STAR-Kids SAI Manual

Version 2.06 (September 27, 2016)

The manual covers all components of Version 2.06 of the STAR Kids Screening and Assessment Instrument (SAI) including the Core, PCAM, NCAM, and MDCP modules, along with item-by-item explanations, definitions and helpful hints.

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This manual corresponds to the STAR Kids Screening and Assessment Instrument Version 2.06 as part of establishing the STAR Kids Medicaid Managed Care Program in Texas.

All questions about the provision of services, program rules, or departmental policy must be addressed by your immediate supervisor.

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Acronym Glossary

A

ADL:	Activities of Daily Living
ALF:	Assisted Living Facility

B

BIMS:	Brief Interview of Mental Status
BIP:	Behavioral Intervention Program
BiPAP:	Bilevel Positive Airway Pressure

C

CDS:	Consumer Directed Services
CFC:	Community First Choice
CLASS:	Community Living and Assistance Support Services
CPAP:	Continuous Positive Airway Pressure
CPS:	Child Protective Services
CPT:	Chest Physical Therapy
CSHCN:	Children with Special Health Care Needs

D

DBMD:	Deaf Blind with Multiple Disabilities
DBS:	Deep Brain Stimulation
DME:	Durable Medical Equipment

E

ECI:	Early Childhood Intervention
ERS:	Emergency Response Services

G

G-button:	Gastrostomy button
G-tube:	Gastric tube

I

IDD:	Intellectual and Developmental Disability
IEP:	Individualized Education Plan
IPPB:	Intermittent Positive Pressure Breathing
ISP:	Individual Support Plan

L

LAR:	Legally Authorized Representative

M

MCO:	Manage Care Organization
MDCP:	Medical Dependent Children Program
MTP:	Medicaid Medical Transportation Program
MN:	Medical Necessity

N

NC:	Nasal Cannula
NCAM:	Nursing Care Assessment Module
NG-tube:	Nasogastric tube

P

PCAM:	Personal Care Assessment Module
PEG:	Percutaneous Endoscopic Gastrostomy
PHQ-9:	Patient Health Questionnaire 9
PHQ-OV:	Patient Health Questionnaire-9 Interview and Observational Versions
PICC:	Peripherally Inserted Central Catheter
PPECC:	Prescribed Pediatric Extended Care Center
PRN:	“pro re nata” when necessary

R

RTC:	Residential Treatment Center
RUG:	Resource Utilization Group

S

SRO:	Service Responsibility Option
SSLC:	State Supported Living Centers

T

TPN:	Total Parenteral Nutrition
TxHmL:	Texas Home Living

V

VNS:	Vagal Nerve Stimulation

W

WNL:	Within Normal Limit

Y

YES:	Youth Empowerment Program

Overview

The Texas Health and Human Services Commission (HHSC) tasked Texas A&M University (TAMU) with creation of the STAR Kids Screening and Assessment Instrument as part of establishing the STAR Kids Medicaid Managed Care Program. Senate Bill 7 (effective September 2013) directed the Texas Health and Human Services Commission to establish the STAR Kids program as a capitated, mandatory, managed health care program to provide Medicaid benefits to children with disabilities. Eligible individuals include children and young adults (under age 21) who receive Supplemental Security Income (SSI) or who are served by one of the following waiver programs:

- Medically Dependent Children Program (MDCP)
- Home and Community-based Services (HCS)
- Community Living Assistance and Supports Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Texas Home Living (TxHmL)
- Youth Empowerment Services (YES)

The STAR Kids Screening and Assessment Instrument (SAI) is designed as a 'one front door' assessment for all children on SSI and in the above mentioned waiver programs. The SAI contains trigger items that advance children into various, more extensive modules. TAMU is responsible for developing the Core of the SAI, the personal care services module (PCAM), and the nursing services module (NCAM). The SAI also contains flags for further follow-up by the Managed Care Organizations (MCOs) on issues such as the need for Durable Medical Equipment (DME), behavioral health services, and other therapies. Information gathered using the SAI is used to create an individual service plan (ISP) for each member, as well as generate potential referrals for additional services the individual might need. For individuals seeking a medical necessity determination for MDCP or Medicaid state plan Community First Choice services (CFC), the SAI is used to gather the information used to make that determination. Finally, the SAI also contains a module for MDCP clients and potential clients (MDCP Module) that includes items used exclusively to determine an individual's service cost limit (budget), based on Resource Utilization Group III (RUG) modeling.

A registered nurse, advance practice nurse, physician assistant, social worker (MSW, LBSW, or LCSW), or licensed vocational nurse (with a minimum of one-year previous service coordination or case management experience and experience with pediatric clients) must administer the SAI Core Module and PCAM, if needed, and these modules may not be provided by any contracted entity that is or will be providing direct services to the Member. A registered nurse or advance practice nurse must administer the SAI NCAM and MDCP module, if needed. The MCO must train all individuals that will administer the SAI using a training module required by HHSC before the individuals administer the SAI. For quality monitoring purposes, the MCO must submit data collected through the SAI to the HHSC Administrative Services Contractor in the format prescribed by HHSC.

The SAI must be completed initially, annually for reassessment, and any time the individual or Legally Authorized Representative (LAR) report a significant change in condition that might impact his or her need for services.

How to Gather Information

The SAI is designed for use by assessors. The forms are not questionnaires. The assessor does not go through the modules and ask respondents each question. The assessors use their judgment to determine the most appropriate source of information to complete each item.

Sources of information may vary by item. However, in general the individual (through observation and discussion) and the caregiver are the main sources of information. The assessor may need to gather information from both in order to decide which response is most accurate (e.g., what is the child's date of birth; what type of assistance does the child receive with dressing). Occasionally, the assessor may wish to access other information to ensure accurate responses (e.g., view the Medicaid card to record accurately the beneficiary number; view and count the number of medications, or review documents from a school, HHSC, or another agency or provider).

If information sources conflict on the proper response to an item, the assessor will need to use her or his professional skills to probe during additional discussion in an attempt to resolve any discrepancies. In the end, he or she will be required to make a reasoned, professional judgment about the "correct" response for a particular item.

Some of the questions in the assessment seek sensitive information. It is important that the assessor use tact when addressing these topics.

Helpful Hints: How to ask sensitive questions

Ask the individual directly, if possible. This information may be embarrassing to the individual or create feelings within the assessor. Care must be taken to acknowledge these feelings. For example, when asking the individual about alcohol usage, use a simple, straight forward, nonjudgmental question, "Do you drink?" If yes, determine the frequency. Address this issue in a gentle way to avoid the individual feeling judged or that he or she is doing something wrong.

If, despite your best efforts, the information you need to code an item is unavailable and will remain unavailable, you should record a "9" in the response box or skip the item if "9" is not available as a coding option. Use this approach sparingly, if at all. If you do use it, you should write a rationale/explanation about why the information was unavailable in the free-text item, "Is there anything else that would be helpful…?" at the end of that section of the instrument if it is available. Please also note there are some items that are MANDATORY REQUIREMENTS for the SAI and cannot be skipped. In those cases, use your best professional judgment to code the fields and then clarify your response in the same free-text item at the end of the section as noted above, if it is available.

For example, if the client/child has aphasia or significant communication deficits as a result of autism and cannot respond and is living with a new foster family, you may be unable to get information on the child/client's "urgent mental/behavioral health service use in the last 6 months" (Item I.2). In such a case, you may skip the item, since it is not mandatory, and then record an explanation about the child and family situation related to that question in Item I.7.

Using this Manual

This manual is meant to be a companion to the other trainings you receive for the SAI. The next chapter will provide a section-by-section breakdown of the assessment, including special directions or tips for that section. The subsequent chapter provides individual definitions for each item in the assessments. It can act as a quick reference for clarification of a response when you are in the field.

Common Items in Instruments

The majority of the questions in the instruments will be coded, where you enter a number into a box that corresponds to a value answer for that question. There are also some questions where you will directly input a value and some open-ended questions.

Throughout the instruments, you will encounter similar types of questions multiple times. The same general instructions can be used to respond to those questions:

- **Other (specify) -** These types of questions allow you to capture an answer choice that is not already included. You will input the code that applies and then include a brief description about the item in the space provided.
- **"Is there anything else…"** – At the end of some sections in the instrument, there is a general question asking for any other relevant information that is not covered in that section but may be important to know. This is also a good place to record something that may be beyond a timeframe or look-back period in the instrument. For example, an individual mentions an upcoming surgery scheduled 6 months from now, falling outside the 90-day period in the associated question. You may feel this surgery would be helpful to know in the future and you may include information about it using this question.
- **Look-back Periods**: Throughout the assessment there will be look-back periods. These may include 7, 14, 30, and 90 days, among others. Pay close attention to the default look-back period for each module, as well as for each question. It may be helpful to reference a holiday or a past event to help the individual recall the period.

The SAI is made up of four modules: the Core assessment, the Personal Care Assessment Module (PCAM), Nursing Care Assessment Module (NCAM), and the Medically Dependent Children Program Module (MDCP). These modules are organized by thematic sections.

- **The Core Assessment** – The Core covers a wide variety of questions aimed at gathering background information on the individual's health, functional status, services, and support system. Responses to specific questions on the Core automatically trigger whether or not an individual receives the PCAM and/or the NCAM and may also draw the assessor's attention to topics that should be discussed further. The core has look-back periods of 30 days, 90 days, six months, and even one year, but the focus tends to be on the individual's current status. Some items in the Core are also used to determine medical necessity for individuals requesting CFC services or MDCP.
- **PCAM** – If an individual's responses to questions in the Core seem to indicate the individual may need attendant services, proceed with the PCAM. The PCAM is used to

determine needs for both PCS and CFC services. The PCAM delves further into a child's health and functional status. This part of the assessment has look-back periods of 30 days.

- **NCAM** - If an individual's responses to questions in the Core seem to indicate the individual may need skilled nursing services, proceed with the NCAM. The NCAM focuses on identifying the individual's skilled nursing needs. Additionally, the NCAM is used as part of medical necessity determinations for CFC and MDCP and should therefore be administered to individuals who request CFC services or currently receive MDCP services or have been released from the interest list for MDCP by HHSC. The look-back periods include 7 and 30 days.
- **MDCP** – If an individual indicates in the Core that the individual has been receiving services in MDCP or has been released from the interest list for MDCP services by HHSC, they will receive the MDCP module. The MDCP module consists exclusively of items that inform the Resource Utilization Group III (RUG) cost limits for determining an individual's budget in this waiver program. These items were formerly found in the MN/LOC assessment and taken almost verbatim. The look-back periods include 7 and 14 days. Please note also that many of these questions are very similar in nature to other items in the Core and NCAM, just with a different, often more narrow look-back period. It is important to explain to the individual and/or caregiver that while the items are similar, they serve a different purpose and are necessary for MDCP budget and planning alone, and not in fact used for medical necessity determinations.

Further explanation of the content and purpose of the questions covered in each form is expounded on below.

Core

Section A. Identification Information

Section A is devoted to collecting demographic information about the individual, their residence and residential preferences, and their physician. Many of these questions should be familiar to both assessors and those being assessed.

Helpful Hints: ID Numbers

It may be helpful to review records, if possible, to gather the necessary identification numbers. It may be possible to complete many of these items using information from these past records.

Section B. School and Work

Understanding the educational and vocational settings an individual may be involved in can help determine the need for more or different services in the home. Some of the questions in this section can be confidential, and the individual or their caregiver may refuse to answer. While refusal to answer these types of questions is rare, these questions are not required to receive services. When responding to the questions related to an individual's Individualized Education Plan (IEP), first ask if the individual and the caregiver would like to share.

Section C. Goals for Care

The individual and caregiver are important members of the healthcare team. It is essential to understand what their goals might be. This could be a starting point to develop a person-centered plan of care or services. These outcomes may relate to almost anything, including improved functional performance, a return to health, increased independence, an ability to maintain community residence, improved social relations, etc.

Helpful Hints: Goals

Talk to the individual and caregiver and phrase your questions about goals of care in the most general way possible.

- For example, ask: "How can we help you?" "Why are you getting (or applying for) services?" "What benefits do you expect to get?" "What changes in yourself do you hope will occur?"

Encourage the person to express personal goals in his or her own words. Remember to be age and developmentally appropriate and respectful in your language and communication.

Some individuals will be unable to articulate a goal, an expected outcome, or even a reason for seeking services. They may say they do not know or that they are getting service at the request of a relative (e.g., "Because mommy said so"). All of these are reasonable responses. Do not make inferences based on what you or other individuals believe should be goals of care. If the individual asks you for clarification on what he or she might expect from services, follow your usual company and applicable state policies.

C.4 and C.5 tend to be a quality control check to ensure the individual has been contacted by a service coordinator and has an ISP. If gaps are identified through these questions, there should be follow-up to address them.

Section D. Diagnoses and Health Care Utilization

Section D covers a variety of topics about the individual's diagnoses, medical care needs and assistive devices.

Helpful Hints: Diagnoses/DME need and Care Transition Planning

The questions D.1, D.2, and D.4, and D.5 focus on issues that have been diagnosed by a medical professional. Question D.3, however, allows for concerns from those who are close to the individual.

You may complete D.13 and D.14 in the order you prefer. Some assessors may use D.13 as an "icebreaker" before delving into specifics while others may prefer to understand the scope of DME need and use (D.14) before discussing overall concerns. To assess if DME reassessment is needed, it may be helpful to use probes such as "has the individual had a recent change in functional status?", "how old is the individual's [equipment]?" or "has the individual had a growth spurt since they got their [equipment]?"

Question D.17 is only designed for individuals ages 12 and older and helps both the individual/caregiver and service planning team determine how the individual's healthcare team has been preparing him/her for their eventual adult healthcare needs. Be prepared for reaction from caregivers that it may seem strange to be asking these items about their teenager. Re-assure the caregiver/individual these items are designed to help ensure proper planning for their long term health needs and that it is never too soon to be thinking about these things and identifying transition planning needs.

Section E. Caregivers and Social Supports

Section E provides a place to include information on the people in the individual's life and household.

Helpful Hints: Caregivers

E.2 and E.3 collect information on two caregivers. If the individual only has one caregiver, you will use the code "8" anywhere an item asks for information related to the second caregiver.

If possible, consult the caregiver away from the individual to assess any feelings of distress concerning their provision of care for the individual.

