Wisconsin

Long Term Care

Functional Screen

Instructions

Department of Health Services

Division of Medicaid Services

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

1.1 Introduction

The Wisconsin Adult LTCFS determines functional eligibility for Wisconsin's Medicaid funded long-term care (LTC) programs for persons who are frail elders or have physical disabilities, dementia, a terminal illness, and/or intellectual/developmental disabilities. In particular, the LTCFS includes eligibility for all three federal Medicaid target groups: frail elders, adults with physical disabilities, and adults with intellectual/developmental disabilities (I/DD). Functional eligibility is the combination of target group(s) and level(s) of care (LOC) determined by the screen after it has been completed and calculated.

The LTCFS has been used by screeners, in paper or electronic format, since 1997. Currently, the LTCFS is completed in Functional Screen Information Access (FSIA), a web-based application, which contains logic that interprets information entered by screeners to determine an adult's eligibility for LTC programs. The LTCFS has been designed, operated, evaluated, and improved through a rigorous quality management system. To maintain a high level of validity and reliability, Department of Health Services (DHS) staff address screener questions, review functional eligibility results, provide training and support to screeners, and notify screeners of updates to the written instructions and FSIA.

Principles used to develop and maintain the quality and accuracy LTCFS include the following:

- **Clarity**: Screeners must clearly understand definitions and answer choices.
- **Objectivity and Reliability**: The LTCFS is designed to be as objective as possible to achieve the highest inter-rater reliability (two screeners would answer the same way for an individual), to ensure fair and proper functional eligibility determinations, and provide statewide consistency.
- **Brevity**: The LTCFS is a functional eligibility tool, not a comprehensive assessment.
- **Inclusivity**: Regardless of age, race, gender, culture, diagnoses, and other life conditions, every individual can be accurately screened with given choices for each question on the screen.

The LTCFS captures the needs of individuals, regardless of their living situation, and the assistance they may need from another person as a result of their diagnosis(es) in the following areas:

- **Activities of Daily Living (ADLs)**
- **Instrumental Activities of Daily Living (IADLs)**
- **Additional Supports**
- **Health-Related Services (HRS)**
- **Communication and Cognition**
- **Behavioral Health including mental health and substance use**
- **Risk**

Individuals must be 18 years of age or older to participate in a Medicaid funded LTC program for which the LTCFS determines eligibility. DHS policy allows for early screening of individuals who are 17 years 6 months or older to assist in planning for transition to adult LTC services.

Other Functions of LTCFS

- Serves as a foundation for the comprehensive assessment performed by the LTC program selected by a person.
- Provides data for quality assurance and improvement studies for DHS and LTC programs utilizing the LTCFS.
- Indicates the need for referrals to adult protective services, mental health services, substance use services, or other community resources.
- Provides actuarial information for rate setting and monthly allocations within LTC programs.

1.2 Wisconsin's Medicaid Home and Community-Based Services (HCBS) Waiver Programs

Wisconsin's Medicaid funded LTC programs are part of the Medicaid HCBS Waivers. The programs that the LTCFS determines functional eligibility for include:

- Family Care (FC)
- Family Care Partnership (FCP)
- Program of All-Inclusive Care for the Elderly (PACE)
- IRIS (Include, Respect, I Self-Direct)

To be eligible for a Wisconsin Medicaid funded LTC program an individual must meet ALL the following criteria:

- Have a LTC condition or have a condition that is expected to result in death within one year.
- Have a condition that meets one or more of the eligible target group definitions for Medicaid funded LTC programs in Wisconsin.
- Have a need for assistance from another person to complete ADLs, IADLs, or HRS tasks that are directly related to the conditions(s) that qualified the individual for a target group.
- Have a need for assistance that meets one or more of the level(s) of care that are eligible for Medicaid funded LTC programs in Wisconsin.
- Meet any other Wisconsin Medicaid funded LTC program eligibility requirements.

More information related to program eligibility is in Module 11.

1.3 Target Groups

There are three federal Medicaid target groups for HCBS waiver program participation:

- Frail elder (FE)
- Physical disability (PD)
- FEDERAL definition of intellectual/developmental disability (I/DD per FEDERAL definition)

Wisconsin has more expansive definitions of the above target groups which include:

- STATE definition of developmental disability (I/DD per STATE 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.

Additionally, there is a severe and persistent mental illness (SPMI) target group. Target groups are defined in state statute or administrative code, these definitions and more information is in Module 11.

1.4 Level of Care (LOC)

Wisconsin's Medicaid HCBS waiver programs require that an individual has at least one qualifying level of care. Qualifying levels of care include:

- Nursing home (NH)
- Intellectual/developmental disability (I/DD)
- Non-nursing home (NNH)

Wisconsin's NH levels of care for adults with disabilities and frail elders include:

- Intermediate care facility (ICF)
- Skilled nursing facility (SNF)
- Intensive skilled nursing services (ISN)

Wisconsin's I/DD levels of care for adults meeting the FEDERAL definition of intellectual/developmental disability include:

- Developmental Disability 1A (DD1A)
- Developmental Disability 1B (DD1B)
- Developmental Disability 2 (DD2)
- Developmental Disability 3 (DD3)

More information related to LOC is in Module 11.

Module #2: Screening Process and Quality Assurance

2.1 Screener Qualifications

Screeners must meet the following qualifications:

- Meet all education and experience requirements as specified below:
  - Bachelor of Arts or Science degree, preferably in a health or human services related field or have a license to practice as a registered nurse in Wisconsin pursuant to Wis. Stat. § 441.06.
  - At least one year of experience working with at least one of the target populations (frail elder, physical disability, or intellectual/developmental disability).
- Meet all training requirements as specified by DHS. This includes successfully completing the certification course, quizzes, refresher courses, and continuing skills testing.

2.2 The LTCFS is Voluntary and Confidential

The LTCFS is voluntary. The person being screened or their legal guardian must consent to the LTCFS being completed.

All information collected for the screening process is confidential.

- **Gathering information to complete the screen:** Screening agencies must comply with confidentiality rules and requirements and must obtain a signed release of information from the person being screened, or their legal guardian, where applicable, to collect health care records and other records needed to complete the screening process.

- **Releasing the LTCFS between screening entities:** When an aging and disability resource center (ADRC) or Tribal Aging & Disability Resource Specialist (ADRS) refers a person for enrollment in a long-term care program, the person's functional screen may be shared with that program without separate written authorization. An individual's LTCFS can be transferred to the new agency without the individual's informed consent under Wis. Stat. § 46.284(7). Refer to DHS publication Transition of Care Between Medicaid Programs or Between Agencies Within a Medicaid Program, P-02364.

- **Releasing the LTCFS to all other individuals and/or entities:** Release of a functional screen to another person or any other entity requires written authorization by the person screened, or their legal guardian, where applicable.

2.3 In-Person Interview

- The screening process requires in person, face to face contact with the individual. The whole interview does not need to be completed in person.

- The in-person interview may take place in any setting. However, best practice is to perform the interview in the individual's residence.

Waiving the In-Person Interview Requirement
In rare instances, there may be a need to complete a screen for an individual who is not able to be seen in person.

In situations where the screener did not complete an in-person interview, the agency must inform the individual that functional eligibility may change after the in-person interview is completed.

Waiving the In-Person Interview Requirement for the Initial Screen for an Applicant Temporarily Out of State
There may be a need for ADRCs or Tribal ADRS to complete an initial screen for an applicant who is currently located in a state other than Wisconsin. In these instances, the screening agency may conduct the screen via telephone or video meeting without requesting a waiver from DHS. The screening agency must document in the notes section why the in-person interview was not completed.

Waiving the In-Person Interview Requirement for an Applicant in a Department of Corrections (DOC) or DHS Institution or Treatment Center
There may be a need to complete a screen for an individual who is currently located in:
- The Department of Correction's (DOC) institutions and centers.
- The Department of Health Services (DHS) secure treatment centers of Sand Ridge and Wisconsin Resource Center.
- DHS's institutes for mental disease (IMD) Mendota and Winnebago Mental Health Institutes.

In these instances, the screener may conduct the screen via telephone or video meeting without requesting a waiver from DHS. The screener must document in the notes section why the in-person interview was not completed.

Waiving the In-Person Interview Requirement for Other Reasons
Requests from a screening agency to waive the in-person interview requirement for reasons other than listed above will be considered on a case-by-case basis. In these instances, the screening agency must obtain approval from the DHS LTCFS team to conduct a screen without an in-person interview. It may be appropriate to request a waiver when one or more of the following criteria are met:
- **Traveling to conduct the in-person interview is a hardship to the agency.** Hardships might include the need for air travel, overnight stay, excessive loss of work time.
- **The ADRC or Tribal ADRS has attempted to arrange for an in-person interview to be performed by another ADRC or Tribal ADRS located closer to the individual (courtesy screen) but the request was denied or is unreasonable.**

To request a waiver:
- The screening agency's LTCFS liaison will email the request to dhsltcfsteam@dhs.wisconsin.gov. The submission must include:
    - The individual's date of birth and initials.

    - The reason(s) for the request.
    - The plan for when a subsequent in-person interview is to occur.
    - Compelling information to support the need for the waiver.
- Within 10 working days of the request, the screening agency's liaison will be notified of DHS' approval or denial.
- A waiver must be requested for each occurrence.

If DHS waives the in-person interview requirement, the screening process must be followed, but information may be gathered from the individual through telephone or video call. The Notes section of the Screen Information page must include the information from the waiver request and the date DHS granted the waiver.

2.4 Interviewing Strategies

The LTCFS is not an interview tool. Information may be gathered in any order. It may take more than one contact with the individual and/or collateral contacts to complete the screen.

Screeners should use their professional interview skills to gather information in a way that is appropriate and respectful to best capture the needs of the individual being interviewed.

- Ask questions in a variety of ways.
- Use open-ended questions.
- Use varying communication methods.
- Consider multi-cultural interviewing strategies.
- Look for visual clues, facial expressions, and interactions between the individual and others present.
- Take a tour of the individual's home and observe them as they perform everyday activities.

2.5 Screening Strategies

Individuals being screened and/or their collateral contacts may provide inaccurate or conflicting information. They may overrate or underrate the individual's abilities. To maintain screen accuracy and reliability, screeners should:

- Seek more details from the individual being screened.
    - Ask for clarifying information. For example, if the individual tells you they bathe themselves independently but cannot dress their lower body, ask additional questions to help determine the individual's needs.
    - If possible, ask the individual to demonstrate tasks. For example, ask the individual to demonstrate transferring in and out of their bathtub.
- Seek additional information from collateral contacts who are familiar with the individual and involved in their direct care. Collateral contacts may include, but are not limited to, an individual's guardian, family members, friends, health care providers, an authorized representative, and service providers.
- Use professional judgment to make the most accurate selections.
    - Follow the LTCFS definitions and instructions as outlined in this document.

    - Be as objective as possible when making selections.
    - Consider inter-rater reliability as defined in Module 1.1.
- Review the individual's previous screens for information and historical perspective.
- Seek guidance from the agency's screen liaison as needed.

2.6 Abilities Fluctuate

Many individuals have conditions and abilities that fluctuate over time. When addressing fluctuating needs, use the following guidelines:

- If the individual's functional abilities vary **day to day**, then make selections that most accurately describe their needs on a "**bad**" day.
- If the individual's functional abilities vary **week to week**, make selections that reflect the assistance needed from another person to maintain the individual's health and safety.
- If the individual's functional abilities vary over **months or years**, then make selections that are closest to the **average** frequency of help needed.

2.7 Notes

Screeners are strongly encouraged to use the Notes sections to support all selections.

Best practice attributes of quality notes should:

- Include date and screener initials or name.
- Be written professionally in a style that is:
    - Individual-specific, factual, objective, unbiased, and concise.
    - Easily read and understood by others.
    - Grammatically correct and free of spelling errors.
- Be current.
    - Notes that are no longer accurate or relevant should be deleted. These notes are saved in screen history.
    - It is not considered plagiarism for screeners to edit or use a note previously written by another screener. When a screener adds their initials or name and dates a note previously written by another screener, they are signing off that the information in the note is accurate.
- Indicate:
    - Why selections have been made.
    - The source of referenced information.

Examples of Quality Notes

- 1/2/2023: Diagnoses: All diagnoses were confirmed from medical records received 12/2022 from Dr. Jones at Healthy Clinic. -Sally Screener, Care Manager, Caring Faces Inc.
- May 2023: Meal Preparation: Ruth needs help to monitor for food spoilage and grocery shop due to cognitive impairments from vascular dementia. She is able to independently prepare sandwiches, salads, and reheat foods in her microwave. -SS

- 6/23: Behaviors: Participant has a history of kicking and hitting caregivers while in the shower. There is a plan in place with preventative interventions that are understood amongst caregivers. These interventions are provided every evening before and during participant's shower. With these interventions provided, participant has not attempted to hit or kick their caregivers in over three months. -S. Screener
- June 1, 2023: Risk: Individual meets the criteria for Risk Box B2 as they need help from another person with 4 ADLs and has had 2 falls resulting injury in the past month. They would be at imminent risk of institutionalization in a nursing home if supports are not provided. -SS, CM

2.8 Screening and Rescreening Requirements

Initial Screen
An initial screen, including an in-person interview, is only completed by the ADRC or Tribal ADRS to determine functional eligibility for individuals who are not enrolled in Medicaid funded LTC programs. ADRC and Tribal ADRS screeners should refer to their guidelines for when to perform a new initial screen for a person who has had a screen performed in the past.

Rescreen
Rescreens, including an in-person interview, must be completed by screeners for the following reasons:

- **Annual Rescreen:** An annual rescreen must be completed by a screener at the agency where an individual is enrolled to re-determine functional eligibility. The screen must be calculated by midnight on the 365th day (which in most years would be the day before the previous screen).
- **Change in Condition Rescreen:** A change in condition rescreen must be completed by a screener at the agency who owns the screen if a person experiences a substantial change in condition. This could be a decline or an improvement in the person's condition. The change may be short term or long term. It is best practice to include an explanation of why a change of condition rescreen was completed in the Notes section.

Rescreens may be completed for other reasons as outlined in the screening agency's guidelines and policies**.**

Screening When Impending Discharge
When screening a person who is actively preparing for discharge from a hospital, skilled health care facility, correctional facility, institute for mental disease (IMD), or other facility, complete the LTCFS based on how the person is expected to function upon their discharge. Examples may include:

- A person is using oxygen and intravenous (IV) medication in a nursing home but is expected to stop these treatments upon discharge, the screener would not make selections for these treatments.
- A person is using a mechanical lift in a hospital, but family members are learning to perform a two-person pivot transfer, the screener would not select this adaptive equipment.

The screener may need to review discharge planning documentation and gather additional information from facility staff and the individual's supports to get the most accurate picture of their needs after discharge.

Edits
In some situations, a screen that has already been calculated may be edited to ensure the screen is accurate. An additional in-person interview is not required. It is best practice to include an explanation of why an edit was completed in the Notes section.

If there has been a change identified in an individual's condition or service an edit is not appropriate.

Edits may be completed:
- If inaccurate information or an error is identified in selections or notes. The information being changed in this circumstance should be changed to what was true at the time the screen was completed.
- If an individual only needs the Basic Information and/or Demographic Information updated.

2.9 Quality Assurance

Quality assurance activities promote the consistency and accuracy of administration of the screen by screening agencies. Components of functional screen quality assurance include:
- **Individual Screener Quality Assurance**
  It is the screener's responsibility to be objective, accurate, informed of the instructions, and to verify information gathered regarding the person. Screeners should contact their screen liaison to address questions or unexpected outcomes.
- **Agency-Level Quality Assurance**
  Agencies are responsible for the accuracy of all screens completed by their staff. Each screening agency must identify a liaison to DHS to oversee screening activities performed by the agency. The duties and responsibilities of this person are defined in contracts between DHS and screening agencies. For additional guidance on the role of the Screen Liaison, refer to the Screen Liaison Toolkit document, Role of the Screen Liaison, P-02783.
- **State-Level Quality Assurance**
  DHS reviews screens and uses quality assurance methods to monitor screener performance, screen accuracy and completeness, and appropriate use of FSIA by staff at all screening agencies. Screening agencies may be required to perform corrective action to improve or remediate DHS findings.

The LTCFS results issue a determination of functional eligibility for Medicaid waiver programs. Therefore, individuals being screened, their collateral contacts, screeners, and the screening agency, should be aware that unethical or fraudulent activity during the screening process may be referred to the DHS Office of the Inspector General for investigation.

Module #3: LTCFS Basic Information, Screen Information, Demographics, and Living Situation

3.1 Overview

Demographic information collected for the LTCFS does not determine eligibility for long-term care services. Demographic information is used for two purposes:

- The foundation of an enrollee's full comprehensive assessment if the person chose to enroll in a long-term care program.
- Quality assurance and program oversight by state and agency administrators.

3.2 Basic Information

Basic Screen Information

Screening Agency
This is a read-only field that is automatically entered by FSIA based on the agency selected by the screener after login.

Referral Date
This is a user entered field. The screener should follow agency or program policy for what date to use in this field.

Screen Type
This is selected after the screener selects the correct individual from the home page.

Screener Name and Screener ID
Select the screener name for the screener who completes the in-person assessment with the individual. The first time a screener's name is selected the Screener ID field will need to be entered. The screener chooses what to enter in this field. One suggestion is to use the C####### number that the screener uses to log in to the UW-Oshkosh curriculum or into the Continuing Skills Test. Once the Screener ID has been entered for a screener, the system will remember it and the screener will only need to select the appropriate name. The screener can change the Screener ID at any time.

Applicant Information

"Applicant" is the person being screened as part of their application (or rescreen) for Family Care, Family Care Partnership, PACE, or IRIS. These selections need to correlate with Social Security Administration (SSA) information. Therefore, the information the screener enters must match Social Security. This ensures that FSIA, CARES, and ForwardHealth are using the same name, date of birth, Social Security number (SSN), and gender criteria.

Name
Enter the name as it is on file with SSA. If the person prefers to be called by a different name, include this in the Notes section.

Gender
The selection of Male or Female should match SSA. If the person's gender identity is different from SSA, include this in the Notes section.

Birth Date
Enter the applicant's date of birth in **MM/DD/YYYY**, as in 01/01/1950. LTCFS programming will not allow dates to be entered that make the applicant more than 150 years old or younger than 17 years, six months.

Social Security Number
Enter the applicant's SSN. If a Pseudo SSN is used, it will prevent enrollment into ForwardHealth. After the SSN is initially entered and saved on the LTCFS, only the four last digits of the SSN will display in FSIA and on all screen reports. If the screener needs to change or confirm the accuracy of the SSN, they may select the View/Edit box in FSIA to temporarily display and/or edit the SSN. After leaving the page, the SSN will again be obscured.

The screener should review the individual's name, date of birth, and SSN based on documentation such as a state-issued ID, driver's license, or Social Security card. If an inconsistency is noted, the screener can try and update those items in the screen, but if there is an error message, the screener should contact the DHS SOS Help Desk. When there is an issue with matching the Master Client Index (MCI number) or choosing the correct applicant and an error occurs, a correction is needed. The screener should first consult the Basic Information for Screeners, P-01604 and if the error cannot be resolved through that reference, then the screener should contact the DHS SOS Help Desk by emailing dhssoshelp@dhs.wisconsin.gov or calling 608-266-9198 for assistance.

Address, City, State, Zip Code, Phone Number
Enter the applicant's "permanent residence" address. If the person is currently residing in a facility (for example, a nursing home or community-based residential facility), the facility may or may not be their "permanent residence." If a person is currently residing in a nursing home but maintains their apartment in the community with the intention of returning home in the next few weeks, the apartment would be the permanent residence, not the nursing home. Use your professional discretion to determine the applicant's permanent residence.

Include street number, street name, apartment number, city, and zip code. Include phone number if available.

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

Residence and Responsibility
County of Residence: Select the county where the individual is physically present and currently living from the drop-down menu.

County of Responsibility: Select the county responsible for providing services from the drop-down menu.

Refer to the Residency Manual for further guidance. **Questions regarding the Residency Manual should be directed to the screening agency's DHS oversight team.**

Directions
This space is available for the screener to enter directions to the individual's home. Keep entries brief and succinct.

3.3 Screen Information

Source of Information

Referral Source
Select from the drop-down menu who contacted the screening agency to refer this person for a functional screen. This is required for initial screens. If the screen is being completed as an annual or change in condition screen, this selection is optional. If "Other" is selected, enter the source of the referral in the text box provided.

Primary Source for Screen Information
Select the primary source for screen information from the drop-down menu. If the primary source is not listed, select "Other" and enter the source of information in the text box provided.

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

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

If the individual uses an interpreter, the individual—not the interpreter—is still the primary source of information.

If the applicant could participate in the screening process, the applicant should participate to the greatest extent possible. This question is meant as a quality assurance reminder that screeners must not complete a screen by only talking with caregivers, staff, or other collateral contacts. If the individual is not the primary source of information, it is expected that in most cases other parts of the screen will indicate significant cognitive limitations.

Location Where Screen Interview Was Conducted
Select the place where the screen was conducted from the drop-down menu.

"Person's current residence" is selected when the individual is screened in the individual's permanent residence and not a temporary living situation.

“Temporary residence (non-institutional)” is selected when the individual being screened 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 community-based residential facility (CBRF).

“Nursing home” is selected when the individual being screened is temporarily living in a skilled nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IIDs) or facility for persons with developmental disabilities (FDDs).

“Hospital” is selected when the individual is screened while in the hospital.

“Agency Office/Resource Center” is selected when the individual is screened in the agency office or resource center.

“Other” is selected when the individual is screened somewhere other than those listed above, such as correctional facility, local library, or restaurant. Enter a description in the text box.

ICA Read Only

This screen item should only be completed by the ADRC or Tribal ADRS and only for an individual pursuing participation in IRIS, otherwise this should be left blank.

The ADRC or Tribal ADRS selects the IRIS consultant agency (ICA) that the individual is interested in enrolling in from the drop-down menu in the ICA Read Only section. This allows that specific ICA to view the LTCFS for that person to assess that person’s needs and to plan for potential enrollment of the person in the ICA.

This field defaults to blank when a rescreen or transfer is completed.

3.4 Demographics

Medical Insurance Information

Medical Insurance
Select all types of insurance coverage that the individual currently has.

If the person has Medicare coverage, VA benefits, or Railroad Retirement insurance, selecting the checkbox will “activate” the policy number field in FSIA. For purpose of the screen, it is not necessary to enter information in these fields.

Private insurance includes employer-sponsored insurances available as a job benefit.

When a person has Medicaid coverage, the MCI number will be automatically entered in FSIA when the Medicaid box is selected.

Ethnicity & Race Information

Any selections made should be based on how the individual self-identifies. For purposes of the LTCFS at the initial screen if the individual chooses not to answer, leave the selection blank. At rescreen, if the individual requests to have this selection changed, the screener should make the change.

The Ethnicity selections include Hispanic or Latino and Not Hispanic or Latino.

The Race selections include (select all that apply):

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other (describe in Notes section, if applicable)

Interpreter Information

If Language Interpreter is Required

Screeners should utilize interpreters when they are needed. This information will help long-term care programs better serve non-English speaking individuals.

Select the appropriate language if an interpreter is needed for the individual being screened. If the screener selects “Other,” record in the text box provided.

Leave this box unselected if no interpreter is needed for the individual being screened, comment in the Notes section if an interpreter is needed to communicate with caregivers.

Contact Information

For each contact person the individual wants to include, select the appropriate contact category. If the person meets more than one contact category, the screener should select the category that may have a legal role. The screener should refer questions about the legal role(s) of a contact person to their program oversight representative.

The contact categories to select from include:

- Adult child
- Ex-spouse
- Guardian of person
- Parent or stepparent
- Power of Attorney
- Sibling

- Spouse
- Other

Provide the contact's information that is available. Any additional information, such as email address, best time to reach, best number to call, if power of attorney is activated, should be provided in the Notes section.

If "Other" is selected, enter a brief description in the text box provided.

If there are multiple contacts for the person, the screener can select Add New and enter in the additional contact's name and address in the new "Contact Information" section.

3.5 Living Situation

Living Situation Information

Current Residence
This selection should be the individual's permanent residence and not a temporary living situation, such as a motel, hospital, or rehabilitation facility. Select "Other" if none of the provided selections is appropriate and record an explanation in the text box. Most living situations fit into one of the options provided. If needed, the screener should provide additional information or clarification regarding the living arrangement in the Notes section.

Own Home or Apartment
This is a residence where the individual owns or is listed on the lease. The individual may or may not receive services. Selections include:

- ☐ Alone
- ☐ With Spouse/Partner/Family
- ☐ With Non-relative/Roommates (this can include typical roommate situations as well as dorms, convents, or other communal settings)
- ☐ With Live-in Paid Caregiver(s) (this includes service in exchange for room and board)

Someone Else's Home or Apartment
This is a residence where the home is owned or rented by another person or entity, and the individual is not listed on the lease. Selections include:

- ☐ Family (this includes adult children living with family)
- ☐ Non-relative
- ☐ Home or Apartment for which the lease is held by support services provider

Group Residential Care Setting
This is a residence that is a home or facility licensed by the state where paid staff are available to support individuals 24/7. Selections include:

- ☐ Certified Adult Family Home (1-2 bed AFH)
- ☐ Licensed Adult Family Home (3-4 bed AFH)

- ☐ CBRF 5-8 beds
- ☐ CBRF more than 8 beds
- ☐ Children's Group Home
- ☐ Residential Care Apartment Complex (RCAC)

Health Care Facility/Institution
This is a residence that is licensed by the state and provides intensive support and services for individuals with specific disabilities. Selections include:

- ☐ Nursing Home (this includes a rehabilitation facility if licensed as a nursing home)
- ☐ Facilities for Persons with Developmental Disabilities/Intermediate Care Facility for Individuals with Intellectual Disabilities (FDD/ICF-IID)
- ☐ Developmental Disability (DD) Center/State Institution for Developmental Disabilities
- ☐ Mental Health Institute/State Psychiatric Institution
- ☐ Other Institute for Mental Disease (IMD)
- ☐ Child Caring Institution
- ☐ Hospice Care Facility

Do not select a health care facility or institution for an individual who is temporarily in one of these types of facilities and continues to maintain a residence elsewhere.

No Permanent Residence
This should be selected for an individual who does not have a permanent address. This could be residing in a homeless shelter or temporarily using a hotel or motel as their residence.

Correctional Facility
This should be selected for an individual whose current residence is a correctional facility at the time of screening. The name of the correctional facility should be entered in the text box provided.

Other
This should be selected for an individual whose current residence does not match any of the above selections. Do not select "Other" for someone in a hospital, swing bed, or other temporary living situation.

Prefers to Live
The "Prefers to Live" question is to be completed based on the individual's informed preference, not what is deemed realistic, possible, or safest. The question should be based on where the person prefers to live in the long term, not short-term and, not where anyone else, including a guardian, wants the person to live**.** Screeners must take the time to explain the individual's options. The individual cannot express a preference if the screener has not informed them of their options first. The screener should use the definitions in Current Residence to select the appropriate option from the drop-down menu.

The drop-down selections are:

- Stay at current residence
- Move to their own home or apartment
- Move to someone else's home or apartment
- Move to an apartment with onsite services
- Move to a group residential care setting
- Move to a health care facility or institution
- No permanent residence
- Unsure or unable to determine person's preference for living arrangement

An individual's preference may be difficult to decipher, as the individual requesting or receiving services may acquiesce to whatever they feel limited to or whatever they have been told. Screeners are to use their best interviewing skills to select the most accurate answer, for example, individuals with intellectual/developmental disabilities often think or are told "group home" is the only option available to them, or an elderly individual may say they "belong in" a nursing home because they would be too much of a bother anywhere else.

Select "Unsure or unable to determine person's preference for living arrangement" if the person cannot comprehend their options and/or cannot communicate their preference.

Guardian or Family's Preference for this Individual

This question captures the guardian or family member preference. The screener should use the definitions in Current Residence to select the appropriate option from the drop-down menu.

The drop-down selections are:

- Not applicable
- Stay at current residence
- Move to their own home or apartment
- Move to someone else's home or apartment
- Move to an apartment with onsite services
- Move to a group residential care setting
- Move to a health care facility or institution
- No consensus among multiple parties
- No response or no preference from guardian or family

Module #4: Diagnoses

Definition:

Cognitive Impairment: A cognitive impairment in the LTCFS is defined as a permanent impairment of thought due to a severe and persistent mental illness, dementia, brain injury, intellectual/developmental disability, or other organic brain disorder.

- A cognitive impairment does not include temporary impairment due to medications and/or substance use intoxication.
- A cognitive impairment does not include temporary impairment due to a temporary medical condition such as infection, electrolyte imbalance, or dehydration.

4.1 The Importance of Diagnoses

Complete and accurate functional screening cannot occur without a thorough understanding of the diagnoses of the person being screened. Although an individual's diagnoses do not determine whether they are eligible for Wisconsin's Medicaid funded LTC programs, both diagnoses and functional limitations are important factors in determining whether a person's condition meets one or more of the target group definitions required for eligibility. Functional limitations correlate closely with diagnoses and diagnoses often explain and provide context for limitations that may be observed by the screener and health care professionals. In addition, diagnoses and functional limitations are included in data used by DHS for research, rate setting, federal reporting, and quality assurance activities.

