

Attachment 1

ASSESSMENT INFORMATION AND TRAINING MODULE

The Medicaid (MA) funded, prior authorized Personal Care Services Program (PCSP) and the related prior authorized home care programs such as CDPAP, PERS, ALP and LLHCSA, provide eligible consumers with some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions and, where appropriate, health related tasks that can be provided by a home health aide and/or skilled tasks that can be provided by a Licensed Practical Nurse (LPN) or Registered Professional Nurse (RPN). The provision of such services must be medically necessary and essential to the maintenance of the consumer's health and safety in his or her own home, as determined by the social services district, or its designee, in accordance with the regulations of the Department of Health; ordered by the attending physician and based on an assessment of the consumer's needs. The overriding basis for service authorization and delivery is dependent on a thorough and adequate assessment.

Research has indicated that use of a strength-based assessment for care planning is most conducive to providing services that are supportive in nature and do not supplant or disregard the abilities and independence of the consumer seeking services. Rather than focusing on "what's wrong", a strength-based approach allows the assessor(s) to identify the positive resources and abilities of consumers and their informal supports. This can be accomplished through a culturally sensitive and individualized approach that reflects the sound casework practices of:

- Active listening;
- Empathy and respect;
- Engagement;
- Strength-based assessment of needs and assets;
- Ongoing service planning.

It is highly recommended that the assessments and reassessments for the delivery of services utilize a strength based approach and reflect those casework practices. The provision of home care is designed to support and enhance the abilities and independence of the consumer. Assessors should not be seeking to replace self-care abilities but should be supporting those abilities.

A thorough assessment must take into consideration the **ability** of the consumer to accomplish activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs are activities related to personal care and include bathing or showering, getting in or out of a bed or chair, ambulating, using the toilet and eating. IADLs are those activities related to independent living and include preparing meals, managing money, shopping for groceries or personal items, performing housework, and using a telephone. It is the purpose of the assessment process to determine the extent of assistance required by the consumer to perform ADLs and IADLs; the formal and informal supports currently available to assist with those activities; and the extent to which these supports will remain in place.

The initial assessment process begins with a request for service. This request can come from a variety of sources. The source of the request guides the next step in the process. For example, when the request for service is made by the consumer, the consumer is advised of the need for completed physician's orders. The agency can provide the consumer with a blank copy of the physician's order form or, at the consumer's request, can send the form directly to the consumer's primary physician for completion. However, when the request for services is made by an individual/agency other than the consumer, response to that request should only be generic (i.e. need for physician's orders, assessment process, home visit, etc.) unless the requestor has provided a release of information that allows that individual/agency to discuss the specifics of the consumer's care needs.

The initial assessments and reassessments must be based on specific regulatory requirements as follows:

- Physician's orders;
- Nursing assessment; and
- Social assessment.

Physician's Orders

For the purposes of the MA funded prior authorized home care services, receipt of physician's orders initiates the assessment process. Verbal orders or simple written requests for assessments are not acceptable. The orders must be signed and documented on a form that has been approved by the Department. The form should allow for the physician to provide medical information regarding the consumer's diagnosis, medications, and physical and mental limitations and must indicate whether or not the consumer can be cared for at home with the requested services. The form utilized by the district must not provide the completing physician with an option of requesting a specific number of hours of care.

When the case management agency receives an initial request for home care services, the consumer, or the consumer's primary physician, should be provided with a physician's order form for completion. In order to assure that the orders reflect current medical information, all completed physician's orders for PCS should be based on a medical examination conducted within 30 days of the date the orders are completed and signed. The completed order form must then be returned to the case management agency within thirty days of the examination. Ideally, the information contained in the physician's order will reflect a link between the **diagnosis** and **functional ability** of the consumer and the **need** for the service.

Following receipt of the orders, the case management agency should review the orders to assure that the form has been completed in its entirety and that the physician has signed

and dated the document. If the initial orders are not complete, the case management agency should have a procedure in place for returning/obtaining a completed, signed form.

The next step in the assessment process is to complete, or to arrange for completion of, a social and a nursing assessment. The time frames for initiation and completion of these assessments can be found in 18 NYCRR 505.14. It is the correlation of the information that the assessors will obtain and document during the assessment process that provides the foundation for determining the service hours required. It is recommended that the nursing and social assessments be conducted jointly to allow for consistency. The forms utilized by the MA funded PCS and related services continue to be the DSS-3139 and the DMS-1 or, in NYC, the M-11s (social assessment) and the M-11r (nursing assessment). Districts that are not utilizing these documents must have submitted their local forms to the Department of Health, Office of Long Term Care, Division of Home and Community Based Services for review and approval prior to use. In addition, in late 2012, the Department will convert all PCSP assessments to a uniform assessment system (UAS-NY). Separate and additional training will be made available in advance of such conversion.

