MISSOURI DEPARTMENT OF
HEALTH & SENIOR SERVICES

PROTECTING HEALTH AND KEEPING PEOPLE SAFE

MISSOURI DEPARTMENT OF
HEALTH &
SENIOR SERVICES

HCBS Overview

DHSS Long Term Services and Supports

Topic Overview

Section 1 Level of Care Transformation & InterRAI Coding

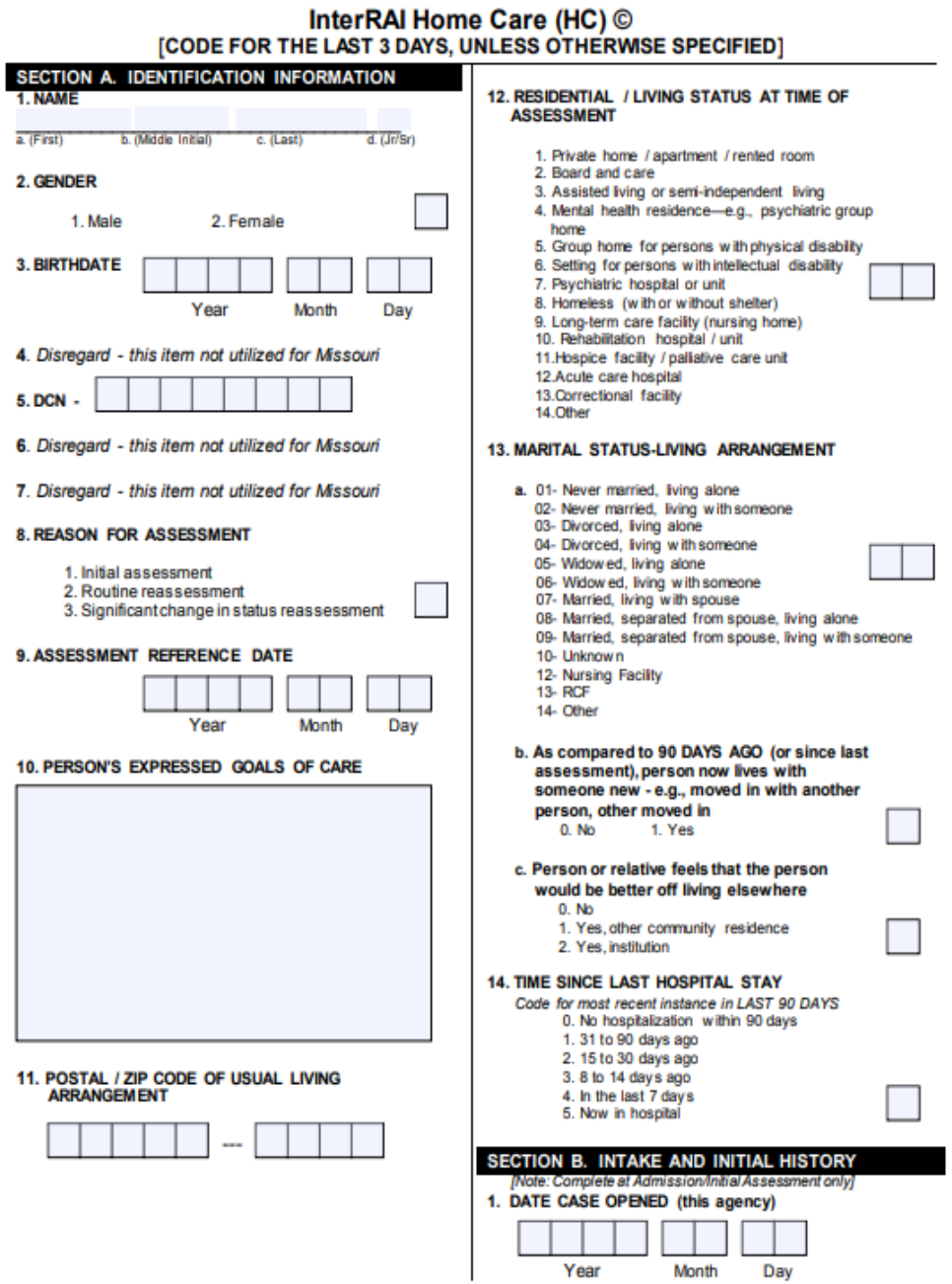
Section 2 Discuss Documentation Requirements

Section 3 Review Care Planning

Section 4 Reassessment Process Overview

Section 01

Level of Care and InterRAI Coding



InterRAI Home Care (HC) ©
[CODE FOR THE LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. IDENTIFICATION INFORMATION

1. NAME
a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. GENDER
1. Male 2. Female

3. BIRTHDATE
Year Month Day

4. *Disregard - this item not utilized for Missouri*

5. DCN -

6. *Disregard - this item not utilized for Missouri*

7. *Disregard - this item not utilized for Missouri*

8. REASON FOR ASSESSMENT
1. Initial assessment
2. Routine reassessment
3. Significant change in status reassessment

9. ASSESSMENT REFERENCE DATE
Year Month Day

10. PERSON'S EXPRESSED GOALS OF CARE

11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT
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12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT
1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other