4.2 Diagnoses Verification

To accurately complete the Diagnoses section of the LTCFS, a screener must verify the current diagnoses of the person being screened. A screener may need to consult with the person's health care provider(s). **It is best practice to verify all diagnoses with written documentation from the person's health care provider(s).**

Diagnoses Must Be Verified
All psychiatric, behavioral, dementia, brain injury, and intellectual disability diagnoses must be verified directly with a health care provider, health record, the Children's Long-Term Support Functional Screen, or a disability determination from the Social Security Administration. It is best practice to document in the Notes section the source of the verification. This could include the year, provider and/or clinic.

Other diagnoses are verified if:

- Stated to screener by a medical doctor (MD), registered nurse (RN), or other health care provider; or
- Copied from current health records; or
- Very clearly stated, in exact medical terms, by the person, family, guardian, advocate, etc.

Do not interpret an individual's complaints or symptoms as verified diagnoses and record them on the LTCFS. At times, a caregiver may report a person being screened has a diagnosis of intellectual disability or a psychiatric, behavioral, or dementia diagnosis when there is limited or no documentation to substantiate that diagnosis or when the person's functioning does not 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 selecting these diagnoses on the screen. In addition, do not infer an individual's diagnoses based on their prescribed medications because any single medication may be prescribed for a variety of different diagnoses.

- 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 (for example, cataracts, retinopathy, glaucoma, macular degeneration) based solely on the woman's self-report. The screener will need to obtain a release of information to contact this woman's health care provider for verification of her current diagnoses.
- Example B: A woman says her elderly father "is having trouble remembering things and is getting Alzheimer's." The screener asks her if a health care provider has made this diagnosis. She says, "No, father hasn't been to a doctor for a while, but he must have it, he forgets so much now." In this case, the screener does NOT check E1: Alzheimer's Disease or E2: Other Irreversible Dementia. The screener will need to obtain a release of information to contact this man's health care provider for verification of his current diagnoses.

If a screener is performing a rescreen, then they may rely on verification of diagnoses that were obtained and documented for previous screen calculations for the person, unless the person has had a change in condition. However, if no verifications have been documented, then the screener responsible for rescreening the person must obtain verification of diagnoses prior to re-calculating the person's eligibility using the LTCFS.

Verifying Diagnoses with the Social Security Administration (SSA)

The Social Security Administration's disclosure of personal information to state and local agencies falls under the following categories:

- Disclosure under a routine use (for example, to administer an income maintenance or health maintenance program similar to an SSA program, or for another purpose that meets SSA's compatibility criteria, that is, disclosure is compatible with a purpose for which SSA collects the information.)
- Disclosure for a law enforcement purpose.
- Disclosure required by federal law. For more specific information, see GN 03314.001.

The following guidelines should be followed when verifying diagnoses with the SSA:

- Agencies should attempt to verify diagnoses with the health care provider or medical record before contacting SSA.
- The need for additional information should be indicated on the SSA's Consent for Release of Information form, SSA-3288. Only the minimal information that is relevant and necessary should be requested. Unless more information is needed, such as IQ scores or results of other cognitive testing or evaluations, agencies should only request diagnoses codes from SSA. To just select diagnoses codes, agencies should select box *#8 Other record(s) from my file (you must*

specify the records you are requesting, e.g., doctor report, application, determination, or questionnaire) and write "Diagnoses codes only" in the space provided.
- Agencies should also be sure that the language in any cover letter that accompanies the Consent for Release of Information form only asks for the information requested on the SSA-3288 form.
- Requests for diagnoses verification should not be sent to SSA once an individual meets the retirement age of 65 years old. Once that age is met, all the individual's records related to their disability are destroyed.

Diagnoses Must Be Current
In addition to verifying diagnoses, the screener needs to determine if the diagnoses are current. If a diagnosis was made more than a year ago, but is still current, the diagnosis may be entered on the screen. Screeners should not include diagnoses that pertain to a condition that has been cured or eliminated by medical treatment, therapy, or surgery.

4.3 Diagnoses Table

The screener will need to complete the Diagnoses Table after the diagnoses have been verified and determined to be current.

Diagnoses Table
- The screener will enter verified diagnoses that are current. For every diagnosis, the screener will need to determine if the diagnosis is listed on the Diagnoses Table and select the relevant box. For convenience, the diagnoses on the Diagnoses Table are grouped by major categories (such as Heart/Circulation, Respiratory, Infections/Immune system). When selecting a code that requires the screener to list a diagnosis, only enter a diagnosis. Do not enter other text, such as a treatment, "see below," or "history of."
- If a diagnosis cannot be verified or is not current, the screener must not select the box on the Diagnoses Table for this diagnosis. This information may be included in the Notes section of the LTCFS.
- If an individual has no diagnoses, the screener must select the "No current diagnoses" box. In addition, the screener should provide some detail regarding the absence of any diagnosis in the Notes section.
    - 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 health records to verify a diagnosis, the screener must select the "No current diagnoses" box. In addition, the screener should enter this information in the Notes section.
    - Example: Mr. Smith has not been to the doctor in over 30 years and continues to refuse to be seen by a health care provider.

Diagnoses Cue Sheet
If a diagnosis is not on the Diagnoses Table, the screener will need to find the code on the Diagnoses Cue Sheet, P-00814, then select the corresponding code on the Diagnoses Table.

- The Diagnoses Cue Sheet lists diagnoses in alphabetical order. While searching for a diagnosis on this cue sheet, the screener may find it helpful to search using "Control+F" and may need to search each of the words in the diagnosis to find the code.
- A key of "Ø" means that the diagnosis is not included on the Diagnoses Table and the screener should not code it. Screeners should include diagnoses of this nature in the Notes section.
- Some diagnoses are noted on the cue sheet to be coded as K6 and the screener should select K6 for these specific diagnoses. K6 should also be selected when a diagnosis is NOT listed on the Diagnoses Table or the Diagnoses Cue Sheet and is NOT needed for a primary or secondary diagnosis. When selecting K6, the screener should record the diagnosis in the text box provided.
- If a screener has a question about capturing or how to code a diagnosis, they should contact their screen liaison.
- **If a screen liaison has questions about capturing diagnoses or if a diagnosis is not listed on the Diagnoses Table or the Diagnoses Cue Sheet and it is a primary or secondary diagnosis needed to complete the LTCFS**, the screen liaison is to contact dhsltcfsdiagnosis@dhs.wisconsin.gov prior to calculating the screen. If DHS LTCFS team provided consultation regarding diagnoses selections, this also must be documented in the Notes section and should be reviewed by the screener with each rescreen.
    - Example: DHS consulted regarding coding of neurocognitive disorder on 1/18/23. Based on information provided at the time of this screen neurocognitive disorder coded as E2. Dx should be reviewed with rescreens and questions should be addressed with liaison and Dx mailbox as needed.

Regarding Dementia

To select a dementia diagnosis, it must be irreversible which is not always discernible by diagnosis alone. A screener may need to consult with a health care provider to confirm whether the dementia experienced by a person being screened is irreversible.

Regarding IQ Scores

For diagnoses that are coded as A1-A10, an IQ score can be important for determining the correct target group and level of care. If the IQ is known, it should be recorded in the text box provided on the Diagnoses Table. Screeners should include the following in the Notes section, if available: name of the clinician who conducted the test, date of the test, and the name of the IQ test used. If this information is not known, screeners are strongly encouraged to request records of the IQ testing.

The screener should use the most recent IQ score for individuals that have had multiple tests.
In order to capture the FSIQ score on the screen, the name of the IQ test should be in the table below.

IQ Test
Comprehensive Test of Nonverbal Intelligence (C-TONI)
Differential Ability Scales (DAS)
Kaufman Adolescent & Adult Intelligence Test (KAIT)
Kaufman Assessment Battery for Children (KABC)
Leiter International Performance Scale (Leiter)
Stanford Binet Intelligence Scales (SB)

Test of Nonverbal Intelligence (TONI)
Universal Nonverbal Intelligence Test (UNIT)
Wechsler Intelligence Scale for Children (WISC)
Wechsler Nonverbal Scale of Ability (WNV)
Wechsler Adult Intelligence Scales (WAIS)
Woodcock Johnson – Test of Cognitive Skills (WJ III COG)

The screen liaison should contact DHS at dhsltcfsdiagnosis@dhs.wisconsin.gov if:

- The name of the test is not known.
- The test is not on the table including an abbreviated form of the test.
- The clinician conducting the IQ test expressed concern about the validity of the results.
- The IQ does not seem to generally match the current functioning of the individual.
- The test was completed prior to the individual's 7th birthday.
- The test result is reported as a range.
- There is an unexpected outcome.
- There are any questions regarding IQ.

Regarding Memory Loss

A person may show signs and symptoms of memory loss but has not yet received a formal, verified diagnosis from a qualified health care provider. This apparent memory loss may impact the person's ability to perform certain tasks without assistance. The following guidelines describe the circumstances under which a screener may select memory loss on the Diagnoses Table in the absence of a verified diagnosis of memory loss.

When a person, their family, caregivers, or other support suspect that memory loss could be impacting the person's functioning, but there has been no verified diagnosis of a condition that may cause a cognitive impairment or memory loss such as dementia, TBI, I/DD, or SPMI, and the person is not under the influence of drugs or alcohol, a memory screen may be offered to the person. Memory screening is always voluntary. Refer to the DHS publication, Memory Screening in the Community, P-01622, for specific guidance.

For purposes of the LTCFS, results of the memory screening conducted by a trained staff at a DHS approved screening agency using the Memory Screening in the Community manual may be used in the place of a verified diagnosis when ALL the statements below are true:

1. The screener is completing a screen for a person who shows signs of apparent memory loss but does not have a verified diagnosis of a cognitive impairment or memory loss as described above.
2. Memory Loss would be selected as a primary or secondary diagnosis for one or more areas of functioning on the functional screen.
3. The results of the memory screening fall within the range when a referral to a provider is recommended as outlined below:

   Total Mini-Cog score = 0-2

   OR

Animal Naming is less than 14 **and** score is zero (0) on either the word recall or the Clock Draw

Coding Memory Loss on the Diagnoses Table as a Result of Memory Screening

- When the memory screening is administered and the results fall within the range where a referral to a provider is recommended, the screener may use E9 on the Diagnoses Table. While these results are not verification of diagnosis of memory loss, they are acceptable evidence of memory loss.
- In absence of getting a diagnosis from a health care provider, for purposes of the LTCFS, administer the memory screen at least annually to continue using memory loss in lieu of a diagnosis.
- If E9 is used, the screener must include the results and date of the memory screening in the text box provided.
- If E9 is used longer than one year, the screener must explain why in the Notes section.
- If a person declines to participate in the administration of one or both screening tools, then Memory Loss may not be selected on the Diagnoses Table.

If you have questions about conducting the memory screen, refer to the Memory Screening in the Community manual or consult your dementia care specialist or lead.

If there are accessibility or health equity concerns as outlined in the Memory Screening in the Community manual or questions about using the results of the memory screening in lieu of a memory loss diagnosis, the agency screen liaison is to contact DHS at dhsltcfsdiagnosis@wisconsin.gov.

Regarding Sensory Deficits

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 or equal to 20 degrees. 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.

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

Regarding Terminal Illness

The screener must select both "K3: Terminal Illness (prognosis less than or equal to 12 months)" on the LTCFS Diagnosis Table **and** the associated diagnosis that has created the terminal condition (such as "J2: Cancer in the past 5 years"). Written documentation from the health care provider of the person being screened that verifies the terminal nature of the condition is not required.

4.4 Identifying Primary and Secondary Diagnoses

To be selected as a primary or secondary diagnosis that causes a need for assistance or support from another person, the need must be due to a physical, cognitive, or memory loss impairment. If symptoms or complications of a disease/condition require assistance from another person, the screener can use that diagnosis as the primary or secondary.

There is one exception to this guidance which is outlined in the section titled "Exception to Physical, Cognitive, or Memory Loss Impairment Requirement."

For each need or additional support identified in the LTCFS, including some selections of adaptive equipment, the diagnoses that cause the need or necessary support must be selected from options prepopulated in a drop-down menu. Only diagnoses that were previously identified on the Diagnoses Table will be prepopulated in the drop-down menus. FSIA will use these diagnoses to assign the correct target group(s) for everyone being screened.

Primary and secondary diagnoses carry equal weight regarding assignment of target group by FSIA. One diagnosis must be selected from the drop-down menu under primary diagnosis for each need or support identified on the screen. Under secondary diagnosis, a selection must be made from the drop-down menu. If there is no secondary diagnosis contributing to the need for assistance, the screener must select "None."

When determining which diagnosis to select from the primary or secondary diagnosis drop-down menu, the screener is to be thoughtful and consistent. The diagnosis selected should justify and explain the need for assistance from another person. If there is only one diagnosis that affects the need for assistance, the screener would select "None" from the drop-down menu under secondary diagnosis. If a person has more than one diagnosis that corresponds to the person's need, the screener could choose one of the other diagnoses as the secondary diagnosis. However, if both diagnoses are clearly related to a single target group it is not necessary to list both on the functional screen. For example, a 74-year-old man needs assistance with getting into the shower due to right-sided weakness after a cerebral vascular accident (CVA). The diagnosis that corresponds to why he needs assistance is a CVA. If he also has a diagnosis of right hemiparesis (right-sided weakness) due to the CVA, while the diagnosis of right hemiparesis could be selected as secondary, it is not required because it is caused by the identified primary diagnosis, and it clearly relates to the same target group.

If the need for assistance is due to multiple diagnoses that are related to different target groups, the screener should select diagnoses from different categories on the Diagnoses Table. This is important for accurate assignment of target group(s). For example, a 43-year-old woman needs hands-on assistance with bathing due to obesity (B8) and cueing with bathing due to intellectual disability (A1). In this example, both the obesity and intellectual disability diagnoses should be selected; one from the drop-down menu under primary diagnosis and one from the drop-down menu under secondary diagnosis. The diagnosis of obesity is relevant to the Physical Disability target group and the diagnosis of intellectual disability is relevant to the Intellectual/Developmental Disability target group. A review of Module 11 Completion of the LTCFS can provide some guidance as to what factors into each target group.

Exception to Physical, Cognitive, or Memory Loss Impairment Requirement
There are occasions when the need for assistance is not due to a physical, cognitive, or memory loss impairment. This is relevant only to certain skilled tasks captured on the HRS Table (Module 7) and IADL Medication Administration and Medication Management (Module 5.14). These skilled tasks may include Medication Administration, Medication Management, Ostomy-related Skilled Services, Oxygen and/or Respiratory Treatments, Dialysis, Transfusions, Tracheostomy care, Ulcer care, Urinary Catheter-related skilled tasks, Other Wound Cares, Ventilator-related interventions, RNAI, and Skilled Therapies.

In these cases, the screener should determine why a primary or secondary diagnosis is selected even though it may not be the cause of a physical, cognitive, or memory loss impairment requiring assistance from another person. The screener should document this in the Notes section.

Examples include (this is not an all-inclusive list):

- A person who is paralyzed from the waist down has a stage 4 ulcer on their coccyx region requiring dressing changes every three days. He has no physical, cognitive, or memory loss impairment preventing him from performing the wound care, but due to the location of the ulcer, he is unable to complete the needed care. In addition, due to the depth of the wound, the physician has ordered a wound care nurse to complete the wound care. The screener would select K4: Wound/Burn/Bedsore/Pressure Ulcer as the primary diagnosis for Ulcer – Stage 3 or 4 on the HRS Table and explain in the Notes section why this selection was made.
- A person has a verified diagnosis of chronic pain treated with a Fentanyl patch. The patch is placed on her back, near the scapula, and the site is changed every three days. She does not have a physical, cognitive, or memory loss impairment, but cannot reach the site, and she requests assistance to place and remove the patch. The screener needs to confirm with the person or her medical professional if the patch must be placed in a location that she cannot reach, or if an alternate accessible location is possible. If the location of the patch does indeed need to be in an inaccessible spot, the screener would select D12: Other Chronic Pain or Fatigue as the primary diagnosis for Medication Administration and explain in the Notes section why this selection was made.
- A person has a verified diagnosis of end-stage kidney disease and receives hemodialysis three times a week at a dialysis center. His need for assistance at a dialysis center is not due to a physical, cognitive, or memory loss impairment. The screener would select G1: Renal Failure, other Kidney Disease as the primary diagnosis for dialysis on the HRS Table and explain in the Notes section why this selection was made.

Regarding Mental Health Diagnoses
For a mental illness to be selected as a primary or secondary diagnosis that causes a need for assistance or support from another person, the person must have a permanent cognitive impairment due to that diagnosis. This does not include impairments that may resolve when medications are taken appropriately or when engaged in ongoing therapy, are situational, or can be reasonably accommodated. The notes should justify why the mental health diagnosis has been used as a primary or secondary diagnosis.

Regarding Substance Use

A screener cannot use temporary effects of substance use intoxication, including physical, cognitive, or memory loss impairment, as a reason for a need for assistance.

Module #5: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Definitions:

Cognitive impairment: A cognitive impairment in the LTCFS is defined as a permanent impairment of thought due to a severe and persistent mental illness, dementia, brain injury, intellectual/developmental disability, or other organic brain disorder.

- A cognitive impairment does not include temporary impairment due to medications and/or substance use intoxication.
- A cognitive impairment does not include temporary impairment due to a temporary medical condition such as infection, electrolyte imbalance, or dehydration.

Declining the task: A person declines a task when that person decides not to complete one or more health-related services or tasks included on the HRS Table or in the IADL Medication Management and Medication Administration. Refer to the **General Guidance** section in this module for specific details to consider when a task has been declined.

Need for assistance: A need for assistance in the LTCFS is the NEED for "help from another person," which is defined as supervision, cueing, and/or hands-on assistance (partial or complete). Refer to the **General Guidance** section in this module for specific details about need for assistance.

Safely: Means without significant risk of harm to oneself or others. Wis. Admin. Code § DHS 10.33(1)(d).

Significant, negative health outcome: A significant, negative health outcome has occurred when a person experiences one or more of the following symptoms: shortness of breath, dizziness, chest pain, exhaustion, falls, incontinence, or debilitating pain **to the point where the individual is unsafe and another person should be present to help with some or all of the components of a task**. Requiring additional time to complete a task is not a significant, negative health outcome in and of itself.

Standby assistance: The need for a person to be next to the individual (within arm's length) to be readily available to help the individual.

5.1 General Guidance for ADLs/IADLs

A determination that an individual is limited in their capacity to perform an ADL or IADL task should always equate with a physical, cognitive, or memory loss impairment.

- The screener should select the level of assistance needed based on the level of help needed from another person.
- The screener should indicate the amount of help the person currently needs from another person, no matter who is providing the help. When a person is in the process of changing their

residence, the screener should estimate what assistance the person might need in their new residence.

- Screeners should select the level of assistance needed based on need and not solely on a diagnosis.
- When a screener identifies a level of help needed in an ADL or IADL, the screener will select the diagnosis that correlates to the deficit.
- If an individual has never performed or is not performing an activity or a task, a screener should not assume that the individual 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, cognitive, or memory loss impairment.
- Although an individual may be 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.
- For a person living in a residential facility, screeners should assess the person's actual need for assistance. Screeners should not select the level of help needed based on the services or equipment available as part of the residential facility package.

NEED for Assistance

To reflect a person's NEED for assistance, the screener should select the most accurate answer that most closely describes the person's NEED for "help from another person," whether the person is actually receiving that assistance or not. Help from another person is defined as supervision, cueing, and/or hands-on assistance (partial or complete).

- If a person has an identified need but is not receiving assistance (this includes declining the assistance and a significant, negative health outcome occurs), the screener should still capture the need for the assistance from another person to complete the task.
- If a person has an identified need but they have declined assistance and there is no significant negative health outcome, the screener is to select Independent.
- If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes and the selection of a need might be appropriate.

Declining a Task

For the IADL Medication Administration and Medication Management, if the individual has declined the **task of taking medications itself** and is able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select "N/A – Has no medications" for the IADL Medication Administration and Medication Management. In this situation, the person has no need for Medication Administration or Medication Management because it is not occurring. For example, if an individual able to perceive potential risk or negative outcome chooses not to take any prescribed medications, the person has no need for medication administration and medication management assistance because no medications are being taken (the task itself is not being done).

- If the person is **not** able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select the frequency of need.

- If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes, and the selection of a need might be appropriate.

If a person can complete a task independently, but it takes them a very long time, a screener should consider if the person needs any help with that task to complete it safely.

- If it takes so much time for the person to complete a task independently and that results in a significant, negative health outcome, then it would be justified to indicate the person has a need for help completing the task.
- If an identified need is due to a significant, negative health outcome, the screener should write a note describing the significant, negative health outcome.

When an individual's conditions and abilities fluctuate over time, reference Module 2.6 Abilities Fluctuate, for assistance on how to complete the LTCFS.

An individual's need for assistance with personal hygiene, such as grooming and mouth care, is not captured on the LTCFS. This information, as well as hygienic conditions of the home, can be captured in the notes section.

It is not uncommon for an individual to underrate their need for help or overstate their independence. Screeners should use the following steps when assessing an individual's level of help needed:

- Select the level of assistance required based on need 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.

Example: Bert tells you he does not 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**: You ask him if you can see his bathroom, where you notice he has a claw-foot bathtub with sides about two 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**: Bert's daughter referred him to the ADRC 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 is afraid, but he has admitted to her that he is unable to get into the bathtub.
- **Step 3: Use your professional judgment to select the best answer**: 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.”

5.2 Communal Living Situations

A screener may encounter a person living in a communal living situation or congregate living arrangement, like a dormitory, convent, or monastery. 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 (for example, 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, cognitive, or memory loss impairment 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:

- Ascertain whether a communal living situation, socioeconomic barriers, religious beliefs, or cultural norm factors result in the individual receiving assistance or lacking experience with a task.
- Determine (if such factors are evident) whether there is a physical, cognitive, or memory loss 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, cognitive, or memory loss 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, cognitive, or memory loss 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, or 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.

5.3 Coding for Who Will Help in the Next Eight Weeks

The LTCFS requires screeners to indicate who will help in the next eight weeks for each ADL and most of the IADLs. The codes for this section are below. Screeners should check all that apply.

- ☐ **U**: Current **UNPAID** caregiver will continue
- ☐ **PF**: Current **PUBLICLY FUNDED** paid caregiver will continue
- ☐ **PP**: Current **PRIVATELY PAID** caregiver will continue

- **N**: **Need** to find new or additional caregiver(s)

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

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

“PP – Current PRIVATELY PAID caregiver will continue” means non-public funding, including the person's own money, that of a family member or friend, etc., private insurance (including long-term care 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 eight weeks, indicate how the nursing home is being paid (Privately Paid or Publicly Funded). If the person is expected to be discharged within the next eight weeks, try to be as accurate as possible with the "Who Will Help in the Next 8 Weeks?" boxes. Record the help the person will need once at home. Many individuals are discharged to their own homes with a mixture of public, private, and unpaid care giving services.

5.4 Selecting Primary and Secondary Diagnoses

To be selected as a primary or secondary diagnosis that causes a need for assistance or support from another person, the need must be due to a physical, cognitive, or memory loss impairment. Additional guidance can be found in Module 4.4 Identifying Primary and Secondary Diagnoses.

5.5 Activities of Daily Living (ADLs)

The six ADLs include:
- Bathing
- Dressing
- Eating
- Mobility in Home
- Toileting
- Transferring

ADL Coding for Level of Help Needed
All ADLs have the same rating system for "Coding for Level of Help Needed to Complete the Task Safely." When recording the level of help an individual needs to safely complete an ADL, a screener should select only one rating of "Level of Help Needed" with each ADL. The rating system used for ADLs in the LTCFS is below.

- 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**. "Help" can be supervision, cueing, or hands-on assistance.
- 2: Help is needed to complete the task safely and **helper DOES need to be physically present throughout the task**. "Help" can be supervision, cueing, and/or partial or complete hands-on assistance.

ADL Adaptive Equipment Guidance
Adaptive equipment is defined as specific types of equipment captured on the LTCFS that an individual may use to safely complete an ADL.

Four of the ADLs (Bathing, Mobility in Home, Toileting, and Transferring) have some adaptive equipment options. Screeners should select only equipment the person currently has, needs, and uses. The only exception to "has, needs, and uses" is prosthesis in 5.9 Mobility in Home. Prosthesis should be selected if the person has a prosthesis; regular use or use only in the home are not requirements.

Do not select one of the equipment options if a person uses an improvised or homemade item as a substitute for the equipment on the list. For example, a person may use a sturdy object to sit on during bathing instead of a tub bench. In this instance, you would **not** select "Uses tub bench" in the Bathing equipment box, because the object is a substitute for a tub bench.

5.6 Bathing

LTCFS ITEM DEFINITION:

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

- Transferring in and out of the bathtub or shower.
- Physically turning on and off the faucets and adjusting the water temperature as desired.
- Determining the proper water temperature. (This component pertains only to people with a cognitive impairment.)
- Washing and drying self.
- Shampooing hair.

CODING FOR LEVEL OF HELP NEEDED

- 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**. "Help" can be supervision, cueing, and/or hands-on assistance.
- 2: Help is needed to complete the task safely and **helper DOES need to be present throughout the task.** "Help" can be supervision, cueing, and/or partial or complete hands-on assistance.

ADAPTIVE EQUIPMENT

Adaptive equipment is defined as specific types of equipment captured on the LTCFS that an individual may use to safely complete an ADL. Screeners should only select the adaptive equipment the person currently has, needs, and uses.

Adaptive equipment option for Bathing is:

☐ Uses Adaptive Equipment, including:
- Grab bar (s)
- Shower bed, gurney, trolley
- Shower chair, bathtub bench (including built-in seating)
- Mechanical lift

Do not select one of the equipment options if a person uses an improvised or homemade item as a substitute for the equipment on the list. For example, a person may use an object to sit on during bathing instead of a bathtub bench. In this instance, you would not select "Uses Bathtub Bench" in the Bathing equipment box, because the object is a substitute for a bathtub bench.

BATHING-SPECIFIC RESPONSE GUIDANCE:

The "Check 0, 1, 2" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Person is independent in completing the activity safely") for a person who:
- Has no physical, cognitive, or memory loss impairments affecting their ability to complete the task of Bathing independently.
- Uses an improvised or homemade item and without it, they would NOT need assistance from another person to complete the task.
- Bathes independently, but:
  - Uses adaptive equipment.
  - Uses simple, reasonable adaptations such as a handheld washing aid, handheld shower attachment, or a shampoo dispenser.
  - It takes additional time to do so and there are NO significant, negative health outcomes.
  - Is unable to wash and/or dry their back.

    - Chooses not to do so unless another person is present somewhere in the home, "just in case."
    - Needs toiletries (such as shampoo, soap, towels) retrieved and/or laid out for them. Review Module 5.16 Laundry and/or Chores.
- Requires assistance with grooming only (such as shaving, brushing hair, mouth care, nail care). Grooming is not considered an ADL on the LTCFS.
- Prefers a sponge bath and can do so independently and maintains adequate hygiene.
- Can maintain adequate hygiene by bathing on good days.
- Has a seizure disorder with no seizures in the last three months and there is no intervention needed; however, another person is present "just in case."

Check "1" ("Help is needed to complete the task safely but helper DOES NOT have to be physically present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with at least one but not all the components of Bathing.
- Bathes independently but doing so results in a significant, negative health outcome and another person should be present to help with at least one but not all the components of Bathing.
- Uses an improvised or homemade item and without it, they would need assistance from another person to complete at least one but not all the components of Bathing.
- Due to a cognitive impairment, regularly requires cueing or else they would not initiate the task of Bathing.
- Prefers to sponge bathe but does not maintain adequate hygiene due to a physical, cognitive, or memory loss impairment.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months but DOES NOT require standby assistance during the entire task of Bathing.

Check "2" ("Help is needed to complete the task safely and helper DOES need to be present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or partial or complete hands-on assistance with ALL the above components of Bathing and another person needs to be present throughout the task.
- Bathes independently but doing so results in a significant, negative health outcome and another person should be present to help with ALL the components of the task.
- Uses an improvised or homemade item and without it, they would need assistance from another person to complete ALL the components of Bathing.
- Requires assistance with ALL the components of Bathing but they can be left alone to soak in the bathtub (without negative health and/or safety concerns). Soaking in the bathtub is not a component of the Bathing ADL.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months AND requires standby assistance during the entire task of Bathing.

5.7 Dressing

LTCFS ITEM DEFINITION:

Dressing: The ability to safely dress and undress as necessary. The Dressing ADL consists of the following components:

- Dressing and undressing the top half of body (includes putting on undergarments).
- Dressing and undressing the bottom half of body (includes putting on undergarments).
- Getting shoes and socks on and off.
- Putting on or removing prostheses, orthotic devices, anti-embolism hose (TED hose), compression products or devices (stockings, bandages, pumps), and/or pressure relieving devices, if applicable.
- Choosing the appropriate clothing to maintain health and safety for the environment and setting. (This component pertains only to people with a cognitive impairment.)