Social Assessment

Social assessments for the MA funded prior authorized home care programs are conducted by professional casework staff from the local Department of Social Services, or its designee, who also have the responsibility for ongoing case management. One of the most important considerations is the evaluation of the family and community support available to enable the consumer to remain in the community. Case work staff has the responsibility of determining the extent of those supports and maintaining them through ongoing case management.

The case manager must discuss, in depth, the role that the other household members and formal and informal supports outside of the household currently play, and will continue to play, in the care and support of the consumer. That information is then documented on page 2, Sections 7, 8 and 9 of the DSS-3139. It is important to encourage and support those individuals and organizations to continue, whenever possible, their involvement with the consumer.

There are frequently multiple agencies providing services to consumers. When consumers are in receipt of other community support services that are administered by other agencies (e.g. home delivered meals, senior transportation, EISEP) or are participating in programs such as the Traumatic Brain Injury Waiver, or other Home and Community Based Services Waivers, it is the responsibility of the case manager, as an integral part of the social assessment, to contact those providers/case managers to determine their services and involvement. Without a firm knowledge base regarding these agencies and the services they provide, a decision cannot be made as to what might constitute a duplication of service. For example, if the consumer is participating in a waiver, the waiver case manager must be contacted and included in the assessment process. The waiver case manager may opt to be present during the face to face assessment or may only be available by telephone to answer questions specific to his or her program. In any case, the goals

included in the consumer's individualized service plan or education plan developed and implemented under the waiver should be reviewed and considered when determining home care needs. For example, if the goal for the waiver participant is to learn to develop menus, shop for needed supplies and prepare meals, the waiver case manager would be responsible for assisting the consumer to achieve those goals and any authorization for personal care services related to shopping or meal preparation may be unnecessary or time limited. Without the important information regarding the service plan and/or goals, the nurse assessor is unable to accurately determine the unmet needs of the consumer and the tasks that must be completed by the personal care service provider.

The case manager is responsible for coordination and completion of the assessment process to ensure that all required documentation is complete. The case manager must review all information received and must evaluate the recommendations made by the assessing nurse. It is the ultimate responsibility of that case manager to determine, based on the compilation of documentation, the appropriateness of the overall plan for the consumer. If the case manager does not agree with the recommendations of the assessing nurse regarding level of care or number of hours/days a week of service, a discussion with the assessing nurse is recommended. If that conference does not resolve the differences in opinion the case, including all required documentation, must be referred to the Local Professional Director for resolution.

In addition, the recommendations for services, other than those that are prior authorized, must be reviewed and all referrals for other services (e.g. adult protective service, EISEP, home delivered meals) should be made by the case manager where appropriate.

The ongoing responsibilities of the PCS case manager are defined in 18 NYCRR § 505.14(g).

Nursing Assessment

Prior to conducting the face to face assessment in the consumer's home, the assessing registered professional nurse (RPN) should have received and reviewed a copy of the completed physician's order. The information included in that document provides the RPN with basic information regarding the consumer's medical diagnosis, current medications, functional limitations and whether the consumer has the ability to self-direct. Additionally, there should be a statement as to whether the attending physician recommends the provision of PCS or related services for their patient. The assessing nurse must keep in mind that this basic medical information does not allow for the variances in function that consumers with the same diagnosis can exhibit. This information serves only as a foundation upon which to build the information gathered during the entire assessment process.

In order to participate in the MA prior authorized home care services, a consumer must require assistance with performance of ADLs and IADLs and/or, in the case of the Consumer Directed Personal Assistance Program (CDPAP), assistance with, or completion of, health related or skilled tasks that can be provided within the scope of the program.

A critical clinical intervention for consumers receiving home care services is to promote independence. In order to promote and support this independence, a key appraisal point of effective home care is the consumer's functional status and ability. Functional ability can be defined as the ability to perform self-care tasks necessary to function in society and in the community. Those self-care tasks are categorized into ADLs and IADLs as follows:

ADLs

- bathing
- dressing
- grooming
- eating
- transferring
- ambulating
- toileting

IADLs

- housekeeping
- laundry
- meal planning and preparation
- use of a telephone
- managing finances
- shopping and errands

The completion of the ADLs and IADLs may be accomplished independently or may require some or total assistance from another individual in order for the consumer to remain in the community. The determination of the functional ability of the consumer to complete these ADLs and IADLs should be based on **observation** and should be reflected accurately on the required assessment forms.

