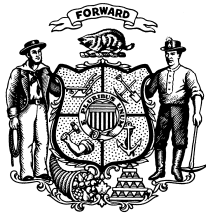


**Wisconsin  
Long Term Care  
Functional Screen  
Instructions**



**Department of Health Services  
Division of Long Term Care**

**December 5, 2011**

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# LTC FS Clinical Instructions

## Module #1: Overview of the Long Term Care Functional Screen (LTC FS)

### Objectives

*By the end of this module you should be able to:*

- Recount the process and major criteria used to develop the LTC FS.
- Explain what the LTC FS is designed to do.
- Explain how the LTC FS is to be administered, by whom, and in what manner.
- Utilize strategies for minimizing identified Screen limitations.
- Accurately document fluctuations in people's abilities and long term care needs.
- Recognize when the services of a medical professional are needed to properly complete the health-related sections of the LTC FS.

### 1.1 History

The Wisconsin Long Term Care Functional Screen (LTC FS) has been under development since 1997. It is a **functional needs assessment describing assistance needed with:**

- **Activities of Daily Living** (ADLs-bathing, dressing, mobility, transfers, eating, toileting)
- **Instrumental Activities of Daily Living** (IADLs-meal preparation, medication management, money management, telephone, transportation, and employment)
- **Health Related Tasks** (including skilled nursing)
- **Diagnoses**
- **Behavioral Symptoms and Cognition**

The LTC FS also includes information on risk factors, mental health and substance use, and where the person would like to live.

The LTC FS computer application has complex logics programmed into it that interpret entered data to determine applicant's nursing home level of care, disability level of care, and functional eligibility level for Wisconsin's long term support programs. Family Care pilot counties have been using the LTC FS since 1998. Use of the LTC FS was expanded to Partnership and PACE programs in November of 2001, and is being expanded to other home and community-based waiver programs throughout Wisconsin.

The LTC Functional Screen's eligibility and nursing home level of care logics have been tested for reliability and validity, and approved by the Centers for Medicare and Medicaid Services to replace previous methods of home and community-based waiver eligibility in Wisconsin. The major advantages of the LTC FS are that eligibility determinations are instantaneous upon completion of the LTC FS and reflect an objective method of eligibility determinations.

The WI LTC FS was developed through four workgroups which included county case managers experienced in LTC eligibility and assessments. The primary screen development workgroup reviewed numerous other screens and assessment such as the Minimum Data Set (MDS) that nursing homes must complete, and the OASIS form that home health agencies must complete.

The WI LTC FS is different from those forms because it had to meet the needs of Wisconsin's LTC redesign effort. In particular, the LTC FS needed to work for all three target groups: frail elders with health conditions or dementia (mild or severe); younger people with physical disabilities, some of whom have no health problems; and people with developmental disabilities with various cognitive functioning levels, behavior symptoms, and/or health problems. The WI LTC FS needed to work to describe people living at home or in substitute care settings (group homes, adult family homes) or in institutions (nursing homes, ICF-MRs). Other criteria used to develop the WI LTC FS include the following:

- Clarity--Definitions and answer choices must be clear to screeners (most of whom are not nurses)
- Objectivity and Reliability--The LTC FS must be as objective as possible to attain highest possible "inter-rater reliability"-i.e., that two screeners would answer the same way for a given consumer. Subjectivity must be minimized to ensure fair and proper eligibility determinations.
- Brevity--The LTC FS is only a "needs assessment" to determine program eligibility. It serves as a baseline for more in-depth assessment to develop a service plan that reflects the consumer's strengths, values, and preferences.
- Inclusiveness--Every individual can be accurately described with given choices for each question--for elders, people with dementia, physical disabilities, or developmental disabilities, healthy or not

Note: For HCBW counties a full assessment and service plan packet must be completed per waiver manuals prior to implementation of the waiver.

## 1.2 The LTC FS Determines Eligibility for Long Term Care Programs

For people age 18 or older, the LTC FS determines functional eligibility for HCBW programs. Wisconsin has five waiver programs for persons who are a frail elder, have a physical disability, or have a developmental disability. These waivers are COP, CIP II, IRIS, Family Care and PACE/Partnership programs.

Once an applicant's LTC FS is complete, the eligibility logic built into the application is able to determine that person's Nursing Home Level of Care (NH LOC), Developmental Disability Level of Care (DD LOC), and Family Care Level of eligibility (Family Care Nursing Home LOC and Family Care Non-Nursing Home LOC) as well as eligibility for the other waiver programs. NH Level of Care or DD Level of Care is absolutely necessary to be eligible for COP/W, CIP II, IRIS, PACE/Partnership because those programs can only serve NH eligible people.

Wisconsin has the following four **nursing home levels of care**:

1. Intermediate Care Facility, Level 2 (ICF-2)-lowest needs
2. ICF Level 1(ICF-1)-moderate needs
3. Skilled Nursing Facility (SNF)-high needs
4. Intensive Skilled Nursing (ISN)-highest needs

Wisconsin has five waiver programs for people with developmental disabilities. They are CIP 1A, CIP 1B, IRIS, Family Care and PACE/Partnership.

Wisconsin has four institutional **levels of care for people with developmental disabilities**:

1. DD1A-DD person with significant medical problems
2. DD1B-DD person with significant behavioral problems
3. DD2-DD person not DD1a or DD1B who needs help with all or most activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
4. DD3-DD person who is more independent with most ADLs and IADLs

Note: Individuals with developmental disabilities who meet certain criteria for no active treatment (NAT) may be placed on a physical disabilities or frail elderly waiver program (see [10.9 No Active Treatment](#)).

For Family Care there are two levels of eligibility:

1. Family Care Nursing Home Level of Care
2. Family Care Non-Nursing Home Level of Care

### **Level of Care in Home and Community-Based Waiver Programs:**

In general, Wisconsin's federally approved home and community-based long-term care programs require that the applicant achieve a qualifying nursing home (NH) or developmental disability (DD) level of care on the Long Term Care Functional Screen as described above. People who do not meet a qualifying level of care on the Functional Screen may still be eligible for COP Level 3 or for a more limited Family Care benefit.

In addition to meeting level of care, the applicant must meet related non-financial eligibility criteria. The applicant must meet residency requirements and his/her physical or medical condition must be expected to last more than one year or result in death within one year and, for applicants who are less than 65 years of age, a disability determination is required.

It is important to remember that level of care and non-financial program criteria do interact as eligibility is determined. For example, applicants who have shorter-term needs (90 days or longer) may still receive a nursing home level of care. However, they will not be eligible for the CIP 1A/1B, CIP II, COP-Waiver, PACE, Partnership and the Family Care home and community-based waiver programs because they have not met the requirement that the physical/medical condition last one year or longer. These applicants may be eligible for reduced benefits under the Family Care program.

The remainder of this section describes NH and DD LOC and how these interact with Family Care eligibility.

### **NH or DD Level of Care and Family Care:**

NH or DD level of care is very important in Family Care as well.

To qualify for NH or DD level of care, a person must have a long-term care condition likely to last more than one year.

Screeners must understand the ways in which NH and DD levels of care interact with the two levels of Family Care eligibility. The two levels of Family Care eligibility are "Family Care Nursing Home LOC" and "Family Care Non-Nursing Home LOC" (A third level would be "Not Eligible for Family Care").

**Family Care Nursing Home LOC:** Family Care Nursing Home LOC level includes all NH eligible people. If someone receives a NH or DD level of care, they are eligible at the Family Care Nursing Home LOC.

**Family Care Non-Nursing Home LOC:** People at the Family Care Non-Nursing Home LOC level usually need help with only one or a few particular ADLs or IADLs and do not have a nursing home LOC or DD LOC. Only those people at the Family Care Non-Nursing Home LOC who have a Medicaid card are entitled to the program.

People at the Non-Nursing Home LOC not eligible for Family Care should be helped by the Resource Center with options counseling.

Screeners should always confirm that the NH or DD level of care seems appropriate for the person. If it seems someone should be nursing home eligible, then the LTC FS should assign them a NH level of care. Be sure you confirm all health-related services with a nurse or other health professional familiar with the consumer. Consult with your Screen Liaison, who can contact the Department if necessary.

## 1.3 Other Functions of the LTC FS

1. Serve as a foundation for the comprehensive assessment done by the long term care program selected by the consumer.
2. Provide data for quality assurance and improvement studies for the Department and long term care programs utilizing the LTC FS, including identifying cases for targeted reviews.
3. Identify whether an applicant is currently in need of Adult Protective Services (this factor affects entitlement for persons at Family Care (Non-Nursing Home LOC).
4. Indicate the need for referrals to Adult Protective Services, mental health services, substance use services, or other community resources.

### **For Family Care Counties, the LTC FS also:**

1. Provides a framework for information-gathering during Pre-Admission Counseling
2. Is used to set monthly payment rates based on people's functional needs
3. Documents factors to aid in prioritizing waiting lists

## 1.4 Requirements for Quality Assurance and Screener Qualifications

As discussed above, the Wisconsin Long Term Care Functional Screen (LTC FS) determines a person's eligibility for Wisconsin's long term support programs, including Family Care, PACE/Partnership, and the home and community- based waiver programs. Family Care is an entitlement, so for Family Care counties, the screen determines entitlement to services. **Because the LTC FS determines program eligibility, special requirements for quality assurance and screener qualifications are necessary.**

### **Screener Qualifications**

**All persons administering the functional screen must meet the following four conditions:**

1. Meet the following **minimum criteria for education and experience:**
  - o Bachelor of Arts or Science degree, preferably in a health or human services related field, and at least one year of experience working with at least one of the target populations; or
  - o Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise prepared by the agency
  - o In HCBW counties, people screening DD individuals must be qualified as QMRPs\*\*.
2. Meet all **training requirements** as specified by the Department
  - o Completion of the web-based clinical certification course is currently the primary way to meet the Department's training requirements. In specific, all screeners should read screen instructions in their entirety.
3. Have **experience working with long term care consumers.**
4. **Pass all Screener Certification exams** after receiving training. There are eight certification tests that are part of the online course. All eight must be successfully completed (a score of 80% or better) to become a certified LTCFS Screener

### **Further, for Family Care, Resource Center and MCO managers and screen liaisons must:**

- Also see the Resource Center and MCO contract for quality assurance requirements.

\*"Qualified Mental Retardation Professional" or QMRP means a person who has specialized training in mental retardation or at least one year of experience treating or working with persons with mental retardation and is one of the following:

1. A Psychologist licensed under ch. 455, stats
2. A Physician
3. A Social Worker with a bachelor's degree or graduate degree from a school of social accredited or approved by the council on Social Work Education.
4. A Physical or Occupational Therapist who meets the requirements of s.HSS 105.27 or 105.28

5. A Speech Pathologist or Audiologist who meets the requirements of s.HSS 105.30 or 105.31
6. A Registered Nurse
7. A Therapeutic Recreation Specialist who is a graduate of an accredited program who has a bachelor's degree in a specialty area such as art, dance, music, physical education, or recreation therapy; **OR**
8. A Human Service Professional who has a bachelor's degree in a human services field other than those noted under 1-7, such as rehabilitation counseling, special education, or sociology.

## 1.5 Screen Quality

Parallel to the screener qualification, training, and certification requirements stated above, there are quality performance and assurance requirements to ensure consistency and accuracy of administration of the screen. There are three levels of functional screen quality assurance.

1. The first efforts are quality assurance beginning with the screener. **It is the screener's responsibility to be objective in screening, to be informed of the instructions, and to corroborate information gathered from the consumer.** Questions that arise can be addressed by the person in your office designated as Screen Liaison.
2. **Among the Screen Liaison's roles is to oversee quality assurance.** The methods each agency will be conducting will, at a minimum, include:
  - Inter-rate reliability testing;
  - Training, mentoring, and monitoring new screeners;
  - Random sampling for accuracy and consistency;
  - Completing reports; and
  - Consulting with state staff on consumers.

For the Family Care program the final step in quality assurance occurs at the State. **Staff at the Department will review screens and quality assurance methods during annual site visits and quarterly examine a series of analyses and comparisons of all agencies' screens.** Each agency will receive a report following such reviews and request the agency to correct and amend screens done in error.

## 1.6 The LTC FS Is Voluntary

**Consumers must consent to having the LTC FS completed in order to enroll in a long term care program (COP, CIP, IRIS, Family Care, or PACE/Partnership).** The person being screened should consent to completion of the LTC FS and its submission to the Department for aggregate data research. No screen should be completed without the person's consent.

Screening agencies shall comply with confidentiality rules and requirements and shall obtain a signed release of information from the person or the person's guardian or power of attorney, where applicable, for the use of medical records, educational records and other records as appropriate before conducting the LTC Functional Screen. Signed releases of information shall be included in the person's records when appropriate.

## 1.7 Confidentiality

**Any information collected for the screen or during the screening process is confidential.** It is to be treated with the same requirements for confidentiality as other long-standing screens and assessments. If a person enrolls in a long term care program the functional screen can be shared with that program without separate written permission.

## 1.8 Screening and Re-Screening Requirements

In the home and community-based waiver programs and the PACE/Partnership programs an initial screen is required to establish eligibility prior to receiving services. An annual screen is required thereafter to ensure continued functional eligibility.

### In Family Care:

**County Resource Centers will be the most common place from which long term care consumers can be screened by the LTC FS to determine their functional eligibility for LTC programs.** It should be noted however, that Resource Centers do more than just administering the LTC FS, they are also places where long term care consumers and their families can go for counseling on all long term care options. Resource Centers are responsible for information and assistance, early intervention and prevention, and informing the public about community resources both within the LTC system and beyond it. The multifaceted nature of Resource Centers is beneficial to consumers, since they are able to get information on all long term care options through a single entry point.

In addition to Resource Centers, the LTC FS may be administered by Family Care--Managed Care Organizations (MCOs) during “re-screening”, or other long term care programs that manage their own eligibility and enrollment processes. MCOs should not be involved with doing someone’s screen prior to enrollment.

**It is critical that whenever the condition of a person enrolled in a LTC program substantially changes, the LTC FS should be updated and the eligibility logic re-run to determine if the change in condition impacts their NH/DD level of care or Family Care Nursing Home LOC or Family Care Non-Nursing Home LOC eligibility.**

Examples when a re-screen is necessary:

- Larry, an 88-year-old Family Care participant suffers a stroke.
- Mary, a 79-year-old woman regains her mobility after healing from a hip fracture.
- Jose, a 44-year-old man with Downs Syndrome is diagnosed with early on-set dementia.

**It is important that when re-screens are done, that the screener review the person's previously completed screens for information and historical perspective.** The LTC FS can be done more often than yearly if someone requests it.

## 1.9 The Screening Process

**The screening process requires face-to face contact with the individual being screened. No screen should be completed without a meeting with the consumer, even if s/he is unable to communicate.**

### *The Interview Process*

The LTC FS was not designed as an interview tool; screeners are expected to use their professional skills to adjust their interview style to the individual and the situation. The screen can be done in any order.

The face-to-face interview can take place in any setting, from the consumer's residence, to a substitute care setting such as a CBRF, to a hospital or nursing home. It may take more than one contact with the consumer to complete the screen.

Screeners should use their professional interviewing skills to gather information in a way that is appropriate for a given consumer. The screener will need to ask questions in a variety of ways, be familiar with the participant target group being interviewed, and use collateral informants as necessary. Collateral informants include family, significant others, formal or informal caregivers, health care providers, and

agencies serving the consumer. The screener must always have a face-to-face contact with the consumer, even if other informants are used.

Sometimes answering the Target Group question requires using the same information gathered later within the LTC FS. This is because the statutory definitions of the target groups require significant functional impairments in several areas of living, including ADLs, IADLs, cognition, behavior, etc. Again, screeners are to use professional interviewing skills to determine the person's needs and abilities. In doing so, you will sometimes be answering the Target Group and the ADL/IADL questions at the same time. Follow all instructions and Target Group guidelines closely.

## 1.10 Reliability of Screen and Screeners

This screen has been repeatedly revised with users' input and statistically proven to have acceptable levels of validity and reliability. However, it is generally recognized that any objective rating of consumers' functioning, cognition, behavior, and symptoms can be difficult. The difficulty calls for extra vigilance to ensure the greatest possible accuracy in the LTC FS. This is why screeners must be certified and why the Department and Wisconsin long term care programs must have ongoing quality assurance processes.

### **Screeners should adhere to the following guidelines:**

- Read and follow screen definitions and instructions closely
- Go slowly and carefully enough to be accurate even with someone you know well
- Do not “inflate” any answers because you think a consumer has special costs not “visible” through the screen. Instead, you should always select the answer that most accurately describes the consumer's status
- All screening agencies should have experienced LTC FS Screeners to assist you with questions. Refer all questions to your designated Screen Liaison Staff. The Screen Liaison in turn will refer unresolved questions to the Department as necessary. In this way, interpretations can be kept consistent and communicated to all programs utilizing the LTC FS, and revisions can be made to the LTC FS if necessary.

An applicant's LTC FS will be taken in total. The LTC FS logic has been programmed to “weigh” all clinical factors in ways that reflect likely needs. The Risk section of the LTC FS plays an important role in how a consumer's screen works in total. The Risk section was specifically developed to be able to “capture” people who might be independent in ADLs and IADLs, without any cognitive impairment-but still at risk. So screeners should never “inflate” their answers in other modules to compensate for risk factors; screeners can document risk factors in the Risk section of the LTC FS.

## 1.11 Screening Limitations

In particular, screeners should **be aware of the following limitations found in national studies to be characteristic of all similar screens:**

- A. Health care and institutional providers tend to overrate the consumer's dependency on others.
- B. Guardians, spouses, and family members often tend to overrate the consumer's dependency on others.
- C. Consumers often underrate their need for help from others and exaggerate their abilities.
- D. Consumers' functional abilities can fluctuate, making it difficult to select a “best” answer.
- E. Consumers can provide conflicting information at different times or to different screeners.
- F. Screen answers vary somewhat depending on whether the screener knows the consumer well or not.
- G. Screen answers vary somewhat depending on the profession of the screener.
- H. While objectivity is the ultimate goal, some subjectivity may remain in some questions.

## 1.12 Strategies to Minimize Screening Limitations

### A and B: Conflicting Information from Different People

Sometimes screeners will get different information from different sources. Consumers may function less independently in day care facilities or institutions than they do at home, and staff at such facilities may tend to perceive more dependency than family or peers in the community might perceive. Screeners are to use their best professional judgment to describe the person's functional abilities as accurately as possible given all the information from multiple sources. Keeping in mind the tendencies noted above, the best source of information (besides the person themselves) is someone who does a lot of direct care for the person and likes her/him. In a health care facility, the screener should (if collaboration is needed) talk to a nurses' aide, not just the nurses. In the home, a personal care worker might provide a more accurate description than family members.

### C: Consumer Gives Apparently Inaccurate Information

Sometimes the consumer's statements about her/his abilities do not seem to cohere with reality. If you feel this is happening, follow this three-step process:

1. Seek more details
2. Seek collateral informants, other people you could ask for additional information
3. Use your professional judgment to select what seems to be the most accurate answers. Follow the definitions and instructions for the screen

Remember that the goal is to be as objective as possible, to have high "inter-rater reliability"-meaning that other screeners would choose the same answer you did. That is why your professional judgment must be based on as much objective information as possible. Objective information can be obtained by asking questions, asking for demonstrations, observing evidence carefully. If the proper answer is still not clear, discuss it with your Screen Liaison, who can then, if necessary, ask the Department for guidance.

So, for example, if someone tells you he bathes himself, but he has obviously poor hygiene and he can barely walk and transfer himself, you should follow the three steps above:

1. Seek more details: Ask him how he bathes (bath? shower? sponge bath?). Ask if you can look at his bathroom to check for accessibility and adaptive equipment. Ask him how he gets in and out of his bathtub. If it has high sides, ask him if he can lift his foot that high, and to show you.
2. Seek collateral informants: Ask him if you can talk with his family members. They may have opinions ("He should be in a nursing home") as well as objective information ("He's really gone downhill since mom died last year, he's fallen at least four times, he can barely move, he hasn't been in that bathtub for months, he won't accept any help from us even when we tell him he needs a bath.")
3. Use your professional judgment to select the best answer: In this example, it seems he's definitely not independent with bathing. It's not exactly clear whether Bathing Level of Help #1 (helper does not have to be present throughout task) or # 2 (helper does have to be present throughout task) is most accurate. With the history of recent falls and his excessive independence, #2 might more accurately reflect what he really needs at this time.

### D. Abilities Fluctuate

"Some similar screens or data collection instruments like the Minimum Data Set (MDS) required of nursing homes and the OASIS (required of home health agencies) were designed to provide a "snapshot" view of functional status. So their questions ask, for example, for functioning in the past seven days, or over the past month. The LTC FS provides a broader view to more accurately reflect an individual's likely long-term care needs. We realize that many long-term care consumers have conditions and abilities that fluctuate over time, and that it is sometimes difficult to choose the best "multiple choice" answer. In completing the screen, please follow the following guidelines:

- If the person's functional abilities vary over **months or years**, select the answer that seems closest to the **average** frequency of help needed.
- If the person's functional abilities vary **day to day**, select the answer that most accurately describes their needs on a "**bad**" day.
- If the person's functional abilities vary **week to week**, try to select answers that reflect **how you would staff them** if you had to.

## 1.13 Screening During Acute Episodes

An acute episode involves conditions which are expected to resolve in the next few weeks. These types of episodes can occur at home, in the hospital, in a nursing home, or in other locations.

The LTC FS may be completed when consumers enter nursing homes and residential facilities. Approximately 70% of people enter nursing homes from hospitals. It is expected, then, that some LTC FS will reflect higher needs due to more acute conditions and that many people may improve over the next several days, weeks, or months. Their improvement will be evident in their next LTC FS. However, if a person experiences a change in condition likely to affect their eligibility, an "02-Rescreen" should be done.

For Family Care, the LTC FS must be completed by the Resource Center as part of pre-admission counseling when consumers enter nursing homes and residential facilities.

## 1.14 Impending Discharge

**When doing the LTC FS on someone preparing for discharge from a skilled health care facility, complete the screen based on how the person would function at home when they go home.** This looking ahead is a normal part of discharge planning. So, if, for example, oxygen and intravenous (IV) will be stopped before person goes home in two days, do not mark them on the screen. If family is learning to do a 2-person pivot transfer to prepare to use at home, mark that on the screen, even if now the hospital does one-person transfers with a mechanical lift. It will take additional time and talking with facility staff, family, etc., to get the most accurate picture of the person's needs at home, after discharge.

The screener must be able to envision the person at home. This is why screeners must have experience in community care for the target group being screened.

## 1.15 Verifying Diagnoses and Health-Related Services

The Health-Related Services table of the LTC FS is extremely important to determining a person's eligibility. The table collects objective data used by the programmed logic to determine whether the person meets nursing home or DD level of care. This in turn determines eligibility for home and community-based waivers and affects the Family Care eligibility (Nursing Home LOC or Non-Nursing Home LOC). Accuracy in this information will be a focus in quality assurance and improvement efforts both locally and at the Department. The diagnoses will provide important data for evaluating Family Care and other long term care programs, but do not have direct role in the eligibility logics. The target group question (discussed in module 2) may require help from health care professionals as well.

No health care providers' signatures are required on the screen, but screeners must take the time to verify health-related information. Screeners will need to verify diagnoses and health-related services for the LTC FS, and can verify information needed for the target group question at the same time. Explain this to the person, and either get permission to contact their physician's office or help arrange an appointment.

**\*\*\*In almost all cases, screeners will need to contact a health care provider to get accurate information on health-related services, diagnoses, and, if necessary, the target group question.\*\*\***

# Module #2: Long Term Care Functional Screen Target Groups

## Objectives

*By the end of this module you should be able to:*

- Describe the key components that constitute a “long-term care condition” in regard to the LTC FS
- Identify the three primary target groups of people for whom the LTC FS is designed to serve
- Explain the definitions of each target group as it relates to the LTC FS
- Accurately deal with issues of “co-morbidity” and multiple diagnosis with regard to the LTC FS

## 2.1 LTC FS Target Groups

The Long Term Care Functional Screen was designed to capture the needs of people who have a long-term care condition related to being a frail elder, physical disability, developmental disability, dementia (onset of any age), or a terminal condition with death expected within one year from the date of the eligibility for long-term care services. **The length of time a person is expected to have a long-term care condition has a bearing on the program for which the person is eligible.** In order for a person to be eligible for any home and community-based waiver, the duration of the long-term care condition has to be at least one year. In order for a person to be eligible for Family Care Nursing Home LOC or Non-Nursing Home LOC, the long-term care condition has to be expected to last 90 days or more.

### **This breaks into three steps:**

1. Person must have a long term care condition or have a condition that is expected to result in death within one year.
2. Person must be in one of the populations or “target groups” intended for Family Care, PACE/Partnership, or Wisconsin’s home and community-based waiver programs.
3. Person in a target group must have ADL/IADL deficits specified for program eligibility.

### **This means three things:**

1. A person could be temporarily “physically disabled” but not have a long term care condition. (EXAMPLE: someone otherwise healthy and independent who breaks a bone.)
2. A person could be in a target group but not eligible for a Wisconsin long term care program -if s/he does not have any ADL/IADL deficits. (EXAMPLE: someone with mild cerebral palsy who is fully independent.)
3. A person could have ADL/IADL deficits, but not be eligible for a long term care program-if s/he is not in one of the target groups served by that program. (EXAMPLE: someone with only schizophrenia, but no other conditions.)

## 2.2 How to Answer the Target Group Question

*The person has a condition related to:*

- Frail Elder
- Physical Disability
- Developmental Disability per FEDERAL definition
- Developmental Disability per STATE definition but NOT Federal definition
- Alzheimer’s disease or other irreversible dementia (onset any age)
- A terminal condition with death expected within one year from the date of this screening
- Severe and persistent mental illness
- None of the above (No Target Group)

**A person can be in more than one target group. Check all that apply.** (Note: if a person meets the Federal definition of Developmental Disability (DD), the State DD definition should NOT be checked.)

The target group question does rely on the professional judgment of the screener applying the **statutory definitions** of these terms.

The statutory definitions are somewhat vague and open to interpretation. The definitions overlap with, but cannot be reduced to, objective data of diagnoses or ADL/IADL needs. Fortunately, county human service staff have been using these definitions for years in current waiver programs. Consult with your peers and managers often. A nurse should be available to assist screeners with questions. For the developmental disability (DD) determinations, a DD logic “decision tree” has been created to help screeners to evaluate whether a person's diagnosis, functioning, and need for active treatment meet the Federal definition of DD. If after collecting all necessary information (such as I.Q. score and diagnoses) and using the “decision tree”, consult with staff of the Bureau of Developmental Disability Services if you need further guidance. Also available are decision trees for physical disabilities and fragilities of aging where the person has a co-morbid condition of mental illness. These decision trees help the screener through the process of determining if the person meets the statutory definition related to the ELIGIBLE target group before proceeding with a screen.

#### **Refer to MD or Psychologist if Necessary**

In some instances, physicians or psychologists will need to be consulted (for example, to help determine whether person meets Federal definition of developmentally disabled). Screeners may occasionally need to help the person get a MD appointment to obtain diagnoses, IQ scores, and to determine whether the person is in one of the target groups. County agencies often have psychologists and psychiatrists who can determine whether an individual meets definitions for developmental disabilities and can help screeners sort through deficits related to mental illness.

**Check the boxes pertaining to the target group condition AND to the disability determination for the person.** Be sure to determine the correct answer to the disability determination question (yes, no, or pending) – **do not guess**. These questions help identify if the person is eligible for long-term care programs available in their county. Refer to [Section 1.2](#) for more information about eligibility for long-term care programs.

## **2.3 Data Entered Elsewhere in the Functional Screen Should Correlate with the Target Group Question**

QA Check: If you checked “Alzheimer's or other irreversible dementia” here, there should be a dementia diagnosis checked in the diagnoses table later in the LTC FS. If such data do not correlate, the LTC FS application will produce a warning message to inform you of the error and ask that you adjust the screen. You will not be able to calculate eligibility until all critical data correlate.

#### **Target Group Definitions**

Each of the statutory definitions is reproduced in bold below, with interpretive guidelines for each.

## **2.4 “Frail Elder”**

**“Frail elder” means an individual aged 65 or older who has a physical disability, or an irreversible dementia, that restricts the individual’s ability to perform normal daily tasks or that threatens the capacity of the individual to live independently (HFS 10.13(25m)).**

***Partnership Sites:** Partnership sites should adhere to the 65 or older age guideline for the Frail Elder target group. Those consumers who are younger than 65 should be included in the Physical Disability target group if they meet the definition described below.*

For additional assistance in determining if someone meets this target group when they have co-morbidities such as mental health and/or AODA, refer to the tool, “Decision Tree for Frail Elders with Co-

Morbidities,” which is located in the appendices at the end of this manual. It’s also available on the Department web site at: <http://dhs.wisconsin.gov/LTCare/FunctionalScreen/ComorbiditiesElders.pdf>.

## 2.5 “Dementia”

**Dementia means Alzheimer’s disease and other related irreversible dementias involving a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder (WI Statutes 46.87(1)(a)).**

“Organic brain disorder” here is not limited to the specific diagnosis “organic brain syndrome.”

“Irreversible” is something you cannot always tell by diagnosis alone. For instance, alcoholic dementia or drug-induced dementia may or may not be irreversible. You need to consult a health care provider to specifically ask whether the dementia diagnosed is irreversible or not.

It is sometimes impossible to distinguish “organic” brain disorders from “mental illness” or from alcohol or other drug abuse. In fact, the separation makes little sense clinically. You certainly can’t tell by looking, and you can’t tell by history: A person could have had mental illness but now be manifesting dementia. You need to get some help from a health care professional. If the consumer does not have a health care provider to contact for diagnoses and other information, you’ll need to facilitate getting the consumer an appointment for an evaluation.

## 2.6 “Physical Disability”

**Physical disability means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person” (WI Statutes 15.197(4)(a) 2).**

**“Major life activity” means any of the following: A. Self-care. B. Performance of manual tasks unrelated to gainful employment. C. Walking, D. Receptive and expressive language, E. Breathing, F. Working, G. Participating in educational programs, H. Mobility, other than walking, I. Capacity for independent living.” (WI Statutes 15.197(4)(a)1).**

For additional assistance in determining if someone meets this target group refer to the tool “Defining Physical Disability for the LTC Functional Screen Target Group,” which is located in the appendices at the end of this manual. It’s also available on the Department web site at: <http://dhs.wisconsin.gov/LTCare/FunctionalScreen/Pddefinition.pdf>.

If the person has co-morbidities such as mental illness, the person must have a another medical or physical condition to consider separately from the mental illness and the screener must consider whether that condition impairs the person’s functioning significantly enough to meet the statutory definition above.

Examples:

- A consumer with chronic mental illness suffered a stroke which results in significant, permanent left sided weakness and cognitive deficits. The consumer needs significant physical assistance throughout the day to complete ADLs, now needs to use a walker and bath equipment, and needs help to complete IADL tasks such as meal prep, money management, and medication management. This person **would meet** the PD target group as well as the severe and persistent mental illness target group.
- A consumer with schizophrenia breaks their leg in an auto accident. The consumer undergoes surgery and their leg is braced to allow it to heal. The consumer needs physical assistance with bathing, dressing and mobility, but with physical therapy, is expected to regain full use of their leg

within six weeks. This person **would not** meet the PD target group since the injury is not permanent and will not last for a year or more. However, the person would meet the severe and persistent mental illness target group.

Refer to the tool “Decision Tree for PD with Co-Morbidities” to help determine if they meet this target group. This tool is located in the appendices at the end of this manual. It’s also available on the DHS web site at: <http://dhs.wisconsin.gov/LTCare/FunctionalScreen/ComorbiditiesPD.pdf>.

## 2.7 Physical Disability or Frail Elder?

In truth, most problems associated with being a frail elder are physical disabilities, so in many instances both definitions might apply. (A good example is arthritis, which in an old person is considered age-related, but in a young person is considered a physical disability.) For eligibility purposes, you can check either one or both target groups. To be precise, however:

- Check only “Frail Elder” if the condition developed late in the person's life, i.e., is related to age.
- Check only “Physical disability” if the person had a physical disability at a young age and now just happens to be age 65 or older.
  - Example: A healthy 66-year-old person with paraplegia from an accident at age 43.
- Check both “Frail Elder” and “Physical disability” if both apply to separate conditions.
  - Example: A 66 year old person with paraplegia from an accident at age 43 who also has congestive heart failure and rheumatoid arthritis.

## 2.8 Dementia or Frail Elder?

Dementia is listed as a separate target group in order to capture people younger than age 65 with dementia. If the person is 65 or older, both target groups can apply.

- Check only “Dementia” if the person does not have any other conditions that meet the definition of “Frail Elder”
- Check both if the person does have other conditions that meet the definition of “Frail Elder”

## 2.9 Dementia or Mental Illness?

You can't tell by looking, and you can't tell by history: A person could have had mental illness but now be manifesting dementia. You need to get some help from a health care professional. If the consumer does not have a health care provider to contact for diagnoses and other information, you'll need to facilitate getting the consumer an appointment for an evaluation.

## 2.10 FEDERAL Definition of Developmental Disability

**A person is considered to have mental retardation if he or she has - (i) A level of retardation described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation, or (ii) A related condition as defined by 42 CFR 435.1009 which states, “Person with related conditions” means individuals who have a severe, chronic disability that meets all of the following conditions:**

- (a) It is attributable to:
1. Cerebral palsy or epilepsy or
  2. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

- (b) It is manifested before the person reaches age 22
- (c) It is likely to continue indefinitely
- (d) It results in substantial functional limitations in three or more of the following areas of major life activity: Self-care; Understanding and use of language; learning; mobility; self-direction; or capacity for independent living.

Note that the consumer must meet the Federal definition of DD in order to be eligible for HCBW waivers.