13. MARITAL STATUS-LIVING ARRANGEMENT

a. 01- Never married, living alone
02- Never married, living with someone
03- Divorced, living alone
04- Divorced, living with someone
05- Widowed, living alone
06- Widowed, living with someone
07- Married, living with spouse
08- Married, separated from spouse, living alone
09- Married, separated from spouse, living with someone
10- Unknown
12- Nursing Facility
13- RCF
14- Other

b. As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new - e.g., moved in with another person, other moved in
0. No 1. Yes

c. Person or relative feels that the person would be better off living elsewhere
0. No
1. Yes, other community residence
2. Yes, institution

14. TIME SINCE LAST HOSPITAL STAY
Code for most recent instance in LAST 90 DAYS
0. No hospitalization within 90 days
1. 31 to 90 days ago
2. 15 to 30 days ago
3. 8 to 14 days ago
4. In the last 7 days
5. Now in hospital

SECTION B. INTAKE AND INITIAL HISTORY
[Note: Complete at Admission/Initial Assessment only]

1. DATE CASE OPENED (this agency)
Year Month Day

InterRAI Coding

Question A10

10. PERSON'S EXPRESSED GOALS OF CARE

Refer to InterRAI Section A: Goals Quick Guide

InterRAI Section A: Goals Quick Guide

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Division of Senior & Disability Services

Goals may come from the participant or legal representative. In the rare circumstance when a participant cannot verbalize a goal, a primary unpaid caregiver may provide the goal for the participant. Case note documentation would be required in these instances.

- A goal is defined as the larger impact receiving services would have on the participants overall safety, health, and well being. It is not simply the immediate benefit of receiving services.
- A goal should be something the participant hopes to accomplish, not a statement of their condition or fact. A goal should focus on promoting safety, health, independence, well being, and/or community integration for the participant with HCBS
- Goals should be participant specific, and Assessors should **not** use identical goals for all participants.
- A goal should include two parts, the **reason** for applying and **how** or **why** these services will help them.

Appropriate	Inappropriate
"I would like assistance around the house in order to allow my broken leg to heal".	"I need my broken leg to heal". This is a statement and not a goal.
"My goal is to receive assistance with cooking as I am concerned with falling and burning myself".	"Due to leg and back pain I am not able to stand up and cook". This is a statement and not a goal.
"I want to be living on my own and retain my independence".	"I don't know or I'm really not sure". Must include a goal with an outcome.
"My goal is to continue receiving services that will provide me support I cannot get through family to remain independent".	"I want to continue to receive services". There is not a stated outcome.
"I wish to remain in the RCF to ensure my medications are administered correctly".	"RCF", "ALF", "Remain in RCF." There is not a stated outcome.
"I would like to ensure I have consistent help available to help me with my day to day needs".	"My grandson helps me a lot and I would like to get him paid." This is not person/participant centered and does not include a stated outcome.

Question A10: Obtain goal from participant when possible

Include the reason requesting services and how or why services will help

InterRAI Coding

Question A12 and Question A13

12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT

1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other

0	2

A12: Residential / Living status at time of assessment

Score as 2. Board and care for RCF/ALF

13. MARITAL STATUS-LIVING ARRANGEMENT

a.
01- Never married, living alone
02- Never married, living with someone
03- Divorced, living alone
04- Divorced, living with someone
05- Widowed, living alone
06- Widowed, living with someone
07- Married, living with spouse
08- Married, separated from spouse, living alone
09- Married, separated from spouse, living with someone
10- Unknown
12- Nursing Facility
13- RCF
14- Other

1	3

A13: Marital Status – Living Arrangement

Score as 13. RCF when resides in RCF/ALF

InterRAI Coding

Question B4b

4. RESIDENTIAL HISTORY OVER LAST 5 YEARS
Code for all settings person lived in during 5 years prior to date case opened [Item B1]