CODING FOR LEVEL OF HELP NEEDED

- ☐ 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**. "Help" can be supervision, cueing, and/or hands-on assistance.
- ☐ 2: Help is needed to complete the task safely and **helper DOES need to be present throughout the task.** "Help" can be supervision, cueing, and/or partial or complete hands-on assistance.

ADAPTIVE EQUIPMENT

This is not applicable for this ADL.

DRESSING-SPECIFIC RESPONSE GUIDANCE:

The "Check 0, 1, 2" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Person is independent in completing the activity safely") for a person who:

- Has no physical, cognitive, or memory loss impairments affecting their ability to complete the task of Dressing independently.
- Dresses independently, but:
  - Uses simple, reasonable adaptations such as wearing pullover sweaters, elastic-waist pants, front-clasp bra, slip-on shoes, or use of a sock aid.
  - It takes additional time to do so and there are NO significant, negative health outcomes.
  - Chooses not to wear appropriate clothing for the environment or setting AND has no cognitive impairment.
  - Refuses to change their clothes, even when clothes are stained or carry an odor AND has no cognitive impairment.

    - May mismatch clothes.
    - Needs clothes retrieved and/or laid out for them. Review Module 5.16 Laundry and/or Chores.
- Requires assistance only with a zipper and/or button(s).
- Has a seizure disorder with no seizures in the last three months and there is no intervention needed; however, another person is present "just in case."

Check "1" ("Help is needed to complete the task safely but helper DOES NOT have to be physically present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with at least one but not all the components of Dressing.
- Dresses independently but doing so results in a significant, negative health outcome and another person should be present to help with at least one but not all the components of Dressing.
- Needs assistance from another person to either get dressed OR undressed, but not both.
- Due to a cognitive impairment:
    - Regularly requires cueing or else they would not dress.
    - Does not wear appropriate clothing for the environment or setting.
    - Requires a cue to change their clothes when clothes are stained or carry an odor.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months but DOES NOT require standby assistance during the entire task of Dressing.

Check "2" ("Help is needed to complete the **task safely and helper DOES need to be present throughout the task") for a person who:**

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or partial or complete hands-on assistance with ALL the above components of Dressing.
- Dresses independently but doing so results in a significant, negative health outcome and another person should be present to help with ALL the components of the task.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months AND requires standby assistance during the entire task of Dressing.

5.8 Eating

LTCFS ITEM DEFINITION:

Eating: The act of getting food or drink from a plate, bowl, or cup to the mouth (chewing if necessary and swallowing) using routine or adaptive utensils. This includes intake of nourishment, including water, by other means such as total parenteral nutrition (TPN) and tube feedings.

Examples of adaptive utensils include weighted and/or built-up eating utensils, scooper plates or bowls, food bumpers, special cups.

CODING FOR LEVEL OF HELP NEEDED

- 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**. "Help" can be supervision, cueing, and/or hands-on assistance.
- 2: Help is needed to complete the task safely and **helper DOES need to be present throughout the task.** "Help" can be supervision, cueing, and/or partial or complete hands-on assistance.

ADAPTIVE EQUIPMENT

This is not applicable for this ADL.

EATING-SPECIFIC RESPONSE GUIDANCE:

The "Check 0, 1, 2" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Person is independent in completing the activity safely") for a person who:

- Has no physical, cognitive, or memory loss impairments affecting their ability to complete the task of Eating independently.
- Eats independently, but:
  - Uses simple, reasonable adaptations.
  - Receives reminders to slow down or chew food thoroughly "just in case."
  - Is not an active choking risk but is supervised "just in case."
  - Is on a special diet (such as diabetic, low-calorie, low-sugar, or low fat).
  - Must have food pureed, minced or follows a mechanical soft diet. Review Module 5.13 Meal Preparation.
  - Requires assistance with the placement of food on the plate or table (serving) or with carrying a plate or cup to the table. Review Module 5.13 Meal Preparation.
  - Requires a cue to obtain food or drink. Review Module 5.13 Meal Preparation.
  - Is a "messy" eater.
  - Takes other people's food.
  - Requires assistance from another person to cut food. Review Module 5.13 Meal Preparation.
  - Requires a cue to go to or assistance to locate the dining area. Review Module 8.4 Cognition.
  - Needs assistance with portion control (except for a person with Prader-Willi syndrome).
  - Needs to have a plate "set up" with food due to their visual impairment. Review Module 5.13 Meal Preparation.
  - Requires food storage area to be secured or locked (except for a person with Prader-Willi syndrome).
- Has no cognitive impairment and chooses not to eat.

- Has a need for assistance due to pica or polydipsia. Review Modules 7.11 Behaviors Requiring Interventions and 9.3 Self-Injurious Behaviors.
- Is fed via TPN or tube feedings and can independently complete the task. Review Modules 7.20 TPN or 7.23 Tube Feedings.
- Has a seizure disorder with no seizures in the last three months and there is no intervention needed; however, another person is present "just in case."

Check "1" ("Help is needed to complete the task safely but helper DOES NOT have to be physically present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with the task of Eating SOME of the time.
- Eats independently, but:
  - Doing so results in a significant, negative health outcome and another person should be present to help with the task of Eating SOME of the time.
  - Requires assistance to put on or remove a splint (or other device such as a universal cuff) with which the person can then hold a utensil and independently feed themselves.
- Is fed via TPN or tube feedings and requires assistance from another person to complete the task SOME of the time. Review Module 7.20 TPN or Module 7.23 Tube Feedings.
- Due to a cognitive impairment, requires cueing to initiate eating after food or drink is placed in front of them.
- Requires supervision due to having an active risk of choking but DOES NOT require standby assistance during the entire task of Eating.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months but DOES NOT require standby assistance during the entire task of Eating.

Check "2" ("Help is needed to complete the task safely and helper DOES need to be present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or partial or complete hands-on assistance with the task of Eating ALL the time.
- Eats independently but doing so results in a significant, negative health outcome and another person should be present to help with the task of Eating ALL the time.
- Due to a cognitive impairment, requires cueing to eat throughout the task of Eating.
- Is fed via TPN or tube feedings and they require assistance from another person to complete the task ALL of the time. Review Module 7.20 TPN or Module 7.23 Tube Feedings.
- Has Prader-Willi syndrome.
- Requires supervision due to having an active risk of choking AND requires standby assistance during the entire task of Eating.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months AND requires standby assistance during the entire task of Eating.

5.9 Mobility in Home

LTCFS ITEM DEFINITION:

Mobility in Home: The ability to move between locations (including stairs) in the individual's living space. Living space is defined as kitchen/dining room, 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, including any stairs to enter the home.

Excluded from the Mobility in Home ADL is transferring. Review Modules 5.6 Bathing, 5.10 Toileting, and 5.11 Transferring.

CODING FOR LEVEL OF HELP NEEDED

- ☐ 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**. "Help" can be supervision, cueing, and/or hands-on assistance.
- ☐ 2: Help is needed to complete the task safely and **helper DOES need to be present throughout the task.** "Help" can be supervision, cueing, and/or partial or complete hands-on assistance.

ADAPTIVE EQUIPMENT

Adaptive equipment is defined as specific types of equipment captured on the LTCFS that an individual may use to safely complete an ADL. Screeners should only select the adaptive equipment the person currently has, needs, and uses. The only exception to "has, needs, and uses" is prosthesis in 5.9 Mobility in Home. Prosthesis should be selected if the person has a prosthesis; regular use or use only in the home are not requirements.

Adaptive equipment options for Mobility in Home include:

- ☐ Uses Cane, Crutches, or Walker in Home*
- ☐ Uses Wheelchair or Scooter in Home
- ☐ Has Prosthesis

*A cane or quad-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.

Do not select one of the equipment options if a person uses an improvised or homemade item as a substitute for the equipment on the list. For example, a person may use a chair with wheels instead of a wheeled walker. In this instance, you would not select "Uses Walker in Home" in the Mobility equipment box because the object is a substitute for a walker.

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

- Ace bandage
- Orthotic devices such as splints or braces
- Anti-embolism hose
- Neoprene wrap
- Orthotic shoes
- Walker, cane, crutches, wheelchair, scooter only used when ambulating outside of their home

Mobility is the only ADL that requires a primary and/or secondary diagnosis when the coding selection is independent and Uses Wheelchair or Scooter in Home or Has Prosthesis has been selected.

MOBILITY IN HOME-SPECIFIC RESPONSE GUIDANCE:

The "Check 0, 1, 2" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Person is independent in completing the activity safely") for a person who:

- Has no physical, cognitive, or memory loss impairments affecting their ability to complete the task of Mobility in Home independently.
- Uses an improvised or homemade item and without it, they would NOT need assistance from another person to complete the task.
- Walks (or wheels) independently, but:
  - Uses adaptive equipment.
  - It takes additional time to do so and there are no significant, negative health outcomes.
  - Needs direction on where to go due to a cognitive impairment. Review Module 8.4 Cognition.
  - Has a fear of falling.
  - Does so slowly and safely.
  - Has a shuffling gait and walks safely.
  - Needs assistance outside of the living space including using steps or ramp to get into the home.
  - Does not get up and walk in the home unless another person is present somewhere in the home, "just in case."
  - Needs assistance putting on or taking off orthotic devices (such as braces, shoe inserts, ankle foot orthosis (AFOs), anti-embolism hose, or orthotic shoes). Review 5.7 Dressing.
- Walks (or wheels) independently with adaptive equipment the individual has, needs, and uses, but at times uses walls, furniture, or railings in lieu of the adaptive equipment because of preference or limited space.
- Has a risk of falling only due to environmental conditions such as clutter, rugs, or uneven flooring.
- Prefers to crawl and can do so independently and there are no significant, negative health outcomes.

- Is unable to access the laundry because it is located outside of the living space. Review Module 5.16 Laundry and/or Chores.
- Uses walls, furniture, or railings for guidance or reassurance only.
- Has a seizure disorder with no seizures in the last three months and there is no intervention needed; however, another person is present "just in case."

Check "1" ("Help is needed to complete the task safely but helper DOES NOT have to be physically present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with the task of Mobility in Home SOME of the time.
- Uses an improvised or homemade item and without it, they would need assistance from another person to complete the task of Mobility in Home SOME of the time.
- Walks (or wheels) independently but doing so results in a significant, negative health outcome and another person should be present to help with the task SOME of the time.
- Due to a cognitive impairment, only requires a cue to use adaptive equipment.
- Walks without the use of adaptive equipment throughout their living space, but must lean on walls, furniture, or railings or would otherwise require the assistance of equipment or another person.
- Walks with the use of adaptive equipment throughout their living space, AND must also lean on walls, furniture, or railings while using adaptive equipment or would otherwise require the assistance of another person.
- Needs assistance only to use steps in their living space or if the person needs and uses a stair lift.
- Requires standby or hands-on assistance with mobility SOME of the time.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months but DOES NOT require standby assistance during the entire task of Mobility in Home.

Check "2" ("Help is needed to complete the task safely and helper DOES need to be present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or partial or complete hands-on assistance with the task of Mobility in Home ALL the time.
- Walks (wheels) independently but doing so results in a significant, negative health outcome and another person should be present to help with the task of Mobility in Home ALL the time.
- Uses an improvised or homemade item and without it, they would need assistance from another person to complete the task of Mobility in Home ALL the time.
- Requires standby or hands-on assistance with mobility ALL the time.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months AND requires standby assistance during the entire task of Mobility in Home.

5.10 Toileting

LTCFS ITEM DEFINITION:

Toileting: The ability to use the toilet, commode, bedpan, or urinal for bowel and/or bladder management in the home. The activity of Toileting consists of the following components, if applicable:

- Locating the bathroom facility. (This component pertains only to people with a cognitive impairment.)
- Transferring on or off the toilet, commode, bedpan, or placing a urinal.
- Maintaining regular bowel program.*
- Cleansing of perineal (peri) area.
- Changing of menstrual products and/or incontinence products.
- Managing a condom catheter or the ostomy or urinary catheter collection bag (including emptying and/or rinsing the collection bag).
- Undressing and/or redressing the bottom half of the body, excluding zippers and/or button(s).
- Emptying the commode, bedpan, or urinal container.
- Flushing the toilet.

The cleaning of the bathroom after incidental soiling during toileting is captured in Module 5.16 Laundry and/or Chores.

Hand washing after toileting is not a component of Toileting.

If the individual has an ostomy or indwelling (including a suprapubic catheter) or straight urinary catheter, screeners should review Sections 7.16 and 7.26 in the HRS Module to ensure the individual's needs have been accurately identified.

*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 such as Metamucil, Ex-lax, stool softeners, or fiber used by a person not on a formal bowel program.

CODING FOR LEVEL OF HELP NEEDED

- ☐ 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**. "Help" can be supervision, cueing, and/or hands-on assistance.
- ☐ 2: Help is needed to complete the task safely and **helper DOES need to be present throughout the task.** "Help" can be supervision, cueing, and/or partial or complete hands-on assistance.

ADAPTIVE EQUIPMENT

Adaptive equipment is defined as specific types of equipment captured on the LTCFS that an individual may use to safely complete an ADL. Screeners should only select the adaptive equipment the person currently has, needs, and uses.

Adaptive equipment options for Toileting include:

- ☐ Uses Grab Bar, Commode, or Other Adaptive Equipment, including:
  - High rise or accessible toilet
  - Elevated or adaptive toilet seat
  - Bed pan
  - Urinal
  - Transfer board or other transfer aids that assist the person to get on or off the toilet
- ☐ Uses Urinary Catheter
- ☐ Has Ostomy
- ☐ Receives Regular Bowel Program

Do not select one of the equipment options if a person uses an improvised or homemade item as a substitute for the equipment on the list. For example, a person may use a container as a urinal. In this instance, you would not select "Uses Commode or Other Adaptive Equipment" in the Toileting equipment box because the object is a substitute.

TOILETING-SPECIFIC RESPONSE GUIDANCE:

The "Check 0, 1, 2" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Person is independent in completing the activity safely") for a person who:

- Has no physical, cognitive, or memory loss impairments affecting their ability to complete the task of Toileting independently.
- Uses an improvised or homemade item and without it, they would NOT need assistance from another person to complete the task some of the time.
- Is incontinent and is independent with managing incontinence products; however, select the appropriate frequency related to the person's incontinence in the sub-section addressing incontinence.
- Only requires assistance with skilled tasks associated with ostomy or urinary catheter care. Review Module 7.16 Ostomy-Related Skills Services and Module 7.26 Urinary Catheter-Related Skilled Tasks.
- Utilizes oral laxatives, fiber, or other bowel medications.
- Needs assistance or reminders about the amount of toilet paper to use or not to flush inappropriate objects.
- Uses the sink or countertop to get to a standing position from the toilet with no significant, negative health outcomes.
- Requires supervision only for offensive or violent behaviors related to toileting such as urinating or defecating in inappropriate places (for example a living room or front porch), or on another

person, or the act of spreading urine or feces. Review Module 7.11 Behaviors Requiring Interventions and Module 9.4 Offensive or Violent Behavior to Others.
- Has a seizure disorder with no seizures in the last three months and there is no intervention needed; however, another person is present "just in case."

Check "1" ("Help is needed to complete the task safely but helper DOES NOT have to be physically present throughout the task") for a person who:
- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with at least one but not all the components of Toileting.
- Uses an improvised or homemade item and without it, they would need assistance from another person to complete at least one but not all the components of Toileting.
- Toilets independently but doing so results in a significant, negative health outcome and another person should be present to help with at least one but not all the components of Toileting.
- Due to a cognitive impairment, requires cueing or they would be incontinent.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months but DOES NOT require standby assistance during the entire task of Toileting.

Check "2" ("Help is needed to complete the task safely and helper DOES need to be present throughout the task") for a person who:
- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or partial or complete hands-on assistance with ALL the components of Toileting.
- Toilets independently but doing so results in a significant, negative health outcome and another person should be present to help with ALL the components of the task.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months AND requires standby assistance during the entire task of Toileting.

INCONTINENCE

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

- ☐ Does not have incontinence or has incontinence less often than weekly
- ☐ Has incontinence less than daily but at least once per week
- ☐ Has incontinence daily

If there are interventions to prevent the incontinence, such as cueing or scheduled toileting, indicate the frequency of the intervention being provided under Toileting. Do not select incontinence.

5.11 Transferring

LTCFS ITEM DEFINITION:

***Transferring*:** The ability to move between surfaces. Transferring includes the ability to get up to a standing position and down to a sitting position from a bed, usual sleeping place, chair, or wheelchair.

Excluded from the Transferring ADL is the need for assistance with a transfer to bathe or use a toilet. Review Module 5.6 Bathing and 5.10 Toileting.

CODING FOR LEVEL OF HELP NEEDED

- 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**. "Help" can be supervision, cueing, and/or hands-on assistance.
- 2: Help is needed to complete the task safely and **helper DOES need to be present throughout the task.** "Help" can be supervision, cueing, and/or partial or complete hands-on assistance.

ADAPTIVE EQUIPMENT

Adaptive equipment is defined as specific types of equipment captured on the LTCFS that an individual may use to safely complete an ADL. Screeners should only select the adaptive equipment the person currently has, needs, and uses.

Adaptive equipment options for Transferring include:

- Uses Mechanical Lift, including stander or pivot disc
- Uses Transfer Board or Pole
- Uses Grab Bars, Bed Bar, or Bed Railing (if used for transferring)
- Uses Trapeze

Do not select one of the equipment options if a person uses an improvised or homemade item as a substitute for the equipment on the list. For example, a person may use an object to assist them in transferring out of bed instead of a bed rail. In this instance, do not select "Grab Bars, Bed Bar, or Bed Railing" in the Transferring equipment box because the object is a substitute for a grab bar.

Do not select one of the equipment options if a person safely uses furniture, such as a nightstand or coffee table, for transfers.

Under Transferring, do not count a lift chair or an electric hospital bed as a mechanical lift. 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.

TRANSFERRING-SPECIFIC RESPONSE GUIDANCE:

The "Check 0, 1, 2" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Person is independent in completing the activity safely") for a person who:

- Has no physical, cognitive, or memory loss impairments affecting their ability to complete the task of Transferring independently.
- Uses an improvised or homemade item and without it, they would NOT need assistance from another person to complete the task.
- Transfers independently, but:
  - Uses adaptive equipment.
  - It takes additional time to do so and there are no significant, negative health outcomes.
  - Has a lift chair or other mechanical device (such as an electric hospital bed).
  - Rocks back and forth to gain momentum to get up from a seated position with no significant, negative health outcome.
  - Has a fear of falling.
  - Does so slowly and safely.
  - Does not unless another person is present somewhere in the home, "just in case."
  - Safely utilizes items such as chair arms, table, nightstand, wheelchair, walker, or cane with no significant, negative health outcome.
  - Needs assistance putting on or taking off orthotic devices (such as braces, shoe inserts, ankle foot orthosis (AFOs), anti-embolism hose, or orthotic shoes). Review Module 5.7 Dressing.
- Requires transfer assistance getting in or out of a vehicle.
- Has a seizure disorder with no seizure in the last three months and there is no intervention needed; however, another person is present "just in case."

Check "1" ("Help is needed to complete the task safely but helper DOES NOT have to be physically present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with the task of Transferring SOME of the time.
- Uses an improvised or homemade item and without it, they would need assistance from another person to complete the task of Transferring SOME of the time.
- Transfers independently but doing so results in a significant, negative health outcome and another person should be present to help with the task SOME of the time.
- Has a lift chair or other mechanical device (such as an electric hospital bed) and cannot independently transfer without it.
- Due to a cognitive impairment, requires a cue to initiate the transfer.
- Due to a cognitive impairment, requires a cue to use adaptive equipment to transfer.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months but DOES NOT require standby assistance during the entire task of Transferring.

Check "2" ("Help is needed to complete the task safely and helper DOES need to be present throughout the task") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or partial or complete hands-on assistance with the task of Transferring ALL the time.
- Uses an improvised or homemade item and without it, they would need assistance from another person to complete the task of Transferring ALL the time.
- Transfers independently but doing so results in a significant, negative health outcome and another person should be present to help with the task ALL the time.
- Needs step-by-step directions to transfer.
- Needs standby or hands-on assistance to complete safe transfers ALL the time.
- Needs to wear a gait belt that is used during transfers.
- Requires supervision due to having an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months AND requires standby assistance during the task of Transferring.

5.12 Instrumental Activities of Daily Living (IADLs)

The six IADLs include:

- Meal Preparation
- Medication Administration and Medication Management
- Money Management
- Laundry and/or Chores
- Telephone
- Transportation

IADL Coding for Level of Help Needed

Each of the IADLs has a separate rating system to capture the level of help needed specific to each IADL. When recording the level of help an individual needs to safely complete an IADL, a screener should select **only one** rating of "Level of Help Needed" with each IADL.

5.13 Meal Preparation

LTCFS ITEM DEFINITION:

Meal Preparation: The 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, which is defined by and includes, but is not limited to, cereal, sandwich, reheating food, such as frozen, leftovers, and food prepared by others.

Ability includes physical, cognitive, and memory.

The task of Meal Preparation consists of the following components:

- Opening food containers
- Opening the refrigerator and freezer

- Safely using kitchen appliances
- Safely preparing a simple meal, such as cereal, sandwich, reheating food including frozen, leftovers, and food prepared by others
- Safely placing food on a plate or in a cup, and carrying it to a table
- Cutting food
- Proper food preparation
- Obtaining groceries. The activity of obtaining groceries consists of the following components:
  - Retrieving the food at the store
  - Moving items between a basket or cart to the checkout counter
  - Getting the bags to a vehicle
  - Getting the bags into the home
  - Putting the groceries away

Meal Preparation does not include when a person makes food choices consistent with their lifestyle and values, even if those food choices are not in agreement with a professional's advice or nutritional goals for the person. Examples include when a person chooses to eat more than three meals per day, eats fewer than three meals per day, or chooses to not follow the federal dietary guidelines, such as not eating recommended amount of fruits and vegetables or exceeding recommended consumption of added sugar or saturated fats. Such food choices may be considered when evaluating for Risk 1. Refer to Module 10.3 Part B – Risk Evident During Screening Process.

CODING FOR LEVEL OF HELP NEEDED

- ☐ 0: Independent
- ☐ 1: Needs help weekly or less often
- ☐ 2: Needs help 2 to 7 times a week
- ☐ 3: Needs help with every meal

MEAL PREPARATION-SPECIFIC RESPONSE GUIDANCE:

The "Check 0, 1, 2, 3" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Independent") for a person who:

- Has no physical, cognitive, or memory loss impairment limiting their ability to complete the task of Meal Preparation independently.
- Is independent with all components of Meal Preparation without significant, negative health outcomes, but:
  - Uses simple, reasonable adaptations, such as an electric can opener, easy jar opener, or food preparation board.
  - It takes additional time to do so.
  - Chooses to only eat cold foods.
  - Is only able to cook or heat up food in a microwave oven.
  - Needs assistance planning a menu or making a grocery shopping list.
  - Requires transportation to the grocery store. Review Module 5.18 Transportation.

    - 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.
    - Needs assistance cleaning up after a meal. Review Module 5.16 Laundry and/or Chores.
    - Needs assistance cleaning the inside of their refrigerator. Review Module 5.16 Laundry and/or Chores.
    - Needs to have liquids thickened or food pureed, minced, or cut.
    - They require breaks to sit down during the task.
    - Lives in a residential facility and does not prepare their meals solely because meals are provided as part of the service in the facility where the person resides.
    - 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. Review Module 5.15 Money Management.
- Could prepare meals safely and independently using an appliance such as toaster oven, stove top, stove, oven, microwave oven, or electric frying pan, whether or not they currently have any of these appliances.
- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Meal Preparation independently, but:
    - Prefers assistance with Meal Preparation due only to a gender, age, or cultural norm.
    - Needs assistance with Meal Preparation due only to a language barrier.
    - Needs assistance with Meal Preparation due only to illiteracy.
    - Has a special diet.
    - Hasn't had experience or learned the task of Meal Preparation and their ability to complete this task has yet to be reviewed to determine the person's ability to complete the task.
- Receives home-delivered meals (HDM) but is physically or cognitively able to prepare meals. There is a variety of reasons why a person may receive HDMs that do not relate to a physical, cognitive, or memory loss impairment to prepare meals independently.
- Can make a simple meal such as cereal, sandwich, reheating food including frozen, leftovers, and food prepared by others.
- Wants to grocery shop more than once a week.
- Can shop independently when groceries are bagged in smaller and lighter bags so they can manage them.
- Has fluctuating abilities and grocery shops on their good days.
- Only needs assistance getting food out of a refrigerator or freezer located in their garage or basement.
- Receives nutrition by tube or intravenous feedings and can independently prepare their liquid nutrition.
- Independently orders their groceries online, calls-in, or emails their grocery order for convenience.
- Has a need for assistance due to pica or polydipsia. Review Modules 7.11 Behaviors Requiring Interventions and 9.3 Self-Injurious Behaviors.

"Check 1, 2, or 3" using guidance provided under CODING FOR LEVEL OF HELP NEEDED, at the appropriate frequency for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, or hands-on assistance with at least one component of Meal Preparation.
- Is independent with Meal Preparation but doing so results in a significant, negative health outcome.
- Needs assistance preparing meals due to their inability to stand long enough to prepare food, even when taking breaks to sit down.
- Needs assistance to have liquids thickened or food pureed or minced to prepare a mechanical soft diet.
- Needs assistance to cut prepared food on a plate.
- Needs assistance preparing their liquid nutrition for their tube or intravenous feedings.
- Needs assistance placing food on plate or table (serving) or with carrying a plate and/or cup to the table.
- Needs assistance to open food containers.
- Needs assistance opening their refrigerator or freezer.
- Is unable to safely use any appliance to heat food.
- Needs to have a plate "set up" with food due to their visual impairment.
- Due to a cognitive impairment, needs a cue to obtain food or drink or would not otherwise eat or drink.

Exceptions to determining appropriate frequencies:

Check "1" (Needs help weekly or less often) for a person who:

- Due to a cognitive impairment, is unable to determine when properly stored food is spoiled.
- Needs assistance only with grocery shopping.
- Due to a cognitive impairment, needs assistance with grocery shopping because they only select food with no nutritional value, for example, only selects soda and candy.

Check "2" (Needs help 2 to 7 times a week) for a person who:

- There are no exceptions to Check "2"; refer to CODING FOR LEVEL OF HELP NEEDED.

Check "3" (Needs help with every meal) for a person who:

- Has Prader-Willi syndrome.

5.14 Medication Administration and Medication Management

LTCFS ITEM DEFINITION:

***Medication*:** A medication is a drug used to treat disease, symptoms, or injury that enters the body in the prescribed manner. The type of medications prescribed for the person can be brand name, generic, or over the counter (OTC). A medication on the LTCFS must meet these three criteria:

1. Approved by the U.S. Food and Drug Administration.
2. Prescribed by a Medicaid-recognized prescriber, such as physician, psychiatrist, nurse practitioner, physician assistant, optometrist, or dentist.

3. Regularly scheduled and used.

PRN Medication: A PRN medication is a medication taken only when needed based on symptoms, and typically PRN medications are not captured on the LTCFS.

For a PRN medication to be captured on the LTCFS, it must meet the definition of a medication and be used as stated here:

- Regularly scheduled and used at minimum once a month every month. Examples include:
  - Pain medicine that is ordered PRN but taken every four to six hours, every day.
  - Skin cream that is ordered PRN but applied every week.
  - A medication to relieve menstrual symptoms, that is ordered PRN but used once every month.
- Sliding scale insulin (where the exact dosage is adjusted according to the blood glucose level) can be treated as a regularly scheduled medication, because it is regularly given, with the dose merely adjusted to blood glucose level.

The following are not considered medications on the LTCFS:

- PRN medications that do not meet the definition of a medication.
- Vitamin (unless injected, such as vitamin B-12 injections), mineral, supplement, and alternative or complementary medicines, even if prescribed by a Medicaid-recognized prescriber.
- Non-vitamin, non-mineral natural substances such as omega 3 or fish oil, glucosamine, ginkgo, antioxidants, ginseng, echinacea, chondroitin, coenzyme Q10, flaxseed, cranberry, garlic, soy, melatonin, green tea, saw palmetto, grape seed, milk thistle, lutein, bark water, or shark cartilage, even if prescribed by a Medicaid-recognized prescriber.
- 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, or acupressure.
- Other dietary supplements with calories, minerals, vitamins, and/or other additives.

In the IADLs, Medication Administration and Medication Management are coded together. This differs from the HRS Table where Medication Administration and Medication Management are coded separately.

The LTCFS application will check to ensure that the level of help indicated in the IADL Medication Administration and Medication Management correlates with the Medication Administration and Medication Management tasks on the HRS Table. If the level of help does not correlate between that IADL task and the Medication Administration and Medication Management tasks on the HRS Table, the screener will receive an error message to prompt review.

Medication Administration: A person's need for assistance from another person to **take or be given** a medication by any route except intravenously (IV). This could be by mouth, under the tongue, injection, onto or into the body, rectally, vaginally, by feeding tube, or by inhaler. Common forms of medication include but are not limited to tablet, capsule, liquid, drops, and skin preparations. The person's need for assistance from another person to use a prescribed medication that is regularly scheduled and used should be captured here.