Section F. Strengths and Challenges in Performing Daily Tasks

This section contains an overview of the individual's functional status and communication skills.

Helpful Hints: ADL/IADLs

If an individual has a condition that affects *any* ADL or IADL, they can be coded as "yes" for the relevant question. The individual should then be further evaluated in the PCAM for specific tasks later in the assessment. As you code these items, consider first if any limitation is in fact developmentally appropriate and not therefore a result of the individual's condition. For example, a typically developing 8-year-old child should not be expected to perform any IADLs but should be able to perform most ADLs such as bathing, dressing, toileting, etc.

Section G. Nutritional Status/Concerns

Section G provides an overview of the individual's nutritional intake, including the most recent and available height and weight measurements.

Section H. Current Treatment and Procedures

Section H starts with questions aimed at understanding the individual's medication regimen, followed by pinpointing services and treatments the individual has received and ends with discussion on the potential for physical improvement. Many of these items are helpful for determining a plan of care. Additionally, many of these items serve as triggers for the NCAM. For further information on the "List of All Medications," see description and hints below Section I; the chart to record the medications appears at the end of the Core.

Helpful Hints: Pain Control and Physical Function Improvement

Question H.7 is about Pain Control. It may be helpful to start the conversation by asking the individual if they have any pain at this time; for younger individuals, you may need to use the Faces Scale. Use this as a beginning to ask the bigger picture question about how their pain management regimen is working for them overall—and if they are following it consistently. You may need the assistance of the caregiver when the conversation turns to the overall pain management plan.

Question H.8 is a two-part question designed to find out the individual's and the caregiver's view of the individual's condition and their potential for physical improvement. Be sensitive in your approach to this question and be aware that a caregiver may have a different response from the individual.

Section I. Mental Health and Behavioral Health Concerns

Section I is devoted to capturing the individual's mental healthcare use and presence of behavior indicators. The second to last question presents a brief look at how the individual's lifestyle may be affecting their health.

Helpful Hints: Mental and Behavioral Health

Keep in mind previous statements made by the individual or caregiver and observations you or others have made of his or her verbal and nonverbal indicators. Some individuals are more verbal than others, and will make direct statements about their feelings. Others will only disclose those feelings when asked directly. Others may be unable to articulate their feelings because they cannot find the words to describe how they feel, they lack insight, or have impaired cognitive capacity. Observe the individual carefully for any indicator.

Remember to be aware of cultural differences in how these indicators may be manifested. Some individuals may be more or less expressive of mental health concerns, emotions, or feelings because of their cultural norms. Be cautious not to minimize your interpretation of an indicator based on your expectations about their cultural background. On the other hand, it is important to be especially sensitive to these indicators when assessing an individual whose culture may make him or her more stoic in expressing concerns.

List of all Medications

Helpful Hints: Medication

The coding instructions for the medication chart are extensive. Please review them carefully. For each drug record, you will need to enter information in all the columns (1.a, 1.b, and so forth). See **H.1 List of all medications** in the next chapter "*Item by Item Definitions/Instructions"* to see an example of a completed chart.

When assessing formal medication care and treatments, consult logbooks that the individual may have in the home and review agency documentation if available.

PCAM

The default look-back period for all Sections of the PCAM is 30 days, unless otherwise specified.

Section J. Cognition and Executive Functioning

Section J provides more in-depth questions on an individual's cognitive status. Some of the questions focus specifically on capturing changes in cognitive status that may be important for service needs.

Section K. Communication and Vision

Section K. focuses on the individual's ability to hear and see.

Helpful Hint: Communication/Vision

When addressing the questions, code for the individual's ability with any assistive devices (e.g. hearing aid, glasses, etc.) normally used. Test the accuracy of your findings by observing the individual during your interactions.

Section L. Additional Behavioral Considerations

L.1 parallels section I of the Core. You can use many of the same techniques and probes you use for that section.

Section M. Functional Status

The purpose of this section is to examine the areas of function that are most commonly associated with independent living and self-care. "Instrumental" activities of daily living (IADLs) include items associated with normal tasks and activities in maintaining a household. Many of these IADL tasks are ones that a younger individual would not be expected to perform independently. This section also looks at basic self-care tasks, or activities of daily living (ADLs), such as bathing, toileting, dressing, and eating. For each item, you will code for both the individual's performance and whether the individual's condition affects the performance of the task during the last 30 days.

Helpful Hints: IADLs/ADLs

Remember, the key to these two questions is the EFFECT. Children are not little adults, and no two children of the same age may be at exactly the same level in their development or abilities. So code the PERFORMANCE sub-item based on what you *observe* or *is reported* by the individual or caregiver. For example, one 3 year-old may be toilet-trained while another one may not, yet both can be developmentally appropriate. What is important for you as the assessor to decide is whether or not the individual's illness or condition has an EFFECT on their ability to perform the task listed. Also, if you do not see the individual perform the task while you are present, don't forget to ask the individual or the caregiver about whether or not the individual performed the task in the last 30 days. If the answer is "No" the task did not occur, code it as "8" for performance, and then SKIP THE EFFECT.

Section N. Continence

Section N is devoted to the individual's continence of the bowel and bladder. These items do not refer to the individual's ability to toilet themselves — e.g., an individual can receive extensive assistance in toileting and yet be continent, perhaps as a result of recognizing the need to void and receiving help from others. Please note that the response codes separate continence/dryness achieved naturally ("0") from dryness achieved through use of a program or appliance, such as an indwelling catheter ("1").

- Remember to consider continence patterns over the last 7 day period, 24 hours a day, which differs from the PCAM default period of 30 days.
- **NURSING NOTE** – If no urine output has occurred in the last 7 days, this is a potential medical emergency. Call your supervisor and 911. If no bowel movement has occurred in the last 7 days, first verify with the caregiver if this is normal for the individual, and then notify your supervisor immediately for further guidance to determine if this may or may not be a medical emergency.

Section O. Sleep

The purpose of this section is to determine if a lack of consistency in sleep patterns is a complication in individual's functional status and if so, to what extent.

Section P. Habilitation Needs

Section P is used exclusively for individuals requesting CFC services. It is devoted to establishing goals and desired outcomes for CFC habilitation. DO NOT ASK THESE ITEMS UNLESS THE INDIVIDUAL OR CAREGIVER REQUESTS OR IS ALREADY RECEIVING CFC SERVICES. It is not necessary that the individual be able to do these activities - rather that they desire to acquire, enhance, or maintain the skills needed to perform them. Make sure to follow-up "Yes" answers by recording the individual's preferred learning style for how to accomplish the tasks or skills.

NCAM

The default look-back period for the NCAM is 30 days, unless otherwise specified.

Section Q. Complex Conditions and Nursing Care

Section Q concentrates on complex conditions and skilled nursing care. These items are used for identifying potential skilled nursing needs and also serve as part of the requirements for determining medical necessity for individuals requesting CFC services or MDCP. This section includes items relating to neurological care, airway management, nutritional care, medication, elimination, integumentary care, and other skilled nursing services. ONLY A REGISTERED NURSE SHOULD COMPLETE THIS SECTION.

Helpful Hint: Complex Conditions and Nursing Care

There are multiple "skip questions" in this section, where the answer to an item may direct you to skip subsequent items.

The nursing services for each body system should focus on formal care needed and received.

MDCP

Section R. MDCP Related Items

The default look-back period for the MDCP module is 7 days, unless otherwise specified.

This section consists of items from the previously utilized MN/LOC assessment regarding the cognition, mood, behavior, functional status, continence, diagnoses, skin conditions, nutritional status, physician care, special treatments, procedures and programs received by an individual being assessed. These items are used to determine the Resource Utilization Group (RUG) level for individuals served by or being considered for entry into the MDCP waiver. The RUG level informs the cost limit, or budget, of the individual and are NOT utilized in the context of this module for medical necessity determination.

Helpful Hints: Introducing the MDCP

Please note that many of these questions are very similar in nature to other items in the Core and NCAM, just with a different, often more narrow look-back period. It is important to explain to the individual and/or caregiver before you start the MDCP module that while the items are similar, they serve a different purpose and are necessary for MDCP budget and planning alone, and not in fact used for medical necessity determinations.

Assessment Summary

Section Z. Assessment Summary

The assessment summary section covers caregiver concerns, emergency services, supports and service delivery options. It also offers one last opportunity for the assessor to provide additional information or recommend referrals not otherwise flagged or triggered elsewhere in the assessment.

NOTE - Item Z.6. ERS (Emergency Response Services) is a service only available through CFC. If an individual requires emergency response services (ERS), check "Yes," and then MAKE SURE ALL ITEMS REQUIRED FOR MEDICAL NECESSITY DETERMINATION ARE COMPLETED FOR CFC.

Item by Item Definitions/Instructions

NOTE: Items or sub-items that are MANDATORY for all types of SAIs are notated as "**(SAI-Req)**" while those that are specifically required for Medical Necessity Determination are marked "**(MN-Req)**." If an item has multiple sub-items that are all required, the item will be labeled as such rather than each sub-item (e.g., Question A.4 has sub-items "a" through "f" which are all "**(SAI-Req)**," so A.4 will be labeled as "**(SAI-Req)**" but not each sub-item). If an item is not mandatory, then a value of "9" may be entered if available, or the item may be skipped (see "How to Gather Information" above for further information).

Core

SECTION A. IDENTIFICATION INFORMATION

A.1 Name (SAI-Req)

Use individual's legal name. If the individual does not have a middle name, leave space blank.

A.2 Gender (SAI-Req)

1. Male
2. Female
9. Unknown

A.3 Birthdate (SAI-Req)

Record the two-digit month, two-digit day and four-digit year in the space provided.

A.4 Ethnicity and Race (SAI-Req)

Ask individual or caregiver which of the categories best describes the individual's race and ethnic background. The individual may identify with more than one category:

a. **Hispanic or Latino -** refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

b. **American Indian or Alaska Native** – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

c. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

d. **Black or African American** – A person having origins in any of the Black racial groups of Africa.

e. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

f. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

A.5 Participants in Assessment

List the names of all persons participating in the assessment of the individual, excluding the individual.

A.6 Individual's Profile

The format is based on work by The Learning Community for Person Centered Practices.

a. A little about myself- Enter a descriptive narrative including general information you have learned about this individual through the discovery process.

b. What people like and admire about me – Enter a descriptive narrative including what you have learned through the discovery process that others like and admire about the individual.

c. What's important to me – *("Important To").* Enter what you have learned through the discovery process that is important to the individual. "Important to" reflects what is important from the individual's perspective and is based on conversation with and/or observation of the individual. The information might include important relationships, how the individual prefers to interact, things the individual likes to do or not do, preferred routines, relevant background information that may affect how the service should be delivered and what the individual wants to do in the future. Remember the individual's response is limited to the knowledge and experiences he/she has to date. Additional efforts should be explored to increase his/her awareness of additional possibilities and experiences to increase his/her options of choice.

d. What others need to know and do to support me – *("Important For").* Enter important information you have learned through the discovery process about the individual, such as how the individual communicates and how to best communicate with him or her. Include what you have learned through the discovery process that is important for the individual, as identified by those who know him or her best. "Important for" reflects information that is important for the service provider to know and understand about the individual. This information should be related to health, safety and any supports regarded as necessary to enhance the individual to be a valued individual of the community. Enter information such as health needs, supervision requirements, specific behavioral needs and special instructions for those who support the individual. This section includes contraindications and special justifications for deviating from typical routines or activities (for example, adult day care three days a week, four hours a day, or a job four days a week, five hours a day). List any barriers that could prevent the outcomes/purposes from being achieved. Things identified as "important for" are not usually included as "important to" the individual.

e. What the people are like that support me best— Enter important information about the *type of* people in the individual's life who provide support to him or her, including characteristics and traits that make those people most supportive (for example, someone with a gentle voice, who enjoys the same activities as individual, etc.). Provide any information that may be important to a successful match between the individual and the CFC PAS/HAB provider. You may also include types and characteristics that do not support the individual well.

f. How I like to spend my day -- Enter important information you have learned through the discovery process about the individual such as what the individual enjoys doing during the day and important routines or rituals for the individual. Indicate if the

individual enjoys being in the community, staying home, being with large groups, or being alone.

g. **The services I am currently receiving are --** Enter important information you have learned through the discovery process about the individual's current services, both professional and non-professional. This may include therapies, waiver and non-waiver supports. This does not need to be an all-inclusive list.

A.7 Language (SAI-Req)

Individual's preferred language for day-to-day communication. If "Yes" (1) is selected for "other" please specify the language in the space provided.

A.8 Interpreter Needed

Ask if an interpreter is needed for either the individual or the caregiver. If no interpreter is needed for either, code "0" for "No" in both boxes and skip to question **A.10**. If an interpreter is needed for either the individual or the caregiver, proceed with question **A.9** to gather the information on the interpreter.

A.9 Interpreter Information

If an interpreter is needed, first print the name of the interpreter in the space provided and have the interpreter sign and date either the assessment (after printing) or an accompanying form, whichever follows your company's policy. If no interpreter is needed, leave blank.

A.10 Numeric Identifiers

a. **Social Security Number *(SAI-Req)* –** Enter the individual's Social Security number. If the individual does not have a Social Security number, enter "000-00-0000."
b. **Medicare Number** - Enter the individual's Medicare number if the individual has one. If the individual does not have a Medicare number, leave blank.
c. **Medicaid Number *(SAI-Req)*** - Enter the individual's Medicaid number. Enter "+" (plus sign) if the individual is being considered for entry to the MDCP waiver and the Medicaid number is pending.

A.11 Does Individual Have Healthcare Needs Not Covered by Current Funding Sources?

Determine if there is any gap in individual's funding sources for other healthcare needs.

- **Healthcare needs** - can cover a multitude of things relating to individual's health such as home modifications.
  - If "Yes" is selected, explain what needs are not met in the space provided.

A.12 Reason for Assessment (SAI-Req) (MN-Req)

NOTE: For more information on system and operational requirements for coding and submitting various assessment types, please see the "MCO Business Rules" document.

0. **Initial assessment** — An assessment that is done at the time of entry into STAR-Kids, or when initially determining eligibility for home care/home health services.
1. **Re-assessment** — A regularly scheduled follow-up assessment to ensure that the care plan is appropriate and current.
2. **Significant change in status re-assessment** — A comprehensive re-assessment conducted at any time during the uninterrupted course of care because the individual's status or condition has significantly changed.