0. No 1. Yes

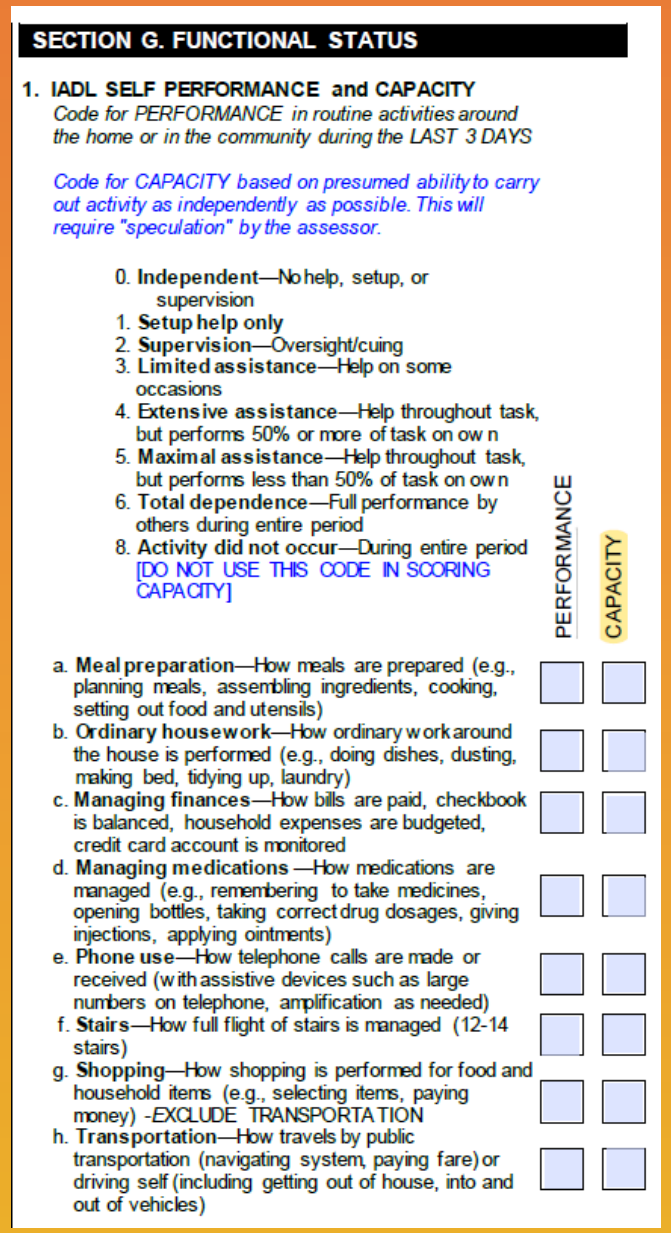
a. **Long-term care facility—e.g., nursing home**	
b. **Board and care home, assisted living**	1
c. **Mental health residence—e.g., psychiatric group home**	
d. **Psychiatric hospital or unit**	
e. **Setting for persons with intellectual disability**	

B4: Residential History over last 5 years

Score B4b as 1 when resident of RCF/ALF at any time in last 5 years including day of assessment

InterRAI Coding

Section G. Functional Status



SECTION G. FUNCTIONAL STATUS

1. IADL SELF PERFORMANCE and CAPACITY

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0. **Independent**—No help, setup, or supervision
1. **Setup help only**
2. **Supervision**—Oversight/cuing
3. **Limited assistance**—Help on some occasions
4. **Extensive assistance**—Help throughout task, but performs 50% or more of task on own
5. **Maximal assistance**—Help throughout task, but performs less than 50% of task on own
6. **Total dependence**—Full performance by others during entire period
8. **Activity did not occur**—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]

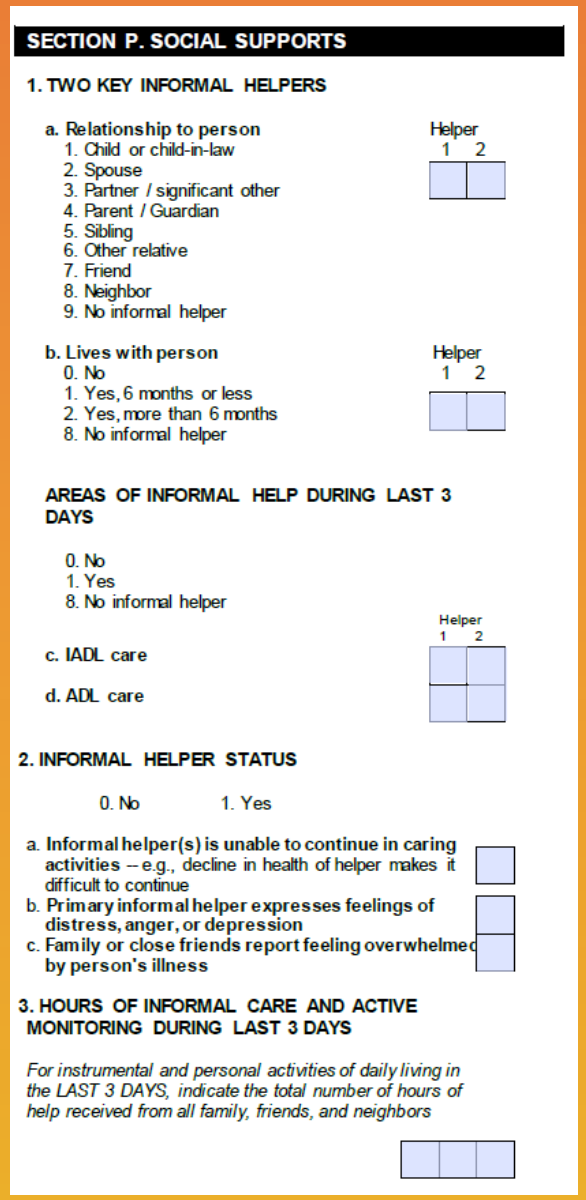
	PERFORMANCE	CAPACITY
a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)		
b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. **Managing finances**—How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored		
d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)		
e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. **Stairs**—How full flight of stairs is managed (12-14 stairs)		
g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money) -EXCLUDE TRANSPORTATION		
h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)		