County records and school records are often helpful, in addition to or instead of health care records. A written diagnosis of mental retardation or developmental disability suffices. Families or guardians often retain copies of such documentation. For the developmental disability (DD) determinations, if you have all the necessary information (such as IQ score and diagnoses), refer to the DD logic “decision tree” (located in the appendices at the end of this manual. It’s also available on) to guide you through the determination process. If you are in need of further assistance, consult with staff of the Bureau of Developmental Disability Services. For additional assistance in determining if someone meets this target group, refer to the Developmental Disabilities resources for certified screeners which are located on the DHS web site at: <http://dhs.wisconsin.gov/LTCare/FunctionalScreen>.

## 2.11 STATE Definition of Developmental Disability

For Family Care: Persons meeting only the State definition but not the Federal definition of developmental disability may still be Family Care eligible. The section below outlines this criteria.

**Developmental disability' means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging” (WI Statutes 51.01(5)(a)).**

**Wisconsin's definition of DD is broader than the Federal definition**, in that it does not include the restrictive clauses “b” (onset before age 22) and “d” (substantial functional limitations) of the Federal definition. In order to be eligible for the home and community-based waivers for DD persons; the consumer must meet the Federal definition of DD.

If a person meets the Federal definition of DD, they will also meet the State definition of DD. However, you should only check FEDERAL definition of DD on the LTC FS target group section.

For the developmental disability (DD) determinations, if you have all the necessary information (such as IQ score and diagnoses), refer to the DD logic “decision tree”. If you need further assistance, consult with staff of the Department. If you do not have necessary information such as IQ score and diagnoses, refer to a MD or psychologist for an evaluation as discussed above.

(Note: Many schools systems have been referring young adults with diagnoses such as learning disorders, attention deficit disorder, hyperactivity, or emotional disturbances, to Resource Centers for Family Care enrollment. In most instances, it is not immediately clear whether or not these young adults meet the Federal definition of DD. To assist in clarifying this issue, use the DD logic “decision tree” guide to evaluate whether the person's diagnosis, functioning, and need for active treatment meet the Federal definition of DD. Again, do not hesitate to call the Department for assistance (when you have information on diagnoses and IQ tests.)

## 2.12 Brain Injury

**In most long term care programs, traumatic brain injury is included with the “Physical Disability” target group** (even if the resulting symptoms are only cognitive or behavioral).

A person with brain injury may meet the Federal definition of DD if the injury occurred before age 22. If the brain injury occurred after the age of 22, the person may meet the State definition of DD\* but not the Federal definition. Screeners should check both of those target groups (PD plus either federal or state DD) for persons with traumatic brain injury. Brain injury will be evident through the diagnoses table of the LTC FS. Application for the Wisconsin Brain Injury Waiver Program requires a separate process that is more in-depth than the LTC FS. The agency should refer the person to that process if appropriate. Note: The screen cannot currently be used to access the Brain Injury Waiver.

\*A special rule only for the State DD definition: If the injury to the brain is vascular in origin it must have occurred prior to age 22.

Refer to the tool “Decision Tree on Brain Injury and Target Groups” to help determine an individual meets the Physical Disability target group. This tool is located in the appendices at the end of this manual. It’s also available on the DHS web site at: <http://dhs.wisconsin.gov/lc/lc/FUNCTIONALSCREEN/biwtgtree.pdf>.

## 2.13 Terminal Condition

For the purposes of the LTC FS, “Terminal Condition” is defined as a condition where death is expected within one year from the date of the screening. If you check this target group you should also be checking K3 on the diagnosis module and also check the associated diagnosis which has created the terminal condition, e.g., AIDS.

If the person only meets this target group you should select “Yes” for the box on the screen that states, “the condition is expected to last more than 12 months or the person has a terminal illness” (death is expected in 12 months or less).

Note: For applicants who are less than 65 years old, a disability determination is required for waiver eligibility. “Terminal” for the LTC FS is 12 months as opposed to 6 months for Hospice patients, and does not require a signed declaration from the primary physician.

## 2.14 Severe and Persistent Mental Illness

For the purposes of the LTC FS, “severe and persistent mental illness” (SPMI) is defined as a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. “Chronic mental illness” includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of mental retardation or alcohol or drug dependence.

Example: A person with a diagnosis of situational depression newly diagnosed due to the death of their spouse who is stable, functional, and treated with anti-depressant medication short-term, would not meet this definition. Conversely, a person with a long-standing diagnosis of schizophrenia who refuses treatment, is frequently unstable and hospitalized, would meet this definition.

SPMI is also used to describe a person with a diagnosis of personality disorder, who has persistent difficulty in certain functional areas of their lives which affects their overall quality of life, e.g., inability to follow through with health care, inability to sustain relationships, vocational goals or cannot perform activities of daily living with consistency.

## 2.15 Mental Illness and Substance Use (“Co-morbidity”)

While “Severe and persistent mental illness” is included in the LTC FS target group choices, LTC programs such as Family Care, PACE/Partnership, CIP 1A/1B and COP-waiver require that consumers also have LTC conditions related to another primary LTC target group (Frail Elder, PD, DD, etc.). Severe and persistent mental illness cannot be the only LTC target group selected if a person is to be found eligible for such LTC programs.

“Co-morbidity” means having more than one diagnosis; in this document it refers to having a mental illness and/or substance use along with physical disability, being a frail elder or developmental disability. Estimates are that from 40 to 70% of long term care recipients also have mental illness and/or alcohol or drug use (AODA) issues. In practice, it is sometimes impossible to distinguish mental illness and AODA-related conditions from “frail elder” or “dementia.”

**To reduce confusion, please follow these steps:**

*First*, ask whether person meets statutory definitions for at least one LTC FS target group: Frail Elder, PD, DD, dementia, or terminal condition. To do so, you must focus only on the physical, medical, or cognitive condition you are considering (ignoring their mental illness) and ask whether it satisfies a statutory definition.

If YES: Check “yes” to all target groups that apply, and continue with the screen.

The person may also have mental health or substance use issues; as noted above, many LTC consumers do. They are eligible for some long term care programs if they are in at least one target group and if they have functional limitations-i.e., they need help with ADLs/IADLs. Note that this method does NOT ask what the PRIMARY diagnosis is, and it does not ask the reason for the ADL/IADL limitations. So, someone whose “primary” diagnosis is mental illness could in fact be eligible for a long term care program-as long as s/he ALSO has PD, DD, frail elder, dementia, or terminal condition, and ADL/ IADL deficits. Remember that to meet a target group, the person has to have deficits **related** to that particular target group definition.

If NO: If person is known to have ONLY mental health and/or substance use issues, none of the LTC FS target groups can be checked because person does NOT have DD, PD, frail elder, or terminal condition in addition to mental illness or substance use. Stop there-this person is INELIGIBLE for LTC FS programs. The screening agency should refer the person to other programs, especially mental health, but also Medicaid fee-for-service for help with ADLs/ IADLs.

*Second*, continue with the screen to see if person is functionally eligible, i.e., has ADL/IADL deficits specified in program eligibility criteria. (Again, the screen does not ask the reason for the ADL/IADL deficits.)

Example: 67 year old man with residual schizophrenia also has advanced COPD (Chronic Obstructive Pulmonary Disease) and CHF (Congestive Heart Failure) that make him very short of breath and weak. It is clear that the COPD and CHF significantly impair his ability to function. (Or would if he ever tried to do his ADLs/IADLs; providers tend to just do them for him because of his schizophrenia.) Check “Frail Elder.”

## 2.16 Mental Illness Co-morbidity and Medications

As noted in previous section, many people in LTC FS target groups will also have mental illness and AODA diagnoses. It does not matter which diagnosis is “primary.” All that matters is that the consumer with mental illness or AODA diagnosis also meets one of the LTC FS eligible target group definitions.

The statutory definitions allow for consideration of the special instance when a person due to mental illness cannot self-manage a physical disability or infirmity of aging.

If the person is unable to self-manage medications or treatments for a medical condition, then the condition counts as an infirmity of aging or a physical disability if the failure to take the medications is *life-threatening*. Examples include insulin for diabetes, or medications for high blood pressure (to prevent strokes) or medications to prevent blood clots.

The logic involves using a counterfactual: If the person didn't have a medical condition requiring life-sustaining medications, she could probably live on her own despite her mental illness (even if not well, e.g., homeless). But because she has diabetes or high blood pressure requiring medications, and because her failure to take the meds would be *life-threatening*, she cannot live on her own. Therefore, the medical condition does “severely impair her capacity for independent living” or self-care. So the medical/physical condition does meet statutory definition of physical disability or frail elder, so she is in a LTC FS target group.

If the medications are not life-sustaining -i.e., if failure to take the meds is not life-threatening-then the medical condition does not “severely impair her capacity for independent living.” Unless it otherwise severely impairs functioning, then it does not meet statutory definition of physical disability or frail elder.

The inability to take only psychotropic medications does not apply here, because there is no separate physical disability or infirmity of aging causing the need for those medications. The mental health system would need to help the person take medications.

This approach may mean that some persons currently being served by mental health clinics – specifically, those who come in daily for meds that include insulin, blood pressure meds, etc-would meet the target group question. Those persons may be functionally ineligible for programs connected to the LTC FS if they do not have a sufficient number of ADL/IADL deficits.

**Family Care Only:** Individuals who are found ineligible for some long term care programs may still be found functionally eligible for Family Care. Family Care eligibility is not the same as eligibility in the current waivers. No Social Security disability determination is needed for Non-Nursing Home LOC. Again, applicants must have a separate medical or physical condition (or dementia) to consider separately from the mental illness and they must ask whether that condition impairs the person's functioning significantly enough to meet the statutory definition for a target group.

## 2.17 What If No Target Group Applies?

Explain to the consumer that s/he does not appear to meet any of the statutory definitions for a LTC FS target group, and so is not eligible for programs connected to the LTC FS. **Since the LTC FS is completed after conversations between the screener and consumer, it is expected to be rare that you would even try to do a screen for someone not in a target group.** If a consumer disagrees with the screener about their target group status, the screener should consult with a supervisor and/or refer to a physician or psychologist for an opinion. The screener will also provide counseling and referrals for the consumer's other service options.

The “No Target Group” category automatically makes a person ineligible for the functional screen. If you choose this option you will not be allowed to select any other target group.

**For Family Care Only:** This option is available to use in instances where payment is sought related to screening ineligible people.

## 2.18 Age

The **minimum age** for programs connected to the LTC FS is **18** years of age. However, individuals 17 years 6 months old or older may be screened by the LTC FS to allow for advance planning. If the date of birth entered indicates that the person is younger than this, the application will not allow the screener to proceed.

## 2.19 HCB Waiver Group

**Note: This question applies to Home and Community-Based Waiver counties and to Resource Center counties without a Managed Care Organization. PACE/Partnership and Family Care agencies should not answer this question.**

Select the appropriate waiver type from the drop-down box. This question does not determine waiver eligibility, but allows The Management Group (TMG), the Community Integration Specialists (CIS) from the Bureau of Long Term Support – Developmental Disabilities Services Section, or the Independent Consulting Agency for the IRIS waiver to review screen information on-line for quality assurance purposes. However, until further notice, care managers should send paper copies of all information as they have been directed.

- By selecting “COP-W and CIP II”, TMG staff will be able to access the screen.
- By selecting “CIP 1A” or “CIP 1B”, CIS staff will have access to the screen.
- 
- By selecting “IRIS”, the Independent Consulting Agency supporting the SDS Waiver (IRIS) will have access to the screen.

This question also applies to recertification screens for persons already on a waiver, but who are being screened for the first time using the LTC FS. If the person does not meet waiver level of care or will not be served in a waiver at this time, do not select a waiver type.

# Module #3: LTC FS Basic Information/Screen Information/Demographics/Living Situation

## Objectives

*By the end of this module you should be able to:*

- Identify what basic screen and demographic information is collected by the LTC FS
- Correctly enter demographic information into the LTC FS
- Define what constitutes an “Activated Power of Attorney for Health Care”
- Explain the importance of the “Prefers to Live” question of the LTC FS

**Demographic information collected for the LTC FS does not determine eligibility for LTC services. Demographic information is used for two purposes:**

1. If an applicant chooses to enroll in a LTC program, demographic information will be used as the foundation of the enrollees full comprehensive assessment
2. Demographic information will be used for quality assurance and program oversight by state and county administrators

“Other” boxes are available in some instances to allow you, the screener, to fill in answers that may not be provided in the drop down boxes.

## 3.1 Screening Agency

This is a read-only field that the application will fill in automatically. To transfer a screen to another agency because of enrollment, referral, or applicant's move to another county, the Transfer utility should be used.

## 3.2 Referral Date

Enter the date someone requested that a functional screen be done. For example, use the date a health care provider refers a consumer to your agency or the date a MCO refers a consumer to a resource center. If no one requested the functional screen, enter the date you start it. For example, use the date you start the screen when completing an annual screen or when completing a screen so than an existing participant has a baseline screen in your system.

## 3.3 Date of Birth

Enter the person's date of birth in **MM/DD/YYYY**, as in 01/01/1909. LTC FS programming will not allow dates to be entered that make the applicant more than 150 years old or younger than 17 years, 9 months.

## 3.4 Screen Type

Select one option from the drop down box. There are two screen type options:

- **Screen type 01, Initial Screen**—The first Long Term Care Functional Screen completed for a person interested in understanding his or her long-term care status. Anyone may request a functional screen. Additionally, anyone can be referred for a functional screen.

- **Screen type 02, Rescreen**—An annual/recertification screen required as long as a consumer is enrolled in a home and community-based waiver program (COP/CIP/W, Family Care, PACE/Partnership). This screen type is used to complete the annual re-determination of a person’s functional eligibility and used to record a person’s significant changes in condition. **For Family Care Only:** If the consumer was enrolled in a waiver program prior to Family Care, they must continue to be recertified according to the date established with the prior waiver. If the consumer was not enrolled in a waiver program prior to Family Care, the screen must be completed annually no later than the end of the month initial eligibility was established.

### 3.5 Street Address/City/State/Zip/Phone Number

**Enter the applicant's “permanent residence” address.** If the person is now in a facility (nursing home, CBRF) that may or may not be their “permanent residence.” If a person is now in a nursing home, but maintains their apartment in the community with the intention of returning to home in the next few weeks, their apartment would be their permanent residence-not the nursing home. Use your professional discretion to determine what is the applicant's permanent residence.

“Applicant” is the consumer you are screening as part of application for HCBW, Family Care, PACE/Partnership, or other long term care program. Include street number, street name, apartment number, city, and zip. Include telephone number if available.

For transient persons, enter the address they lived at the most in the last 6 months.

### 3.6 County of Residence and County/Tribe of Responsibility

Select the appropriate county/tribe from the drop down box. In most cases these will be the same. In a few instances, persons may live in one county but another county/tribe is responsible for services, costs, and/or protective services. For the purposes of screening, residency is physical presence or the intent to reside.

**Family Care MCO Counties Only:**

For more information, refer to the “Permanent Moves Protocol,” which is located on the Department’s web site at: <http://dhs.wisconsin.gov/LTCare/Partners/PDFs/MovesProtocol.pdf>.

### 3.7 Location Directions

This space is available for you to enter directions to the applicant/consumer's home. Keep your entries brief and succinct.

### 3.8 Referral Source

Select from the drop down box who (the applicant, a family member, friend, etc.) contacted the screening agency to refer this person for a Screen. If the screen is being completed as an annual screen,” select “Rescreen” from the drop down box.

### 3.9 Primary Source for Screen Information

Select the primary source (person) for screen information from the drop down box. If the primary source is not listed, select other and fill in the other box.

In most cases, the primary source for screen information should be the consumer. Often, screeners will also need to have collateral contacts with family, residential staff, health care providers.

In some instances information will be obtained almost equally from multiple sources. "Primary" means the majority, over 50 %. Please select the source that seems most accurate.

If the consumer uses an interpreter, the consumer -- not the interpreter-- is still the primary source of information.

This question is meant as a quality assurance reminder that screeners must not take shortcuts and complete a screen by only talking with caregivers, staff, etc. If the applicant could participate in the screen, the applicant should participate in the screen interview. If the person is not the primary source of information, it is expected that in most cases other parts of the screen will indicate significant cognitive limitations. It will also be used in research to explore differences in LTC FS depending on who provides information.

### **3.10 Where Screen Interview Was Conducted**

Select the place where the screen was conducted from the drop down box.

"Person's current residence" includes private homes, residential facilities, or nursing homes.

"Nursing home" includes ICF-MRs and FDDs. Select "nursing home" if the nursing home is not the consumer's primary residence (i.e., they have a permanent residence elsewhere). If the nursing home is the consumer's primary residence, select "person's current residence" instead. We know that this question is not always easy to answer and rely on screeners' experience and expertise to select the most accurate answer.

"Temporary residence (non-institutional)" is intended for instances when consumer is staying with family or friends temporarily, for instance to recuperate from an illness or surgery. It also includes temporary stays in residential facilities, such as respite in a CBRF. Do not select this if the person is in an institution such as hospital or nursing home.

If you select "Other" please write a description such as Resource Center or county office.

### **3.11 Medical Insurance**

**Check ALL that apply.**

If Medicare is checked, enter the person's Medicare number, and check box to indicate Part A or B or Medicare Managed Care as applicable. (Note: Medicare Managed Care is a new form of voluntary HMO Medicare called "Medicare Plus Choice." You may see it written as "M + C". If the person has Medicare Gold, check the "Medicare Managed Care" box.) The effective dates for Medicare Part A or B are optional to complete.

Private insurance includes employer-sponsored insurances (e.g., an HMO) available as a job benefit. BaderCare and MAPP are forms of Medicaid. If the person is on BadgerCare or MAPP, enter this information under Medicaid with the number, and put a comment about this information in the Notes section.

### **3.12 Race/Ethnicity**

**RACE**

This is NOT a required field. Please select all boxes that apply. For persons with mixed heritage you can check all boxes that apply or check "Other" and write in the multiple races. The choices here match federal insurance reporting requirements. If needed, use the following definitions to identify the appropriate option:

- **Black or African American:**  
“Black” refers to people having origins in any of the Black racial groups of Africa. It includes people who indicate their race as “Black,” African American, Afro-American, Nigerian, or Haitian.
- **Asian or Pacific Islander:**  
“Asian” refers to people having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent. It includes people who indicate their race or races as “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” or “Other Asian,” or as Burmese, Hmong, Pakistani, or Thai.  
  
“Pacific Islander” refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race or races as “Native Hawaiian,” “Guamanian or Chamorro,” “Samoan,” or “Other Pacific Islander,” or as Tahitian, Mariana Islander, or Chuukese.
- **White:**  
“White” refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as “White” or as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.
- **American Indian or Alaskan Native:**  
“American Indian and Alaska Native” refers to people having origins in any of the original people of North and South America (including Central America), and who maintain tribal affiliation or community attachment. It includes people who indicate their race or races as Rosebud Sioux, Chippewa, or Navajo.
- **Other:**  
Check this box if the person does not meet any of the other racial definitions listed above and enter a comment to explain.

## ETHNICITY

This is NOT a required field. If needed, use the following definition to identify the appropriate option:

- **Spanish / Hispanic / Latino:**  
A person of Mexican, Puerto Rican, Cuban, Central, South American, or other Spanish culture or origin, regardless of race. (Hispanics and Latinos may be of any race.)

## 3.13 Interpreter Language Required

Leave this box unselected if no interpreter is needed.

Select the appropriate language if an interpreter is needed. If “Other,” please type in the language needed. Human service and health care providers should always obtain interpreters when they are needed. This information will help show the extent of such needs, and will also help long term care programs better serve non-English speaking consumers.

## 3.14 Contact Information

The valid contact types to list here are:

- Adult Child
- Ex-Spouse
- Guardian of Person
- Parent/Step-Parent
- Power of Attorney

- Sibling
- Spouse
- Other Informal Caregiver/Support (an 'Other' text box must be filled in if 'Other' is selected.)

If the person does have a valid contact to list, check the box and provide the contact's name, phone number and full address. This information is needed to complete the screen, and to notify the contact of the consumer's eligibility determination if appropriate.

If there is shared guardianship, you can write in the second guardian's name and address in the Contact Information 2 area.

Representative payees and un-activated power of attorneys were not considered necessary for this screen and should not be listed in the Contacts section. Some people may have a durable power of attorney document drafted by their attorney that they think has been active from the time it was initially drawn up. However, such documents do not count as an "Activated POA for health care." Such a POA is "in force" when it is first filled-out, but the consumer makes all her own decisions until she loses capacity to do so. The HCPOA cannot make decisions for her until after she is incapacitated. That is what is meant on the screen by "activated." A health care POA is "activated" only after the consumer has lost decisional capacity. Activation is usually documented as a doctor's note or addendum to the HCPOA.

### 3.15 Current Residence

Select the appropriate answer from the drop down menu. If you need to select other, type in an explanation in the "other" box. Most living arrangements fit into one of the options provided. The "other" box should be used **only** if no other box is appropriate. If you need to provide additional information or clarification regarding the living arrangement use the notes section. For further clarification of the drop down menu choices:

- If the person you are screening lives in what is known as an "assisted living facility", select Residential Care Apartment Complex (RCAC)
- CBRFs include "group home."
- If an applicant lives with family who is being paid as an adult family home, select "lives with spouse/partner/family."
- If an applicant lives with family who is being paid to provide services such as personal care, select "lives with spouse/partner/family."
- If applicant lives with non-related roommates and has a live-in paid caregiver, select "lives with live-in paid caregiver."
- If applicant is currently in a hospital or nursing home for rehabilitation, but they maintain a home elsewhere (example: an apartment), then the home elsewhere (example: an apartment) is their current residence. Hospital swing beds are also generally a temporary living arrangement. The person's permanent living arrangement should be indicated rather than the swing bed.
- Most brain injury rehabilitation units are licensed as nursing homes. If the person does not have another living arrangement in the community, Nursing Home should be selected.
- A dormitory, communal living situation and most convents would fall under "With non-relatives/roommates."
- If a person is served by hospice in a home, apartment or nursing home, select the appropriate living arrangement from the list. If the person lives in a facility owned by the hospice provider, select "Hospice Care Facility."
- Other IMD = Other Institute for Mental Disease.
- A hotel or motel would go under "no permanent residence" if it is a temporary arrangement. If the hotel or motel serves as the permanent residence the screener should select one of the options under the 'Own Home or Apartment' category.

Again, if you need to provide additional information about the living arrangement, please use the notes section rather choosing "other" when an existing option would be appropriate.

### 3.16 Prefers to Live

Select the appropriate answer from the drop down box menu.

The “Prefers to Live” question asks precisely and only for the consumer's own stated preference. It will be used to see if long term care consumers are living where they want to live and to track changes over time. This question is asking the PERSON'S INFORMED PREFERENCE. **Record where s/he would like to live-not where anyone else wants them to live, and not where you or others think is realistic.** Screeners must take the time to explain the person's options. The consumer cannot express a preference if the screener has not informed them of their options first.

It is well known that people often acquiesce to whatever they feel limited to or whatever they've been told. For example, people with developmental disabilities who live in institutions often think “group home” is the only option available to them. You must take the time to ask questions to help the person articulate her/his preferences. Some people like to live with others; others highly value having their own space. While the person's preference may be difficult to ascertain, screeners are to use their best interviewing skills to select the most accurate answer.

As another example, an old woman may say she “belongs in” a nursing home because she'd be too much of a bother anywhere else. The screener should take the time to ask what she would like, not what she thinks is reasonable.

Screeners should select the answer that most accurately reflects what the person is saying. An elder may articulate a preference for “an apartment with onsite services (RCAC, independent apartment CBRF).” But if a person with developmental disability is telling you that she just wants “a place of my own,” then you select the most appropriate selection of “own home or apartment”. Do NOT select “someone else's home or apartment” or an “apartment with services” even if that is probably what the person would get. The purpose of this question is to record what the person says, not what the system will provide or what you think s/he really needs.

Note: “Own home” can also include life estate situations where the elder has sold the property to another and retains the right to live there.

Select “Unable to determine person's preferred living arrangement” if the person cannot comprehend their options and/or cannot communicate their preference.

If the applicant's preferred living situation is not listed, select “Other” and please type in what the “Other” is, for possible screen revisions in future.

### 3.17 Guardian/Family's Preference of Living Arrangement for this Person

This question was added because screeners found completing the “Prefers to Live” too difficult to answer when the guardian or family disagreed with the consumer being screened. Select the most appropriate option from the drop down box menu.

# Module #4: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

**NOTE:** In 2009, Department staff recorded two training webcasts that provided overviews of changes made to this module. To view the webcasts go to:

- **ADLs:** <http://dhsmedia.wi.gov/main/Viewer/?peid=186b394a-49b8-4a00-b372-d021b136fd9a>
- **IADLS:** <http://dhsmedia.wi.gov/main/Viewer/?peid=5982c9831fce4abb8d8700be516b9627>

(If you have not viewed a webcast before check your computer to see if it meets the minimum requirements at <http://dhs.wisconsin.gov/webcast/help.htm>.)

## Objectives

*By the end of this module you should be able to:*

- Define the six activities that make up the Activities of Daily Living section and the seven activities that make up the Instrumental Activities of Daily Living section of the LTC FS.
- Apply the rating system used with each ADL/IADL accurately and reliably. This means that other screeners would select the same answer as you did.
- Properly Code “who will help in the next 8 weeks” for each ADL/IADL.
- Identify the adaptive equipment items that are included in the ADL section of the LTC FS.
- For someone preparing for discharge from a skilled healthcare facility, complete the ADLs/IADLs sections reflecting how the person would function at home.
- Utilize strategies to counter an individual’s tendency to underrate/overrate their need for assistance with ADLs/IADLs.

## 4.1 Sections in this Module of the LC FS: ADLs and IADLs

### Activities of Daily Living (ADL)

1. Bathing
2. Dressing
3. Eating
4. Mobility in Home
5. Toileting
6. Transferring

### Instrumental Activities of Daily Living (IADL)

1. Meal Preparation
2. Medication Management and Administration
3. Money Management
4. Laundry and/or Chores
5. Telephone
6. Transportation
7. Employment

## 4.2 Overview of the ADLs/IADLs Module

The Long Term Care Functional Screen (LTC FS) collects data on an individual's ability to accomplish Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Many times individuals have adapted to a deficit, and may appear fairly functional, but still have the underlying deficit.

Each ADL and IADL is defined in the LTC FS Instructions. Follow those definitions closely.

**While one rating system has been developed for all of the ADLs, the IADLs require separate ratings because their respective descriptions are so different.**

### ADL RATING SYSTEM:

- **0:** Person is **independent** in completing the activity safely.
- **1:** Help is needed to complete the task safely but **helper DOES NOT have to be physically present throughout the task.**
- **2:** Help is needed to complete the task safely and **helper DOES need to be present throughout the task.**

Note: Help can be supervision, cueing, and/or hands-on assistance (partial or complete).

### IADL RATING SYSTEM: (Vary by IADL)

**In all cases, the rating has been simplified to meet the following criteria:**

- Simplicity for maximum uniformity (inter-rater reliability): This is imperative for accurate and equitable determination of eligibility and entitlement.
- Inclusive: A screener is able to select one "most accurate" answer for every individual of any of the LTC FS target populations.
- Make sense for eligibility: Some things should not "count" toward eligibility for a LTC program.
- Relate to long term care costs.

### Tips for completing the ADL/IADL Module:

- Identify the need and select the level of help needed from another person.
- Be careful not to overlook deficits because of adaptations made. Consider a person's use of self-made assistive devices used in lieu of more standard medical equipment (e.g., use of a lawn chair as a shower chair).
- It is not uncommon for individuals to under-rate their need for help or overstate their independence. Remember to use the following five steps when reviewing the level of help needed:
  - Select the level of assistance needed based on need and not solely on a diagnosis.
  - Select the level of assistance needed and not solely on the report of the individual.
  - Seek more details and consider asking for a demonstration on how a task is completed.
  - Seek collateral informants, other people you could ask for additional information.
  - Use your professional judgment and assessment skills to select the best answer. Follow the definitions and instructions for the screen.
- For a person living in a residential facility, assess the person's actual need for assistance and do not select the level of help needed based on the services or equipment available as part of the residential facility package.
- When an individual's conditions and abilities fluctuate over time, reference Module 1.12 Strategies to Minimize Screening Limitations, Abilities Fluctuate, for assistance on how to complete the LTC FS.

Example: Bert tells you he doesn't need any help with bathing. He lives alone. He is unkempt and has body odor. He walks very unsteadily with a cane and is bent over. It is quite clear to you that he is not able to safely get in and out of his bathtub and that he in fact has not bathed for many weeks.

Step 1: Seek more details:

- o You ask him if you can see his bathroom, where you notice he has a claw-foot bathtub with sides about 2 feet high off the floor (with no grab bars, bench, or non-slip mats). You observe his ambulation and ask him to lift his foot high for you. He lifts it about four inches. You ask him for details on how he gets in and out of the bathtub.

Step 2: Seek collateral informants:

- o Bert's daughter referred him to the Resource Center and is present during the screen interview. With Bert's approval, you speak to her privately on the way out to get her perspective on her dad's functioning. She says he is lying now because he's afraid, but he's admitted to her that he is unable to get into the bathtub.

Step 3: Use your professional judgment to select the best answer:

- o You can see from Bert's general body movement that he would need help with all aspects of bathing and would require his helper to be present throughout the entire task. For bathing, select Box 2, "Helper needs to be present throughout the task".

If you have identified a level of help needed in ADLs or IADLs, be sure to indicate a diagnosis that correlates to the deficit. In the event no diagnosis is currently available to verify the care need, clearly state in the notes section why the deficit is present. This is also true for the other modules where deficits are noted.

The need for assistance with personal hygiene such as grooming and mouth care are not captured on the LTC FS. This information, as well as hygienic conditions of the home should be captured on a comprehensive assessment.

Employment is not traditionally considered an IADL, but is on the LTC FS. On the LTC FS, chores and laundry are included in the IADL section but do not "count" as IADL deficits in the current eligibility logic. Also included in this section is a question regarding Overnight Supervision, however this is not an IADL.

## 4.3 Choosing Level of Help Ratings for ADLs/IADLs

The ADLs/IADLs Module of the LTC FS is intended to determine whether a cognitive or physical impairment limits a person's ability to perform an activity or causes significant difficulty in performing an activity alone, with or without adaptive aids. A determination that an individual is limited in his/her capacity to perform an ADL or IADL task should always equate with a **cognitive or physical impairment**.

**Always select the answer that most closely describes the person's need for help from another person--whether they are actually getting that help or not. Always select ONLY ONE rating of help needed with each ADL and IADL.**

For each ADL and IADL, **indicate the amount of help the person currently needs from another person--no matter who is providing the help**. The only exception to this is when a person is about to change residences, estimate what assistance they'll need in their new residence.

If a person can complete a task independently, but it takes them a very long time, you need to consider if the person needs any help with that task to complete it safely. If they are in fact completing tasks safely, it

does not matter if it takes two or three times longer than for most people. However, if it takes a significant amount of time for the person to complete a task independently and that results in a significant, negative health outcome for the person doing the task so slowly, to the point that another person should be present to help with some or all of the task, than it would be justified to indicate the person has a need of help completing the task.

**REMINDER:** A screener should document an individual's **NEEDS**, not just what services/assistance they are currently receiving. So, if a person has an identified need, but for some reason is not receiving assistance (including refusing the service, etc.), the screener should still capture the need for the assistance in this section.

**REMINDER:** If a person has never performed an activity or a task, do not assume the person is physically or cognitively capable or incapable of doing so. A lack of experience is not the same as the inability to perform a task due to a physical or cognitive impairment. And, although a person is currently receiving assistance with a task they may be able to perform the activity independently or with limited assistance if given the opportunity and training.

## 4.4 Communal Living Situations

A screener may encounter a person living in a communal living situation or congregate living arrangement, like a dormitory, convent, monastery, etc. This person may lack experience performing certain tasks. Socioeconomic barriers, religious beliefs, or cultural norms may be factors that result in this person having fewer opportunities to perform select IADLs (e.g., making phone calls, managing a checkbook, driving, or food preparation). In a communal living situation, activities are often centralized and tasks assigned to certain individuals for the convenience of the community or setting.

When a person resides in a communal living situation, do not presume ADL and IADL tasks cannot be performed by the person unless a physical or cognitive limitation is evident. Assume the person can be independent when the opportunity and training are provided to learn new tasks. When a person is receiving assistance with an ADL/IADL task or has no experience performing the task, the screener must:

1. Ascertain whether there are communal living situation, socioeconomic barriers, religious beliefs, or cultural norms factors that result in the individual receiving assistance or lacking experience with a task.
2. If such factors are evident, determine whether there is a physical or cognitive impairment limiting the person's capacity to perform the task.

Examples:

- A college student living in a dormitory who has relied on his parents to manage his financial matters. Do not assume this student is unable to manage money and pay bills unless he has a physical or cognitive impairment limiting his ability to do so.
- A nun has taken a vow of poverty and has spent her adult life in a convent. Financial resources have always been pooled and bills paid centrally. Money available to her has been limited to a small stipend. Do not assume this nun is unable to manage money and pay bills unless she has a physical or cognitive impairment limiting her ability to do so.
- A large farm cooperative is managed by a religious order of monks living at the farm in a monastery. The monks have experience with farming tasks but not driving, shopping, and food preparation. When determining a monk's ability to perform these IADL tasks, assess for any functional or cognitive limitations that may diminish his capacity to perform these IADL tasks, not the inexperience or lack of training opportunities.

## 4.5 Adaptive Equipment

Four of the ADLs (Bathing, Mobility, Toileting, and Transferring) and two of the IADLs (Meal Preparation and Laundry and/or Chores) have some adaptive equipment listed. **Select only equipment the person currently needs, has, and is actually using.**

Sometimes a person will improvise to meet a need for equipment. For example, instead of a tub bench they may use a sturdy object to sit on during bathing. In this instance, you *would not select* 'Uses tub bench' in the bathing equipment box. *Do not* capture a person's use of improvised or home-made items as a substitute for the equipment on the list. A screener should only select the types of equipment listed on the LTC FS the person needs, has, and uses.

Do NOT select a type of equipment that is a facsimile of what is on the list.

If a person uses an improvised or home-made item and *without it, they do not need* any assistance from another person to complete the task, the screener should select 0: (Independent). Do NOT check the use of any equipment.

