DHS Oregon Department of Human Services

Aging and People with Disabilities

Information Memorandum Transmittal

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Number: APD-IM-13-050
Issue date: 8/9/2013

Topic: Long Term Care

Subject: Helpful tips on FAQ and OACCESS narration with documents for direct and indirect case management services

Applies to (check all that apply):

- ☐ All DHS employees
- ☒ Area Agencies on Aging
- ☒ Aging and People with Disabilities
- ☐ Children, Adults and Families
- ☐ County DD Program Managers
- ☐ County Mental Health Directors
- ☐ Health Services
- ☐ Other (please specify):

Message: In order to assist in implementing the Waivered Case Management expectations, Aging and People with Disabilities (APD) has put together two documents to help in this process. The two documents will cover the following information:

1. Frequently asked questions (FAQ) with answers of questions asked by case managers and other staff at the Case Management Services webinars.

2. Examples of OACCESS narration based on the type of case management services provided.

Thoughts on narration: Use action type words and phrases that relate to the individual's service plan, such as: analyzed service plan; discussed hours with the consumer's representative; worked with the individual, offered interventions; monitored the service plan; shared information; reviewed service plan with the consumer; addressed the service plan. Remember to be objective in your narrations and clearly state the actions you took to address your service plan.

If you have any questions about this information, contact:

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Case Management as a Waivered Service
FAQs

Why are we changing from case management as an administrative function to case management as a service?

The majority of APD clients receive Medicaid because they have qualified for the waiver. The waiver allows us to serve individuals whose income is greater than the standard Medicaid eligibility. We often call this the "special income category."

Under the K State Plan, individuals in the special income category must receive one waivered service every month to retain eligibility. Since all of the direct services have moved to the "K," individuals must receive waivered case management monthly to retain their eligibility.

Please discuss the difference between waiver and state plan.

1915(c) waivers allow states to provide long term care services in home and community based settings under the Medicaid Program rather than providing care in institutions such as nursing facilities. Traditionally, waivers provide states more flexibility than traditional Medicaid. States can offer a variety of services under an HCBS Waiver program including home and community based services and case management. Up to June 30, 2013 DHS used 1915 (c) waivers to fund all home and community based care services.

A State Plan is a contract between a state and the Federal Government describing how that state administers its Medicaid program. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative requirements that States must meet to participate. In the past, state plan requirements were more restrictive than waivers. In the last few years, the Federal Government has added State Plan 'Options."

The K State Plan Option, or the "Community First Choice Option," is a new state plan option that lets States provide home and community-based services under a State Plan. This option provides a 6 % increase in Federal matching funds for home and community based care services. Starting in July 1, 2013, Oregon will use the K to fund the majority of home and community based care services for seniors, people with intellectual or developmental disabilities and people with physical disabilities will be funded through the State Plan K option.

The K State Plan will allow us to expand services, increase our specialized capacity and better serve our consumers. A piece of this is because of the new federal funding. Another is allowed services in the K. As an example, we will now be able to add in chore services to help individuals remain in their own

homes.

Why is CM training mandatory?
CMS has mandated all case managers receive training on waivered case management in order to understand the different requirements between case management as a Medicaid administrative function and waivered case management.

Why are there different requirements between Medicaid administration CM and Waivered CM services?
Case management as a waivered service are services that assist individuals eligible for the waiver in gaining access to needed medical, social, educational, and other services. It is intended to ensure that individual's service plan is meeting their needs, that issues are resolved and that their safety and well-being assured. CM as a Medicaid Administration activity is similar but also focuses on eligibility, program integrity and payment authorization.

So How should APS and D/T services be counted?

- **Diversion Transition**
  - **Diversion from a NF** to a home or community based setting counts as Direct.
  - **Transition** from a NF does not count as a waivered case management service. It will remain as Medicaid Administration.

- **APS**
  - APS discussions between the CM and the consumer are direct.
  - APS referrals are indirect.
  - APS investigations can be either direct or indirect depending on who the APS investigator is working with. Direct if with the consumer. Indirect if with anyone else.

  APS as case management is not mandatory at this point. The idea is to have a broad pool of qualified staff that can perform the CM activities to "lighten the load." Since APS staff are paid for under other funding authorities, we will not be billing for CM services performed by APS workers.

