EWE AND RISK ASSESSMENT CHANGES
MANDATORY WEBINAR Q & A 3/6/19

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EWE Related Q & A

EWE Related Questions?	Answers
I am guessing if the EWE case is already open, they will stay open, during a PMDDT determination correct?	The consumer would continue to receive their prior benefit (in admin status) until the PMDDT decision is made.
The new EWE Eligibility Planning form does that need to be submitted with new and ongoing requests for EWE?	Yes, the *NEW* Extended Waiver Eligibility Planning Form needs to be submitted with new or renewal EWE Cases.
In your EWE example with Phil, it sounds like he only needs housekeeping supports. Housekeeping alone does not make someone an SPL 14-18. Can you please explain why we would consider EWE if his SPL is maybe a 99?	We were trying to give a high-level scenario to show a possible example of the OARS 411-015-0030(1)(b) based on a history of evictions or threats of evictions, which would lead the individual to deteriorate or decompensate. The example provided does not go into detail on his other care needs are.
I am really confused about how the housekeeping and the concerns around exploitation connect to have unmet needs that will result in being institutionalized or hospitalized within 30 days. Please elaborate.	If an individual faces a loss in housing due to the condition of the home or not paying their rent (due to the exploitation), resulting in homelessness, it is reasonable to assume that the individual faces institutionalization or hospitalization within 30 days.
What is the effective date of SPL 18 being eligible for EWE?	February 27, 2019.
What if the consumer doesn't make progress to get off EWE? Not because they don't want to, but because they may not have the ability to follow through with the steps necessary to move forward.	When writing the EWE Planning Form, the consumer needs to understand what they are agreeing to do. Also, on EWE Planning Form, any additional supports that may assist the consumer to help them with the plan should be identified.
Is the pay-in going to be calculated differently? I think an old PT said someone in CO would have to manually calculate it. Is that still the case?	Yes, that is still the case for in-home consumers.
Can you speak to the "acute need" part of the rule? We see a lot of folks in need of short-term NF care but then end up EWE eligible and staying in the NF long term due to history of homelessness. For example, consumer is homeless, ends up in a NF due to an acute medical event (broken hip). Eight weeks	If they meet all of the program requirements, yes, they are EWE eligible. However, they will still be required to work on the agreement in the EWE planning form.

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later we reassess them and they are an SPL 18. Are they EWE eligible?	
On the SPAN form, if the consumer is SPL 15 do you check the box eligible for EWE or do you wait until you get EWE approval from CO before notifying the consumer they are eligible?	If an EWE referral is made, you will need to wait for EWE decision by Central Office prior to sending out the SPAN.
If MAGI clients are eligible for in-home services/CBC and NF placement without a PMDDT determination, why do EWE 14-18 need a PMDDT determination?	The EWE program is part of the 1915(c) waiver only. MAGI consumers do not qualify for this waiver. When receiving the traditional in-home/CBC/NF services, that is authorized through the 1915(k) State Plan, which MAGI consumers do qualify for.
Does the new EWE form have to be signed? The previous forms that this is replacing did, but the form in the slide does not appear to include a place for signatures.	Yes, the Form needs to be signed and dated by both CM and Consumer. This is located on page 3 for the new EWE Eligibility Planning form.
We were told one of the reasons we had the training was because many people were being made eligible because of an inability to manage their medication. Now they are eligible for EWE?	Previously, having a need in the IADL medication management or certain treatments only (resulting in SPL 18) was not a qualifier for EWE. Policy has since changed to include those with this specific need.
So just to clarify about the six-month review in EWE PT, do we no longer have to do the EWE six-month review? Or was that a clarification that we don't have to do a CA/PS reassessment but one time a year?	EWE must be renewed every 6 months. An assessment only needs to be done yearly or if the needs or environment of the consumer changes.
What do we do if a consumer refuses to sign the EWE form?	The consumer is expected to participate in the process to help determine if EWE requirements are met. The consumer can't be approved for EWE if this is the case. As of 3/22/19, the SPAN form does not accommodate this notice reason. Please contact Central Office for notice assistance in this specific scenario.
Why aren't MAGI's going through PMDDT in general? It's appearing we are now assessing without supports from other needs besides just cognition. All examples appear we are assessing without supports.	Because not all MAGI consumers are eligible for PMDDT. If you have a consumer who has physical disabilities and would meet SSA requirements to be disabled, then you should recommend that they complete the PMDDT process to determine eligibility for OSIPM. If they are on services, you should recommend that they apply for OSIPM via the PMDDT process. For them to be approved for OSIPM via PMDDT they must meet SSA sequential process for being disabled and unable to work/return to work/etc.

