment .
- Take every precaution to maintain confidentiality of client information.
- Utilize as much time as necessary to complete the assessment.
- Ensure the assessment include demographic information, including family income: physical health; activities of daily living and instrumental activities of daily living; physical environment; mental and emotional status; assistive dev ices, sensory impairment, and communication abilities ; formal and informal resources; and a summary and judgment.
- Determine the fee-paying status based upon the income, size of family, and extraordinary out of pocket medical expenses .

- Determine assessed level of need: Level I, home visit conducted every other month and will be assigned a case manager ; Level 2, a home visit conducted every four months and will be assigned a case manage r; or Level 3, a home visit will be conducted every six months and client shall have a case manager or a Social Service Assistant.
- The ICC/Case Manager shall complete a reassessment annually based on the client's initial assessment date
- The ICC/Case Manager shall complete a reassessment prior to the annual reassessment date if the client has a significant change in their situation and/or functioning.

QUALITY ASSURANCE:

- The number of days before assessments are completed and returned will be monitored on the Initial Assessments to ensure quality of service .
- A client's level of functioning and need for assistance with AOL's and IADL' s will be reviewed on every new assessment and approval given for number of service units.
- Client's financial assessment and fee schedule will be checked on every initial assessment for accuracy.
- Completion of assessment tools such as the nutritional risk, caregiver stress, dementia check- list, and alcohol/drug questions will be reviewed in relation to client needs via the Client Chart Review for Initial Assessments.

CASE MANAGER LOG

For Clients:

- This does not directly apply.
- It is available for informational purposes and geared toward KIPDA's internal staff.

For KIPDA's Staff:

Policy: Case managers have access to a client log to assist them in keeping track of the type of client monitoring that is due each month.

Procedures:

- Level one (1) clients will have a home visit every other month and a phone call on the alternating months . Level two (2) clients will have a home visit every four (4) months and a phone call on months no home visit is completed. Level three (3) clients will have a home visit every six (6) months and a phone call on months no home visit is complete .
- The log consists of client's name, address, phone, and list HY if a home visit is due, TM if a telephone monitoring is due, or RE if a reassessment is due .
- Case managers should monitor the client's appraisal of services based on the level of contact defined or as needed.

QUALITY ASSURANCE:

- Case manager logs will be reviewed every month to ensure continuity of case management.

For Agencies/Contractors:

- This does not directly apply.
- It is available for informational purposes, and geared toward KIPDA's internal staff.

CLIENT REPRESENTATIVES

For Clients:

- This policy applies to both clients and their representatives for the duration of the program.
- Clients should consider designating a trusted individual as a Durable Power of Attorney, Health Care Surrogate, or some other form of legal authority that becomes active in one of two circumstances:

    1. When a client chooses to allow someone else to speak, sign and act on their behalf.
    2. When a client is no longer capable of speaking, signing or acting on their behalf.

For Client Representatives

Policy: The caregiver, who has Durable Power of Attorney giving them authority to act on the client's behalf regarding health care and other decisions, shall agree to receive services, sign an application requesting services, agree to pro-
vide information necessary to complete a plan of care, and participate in the development of the care plan.

For KIPDA Staff:

KIPDA staff are required to enforce and follow this policy and procedure on a regular basis.

For Agencies/Providers:

This policy applies to agencies in the In-Home Services as well. Agencies are required to be aware of who they should communicate with during scheduling and as questions arise .

Procedures:

- ICC will indicate in the initial assessment that documentation to verify legal authority of the caregiver has been viewed. The type of authorization and date viewed should be indicated on the enrollment form.
- Caregivers with legal authority to act on a client's behalf will sign a statement of understanding and will receive a copy of the caregiver responsibilities.
- When the client is accepted into the In-Home Services Program, the caregiver shall:

    1. Notify the Provider if the client is not going to be home when services are scheduled. If the client misses three (3) consecutive service dates without notifying the KIPDA Case Manager,

services are subject to termination.

2. Notify the KIPDA Case Manager if the Provider fails to deliver services as scheduled.
3. Never sign a time sheet that is blank or does not have the correct time that the aide has been in the home.
4. Never sign a time sheet when the aide does not follow the client's care plan. Never ask the aide to do things that are not on the care plan.
5. Treat the aide with respect. Verbal abuse will not be tolerated and may result in the termination of services. Never ask the aide for their home telephone number or address.
6. Never phone the aide at home.
7. Be available monthly for home visit or telephone monitoring by the **KIPDA** case manager. Be available annually for reassessment by the **KIPDA** case manager.
8. Risk reduced or cancelled services for failure to fulfill caregiver responsibilities as the legal representative for client.

Policy: When clients are unable cosign their KIPDA application and other assessment forms due to physical or mental incapacity, a representative/proxy must have legal authorization in order to sign the forms and make financial and/ o r health care decisions for the client. Representatives should have Guardianship, Power of Attorney, or Durable Power of Attorney or another form of legal designation.

Procedures:

- At the time of the Initial assessment, ICCs are to ask for verification of legal authority when another person is signing **KIPDA** forms for the client.
- On the client enrollment form, the ICC should designate the type of authority the representative has along with the name of the person or agency, effective date and phone number.
- If the client is incapacitated and unable to sign the enrollment form, care plan, and fee determination form (if applicable), the legal representative may sign for the client during the initial assessment.
- The ICC will info r m the client and representative of their rights and obligations under the In-Home Services Program to verify the client's eligibility for service and the representative's legal basis for authority to speak for the client.
- During the initial assessment, ICCs are to inquire if the client has an advanced directive and give an explanation/ description on the enrollment form whether the legal document is a Living Will, Do Not Resuscitate Order or a separate document appointing a Health Care Surrogate.
- When appropriate, ICCs will instruct the client's legal representative to sign authorization forms giving KIPDA In-Home Services permission to use or share client Protected Health Information (PHI).
- Caregivers with legal authority to act on behalf of a client will be given a copy of the caregivers' responsibilities policy at the time a ICC completes the initial assessment for In-Home services.

QUALITY ASSURANCE:

- For each initial assessment, the enrollment form will be reviewed and monitored for the verification of the legal representative's authority to act on behalf of the client.

    - Signatures of the legal representative on all applicable forms in the completed assessment packet will be reviewed for consistency
    - Caregivers with legal authority to act on behalf of a client will be given a copy of the caregivers' responsibilities policy at the time a ICC/case managers completes the initial assessment for the In-Home Services Program

Policies: The caregiver, who has Durable Power of Attorney giving them authority to act on the client's behalf regarding health care and other decisions, shall agree to receive services, sign an application requesting services, agree to provide information necessary to complete a plan of care, and participate in the development of the care plan.

QUALITY ASSURANCE:

- The Quality Assurance Planner will review a sample of initial assessments to monitor that verification of legal authority has been noted .
- Caregivers with legal authority to act on behalf of a client will be given a copy of the caregivers' responsibilities policy at the time an ICC Coordinator completes the initial assessment for the In-Home Services Program.

CLIENT COMPLAINTS/CONCERNS

For Clients:

On admission to the In-Home Services Program, each client shall be given a copy of the Quality Service Agreement (DAIL-HC-02) and the Request for Fair Hearing Form. The Agreement shall be read and explained co the client when necessary. The client shall acknowledge receipt when signing the care plan. Use of the standardized form is required. Clients have the right to file complaints using general policies and procedures related to KIPDA's Division of Social Services. Clients may also request a Fair Hearing. This process is also detailed in ocher KIPDA policies and procedures.

For KIPDA Staff:

- This policy applies to KIPDA staff on a regular basis.

For Agencies/Contractors:

- Agencies/Contractors should develop and maintain policies and procedures related to complaints that reflect and coordinate with KIPDA's as appropriate.
- Agencies/Contractors should respond as needed and requested to client complaints and should maintain open communication .

Policy: On admission to the In-Home Services Program, each client shall be given a copy of the Quality Service Agreement (DAIL-HC-02). The Agreement shall be read and explained to the client when necessary. The client shall acknowledge receipt when signing the care plan. Use of the standardized form is required.

Procedures:

- Each In-Home client is to be given a completed Quality Service Agreement on admission that contains the name, address and phone number of the current ICC/Case manager and Social Service Assistant and the Quality Management Planner and/or In-Home Services Coordinator .
- If an In-Home client calls or contacts the ICC/Case manager, Social Service Assistant, Quality Assurance Planner or In-Home Services Coordinator, the individual receiving the call or having the contact shall complete a Report of Complaint or Concern form.

Policy: All complaints regarding staff and/or quality of services shall be documented in the client's file record. This could mean electronic or paper file.

Procedures:

- Each time a complaint is made, a copy of the written complaint will be kept as well as entered in the appropriate data system.
- When the provider responds to the concern/complaint a copy shall be placed in the binder or the information will be entered into the appropriate data system.
- Any action taken by the case manager/ICC Coordinator to assist the client or to resolve the complaint shall be noted . This could be a case note attached to the complaint, or a brief note written under the comment/complaint section.

QUALITY ASSURANCE:

- The In-Home Services Coordinator and the Quality Assurance Planner will do periodic monitoring of complaints and concerns.

- ICC/Case manager and Social Service Assistant will be encouraged to discuss complaints/concerns with the In-Home Services Coordinator and/or the Quality Assurance Planner to determine ways to resolve the complaint as needed.