The preparation of medications, such as crushing a tablet to be diluted or measuring to fill a syringe or dosage cup, may be considered Medication Administration when it is prepared within one hour of when the dose is to be taken.

Excluded are:

- IV medications. Review Module 7.13 IV Medications, Fluids, or Line Flushes.
- Topical medications used for ulcer, wound care. Review Modules 7.24 Ulcer–Stage 2, 7.25 Ulcer–Stage 3 or 4, and/or 7.27 Other Wound Cares.
- Medications used for nebulizer treatments. Review Module 7.18 Oxygen and/or Respiratory Treatments.

Medication Management: A person's need for assistance from another person to set up or monitor their prescribed and regularly scheduled and used medications. **The two components of Medication Management include:**

1. **Medication Set-Up**: To separate out the proper dosage and **set it aside for later use by the individual**. Medication set-up is completed for several reasons. One reason is to ensure the **proper medication, at the proper dosage** is selected when the individual is unable to select it due to a physical, cognitive, or memory loss impairment. Another reason is to **arrange** the medications to **help the person remember** to take them at proper times and to make it easier to tell that medications were or were not taken.

   Examples of medication set-ups:
   - Medication boxes with compartments labeled for different times and each day of the week, into which pills are placed.
   - Any other "set-up" system in which medications and dosages are preselected by another person, such as a bubble pack.
   - Automated medication dispensers, that can be programmed (often weekly) to dispense pills.
   - Prefilling of syringes, such as insulin syringes.

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

   The preparation of medications, such as crushing a tablet to be diluted or measuring to fill a syringe or dosage cup, may be considered Medication Management when it is NOT prepared within one hour of when the dose is to be taken.

2. **Medication Monitoring**
   Medication monitoring includes the following components:

- Due to a memory loss or cognitive impairment, oversight is required for monitoring of effects, side effects, or adjustments. This oversight is captured at a frequency of one to three times per month.
- The need to collect medication-related data, as ordered by the prescriber, prior to administering a medication, such as blood glucose level, blood pressure, or heart rate, and that the data collection is occurring.
- The need to collect medication-related data, as ordered by the prescriber, such as vital signs, weights, seizure activity or in-home assistance to draw blood for a lab test, and that the data collection is occurring and reported to a health care provider.

Common reasons for a need for assistance with Medication Monitoring (this is not an all-inclusive list of examples):

- **Uncontrolled Seizure Disorder.** An individual's need for assistance in their residence from another person when the individual has an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months, and medication is frequently adjusted.
- **Pain Management.** An individual's need for assistance from another person to adjust their medications, in the individual's residence, to manage pain. This does not include care at a pain clinic or any other setting outside the person's residence. This also does not include prescription or OTC PRN medications that do not meet the definition of a Medication as described at the beginning of this module.
- **Blood Levels.** A person's need for assistance from another person to draw blood samples, in their residence, for laboratory tests. Most of these tasks are related to medications such as Pro-Times to regulate warfarin administration or potassium levels for a person on diuretics. Blood levels also include "finger-sticks" for capillary blood to test blood glucose levels.

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. The condition or treatment may stabilize over time and then the frequency of medication monitoring would decrease. A rescreen should be completed when a person's condition stabilizes to reflect this and any other changes.

CODING FOR LEVEL OF HELP NEEDED

- ☐ N/A: Has no medications
- ☐ 0: Independent
- ☐ 1: Needs help 1 to 2 days a week or less often
- ☐ 2a: Needs help at least once a day 3-7 days per week--CAN direct the task
- ☐ 2b: Needs help at least once a day 3-7 days per week--CANNOT direct the task

Considering "can direct the task" versus "cannot direct the task"
As listed on the LTCFS, 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 determine the person's ability to direct the task of taking or withholding their medications.

A person cannot direct the task of managing their medication if, due to a cognitive or memory loss impairment, the person needs a cue to take their medication. To code cueing assistance for a medication, the cue must be done within an hour of when the dose is to be taken.

In addition, not every person with a cognitive impairment will be unable to direct the task of managing their medication. Some individuals with a cognitive limitation can independently take their medication as prescribed, without misuse or error once the medication is set up. For such a person, the selection of "1: Needs some help 1-2 days per week or less often," would be applicable.

MEDICATION ADMINISTRATION and MEDICATION MANAGEMENT-SPECIFIC RESPONSE GUIDANCE:

The "Check N/A, 0, 1, 2a, 2b" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "N/A" (Has no medications) for a person who:

- Has no medications.
- Does not take regularly scheduled medication but needs assistance from another person with an infrequently taken prescription PRN medication (taken less than once a month every month). Such a PRN medication does not meet the LTCFS definition of a medication. Refer to the PRN Medication definition.
- Chooses not to take any medications (the person is declining the task of taking medications itself). If the individual has declined the **task of taking medications itself and** is able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select "N/A–Has no medications." In this situation, the person has no need for Medication Administration or Medication Management because it is not occurring. For example, if an individual able to perceive potential risk or negative outcome chooses not to take any prescribed medications, the person has no need for medication administration and medication management assistance because no medications are being taken (the task itself is not being done).
    - If the person is **not** able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select the frequency of need.
    - If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes, and the selection of a need might be appropriate.

Check "0" (Independent) for a person who:

- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Medication Administration and Medication Management independently.
- Takes medication as prescribed, can contact the prescriber with concerns and understands the prescriber's recommendations.
- Takes medication as prescribed and can independently collect medication-related data, such as blood glucose levels, blood pressure, weights, or pulse.

- Is independent with Medication Administration and Medication Management, but:
  - Uses simple, reasonable adaptations, such as large-print or Braille labels, “talking” glucometer, easy-open pill bottles.
  - Uses an alarm on their watch, clock, or phone as a reminder to take medications.
  - Uses a medication box or automated pill dispenser as a convenience.
  - Has an unorthodox system of organizing medications with no history of medication misuse or errors.
  - Needs assistance to prevent someone else, including a pet, from having access to the medication.
  - Needs assistance reordering or obtaining medication refills. This includes assistance to arrange for a medication refill, such as a request to the pharmacy. Review Module 5.16 Laundry and/or Chores.
  - Requires transportation to the pharmacy. Review Module 5.18 Transportation.
  - Does not administer or manage their medications because medications are provided as part of the services in the facility where they reside.
  - Receives routine monitoring for general health, behavior, etc., by the person’s agency’s staff because that monitoring is provided to all residents.
  - Due to the policy of the person’s provider agency, such as hospice or a personal care provider, does not administer or manage their medications because this is a service provided by the agency.
  - Is left a written reminder from another person as a cue to take their medications.
  - Is contacted by another person to check if the person has or has not taken their medication and the cueing or call is not needed.
  - Takes a medication that only comes preselected from the manufacturer, such as birth control pills, some antibiotics, some steroids, or insulin in dispensing pens.
  - Only needs assistance getting food or drink needed to take their medications at mealtimes.
- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Medication Administration and Medication Management independently, but:
  - Prefers assistance with Medication Administration and Medication Management due only to a gender, age, or cultural norm.
  - Needs assistance with Medication Administration and Medication Management due only to a language barrier.
  - Needs assistance with Medication Administration and Medication Management due only to illiteracy.
- Is independent with Medication Administration and Medication Management as prescribed, and receives services outside their residence, such as:
  - Has medication monitoring, including blood draws, done outside the person’s residence, such as at the physician’s office, clinic, pharmacy, or health care facility.
  - Receives injections, such as vitamin B-12, outside their residence, such as at a clinic.
  - Takes medication through an intrathecal drug pump, also known as a pain pump or internal morphine pump, that requires only intermittent refills and maintenance in the clinic setting but does not require monitoring in their residence.
  - Has a drug delivery implant, such as the birth control implant.
- Is independent with Medication Administration and Medication Management; however, a lock box is used:

- Due to the policy of their provider agency (such as a hospice agency or personal care provider agency).
- To prevent another person or a pet from having access to the medication.
- Solely due to suicidal ideations or substance use issues.
- Due to taking their medication other than as prescribed.

- Requires Medication Administration and Medication Management assistance less often than monthly.
- Does not have a cognitive or memory loss impairment and the person cannot name each of their medications but can tell you what health issues they take medication for. Examples include but are not limited to when a person cannot name their hypertension medication, such as hydrochlorothiazide, but can tell you, "That little yellow pill is my water pill. I have high blood pressure." Or they can tell you, "I take a pill once a week for my osteoporosis" when they are prescribed alendronate.
- Is given medication by IV only. Review Module 7.13 IV Medications, Fluids, or Line Flushes.

Check "1, 2a, or 2b" using guidance provided under CODING FOR LEVEL OF HELP NEEDED, at the appropriate frequency for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with the task of Medication Administration and Medication Management. To code cueing assistance for a medication, the cue must be done within an hour of when the dose is to be taken.
- Needs assistance to crush their medication or assistance to put their medication in food, such as applesauce, for it to be taken.
- Needs assistance to check their blood glucose level or to adjust their insulin dose given the current blood glucose level.
- Needs assistance to prepare a medication for administration via a feeding tube. For example, crushing a tablet to be diluted and administered through a G-tube.
- Needs assistance flushing a feeding tube after administration of a medication when the tube is only used to administer medication.
- Has an unstable condition and medication is frequently adjusted and, due to a cognitive impairment, they need someone to monitor them for specific medication effects and side effects and report those to the prescriber.
- Has cognitive impairment and has a court-ordered medication.
- Requires assistance with a medication delivered subcutaneous with a pump, such as an insulin pump.
- Needs someone to physically assist with the medication but is self-directing and has the cognitive ability to select the proper medication and dosage, and has the judgment to understand the medication's purpose, side effects, and report problems. An example of this is a person with quadriplegia who instructs their helper, "Please put one of those three pills on my tongue and give me a drink."
- Due to a cognitive or memory loss impairment, needs someone to assist with the medication because the person is not self-directing, does not have the cognitive ability to select the proper medication and dosage, lacks the judgment to understand the medication's purpose, side effects, and report problems.

- Is independent with Medication Administration and only needs assistance getting food or drink, outside of Meal Preparation, needed to take their medication.

Exceptions to determining appropriate frequencies:

Check "1" (Needs help 1 to 2 days per week or less often) for a person who:

- Only requires assistance with Medication Administration and Medication Management at the "1 to 3 times/month" or "Weekly" frequency as on the HRS Table.
- Is independent with Medication Administration; however, only requires assistance with the filling of a medication box. Medication boxes are typically filled at the "1 to 3 times/month" frequency, since two or more medication boxes can be prefilled at one time. If this usual method does not work well for an individual due to their physical, cognitive, or memory loss impairment, more frequent medication set-up may be necessary.
- Only requires assistance with prefilling insulin syringes as they can typically be completed weekly, since prefilled syringes can be stored in the refrigerator for a week. This task should be indicated at the "Weekly" frequency on the HRS Table.
- Only requires assistance with measuring medication from a larger container to a smaller dosage cup as this can typically be completed weekly. This task should be indicated at the "Weekly" frequency on the HRS Table.
- Has a cognitive or memory loss impairment but takes medication as prescribed, without misuse or error once the medication is set up.
- Only requires oversight due to a memory loss or cognitive impairment for monitoring of effects, side effects, or adjustments. This oversight is captured at a frequency of 1 to 3 times per month on the HRS Table.

Check 2a (Needs help at least once a day 3-7 days per week—CAN DIRECT the task) only for a person WITH A PHYSICAL IMPAIRMENT who:

- There are no exceptions to Check "2a"; refer to CODING FOR LEVEL OF HELP NEEDED

Check 2b (Needs help at least once a day 3-7 days per week—CANNOT direct the task) only for a person WITH A COGNITIVE OR MEMORY LOSS IMPAIRMENT who:

- There are no exceptions to Check "2b"; refer to CODING FOR LEVEL OF HELP NEEDED

5.15 Money Management

LTCFS ITEM DEFINITION:

Money Management: The ability to handle money, which includes allocating funds to pay bills and completing financial transactions needed for basic necessities (food, shelter, and clothing). These financial transactions include but are not limited to any of the following types of money transactions: cash, credit card, debit card, gift card, charge account, personal check, money order, automatic withdrawal, automatic deposit, the exchange of currency, online banking, or mobile banking.

The task of Money Management consists of the following components:

- Having a basic understanding of a monetary transaction; for example, an individual knows they need money to complete a transaction at a store and they know they have enough money to complete the transaction (this component pertains only to people with a cognitive or memory loss impairment).
- Having a basic understanding of how to allocate or budget money to pay bills needed for meeting the basic necessities of food, shelter, and clothing (this component pertains only to people with a cognitive or memory loss impairment).
- Having the physical ability to complete a transaction and pay bills (this component pertains only to people with a physical impairment).

Money Management does not include when a person without a cognitive impairment makes money management choices consistent with their lifestyle, values, and goals, even if those choices do not align with the screener's or other persons' values or goals. Examples include a person who spends most of their money on gambling, drugs, alcohol, or cigarettes.

A screener must review a person's ability to manage money even if a person has formal or informal supports who assist the individual with money management; for example, do not assume a person cannot manage their money even if they have 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, guardian of the person, or guardian of estate.

CODING FOR LEVEL OF HELP NEEDED

- ☐ 0: Independent
- ☐ 1: Can only complete small transactions (Needs help to complete some components of Money Management)
- ☐ 2: Needs help with all transactions

MONEY MANAGEMENT-SPECIFIC RESPONSE GUIDANCE:

The "Check 0, 1, 2" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Independent") for a person who:

- Has no physical, cognitive, or memory loss impairment limiting their ability to complete the task of Money Management independently.
- Is independent with Money Management, but:
  - Uses simple, reasonable adaptations, such as using a debit card, online banking, or folding bills based on denomination for identification.
  - Requires transportation to the bank. Review Module 5.18 Transportation.
  - Needs assistance with mailing the bill. Review Module 5.16 Laundry and/or Chores.
  - Needs assistance with setting up automatic payments.

- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Money Management independently, but:
  - Prefers assistance with Money Management due only to a gender, age, or cultural norm.
  - Needs assistance with Money Management due only to a language barrier.
  - Needs assistance with Money Management due only to illiteracy.
  - Hasn't had experience or learned the task of Money Management and their ability to complete this task has yet to be reviewed to determine the person's ability to handle at least some money transactions. Examples of a person with the cognitive ability to manage their money, but does not have the experience of doing so, could include a person with a severe and persistent mental illness or an intellectual/developmental disability, a young adult, a recent immigrant, or even a recent widow or widower whose partner handled all the couple's finances.
  - Has inadequate income to meet their basic needs and the only reason they need helps is due to the inadequate income.
  - Has a representative payee, money manager, or receives other assistance allocating their money due to a history of poor money management related to personal choices or issues with alcoholism, a drug addiction, or a gambling addiction.

Check "1" (Can only complete small transactions) (Needs help to complete some components of Money Management) for a person who:

- Due to a cognitive or memory loss impairment requires assistance with allocating or budgeting money but is independent with transactions.
- Due to a cognitive or memory loss impairment requires assistance with transactions but is independent with allocating or budgeting money.
- Due to a physical impairment requires assistance to complete transactions and pay bills beyond simple reasonable adaptations but understands allocating and budgeting.

Check "2" (Needs help with all transactions) for a person who:

- Due to a cognitive or memory loss impairment requires assistance to complete a transaction **and requires assistance** to allocate or budget money to pay bills needed for basic necessities of food, shelter, and clothing.

5.16 Laundry and/or Chores

LTCFS ITEM DEFINITION:

Laundry and/or Chores: The ability to complete one's personal laundry, routine housekeeping, and basic home maintenance tasks.

The task of Laundry consists of, but is not limited to, the following components:

- Getting personal laundry to the washing machine and dryer. This includes accessing the laundry area associated with their residence such as in a kitchen, in a laundry room, in a basement, or another building in an apartment complex.
- Loading the laundry in washing machine.
- Adding detergent.

- Setting dial(s).
- Transferring the laundry from washer to dryer.
- Removing the laundry from dryer.
- Putting the laundry away.

Examples of Chores include, but are not limited to:
- Routine Housekeeping
  - Vacuuming and floor washing
  - Dusting and surface cleaning
  - Cleaning up after meals including clearing and cleaning the eating area and food storage
  - Washing and putting away dishes and utensils
  - Cleaning bathroom
  - Cleaning appliances
  - Taking out the garbage
- Routine outdoor property maintenance
  - Snow and ice removal
  - Lawn mowing
- Mailing bills
- Reordering medications

Laundry and/or Chores does not include when a person makes laundry and/or chore choices consistent with their lifestyle choices, values, and goals, even if those choices do not align with the screener's or other person's values or goals. Examples include how often a person washes the dishes or their clothes, or how clean they keep their home.

Laundry and/or Chores only include one's personal laundry, routine housekeeping, and basic home maintenance tasks. It does not include requests for housecleaning assistance due to having a pet(s) in their home, completing other household members' laundry (such as spouse's or children's laundry), or the cleaning of living spaces not used by the individual (such as teenager's bedroom or bathroom).

CODING FOR LEVEL OF HELP NEEDED

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

LAUNDRY and/or CHORES-SPECIFIC RESPONSE GUIDANCE:

The "Check 0,1,2" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Check "0" ("Independent") for a person who:
- Has no physical, cognitive, or memory loss impairment limiting their ability to complete the task of Laundry and/or Chores independently.

- Is independent with Laundry and/or Chores, but:
  - Uses simple, reasonable adaptations, such as using pre-measured laundry detergent or sitting while washing dishes or folding laundry.
  - It takes additional time to do so and there are NO significant, negative health outcomes.
  - Resides in a residential facility or institution and the provision of Laundry and/or Chore services is provided as part of the facility package.
  - Requires transportation to and from a laundromat. Review Module 5.18 Transportation.
  - Due to a cognitive impairment, requires assistance with determining when properly stored food is spoiled. Review Module 5.13 Meal Preparation.
- Is independent with Laundry and/or Chores but needs assistance with tasks beyond routine housekeeping and routine outdoor property maintenance, such as:
  - Heavy-duty cleaning done infrequently, such as carpet, drapery, and window cleaning, or wall washing.
  - Infrequent seasonal outdoor maintenance, such as window washing, gardening, weatherization, cleaning gutters, and yard maintenance such as weeding, pruning hedges, raking leaves, and aerating or fertilizing the grass.
  - Enhancing the dwelling's appearance, such as painting.
- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Laundry and/or Chores independently, but:
  - Prefers assistance with Laundry and/or Chores due only to a gender, age, or cultural norm.
  - Needs assistance with Laundry and/or Chores due only to a language barrier.
  - Needs assistance with Laundry and/or Chores due only to illiteracy.
  - Hasn't had experience or learned the task of Laundry and/or Chores and their ability to complete this task has yet to be reviewed to determine the person's ability to complete the tasks.
- Would require assistance completing routine outdoor property maintenance but is not responsible for these tasks.

Check "1" ("Needs help weekly or less often") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with Laundry and/or Chores tasks that typically occur weekly or less often.
- Is independent with Laundry and/or Chores tasks that typically occur weekly or less often but doing so results in a significant, negative health outcome.
- Needs assistance with the task of Laundry when the person is NOT in need of more frequent laundry assistance due to incontinence or other documented medical reason, such as a MRSA infection.
- Needs assistance with vacuuming and/or dusting when the person is NOT in need of more frequent vacuuming or dusting assistance due to a documented medical reason, such as severe allergies or respiratory condition.
- Needs assistance with surface cleaning and/or floor washing when a person is NOT in need of more frequent assistance due to incontinence or other documented medical reason, such as a MRSA infection.
- Needs assistance with cleaning the bathroom when a person is NOT in need of more frequent cleaning of the bathroom due to incontinence, incidental soiling during toileting, or other documented medical reason, such as a MRSA infection.

- Needs assistance with cleaning the inside of their refrigerator. This does not include determining if properly stored food is spoiled. Review Module 5.13 Meal Preparation.
- Needs assistance with re-ordering or obtaining medication refills. This does not include needed transportation to and from the pharmacy or assistance with the money transaction to pay for the item(s). Review Module 5.18 Transportation and Module 5.15 Money Management.
- Needs assistance with shopping other than for groceries, such as trying on clothes when shopping for clothes. This does not include needed transportation to and from the store or assistance with the money transaction to pay for the item(s). Review Module 5.18 Transportation and Module 5.15 Money Management.
- Needs assistance with mailing bills.
- Needs assistance cleaning appliances.
- Needs assistance completing routine outdoor property maintenance, only if responsible for these tasks.
- Needs assistance with washing and putting away dishes and utensils.
- Needs assistance with retrieving and/or laying out toiletries (such as shampoo, soap, towels) for bathing.
- Needs assistance with retrieving and/or laying out clothes for dressing.

Check "2" ("Needs help more than once a week") for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with Laundry and/or Chores tasks that typically occur more than once a week.
- Is independent with Laundry and/or Chores tasks that typically occur more than once a week but doing so results in a significant, negative health outcome.
- Needs assistance with laundry due to incontinence or other documented medical reason, such as a MRSA infection, and needs more frequent laundry assistance.
- Needs assistance with vacuuming and/or dusting due to a documented medical reason, such as severe allergies or a respiratory condition, and needs more frequent vacuuming and/or dusting.
- Needs assistance with surface cleaning and/or floor washing due to incontinence or other documented medical reason, such as a MRSA infection, and needs more frequent floor washing.
- Needs assistance with cleaning the bathroom due to incontinence, incidental soiling during toileting, or other documented medical reason, such as a MRSA infection, and needs more frequent cleaning.
- Needs assistance with cleaning up after a meal.
- Needs more frequent assistance with washing and putting away dishes and utensils.
- Needs more frequent assistance with retrieving and/or laying out toiletries (such as shampoo, soap, towels) for bathing.
- Needs more frequent assistance with retrieving and/or laying out clothes for dressing.

5.17 Telephone Use

LTCFS ITEM DEFINITION:

Telephone Use: The ability of a person to use a phone to exchange information with others (two-way communication) with or without simple reasonable adaptations. This includes, but is not

limited to, voice call and video calls such as FaceTime or Skype, texting or messaging, telecommunications relay service, large button phones, or other assistive devices. Telephone use captures routine phone calls. Routine phone use is person-specific and includes the familiar and frequent exchanges of information a person makes and receives.

Types of phones include but are not limited to landlines, cell, or mobile phones (basic or smart phones).

Telephone use does not include when a person inappropriately uses a phone. Examples include calling 911 when no emergency exists or calling others and making sexual comments or direct threats. Review Modules 7.11 Behaviors Requiring Interventions, 8.4 Cognition for Daily Decision Making, and/or 9.4 Offensive or Violent Behavior to Others.

CODING FOR LEVEL OF HELP NEEDED (both items require a selection)

Ability to Use Phone:

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

Access to Phone:

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

TELEPHONE-SPECIFIC RESPONSE GUIDANCE:

The "Check 1a, 1b" list contains common, illustrative examples. This list is not an all-inclusive list of examples.

Ability to Use Phone:

Check "1a" (Independent. Has cognitive and physical abilities to use a phone) for a person who:

- Has no physical, cognitive, or memory loss impairments affecting their ability to use a phone independently.
- Independently uses a phone, but:
  - Requires supervision to use appropriately.
  - Needs assistance with a phone other than their personal phone.
  - Uses simple, reasonable adaptations, such as preprogrammed numbers or contacts.
- Has no physical, cognitive, or memory loss impairments affecting their ability to use a phone independently, but:
  - Prefers assistance with using a phone due only to gender, age, or cultural norm.
  - Needs assistance with using a phone due only to a language barrier.

Check "1b" (Lacks cognitive or physical abilities to use phone independently) for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with using a phone.
- Will answer a ringing phone but is not able to place a call.

- Is unable to participate fully in a two-way exchange of information due to significant communication impairment.

Access to Phone:

Check "2a" (Currently has working phone or access to one) for a person who:
- Has access to a phone in their residence.

Check "2b" (Has no phone and no access to phone) for a person who:
- Does not have access to a phone in their residence.

5.18 Transportation

Definition: At the time of the screening, the person is physically and cognitively capable of driving a regular or adapted vehicle.

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

A **regular vehicle** is a standard model vehicle the person operates without needing specialized adaptations to drive.

A regular vehicle may be equipped with modifications that allow the person to enter/exit the vehicle or allow his/her mobility device to be transported with him/her. While these modifications may be needed for the person to RIDE in the vehicle, they are not necessary for the person to operate the vehicle.

Examples of vehicular modifications include, but are not limited to, a car top carrier for a wheelchair, trunk lift for carrying a wheelchair or scooter, grab bar, automatic door opener, van lift used to enter/exit the van when sitting in a wheelchair or scooter, etc.

For the purposes of the LTCFS, a vehicle with these and similar modifications is not an adapted vehicle.

Select 1a: Person drives regular vehicle if they can drive a vehicle with or without modifications described above.

An **adapted vehicle** is one the person operates that has after-market specialized equipment making the vehicle accessible for the person to DRIVE; without the specialized adaptations, the person would not be able to drive the vehicle.

These adaptations help the driver control the vehicle's speed and direction and may include, but are not limited to, hand controls, adaptive pedal extensions, switch pad controls, extended gearshift handle, etc.

Select 1b: Person drives adapted vehicle if they are only able to drive a vehicle that has specialized or adaptive driving equipment described above.

Serious Safety Concerns
Serious safety concerns may be evident when a person with a physical, psychiatric, or cognitive impairment drives a motor vehicle. The screener will rely on professional judgment when reviewing how limitations may affect the person's ability to safely drive a vehicle.

Some examples of a person driving with serious safety concerns can include but are not limited to a person who drives:

- With a diagnosis of dementia.
- With impaired vision.
- With paresis without using specialized equipment.
- Under the influence of alcohol or a controlled substance.

REMINDER: Do not select **1b: Person drives adapted vehicle** when the person could drive an adapted vehicle but does not currently have the needed specialized equipment in their vehicle.

Select 1c: Person drives a regular vehicle, but there are serious safety concerns if the person has a diagnosis, condition, or driving history described above and they drive a **regular vehicle**.

Select 1d: Person drives adapted vehicle, but there are serious safety concerns if the person has a diagnosis, condition, or driving history described above and they drive an **adapted vehicle**.

Serious safety concerns should **not** be selected for a person who has made a reasonable accommodation(s) that limits driving to:

- Only during daylight hours
- Non-rush hours (typically weekdays, 9:00 a.m. to 3:00 p.m.)
- Neighborhood driving
- Only short distances from their residence
- Comply with the Division of Motor Vehicles (DMV) restrictions on their license
- Comply with the limits associated with their occupational license

Select 2: Person cannot drive due to physical, psychiatric, or cognitive impairment if at the time of the screening, the person does not drive or is not capable of driving due to a physical condition (for example, blindness or hemiparesis), psychiatric condition (for example, schizophrenia), or cognitive impairment (for example, dementia).

Select 3: Person does not drive due to other reasons if at the time of the screening, the person **does not have** a physical, psychiatric, or cognitive impairment limiting their ability to drive, but the **only reason they do not drive** is because the person:

- Never learned to drive.
- Lacks a valid driver license due to a reason other than a physical, psychiatric, or cognitive impairment.
- Does not own a vehicle or have access to one.
- Cannot afford to maintain a vehicle.
- Cannot afford vehicle insurance coverage.
- Only utilizes mass transit or taxi service.
- By choice, is only driven by family members or friends.
- Adheres to an age, gender, or cultural norm.

Module #6: Additional Supports

6.1 Introduction

This section describes additional supports that may be received by individuals who are being screened for eligible LTC services.

6.2 Selecting Primary and Secondary Diagnoses

To be selected as a primary or secondary diagnosis that causes a need for assistance or support from another person, the need must be due to a physical, cognitive, or memory loss impairment. Additional guidance can be found in Module 4.4 Identifying Primary and Secondary Diagnoses.

6.3 Overnight Care or Overnight Supervision

To select a need for "Overnight Care or Overnight Supervision," the individual must have a physical, cognitive, or memory loss impairment limiting their ability to independently complete overnight care tasks or that require overnight care or overnight supervision.

Overnight care is defined as the need for hands-on assistance or verbal cuing 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 (for example, a vulnerable adult).

Overnight supervision is not indicated for a person without a physical, cognitive, or memory loss impairment who is uneasy being alone at night.

A person currently residing in a FDD/ICF-IID, nursing home, or residential care facility DOES NOT necessarily require overnight care or overnight supervision. You should ask yourself, "Would this person require overnight care or overnight supervision were the person 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.
- Has a physical limitation that may require overnight care or supervision. To reflect a person's NEED for assistance, the screener should select the most accurate answer that most closely describes the person's NEED for "help from another person," whether the person is actually receiving that assistance or not. Help from another person is defined as supervision, cueing, and/or hands-on assistance (partial or complete).
  - If a person has an identified need but is not receiving assistance (this includes declining the assistance and a significant, negative outcome occurs), the screener should still capture the need for the assistance from another person to complete the task.
  - If a person has an identified need but they have declined assistance and there is no significant negative health outcome, the screener is to select Independent.
  - If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes and the selection of a need might be appropriate.
- Has limited cognitive abilities and needs overnight supervision, although the person does 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 three months that requires supervision and/or care.
- Lives independently without assistance during the daytime but requires intervention or supervision during the nighttime due to an unstable mental health condition (such as posttraumatic 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 remote 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.
- 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 uses it during the nighttime hours 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 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 seizure disorder with no seizures in the last three months and there is no intervention needed; however, another person is present "just in case."
- Has a cognitive impairment without a physical limitation and can safely get through a day without needing a cue or reminder. Additionally, the person can 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 that 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, FDD/ICF-IID, 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 six hours of uninterrupted sleep per night, although the 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 six hours of uninterrupted sleep per night, although the person does not need overnight care or overnight supervision.
- For a person with a cognitive impairment, 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.