Capacity column reflects amount of assistance required to safely complete IADLs while living in the community

Performance will reflect level of assistance provided in current living situation (RCF/ALF)

InterRAI Coding

Section P: Social Supports



SECTION P. SOCIAL SUPPORTS

1. TWO KEY INFORMAL HELPERS

a. Relationship to person — Helper 1 2

1. Child or child-in-law
2. Spouse
3. Partner / significant other
4. Parent / Guardian
5. Sibling
6. Other relative
7. Friend
8. Neighbor
9. No informal helper

b. Lives with person — Helper 1 2

0. No
1. Yes, 6 months or less
2. Yes, more than 6 months
8. No informal helper

AREAS OF INFORMAL HELP DURING LAST 3 DAYS

0. No
1. Yes
8. No informal helper

Helper 1 2

c. IADL care

d. ADL care

2. INFORMAL HELPER STATUS

0. No 1. Yes

a. Informal helper(s) is unable to continue in caring activities -- e.g., decline in health of helper makes it difficult to continue

b. Primary informal helper expresses feelings of distress, anger, or depression

c. Family or close friends report feeling overwhelmed by person's illness

3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS

For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors

Facility staff are not scored as informal help

Informal helpers are unpaid helpers

InterRAI Coding

Section S. Back Up Plan


SECTION S. BACK UP PLAN

1. Enter the Back Up Plan

Refer to InterRAI Section S: Back-up Plan

InterRAI Section S: Back-up Plan
Quick Guide

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
Division of Senior & Disability Services

- Back-up plans should include the contact(s) first and last name, phone number, relationship to the participant, and assistance they would provide if needed.
- Back-up plans must be accurately entered into the case record to meet CMS federal requirements.
- 911 should only be used in rare situations. We should assist the participant in exploring all possible contacts outside of calling 911. Examples may include neighbors, friends, family members, church members, etc. The person listed in the back up plan is not required to actually complete all unmet needs but could assist in care coordination in the event of an emergency. If 911 is used as the Emergency Contact on the InterRAI, a case note is required further detailing there are no other options for a back-up plan.

Appropriate	Inappropriate
• Jane Doe/Daughter/555-555-555 Jane is available to assist with all daily unmet needs if needed.	• I do not need a back-up plan. I can take care of myself.
• John Smith/Son/Phone # - John is available to prepare or bring meals if needed. Participant is able to complete all other tasks in the event of emergency or absence of aid.	• I would call DSDS or my case manager.
• Susie Davis/Neighbor/Phone # - Susie checks on Pt daily. If aide was unavailable, Pt could rely on her neighbor to meet unmet needs.	• Someone would assist me eventually.
	• Listing "RCF" or "ALF."
	• Emergency contact name, relationship, and phone number.

Sample questions to obtain back-up plan:

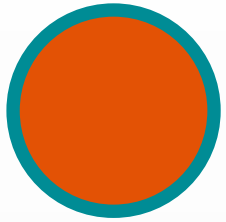
- In the event your aide/attendant is unavailable, can you provide a name, telephone number, and relationship status for someone who can directly assist you on short notice? What tasks will they be able to assist you with?
- How would your emergency contact listed in your back up plan specifically assist you to ensure your needs are met and you remain safe in your home?

Back up plan must include name, relationship, contact information, and what help person can provide

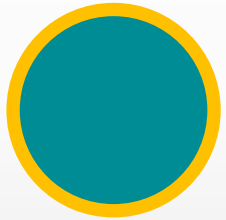
RCF/ALF staff are acceptable back-up plan if no other plan available

Transformed Level of Care

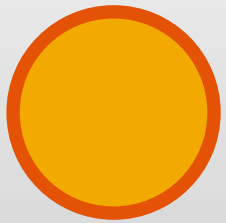
	Min	Mod	Max	Trigger
Mobility	3	6	X	18
Eating	3	6	9	18
Toileting	3	6	9	X
Dressing/Grooming	3	6	X	X
Bathing	3	6	X	X
Treatments	X	6	X	X
Cognition	3	6	9	18
Behavorial	3	6	9	X
Rehab	3	6	9	X
Med Management	3	6	X	X
Meal Prep	3	6	X	X
Safety	3	6	9	18



Currently operating with Standard and Transformed LOC



Transformed Level of Care = 18 points



Transformed only after full expenditure of 9817 ARPA Funding

Behavioral Category

Section E

- E3a - Wandering
- E3c - Physical abuse
- E3d - Socially inappropriate or disruptive behavior
- E3e - Inappropriate public sexual behavior or public disrobing
- E3f - Resists care

Section J Psychiatric

- J3g – Abnormal Thoughts
- J3h – Delusions
- J3i – Hallucinations

Section N

- N7b – Mental Monitoring

Cognition Category

Section C

C1 Cognitive Skills for Daily Living (Coma – Trigger)