CLIENT RESPONSIBILITIES

Upon being accepted into the In-Home Service Program, the client shall:

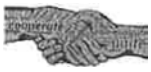
- Notify the personal services agency or KIPDA case manager if they are not going to be home when services are scheduled;
- Notify the **KIPDA** case manager if the Contractor/a agency fails to deliver services as scheduled ;
- Never sign a time sheet that is blank or does not have correct time that the aide has been in the home, shopping or at the laundry center ;
- Neve r sign a time sheet when the aide does not follow your care plan;
- Submit payment upon receipt of bill. Late payment may cause services to stop. This applies to fee-paying clients only;
- Never ask the aide to do things that are not on the care plan;
- Realize that aides are forbidden to complete work caused by visitors or pets in your home;
- Treat the aide with respect. Verbal abuse will not be tolerated and may result in the termination of services;
- Neve r ask the aide for their ho me tele pho ne numb er or address or contact the aid directly. Communication should be with the agency providing care;
- Have grocery shopping list prepared for aide upon arrival. Aide is only allowed to complete shopping at the closest grocery store:
- Be available monthly for home visit or telephone monitoring by the **KIPDA** case manager;
- Be available every six (6) months or annually for re-assessment by the KIPDA case manager;
- Never risk reduced or cancelled services for failure to fulfill client responsibilities.
- Never give aides money for services provided;
- Notify their Case Manager if they become eligible for Medicaid Waiver

Client Responsibilities for KIPDA Staff:

- Remind clients as needed to fulfill these obligations.
- Refer to client responsibilities if a corrective action plan needs to be issued due to lack of compliance

Client Responsibilities for Agencies

- Train aids on not giving their phone numbers to clients.
- Train aids on not providing services off-the-clock.
- Educate and encourage clients to follow responsibilities listed he re



CLIENT RESPONSIBILITIES

POLICY: The client shall agree to receive services, sign an application requesting services (as required), agree to provide information necessary to complete a plan of care, and participate in the development of the care plan.

For Clients: This policy explains what clients need to do to comply with the program, as well as what to expect.

For KIPA Staff: Staff should provide forms, educate, and enforce these responsibilities as needed.

For Contractors/Providers: This is for information purposes, and providers should educate and enforce these responsibilities as needed.

PROCEDURES:

- Each client shall sign an application for services within 30 days of receiving services under the In-Home Services Program.
- The client and/or caregiver will be asked to verify income, if questionable ; sign a release of information to specified agencies; to agree that the Cabinet for Health and Family Services and KIPDA shall have access to case records for monitoring purposes; and agree to the "Client Responsibilities"
- If a client is unable, for physical or mental reasons, to consent and has a Durable Power of Attorney, (DPOA) the person with POA must sign the application.
- The ICC/Case manager and Social Service Assistant must verify that the person has the legal documentation to sign on behalf of the client.
- The client or DPOA is requested to specify needs, discuss goals and make choices as to a service provider.

POLICY: When accepted into the In-Home Services Program, the client and/or caregiver shall agree to cooperate with the service provider. If the client is unable to make decisions regarding their needs, another person agrees to act on their behalf If they have the legal authority to do so. ICC/Case manager and Social Service Assistant will verify legal documents and make note of them in the case record.

PROCEDURES:

- When the client is not going to be at home when services are scheduled, the ICC/Case manager and Social Service Assistant should be notified.
- The client should notify the ICC/Case manager and Social Service Assistant if the worker does not arrive on a scheduled service day.

- When a client misses three (3) consecutive service dates without notifying the service provider and/or case manager, services may be terminated. The client will be asked for a reason for the missed service dates.
- Fee paying clients, for some or all of their services, will be required to pay that fee when billed. Clients should contact the ICC/Case manager and Social Service Assistant when they have a question about the fee. Failure to pay the bill may cause services to stop.
- The client should not sign a time sheet that is blank or does not have the correct time that the worker was at the home, shopping or at the laundry center.
- The client should not sign a time sheet when the aide/worker does not follow the care plan.
- The client should not ask the aide to do things that are not part of the care plan. ff the client needs additional services, they should contact the case manager.
- The client should not ask the aide to complete household tasks that are related to visitors or pets.
- The aide should be treated with respect. Physical abuse, verbal abuse or sexual harassment is not acceptable for the client or the aide.
- The client should not ask the aide for a home phone number or address.
- The client should not call the aide at home.
- The client should have a grocery list prepared for the homemaker upon arrival. The aide is only allowed to complete shopping at the closest grocery store.
- The client should be available monthly for telephone monitoring or a home visit by the case manager or Social Service Assistant depending on the service level of the client. Documentation of visit or call should be completed within one week of contact.
- The client should be available annually for the reassessment visit by the case manager. Documentation of the visit should be completed within three (3) days when there are changes to the care plan.
- Services for the client may be terminated for failure to cooperate with these responsibilities.

POLICY: A provider may request suspension of service to a client where the provider, upon consultation with KIPDA, determines that providing service poses a danger to any person.

PROCEDURES:

- Suspended service may remain in effect until **KIPDA** staff determines that a dangerous situation has been abated or eliminated.
- No advance notice is required if the aide feels an imminently dangerous situation exists.

QUALITY ASSURANCE:

- A sample of responsibilities of both client and service provider staff will be monitored every six months via case records, billing reports and documented client and service provider contacts.

- Timeliness in reporting any concerns and/or incidents will be monitored by the In-Home Services Coordinator on an ongoing basis in order to assure client and service provider satisfaction and safety.

- ICC/Case manager and Social Service Assistant are encouraged to discuss any disparity/violation of these responsibilities with the In-Home Services Coordinator within three days of the occurrence.

CLIENT TRANSITION PLAN

For Clients:

- Clients should contact their KIPDA case manager if they wish to request a new provider.

For KIPDA Staff:

- These policies and procedures should be followed when clients wish to transfer.

For Agencies/Contractors

- Agencies/contractors should cooperate and coordinate when KIPDA clients are transferring between agencies.
- Agencies should review processes for KIPDA staff and clients.

Policy: When clients are transferred to a new provider or new ICC/Case manager and Social Service Assistant for service, confidentiality of all written and verbal information provided by or about any client will be assured. Whenever possible, applicable records will be transferred to the new service provider within one business day.

Procedures:

- The ICC/Case manager and Social Service Assistant will discuss the transfer of duties to the new service provider with the client.
- The ICC/Case manager and Social Service Assistant will assure the client that there will be no interruption in services, and the quality of services will be maintained.
- Transfer summaries are completed and any pertinent information about the client is shared with the new case manager and/or new provider.
- Client case records are maintained in a secured location and appropriate portions copied and forwarded to the new service provider.
- When a provider closes a case or transfers to a new service provider, the agency can provide KIPDA with copies of all client files where all information is recorded for the fiscal year, or provide KIPDA with the original client files and KIPDA will maintain the records according to state regulations.

QUALITY ASSURANCE:

- A letter from In- Home Services staff will be sent to clients informing them of a change in service and/or provider, along with an assurance that services will not be interrupted.
- The case manager's objective is to ensure a smooth transition with the least amount of anxiety for the client. All complaints regarding delay in service will be documented in the case record.
- Case managers are to be available to clients to answer questions about the transitions.
- Transfers will be monitored to ensure continuity and quality of services.

CONFIDENTIALITY/CLIENT'S RIGHT TO PRIVACY/HIPAA

For Clients:

- No information will be released without the informed written consent of the client . Only the minimum information necessary to achieve the desired purpose should be released, and only to agencies listed on the Authorization to Use/Share Client Protected Health Information (PHI)

For KIPDA Staff:

Policy: No information will be released without the informed written consent of the client. Only the minimum information necessary to achieve the desired purpose should be released, and only to agencies listed on the Authorization to Use/Share Client Protected Health Information (PHI). All other policies, rules, and regulations surrounding HIPAA/HITECH and privacy will be followed.

For Agencies/Contractors:

- Agencies/Contractors should follow all HIPAA/HITECH/Confidentiality regulations, protocols, and processes listed here and in KIPDA's HIPAA/HITECH policies.
- Agencies/Contractors need to create their own HIPAA/HITECH/Confidentiality processes that should be available at monitoring time.

Procedures:

- The ICC/Case manager conducts client interviews in the presence of others only with explicit written consent of the client . Exceptions include the client's inability to understand a request of consent or the client's inability to hear and/or speak.
- The ICC / Case manager and Social Service Assistant obtains information from other persons or agencies and/or shares information with others only when it serves the purpose of meeting the client 's needs or as required by law.
- The ICC/Case manager and Social Service Assistant will not share information about clients, including photographs, with members of the media without the client's written permission.
- The ICC/Case manager and Social Service Assistant must never share information about clients for commercial or marketing purposes .
- The ICC /Case manager and Social Service Assistant , when providing information regarding clients , will tell the client who will be getting the information and ask the client what he/she does not want

communicated with other persons or agencies.

- The ICC/Case manager and Social Service Assistant may not honor confidentiality if the client is a danger to self or others or if elder abuse is suspected. Sharing this type of information is required by state law.
- The client will sign and date the "Application for Services" and the "Release of Information" forms in order to re- lease information to agencies that are listed on the form. Both forms are completed in the presence of the client.
- In-Home Services staff should never converse about clients in common areas at the office, in the community or at home.
- In-Home Services staff must never take client files or other client-related information home, or keep them in a personal vehicle outside of routine work activities.
- In-Home Services staff should keep client information as confidential as possible in their work space.

QUALITY ASSURANCE:

- Client signatures on applications and release of information forms are reviewed on every new assessment before forms are mailed out to providers.
- Any reports made for suspected elder abuse will be documented in the client file and followed in conjunction with appropriate agencies.
- ICC/Case manager will document in the client file that they have seen POA, living will, health care surrogate, and legal guardian forms.
- Staff and volunteers having access to client files will receive HIPAA training and orientation in the principles and practices of confidentiality, and will sign confidentiality statements as appropriate.

For Agencies/Contractors:

- Agencies/Contractor s should follow all HIPAA/HITECH/Confidentiality regulations, protocols, and processes listed here and in KIPDA's HIPAA/HITECH policies.
- Agencies/Contractors need to create their own HIPAA/HITECH/Confidentiality processes that should be available at monitoring time.