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If we are aware of consumers who were closed at SPL 18, are we retro actively pursuing individuals to now request EWE for them?	The rule has an effective date, so we are not able to retroactively apply the rule. However, if the consumer has requested, but not received, an administrative hearing, EWE should be considered.
The SPAN states: 'You have been determined to meet EWE criteria. You will receive a separate notice with additional information regarding this decision.' What notice is that? My three EWE clients did not receive a separate notice from CO and I am not aware of a separate notice I am supposed to send. Can you clarify?	According to APD-PT-19-010, a separate decision notice is needed specifically for in-home services (for the 10 hours per pay period). An additional notice is not required for the other settings. Thank you for mentioning this, as the SPAN does need a change in it's wording in this section.
When we submit the planning form, when would we expect to hear a decision from CO?	We try to process them within 1 week of a completed request. In some instances, may we need to ask clarifying questions on the request or have the form properly signed.
So, is this change due to funding for EWE? Historically, we did not serve clients under 65 unless they had a disability decision or PMDDT/during GP or OHP. Why the change with going from OHP to MAGI?	The change in rule is recognizing a need to serve consumers that have med management or certain treatment needs (SPL 18) and would face the risk of hospitalization or institutionalization if they are not EWE eligible. MAGI is a form of Medicaid, with different eligibility requirements than OSIPM. If an individual is eligible for Medicaid (either way), the consumer may receive services. However, if under the age of 65, the primary need for services must still be physically related.

Risk Assessment Related Q & A

Risk Assessment Related Questions?	Answers
High risk includes informed individual choice. Example, a consumer that knows if he doesn't take his insulin he could have very severe health complications, still chooses not to take the insulin. Would we mark him high risk and do monthly direct contacts in this situation?	Yes, as per your example, if a consumer chooses to not take his/her insulin and understands that this choice could result in severe health complications, he or she would be marked as high risk in physical functioning. The CM would have monthly direct contacts with the consumer and continue to discuss ongoing risks and actions/solutions needed to minimize the high risk. Perhaps a Long Term Care Community Nurse could visit to help educate the consumer and problem solve. The CM would also regularly document the individual's ability to understand and accept or decline any plan or intervention related to the high-risk activity and workout a contingency plan with the consumer, natural supports, etc.

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	In this scenario the person understands the risk, in other situations the person may not have the capacity to understand the risk and would need a representative to support the person with decision-making or make decisions for the person.
What about people who are of sound mind and make poor choices? Isn't there some onus put on personal responsibility?	Yes, informed individual choice is the basis of person-centered care and the consumer-employer responsibility (OAR 411-030-0050(2)). The consumer or their representative is responsible for service plan decisions. CMs are responsible to identify what risk factors the individual has, discuss the risks with the individual, work with him or her to eliminate or minimize the risks, monitor and continue to offer options over time to assist the individual in evaluating risks, developing a contingency plan, and document all the above in narration. To your point we may place limits on "rescuing" people for their own bad decisions causing them to face the consequences of their choices. For example, we may only pay for a big house clean out or muck-out once. Or we may limit paying for to get past electric bills covered to turn on electricity if we have offered bill paying help and it is rejected. Or, a person may create a hostile work environment and not be able to have a home care worker or In-home agency staff. It is about both rights and responsibilities. Competent individuals get to make their own choices and take responsibility for the outcomes of those decisions.
If a high risk does include informed choice, this seems like we are taking away someone's right to poor choices and forcing them to make socially acceptable choices?	To be clear, there is no intention to take away someone's right to make what others feel are poor choices. The expectation would be that increased monitoring is to check-in on how the person is doing and offer choices without judgement. If you are coming about it from a position of caring, compassion and support that will hopefully be accepted. Assessing an individual as high risk based upon a choice he or she makes does not force them to change. However, future changes for high risk individuals involving monthly direct contacts and efforts to mitigate high risks will be done to help an individual understand and possibly choose actions that will lower his or her high-risk factor(s).

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Will the physical Risk Assessment in CA/PS be changing or are these noted changes just for our knowledge to apply to the current Risk Assessment?	You will not see any changes in Oregon ACCESS until the new Risk Assessment policy is implemented. When it is implemented, a few minor changes to the tool will be made, a new report will be added, and a change in how risk related contacts are recorded. It is proposed that you will filter all the areas through the definition of "high risk" mentioned in the Webinar to determine if a person is high risk. We intended to share information about a proposed future change and ask for your help and feedback prior to implementing. We want you to use the new high-risk definition as you evaluate current high-risk consumers.
Regarding changes in the Risk Assessment what are the requirements and expectations for consumers that are high risk in a facility setting?	At this time, no there are no policy changes being made regarding Risk Assessment procedures for consumers in a community-based setting. However, if someone is at high risk and they live in a community-based setting, staff may complete the risk assessment appropriately, and if they are high risk, they will be listed on a report.
Will Oregon ACCESS have an update that will allow CMs a way to quickly identify consumers that are high risk on the CM Service Due Report? I feel like this would be useful so that client could be monitored correctly?	When the new Risk Assessment policy is implemented in the future, Oregon ACCESS will have report to quickly identify these individuals.
With the new Risk Assessment stuff, are we going to be able to edit our risk assessments, so we do no need to complete the entire thing every 30 days?	Yes, if a consumer's risk assessment needs to be updated or edited, you will be able to change a particular risk assessment category on the Client Details page without changing the entire risk assessment report.
The examples of high risk would be for at least 50% of all new clients applying for Medicaid/Services. If the client does not want to participate in Risk Monitoring or Waivered Case Management services, what would be an example to mitigate? We are dealing with increasing homeless populations, increasing MH populations which increases our programs/employees/resources…..	New applicants may often would present as high risk and is likely a factor in seeking services. The implementation of a service plan will mitigate some or all the risks. If the person remains high risk, then monitoring and risk mitigation attempts would be tried monthly or more often until risk level is reduced.
Will these new definitions be in use now or when this becomes available in June/July?	We would like you to test how this new high-risk definition would affect your reviews in April and May. Does this reduce the number of current people assessed as high risk? The new definition will not formally be in effect until the PT announcing this change in June of July 2019