3. **Minor correction to recent assessment** – Any correction to a previously conducted and submitted assessment or re-assessment within the PAST 14 DAYS that does NOT involve Items marked "MN-Req."
4. **Major correction to recent assessment -** Any correction to a previously conducted and submitted assessment or re-assessment within the PAST 14 DAYS that involves ONLY Items marked "MN-Req."

A.13 Assessment Reference Date (SAI-Req)

The assessor should enter the assessment reference date as the date the assessment is submitted to HHSC's administrative services contractor (ASC). For assessments that include a request for medical necessity determination, this reference date will be used as the begin date for medical necessity. The medical necessity end date will be the reference date, plus 365 days.

A.14 Phone Number

To establish a record of contact information in case further clarification of responses is needed.

a. Primary – Enter the individual's primary phone number.
b. Alternate - Enter an additional number to reach the individual if unreachable via the primary number.

A.15 Address of Current Residence (SAI-Req)

Enter the street address and city in the spaces provided.

A.16 Postal/Zip Code of Current Residence (SAI-Req)

The last 4 digits of the ZIP code are optional.

A.17 As Compared to 90 DAYS AGO (or since last assessment), Individual Now Lives with Someone New (e.g., moved in with another person(s), other(s) moved in)

For example, the individual has moved in with another person; someone else has moved in with the individual; or the individual's mother has died in the last 90 days.

A.18 Current Residence (SAI-Req)

Own home or apartment

a. Alone - Code "1. Yes" if the individual lives alone. (This includes an individual living alone who receives in-home services.)
b. With family - Code "1. Yes" if the individual lives in his or her own home and a relative lives with the individual. If a relative is being paid to provide care for the individual, this box should be checked. **NOTE: Code this box for all children under the age of 18 living with their parent(s).**
c. With spouse/partner - Code "1. Yes" if the individual lives in his or her own home with a spouse/partner.
d. With non-relative/roommates - Code "1. Yes" if the individual lives in his or her own home and a non-relative or with other roommates live with the individual. This includes if a caregiver that is paid or unpaid lives with the individual, or if the individual lives in a dorm or community living situation.

Someone else's home or apartment

e. Family - Code "1. Yes" if the individual lives in a relative's home, regardless of whether or not the relative is paid or unpaid support.
f. Foster family – Code "1. Yes" if the individual lives with a foster or host family. The individual's foster/host family may be a paid or unpaid support, providing services such as personal care to the individual.
g. Non-relative/roommates - Code "1. Yes" if the individual lives with a non-relative that may also be the individual's caregiver that is paid or unpaid
h. Certified or licensed group home - Code "1. Yes" if the individual lives in a group home. This includes three - or four-person residences operated by certified Home and Community-based Services (HCS) program providers.

Group residential living

i. Assisted living facility (ALF) - Code "1. Yes" if the individual lives in an assisted living facility.
j. Residential treatment center (RTC) - Code "1. Yes" if the individual lives in a residential treatment center.

Institution

k. Nursing home - Code "1. Yes" if the individual lives in a nursing home as their permanent residence. If the individual is currently in a hospital or nursing home for rehabilitation, but maintains a home elsewhere, do not select this box. For example, if the individual is in the nursing facility for rehabilitation but has an apartment that he or she intends to return to, then the apartment is their current residence. The individual's permanent living arrangement should be indicated rather than the temporary setting.
l. Intermediate care facility for individuals with intellectual disability or related conditions (ICF/IID) - Code "1. Yes" if the individual lives in an ICF/IID facility. This includes State Supported Living Centers (SSLCs).

Other living arrangements

m. No permanent residence - Code "1. Yes" if the individual does not have a permanent residence. For example, Code "1. Yes" if the individual lives in a homeless shelter. A hotel or motel would go under "no permanent residence" if it is a temporary arrangement. If the hotel or motel serves as the permanent residence, select one of the options under the 'Own Home or Apartment" category.
n. Other - specify - Code "1. Yes" only if no other box is appropriate, then specify the individual's living arrangement in the space provided.

A.19 Prefers to Live

Own home or apartment

a. Alone - Code "1. Yes" if the individual prefers to live alone. (This includes living alone while receiving in-home services.)
b. With family - Code "1. Yes" if the individual prefers to live in his or her own home with a relative, including a relative that is being paid to provide care for the individual.
c. With spouse/partner - Code "1. Yes" if the individual prefers to live in his or her own home with a spouse/partner, including a spouse/partner that is being paid to provide care for the individual.
d. With non-relative/roommates - Code "1. Yes" if the individual prefers to live in his or her own home and with a non-relative or with other roommates. This includes if a caregiver

that is paid or unpaid lives with the individual, or if the individual lives in a dorm or community living situation.

Someone else's home or apartment

e. Family - Code "1. Yes" if the individual prefers to live in a relative's home. The individual's relative may be a paid or unpaid support providing services such as personal care to the individual.

f. Foster family – Code "1. Yes" if the individual prefers to live with a foster or host family. The individual's foster/host family may be a paid or unpaid support providing services such as personal care to the individual.

g. Non-relative/roommates - Code "1. Yes" if the individual prefers to live with a non-relative that may also be the individual's caregiver that is paid or unpaid.

h. Certified or licensed group home - Code "1. Yes" if the individual prefers to live in a group home. This includes three - or four-person residences operated by certified Home and Community-based Services (HCS) program providers.

Group residential setting

i. Assisted living facility (ALF) - Code "1. Yes" if the individual prefers to live in an assisted living facility.

j. Residential treatment center (RTC) - Code "1. Yes" if the individual prefers to live in a residential treatment center.

Institution

k. Nursing home - Code "1. Yes" if the individual prefers to live in a nursing home as their permanent residence.

l. Intermediate care facility for individuals with intellectual disability or related conditions (ICF/IID) - Code "1. Yes" if the individual prefers to live in an ICF/IID facility. This includes State Supported Living Centers (SSLCs).

Other living arrangements

m. No permanent residence - Code "1. Yes" if the individual prefers not to have a permanent residence. For example, Code "1. Yes" if the individual lives in a homeless shelter. A hotel or motel would go under "no permanent residence" if it is a temporary arrangement. If the hotel or motel serves as the permanent residence, select one of the options under the 'Own Home or Apartment" category.

n. Unable to determine individual's preference for living arrangement.

o. Other - specify - Code "1. Yes" only if no other box is appropriate, and specify the individual's living arrangement preference in the space provided.

A.20 Does Individual Want More Information About Community Living?

This question is intended for individuals that would find a community living situation age appropriate (age 18 or older). Ask the individual if they are interested in more information about community living. Code "0. No" or "1. Yes" or if the question is not applicable, code "8."

A.21 What Is the Guardian's/LAR's Preference for Living Arrangements for This Individual?

Only ask this question if the LAR is the primary participant due to the individual's age or disability, and if such a question is age appropriate (age 18 or older).

a. **Not applicable –** Code "1. Yes" if there is no family or guardian or if the family or LAR does not have any preferences around the individual's places of residence.

b. Move to own home/apartment - Code "1. Yes" if LAR prefers that the individual move to his/her own home or apartment (includes living with spouse/family).
c. Move to an Assisted Living Facility (ALF) - Code "1. Yes" if LAR prefers that the individual move to an ALF (includes all size ALFs).
d. Move to a foster/host home - Code "1. Yes" if LAR prefers that the individual move to a foster/host home.
e. No consensus among multiple parties - Code "1. Yes" if there is no consensus or if involved parties disagree about the living arrangements for the individual.
f. Stay at current residence - Code "1. Yes" if LAR prefers that the individual stay at the current residence.
g. Move to a certified or licensed group home (includes three - and four-person residences operated by certified HCS program providers) - Code "1. Yes" if LAR prefers that the individual move to a certified or licensed group home.
h. Move to a nursing home or other institutional setting (ICF/IID, SSLC, RTC) - Code "1. Yes" if LAR prefers that the individual move to a nursing home or other institutional setting.
i. Move to someone else's home (including a family, non-relative's, or care-giver's home) - Code "1. Yes" if LAR prefers that the individual move to someone else's home.

A.22 Does The Guardian Want More Information About Community Living?

Only ask this question if the LAR is the primary participant due to the individual's age or disability, and if such a question is age appropriate (age 18 or older). Ask the guardian/LAR if they are interested in more information about community living. Code "0. No" "1. Yes" or if the question is not applicable, code "8."

A.23 Assessor Information (SAI-Req)

Enter your information here and include the date you conducted the assessment.

A.24 Medical Provider Information (SAI-Req)*

**At a minimum, Item A.24.a must be asked and populated. If the answer is "No" (0) that the individual does NOT have a regular provider, then the other sub-items may be skipped. If the answer to A.24.a is "Yes" (1), then all other sub-items A.24.b through A.24.j must be asked and populated, except as noted for sub-item A.24.f. Please note that the provider listed in this item will be the provider contacted for the purposes of requesting additional information for medical necessity determinations that are pending denial.*

Ask the individual and caregiver for permission to review any existing personal records that contain relevant information.

a. Does the individual have a regular provider that meets their medical needs?
A medical provider is a doctor, pediatrician, nurse practitioner, physician assistant, or specialist that acts in the capacity of a primary care provider (PCP). They may also be referred to as the "main doctor."
b. If yes, does the provider accept Medicaid?
c. Printed name of provider
d. Length of time individual has been in care of this provider – the amount of time individual has gone to this provider for their medical needs.

e. **Date of last visit with provider –** the month and year individual last visited provider, regardless of purpose of the visit.
f. **National Provider Identifier (NPI) or Alternative Provider Identifier (API) – Do NOT expect the individual to have nor ask the individual for this information.** It may be available in their personal medical records, but most likely this is a field you will leave blank *initially* and populate at a later time before you submit the assessment, once you confirm the provider has a number (i.e., after you return to the office following the assessment).
g. **Provider telephone**
h. **Provider fax**
i. **Address of the provider**
j. **Zip code of provider –** last 4 digits are optional

A.25 Guardian/LAR (SAI-Req)

a. Name of Guardian/LAR

Enter the first, middle, and last name of the guardian/LAR. For individuals under 18 with both parents having joint custody (e.g., mother and father are married to each other), ask the family to provide one individual for the record.

A.26 Legal Responsibilities/Guardianship

For individuals age 18 or older, it is important to note if legal guardianship has been pursued. Individuals with IDD often use supported decision making and do not have a legal guardian. This question also applies to individuals under age 18, as there may be some cases where one parent has custody ("legal guardian") but not another.

A.27 Current Dispute Over Custody/Access

The purpose of this question is to record parental discord related to the custody, living arrangement, or visitation of the individual or other individual in the family. Such conflict may affect the consistency of care.

a. **This individual -** Code "1. Yes" if a dispute over custody or access involves the individual.
b. **Other individual(s) in household/family -** Code "1. Yes" if a dispute over custody and access involves other individual in the family unit.

SECTION B. SCHOOL AND WORK

B.1 Type of Current School or Day Program

a. **Day Care**
b. **ECI –** Early Childhood Intervention. A specialized program for infants and toddlers with disabilities under 36 months of age; see explanation on Question D.4 in this Manual for further information about ECI
c. **Head Start or Pre-Kindergarten**
d. **Kindergarten, Elementary, Middle or High School –** Public or Charter School. *If the individual attends a PRIVATE school, record it under B.1.j.*
e. **Home-based (through school system) –** The individual receives his/her education at home but it is provided for by the local education agency (ISD)

f. **Home school –** The parent(s) or caregiver serves as the primary educator for the child outside of the local education agency (ISD) and school system
g. **Alternative school -** Non-traditional educational setting other than home or public school designed specifically to accommodate educational, behavioral, and medical needs
h. **Vocational or technical/day program**
i. **College or Junior College**
j. **Other (specify) -** If the individual attends a PRIVATE school, code "Yes" (1) and note that in the space provided, along with the level (Kinder, Elementary, Middle, High School).
k. **Not applicable –** If the individual already has graduated from high school and college or junior college and is no longer in the education or higher education system, code "Yes" (1) here.

B.2 Name and Address of Current School or Day Program

Record the full name and address of any school or day program in which the individual participates.

B.3 Current Special Education

a. **General education** – A classroom setting with typically developing peers
b. **Resource room –** For purposes of this assessment, a "resource room" is a special education classroom at school where a special education teacher provides *one-to-one instruction* with the individual for a defined period of time in the school day.
c. **Self-contained room** – For purposes of this assessment, a "self-contained room" is a special education classroom at school where a special education teacher instructs *multiple students* in a small-group for a defined period of time in the school day.
d. **Special school –** A facility dedicated for individuals in special education
e. **Home-based –** The individual receives special education services at home
f. **Other (specify)**

B.4 Individual Has Individualized Education Plan (IEP)

An IEP is a customized, written education plan developed to ensure that a child or adolescent with a disability who attends a public elementary or secondary school receives the specialized care and instruction he or she needs under law.

B.5 Individual or caregiver consents to share IEP with assessor and those involved with Individual's care

If the member has an IEP, ask the family if they are willing to share it with the assessor, service coordinator, and/or other providers. Because IEP is confidential and protected by FERPA (a federal education law), the guardian/LAR or individual is not required to provide a copy. However, with the family's permission access to the document will promote the coordination of care with school-based providers.

B.6 Services Currently Provided at School or Day Program (Including ECI, If Applicable) In Last 30 Days (or since last assessment if individual has not been in school or day program in last 30 days)

- **Services** – any of the special education and related services the individual's school provides to reach educational goals as outlined in the IEP. Some but not all these services are provided *by* the school district.