DOCUMENTATION GUIDELINES

For Clients:

- Clients should read documents and ask the ICC/case manager for clarification before signing them.
- Clients should keep their copies of program-related documents for reference.
- Clients should sign information release forms when they wish to share information.
- Clients should ask their case managers whenever they have questions about their documentation.

For KIPDA Staff: KIPDA staff should follow this in daily operations.

Policy: ICCs will provide accurate and comprehensive documentation on agency specific forms related to the provision of quality services to all in-home services clients.

Procedures:

- All paperwork will be completed in the assessment packets before a request for copy is made for them to be mailed out.
- Before mailing out any information from the assessment packet , a PHI form is to be completed in order to share the information.
- As the client's needs change, the care plan will be revised.
- All client support systems are listed on the care plan.
- When there is a change to the clients care plan, a copy of the care plan must be mailed to the client.
- When a request for a change in the service day is sent, the case manager is to respond within two days.
- The written care plan and information in the data system must match.
- Progress notes are to be written in the electronic data system whenever there is contact with the client, caregiver, family, provider, and/or other agency. All contacts should be recorded within three days after the contact.
- Progress notes are signed and credentialed as well as having the time in and time out indicated.
- Handwritten information must be legible but should be avoided whenever possible .
- Records are written in black ink or typed with each entry dated.

- When correcting paperwork, a line is to be drawn through the mistake and the correction is to be initialed. Never use white out.
- Do not back date any schedules, suspensions, start dates, or end dates .
- ICCs must indicate on the In-Home Services client logs (every two weeks) any home visit, phone call or reassessment visit.
- ICCs must indicate on the In-Home Services client logs (every two weeks) any home visit, phone call or reassessment visit.
  - Bill all units to the correct codes and programs.
  - All billed units are to have a corresponding case note.
  - ICCs must make any necessary fee changes on the client's face sheet and date the change.
  - Case managers/ICC should bill only for the time spent with the client, on the client's behalf, with a client's POA or activities on client's behalf.
  - Case managers/ICCs are to contact past-due clients and arrange for the bill payment to be made.
  - Maintain standard confidentiality and HIPAA standards of all documentation.

QUALITY ASSURANCE:

- Documentation in randomly selected case records will be reviewed every month by the In-Home Services Coordinator and/or the Quality Assurance Planner to ensure accuracy, comprehensiveness, eligibility and provision of services to meet the assessed needs.
- Initial assessments will be returned to the ICC for corrections/changes if applicable.

For Agencies/Contractors

- Review documentation requirements for KIPDA staff
- Bill all units to the correct codes and programs.
- All billed units are to have a corresponding case note .
- Progress notes are signed and credentialed as well as having the time in and time out indicated.
- Handwritten information must be legible but should be avoided whenever possible.
- Records are written in black ink or typed with each entry dated.
- When correcting paperwork, a line is to be drawn through the mistake and the correction is to be initialed. Never use white out.
- Do not back date any schedules, suspensions, start dates, or end dates .
- Maintain standard confidentiality and HIPAA standards of all documentation.

EDUCATION AND TRAINING RESPONSIBILITIES FOR AGENCIES/PROVIDERS

For Clients:

- This is largely for informational purposes, and to set expectations for what knowledge and skills that they can expect from agency-provided caregivers.

For KIPDA Staff:

- KIPDA will enforce these requirements at monitoring time and offer guidance if contracting agencies have questions.

For Agencies/Providers:

- This section is primary geared towards this audience. They should follow the provisions here in daily operations and service delivery.

-The designated KIPDA contractor shall provide education and training in accordance with the requirements of KIPDA AAA as prescribed by DAIL.

-Contracted Agencies' staff shall initially be provided a comprehensive training course of a minimum of 16 hours, 8 of which must be provided prior to any work assignments. Initial training topics to include: An Overview of the Aging Population and Needs (working with older individuals, role of the family, working with individuals with disabilities, death and dying), The Role of the Homemaker (personal care services, medications, food and nutrition/meal planning and preparing, maintaining a clean and safe environment, Records (Client confidentiality, record keeping, communication). Cultural humility, person-centered services, and training from the Office Dementia Services is now required.

-Professional Responsibilities (recognizing and reporting abuse, neglect and exploitation of children and adults, person- centered planning)

-Additionally, in the initial training, an in-home service caregiver must participate in eight (8) hours shadowing an experienced trained in-home services caregiver prior to working independently.

-For every year thereafter, agency staff and in-home service caregivers shall complete annual training of eight (8) hours of refresher courses/training annually. Annual training topics to include but are not limited to: understanding cultural differences, and cultural humility. Cancers, heart disease, diabetes, stroke, range of motion exercises, body mechanics, special diets: low sodium, low fat, diabetic, ulcers, basic CPR, first aid re-certification, protecting oneself and others in potentially dangerous situations, continuous personal care of the bed bound client, HIPPA and advance directives, emergency preparedness. It can also include working with individuals who are older, individuals with disabilities, and

individuals with dementia.

-In-home service caregivers who have worked for the contracted agencies for a long period of time shall also participate in the 8 hours of annual training. The training requirements for In-Home Service caregivers are set forth by Kentucky Regulations and KIPDA.

-Each caregiver who produces proof of successful completion of Certified Nurse's Aide training in a hospital, long-term care facility or home health agency shall be required to complete all training required by this policy which were not included in the facility or home health curriculum. A copy of the curriculum will be required.

-KAR I: 180 states that training must include:

Procedures for reporting abuse, neglect, or exploitation of an adult pursuant to KRS 209.030(2) and (3), or child abuse or neglect pursuant to KRS 620.030(I);

Procedures for facilitating the self-administration of medications if personal services agency staff facilitate the self-administration of medication; and

Effective communication techniques tailored to individual client needs.

-Records of in-home service caregiver training and in-services shall be maintained including:

Attendance; number of hours

Subject; instructor; course outline

Results of test or return demonstrations

ELIGIBILITY

For Clients:

- This should be used as a guide for clients to know whether or not they meet eligibility requirements for this program.

For KIPDA Staff:

- These processes should be followed when individuals want to apply for this program.

For Agencies/Providers:

- This does not directly apply, but it is useful information for agencies.

Each applicant for In-Home Services shall file an application for participation. Eligibility is based on the following criterion:

- A person 60 years of age or older whose functional limitations are such that the individual requires a sheltered environment with provision of meals and/or other social and health related services specific to their activities of daily living.
- Impaired in at least two (2) physical Activities of Daily Living (feeding self, getting in/out of bed or other transfers, dressing, bathing, toileting) , or
- Impaired in at least three (3) Instrumental Activities of Daily Living (meal preparation, light house- work, heavy housework, laundry. shopping, taking and/or organizing medicine), or
- Impaired in a combination of one (I) activity of daily living and two (2) instrumental activities of daily living.

OR

- A person 60 years of age or older with an essentially stable medical condition requiring non-medical health services along with services related to activities of daily living who would otherwise require an institutional level of care, A person 60 years of age or older currently residing in a skilled nursing facility, an intermediate care facility or a personal care facility who can be maintained at home if appropriate living arrangements and support systems can be established.

- Eligibility shall be determined at the initial assessment and at each reassessment. Only

individuals who have been trained and meet the qualifications of an assessor or case manager pursuant to 910 KAR 1:180 Section 5(1) shall determine eligibility.

- In-Home Service applicants shall be informed within thirty days of the assessment that they shall be eligible for services if they meet eligibility requirements. The eligible applicant shall then be called a "client".

- Eligibility determination shall be based upon physical (functional) impairments; however, the assessor and case manager may consider individuals whose deficiencies are caused by mental or emotional impairments including Alzheimer's or other related disorders if these impairments affect physical (functional) capacities.

- The In-Home Service program shall not supplant or replace services provided by the person's informal support system or natural supports. Careful consideration should be given to persons whose supports are strained by meeting the person's needs. A person who is eligible for Respite services shall not be deemed ineligible as a result of this definition. Caregiver relief is important to the person's health, safety, and welfare and will qualify a person for Respite services.

Emergency In-Home Service Eligibility

- A person who is 60 years of age or older, screened with a high priority score, has limited or non-existent informal or natural supports and would be institutionalized. Or, has recently been discharged from a hospital or institution with little or no support and has the risk of returning. Or, has a Caregiver who is ill and cannot fully perform in a caregiving role . Or, who is terminally ill and eligible for Hospice but requires in-home services either not provided by a Hospice agency or as an additional support to the caregiver.

EMERGENCY AND HOLIDAY SCHEDULING

For Clients: This policy is a guide to what you should expect from scheduling during these times .

For KIPDA Staff: KIPDA staff should be aware of this policy so it can be enforced from a case management perspective.

For Agencies/Contractors: This policy applies to agencies and contractors in the In-Horne Services program. They are expected to follow these provisions as much as possible.

To ensure quality service during any holiday period, inclement weather, and weather emergencies, KIPDA has developed the following holiday policy:

- Clients needing essential services shall receive them either on the holiday or one (I) day either prior to or following the holiday. Clients needing essential services include individuals that need one or more of the following:
  -Assistance in and out of bed;
  -At least 5 day per week meal prep;
  and/or need incontinent care

- Clients receiving non-essential services shall receive make-up service the week of the holiday. Make-up service must be rescheduled with the client in advance and cannot be rescheduled into the next month. Non-essential services include: escort, homemaking, personal care not included in previous listing, home repair, and/or chore.

- If the client's regularly frozen meal delivery falls on a holiday, meals should be delivered prior to the holiday to avoid a lapse in coverage . For clients receiving hot meals, a shelf stable meal can be delivered in lieu of the hot meal prior to the holiday.

