

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



Level of Care and InterRAI Coding



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SECTION A. IDENTIFICATION INFORMATION	12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT				
a. (First) b. (Middle Initial) c. (Last) d. (Jir/Sr) 2. GENDER 1. Male 2. Female 3. BIRTHDATE Year Month Day 4. Disregard - this item not utilized for Missouri 5. DCN -	 Private home / apartment / rented room Board and care Assisted living or sem-independent living Mental health residence—e.g., psychiatric grownome Group home for persons with intellectual disability Setting for persons with intellectual disability Psychiatric hospital or unit Homeless (with or without shelter) Long-term care facility (nursing home) Rehabilitation hospital / unit Hospice facility / paliative care unit Acute care hospital Correctional facility 				
6. Disregard - this item not utilized for Missouri	14.0ther 13. MARITAL STATUS-LIVING ARRANGEMENT				
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	a. 01- Never married, living alone 02- Never married, living with someone 03- Divorced, living alone 04- Divorced, living with someone 05- Widow ed, living alone 06- Widow ed, living alone 07- Married, separated from spouse, living alone 08- Married, separated from spouse, living with someone 09- Married, separated from spouse, living with someone 10- Unknow n 12- Nursing Facility 13- RCF 14- Other b. As compared to 90 DAYS AGO (or since lat assessment), person now lives with someone new - e.g., moved in with another person, other moved in 0. No 1. Yes				
11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT	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				

omeone

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

Question A10

10. PERSON'S EXPRESSED GOALS OF CARE



Refer to InterRAI Section A: Goals Quick Guide





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.



 "My goal is to receive assistance with cooking as I am concerned

with falling and burning myself".

"I want to be living on my own and

"My goal is to continue receiving

support I cannot get through family

services that will provide me

"I wish to remain in the RCF to

ensure my medications are administered correctly".

 "I would like to ensure I have consistent help available to help me

with my day to day needs".

to remain independent".

retain my independence".

leg to heal".

- "I would like assistance around the house in order to allow my broken
 "I need my broken leg to heal". This is a statement and not a goal.
 - "Due to leg and back pain I am not able to stand up and cook". This is a statement and not a goal.

Inappropriate

X

- "I don't know or I'm really not sure". Must include a goal with an outcome.
- "I want to continue to receive services". There is not a stated outcome.
- "RCF", "ALF", "Remain in RCF." There is not a stated outcome.
- "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

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



3

1

- 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

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- Widow ed, living alone 06- Widow ed, living with someone 07- Married, living with spouse 08- Married, separated from spouse, living alone 09- Married, separated from spouse, living with someone 10- Unknow n 12- Nursing Facility 13- RCF

Question A12 and Question A13

A12: Residential / Living status at time of assessment

Score as 2. Board and care for RCF/ALF

A13: Marital Status – Living Arrangement

Score as 13. RCF when resides in RCF/ALF

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
- 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

SECTION G. FUNCTIONAL STATUS

 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.

 Independent—No help, setup, or supervision Setup help only Supervision—Oversight/cuing Limited assistance—Help on some occasions Extensive assistance—Help throughout task but performs 50% or more of task on ow n Maxim al assistance—Help throughout task, but performs less than 50% of task on ow n Total dependence—Full performance by others during entire period 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) -<i>E</i>XCLUDE 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)		

Section G. Functional Status

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)

Section P: Social Supports

SECTION P. SOCIAL SUPPORTS 1. TWO KEY INFORMAL HELPERS a. Relationship to person Helper 1. Child or child-in-law 1 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

Section S. Back Up Plan

InterRAI Section S: Back-up Plan

Ouick Guide



- 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.



Jane Doe/Daughter/555-555-555

Jane is available to assist with

all daily unmet needs if needed.