Alongside responses from the individual and caregiver, it may be helpful to review any documentation that the individual and caregiver are willing and able to share. Documentation can be especially useful in determining whether individual receives skilled nursing visits or private duty nursing in the school or day program.
Code "0. No" if the individual does not receive the following services and code "1. Yes" if the individual has received services in the last 30 days. Code "8. N/A" if the question does not apply to the individual.

a. Personal care aide – assists individual with self-care and everyday tasks (either hands-on or cueing) while at school or day program

b. Occupational therapy – occupational therapy services provided at school or day program, often to assist individual to participate in learning and school activities – such as paying attention in class, handwriting, or holding a pencil or book in the easiest way

c. Physical therapy – physical therapy services (e.g. exercises, training, assistance with developmental activities, safety instruction) provided at school or day program through school district.

d. Speech therapy – speech therapy services provided at school or day program and/or through the school district.

e. Orientation and Mobility specialist – a specialist who teaches individual how to move around the school or day program,

f. Behavioral Intervention Program (BIP) or Intensive Behavioral Intervention (IBI) – a Behavioral Intervention Program is plan to support the individual in order to help them change their behavior. Behavior plans typically include activities such as teaching the individual alternative behaviors, assisting the individual in identifying and avoiding behavior triggers. Similar to behavioral intervention programs, Intensive Behavioral Intervention is for individuals with autism to learn appropriate behaviors as alternatives to problem behaviors. Behavior change is broken into steps and rewards are given for positive behavior while difficult behavior is ignored. IBI is noted to be particularly intensive, usually consisting of 20-40 hours a week.

g. Skilled nursing visit - a visit in which a professional nursing task is initiated and completed at the school or day program. This can be hands-on nursing care, or observation and assessment.

h. Private duty nursing – when the individual requires more individual and continuous care than available from a visiting nurse, private duty nursing (PDN) may be used for nursing services at the school or day program. These services typical include observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings

i. **Audiology services –** services provided to students with hearing impairments and listening problems in the school or day program (e.g. hearing evaluation, audiology training, counseling regarding hearing loss, assistance with hearing devices)
j. **Other (specify) –** any other identified services provided at school that are not previously mentioned.

B.7 Any Additional Services Received at School Not Previously Mentioned

If there are any additional services, code "0. No" or "1. Yes" or "8. N/A" If "Yes," please specify in the space provided.

B.8 Individual Has Preferred Learning Style

This item addresses how the individual prefers to learn or practice new things. For example, if the individual is a visual and active learner who prefers to watch an example and then attempt to do a task on his/her own. Other examples of learning styles include:

- Visual (spatial) – using images, pictures, color and other visual media to learn. Examples: using visual associations, pictures to replace words, highlighting
- Aural – using sounds, rhymes and music to learn. Examples: writing songs or rhymes to remember lessons.
- Verbal – preference for using speech or writing. Examples: recording lessons, writing speeches.
- Physical – using body, hands or sense of touch to learn. Examples: role-playing, drawing, acting.
- Solitary – prefer to learn alone, with self-study.
- Social – prefer to learn with groups or with other people. Examples: role-playing, sharing what you learned with a group
- Logical – prefer to learn with logic, reasoning and systems.

The above list is not exhaustive or exclusive. Other phrasing or examples can be used; the intent of this question is to have a general idea of how the individual best learns. If the individual has a preferred learning style code "1. Yes" or "0. No" or "8. N/A". If yes, explain the style on the lines provided.

B.9 Are There Any Concerns About How Individual's Health Condition or Behavior Affects Their Education?

If yes, specify concerns in the space provided.

B.10 Transition Planning Needed

The purpose of this question is to establish if the individual needs assistance to find alternative education or vocational programs or needs to transition between the two. If "1. Yes," specify the needed changes in the space below.

B.11 Current Employment Status

Ask the individual about his or her current employment status. If this item is inappropriate because of the individual's age (less than 14 years old), code "8. Not applicable." If an individual is over 14 years old and unable to work, select "4. Not employed". Further information as to their ability to work can be captured in other questions.

B.12 Employment Interest

Ask the individual about his or her current employment interest. If this item is inappropriate because of the individual's age (less than 14 years old), code "8. Not applicable."

B.13 Type of Employment or Volunteer Work

a. Attends pre-vocational day/work activity program – teaches individuals skills they need before entering a workplace.
b. Attends sheltered workshop – Centers that have historically provided rehabilitation services, day treatment, training, and/or employment opportunities to individuals with disabilities.
c. Has paid job in the community
d. Works at home
e. Does volunteer work

B.14 Need for Assistance to Work

- **Need for Assistance to Work –** the level of assistance individual needs to work, not what they are currently receiving.

If this item is inappropriate because of the individual's age (less than 14 years old), OR the individual is not interested in working, code "8. Not applicable."

SECTION C. GOALS FOR CARE

C.1 Individual's Expressed Goals of Care (SAI-Req)

The individual being assessed is an important member of the health care team. It is essential to ask him or her to identify what his or her goals of care might be. By doing so, the assessor encourages the individual to be an active member of the team. This can also be a starting point to develop a person-centered plan of care for services. Use the first text box to enter any and all goals stated by the individual; use the space after the box to enter the *most important goal* to the individual, even if this goal may be duplicated from information entered in the box before. For example, the individual might say he wants to stop using crutches, walk independently, and kick a soccer ball, and then he states that most importantly he wants to kick a soccer ball. All three goals should be entered into the first text box, and "to kick a soccer ball" should be recorded in the next line/space beneath as the primary goal. Please note that it is more than likely that the responses to this question will differ from those provided by the caregiver in Question C.2.

C.2 Primary Caregiver's Expressed Goals of Care for Individual (SAI-Req)

The primary caregiver is another important member of the health care team. It is essential to ask him or her to identify what the goals of care might be for the individual. By doing so, the assessor encourages the caregiver to be an active member of the team. Use the first text box to enter any and all goals stated by the caregiver; use the space after the box to enter the *most important goal* to the caregiver, even if this goal may be duplicated from information entered in the box before. For example, the caregiver might want the individual to take medication more independently and with a greater level of cooperation, use the toilet independently, and eat more solid foods, and then she states that most importantly she wants the individual to use the toilet independently. All three goals should be entered into the first text box, and "to use the toilet independently" should be recorded in the next line/space beneath as the primary

goal. Please note that it is more than likely that the responses to this question will differ from those provided by the individual in Question C.1.

C.3 One or More Expressed Care Goals Met Since Last Assessment (SAI-Req)

To identify if any of the individual's or caregiver's care goals have been achieved since the last assessment. If this is the initial SAI, code "N/A" (8).

C.4 Individual or Individual's Family Has Been Contacted by an MCO Service Coordinator (SAI-Req)

- **Service Coordinator -** the person with primary responsibly for providing specialized case management services to STAR Kids Member.

C.5 Individual Has A STAR Kids ISP in Place Tailored to Specific Needs (SAI-Req)

The purpose of the question is to ensure every STAR Kids Member has a person-centric ISP in place. The ISP is a helpful tool to communicate and help align expectations between the member, the family, the MCO and key service providers.

- **Individual Service Plan (ISP) -** Each STAR Kids MCO must create and regularly update a comprehensive person-centered ISP for each STAR Kids Member. The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and Member preferences.

C.6 Does Individual Receive Services Through the Following Programs? (SAI-Req)

NOTE: Do NOT use "Not Applicable" (8) on this question. *If the individual is not receiving the services of one of these programs, code "Does not receive" (2).*

This information may be useful to determine eligibility for additional services.

a. Intermediate Care Facility for Individuals with an Intellectual or Developmental Disability or Related Condition (ICF/IID) - the Medicaid program serving individuals with intellectual disabilities or related conditions who receive care in intermediate care facilities other than a state supported living center.

b. Nursing Facility - (also called nursing home or skilled nursing facility) means an entity or institution that provides organized and structured nursing care and services.

c. Community Living and Assistance Support Services (CLASS) – Medicaid program providing home- and community-based services to people with related conditions as a cost effective alternative to placement in an intermediate care facility for individuals with an intellectual disability or a related condition (ICF/IID waiver).

d. Home and Community-based Services (HCS) - specialized Medicaid program that provides Home and Community – Based long-term services and supports as cost - effective alternatives to institutional care for individuals with an intellectual or developmental disability or related condition (ICF/IID waiver).

e. Deaf Blind with Multiple Disabilities (DBMD)- Medicaid program that provides home and community-based services to people who are deaf-blind with multiple disabilities as a cost-effective alternative to institutional placement

f. Texas Home Living (TxHmL)- Medicaid program that provides selected essential services and supports to people with a diagnosis of intellectual or developmental disabilities (IDD) or a related condition who live in their family homes or their own homes (ICF/IID waiver).

g. **Youth Empowerment Services (YES)-** provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a month before a youth's 19th birthday, who have a serious emotional disturbance.
h. **Medically Dependent Children Program (MDCP) –** a program that provides Home and Community-Based long-term services and supports for individuals under the age of 21 with complex medical needs as a cost-effective alternative to living in a Nursing Facility.

SECTION D. DIAGNOSES AND HEALTH CARE UTILIZATION

D.1 Diseases (Record diagnoses and ICD-10 codes) (SAI-Req) (MN-Req)

Do NOT expect the individual to have nor ask the individual for the ICD codes associated with the diagnosis. It may be available in their personal medical records (e.g., home health chart), but most likely this is a field you will leave blank *initially* and populate at a later time (i.e., after you return to the office following the assessment) before submitting the assessment.

1. **Primary diagnosis stable; no change past 30 days –** Disease is main reason for support or services being provided, but the disease has not improved or worsened in the past 30 days.
2. **Primary diagnosis; acute or acute exacerbation past 30 days –** Disease is main reason for support or services being provided, and the disease has become more problematic or required different treatment in the past 30 days.
3. **Other diagnosis present, active treatment, no change past 30 days –** Other diagnoses being actively treated apart from primary diagnosis. Treatments can include medications, therapy, or other skilled interventions such as wound care or suctioning and the disease is stable during the past 30 days.
4. **Other diagnosis present, active treatment, exacerbation past 30 days** –Other diagnoses being actively treated apart from primary diagnosis. Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning and the disease has become more problematic or required different treatment in the past 30 days.
5. **Other diagnosis present, monitored, no change past 30 days -** Individual has a secondary diagnosis that is being monitored (for example, with laboratory tests or vital signs), but no active treatment is being provided.

Record the diagnosis and assessment code. Make your best attempt to judge "primary" versus "other" diagnoses based on what the individual/caregiver states and any clinical records provided, recognizing that it may be possible for an individual to have more than one of each. For example, an individual may have Asperger's syndrome and severe asthma which are unrelated to each other but could both be coded as a "primary" diagnosis. Then, enter the ICD-10 code in the boxes below. If known, enter the month/year of diagnosis of condition in the boxes on the right of the ICD code. If the month or year is unknown enter in 99 or 9999 respectively. If the entire date is unknown, enter 99-9999. Any additional diagnoses can be recorded in the free-text item, "Is there anything else that would be helpful…?" at the end of Section D.

D.2 Individual Has No Discernable Consciousness, is in A Persistent Vegetative State or Is in A Coma (SAI-Req) (MN-Req)

Comatose (coma) is a pathological state in which neither arousal (wakefulness, alertness) or awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak, and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain). Record 1 "Yes" if a coma or persistent vegetative state has been diagnosed by a medical professional.

D.3 Caregiver, Individual or Others Are Concerned About Individual's Development

a. **Related to motor skills (sitting, walking, range of motion, balance, running, jumping)** – any concerns in gross or fine motor skills (e.g., sitting, turning over, crawling, walking, jumping, moving blocks from hand to hand, using thumb and forefinger to pinch objects, moving thumb independent of fingers, grasping objects).
b. **Related to communication (talking, understanding)**
c. **Related to learning or academic skills (coloring, reading, writing, math)**
d. **Related to self-care (dressing, bathing, using toilet, self-care)**
e. **Related to social/emotional skill**

D.4 Further assessment is needed to determine if individual is eligible/should be referred for ECI services (SAI-Req)

Based on earlier questions and conversation with the caregiver, determine if there is any need for further evaluation. An individual may be eligible for ECI services if they are less than three years old and:

- Have a qualifying medical diagnosis (see https://dmzweb.dars.state.tx.us/prd/qdiag/);
- Have an auditory or visual impairment; or
- Have a developmental delay that affects functioning in one or more areas of development, including cognition, communication, gross or fine motor, social-emotional and adaptive/self-help.

D.5 Documented severity of intellectual disability (SAI-Req)

This is a level of ID diagnosed by a health professional. Responses to this question can be provided by the caregiver or through reviewing pertinent documentation. Only mark severity if there has been a previous assessment (e.g., an assessment with the ID/RC). If no previous assessment but ID is suspected, mark "6".

D.6 Surgeries (SAI-Req) (MN-Req)

If the individual has had no history of MAJOR surgeries, record "No" (0) and skip to Item D.7. Otherwise, write each surgery in the line provided and the year (XXXX). If the individual does not remember the year the surgery occurred, entered "9999." Remember that MAJOR surgeries are defined by the individual and caregiver. For one individual, the answer may include open heart surgery, while for another, it may mean a tonsillectomy.

D.7 Allergies (SAI-Req)

Do not forget to enter the specific allergen and reaction in the space provided if you enter "Yes" (1).

a. Individual has environmental allergies – Individual has reactions to allergens in the environment (e.g., pollen, pet dander).

b. Individual has food allergies – Individual has reactions to certain ingredients or food (e.g., peanuts, strawberries, wheat).

c. Individual has allergies to medication

D.8 Prenatal History/Prematurity (SAI-Req) (MN-Req)

The sub-items in this question are designed to determine how familiar the caregiver is with the individual's prenatal and birth history. If the caregiver does not know the answer to one of these sub-items, code "9" in that appropriate box and proceed to the next sub-item.

a. Premature birth – a birth that occurs before the 37th week of pregnancy.

b. Birth weight <1500g (3lbs. 5 oz.)

c. Maternal health problems during pregnancy (e.g., preeclampsia, toxemia, substance abuse, gestational diabetes)

D.9 Prevention (SAI-Req)

The following definitions include recommended benchmarks for the examinations. Some of these recommendations can change dependent on the individual's condition(s) (i.e., a physician may recommend more frequent screenings). When possible, use other sources of information (i.e. medical records) to double-check responses.

a. Complete physical examination up-to-date – According to the American Academy of Pediatrics (AAP), well child visits should be scheduled at the following ages:

3 to 5 days	12 months
1 month	15 months
2 months	18 months
4 months	24 months
6 months	30 months
9 months	Once a year starting at age 3 years

b. Dental exam up-to-date – According to the American Dental Association, an individual's first dental visit should be within 6 months of their first tooth but not later than a year old. Afterwards, regular dental visits should be every 6 months.

c. Eye screening up-to-date – While vision is often assessed at every well child visit, vision acuity tests are recommended by the AAP at the following ages:

3 years	10 years
4 years	12 years
5 years	15 years
6 years	18 years
8 years	

d. Hearing screening up-to-date – While hearing is often assessed at every well child visit, hearing tests are recommended by the AAP at the following ages:

Newborn	6 years
4 years	8 years
5 years	10 years

e. **Influenza vaccine up-to-date –** Individual has had an influenza shot within the last year if greater than 6 months of age.

f. **Immunizations up-to-date –**The CDC recommended schedule for immunizations can be found here: http://www.cdc.gov/vaccines/schedules/easy-to-read/child.html.

g. **Autism screening performed (if applicable)-**According to the American Academy of Pediatrics developmental screening tests should be administered regularly at the 9-, 18-, and 24- or 30-month well child preventive care visit.