FEES AND CONTRIBUTIONS FROM IN-HOME SERVICES CLIENTS

For Clients:

- A fee shall not be assessed for an eligible individual who meets the definition of "needy aged" as governed by KRS 205.0101(6).
- SSI income shall not be deemed available to other family members. The applicant receiving SSI benefits shall be considered a family of one (I) for the purpose of fee determination.
- Eligible clients shall be charged a fee determined by the cost of the service unit multiplied by the applicable percent- age rate based upon income and size of family as set forth below. Service unit cost shall be determined by **KIPDA** in accordance with its contract.
- Contributions from individuals, families or other entities shall be encouraged. Pressure shall not be placed upon the client to donate or contribute. Services shall not be withheld from an eligible client based upon his/her failure to contribute to support services.
- In all cases the client shall be informed of his right to a fair hearing and provided with a copy of DSS-154 Request for Fair Hearing form. Clients shall be advised that staff will provide assistance to complete DSS-154

For KIPDA Staff

- A fee shall not be assessed for the provision of assessment or case management services .
- The assessor or case manager shall consider extraordinary out-of- pocket expenses to determine a client's ability to pay. Waiver or reduction of fee due to extraordinary out -of- pocket expenses shall be documented on the FEE DETERMINATION WORKSHEET for Extraordinary Expenses , herein incorporated by reference.
- A fee shall not be assessed for an eligible individual who meets the definition of "needy aged" as governed by KRS 205.0101(6).
- SSI income shall not be deemed available to other family members. The applicant receiving SSI benefits shall be considered a family of one (I) for the purpose of fee determination.
- Eligible clients shall be charged a fee determined by the cost of the service unit multiplied by the applicable percent- age rate based upon income and size of family as set forth below . Service unit cost shall be determined by KIPDA in accordance with its contract.
- Contributions from individuals, families or other entities shall be encouraged. Client will be informed by case management that a contribution letter may be received monthly from their provider. Pressure shall not be placed up- on the client to donate or contribute . Services shall not be withheld from an eligible client based upon his/her failure to contribute to support services.
- **KIPDA AAA** shall review and approve the procedures implemented by provider agencies for the collecting, accounting, spending and auditing of donations. **KIPDA** shall be responsible for billing fee-paying clients.
- Fee paying clients who fail to submit payment for two months after proper billing may be terminated from the program. The Database Technician shall prepare and deliver a listing of clients who are two months in arrears to the Assessment and Case Management Coordinator. The Coordinator shall meet with the client's Case Manager and if necessary, the Community Services and Supports Manager to discuss any special circumstances that might exist. If it is determined that special circumstances do not exist, then the Case Manager shall send notice to the client of possible termination

and a form to appeal the decision. The notice shall inform the client that they are in arrearage and will be terminated from the program if payment is not received within one month of notice or if arrangements are not worked out with KIPDA for a payment plan. If a client files an appeal of the decision, services will be continued until a hearing can be held and a determination can be made. When special circumstances are found to exist, services to client may continue with the approval of the Program Coordinator and/or Division Director.

- In all cases, the client will be informed of their right to a fair hearing and provided with the request for Fair Hearing Form. Clients will be advised that staff can provide assistance with the form.

Guidance for Agencies/Contractors

- They are not obligated to collect fees under these circumstances.

IN-HOME EMERGENCY SERVICES

For Clients:

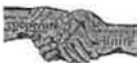
- This information advises clients on this option, and whether or not they are qualified for this service .

For KIPDA staff:

- These policies and procedures should be followed by KIPDA staff.

For Agencies/Providers:

- This is for informational purposes.



The intent of the In-Home Emergency Services Program is to provide temporary service intervention to prevent premature or inevitable nursing home placement.

Services offered include: Homemaking, Respite, and Personal Care as defined under the Homecare program. One unit of service equals one hour. Other services may be provided through other available programs based on client need.

Acceptance into the In-Home Emergency Services Program requires a face-to-face assessment by a qualified **KIPDA** Assessor. The assessment will identify the physical needs of the person. The service will be time limited and will not extend beyond eight (8) weeks. Services should begin within 24 hours after the assessment is completed, and the client is deemed eligible.

There is no fee for this program, however, if services are needed beyond the eight (8) week period, the client will be assessed for the KIPDA Homecare Program contingent upon the availability of Homecare funds. Homecare is a sliding fee scale program. Finances are assessed to determine if the client will be required to pay a percentage of the Homecare service cost.

INITIAL CONTACT/INTAKE

For Clients:

- Please call KIPDA's Aging and Disability Resource Center (ADRC) if you or your family member is interested in learning more about KIPDA's In-Home Services.

For KIPDA Staff

Policy: Follow-up will occur for all referrals and initial calls from potential within 24 hours by the ADRC staff or the next business day.

Procedures:

The ADRC staff will be responsible for:

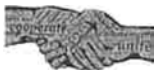
- Providing information about case management, specific services available, waiting list status, and complete a preliminary assessment of eligibility.
- Gathering basic demographic information, health and functional capacity, income, and information in regard to client's support system.
- Informing the potential client or family member whether they qualify for In-Home services based on the information they have been given.
- Informing the potential client or family member that a home visit is required and that an Independent Care Coordinator (ICC) will call to set up an appointment.
- Entering intake information into the data system with a hard copy printed out for the assigned ICC.
- The potential client is placed on a waiting list based on service need and given a code that runs from the lowest need (need only for housekeeping) to the highest need (always requires personal care, transportation, and/or respite and other services).
- The ICC will be assigned the intakes on a weekly schedule and replacements will be distributed as needed.
- Intakes will be assigned to ICC based on zip code areas in Jefferson County. Each rural county will have an assigned case manager.
- The ICC will contact the potential client within 3 days after reviewing the intake. If the case manager is unable to contact the client, a case note must be written indicating the reason and return it to the Social Service Technician.
- All initial assessments will be completed and turned in within 3 working days of first face to face contact.
- Determine if language or other communication services are needed (all KIPDA contractors and all KIPDA staff follow the policy in the General policies and procedures) and provide for those needs. They will be followed through the duration of service.

QUALITY ASSURANCE:

- Assessed clients who are waiting for service will be monitored on a monthly basis.
- Priority status will be designated by a numerical ranking system that is designed to ensure that clients with greatest needs are served first (minority, non-English speaking, rural, lives alone, exceptionally frail, and other characteristics as defined by contract, regulations, other policies and procedures, etc.)
- Caseloads and service areas will be monitored quarterly by the In-Home Services Coordinator to ensure efficiency of travel by case managers and ICC Coordinator making home visits.
- Every three months the waiting list (clients waiting to be assessed) will be purged and the status of client will be checked via a phone call by In-Home Services support staff.
- The In-Home Services Coordinator and/ Eligibility Coordinator will receive, review, and maintain the waiting list numbers and priority ranking of clients regularly.

For In-Home Services Agencies/Contractors

- Agencies/contractors are not involved in the process until after the assessment.
- If there are potential new clients, agencies should refer them to KIPDA's ADRC at 266.5571 .



INFORMED CONSENT

For Clients:

Policy: Clients have the right to participate in their care planning. Clients have the right to receive information necessary to give informed consent or refusal for all or part of their care.

Procedures:

- At the time of the assessment the client is encouraged to take an active role in the plan of care.
- If the ICC/case manager determines that the client is unable to provide needed information, a proxy will be consulted. However, the ICC/case manager should still actively involve the client in decision-making.
- The case manager and the client are to agree on the needs and work together to find solutions.
- The In-Home services program shall not supplant or replace services provided by the client's informal support system.
- When provider options are applicable, clients will be given fact sheets from service providers and encouraged to choose their preferred provider agency.

For KIPDA Staff:

- Please review the guidance provided for clients.
- If the ICC/case manager determines that the client is unable to provide needed information, a proxy will be consulted. However, the ICC/case manager should still actively involve the client in decision-making.
- The case manager and the client are to agree on the needs and work together to find solutions.
- The In-Home services program shall not supplant or replace services provided by the client's informal support system.
- When provider options are applicable, clients will be given fact sheets from service providers and encouraged to choose their preferred provider agency.

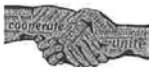
QUALITY ASSURANCE

- Client must understand and approve of the care plan goals. A yearly satisfaction survey of In-Home Services clients selected at random will be conducted to evaluate client's understanding and participation in their care plan.

- The client and ICC Coordinator will sign the care plan. Signatures on all initial assessments will be randomly reviewed by the Program Coordinator or Quality Assurance Planner to ensure accuracy and completeness.

For Agencies/Contractors:

- Review processes for KIPDA staff and clients.
- Seek informed consent from the client when applicable in matters related to agencies/contractors.
- Seek direction from the ICC/case manager if there are questions.



KIPDA's IN-HOME SERVICES OPERATIONS

For Clients: This does not directly apply. It is for informational purposes.

For KIPDA Staff:

- KIPDA staff should follow the provisions in this policy and procedure on a daily basis.

For Agencies/Contractors:

- Does not directly apply. It is for informational purposes only.

Policy: Full-time support staff will provide assistance to the In-Home Services Program in the areas of mailing; filing; copying; typing letters, documents, etc.; compiling case charts; printing case manager logs; answering phones; providing information; opening and closing case filing cabinets; providing back-up for intake social services technician; etc. The support they provide assists the case manager, the quality assurance planner, the in-home services coordinator, and other staff to function in the provision of services to older adults.

Procedures:

1) Filing cabinets containing client case records are to be unlocked at the beginning and close of every work day. Staff support personnel will keep the keys to the files in a secure area.
2) Client forms are to be maintained in a forms drawer with support staff replenishing the forms as needed in designated folders.
3) Support staff will file client progress notes on a weekly basis and maintain consistency of forms placement in the client case record.
4) Support staff person will check the obituaries from the

daily newspaper to determine if any In-Home Service program clients are deceased. Names of active clients that have died will be given to the assigned case manager. Support staff will remove deceased clients from the data system.

