Adult Family Home Council

OF WASHINGTON STATE

Understanding the Comprehensive Assessment Reporting Evaluation – CARE

Updated 2021

Presented by

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Adult Family Home Council

Goals for Today's Session

Understand:

- Medicaid Programs and funding
- The purpose of the CARE tool
- How CARE affects daily rates
- Your role in the CARE assessment
- Additional information captured in CARE

Know your resources:

- Appropriate WAC sections
- CARE Assessor's Manual
- LTC Manual

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Medicaid Programs

- State and Federal funding
- Medicaid Medical benefits (managed by the Health Care Authority)
- Nursing Home Services
- Home and Community Based Services
- MPC, CFC and Waiver Programs

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What is the purpose of an assessment?

WAC 388-106-0055

The purpose of an assessment is to:

(1) Determine eligibility for long-term care programs;

(2) Identify your strengths, limitations, and preferences;

(3) Evaluate your living situation and environment;

(4) Evaluate your physical health, functional and cognitive abilities;

(5) Determine availability of informal supports and other non-department paid resources;

(6) Determine need for intervention;

(7) Determine need for case management activities;

(8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;

(9) Determine need for referrals; and

(10) Develop a plan of care, as defined in WAC 388-106-0010.

(11) In the case of New Freedom consumer directed services, the purpose of an assessment is to determine functional eligibility and for the participant to develop the New Freedom spending plan, as defined in WAC 388-106-0010.

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Assessment—Qualified assessor—Required.

WAC 388-76-10345

The adult family home must ensure the person performing resident assessments is:

(1) A qualified assessor; or

(2) For a resident who receives care and services paid for by the department, an authorized department case manager.

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Assessment—Updates required.

WAC 388-76-10350

The adult family home must ensure each resident's assessment is reviewed and updated to document the resident's ongoing needs and preferences as follows:

(1) When there is a significant change in the resident's physical or mental condition;

(2) When the resident's negotiated care plan no longer reflects the resident's current status, needs and preferences;

(3) At the resident's request or at the request of the resident's representative; or

(4) At least every twelve months.

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Significant Change Assessment

Case Managers/Social Workers are required to:

Perform a Significant Change assessment if requested by the provider. When a change in the client's functional abilities and/or health status is reported by the provider, you must complete the Significant Change assessment in a timely manner. After completing the assessment, you must:

- Revise the client's plan of care, as needed;
- Review the Assessment Details and Service Summary with the provider;
- Obtain the client's and provider's consent and signatures; and
- Revise the payment authorization (if necessary).

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Significant Change Assessment

Washington State Department of Social & Health Services
Transforming lives

Adult Family Home (AFH) Resident
Significant Change Assessment Request

RESIDENT'S NAME	ADSA ID NUMBER	CLIENT ID NUMBER (ALTSA)
AFH PROVIDER'S NAME		PHONE NUMBER (WITH AREA CODE)
Date of most recent medical appointment:		
MEDICAL PROVIDER'S NAME		PHONE NUMBER (WITH AREA CODE)
Describe the changes in the resident's health or level of independence since their most recent CARE assessment:		
Provide a detailed description of the additional supports being provided due to the changes in the resident's health level of independence:		

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The Role of AFH staff

Direct caregivers. Formal caregivers talk with and listen to the clients on a regular basis. They observe and assist the client's performance of ADLs and involvement in activities. They observe the client's physical, cognitive and psychosocial status frequently during the assessment period.

CARE LTC Assessor's Manual

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How is my need for personal care services assessed in CARE?

WAC 388-106-0075

The department gathers information from you, your caregivers, family members and other sources to assess your abilities to perform personal care tasks. The department will also consider developmental milestones for children as defined in WAC 388-106-0130 when individually assessing your abilities and needs for assistance. The department will assess your ability to perform:

(1) Activities of daily living (ADL) using self-performance support provided, status and assistance available, as defined in WAC 388-106-0010. Also, the department determines your need for "assistance with body care" and "assistance with medication management," as defined in WAC 388-106-0010; and

(2) Instrumental activities of daily living (IADL) using self-performance difficulty, status and assistance available, as defined in WAC 388-106-0010.

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How is the amount of long-term care services I can receive in my own home or in a residential facility determined?

WAC 388-106-0080

The amount of long-term care services you can receive in your own home or in a residential facility is determined through a classification system. Seventeen classifications apply to clients served in residential and in-home settings. The department has assigned each classification a residential facility daily rate or a base number of hours you can receive in your own home.

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What criteria does the CARE tool use to place me in one of the classification groups?