D.10 Hospital Use, Emergency Room Use, Physician Visit, Nursing Home Stay (SAI-Req) (MN-Req)

Try to get caregiver to give best estimate instead of coding all 9's.

a. **Inpatient acute hospital admission planned (non-psychiatric)** – for example, admission for a scheduled surgery.

b. **Inpatient acute hospital admission unplanned (non-psychiatric)** – for an acute worsening of condition, or unplanned surgery (appendicitis, testicular torsion, etc.).

c. **Emergency room visit (with no inpatient admission) -** Any visit to an emergency room, regardless of reason. Do not include an emergency room visit that resulted in an overnight stay.

d. **Physician visit planned (or authorized assistant or practitioner)** Scheduled visit with a physician (exclude psychiatrist). This item includes a very broad spectrum of medical providers or specialists (for example, MD or DO, who is either the primary physician or consultant). Also include, for example, an authorized physician assistant or nurse practitioner. **Do not include visits with a psychiatrist.**

e. **Physician visit unplanned (or authorized assistant or practitioner)** Visit with a physician (exclude psychiatrist) because of a worsening of condition. This item includes a very broad spectrum of medical providers or specialists (for example, MD or DO, who is either the primary physician or consultant). Also include, for example, an authorized physician assistant or nurse practitioner. **Do not include visits with a psychiatrist.**

f. **Nursing home stay**

D.11 Time Since Last Hospital Admission (SAI-Req) (MN-Req)

Note that the look-back period for this question is 1 YEAR.

D.12 Any Planned Hospitalizations or Surgeries (In-Patient or Out-Patient) Scheduled in The NEXT 90 DAYS?

If the individual has no planned surgeries or hospitalizations in the next 90 days, record "No" (0) and skip to Item D.7. Otherwise, write each hospitalization/surgery in the line provided and the approximate date scheduled (MO-YEAR). If the individual or caregiver does not remember the approximate date, enter "99-9999."

D.13 Results of Discussion of Assistive Devices/DME Needs with Individual or Caregiver

This item records the caregiver/individual's responses to an inquiry about devices/DME needs. Report the conclusion reached by the caregiver/individual about assistive devices/DME needs. If there are no concerns expressed about current DME/assistive device needs, write "0" in the box provided and proceed to D.14 in order to document the DME/assistive devices in use and status of need regarding each device listed (it is possible

the caregiver/individual may identify needs not previously recognized when DME/assistive devices are itemized in D.14). If the individual or caregiver believes new or additional DME is needed, write "1" in the box provided and proceed to D.14 in order to document DME/assistive devices and status of need regarding each device listed. Only code "8" in the box and skip to question D.15 if individual does not use *and does not need* any DME/assistive devices.

D.14 Individual Currently Uses or Has a Need for Assistive Devices/DME

If individual uses or has a need for DME/assistive device, specify the type(s) in space provided. **If the type of DME/assistive device is not known, specify the functional limitation that needs correction.** Code "1" if assistive device/DME is available and adequate. Code "2" if referral in place for assistive device/DME need. Code "3" if referral needed to assess for unmet assistive device/DME need. Code "4" if the DME provider needs to reassess the appropriateness of the current DME/assistive device due to a change in the individual's age, condition, and/or functionality."

D.15 Individual Needs Care Supplies (e.g., formula, wipes, qtips, etc.)

Use this area to specify supplies needed for personal care or medical needs, such as diaper wipes or dressings for tracheostomies.

D.16 Medical Emergency Plan

- **Condition that requires an emergency plan –** any condition (e.g., allergies, asthma, aspiration) that can require an immediate medical response. If the response is "…a plan is NOT in place" (2) make sure to make a note for the Service Coordinator to follow-up under the free-text item, "Is there anything else that would be helpful…?" at the end of Section D.

D.17 Care Transition Planning

The questions in this section are for children twelve years and older. If individual is younger than 12 years old, code 9 for all questions. Please note that the MCO transition process begins at 15 years of age.

a. **Has the individual's doctor or health care provider discussed having the individual see doctors or other health care providers who treat adults?**
    i. **If no, would discussions about transitioning care to adult providers have been helpful?**
b. **Has the individual's doctor or other health care provider discussed changes in individual's health care needs as he or she becomes an adult?**
    i. **If no, would discussions about the individual's heath care needs have been useful?**
c. **Has anyone discussed how to obtain or maintain some form of health insurance coverage as the individual becomes an adult?**
    i. **If no, would discussions about the individual's health insurance have been helpful?**
d. **How often does the individual's doctors or health care providers encourage him or her to take responsibility for his or her health care needs (i.e., taking medications, understanding his or her health, following medical advice)?**

D.18 Is There Anything Else That Would Be Helpful to Know About Individual's General Medical History? (SAI-Req) (MN-Req)

The purpose of this question is to provide time to discuss, and space to document, any additional comments, concerns or issues the individual or caregiver has that have not been previously discussed. If "yes" is selected, please specify in space provided.

SECTION E. CAREGIVERS AND SOCIAL SUPPORTS

Note: The MCO may use information gathered in this section to make appropriate referrals for the caregiver(s) to receive services from appropriate programs or agencies, such as the Area Agency on Aging (AAA).

If the caregiver meets one of the following criteria, s/he may qualify for services from AAA. If so, and if the individual indicates s/he would like assistance, make the referral.

AAA Eligibility Screening Criteria: The individual may qualify for services from AAA if he or she is:
• 60 years of age or older and is caring for an individual of any age;
• 55 years of age or older and is caring for a grandchild under the age of 18 in his/her home because the biological or adoptive parents are unable or unwilling; or has legal custody or guardianship or is raising the child informally; or is caring for a recipient age 19-59 with severe disabilities; or
• a caregiver for an individual of any age who has Alzheimer's or dementia.

E.1 Important People in The Individual's Life

List the people who are close to the individual and who know and care about him or her. This may include family, friends, classmates or teachers, or people in the community (e.g., pastor, coach, bus driver), among others. These may also include key informal caregivers, since Question E.2 does not ask for them by name. This will help the Service Coordinator determine who to speak with in certain situations. It will also help to ensure that the individual does not lose contact with important people in his or her life. Up to eight people may be entered as a response to this question. (Additional contacts may be provided under the free-text item, "Is there anything else that would be helpful…?" at the end of Section E.). Enter as much information about person as available, including the name, relationship, telephone number, address, email address and the reason the individual or caregiver has identified this person as being important to list on this form.

Examples of **"Important because"** are:

- He takes the individual to work.
- She is a friend the individual calls every weekend.
- He stays with the individual until mom comes home from work.
- She is the individual's favorite teacher and helps tutor on weekends.
- He takes the individual to Special Olympics practices and out to eat.
- The individual stays with him during the holidays.

E.2 Key Informal Caregiver(s)

This question should discreetly be directed to the caregiver(s). Collect information on up to two caregivers. If the individual only has one caregiver, you will use the code "8" anywhere an item asks for information related to the second caregiver.

a. **Relationship of caregiver(s) to individual**
b. **Gender of caregiver(s)**
c. **Age of caregiver(s) –** If "8" is coded above, enter "00" for the age of the respective informal caregiver.
d. **Caregiver(s) live(s) with individual**

E.3 Informal Caregiver(s) Status/Challenges

This question should discreetly be directed to the caregiver(s). Collect information on up to two caregivers. If the individual only has one caregiver, you will use the code "8" anywhere an item asks for information related to the second caregiver.

a. **Caregiver in school full-time** - Caregiver is enrolled and attending school (e.g., high school, GED course, college, vocational training) on a full-time basis according to the definition used by the institution (e.g., usually > 12 semester in fall and spring semesters or > 9 quarter hours for three quarters per year).
b. **Caregiver in school part-time -** In school part-time, but not full time.
c. **Caregiver working full-time -** Working ≥ 30 hours per week.
d. **Caregiver working part-time** - Working, but not full time.
e. **Caregiver's sleep interrupted frequently throughout the night because of caregiving related to individual's condition** - Due to the demands of the individual's health condition *(could include behaviors that disrupt sleep)*, caregiver unable to get 6-8 hours of uninterrupted sleep.
f. **Because of physical limitations or disabilities (strength/stamina), caregiver unable to assist individual with some ADLs or IADLs**
g. **Caregiver has intellectual limitation** – Limited ability to learn or consistently and adequately perform key caregiving tasks, may include educational deficits.
h. **Caregiver has mental/emotional limitations (includes substance abuse)** – Limited ability to learn or consistently and adequately perform key caregiving tasks because of emotional or mental state.
i. **Caregiver expresses feelings of distress, anger or depression -** Caregiver expresses, by any means, that he or she is distressed, angry, depressed, or in conflict because of caring for the individual.
j. **Caregiver indicates being overwhelmed by caregiving responsibilities**
k. **Caregiver has very limited access to social support system (e.g. family, friends, church)** - The caregiver indicates that they do not have a supportive relationship with family or friends. They feel they have nobody to "rely on."
l. **Caregiver reports hurtful criticism of his/her caregiving from friends or relatives** - The caregiver mentions feeling upset/frustrated (or other similar emotions) because family or friends criticize their caregiving methods or abilities.
m. **Other caregiver challenge/situation (specify)** – If there are other challenges discussed they should be noted here.

E.4 Household Composition

Do not count the individual being assessed for any of the items.

a. **Number of other children in household**
b. **Number of other children with special needs (other than individual being assessed) -** Special needs can be defined as an individual that receives additional education, medical, or psychological services.
c. **Number of other children receiving Medicaid home care services (other than individual assessed) – "**Skilled nursing" and "private duty nursing" (PDN) are two different programs which similarly involve the care of a home health nurse. The individual or caregiver may not necessarily know the difference, so you may need to ask some more detailed questions. PDN is usually authorized for long term care for chronic illness, while skilled nursing is usually provided for a short term period around an acute spell of illness. If necessary, consult the home health chart for further information.

E.5 Level of Informal Care Is Expected to Decrease Within Next 90 Days

Ask the informal caregiver(s) about the ability of the caregiver(s) to continue providing care. For this item, you need to consider the current situation and also future needs. Take this information into consideration and use your professional judgment to make the assessment. This is a sensitive issue and should be handled carefully. Listen carefully to what is being said.

- **Level of informal care is expected to decrease -** For example, a decline in the health of a caregiver makes it difficult to continue. The caregiver, person, or assessor believes that the caregiver(s) is (are) not able to continue in caring activities. This can be for any reason—for example: lack of desire to continue; geographical inaccessibility; other competing requirements, such as child care or work requirements; or personal health issues.

E.6 Alternate Plan for Caregiving

The purpose of this question is to be aware of future placement changes for the individual and how this impacts treatment and care planning. Additionally, this helps determine if the primary informal support person has made alternative care arrangements should he or she express inability to meet the individual's current needs or is unable to provide ongoing care (for example, illness or death). The intent of this question is to if there are any upcoming changes (within, for example, the next year) to the caregiving situation, and if so, are plans in place to address this change.

- **Alternate plan for caregiving -** Responsibility for the individual's care provision would pass from the primary informal support person to another family member or friend, or a formal health care program/facility or social service (for example, long-term care facility, mental health unit, group home, or assisted-living facility). The arrangement could consist of a verbal agreement with family or friends, or the individual's name is placed on a waiting list for placement.

E.7 Individual's Social Relationships/Strengths in LAST 30 DAYS

If possible, ask the individual for his or her point of view. If not, engage caregiver or family members. What activities does he or she enjoy participating in? When was the last time he or she was able to participate? Who tends to come to visit, and when was the last time that individual visited? Are there other ways the person contacts family or friends (for example,

by telephone or e-mail)? Is the person generally content or unhappy in relationships with family and friends? If the person is unhappy, what specifically is he or she unhappy about?

a. **Participates in activity that he/she enjoys –** expresses positive response or emotion when engaging in or discussing an activity (i.e. smiling and showing a drawing to a parent, recalling a swimming lesson as fun, anticipates activity with expressions of pleasures).
b. **Is flexible about changes in daily routine** – accepts unexpected changes in routine without excessive stress or negative reaction.
c. **Is cooperative in living situation** – listens and communicated effectively with other people residing in the same living arrangement or household.
d. **Positive towards household members** – expresses mostly positive comments or reactions to people residing in the same living space.
e. **Positive towards peers** – expresses mostly positive comments or reactions to persons of the same age group.

E.8 Is There Anything Else That Would Be Helpful to Know About Individual's Social Support?

The purpose of this question is to provide time to discuss, and space to document, any additional comments, concerns or issues the individual or caregiver has that have not been previously discussed. If "yes" is selected, please specify in space provided.

SECTION F. STRENGTHS AND CHALLENGES IN PERFORMING DAILY TASKS

F.1 Decline in Functional Status as Compared to 90 Days Ago, Or Since Last Assessment If Less Than 90 Days Ago.

Ask the individual, or others who would be familiar with his or her functioning, if there has been a change in his or her ability to perform IADLs or ADLs, as compared to 90 days ago. To help identify the 90-day time period, ask the individual or others to pinpoint an event that occurred 3 months ago and then to relate the individual's functioning to that event. For example, if the individual stayed with a grandparent 3 months ago, or was away at camp, ask how capable he or she was during activities like eating or walking during that time.