The assessment must be conducted in the consumer's home. If the consumer is self-directing, the assessors should support and identify the **consumer's** expectations and desires. When the consumer is not self-directing, the individual who is acting on the consumer's behalf should be present during the assessment process. This assessment is achieved through discussion and visual observance of the consumer's ability to perform their ADLs and IADLs. The completion of the DSS-3139, or its equivalent, is designed to provide a standardized method for assessors to determine the following:

- Is the home the appropriate environment for this consumer's needs?
- What is the functional ability of this consumer?
- What services are necessary to maintain this consumer within the home setting?

Copies of the DSS-3139 and the instructions for completion are available on the OHIP Library of Official Documents in the section labeled Bureau of Medicaid Long Term Care Forms.

When assessing a consumer, it is necessary to ask open ended questions and to observe the consumer's ability to accomplish the necessary self-care tasks that will allow the consumer to remain in the community and/or his or her own home. These abilities and/or needs are listed specifically on page 4 of the DSS-3139/Services Required. For example, asking open-ended questions such as "how do you take a bath?" will provide the assessor with more information than asking the consumer "do you want help with your bath?" Requesting that the consumer show you the kitchen or the bathroom will allow the assessor to observe ambulation and transfer ability.

As the assessing nurse, you can also determine whether the consumer requires adaptive equipment or other services that can enhance independence. If the consumer indicates that bathing is difficult because he or she is unable to get into the tub, perhaps installation of grab bars will eliminate the need for an aide to assist with bathing. In another situation, the provision of a bedside commode for overnight use could increase the safety factor for a consumer who has difficulty getting to the bathroom during the night. The use of such efficiencies must be considered and utilized if the use of the efficiency does not jeopardize the consumer's health and safety (if not contraindicated by a physician) when assessing for and determining service need. Information for assessors regarding the use of durable medical equipment, or other cost-effective options can be found in 18 NYCRR § 505.14(b)(3)(iv).

The assessing nurse must not only determine whether the consumer **requires** assistance but must document the frequency of the service required and the responsible informal or formal support(s) that will provide the assistance. It is not the responsibility of the PCS or CDPAP to supplant services already in place when the provider of those services is willing and able to continue to be involved but rather to serve as a support to such services.

The correct completion of the DMS-1 is based on a review of the physician's order, answers to the open-ended questions and observation of the consumer's abilities. It is important for nurse assessors to review the instructions periodically in order to accurately complete the form. For example, do not indicate that a consumer requires some assistance with eating when assistance with meal preparation is the task required.

The assessing nurse must also make sure that all documentation is consistent. If the DMS-1 indicates that the consumer is self-care with bathing then the DSS-3139 must also indicate that the individual is self-care.

In all cases, the assessment of need is based on the service requirements of the consumer only. When there are other household members who are not included in the service authorization, the common areas of the household are not the responsibility of the PCS provider. The care plan is developed to meet the needs of the consumer only. For example:

- A single mother with minor children whose needs are not being met due to parental illness or incapacity is assessed for PCS. The assessor must only consider and recommend services related to maintaining the consumer in her home. Caring for minor children or completing tasks such as laundry, shopping and meal preparation for the minor children cannot be the responsibility of the PCA. In this situation, the assessors should make a referral to the LDSS for additional assistance that may be provided through use of Title XX funds.
- An elderly woman is residing with her married daughter. The consumer is assessed as requiring assistance with all ADLs and IADLs. Included on the plan of care is housekeeping/cleaning kitchen and bathroom. These tasks are only applicable when the assistance with peripheral tasks such as bathing or meal preparation is done for the consumer. Cleaning up after using the kitchen and/or bathroom is appropriate but general cleaning of those areas would be the responsibility of the daughter or her family.
- The household consists of a husband and wife and one teenage son. The wife has a medical condition that prevents her from completing her ADLs and IADLs without assistance from another person. The husband works outside the home and the son attends school. The husband and the son are independent in their ADLs and IADLs. The assessment indicates that the wife requires assistance with bathing and is unable to do laundry or shopping or housework as a result of her functional limitations. When developing a plan of care for the wife, it must be clear that any laundry or shopping related to the other household members is not the responsibility of the PCA and is not included in the plan of care. Additionally, general household cleaning must be the responsibility of the other members of the household who are not included in the PCS authorization.

The goal of a complete and accurate assessment is to develop a plan of care that supports the independence and the abilities of the consumer. In those instances where the consumer is able to perform ADLs and IADLs independently but requires supervision or guidance in completion of those tasks, referrals to other agencies and/or service providers must be considered. It cannot be the responsibility of an MA prior authorized aide to supervise or teach a consumer how to perform their ADLs or IADLs.

The Department strongly encourages that the social and nursing assessment be completed jointly. This allows the assessors to develop a plan for service provision that supports the consumer's desire to remain in the most integrated setting possible to meet his or her needs.