WAC 388-106-0085

The department uses CARE to assess your characteristics. Based on this assessment, the CARE tool uses the following criteria to place you in one of the classification groups:

(1) Cognitive performance.

(2) Clinical complexity.

(3) Mood/behaviors symptoms.

(4) Activities of daily living (ADLs).

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How does the CARE tool measure cognitive performance?

WAC 388-106-0090

(1) The CARE tool uses a tool called the cognitive performance scale (CPS) to evaluate your cognitive impairment. The CPS results in a score that ranges from zero (intact) to six (very severe impairment). Your CPS score is based on:

(a) Whether you are **comatose**.

(b) Your ability to make decisions, as defined in WAC 388-106-0010 **"Decision making."**

(c) Your ability to make yourself understood, as defined in WAC 388-106-0010 **"Ability to make self understood."**

(d) Whether you have **short-term memory problem** (e.g. can you remember recent events?) or whether you have delayed recall; and

(e) Whether you score as total dependence for **self performance in eating**, as defined in WAC 388-106-0010 "Self performance of ADLs."

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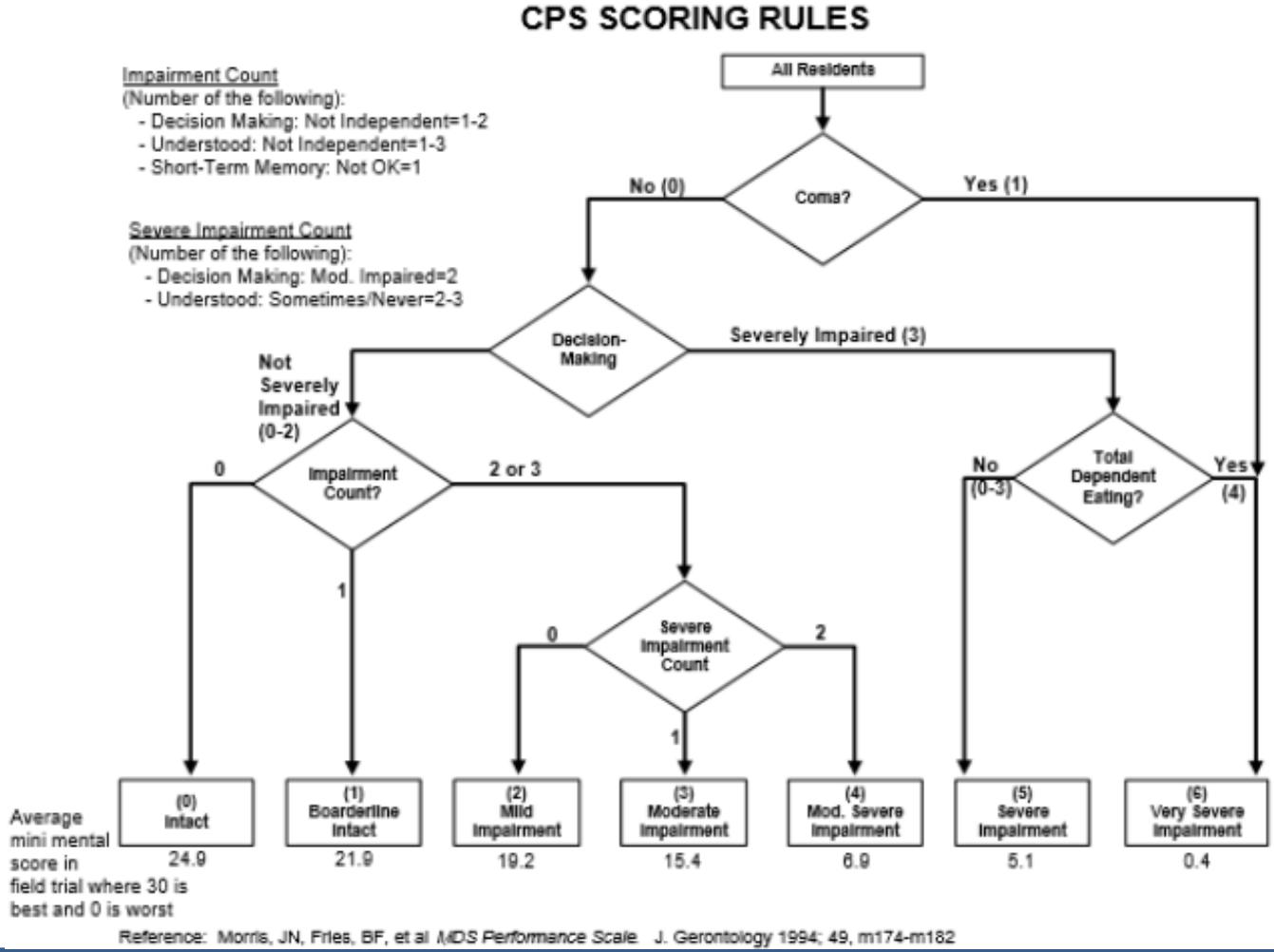
How does the CARE tool measure cognitive performance?