5) When an active case is closed the client fries will be placed in a folder and put in a box in the closet. Closet door must be kept secure and closed at all times.

6) Phone coverage must be maintained from 8:00AM to 5:00PM, Monday through Friday. The phone should be answered within three rings.

7) Support staff will be responsible for filing client forms that are returned via the mail.

8) Support staff will enter new clients into the data system according to information gathered from the initial assessments. Charts will be opened for services or placed on a waiting list. Providers are to receive a copy of the care plan and summary/judgment for all clients that are to receive assistance in their homes.

9) Support staff will add new clients to the "logs" system.

10) A Request for Copy form is completed for each new assessment and reassessment indicating to the support staff which forms are to be mailed to the provider, doctor and/or family to sign and mail back.

11) When a client is to receive Adult Day Care, copies of the entire assessment packet are mailed to the provider.

12) Client reassessments are to be checked and matched with the previous assessment and/or reassessment and changes are put in the data system.

13) Support staff shall check the mail for client closures, chore orders, revised care plans, address changes, etc.; make necessary changes and file charts.

Other procedures for in-home service programs may be added and implemented in accordance with the specific program rules, structure and regulations.

Quality Assurance:

- All support staff are given three pages of mailing instructions pertaining to incoming and outgoing mail relevant to client records.
- A sampling of client charts on a monthly basis to monitor placement of forms, consistency of records, etc. will be reviewed.
- All initial assessments will be read and returned to the ICC to make corrections if needed. After the assessments are returned they will be given to support staff to enter data and make charts.

ONGOING CASE MANGEMENT

For clients:

- The case manager will continue contact with clients to ensure that services are being provided in accordance with the care plan and to ascertain whether these services continue to meet the client's needs.

For KIPDA Staff:

Policy: The case manager will continue contact with service providers and clients to ensure that services are being provided in accordance with the care plan and to ascertain whether these services continue to meet the client 's needs. Level I assessed clients will receive a home vis it every other month and phone call on alternating months. Level 2 assessed clients will receive a home visit every four (4) months and a phone call on the alternating months. Level 3 assessed clients shall receive a home visit every six (6) months and a phone call on months no home visit is completed.

Procedures:

- Case managers will maintain a good relationship with the client, which includes frequent, informal communication.
- Case managers will make a home visit based off client's service level or more often as necessary based on clients' needs, in ongoing problem solving and inquire about satisfaction of service.
- Case managers may contact family members to provide information for monitoring purposes if the client gives written consent.
- Clients and family members are informed that they can contact the case manager if issues arise regarding current services or additional service needs.
- All client contacts are noted in writing in the client file.
- The provider informs the client and/or family members about the aide who is coming to the home, when they are coming and what the aide's tasks are.
- The case manager requests that the client advise him or her if a provider fails to arrive or if services are not being performed satisfactorily.
- The case manager documents any information from clients regarding dissatisfaction with service provision and follows-up regarding resolution.
- The case manager phones the client within a week after services have been arranged to make sure everything is going well.
- Through careful monitoring the case manager will be able to detect changes in the client's status.

ONGOING CASE MANGEMENT Continued

QUALITY ASSURANCE:

- The number of suspensions and closed cases will be monitored, in the on-going case record, on a regular basis by the In-Home Services Coordinator.
- All case manager logs will be reviewed monthly by the In-Home Services Coordinator or the Quality Assurance Planner.
- Case manager follow-up phone contacts will be monitored in the on-going case record to ensure that services are being implemented by the provider.
- A yearly client satisfaction survey will be conducted to evaluate the case manager's interaction and role in the case management process.

For Agencies/Contractors:

- Ongoing communication between KIPDA's case management team and the providers/agencies will be maintained as a key component of service.

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PAST DUE ACCOUNTS FOR HOMECARE AND PRIVATE PAY SERVICES

For Clients:

- Clients should strive to stay current with payments for in-home services programs.

For KIPDA Staff:

Policy: Fee-paying In-Home services clients shall submit a payment upon receipt of their bill. Clients who fail to submit payment for two months after proper billing may be terminated from the program.

Procedures:

- A past due account list is printed each month and given to the case manager/ICC Coordinator of record.
- The case manager will contact the client with a reminder of the past due account, as well as document how and when they intend to pay the overdue service fee.
- A progress note shall be in each of the client records indicating the date the case manager contacted the client regarding the past due account.
- If the case is closed, the client is responsible for the payment of past services received.
- If the client is deceased, the case manager will make the In-Home Services Coordinator aware of the situation.
- If the client bill remains unpaid the In-Home Services Coordinator will meet with the client's case manager after 30 days to discuss any special circumstances that might exist.
- If no special circumstances exist, the In-Home Services Coordinator shall notify the client of possible termination and offer a form to appeal the decision. The notice will also inform the client that they will be removed from the program if payment is not received within one month or arrangements are made with KIPDA In-Home Services for a payment plan.
- When special circumstances are found to exist, services to the client may continue with the approval of the In- Home Services Coordinator and the Director of Social Services .
- The client may file an appeal of the termination decision; however, services will be continued until a hearing can be held.

QUALITY ASSURANCE:

In all cases the client shall be informed of the right to a fair hearing and provided with a copy of DAIL-HC-03 (Report of Complaint or Concern form). If requested by the client, a staff member will assist clients in the completion of the DAIL-HC-03. Progress notes in the client case files are monitored every two months in regard to contacts with fee-paying clients with overdue accounts.

PAST DUE ACCOUNTS FOR HOMECARE AND PRIVATE PAY SERVICES CONTINUED

- Closures will be monitored to determine the number related to unpaid accounts.
- Past due client files will be reviewed to determine if terminations were in accordance with policy and procedures.

For Agencies/Contractors:

- Provided for information only.
- Does not directly apply.

PHYSICAL MOVEMENT AND TRANSFERS OF CLIENTS

For Clients: Some clients may quality for transportation and/or escort services for necessary care such as medical appointments to the doctor, dentist , etc. *as* part of their In-home services plan of care. Each of these services has specific rules and criteria that should be discussed in detail with case management. Sometimes clients will be referred to TARC 3 or other services. Any in-home services policies surrounding client transfer and mobility are in place for the safety of the client and staff who serve them.

For KIPDA Staff:

ASSISTED TRANSPORTATION (ESCORT) FOR WHEELCHAIR AND NON- WHEELCHAIR USERS

Policy: In-Home Services clients eligible for Escort services will require the accompaniment of a per- son for reasons of safety or protection to and/or from a physician, dentist, or other necessary ser-
vices.

Procedures:

- Escort rates will be the same for all assisted transportation.
- Each client will have a maximum number of units (30) per service per month.
- Exceptions are considered on a case-by-case basis.
- When a client has not used escort services in a two-month period, the service should be re- viewed for closure. Escort services will be discontinued if the client does not indicate specific needs.
- In order to be considered for assisted transportation, clients will have been denied transportation from Louisville Wheels and Tarc3.
- Clients who are recipients of Medicaid will be referred for Medicaid transportation.
- Case managers will complete Escort request forms and indicate for the provider whether the client needs a companion to stay for the entire trip.
- Escort service vehicles should be accessible requiring minimal assistance in helping frail elders.
- Case managers should use less costly non-emergency transportation in outlying counties when appropriate.

QUALITY ASSURANCE:

- The number of escort units will be monitored each month.
- Assisted transportation needs will be reassessed each month through phone call or home visit by the case manager.
- Complaints regarding the transportation service will be documented and providers contacted.

PHYSICAL TRANSFER OF CLIENT

Policy: All In-Home Services clients requiring assistance with transfers in their home or into a vehicle (when utilizing Escort services) must be able to stand and pivot on one foot in order to prevent injury to either the client or aide.

Policy: In-Home Services clients that require a total lift in order to safely execute transfers will be required to have a Hoyer lift. Aides who provide service to total-lift clients will have appropriate training in using this equipment.

Procedures:

- When a client needs assistance with transfers, this should be indicated on the care plan only if the assessor or case manager has made sure that such transfers are appropriate and create no risk for the client or aide .
- The case manager should indicate on the care plan any durable medical equipment that the client has or needs in order to ensure safety for the client and/or aide when providing the needed service.
- In order to use gait belts when assisting clients with walking or transferring, aides must have appropriate training in the use of this supportive device.
- Information about acquiring necessary durable medical equipment should be given to the client and/or family by the assessor/case manager.
- All In-Home Services aides should be trained in appropriate transfer skills to ensure safety for themselves and the client .

QUALITY ASSURANCE:

- All In-Home Services aides utilizing assistive devices will receive training in the use of gait belts, Hoyer lifts, and any other equipment.
- When reviewing initial assessment samples, the Program Coordinator or Quality Assurance Planner will note the circumstances of those clients requiring assistance with transfers.
- Case managers will be encouraged to confer with the In-Home Services Coordinator if questions arise in regard to safety issues related to the use of durable medical equipment nt.

PHYSICAL MOVEMENT AND TRANSFERS OF CLIENTS (Continued)

For Agencies/Providers/Contractors:

- The provisions of this policy and procedure apply to agencies and contractors for this program.
- All In-Home Services aides who utilize them will receive training in the use of gait belts and Hoyer lifts.
- Vehicles of those who transport will be appropriately maintained.
- Individuals providing escort services will receive training on safely transferring clients.