- **Licensing**
  - Licensing discussions with providers are indirect.
  - Licensing discussions with consumers are direct.

Licensors documenting case management is not mandatory at this point. The idea is to have a broad pool of qualified staff that can perform the CM activities to "lighten the load."

Maybe you need to write a list of all direct and indirect activities and send it out?
A comparison chart is attached to the IM sent on August 9, 2013.

Could you review again what the community nurse's activities count as?
The work performed by Community Nurses does not count towards the waivered case management requirement. The CM contacting the RN, authorizing the service, reviewing the nursing plan and working with the RN on any issues counts as **indirect** case management.

When will the new 914 be ready to use?
It is ready for use.

A direct contact would be counted when we talk with the authorized representative?
Talking with an authorized representative counts as direct case management as long as it is around the needs of the individual, the service plan or provision of the services.

Why can't workers get their own past due lists?
Case managers will be getting alerts and "past due lists" that they can print. They just can't run prospective lists (i.e., all of my cases for the next 6 months.) We are seeing if we can add that functionality but if we can do it, it will be later this fall.

Why is the date on the alert the 20th, seems kind of late?
The implementation team thought that the 20th was enough time to "catch" any cases that have not been contacted earlier in the month. Supervisors and managers can run prospective lists to help with planning.

Does SNAP work count?

- Referrals to SNAP CMs counts as indirect.
- Taking calls from the consumer or their authorized representative about their SNAP benefits counts as direct.
- Eligibility, processing etc does not count toward the waivered case management requirement. SNAP work is covered under another authority

and cannot be counted as contact. Only referrals for SNAP may count and only if it is listed as a need for referral in the service plan.

If we leave a VM for a client and they do not return call what does that count as?
Sorry, this does not count as either indirect or direct.

Does mailing resources to a client count as direct?

- The discussion with the client counts as direct. The action of mailing something to a client (printing the materials, writing the envelope etc) does not count toward the waivered case management requirement. (On a side note, mailing notices does not count either.)
- If you proactively decide to mail something to the client, it can count as indirect as long as you are meeting an identified need.

Is there any retroactivity in doing a direct or indirect, or is it just retro as far as the documentation (i.e., narrate on 8/2 that the contact was done on 7/28)?
The retroactivity is only for documentation. Indirect must happen monthly and direct must happen at least once a quarter.

Please remember to document every indirect or direct case management activity even if they occur on the same day. Since this is new for all of us, the better documentation we have will let us plan into the future.

Have you determined what counts as direct for a non-responsive client in a facility who has no family or decision maker?
Not yet. We will update you as soon as we do.

Do we have to spell out Direct Contact or Indirect Contact in narrative, or if we just say we talked with client, is that adequate?
Spelling it out will be helpful. We would recommend starting each narration with just a few words like:

- "Direct CM with client re: HCW."
- "Indirect CM" reviewed voucher to see if it matched the service plan.
    - PLEASE NOTE: This must be more than reviewing a form to see if the form was filled out correctly. The CM must be reviewing the voucher to see if the services are being delivered as agreed to in the service plan, if the services continues to meet the needs of the individual and that no changes are needed to the service plan.

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You mentioned PACE, but we didn't get whether or not they're included in the K plan.
PACE clients are not included in the K since the PACE option is in a separate state plan amendment. Areas with clients in PACE programs may want to document for all clients to ensure consistency.

When a case manager is out, there could be 10 people helping cover a caseload, this will be difficult to track what has happened and what needs to happen.
Managers will be able to pull lists of needed case management activities. The list will sort by case manager. Any case management activity (indirect or direct) that occurs can be documented.

Will manager or back-up staff have access to the alerts so we can assure services during CM vacation or leave?
Managers will be able to run a report as frequently as they would like. The report can be run for specific time periods to ensure "future" coverage as well as overdue case management activities. We do not have a solution at this time that will allow back up case managers to pull lists of cases that are temporarily assigned to them.

Will the state provide a mechanism to download caseload list into Excel so we can plot out the quarter?
Not at this time.

For SNAP benefits it appears that the interview process would be direct, but the processing of the application to determine the eligibility is an indirect contact?
Interviewing and processing applications for SNAP is not a waivered case management activity. This is an eligibility function.