Reference: Morris, JN, Fries, BF, et al *MDS Performance Scale*. J. Gerontology 1994; 49, m174-m182

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How does the CARE tool measure clinical complexity?

WAC 388-106-0095

The CARE tool places you in the clinically complex classification group only when you have one or more of the following criteria and corresponding ADL scores:

Condition	AND an ADL Score of
ALS (Lou Gehrig's Disease)	>14
Aphasia (expressive and/or receptive)	>=2
Cerebral Palsy	>14
Diabetes Mellitus (insulin dependent)	>14
Diabetes Mellitus (noninsulin dependent)	>14

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How does the CARE tool measure mood and behaviors?

WAC 388-106-0100

Behavior/Mood	AND Status, Frequency & Alterability
Assaultive	Current
Combative during personal care	Current
Combative during personal care	In past and addressed with current interventions
Crying tearfulness	Current, frequency 4 or more days per week
Delusions	In past, addressed with current interventions
Depression score of 14 or greater	N/A
Disrobes in public	Current and not easily altered
Easily irritable/agitated	Current and not easily altered
Eats nonedible substances	Current
Eats nonedible substances	In past, addressed with current interventions

How does the CARE tool measure mood and behaviors?

WAC 388-106-0100

Status	Intervention	Frequency	Weight
Past	No Intervention	N/A	0
Past	With Intervention	N/A	0.25
Current	N/A	1-3 days/wk	0.5
Current	N/A	4-6 days/wk	0.75
Current	N/A	Daily	1

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How does the CARE tool measure mood and behaviors?

WAC 388-106-0100

Behavior	Value	
	Easily Altered/Past	Not Easily Altered
1. Crying and Tearfulness	.5	1
2. Easily Irritable/Agitated	.5	1
3. Obsessive about health or body functions	.5	1
4. Repetitive Physical Movement	.5	1
5. Hiding Items	.5	1
6. Hoarding/Collecting	.5	1
7. Inappropriate Verbal Noise	.5	1

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How does the CARE tool measure activities of daily living (ADLs)?

WAC 388-106-0105

(1) CARE determines an ADL score ranging from zero to twenty-eight for each of the following ADLs.

(a) Personal hygiene;

(b) Bed mobility;

(c) Transfers;

(d) Eating;

(e) Toilet use;

(f) Dressing;

(g) Locomotion in room;

(h) Locomotion outside room;

(i) Walk in room; and

(j) Medication management

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How does the CARE tool measure activities of daily living (ADLs)?

ADL Scoring Chart	
If Self Performance is:	**Score Equals**
Independent	0
Supervision	1
Limited assistance	2
Extensive assistance	3
Total dependence	4
Did not occur/no provider	4
Did not occur/client not able	4
Did not occur/client declined	0

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Self Performance Definitions

- ADL Self Performance Codes for Bathing ONLY:
  - Independent – No help provided
  - Supervision – Oversight help only
  - Physical help limited to transfer only
  - Physical help in part of bathing activity
  - Total dependence
  - Activity itself did not occur during entire 7 days

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How does the CARE tool evaluate me for the exceptional care classification of the E Group?

WAC 388-106-0110

Diagram 1
You have an ADL score of greater than or equal to 22.
AND
You need a turning/repositioning program.
AND
You need at least one of the following: ■ External catheter; ■ Intermittent catheter; ■ Indwelling catheter care; ■ Bowel program; ■ Ostomy care; or ■ Total in self performance for toilet use.
AND
You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting, or provided by AFH/boarding home staff, facility RN/LPN, facility staff or private duty nursing when living in a residential setting: ■ Active range of motion (AROM); or ■ Passive range of motion (PROM).

How does the CARE tool evaluate me for the exceptional care classification of the E Group?

Diagram 2
You have an ADL score of greater than or equal to 22.
AND
You need a turning/repositioning program.
AND
You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting, or provided by AFH/boarding home staff, facility RN/LPN, facility staff or private duty nursing when living in a residential setting: ■ Active range of motion (AROM); or ■ Passive range of motion (PROM).
AND
All of the following apply: ■ You require IV nutrition support or tube feeding; ■ Your total calories received per IV or tube was greater than 50%; and ■ Your fluid intake by IV or tube is greater than 2 cups per day.
AND
You need assistance with one of the following, provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting or provided by AFH/boarding home staff, facility RN/LPN, facility staff, a private duty nurse or nurse delegation when living in a residential setting: ■ Dialysis; or ■ Ventilator/respirator.