PLANS OF CARE

For Clients:

- A care plan is written for every client who, after assessment, is determined to be eligible for services.
- Person-centered principles are incorporated into plans of care.
- The client must be involved in the development of the care plan, agree with and sign the care plan.
- The client will be assessed for home-delivered meals.
- KIPDA's In-Home Services are considered an option of last resort. Family and natural supports as well as other programs must be considered in the development of the plan of care.
- Plans of care can involve several services including homemaking, personal care, meals, escort services, supplies (supplies are available at $700 per client per fiscal year per DAIL contract FY 23).

For KIPDA's Staff

Policy: A care plan is written for every client who, after assessment, is determined to be eligible for services using person-centered concepts. The care plan shall relate to the assessed problem(s). The care plan should identify the goals to be achieved. The care plan must be supported by information in the assessment.

Policy: The client must be involved in the development of the care plan, agree with and sign the care plan. A copy of the plan of care will be provided to client as soon as possible. The care plan is written on a standard form. The care document will be completed and maintained in the file.

Policy: In developing the care plan, the ICC will consider client's need for home-delivered meals and ability to utilize frozen meals. If client's ability and choice for frozen meals is affirmed , the care plan shall include home-delivered meals. If not affirmed, the care plan shall include meal preparation and/or referral to Title 111-C delivered meals for hot meal delivery.

Policy: In developing the care plan, the ICC's responsibility is to reflect services and assistance received; and, service gaps and a plan for how the gaps will be addressed. In- ho me services provided through the Homecare Program should be considered as the last resort and other options are to be considered, including Medicaid Home and Community-Based Waiver and private pay. Homecare in-home services should not replace existing services that could be provided by an agency or the family support system.

Procedures:

- The ICC Coordinator summarizes the client's needs, discusses the client's and the primary supporters' (family and friends) perceptions of needs until agreement is reached .

Plans of Care Continued

- The ICC Coordinator and client will determine an appropriate service package tailored to the client's needs.
- The ICC Coordinator will discuss the implementation of in-home services and the case manager's role in arranging for the provision of services by appropriate agencies and persons.
- The ICC will explain to the client that the services will be provided only as long as the client is eligible.
- The ICC informs the client and family of all options available as well as those services that are not available. Where possible, clients will be given a choice of providers and given information about such agencies.
- The ICC shall inform the client and/or family (caregiver) of necessary referrals to other agencies for services not available through homecare.
- Should a client refuse to select a provider, the ICC Coordinator will assign a provider by a rotation method.
- The ICC completes the plan of care indicating the needs, services, providers, tasks to be performed and timeframes.
- All potential sources of informal support are investigated.
- Service alternatives are explored with an awareness of the client's financial situation (Fee documentation work- sheet).
- The ICC identifies the scope, duration and number of service units required.
- The ICC Coordinator describes the clients physical/health status, identifies clients need for assistance with AOL'S and IALD'S, environment, need for physical aides, social support system, mental and emotional status, and economic resources on the care plan document.
- The ICC Coordinator will write a new care plan each time a client is reassessed. Each plan will indicate the new date. Changes in a client's needs may necessitate the need for a revised care plan prior to the annual reassessment.
- The client signs the care plan and is given a copy for future reference .
- A copy of the completed care plan is given to service providers.
- When the client is unable to participate in the development of the care plan, verification of the legal representative's authority to action on behalf of the client should be noted by the case manager in the client record.

QUALITY ASSURANCE

The completed care plan will be reviewed by KIPDA staff on every initial assessment as to the

comprehensiveness of documentation in the following sections:

- Health, nutrition and functional status
- Environment and need for physical aids
- Cognitive, social and emotional status
- Financial and resource status
- Client goals listed on the care plan are reviewed and updated as needed per requirements.
- Units of service and provider referrals will be monitored to ensure adequate support.
- Care plan will be checked for client signature and initials .
- A yearly survey will be conducted to determine clients' satisfaction with the care plan and appropriateness of services received.
- Alt initial assessments will have care plans reviewed within three days of completion.
- KIPDA will ensure that the plan of care is entered, updated, and maintained per rules, regulations, and so it is accessible to contractors and providers.

For Agencies/Contractors:

- Agencies must follow the plan of care when providing services.
- Agencies must complete only tasks that are listed on the plan of care.
- Agencies must submit units according to reporting requirements.
- Agencies must communicate with **KIPDA** as appropriate when the plan of care cannot be followed.
- Agencies must review plans of care when there are changes because of reassessments or any reason.

PROVIDER/AGENCY/CONTRACTOR RESPONSIBILITIES

For Clients:

- Clients should be aware of the responsibilities of their care providers.
- Clients should convey concerns to their KIPDA case manager or agency/contractor staff as appropriate.

For KIPDA staff:

- KIPDA staff will provide direction and oversight to providers/agencies/contractors regarding services.
- KIPDA staff will provide a copy of these responsibilities as well as other standard contract forms.

For Agencies/Contractors

Policy: The contract agency for In-Home services will assure the provision of services throughout the geographic area covered under its plan or proposal.

Procedures:

Provider staff will treat the client in a respectful and dignified manner, involve the client and caregiver in the delivery of services and provide services in a safe, timely manner.

- The provider agency will designate a supervisor and assure that staff providing In-Home services are provided professional supervision.
- The provider agency will ensure that all homecare aides that work with KIPDA clients attend required training as mandated by state regulations.
- The provider agency will input units of service in the client data-based system by required deadlines, and input case notes within three days of occurrence.
- Provider staff shall notify Adult Protective Services and KIPDA when neglect and/or abuse of clients is suspect- ed, and when unsafe or hazardous conditions exist that may place the client , ICC /Case manager and Social Service Assistant, and aides or others in imminent danger.
- Provider staff will notify the ICC/Case manager and Social Service Assistant when a client refuses a particular service and indicate the number of times the client has refused services.
- The provider agency will transfer all appropriate records of those KIPDA clients who request services provision from a new contract agency.

QUALITY ASSURANCE:

I) The Program Coordinator or the Quality Assurance Planner will serve as the liaison between provider agencies about In-Home Services training questions.

2) The provider training program is monitored annually.

REASSESSMENT

For Clients:

- A reassessment is conducted annually for all clients following the initial assessment. The reassessment is conducted to re-establish eligibility. The reassessment schedule may vary if a major change in client status, functioning, or circumstances occurs. When a reassessment is conducted, following an event or crisis , the next scheduled reassessment should follow in at least **6** months.
- The client will be advised of any changes to the plan of care based on the reassessment.
- Client eligibility depends on reassessments and the completion and signing of corresponding paperwork.

For KIPDA Staff:

Policy: A reassessment is conducted annually. for all clients following the initial assessment. The reassessment is conducted co re-establish eligibility. The reassessment schedule may vary if a major change in client status, functioning, or circumstances occur. When a reassessment is conducted , following an event or crisis, the next scheduled reassessment should follow in at least 6 months.

For Agencies/Contractors

- Be aware of any plan of changes associated with assessments.
- Communicate regularly with KIPDA.

Policy: A reassessment format will be completed as prescribed by DAIL. The development of a new care plan or notation that the existing plan remains valid is necessary.

Procedures:

- The assigned ICC Coordinator should conduct the reassessment.
- The reassessment is completed in the client's home in-person rather than over the phone unless exceptional circumstances occur such as a world-wide pandemic, extreme natural disaster or other extenuating event.
- The reassessment is a formal comprehensive review of the client situation to assess the current needs of the client and re-establish eligibility.

- All changes and updates to the care plan must be noted.
- Any improvements and/or deterioration in the client's functional status must be noted.
- The client's signature on the care plan indicates agreement as to whether services change or remain the same.
- At the time of the reassessment , a month for the next reassessment is to be indicated on the care plan.
- Changes in service units on reassessments are pre-approved by the In-Home Services Coordinator.

Quality Assurance:

- All completed reassessments are to be turned in within 3 days whenever possible.
- The new care plan is reviewed on reassessments when there are changes in type of service and unit.
- Reassessment documents will be randomly reviewed every six months as case records are audit e d by the In- Home Services Coordinator and/or the Quality Assurance Planner r.

SAFE WORKING ENVIRONMENT

For Clients: Clients should do their best to provide a safe-working environment in their homes. Clients should also review client responsibilities, and the other policies and procedures surrounding safe working environments.

For KIPDA Staff:

Policy: Through the KIPDA In-Home Services case management assessment, required monthly monitoring by case managers and the provision of homecare services by agency provider aides, a safe and healthy working environment for all staff and clients will be maintained.

Policy: Both staff and clients shall have the right to take appropriate precautions to protect themselves from harm under specific conditions.

Policy: Under some circumstances a client's service may be placed on hold or discontinued.

For Agencies/Contractors:

- The same policies and procedures apply to agency staff as KIPDA staff.

Examples of conditions that would warrant KIPDA staff, aides, or clients to take actions to protect themselves from harm:

- Staff, aide, client or family member exhibits behavior regarded as a threat such as yelling, aggressive or inappropriate gestures or movements, display of items that could be considered weapons, inappropriate verbal statements especially related in a sexual, abusive or threatening context.
- There exists a criminal history of a worker or client convicted of an offense related to the physical harm of another individual, felony theft, drug or use of weapons.
- If the sanitary conditions of the residence presents a health hazard to the worker or client such as: human or animal waste uncontained in the home, medical waste such as syringes or other bio hazardous waste uncontained in the home, uncontrollable infestation of rodents and/or insects, etc.
- Illegal drugs or drug paraphernalia openly present in the home, etc.
- Unrestrained animals are present and may cause a hazard.
- Unknown persons are present in the home at the time of service and may represent a threat .