Can you clarify on the $710 comment? It sounded like you said that people who are above $710 need to be monitored and people below at or below $710 would not. It seems like if they are on K plan it would need to be monitored no matter what.
Everyone enrolled in home or community based services should receive the waivered case management service. As mentioned earlier, the "one-waivered service" as a condition of eligibility is tied to those individuals with incomes over SSI. For individuals who are categorically eligible for Medicaid (incomes at, or below SSI) and who meet service eligibility cannot be compelled to receive case management services as a condition to receive home and community based

services. Only individuals with incomes above the SSI standard must receive the waivered service to continue to be eligible for HCBC.

So, TBI and advanced dementia who cannot answer the phone (or have a phone) and have no family or representatives but the facility is the representative we still have to physically go in 4 times a year to physically see them?
Yes, this must be an in person contact.

If more than one direct service occurs in a quarter should it be entered into access?
Yes, all case management services should be entered into OACCESS regardless of the frequency. The more services that are entered, the better idea we will have for future costing, staffing etc. All CM activities should be entered.

Do I understand this correctly? All of this is to begin next week?
Yes, this new expectation starts at July 1, 2013. Indirect case management services must be completed by July 30, 2013. The first direct case management service must occur sometime between July 1, 2013 and September 30, 2013.

This was the first I heard APS and Licensors are impacted by the K Plan...will there be another webinar to ensure these folks are educated?
The concept of using APS and Licensor contacts as case management is a way to "share the load." The intent is not to add additional workload on these staff but to capture work that they are already doing. The only difference is to develop a way to document this work. Additional instructions will be forthcoming.

Can a CM and APS investigator enter service activity for the same day?
Yes, all case management services should be entered into OACCESS regardless of the frequency. The more services that are entered, the better idea we will have for future costing, staffing etc. All CM activities should be entered.

Can both an indirect and direct service activity be entered on the same day?
Yes, see above.

Please explain again the requirement with NF clients
There is no change for NF clients. You do not need to document case management activities. To reinforce the "habit" of documenting case management activities, we recommend recording case management activities in the same manner.

How is this being coded in RDSS?

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Most waivered case management activities will be recorded with code 9H.

What is the expectation for how quickly CM data should be entered in OACCESS following contact (for example within 3 days of service)?
We highly recommend entering the data as soon as possible. Remember to go to the CM Services tab before going to narration. When you navigate away from the CM Services tab, you will automatically be taken to the narration screen. You will need to enter a minimum of 10 characters. However, you can enter information for the proceeding calendar month. As an example, you can enter July 10th CM services all the way through August 31st.

Do the workers need to get the 914 Service Options form signed by the client?
Not immediately. At next assessment and service planning will be fine.

If we have both direct and indirect contact, which is possible, do we narrate both, or does one contact have priority over another.
Please document and narrate both contacts. This can be included in one narration.

How can APS log a direct contact when their information is protected and not put in narration?
The information does not need to be specific. APS narration is around general service provision. Additional information will be forthcoming.

If you talk to the POA or a guardian, is that considered a direct contact?
Yes, if relates to the care plan, assessment of need or other direct service provision issues.

Is signing a voucher an indirect contact?
Signing paperwork, authorizing services etc. does not count as a case management service. Reviewing the voucher to see if the service provision is occurring as planned is indirect contact.

So, in the future, if a client does not comply with the monthly monitoring, then will we be potentially closing them?
We have not established this policy yet. If you are unable to provide direct CM via phone or email, an in person visit will be necessary.

Who are we supposed to do the direct with while you are determining what to do if someone has no authorized representative?
An in person contact will be necessary to ensure that the client is receiving the appropriate services and supports and that the service plan is meeting their needs.

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Even if the individual cannot discuss the services and service provision with you, you will be able to ensure that the authorized services are being provided appropriately.

Do we need to get new 001N's for everyone now or wait till next review?
You may wait until the next review.

And if an individual is temporarily in a Nursing Facility, do we need to continue with direct/indirect contacts?
No, you do not.

Would referrals to Behavior Supports Services count as indirect?
Yes, as long as it identified as a need in the service plan.