F.2 IADL Self-Performance (SAI-Req)

The intent of this question is to examine the areas of function that are most commonly associated with independent living. These are often referred to as "instrumental" activities of daily living (IADLs) and include items associated with normal tasks and activities. Many of these IADL tasks are ones which a younger individual would not be expected to perform independently. If an individual is too young to complete these tasks independently then how their condition affects the caregiver's performance of the task should also be considered. For example, because an individual's condition requires a special diet, the caregiver spends additional time making meals. The impact of the individual's condition may be on the individual's performance of the activity or on the amount of help needed from a caregiver with performance of the activity. Code the EFFECT the individual's condition has his/her ability to perform the task.

- **Meal preparation -** How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils).

- **Ordinary housework -** How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry).
- **Managing money -** How money or allowance is spent or saved, plans for small purchases.
- **Laundry** - sorting, washing, folding, and putting away personal laundry (e.g., clothing, underwear), bedding and towels.
- **Managing medications -** How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments).
- **Phone use -** How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).
- **Shopping -** How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION.
- **Transportation** - How individual travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles).

F.3 ADL Self-Performance (SAI-Req)

This question allows the assessor to record how an individual's condition impacts his/her ability to perform basic activities of daily living (ADLs). A younger individual may not be able to perform some of these tasks due to their age, but remember the intent of this section is to determine how the individual's condition may affect the individual's performance of an activity or on the amount of help needed from a caregiver with performance of the activity. Code the EFFECT the individual's condition has his/her ability to perform the task.

- **Bathing –** How individual takes a full-body/shower. Includes making transfers in and out of tub or shower AND how each part of the body is bathed: arms, upper and lower legs, chest, abdomen and perineum – EXCLUDE WASHING OF BACK AND HAIR.
- **Personal hygiene -** How individual manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS.
- **Dressing -** How individual dresses and undresses (street cloths, underwear), including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, pullovers, etc.
- **Walking or moving around –** How individual walks between locations on same floor indoors, and how moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair.
- **Using the toilet -** How individual uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET.
- **Bed mobility –** How individual moves to and from lying positions, turns from side to sides, and positions while in bed.
- **Positioning in chair or other furniture or assistive devices**
- **Transfers –** moves between surfaces, to/from bed, chair, wheelchair, standing position (EXCLUDE bath/shower transfers).
- **Eating—**How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

F.4 Cognitive Skills for Daily Decision Making (SAI-Req) (MN-Req)

Record the individual's actual performance in making everyday decisions about the tasks of daily living. This item will help determine the nature of supervision and oversight an individual may need on a daily basis. For example, it's not expected that four-year-olds will consistently make weather-appropriate decisions about clothing; however, they should be able to choose a shirt, pants and shoes or other similarly complete outfits. In a situation like this, the code for decision making would be a 2 "moderately impaired" as the individual needs some cueing/supervision to choose reasonable clothing choices.

Consult the caregiver. Observations of the individual can also be helpful. Review the events of each day. The inquiry should focus on whether the individual is actively making these decisions, not whether there is *belief* on the part of the individual or a family member that the individual might be capable of daily decision making.

NOTE: *Code 3 "severely impaired,"* is appropriate for infants and toddlers and for any child when the parent/caregiver has assumed all responsibility for daily decisions.

- **Modified independence:** The individual functions well with decision making when involved in his or her customary routines and in familiar environments. However, when she or he encounters or is involved in a new, unfamiliar situation or setting, the individual has difficulty making consistent, reasonable, or safe decisions. There may also be certain specific situations in which the individual does not function well and needs supervision by others or requires cueing to make decisions about daily tasks. The emphasis is on SPECIFIC, NEW or UNFAMILIAR settings or situations that alter usual decision-making.

F.5 Making Self Understood (Expression) (SAI-Req) (MN-Req)

Document the individual's performance with respect to expressing or communicating requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

Interact with the individual. Observe and listen to the individual's efforts to communicate with you. If possible, observe his or her interactions with family members.

0. **Understood** – Individual expresses self without difficulty.
1. **Usually understood** – The individual expresses self, but has difficulty finding words or finishing thoughts, requires some prompting.
2. **Sometimes understood** — the individual has limited ability, but is able to express concrete requests regarding at least basic needs (such as food, drink, sleep, and toilet).
3. **Rarely or never understood** — At best, understanding is limited to interpretation of highly individual, person-specific sounds or body language (for example, caregiver has learned to interpret person signaling the presence of pain or need to toilet).

NOTE: Please be aware that different individuals communicate differently and not always verbally, and take this into account. For example, an individual may use a picture book to point to a caregiver, or lead you by the hand to her room when prompted, or make the sign for "eat" and point at the refrigerator when asked what he ate for breakfast. These would all be valid responses to these questions as the individual is using responsive communication.

F.6 Ability to Understand Others (Comprehension) (SAI-Req) (MN-Req)

Describe the individual's performance in terms of comprehending information whether communicated to the individual orally, by writing, or in sign language or Braille. This item measures not only the individual's performance in terms of hearing messages but also in terms of processing and understanding language.

0. **Understands -** Clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.
1. **Usually understands** - With little or no prompting, individual misses some part or intent of the message but comprehends most of it. The individual may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
2. **Sometimes understands** - The individual demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions. When the message is rephrased or simplified, or gestures are used, the individual's comprehension is enhanced.
3. **Rarely or never understands -** The individual demonstrates very limited ability to understand communication, or the assessor cannot determine whether the person comprehends messages, based on his or her verbal and nonverbal responses. Includes situations where the individual can hear sounds but does not understand messages.

NOTE: Please be aware that different individuals communicate differently and not always verbally, and take this into account. For example, an individual may use a picture book to point to a caregiver, or lead you by the hand to her room when prompted, or make the sign for "eat" and point at the refrigerator when asked what he ate for breakfast. These would all be valid responses to these questions as the individual is using responsive communication.

F.7 Is There Anything Else That Would Be Helpful to Know About Individual's Performance of Daily Tasks?

The purpose of this question is to provide time to discuss, and space to document, any additional comments, concerns or issues the individual or caregiver has that have not been previously discussed. If "yes" is selected, please specify in space provided.

SECTION G. NUTRITIONAL STATUS/CONCERNS

G.1 Height and Weight (SAI-Req) (MN-Req)

For weight, record the most recent weight taken, preferably within last 30 days and preferably during a visit to a health care provider. Ask the individual, if able to provide this information, or the caregiver. If the weight taken at the physician's office was more than 30 days ago, ask for any recent weight taken by the individual and caregiver. For height, ask the individual, if the individual is unable to report, ask the caregiver. Record in either inches/pounds or cm/kg; you do not have to convert one to the other.

G.2 Are There Any Concerns About Individual's Weight Gain/Loss in LAST 6 MONTHS? (SAI-Req) (MN-Req)

Marked, unintended changes in weight can indicate failure to thrive; a sign of a potentially serious medical problem; or poor nutritional intake due to physical, cognitive, or social factors.

Ask the individual or family about weight changes over the last 6 months. Use actual records of weight if available. A subjective estimate of weight change from the individual or caretaker can be used if no written records are available. Identifying a particular time approximately 6 months earlier (such as "compared to last New Year's") may help the individual remember his or her approximate weight 6 months ago.

You may be able to help the individual answer the question by asking "How much weight do you think you have lost?" You can also ask, "Have you lost a lot of weight? Do you feel much thinner or weaker?" or "Your clothes seem very loose on you. Were you much heavier 6 months ago?"

G.3 Mode of Nutritional Intake (SAI-Req) (MN-Req)*

**At a minimum, Item G.3.a must be asked and populated. If the answer is "Yes" (1) that the individual has a normal mode of nutritional intake, then the rest of the sub-items may be skipped. If the answer to G.3.a is "No" (0), then all sub-items G.3.b through G.3.f must be asked and populated.*

a. Normal – Swallows all types of typical foods.
b. Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown.
c. Requires diet modification to swallow solid food – mechanical diet (e.g., pureed, minced) or only able to digest specific foods.
d. Requires modifications to swallow liquids – e.g., thickened liquids.
e. Feeding tube – nasogastric or abdominal (PEG).
f. Parenteral feeding – includes all types of parenteral (intravenous) feeding, such as total parenteral nutrition (TPN).

G.4 Dietary Requirements

a. Individual requires special diet (e.g., gluten-free) *(SAI-Req) (MN-Req)* – If yes, please specify in space provided.
b. Special ordered diet is new or has been changed since last assessment
c.* Additional electrolyte drink/formula/protein shake/juice given between meals *(SAI-Req) (MN-Req)

G.5 Is There Anything Else That Would Be Helpful to Know About the Individual's Nutrition? (SAI-Req) (MN-Req)

The purpose of this question is to provide time to discuss, and space to document, any additional comments, concerns or issues the individual or caregiver has that have not been previously discussed. If "yes" is selected, please specify in space provided.

SECTION H. CURRENT TREATMENT AND PROCEDURES

H.1 List of all medications (SAI-Req) (MN-Req)

Medications - These include all prescribed, non-prescribed, and over-the-counter medications that the individual consumed in the last 30 days. Medications may be taken by mouth, placed on the skin or in the eyes, injected, given intravenously, etc. This includes prescriptions now discontinued but taken in the last 30 days and drugs prescribed PRN (as needed) that were taken during this period. It also includes medications that are prescribed on a maintenance schedule, such as vitamin injections given every few months, even if they were not given in the last 30 days.

a. Name - The name of the medication. Either the generic name or the trade name is acceptable.

b. Dose - the dose received. This is a positive number-for example, 0.5, 5, 150, or 300. Occasionally, dosages of medication may have changed during the 30-day assessment period. In this case, each dosage of the medication should be recorded separately on a new line.

c. Unit - Code using the included list.

d. Route of administration - Code using the included list. "OTH" means "other."

e. Frequency - The number of times per day, week, or month the medication is administered.

f. Stability – Indicate whether or not medication is stable (S), new (N) or being adjusted (A)

g. PRN – If the medication is given on an as needed basis, use this column to describe how often it is given (e.g., Tylenol three times a day would be coded here as "5"). NOTE: IF A MEDICATION IS NOT PRN, CODE "0" MUST STILL BE ENTERED.

h. Administrator – If more than one individual on this list administers the medication, write in this box the HIGHEST LEVEL OF SUPERVISION required (e.g., if both a RN and the caregiver administer a medication via enteral tube, code this as "LP"). If your company allows for multiple values to be entered in this field, then follow company policy.

Example of completed chart:

a. **Name**	b. **Dose**	c. **Unit**	d. **Route**	e. **Freq.**	f. **Stability**	g. **PRN**	h. **Administrator**
1. Amicillin	250	Mg	po	q6h	S	0	CG
2. Beconase	1	Puffs	nas	bid	S	0	CG
3. Compazine suppository	5	Mg	rec	q3h	S	2	CG
4. Lanoxin	0.25	Mg	pr	q2d	S	0	CG
5. Lanoxin	0.125	Mg	pr	q2d	S	0	CG
6. Peri-colace	0.125	Mg	pr	bed	S	0	CG
7. Humulin N	15	units	sq	daily	S	0	LP
8. Humulin R	5	units	sq	q3d	S	0	LP
9. Humulin R	10	units	sq	q3d	S	0	LP
10. Claritin	10	Mg	po	daily	N	0	CG

11.							
12.							
13.							
14.							
15.							
16.							
17.							

H.2 Resists Medications

Individual avoids taking medications. If yes, specify the signs of resistance used. Signs of resistance may be verbal or physical (such as verbally refusing medicines, pushing caregiver away, scratching caregiver, etc.). This timeframe for this question should be focused around the individual's current or general behavior.

H.3 Does the Individual Receive Any Medications Via an Enteral (Feeding) Tube? (SAI-Req) (MN-Req)

This is important in determining need for delegation by nurse for unlicensed paid provider. This timeframe for this question should be focused around the individual's current or general needs.

H.4 Does the Individual Receive Medications Via Injections (Shots)? (SAI-Req) (MN-Req)

This is important in determining need for nursing care and delegation assessment. This timeframe for this question should be focused around the individual's current or general needs.

H.5 Formal Treatments In LAST 30 DAYS (SAI-Req) (MN-Req)

a. Chemotherapy - Includes any type of chemotherapy (anticancer drug) given by any route.

b. Dialysis – can be any dialysis (e.g. hemodialysis, peritoneal dialysis, hemofiltration, hemodiafiltration, or intestinal dialysis)

c. IV medication - Includes any drug or biological (e.g. contrast material) given by intravenous push or drip through a central or peripheral port.

d. Oxygen therapy – e.g., Administration of oxygen or supervision, oxygen pulse ox.

e. Radiation - Includes radiation therapy or having a radiation implant.

f. Suctioning - Suctioning of secretions from the upper-most part of the throat, behind the nose (e.g., often used with pediatric bronchitis patients). May also include suctioning of a tracheostomy to maintain patent airway and prevent aspiration.

g. Tracheostomy care - Includes removal of cannula and cleansing of tracheostomy site and surrounding skin with appropriate solutions.

h. Transfusion - Includes transfusion of whole blood or any type of blood products.

i. Ventilator – To manage equipment; mechanical device designed to provide adequate ventilation in persons who are, or may become, unable to support their own respiration. Include any individual who was in the process of being weaned off of the ventilator or respirator in the last 30 days. This does not include nebulizers or CPAP/BiPap machines (used for apnea).

j. **Wound care** – Treatment or dressing of stasis or pressure ulcer, surgical wound, burns, open lesions.

k. **Nebulizer -** Administration assistance or supervision of machine to administer medication via mask and fine mist externally through the airways.

l. **Urinary catheter care – insertion or maintenance** (e.g., change, irrigation).

m. **Comatose or persistent vegetative state – managing care.**

n. **Continuous positive airway pressure (CPAP) or Bi-level positive airway pressure (BiPAP) -** includes any use (e.g., management, assistance with, care) of CPAP/BiPap machines

o. **Chest percussive therapy** – for loosening or clearing of respiratory secretions on a regular basis or PRN, usually under a medical provider's order, can be care for manual or vest therapy

p. **Active medication adjustment –** adding, discontinuing or change in dose of medication by physician in response to change in individual's condition

q. **IPPB -** Intermittent positive pressure breathing (IPPB) - respiratory therapy treatment.

r. **Seizure management** – administration of medications (daily or as intervention), oxygen or use of VNS in response to seizure

s. **Other -** Enter any other treatments not listed.