Procedures:

- Worker may remove themselves from the premises immediately indicating the reason for doing so, or client may request that worker leave the premises immediately.
- Notify supervisors or agency immediately.
- Request a review of the situation by agency staff.
- In some cases, referral of the client to Adult Protective Services may be appropriate and should be made by the worker.
- Following the review, the worker and/or client shall be notified in writing by the case managers of the unacceptable behavior and shall be offered one opportunity to correct the situation.
- If the situation is not corrected to the satisfaction of the worker or client, that agency may discontinue ser- vice provision to an offending client or reassign another worker to provide the client's service; or in the case of an offending worker, the agency may reassign or dismiss the offending staff.
- The worker or client shall have the right to the fair hearing appeal process, if desired.
- If an acceptable resolution is accomplished after services have been discontinL1ed, the client may be placed back on the program when an opening becomes available.

QUALITY ASSURANCE:

- The In-Home Services Coordinator, QA Planner and/or Social Services Director will conduct a review and investigation of any threatening circumstances and shall make every effort to resolve the situation.
- The In-Home Services Coordinator, Quality Assurance Planner, and/or Division of Social Services Director will review all documentation regarding the occurrence for clarity and completeness of information needed.

STAFFING AT KIPDA:

For Clients: This is to advise you of the credentials of your professional team at KIPDA.

For KIPDA Staff: These provisions should be followed.

For Agencies/Contractors: This is for informational purposes.

Case Management

Policy: Case management means a process, coordinated by a case manager, linking a client to appropriate, comprehensive, and timely home or community-based services as identified in the Plan of Care. The coordination of a broad range of services arranged in response to the assessed needs and resources of older persons and uses all available, appropriate funding sources . Case management recognizes the unique needs and preferences of the persons receiving assistance and the right to exercise control over their own lives. Case management supports older persons and their families in making appropriate and informed decisions about needed assistance. Case management is a collaborative process that provides support for the medical, physical, emotional and social needs of older adults.

Case Managers and other In-Home Services Staff

Policy: Case managers assist clients and their families in navigating a complex system of services and strive to maximize service potential and avoid duplication of effort. The Case Manager coordinates services and supports from all agencies involved in providing services to the client as required by the Plan of Care; ensures all service providers have a working knowledge of the Plan of Care; and ensure services are delivered as required.

Procedure:

-KIPDA In-Home services will hire qualified and competent professionals to serve as case managers and other professionals in the region.

-Case Managers and others will meet minimum criteria as set forth in 910 KAR 1 : 80 including the following requirements:

- Completion of all required background checks
- Completion of preemployment requirements
- Possess a Bachelor's degree in a health or human services related field from an accredited college or university with one year experience in health or human services; or the educational or experiential

  equivalent in the field of aging or physical disabilities.
- Hold a current RN license as defined in KRS 314.011 (5) with at least two (2) years' experience as a professional nurse in the field of aging or physical disabilities.
- Hold an LPN license as defined in KRS 314.011(9) and have at least three (3) years' experience in the field of aging or physical disabilities and an RN to consult and collaborate with regarding changes to the

  Plan of Care; or
- Have a Master's degree from an accredited college or university which serves as a substitute for the experience required.
- In-Home Services staff will complete any required annual trainings*.

Policy: The Independent Care Coordinator (ICC) is responsible for the assessment and reassessment functions for the Homecare Program. Independent care coordinator means, the individual that completes the initial assessment, plan of care, and annual reassessment. Eligibility shall be determined by the ICC. A client shall be assessed initially and reassessed as least annually thereafter by an ICC. After each assessment or reassessment, the ICC shall determine eligibility and service level of each assessed individual. The ICC shall be responsible for determining fee paying status, extraordinary out of pocket expenses, leveling

of clients and changes in plan of care between assessments.

Procedure:

- KIPDA In-Home services will hire qualified and competent professionals to serve as case managers in the region.
- Independent Care Coordinators (ICC) will meet minimum criteria as set forth in 910 KAR 1:180 including the following requirements:
- Possess a Bachelor's degree in a health or human services related field from an accredited college or university with one year experience in health or human services; or the educational or experiential equivalent in the field of aging or physical disabilities.
- Hold a current RN license as defined in KRS 314.01 (5) with at least two (2) years' experience as a professional nurse in the field of aging or physical disabilities Hold an LPN license as defined in KRS 3 14.011(9) and have at least three (3) years experience

Quality Assurance:

Case records are reviewed randomly by the In-Home Services Planner/Assessment and Case Manager Supervisor and/or the Quality Management Planner to monitor services.

Unmet needs, when there are no available resources, are monitored by review of the client summary on all initial assessments within three days of completion.

Case records will be reviewed randomly by mean of an audit checklist as to completion of release of in- formation forms, quality of assurance agreement and client's right to a fair hearing form.

Efforts to empower/educate client and/or family to make informed decisions will be noted in case re- views annually. Caregiver stress assessments and dementia checklists are monitored on every initial assessment to see if respite care or referral to the **KIPDA** Caregiver program is needed.

The In-Home Services Planner/Assessment and Case Manager Supervisor and/or Quality Management Planner will review caseloads monthly to ensure continuity of geographic areas per client location and assigned case manager.

The In-Home Services Planner/Assessment and Case Manager Supervisor and/or Quality Management Planner will review and evaluate the appropriateness of client levels quarterly and adjust when necessary if not consistent with criteria.

*Training Requirements for In-Home Services KIPDA Staff FY 2023 (for annual review)

Requirements:

_____16 hours of DAIL-approved contract training*

The following topic requirements are to be part of the 16 hours of contract required training:

_____DAIL Dementia Series
_____Abuse, neglect, and exploitation of vulnerable/older adults
_____Racial Equity and Cultural Competency
_____Person-Centered Care Planning

*SHIP trainings are not counted in this at this time.

SUSPENSION, EMERGENCY AND HOLIDAY SCHEDULING, REDUCTION, AND TERMINATION OF SERVICES

For Clients:

- If a client notifies the case manager of unavailability for services, the case manager advises the provider agency via the data system. If this notification does not occur prior to 3:00pm the day before scheduled service delivery, pro-
  providers are not required to reschedule.
- Clients receiving essential services shall receive them either on the holiday or one day either prior to or following the holiday.
- Clients receiving non-essential services shall receive make-up service the week of the holiday.
- ICC/Case managers will provide lists and referrals to clients and their families to other agencies/providers as need- ed.
- Clients maintain the right to file complaints as necessary.
- Clients should keep an open line of communication with **KIPDA** case management.
- Clients should advise KIPDA as soon as possible if there is a change in their circumstances such as a hospitalization, a move, etc. This can impact services.

For KIPDA staff:

- KIPDA staff is required to follow the previsions in this policy and procedure as it applies in daily operations.

For Agencies/Providers:

- In-Home Services agencies are required to follow the previsions in this policy and procedure as it applies in daily operations.

Suspension Policy:

- If a client notifies the case manager of unavailability for services, the case manager advises the provider agency via the data system. If this notification does not occur prior to 3:00pm the day before scheduled service delivery providers are not required to reschedule.
- The case manager, as a part of each telephone and home visit monitoring, reviews the status of client 's hold/ suspension and informs the provider(s) of anticipated closure or reinstatement.

Emergency And Holiday Scheduling Policy:

- Clients receiving essential services shall receive them either on the holiday or one day either

prior to or following the case manager, as a part of each telephone and home visit monitoring, reviews the status of client 's hold/ suspension and informs the provider(s) of anticipated closure or reinstatement.

Emergency And Holiday Scheduling Policy:

- Clients receiving essential services shall receive them either on the holiday or one day either prior to or following the holiday. Case managers will review client's needs and follow-up with providers as to their compliance in adhering to this schedule. Essential services include one or more of the following: a) Assistance in and out of bed, b) 5 days per week meal preparation, and c) incontinent clients receiving personal care through KIPDA Homecare.
- Clients receiving non-essential services shall receive make-up service the week of the holiday. Case managers will coordinate service schedules with providers. Non-essential services include : a) Escort service b) Ho me making, c) Personal care less than 5 days per week, d) Home repair, and e) Chore service.

Reduction and/or Termination Policy:

- The case manager and/or the client will decide when to reduce or terminate services based on the following circumstances: a) the client's condition or support system improves, b) a determination is made that the care plan cannot be followed, c) information received from the provide r indicates that services could be completed in less time than indicated on the client's care plan , d) timely payment is not received from fee-paying clients , e) when services have been placed on hold in excess of 21 working days, f) when the client goes into a long term care facility, g) loss of program funding, or h) the client expires. .
- When a provider refuses to serve a client, the agency shall provide written documentation to KIPDA In-Home services stating the reason for the refusal. Services must continue until the In- Home Services Coordinator reviews the case and approves the case closure with the provider.
- When services are terminated or reduced due to reasons unrelated to the client's needs or condition, the In- Home Services Coordinator, in conjunction with the case manage r, will determine reduction or termination on a case-by-case basis.
- The client should be informed of the right to file a complaint by the case manager.
- The case manager shall write a closure note in the case file, whether a current client or waiting list client, stating the reason for closure.
- The case manager refers the family and client to other agencies if applicable.

QUALITY ASSURANCE:

- Reductions and terminations in service will be monitored to ascertain reduction in units on a monthly basis by the In-Home Services Coordinator.
- Refusals from providers to serve clients will be documented by case managers and reported to the In- Home Services Coordinator per occurrence.
- Provision of essential services over holidays will be monitored to assure quality of care.

- Reasons for case closures will be monitored on a six-month basis during client file audits.
- Fee-paying clients will be monitored for timeliness of payment on a monthly basis.