6.4 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 IADLs (for example, transportation or personal care) is captured in other sections of the LTCFS, this section specifically captures supports necessary for **successful performance of work tasks**.

Screeners should clearly inform the person being screened that responses to the employment questions will not detract from the person's eligibility for Social Security, Medicaid, LTC programs, or other benefits.

The employment questions help to capture if individuals participating in LTC services are working and, if not working, if they are interested or may be interested in employment. These questions are asking for the ***person's preference***. **The employment questions should not consider anyone else's preference for whether the individual should work, where anyone else wants the individual to work, nor whether the screener or anyone else thinks it is realistic for the individual to work.**

For an individual who is employed, the screener is asked to select the setting or settings where the person works. If the person is working in a facility-based setting, the screener must ask if the person is interested in working in the community. It is common that people will respond consistent with what they have experienced, been exposed to, or been told is an option. For example, people with intellectual/developmental disabilities who work in facility-based settings often think this type of work is the only option available to them. In this example, the screener should take the time to ask if the facility-based setting is their preference or if they have an interest in working in the community. When making a selection for an employment setting, screeners should ask questions to help the person articulate their preferences. While the person's preference may be difficult to ascertain, screeners are to use their best professional judgment to select the most accurate answer.

EMPLOYMENT RATING SYSTEM

A. Current Employment Status:

- ☐ 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 Paid Work, Where? (Check all that apply):

- ☐ 1: Facility-Based Setting
- ☐ 2: Group-Supported employment in the community (two or more) or individual employment in the community, with or without employment services, paid at subminimum wage
- ☐ 3: Individual employment in the community, with or without employment services, paid at a competitive wage (minimum wage or higher)
- ☐ 4: At home or self-employed

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 (for example, 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)." This may include volunteer activities.

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 age 65 or older and is not in the workforce. Instead, check "1: Retired (Does not include people under 65 who stopped working for health or disability reasons)."

If the response to A. Current Employment Status = 2: Not working (No Paid Work), and the person is between the ages of 18 and 64, the following question must be answered: **Is the individual interested in employment?** The answer to this question will be either "**Yes**" or "**No**."

- Select "Yes" if the individual indicates that they are interested in paid employment options.
- Select "Yes" if the individual indicates that they may be interested in paid employment options.
- Select "No" if the individual is not interested in paid employment options.
- Select "No" if the individual is only interested in unpaid, pre-vocational, or volunteer activities.
- Select "No" if the individual refuses or is unable to answer the question based on their preference.

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 group-supported employment in the community that includes two or more workers 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 (for example, 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 at facility-based employment and is paid by piece-rate, not hourly, and on average, is paid fewer than 30 hours per week.
- Is earning income through group-supported employment that includes two or more workers 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 averages 30 or more hours per week)."

Note: In pre-vocational service settings, 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 pre-vocational service 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 Paid Work, Where? (Check all that apply):

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: Facility-Based Setting
A facility-based setting is a sheltered workshop, also known as a community rehabilitation program, work center, or facility-based employment. They are distinguishable from mainstream employers by the fact that the primary mission of the corporation or entity is to provide services to individuals with disabilities, and they typically employ a large number of individuals with disabilities in one or more facilities. Facility-based settings may be licensed to pay sub-minimum wages to a group of workers with disabilities. Many facility-based settings provide other rehabilitation and long-term support services besides facility-based employment, which may include individual and small group supported employment, day services, therapies, and transportation.

If the response to B. If Paid Work, Where? = 1: Facility-based setting, the following question must be answered: **Is the individual interested in working in the community?** The answer to this question will either be "**Yes**" or "**No**."
- Select "Yes" if the individual indicates they are interested in employment in the community.
- Select "Yes" if the individual indicates they may be interested in employment in the community.
- Select "No" if the individual is not interested in employment in the community.

- Select “No” if the individual is only interested in unpaid, prevocational, or volunteer activities, or if they prefer to work in a facility-based setting.
- Select “No” if the individual refuses or is unable to answer the question based on their preference.

2: Group-supported employment in the community (two or more) OR individual employment in the community, with or without employment services, paid at subminimum wage
Group-supported employment is employment in a regular business, industry, or community setting where two or more workers with disabilities are employed as a group. Examples include mobile crews and other business-based work groups employing groups of workers with disabilities in the community. The worker may be compensated in accordance with applicable state and federal wage laws and regulations (for example, subminimum, minimum, or above minimum wage).

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

Individual employment in the community, with or without employment services, paid at subminimum wage, is work compensated at **less than** the applicable state or local minimum wage (customary wage). The work should be at a location typically found in the community, where the employee with a disability interacts with people who do not have disabilities. Individual employment in the community may be performed by the person with a disability with or without employment support.

3: Individual employment in the community, with or without employment services, paid at a competitive wage (minimum wage or higher)
Individual employment in the community, with or without employment services, paid at a competitive wage (minimum wage or higher) is also known as competitive integrated employment (CIE). This is defined as work performed on a full-time or part-time basis and compensated **not less than** the applicable state or local minimum wage law (customary wage). The worker should be eligible for the level of benefits provided to other employees. The work should be at a location typically found in the community, where the employee with a disability interacts with people who do not have disabilities and are not in a supervisory role, and the job presents opportunities for advancement. Individual employment in the community may be performed by the person with a disability with or without employment support.

4: At home or self-employed
At home employment or self-employment is defined as work performed on a full-time or part-time basis that yields income comparable to a person without disabilities doing similar tasks. The work is located in the worker’s home or in an integrated work setting in the general workforce. Operating a microenterprise may be considered self-employment. Microenterprise is defined as a business operating on a very small scale, generally with a sole proprietor and fewer than 10 employees.

C. Need for Assistance to Work

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

A selection is not required and can be left blank for people who are:

- Under age 18.
- Retired AND over age 64.

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 (for example, 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, beyond reasonable accommodations, the person would likely need to work. This might be deduced from the person's overall functioning and abilities. The screener should consider other information captured on the functional screen. The presence of a particular type of disability or health disorder (e.g., cognitive disability, seizures, chronic pain) or a guardianship does not automatically mean an individual will need the assistance of another person for successful performance of work tasks.

To decide which of the answer choices best represents the level of help needed to work, the screener should also consider the following:

- If the person worked before and their ability to perform work tasks is unchanged, indicate the level of job help needed in the past.
- Think about other factors not captured elsewhere on the LTCFS 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 LTC needs. The existence of any of these does not automatically mean a person would need employment supports.

4: Not applicable

- Should only be selected if the person aged 18-64 is severely ill or in a semi-comatose state. Severe disabilities 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 retired or 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 18–64-year-old person, even with continuous assistance from another person.

6.5 Educational Information

Included in this section of the LTCFS are two questions that require a response of either Yes or No.

Question 1. Is the individual currently participating in an educational program?
Question 2. Does the individual need assistance from another person to participate in an educational program?

Participation in an educational program is defined as current and active enrollment in a class, and needing help from another person, above and beyond reasonable accommodations such as those listed below.

Educational programs include, but are not limited to, high school, technical school, and college with the intent to receive or maintain a degree, certification, or licensure. This also includes special education classes, educational programs requiring an IEP (Individualized Educational Program), or classes and courses where an individual requires consistent one-to-one assistance or an aide.

Educational programs do not include extracurricular or enrichment programs that are not part of a formal program as described above. Examples include, but are not limited to, recreational sports, arts and crafts, or introduction to a foreign language.

To capture the need for assistance to participate in an educational program, the individual must have one of the following:

- Significant medical needs
- Behavioral needs
- Intellectual or cognitive impairments

Reasonable accommodations include, but are not limited to:

- Transportation to and from the educational site.
- Assistive devices and technologies.
- Service animals.
- Alternative format materials, such as Braille.
- Limited English proficiency interpretation.
- Simple, reasonable adaptations, such as taking one class at a time, course load reduction, priority seating, or help with registration.

6.6 Guardianship

This section captures when an individual has a court-appointed guardian and the reason or diagnosis for which the guardianship was granted.

Does this individual have a guardianship?
If a person has been found incompetent and has a court-appointed guardian of person, estate, or both, select “Yes.”

If the person has not been found incompetent and does not have a court-appointed guardian of person, estate, or both, select “No.”

Typically, when an individual has a guardian, this is due to a diagnosis that is coded in the A, E, or H categories on the Diagnoses Table.

6.7 I/DD Diagnosis with Onset Before Age 22

This section has a question that only pertains to individuals with A1-A10 diagnosis(es).

Was the onset of at least one of the A1-A10 diagnosis(es) before the age of 22?

If a diagnosis is coded as A1-A10, and if the onset of the condition that caused the diagnosis was prior to age 22, select “Yes.”

If a diagnosis is coded as A1-A10, and if the onset of the condition that caused the diagnosis occurred at age 22 or older, select “No.”

6.8 Expected Duration of Diagnosis and Social Security Disability Determination

Included in this section of the LTCFS are three questions that require a response of either YES or NO.

Question 1. Are the needs that are caused by the individual’s primary and/or secondary diagnosis(es) expected to last more than 90 days? Most short-term injuries (for example, from bone fracture) and a related need for assistance from another person would not be expected to continue beyond 90 days.

Question 2. Are the needs that are caused by the individual’s primary and/or secondary diagnosis(es) expected to last more than 12 months OR does the individual have a terminal illness? For purposes of the LTCFS, a terminal illness is defined as a condition where death is expected within one year.

Question 3. Does the individual have a disability determination from the Social Security Administration? In addition to YES or NO, PENDING may be selected as a response to this question. If a person has a presumptive or final disability determination, the screener should select YES in response to this question. PENDING is the correct response when a final decision has not been made about the level of disability for a person who has applied to the Social Security Administration (SSA) for disability-related benefits.

A child’s disability determination from SSA is valid until they reach 22 years of age. When a young adult who has been participating in the Children’s Long-Term Support Waiver program reaches the age of 18, they often transition to a LTC program that serves adults. Although a rare occurrence, it is possible that a child with a children’s disability determination from SSA may not meet adult

disability determination criteria. A child may first apply for an adult disability determination with SSA when they reach 18 years of age.

A lack of disability determination does not affect the person's level of care determination and functional eligibility, but it may be required to meet the LTC programs' Medicaid non-financial eligibility requirements.

A person can have a disability determination from SSA and NOT meet the definition for a target group that is eligible for adult LTC programs.

Module #7: Health-Related Services (HRS) Table

7.1 Background of the HRS Table

To be eligible for federal home and community-based waiver programs, a person must be functionally eligible to receive care in a nursing home or FDD/ICF-IID. This functional eligibility requirement is also known as meeting a nursing home or intellectual/developmental disability level of care. The HRS Table is extremely important in determining a person's program eligibility.

7.2 The HRS Table and Need for Health Care Provider Consultation

Screeners are not expected to be medical or nursing experts and should consult as needed with health care providers to accurately complete the HRS Table. Screeners who are nurses may not need to consult another medical professional, but screeners who are not nurses may need to obtain information through one of the following methods:

- Consult with your agency nurse on completing the HRS Table.
- Fax a health information form to the person's physician. Ask what type of health-related services the person needs and at what frequency. It is important to determine if the person is independent or needs assistance from another person to complete the task.
- Talk to the person's physician or nurse. Ask them the same questions in the above bullet.

7.3 Completing the HRS Table and General Rules for its Use

The HRS Table should be completed to show the presence and frequency of each health-related service according to the instructions in this module. Some frequencies, which are not applicable for a particular service, are blanked out.

A supplement to the HRS module has been developed. This supplement contains some HRS tasks that are seen more consistently in the community than in the past and are not currently included on the HRS Table.

Refer to the HRS Supplement, P-02525 for more information.

General Rules for the HRS Table

- It does not matter who is performing the skilled task (except for the "Requires Nursing Assessment and Interventions" task). Family members are often taught to complete very technical skilled nursing tasks.
- Be careful not to overlook assistance provided by informal supports. Sometimes a person may appear independent with an HRS task, but in reality, they are receiving assistance (for example, telephone calls to remind the person to take their medication).
- The HRS Table records skilled nursing tasks primarily provided in the person's home, not in a hospital, clinic, or office. A person's home or current residence is defined in Module 3.5. The

only exceptions are dialysis, transfusions, skilled therapies, ulcer care or wound care (under certain situations), and behaviors requiring interventions, including wandering, self-injurious behavior, or an offensive or violent behavior towards others. See the applicable sections in this module for additional information.
- When more than one "Frequency of Help/Services Needed from Other Persons" (column) applies to one HRS task (row), select the frequency of the task completed most often. Module 7.7 provides an example.
- The "Check this for a person who" and the "Do not check this for a person who" lists contain common, illustrative examples. These are not all-inclusive lists of examples.

"Needs" Versus "Receiving"
- The HRS Table is designed to document a person's need for assistance with health-related service(s), not just the assistance they are currently receiving. For example, a person receives weekly medication management assistance when the person's daughter refills their medication box during her visit each Sunday, although that assistance is only needed at a frequency of one to three times per month. In this case, select the "1-3 times/month" frequency of assistance needed.
- Be sure to indicate if the person is independent with an HRS task, even if they are currently receiving assistance with the task. For example, a nursing home resident may be physically and cognitively capable of taking their medications independently even though nurses administer their medications.
- For a person living in a residential care facility, assess the person's actual need for assistance and do not select the level of assistance needed based on the services provided as part of the residential facility package.
- Assess the person's need for assistance based on a physical, cognitive, or memory loss impairment and do not select the level of assistance provided based on a diagnosis, age bias, gender role, or cultural norm.
- The HRS Table is **not** designed to capture acute, primary, or in-clinic services (except for dialysis, transfusions, ulcer care, or wound care [under certain situations], and skilled therapies). See the applicable sections in this module for further information.
- Be sure to indicate if the person is independent with a task, even if the person is currently receiving help or services.
- Assess the person's need for assistance and do not select the level of assistance needed based on an age, gender, or cultural norm.

Need for Assistance:
To reflect a person's NEED for assistance, the screener should select the most accurate answer that most closely describes the person's NEED for "help from another person," whether the person is actually receiving that assistance or not. Help from another person is defined as supervision, cueing, and/or hands-on assistance (partial or complete).
- If a person has an identified need but is not receiving assistance (this includes declining the assistance and a significant, negative health outcome occurs), the screener should still capture the need for the assistance from another person to complete the task.
- If a person has an identified need but they have declined assistance and there is no significant negative health outcome, the screener is to select Independent.

- If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes and the selection of a need might be appropriate.

Declining the task:
If the individual has declined to complete the **health-related service or task itself,** and is able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should leave the default selection of "N/A." In this situation, the person has no need for assistance with the health-related service or task because the health-related service or task is not occurring.

Examples include, but are not limited to:
- If an individual able to perceive potential risk or negative outcome chooses not to take any prescribed medications, the person has no need for medication administration or medication management assistance because no medications are being taken.
- If an individual able to perceive potential risk or negative outcome chooses not to use oxygen and/or respiratory treatments, such as a Bi-PAP machine, the person has no need for assistance because no task is occurring.
- If an individual able to perceive potential risk or negative outcome chooses not to participate in skilled therapies, the person has no need for assistance because no therapy is occurring.

If the person is not able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select the frequency of need.

If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes, and the selection of a need might be appropriate.

7.4 Avoid Double-Dipping on the HRS Table

If assistance with a task is indicated in one row of the HRS Table, that need for assistance should not also be indicated in another row. HRS needs are to be recorded on only one row of the HRS Table.

Examples can include, but are not limited to:
- When an individual only needs assistance with their IV medication, this does not also indicate a need for assistance to record on the Medication Administration and Medication Management rows.
- When an individual receives a registered nurse's assistance with their needed ulcer care ("Ulcer – Stage 2" or "Ulcer – Stage 3 or 4"), this does not also indicate a need for assistance to record on the Requires Nursing Assessment and Interventions row.
- When an individual receives a registered nurse's assistance with needed pain management (Medication Management), this does not also indicate a need for assistance to record on the Requires Nursing Assessment and Interventions row.

- An individual with congestive heart failure has just had their fluid retention medication adjusted. A registered nurse comes to the home to access their fluid retention and the effectiveness of the medication adjustment (Medication Management), this does not also indicate a need for assistance to record on the Requires Nursing Assessment and Interventions row.
- When an individual has a registered nurse come to their home to draw a blood sample for a laboratory test (Medication Management), this does not also indicate a need for assistance to record on the Requires Nursing Assessment and Interventions row.

HEALTH-RELATED SERVICES

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

Health-Related Services	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
Behaviors Requiring Interventions							
Exercises / Range of Motion							
IV Medications, Fluids or IV Line Flushes							
Medication Administration (not IV) or Assistance with Pre-Selected or Set-Up Medications							
Medication Management: Set up and/or Monitoring (for Effects, Side Effects, Adjustments, Pain Management) and/or Blood Levels							
Ostomy-Related Skilled Services							
Positioning in Bed or Chair Every 2-3 Hours							
Oxygen and/or Respiratory Treatments, Tracheal Suctioning, C-PAP, Bi-PAP, Nebulizers, IPPB Treatments (Does NOT include inhalers)							
Dialysis							
TPN (Total Parenteral Nutrition)							
Transfusions							
Tracheostomy Care							
Tube Feedings							
Ulcer – Stage 2							
Ulcer – Stage 3 or 4							
Urinary Catheter-Related Skilled Tasks (Irrigation, Straight Catheterizations)							
Other Wound Cares (Not Catheter Sites, Ostomy Sites, IVs, or Ulcers – Stage 2, 3, or 4)							
Ventilator-Related Interventions							
Requires Nursing Assessment and Interventions							
Other—Specify:							

Skilled Therapies—PT, OT, SLP (Any One or a Combination, at Any Location) ☐ 1-4 sessions/week ☐ 5+ sessions/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)

7.5 Person is NOT Independent in Completing and Managing a Health-Related Service

If the person is not independent in completing and managing a health-related service, select the column indicating the most accurate "Frequency of Help/Services Needed from Other Persons."
The frequencies of help/services needed from another person are as follows:

- ☐ Person is independent
- ☐ 1 to 3 times/month
- ☐ Weekly
- ☐ 2 to 6 times/week
- ☐ 1 to 2 times/day
- ☐ 3 to 4 times a day
- ☐ 5 or more times a day

The definitions for each HRS task (each row) list the skilled tasks the screener is to focus on, and in some cases includes which tasks to ignore. For instance, in the Urinary Catheter-Related Skilled Tasks row, the screener is to ignore the unskilled task of emptying the bag and only consider the skilled tasks (replacing the catheter, irrigating the catheter).

When more than one "Frequency of Help/Services Needed from Other Persons" (column) applies to one HRS task (row), select the frequency of the task completed most often. (Module 7.7 provides an example.)

7.6 Person is INDEPENDENT in Completing and Managing a Health-Related Service

If the person is independent in completing and managing a health-related service, select the column "Person is Independent."

The HRS Table is designed to document the person's need for assistance with health-related service(s), not just what assistance the person is currently receiving. **Be sure to indicate if the person is independent, even if the person is currently receiving help or services with other tasks.**

Example: Amy is currently in the hospital but will be discharged soon. She has the physical and cognitive ability to manage and administer her own medications. However, hospital policy requires that all medications be managed by hospital nurses. The screener should indicate Amy is independent with Medication Management and Administration, even though she currently receives assistance from the hospital's nurses.

7.7 Person is INDEPENDENT With Some Tasks, but NOT Independent With Others

In many cases, a person is independent with some tasks, but needs help from another person with other tasks related to the same health condition. For example, with the task of Medication Management, a person may independently set up their medications but needs assistance with their blood glucose checks. **Pay attention to the column headings that indicate the "Frequency of Help/Services Needed from Other Persons."**

Example: Inez does her own ankle dressing for a wound twice a day but can't see well and is unable to 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. The screener would select "Weekly" for the "Frequency of Help/Services Needed from Other Persons." Do not select the "1-2 times/day" frequency since Inez independently completes her wound care, twice a day.

7.8 Person Declines the Task

Declining the task:
If the individual has declined to complete the **health-related service or task itself,** and is able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should leave the default selection of "N/A." In this situation, the person has no need for assistance with the health-related service or task because the health-related service or task is not occurring.

Examples include, but are not limited to:

- If an individual able to perceive potential risk or negative outcome chooses not to take any prescribed medications, the person has no need for medication administration or medication management assistance because no medications are being taken.
- If an individual able to perceive potential risk or negative outcome chooses not to use oxygen and/or respiratory treatments, such as a Bi-PAP machine, the person has no need for assistance because no task is occurring.
- If an individual able to perceive potential risk or negative outcome chooses not to participate in skilled therapies, the person has no need for assistance because no therapy is occurring.

If the person is **not** able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select the frequency of need.

If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes, and the selection of a need might be appropriate.

7.9 Indicate Frequency of Skilled TASKS, Not Duration of Condition

For conditions that are continually present (e.g., an in-dwelling or continuous urinary catheter), **the screener should indicate the frequency of skilled tasks related to the health-related service.**

When one HRS condition involves more than one skilled task, provided at different frequencies, select the frequency of the task completed most often from another person. Or, in other words, the highest frequency at which help is needed from another person.

Example: Bob has a permanently placed urinary catheter. A nurse changes the catheter every 30 days. Daily catheter care is just soap and water cleaning completed during bathing (which is not to be considered an HRS task) and no other urinary catheter care is needed. Bob also has a tracheostomy. Tasks related to his tracheostomy include having a nurse change the tracheostomy tube monthly and an aide clean the tracheostomy site twice a day. He is generally self-directing and stable and visits his doctor's office only once every four to six months.

In this example, the screener should make TWO selections on the HRS Table: 1) Urinary Catheter-Related Skilled Tasks at "1-3 times/month" and 2) Tracheostomy Care at "1-2 times/day."

7.10 Selecting Primary and Secondary Diagnoses

To be selected as a primary or secondary diagnosis that causes a need for assistance or support from another person, the need must be due to a physical, cognitive, or memory loss impairment. Additional guidance can be found in Module 4.4 Identifying Primary and Secondary Diagnoses.

7.11 Behaviors Requiring Interventions

Definition: Due to a cognitive impairment, the person exhibits the behavior of wandering, a self-injurious behavior, or an offensive or violent behavior to others, and a behavior plan is needed to either prevent the behavior or intervene when the behavior is exhibited. To record a need for assistance with Behaviors Requiring Interventions, the person's cognitive impairment needs to cause the behavior.

A cognitive impairment includes a permanent impairment of thought due to a severe and persistent mental illness, dementia, brain injury, intellectual/developmental disability, or other organic brain disorder. It does not include temporary impairment due to substance use intoxication.

Preventions and interventions on the HRS Table include, but are not limited to:

- Providing support to prevent a behavior.
- Having someone present to prevent the person from exhibiting the behavior.
- Redirecting the person when they exhibit the behavior.
- Physically preventing the person from exhibiting the behavior.

- Monitoring the person when they exhibit the behavior.
- Responding to problems caused by the person's behavior.

To make a selection on the HRS Table, all the following criteria must be present:
- Person has a cognitive impairment.
- Preventions and/or interventions are required from another person.
- A behavior plan to prevent or respond to the behavior.

A behavior plan 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. They are typically formal, written, behavior plans, but can include an informal behavior plan if everyone working with the individual is well aware of how to prevent the behavior or how to intervene when the behavior is exhibited.

The following lists contain common, illustrative examples of behaviors related to when the selection of a need for assistance may or may not be warranted with a wandering, self-injurious, or offensive or violent behavior.

Wandering on the HRS Table, for a person with a cognitive impairment, is defined as unsafe leaving or attempting to leave an immediate area (residence, community setting, workplace, etc.) without informing others and doing so requires intervention. A person may still exhibit wandering behavior even if elopement is impossible due to preventative measures, such as a facility security system or bed and wheelchair alarms.

Examples included are not all-inclusive.

Check this for a person who, due to a cognitive impairment:
- Wanders and requires a behavior plan to either prevent the behavior and/or to intervene when the behavior is exhibited.
- Only wanders and requires a behavior plan when in new situations but does not wander in their routine and familiar situations.
- Elopes or attempts to elope from their residence and requires a behavior plan.

Do NOT check this for a person who:
- Does not have a cognitive impairment.
- Purposefully tries to leave their immediate area (residence, community setting, workplace, etc.) and they are safe.
- Keeps trying to, or does, leave their residence only when intoxicated or to use alcohol or other substances.
- Paces within their residence due to anxiety, nervousness, or boredom.
- Roams within their residence **but does not require intervention(s)**. For example, a person may roam about their residential facility by going room to room but does not try to elope from the facility.
- Has a sleep disorder (e.g., sleepwalks, sleep talks, etc.).

- Has as the **only** response in their behavior plan that someone call 911 for emergency assistance or administers a PRN medication.

A **Self-injurious Behavior** on the HRS Table, for a person with a cognitive impairment, is defined as a behavior that causes, or is likely to cause, injury to one's own body and requires intervention as part of a behavioral support plan. Self-injurious behaviors are physical self-abuse and do not include the absence of self-care or behaviors that may have unhealthy consequences.

Examples included are not all-inclusive.

Check this for a person who, due to a cognitive impairment:
- Requires a behavior plan to either prevent the behavior and/or to intervene when the behavior is exhibited.
- Exhibits self-abuse that causes, or is likely to cause, self-injury (e.g., hitting, biting, head banging, etc.).
- Eats inedible objects (e.g., person has pica).
- Has excessive thirst manifested by excessive fluid intake (e.g., person has polydipsia).
- Engages in self-injury that requires prevention and/or intervention (e.g., person cuts their skin).

Do NOT check this for a person who:
- Does not have a cognitive impairment.
- Smokes, uses alcohol or other substances, or misuses medications (legal or illegal).
- Is sexually promiscuous.
- Has unprotected sex.
- Makes poor eating choices given their physical health. Examples can include, but are not limited to, a person who eats a diet high in sugar content although they have insulin-dependent diabetes mellitus or a person who does not follow their recommended low-fat diet.
- Has a habit that is harmless and is unlikely to offend others. An example can include, but is not limited to, a person who displays a repetitive activity (e.g., repetitive tapping, rocking, or finger waving).
- Has or seeks multiple body tattoos or piercings.
- Rubs their skin or picks at their skin or scabs without the need for medical intervention beyond applying a band aid.
- Has suicidal ideations or a history of attempting suicide but has no current preventions and/or interventions. These thoughts or actions would be captured in the Mental Health section of Module 9.
- Has anorexia or bulimia-related behaviors.
- Has a self-managed plan that does not require that intervention is initiated from another person, and it is a self-help plan of action to prevent self-injurious behavior or steps for the individual to take in response to displaying a self-injurious behavior. A person self-managing their plan is not a type of behavior plan to record on the HRS Table.
- Has as the **only** response in their behavior plan that someone call 911 for emergency assistance, administers a PRN medication, or participates in professional mental health services.
- Exhibits behavior(s) only when intoxicated due to alcohol or other substance use.

An **Offensive or Violent Behavior to Others** on the HRS Table is defined, for a person with a cognitive impairment, as a behavior that causes, or can reasonably be expected to cause, discomfort, distress to others, or threatens to cause emotional or physical harm to another person. The disturbing behavior impacts others in the person's community, such as others in a facility, neighbors, or community at-large and requires a behavior plan to either prevent the behavior or intervene when the behavior is exhibited.

Examples included are not all-inclusive.

Check this for a person who, due to a cognitive impairment:

- Requires a behavior plan to either prevent the behavior and/or to intervene when the behavior is exhibited.
- Disrobes or masturbates in front of others.
- Engages in inappropriate touching or sexual advances towards others.
- Spits at or on others.
- Routinely places their nasal mucous on another person or on places within their residence.
- Routinely smears their fecal matter or spreads their urine on themselves, another person, or on places within their residence.
- Urinates or defecates on another person or in inappropriate places.
- Screams incessantly.
- Uses profanity in conversation that is offensive and threatening to the point where law enforcement would be contacted to intervene.
- Verbally and physically threatens others, including, but not limited to, aggressive gestures or a raised fist, to the point where law enforcement would typically be contacted to intervene.
- Tortures, maims, or otherwise abuses animals.
- Strikes out at or strikes, kicks, bites, or otherwise batters others.
- Commits or has a history of sexual aggression, pedophilia, or arson, and the behavior continues to be an active concern.