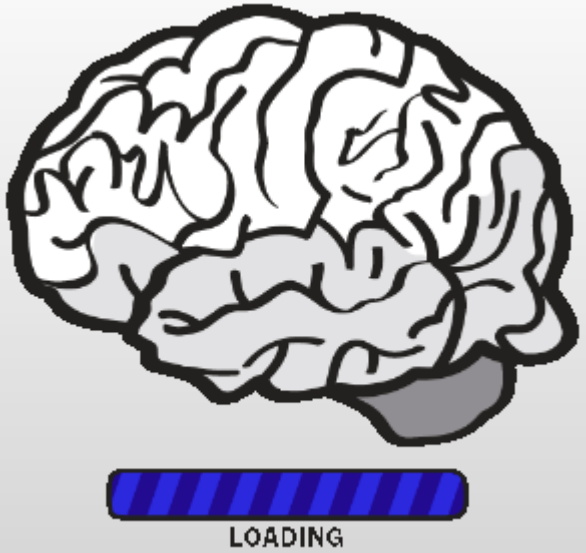
C2 Memory / Recall Ability

C3 Periodic Disordered Thinking / Awareness

Section D

D1 Making Self Understood

D2 Ability to Understand others

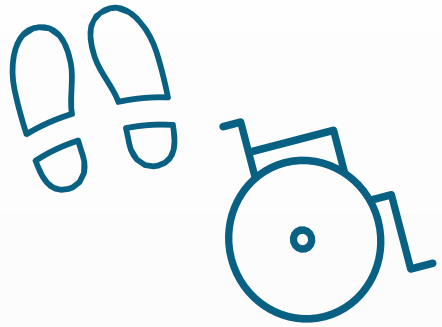


High Hierarchy / Late Loss ADLs

Mobility Category

G2f – Locomotion

G3a - Primary Mode of Locomotion



Eating Category

G2j – Eating

K2e Physician Ordered Diet

Toileting Category

G2g – Transfer Toilet

G2h – Toilet Use

Low Hierarchy / Early Loss ADLs

Bathing Category

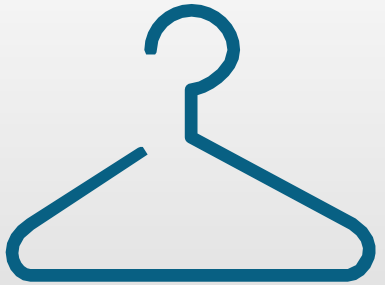
G2a – Locomotion

Dressing/Grooming

G2b – Personal Hygiene

G2c – Dressing Upper Body

G2d – Dressing Lower Body



Low Hierarchy / Early Loss ADLs

Meal Prep Category

G1a – Meal Prep

Med Management Category

G1d – Managing Medications

Treatments Category

Section H

- H 1 - Bladder Continence
- H 2 - Urinary Collection Device
- H 3 - Bowel Continence

Section K

- K3 – Mode of Nutrition

Section N

- N2g - Suctioning
- N2h – Tracheostomy Care
- N2j – Ventilator or Respirator

Treatments Category Continued

Section L

L1 – Pressure Ulcer
L3 – Presence of Skin Ulcer
L4 – Major Skin Problems
L5 – Skin Tears or Cuts

Section N

N2k – Wound Care

Rehabilitation Category

Section N

N3e – PT

N3f – OT

N3g – Speech

N3i – Cardiac Rehab

Safety Category

Section A

- Age – 75+

Section B

- B4 Institutionalization

Section D

- D4 Vision

Section J

- J1 Falls
- J3 Balance

Standard LOC Items

Section M
M4 – Complex Drug

Section N
N6f - ITP
N7a – Physical Monitoring

Stairs
G1f - Stairs

Section

02

Documentation

Case Note Documentation

Assessors are required to document:

Number of Medication passes

Assistance with Medically Related Household Tasks

Verify information with facility staff

Clarify the “above and beyond”

Case Note Documentation

Assessors are required to document:

“Other” Nursing Tasks

Condition of participant’s personal space

Source of information gathered

Back Up Plan

Include:

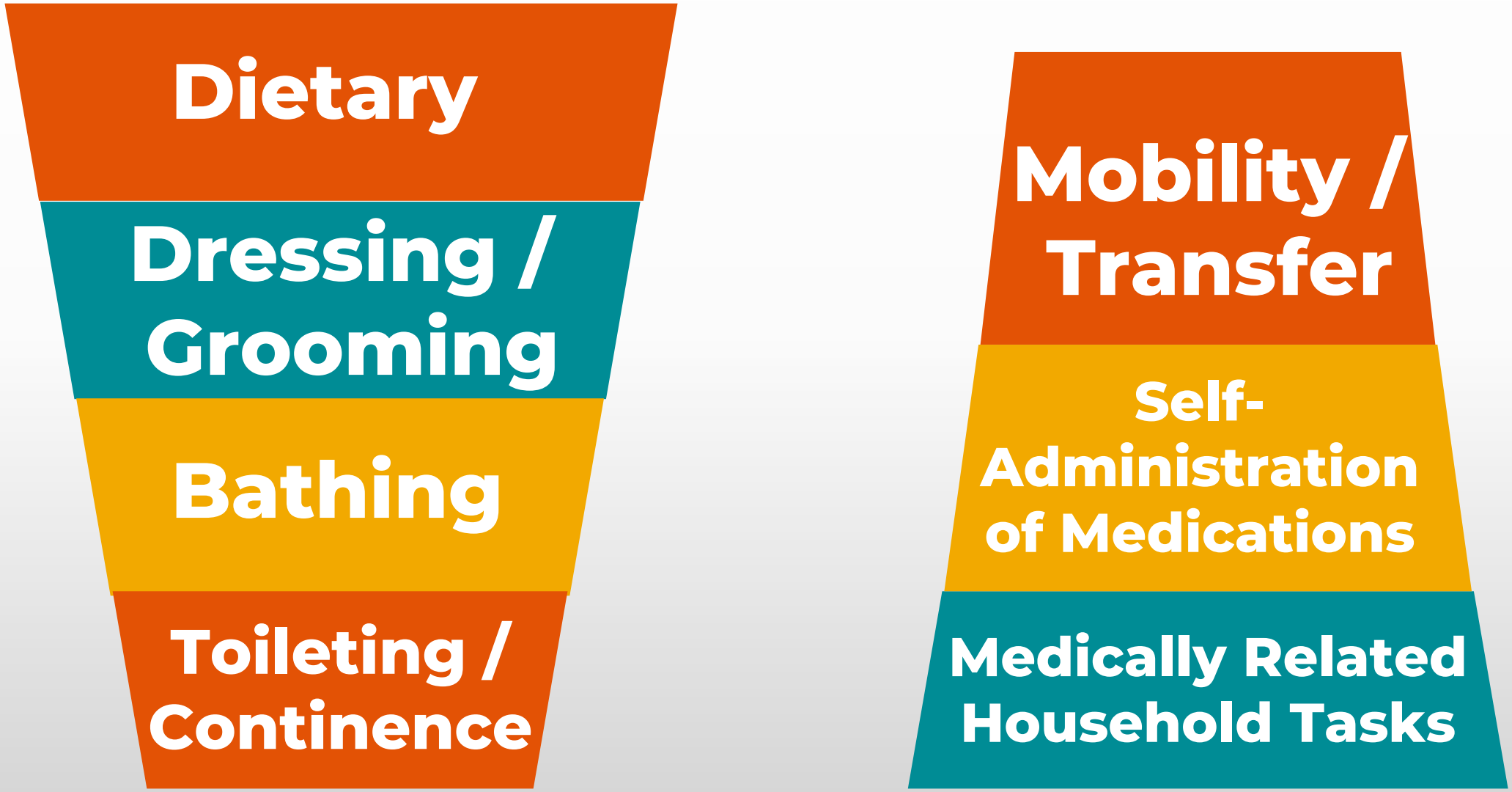
- Contact Person
- Relationship
- Assistance provided?
- Contact Information

Section

03

Care Planning

RCF/ALF Personal Care



Dietary Task

Feeding

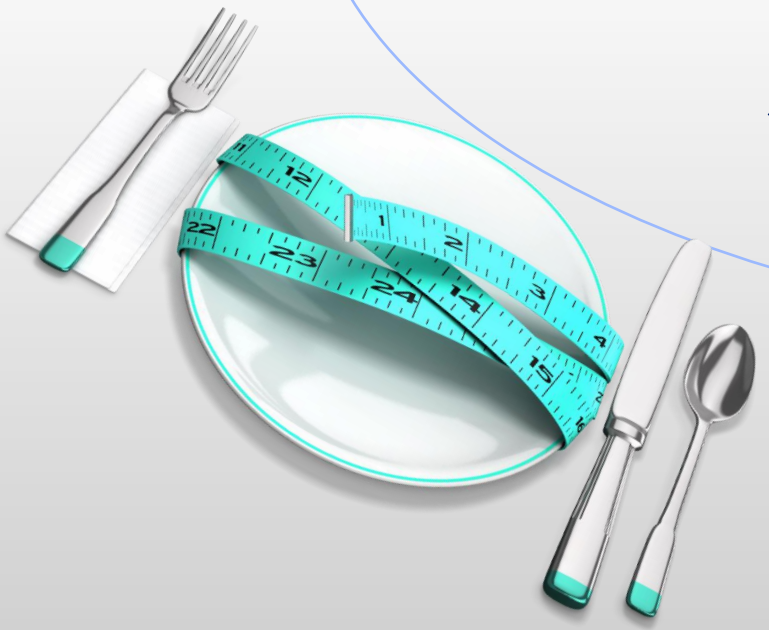
Cut up food

Physician Ordered Diet

Carry tray to table

Dietary Task Authorization

1 meal = 15 minutes or 1 unit when authorized for physician ordered diet, more time can be given for additional tasks



RCF / ALF Personal Care

Dressing / Grooming & Bathing

Dressing / Grooming

Include hands on assistance
Prompting and cuing cannot be a task

Bathing

Include subtasks, prompting and cuing can be a component of the task, not the task alone

RCF / ALF Personal Care

Toileting / Continence and Mobility / Transfer

Toileting & Continence

Task includes time assisting with all subtasks of toileting including on/off the toilet or commode, adjusting clothing, changing bed linens, cleaning self following an incontinent episode