Contact with a POA/Guardian count as a direct CM?
Yes

Does a request to change a medical/dental plan count as an in-direct contact?
If you are speaking directly with the client, it is a direct contact. If you are processing an administrative request, it is indirect.

What do you do if you call a client and they don't answer or call back so you are unable to complete the contact?
An in-person visit will be necessary. You should remind the consumer that this contact

Have clients been notified that they will now be required to participate in CM contacts monthly in order to remain eligible?
No, clients have not been notified. The Internal Workgroup (comprised of Central office, Local office, QA and other staff) and the Design and Implementation Council (comprised of consumer representatives and other stakeholders) advised us that a letter may be more confusing than helpful.

0001N and the 914 forms are being updated to include the case management expectation.

What if you need to complete a direct contact but the client does not have any needs that meet the criteria of direct contact?
Clients must receive a direct contact at least quarterly either in person, via an email exchange or a phone conversation.

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What do you do if you have a client that has dementia or is otherwise unable to participate in direct contact?
Please be in contact with the authorized representative.

As a licensor, If I review the record for, or speak to the AFH licensee about a Medicaid client, would that be an indirect contact?
Yes

Will you hire help?
This is undetermined at this time. We have committed to measuring the effect of this new workload this fall.

Who is tier 3?

Central Office staff.

Q: I thought part of this was changing the criteria for people who want LTC in a nursing facility. What is that part called?
Our current criteria have not changed.

Can you give an example of health related tasks at the end?
We are still working on this. As an example, we currently provide medication management.

Do we have a list of health-related tasks for future?
We do not have a list at this time. As we move forward with implementing the K State Plan, we will provide additional information.

Is shopping a possibility in the future for SPPC clients (under the K)?
No. State Plan Personal Care services are not part of the K State Plan Option. The Services will stay the same.

Are there any efforts in place to develop tools to make this easier to track?
Some of the offices/districts have been working on ways to manage this new responsibility. Central Office is reviewing and as we determine that they are allowable, we will be sending them out.

Sample OACCESS Narration
For Waivered CM Services

Direct CM Services	Indirect CM
APS Investigation	**APS Referral**
Direct CM: Home visit with consumer in response to APS referral.	Indirect CM: APS referral submitted for investigation of financial exploitation.
Direct CM: Phone call with guardian in response to APS referral.	Indirect CM: Phone call to AFH provider to investigate allegation.
Direct CM: Email exchange with consumer in response to APS referral.	Indirect CM: Visit with AFH provider as part of an APS investigation.
	Indirect CM: Phone call to consumer's daughter to discuss APS investigation.
Crisis Response & Intervention	**Crisis Response & Intervention**
Direct CM: Office visit with consumer's representative. She explained that the consumer does not have electricity due to non-payment of bill. Suggested she contact the electric company to have electricity turned on and maybe set up a payment plan. She said she would take care of this. She will let CM know if she is not able to resolve the issue	Indirect CM: Phone call from neighbor. She has not seen CL for at least 3 days. CM will call family to see if they can check in. If not, CM will perform a wellness check.
Direct CM: Phone call from consumer explaining that the HCW didn't show up this morning to help her get out of bed. Gave her the HCW's phone # and she said she will call her and get back to me if the HCW still isn't coming. Discussed other options such as in-home agency services and the potential for short term natural supports.	Indirect CM: HCW called. She is not able to get to the CL's home. Case Aid will call CL to see if she is okay and needs help.
Direct CM: Email exchange with consumer explaining that she is very frustrated with her HCW, as she is unreliable. Offered her the HCW registry and discussed hiring an in-home agency.	Indirect CM: AFH called. CL is being very disruptive and AFH may not be able to keep CL. CM made referral to BSS.

Direct CM Services	Indirect CM
Diversion Activities	**Diversion Activities**
Direct CM: Home visit with the consumer and their representative to discuss the various Medicaid community based services in lieu of nursing facility services.	Indirect CM: Office visit with consumer's daughter. I explained that nursing facility services are not the only available Medicaid service available. Counseled her on other community based services available. Daughter will discuss with CL.
Direct CM: Phone call with the consumer to explain that nursing facility is not the only option available. She thinks an AFH may be best. CL is willing contact providers. CM has sent an updated list and CL plans to contact them.	Indirect CM: Phone call to AFH provider to check if they had availability and if the consumer would be a good fit with the facility.
Indirect CM: Email exchange with consumer's daughter/ guardian. Discussed consumer's eligibility for the various community based services in lieu of nursing facility care. At daughter's request, I emailed her the list of AFHs, RCFs and ALFs in our area. Explained different settings.	Indirect CM: Email exchange with ALF provider. Located an available Medicaid room. Scheduled a date and time for the consumer and daughter/ guardian to visit the ALF.