If a person uses an improvised or home-made item and *without it, they would need* assistance from another person to complete the task, the screener should select 1: (Help is needed-helper need not be present throughout the task). Do NOT check the use of any equipment (for the improvised or home-made item).

## 4.6 Coding for Who Will Help in the Next 8 Weeks

**For each ADL and most of the IADLs there are codings to indicate who will help in the next 8 weeks. Check all that apply.**

- U: Current UNPAID caregiver will continue.
- PP: Current PRIVATELY PAID caregiver will continue.
- PF: Current PUBLICLY FUNDED paid caregiver will continue.
- N: Need to find new or additional caregiver(s).

Although the level of unpaid or privately paid assistance a person receives will NOT affect a person's level of payment in the new system, this information will be used for two purposes:

1. To inform the LTC program that the person may need services immediately or soon, so the team can anticipate finding additional assistance for the person.
2. To inform the Department of reasons for low costs for persons with high needs, so that adequate average payments can be established.

If the level of assistance needed for a particular ADL/IADL task is selected as 0: (Independent) or NA: (Has no medications), the boxes for "Who Will Help in the Next 8 Weeks?" should be left blank.

If it is determined the person needs assistance with a task, the "Who Will Help in the Next 8 Weeks?" category is mandatory to complete. In other words, if a level of assistance indicated for an ADL or IADL task is "1" or greater the screener must select at least one of the "Who Will Help" boxes.

PP: (Current Privately Paid caregiver will continue) means non-public funding, including the person's own money, or that of family, friend, etc., private insurance (including LTC insurance benefits), or a trust fund.

PF: (Currently Publicly Funded paid caregiver will continue) means funded with public program assistance including but not limited to services funded by Medicare, Medicaid, waiver programs, Veterans Affairs, and any other federal, state, or county funding sources.

## Nursing Home or Hospital Resident

If a person resides in a nursing home or hospital and discharge is not expected in the next 8 weeks, indicate how the nursing home is being paid (Privately Paid or Publicly Funded). If a person is in a nursing home and they are expected to be discharged within the next 8 weeks, try to be as accurate as possible with the "Who Will Help" boxes. Record the help the person will need once at home. Many elders are discharged to their own homes with a mixture of public, private, and unpaid care giving services.

## Definitions and Discussion of ADLs

### 4.7 Bathing

Definition: The ability to safely shower, bathe, or take a sponge bath for the purpose of maintaining adequate hygiene. The activity of bathing consists of the following components:

- Ability to get in and out of the bathtub/shower
- Turning on and off the faucets
- Regulating the water temperature
- Washing and drying self fully
- Shampooing hair

Equipment that can be counted under bathing includes:

- Shower chair
- Tub bench
- Grab bars
- Mechanical lift

#### Check this for a person who:

- Requires supervision, cueing, and/or hands-on assistance (partial or complete) with any of the above mentioned components of bathing.
- Requires regular cueing or would not bathe, due to a cognitive impairment.
- Gives themselves a sponge bath because they are unable to get in and out of tub/shower.
- Is able to bathe themselves but it takes additional time to do so and results in a significant, negative health outcome. During the task of Bathing, a significant, negative health outcome is indicated when a person experiences any of the following results: out-of-breath, dizzy, chest pains, exhausted, incontinence, or increased pain, **to the point that another person should be present to help with some or all of the task.**
- Requires assistance with the aspects of bathing but can be left alone to soak in the tub.

#### Do NOT check this for a person who:

- Has no cognitive impairment and chooses not to bathe.
- Bathes independently with the use of a hand held shower aid.
- Requires assistance with grooming tasks (shaving, brushing hair, mouth care, nail care, etc.).
- Prefers to have a sponge bath and can do so independently.
- Is able to bathe independently but doesn't bathe unless a family member/staff is present somewhere in the home, "just in case."
- Is able to bathe independently but it takes additional time to do so WITHOUT significant hardship or negative outcomes.

## 4.8 Dressing

Definition: The ability to dress and undress as necessary, with or without the aid of adaptive devices. The activity of dressing consists of the following components:

- Dressing the top half of body (includes putting on undergarments).
- Dressing the bottom half of body (includes putting on undergarments).
- Getting shoes and socks on and off.
- The ability to put on or remove prostheses, braces, and/or anti-embolism hose (e.g., TED stockings).
- The ability to work fasteners (e.g., snaps, buttons, and zippers) except at the back of a dress or blouse.
- Choosing the appropriate clothing for the weather.

### Check this for a person who:

- Requires supervision, cueing, and/or hands-on assistance (partial or complete) with any of the above mentioned components of dressing.
- Needs clothes laid out for them, but can put them on.
- Is able to dress themselves but it takes additional time to do so and results in a significant, negative health outcome. During the task of Dressing, a significant, negative health outcome is indicated when a person experiences any of the following results: out-of-breath, dizzy, chest pains, exhausted, incontinence, or increased pain, **to the point that another person should be present to help with some or all of the task.**

### Do NOT check this for a person who:

- Only requires assistance with a zipper or button(s) at the back of a dress or blouse.
- Does not have a cognitive impairment, but chooses not to wear appropriate clothing.
- Can dress, but refuses to change their clothes, even when clothes are stained or carry an odor.
- May mismatch clothes.
- Is able to dress themselves but it takes additional time to do so WITHOUT significant hardship or negative outcomes.

## 4.9 Eating

Definition: The act of getting food or drink from a plate or cup to the mouth (chewing if necessary and swallowing) using routine or adaptive utensils. This also includes the ability to cut the food. Assess the individual's actual need for assistance. Do not select the level of assistance needed based solely on a diagnosis.

(Note: If the person is fed via tube feedings or intravenously, check Box 0 if they can independently complete that task, or Box 1 or 2 if they require assistance from another person.)

Adaptive utensils can consist of: weighted and/or built up eating utensils, scooper plates/bowls, food bumpers, special cups, etc.

### Check this for a person who:

- Requires monitoring, supervision, hands-on assistance, or cueing to even complete the process of eating.
- Requires supervision due to a risk of choking.
- Requires assistance from another person to cut food.
- Has Prader-Willi Syndrome.

- Requires assistance to put on or remove a splint with which they can then hold a utensil and independently feed themselves.

**Do NOT check this for a person who:**

- Has no history or risk of choking but is monitored “just in case.”
- Needs portion control for weight reduction.
- Is on a special diet (diabetic, low-cal, low-sugar, low fat, etc.).
- Must have food pureed, minced, or follows a mechanical soft diet (these needs are captured in Module 4.13 Meal Preparation tasks).
- Needs assistance placing food on a plate or with carrying a plate/cup to the table (these needs are captured in Module 4.13 Meal Preparation).
- Needs to have a plate “set up” with food due to his/her visual impairment.
- Is a messy eater.
- Takes other people’s food.
- Needs the refrigerator, pantry, etc. to be locked to deter snacking or stealing (except for a person with Prader Willi Syndrome).
- Has pica or polydipsia (these needs are captured in Module 8 Behaviors/Mental Health as Self-Injurious Behaviors).
- Is able to feed themselves independently with adaptive utensils.

## 4.10 Mobility in Home

Definition: The ability to move between locations (including stairs) in the individual's living space. Living space is defined as kitchen, living room, bathroom, and sleeping area. A person’s living space *does not include* the basement, attic, garage, yard, and places outside of the home. Excluded from the task of Mobility in Home is the need for assistance with a transfer to get up to a standing position to walk (this need is captured in Module 4.12 Transferring).

For an individual able to independently move about the home while using one of the types of equipment listed below, select 0 – Person is independent in completing the activity safely. Then check the corresponding box to indicate what equipment the individual uses.

The only equipment that can be counted under Mobility in Home includes:

- Walker
- Cane/quad cane\*
- Crutches
- Wheelchair (used in the home)
- Scooter (used in the home)
- Artificial foot or leg(s)

**Do not include the following types of equipment or medical supplies** used by an individual as a type of equipment counted under Mobility in Home:

- Ace bandage
- Leg brace
- Foot brace
- Anti-embolism hose
- Neoprene Wrap
- Orthotic shoes
- Walker, cane, crutches, wheelchair, scooter, prostheses *only* used when ambulating outside of their home.

\*A cane intended solely as a probe to identify obstacles or as an indicator of visual impairment does not count as an aid for Mobility in Home.

**Check this for a person who:**

- Uses the furniture or walls for balance.
- Requires standby\*\* or hands-on assistance with mobility.
- Is able to walk (or wheel) themselves with or without equipment, but it takes them additional time to do so and results in a significant, negative health outcome. During the task of Mobility in Home, a significant, negative health outcome is indicated when a person experiences any of the following results: out-of-breath, dizzy, chest pain, exhausted, incontinence, or increased pain, **to the point that another person should be present to help with some or all of the task.**
- Can independently move about their home, but needs assistance to use steps in their living space (limited to the kitchen, bathroom, bedroom, and living room).

**Do NOT check this for a person who:**

- Is able to walk (or wheel) themselves when using adaptive equipment.
- Is able to walk (or wheel) themselves but needs direction on where to go due to a cognitive impairment.
- Requires assistance with mobility outside of the home.
- Is able to walk independently once assisted to a standing position (this need is captured in Module 4.12 Transferring).
- Is able to walk (or wheel) themselves but has had a joint replacement surgery.
- Is able to walk (or wheel) themselves, but has an uncontrolled seizure disorder.
- Is able to walk (or wheel) themselves but has a vision impairment.
- Is able to walk (or wheel) themselves but has a fear of falling.
- Is able to walk (or wheel) themselves but does so slowly and safely.
- Is able to walk (or wheel) themselves but has a shuffling gait and walks safely.
- Is able to walk (or wheel) themselves but it takes additional time to do so WITHOUT significant hardship or negative outcomes.
- Is able to walk (or wheel) themselves but needs assistance using steps or ramp outside of living space.
- Is able to walk (or wheel) themselves but does not get up and walk in the home unless a family member/staff is present somewhere in the home, "just in case."
- Is able to walk (or wheel) themselves but needs assistance putting on or taking off braces, anti-embolism hose, or orthotic shoes. These needs are captured in Module 4.8 Dressing.

\*\*Standby assistance is defined as the need for a person to walk next to the individual in order to be readily available to help the individual in the event they fall or lose balance. In other words, the assisting person is within arm's length away in order to catch the individual if they were to lose balance and by doing so will prevent the individual from being injured.

## 4.11 Toileting

Definition: The ability to use the toilet, commode, bedpan, or urinal for bowel and/or bladder management. The activity of toileting consists of the following components:

- Locating the bathroom facility
- Transferring on/off the toilet, commode, bedpan, or urinal

- Maintaining regular bowel program\*
- Cleansing of self
- Changing of menstrual products and/or incontinence products (if applicable)
- Managing a condom catheter or the ostomy or urinary catheter collection bag (including the emptying and/or rinsing the collection bag)
- Adjusting clothes
- Emptying the commode, bedpan, or urinal

\*A regular bowel program includes using suppositories, enemas, and digital/manual stimulation with the goal of having regular bowel movements at a predictable time and frequency. This **does not** include the use of oral laxatives, fiber, or medications (Metamucil, Ex-lax, etc.). used by a person not on a formal bowel program.

Equipment that can be counted under toileting includes:

- Toilet grab bars/rails
- Commode
- High rise/accessible toilet
- Elevated/adaptive toilet seat
- Ostomy or catheter collection bags
- Bed pan
- Urinal
- Transfer board or other transfer aids that assist the person to get on/off the toilet

If there are interventions to prevent the incontinence (e.g., cueing or scheduled toileting) indicate the frequency of intervention being provided.

**Check this for a person who:**

- Requires supervision, cueing, and/or hands-on assistance (partial or complete) with any of the above mentioned components of toileting.
- Requires regular assistance or cueing to use the bathroom or would be incontinent.
- Is incontinent and requires assistance with changing incontinence pads.

**Do NOT check this for a person who:**

- Is incontinent and is **independent** with managing incontinence pads - however, select the appropriate frequency related to the person's incontinence in the sub-section dealing with incontinence.
- Only requires assistance with skilled tasks associated with ostomy or urinary catheter care (see Sections 6.14 and 6.24 in the Health Related Services Module).
- Utilizes oral laxatives, fiber, or other medications.
- Needs assistance or reminders only with flushing the toilet or the amount of toilet paper to used.

**INCONTINENCE**

Select the applicable level of bowel and/or bladder incontinence in this section. Urge incontinence is the sudden uncontrollable urge to frequently urinate. Do not count stress incontinence, which is leakage of urine during sneezing, coughing, or other exertion. Incontinence options include:

- Applicant does not have incontinence
- Has incontinence daily
- Has incontinence less than daily but at least once per week

If there are interventions to prevent the incontinence, e.g., cueing, scheduled toileting, indicate the frequency of intervention being provided.

Remember: If the individual has an ostomy or indwelling or straight urinary catheter, screeners should review Sections 6.14 and 6.24 in the Health Related Services Module to assure the individual's needs have been accurately identified.

## 4.12 Transferring

Definition: The physical ability to move between surfaces. The task of Transferring includes the ability to move from a bed, usual sleeping place, chair, to a wheelchair, or up to a standing position. Excluded from the task of Transferring is the need for assistance with a transfer to bathe or use a toilet (these needs are captured in Module 4.7 Bathing and 4.11 Toileting).

For an individual able to transfer independently, while using one of the types of equipment listed below, select 0 – Person is independent in completing the activity safely and check the corresponding box to indicate what equipment the individual uses. An example of when the selection of a 1 – Help is needed to complete the task safely but helper does not have to be physically present throughout the task, would be applicable is for a person who needs assistance at night when they are fatigued from the day, but for the rest of the day, complete all other transfers independently.

The **only** equipment that can be counted under Transferring includes:

- Mechanical lift or power stander
- Transfer board
- Grab bars, bed bar, or bed railing (if used for transferring)
- Trapeze
- Transfer pole

REMINDER: **DO NOT** count a lift chair or an electric hospital bed as a mechanical lift here. However, a screener may select a need for transfer assistance for a person who uses a lift chair or electric hospital bed, if the person is unable to transfer from the chair or bed without them. (See below)

**Check this for a person who:**

- Needs to wear a gait belt that is used during transfers.
- Needs hand-on assistance to complete safe transfers.
- Does not need assistance with transfers but it takes them a significant amount of time to do so and results in a significant, negative health outcome. During the task of Transferring, a significant, negative health outcome is indicated when a person experiences any of the following results: out-of-breath, dizzy, chest pains, exhausted, incontinence, or increased pain, **to the point that another person should be present to help with some or all of the task.**
- Needs cueing or step-by-step directions to transfer.
- Has a lift chair or other mechanical device (e.g., electric hospital bed), and **cannot** independently transfer without it.

**Do NOT check this for a person who:**

- Has a lift chair or other mechanical device (e.g., electric hospital bed), but **can** independently transfer without it.
- Is independent with transfers by pushing on chair arms, other furniture, wheelchair, walker, or cane.
- Is independent with transfers after rocking back and forth to gain momentum to get up from a seated position.
- Is independent with transfers but needs additional times to do so WITHOUT significant hardship or negative outcomes.
- Gets up independently when prompted.

- Requires transfer assistance getting in or out of a vehicle.
- Doesn't transfer in the home unless a family member/staff is present somewhere in the home, "just in case."

## **Definitions and Discussion of IADLs**

### **4.13 Meal Preparation**

Definition: The physical and cognitive ability to obtain and prepare basic routine meals, including the task of grocery shopping. What constitutes a meal is an individual choice. Meal Preparation includes the ability to make a simple meal, such as cereal, sandwich, heat frozen foods, or reheat food prepared by others.

Meal Preparation does not include needed transportation to and from a grocery store or assistance with the money transaction to pay for the groceries. (These needs are captured in Module 4.18 Transportation and Module 4.15 Money Management.)

REMINDER: A person may request assistance with Meal Preparation due to a gender, age, or cultural norm. To select a need for assistance with Meal Preparation, a person needs to have a **physical or cognitive limitation** impairing their ability to complete the task independently.

REMINDER: A screener should not automatically assume assistance is needed because a person makes food choices consistent with their lifestyle and values, even if those food choices are not in agreement with professionals' advice and nutritional goals for the person.

REMINDER: When there is a need for assistance with grocery shopping only, the frequency of assistance should be selected as a 1: (Needs help from another person weekly or less often), as more frequent grocery shopping is not necessary.

The activity of Meal Preparation may include the following components:

- Open food containers
- Open the refrigerator and freezer
- Safely use their kitchen appliances
- Prepare a simple meal, such as cereal, sandwich, heat frozen foods, or reheat foods prepared by others
- Safely place food on a plate or in a cup, and carry it to a table
- Proper food preparation and storage
- Obtain groceries

The activity of obtaining groceries may include the following components:

- Selecting the food from the store shelves
- Moving items between a basket or cart to the checkout counter.
- The money transaction to pay for the groceries. (This need is captured in Module 4.15 Money Management).
- Bagging the food
- Getting the bags to a vehicle
- Getting the bags into the home
- Putting the groceries away

#### **MEAL PREPARATION RATING SYSTEM**

- 0: Independent
- 1: Needs help from another person weekly or less often

- 2: Needs help 2 to 7 times a week
- 3: Needs help with every meal

**Check this for a person who:**

- Has a physical or cognitive limitation impairing their ability to complete the task of Meal Preparation independently.
- Is able to independently complete the tasks involved in preparing a meal and grocery shopping but doing so results in a significant, negative health outcome. During the tasks involved in preparing a meal and grocery shopping, a significant, negative health outcome is indicated when a person experiences any of the following results: shortness of breath, dizziness, chest pains, exhaustion, incontinence, or increased pain, **to the point that another person should be present to help with some or all of the task.**
- Needs assistance to have food pureed, minced, thickened, or to prepare a mechanical soft diet.
- Needs assistance preparing their liquid nutrition for their tube or intravenous feedings.
- Needs assistance placing food on plate or with carrying a plate and/or cup to the table.
- Needs assistance to open food containers, even with adaptive aids (e.g., electric can opener).
- Due to a physical impairment, needs assistance opening their refrigerator or freezer, even with adaptive aids.
- Needs assistance preparing meals due to their inability to stand long enough to cook food even when taking breaks to sit down during the task of making a meal.
- Is unable to safely use at least one of their appliances to cook or heat food.
- Has Prader-Willi Syndrome.
- Needs assistance with Meal Preparation tasks due to a cognitive impairment related to their Severe and Persistent Mental Illness.
- Is unable to determine when food is spoiled.

**Do NOT check this for a person who:**

- Does not have a physical or cognitive limitation impairing their ability to complete the task of Meal Preparation independently.
- Chooses to only eat cold foods.
- Is able to independently complete the tasks involved in preparing a meal and grocery shopping but it takes additional time to do so WITHOUT causing significant hardship or negative outcomes.
- Needs assistance planning a menu, making a grocery shopping list, requires transportation to the grocery store, or wants to grocery shop more than once a week.
- Receives Home Delivered Meals (HDM) but is cognitively or physically able to prepare meals. There is a variety of reasons why a person may receive HDMs that do not relate to a cognitive or physical limitation to prepare meals independently.
- Can make a simple meal (cereal, sandwich, etc), can heat food (frozen, leftovers, or food prepared by others), or chooses to only eat cold foods.
- Needs to use the grocery store's scooter or wheelchair to shop.
- Needs assistance from a grocery store employee or fellow shopper to retrieve items from high or low shelves because they cannot reach the items without assistance.
- Can shop independently when their groceries are bagged in smaller and lighter bags so they can manage them.
- Chooses not to eat according to the food pyramid, eats more than three meals a day, or eats fewer than three meals per day.

- Resides in a substitute care setting or nursing home and solely because of where they reside they are not allowed to use the kitchen to prepare their meals.
- Does not prepare their meals solely because meals are provided as part of the services in the facility where they reside.
- Only needs assistance getting food out of a refrigerator or freezer located in their garage or basement.
- Can prepare a meal if they take breaks to sit down during the task.
- Is only able to cook or heat up food in a microwave oven.
- Needs assistance cleaning up after a meal. (This need is captured in Module 4.16 Laundry and/or Chores.)
- Is on a special diet (diabetic, low-cal, low-sugar, low-sodium, etc.).
- Needs to have their food pureed, minced, cut, or thickened and can do so independently with or without adaptive aids.
- Has a vision impairment that does not affect their ability to independently prepare meals.
- Needs assistance cleaning the inside of their refrigerator, including the removal of spoiled food. (This need is captured in Module 4.16 Laundry and/or Chores.)
- Receives nutrition by tube or intravenous feedings and can independently prepare their liquid nutrition.
- Has fluctuating abilities and grocery shops on their good days. For additional information on screening a person with fluctuating abilities, review Module 1.12 Strategies to Minimize Screening Limitations, D. Abilities Fluctuate.
- Could prepare meals safely and independently using a toaster oven, toaster, stove top, stove, oven, microwave oven, or electric frying pan, but they don't currently have any of these appliances.
- Needs assistance with the money transaction to pay for the groceries with cash, credit card, debit card, gift card, personal check, or by store charge account. (This need is captured in Module 4.15 Money Management.)
- Independently orders their groceries online, calls-in, or e-mails-in their grocery order for convenience.

## 4.14 Medication Management and Administration

### Definition of a "Medication" on the LTC FS

A medication is a drug used to treat disease, symptoms, or injury that enters the body in the prescribed manner. On the LTC FS, a "medication" is defined more precisely. The screener must read the following section carefully to ensure the LTC FS is completed accurately.

### A medication on the LTC FS must meet these three criteria:

1. Approved by the U.S. Food and Drug Administration.
2. Prescribed by a Medicaid-recognized prescriber (physician, psychiatrist, nurse practitioner, physician's assistant, optometrist, or dentist).
3. Regularly scheduled and used. Regularly scheduled medications are typically taken daily, 4 times a day, or every 8 hours.

*Excluded* as a regularly scheduled and used medication is an "as-needed" (PRN) medication. A PRN medication is taken only when needed based on symptoms.

- a. Exception: Sliding scale insulin (where the exact dosage is adjusted according to the blood sugar level) can be treated as a regularly scheduled medication, because it is regularly given, with the dose merely adjusted to blood sugars.
- b. Exception: If a medication is ordered as needed (PRN), but it is taken regularly and frequently, then it can be treated the same as a regularly scheduled medication on the LTC FS. An example of this is pain medicine ordered PRN but taken every 4 to 6 hours, every day.

**Note:** Over-the-counter medications are included if they meet all of the above conditions 1 through 3.

**Note:** On the LTC FS, a vitamin is a medication only if it is **injected** (e.g., vitamin B-12 injection).

**A medication on the LTC FS DOES NOT include the following:**

1. Vitamin (unless injected), mineral, supplement, and alternative or complementary medicines, even if prescribed by a Medicaid-recognized prescriber (physician, psychiatrist, nurse practitioner, physician's assistant, optometrist, or dentist).
2. Non-vitamin, non-mineral natural substances such as Omega 3 or fish oil, glucosamine, ginkgo, anti-oxidants, ginseng, Echinacea, chondroitin, Coenzyme Q-10, flaxseed, cranberry, garlic, soy, melatonin, green tea, saw palmetto, grape seed, milk thistle, lutein, barkwater, shark cartilage, etc., even if prescribed by a Medicaid-recognized prescriber (physician, psychiatrist, nurse practitioner, physician's assistant, optometrist, or dentist).
3. Other complementary or alternative medicines such as a homeopathic, naturopathic, or herbal therapy; or other treatment such as aromatherapy, flower remedies, crystal or magnet therapy, chelation, bowel cleansing, detoxifier, acupuncture, acupressure, etc.
4. Other dietary supplements with calories, minerals, vitamins, and/or other additives.

**I.) MEDICATION MANAGEMENT**

For purposes of the LTC FS, this task focuses on the individual's need for assistance in order to take medication as prescribed and to identify and report problems to the prescriber. It does not include medication reviews done outside the individual's home at their prescriber's office, clinic, pharmacy, or health care facility.

**Medication Management has two components: Medication Set-Up and Medication Monitoring.**

**A. Medication set-up:** To set-up a medication is to separate out the proper dosage and **set it aside** in an assigned place **for later use**. This is also called "pre-selection." Set-up is done for two reasons:

1. To ensure the **proper medication at the proper dosage** is selected when the individual is unable to select it due to their cognitive or physical limitations.
2. To **arrange** the medications to **help the person remember** to take them at proper times, and to make it easier for them to visually see what medications were or were not taken. An example of this is putting numerous pills into a medication box containing slots for morning, noon, dinner, and bed time pills, for each day of the week.

**Medication Boxes**

A medication box is commonly used for convenience in organizing and remembering one's medications, even by people with no cognitive or physical impairments. When a person uses a medication box, the screener needs to determine whether due to a cognitive or physical impairment the person **needs** to use the medication box, and/or needs the assistance of another person to fill it.

REMINDER: The filling of a medication box should typically be indicated at the “1 to 3 times/month” frequency, since two or more medication boxes can be pre-filled at one time. If this usual method does not work well for an individual, more frequent medication set-up may be necessary.

REMINDER: Pre-filling insulin syringes can typically be done 2 to 3 times per month, since pre-filled syringes can be stored in the refrigerator for at least 10 days. This task should be indicated at the “1 to 3 times/month” frequency.

## **B. Medication Monitoring**

Medication monitoring includes two components:

1. The ability to report a problem related to medication use, should it arise, and
2. The ability to collect medication-related data as ordered by the prescriber, such as vital signs, weights, blood sugar level, response to pain medications, etc. Data collection also includes in-home assistance to draw blood for a lab test.

### **Frequency of Medication Monitoring**

The frequency of medication monitoring is usually far lower than the frequency that the medication is taken. Most data collection for medication monitoring is done less often than daily. One exception to this is blood sugar checks, which are commonly done 3 or 4 times a day.

If the person’s condition is unstable and medication is frequently adjusted, then the need for medication monitoring may be several times per week or even daily. It is expected the condition and treatment will stabilize over several weeks, and the frequency of medication monitoring will drop. A Rescreen should be done when the person’s condition stabilizes to reflect this and other changes.

## **II.) MEDICATION ADMINISTRATION**

Definition: For the purposes of the LTC FS, Medication Administration is the physical and cognitive ability to get a medication into or onto the body as prescribed.

The task of Medication Administration includes:

1. The self-administration of medication
2. The need for assistance from another person with medication. A person can assist someone with the taking of their medication in two ways:
  - a. With a verbal prompt or reminder to take medication (in person or by telephone). The verbal cue is a reminder for the person to take their medication at a certain time.

Note: Asking the question, “Did you take your pills?” only counts as a verbal reminder when it is asked timely enough for the person to take the missed dose. Asking this question hours after a dose was due, or asking it once a week, does not count as help with taking medication.

- b. Hands-on assistance to take medications.

REMINDER: A person’s use of an automated pill dispenser (e.g., Compu-med) is not included as a need for Medication Administration.

REMINDER: Leaving a written reminder for a person is not included as a need for Medication Administration.

### III.) MEDICATION MANAGEMENT and ADMINISTRATION RATING SYSTEM

- NA: Has no medications.
- 0: Independent (with or without assistive devices).
- 1: Needs help 1 to 2 days a week or less often. Includes having someone set-up medications, pre-fill syringes, or the administration of medication.
- 2a: Needs help at least once a day 3-7 days per week --CAN direct the task and can make decisions regarding each medication.
- 2b: Needs help at least once a day 3-7 days per week --CANNOT direct the task; is cognitively unable to follow through without another person to administer each medication.

#### **N/A: Has no medications**

##### **Check this for a person who:**

- Takes no medications.
- Only takes PRN (as needed) medication on an irregular basis.

#### **0: Independent**

##### **Check this for a person who:**

- Receives assistance with their medication but does not require that assistance due to a physical or cognitive impairment.
- Takes medication as directed and has medication monitoring done outside their home at their physician's office, clinic, pharmacy, or health care facility.
- Requires medication management and/or administration assistance less often than monthly.
- Takes medication as directed and is able to contact the prescriber with concerns and follow their recommendations.
- Independently sets-up and uses his/her medication box.
- Independently uses a medication box primarily as a convenience.
- Is cognitively intact and chooses not to take prescribed medication.
- Is limited solely by a language barrier or illiteracy, not a cognitive or physical impairment.
- Is independent using adaptations such as large-print or Braille labels, "talking" glucometer, easy-open pill bottles, etc.
- May have an unorthodox system of organizing medications, but has no history of medication misuse or errors.
- Has blood drawn at their physician's office, clinic, health care facility, or laboratory, and follows through with any changes as instructed by the prescriber.
- Takes medication as instructed and is able to independently check their blood sugar level, blood pressure, weights, pulse, etc.
- Has a cognitive impairment but has learned to take medication as directed, and only needs Medication Management assistance less than monthly.
- Only needs help getting refills from the pharmacy. (Note: Automatic medication refills may be arranged with the pharmacy. Note: The need for assistance with getting the medication from the pharmacy to the person is captured in Module 4.16 Laundry and/or Chores.)
- On a regular basis receives routine monitoring for general health, behavior, etc. by agency/facility staff because that monitoring is provided to all residents.

## 1: Needs help 1 to 2 days per week or less often

REMINDER: The minimum frequency of needed assistance is once a month. A frequency less than once a month should not be indicated on the LTC FS, but could be recorded in the Notes section.

### Check this for a person who:

- Due to a physical or cognitive impairment, needs someone to fill their medication box(es) or to dispense or to pre-fill insulin syringes.
- Needs someone to monitor them for specific medication effects and side-effects and report to the prescriber as needed because of a cognitive impairment.
- Is medically unstable and frequent medication and health status monitoring is warranted.

### Do NOT check this for a person who:

- Is able to fill their own medication box(es) or could take medications without using a medication box.
- Takes their medication and does not need frequent monitoring for medication effects or side effects.
- Has blood drawn at their physician's office, clinic, health care facility, or laboratory, and follows through with any changes as instructed by the prescriber.
- Is able to monitor and report effects and side effects themselves.

## 2a: Needs help at least once a day 3-7 days per week—CAN DIRECT the task

### CHECK this for a person who:

- Needs **physical help** taking medication but is able to instruct helpers. An example of this is a person with quadriplegia who instructs their helper, "Please put 1 of those 3 pills on my tongue and give me a drink."

### Do NOT check this for a person who:

- Needs help taking medication and is cognitively unable to instruct their helpers.
- Is unable to communicate in order to direct their helpers.
- Is non-English speaking and is unable to communicate with their helper(s) in order to direct the helper(s).
- Is able to take medication with less frequent assistance. An example of this is a person able to independently take their medication once another person assists them in setting up their medication box(es). In this case, select 1: (Needs help 1 to 2 days a week or less often.)

### Considering 'can direct the task' versus 'cannot direct the task'

As listed on the LTC FS, the distinction between 'can direct the task' and 'cannot direct the task' applies only if the person needs help at the higher frequency of 'at least once a day 3-7 days per week.' If the person needs help less often than 3-7 days per week, the screener does not need to make a determination about the person's ability to direct the task of taking or withholding of their medications.

## 2b: Needs help at least once a day 3-7 days per week--CANNOT direct the task

### Check this for a person who:

- Needs help taking medication and is unable to instruct their helpers because of a physical or cognitive impairment.

**Do NOT check this for a person who:**

- Needs help taking medication due to a physical limitation, but is able to direct helpers in selecting and taking the medication appropriately.
- Has a cognitive impairment but takes medication as directed, without misuse or error, once the medication is set-up.
- Is blind or vision impaired, without assessing how they manage and administer their medications with reasonable accommodations (e.g., Use of Braille on a pill bottle to indicate what the medication is.)

## 4.15 Money Management

Definition: The physical and cognitive ability to handle money, pay bills, and complete financial transactions needed for basic necessities (food, shelter, and clothing). These financial transactions include any of the following types of money transactions: cash, credit card, debit card, personal check, money order, automatic withdrawal, automatic deposit, or the exchange of currency.

REMINDER: A person is independent with the task of Money Management if they do not have a physical disability or cognitive impairment preventing them from learning the task. Do not indicate a need for assistance when the limitation is due to a language barrier, illiteracy, or a gender, age, or cultural norm.

REMINDER: A person without a cognitive impairment is independent with the tasks of Money Management if they manage their money consistent with their lifestyle, values, and goals, while those financial choices may not necessarily be in agreement with professionals' values or goals.

REMINDER: The selection of the frequency of needed assistance with the task of Money Management should be determined by the person's ability to manage their finances, not the frequency with which their finances are managed. For example, a person with a diagnosis of dementia and a guardian of their person lives in an Adult Family Home (AFH) and once a month, their guardian writes the needed checks for their AFH room/board, and pharmacy bill, and balances their checkbook. Although only monthly assistance is provided to manage their finances, the person's need for assistance is actually with every transaction. The screener should select option 2: [Needs help from another person daily or more often (e.g., with every transaction)].

REMINDER: Selecting 1: (Needs help from another person weekly or less often) is indicated when the person can independently handle minor money transactions and smaller amount of currency. Selecting 2: [Needs help from another person daily or more often (e.g., with every transaction)] is indicated when the person requires assistance anytime they handle money or with all of their financial matters.

### MONEY MANAGEMENT RATING SYSTEM

- 0: Independent
- 1: Needs help from another person weekly or less
- 2: Needs help from another person daily or more often

**Check this for a person who:**

- Has a physical or cognitive limitation impairing their ability to complete the task of Money Management independently.
- Lacks or has limited fine motor dexterity.
- Has a cognitive impairment (brain injury, developmental disability, severe and persistent mental illness, or Alzheimer's disease/dementia) limiting their ability to manage their money.
- Needs assistance with the money transaction to pay for purchases with cash, credit card, debit card gift card, personal check, money order, or by store charge account.
- Needs assistance recognizing money denominations.

- Needs assistance to write a personal check or balance a checkbook, due to a physical or cognitive impairment.