Do NOT check this for a person who:

- Does not have a cognitive impairment.
- Uses profanity in conversation that is not offensive or threatening to the point where law enforcement would typically be contacted to intervene.
- Uses swear words or racial slurs on a routine basis.
- Hoards items.
- Has poor housecleaning skills or practices.
- Steals items.
- Has poor personal hygiene. Examples can include, but are not limited to, a person with excessive body odor, including a person with a strong urine or fecal odor.
- Is uncooperative with a task.
- Enters another person's living space without permission.
- Has a difficult personality. Examples can include, but are not limited to, a person who is obstinate, vulgar, ill-tempered, or doesn't get along with their family members or caregivers.
- Exhibits behavior that may indicate a need for medical treatment, mental health treatment, or substance use treatment, but does not require an intervention. Examples can include, but are

not limited to, a person with an anxiety disorder who needs frequent reassuring, or a person with an obsessive-compulsive disorder who repeatedly checks if the door is locked.
- By appearance or mannerisms may elicit social prejudices, such as avoidance or stigmatization. Examples can include, but are not limited to, a person who mutters, talks to themselves, makes noises, has body tics, or has Tourette's syndrome.
- Vaguely threatens others. An example can include, but is not limited to, a person who says, "Somebody's going to pay."
- Has a self-managed plan that does not require that intervention is initiated from another person, and it is a self-help plan of action to prevent offensive or violent behavior to others or steps for the individual to take in response to displaying a self-injurious behavior. A person self-managing their plan is not a type of behavior plan to record on the HRS Table.
- Has as the **only** response in their behavior plan that someone call 911 for emergency assistance, administers a PRN medication, or participates in professional mental health services.
- Exhibits behavior(s) only when intoxicated due to alcohol or other substance use.

REMINDER: On the HRS Table, to select a need for assistance with a Behavior Requiring Interventions, the individual must have a cognitive impairment, while Self-injurious Behaviors and Offensive or Violent Behaviors in Module 9, Behaviors/Mental Health, do not. Screeners should review both sections to ensure the individual's needs have been accurately recorded.

How to Determine the Frequency: Use of the "Person is Independent" column is not an option for the Behaviors Requiring Interventions row. Select the frequency column which reflects the combined number of preventions and/or interventions needed from another person for wandering, self-injurious behaviors, and offensive or violent behaviors to others.

7.12 Exercises/Range of Motion

Definition: This row addresses the performance of physical exercise or range of motion exercises, completed in the person's residence, to restore or maintain physical capabilities when the person is at risk for loss of function due to a related health condition. The person may perform these exercises themselves or another person 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.

Check this for a person who:
- Engages in a routine of therapeutic exercise to restore or prevent loss of physical function. For example, after a stroke a person may receive range of motion exercises to their affected side, three times a day, to regain joint or muscle function; or a person may receive stretching or motion exercises to treat contractures.
- Completes prescribed physical therapy exercises, although no longer receiving formal physical therapy.
- Receives occupational therapy (OT), physical therapy (PT), or speech-language pathology (SLP) from someone other than a licensed OT, PT, or SLP. This includes exercises completed with a family member, someone significant in the person's life, caregiver, physical therapy assistant, or an occupational therapy assistant, even if under the instructions of an OT, PT, or SLP.

Do NOT check this for a person who:

- Completes exercises with a rehabilitation therapist (i.e., a physical therapist, occupational therapist, or speech-language pathologist). Review Module 7.31 Skilled Therapies.
- Engages in basic fitness exercise (e.g., walking, weightlifting).
- Goes to a gym or pool to exercise.
- Participates in an exercise class.
- Participates in cardiac or pulmonary rehabilitation outside their residence.

How to Determine the Frequency: Use the "Person is Independent" column if the person completes their Exercises/Range of Motion without help from another person. If the individual needs assistance, select the applicable "Frequency of Help/Services Needed from Other Persons" column according to the guidelines in Module 7.5 – 7.9.

7.13 IV Medications, Fluids, or IV Line Flushes

Definition: "IV" is an abbreviation for the word "intravenous" and pertains to medications, fluids, or flushes delivered into a vein. This may consist of an IV injection or IV infusion. Most common are small bags of antibiotics that "drip" in (usually via an IV pump for safety) and can include a PICC (peripherally inserted central catheter) line or a central line.

Check this for a person who:

- Receives IV medications, IV fluids, or IV line flushes that are provided in their residence.
- Requires IV medication, like an antibiotic to drip into their vein to treat a serious infection. IV medications usually drip in over 30 to 60 minutes.
- Requires IV fluids because they are unable to consume enough liquids and are dehydrated. Typically, these fluids consist of saline or weak solutions of dextrose given in response to acute dehydration or until tube feeding can be established.
- Requires their IV to be flushed, which means the IV is irrigated or washing out with a sterile solution or medication, and IV flushing is the only IV intervention being provided. On the HRS Table, do not record the task of IV flushing separately if it's part of one intervention that combines several tasks (e.g., starting the medication, flushing, and disconnecting). When a person only needs assistance with their IV Medications, do not also record a need for assistance on the Medication Administration and Medication Management rows.
- Requires site cares to be provided, such as cleaning and re-bandaging the IV site. Site care is typically completed every few days.

Do NOT check this for a person who receives:

- IV services provided outside their residence (e.g., in a primary care setting, such as a clinic).
- Chemotherapy treatments outside of their residence.
- Intramuscular (IM) injections or subcutaneous injections (an injection into the layer between the skin and muscle).
- TPN or Transfusions, which have separate HRS Table rows, unless they receive either of those specific HRS tasks (see Module 7.20 and 7.21).

How to Determine the Frequency: Skilled IV interventions are often provided in combination with several tasks over a few minutes. The HRS Table should reflect the number of times per day, week, or month the cluster of tasks must be completed. To determine the frequency of IV interventions, combine the tasks that can be completed within an hour and multiply by the number of times per day (or week or month) that the cluster of tasks must be completed. The following illustrative examples are not an all-inclusive list:

1 – 2 times/day examples:

- An IV medication is prescribed to drip in over 30 to 60 minutes. The nurse arrives, ensures the IV catheter is patent (unblocked), hooks up the IV tubing, drips in the IV antibiotic, follows that with a bit of IV fluid, then disconnects the tubing and administers a small heparin flush to keep the line open. All these skilled tasks take the nurse about one hour to complete. All this counts as one time per day assistance with the person's IV and the screener should select the "1-2 times/day" frequency of assistance needed from another person.
- The person receives an IV infusion throughout the night. There is one cluster of skilled IV tasks to start the infusion at bedtime, and another cluster of skilled tasks to disconnect it and flush the line each morning. The two separate clusters of skilled tasks make "1-2 times/day" the correct frequency of assistance needed from another person.
- The person has an IV line but is not currently receiving any fluids or medications through it and to prevent the line from clotting off, a small flush of heparin is administered into the IV twice daily. This is a skilled task that occurs twice daily and makes the selection of "1-2 times/day" the correct frequency of assistance needed from another person.

3 - 4 times/day examples:

- Same as the once per day example in the first bullet above, except the IV medication is administered three times per day. Thus, there are three separate clusters of IV tasks (assessing patency, hooking up tubing, administering medication, disconnecting tubing, and flushing the IV) all completed within an hour, three separate times per day and makes the selection of "3-4 times/day" the correct frequency of assistance needed from another person.
- The person has a continuous drip of IV fluid. Family caregivers have learned how to work the IV pump and how to add a full IV bag three times per day, and what problems to report to the nurse. The nurse starts a new IV in another vein (to reduce infection) every three days. The screener would select the highest frequency of interventions, which makes the selection of "3-4 times/day" the correct frequency of assistance needed from another person.

2 to 6 times/week examples:

- Several days of IV medications can be put into a computerized pump that delivers the medication slowly or intermittently and prevents the IV from clotting off. The pump only needs to be refilled and re-programmed every three days or so. In between refills (aka, set-ups), the IV stays hooked up and there are no IV tasks to be done; it works fine, and the person or caregivers know how to handle and/or report problems. The frequency of assistance needed from another person with these IV medications is "2-6 times/week," to record the IV set up assistance needed every 2 to 3 days.
- Other skilled IV tasks that usually occur once every three days are:
    - Changing the IV dressing.

- Starting a new IV in a new place (to reduce risk of infection in "peripheral" IVs in the person's hand or forearm).

7.14 Medication Administration (not IV) or Assistance with Pre-Selected or Set-Up Medications

Definition of a medication: A medication is a drug used to treat disease, symptoms, or injury that enters the body in the prescribed manner. The type of medications prescribed for the person can be brand name, generic, or over-the-counter (OTC). A medication on the LTCFS must meet these three criteria:

1. Approved by the U.S. Food and Drug Administration.
2. Prescribed by a Medicaid-recognized prescriber, such as a physician, psychiatrist, nurse practitioner, physician's assistant, optometrist, or dentist.
3. Regularly scheduled and used.

PRN Medications: A PRN medication is a medication taken only when needed based on symptoms and typically PRN medications are not captured on the LTCFS.

For a PRN medication to be captured on the LTCFS, it must meet the definition of a Medication as described above and be used as stated here:

- Regularly scheduled and used at minimum once a month every month. Examples include:
  - Pain medicine that is ordered PRN but taken every four to six hours, every day.
  - Skin cream that is ordered PRN but applied every week.
  - A medication to relieve menstrual symptoms that is ordered PRN but used once every month.
- Sliding scale insulin (where the exact dosage is adjusted according to the blood glucose level) can be treated as a regularly scheduled medication, because it is regularly given, with the dose merely adjusted to blood glucose level.

The following are not considered Medications on the LTCFS:

- PRN medications that do not meet the definition of a medication.
- Vitamin (unless injected for example, vitamin B-12 injections), mineral, supplement, and alternative or complementary medicines, even if prescribed by a Medicaid-recognized prescriber. Non-vitamin, non-mineral natural substances such as, omega 3 or fish oil, glucosamine, ginkgo, antioxidants, ginseng, echinacea, chondroitin, coenzyme Q10, flaxseed, cranberry, garlic, soy, melatonin, green tea, saw palmetto, grape seed, milk thistle, lutein, bark water, or shark cartilage, even if prescribed by a Medicaid-recognized prescriber.
- Other complementary or alternative medicines, such as homeopathic, naturopathic, or herbal therapy; or other treatment such as aromatherapy, flower remedies, crystal or magnet therapy, chelation, bowel cleansing, detoxifier, acupuncture, or acupressure.
- Other dietary supplements with calories, minerals, vitamins, and/or other additives.

In the IADLs, Medication Administration and Medication Management are coded together. This differs from the HRS Table where Medication Administration and Medication Management are coded separately.

The LTCFS application will check to ensure that the level of help indicated in the IADL Medication Administration and Medication Management correlates with the Medication Administration and Medication Management tasks on the HRS Table. If the level of help does not correlate between that IADL task and the Medication Administration and Medication Management tasks on the HRS Table, the screener will receive an error message to prompt review.

Definition of Medication Administration: A person's need for assistance from another person to **take or be given** a medication by any route except intravenously (IV). This could be by mouth, tongue, injection, onto or into the body, rectally, vaginally, by feeding tube, or by inhaler. Common forms of medications include but are not limited to tablet, capsule, liquid, drops, and skin preparations. The person's need for assistance from another person to use a prescribed medication that is regularly scheduled and used should be captured here.

The preparation of medications, such as crushing a tablet to be diluted or measuring to fill a syringe or dosage cup, may be considered Medication Administration when it is prepared within one hour of when the dose is to be taken.

Excluded are:

- IV medications. Review Module 7.13 IV Medications, Fluids, or Line Flushes.
- Topical medications used for ulcer, wound care. Review Modules 7.24 Ulcer – Stage 2, 7.25 Ulcer – Stage 3 or 4, and/or 7.27 Other Wound Cares.
- Medications used for nebulizer treatments. Review Module 7.18 Oxygen and/or Respiratory Treatments.

Do NOT check this for a person who:

- Has no medications.
- Does not take regularly scheduled medication but needs assistance from another person with an infrequently taken prescription PRN medication (taken less than once a month every month. Such a PRN medication does not meet the LTCFS definition of a medication. Refer to the PRN Medication definition.
- Chooses not to take any medications (the person is declining the task of taking medications itself). If the individual has declined to complete the **health-related service or task itself**, and is able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should leave the default selection of "N/A." In this situation, the person has no need for assistance with the health-related service or task because the health-related service or task is not occurring.
    - If the person is **not** able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select the frequency of need.
    - If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes, and the selection of a need might be appropriate.

Check "Person is independent" for a person who:

- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Medication Administration independently.
- Is independent with Medication Administration, but:
  - Uses simple, reasonable adaptations such as large-print or Braille labels, "talking" glucometer, easy-open pill bottles.
  - Does not administer their medications because medications are provided as part of the services in the facility where the person resides.
  - Due to the policy of the person's provider agency, such as hospice or a personal care provider, does not administer their medications because this is a service provided by the agency.
  - Is left a written reminder from another person as a cue to take their medications.
  - Is contacted by another person to check if the person has or has not taken their medication but the cueing or call is not needed.
  - Only needs assistance getting food or drink needed to take their medications at mealtimes.
- Is independent with Medication Administration however requires assistance with the filling of a medication box.
- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Medication Administration independently, but:
  - Prefers assistance with Medication Administration due only to a gender, age, or cultural norm.
  - Needs assistance with Medication Administration due only to a language barrier.
  - Needs assistance with Medication Administration due only to illiteracy.
- Is independent with Medication Administration as prescribed, and receives services outside their residence, such as:
  - Has medication monitoring, including blood draws, done outside the person's residence such as at the physician's office, clinic, pharmacy, or health care facility.
  - Receives injections, such as vitamin B-12, outside their residence such as at a clinic.
  - Takes medication through an intrathecal drug pump, also known as a pain pump or internal morphine pump, that requires only intermittent refills and maintenance in the clinic setting but does not require monitoring in their residence.
  - Has a drug delivery implant such as the birth control implant.
- Requires Medication Administration less often than monthly.
- Has a cognitive or memory loss impairment but takes medication as prescribed, without misuse or error once the medication is set up.
- Is given medication by IV only. Review Module 7.13 IV Medications, Fluids, or Line Flushes.

Check the appropriate frequency, using guidance provided under 7.5 Person is NOT Independent in Completing and Managing a Health-Related Service, for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with the task of Medication Administration. To code cueing assistance for a medication, the cue must be done within an hour of when the dose is to be taken.
- Requires assistance with Medication Administration at the "Check 1," "Check 2a," or "Check 2b" frequency as on IADLs Medication Administration and Medication Management, Module 5.14.

- Needs assistance to crush their medication or assistance to put their medication in food, such as applesauce, for it to be taken when it is prepared within one hour of when the dose is to be taken.
- Needs assistance flushing a feeding tube after administration of a medication when the tube is only used to administer medication.
- Needs assistance to prepare a medication for administration via a feeding tube. For example, crushing a tablet to be diluted and administered through a G-tube when it is prepared within one hour of when the dose is to be taken.
- Has a cognitive impairment and has a court-ordered medication.
- Needs someone to physically assist with the medication but is self-directing and has the cognitive ability to select the proper medication and dosage, and has the judgment to understand the medication's purpose, side effects, and report problems. An example of this is a person with quadriplegia who instructs their helper, "Please put one of those three pills on my tongue and give me a drink."

Exception to determining appropriate frequencies:

Check "1-2 times/day" for a person who:
- Is independent with Medication Administration and only needs assistance getting food or drink, outside of Meal Preparation, needed to take their medication.

How to Determine the Frequency: Use the "Person is Independent" column if the person can take all their medications without any help from another person. If they need assistance, select the applicable "Frequency of Help/Services Needed from Other Person" column according to the guidelines in Module 7.5 – 7.9.

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

Definition of a medication: See Module 7.14 above for the definition of a medication.

In the IADLs, Medication Administration and Medication Management are coded together. This differs from the HRS Table where Medication Administration and Medication Management are coded separately.

The LTCFS application will check to ensure that the level of help indicated in the IADL Medication Administration and Medication Management correlates with the Medication Administration and Medication Management tasks on the HRS Table. If the level of help does not correlate between that IADL task and the Medication Administration and Medication Management tasks on the HRS Table, the screener will receive an error message to prompt review.

Definition of Medication Management: A person's need for assistance from another person to set up or monitor their prescribed and regularly scheduled and used medications.

The two components of Medication Management include:

1. **Medication Set-up**: To separate out the proper dosage and **set it aside** for **later use by the individual**.

   Medication set-up is completed for several reasons. One reason is to ensure the **proper medication, at the proper dosage** is selected when the individual is unable to select it due to a physical, cognitive, or memory loss impairment. Another reason is to **arrange** the medications to **help the person remember** to take them at proper times and to make it easier to tell that medications were or were not taken.

   Examples of medication set-ups:
   - Medication boxes with compartments labeled for different times and each day of the week, into which pills are placed.
   - Any other set-up system in which medications and dosages are pre-selected by another person, such as a bubble pack.
   - Automated medication dispensers that can be programmed (often weekly) to dispense pills.
   - Prefilling of syringes, such as insulin syringes.

   Medication set-ups are commonly used for convenience in organizing and remembering one's medications, even by people with no physical, cognitive, or memory loss impairment. When a person uses a medication set-up, the screener needs to determine whether, due to a physical, cognitive, or memory loss impairment, the person **needs** to use the medication set-up, and/or **needs** the assistance of another person to fill it.

   The preparation of medications, such as crushing a tablet to be diluted or measuring to fill a syringe or dosage cup, may be considered Medication Management when it is NOT prepared within one hour of when the dose is to be taken.

2. **Medication Monitoring**

   Medication monitoring includes the following components:
   - Due to a memory loss or cognitive impairment, oversight is required for monitoring of effects, side effects, or adjustments. This oversight is captured at a frequency of 1 to 3 times per month.
   - The need to collect medication-related data, as ordered by the prescriber, prior to administering a medication, such as blood glucose level, blood pressure, or heart rate, and that the data collection is occurring.
   - The need to collect medication-related data as ordered by the prescriber, such as vital signs, weights, seizure activity, or in-home assistance to draw blood for a lab test, and that the data collection is occurring and reported to a health care provider.

   Common reasons for a need for assistance with Medication Monitoring. This is not an all-inclusive list:

- **Uncontrolled Seizure Disorder.** An individual's need for assistance in their residence from another person when the individual has an uncontrolled seizure disorder, evidenced by one or more seizures in the last three months, and medication is frequently adjusted.
- **Pain Management.** An individual's need for assistance from another person to adjust their medications, in the individual's residence, to manage pain. This does not include care at a pain clinic or any other setting outside the person's residence. This also does not include prescription or OTC PRN medications that do not meet the definition of a medication as described at the beginning of this module.
- **Blood Levels.** A person's need for assistance from another person to draw blood samples, in their residence, for laboratory tests. Most of these tasks are related to medications, such as Pro-Times to regulate warfarin administration or potassium levels for a person on diuretics. Blood levels also include "finger-sticks" for capillary blood to test blood glucose levels.

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. The condition or treatment may stabilize over time and then the frequency of medication monitoring would decrease. A rescreen should be completed when a person's condition stabilizes to reflect this and any other changes.

Do NOT check this for a person who:

- Has no medications.
- Does not take regularly scheduled medication but needs assistance from another person with an infrequently taken prescription PRN medication (taken less than once a month every month). Such a PRN medication does not meet the LTCFS definition of a medication. Refer to the PRN Medication definition.
- Chooses not to take any medications (the person is declining the task of taking medications itself). If the individual has declined the **task of taking medications itself and** is able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select "N/A – Has no medications." In this situation, the person has no need for Medication Administration or Medication Management because it is not occurring. For example, if an individual able to perceive potential risk or negative outcome chooses not to take any prescribed medications, the person has no need for medication administration and medication management assistance because no medications are being taken (the task itself is not being done).
    - If the person is **not** able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select the frequency of need.
    - If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes, and the selection of a need might be appropriate.

Check "Person is independent" for a person who:

- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Medication Management independently.

- Takes medication as prescribed and can contact the prescriber with concerns and understands the prescriber's recommendations.
- Takes medication as prescribed and can independently collect medication-related data, such as blood glucose levels, blood pressure, weights, pulse.
- Is independent with Medication Management, but:
  - Uses simple, reasonable adaptations, such as large-print or Braille labels, "talking" glucometer, easy-open pill bottles.
  - Uses an alarm on their watch, clock, or phone as a reminder to take medications.
  - Uses a medication box or automated pill dispenser as a convenience.
  - Has an unorthodox system of organizing medications with no history of medication misuse or errors.
  - Needs assistance to prevent someone else, including a pet, from having access to the medication.
  - Needs assistance reordering or obtaining medication refills. This includes assistance to arrange for a medication refill, such as a request to the pharmacy. Review Module 5.16 Laundry and/or Chores.
  - Requires transportation to the pharmacy. Review Module 5.18 Transportation.
  - Does not manage their medications because medications are provided as part of the services in the facility where the person resides.
  - Receives routine monitoring for general health, behavior, etc., by the person's agency's staff because that monitoring is provided to all residents.
  - Due to the policy of the person's provider agency, such as hospice or a personal care provider, does not manage their medications because this is a service provided by the agency.
  - Takes a medication that only comes preselected from the manufacturer, such as birth control pills, some antibiotics, some steroids, or insulin in dispensing pens.
- Has no physical, cognitive, or memory loss impairment affecting their ability to complete the task of Medication Management independently, but:
  - Prefers assistance with Medication Management due only to a gender, age, or cultural norm.
  - Needs assistance with Medication Management due only to a language barrier.
  - Needs assistance with Medication Management due only to illiteracy.
- Is independent with Medication Management as prescribed, and receives services outside their residence, such as:
  - Has medication monitoring, including blood draws, done outside the person's residence, such as at the physician's office, clinic, pharmacy, or health care facility.
  - Receives injections, such as vitamin B-12, outside their residence such as at a clinic.
  - Takes medication through an intrathecal drug pump, also known as a pain pump or internal morphine pump, that requires only intermittent refills and maintenance in the clinic setting but does not require monitoring in their residence.
  - Has a drug delivery implant, such as the birth control implant.
- Is independent with Medication Management; however, a lock box is used.
  - Due to the policy of their provider agency (for example, a hospice agency or a personal care provider agency).
  - To prevent another person or pet from having access to the medication.

    - Solely due to suicidal ideation or substance use issues.
    - Due to taking their medication other than as prescribed.
- Requires Medication Management assistance less often than monthly.
- Does not have a cognitive or memory loss impairment and the person cannot name each of their medications but can tell you what health issues they take the medication for. Examples include but are not limited to when a person cannot name their hypertension medication, such as hydrochlorothiazide, but can tell you, "That little yellow pill is my water pill. I have high blood pressure." Or they can tell you, "I take a pill once a week for my osteoporosis" when they are prescribed alendronate.

Check the appropriate frequency, using guidance provided under 7.5 Person is NOT Independent in Completing and Managing a Health-Related Service, for a person who:

- Due to a physical, cognitive, or memory loss impairment requires supervision, cueing, and/or hands-on assistance with the task of Medication Management.
- Requires assistance with Medication Management at the "Check 1," "Check 2a," or "Check 2b" frequency as on IADL Medication Administration and Medication Management Module 5.14.
- Needs assistance to crush their medication or assistance to put their medication in food, such as applesauce, for it to be taken when it is NOT prepared within one hour of when the dose is to be taken.
- Needs assistance to check their blood glucose level or to adjust their insulin dose given the current blood glucose level.
- Needs assistance to prepare a medication for administration via a feeding tube. For example, crushing a tablet to be diluted and administered through a G-tube when it is NOT prepared within one hour of when the dose is to be taken.
- Has an unstable condition and medication is frequently adjusted and the person needs someone to monitor them for specific medication effects and side effects and report those to the prescriber.
- Has cognitive impairment and has a court-ordered medication.
- Requires assistance with a medication delivered subcutaneous with a pump, such as an insulin pump.
- Due to a cognitive or memory loss impairment, needs someone to assist with the medication because is not self-directing, does not have the cognitive ability to select the proper medication and dosage, and lacks the judgment to understand the medications' purpose, side effects, and report problems.

Exception to determining appropriate frequencies:

Check "weekly" for a person who:

- Only requires assistance with prefilling insulin syringes, as they can typically be completed weekly, since prefilled syringes can be stored in the refrigerator for a week. This task should be indicated at the "Check 1" frequency on IADL Medication Administration and Medication Management.
- Only requires assistance with measuring medication from a larger container to a smaller dosage cup as this can typically be completed weekly. This task should be indicated at the "Check 1" frequency on IADL Medication Administration and Medication Management.

Check "1-3 times/month" for a person who:

- Requires assistance with the filling of a medication box. Medication boxes are typically filled at the "1 to 3 times/month" frequency, since two or more medication boxes can be prefilled at one time. If this usual method does not work well for an individual, more frequent medication set-up may be necessary.
- Has a cognitive or memory loss impairment but takes medication as prescribed, without misuse or error once the medication is set up.
- Only requires oversight due to a memory loss or cognitive impairment for monitoring of effects, side effects, or adjustments. This oversight is captured at a frequency of "Check 1" frequency on IADL Medication Administration and Medication Management.

How to Determine the Frequency: Use the "Person is Independent" column if the person can manage all their medication without any help from another person. If they need assistance from another person with any of the Medication Management activities, select the frequency column according to the guidelines in Module 7.5 – 7.9.

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

- **CASE #1**: Use the Medication Administration column to capture when a person is independent with their insulin injections. If the person is completing their own blood glucose level checks, you would also select in the "Person is Independent" 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 select the "Person is Independent" row for Medication Administration, to reflect that they take their own insulin and pills. In the row for Medication Management, you would select the frequency at which someone must set up the pills. This is typically completed 1-3 times per month.

7.16 Ostomy-Related Skilled Services

Definition: An ostomy is a surgically created opening through the skin into an organ for the discharge of body wastes.

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

Ostomies are named for the organs they access—for instance, colostomy (into the colon or large intestine), ileostomy (into the end of the small intestine), cystostomy (into the bladder), or urostomy (into the urinary tract).

Unskilled tasks related to an ostomy, to EXCLUDE from the HRS Table include:

- Emptying the ostomy bag.
- Reconnecting the bag to the wafer (which is attached to skin).
- Site care consisting of just soap and water, or application of gauze to intact skin.
- Irrigation of bowel ostomy (similar to enema), in a **well-functioning** ostomy (one that has been in place for more than four weeks).

Skilled tasks related to an ostomy to INCLUDE on the HRS Table:

- Changing the wafer (which adheres to the skin and needs to be cut to the proper size to avoid skin breakdown around the ostomy). For a stable ostomy, the wafer is typically changed once every 7 to 10 days.
- Special skin care and application of a wafer for a new ostomy (one that has been in place for less than four weeks), or for a leaky, excoriated (raw), or infected ostomy site.
- Irrigation of new ostomy (one that has been in for place less than four weeks) or one that is functioning **poorly**.

Check this for a person who:

- Needs assistance with an ostomy-related skilled task listed above.

Do NOT check this for a person who:

- Needs assistance with an ostomy-related skilled services provided outside their residence (i.e., in a primary care setting such as a clinic).
- Only needs assistance with an unskilled ostomy-related task.
- Has someone checking/monitoring the ostomy, but the ostomy site has been problem-free.
- Has a drainage tube from a wound or their chest cavity. This type of tube is not considered an ostomy for the purposes of the HRS Table. Review Module 7.30 “Other” Row.
- Has a tracheostomy. Review Module 7.22 Tracheostomy Care.

How to Determine the Frequency: Use the “Person is Independent” column if the person can manage their Ostomy-related Skilled Services without any help from another person. If they need assistance, select the frequency of the task completed most often and according to the guidelines in Module 7.5 – 7.9.

7.17 Positioning in Bed or Chair Every 2-3 Hours

Definition: Moving a person to redistribute pressure applied to their body. Changing a person’s position is a precautionary measure to help prevent bedsores and pneumonia.

Check this for a person who:

- Needs to be repositioned by another person at least every 2-3 hours, in a bed or chair.
- Requires assistance with repositioning from another person to adjust their tilt-in-space wheelchair.

Do NOT check this for a person who:

- Can independently reposition themselves with or without a repositioning device (e.g., bed trapeze, bed rail, tilt-in-space wheelchair).
- Needs assistance to be repositioned less than 3 times/day.
- Needs a verbal prompt to cue them to reposition themselves.
- Can independently reposition themselves with an alternating pressure mattress or wheelchair pad.

How to Determine the Frequency: There are only two frequency options, "3-4 times a day" or "5+ times a day." If the person is positioned by another person every day, select the column that best describes the frequency.

Tip: The LTCFS application will check to ensure the level of help indicated in the Bathing, Dressing, Mobility, Toileting, and Transferring ADLs correlates with the Positioning in bed or chair task on the HRS Table. If the level of help does not correlate between those ADL tasks and the Positioning task, the screener will receive an error message to prompt correction.

7.18 Oxygen and/or Respiratory Treatments: Tracheal Suctioning, C-PAP, Bi-PAP, Nebulizers, IPPB Treatments (Does NOT include inhalers)

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

Oxygen is provided from tanks of compressed gas or from an oxygen concentrator. Oxygen flow (usually 1 to 3 liters/minute) is adjusted by turning a dial to a specified number. Oxygen is delivered to a person through tubing connected to a nasal cannula (2 short plastic prongs at nostrils) or to a mask to the nose, nose and mouth, or a tracheostomy. The tubing often runs through a bottle of distilled water to humidify the oxygen.