Level of Care (LOC)/ Assessment/ Reassessment	Level of Care (LOC)/ Assessment/ Reassessment
Direct CM: Home visit with the consumer. Discussed the assessed needs and hours she is eligible to receive. Provided information on hiring a HCW from the HCW Registry. She said she would contact me once she made a final decision of which HCW to hire.	Indirect CM: AFH provider called. Discussed the changes she is noticing regarding the CL's needs.
Direct CM: Phone call from consumer. Requested more in-home hours for transferring in and out of bed each day. Annual reassessment due. Scheduled reassessment for the following week, as the consumer has already received the automated Buckley Bill notice. Will reevaluate the service needs as part of the assessment process at that time.	Indirect CM: Phone call from son. CL was hospitalized last week. He is being discharged back to home. Son thinks he may need more help. Scheduled reassessment for the following week.
Direct CM: Following the automated Buckley bill notice, email exchange with consumer's representative to discuss the annual reassessment scheduling. Representative said the consumer has had some changes to his service need. Set up home visit time with representative.	Indirect CM: Phone call from CCO. They are seeing an increased use of ER. Are requesting that we review the case to see if the CL is receiving enough support. CM will call the CL.
Other Program Coordination	**Other Program Coordination**
Direct CM: Home visit with the consumer. Due to consumer's low income and difficulty paying her rent, discussed housing assistance programs and provided a housing assistance brochure to the consumer.	Indirect CM: Office visit with representative. Provided representative with information and brochure on volunteer programs. This resource may be able to assist with removal of yard debris which is blocking the front entrance to consumer's home.

Direct CM: Phone call from the consumer asking how to get SNAP benefits. I provided her with the phone # of the office to contact about SNAP benefits.	Indirect CM: Phone call discussion with HCW/natural support to explain where consumer needs to apply for SNAP benefits.
Direct CM: Email exchange with consumer's representative and provided Volunteer Program information to her so that the consumer could have yard work completed, as yard is a safety hazard with debris in pathways.	Indirect CM: Phone call to housing assistance program to find out if the consumer is still on the housing waitlist and how long it might be until she will be able to get into subsidized housing. Was told it would be about 3 more months.
Risk Assessment/Monitoring	**Risk Assessment/Monitoring**
Direct CM: Completed risk assessment during home visit with consumer. Worked with the consumer to create a service plan to reduce home safety risk factors. Consumer is high risk in 2 areas of the risk assessment. See Risk Assessment for detail. Added in-home hours in mobility and bathing to reduce the risk of falling in the home. Tickler set to contact consumer in 3 months to determine if service plan adjustments are needed.	Indirect CM: Office visit with consumer's daughter. She brought in a letter from apartment manager which explained that she has 30 days to clean up the apartment to meet housing standards; otherwise she will receive an eviction notice. Arranged to visit the consumer at her apartment to evaluate options to reduce this risk, such as housekeeping hours.
Direct CM: Phone call to consumer to review and discuss effectiveness of service plan. Consumer states the # of hours approved are sufficiently meeting the need to reduce her risk of falling in her home.	Indirect CM: Reviewed service plan to determine if service hours are effectively meeting the consumer's risk factors addressed through the risk assessment.
Direct CM: Email exchange with consumer to review service plan and to find out if the AFH service plan she moved into 3 months ago is effectively meeting her needs. Consumer responded that she is very pleased with the plan in place and doesn't want any changes.	Indirect CM: Email to consumer's apartment manager to explain that housekeeping hours are being authorized. This is an attempt to prevent the consumer from being evicted from housing due to the uncleanliness of the apartment.