H.6 Formal Care in LAST 30 DAYS (SAI-Req) (MN-Req)

- **Care -** Includes direct services provided to the individual (both ADL and IADL support), the management of care received (for example, making medication schedules, planning for future needs), and the provision of therapeutic care by any formal agency or service provider.

a. **Personal care services/attendant care/home health aide** — Aides who traditionally provide "hands-on" ADL support and simple monitoring (such as taking blood pressure).

b. **Nursing services –** Includes private duty nursing (PDN), home health skilled nursing, and other nursing services.

c. **Medical transportation program** – Program that offers rides to get to medical appointments and care (e.g., doctor, dentist, hospital, drug store).

d. **Homemaking services** — Services that traditionally include IADL support, usually in the form of housekeeping services, shopping, and meal preparation.

e. **Meals** — Prepared meals that are delivered to the individual for immediate or later consumption (for example, meals-on-wheels).

f. **Respiratory therapy -** Therapy services that specialize in cardiology and pulmonology services provided or directly supervised by a qualified respiratory therapist. A qualified respiratory therapy assistant may provide therapy, but may not supervise others giving therapy. Includes any professional care services related to airway management, percussive therapy, etc.

g. **Physical therapy** — Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy, but may not supervise others giving therapy.

h. Occupational therapy — Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy, but may not supervise others giving therapy.

i. Speech-language pathology or audiology services - Therapy services that are provided or directly supervised by a qualified speech therapist.

j. Palliative care program – The care of individuals whose diseases are not responsive to curative treatments. It targets pain and symptom relief without precluding the use of life-prolonging treatments, and provides support systems for the person and his/her family.

k. Hospice - care to persons who have a terminal illness with a prognosis of less than six months to live, as certified by the physician. The goal of hospice care is to provide comfort and quality of life while assisting the person and family.

l. PPECC - Prescribed Pediatric Extended Care Center - continual medical care in a non-residential setting.

m. Other (specify) – Enter any other treatments not listed.

H.7 Pain Control – Adequacy of Current Therapeutic Regimen to Control Pain (SAI-Req)

Assess for indications that the individual experiences pain and assess whether the individual adheres to the pain regimen in place and whether it sufficiently manages their pain.

H.8 Physical Function Improvement Potential

Assess for indications that the individual thinks he or she can be more self-sufficient. Ask what health professionals have told the individual and family. Do their statements seem reasonable? Is the individual's description clear and unequivocal? Could the individual be more self-sufficient if mood or motivational problems were addressed? Speak with caregivers. What is their perception of the individual's capacity? How does this relate to the individual's perception and your observations? Assess whether the individual's functional performance has recently changed. Has there been an intervening acute episode? What is the likelihood that the individual will recover from the current disease or condition?

H.9 Is There Anything Else That Would Be Helpful to Know about Individual's Treatment Regimen? (SAI-Req) (MN-Req)

The purpose of this question is to provide time to discuss, and space to document, any additional comments, concerns or issues the individual or caregiver has that have not been previously discussed. If "yes" is selected, please specify in space provided.

SECTION I. MENTAL HEALTH AND BEHAVIORAL HEALTH CONCERNS

I.1 Any Medications to Assist with Behavioral Health Issues (E.G., Anti-Anxietal, Anti-Depressant, Sedative, Hypnotic, Anti-Psychotic or Anti-Convulsive)?

Please be aware that medications originally approved as anti-convulsants have been found to be effective as mood stabilizers.

I.2 Urgent Mental/Behavioral Health Service Use in LAST 6 MONTHS

Code "Yes" (1) if there was any need for crisis mental/behavioral health services during the look-back period, and be aware that it is six months.

I.3 Formal Care or Treatment Received in The LAST 30 DAYS

If the answer is "Needed and not received" (2) to any of these sub-items, make sure to include an explanation in the space provided. Also be aware that the look-back period is 30 days, as opposed to the longer period for Question I.2.

a. Psychiatric facility admission (or psychiatric unit of acute care hospital)

b. Visit to Psychiatrist, Psychologist, licensed mental health professional or developmental specialist

c. Substance abuse program – inpatient or outpatient, individual or group counseling, mental health services, drug use monitoring,

d. Targeted Case Management-TCM services help adults with a serious and persistent mental illness (SPMI) and children with a severe emotional disturbance (SED) gain access to needed medical, social, educational, vocational, financial and other necessary services as they relate to the recipient's mental health needs.

I.4 Specific Mental State Indicators

When combined with other observations in the assessment, these indicators can provide information about the severity of the individual's condition.

a. Persistent anger with self or others

b. Pattern of irritability

c. Pattern of defiance

d. Pressured speech or racing thoughts

e. Compulsive behavior – An uncontrollable, persistent urge to perform an act repetitively, often according to certain rules, manners, or patterns; e.g., hand washing, repetitive checking of room, counting, hoarding.

f. Impulsive – responds to environment with lack of planning or insight; e.g., running into traffic; takes risky actions without thinking; difficulty taking turns; interrupts.

g. Easily distracted

h. Flat or blunted affect

i. Episodes of panic – Cascade of symptoms of fear, anxiety, or loss of control. For example, individual thinks he or she is losing control; experiencing shortness of breath, excessive perspiration.

j. Hallucinations (auditory or visual)

k. Delusions

I.5 Behavior Symptoms

These items are designed to pick up problem behaviors exhibited by the individual that may be considered as "combative or agitated" by some health professionals. Be sure to probe. Family members tend to "normalize" an individual's usual behavior and thus under-report the presence, frequency and intensity of behaviors. You might try to avoid using phrases such as "difficult," "challenging" or "maladaptive" behaviors, since loved ones often deny the behavior is a problem. Simply focus on the behavior (e.g., ask "Does _____ ever wander

around the house or outside without seeming to be aware of where he/she is going or whether it is safe to do so?").

Ask the family member/caregiver if each specified behavior occurred. Take an objective view of the individual's behavioral symptoms, and focus on the individual's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Some family members may have become accustomed to a behavior or minimize the difficulty of the individual's behavior because they see it often or understand its cause (e.g., "Oh, no. He's not physically abusive. He doesn't really mean to hurt anyone--he's just frightened."). Such assumptions about the cause, while they may be factually correct, should not be considered in deciding whether the behavior was present or not and in coding items.

Rather, code each item based on whether the individual manifested the behavioral symptom.

If you have the opportunity during your visit, observe the individual and how the individual responds to attempts by family members or others to deliver care. Ask the caregiver(s) if they know what occurred throughout the day and night (i.e., 24-hours a day) for up to the past 30 days. If possible, try to do this when the individual is not in the room. Recognize that responses given with the individual present may need to be validated later. For example, an individual's behavior in school where there may be a lot of external stimulation may be different from what is observed at home. Similarly, behavior may differ between day and night.

a. **Wandering/elopement -** moving (locomotion) with no apparent rational purpose; seemingly oblivious to needs for safety, or attempted to or exited/left home/school etc. at inappropriate time, without notice/permission, with impaired safety awareness.
b. **Resists care**
c. **Verbally abusive**
d. **Physically abusive**
e. **Bullying others**
f. **Repetitive behavior that interferes with normal activities**
g. **Destructive behavior toward property**
h. **Fire-setting or preoccupation with fire**
i. **Problematic sexual behavior**
j. **Cruelty to animals**

I.6 Lifestyle

These questions can be difficult both for the individual and caregiver, so please proceed with added care and sensitivity. Do not always assume that just because an individual is pre-teen, for example, that this question does not apply. While it is NOT a MANDATORY question for completion of the SAI, you should still make your best effort to complete it.

Ask the individual directly, if possible. This information may be sensitive to the individual or create feelings within the assessor. Care must be taken to acknowledge these feelings. For example, when asking the person about alcohol usage, use a simple, straightforward, nonjudgmental question, "Do you drink?" If yes, determine the frequency. Address this issue

in a gentle way to avoid the person feeling judged or that he or she is doing something wrong.

a. **Uses any tobacco daily -** Includes all inhaled forms such as cigars and cigarettes but also smokeless forms such as chewing tobacco, dipping tobacco, etc.
b. **Alcohol - highest number of drinks in any "single setting" in <u>LAST 14 DAYS</u>** includes beer, wine, mixed drinks, liquor and liqueurs.
    - **Single setting -** Refers to any given point in time (e.g. at dinner, after work, while out at a social event, watching television).
c. **Uses illegal drugs or misuses prescription medicine**

    misuses prescription medication - individual takes a legal prescription medication for a purpose other than the reason it was prescribed, or individual takes a drug not prescribed to him or her
d. **Engages in risky sexual behavior –** Includes engaging in unprotected anal, vaginal or oral sex, sex with multiple partners or paid money for sex/traded drugs for sex.

I.7 Is There Anything Else That Would Be Helpful to Know About Individual's Mental State or Behavior

The purpose of this question is to provide time to discuss, and space to document, any additional comments, concerns or issues the individual or caregiver has that have not been previously discussed. If "yes" is selected, please specify in space provided.

PCAM

Note: *Even if triggered, the assessor should NOT complete this module for individuals in the Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living Assistance and Support Services (CLASS) and Deaf Blind with Multiple Disabilities (DBMD) waivers.*

The default look-back period for the PCAM is 30 DAYS unless otherwise specified.

SECTION J. COGNITION AND EXECUTIVE FUNCTIONING

J.1 Memory/Recall Ability

a. Short-term memory OK- Seems/appears to recall after 5 minutes

You may rely on the opinion of the caregiver, although you need to make clear that you are asking about the individual's ability to recall things that are very recent, such as what he/she ate for breakfast or whether the individual can remember things he/she was told a few minutes earlier. When feasible, you may want to talk with the individual directly. You can talk about the same kinds of issues – as long as you know what actually occurred quite recently (e.g., Did you just have lunch? What did you have?) Or you can ask the individual to remember an object that you then put away (e.g., book, watch, apple) for a few minutes.

b. Long-term memory OK– seems/appears able to recall more distant past (e.g., remembers activities last week or special events)

Again, you can ask the caregiver or ask questions of the individual to determine whether he/she had problems with long-term memory. Depending on the individual's age, they should be able to tell you their name, where they are, where they live, their siblings' and/or pet's names, and the name of their school. Additional questions might include names of their friends, a favorite teacher from prior years, and so on. If the individual has difficulty remembering events or people from his/her past, code "1" = Memory/recall problem. "0" means no problem.

c. Procedural memory OK - Can perform all or almost all steps in a multitask sequence without cues

This item refers to the cognitive ability needed to perform sequential activities. Dressing is an example of such a task, as it requires multiple steps to complete the entire task. Bathing and washing hair or managing medications are other examples of tasks that have multiple steps that should be performed in sequence (turning on water, using soap, rinsing, and drying, putting on clean clothing).

The individual must be able to perform or remember to perform all or almost all of the steps independently in most multi-step tasks in order to be scored a "0." If the individual demonstrates difficulty in completing most tasks involving two or more steps, code as "1".

Note: Individuals in need of services in the home often have physical limitations that impede their independent performance of activities. Do not confuse such physical limitations with the cognitive ability (or inability) to perform sequential activities.

d. Situational memory OK - Both: recognizes caregivers' names/faces frequently encountered AND knows location of places regularly visited (bedroom, bathroom, classroom)

This two-part measure of orientation assesses the individual's cognitive ability to recognize both people and places. To be coded as OK, the individual must **both** recognize the names/faces of frequently encountered family members or caregivers **and** know the location of places regularly visited (bedroom, dining room, places visited outside the home). It is not necessary for the person to know the street number of the house or apartment, but he or she should be able to find the way to his or her room, recognize the purposes of particular rooms, etc.

Note: If after working with the individual and/or the caregiver, it is determined that it may not be possible to assess the individual's memory/recall ability, Code "9. Unable to Assess." This may be especially true for younger individuals under the age of 2. HOWEVER, please be aware that different individuals communicate differently and not always verbally, and take this into account. For example, an individual may use a picture book to point to a caregiver, or lead you by the hand to her room when prompted, or make the sign for "eat" and point at the refrigerator when asked what he ate for breakfast. These would all be valid responses to these questions as the individual is using responsive communication.

J.2 Periodic Disordered Thinking or Awareness

The key to this question will be involvement from the caregiver and rest of the family if present. Be respectful as you ask this question since it will involve asking the caregiver/family about their view of the individual's behavior.

J.3 Acute Change in Mental Status from Individual's Usual functioning – e.g., restlessness, lethargy, difficult to arouse, altered environmental perception

Any sudden or recent change in the individual's usual level of functioning; such changes may include restlessness, lethargy, being difficult to arouse or altered environmental perception.

J.4 Change in Decision-Making as Compared to 90 DAYS AGO (or since Last Assessment)

The changes may be permanent or temporary, and the cause may be known (for example, psychotropic medication or new pain) or unknown.

SECTION K. COMMUNICATION AND VISION

K.1 Hearing

Evaluate the individual's hearing after the individual has any hearing appliance in place and turned on, if the individual uses an appliance. For example, be sure to ask if the battery works and the hearing aid is on if the individual uses such a device. Interview and observe the

individual, and consult the family. Test the accuracy of your findings by observing the individual during your verbal interactions.

Be alert to what you have to do to communicate with the individual. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the individual needs to see your face to know what you are saying, or if you have to take the individual to a quieter area to conduct the interview - all of these are cues that there is a hearing problem, and should be so indicated in the coding.

Also, if possible, observe the individual interacting with others (e.g., family member).

K.2 Proximity Vision

AND

K.3 Distance Vision

Ask the individual, if appropriate, about his or her visual abilities. For example, an individual who cannot read can usually tell you whether he/she can see distinct leaves on a tree in the yard or identify numbers. Otherwise, ask the caregiver. You can use some of the probes designed for use with the individual to ask more specific questions of family members as well.

Be sensitive to the fact that some individuals are not literate, may not read English, or may not read at all. In such cases, see whether the individual can read printed dates or page numbers or is able to name items in small pictures.

- **"Adequate" lighting -** Lighting that is sufficient or comfortable for a person with normal vision, excludes both lighting that is too low and light that is glaring.