Unskilled tasks related to oxygen to EXCLUDE from the HRS Table:

- Connecting, cleaning, or changing oxygen tubing, masks, bottles, etc.
- Refilling the humidifier bottle.
- Refilling portable oxygen tanks.
- Moving the tank/compressor and/or the tubing from room to room.
- Reporting equipment problems, reordering supplies, or reordering oxygen, if the tank(s) gets low, with the oxygen vendor.
- Ensuring oxygen safety (no sparks or flames nearby).
- The oxygen vendor's services.

Skilled tasks related to oxygen to INCLUDE on the HRS Table:

- Placing or removing the nasal cannula or mask.
- Starting the oxygen or adjusting the flow rate based on the person's respiratory status.
- Applying and using a pulse oximetry (which measures blood oxygen levels).
- Providing skilled interventions in response to low blood oxygen (adjusting oxygen flow, repositioning, cueing pursed-lipped deep breathing, etc.) in an acutely unstable condition.

Suctioning is completed when the person is unable to cough up their own secretions.

Unskilled tasks related to suctioning to EXCLUDE from the HRS Table:

- Suctioning only in the mouth (or nostrils).
- Cleaning or replacing the tubing or equipment.

Skilled tasks related to suctioning to INCLUDE on the HRS Table:

- "Deep" suctioning into trachea/windpipe.

Bi-PAP and C-PAP machines are noninvasive devices that provide continuous or bi-level positive airway pressure, provided via a mask, to open the airways and improve oxygenation of the lungs. A person typically only uses a C-PAP or Bi-PAP during sleep. A C-PAP or Bi-PAP is a small electric machine with specific pressure settings and alarm settings, a reservoir for distilled water, and tubing to a mask over the nose or over nose and mouth.

Unskilled tasks related to use of a C-PAP or Bi-PAP to EXCLUDE from the HRS Table:

- Connecting, cleaning, or changing the tubing, mask, bottle, etc.
- Refilling the humidifier bottle.

Skilled tasks related to use of a C-PAP or Bi-PAP to INCLUDE on the HRS Table:

- Placing or removing the C-PAP or Bi-PAP mask.
- Initiating use of the Bi-PAP or C-PAP (starting the machine, ensuring pressures and alarms are correctly set) at night, for nap, or as needed.

Nebulizer: This is a machine that uses pressurized air to turn liquid medication into a fine mist for inhalation. The medication usually comes in a pre-measured plastic vial; the vial top is twisted off, the medication squirted into a plastic chamber, the chamber attached to the tubing, and the tubing attached to the machine and the mouthpiece or mask. The machine is turned on to create an airflow that delivers the medication as a mist the person breathes in through a mouthpiece or a mask, usually over 5 to 10 minutes.

Unskilled tasks related to use of a nebulizer to EXCLUDE from the HRS Table:

- Cleaning or changing the tubing or mask.
- Bringing someone their nebulizer when they need to use it.

Skilled tasks related to use of a nebulizer to INCLUDE on the HRS Table:

- Administering a medicated nebulizer treatment.

Cough Assist Device (e.g., an In-Exsufflator Machine): Helps to clear airway secretions in people unable to cough on their own. It is a machine that creates a few seconds of strong pre-set airflow pressures through tubes to a mask over the mouth and nose. The machine applies inward pressure during inspiration and negative pressure (sucking) to pull secretions out. Treatments are usually done several times daily.

Unskilled tasks related to use of a cough assist device to EXCLUDE from the HRS Table:

- Connecting, cleaning, or changing the tubing or mask.

Skilled tasks related to use of a cough assist device to include on the HRS Table:

- Administering a cough assist treatment.

IPPB Treatments: "IPPB" is an abbreviation for intermittent positive pressure breathing. An IPPB machine provides short-term mechanical ventilation to expand the lungs, deliver aerosol medication, or assist ventilation.

Unskilled tasks related to IPPB Treatments to EXCLUDE from the HRS Table:

- Connecting, cleaning, or changing the tubing or mask.

Skilled tasks related to IPPB Treatments to INCLUDE on the HRS Table:

- Administering an IPPB treatment.

Chest physiotherapy (CPT), chest percussion and postural drainage (P/PD), or use of a percussive vest are all ways to physically loosen secretions in the lungs and move them into major airways where they can be coughed and/or suctioned out. They involve cupped-hand clapping on or vibration of the chest wall and back; the percussive vest is a machine replacement of a person doing it. These treatments are likely to be prescribed several times per day during acute pneumonia in someone unable to cough on their own or daily for someone with cystic fibrosis.

Unskilled tasks related to CPT, P/PD, or use of a percussive vest to EXCLUDE from the HRS Table:

- Connecting, cleaning, or changing the tubing or mask.

Skilled task related to CPT, P/PD, or use of a percussive vest to INCLUDE on the HRS Table:

- Administering any of these treatments.

Check this for a person who:

- Needs assistance with a skilled task listed above to use oxygen or receive a respiratory treatment as defined above.

Do NOT check this for a person who:

- Needs assistance with an unskilled task listed above to use oxygen or receive a respiratory treatment.
- Uses oxygen independently and the screener selects the frequency of help needed from another person at 1-3 times/month to reflect the frequency of the oxygen vendor's trips (usually every few weeks) to provide new oxygen tanks. For this person, the frequency selection would be "Person is Independent."
- Uses a handheld inhaler or aerosol, which has pre-metered doses. Review Module 7.14 Medication Administration.
- Needs to use a mechanical volume ventilator (see Module 7.28).
- Needs cueing to not smoke when using oxygen.
- Chooses not to use their respiratory treatment, such as CPAP or nebulizer (the person is declining the task itself). If the individual has declined to complete the **health-related service or task itself**, and is able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should leave the default selection of "N/A." In this situation, the person has no need for assistance with the health-related service or task because the health-related service or task is not occurring.

- If the person is **not** able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select the frequency of need.
- If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes, and the selection of a need might be appropriate.

- Is prescribed to use a respiratory treatment device (for example, a C-PAP or nebulizer) but does not currently have a working device.
- Requires tracheal suctioning but does not have a tracheostomy.

How to Determine the Frequency: Use the "Person is Independent" column if the person can manage their Oxygen and/or Respiratory Treatments tasks without help from another person. If they need assistance, select the frequency of the task completed most often according to the guidelines in Module 7.5 – 7.9.

7.19 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, and it is provided at a hemodialysis center. Peritoneal dialysis is where the person's abdominal cavity is used to filter the blood and it is completed at the person's residence.

Arteriovenous Fistulas/Shunts/Grafts
Most dialysis patients will have a catheter in their forearm that loops from a vein to an artery, to allow easy access for dialysis and blood draws. There are two entry points (at the vein and artery), which are usually covered by one large sterile dressing, with the U-shaped catheter secured to the dressing and clamped off. This is called an arteriovenous (A-V) fistula or shunt or graft. Skilled cares for the A-V shunt are usually completed in the dialysis center and are recorded in the Dialysis row of the HRS Table. There are usually not any other skilled tasks completed between dialysis treatments. In the rare case when additional skilled cares to an A-V shunt are needed, that assistance would be recorded in the IV row. An example would be daily site care/dressing changes to an A-V shunt site (see Module 7.13).

Check this for a person who:
- Is undergoing dialysis at their residence **OR** in a dialysis center.

Do NOT check this for a person who:
- Needs transportation to the dialysis center; transportation is captured as an IADL task (see Module 5.18).

This row is an exception to the rule that recorded HRS tasks must only be those provided in the person's residence.

How to Determine the Frequency: If the person is receiving hemodialysis, capture the frequency of dialysis treatments at the dialysis center. Most people receive this type of dialysis three times a week.

If the person is undergoing peritoneal dialysis, this usually occurs overnight in the person's residence. The person is often independent with this task, or they could have a nurse or family member assisting. If assistance is needed from another person, record the tasks of connecting and disconnecting the peritoneal dialysis as two separate tasks.

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

7.20 TPN (Total Parenteral Nutrition)

Definition: This is a type of liquid nutrition administered through an IV. It supplies all 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.

Check this for a person who:
- Receives TPN at their residence.

Do NOT check this for a person who:
- Receives tube feedings, which are a different type of supplemental nutrition (see Module 7.23).
- Receives IV medications, IV fluids, or IV line flushes, which has a separate HRS Table row, unless they receive that specific HRS task (see Module 7.13).

How to Determine the Frequency: Use the "Person is Independent" column if the person can manage their TPN without help from another person. If they need assistance, select the frequency column according to the guidelines in Modules 7.5 – 7.9.

Sometimes TPN runs into the person continuously. If this is the case **and** they need help from another person, select the frequency this hook-up occurs, which is usually 3-4 times a day.

7.21 Transfusions

Definition: An infusion of 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. A skilled health care provider would need to administer a transfusion.

Check this for a person who:
- Receives transfusions at their residence, in a clinic, or hospital.

Do NOT check this for a person who:

- Receives IV medications, IV fluids, or IV line flushes, which has a separate HRS Table row, unless they receive that specific HRS task (see Module 7.13).

This row is an exception to the rule that HRS tasks recorded must be only those provided in the person's residence.

REMINDER: When a person receives transfusions do not also select the IV Medications, fluids, or IV line flushes row, unless they receive that specific HRS task (see Module 7.13).

How to Determine the Frequency: Use the "Person is Independent" column if the person can manage their Transfusions without help from another person. If the person receives transfusions at their residence, in a clinic, or hospital, select the frequency column according to the guidelines in Module 7.5 – 7.9.

7.22 Tracheostomy Care

Definition: A tracheostomy is an artificial opening through the throat into the trachea or windpipe. It is kept open with a double-layered tube or cannula.

The outer cannula is held in place by ties around the neck and is changed once a month. The inner cannula can be slid out and cleaned a few times a day. If mucous plugs up the tube, the inner cannula can be slid out, usually bringing the plug with it, and leaving the outer cannula clear. The inner cannula can then be cleaned and slid back in.

Tracheostomy care tasks include:

- Removing, cleaning, or replacing the inner cannula.
- Replacing the outer cannula.
- Completing tracheostomy site care, which includes cleansing the skin around the tracheostomy opening, or applying ointment or dressing.
- Changing the straps or ties that hold the tube in place.

Check this for a person who:

- Needs assistance with any of the tracheostomy care tasks listed above.

Do NOT check this for a person who:

- Needs assistance with tracheostomy care completed outside their residence (e.g., in a clinic or hospital).
- Needs assistance wiping or applying gauze to a partially healed tracheostomy in which the tube is no longer needed and was removed.
- Only needs assistance suctioning their trachea. Review Module 7.18 Oxygen and/or Respiratory Treatments.

How to Determine the Frequency: Use the "Person is Independent" column if the person can complete their Tracheostomy Cares without help from another person. If they need assistance, select the frequency of the task completed most often according to the guidelines in Module 7.5 – 7.9.

7.23 Tube Feedings

Definition: The administration of nutritionally balanced liquefied foods or nutrients, including water, through a tube. If a person cannot eat or cannot eat safely to obtain adequate nutrition, a feeding tube may be placed in the stomach or upper small intestine to provide 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 tube down the nose (or mouth) and esophagus to the stomach. An NG tube is typically used short term due to risk of aspiration into their lungs and discomfort in their nose and throat.
- PEG or G-tube (Percutaneous endoscopic gastrostomy) or "Button": A tube through the abdomen into the stomach.
- Duodenostomy: A tube through the abdomen into the small intestine just below the stomach. (Commonly called a G-tube.)
- J-tube (Jejunostomy): A tube goes through the abdomen into the second part of the small intestine just below the stomach. (Commonly called a J-tube.)

Tube feeding tasks include:

- Hooking up the bag of nutrition solution, tubing, and pump.
- Starting the drip.
- Ensuring the proper flow rate.
- Disconnecting the tube feeding, flushing the tube or button (feeding port), and capping the tube off.
- Administration of bolus feeding by syringe.
- Flushing a tube that is not used for nutrition or medications to maintain functioning.
- Site care for an excoriated (raw) feeding tube site.

Check this for a person who:

- Needs assistance with any of the tube feeding tasks as listed above.

Do NOT check this for a person who:

- Only needs assistance with tube feedings completed outside their residence.
- Only needs assistance with soap and water cleaning around their feeding tube site.
- Can eat without any problems and a G-tube is only used to administer medication. In this circumstance, flushing the tube after giving the medication is not captured on this row, but is a Medication Administration task (see Modules 5.14 and 7.14).
- Receives TPN. TPN is a different type of supplemental nutrition (see Module 7.20).

How to Determine the Frequency: Use the "Person is Independent" column if the person can complete their Tube Feedings without help from another person. If they need assistance, select the frequency of the task completed most often and according to the guidelines in Module 7.5 – 7.9.

7.24 Ulcer – Stage 2

Definition: An area of partial-thickness skin loss, presenting superficially as a pink/red area, abrasion, blister, or small crater. This is only the very beginning of skin breakdown. Ulcer – Stage 2 wound care will include cleansing or dressing the wound.

Check this for a person who has been diagnosed as having an Ulcer – Stage 2 and:

- Needs assistance with prescribed and completed Ulcer – Stage 2 wound care provided in their residence.
- Needs assistance with prescribed and completed wound care provided outside their residence because the Ulcer – Stage 2 wound care cannot be provided in their residence.
- Has whirlpool or water therapy provided by a physical therapist, even if this type of Ulcer – Stage 2 wound care is provided outside of their residence.

Do NOT check this for a person who:

- Needs assistance with prescribed and completed Ulcer – Stage 2 wound care provided outside their residence if it can be provided in their residence.
- Needs assistance with routine skin care (e.g., applying non-prescription lotion).
- Needs assistance monitoring their skin's integrity when they are at risk for impaired skin integrity.
- Only needs assistance changing a band aid to the area.

REMINDER: On the HRS Table, if a person has more than one type of skin ulcer, record their need for assistance on both the Ulcer – Stage 2 and the Ulcer – Stage 3 or 4 rows.

How to Determine the Frequency: Use the "Person is Independent" column if the person can complete their Ulcer – Stage 2 wound care without help from another person. If they need assistance, select the frequency of the task completed most often and according to the guidelines in Module 7.5 – 7.9.

7.25 Ulcer – Stage 3 or 4

Definition: A Stage 3 ulcer has full thickness skin loss and presents as a deep crater with or without affecting the adjacent tissue. A Stage 4 ulcer has full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. Ulcer – Stage 3 or 4 wound care will include cleansing, packing, or dressing the wound.

Check this for a person who has been diagnosed as having an Ulcer – Stage 3 or 4 and:

- Needs assistance with prescribed and completed Ulcer – Stage 3 or 4 wound care provided in their residence.

- Needs assistance with prescribed and completed Ulcer – Stage 3 or 4 wound care provided outside their residence because the wound care cannot be provided in their residence.
- Has whirlpool or water therapy provided by a physical therapist, even if this type of wound care is provided outside of the person's residence.

Do NOT check this for a person who:
- Needs assistance with prescribed and completed Ulcer – Stage 3 or 4 wound care provided outside their residence if it can be provided in their residence.
- Needs assistance with routine skin care (e.g., applying non-prescription lotion).
- Needs assistance monitoring their skin's integrity when they are at risk for impaired skin integrity.
- Only needs assistance changing a band aid to the area.

REMINDER: On the HRS Table, if a person has more than one type of skin ulcer, record their need for assistance on both the Ulcer – Stage 2 and the Ulcer – Stage 3 or 4 rows.

How to Determine the Frequency: Use the "Person is Independent" column if the person can complete their Ulcer – Stage 3 or 4 care without help from another person. If they need assistance, select the frequency of the task completed most often and according to the guidelines in Module 7.5 – 7.9.

7.26 Urinary Catheter-Related Skilled Tasks (Irrigation, Straight Catheterizations)

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 typically with straight catheterization, also known as "straight caths" or "intermittent urinary catheterizations" and are an "in and out" catheterization usually completed every 4 or 8 hours. Long-term use is typically with an indwelling catheter that is left in place and is connected to a drainage bag.

Urinary catheter-related skilled tasks include:
- Changing (replacing) the catheter.
- Irrigating the catheter.
- Completing a straight (in and out) catheterization.
- For a suprapubic catheter, completing site care (i.e., cleansing the skin around the opening, applying ointment, or applying a dressing).

Check this for a person who:
- Needs assistance with any of the skilled tasks listed above.
- Independently completes their straight catheterizations.

Do NOT check this for a person who:

- Receives routine catheter care for an indwelling catheter (that is not a suprapubic catheter). Routine catheter care is usually just soap and water cleansing, which is a normal part of bathing.
- Uses a condom catheter.

REMINDER: If Urinary Catheter-Related Skilled Tasks is selected on the HRS Table, then the Toileting ADL, "Uses urinary catheter" should also be selected.

How to Determine the Frequency: Use the "Person is Independent" column if the person can complete their Urinary Catheter-Related Skilled Tasks without help from another person. If they need assistance, select the frequency of the task completed most often and according to the guidelines in Module 7.5 – 7.9. If an indwelling catheter is only used at night, the task of putting it in and taking it out are two separate tasks.

7.27 Other Wound Cares (Not Catheter Sites, Ostomy Sites, IVs, or Ulcer – Stage 2, 3, or 4)

Definition: Use this row when a person needs wound care from a postsurgical incision or puncture, orthopedic pin site, postsurgical drainage site, serious burn, traumatic injury, or serious infection. Other Wound Cares can include, but are not limited to, care for a boil, cellulitis, stasis dermatitis, or stasis ulcer. This prescribed wound or site care includes cleansing, packing, or dressing the wound or site.

Check this for a person who:

- Needs assistance with prescribed and completed wound care provided in their residence for a type of wound listed in the above definition.
- Has a history of infection or a need to seek medical attention when they pick or rub their skin and that behavior has resulted in an open area needing treatment.
- Needs assistance with prescribed and completed wound care provided outside their residence because the Other Wound Cares cannot be provided in their residence.
- Has whirlpool or water therapy provided by a physical therapist, even if this type of wound care is provided outside of the person's residence.

Do NOT check this for a person who:

- Needs assistance with a catheter site, ostomy site, or IV site (including a PICC line or central line site).
- Only needs assistance changing a band aid to the area.
- Already has the Ulcer – Stage 2 or Ulcer – Stage 3 or 4 row(s) selected 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.
- Needs assistance with wound care provided outside their residence if it can be provided in their residence.
- Receives site care to an area where an IV was taken out and an IV is no longer in place.
- Needs assistance with routine skin care (e.g., applying non-prescription lotion).

- Needs assistance monitoring their skin's integrity when they are at risk for impaired skin integrity.

REMINDER: On the HRS Table, if a person has more than one type of wound, record their need for assistance on the applicable HRS Table rows.

How to Determine the Frequency: Use the "Person is Independent" column if the person can complete their Other Wound Cares without help from another person. If they need assistance, select the frequency of the task completed most often and according to the guidelines in Module 7.5 – 7.9.

7.28 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 this row when a person needs to use a mechanical volume ventilator.

Check this for a person who:
- Uses a ventilator as defined above.

Do NOT check this for a person who:
- Uses a C-PAP or Bi-PAP machine. Review Module 7.18 Oxygen/Respiratory Treatments row.

How to Determine the Frequency: Use the "Person is Independent" column if the person can complete their Ventilator-Related Interventions without help from another person. If they need assistance, select the frequency of the task completed most often and according to the guidelines in Module 7.5 – 7.9.

7.29 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 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, tasks delegated or assigned to others, and 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 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 selected:

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. **Cannot be captured in any other row of the HRS Table.**

REMINDER: An individual's need for telephone contact with a nurse can be recorded on this row 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 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 mellitus. She is frail and unstable, with medication changes based on her vital signs and comfort level. However, her ongoing 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 this assistance is captured in the Ulcer – Stage 3 or 4 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. These are captured in the Dialysis row, not in the RNAI row.

Check this for a person who:

- Meets the required 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 selected recording all nursing assessment and interventions the individual needs.
- Has a cognitive impairment but does not have an acute, unstable health condition requiring nursing assessments and interventions.
- 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.
  - 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 include, but are not limited to:
    - PRN medications for 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 glucose test result).
    - When the individual's lower legs retain fluid, they are to elevate their legs above their heart for at least 30 minutes.
    - When the individual becomes short of breath, they are to use their oxygen.
  - Has a personal care worker or others who perform delegated tasks that need nursing oversight and supervision.
  - Has nursing assessments only because they are routinely provided by the agency or residential care facility.
  - Has nursing care management activities.
  - Has RN or NP participation on an interdisciplinary team.
  - Receives skilled nursing care provided in a clinic setting for dialysis, wound care, transfusions, or other services noted elsewhere on the HRS Table.
  - Has a history of skin breakdown and has an RN or NP check the integrity of their skin.
  - Receives ventilator-related interventions completed by an RN or NP, without first confirming the care need meets the required four criteria.
  - Needs data collection. Examples include but are not limited to:

- The documenting of weights, blood pressure, heart rate, blood sugars, seizure activity, etc., almost always involves the effectiveness, side effects, or adjustments of medication 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).

How to Determine the Frequency: Use of the "Person is Independent" column is not an option for the RNAI row. If the person needs assistance from another person, select the frequency column according to the guidelines in Module 7.5 – 7.9.

7.30 "Other" Row

Check this for a person who:

- Needs health-related services provided in their residence that you are unable to capture on any other row of the HRS Table.
- Has a chest or abdomen drainage tube.
- Needs assistance to use their TENS (transcutaneous electrical nerve stimulation) unit.

Do NOT check this for a person who:

- Needs assistance with a task that should be recorded elsewhere on the screen or should only be included in the screen's Notes section to further describe the person's needed service.

How to Determine the Frequency: Use the "Person is Independent" column if the person can complete their Other tasks without help from another person. If they need assistance, select the frequency of the task completed most often, according to the guidelines in Module 7.5 – 7.9.

7.31 Skilled Therapies: PT, OT, SLP (Any One or a Combination, at Any Location)

Definition: Use of this row reflects the person is receiving services from a physical therapist, occupational therapist, or speech-language pathologist.

- **Physical Therapist (PT)**: A physical therapist helps with the body's recovery after a person'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 cane, walker, or wheelchair.
- **Occupational Therapist (OT)**: An occupational therapist helps the person 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 residence or for working.

- **Speech Therapist (SLP)**: A speech-language pathologist helps with speaking, listing, reading, and writing problems. In addition, they help the person with swallowing problems or who have difficulties in thinking and memory. When a person has speaking difficulties, the speech-language pathologist can help the person and others in their life develop alternative ways to communicate with each other.

Check this for a person who:
- Receives therapies from a licensed PT, OT, SLP at any location. This row is an exception to the rule that HRS tasks provided in the person's residence can be recorded on the HRS Table.
- Receives therapy from a licensed PT, OT, or SLP during the school year while attending high school.

Do NOT check this for a person who:
- Receives PT, OT, or SLP from someone other than a licensed PT, OT, or SLP. This includes exercises completed with a family member, someone significant in the person's life, caregiver, physical therapy assistant, or an occupational therapy assistant, even if under the instructions of an OT, PT, or SLP. Review Module 7.12 Exercises/Range of Motion.
- Needs assistance with the completion of their range of motion exercises or completes these exercises independently. Review Module 7.12 Exercises/Range of Motion.
- Receives therapy other than physical therapy, occupational therapy, or speech-language pathology. Those types of therapies include, but are not limited to, the following: art, cardiac, massage, music, pulmonary, or therapeutic horseback riding.
- Has a current physician's order for PT, OT, or SLP but that therapy is not available, and they are on a wait list. They lack access to the therapy but are planning on accepting the service. In this case, do not select "Person is Independent" or any other "Frequency of Help/Services Needed from Other Persons" option.
- Chooses not to have skilled therapy (the person is declining the task itself). If the individual has declined to complete the **health-related service or task itself,** and is able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should leave the default selection of "N/A." In this situation, the person has no need for assistance with the health-related service or task because the health-related service or task is not occurring.
    - If the person is **not** able to perceive and recognize the potential risk or negative health outcome that could result from declining the task, the screener should select the frequency of need.
    - If a person has a legal guardian, an activated power of attorney for health care, or is currently involved with adult protective services, that person may be considered not able to perceive and recognize potential risks or negative health outcomes, and the selection of a need might be appropriate.

REMINDER: Once a person no longer receives OT, PT, or SLP, their LTCFS should be updated to reflect that the therapy is no longer provided. For example, at the time of the screening, the person was receiving OT and PT on a short-term basis while rehabilitating from hip replacement surgery and would most likely complete OT and PT within several months of surgery.

How to Determine the Frequency: There are only two frequency options, “1-4 sessions/week” or “5+ sessions/week.” Select the frequency column which reflects the combined number of the person’s OT, PT, and SLP sessions each week.

For example: A person receives PT and OT once each day, 2 days per week and receives SLP once a day, 3 days per week. This adds up to seven sessions per week to record in the “5+ sessions per week” column.

Module #8: Communication and Cognition

Definitions:

Cognitive Impairment: A cognitive impairment in the Adult LTCFS is defined as a permanent impairment of thought due to a severe and persistent mental illness, dementia, brain injury, intellectual/developmental disability, or other organic brain disorder.

- A cognitive impairment does not include temporary impairment due to medications and/or substance use intoxication.
- A cognitive impairment does not include temporary impairment due to a temporary medical condition such as infection, electrolyte imbalance, or dehydration.

Safely: Means without significant risk of harm to oneself or others. Wis. Admin. Code § DHS 10.33(1)(d).

Significant, negative health outcome: A significant, negative health outcome has occurred when a person experiences one or more of the following symptoms: shortness of breath, dizziness, chest pain, exhaustion, falls, incontinence, or debilitating pain **to the point where the individual is unsafe and another person should be present to help with some or all of the components of a task**. Requiring additional time to complete a task is not a significant, negative health outcome in and of itself.

8.1 Selecting Primary and Secondary Diagnoses

To be selected as a primary or secondary diagnosis that causes a need for assistance or support from another person, the need must be due to a physical, cognitive, or memory loss impairment. Additional guidance can be found in Module 4.4 Identifying Primary and Secondary Diagnoses.

8.2 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 LTCFS, a person's ability to communicate should be assessed in the context of their residence and not regarding 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:

- ☐ 0: Can fully communicate with no impairment or only minor impairment (for example, slow speech)

- ☐ 1: Can fully communicate with the use of an assistive device
- ☐ 2: Can communicate ONLY BASIC needs to others
- ☐ 3: No effective communication

0: **(Can fully communicate with no impairment or only minor impairment [for example, slow speech])**

Check "0" for a person who communicates fully (feelings, thoughts, complex or abstract ideas beyond basic needs):

- With a speech impediment (stutters, slurred speech, etc.) but can 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 can 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 "1" 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 "2" 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 (for example, 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 can 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 (for example, a person with late-stage dementia, a neurodegenerative disease, profound intellectual disability, etc.).

REMINDER: On the LTCFS, 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 cannot 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.

8.3 Memory Loss

Capturing memory loss in Module 8 is different from choosing memory loss as a primary or secondary diagnosis. Refer to Module 4.3 Completing the Diagnoses Table to find out when memory loss may be selected as a diagnosis. This section is intended for people who are showing signs of memory loss even if they do not have a diagnosis of memory loss.

This section has three types of memory loss that can be captured: short-term memory loss, unable to remember things over several days or weeks, and long-term memory loss.

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

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 or complete a memory screen to support what is selected. A screener should observe and collect significant evidence to support their selection.

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

Memory Options (Check all that apply; 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.

"0" (No memory impairments evident during screening process): When "0" 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 a 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 (for example, a 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 (for example, 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 (for example, 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.

8.4 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 5.

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 (for example, whether to watch TV, work on a puzzle).
- 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 are not limited to:

- Household or vehicle repairs.
- Larger purchases (for example, new vehicle, appliances, furniture).
- Purchase of insurance (for example, health, homeowner, or vehicle).
- Applying for assistance (for example, 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 "0" 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 "1" 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 (for example, 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 (for example, 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 (for example, 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 "2" 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 "3" 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.

8.5 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 LTCFS as an ADL or an IADL care task.**

Excluded in the module are those cares **NOT listed on the LTCFS 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 LTCFS.

In this section, while a person must have a cognitive impairment to indicate they are *physically resistive* to care, it is not necessary that they have a guardian or other authorized representative appointed or activated (examples include activated power of attorney for health care, durable power of attorney). 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

0: **No** includes, but is not limited to, a person who:

- Is physically resistive or uncooperative, to care(s), but does not have a cognitive impairment.
- Has a cognitive impairment and is uncooperative, such as crying, repeatedly saying “No,” or refusing, when care is suggested or during the provision of their care(s) but is not physically resistive to 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.

REMINDER: This section addresses physical combativeness during the provision of ADLs and IADLs captured on the LTCFS (for example, bathing or toileting). It does not address ongoing behavior

patterns that involve violent or offensive acts. Such behaviors requiring interventions are captured in Module 7 Health-Related Services Table and Module 9 Behaviors/Mental Health.