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For a newly eligible client…can they be their own employee rep if assessed full assist in cognition and just place on high risk? Or does this apply to those that are currently clients and their cognition has declined to that point?	At this point in time, OAR 411-030-0040 (b) indicates that if a consumer fails to meet the employer responsibilities, the Department may require a representative. This allows the consumer an opportunity to manage the responsibilities first. Rule or policy changes in this area are currently being considered.
What would you recommend if we believe a consumer is high risk, but the consumer or rep states they can mitigate those risks although we do not agree based on past experiences?	In this scenario, the CM would need to maintain monthly contacts (or more frequent contacts if needed) and offer ongoing mitigation and monitoring if the risk stays in place. The CM would need to continue documenting his or her interaction with the consumer or the consumer's representative. The CM should also help the consumer and the consumer representative identify a contingency plan for emergencies.
Will the CM Services Due Report in OA reflect high risk consumers as Direct contacts when the report is pulled?	A new report will indicate which consumers have been assessed as high risk. The CM Services Due Report in OA will show when a Direct Contact for risk mitigation/monitoring is required when the risk assessment changes are made in June or July.
What is inspiring this change and why?	CMS has an expectation that we assess risk and try to minimize the risk as part of service planning. The Secretary of State Audit (October 2017), mandated that APD address monitoring of consumer's care to ensure direct and indirect contacts, utilize the OA risk assessment tool to identify consumers most at risk, and track compliance with risk-based monitoring in accordance with current APD policies. To comply with this audit, changes are being made to better identify high risk consumers and strengthen mitigation and monitoring strategies.
When will the Risk Assessment paper tool be updated on the CM Tools website?	When the Policy Transmittal outlining risk-assessments is released in June or July.
Will there be a PT coming out about this before it gets implemented?	Yes, the PT will come out when he changes are ready to be implemented. However, CO will provide more information, interaction with field offices, and opportunities to understand new risk assessment procedures and changes before any future PT is released.
If the risk is mitigated, would we then change their risk level on the Risk Assessment?	Yes – changes in risk level, when mitigated, move from high risk to moderate, low or no risk.
If they are MAGI, Direct and Indirect WCM contacts are not required…. Correct?	Yes – currently they are not required. However, in the future a CM Services Due Report and a monthly

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	Direct Contact will be required for MAGI high risk consumers.
When this change is implemented, will there be an option for CMs to edit the Risk Assessment rather than having to complete a new one each time?	Yes.
Can Direct WCM contacts still be completed over the phone or is there an expectation that we see them face to face?	Yes, direct WCM contacts can still be conducted over the phone. However, if you are working with a consumer that is difficult to contact or may not be able to speak on the phone, there may be cause for concern which would prompt a face to face visit.
Do you know what will be included in Phase 1 vs. Phase 2 of the Risk Assessment updates? When will each occur?	Phase 1 will occur in June or July and will involve the use of the new definition of high risk, monthly contacts for those consumers who have one or more high risks based on this definition, and changes in OA related to high risk reporting. Phase 2 changes will include a redesigned risk assessment tool, however do not have a firm date.
For a consumer that lives in an ALF that is dealing with MH and is a high risk, does the facility have any responsibility to help minimize this type of risk?	Yes, the facility is responsible to work with the consumer or the consumer's representative to identify and mitigate risks (OAR 411-054-0034(5)(m) and 411-054-0036 (6)).
I'm happy to see that natural disaster and power outages are off the table regarding high risk factors…. My question is: Can we get some funding or information about local resources and some suggestions for people that are on the high-risk list? Housing opening are rare so if I have someone living in sub-standard house what can I do? I can offer ALF, RCF and AFH placement, but there are not many openings there either. Also, consumer may have barriers keeping them from accepting or receiving placement.	Natural disasters, weather and power outages may still be categorized as high-risk factors, resulting in having them identified in the Emergency Concerns Report; however, they will not require monthly direct contacts. It is important to use the resources available from ADRC to discover community-based resources (Aging and Disability Resource Connection, ADRC). ADRC's are funded to track and know the resources at the local level and statewide. Complex Case consultations is also an option to consider. Finding appropriate housing options is a big challenge everywhere. There are almost always options but not always great options. Options may be to stay at home without services or with limited serves, move into a local residential setting, move in with relatives, or move out of area. Our job is to provide as many options as possible so the person or the representative can choose what is best for them.