**Do NOT check this for a person who:**

- Does not have a physical or cognitive impairment limiting their ability to complete the task of Money Management independently.
- Has inadequate income to meet their basic needs.
- Needs assistance related to a lack of experience with managing money due to their gender, age, or a cultural norm.
- Is blind or vision impaired, without assessing how they manage their money with reasonable accommodations (e.g., Use of a debit card instead of writing a check.)
- Hasn't had experience managing money and their ability to complete this task has yet to be tested. Examples of a person with the cognitive ability to manage their money, but not the experience of doing so could include but is not limited to a person: with a severe and persistent mental illness, a developmental disability, young adult, recent immigrant, or even a recent widow/widower, whose partner handled all of the couple's finances.
- Has a representative payee or money manager due to a history of poor money management related to personal choices or issues with alcoholism, a drug addiction, or a gambling addiction.
- Has a representative payee, durable power-of-attorney, power-of-attorney, authorized representative, activated power-of-attorney for health care decisions, designated power-of-attorney for health care decisions, conservatorship, or a guardian of the person and/or estate without reviewing their ability to handle at least some money transactions.
- Does not speak, read, or write English.
- Is illiterate.
- Needs transportation to the bank. (This need is captured in Module 4.18 Transportation.)
- Has a diagnosis of a cognitive impairment (e.g., brain injury, developmental disability, severe and persistent mental illness, or Alzheimer's disease/dementia) without reviewing their ability to manage their money.
- Needs assistance budgeting their income. How a person plans or doesn't plan to spend their money is not a Money Management task included in the LTC FS.
- Uses a charge account at a store (e.g., grocery store) without reviewing their ability to manage their money. The charge account may be set up as a convenience for the person paying the account's tab.

## 4.16 Laundry and/or Chores

Definition: The physical and cognitive ability to complete one's personal laundry, routine housekeeping, and basic home maintenance tasks, including the tasks of snow shoveling and lawn mowing.

Assistance with some Laundry and/or Chores tasks is not typically provided on a daily basis. On the rating system, a **1** would be selected for the frequency of assistance needed with the following Laundry and/or Chores tasks:

- Laundry (unless the person is incontinent and in need of more frequent laundry assistance)
- Snow shoveling
- Lawn mowing
- Vacuuming (unless the person has a documented medical reason and need for more frequent vacuuming)
- Floor washing (unless the person has incontinence or other documented medical reason and is in need of more frequent floor washing)

REMINDER: Screeners need to acknowledge the person's lifestyle choices, values, and goals related to their level of laundry and/or household cleanliness may not necessarily be in agreement with the professionals'.

REMINDER: The frequency of needed assistance with the tasks of Laundry and/or Chores is to be based on need, not the availability of staff to assist the person.

#### LAUNDRY AND/OR CHORES RATING SYSTEM

- 0: Independent
- 1: Needs help from another person weekly or less often
- 2: Needs help more than once a week

#### Check this for a person who:

- Has a physical or cognitive limitation impairing their ability to complete their laundry and/or household chores.
- Is able to independently complete the tasks involved in completing their laundry and/or household chores but doing so causes a significant, negative health outcome. During the tasks involved in completing their laundry and/or household chores, a significant, negative health outcome is indicated when a person experiences any of the following results: shortness of breath, dizziness, chest pains, exhaustion, incontinence, or increased pain, **to the point that another person should be present to help with some or all of the task.**
- Hoards personal items or food and this behavior creates a potential health or safety issue.
- Needs assistance cleaning up after a meal.
- Needs assistance cleaning the inside of their refrigerator.
- Needs assistance to re-order medications.

#### Do NOT check this for a person who:

- Does not have a physical or cognitive limitation impairing their ability to complete their laundry and/or household chores.
- Is able to independently complete the tasks involved in completing their laundry and/or household chores but it takes additional time to do so WITHOUT causing significant hardship or negative outcomes.
- Needs assistance with window washing, gardening, weatherization, grooming the yard (including weeding, pruning hedges, raking leaves, and aerating or fertilizing the grass).
- Needs housecleaning assistance more than weekly due to having a pet(s) in their home and has related allergies.
- Needs assistance with home repairs that are beyond basic cleaning but enhance the dwelling's appearance (e.g., painting).
- Resides in a residential facility or institution and the provision of Laundry and/or Chore services is provided as part of the facility package, without reviewing their need for assistance with these tasks.
- Needs assistance completing other household members' laundry (e.g., spouse's or children's laundry) or the cleaning of living spaces not used by the individual (e.g., teenager's bedroom or bathroom).
- Needs assistance with heavy-duty cleaning done infrequently, such as carpet, drapery, and window cleaning or wall washing.
- Needs assistance related to a lack of experience completing their laundry and/or household chores due their age, gender, or cultural norm and does not complete these tasks.

## 4.17 Telephone

Definition: The physical and cognitive ability of a person to use their personal telephone to make and receive a routine telephone call with or without assistive devices. What constitutes a routine telephone call is very person-specific. They are the familiar and frequent telephone calls a person makes and receives.

The ability to use the telephone **does not include** the assistance a person may need to make or receive a non-routine telephone call. The need for assistance with non-routine telephone calls is captured in the Cognition for Daily Decision Making task in the Communication and Cognition Section of the LTC FS.

Examples of non-routine telephone calls can include but are not limited to a person's need for assistance making an appointment with the Income Maintenance Unit for an annual financial review; making an appointment with a health care specialist every three months, or responding to their doctor's office sporadic calls to change an appointment time.

### TELEPHONE RATING SYSTEM

- 1a: Independent. Has cognitive and physical abilities to make calls and answer calls
- 1b: Lacks cognitive or physical abilities to use phone independently

-and-

- 2a: Currently has working telephone or access to one
- 2b: Has no phone and no access to phone

#### **1a: Independent. Has cognitive and physical abilities to make calls and answer calls.**

##### **Check this for a person who:**

- Needs assistance with a telephone other than their personal telephone, but can independently use their personal telephone.
- Independently uses a telephone with preprogrammed numbers or list of frequently called numbers.
- Independently uses a telephone with an assistive device or with assistance from a telecommunications relay service.
- Does not have a landline, but does use a cell phone.
- Does not speak or understand spoken English.
- Does not use a telephone due to their age, gender, or cultural norm.
- Needs assistance with non-routine telephone calls.

#### **1b: Lacks cognitive or physical abilities to use phone independently.**

##### **Check this for a person who:**

- Would be independent with this task if they used an assistive device, but they don't currently have it. A person's untried potential for using an assistive device should not be considered when assessing the person's current need for assistance.
- Will answer a ringing telephone but is not able to place a call.
- Is hard of hearing, deaf, or has a speech impairment, and does not have a teletypewriter (TTY) or other adaptive device to use with their telephone.
- Is unable to make themselves understood due to significant communication impairment (e.g., aphasia).

## 4.18 Transportation

Definition: The physical and cognitive ability to **drive** a regular or adapted vehicle.

A **regular vehicle** is one the person rides in or operates without any needed adaptations in order to drive the vehicle.

A regular vehicle may be equipped with modifications that allow the person to enter/exit the vehicle, be a passenger in the vehicle, or allow their mobility device to be transported with them. While these modifications may be needed in order for the person to ride in the vehicle to meet their transportation needs, they are not needed for the person to operate the vehicle.

Examples of such modifications made to a regular vehicle include, but are not limited to, a car top carrier for a wheelchair, trunk lift for carrying an unoccupied wheelchair or scooter, grab bar, automatic door opener, or a van lift used by a person to enter/exit the van when sitting in their wheelchair or scooter.

An **adapted vehicle** is one the person operates with adaptations made to the vehicle that are needed in order for the person to DRIVE the vehicle.

These adaptations help the driver control the vehicle's speed and direction. Examples of such vehicle adaptations include, but are not limited to, hand controls, pedal extensions, switch pad controls, or an extended gearshift handle.

### Serious Safety Concerns

The determination of whether the person is driving with or without serious safety concerns should be based on their physical and cognitive ability to drive a vehicle. The screener will need to use their professional judgment when reviewing how a person's limitations may be affecting their ability to safely drive a vehicle.

There may be *serious safety concerns* about a person who drives with a diagnosis of dementia or low vision or they drive under the influence of alcohol or a controlled substance.

*Serious safety concerns* should not be marked for a person who has made a reasonable accommodation to limit their driving to only daylight hours, non-rush hours (typically weekdays, 9:00 a.m. to 3:00 p.m.), or to locations they are familiar with, or short distances from their home.

### TRANSPORTATION RATING SYSTEM

- 1a: Person drives regular vehicle
- 1b: Person drives adapted vehicle
- 1c: Person drives regular vehicle, but there are serious safety concerns
- 1d Person drives adapted vehicle, but there are serious safety concerns
- 2: Person cannot drive due to physical, psychiatric, or cognitive impairment
- 3: Person does not drive due to other reasons

REMINDER: Do not select 1b: (Person drives adapted vehicle), when the person could drive an adapted vehicle but does not currently have the needed assistive devices in their vehicle.

REMINDER: Do not select 2: (Person cannot drive due to physical, psychiatric, or cognitive impairment), when a person does not drive due solely to their age, gender, or a cultural norm.

REMINDER: The following are examples of when it would be correct to select option 3: (Person does not drive due to other reasons):

- Person never learned to drive.
- Person lacks a valid driver license due to a reason other than a physical or cognitive impairment.
- Person does not own a vehicle or have access to one.
- Person cannot afford to maintain a vehicle.

- Person cannot afford vehicle insurance coverage.
- Person only utilizes mass transit or taxi service.
- Person could drive, but is only driven by family members or friends.

## 4.19 Overnight Care or Overnight Supervision

The need for Overnight Care or Overnight Supervision is not an ADL or an IADL task but is included in this Module. To select a need for Overnight Care or Overnight Supervision, the individual must have a **physical or cognitive limitation** impairing their ability to independently complete overnight care tasks **or** have a limitation requiring overnight care or overnight supervision.

Overnight Care is defined as the need for hands-on assistance or verbal cueing from another person, to complete an ADL or Health Related Services task, during the overnight hours.

Overnight Supervision is defined as the need for someone to be present to prevent, oversee, manage, direct, or respond to a person's disruptive, risky, or harmful behaviors, during the overnight hours. Overnight Supervision is indicated for a person unable to respond appropriately in an emergency (e.g., a vulnerable adult).

Overnight Supervision is not indicated for a person without a physical or cognitive limitation who is uneasy being alone at night.

All people currently residing in ICF-MRs, nursing homes, or residential care facilities DO NOT necessarily require Overnight Care or Overnight Supervision. You should ask yourself, "Would this person require overnight care or overnight supervision were they not residing in an institutional or residential care facility?" Ask the facility's staff whether the person being screened has ever demonstrated a need for assistance during the night shift. Does the person need to use the call button for staff at night? Or rather, does the person independently get to and from the bathroom at night?

REMINDER: Although licensed facilities have policies that require staff to monitor the residents at night, overnight care or overnight supervision is not necessarily needed by each resident.

### OVERNIGHT CARE or OVERNIGHT SUPERVISION RATING SYSTEM

- 0: No
- 1: Yes; caregiver can get at least 6 hours of uninterrupted sleep per night.
- 2: Yes; caregiver cannot get at least 6 hours of uninterrupted sleep per night.

#### Check this for a person who:

- Needs help overnight from another person due to a physical or cognitive limitation jeopardizing their health and safety during that time.
- Competently **chooses to be alone** overnight, although they have a physical limitation typically requiring overnight care or overnight supervision (e.g. a need for assistance with transfers). Although the person is competently refusing the care or supervision, the need for the assistance still exists.
- Has limited cognitive abilities and needs Overnight Supervision, although they do not need Overnight Care.
- Has disruptive or risky nighttime behavior that requires intervention.
- Has an uncontrolled seizure disorder, evidenced by one or more seizures in the last six months.
- Lives independently without assistance during the daytime, but requires intervention or supervision during the nighttime due to an unstable mental health condition (e.g., Post Traumatic Stress Disorder).
- Can safely get through a day without needing a cue or reminder, is able to make safe routine decisions, but **does not have the cognitive capacity to know** when to call for help and requires assistance in an emergency such as a flood, fire, or tornado.

- Has a monitoring system with an onsite or offsite response person and in the last six months the system's intervention was initiated in response to a need, at least once (e.g., WanderGuard or Sound Response System).
- Has a need for a room-to-room monitor, bed alarm, or door alarm system with an onsite or offsite response person.
- Has a Personal Emergency Response System (PERS) and during the nighttime hours uses it to summon assistance with a physical care need.

**Do NOT check this for a person who:**

- Does not have a physical or cognitive limitation jeopardizing their health and safety overnight.
- Desires overnight care or overnight supervision based solely on an age, gender, or cultural norm.
- Receives overnight care or overnight supervision but does not have an identified physical or cognitive limitation requiring that care or supervision. For example, a family member is uncomfortable with the person being alone at night, the person's roommate requires overnight care or overnight supervision, or the person is up during the nighttime hours without a need for care or supervision.
- Has a Personal Emergency Response System (PERS) and only uses it as a means of accessing assistance in the event of an emergency. The presence of a PERS alone **does not** by itself indicate a need for Overnight Care or Overnight Supervision.
- Has a controlled seizure disorder, evidenced by no seizures in the last six months.
- Has a cognitive impairment without a physical limitation and can safely get through a day without needing a cue or reminder. Additionally, the person is able to make safe routine decisions and **has the cognitive capacity to know** when to call for help, and only requires assistance in an emergency such as a flood, fire, or tornado.
- Has a cognitive impairment and a safety plan they can articulate, which indicates they know how to respond appropriately in the event of an emergency.
- Has a specific diagnosis. A need for Overnight Care or Overnight Supervision is not based solely on the person's diagnosis.
- Lives in a residential care setting, ICF-MR, or nursing home where overnight care or overnight supervision are provided based on facility policy and the person does not have an assessed need for those services.
- Lives in a residential care setting with 'sleep staff,' which refers to staff able to get at least 6 hours of uninterrupted sleep per night although this person does not need Overnight Care or Overnight Supervision.
- Lives in a residential care setting with 'awake staff,' which refers to staff unable to get at least 6 hours of uninterrupted sleep per night, although this person does not need Overnight Care or Overnight Supervision.
- Has a monitoring system with an onsite or offsite response person and in the last six months the system's intervention was NOT initiated.
- Needs monitoring overnight related to their use of the Internet.

## 4.20 Employment

This section concerns the need for assistance to perform employment-specific activities (job duties). Since a person's need for help with ADLs and other IADLs (e.g., transportation, personal care) is captured in other sections, this section essentially concerns supports necessary for **successful performance of work tasks**.

The screener should clearly inform the person they are screening that responses to the employment questions will not detract from their eligibility for Social Security, Medicaid, long-term care, or other benefits.

### EMPLOYMENT RATING SYSTEM

**A. Current Employment:**

- 1 Retired (Does not include people under 65 who stopped working for health or disability reasons)
- 2 Not working (No paid work)
- 3 Working full time (Paid work averaging 30 or more hours per week)
- 4 Working part-time (Paid work averaging fewer than 30 hours per week)

**B. If Employed, Where:**

- 1 Paid work where the environment and the work tasks are designed for people with disabilities (e.g., sheltered workshop)
- 2 Paid work in other group situation for people with disabilities (e.g., work crew/enclave)
- 3 Paid work outside the home (situations other than those described in B1 and B2)
- 4 Paid work at home

**C. Need for Assistance to Work (Mandatory for ages 18-64; otherwise optional):**

- 0 Independent (with assistive devices if uses them)
- 1 Needs help weekly or less (e.g., if a problem arises)
- 2 Needs help every day but does not need the continuous presence of another person
- 3 Needs the continuous presence of another person
- 4 Not applicable (please explain)

**A. Current Employment Status**

Choose one option that best describes the individual's status:

**1: Retired (Does not include people under 65 who stopped working for health or disability reasons)**

**Check this for a person who:**

- Is age 65 or older and is not in the workforce (whether receiving retirement benefits or not).
- Is under age 65, receiving retirement benefits, and did not stop working because of a health problem or a disability.

**Do NOT check this for a person who:**

- Stopped working before age 65 due to a health problem or a disability, even if the person describes it as an "early retirement." Instead, check 2: Not working (No paid work).
- Is involved in unpaid pre-vocational activities only. Instead, check 2: Not working (No paid work).

**2: Not working (No paid work)**

**Check this for a person who:**

- Is under age 65 and is not working for pay for any reason (unless retired).
- Is under age 65 and stopped working due to a health problem or a disability.
- Is involved in unpaid pre-vocational activities.
- Is involved in volunteer activities (including volunteer and in-kind work to meet Medicaid Purchase Plan (MAPP) eligibility requirements).

**Do NOT check this for a person who:**

- Is over age 65 and is not working for pay. Instead, check 1: Retired (Does not include people under 65 who stopped working for health or disability reasons).

### 3: Working full time (Paid work averaging 30 or more hours per week)

#### Check this for a person who:

- Is earning income for working, on average 30 hours per week or more.
- Is earning income at facility-based employment on average 30 hours per week or more. This includes pre-vocational activities if paid, on average 30 hours per week or more.
- Is earning income through supported employment or work crew/enclave if paid on average 30 hours per week or more.

#### Do NOT check this for a person who:

- On average, is paid for fewer than 30 hours per week. Instead, check 4: Working part-time (paid work averaging fewer than 30 hours per week).
- Attends a facility-based pre-vocational program (e.g., sheltered workshop) but is not participating in paid work for 30 hours per week or more.

### 4: Working part-time (Paid work averaging fewer than 30 hours per week)

#### Check this for a person who:

- Is earning income for working, on average, fewer than 30 hours per week.
- Is earning income at facility-based employment, on average, fewer than 30 hours per week. This includes pre-vocational work if **paid**, on average, fewer than 30 hours per week.
- Is working facility-based employment and is **paid** by piece-rate not hourly, on average, is paid fewer than 30 hours per week.
- Is earning income through supported employment or work crew/enclave paid hours and is **paid**, on average, fewer than 30 hours per week.

#### Do NOT check this for a person who:

- Is not working for pay.
- On average, is paid for 30 or more hours per week of work. Instead, check 3: Working full time (Paid work averaged 30 or more hours per week).

Note: In sheltered workshops, wages are often paid by piece-rate rather than hourly. The screener only needs to determine if the **time** involved working **for pay** is fewer than 30 hours per week. This is most common. Typical full time program attendance is 30 hours per week; not all hours are typically paid, so paid hours are usually fewer than 30 hours per week.

### B. If Employed, Where

Skip this section if in Section A, 1: Retired or 2: Not Working was selected.

Check all that apply, as some individuals work in more than one type of employment location.

#### 1: Paid work where the environment and the work tasks are designed for people with disabilities (e.g., sheltered workshop)

**This item includes paid work in a sheltered workshop, also known as a community rehabilitation program (CRP), work center, or facility-based employment.** These entities are distinguishable from mainstream employers by the fact that the primary mission of the corporation/entity is to provide services to individuals with disabilities and they typically employ a large number of individuals with disabilities in one or more departments or divisions. These entities are typically licensed to pay sub-minimum wages to a group of workers with disabilities. Most provide other rehabilitation and long-term support services besides employment, including day services, therapies, and transportation.

## **2: Paid work in other group situation for people with disabilities (e.g., work crew/enclave)**

Work crews and enclaves are group employment arrangements where two or more individuals with disabilities work in a team to perform work that is typically sub-contract work in a community setting. The employer of record is typically the support provider agency (e.g., sheltered workshop/community rehabilitation facility/work center). Because people with disabilities are grouped together, this is considered segregated employment, not community-integrated employment, even if the work crew or enclave does its work in a community setting.

## **3: Paid work outside the home (situations other than those described in B1 and B2)**

This is work an individual does that is not done in a sheltered workshop or in the individual's home, and which is not done as part of participation in a work crew or enclave. In other words, a paid job in the community is any work done for pay that does not fall into one of the other three categories. This includes supported employment, as well as working independently.

## **4: Paid work at home**

This is work an individual does in his/her place of residence, or in an office/work area attached to, or on the grounds of, his/her place of residence.

## **C. Need for Assistance to Work**

This item is optional for people age 65 or older or under age 18.

This item is mandatory for people aged 18-64, even if the person is not currently working.

Choose one option that best describes the individual's current or anticipated need.

- 0: Independent (with assistive devices if uses them)
- 1: Needs help weekly or less (e.g., if a problem arises)
- 2: Needs help every day but does not need the continuous presence of another person
- 3: Needs the continuous presence of another person
- 4: Not applicable (Please explain)

## **Predicting the need for assistance to work for those not currently working**

If the person is not currently working, the screener will need to estimate the level of help the person would likely need to work. This can be deduced from the person's overall functioning and abilities. The screener should consider other information such as the frequency of help needed at home; cognition for daily decision making; IADLs; ADLs and other physical activities, behavioral supports, and skilled nursing needs. The presence of a particular type of disability or health disorder (e.g., cognitive disability; seizures) or guardianship does not automatically mean an individual will need the continuous presence of another person in order to work.

To decide which of the five answer choices best represents the level of help needed to work, the screener should follow these steps:

1. If the person worked before and their work abilities are unchanged, indicate the level of job help needed in the past.
2. Deduce from the level of supports indicated elsewhere in the LTC FS:
  - Cognition for Daily Decision Making
  - Communication impairments
  - Behavioral interventions
  - Assistance with ADLs and IADLs
  - Health care tasks (blood sugar checks, catheters, repositioning, etc.).

3. Consider other factors not captured elsewhere on the LTC FS that create the need for employment supports. Examples include learning disorders, mental health or behavioral challenges, language barrier, or the need for job training or supervision not related to long term care needs.

**4: Not applicable**

- Should only be selected if the person is severely ill or in a semi-comatose state. Severe disabilities in themselves do not render a person unable to work. For a person with marked cognitive and/or physical disabilities, the screener should consider whether selection of 1, 2, or 3 is the most accurate choice.
- Should **not** be selected simply because the person is not interested in seeking employment. Even if the person is not expected to seek employment in the near future, the screener should estimate the level of assistance that would be needed if the person did begin work.
- Explain in the notes section why it is unreasonable to consider employment for this working-age person, even with continuous assistance from another person.

# Module #5: Diagnosis

## Objectives

*By the end of this module you should be able to:*

- Accurately complete the diagnosis section of the LTC FS.
- Explain how to confirm a diagnosis.

## 5.1 Diagnoses Must be Confirmed

Medical information is often not readily available when a screen is being done in a community setting. **To accurately complete the Diagnoses section of the LTC FS, a screener must confirm the person's diagnoses.**

**Medical information is confirmed if it is:**

1. Stated to screener by an MD, RN, or other health care professional, or
2. Copied from current health care records, or very clearly stated, in exact medical terms, by the person, family, guardian, advocate, etc. It is best practice to confirm diagnoses with written documentation from the person's health care provider(s).

**The exceptions to these criteria are:**

- **psychiatric diagnoses,**
- **behavioral diagnoses,**
- **dementia diagnoses, and**
- **the diagnosis of mental retardation.**

People commonly say someone has "Alzheimer's," "anxiety," "depression," or "attention deficit/hyperactivity disorder," without a confirmed diagnosis. At times, a family member reports the person being screened has a diagnosis of mental retardation or a psychiatric, behavioral, or dementia diagnosis when there is limited or no documentation to substantiate that diagnosis, and, the person's current functioning does not seem to match the usual functional limitations associated with that diagnosis.

While such statements may be helpful in the assessment process, they are **insufficient** evidence to support marking these diagnoses on the screen. **A screener must confirm a psychiatric, behavioral, dementia, or mental retardation diagnosis directly with a health care provider, medical record, the Children's Long Term Support Functional Screen, or the disability determination diagnosis from the Social Security Administration.**

**If a diagnosis can not be confirmed:**

If after review of medical records and contact with health care providers it is determined the person has no current diagnosis, the screener must choose the "No current diagnoses" box. In addition, the screener should provide some detail regarding the absence of any diagnosis in the Notes section of the LTC FS. (Example: "After talking with Mr. Smith's doctor, it was determined that Mr. Smith has no diagnosis.")

If an individual refuses to see a health care professional and does not have any medical records to confirm a diagnosis, enter this information in the Notes section of the LTC FS. (Example: "Mr. Smith has not been to the doctor in over 30 years and refuses to be seen by a health care provider today.")

## 5.2 Diagnoses Table Does Not Impact Eligibility

**Completion of the LTC FS Diagnoses Table does not impact the eligibility determination; it is for research purposes only.** However, the accurate documentation of diagnoses is very important to population profiles and to show that Family Care participants in community settings are similar to populations in long-term care facilities.

## 5.3 Completing the Diagnoses Table

**The Diagnoses Table is not meant to be all-inclusive; only some of the more common diagnoses are here.** This table does include almost all of the diagnoses on the Minimum Data Set (MDS) form that nursing home staff must complete. It is permissible to refer to the MDS or any other health care providers' documentation to complete the table, but a screener must confirm that information is still current. "Current" is defined as no more than 12 months old and still applicable. A screener needs to check with the person's health care provider(s) to confirm the medical information is still applicable.

**On the Diagnoses Table, check ALL that apply.**

For convenience, the diagnoses are grouped by major categories (e.g., Pulmonary, Cardiovascular, Neurological, etc.).

Use the "Diagnoses Cue Sheet" provided by the Department in order to determine which box to check for a given diagnosis not listed on this table.

For any diagnosis not listed on the Diagnoses Table, first see if it is listed on the Diagnoses Cue Sheet. If it is, check the box indicated on the cue sheet.

REMINDER: If the diagnosis is not on the cue sheet, then a screener must check the K5: Other box and enter the name of the diagnosis in the space provided. A screener may not assign a Diagnosis Table category for a diagnosis not listed on the Diagnoses Cue Sheet.

Ongoing screen quality reviews indicate screeners are over-using the K5: Other box and are writing in diagnoses that are in fact already on the Diagnoses Cue Sheet. The number of synonyms and misspellings indicate screeners may not always be contacting health care professionals to confirm the diagnoses.

REMINDER: The selection of I3: Deaf is correct when the person's hearing loss **cannot be overcome with hearing aids**. And, the selection of I4: Other Sensory Disorders is correct when a person has a partial hearing deficit or when a person's hearing loss is able to be overcome with hearing aids.

REMINDER: The selection of I1: Blind is correct when the person's vision loss **cannot be corrected to 20/200 or their visual field with both eyes is less than 20 degrees**. And, the selection of I2: Visual Impairment is correct when a person's vision loss can be corrected to 20/200 or their visual field with both eyes is more than 20 degrees.

REMINDER: Do not interpret an individual's complaints or symptoms and enter unconfirmed diagnoses. In addition, do not infer an individual's diagnoses based on their prescribed medications. The same medication can be prescribed for a number of diagnoses or conditions.

- Example A: An 82 year old woman has diabetes mellitus and is complaining of increasingly poor vision. The screener does NOT check I2: Visual Impairment (e.g., cataracts, retinopathy, glaucoma, macular degeneration) based solely on her self-report.
- Example B: An adult daughter says her elderly father is "really losing it," and "He's getting Alzheimer's." The screener asks her if a doctor has made this diagnosis. She says, "No, father hasn't been to a doctor for awhile, but it's gotta be, he forgets so much now." The screener does NOT check E1: Alzheimer's Disease or E2: Other Irreversible Dementia. The screener will need

to obtain a release of information in order to contact his doctor for the confirmation of his current diagnoses.

**If an individual has no diagnoses, choose the “No current diagnoses” box.**

*Quality Assurance Checks:* The LTC FS application will check to ensure that target group selections are supported/confirmed by selections on the Diagnosis Table. For example, selecting the “Terminal Condition” target group should be supported by the selection of K3: Terminal Illness” (prognosis < or = 12 months) and any related terminal illness diagnosis on the Diagnoses Table. If selections do not match, the LTC FS application will display a cross edit statement prompting the screener to correct the recorded information.

# Module #6: Health-Related Services (HRS) Table

## Objectives

*By the end of this module you should be able to:*

- Explain the importance of the HRS Table to the determination of nursing home and DD level of care eligibility.
- Accurately complete the HRS Table of the LTC FS.
- Indicate when items in the HRS Table correlate well with items found elsewhere in the LTC FS.

## 6.1 Background of the Health-Related Services (HRS) Table

To be eligible for federal home and community-based waivers, a person must be eligible for a nursing facility or ICF-MR (also known as meeting nursing home or DD level of care). **The HRS table is extremely important in determining a person's waiver eligibility and Family Care eligibility.** (See Instructions 1.2 for more information.)

## 6.2 The HRS Table and Need for Health Care Provider Consultation

Screeners are not expected to be medical or nursing experts. **Screeners should consult as needed with a health care provider in order to accurately complete the HRS table.** Screeners who are nurses may not need to consult another medical expert, but screeners who are not nurses would obtain help through one of the following methods:

- Consult with your agency nurse on completing the HRS table based on available information you have.
- Fax a health information form to the person's doctor. Ask what type of health-related services the person needs and at what frequency. Find out if they are independent with doing them.
- Talk to the person's doctor or nurse. Ask them the same questions in the above bullet.

## 6.3 Completing the HRS Table and General Rules for its Use

The HRS Table should be completed by the screener to show the presence of and frequency of each health-related service according to the instructions in this section. Some frequencies which are not applicable for a particular service have been deleted as it would not be logical to allow them to be selected (see blank areas on the following screen shot under Behaviors and Positioning).

### General Rules for the HRS Table

- The HRS Table is designed to document people's health-related service **NEEDS**, not just what they are currently getting. So if a person has an HRS need, but refuses services for it or can't pay for it and isn't receiving needed services, you should still capture the need on the HRS table.
- Select the answer that most closely describes the person's need for help—whether they are actually getting that help or not.
- It does not matter who is performing the task (except for the second row where a nurse is required to perform the assessment and interventions). Families are often taught to do even very technical skilled nursing tasks.

- The table is primarily looking for “skilled nursing tasks,” primarily provided in the home. (A person’s home or “current residence” is defined in Instructions 3.15.)
- The table is NOT designed to capture acute, primary, or in-clinic services (except for dialysis, transfusions, ulcers and wound care (under certain situations), and skilled therapies). See those sections in this Module for further information.
- When more than one “frequency of help” (column) applies to one condition (row), place a checkmark to show the highest frequency (see examples provided in 6.7).
- Be sure to indicate if the person is independent, even if they are currently receiving help or services.

## HEALTH RELATED SERVICES

Check only one box per row—Leave row blank if not applicable

Health-Related Services Needed	Person is Independent	Frequency of Help / Services Needed from Other Persons					
		1-3 times/month	Weekly	2-6 times/week	1-2 times/day	3-4 times/day	5+ times a day
<b>Behaviors</b> requiring interventions (wandering, SIB, offensive / violent behaviors)							
<b>Exercises / Range of Motion</b>							
<b>IV Medications</b> , fluids or IV line flushes							
<b>Medication Administration</b> (not IV)—includes assistance with pre-selected or set-up meds							
<b>Medication Management</b> —Set-up and/or monitoring (for effects, side effects, adjustments, pain management)—AND / OR blood levels (e.g., drawing blood sample for laboratory tests or “finger-sticks” for blood sugar levels.)							
<b>Ostomy-related SKILLED Services</b>							
<b>Positioning</b> in bed or chair every 2-3 hours							
<b>Oxygen and / or Respiratory Treatments</b> —tracheal suctioning, C-PAP, Bi-PAP, nebulizers, IPPB treatments (does NOT include inhalers)							
<b>Dialysis</b>							
<b>TPN</b> (total parenteral nutrition)							
<b>Transfusions</b>							
<b>Tracheostomy care</b>							
<b>Tube Feedings</b>							
<b>Ulcer – Stage 2</b>							
<b>Ulcer – Stage 3 or 4</b>							
<b>Urinary Catheter-related skilled tasks</b> (irrigation, straight catheterizations)							
<b>Other Wound Cares</b> (not catheter sites, ostomy sites, or IVs or ulcers)							
<b>Ventilator-related interventions</b>							
Requires <b>Nursing Assessment and Interventions</b> Each of the following four criteria <b>MUST</b> be present: 1. A current health instability that 2. requires skilled nursing assessment and interventions, AND 3. involves <b>CHANGES</b> in the medical treatment or nursing care plan, AND 4. cannot be captured in any other HRS row.							
<b>Other—Specify:</b>							

**Skilled Therapies—PT, OT, ST** (any one or a combination, at any location)     1-4 days / week     5+ days / week

**Who will help with all health-related needs in next eight (8) weeks** (check **all** that apply)

- U** Current **UNPAID** caregiver will continue
- PP** Current **PRIVATELY PAID** caregiver will continue
- PF** Current **PUBLICLY FUNDED** paid caregiver will continue
- N** **Need** to find new or additional caregiver(s)

## 6.4 Person is NOT Independent in Managing a Health-Related Service

If the person is not independent in performing and managing a health-related service, you place one checkmark in the column showing the most accurate frequency of “Help Needed by Another Person.” The frequency of help ranges are:

- 1 to 3 times/month
- Weekly
- 2 to 6 times/week
- 1 to 2 times/day
- 3 to 4 times a day
- Over 4 times a day

The definitions for each condition (each row) will list the “skilled” tasks that you are to focus on, and in some cases tell you which tasks to ignore. For instance, in the rows for urinary catheter, you are to ignore the unskilled tasks like emptying the bag, and only consider the skilled tasks (replacing the catheter, irrigating it).

When more than one “frequency of help” (column) applies to one condition (row), place a checkmark to show the highest frequency (see examples provided in 6.7).

## 6.5 Person is INDEPENDENT in Managing a Health-Related Service

If the person is completely independent in doing the tasks and managing a health-related service, place a checkmark in the column to show that “Person is Independent.” There should be no frequency checked at which the person needs help from another.

Be careful not to overlook help provided by informal supports. Sometimes consumers appear independent with tasks, but in reality they are receiving supports (such as telephone cues to take meds twice a day).

**Be sure to indicate if the person is independent, even if they are currently receiving help or services.** The HRS Table is designed to document people's health-related service NEEDS, not just what they are currently getting.

Example: Amy is currently in the hospital but will soon be discharged. She has the physical and cognitive ability to manage and administer her own medications. However, hospital policy requires that all medications are managed by hospital staff for all patients. Screeners should indicate that Amy is independent with med management and administration, even though she currently receives help from the nurse.