John Smith/Son/Phone # - John is

available to prepare or bring

the event of emergency or

absence of aid.

needs.

meals if needed. Participant is able to complete all other tasks in

Susie Davis/Neighbor/Phone # -

her neighbor to meet unmet

Susie checks on Pt daily. If aide

was unavailable, Pt could rely on

- Inappropriate
- I do not need a back-up plan. I can take care of myself.
 - I would call DSDS or my case manager.
 - 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

SECTION S. BACK UP PLAN

1. Enter the Back Up Plan



Transformed Level of Care

	Min	M o d	Max	Trigger			
Mobility	3	6	Х	18			
Eating	3	6	9	18			
Toileting	3	6	9	Х			
Dressing/Grooming	3	6	Х	Х			
Bathing	3	6	Х	Х			
Treatments	Х	6	Х	Х			
Cognition	3	6	9	18			
Behavorial	3	6	9	Х			
Rehab	3	6	9	Х			
Med Management	3	6	Х	Х			
Meal Prep	3	6	Х	Х			
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

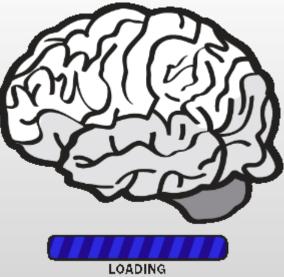


Cognition Category

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

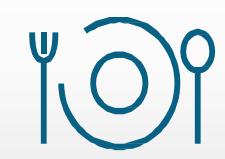
- G2f Locomotion
- G3a Primary Mode of Locomotion

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 Gla – Meal Prep

Med Management Category Gld – Managing Medications



Treatments Category



Section H

- H1-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









Section A

• Age – 75+

Section B

 B4 Institutionalization

Section DD4 Vision

Section J

- J1 Falls
- J3 Balance

Standard LOC Items

Section M M4 – Complex Drug

Section N N6f - ITP N7a – Physical Monitoring



Stairs Glf - Stairs



Documentation

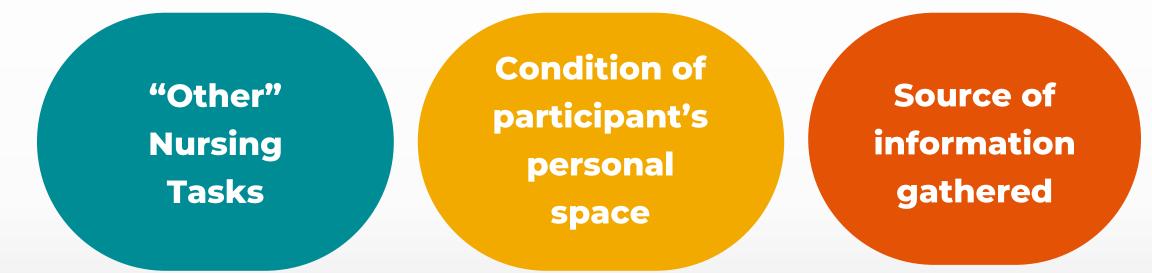
Case Note Documentation

Assessors are required to document:



Case Note Documentation

Assessors are required to document:









Back Up Plan

Include:







RCF/ALF Personal Care

Dietary

Dressing / Grooming

Bathing

Toileting / Continence

Mobility / Transfer

Self-Administration of Medications

Medically Related Household Tasks

Dietary Task





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

Physician

Ordered

Diet

Carry tray to table

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



Note: Maximum number of visits, 26 visits in a 6 month period



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:

		18 C -		
	Division of Senior and Disability Services			
	RCF/ALF Quick Guide	-		
	Guidance given in <u>Pallay</u> , <u>PCOs</u> , and Quick Guides regarding how to conduct an assessment also applies when assessing an individual in an RCF/ALF setting.			
	The facility receives a reimbursement from the resident (SSI, SSA, etc.) and a supplemental cash grant from the Department of Social Services (DSS) This is intended to cover safe shelter needs (including housekeeping, basic linens, and the maintenance thereof) and nutritional needs (food and food preparation). HCBS are authorized to meet the needs of the participant that are above and beyond the basic needs met by the facility as referenced in the <u>RCF/ALF Personal Care-State Plan policy</u> .			
	 Time cannot be authorized for prompting and cueing alone. There must be a need for hands on assistance or active participation with the task by RCF/ALF staff. 			
	RCF/ALF residents must be mentally and physically able to navigate a normal path to safety in emergent situations with minimal assistance.			
	 An ALF II may accept residents with an impairment that prevents their safe evacuation with minimal assistance, only if the facility meets certain staffing requirements to assist in evacuation and includes an individualized evacuation plan for the resident. 			
F/ALF Quick Guide				
erRAI Coding	Initiating a RCF/ALF (Re)Assessment	Product of	1	
ticipants who reside in RCFs/ALFs common ctioning and cognition, for this reason it is ility staff (e.g. administrator, licensed nurs	- Hor to have grade participant of the full assessment, how even activities and grade and	TH 8 RVIELS		WEALTHING STRUCTURE Devices of Bender & Dealethy Devices
ttinely) to ensure the coding of the assest thorized. If the participant lacks the capacity to articula	of the need for (re)assessment.		nits*	Items to Consider Does the participant have a medically-related need for
be acceptable for a collateral contact (listed behalf. (For further guidance see the <u>Goals O</u> ki2 should be coded a 2 (board and care) for ki3 should be coded a 13 for RCF/ALF.	 Any time a (re)assessment is completed by DSDS or its designee, the assessor shall announce themselves to facility staff and indicate the intent of the visit before meeting with the current or potential participant. 			medically-related need for housekeeping that requires the facility to g above/beyond the standard of care, such as : • Pt has hoarding or destructive tendencies causing unsanitary
34b should be coded 1 for a participant that is When coding section G, keep in mind safety hase tasks in a less restrictive setting. • GI - Capacity should be coded according Section P - RCF/ALF staff are not considered is	 Participant must be present during the (re)assessment. Part <u>HCBS 11-19-02</u>, the assessor must view the participant's chart in order to verify information, including: 	arding: f	NOCI.	 Incontinence requiring more linen changes and room cleaning Allergies requiring more frequent cleaning of room
Section S: Back up Plan - must include the r	Number of med passes per day	900		 Participants ability to clean self appropriately after
that individual can provide to the participant, Options outside of the RCF should be explore manager/staff. If RCF/ALF manager/staff is case notes must clarify there are no other su	Doctor's name and frequency of visits Diagnosis The and/or treatments	ntal iato	l fed.	 Participant's ability to adjust clothing/change depends
Ex: "24hr personal care assistance is available		r nt		 Assistance with use of feminine hygiene products
(555-555-5555) will continue to provide a se Note Documentation Document the number of medication passes.	 Assessor must view the participant's private room in the facility. 	lean iized out or	•	
Decument the need for any assistance as documentation should clarify why the fac obligations of care established in licensure re Document times/tasks needed to assist th Jong with all other information gathered duri	 Initial Assessments (DSDS Starr Only) - The effective date of the care plan shall be the date the assessment was completed with the participant, and LOC was determined per <u>INFO 06-21-03</u>. 2/2024 	e ote ir.	anth of	 If more than 1 RN task can be completed during the same visit/day, only 1 RN authorization should be authorized.
If the nursing task "other" is authorized, inc authorized for. This can be documented authorization (preferred), OR within the case	Sude information regarding what the time is being stance, then no task should be authorized. The station of medication start to ensure medication to note itself. (Bongmines of the firmults that basis the static s		anth anth	
be: injections, nail care) Document the condition of the participant's p	a secure location so staff have to retrieve the	; mental	d is ju:	stified. Case notes should explain
DSDS or its designee shall document in cas collateral contacts	ie notes the source of information gathered from all 2/2024 idents.			
	Facility prepares all toods per dietary guidelines but the diet is not a physician-ordered diet. 2/2024			
		2/2024		2/2024
			-	27024

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



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.



QUESTIONS?

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