For Agencies/Providers/Contractors:

- If a client notifies the case manager of unavailability for services, the case manager advises the provider agency via the data system. If this notification does not occur prior to 3:00pm the day before scheduled service delivery, providers are not required to reschedule.
- The case manager, as a part of each telephone and home visit monitoring, reviews the status of client's hold/ suspension and informs the provider(s) of anticipated closure or reinstatement

Emergency And Holiday Scheduling Policy:

- Clients receiving essential services shall receive them either on the holiday or one day either prior to or following the holiday. Case managers will review client ' s needs and follow-up with providers as to their compliance in adhering to this schedule. Essential services include one or more of the following: a) Assistance in and out of bed, b) 5 days per week meal preparation, and c) incontinent clients receiving personal care through **KIPDA** Homecare.
- Clients receiving nonessential services shall receive make-up service the week of the holiday. Case managers will coordinate service schedules with providers. Nonessential services include: a) Escort service b) Homemaking, c) Personal care less than 5 days per week, d} Home repair, and e) Chore service.
- When a provider refuses to serve a client, the agency shall provide written documentation to KIPDA In-Home services stating the reason for the refusal. Services must continue until the In-Home Services Coordinator re- views the case .
- Providers/agencies should keep open lines of communication with **KIPDA** staff and the client per other policies and procedures.

CLIENT WAITING LIST

For Clients:

This is for informational purposes so clients are aware of how determinations are made on who receives services.

For KIPDA staff:

This policy and procedure should be applied by KIPDA staff in daily operations.

For Agencies/Providers:

This is mostly for informational purposes as it is helpful for contracting agencies to understand how KIPDA determines who will receive what services and when.

Policy: Waiting lists in the required databases shall be maintained when services are unavailable. Prospective clients will be prioritized based on their physical or mental incapacities which constitute level of need . Waiting lists are specific to the following categories:

- Potential clients who are waiting to be assessed by an assessor
- Clients who have been assessed and are waiting for service
- Clients who are already receiving services and are waiting for additional services.

Procedure:

I) Potential clients are screened during intake. Priority is given to potential clients based on the greatest need .

- The priority rating is updated after the Assessor has conducted a comprehensive assessment and client is placed on waiting list for services based on new priority rating. The Home Services Coordinator reviews the case .
- Providers/agencies should keep open lines of communication with **KIPDA** staff and the client per other policies and procedures.

- **POLICY:** After the intakes are processed for In-Home services, all potential clients are prioritized and placed on a waiting list. When initial assessments are assigned and completed by an assessor, they will reassess the priority number based on the number of unmet needs for service. After the initial assessment, clients are placed on an assessed and waiting for services list .

- **POLICY :** Clients could be placed on three different waiting lists : I) clients who are waiting to be assessed 2) Clients who have been assessed but are waiting for services 3) Clients who are waiting for additional services. Case Managers determine client's need for additional services during monitoring and reassessment.

QUALITY ASSURANCE:

- Sample case reviews are conducted periodically by the In-Home Services Coordinator or the Quality Management Planner, to track the following data to ensure that target populations are receiving quality services.
    - percent of minority clients
    - number of non-English speaking
    - percent of clients living in rural counties
    - percent of clients who have dementia or mental health issues number of clients **with** three or more diagnoses
    - percent of low-income clients
    - clients living alone

The In-Home Services Coordinator will monitor all waiting lists as to priority and instruct appropriate staff when cases are to be opened, assigned for assessment or approved for additional services as funding allows.

CLIENT PRIORITY LIST

POLICY: A potential client must be impaired in at least two (2) physical Activities of Daily Living, or impaired in at least three (3) Instrumental Activities of Daily Living, or the client has an essentially stable medical condition requiring skilled health services along with services related to activities of daily living who would otherwise require an institution- al level of care, or the client resides in a nursing facility and could be maintained at home if appropriate living arrangements and support systems can be established.

POLICY: At intake, KIPDA staff will complete the required assessments in the assigned database associated with determining ADLs, IADLs, and any required functional assessment tools. These tools will help determine which clients are a higher priority rating. Samples of the required assessments for the current fiscal year are available through the In-Home Services Coordinator.

PROCEDURES:

I) As previously mentioned, clients could be placed on three waiting lists as defined below. All three waiting lists are maintained in the appropriate database. All three lists have reports run at least once per month.

A) Waiting list possibility number one is the " waiting to be assessed" list. Information is kept in the appropriate database with assessment priority based on the **DAIL GA-0** l for potential clients.

B) Waiting list possibility number two is clients who have been assessed, and found to be eligible, but are now waiting for services to start. Sometimes the assessor contacts these individuals even if they do not have case management or meet eligibility to see if there have been changes in their condition.

C) Waiting list possibility number three is clients who have case management because they are receiving meals, need an alert system, chores, or escort services, but personal care and homemaking are not opened.

2) The required prescreening and assessment forms will be completed on all initial In-Home services clients. Current copies of these assessments are available through the In-Home Services Coordinator.

3) If a client is determined not to need services, they will be called once per quarter to check on their condition.

4) Clients who are waiting to be assessed for services will be placed on a waiting list based on their priority rating as determined by the required assessments in the data system. At the time of this writing, clients who score 50 in the assessment tool (previously known as NAPIS) or higher are open immediately whenever possible.

5) Assessed clients are placed on the assessed and waiting for service list based on a new priority rating. Files on assessed clients and clients on waiting lists will be maintained by In-Home regularly by the Coordinator.

6) Clients who remain on the intake waiting list for six months are called. The intake is then updated and/or purged depending on their status.

7) All clients on the assessed list and waiting list will be called quarterly. Their need for services is reviewed, and changes made in their priorityy number if appropriate .

QUALITY ASSURANCE:

1) The In-Home Services Coordinator will monitor funding and staffing availability and notify case managers as to the number of priority clients that can begin services.

2) The Program Coordinator or the Quality Assurance Planner will review three clients from the waiting list quarterly to ensure that quarterly calls are being made to those on the waiting list.

3) If deemed necessary, the Quality Assurance Planner will maintain a monthly log of waiting list clients to call and monitor for potential changes in priority.

Appendix

Taxonomy

DEFINITIONS and DAIL TAXONOMY FY 2023

For Clients: these definitions can explain what services you might qualify for, and what to expect within these services.

For KIPDA Staff: This taxonomy and its terms should be implemented, followed, enforced, and incorporated into daily operations.

For providers/agencies: Providers are expected to follow the provisions in this policy and procedure.
KIPDA will monitor compliance at the annual monitoring time.

Assessment (1 Unit = 1/2 Hour)
The collection and evaluation of in-depth information about a person's situation and functioning capacity including formal and informal resources (present and potential) for the purpose of identifying needs and developing a comprehensive plan of care.

Authority: 910 KAR 1:180

Requirement: DAIL Approved Assessment

Tool Case Mana eme nt (1 Unit = 1/2 Hour)
The process of planning, referring, monitoring and advocating to assure that appropriate, comprehensive, timely and cost-effective services are provided to meet the client's individual needs as identified in the assessment.

Authority: 910 KAR 1:180

Requirement: DAIL Approved Assessment Tool, Plan of Care, and Case Management. Client contact shall be reported in the journal entries and entered according to program requirements.

Chore (1 Unit = 1/2 Hour)
The performance of heavy housecleaning, minor household repairs, yard tasks, and other activities needed to assist in the maintenance of a functionally impaired elderly person in his own home.

Authority: 910 KAR 1:180

Requirement: DAIL Approved Assessment Tool, Plan of Care, and Case

Management. Escort one way trip (l Unit = l /2 Hour)

The accompaniment of a person who requires such assistance for reasons of safety or protection to or from his physician, dentist, or other necessary services.

Authority: 910 KAR I: 180

Requirement: DAIL Approved Assessment Tool, Plan of Care, and Case Management.

Homemaker (1 Unit = 1/2 Hour)
General household activities, including but not limited to nonmedical personal care, shopping, meal preparation, and routine household care, provided by a trained homemaker when the person regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or others in the home.

Authority: 910 KAR I: 180

Requirement: DAIL Approved Assessment Tool, Plan of Care, and Case Management.

Home Health Aide (1 Unit= 1/2 Hour)
The performance of simple procedures, including but not limited to personal care, ambulation, exercises, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.

Authority: 910 KAR I: 180

Requirement: DAIL Approved Assessment Tool, Plan of Care, and Case

Management. Home ReL?air (1 Unit= 1 Activity)
The provision of minor home adaptations, additions, or modifications to enable the elderly to live independently or sarely or to facilitate mobility including, where appropriate, ernergem;y summons

systems. Authority: 910 KAR I: 180

Requirement: Requirement: DAIL Approved Assessment Tool, Plan of Care, and Case Management

Homecare Supplies (1 Unit = 1 activity)
The purchase of supplies for eligible participants of the Homecare program shall be to assist individuals to remain safely in their own home. No more than ten (10) percent of the total Home Care allocation can be designated for supplies. The maximum expenditure per participant per fiscal year is **$500;** Each purchase of supplies shall be considered one (I) activity recorded as one (I) contact.
Documentation shall be recorded in each participant's electronic file that receives supplies with assurance that all other resources have been considered and/or exhausted prior to providing Homecare funding for supplies. Supplies shall be recorded in the state data system as a service of Homecare when home care funding is utilized. Supplies are provided only for the use and well-being of the individual Homecare participant; no other person(s) shall knowingly be provided supplies funded by the Homecare program.

Authority: DAIL contract

Requirement: DAIL Approved Assessment Tool, Plan of Care, and Case Management.

Per sonal Care (I Unit = I/2 Hour)
Services directed toward maintaining, strengthening or safeguarding the functioning of a person in the home; includes helping a person with the activities of daily living such as bathing, eating, dressing, grooming, transferring, and toileting.

Authority: 910 KAR I: 180

Requirement: DAIL Approved Assessment Tool, Leveling, Plan of Care, and Case Management

Respite (I Unit= I/2 Hour)
Care provided by an approved caregiver or agency for a designated time period because of absence or need for relief of a primary caregiver.

Authority: 910 KAR I: 180

Requirement: DAIL Approved Assessment Tool, Plan of Care, and Case