## 6.6 Person is INDEPENDENT in some tasks, but NOT Independent in Others

In many cases, the person is independent in some tasks, but needs help from another person with other tasks related to the same condition (i.e., in the same row of the HRS table). **Pay attention to the column heading that shows that the frequencies are “Frequency of help/services needed from other persons.”**

Example: Inez does her own ankle dressing for a wound twice a day. But Inez can't see well and can't judge if it's getting worse or better. A nurse examines it once a week to be sure it's healing well and to adjust the wound care as needed. Inez calls the nurse if she has any problems in between. You mark "Weekly" for the "frequency of help/services needed from other persons." Be careful not to mark the twice a day task that Inez does independently under the heading for help from other persons.

## 6.7 Indicate Frequency of Skilled TASKS, Not Duration of Condition

**For conditions that are continually present** (e.g., a permanently placed urinary catheter), **your checkmark should indicate the frequency of tasks related to the health-related service. When one HRS involves more than one task, check the most frequent task with which help is needed from others.**

Example: Bob has a permanently placed urinary catheter. The catheter is changed (by a nurse) every 30 days. Daily "cath care" is just soap and water as normal part of bathing and is not really considered a "health-related service" on this table. No other care is needed. Bob also has a tracheostomy. Tasks related to this include having a nurse change the trach tube once every month, and an aide clean the trach site ("trach care") twice a day. He is generally self-directing and stable and visits his doctor's office only once every 4 to 6 months.

The screener should place TWO checkmarks on the HRS table: 1) Urinary catheter-related skilled tasks at "1 to 3 times/month" and 2) Tracheostomy Care at "1-2 times/day."

## Instructions for Particular Health-Related Services

### 6.8 Interventions Related to Behaviors

**Definition:** These types of interventions include monitoring and having someone present to prevent a behavior in someone with a cognitive impairment, as well as more direct interventions such as redirecting the person, physically preventing the behavior and responding to problems caused by the behavior.

"Preventing" includes redirecting the person, physically preventing the behavior and responding to problems caused by the behavior.

"Cognitive Impairment" includes impairment of thought due to severe mental illness, dementia, brain injury, developmental disabilities, or other organic brain disorders. It does not include the temporary impairment due to intoxication.

"Behaviors" includes any of the following if occurring in a person who has a cognitive impairment:

- Wandering
- Self-Injurious Behaviors
- Offensive or Violent Behaviors to Others

Note: Items in the **Behaviors/Mental Health Module** of the LTC-FS can be marked for persons **who do not have a cognitive impairment.**

To mark **behaviors on the HRS Table**, however, requires that the individual **have a cognitive impairment.** This is because the HRS Table determines nursing home level of care. In determining level of care in nursing homes, behaviors can only count in individuals that have cognitive impairments.

**To check this row, all** of the following must be present:

- Person has a cognitive impairment.
- Interventions are required.

- There is a behavior plan to prevent and/or respond to the behavior.

Behavior plans can be developed by a psychiatrist, psychologist, behavioral specialist, interdisciplinary team, or the individual's family. These plans typically involve the use of professional or non-professional caregivers, medications or restraints.

**Examples:**

An elderly woman with advanced Alzheimer's is being cared for at home by her family. Due to her dementia, she becomes extremely agitated when confused. The family has developed a formalized plan to deal with these behaviors. The family makes sure everyone knows about this plan and knows what to do when her agitation starts.

A young man with a developmental disability has polydipsia, meaning he will drink dangerously (life-threatening) large amounts of water. He needs an intervention whenever he heads for the water faucet. The facility has developed a formalized plan to deal with these behaviors.

**Do NOT Use This Row:**

- For someone without a cognitive impairment or thought processing problem.
- When there is not a formalized plan to manage and contain behaviors.

**Examples:**

A man with a developmental disability is being cared for at home by his family. When he is feeling nervous or stressed he will pace back and forth. When he is feeling better, he will cease the pacing. When this pacing occurs, some family members ignore the behavior, others try to intervene and redirect the individual. The family has not developed any consistent or formalized plan to deal with this behavior.

A man with paraplegia and alcoholism has recent history of indecent exposure and attempts to seduce children. Behavior interventions by his personal care workers, care manager and family have kept him out of trouble for the past year. "Offensive and Violent Behaviors to Others" **would** be checked in Module 8, but the HRS row **would not** be checked because he does not have a cognitive impairment.

**How to Determine the Frequency:** If the person requires interventions related to behaviors, select the frequency according to the guidelines detailed in section 6.4.

**Tip:** Other sections of the LTC FS that should correlate with this row are "Offensive or Violent Behaviors," "Physically Resistive to Care," "Wandering," and "Self -Injurious Behaviors." There may be a difference between the amount of behavior interventions documented in the HRS section and the other sections. To ensure accuracy, the LTC FS programmed logic will warn you, the screener, when these items do not correlate.

The HRS table requires that the individual have a cognitive impairment, while self-injurious behaviors and offensive and violent behaviors in Module 8 – Behaviors/Mental Health do not. Screeners should review both sections to assure that the individual's needs have been accurately checked.

## 6.9 Requires Nursing Assessment and Interventions

**Definition:** The 'Requires Nursing Assessment and Interventions' (RNAI) row is marked to indicate a current, usually short-term, health instability that requires skilled nursing assessment by a registered nurse (RN) or nurse practitioner (NP), and interventions to make or follow through on **changes** in the medical treatment or nursing care plan.

- **Nursing assessment** is the systematic collection and evaluation of data about the health status of an individual and the individual's response to the current medical treatment and nursing interventions.

- **Nursing interventions** are nursing activities such as administering skilled care, delegating tasks, adjusting the care plan, consultation and education of individuals, family members, and caregivers; consulting with physicians and other healthcare professionals; and providing psychosocial counseling.
- **Nursing care** plan includes nursing interventions, plus tasks delegated or assigned to others, plus recommendations regarding the individual's health. In interdisciplinary models, it is not a separate document, but is part of the person-centered plan or Individual Service Plan (ISP). It refers to the **nursing aspects** of a person-centered plan or ISP. It does not include other activities like ordering supplies or general care management.
- **Short-term** means less than 90 days.

Most nursing assessments and interventions are captured in **other rows** of the Health Related Services (HRS) Table. The RNAI row is intended only for a small minority of cases in which nursing care is not captured elsewhere in the HRS Table.

**Each of the following four criteria MUST be present whenever the RNAI row is checked:**

1. **A current health instability that**
2. **requires skilled nursing assessment and interventions, AND**
3. **involves CHANGES in the medical treatment or nursing care plan, AND**
4. **is not captured in any other HRS row.**

REMINDER: An individual's need for telephone contact with a nurse counts only if the four criteria above are met.

REMINDER: Medication changes that do not require skilled nursing assessment and interventions must be recorded in the Medication Management row of the HRS Table, not in the RNAI row.

**RNAI is generally a short-term need because:**

- Nursing interventions are either effective over several weeks or months, or other plans must be established to ensure the individual's safety and health.
- RNAI includes only those skilled nursing assessments and interventions that are needed to address a current health **instability** requiring **changes** to the medical treatment or nursing care plans.

**Almost all needs for ongoing health-related or skilled nursing services must be recorded elsewhere on the HRS Table.** Examples:

- A 79-year-old woman is on numerous medications for atrial fibrillation, congestive heart failure, hypertension, arthritis, and diabetes. She is frail and unstable, with medication changes based on her vital signs and comfort level. However, her on-going nursing assessments all relate to her medications. These are captured in the Medication Management row, not in the RNAI row.
- Individual has a Stage 3 ulcer. The RN does comprehensive wound care, which includes assessments and interventions concerning healing, nutritional status, fluid status, mobility, cognition, coping, etc. All of this assistance is captured in the Ulcer Stage 3 row, not in the RNAI row.
- Nursing assessments and interventions related to oxygen level checks are recorded in the Oxygen or Respiratory Treatments row, if the individual is on oxygen or getting respiratory treatments, not in the RNAI row.
- Dialysis treatments at a clinic include comprehensive nursing assessments 3 times/week. Check Dialysis, 2 to 6 days/week, and do not check the RNAI row.

**Check this for a person who:**

Meets the four criteria above, including an individual who:

- Has a current health instability in a medical or **psychiatric** condition that requires skilled nursing assessment, intervention, and changes in medical treatment or nursing care plan that are not captured in other rows of the HRS table, or
- Was **recently discharged** from a hospital or nursing home, is weak and unstable, with new limitations and new medications, requiring nursing visits several times a week for assessments, care planning, and skilled nursing interventions. This individual has instabilities likely requiring changes to medical treatment or nursing care plan, at least for a few weeks.

**Do NOT check this for a person who:**

- Has other HRS Table rows checked recording all nursing assessment and interventions the individual needs, or
- Has a cognitive impairment, but does not have an acute, unstable health condition requiring nursing assessments and interventions, or
- Does not have an acute, unstable health condition requiring nursing assessments and interventions, even if that person:
  - Has a need for skilled nursing interventions without a need for nursing assessment or changes in medical treatment or nursing care plan; or
  - Has long-term health instabilities without a need for changes in medical treatment or nursing care plan, because there is an established plan of care (“standing orders”) in place for a long-term instability. Examples:
    - PRN (as necessary) medications for uncontrolled seizures;
    - PRN medications or treatments for chronic pain or other chronic conditions
    - Sliding scale insulin (when each insulin dosage is adjusted based on the blood sugar test result);
    - When the individual’s lower legs retain fluid he/she is to elevate them above their heart for at least 30 minutes;
    - When the individual becomes short of breath he/she is to use their oxygen, or
  - Has personal care workers or others who perform delegated tasks that need nursing oversight and supervision; or
  - Has nursing assessments only because they are routinely provided by the agency or residential care facility; or
  - Has nursing care management activities; or
  - Has RN or NP participation on an interdisciplinary team; or
  - Receives skilled nursing care provided in a clinic setting for dialysis, wound care, transfusions, or other services noted elsewhere on the HRS Table; or
  - Has a history of skin breakdown and has an RN or NP check the integrity of their skin; or
  - Needs data collection. Examples:
    - The documenting of weights, blood pressure, heart rate, blood sugars, seizure activity, etc., almost always involves the effectiveness, side effects, or adjustments of medications and is recorded in the Medication Management row of the HRS Table;
    - The needed measurement of an individual’s fluid intake and output (I & O) is recorded in the “Other” row of the HRS Table, with description of the care need added to the notes section;

- Caregiver(s) documenting an individual's health status, e.g., daily or at the end of each shift, is not recorded on the LTC-FS.

REMINDER: Determine the frequency of RNAI according to the guidelines detailed in section 6.4.

## 6.10 Exercises/Range of Motion

**Definition:** This row reflects exercising and/or performing “range of motion” exercises to promote or maintain muscular function. The person is at risk for loss of muscular function due to a health condition. The person may perform these exercises themselves or family or staff may help perform them. The exercise program may or may not have been set up by a rehabilitation therapist and helpers may or may not have been trained by the therapist.

### Use This Row When:

- The person is engaging in exercises to prevent loss of function and maintain muscular tone. For example, after a stroke a person receives “range of motion” exercises to their affected side three times a day to promote muscular function lost.

### Do NOT Use This Row:

- If the exercises are being performed by a rehabilitation therapist. Instead, use the “Skilled Therapy” row at the bottom of the HRS table (described in section 6.27).

**How to Determine the Frequency:** The person may be independent in this activity or they may need help from another for this task. Depending on the situation, select the frequency according to the guidelines in section 6.4 or 6.5.

## 6.11 IV Medications, Fluids or IV Line Flushes

**Definition:** “IV” stands for intravenous, and intravenous pertains to medications, fluids or flushes delivered within or into a vein. This may consist of IV injection or IV infusion. Most common are small bags of antibiotics that “drip” in (usually via an IV pump for safety).

### Use This Row When:

- IV medications, fluids or IV line flushes are provided in the home.
- The person requires IV medicine, like an antibiotic to drip into their vein to treat a serious infection. IV medications usually drip in over 30 to 60 minutes.
- The person requires IV fluids because they are unable to consume enough liquids and are dehydrated. Typically these fluids consist of “normal saline” or weak solutions of “dextrose” which are given for acute dehydration or until tube feedings can be established.
- The IV is “flushed,” which means irrigating or washing out with a bit of sterile solution or medication, and flushing is the only IV intervention being provided. Don’t count flushing separately if it’s part of one intervention that combines several tasks (e.g., starting the med, flushing, and disconnecting).
- “Site cares” are provided, such as cleaning and re-bandaging the IV site. Site cares usually occur every few days, but it depends on what the doctor has ordered.

### Do NOT Use This Row:

- For IV services provided outside the home (i.e., in a primary care setting such as a clinic).
- For TPN, which has a separate row (see section 6.18).

**How to Determine the Frequency:** In most cases, IV medicines drip in over 30 or 60 minutes, which is essentially one visit by a nurse; this can be called one intervention even though it combines several tasks

(starting the med, flushing and disconnecting afterwards). Mark the frequency of interventions needed, not the frequency of med administration.

Example: Many times a computerized IV pump delivers a med three times a day, but the IV only needs to be set up (refilled and re-programmed) every two or three days. In between sets-ups, the IV works fine and the consumer/family know how to handle problems and when to contact the nurse. You'd check the "2 to 6 days a week" column for the set-up every 2 to 3 days.

**Mark the frequency of interventions needed, not just administration of fluids.** For instance, starting an IV infusion in the p.m. and disconnecting it in the a.m. equals two tasks.

For additional guidance in determining the frequency for this health-related service, refer to section 6.4.

## 6.12 Medication Administration (not IV) or Assistance with Pre-Selected or Set-Up Meds

**Definition:** This row is about a person taking or being given a medication by any route except IV. This could be by mouth or under the tongue, by an injection, or rectally or vaginally. Sometimes a person just needs assistance in taking the medication and that activity is captured on this row as well. Use of medication that is regularly scheduled, not "as-needed" meds, should be captured here. (If the person is unable to self-manage the use of "as-needed" medicine, they may qualify for checking the nursing assessment row if all criteria there is met). The type of regularly scheduled meds can be brand name, generic, or over the counter (OTC). If the person takes no regularly scheduled medication then this row is not applicable.

### Use This Row When:

- The person takes regularly scheduled meds. If the person can take medications independently, check the "Person is Independent" column. If the person needs someone to give them their medications, there are three general possibilities that are included under this row:
  1. **Med Administration:** This is a skilled task in which the nurse or someone trained by a nurse administers the meds. Administration includes selecting the proper med and dosage and being able to judge whether a medicine should be taken or withheld due to symptoms or side effects.
  2. **Assistance with Pre-Selected Meds:** An unskilled person (without the judgment about giving or holding a med) can "assist" with medications that have been "pre-selected" – that is, the proper med and dosage have been selected in advance by a pharmacist, a nurse, or someone trained by a nurse. Qualifying assistance here could include a son calling his elderly mother to remind her to take her medications. Instances as verbal cueing count as Medication Administration.
  3. **Assistance with Self-Medication:** This is when a self-directing consumer has the cognitive ability to select the proper med and dosage and the judgment to understand the medications' purpose and side effects and to report problems, but needs someone to physically assist with the medicine. This includes the person with quadriplegia who instructs a personal assistant to help him with this meds under his close direction.

### Do NOT Use This Row:

- If the person is given medication by IV only. This is captured on the IV Medication row (see 6.11).
- If the person only takes "as needed" medications (e.g., aspirin or ibuprofen for occasional headaches).

**How to Determine the Frequency:** Use the Independent column if the person can take all their meds themselves without any help. If they need someone to give them their meds or some form of assistance, mark the frequency column according to the guidelines in section 6.4.

## 6.13 Medication Management: Set-up and/or Monitoring Meds (for Effects, Side-Effects, Adjustments, Pain Management) and/or Blood Levels

**Definition:** Use of this row reflects that a person's regularly scheduled meds require management of some form. Examples include that they need to be set-up in a pill box each week, or side effects or efficacy need to be monitored, or that blood levels for lab tests relating to the medication needs to be drawn in the home. It could also be for blood draws not strictly related to medications when drawn in the home.

### Use This Row When:

A person has regularly scheduled meds which require management of some sort. Examples of medication management activities include:

- 1. Medication set-up, such as:**
  - "Bubble-packs" from a pharmacy.
  - "Pill boxes" or "med boxes" with compartments labeled for different times and each day of the week, into which a nurse or other trained person places the pills that are to be taken at those times on those days.
  - Any other "set up" system in which meds and dosages are pre-selected which includes daily pre-selections for someone unable to both self-administer, identify correct dosage, and monitor effects.
  - Medication dispensing machines that can be programmed (often weekly) to dispense pills.
  - Pre-filling of syringes (most commonly insulin syringes).
- 2. Medication Monitoring**

This is monitoring for the effects and side-effects of medicines. It includes reporting such information to the prescribing physician or nurse practitioner and making changes as prescribed by them. For example, adjusting insulin, coumadin, or anti-hypertensive medication. Or a person may have an internal morphine pump that might require monitoring in the home to determine if the amount of medication released is effective.
- 3. Pain management**

This includes adjusting meds in order to manage pain. This does not include chiropractic care, care at a pain clinic, or non-prescription meds, e.g., an occasional Tylenol for arthritis.
- 4. Blood levels**

Includes drawing blood samples for laboratory tests. The majority of these are related to medications (e.g., Pro-Times to regulate Coumadin administration, or potassium levels for a person on diuretics). Other blood draws not strictly related to medications can be included here as well, such as CBC (complete blood count) or Creatinine (to check kidney function). Blood levels also includes "finger-sticks" for capillary blood to test blood sugar levels.

Sometimes it is difficult for screeners to decide if the medication administration row applies, or the medication management row, or that possibly both rows apply. However, it's important to use either or both of these rows as they apply to the person in order to capture any eligibility weight attached to the activity.

**The following section provides examples when to use the Medication Administration and/or Medication Management rows on the HRS table.**

CASE #1: You would use the Medication Administration column to capture when a person is independent with his/her insulin injections or the use of an insulin pump. If the person is doing their own blood sugar checks, you would also put a checkmark in the left-most column ("person is independent") in the row for Medication Management.

CASE #2: If the person is independent with their insulin but needs someone else to set up their pills, you would mark the left-most column (“Person is independent”) in the row for Medication Administration, to reflect that she takes her own insulin and her own pills. In the row for Medication Management you check the frequency at which someone must set up the pills.

CASE #3: In the case where someone is “cheeking” his/her medicine (hiding it in their cheeks and not swallowing it), you would mark the frequency at which someone assists with either Medication Administration or Medication Management or both. Most of the time when someone is cheeking her/his meds it is because of mental illness or other cognitive impairment, and they are already having someone assist them with their meds.

CASE #4: If the person takes their medication themselves out of the bottles and require no other medication management services such as med set-up, then just use the Medication Administration row.

CASE #5: If the person requires a monthly blood draw at home for a complete blood count but takes no medication, then just use the Medication Management row.

**Do NOT Use this Row:**

- For blood draws done outside the home (i.e., in a primary care setting such as a clinic).
- If an internal morphine pump does not require monitoring for effectiveness in the home, but only intermittent re-fills and maintenance in the clinic setting.

**How to Determine the Frequency:** Use the Independent column if the person can manage all of their meds themselves without any help. If they need help from another person with any of the medication management activities, mark the frequency column according to the guidelines in section 6.4.

**Tip:** The LTC FS application will check to ensure that the level of help indicated in the Medication Management IADL (discussed in Module 4) correlates with the Medication Administration and Medication Management rows in the HRS Table. If the level of help does not correlate between the Medication Management IADL and the Medicaid Administration and Medication Management rows, the screener will receive an error message to prompt correction.

## 6.14 Ostomy-Related Skills Services

**Definition:** An ostomy is a surgically created opening in the body for the discharge of body wastes. There are several different types of ostomies, e.g., colostomy: opening in the colon; ileostomy: opening in the small intestine; urostomy: opening in the bladder.

Use of the row reflects that skilled tasks are being provided to an ostomy site or opening.

**Use this Row When:**

- Ostomy-related skilled services are being done. “Skilled” tasks include changing the wafer (which adheres to the skin and needs to be cut to proper size to avoid skin breakdown around the ostomy), doing site care (skin around the ostomy, where the wafer will attach), and irrigations. Wafer changes and site care is usually done only once every 7 or 10 days for a stable ostomy, but much more frequently for a new ostomy or one with problems like leaking and skin breakdown.

**Do NOT Use this Row:**

- For ostomy-related skilled services provided outside the home (i.e., in a primary care setting such as a clinic).
- For the unskilled task of emptying the ostomy bag.

**How to Determine the Frequency:** Use the Independent column if the person can manage all of their ostomy-related skilled services themselves. If they need help from another person with any of these tasks mark the frequency column according to the guidelines in section 6.4.

## 6.15 Positioning in Bed or Chair Every 2-3 Hours

**Definition:** Positioning means a person is moved to redistribute pressure applied to the body. Changing a person's position is a preventive measure to help avoid bedsores and pneumonia. Positioning is not a skilled task, but was added to the HRS table at the request of the screeners.

**Use this Row When:**

- The person needs to be positioned by another at least every 2-3 hours.

**Do NOT Use this Row:**

- If the person can position independently.
- If the person need to be positioned less than 3-4 times/day.

**How to Determine the Frequency:** No frequency column applies to this activity except "3-4 times a day" or "over 4 times a day." If the person is positioned by another every day, pick either of these columns which best describes that frequency.

**Tip:** The Bathing, Dressing, Mobility, Toileting and Transferring ADLs of the LTC FS should be checked as a need as appropriate to correlate with any need for positioning in bed or chair. To ensure accuracy, the LTC FS programmed logic will warn you, the screener, when these items do not correlate.

## 6.16 Oxygen and/or Respiratory Treatments: Tracheal Suctioning, BI-PAP, C-PAP, Nebulizers, IPPB Treatment (Does NOT include inhalers)

**Definition:** Use this row to reflect the use of oxygen or provision of respiratory treatments as defined below:

- **Oxygen:** Some people with asthma, emphysema, chronic bronchitis, occupational lung disease, lung cancer, cystic fibrosis, or congestive heart failure use oxygen at home to treat their oxygen deficiency. Three common ways of providing it are by compressed gas, liquid oxygen, or by an oxygen concentrator. Three common means of delivery are nasal cannula, a mask, or transtracheal (a flexible catheter inserted into the trachea or windpipe).
- **Tracheal Suctioning:** If a person has a tracheostomy (an artificial opening into a trachea or windpipe) they may require suctioning of this area to clear secretions.
- **Bi-PAP and C-PAP:** These terms mean that positive airway pressure is provided via a mask to maintain adequate oxygen delivery or to alleviate an excessive breathing workload.
- **Nebulizer:** This is a device that uses pressurized air to turn liquid medication into a fine mist. The pressurized air typically comes from a portable pump unit that internally consists of a motor-driven air pump that resembles the fancier types of aquarium pumps. It forces air through a plastic tube into the plastic nebulizer unit. Inside, the nebulizer unit acts much like a perfume atomizer, creating a fine mist that is directed either through a tube that is inhaled through or a mask that directs the mist into the nose and mouth.
- **IPPB Treatments:** "IPPB" stands for intermittent positive pressure breathing. This is a technique used to provide short-term or intermittent mechanical ventilation by way of a pressure-cycled ventilator. This type of treatment is used to expand the lungs, deliver aerosol medication, or assist ventilation.

**Use this Row When:**

- The person is using oxygen or requires respiratory treatments as defined above. If the person is on some other form of respiratory treatment such as chest physiotherapy and postural drainage you can also use this row.

**Do NOT Use this Row:**

- To record the oxygen vendor's trips (usually every few weeks) to provide new oxygen tanks.
- For hand-held inhalers or aerosols, which have pre-metered doses. (If the person needs help with those, include them on the Medication Management/Medication Administration rows.)
- If a person needs to use a mechanical volume ventilator (see section 6.26).

**How to Determine the Frequency:** Determine if the person is independent or not with their oxygen and/or respiratory treatments. Special consideration to cognitive functioning must be applied if oxygen is used. For example:

Oxygen is often worn continually; screeners should find the frequency at which the person needs help from others with particular tasks related to the oxygen. If the person is independent in oxygen and/or respiratory treatments such as turning the oxygen on and off, taking it on and off, checking their oxygen saturation level, and changing water bottles and tubing, then check the column for "Person is Independent." If a person with Alzheimer's or dementia requires oxygen, examine the level of help required from others. Do not list the person as "Independent."

If the person does need some level of help, mark the frequency according to the guidelines in section 6.4. If the person is not independent in certain treatments which vary in frequency, check the number of times on average that the person needs them.

## 6.17 Dialysis

**Definition:** Dialysis artificially filters and removes waste products and excess water from the blood, a process normally performed by the kidneys. There are two types of dialysis – hemodialysis and peritoneal dialysis. Hemodialysis is where an external machine cleans the blood. Peritoneal dialysis is where the person's abdominal cavity is used to filter the blood.

**Use this Row When:**

- The person is undergoing dialysis at home **OR** in a clinic. This row is an exception to the rule that HRS tasks recorded must be only those provided in the home.

**Do NOT Use this Row:**

- To capture transportation to the dialysis clinic; transportation is captured as an IADL.

Be careful to avoid "double dipping" here. Only also use the "Requires nursing assessment" row (in addition to the dialysis row) if the person is very unstable at home (or has other problems) and meets all the criteria for unable to self-manage as required to use the nursing assessment row.

**How to Determine the Frequency:** If the person is receiving hemodialysis, capture the frequency of dialysis clinic visits. Usually these are three times a week. Most people receive this type of dialysis.

If the person is undergoing peritoneal dialysis, this usually occurs overnight in the home. The person is often independent with this task, or they could have a nurse or family member assisting.

**Count hooking up and disconnecting as two separate tasks.** So, if a person has overnight peritoneal (through the abdomen) dialysis and requires help from another with this procedure, it counts as two tasks (hooking up and disconnecting) at a minimum.

## 6.18 TPN (Total Parenteral Nutrition)

**Definition:** This is a type of liquid nutrition that is administered through an IV. It supplies all of the person's daily nutritional requirements and is used when the person cannot eat, or cannot get enough nutrients from the foods they eat. It is always administered through an IV pump to precisely control the infusion rate.

**Use this Row When:**

- The person is receiving TPN at home.

**Do NOT Use this Row:**

- If the person is receiving tube feedings (described in section 6.21). That is a different type of supplemental nutrition.

**How to Determine the Frequency:** Use the independent column if the person can manage their TPN themselves. If they need help from another person mark the frequency column according to the guidelines in section 6.4.

Sometimes TPN runs into the person continuously. If this is the case **and** they need help from another to "hook up" a new bottle or bag of liquid, mark the frequency this hook-up occurs – usually 3-4 times a day.

## 6.19 Transfusions

**Definition:** This means that blood or one of its components, such as red blood cells or platelets, is delivered into a person's blood stream. The blood or blood product is delivered through an IV.

**Use this Row When:**

- The person receives transfusions at home OR in a clinic. This row is an exception to the rule that HRS tasks recorded must be only those provided in the home.

**Do NOT Use this Row:**

- Unless the person requires this service as defined above.

**How to Determine the Frequency:** A skilled health care provider would need to administer a transfusion. Use of the independent column would not be applicable here. If the person receives transfusions at a clinic or at home, check the frequency column according to the rules in section 6.4.

## 6.20 Tracheostomy Care

**Definition:** If a person has a tracheostomy (an artificial opening into a trachea or windpipe) they will require what is known as "tracheostomy cares." These cares include cleaning the tracheostomy site, changing the tracheostomy tube, and changing the straps or ties which hold the tube in place.

**Use this Row When:**

- A person requires tracheostomy cares as defined above.

**Do Not Use this Row:**

- For tracheostomy care provided outside the home (i.e., in a primary care setting such as a clinic).

**How to Determine the Frequency:** Use the independent column if the person is able to do their trach cares themselves. If they need help from another person with any or all of the tasks, check the frequency of the most frequently done task. For example, the trachea tube is changed once a month and site care is done by another twice a day. The screener should put a checkmark in the 1 to 2 times a day column.

## 6.21 Tube Feedings

**Definition:** Sometimes people with an illness or injury have trouble swallowing or are not alert enough to eat. If they cannot eat or cannot eat safely to obtain adequate nutrition, a feeding tube is placed in the body to give the needed nutrition.

There are several different locations where a feeding tube can be placed on a person's body. The name of the type of tube matches the location. The types of tubes are:

- NG (Nasogastric): A feeding tube down the nose (or mouth) and esophagus to the stomach. (Rare and temporary, due to risk of aspiration into lungs and discomfort in nose and throat).
- G-tube (Gastrostomy): Tube goes through the abdomen into the stomach.
- J-tube (Jejunostomy): Tube goes through the abdomen into the intestine just below the stomach.

**Use this Row When:**

- The person requires tube feedings as defined above.

**Do NOT Use this Row:**

- For tube feedings done outside the home.
- When the person can eat without any problems and a G-tube is only used to administer medication. In this circumstance flushing the tube after giving the meds is not captured on this row, but as part of the med administration row. The only task to capture in this type of circumstance is changing the G-tube every 30 days or so.
- For TPN which is given through an IV/vein. That is a different type of supplemental feeding (see section 6.18).

**How to Determine the Frequency:** Sometimes a person can be independent with some steps of the tube feeding like administering it or caring for the skin around the tube. Changing the feeding tube must be done by a skilled health care provider.

You do not need to separate out every single task if several are done at the same time. Instead, **indicate the general number of times a day that the tube feeding is changed, started, stopped, etc.** If they are fairly independent with tube feeds, they might only need help from another person every 30 days or so to change the tube.

If the person is on continuous tube feeding and needs help from another person with everything, the tasks (checking for placement, starting a new bag of feeding, etc.) are most often done "over 4 times a day" and you should indicate that frequency.

## 6.22 Ulcer - Stage 2

**Definition:** If a person has a sore area that's classified as an "Ulcer-Stage 2" this means that the areas has partial-thickness skin loss, presenting superficially as an abrasion, blister, or small crater. This is only the very beginning of skin breakdown. This breakdown occurs due to external and internal factors and commonly occurs on the area above the tailbone, elbows, heels, hips, ankles, shoulder and back.

**Use this Row When:**

- A person has been diagnosed as having an "Ulcer-Stage 2" and special wound care for it is being done. Special care will include wound cleansing and wound dressings.

**Do NOT Use this Row:**

- For routine skin care or only when band-aids are used.
- For Ulcer-Stage 2 wound care provided outside the home UNLESS skilled services for this condition cannot be provided in the home. You can use this row for health-related services provided in a clinic setting under certain circumstances.

Example: The person requires treatments for this condition which are complex in nature. Local home health agencies cannot provide the needed cares due to the complexity and cost, and no family member is available to perform the needed care. The person must be transported to an area clinic/wound clinic to receive needed cares because they cannot be provided in the home. Under these circumstances this row maybe used for services provided in a clinic setting.

**How to Determine the Frequency:** The person may be independent in this activity or they may need help from another for this task. Use the independent column if the person can do the special wound care themselves. If they need help from another, mark the frequency column according to the guidelines in section 6.4.

Example: Inez does her own ankle dressing twice a day. A nurse examines it once a week to be sure it's healing well and to adjust the wound care as needed. Inez calls the nurse if she has any problems in between. You mark "Weekly" for the "frequency of help/services needed from another person". Be careful not the mark the twice a day task that Inez does independently under the heading for help from another person.

## 6.23 Ulcer-Stage 3 or 4

**Definition:** If a person has a sore area that's classified as an "Ulcer-Stage 3 or 4," this means that there is more extensive damage to the area than is seen in a Stage 2 ulcer. A Stage 3 ulcer has full thickness skin loss, and presents as a deep crater with or without undermining of adjacent tissue. A Stage 4 ulcer has full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures. These types of sores occur due to external and internal factors and commonly occur on the area above the tailbone, elbows, heels, hips, ankles, shoulder and back.

### Use this Row When:

- A person has been diagnosed as having an "Ulcer-Stage 3 or 4" and special wound care for it is being done. Special care includes wound cleansing and wound dressings.

### Do NOT Use this Row:

- For Ulcer-Stage 3 or 4 wound care provided outside the home UNLESS skilled services for this condition cannot be provided in the home. You can use this row for health-related services provided in a clinic setting under certain circumstances.

Example: The person requires treatments for this condition which are complex in nature. Local home health agencies cannot provide the needed cares due to the complexity and cost, and no family member is available to perform the needed care. The person must be transported to an area clinic/wound clinic to receive needed cares because they cannot be provided in the home. Under these circumstances this row maybe used for services provided in a clinic setting.

**How to Determine the Frequency:** The person may be independent in this activity or they may need help from another for this task. Use the independent column if the person can do the special wound care themselves. If they need help from another, mark the frequency column according to the guidelines in section 6.4. You can also refer to the example in section 6.22 for help in determining the frequency.

## 6.24 Urinary Catheter-Related Skilled Tasks (Irrigation, Straight Caths)

**Definition:** A urinary catheter is any tube system placed in the body to drain and collect urine from the bladder. A health care provider will recommend use of the catheter for short-term use or long-term use. Short-term use is also known as "straight caths" or "intermittent urinary catheterizations" and are an "in and out" cathing, usually done every 4 or 8 hours. Long-term use is also known as an "indwelling" catheter that is left in place for a period of time and is connected to a drainage bag.

**Use this Row When:**

- Skilled tasks relating to the care of a urinary catheter are done. Skilled tasks include changing (replacing) the catheter, and irrigating the catheter (done for infections and if catheter tends to get clogged with sediment) or doing an “in and out” cathing.
- “Site care” is provided to a suprapubic catheter (one which goes in through a small hole in the skin just above the pubic bone). “Site care” means that special care is given to the area where the catheter goes into the abdomen. “Site care” is usually cleansing this area with soap and water and covering with a dry gauze.

**Do NOT Use this Row:**

- For routine “cath care” for an indwelling catheter – this is usually just soap and water as a normal part of bathing. Do not confuse “site care” for a suprapubic catheter with “cath care” for an indwelling catheter.