Mobility & Transfer

Task includes mobility assistance to a person that can bear some weight

RCF / ALF Personal Care

Self Administration of Medication

3 medication passes per day = 1 unit

4 or more medication passes per day = 2 units

Medically Related Household Tasks

Authorized when household tasks go above and beyond the minimum obligations of the RCF/ALF

Can authorize linen changes as medically related household task

Advanced Personal Tasks

Advanced Personal Care (APC) Authorization

- Time / task authorized as appropriate
- Nurse is authorized to Evaluate APC monthly when APC authorized on care plan

RCF/ALF Nurse Visits

Task Authorization

- Other Nursing Tasks
- Nail Care
- Monitor Skin Condition
- Evaluate APC Care Plan
- Note: Maximum number of visits, 26 visits in a 6 month period

04

Assessment Overview

Provider Change Request

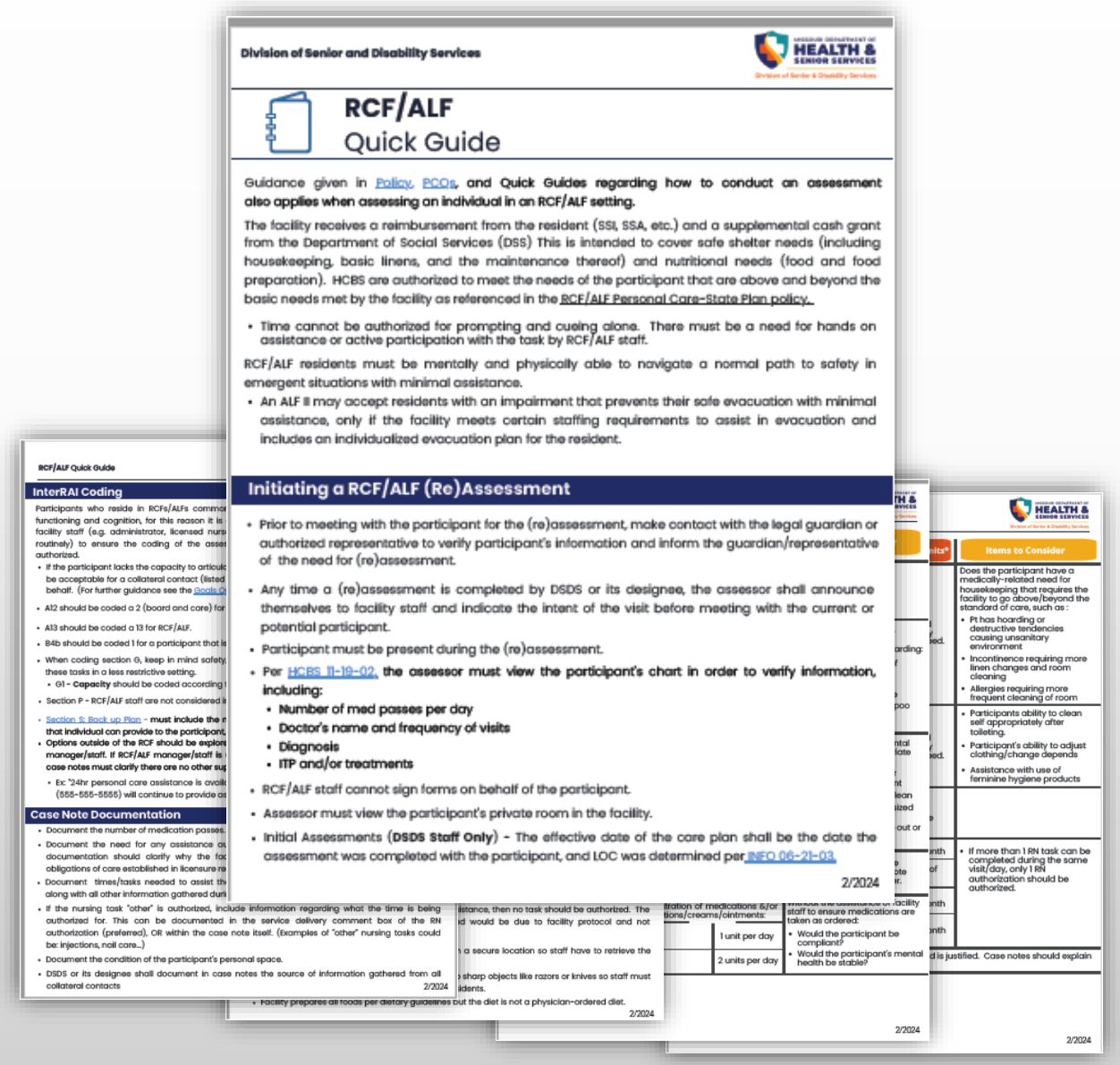
If a provider change is requested due to transfer between RCF/ALFs, when request is made within 2 weeks, start date is date of admission

If provider change request is made after 2 weeks of admission, start date is date of request received by the PCCP Team