Service Plan Development & Review	Service Plan Development & Review
Direct CM: Home visit with the consumer. Completed CAPS assessment. With consumer's assistance, developed an in-home hourly service plan.	Indirect CM: Call to CL's daughter re: natural supports. Daugh is willing to continue shopping and dinner prep 3 times per week.
Direct CM: Phone call from the consumer. She explained that additional HCW hours are needed for bathing and dressing, as the natural support is no longer able to provide for these services. Authorized 5 more hours/month.	Indirect CM: Discussed service plan and rates with AFH.
Direct CM: Email exchange with the consumer's representative. Discussed the HCW schedule and the duties they will be providing.	Indirect CM: Phone call to HCW. Authorized hours to assist the consumer with increased assistance needed for bathing.
Service Plan Monitoring and Implementation	**Service Plan Monitoring and Implementation**
Direct CM: Follow up home visit with the consumer to determine if the in-home service plan is mitigating the risk factors identified in the risk assessment. Consumer explained that she needs more hours in bathing, as she is unable to bathe as frequently as she needs with the hours provided. Approved 5 more hours/month to assist with bathing tasks.	Indirect CM: Office visit with consumer's son. Authorized additional meal prep hours, as son explained the consumer is unable to prepare meals any longer due to weakness.
Direct CM: Phone call to follow-up on the effectiveness of the service plan to mitigate health and safety concerns addressed in the CAPS assessment and Risk Assessment. Plan is adequately meeting the consumer's needs.	Indirect CM: Reviewed HCW voucher and researched why the consumer didn't use all the authorized hours. HCW said that during the son's visit last week, he provided for most of his mother/consumer's care needs.

Direct CM: Email exchange with consumer's guardian explaining that the consumer needs assistance transferring in and out of her recliner while the consumer recovers from a sprained ankle. Authorized an additional 4 hours/month in mobility. 3 month tickler set to determine if a reduction of hours is needed following recovery of ankle.	Indirect CM: Called RCF. Discussed how the CL is settling in and if the MH treatment has started.
Service Provision Issues	**Service Provision Issues**
Direct CM: Phone call from the consumer explaining that she had a disagreement with her AFH provider and consumer wants to move out. Throughout conversation, the consumer calmed down and decided she would let this go, as it was not a big deal and she stated the provider is giving her good care.	Indirect CM: Review of HCW voucher. More hours claimed than were authorized. HCW explained that extra "one-time" hours were needed to clean the apartment to pass housing inspection. Approved the extra "one-time" hours. Explained all future hours must be prior authorized or are at risk for non-payment.
Direct CM: Home visit with the consumer. Consumer explained she is weak and tired and having difficulty preparing meals. Discussed increasing in meal prep hours and/or HDMs. Set up HDMs at consumer's request. No increase in meal prep hours.	Indirect CM: Reviewed Community LTC nurses assessment notes, discussed with nurse and determined additional hours are needed for bathing and dressing. Authorized additional hours to HCW.
Direct CM: Email exchange with the consumer. Agreed to authorize transportation hours and mileage for shopping.	Indirect CM: Received FAX from dialysis center stating the consumer is now receiving dialysis. Will likely be exhausted the day following the treatment and will need more assistance with mobility on those days. Approved additional 6 hours/month.

Direct CM: Consumer came into the office to discuss changing in-home agencies. She does not like that IHA providers have been smoking before coming into her apartment. Agreed to call the IHA to see if they can help.	Indirect CM: Reviewed FAXED hospital records about the consumer. Approved hours to meet the consumer's mobility issues when she discharges on Friday. Set tickler to contact consumer for home visit when she returns from the hospital.
Service Options Choice Counseling	**Service Options Choice Counseling**
Direct CM: Home visit with consumer, explained all the Medicaid service options available. Consumer selected HCBC (ALF) service option and signed the Service Option 914 form.	Indirect CM: Office visit from the consumer's daughter. Went over the difference between various service options, including in-home services, AFH, RCF, ALF, SPPC and nursing facility.
Direct CM: Phone conversation with consumer. Explained the difference between AFH, RCF, ALFs and in-home services.	Indirect CM: Phone call from consumer's mother. Explained all service options available to the consumer.
Direct CM: Email exchange with consumer. Explained all the various Medicaid service options. Consumer responded that she is interested in in-home services.	Indirect CM: Email exchange with consumer's doctor explaining all the various Medicaid service options.