**How to Determine the Frequency:** If the person has been taught how to do their own urinary catheter skilled tasks themselves, mark the independent column. If they need help from another with any skilled urinary catheter tasks, mark the frequency column according to the guidelines in section 6.4.

**Examples:**

- If a person can do their own intermittent catheterizations, mark the independent column.
- If a nurse needs to change an indwelling catheter every 30, 60 or 90 days, check the 1-3 times per month column.
- If an indwelling catheter is just used at night, putting it in and taking it out counts as two separate tasks if done by another. Mark the 1-2 times a day column.

**Tip:** If urinary catheter related skilled tasks is checked on the HRS Table, then the Toileting ADL adaptive equipment “catheter” should match. To ensure accuracy, the LTC FS programmed logic will warn you, the screener, when these items do not correlate.

## **6.25 Other Wound Cares (Not cath sites, ostomy sites, IVs or Ulcer Stage 2, 3, or 4)**

**Definition:** Use of this row means a person needs wound care from a serious burn, traumatic injury or serious infection.

**Use this Row When:**

- The person needs special wound care caused by any of the problems listed in the above definition. Special wound care includes wound cleaning and wound dressing.

**Do NOT Use This Row:**

- For catheter sites, ostomy sites or IVs.
- If it only involves changing Band-Aids.
- If you already checked “Ulcer-Stage 2” or “Ulcer-Stage 3 or 4” because that is a different type of wound care. Use this row only if the person has other wounds as described in the definition above.
- For wound care provided outside the home UNLESS skilled services for this condition cannot be provided in the home. You can use this row for health-related services provided in a clinic setting under certain circumstances.

**Example:** The person requires treatments for this condition which are complex in nature. Local home health agencies cannot provide the needed cares due to the complexity and cost, and no family member is available to perform the needed care. The person must be transported to an area clinic/wound clinic to receive needed cares because they cannot be provided in the home. Under these circumstances this row maybe used for services provided in a clinic setting.

**How to Determine the Frequency:** The person may be independent in this activity or they may need help from another. Use the independent column if applicable. If they need help from another, mark the frequency column according to the guidelines in section 6.4.

If the person has more than one treatment or more than one wound, put one checkmark to show the highest level of help needed if applicable.

## 6.26 Ventilator-Related Interventions

**Definition:** A ventilator (also known as a respirator) is the equipment used to mechanically assist breathing by delivering air to the lungs. A ventilator can take over the act of breathing completely or assist weakened respiratory muscles. Use of the ventilator can be short-term or long-term, depending on the individual's medical needs and condition. Use of this row means the person needs to use a mechanical volume ventilator.

**Use this Row When:**

- The person uses a ventilator as defined above.

**Do NOT Use this Row:**

- If the person uses a "C-PAP" or "Bi-PAP" (record this on the oxygen/respiratory treatments row).

**How to Determine the Frequency:** If the person can self-manage their ventilator, check the independent column for frequency.

Example: Many part-time or nocturnal ventilator users live independently.

Often people with ventilators require very frequent help and interventions around the clock. If that is the case, mark the frequency column according to the guidelines in section 6.4.

Example: Some ventilator users are totally dependent and require nurses or attendants around the clock who are trained in the use of the equipment and secretion removal techniques.

## 6.27 Skilled Therapies: PT, OT, ST (Any one or a combination, at any location)

**Definition:** Use of this row reflects that the person is receiving services from a skilled rehabilitation therapist. These therapists provide the following services:

- **Physical Therapist (PT):** A physical therapist helps with the body's recovery after a patient's accident or illness. The physical therapist helps with muscle strength, movement of the joints and more complicated body skills such as sitting, walking and balance, or the use of a walker or wheelchair.
- **Occupational Therapist (OT):** An occupational therapist helps the patient regain everyday skills that might have been lost because of an injury or illness. The occupational therapist will help with everyday activities like eating, brushing teeth, cooking and housework. They also work on the problem-solving skills needed for managing a home or working.
- **Speech Therapist (ST):** A speech therapist (or more properly, the speech-language pathologist) helps with speaking, listening, reading and writing problems. In addition, he or she helps patients who have swallowing problems or who have difficulties in thinking and memory. When patients have speaking problems, the speech therapist helps the patient and family develop other ways to "talk" with each other.

**Use this Row When:**

- The person receives therapies from a licensed therapist (PT/OT/ST) at any location. This row is an exception to the rule that HRS tasks recorded must be only those provided in the home.

**Do NOT Use This Row:**

- For exercises done by the person alone or by other caregivers, even if under the instructions of a therapist. Use the “exercises/range of motion” row for those types of circumstances.

**How to Determine the Frequency:** Mark the frequency column which reflects the “combined frequency” of PT/OT/ST.

“Combined frequency” equals the maximum number of sessions per week of therapy services provided. For example: PT/OT/ST once each day, 2 days per week = 6 sessions per week, which converts into 6 days per week on the screen. Record this frequency under the 5+ days/week column on the skilled therapy row.

Use of the Independent column is not applicable for this row.

## 6.28 “Other” Row

**Use this Row When:**

- Recording those health-related services you are unable to capture on any other row of the table. Remember that the use of the table primarily pertains to in-home services.

**Do NOT Use This Row:**

- For unskilled tasks which are captured elsewhere on the screen or as a “notes” section to further describe details about HRS for the person. For example, the use of “TED” (anti-embolism) stockings should be captured under the Dressing ADL, not on the HRS “other” row.

**Tip:** Use of the “other” row will be monitored by the Department at regular intervals and cases will be referred to screen liaisons as necessary for follow-up.

# Module #7: Communication and Cognition

## Objectives

*By the end of this module you should be able to:*

- Accurately complete the Communication, Memory, Cognition for Daily Decision Making, and Physically Resistive to Care sections of the LTC FS.
- Describe how Memory Loss in this module is addressed differently from other areas of the LTC FS that collect cognition information.
- Distinguish between a competent person refusing help and a person being “physically resistive to care.”

## 7.1 Four Sections in this Module

1. Communication
2. Memory Loss
3. Cognition for Daily Decision Making
4. Physically Resistive to Care

## 7.2 Communication

**Communication includes the ability to express oneself in one's own language**, including non-English languages, American Sign Language (ASL), or other generally recognized non-verbal communication. For the purposes of the LTC FS, a person's ability to communicate should be assessed in the context of their residence and not in regard with their ability to communicate with people in society at large.

REMINDER: A person with a diagnosis of deafness has hearing loss that cannot be overcome with the use of hearing aids. A person with deafness may be able to fully communicate with others by reading lips, speaking, using written language, or by using sign language. For this person, the selection of 0: (Can fully communicate with no impairment or only minor impairment) is correct.

### **Communication Options:**

- Can fully communicate with no impairment or only minor impairment (e.g., slow speech)
- Can fully communicate with the use of an assistive device
- Can communicate ONLY BASIC needs to others
- No effective communication

0: (Can fully communicate with no impairment or only minor impairment (e.g., slow speech))

Check this for a person who communicates fully (feelings, thoughts, complex or abstract ideas beyond basic needs):

- With a speech impediment (stutters, slurred speech, etc.) but is able to be understood by others.
- With a delayed response.
- In a non-English language.
- In American Sign Language or signed English.
- In writing (including cell phone texting) but is able to fully communicate verbally.

1: (Can fully communicate with the use of an assistive device) includes communicating through an adaptive device designed to help aid a person when expressing themselves.

**Check this for a person who:**

- Uses a computer, cell phone, or other communication device as their only means of communicating their feelings and ideas in detail, because they are unable to fully communicate verbally.
- Uses a voice amplification device or battery powered artificial larynx.

2: (Can communicate only basic needs to others) includes but is not limited to the person's ability to tell their immediate family, friends, or caregivers they are hungry, thirsty, in pain or discomfort, or need to use the bathroom. Such a person may have receptive language but is unable to participate fully in a two-way exchange of information involving abstract ideas, concepts, or feelings due to limited expressive language.

**Check this for a person who:**

- Uses a picture or word board and is unable to communicate more than their basic needs.
- Can be understood by their ongoing caregiver, parent, etc., and not a new person meeting them for the first time (e.g., new caregiver, 911 operator, etc.).
- Is nonverbal but communicates by body language, answering yes/no questions by blinking their eyes, raising a hand, or leading a person to what they want or need.
- Has rambling or incoherent speech but is still able to communicate their basic needs.
- Speaks in short phrases or with few words, but fully understands verbal communication and is able to communicate their basic needs or preferences.
- Has aphasia and only speaks one or a few set words, but fully understands verbal communication.

3: (No effective communication) is evident when a person with a health condition, that physically or cognitively limits their ability to communicate, is unable to express their basic needs or preferences. This includes but is not limited to a person physically or cognitively unable to tell someone they are hungry, thirsty, in pain or discomfort, or need to use the bathroom (e.g., a person with late stage dementia, a neurodegenerative disease, profound mental retardation, etc.).

REMINDER: On the LTC FS, the term 'assistive device' does not include hearing aids.

REMINDER: The Communication item is not meant to capture all nuances of communication. As a general rule, if a person can't fully or consistently meet a higher functioning level with communication that is efficient and accurate, select the lower functioning level that most closely approximates their ability.

## 7.3 Memory Loss

A person's memory loss should be reviewed in the context of their health, safety, or risk, during a typical day. At issue is the severity of the person's memory loss.

Good interviewing skills will allow the screener to gather information about the person's true memory capacity. Here, the screener is not required to obtain verification from a health care provider to support what is selected. A screener should observe and collect significant evidence to support their selection. To help evaluate a person's memory the screener may want the person to complete a short memory test (e.g., animal fluency test, mini mental status exam, etc.). The level of memory loss indicated here should correlate with the person's need for assistance with ADL and IADL tasks.

REMINDER: Claims of memory loss made by the person being screened or opinions voiced by family members should not simply be accepted as fact when what is reported is inconsistent with what the

screeners observe. Such opinions should be supported by the screener's observations, collateral information, or other evidence, such as medical records.

**Memory Options (at least one must be checked):**

- 0: No memory impairments evident during screening process
- 1: Short Term Memory Loss (seems unable to recall things a few minutes up to 24 hours later)
- 2: Unable to remember things over several days or weeks
- 3: Long Term Memory Loss (seems unable to recall distant past)
- 4: Memory impairments are unknown or unable to determine. Explain why

If 0: (No memory impairments evident during screening process) is selected that is the screener's only selection and no other box should be checked.

We all forget things from time to time and some forgetfulness is normal. Everyday forgetfulness that does not interrupt the person's daily life or activities is not memory loss.

Memory loss is not:

- Occasionally forgetting where you parked your car or left your keys.
- Being unable to recall the specific calendar date or someone else's telephone number or address.
- Occasionally forgetting appointments.
- Occasionally forgetting to take prescribed medication.
- When a person with a low IQ has difficulty remembering due to their cognitive impairment that limits their ability to retain information and reason.

1: (Short Term Memory Loss) is defined as the inability to recall recent events or new information, a few minutes up to 24 hours later. Memory loss occurs when new events or information are not transferred to the person's memory once their attention has shifted and they are then unable to recall what just transpired.

A person can have poor short term memory but have good long term memory (e.g., person in an early stage of dementia).

Indicators of short term memory loss can include but are not limited to when a person is unable to recall:

- When or what they last ate.
- The name of person they met moments ago.
- A conversation earlier in the day.
- They repeatedly ask the same questions.
- They have left water boiling on the stove or food cooking on the stove or in the oven, etc.
- Where an item was placed and they cannot re-trace their steps to find the "lost" item.
- Where an item was placed and a "lost" item is found in inappropriate place (e.g., house keys in the freezer).

2: (Unable to remember things over several days or weeks) is a level of memory loss evident when a person does not remember recent or special events from the last few days or weeks (e.g., a birthday gathering, a recent holiday, seeing a movie at a theatre, dining out for a fish fry, etc.).

3: (Long Term Memory Loss) is defined as the inability to recall memories that were stored years ago. Long term memory loss occurs because of a neurodegenerative process or trauma.

Indicators of long term memory loss can include but are not limited to when a person is unable to:

- Recognize family members
- Recall their date of birth
- Recall memories of childhood or special events

4: (Unable to determine. Explain Why) is the correct selection for a person with cognitive or other deficits when the screener is unable to determine whether the person being screened has any memory loss.

The sections of Memory Loss and Cognition for Daily Decision-Making do overlap, but the distinction helps clarify the person's specific need for assistance. Follow the definitions closely.

## 7.4 Cognition for Daily Decision Making

This section is meant to capture the person's ability to make **daily decisions beyond those that involve managing their medications and finances**. These two cognition related tasks are captured in the IADL section of Module 4.

### ***Cognition for Daily Decision Making Options:***

- 0: Person makes decisions consistent with their own lifestyle, values, and goals
- 1: Person makes safe, familiar/routine decisions but cannot do so in new situations
- 2: Person needs help with reminding, planning, or adjusting routine, even with familiar routine
- 3: Person needs help from another person most or all of the time

**Options 1, 2, and 3 include the ability to make routine decisions and exclude the ability to make non-routine decisions.** Some examples of **routine**, daily decisions a person typically makes independently can include but are not limited to:

- What time to get up or go to bed
- What to do with their free time (e.g., whether to watch TV, work on a puzzle, etc.)
- Whether to go visit friends, attend activities, shop, etc.
- Using scheduling cues such as clocks, calendars, or reminder notes

The inability to make such routine daily decisions without help may indicate a cognitive deficit.

It is normal for adults to seek advice from others when making some decisions. Seeking input from others does not automatically indicate a lack of cognitive function. Some examples of **non-routine** decisions a person typically does not make independently but makes with input from others can include but is not limited to:

- Household or vehicle repairs
- Larger purchases (e.g., new vehicle, appliances, furniture)
- Purchase of insurance (e.g., health, homeowner, or vehicle)
- Applying for assistance (e.g., Medicaid, Food Stamps, Homestead Credit)
- Surgery or medical treatment
- Change of residence
- Sale of their house
- Financial investments
- Enrolling in a LTC program

The inability to make such non-routine decisions may not indicate a cognitive deficit.

0: (Independent-Person makes decisions consistent with their own lifestyle, values, and goals)

### **Check this for a person who:**

- Can safely get through a day without needing a cue or reminder.
- Only needs assistance making non-routine decisions.
- Understands when and how to call for help if a problem or emergency arises.
- Can be left alone for short or long periods of time.

1: (Person makes safe, familiar/routine decisions but cannot do so in new situations)

**Check this for a person with a cognitive impairment who:**

- Can safely get through a day without needing a cue or reminder but is unable to problem solve a new event or situation that is typically a routine daily decision for others.
- Can safely get through a day without needing a cue or reminder but is unable to respond appropriately to unexpected events, emergencies, or problems typically a routine daily decision for others (e.g., When the person is locked out of their apartment and doesn't know what to do.).
- Can safely get through a day without needing a cue or reminder and is able to be left alone for up to an hour, but not longer.
- Can safely get through a day without needing a cue or reminder but does not have the capacity to know when to call for help (e.g., Person wouldn't call 911 when appropriate to do so.).
- Can safely get through a day without needing a cue or reminder but does not have the capacity to know who to call for help (e.g. Person wouldn't know who to call when their toilet stops working.).

2: (Person needs help with reminding, planning or adjusting routine, even in familiar routine)

**Check this for a person with a cognitive impairment who:**

- Cannot safely get through a day without needing cues, reminders, or guidance to initiate, plan, or complete routine everyday activities but can be left alone for up to an hour.

For example, without assistance the person would spend their day in bed or on the couch, watching television and sleeping; although they do not require line-of-sight supervision, they do require help during some periods of the day.

- Needs cues or reminders to eat, bathe, dress, or brush their teeth but can be alone for up to an hour.

3: (Person needs help from another person most or all of the time)

**Check this for a person with a cognitive impairment who:**

- Cannot be left alone for any length of time.
- Needs line-of-sight supervision.
- Needs one-to-one assistance due to a cognitive impairment.

## 7.5 Physically Resistive to Care

This section addresses those persons who have a **cognitive impairment and who are physically resistive to their care(s)**. A person is *physically resistive* when they become combative; they kick, bite, punch, or pinch another person during a care task; and in doing so, injury is possible and care is impeded.

A person is **not** considered *physically resistive* to their care when they **avoid** a task, **ignore** a prompt or cue to complete a task, or **refuse** to complete a task. Examples of behaviors that are **not** considered *physically resistive* include but are not limited to a person walking away from another person prompting them to complete a task or when a person turns their head away from another person assisting them with oral hygiene.

When determining if a person is *physically resistive* to care, the types of care considered are **only those listed on the LTC FS as an Activity of Daily Living (ADL) or an Instrumental Activity of Daily Living (IADL) care task**.

**Excluded** in the module are those cares **NOT listed on the LTC FS as an ADL or IADL care task**. For example, a person being *physically resistive* to assistance in the completion of hygiene or grooming tasks is **not recorded** on the LTC FS.

In this section, while a person must have a cognitive impairment in order to indicate they are *physically resistive* to care, it is not necessary that they have a guardian or other authorized representative appointed or activated (e.g., activated power-of-attorney for health care, durable power-of-attorney, etc.). However, there should be a medical diagnosis with collaborating evidence in other parts of the screen, indicating that a significant cognitive impairment is present. Included in this section is a person physically resistive to their care(s) due to the cognitive impairment associated with their Severe and Persistent Mental Illness.

### **Physically Resistive to Care Options:**

- 0: No
- 1: Yes, person is physically resistive to cares due to a cognitive impairment
- 2: Unknown

0: (No) includes but is not limited to a person who:

- Is resistive to care(s) but does not have a cognitive impairment.
- Is uncooperative during the provision of their care(s) but is not physically resistive to their care(s).
- Is competent and refuses care(s).
- Reacts verbally reacts by complaining, crying, or repeatedly says “No” when care is suggested or during the provision of their care(s).

1: (Yes, person is physically resistive to cares due to a cognitive impairment) includes but is not limited to a person who:

- Strikes out or throws objects at a caregiver when care is provided.
- Kicks, punches, or pinches another person when care is provided.

2: (Unknown) includes but is not limited to a person who, during the screening process, the screener is unable to determine whether the person is physically resistive to their care(s).

**REMINDER:** This section addresses physical combativeness during the provision of ADLs and IADLs captured on the LTC FS (e.g., bathing, toileting, etc.). It does not address ongoing behavior patterns that involve violent or offensive acts. Such behaviors requiring interventions are captured in Module 6, Health Related Services Table and Module 8, Behaviors/Mental Health.

**REMINDER:** A screener would NOT select "Yes" for the competent adult who refuses care. All competent adults have the right to refuse any services. For each ADL and IADL task the screener is to indicate the help the person needs, whether or not they are receiving the help now and whether or not they accept the assistance. If the person's refusal to accept assistance puts them at risk, the screener indicates that in the Risk Module.

**REMINDER:** Although a person's behavior of being physically resistive to care may be part of a larger pattern of offensive or violent behavior, the two do not always occur together. For example, an otherwise docile and cooperative person may resist the intrusive nature of help provided with their bath.

## Module #8: Behaviors/Mental Health

**NOTE:** On July 1, 2008, Department staff recorded a training webcast that provided an overview of the changes to this module.

To view the webcast go to <http://media1.wi.gov/DHFS/Viewer/?peid=5742a3b6-1b05-4dda-af43-4b7a27e07ce9>.

(If you have not participated in a webcast before check your computer to see if it meets the minimum requirements at <http://dhs.wisconsin.gov/webcast/help.htm>).

### Objectives

*By the end of this module you should be able to:*

- Accurately complete the Wandering, Self-Injurious Behaviors, Offensive or Violent Behavior, Mental Health, and Substance Use sections of the LTC FS.
- Distinguish behaviors as defined on the LTC FS from simply unhealthy choices.
- Document when a person who is mentally ill or has substance use issues needs further mental health or substance use services.

### 8.1 Four Sections in this Module of the LTC FS

1. Wandering
2. Self-Injurious Behaviors
3. Offensive or Violent Behavior to Others
4. Mental Health Needs and Substance Use

### 8.2 Overview of the Behaviors/Mental Health Module

**This module relies on both a history and a structured interview process to accurately record an individual's behavior that may have an effect on the cost of the individual's long term care services.**

“Cognitive Impairment” includes impairment of thought due to severe mental illness, dementia, brain injury, developmental disabilities, or other organic brain disorders. It does not include the temporary impairment due to intoxication.

“Interventions” in this module include:

- Monitoring the person when he/she exhibits the behavior.
- Having someone (a caregiver, spouse, etc.) present to prevent the person from exhibiting the behavior.
- Redirecting the person when he/she exhibits the behavior.
- Physically preventing the person from exhibiting the behavior.
- Responding to problems caused by the person's behavior.

If the screener is uncertain about whether a behavior fits one of the categories above, they should consult with their screen liaison or assigned state staff.

If the intent is to capture/record a behavior issue that the screener believes should be documented but the issue does not clearly “fit” into one of the categories listed, it should be described in the notes section of the screen.

Examples included in each section of this module are not all-inclusive.

**REMEMBER:** A screener should document an individual’s NEEDS, not just what services/assistance they are currently receiving. So, if a person has an identified need, but for some reason is not receiving assistance (including refusing the service, etc.), the screener should still capture the need for the assistance in this section.

*QA Check:* There may be a difference between the amount of behavior interventions documented in this section and the HRS table. In order for the behavior row on the HRS table to be checked, the individual must have a cognitive impairment. However, in this module, it is not necessary to have a cognitive impairment to indicate self-injurious, offensive or violent behaviors. Screeners should review both modules to assure that the individual’s needs have been accurately checked.

## 8.3 Wandering

**Definition:** For a person with cognitive impairments, unsafely leaving or attempting to leave an immediate area (home, community, workplace, etc.) without informing others that **requires intervention**. The person may still exhibit wandering behavior even if elopement is impossible due to preventative measures, such as facility security systems, bed and wheelchair alarms, etc..

**Check this for a person who:**

- Wanders and requires interventions.
- Elopes or attempts to elope from a residence and requires interventions.

**Do NOT check this for a person who:**

- Does not have a cognitive impairment, but is purposefully trying to leave, escape, etc.
- Paces within their residence due to anxiety, nervousness or boredom.
- Wanders but does not require interventions.

**Wandering Options:**

- Does not wander
- Daytime wandering but sleeps nights
- Wanders at night or day and night

*QA Check:* If any type of wandering is marked here, the screener will be instructed to mark the Interventions related to the Behaviors row on the HRS Table as well. On the HRS Table, the screener should select the appropriate amount of interventions needed.

## 8.4 Self-Injurious Behaviors

**Definition:** For a person with or without a cognitive impairment, self-injurious behaviors include those that cause or are likely to cause injury to one’s own body **AND that require interventions**. Self-injurious behaviors are defined as physical self-abuse and do not include the absence of self-care or behaviors that may have unhealthy consequences.

**Check this for a person who:**

- Exhibits self-abuse that causes or is likely to cause self-injury (hitting, biting, head banging, etc.)
- Has pica (eating inedible objects)
- Has Polydipsia (engages in water intoxication)
- Self-mutilation that requires intervention

**Do NOT check this for a person who:**

- Smokes, drinks alcohol, misuses drugs (legal and illegal)
- Is sexually promiscuous
- Makes poor eating choices (eating high sugar-content foods despite diabetes)
- Has habits that are innocuous and do not result in injury, such as repetitive head tapping or self-stimulation
- Self-mutilation that does not require interventions
- Recently attempted or has a history of attempting suicide or has suicidal ideations (this should be captured in the mental health section of this module)

**Self-Injurious Behaviors options:**

- No injurious behaviors demonstrated
- Some self-injurious behaviors that require interventions weekly or less
- Self-injurious behaviors that require interventions 2 to 6 times per week OR 1 to 2 times per day.
- Self-injurious behaviors that require intensive 1-on-1 interventions more than twice each day.

Select the answer that most accurately reflects the frequency of interventions needed for this behavior.

QA Check: There may be a difference between the amount of behavior interventions documented in this section and the HRS table. In order for the behavior row on the HRS table to be checked, the individual must have a cognitive impairment. However, in this section, it is not necessary to have a cognitive impairment to indicate self-injurious behaviors. Screeners should review both sections to assure that the individual's needs have been accurately checked.

## 8.5 Offensive and Violent Behavior to Others

This section is intended to capture behaviors of individuals with or without a cognitive impairment that impact others in the person's community; including other residents in a facility, neighbors or people in the community at large **AND** that **require intervention**.

**OFFENSIVE BEHAVIOR:** Behavior that causes or can be reasonably expected to cause discomfort or distress to others:

**Check this for a person who:**

- Disrobes or masturbates in front of others
- Engages in inappropriate touching, sexual advances toward others
- Spits at or on others
- Urinates or defecates in inappropriate places (e.g., living room, front porch, etc.) or on another person or the act of spreading urine or feces
- Reacts/responds to stimuli with incessant screaming or another behavior response that disturbs or disrupts his/her community.

**Do NOT check this for a person who:**

- Uses profanity in conversation
- Hoards or who has poor housekeeping skills/practices
- Has poor personal hygiene, body odor, incontinence
- Intrudes into another's living space, office, etc.
- Has a difficult personality (e.g., is obstinate, vulgar, does not get along with his/her caregivers, staff, etc.)
- Exhibits behavior(s) that may indicate a need for medical treatment/mental health services but that do not require intervention (e.g., anxiety disorder, OCD)
- By appearance or mannerisms, etc. may elicit social prejudice such as avoidance, stigmatization, etc. (e.g., Tourette's Syndrome)

**VIOLENT BEHAVIOR:** Behavior of individuals with or without a cognitive impairment that causes or threatens to cause physical harm to another person or is a risk to the community and requires intervention.

**Check this for a person who:**

- Strikes out at or strikes, kicks, bites, or otherwise batters others
- Commits/has history of sexual aggression, pedophilia, arson, etc.
- Tortures, maims or otherwise abuses animals
- Verbally, aggressively threatens others; includes aggressive gestures, raised fists, etc.

**Do NOT check this for a person who:**

- Expresses anger, frustration using profanity
- Threatens/commits self injury (see Section 8.4 above)
- Vaguely threatens others (e.g., “somebody’s going to pay...”)

**Offensive or Violent Behavior to Others options:**

- No offensive or violent behaviors demonstrated
- Some offensive or violent behaviors that require occasional interventions weekly or less
- Offensive or violent behaviors that require interventions 2 to 6 times per week OR 1 to 2 times per day
- Offensive or violent behaviors that require intensive 1-on-1 interventions more than twice each day.

Select the answer that most accurately reflects the frequency of interventions needed for this behavior.

*QA Check:* There may be a difference between the amount of behavior interventions documented in this section and the HRS table. In order for the behavior row on the HRS table to be checked, the individual must have a cognitive impairment. However, in this section, it is not necessary to have a cognitive impairment to indicate offensive or violent behaviors. Screeners should review both sections to assure that the individual’s needs have been accurately checked.

## 8.6 Mental Health Needs and Substance Use

**It is estimated that from 40 to 70% of long-term care consumers also have mental health and/or substance use issues.**

It is recognized that many people will not divulge this information during the screening process. However, the information is important to share with the LTC program the consumer chooses to enroll in, and for rate-setting and quality assurance. **Screeners should ask about mental health and substance use diagnoses when confirming other diagnoses, health-related services, and target group questions.**

**Screeners should also use their professional interviewing skills and observation to elicit the most accurate possible answers to these questions.**

**Mental Health Needs Options:**

- No known diagnosis of mental illness--no mental health problems or needs evident
- No known diagnosis of mental illness-person may be at risk and in need of some services
  - “Person may be at risk and in need of some mental health services” is an opportunity for the screener to indicate their professional judgment that the person may be at risk and in need of some mental health services. Frequent crying, hand wringing, frowning, poor eye contact, flat affect, expressions of despair, self-hate or hopelessness, etc., can all be signs of depression or unresolved grief with which the person may need help. The screener is not diagnosing anything, they are merely indicating that the person “may be at risk and in need of mental health services.” Current system problems (such as cultural or funding barriers to access of

mental health services) should not prevent the screener from indicating what is perceived in the applicant's demeanor and situation.

- Person has current diagnosis of mental illness that is currently stable
  - “Stable” here means the person is functioning well with routine periodic oversight/support, and is currently receiving such oversight/support
- Person has current diagnosis of mental illness that is currently not stable
  - The person needs intensive mental health services (whether they are currently getting them or not--they need them.)

A current diagnosis of mental illness does not need to be limited to a major mental illness but can include anxiety disorders, depression, personality disorders etc. Psychiatric diagnoses must be confirmed with a health care provider or medical record.

Screeners should not deduce a diagnosis from a list of medications. For example, anti-depressants are prescribed for other reasons than depression, such as chronic pain. Contact a health care professional to find out what the antidepressant is for. This applies to the diagnosis table as well as the mental health question. Screeners are never to deduce, infer, or otherwise “make up” diagnoses.

Unstable does not equate with Community Support Program (CSP) enrollment. There are many individuals who receive CSP services who are extremely stable. Indicators of mental health instability are hospitalizations more than once a year as a result of the person's mental illness, exacerbations of positive symptoms (hallucinations, delusions) to the point where it interferes with work or other activities of daily living and disrupts relationships. Other indicators would be a need for frequent adjustments in psychotropic medications or frequent emergency room visits. This list is not all-inclusive but, includes some of the indicators you would want to ask about.

*QA Check:* If mental health needs are identified as a 2 or 3 (current diagnosis), a corresponding diagnosis under H on the diagnosis page should be checked.

***Substance Use Options:***

- No active substance use problems evident at this time
- Person or others indicate a current problem, or evidence suggests possibility of a current problem or high likelihood of recurrence without significant on-going support or interventions
- In the past year, the person has had significant problems due to substance use. (Examples: police interventions, detox, inpatient treatment, job loss, major life changes.)

The information collected from the mental health and substance use questions play no role in the eligibility logic. They are informational for the LTC program enrolled in by the consumer. These questions may be used for quality assurance and improvement studies to see that mental health or substance use problems noted in the LTC FS are being addressed by the LTC program in which the consumer enrolls.

# Module #9: Risk

## Objectives

By the end of this module you should be able to:

- Accurately complete the Risk section of the LTC FS.
- Describe “imminent risk of institutionalization” and why it's important.
- Identify when Risk Box 2 should be selected based on the person’s level of risk if they would be without needed assistance from another person over a 6 to 8 week time period. Understand how Risk items relate to APS or EA/AAR services for a person being screened with the LTC FS.

## 9.1 Overview

**The Risk Module of the LTC FS has been designed to do the following:**

- Increase awareness of when a person may be at risk of institutionalization in a nursing home or Intermediate Care Facility for the Mentally Retarded (ICF-MR).
- Convey risk factor information to the LTC program.

Newly discovered cases of abuse, neglect, or exploitation should, in most instances, result in a referral to the APS or EA/AAR agency for investigation, case planning, and any necessary court related services.

**Screeners are expected to recognize signs of abuse, neglect, or exploitation, and to know how to respond appropriately.** Wisconsin Statute 46.90 defines abuse as physical, sexual, emotional, restraint, confinement, and treatment without consent; neglect includes self-neglect or neglect of others or financial exploitation.

Hereafter, abuse, neglect, or exploitation will refer to any of the types listed above.

## 9.2 Part A - Current Adult Protective Services (APS) or Elder Adult/Adult at Risk (EA/AAR) Client

**Current APS or EA/AAR Client Options:**

- A1: Known to be a current client of Adult Protective Services (APS)
- A2: Currently being served by the lead Elder Adult/Adult at Risk (EA/AAR) agency

The A1 and A2 lists below contain common, illustrative examples. These lists are not all inclusive lists of examples.

Check all applicable boxes.

**A1: (Known to be a current client of Adult Protective Services [APS]) is selected when:**

- APS is pursuing or has established a temporary guardianship of the person or estate.
- APS is pursuing a guardianship of the person or estate.
- APS is pursuing a temporary or final protective placement order.
- APS is working with the person to evaluate their level of competency.
- APS is working with the person to evaluate their level of need for assistance.
- APS has filed for or obtained a temporary restraining order or permanent injunction for the individual at risk (Wisconsin Statute 813.123).
- Person has a court order for protective services or a protective placement.

REMINDER: Do not select A1 when a person's guardianship has been finalized and there is no protective placement order in place.

**A2: (Currently being served by the lead Elder Adult/Adult at Risk [EA/AAR] agency) is selected when:**

- The EA/AAR agency is working with the person to determine an appropriate response to the referral.
- The EA/AAR agency is working with the person to evaluate their level of need for assistance.

## 9.3 Part B - Risk Evident During Screening Process

A person's level of risk may be influenced by a number of factors. These may include choices they make about how they live their lives; whether they follow or disregard medical advice or accept or refuse assistance from others. On the other hand, a person may be at risk due to the action or inaction of another individual.

Generally, a competent person has the right to live with a level of risk others may not agree with or support. Regardless of choices the person makes, they may still have a need for assistance or supervision and that need should be recorded on the LTC FS.

**Risk Evident During Screen Process Options:**

- 0: No risk factors or evidence of abuse, neglect, or exploitation apparent at this time
- 1: The person is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes
- 2: The person is at imminent risk of institutionalization (in a nursing home or ICF-MR) if they do not receive needed assistance or person is currently residing in a nursing home or ICF-MR
- 3: There are statements of, or evidence of, possible abuse, neglect, or exploitation
- 4: The person's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months)

At least one box in Part B must be checked. Check all applicable boxes, however if box "0" is checked, do not check boxes 1, 2, 3, or 4.

***0: (No risk factors or evidence of abuse, neglect, or exploitation apparent at this time)***

***1: (The person is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes)***

The 'Check this for a person who' list contains common, illustrative examples. This list is not an all inclusive list of examples.