Assessment Process

Initials completed by DSDS Staff / Reassessments may be completed by provider staff

Assessors are advised:



Must contact guardian first, guardian must approve services authorized

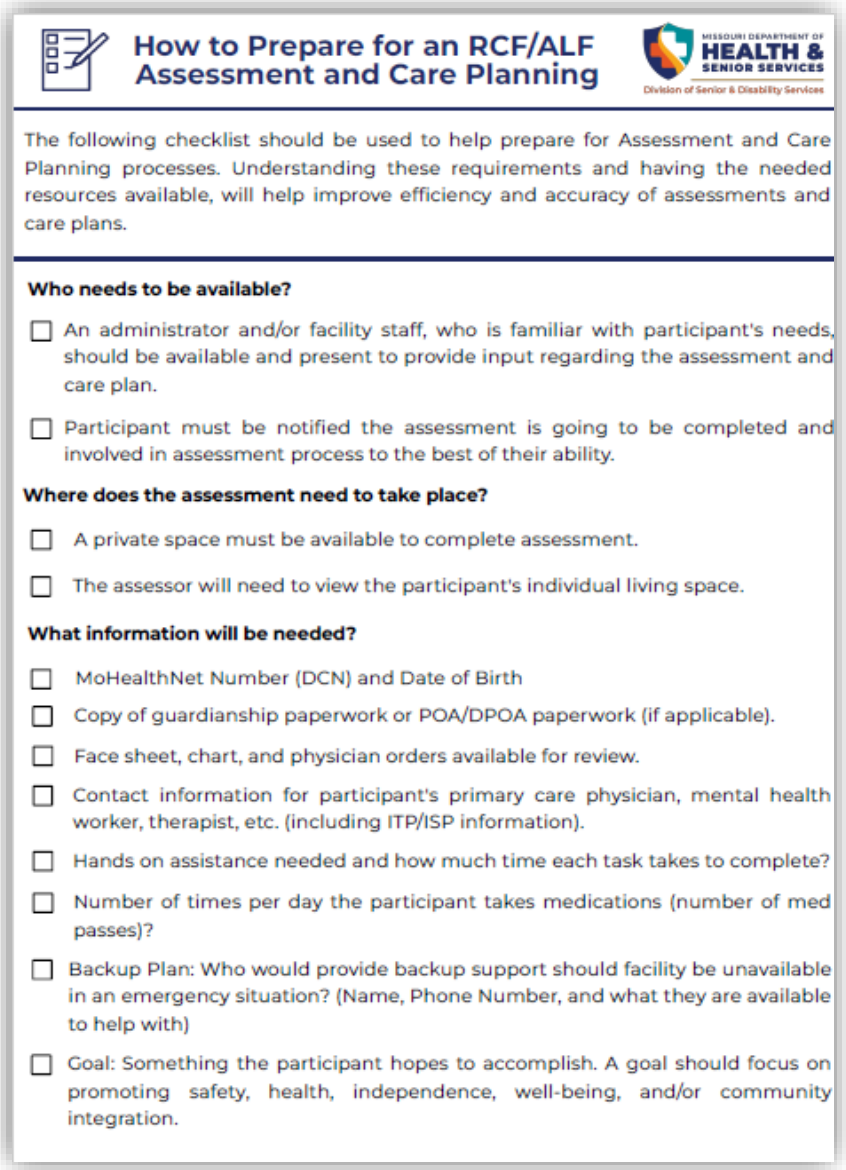
Authorize personal care tasks that go above and beyond contractual responsibilities

Prompting and cuing can be a component of a task, not an authorized task

Utilize RCF/ALF Quick Guide

How can you be prepared?

RCF / ALF Preparation Guide



How to Prepare for an RCF/ALF Assessment and Care Planning

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Division of Senior & Disability Services

The following checklist should be used to help prepare for Assessment and Care Planning processes. Understanding these requirements and having the needed resources available, will help improve efficiency and accuracy of assessments and care plans.

Who needs to be available?

- ☐ An administrator and/or facility staff, who is familiar with participant's needs, should be available and present to provide input regarding the assessment and care plan.
- ☐ Participant must be notified the assessment is going to be completed and involved in assessment process to the best of their ability.

Where does the assessment need to take place?

- ☐ A private space must be available to complete assessment.
- ☐ The assessor will need to view the participant's individual living space.

What information will be needed?

- ☐ MoHealthNet Number (DCN) and Date of Birth
- ☐ Copy of guardianship paperwork or POA/DPOA paperwork (if applicable).
- ☐ Face sheet, chart, and physician orders available for review.
- ☐ Contact information for participant's primary care physician, mental health worker, therapist, etc. (including ITP/ISP information).
- ☐ Hands on assistance needed and how much time each task takes to complete?
- ☐ Number of times per day the participant takes medications (number of med passes)?
- ☐ Backup Plan: Who would provide backup support should facility be unavailable in an emergency situation? (Name, Phone Number, and what they are available to help with)
- ☐ Goal: Something the participant hopes to accomplish. A goal should focus on promoting safety, health, independence, well-being, and/or community integration.

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QUESTIONS?

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