How does CARE use criteria to place me in a classification group for residential facilities?

WAC 388-106-0115

Classification	ADL SCORE	Group Description
E Medium	22-25	If you meet the criteria for exceptional care, then CARE will place you in Group E.
E High	26-28	

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WAC 388-106-0115
How does CARE use criteria to place me in a classification group for residential facilities?

Classification	ADL SCORE	Group Description
D Low	2-12	If you meet the criteria for clinical complexity and have a cognitive performance score of 4-6 then you are classified in Group D regardless of your mood and behavior qualification or behavior points
D Medium	13-17	
D Med-High	18-24	
D High	25-28	

WAC 388-106-0115

How does CARE use criteria to place me in a classification group for residential facilities?

Classification	ADL SCORE	Group Description
C Low	2-8.	If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in Group C regardless of your mood and behavior qualification or behavior points.
C Medium	9-17	
C Med-High	18-24	
C High	25-28	

WAC 388-106-0115
How does CARE use criteria to place me in a classification group for residential facilities?

Classification	ADL SCORE	Group Description
B Low	0-4	If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into Group B
B Medium	5-14	
B High	15-28	
or	Behavior Score	If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups
B Low	greater than 1	
B Medium	greater than 4	
B Med-High	greater than 6	
B High	12 or greater	

WAC 388-106-0115

How does CARE use criteria to place me in a classification group for residential facilities?

Classification	ADL SCORE	Group Description
A Low	0-4	If you are not clinically complex and you do not qualify under either mood and behavior criteria, then you are classified in Group A
A Medium	5-9	
A High	10-28	

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Additional Information Captured in CARE

- Community Integration
- Community Integration Mileage
- Medical Mileage
- ECS/SBS
- Meaningful Day
- Medical Escort Services
- Exception to Rule (ETR)

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Community Integration

Community Integration means ensuring access for residents who elect to be in the local community and participating in activities of one's choosing.

When the assessment notes the need for CI and the care plan determines the provider will provide the support. The CI rate will be added to the base daily rate

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CI & Medical Mileage Reimbursement

- Community Integration mileage reimbursement: up to 100 miles
- Medical mileage reimbursement: up to 50 miles per month

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Residential Service Waiver (RSW)

- Serves clients who are returning to the community from state or local hospital psychiatric units, or have a history of failed/denied placements, or are at risk of losing their current placement due to behavioral challenges
  - Expanded Community Services
  - Specialized Behavior Supports

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Expanded Community Services (ECS)

- The contracted behavior support services include:
  - Person-centered, on-site client training for the client and caregiving staff
  - An individualized crisis response and behavior support plan that is reviewed monthly and modified as the client's needs change
  - Monthly psychopharmacological medication reviews
- Effective July 1, 2020 the ECS daily rate is $135.00 (or Base Daily Rate, whichever is greater)

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Specialized Behavior Supports (SBS)

- Same services as ECS setting plus additional staffing
  - The additional staffing requirements are:
    - 1 SBS client = 6-8 hours
    - 2 SBS clients = 12-16 hours
    - 3 SBS clients = 18-24 hours
- Effective July 1, 2020 the SBS add-on rate in addition to the Base Daily Rate is $153.00

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Meaningful Day

- Person-centered daily activities with the goal of increasing participation, redirection of behaviors and improved quality of life

- Eligibility Criteria
  - Current CARE assessed behavior score of 12 or > of diagnosis of dementia (with behavioral challenges)
  - Not currently receiving ECS/SBS services
  - AFH provider must complete training and contracting process

- Meaningful Day add-on rate is thirty dollars ($30.00) per day

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Medical Escort Services

- Reimbursement for providing medical escort to Medicaid resident
  - AFH must provide transportation and accompany the resident to the appointment
  - All other means of escort and transportation have been exhausted

- Rate: $18.00/hour, up to 24 hours per client per year

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Exception to Rule (ETR) Requests

- After being notified through DSHS 05-246 that an ETR was not initiated, a client, client representative, or AFH provider may contact the HQ ETR Committee directly to request the ETR.

- Visit the AFH Council website www.adultfamilyhomecouncil.org or call (360)754-3329 for support with writing an ETR

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THANK YOU

Any questions?

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