**Check this for a person who:**

- Is competent and refuses needed services.
- Is competent and mismanages their disease. For example, a person with insulin dependent diabetes mellitus who eats a diet high in sugar and carbohydrates.
- Is competent and participates in a high risk behavior. For example, a person prescribed continuous oxygen who smokes cigarettes. High risk behavior can include but is not limited to: poor nutrition, substance use, self-neglect, hoarding, refusing to take prescribed medications, or refusing to take medications as prescribed.
- Does not receive assistance from another person to complete any ADL or IADL task, but may need access to community services (e.g., a person needing access or assistance to apply for Food Stamps or Medicaid coverage).
- Is not at imminent risk that institutionalization (in a nursing home or ICF-MR) will occur within the next 6 to 8 weeks. However, without needed assistance the person may be at risk of entering a nursing home or ICF-MR beyond eight weeks.

- May be at risk of entering an Institute for Mental Disease (IMD) or hospital for psychiatric services.
- Risk Box 1 and Risk Box 2 often overlap. Risk Box 1 is broader than Risk Box 2, and can include a person for whom Box 2 does not apply.

**2: (The person is at imminent risk of institutionalization (in a nursing home or ICF-MR) if they do not receive needed assistance or person is currently residing in a nursing home or ICF-MR)**

This is federal language referencing when a person will be deemed nursing home eligible because they are at imminent risk of institutionalization if they do not receive needed assistance. Whether a person is at imminent risk of institutionalization is critical in determining whether he or she is eligible for a nursing home level of care. The federal Centers for Medicare and Medicaid Services has advised states that imminent risk of institutionalization means the person would require nursing home or ICF-MR care within 6 to 8 weeks, if community-based services were not provided. Screener should consider carefully whether the individual meets this criteria.

Risk Box 2 also applies to and should be selected for a person currently residing in a nursing home or ICF-MR.

The selection of Risk Box 2 is appropriate if the person's health, without any needed assistance from another person, within 6 to 8 weeks, would likely decompensate to the point where they would need to consider entering a nursing home or ICF-MR to receive care. It's not an issue of whether the person states they will never agree to or never plans to enter a nursing home or ICF-MR.

When evaluating a person's level of risk, the screener should review the type and amount of assistance the person needs from another person. This review needs to consider how the person would be doing within 6 to 8 weeks if they went without any paid or unpaid assistance from others. Assistance includes needed care provided by a spouse, partner, friend, neighbor, or other person providing informal support. Whether a person is paid or not for providing assistance does not diminish the value of that assistance in helping a person live outside of a nursing home or ICF-MR.

The evaluation of a person's level of risk should not factor-in the person's need to use an adaptive aid to complete an ADL or IADL task. A person's independent use of an adaptive aid does not indicate a need for assistance from another person and does not indicate a level of risk.

**REMINDER:** When a person has a guardian or activated power of attorney for health care agent, do not automatically select Risk Box 2, without reviewing whether the person being screened would be at risk of entering a nursing home or ICF-MR.

The 'Check this for a person who' list and the 'Do NOT check this for a person who' list contain common, illustrative examples. These lists are not all inclusive lists of examples.

**Check this for a person who:**

- Has daytime incontinence daily and needs assistance with changing incontinence pads, if used.
- Has fallen more than once in the last month and sustained at least one injury requiring medical treatment.
- Is in the end-stage of a terminal illness.
- Due to a physical health exacerbation, had 3 or more hospital admissions in the last 6 months.
- Is currently residing in a nursing home or ICF-MR.
- Requires assistance from another person with three or more ADLs.
- Is residing in a licensed residential care facility and needs that level of care or supervision.
- As a result of developmental disability, degenerative brain disorder, serious and persistent mental illness, or other like incapacities, the individual will incur a substantial risk of physical harm or deterioration or will present a substantial risk of physical harm to others if protective services are not provided (Wisconsin Statute 55.08(2)(b)).
- Meets at least one of the criteria above, but they, their family members, or their authorized representative express unwillingness to have the person ever reside in a nursing home or ICF-MR.

**Do NOT check this for a person who:**

- Uses an adaptive aid or mobility device independently to complete an ADL or IADL task and as a result, does not need any assistance from another person to complete the ADL or IADL task.
- Only needs assistance with grocery shopping.
- Only needs assistance with snow removal or lawn care.
- Only needs assistance with the Transportation IADL.
- Is at risk of admission to a hospital or Institute for Mental Disease (IMD) for psychiatric services.
- Is at risk of entering a jail or prison.
- Voluntarily or by court order receives Chapter 51 community-based services. Chapter 51 services are in response to a person's need for treatment, not nursing home or ICF-MR care.
- Has a guardian of the person without first reviewing whether they are at risk of entering a nursing home or ICF-MR.

REMINDER: Risk Box 2 should not be selected based solely on a person's target group. Although a person's condition meets a target group definition, this is not in and of itself sufficient to meet the imminent risk criteria.

**3: (There are statements of, or evidence of, possible abuse, neglect, or exploitation)**

The screener should select this box to provide notification to the person's selected LTC program that the person is at risk.

Risk Box 3 should be selected when an applying minor child (age 17 and 6 months or older), adult, or an adult at risk is at imminent risk of serious bodily harm, death, sexual assault, or exploitation and is unable to make an informed judgment about whether to report the risk.

An adult at risk is defined as any adult with a physical or cognitive condition that substantially impairs their ability to care for their needs and who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, or exploitation.

When Risk Box 3 is selected, the screener will most often make a referral for an investigation to the local APS or EA/AAR agency. According to Chapters 46.90 and 55.043, professionals are not required to make such a referral if they believe that doing so would not be in the best interest of the elder/adult at risk.

REMINDER: A competent adult cannot refuse to have a reporter make a referral for an investigation, but the adult can refuse to accept any services offered as a result of the investigation.

The 'Check this for a person who' list contains common, illustrative examples. This list is not an all inclusive list of examples.

**Check this for a person who:**

- Is an adult at imminent risk of serious bodily harm, death, sexual assault, or exploitation and is unable to make an informed judgment about whether to report the risk.
- Is being referred to the APS or EA/AAR agency for an investigation of abuse, neglect, or exploitation.
- Is not being referred to the APS or EA/AAR agency, because it is the screener's professional judgment that making the referral will not be in the best interest of the person.

Example: Helen is a 90-year-old woman living alone, independent in all ADLs and IADLs, with no obvious cognitive impairment, physical impairment, or behavioral problem. Yet she is living in a tiny rundown house with 32 cats, filthy conditions, and broken plumbing. She says she eats three meals a day, doesn't mind the cat hair, cat urine and feces, etc., throughout the house, and doesn't need any help. She has no medical conditions or need for any health related services. She receives no assistance from another person. The screener should select Risk Box 1 and Risk Box 3, but not Risk Box 2.

Risk Box 1 should be selected because Helen is at high risk of failing to maintain her safety adequate to avoid significant negative health outcomes related to her lifestyle choices.

Risk Box 2 should not be selected because it is not clear Helen would be at risk of being functionally eligible to enter a nursing home within 6 to 8 weeks.

Risk Box 3 should be selected because there is evidence of Helen's self-neglect related to her lifestyle choices.

***4: (The person's formal and informal support network appears adequate at this time, but may be fragile in the near future [within next 4 months])***

The 'Check this for a person who' list contains common, illustrative examples. This list is not an all inclusive list of examples.

**Check this for a person who:**

- Has an informal caregiver who is physically or emotionally exhausted from providing the person's care.
- Has an informal caregiver who will no longer be able to provide care (e.g., caregiver winters in a southern state, caregiver grandchild will be attending college out of the area, etc.).
- Is at risk of losing their residential care due to a change in their financial circumstances, the residential care facility closing, or their increased physical, cognitive, or behavioral care needs.

# Module #10: Completion of the LTC FS

## Objectives

*By the end of this module you should be able to:*

- Accurately complete the time it took to complete a screen
- Utilize the Notes utility built into the LTC FS application

## 10.1 Screen Completion Date

Indicate the date on which all sections of the LTC FS were complete. It may take more than one day to complete all sections (ADL, IADL, HRS table, etc), especially if a screener must wait for information from health care providers. It is acceptable for one person to enter the demographic information (module 1) and for the certified screener to complete the clinical entries (module 2-6). However, all of the screen entry time should be combined and put under the certified screener's name.

When correcting information on a screen, do not change the "screen completion date." Enter the exact time it took to correct or update a screen. If you are simply making changes to the demographics (e.g., change of address), then enter "0". You must re-calculate eligibility after making screen corrections as required in section 10.8.

Note: The screen completion date is the date when all sections were completed by the certified screener, not the date information is entered into the computer.

## 10.2 Face to Face Contact with Person

This is the amount of time the screener spent face-to-face meeting with the consumer. Please round time to the nearest 15 minutes (00, 15, 30, 45).

## 10.3 Collateral Contacts

This is the amount of time the screener spent face-to-face meeting with collateral contacts (family members, friends, health care providers, etc). And/or the amount of time the screener spent on the phone talking with collateral contacts. Please round time to the nearest 15 minutes (00, 15, 30, 45).

## 10.4 Paper Work

This is the amount of time the screener spent doing paperwork and paper research to complete the LTC FS. Phone contact with the consumer should be included in this category. Please round time to the nearest 15 minutes (00, 15, 30, 45).

## 10.5 Travel Time

This is the amount of time the screener spent traveling to and from appointments associated with the gathering of information necessary to complete the LTC FS. Please round time to the nearest 15 minutes (00, 15, 30, 45).

- Write all times as hours and minutes rounded to the nearest 15 minutes.
- The LTC FS application will sum them up for the total time.

## 10.6 Notes

Throughout all sections of the LTC FS screeners may click on the “Notes” link on the left bar of the screen to enter notes.

- Notes should be dated and initialed by the screener.
- Notes should be concise and provide additional information that the screener thinks would be of value to the LTC program selected by the person being screened.
- Example of appropriate note entry:  
 “January 12, 2003:  
 “Ms. Washington has many throw rugs on her wooden floors. We spoke briefly about falling, but this should be pursued further. She is able to prepare meals, but is inclined to get by on sweets because it is too much trouble to “cook for one.”  
 “--S. Smith, RN

## 10.7 Calculating Eligibility

The act of calculating eligibility is the final step that makes a functional screen ‘complete’. This applies to new screens, or updates to existing screens.

When you enter a new screen, that screen will be considered ‘incomplete’ until eligibility is calculated. If there is no red check mark next to eligibility on the left-hand navigation bar, then the screen is currently ‘incomplete’. You must calculate eligibility to make this screen ‘complete’, which will show up as a red check mark next to eligibility on the left-hand navigation bar.

When you are making a change to an existing screen, there are some times when you must re-calculate eligibility, and some times when re-calculating eligibility is not required.

Any time you change any data which may cause a change in eligibility (i.e., a change to ADLs or IADLs or HRS, etc), you must re-calculate eligibility, even though the LOC scores may not have changed. In addition, any time you make a change to applicant name, applicant SSN, or applicant birth date, eligibility must be re-calculated, even though these data items won’t have any affect on LOC score.

If you change any of the following data, you will not have to re-calculate eligibility:

- Applicant address
- Applicant phone number
- Applicant gender
- County/tribe of residence
- County of responsibility
- Directions
- Screener’s name
- Referral date

How can you tell when you need to re-calculate eligibility? ***Always check for the red check mark next to eligibility on the left-hand navigation bar.*** If there is a red check mark, the screen is considered ‘complete’. No red check mark means the screen is considered ‘incomplete’.

## 10.8 COP Level 3 (For Home and Community Based Waiver Counties Only)

**Note: COP Level 3 only applies to Home and Community-Based Waiver Counties and to Resource Center Counties without a Managed Care Organization.**

The COP Level 3 page is optional and should be used after the person has been fully screened to test for waiver eligibility.

### **Part A - Alzheimer's and related diseases:**

**1. The person has a physician's written and dated statement that the person has Alzheimer's and/or another qualifying irreversible dementia.**

**2. The person needs personal assistance, supervision and protection, and periodic medical services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative need, but not regular nursing care.**

Alzheimer's disease and other irreversible related dementia describes a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder.

Irreversible dementia diagnoses include:

- Alzheimer's Disease
- Creutzfeld-Jacob Disease
- Friedrich's Ataxia
- Huntington's Disease
- Irreversible Multi-Infarct Disease (DSM III, 290.4x)
- Parkinson's Disease
- Pick's Disease
- Progressive Supranuclear Palsy
- Wilson's Disease

### **Part B – Interdivisional Agreement 1.67:**

**1. The person resided in a nursing home or received CIP II/COP-W services and was referred through Interdivisional Agreement 1.67 in accordance with s. 46.27(6r)(b)(3).**

Applies to individuals for whom a DHS/Division of Quality Assurance nursing home surveyor has issued a 1.67 administrative order to refer the individual to the county for nursing home discharge and alternative living arrangement (or other needed services).

## 10.9 No Active Treatment (NAT) (Family Care MCO Counties Only)

**Note: The NAT page in the LTC FS only applies to Family Care counties with a Managed Care Organization.**

To augment your understanding of the text that follows, refer to the NAT page on the paper form and the NAT algorithm in the Appendices at the end of this instruction manual.

"No Active Treatment" (NAT) is a designation given to individuals with a developmental disability who, for either health reasons or because of advanced age, no longer require treatment related to their developmental disability. In addition, a person with a developmental disability such as cerebral palsy but with a normal IQ could be appropriate for a NAT designation.

In order to use Medicaid funds for Family Care (FC) services, the U.S. Center for Medicaid and Medicare Services (CMS), has granted Wisconsin two separate home and community-based waivers. One is for frail elders and people with physical disabilities, and one is for people with developmental disabilities. CMS requires that individuals with a developmental disability receive services through the developmental disabilities waiver unless there is documented evidence that active treatment for the developmental disability is not required. This decision would result in a NAT designation for such an individual.

There are limited circumstances in which a NAT designation would be beneficial to a FC consumer. The care planning process in FC is the same for all members, whether they have a developmental disability or not, so any appropriate active treatment would be included no matter which waiver they are in. The only reason to process a NAT designation is related to a difference in the residential services allowable for people enrolled in the FC developmental disabilities waiver, versus people enrolled in the FC elderly/physical disabilities waiver. Residential services for individuals in the FC developmental disabilities waiver must be provided in a setting of 4 or fewer beds (MCOs can obtain a waiver for settings up to 8 beds). For individuals in the FC elderly/physical disabilities waiver, there is no limit on size or type of residential facility.

The county Economic Support (ES) unit must enter the appropriate waiver and level of care on the CARES system to complete the eligibility determination and FC enrollment process. In non-FC counties, the assessment and care planning activities occur before eligibility determination, so the long-term care program has had an opportunity to determine if an individual with developmental disabilities should receive active treatment, or whether he/she should have a NAT designation. In Family Care counties, the MCO does the assessment and care plan after the individual enrolls.

In order for an appropriate waiver to be designated at enrollment, before the MCO has finished the comprehensive assessment and care plan, the initial Long Term Care Functional Screen (LTC FS) will automatically designate the developmental disabilities waiver if the individual has been checked as being in the federal developmental disabilities target group, (regardless of other target groups checked). Similarly, if a diagnosis normally associated with a developmental disability (i.e., cerebral palsy, muscular dystrophy) has been checked, the LTC FS will default to the FC developmental disabilities waiver.

A NAT designation can be entered if the resource center has certain information, or if the MCO comprehensive assessment supports an NAT designation.

The resource center may check the NAT screen if any of the following are true:

- The person has a terminal illness;
- The person has a documented IQ greater than 75 (The RC must give the documentation about IQ level to the MCO); and/or
- The person is ventilator-dependent.

After completing the comprehensive assessment, or at the time of a re-certification or change of condition screen, the MCO may indicate a NAT designation on the LTC FS, or may request the resource center to do so, if:

- The person meets any of the criteria described in the above paragraph;
- The person has physical or mental incapacitation due to advanced age such that his/her needs are similar to a geriatric nursing home resident;
- The person is elderly (over 65) and would no longer benefit from or no longer wants to participate in active treatment for his or her developmental disability; and/or
- The person has severe chronic medical needs requiring skilled nursing care.

Documentation that supports why the person has a NAT designation must be part of the member's record at the MCO. The Department will monitor the appropriateness of NAT designations by including individuals with NAT designations in targeted care plan reviews.

# Appendices

## A. Glossary of Acronyms

ADL	Activity of Daily Living
AFCSP	Alzheimer's Family Caregiver Support Program
AODA	Alcohol and other Drug Abuse
APS	Adult Protective Services
ASL	American Sign Language
Bi-PAP	Bi-level positive airway pressure
CARES	Client Assistance for Reemployment and Economic Support
CBRF	Community Based Residential Facility
CIP	Community Integration Program
CIS	Community Integration Specialist
CMS	Centers for Medicare & Medicaid Services (formerly known as HCFA)
COP	Community Options Program
COPD	Chronic Obstructive Pulmonary Disease
C-PAP	Continuous positive airway pressure
CSP	Community Support Program
DD LOC	Developmental Disability Level of Care
DD	Developmental Disability
DD1A	Developmental Disability Level person with significant medical problems
DD1B	Developmental Disability Level person with significant behavioral problems
DD2	Developmental Disability Level person who needs help with all or most ADLs and IADLs
DD3	Developmental Disability Level person who is more independent with most ADLs and IADLs
DQA	Division of Quality Assurance
EAN	Elder Abuse and Neglect
ER	Emergency Room
ES	Economic Support
FC	Family Care
FDD	Facilities for Persons with Developmental Disabilities
HCBW	Home and Community Based Waiver
HCFA	(See CMS) Health Care Financing Administration
HRS	Health Related Services
IADL	Instrumental Activity of Daily Living
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility for the Mentally Retarded
IMD	Institute for Mental Disease

IPPB	Intermittent Positive Pressure Breathing
IRIS	Include, Respect, I Self-Direct (Self Directed Supports Waiver)
ISN	Intensive Skilled Nursing
IV	Intravenous
LOC	Level of Care
LTC FS	Long Term Care Functional Screen
LTC	Long-Term Care
MCO	Managed Care Organization
MAPP	Medicaid Purchase Plan
MDS	Minimum Data Set
NAT	No Active Treatment
NNH LOC	Non-Nursing Home Level of Care
NH LOC	Nursing Home Level of Care
OASIS	Outcome and Assessment Information Set
OTC	Over the Counter
PACE	Program of All-Inclusive Care for the Elderly
PD	Physical Disability
PF	Public Funded
POA	Power of Attorney
POAHC	Power of Attorney for Health Care
PP	Private Pay
QA	Quality Assurance
QMRP	Qualified Mental Retardation Professional
RC	Resource Center
RCAC	Residential Care Apartment Complex
SDS	Self Directed Supports
SNF	Skilled Nursing Facility
SPMI	Serious and Persistent Mental Illness
SS	Social Security
SSN	Social Security Number
TMG	The Management Group
TPN	Total Parenteral Nutrition
WI DHS	Wisconsin Department of Health Services

## B. “Mark It” – Reminders for Screeners

- **DHS Screener Resources Web Site** (Paper Form, Diagnoses Cue Sheet, etc.)  
<http://dhs.wisconsin.gov/LTCare/FunctionalScreen/#adult>

- **LTC FS Application**  
<https://fsia.wisconsin.gov/>

- **Security or Password Problems?**  
Can't get into the LTC FS application? Forgot your password? Call the DHS SOS Desk at:

DHS SOS Desk  
Tel: 608/266-9198  
Fax: 608/267-2437  
E-mail: [dhssoshelp@wisconsin.gov](mailto:dhssoshelp@wisconsin.gov)

If you need help at other times, you may leave a voicemail and someone will return your call. Indicate you need Functional Screen help.

- **Application or Technical Problems?**  
LTC FS application not working correctly? Call the DWD Service desk at:

DWD Service Desk  
608-266-7252

- **Still need help?**  
Check with your screen liaison. A screen liaison has been designated for every screening agency/county. Screen liaisons are THE local resource for information and they also have the login instructions for the screen training course. If your screen liaison isn't able to answer your question, he or she will consult with the appropriate staff at the State.

- **Need to take the Web-Based Screener Certification Course?**  
All screeners must pass the screener training course in order to become certified. The on-line course is available from any computer with Internet access.

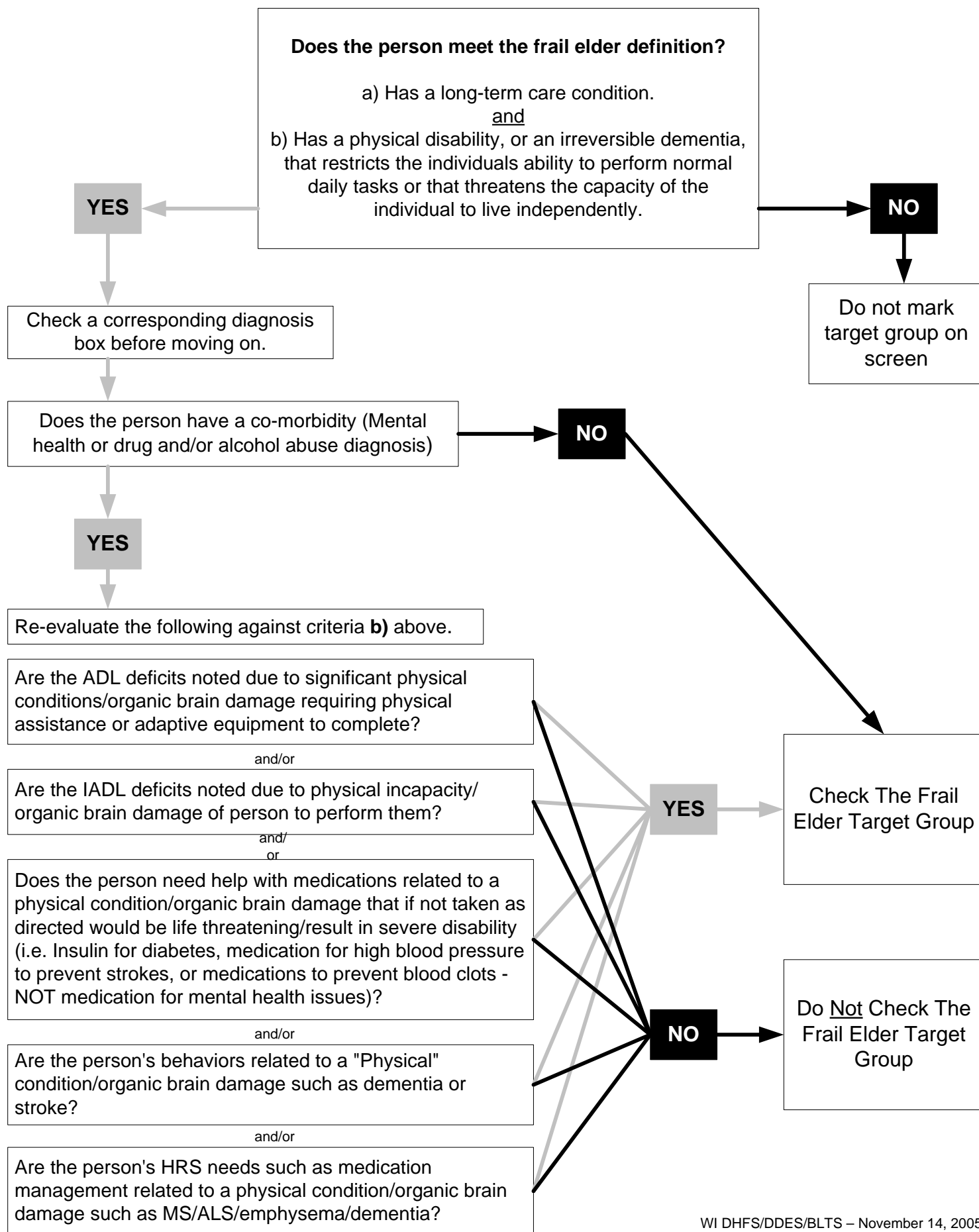
Functional Screener training course at: <http://mynursingce.son.wisc.edu/index.pl?id=17777>

- **Need help registering for the course?**  
Need help registering? Forgotten your password? Quizzes aren't available? Contact the DHS SOS Desk at 608-266-9198 or e-mail them at [dhssoshelp@wisconsin.gov](mailto:dhssoshelp@wisconsin.gov). Indicate that you need help pertaining to the Functional Screen training course.

- **Webcast Trainings:**

- ADLs: <http://dhsmedia.wi.gov/main/Viewer/?peid=186b394a-49b8-4a00-b372-d021b136fd9a>
- IADLs: <http://dhsmedia.wi.gov/main/Viewer/?peid=5982c9831fce4abb8d8700be516b9627>
- Behaviors/Mental Health: <http://dhsmedia.wi.gov/main/Viewer/?peid=5742a3b6-1b05-4dda-af43-4b7a27e07ce9>
- Brain Injury: <http://dhsmedia.wi.gov/main/Viewer/?peid=2c3fd02d-cc86-4f26-8019-1e7b203bd43a>
- Application 101: <http://dhs.wisconsin.gov/LTCare/FunctionalScreen/training.htm>
- Webcast prerequisites: <http://dhs.wi.gov/webcast/help.htm>

# Decision Tree for Frail Elders with Co-Morbidities



## DEFINING “PHYSICAL DISABILITY” FOR LTC FUNCTIONAL SCREEN TARGET GROUP Guidelines for Screeners Developed with DHFS Workgroup\*

The WI statutory definition of Physical Disability is on the back page of the functional screen (LTC FS). Screeners check the PD target group only if the person’s condition meets the statutory definition. Physical disability is defined in section 15.197 (4) (a) (2) of the Wisconsin statutes as follows:

*“A physical condition, including an anatomical loss, or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person.”*

The phrase “major life activity” is defined in subsection (4) (a) (1) of the same statute and includes:  
*“self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking, and capacity for independent living.”*

---

LTC FS target group question requires that a “Person has long-term care needs related to...” one or more of the listed target groups. Consider these questions:

### 1. Does person have “long-term care needs”-- defined as help from other people (or specific adaptive aids for mobility and bathing)?

Sometimes people have debilitating conditions but they do not create long-term care needs defined as help from other people (or specific adaptive aids for mobility and bathing). For example, a person may lose their job due to multiple chemical sensitivities. They need environmental accommodations to work, but they do not necessarily have long-term care needs defined as help from other people (or specific adaptive aids for mobility and bathing). Ask what long-term care needs the person has, especially in his or her own home.

### 2. Are the LTC needs expected to last according to your program’s requirements?

Sometimes the person’s functioning has already been limited prior to the screening date, but the screen requires them to last according to your program’s requirements.

### 3. Are the needs related to one of the LTC FS Target Groups?

For physical disability, ask whether the physical condition meets the statutory definition. This means the condition must significantly interfere with or significantly limit at least one major life area. “Significantly” means that the limitation meets both criteria A and B, below:

A. Cannot be accommodated with adaptations people commonly make. Examples of common adaptations:

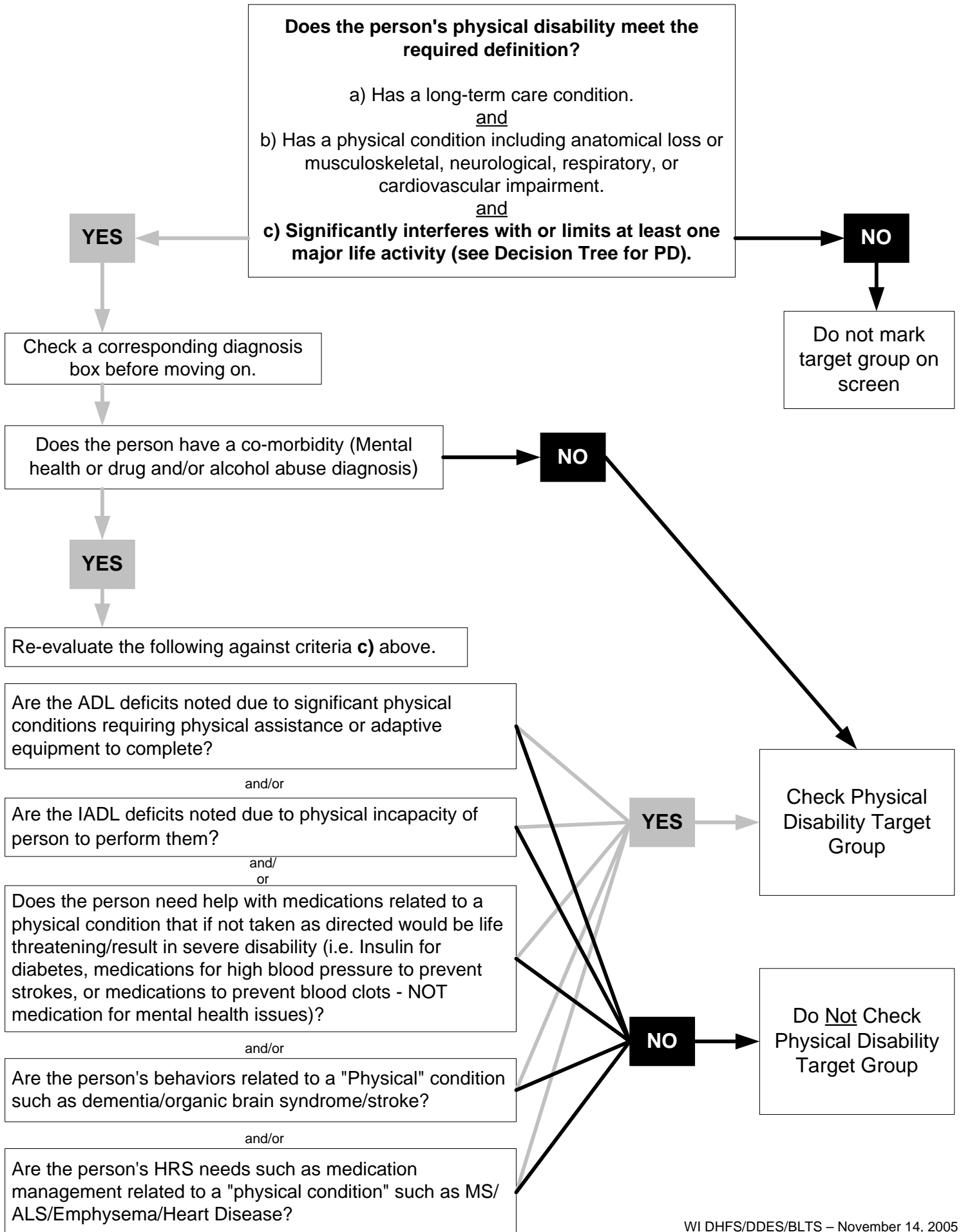
- Knee brace, other over-the-counter braces.
- Lighter grocery bags if unable to lift over 5 lbs; buy quart of milk if unable to lift gallon.
- Wear shoes with more toe space for hammertoe.
- Sit in chair if uncomfortable standing, e.g., while washing dishes or preparing meals.
- Use public transportation if unable to drive.
- Move to first floor apartment if unable to climb stairs.
- Change jobs to accommodate condition. Examples:
  - Painter who develops allergy to paint fumes changes to management job.
  - Teacher with multiple chemical sensitivities to perfumes and soaps changes to desk job in small office where scent-free accommodations can be made.

B. Person is not able to perform the tasks to meet their needs, and requires help from others.

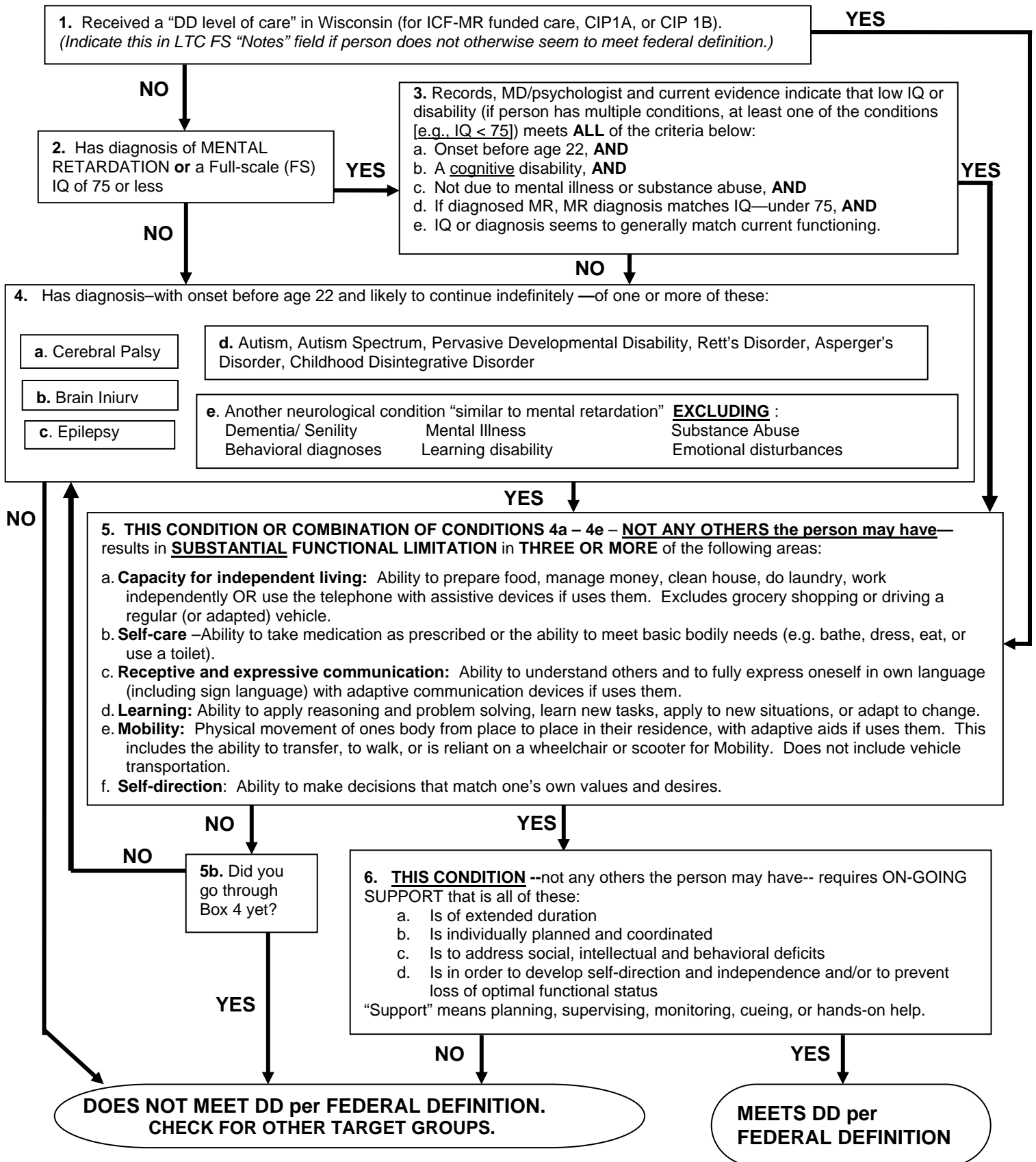
- “Unable” means that the person is not able to complete a task now without significant negative outcomes.
- “Unable” also means that if the person is getting help now, and if the help were unavailable, they could not do it themselves (without negative outcomes).