REMINDER: A screener would NOT select "Yes" for an individual able to perceive potential risk or negative outcome who refuses care. All adults able to perceive and recognize the potential risk or negative health outcome that could result from declining the care 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 #9: Behavioral Health

Definition:

Cognitive Impairment: A cognitive impairment in the Adult LTCFS is defined as a permanent impairment of thought due to a severe and persistent mental illness, dementia, brain injury, intellectual/developmental disability, or other organic brain disorder.

- A cognitive impairment does not include temporary impairment due to medications and/or substance use intoxication.
- A cognitive impairment does not include temporary impairment due to a temporary medical condition, such as infection, electrolyte imbalance, or dehydration.

9.1 Overview of the Behaviors/Mental Health Module

This module relies on history, the screening interview process, and the assessment and care planning processes (including collateral contacts) to accurately gather and record information about symptoms and behaviors exhibited by a person who is being screened for functional eligibility.

Completion of any part of this module does not supersede requirements to report or refer persons for protective services, or other interventions, as specified by law or best practice.

Preventions and interventions include, but are not limited to, those:

- Providing support to prevent a behavior.
- Having someone present to prevent the person from exhibiting the behavior.
- Redirecting the person with behaviors when they exhibit the behavior.
- Physically preventing the person from exhibiting the behavior.
- Monitoring the person when they exhibit a behavior.
- Responding to problems caused by the person's behavior.

When completing Module 9 of the LTCFS, select the option that most accurately reflects the frequency of intervention needed for this behavior.

When a screener needs to record a behavioral concern that does not clearly "fit" into a common category (i.e., wandering, self-injurious behavior, or offensive/violent behavior), the behavior should be described in the Notes section of the LTCFS.

Many symptoms and behaviors that are recorded during completion of Module 9 will be included in a written behavioral plan. A behavioral plan can be developed by a psychiatrist, psychologist, behavioral specialist, interdisciplinary team, or a long-term care participant's family. These plans typically involve the use of professional or non-professional caregivers. They are typically written plans but can be informal when all parties caring for the person are well aware of strategies to prevent the behavior(s) and/or intervene when the behavior is exhibited.

REMINDER: The screener should document a person's NEEDS, not just the services or assistance the person is currently receiving. When a person with an identified need is **not** receiving assistance, or is refusing the service, the screener should still capture the need for the assistance while completing Module 9 of the LTCFS.

9.2 Wandering

For a person with cognitive impairments, **wandering is defined as**: unsafely leaving or attempting to leave an immediate area, such as a home, community setting, or workplace without informing others **and the behavior requires intervention**. A person may still exhibit wandering behavior even when elopement is impossible due to preventative measures, such as facility security systems and bed and wheelchair alarms.

Wandering is the only behavior recorded during the completion of Module 9 on the LTCFS for which a cognitive impairment must be present. A cognitive impairment includes impairment of thought due to a severe and persistent mental illness, dementia, brain injury, intellectual/developmental disability, or other organic brain disorder. Temporary impairment due to intoxication from substance use is not included in the definition of cognitive impairment.

Wandering Options:

- ☐ 0: Does not wander
- ☐ 1: Daytime wandering, but sleeps nights
- ☐ 2: Wanders during the night, or during both day and night

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

Check this for a person who, due to a cognitive impairment:

- Wanders and requires a behavioral plan to prevent the behavior and/or to intervene when the behavior is exhibited.
- Wanders and requires a behavioral plan when in a new situation but does not wander in routine and familiar situations.
- Elopes or attempts to elope from their residence and requires a behavioral plan.

Do NOT check this for a person who:

- Does not have a cognitive impairment.
- Purposefully tries to leave their immediate area (residence, community setting, workplace, etc.) and they are safe.
- Attempts to leave, or leaves their residence, only when intoxicated or to use alcohol or other substances.
- Paces within their residence due to anxiety, nervousness, or boredom.
- Roams within their residence but **does not require interventions**. For example, a person may roam about within their residential facility, but not attempt to elope.
- Has a sleep disorder, such as sleepwalking or sleep talking.

- Has as the **only** response in their behavioral plan that someone call 911 for emergency assistance or administers a PRN medication.
- Carries a global positioning system (GPS) device to permit tracking of the person.

9.3 Self-Injurious Behaviors

Self-injurious behavior is defined as: behavior that causes, or is likely to cause, injury to one's own body **and** requires intervention as part of a behavioral support plan. Self-injurious behaviors are physical self-abuse and do not include the absence of self-care or behaviors that may have unhealthy consequences.

An individual does not need to have a cognitive impairment to make a selection for self-injurious behaviors in Module 9.

Self-Injurious Behaviors Options:

- ☐ 0: No injurious behaviors demonstrated
- ☐ 1: Some self-injurious behaviors that require interventions weekly or less
- ☐ 2: Self-injurious behaviors that require interventions 2 to 6 times per week OR 1 to 2 times per day
- ☐ 3: Self-injurious behaviors that require intensive one-on-one interventions more than twice each day

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

Check this for a person who:

- Requires a behavior plan to either prevent the behavior and/or to intervene when the behavior is exhibited.
- Exhibits self-abuse that causes, or is likely to cause, self-injury (for example, hitting, biting, head banging, etc.).
- Eats inedible objects (for example, person has pica).
- Has excessive thirst manifested by abnormal fluid intake (for example, person has polydipsia).
- Engages in self-injury that requires prevention and/or intervention (for example, person cuts their skin).

Do NOT check this for a person who:

- Smokes, uses alcohol or other substances, or misuses medications.
- Is sexually promiscuous.
- Makes poor eating choices, given their physical health. Examples include consumption of a diet high in sugar by a person with insulin-dependent diabetes mellitus and failure to follow a recommended low-fat diet.
- Has a habit that is harmless and is unlikely to offend others. Examples include repetitive tapping, rocking, or finger waving.
- Has or seeks multiple body tattoos or piercings.
- Rubs their skin or scabs without the need for medical intervention beyond application of a band aid.

- Has suicidal ideations or history of attempting suicide but has no current preventions and/or interventions. These thoughts or actions should be captured in the Mental Health section of Module 9.
- Has anorexia- or bulimia-related behaviors.
- Has a self-managed, self-help plan of action to prevent self-injurious behavior or a plan that includes steps to take in response to their own displays of self-injurious behavior that **does not require that intervention to be initiated by another person**.
- Has as the **only** response in their behavioral plan that someone call 911 for emergency assistance, administers a PRN medication, or participates in professional mental health services.
- Exhibits behavior(s) only when intoxicated due to alcohol or other substance use.

9.4 Offensive or Violent Behavior to Others

Behavior that is **offensive to others or violent toward others is defined as**: behavior that causes, or can reasonably be expected to cause, discomfort or distress to others or threatens to cause emotional or physical harm to others. The disturbing behavior impacts others in the person's community, such as others in a facility, neighbors, or community at large, and requires a behavioral plan to either prevent the behavior or intervene when the behavior is exhibited.

An individual does not need to have a cognitive impairment to make a selection for offensive or violent behavior to others in Module 9.

Offensive or Violent Behavior to Others Options:

- ☐ 0: No offensive or violent behaviors demonstrated
- ☐ 1: Some offensive or violent behaviors that require interventions weekly or less
- ☐ 2: Offensive or violent behaviors that require interventions 2-6 times per week OR 1-2 times per day
- ☐ 3: Offensive or violent behaviors that require intensive one-on-one interventions more than twice each day (list behavior)

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

Check the appropriate option for a person who:

- Requires a behavior plan to either prevent the behavior and/or to intervene when the behavior is exhibited.
- Disrobes or masturbates in front of others.
- Engages in inappropriate touching or sexual advances toward others.
- Spits at or on others.
- Urinates or defecates in inappropriate places (for example, living room, front porch) or on another person, or the act of spreading urine or feces.
- Screaming incessantly.
- While conversing, uses profanity that is offensive and threatening to a point where law enforcement is typically contacted to intervene.
- Verbally and physically threatens others, including, but not limited to aggressive gestures or a raised fist, to a point where law enforcement is typically contacted to intervene.

- Tortures, maims, or otherwise abuses animals.
- Strikes out at, hits, kicks, bites, or otherwise batters others.
- Commits or has a history of sexual aggression, pedophilia, or arson, and the behavior continues to be an active concern.

Do NOT check Offensive or Violent Behaviors to Others for a person who:

- While conversing, uses profanity that is not offensive or threatening to a point where law enforcement would typically be contacted to intervene.
- Uses profanity or racial slurs on a routine basis.
- Hoards items.
- Has poor housekeeping or cleaning skills or practices.
- Steals items.
- Has poor personal hygiene. Examples may include but are not limited to excessive body odor, including strong urine or fecal odor.
- Is uncooperative with the performance of a task.
- Enters another person's living space without permission.
- Has a difficult personality. Examples include but are not limited to a person who is obstinate, vulgar, ill-tempered, or does not get along with their family members or caregivers.
- Exhibits behavior(s) that may indicate a need for medical treatment, mental health treatment, or substance use treatment, but does not require an intervention. Examples include but are not limited to a person with an anxiety disorder who needs frequent reassurance, or a person with obsessive-compulsive disorder who frequently checks whether a door is locked.
- Has an appearance, or mannerisms, that may elicit social prejudice, such as avoidance or stigmatization. Examples include but are not limited to a person who mutters, talks to themselves, makes unusual or unexpected vocalizations, or has body ticks.
- Has as the **only** response in their behavioral plan that someone call 911 for emergency assistance, administers a PRN medication, or participates in professional mental health counseling.
- Exhibits behavior(s) only when intoxicated due to alcohol or other substance use.

9.5 Mental Health Needs and Substance Use Disorder Questions

It is estimated that between 40 and 70 percent of long-term care consumers also have mental health concerns and/or substance use disorders.

It is recognized that many people will not divulge behavioral health information during the screening process. However, behavioral health information is important to the long-term care program in which a person chooses to enroll to ensure that all needs of each person are considered during assessment, care planning, and quality assurance activities. **Screeners should ask about mental health and substance use needs and diagnoses when confirming physical health diagnoses and determining the need for health-related services.**

Screeners should use their professional interviewing skills and observation to elicit the most accurate possible answers to these questions. The importance of a tactful and sensitive approach

when interviewing people about their behavioral health needs cannot be overstated. Best practice includes the following:

- Do not read any behavioral health sections of the LTCFS to the person verbatim. Rather, use common language and non-judgmental words to elicit information from the person being screened.
- Do not provide any behavioral health sections of the LTCFS to the person being screened, their family, or caregivers in the form of a checklist for their completion. Rather, maintain familiarity with the behavioral health sections of the LTCFS and collect information to complete these sections during the screening interview.

Mental Health Needs Options (screener may select only one of three options):

- ☐ 0: No mental health problems or needs evident. No symptoms that may be indicative of mental illness, not on any medications for psychiatric diagnosis.
- ☐ 1: No current diagnosis. Person may be at risk and in need of some mental health services. (Examples include symptoms or reports of problems that may be related to mental illness, requests for help by the person or family/advocates, or risk factors for mental illness. Examples of risk factors are symptoms of depression that have lasted more than two weeks and/or interfere with daily life, recent trauma, or loss.)
- ☐ 2: Person has a current diagnosis of mental illness.

A current diagnosis of mental illness does not need to be limited to a major mental illness. This diagnosis may include anxiety disorders, depression, or personality disorders. 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, antidepressants are prescribed for other reasons than depression, such as chronic pain. Contact a health care professional to determine the condition for which an antidepressant is prescribed. This applies when selecting options on the Diagnoses Table as well as the mental health question on the LTCFS. Screeners are never to deduce, infer, or otherwise "make up" diagnoses.

REMINDER: If mental health needs are identified as "2: Person has a current diagnosis of mental illness," then a corresponding diagnosis under H on the Diagnoses Table must be checked.

Substance Use Disorder Options (screener may select only one of three options):

- ☐ 0: No substance use issues or diagnosis evident at this time.
- ☐ 1: No current diagnosis. Person or others indicate(s) a current substance use problem, or evidence suggests possibility of a current problem or high likelihood of recurrence without significant ongoing support or interventions. Examples include police intervention, detox, history of withdrawal symptoms, inpatient treatment, job loss, or major life changes.
- ☐ 2: Person has a current diagnosis of substance use disorder.

The information collected from the mental health and substance use disorder questions play no role in the determination of functional eligibility. They are informational for ADRCs and Tribal ADRS and the long-term care program in which the person enrolls. These questions may be used for quality assurance and improvement activities to ensure that mental health or substance use

disorders noted in any person's LTCFS are being addressed by the long-term care program in which the person enrolls.

9.6 Behavioral Information Supplement

The Behavioral Information Supplement collects information about symptoms and actions that are consistent with behavioral health needs. Collection of this information may assist care management staff to identify symptoms and actions on the part of program members that may indicate a need to develop new approaches to the care and supervision provided to these individuals.

The Behavioral Information Supplement is not completed by screeners at ADRCs or Tribal ADRS. Screeners at managed care organizations and IRIS consultant agencies may choose to complete the Supplement but are not required to complete it. If a managed care organization or IRIS consultant agency chooses to complete the Supplement, the screener will need to select "Behavioral Info Supplement" from the left side navigation menu.

Information collected within the Behavioral Information Supplement is intended for use by care management staff and DHS; the Supplement is not a checklist for completion by, or in the presence of, the person being screened. Information collected on the Behavioral Information Supplement does not appear on the printed screen report.

The Behavioral Information Supplement identifies:

- Orientation toward person, place, time, or situation
- Symptoms, behaviors, or actions
- Frequency of symptoms, behaviors, or actions
- Presence and frequency of interventions
- Presence of dedicated staffing
- Presence of a behavioral support plan

Information collected in the Supplement does not affect functional eligibility, other screening tools, or the budget calculated for IRIS participants.

The Behavioral Information Supplement provides the screener with the opportunity to identify behavioral concerns in greater detail than is possible within other sections of this module. Symptoms or behavior on the Supplement may be selected regardless of whether the person being screened has a cognitive impairment, requires intervention from another person, or has a behavioral plan in place.

Special considerations for agencies choosing to use the Behavioral Information Supplement:

- When identifying whether the person being screened is disoriented, check all options that apply at the time the Supplement is being completed. Do not identify disorientation that occurred in the past and is no longer present.
- Symptoms or behavior identified on the Supplement may have occurred more than 12 months in the past. In many instances, successful, ongoing interventions that prevent the behavior may

be in place. Record symptoms or behavior that are historical when these continue to be relevant, or when interventions are ongoing.

- Symptoms and behavior identified on the Supplement may meet the definition of offensive, violent, or self-injurious. Select these symptoms and behaviors in all applicable sections of the LTCFS. This will ensure symptoms and behaviors are included in the determination of functional eligibility, data collection, and the information that informs care management staff.
- Dedicated staffing is defined as a person whose sole work duties are to prevent, respond to, or manage behavioral symptoms or actions of the person being screened. This staffing may be paid, unpaid, formally or informally trained, relatives or non-relatives.
- Consequential symptoms or behaviors (see Behavior Toward Self, items “o.” and “p.”) are defined as those that jeopardize health, employment, living arrangement, financial security, or the ability to live independently.
- Personal space (see Behavior Toward Others, item “c.”) is defined as both the immediate area around the body of another person or the designated living space of another person.
- Since information in the Supplement is not used to determine functional eligibility or to determine the budget allocation for IRIS participants, the Supplement does not appear on the Functional Screen Report. Release of the Supplement to any person other than the person screened or their guardian may occur only after the person, or their guardian, has signed a release of information form that specifically identifies that the Behavioral Information Supplement may be released. Only the long-term care program agency in which the person is currently enrolled may release the Supplement.

Module #10: Risk

10.1 Overview

The Risk Module of the LTCFS has been designed to do the following:

- Increase awareness of when a person may be at risk of institutionalization in a nursing home or FDD/ICF-IID.
- 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 financial exploitation as defined in Wis Stat. § 46.90 and to know how to respond appropriately.

10.2 Part A - Current Adult Protective Services or Elder Adult/Adult at Risk 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. Wis. Stat. § 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.

10.3 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.

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 LTCFS.

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 FDD/ICF-IID) if they do not receive needed assistance or person is currently residing in a nursing home or FDD/ICF-IID and needs that level of care or supervision.
- ☐ 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 within the 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 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 FDD/ICF-IID) will occur within the next six to eight weeks. However, without needed assistance the person may be at risk of entering a nursing home or FDD/ICF-IID beyond eight weeks.
- May be at risk of entering an institute for mental disease (IMD) or hospital for psychiatric services.

2: (The person is at imminent risk of institutionalization [in a nursing home or FDD/ICF-IID] if they do not receive needed assistance or person is currently residing in a nursing home or FDD/ICF-IID and needs that level of care or supervision)

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 they are eligible for a nursing home level of care. The federal Centers for Medicare & Medicaid Services (CMS) has advised states that imminent risk of institutionalization means the person would require nursing home or FDD/ICF-IID care within six to eight weeks if community-based services were not provided. The screener should consider carefully whether the individual meets the criteria.

The selection of Risk Box 2 is appropriate if the person's health, without any needed assistance from another person, within six to eight weeks, would likely decompensate to the point where they would need to consider entering a nursing home or FDD/ICF-IID to receive care. It is not an issue of whether the person states they will never agree to or never plans to enter a nursing home or FDD/ICF-IID.

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 six to eight 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 FDD/ICF-IID.

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, do not automatically select Risk Box 2 without reviewing whether the person being screened would be at risk of entering a nursing home or FDD/ICF-IID.

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 daily daytime incontinence 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 three or more hospital admissions in the last six months.
- Is currently residing in a nursing home or FDD/ICF-IID and needs that level of care or supervision.
- 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 intellectual/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. Wis. Stat. § 55.08(2)(b).
- Meets at least one of the criteria above, but the person or the person's family members or authorized representative express unwillingness to have the person ever reside in a nursing home or FDD/ICF-IID.

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 IMD for psychiatric services.
- Is at risk of entering a correctional facility.
- Voluntarily or by court order receives community-based services without first reviewing whether they are at risk of entering a nursing home or FDD/ICF-IID.
- Has a guardian of the person without first reviewing whether they are at risk of entering a nursing home or FDD/ICF-IID.

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 years 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 in accordance with Wis. Stat. §§ 46.90(4) and 55.043(1m).

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.

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 (for example, caregiver winters in a southern state, caregiver grandchild will be attending college out of the area).
- 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 #11: Completion of the LTCFS

11.1 Overview

Once the screener has entered the relevant information related to the needs of the individual in FSIA, there are some final steps to completing the LTCFS. Screeners must record the time spent working on the screen, complete the No Active Treatment (NAT) section if applicable, and calculate functional eligibility. It is important to understand target group definitions and level of care results to identify if the outcome is appropriate based on the needs of the individual.

11.2 Screen Time Information

All times are rounded to the nearest 15-minute increment.

Screen Completion Date (mm/dd/yyyy)
Refer to your agency policy regarding the date to enter in this field.

The screen completion date should not be changed when making an edit or when transferring a screen to another screening agency.

Face-to-Face Contact with Person
The amount of time the screener spent with the person being screened and any collateral contact(s) present during the in-person interview should be entered in this field.

Collateral Contacts
The amount of time the screener spent communicating with collateral contacts to gather information for the screen when the individual is not present should be entered in this field.

Paper Work
All other screen-related activity should be entered in this field. This may include:

- Communication with the person being screened outside of the in-person interview.
- Review of previous functional screens, assessments, plans, health records, and other written documentation.
- Consultation with the agency screen liaison, coworkers, or DHS staff regarding any aspect of an individual's screen.
- Entering the LTCFS into FSIA.

Travel Time
The amount of time the screener spent traveling to gather information necessary to complete the LTCFS should be entered in this field.

11.3 No Active Treatment (NAT)

The NAT section will appear and must be completed for any individual who has at least one A1-A10 diagnosis selected on the Diagnoses Table.

A NAT determination is not the same as a Pre-Admission Screening and Annual Resident Review (PASARR) determination. When an individual has received a determination of NAT, they are not necessarily exempt from a PASARR determination.

NAT is a designation given to individuals with an intellectual/developmental disability who, for either health reasons or because of advanced age, no longer require treatment related to their intellectual/developmental disability. In addition, a person with an intellectual/developmental disability such as cerebral palsy, but with a normal IQ, could be appropriate for a NAT designation. An NAT designation can impact allowable residential settings for a person. **Questions regarding NAT should be directed to the screening agency's DHS oversight team.**

Instructions
The NAT section contains two parts, A and B. Part A statements will have automatic default selections based on entries made on the Diagnosis Table. If a screener needs to change a default selection in Part A, they should include an explanatory note about why the default selection was changed.

Part A statements:

Statement 1: The person has a terminal illness.
- Yes: Selected if K3 Terminal Illness is selected on the Diagnoses Table
- No: Selected if K3 Terminal Illness is not selected on the Diagnoses Table

Statement 2: The person has an IQ greater than 75.
- Yes: Selected if IQ score on the Diagnosis page is greater than 75
- No: Selected if IQ score on the Diagnosis page is less than or equal to 75
- N/A: Selected if IQ score on the Diagnosis page is selected as unknown.

Statement 3: The person is ventilator-dependent.
- Yes: Selected if F4 Ventilator Dependent is selected on the Diagnoses Table
- No: Selected if F4 Ventilator Dependent is not selected on the Diagnoses Table

After an individual enrolls in Family Care, PACE, Partnership, or IRIS, the program's screener should complete Part B of the NAT section.

Part B Statements:

Statement 1: The person has physical or mental incapacitation, typically but not always due to advanced age, such that their needs are similar to those of geriatric nursing home residents.
- Yes: Select Yes if person of any age has needs that are similar to those of geriatric nursing home residents

No: Select No if person of any age does not have needs similar to those of geriatric nursing home residents

Statement 2: The person is age 65 or older and would no longer benefit from active treatment.
- Yes: Select Yes if person is age 65 or older and the program has determined the person would no longer benefit from active treatment
- No: Select No if person is under age 65

Statement 3: The person has severe, chronic medical needs that require skilled nursing care.
- Yes: Select Yes if person of any age has severe, chronic medical needs that require skilled nursing care
- No: Select No if person of any age does not have severe, chronic medical needs that require skilled nursing care

11.4 Calculating Eligibility

The Calculate Eligibility button must be selected to complete a functional screen. **Do not** calculate eligibility until you have completed an in-person interview and have entered all information into the screen, including notes.

Eligibility must be calculated for a screen to be transferred. If the screen is complete, the screener **does not need** to recalculate eligibility before transferring a screen to another screening agency.

If a screener needs to change an individual's name, Social Security number, or date of birth after eligibility has been calculated, the screener should reference the Basic Information for Screeners, P-01604 for guidance.

11.5 Information Available on the Eligibility Results Page

Once the screener has selected Calculate Eligibility in FSIA, a new page will appear with target group and eligibility results. It will also include agency and screener information, target groups, level of care results and transfer of level of care results.

The results indicate that the individual meets or does not meet functional eligibility for adult LTC. HCBW Eligibility, HCBW LOC, and COP level 3 Eligibility are no longer recognized in adult LTC.

Target Groups

Target groups are defined in state statute and administrative code. Target group results and their definitions are listed below.

Frail Elder Target Group
"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. Wis. Admin. Code § DHS 10.13(25m).

Physical Disability Target Group
"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. Wis. Stat. § 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. Wis. Stat. § 15.197(4)(a)1.

FEDERAL Definition of Intellectual/Developmental Disability Target Group
Under Federal law a person is considered to have an intellectual disability if they have: (i) A level of intellectual disability described in the American Association of Intellectual and Developmental Disabilities' Manual on Classification in Intellectual Disability, or (ii) A related condition as defined C.F.R. § 435.1010 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 intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled 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.

Refer to the Guide for I/DD per Federal Definition, P-00935 for more information.

STATE Definition of Developmental Disability Target Group
Wisconsin state law defines a developmental disability as a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, intellectual disability, or another neurological condition closely related to an intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability, 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. Wis. Stat. § 51.01(5)(a).

Wisconsin's definition of developmental disability 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) that are found within the federal definition.

Alzheimer's Disease or Other Irreversible Dementia Target Group
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. Wis. Stat. § 46.87(1)(a).

Terminal Condition Target Group
Terminal condition is defined as a condition with which a person's death is expected within one year from the date of the person's screening.

Severe and Persistent Mental Illness Target Group
"Severe and persistent mental illness" is defined as a mental illness that is severe in degree and persistent in duration, that 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, that may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support, and that may be of lifelong duration. "Serious and persistent mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include degenerative brain disorder or a primary diagnosis of a developmental disability or of alcohol or drug dependence. Wis. Stat. § 51.01(14t).

No Target Group
Individuals who do not meet the definition of any adult LTC program target group, will not be found eligible.

Target Group General information
- An individual's condition may meet the definitional requirements of more than one target group at a time.
- An individual may have a disability determination and NOT meet a target group definition.
- An individual will NOT meet a target group definition if they have a temporary condition.
- An individual meeting only the "No Target Group" definition will NOT be functionally eligible for a Wisconsin Medicaid funded LTC program.
- An individual may meet target group definition(s), but NOT be eligible for a Wisconsin Medicaid funded LTC program if they do NOT have a need for assistance with ADL, IADL, or HRS tasks.
- An individual may need assistance with an ADL, IADL, or HRS task, but NOT be eligible for a Wisconsin Medicaid funded LTC program if they do NOT meet one of the eligible target group definitions.
- An individual meeting ONLY the SPMI target group definition will NOT be functionally eligible for a Wisconsin Medicaid funded LTC program.
- An individual meeting ONLY the STATE definition of developmental disability target group will NOT be functionally eligible for IRIS.
- Except for diagnoses of Alzheimer's disease, other irreversible dementias, and terminal illness, a diagnosis alone is not sufficient to qualify an individual to meet a target group definition.

Brain Injury Information
Traumatic brain injury is included with the physical disability or frail elder target group, even if the resulting symptoms are only cognitive or behavioral.

A person with brain injury may meet the FEDERAL definition of I/DD if their injury occurred before age 22. If the brain injury occurred at age 22 or after, the person's condition may meet the STATE definition of I/DD, but not the federal definition.

Level of Care (LOC) Results

The following describes nursing home (NH) and intellectual/developmental disability (I/DD) levels of care and how these interact with functional eligibility for each Medicaid funded HCBS Waiver program.

Family Care and NH or I/DD Level of Care
To qualify for Family Care, a person must have a long-term care condition likely to last more than 90 days.

There are two levels of Family Care eligibility which are "Family Care Nursing Home LOC" and "Family Care Non-Nursing Home LOC."

- **Family Care Nursing Home LOC** includes all three nursing home levels of care and all four I/DD levels of care. Refer to Wis. Stat. § 46.286(1)(a)1m for complete definition.
- **Family Care Non-Nursing Home LOC** includes individuals who do not have a nursing home LOC or I/DD LOC but require minimal assistance in ADLs and/or IADLS. Refer to Wis. Stat. § 46.286(1)(a)2m for complete definition.

PACE/Partnership and NH or I/DD Level of Care
To qualify for PACE and/or Family Care Partnership, a person must have a long-term care condition likely to last more than 90 days and meet a NH or I/DD level of care.

IRIS and NH or I/DD Level of Care
To qualify for IRIS, a person must have a long-term care condition likely to last longer than 1 year and meet a NH or I/DD level of care.

Wisconsin's NH levels of care for adults with disabilities and frail elders:

- Intermediate care facility (ICF)-Low to moderate needs
- Skilled nursing facility (SNF)-High needs
- Intensive skilled nursing services (ISN)-Highest needs

Wisconsin's I/DD levels of care for adults meeting the FEDERAL definition of intellectual/developmental disability:

- Developmental Disability 1A (DD1A)-People with significant medical support needs in addition to a cognitive disability
- Developmental Disability1B (DD1B)-People with significant behavioral support needs in addition to a cognitive disability

- Developmental Disability 2 (DD2)-People who have a cognitive disability and are neither DD1A nor DD1B level of care and need help with all or most ADLs and IADLs
- Developmental Disability 3 (DD3)-People who have a cognitive disability and are more independent with most ADLs and IADLs

Level of Care General information
- An individual may meet target group definition(s) but may not meet a qualifying Level of Care.
- An individual meeting either a NH or I/DD Level of Care may qualify for a Wisconsin Medicaid funded LTC program.

Transfer Level of Care Results
This area will display if and when the LOC details were sent to CARES.

11.6 Confirming the Functional Eligibility Results

Expected Outcome
When a screener believes the target group and level of care results accurately reflect the individual's needs, the screen is considered complete and accurate. The results may be different from prior screens, but if that change appears appropriate, then the results are not unexpected.

If the outcome is expected the screener can select the check box to immediately transfer the results to CARES, otherwise the results will transfer automatically on the 11th day after calculation.

Unexpected Outcome
If the target group and/or level of care result do not appear to be congruent with the individual's needs, this is an unexpected outcome. A thorough review of the screen must be completed, and the screener should follow agency policy regarding the transfer of results to CARES.

If the results of the screen remain unexpected after that review, the agency screen liaison is to contact DHS at dhsltcfsdiagnosis@dhs.wisconsin.gov who will perform a full review of the screen and consult with the screen liaison until the screen results are considered complete and accurate. Once the screen is considered complete and accurate, the screener takes the action that is required of them by their screening agency based on the results of the screen.