\*Although this tool may help determine if a person meets this target group, it does not help determine MA financial eligibility. Additionally, people under age 65 require a disability determination to be eligible for waiver services.

# Decision Tree for PD with Co-Morbidities



# DECISION TREE for the “DEVELOPMENTAL DISABILITY PER FEDERAL DEFINITION” TARGET GROUP on WI LONG TERM CARE FUNCTIONAL SCREEN



# **INSTRUCTIONS FOR DECISION TREE FOR “FEDERAL DEFINITION OF DEVELOPMENTAL DISABILITY” TARGET GROUP ON WI LONG TERM CARE FUNCTIONAL SCREEN**

The attached decision tree was developed to assist qualified screeners<sup>1</sup> to complete the target group question on the Wisconsin Long Term Care Functional Screen (LTC FS), which asks whether the applicant meets the federal definition of developmental disabilities (DD). In some cases, deciding whether someone meets the federal definition of DD can be complicated. It requires accurately answering numerous questions in the right order.

This decision tree is the product of a workgroup from the Department of Health and Family Services including staff from the Bureau of Long Term Support and the Bureau of Mental Health and Substance Abuse who have over 40 years combined experience in determining DD levels of care, consulting on DD levels of care, writing guidelines and handling appeals. See the Federal DD Definition Decision Tree, its instructions, and accompanying Questions & Answers document.

This decision tree incorporates guidelines previously developed to help DHFS staff make consistent decisions on whether people meet the federal definition of DD. The federal definitions of DD are open to interpretations. Different states have somewhat different interpretations. To complicate matters, diagnoses like mental retardation are quite often misapplied. In the past, waiting lists and program funding limits acted as “gate-keepers” to the long-term care system. Because Family Care is an entitlement with no waiting lists and monthly capitation payments, eligibility determination (including the target group question) must be precise and accurate.

This decision tree has been tested on several dozen cases—some that obviously meet the definition of DD, and many that are unclear. A few pragmatic decisions were made to fit unusual situations.

This decision tree only works if you follow it in order, top to bottom, and follow every arrow. Focus on one box at a time. Answer each separate question as accurately as possible using the definitions provided. Following are an overview of the DD Decision Tree, an outline of the general process for using it, contact information for DHFS staff, and some key points on the decision tree.

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<sup>1</sup> To be qualified to complete the WI LTC FS, the screener must be (a) an employee approved by WI DHFS to perform screens, (b) meet educational and experience requirements, (c) participate in DHFS screen training, and (d) pass the online screen certification exams. For Home and Community Based Waiver counties, people screening DD individuals must be qualified as QMRPs.

## **PART 1 - OVERVIEW OF FEDERAL DEFINITION OF DD DECISION TREE**

### **A. WHY THE DD DECISION TREE WAS DEVELOPED**

Since Family Care started, Aging and Disability Resource Centers have been inundated by school systems referring 18 year olds with learning disabilities, mental illness, and emotional disturbances. Others have received many referrals of people with average or low-average intelligence who need monitoring to prevent criminal activities, people with cognitive impairments due to alcohol or drug abuse, or people living unfortunate lives due to socioeconomic deprivation, choices, self-neglect, etc. These conditions do not in themselves meet the federal definition of DD. Screeners completing the LTC FS needed clear, succinct instructions to guide them through what has turned out to be a difficult determination.

All screeners must be certified to administer the WI LTC FS. Screeners are to contact the WI Bureau of Long-Term Support for consultation as needed on DD cases (see page 4 for contact information). Screeners are to refer people for further evaluation whenever it might impact their eligibility.

### **B. WHAT THE DECISION TREE CAN DO**

- a. Shows that people with normal IQ--including those with learning disabilities, emotional disturbances, mental illness, or substance abuse--do not meet federal definition of DD.
- b. Shows that people whose cognitive impairment is not developmental--e.g., that result from substance abuse or mental illness--do not meet federal definition of DD.
- c. Shows that someone with normal intelligence who needs 24-hour monitoring to prevent pedophilia or other behaviors--including those misdiagnosed with mental retardation (MR)--do not meet federal definition of DD.
- d. Can handle misdiagnoses and missing diagnoses, which turn out to be very common.  
Example: Person with IQ of 87 misdiagnosed as mentally retarded; person with IQ of 59 (at age 9) diagnosed "learning disabled" instead of MR; person diagnosed with Pervasive Developmental Disability who has IQ of 94 and no significant limitations (PDD is misdiagnosed).
- e. Can handle multiple diagnoses---e.g., autism plus MR plus learning disability plus emotional disability.  
Box 4 asks that at least one of the multiple diagnoses meets the criteria listed in 4 a-e.  
If person's IQ is below 75 (and that low IQ is developmental and not due to substance abuse or mental illness and appears accurate), then that fact "overrides" the fact that they were misdiagnosed as learning disabled instead of MR.

- f. Shows that people who do not have substantial functional limitations in at least three of six major life areas (defined in Box 5) do not meet the federal definition of DD-- regardless of diagnosis. Due to this, a change has been made to the DD decision tree that takes a “Yes” answer in Box 1 to Box 5, instead of automatically saying the person meets the federal DD criteria. Regardless of an individual meeting a DD level of care in the past five years, they still must have a substantial functional limitation in 3 or more of the areas defined in Box 5 and a need for ongoing support.
- g. Presents questions in the right order. Provides more objective, reliable, and accurate decision process than old method of having individual professionals using their professional judgment. Controls for excessive subjectivity in the question of “other neurological condition similar to mental retardation” found in federal definition of DD. Allows for—requires—detailed assessment of person’s abilities in Box 5 (functional limitations) and Box 6 (support needed).

### **C. DECISIONS SHAPING THE DECISION TREE**

- a. We are forced to use full-scale IQ scores as a way to address the over-use and under-use of the diagnosis of mental retardation (MR). We are aware of the limitations of IQ testing. The federal definition of MR is a full-scale IQ below 70. Federal guidelines do acknowledge an IQ score error range of 5 points. We have chosen to use 75 as a “cut-off” point instead of 70 in recognition of that error range. We did research other states’ eligibility determination methods, and most of them do use IQ as a factor in determining whether a person meets federal definition of DD.
- b. A person with cerebral palsy (CP) or other neurological/ physical disability with no cognitive impairment would be determined with this decision tree to not meet the federal definition of DD. (They would meet the state definition of DD.) Federal language varies on this issue, and there is variation among states and within Wisconsin on whether adults with CP or other physical disabilities should be considered “DD.” This decision tree was developed to determine a target group on the LTC Functional Screen. People with cerebral palsy or other neurological/ physical disability could meet the Physical Disability target group on the LTC Functional Screen.

Box 5 of the decision tree says that the person must have substantial functional limitation in three or more of the six listed areas. A person with a physical disability but no cognitive disability would probably only meet criteria a (capacity for independent living) and b (self-care), but be independent—with adaptive aids if uses them—in the other 4 criteria (communication, learning, mobility, and self-direction).

Box 6 c says help must be “to address social, intellectual and behavioral deficits.” Persons with CP or other neurological/ physical disabilities and normal IQ would thus not make the Federal definition of DD target group. They could make the “Physical Disability” target group.

- c. Autism spectrum disorders override IQ scores. A person with any of the autism spectrum disorders would pass the decision tree if the condition satisfies criteria in Boxes 5 (functional limitations in 3 or more areas) and 6 (on-going support needed). A high-functioning person with such a diagnosis--or misdiagnosis (which are common)--would not pass Box 5 or 6.
- d. People with traumatic brain injury before age 22 might make the Federal definition of DD. People with traumatic brain injury after age 22 would not make the federal definition of DD. On the LTC FS, brain injury is considered a physical disability, if it meets the statutory definition of physical disability. The screener could check “State definition of DD” target group as well.

## **PART 2 - USING THE DD DECISION TREE**

### **A. GENERAL PROCESS AND CONTACT INFORMATION**

1. When the person has multiple diagnoses including mental illness, substance abuse, learning disorders, emotional disturbances, behavioral diagnoses, or dementia, a second screener should be consulted.
2. When two screeners do not have consensus in a particular case, or when the decision tree result seems incorrect for a given individual, or when the screener has full information but is not clear on how to apply the decision tree in a given case, the screener (or agency’s screen lead staff) should contact the following:
  - Kim Nelson, WI Bureau of Long Term Support (BLTS) 608-873-0007, [Kimberly.Nelson@wisconsin.gov](mailto:Kimberly.Nelson@wisconsin.gov)
3. In Home and Community Based Waiver counties, people screening DD individuals must be qualified as QMRPs.

### **B. SOME DETAILED POINTS**

#### **Diagnoses and Misdiagnoses**

The federal definition of DD refers to mental retardation (MR), which is in turn defined by IQ test scores and functioning. The cognitive impairment must be developmental—meaning that it occurs before the age of 22 and is not due to mental illness or substance abuse. Sometimes IQ scores do not match the person’s functioning, and sometimes diagnostic labels are misapplied. We have seen people with normal intellectual functioning labeled mentally retarded. That is why the decision tree uses both IQ scores and diagnoses so that it works when mental retardation was properly diagnosed, missed, or inappropriately diagnosed.

We have found that misdiagnoses are common. Generally speaking, mental retardation (MR) should be given when the person has full scale IQ scores less than 70; learning disability should only be diagnosed when the person has a full scale IQ above the MR range.

Learning disability is appropriate diagnosis only if person's full scale IQ is above the range for mental retardation.

Per DSM-III, "mixed specific developmental disorder" should not be diagnosed if IQ is above 70.

Emotional disturbance is appropriate diagnosis only if others above do not apply, and IQ is above 75.

### Multiple Diagnoses

In practice, it is often extremely difficult to draw the line between DD and mental illness, substance abuse, or emotional, behavioral, or learning disorders. If the person has multiple diagnoses including mental illness or substance abuse, their effects must be ignored to ask whether the DD condition alone causes "substantial limitations in at least three areas of life..." and requires active treatment. This "thought experiment" is the most difficult part of deciding whether someone meets the federal definition of DD. It is unavoidable. When the person has multiple diagnoses including the ones specifically excluded in Box 4 e, then the screener should consult with another QMRP. If the two QMRPs are not clear, the screener should contact DHFS staff for advice.

The federal definition of DD includes conditions "similar to mental retardation." To avoid overly broad interpretation here, the decision tree excludes other types of diagnoses--namely, psychiatric diagnoses, behavioral diagnoses, learning disability, emotional disturbances, substance abuse diagnoses, and dementia/senility. Psychiatric diagnoses here includes any mental illness diagnoses, e.g.,

- Schizophrenia, psychoses;
- Anxiety disorder, dissociative disorder, sleep disorder, eating disorders, somatoform disorders, or impulse-control disorders;
- Mood disorders--including bi-polar (or "manic-depressive") disorder, depression; and
- Personality disorders (PD)--e.g., schizoid PD, borderline PD, antisocial PD, paranoid PD.

### Behavioral Disorders include but are not limited to:

• Impulse-control disorder	• Oppositional defiant disorder
• Hyperactivity	• Pica
• Attention deficit disorder	• Obsessive-compulsive disorder (OCD)
• Attention-deficit, hyperactivity disorder (ADHD)	• Conduct disorder

### School Assignments Do Not Reveal DD Status

School placement (e.g., special ed) does not mean the person meets federal definition of DD. Schools' categories of ED, LD, and CD (emotional disabilities, learning disabilities, and cognitive disabilities) are often based on local conditions (funding & staff) and stigma avoidance.

### Criminal System Does Not Reveal DD Status

Whether or not the legal system considers a person competent enough to stand trial and be imprisoned cannot be used to decide whether a person meets federal definition of DD.

## **Brain Injury**

Screener should ALSO check Physical Disabilities Target group question. Both the brain injury and the Cerebral Palsy in this case appear to meet statutory definition of physical disability.

## **Cerebral Palsy**

Note that Box 6, criteria c requires that on-going support is “to address social, intellectual and behavioral deficits.” A person with moderate to severe CP who has no cognitive impairments would fail to meet criteria 6. A person with milder CP might fail to meet 3 areas of limitation required in Box 5.

Moderate to severe CP would probably meet the statutory definition of Physical Disability, so PD target group should be checked. . Mild CP might not meet the statutory definition of PD.

## **Other Target Groups**

Screeners should always check to see if other health conditions are severe enough to meet the statutory definition of physical disability.

## **Special Consideration of Young Adults**

It is common that young adults--especially males--have not yet had the chance to learn to handle their own meal prep, laundry, chores, money management, or even learning to ride the bus, because their parents have been doing many things for them.

Screeners need to ask whether the applicant is in fact able to do those things alone now. If not, they may currently meet the federal definition of DD. If they eventually learn to develop all possible skills, some of them may no longer meet the federal definition of DD.

Be cautious when considering young adults against this tree. An SSA determination based on a learning disability or emotional disturbance does not meet the criteria for federal DD.

## **Box 5 – Substantial Limitations in 3 or more areas.**

Remember Box 5 asks if MR or conditions 4 a through 4 e cause(s) substantial limitations. Screeners should ignore problems caused by other excluded diagnoses listed in 4 e.

Being unemployed does not in itself indicate an inability to manage money or economic self-sufficiency. A person may be unemployed for other reasons, including socioeconomic and cultural factors.

Note that driving or vehicular transportation is not included among six areas listed in Box 5.

Economic self-sufficiency is no longer present in the federal definition of DD used for home and community-based waiver eligibility determinations. It may be included under “capacity for independent living,” but only if the person is unable to work because of MR or condition(s) 4 a-e; not for any other reasons such as socioeconomic or cultural factors, motivation, mental illness or substance abuse. People can be unemployed for reasons having nothing to do with developmental disability. Unemployment does not necessarily mean the person is unable to manage money.

In most cases if the person is unable to work due to cognitive limitations (not due to lack of motivation or depression, a substance abuse problem, an economic recession, etc.), you would determine that the substantial limitation to working is due to problems in learning. If this is the case, it may be appropriate to say that this also is evidence of a substantial limitation to capacity for independent living. However, it is important to see if there are other issues causing the substantial limitation in capacity for independent living (e.g., budgeting, grocery shopping, etc.). While it is not easy to make these distinctions, it is critical to do so. The overall picture of the person should make sense as a description of a person with a developmental disability.

### **Box 6 – On-Going Treatment**

All four criteria must be met. Note that 6c (“Is to address social, intellectual and behavioral deficits”) excludes people with only physical impairments, such as those with cerebral palsy. “Support” here does not have to occur every day, but does have to meet all four criteria in Box 6.

“No Active Treatment” (NAT) is a separate question. See DD Decision Tree Questions & Answers document for more information on NAT.

## **PART 3 – QUESTIONS & ANSWERS ON THE DECISION TREE**

### **1. What about “No active treatment?”**

This decision tree is designed to answer one and only one question: "Does the person meet the ‘federal definition of DD’ target group on the LTC FS?" This decision tree does not answer other questions. For instance, if both DD and physical disability target groups apply, the decision tree does not indicate which is “primary.” In counties without Family Care CMOs, this decision tree does not indicate whether the person would be better served in the DD or physical disability system. The decision tree does not indicate whether someone would be “no active treatment” (NAT) or whether a nursing home could or would admit them. It only answers the question of whether a person meets the federal definition of DD.

### **2. What about persons with Downs Syndrome who develop Alzheimer’s disease before age 60? At what age does someone become aged?**

There are several questions here.

- “Frail Elder” should be checked only if person is age 65 or older.
- If the person has a verified diagnosis of Alzheimer’s disease (or another irreversible dementia), then the “Alzheimer’s disease” (or the “Other irreversible dementia”) target group should be checked, regardless of the person’s age. So a 40-year-old person with Downs Syndrome and mental retardation and early Alzheimer’s could meet both the “Federal definition of DD” and the “Alzheimer’s disease” target groups.

Again, the question of “no active treatment” or NAT goes beyond the scope of this decision tree. A 67-year-old person with moderate mental retardation could pass all steps of this decision tree and would meet the federal definition of DD target group on the LTC FS. NAT

determination is a separate, secondary question to decide which waiver the person should be on.

**3. Can a screener check “Frail Elder” or “dementia” target group when someone with a developmental disability no longer meets the standard for active treatment (on-going support?)**

Only if the person has a condition that meets the statutory definition of “Frail Elder” or has a confirmed diagnosis of Alzheimer’s disease or irreversible dementia. Not all cognitive impairment is “dementia.”

If the person really doesn’t need any support, then the criteria in Boxes 5 and 6 would not be met, so the person would not meet the federal definition of DD. If they do meet the federal definition of DD, then the question of NAT (e.g., due to medical problems) is a separate question. (See question 2 above for discussion of NAT.)

**4. What about persons diagnosed with Prader-Willi syndrome as found in Wisconsin’s definitions?**

Prader-Willi syndrome is specifically mentioned in Wisconsin’s definition of DD, which is broader than the federal definition of DD. Prader-Willi syndrome is not mentioned in the federal definition of DD, so is not specifically mentioned in Box 4. It can be considered a condition similar to mental retardation (Box 4). The majority of people with Prader-Willi would meet all criteria of this decision tree, and so meet the federal definition of DD. Only a few, with milder limitations, would fail at Box 5 and Box 6.

**5. Is contacting the Social Security Administration for disability determination records optional?**

Yes. In most cases, continuing with the decision tree will yield positive results faster. If a person does not pass the decision tree, the screener should consider any other avenues that might render the person eligible. This includes requesting SSA records if disability determination may show developmental cognitive disability. A SSA determination does not automatically make an individual meet the federal definition of DD.

**6. State statutes define brain injury very precisely. How does that fit in this decision tree?**

For purposes of this decision tree, the screener needs a confirmed medical diagnosis of “head injury” or “traumatic brain injury.” Reports of suspected brain injury do not count. To meet the federal definition of DD, the brain injury must be documented to have occurred before the age of 22, and must meet all criteria in boxes 5 and 6 of the DD decision tree.

This decision tree does not determine whether someone is eligible for the brain injury waiver program. Brain injury waiver program eligibility is more clinically complex,<sup>2</sup> and will retain a separate eligibility review process in home and community based waiver counties. In Family

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<sup>2</sup> For example, brain injury waiver eligibility must consider complex questions about the person’s prognosis for rehabilitation, and whether behavior or cognitive problems were present before the brain injury.

Care counties, there is not a brain injury waiver program, however individuals with brain injury may be served in Family Care under the physical disability target group with traumatic brain injury after the age of 22.

**7. Is a brain tumor a physical disability? Is it a physical disability when the tumor occurs within the developmental period?**

A brain tumor is a condition that may or may not meet the statutory definition of physical disability. If the brain tumor occurred after the age of 22, of course it does not meet the federal definition of developmental disability. If the brain tumor occurred before the age of 22, it might pass the federal DD decision tree in one of two ways. One, the child may have been diagnosed mentally retarded and/or have a full-scale IQ of less than 75 (Box 2). If the MR or low IQ satisfy all criteria in Boxes 3, 4, 5, 6, the federal definition of DD is met. (In this case, the cause of the MR or low IQ is less important than the MR or low IQ.)

Another person with a brain tumor might not have the diagnosis of MR or IQ scores. In this case, the brain tumor might be considered a “neurological condition [possibly] similar to MR” (Box 4). If that condition meets all criteria in Boxes 4, 5 and 6, then the federal definition of DD is satisfied.

If the brain tumor occurs after the age of 22, it does not meet the federal definition of developmental disability.

Whether or not the person meets the federal definition of DD, the screener should also ask whether the brain tumor--or, more precisely, conditions it might cause, such as paralysis--meets the statutory definition of physical disability. (This is not very important if the person met the federal definition of DD target group and if screener properly indicates traumatic brain injury in diagnosis table.)

**8. Is epilepsy synonymous with seizure disorder?**

Yes, it is.

**9. Is epilepsy a physical disability if there exists no sub-average intelligence (IQ < 75)?**

Only if it meets the statutory definition of physical disability. In most cases, it would not.

**10. Can cerebral palsy be considered a physical disability?**

Yes, of course--if it meets the statutory definition of physical disability. Some people have mild CP which does not “significantly limit activity in at least one major life area.”

**11. How do “other neurological disorders” relate to the neurological disorders allowed in the definitions of a physical disability (simply because of similarity to mental retardation)? Still not sure what some these disorders would be.**

The statutory definition of physical disability is “a physical condition, including...neurological ...which results from injury, disease, or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person.”

So, a particular neurological condition might satisfy the definition of physical disability and also be used in the federal definition of DD (Box 4 of the decision tree) as an “other neurological condition similar to mental retardation.” In other words, a neurological condition might meet both DD and physical disabilities target group.

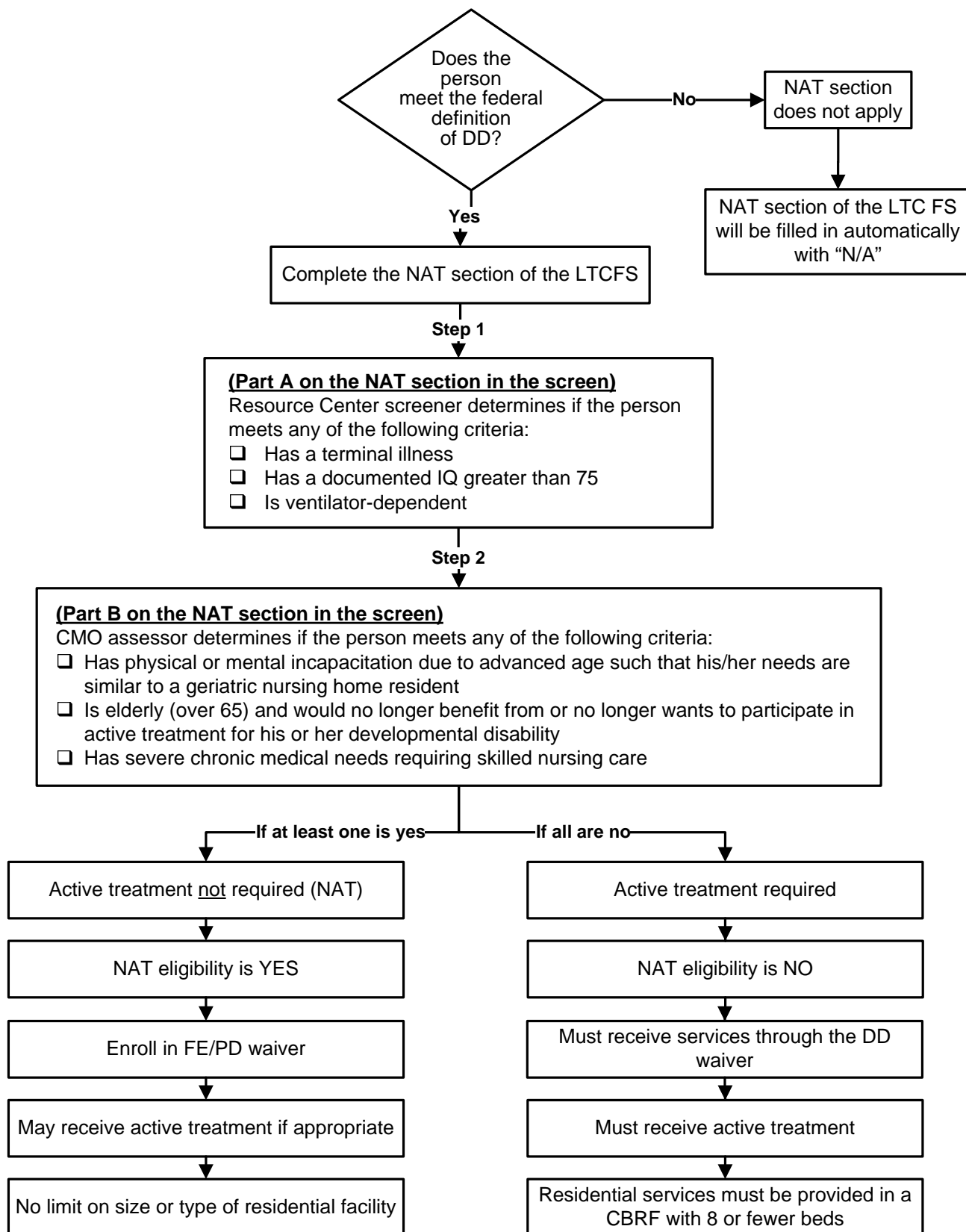
A few examples of such neurological conditions that might satisfy both definitions, if they occur before age 22 and cause significant limitations, include hydrocephalus, spina bifida, traumatic brain injury (including shaken baby syndrome), encephalitis, brain tumor, etc.

The “other neurological condition similar to mental retardation” can involve some subjectivity. But note that Box 4 specifically excludes mental illness, behavioral diagnoses, learning disabilities, emotional disturbances, dementia (also called senility), and substance abuse.

A neurological disorder might meet several target groups. Screeners need to consult with a health care professional to obtain the diagnoses and to understand their effects on the person’s functioning.

# For Family Care ADRC/MCO Counties Only

## Determining active treatment needs of people in the developmental disabilities target group on an initial screen\*



\*Step 1 (Part A on the NAT section in the screen) can be omitted for 02 (recertification) and 03 (change in condition) screens.



# LTC: Frequently Asked Questions

## Questions/Answers on ADLs and IADLs

1. [Question: I'm not getting an eligibility determination on the electronic screen that I expect for someone with a lot of functional deficits and HRS needs. Do you know why this would happen?](#)
2. [Question: Am I supposed to record just the services the person is receiving or also those that they need but are not currently receiving?](#)
3. [Question: How do you mark a screen for an elderly person who minimizes their deficits or when families exaggerate deficits?](#)
4. [Question: It takes someone I am screening a really long time to complete some of their ADLs. Can I mark the screen for deficits due to this slowness?](#)
5. [Question: How would I mark a screen in the "who will help in the next 8 weeks column" where a person needs help but refuses it?](#)

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**Q** **Question:** I'm not getting an eligibility determination on the electronic screen that I expect for someone with a lot of functional deficits and HRS needs. Do you know why this would happen?

**A** **Answer:** The screen should be complete and accurate and should paint a consistent clinical picture of the person you know. Go back and make sure you have recorded all the person's deficits and needs under ADL, IADL, HRS, memory and cognition. Make sure you have selected the appropriate risk box to reflect their situation. Make sure you selected a qualifying target group! Then re-calculate eligibility. If you still do not get the result you expect, consult with your screen lead. If you still disagree with the result ask that your screen lead consult with the functional screen consultant for your program (TMG/BALTCCR/CIS or CDSD).

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**Q** **Question:** Am I supposed to record just the services the person is receiving or also those that they need but are not currently receiving?

**A** **Answer:** You should record all the services the person needs which will reflect their deficits. Sometimes a person will refuse services or there could be a resource issue in their area, but they still have a deficit that is important to capture on the screen. All of the deficits help add up towards a nursing home level of care.

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**Q Question:** How do you mark a screen for an elderly person who minimizes their deficits or when families exaggerate deficits?

**A Answer:** It's important as a trained, experienced screener to sort out these nuances. You need to put your finger on the person's true level of functioning and mark the deficits on the screen accordingly. Some elderly deny deficits due to pride, while some families exaggerate weaknesses of their elderly family member to obtain eligibility. Your job is to sort through the data you collect through interviews and observation, and record the most accurate information possible on the screen. To help you sort things out you could:

- Do a "get up and go" test on the person
- Check the bathroom for use and accessibility
- Use collateral contacts as possible to gather additional information

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**Q Question:** It takes someone I am screening a really long time to complete some of their ADLs. Can I mark the screen for deficits due to this slowness?

**A Answer:** The clinical screen instructions do state the time it takes a person to complete a task could be a factor that the screener takes into consideration as a possible deficit if there is significant hardship or negative outcomes for the person. The task should be rated depending on the person and their needs.

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**Q Question:** How would I mark a screen in the "who will help in the next 8 weeks column" where a person needs help but refuses it?

**A Answer:** You should mark "needs to find a helper" in that column and explain in the notes section.

# LTC: Frequently Asked Questions

## Questions/Answers on Risk

1. [Question: I understand that Risk Part B Box #2 plays a part in the waiver level of care logic. I am uncomfortable with the language there that says, "The person is at imminent risk of institutionalization in a nursing home or ICF-MR if s/he does not receive needed assistance or is currently residing in an institution." I feel that many of the people I screen would not accept institutional care or are not at imminent risk of institutionalization. Why is this box so important?](#)

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**Q** **Question:** I understand that Risk Part B Box #2 plays a part in the waiver level of care logic. I am uncomfortable with the language there that says, "The person is at imminent risk of institutionalization in a nursing home or ICF-MR if s/he does not receive needed assistance or is currently residing in an institution." I feel that many of the people I screen would not accept institutional care or are not at imminent risk of institutionalization. Why is this box so important?

**A** **Answer:** This is federally mandated language that is required in this section of the screen. If the person has a lot of deficits and HRS needs and you believe they are eligible for your waiver, in essence you are agreeing to the wording contained in this box. Remember that when a waiver participant signs the individual service plan, he/she is confirming a choice between an institution and community services, thus implying eligibility for and risk of institutionalization. This box carries weight towards waiver eligibility so don't hesitate to select it if the person truly meets this definition.

# LTC: Frequently Asked Questions

## Questions/Answers on Target Group/Waiver Eligibility

1. [Question: What do we do if we receive a transfer from another county or agency and we don't think the person is eligible functionally?](#)
2. [Question: I am wondering if a new IQ test should be done on a participant with a developmental disability. The original IQ test is 71 and was done when the man was 14 and he is now age 32.](#)
3. [Question: I'm wondering about LOC on an applicant I know. They are bipolar, have sliding scale, insulin dependent diabetes and hypertension. Would they be eligible under a waiver?](#)
4. [Question: Completed screen on a man age 49--by-pass surgery 6 wks ago--also has mental health needs. Deficits are related to behavior issues--not many outside of a couple IADLs. Is he eligible for a waiver?](#)
5. [Question: What is the correct target group for a 19 year old woman who has had a brain injury \(TBI or stroke\)?](#)
6. [Question: My client has a heart condition, and must go into the clinic several times a week for blood draws. She also sees the doctor every month. How would I record this on the screen?](#)
7. [Question: If a person has a disability determination are they automatically eligible for a waiver?](#)
8. [Question: If a person was eligible for a waiver last year, are they automatically eligible this year?](#)

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**Q** **Question:** What do we do if we receive a transfer from another county or agency and we don't think the person is eligible functionally?

**A** **Answer:** It might be that the person is no longer eligible by the time you receive the transfer. You should review the screen and update it so it's current. Talk to the previous case manager to obtain additional information. If you are still having problems with eligibility consult your screen rep (TMG, CIS, CDS). Always remind the consumer they have appeal rights and give them the information they need if they want to pursue that option.

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**Q Question:** I am wondering if a new IQ test should be done on a participant with a developmental disability. The original IQ test is 71 and was done when the man was 14 and he is now age 32.

**A Answer:** It depends. At age 14 an IQ is usually valid. If you have reason to believe the functional level is not matching the IQ have it redone. This is when your professional judgment as a screener comes into play. Beware of the affect of alcohol and drugs on a person's IQ--low IQ due to brain damage does not meet the federal definition of DD.

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**Q Question:** I'm wondering about LOC on an applicant I know. They are bipolar, have sliding scale, insulin dependent diabetes and hypertension. Would they be eligible under a waiver?

**A Answer:** It depends on whether this person meets one of the qualifying target groups outside of their mental illness. To help sort out these type of target group questions two algorithms were developed--"The Decision Tree for PD with Co-Morbidities" and "The Decision Tree for Frail Elders with Co-Morbidities." To access these and other screener tools go to [www.dhfs.wisconsin.gov/LTCare/FuntionalScreen](http://www.dhfs.wisconsin.gov/LTCare/FuntionalScreen)

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**Q Question:** Completed screen on a man age 49--by-pass surgery 6 wks ago--also has mental health needs. Deficits are related to behavior issues--not many outside of a couple IADLs. Is he eligible for a waiver?

**A Answer:** Remember that to meet waiver eligibility this person needs to have a long-term care need linked to a physical condition that is expected to last a year or more. You will need to sort out short-term versus long-term care needs. The physical needs related to heart surgery are often very short-term and this person might not meet the qualifying waiver eligibility criteria.

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**Q Question:** What is the correct target group for a 19 year old woman who has had a brain injury (TBI or stroke)?

**A Answer:** The target group is Federal Developmental Disability for any consumers under age 22 at the time of the brain injury. Note: Determination of her IQ is needed to determine NAT and waiver eligibility.

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**Q Question:** My client has a heart condition, and must go into the clinic several times a week for blood draws. She also sees the doctor every month. How would I record this on the screen?

**A Answer:** Be careful to only record on the HRS table activities that primarily occur in the home. Clinic visits for blood draws and doctor appointments are not included.

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**Q Question:** If a person has a disability determination are they automatically eligible for a waiver?

**A Answer:** Having a disability determination is not an automatic match with waiver eligibility. The person must also have long term care needs which affect their functional ability, i.e., nursing home level cares. They must also have a diagnosis connected to the eligible target group in the waivers they are applying for.

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**Q Question:** If a person was eligible for a waiver last year, are they automatically eligible this year?

**A Answer:** No. Sometimes people get better and their functional ability improves. That is why an annual re-screen is required. They may no longer be functionally eligible based on improvement.