SECTION L. ADDITIONAL BEHAVIORAL CONSIDERATIONS

L.1 Individual Has Behavior Problems That Respond to Caregiver Intervention

a. Individual can be redirected – That is when problem behavior occurs, the individual can be redirected to more appropriate behavior (e.g., instead of breaking an object, the individual can go outside and bounce a ball).

b. Individual responds to verbal reinforcement – When behavior is appropriate, appears to enjoy recognition and praise from others.

c. Individual responds to rewards – Is willing to work for salient rewards for appropriate behavior such as earning video game time for completing homework; does well with token economy systems.

SECTION M. FUNCTIONAL STATUS

M.1. Instrumental Activities of Daily Living (IADLs) Self-Performance

Many of these IADL tasks are ones which a younger individual would not be expected to perform independently. The intent of this question is to determine the amount of assistance provided on a regular basis.

The need for services is a separate determination, although it does require accurate information on this and the other items. Younger individuals may receive total assistance

(exhibit Total Dependence) in all of these activities simply because of their age. If that is the case, then record it as such –Total Dependence.

- **NOTE:** You will also be coding EFFECT on the same activities.

Performance of IADL

a. Meal preparation— Assisting individuals in preparing meals and snacks; cooking; assembling ingredients; cutting, chopping, grinding or pureeing food; setting out food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning area after meal; washing dishes.

b. Medication assistance or administration - Assisting the individual with oral medications that are normally self-administered, including administration through a permanently placed feeding tube with irrigation.

c. Telephone use or other communication – Assisting the individual in making or receiving telephone calls; managing and setting up communication devices; making and receiving the call for the individual.

d. Escort or assistance with transportation services - Assisting the individual in making transportation arrangements for medical and other appointments; accompanying the individual to a health care appointment to assist with needed ADLs.

e. Laundry – Assisting the individual with doing laundry; gathering, sorting, washing, drying, folding, and putting away personal laundry, bedding, and towels; removing bedding to be washed and remaking the bed; using a laundry facility.

f. Light housework – Performing or assisting the individual in performing light housework such as; cleaning and putting away dishes; wiping counter tops; dusting; sweeping, vacuuming or mopping; changing linens and making bed; cleaning bathroom; taking out trash.

g. Grocery or household shopping – Shopping for or assisting individuals in shopping for grocery and household items; preparing a shopping list; putting food and household items away; picking up medication and supplies.

h. Money management - Assisting the individual with managing their day-to-day finances; paying bills; balancing checkbook; making deposits or withdrawals; assisting in preparing and adhering to a budget.

Code column P for assistance provided to the individual in routine activities around the home or in the community during the last 30 days. Consider assistance provided over 24-hours per day.

The individual and the caregiver are questioned directly about the assistance provided and the individual's performance of normal activities around the home or in the community in the last 30 days. You also should use your own observations as you are gathering information for other items.

If an individual received two types of assistance during the last 30 days (e.g., supervision/cueing/redirection 4 times and limited assistance 2 times) code to the level where the individual received assistance three or more times.

If the individual performed some of the task during the last 30 days, the individual cannot be coded as a "5" – total dependence. Similarly, if the individual received any assistance from

someone else with a task, the individual cannot be coded as a "0" – independent. So, work your way to the correct code from the extremes.

Additional Definitions

- **Independent** - No set-up, supervision/cueing/redirection, or hands-on assistance OR individual received some type of help (e.g., set-up, cueing, hands-on assistance) only 1 or 2 times.
- **Set-up help only** - Article or device provided or placed in reach of the individual three or more (≥ 3) times during the last 30 days; someone else sets-up things that are needed in order for the individual to perform the task (e.g., setting out pots and pans for cooking; getting out the detergent and softener needed to do laundry; placing pills in a multi-day/weekly "medication caddy" for medication management).
- **Cueing/Redirection** - Oversight, task supervision, stand-by monitoring, redirection, encouragement or cueing provided three or more (≥ 3) times.
- **Limited assistance** - Individual highly involved in activity; received hands-on help only on some occasions (at least ≥ 3 times) but not all the time.
- **Extensive assistance** - Individual received help throughout task most of the time, or full performance by others some, but not all, of the time.
- **Total Dependence** - Full performance of the activity by others during entire period.
- **Activity did not occur** - During entire period.

Coding Example: Medication assistance or administration

Wyatt is a 10-year old with ADHD, and he takes a low dose of Ritalin three times a day. When you ask him how he manages his medications, he says he takes care of it himself. So, you ask how he does that. He tells you that each week, his mother puts his morning and afternoon pills in a medication caddy. For each day, he takes one in the morning before breakfast and one in the afternoon when he comes home from school. At school, he remembers to go to the school nurse who dispenses a pill at lunchtime. When you check with his mother, she agrees with what Wyatt said and reports that he is very good about remembering, and on the weekend he even remembers to take the three pills she puts in the caddy for Saturday and Sunday.

Code Medication assistance: "3" for Limited assistance.

Rationale: Wyatt gets set-up help from his mother. The only hands-on help he gets is from the school nurse who dispenses the medication. Wyatt remembers to go to the nurse and, if he had access to the medication might be able to take it himself, but you are coding his performance, not capacity.

Effect of IADL

0. Client's condition does <u>not</u> affect the performance of the task (i.e., time it takes to do task or the number of persons needed to do task).

1. Client's condition affects the performance of the task (because of client's condition, task regularly takes longer to perform, two-person assistance regularly provided/needed OR assistive devices are necessary).

Code "1" if the client's problem or condition affects the time it takes to perform task or if two-person assistance is regularly needed. Code "0" if problem or condition does not affect the client or responsible adult's performance of task.

Coding Example: Meal preparation

Jackson is a 4-year old who, because of absorption problems in his intestinal tract, must be fed foods on a special diet list that takes considerable time to prepare.

Code Meal preparation: "1" - Client/Child's condition affected the performance of the task

Rationale: Jackson's condition affects the frequency and difficulty of the performance of meal preparation.

Coding Example: Medication assistance

Wylie is a 5-year old who must receive medication 4 times a day to avoid seizures. His parents administer the medication. He takes the medication without resistance.

Code Medication assistance: "0" - Client/Child's condition did not affect the performance of the task

Rationale: Wylie must take medication because of his condition, but his condition does not affect the level of assistance required with the task. At five-years old, he does not yet read and is unable to manage his own medications.

M.2 Activities of Daily Living (ADLs) Self-Performance

This item addresses what the individual actually did for himself or herself and how much help was provided by caregiver. Younger individuals may not be able to perform some of these tasks due to their age, but remember the intent of this section is to determine how much assistance the individual receives in performing each task over the last month, regardless of their age or developmental level. Include all 24 hours of the day. The goal is not to estimate how much help they should receive, rather to indicate how much assistance they are currently receiving.

- **NOTE:** You will also be coding EFFECT on the same activities.

Performance of ADL

First identify what the individual actually does for himself or herself, noting when assistance is received and then clarifying the types of assistance provided (verbal cueing, physical

support, etc.) and how often it was provided during the last month. Be sure to consider performance across 24-hours a day.

Do not record your assessment of the individual's *capacity* for involvement in self-care — i.e., what you believe the individual *might or should be able to do* for himself/herself.

Do not record the type and level of assistance that the individual "should" be receiving according to your expectations of what assistance current health care providers or family members should provide. The type and level of assistance actually provided may be quite different from what is indicated in a service plan or even from what you may think the individual *needs*. Record what is actually happening. (You may, however, refer the individual for physician review or services based on your observation of what the individual needs that he/she is not receiving.)

An individual's ADL self-performance may vary from day to day, or within the day. There are many possible reasons for these variations, including mood, medical condition, stamina, relationship issues (e.g., willing to perform for a mother, the child obeys, but not for the sister who provides care most afternoons before the mother gets home from work).

Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing bathing, be sure to inquire specifically how the individual gets in and out of the tub or shower and score that under "bathing." Then ask about the other activities associated with bathing. An individual can be independent in one aspect of bathing yet require extensive assistance in another.

Since accurate coding is an important basis for making decisions on the type and amount of PCS the individual may need, be sure to consider each activity definition fully.

ADL Performance - Measures what the individual actually did (not what he or she might be capable of doing) within each ADL category over the last 30 days according to the performance-based scale.

a. Locomotion or mobility – Assisting the individual with moving between locations; assisting the individual with walking or using wheelchair, walker, or other mobility equipment.

b. Positioning – Assisting the individual with positioning their body while in a chair, bed, or other piece of furniture or equipment; changing and adjusting positions; moving to or from a sitting position; turning side-to-side; assisting the individual to sit upright.

c. Eating – Assisting the individual with some or all parts of eating and drinking; feeding the individual, assistance with utensils or special or adaptive eating devices; clean up after task is completed.

d. Transferring – Assisting the individual with moving from one surface to another with or without a sliding board; moving from bed, chair, wheelchair or vehicle to a new surface; moving to or from a standing or sitting position; moving the individual with lift devices.

e. Toileting – Assisting the individual with some or all parts of toileting; using commode, bedpan, urinal, toilet chair; transferring on and off; cleansing; changing diapers, pad, incontinence supplies; adjusting clothing; clean up after task is completed.

f. Dressing – Assisting the individual with any or all parts of getting dressed; putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; choosing and laying out weather appropriate clothing.

g. Personal hygiene – Assisting the individual with some or all parts of personal hygiene; routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, perineum; basic nail care; applying deodorant; routine skin care; clean up after task is completed.

h. Bathing – Assisting the individual with any or all parts of bathing; selecting appropriate water temperature and flow speed, turning water on and off; laying out and putting away supplies; transferring in and out of bathtub or shower; washing and drying hair and body; clean up after task is completed.

If ***all*** episodes are performed at the same level, score ADL at that level. If ***any*** episodes at level 5, and others less dependent, score ADL as a 4. Otherwise, focus on the three most dependent episodes.

If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.

Additional Definitions:

- **No help/Independent** - individual performed the ADL activity without any type of assistance or received help (set-up, supervision/cueing, or hands-on assistance) only 1-2 times.
- **Set-up help only** - Think in terms of someone doing nothing but providing or setting out the things or equipment the individual needed to perform the task such as bringing the individual his mobility appliance or setting out her clothing.
    - Examples of "set-up" help:
        - For dressing- selecting and setting out clothing
        - For locomotion- bringing an assistive device or equipment to the individual (e.g., wheelchair, cart, walker)
        - For positioning- bringing individual wedge or other assistive device to help individual maintain position in bed or chair
        - For eating- cutting food, opening bottles or cartons
- **Cueing/Redirection** - Think in terms of verbal help only or of oversight/stand-by assistance, or redirection.
- **Limited assistance** - Think in terms of hands-on assistance but no help that involved weight-bearing support.
- **Extensive assistance** - Think in terms of weight-bearing or full task performance by a caregiver for some but not all of the time. Also, with extensive assistance, the individual is involved physically in some way in the activity.
- **Total dependence** - Think in terms of someone else doing the entire task all the time for the individual – the individual did not physically perform any part of the task.
- **Activity did not occur during entire period** - **THIS CODE SHOULD NOT BE USED IN THE 30 DAY LOOK-BACK PERIOD FOR ANY TASK.** Do not confuse an individual who is totally dependent in an ADL activity (Code 5 -Total Dependence) with the activity itself not occurring. For example- even an individual who receives tube feedings and no food or fluids by mouth is engaged in eating (that is, receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. An individual who is highly involved in giving himself a tube feeding is not totally dependent and should NOT be coded as a "5" – totally dependent.

Effect of ADL

0. Client's condition does not affect the performance of the task (i.e., time it takes to do task or the number of persons needed to do task).

1. Client's condition affects the performance of the task (because of client's condition, task regularly takes longer to perform, two-person assistance regularly provided/needed OR assistive devices are necessary).

Code "1" if the client's problem or condition affects the time it takes to perform task or if two-person assistance is regularly needed. Code "0" if problem or condition does not affect the client or responsible adult's performance of task.

M.3 Individual Needs Cueing/Redirection During ADLs or IADLs Due to A Mental, Behavioral or Developmental Problem/Condition

Determine whether the individual exhibits certain behaviors during the performance of ADLs or IADLs that interfere with their completion. For example, code this as "Yes" (1) if there has been a history of scratching or hitting during a bath or hair pulling during a diaper change.

M.4 Primary Mode of Locomotion

Observe the individual while consulting the caregiver and determine if any assistive devices are used to aid locomotion. Focus on the main mode of locomotion over the last 30 days. If individual uses a wheelchair the majority of time but was bedbound for a few days, use the code for wheelchair.

M.5 Change in ADL Status as Compared to 90 DAYS AGO, Or Since Last Assessment If Less Than 90 DAYS AGO

The intent is to compare the client's current functional status to that of 90 days ago (or since the last assessment, if that was less than 90 days ago). The decreased or increased performance in functioning may be permanent or temporary, and the cause may be known (for example, psychotropic medication or new pain) or unknown.

Talk to the individual or caregiver. Ask them to compare how the individual performs ADL tasks now versus 90 days ago. If necessary, to help identify the 90-day period, ask the individual or caregiver to pinpoint an event that occurred 3 months ago and then to relate the client's functioning to that event. For example, if the client visited a family member 3 months ago, ask how he or she was performing ADLs during that trip as compared with current performance.

SECTION N. CONTINENCE

N.1 Bladder Continence

Bladder Continence – This question has a 7-day look-back period. It refers to control of urinary bladder function and whether the individual has episodes of being wet. This item describes the bladder continence pattern with scheduled toileting plans or continence training programs. It does not refer to the individual's ability to toilet themselves - e.g., an individual can receive extensive assistance in toileting and yet be continent, perhaps as a result of recognizing the need to void and receiving help from others.

Code for the actual bladder continence pattern, i.e. the frequency with which the individual is wet or dry during the 7-day period. Do not record the level of control that the individual might have achieved under optimal circumstances.

If the individual stays dry by going to the toilet every two hours (i.e., scheduled toileting) or because a caregiver has developed an individualized plan, based on the individual's urination pattern (e.g., morning, 30 minutes after each meal, 3:00 each afternoon, and so on) and reminds the individual to go to the toilet – the individual should be coded as "0" (Continent).

Someone with "stress incontinence" might experience anything from infrequent incontinence to frequently incontinent, depending on the frequency of the episodes of wetness. *(Stress incontinence is involuntary leakage of urine from the bladder accompanying some type of physical activity (e.g., laughing, coughing, sneezing, and physical exercise) which places increased pressure on the abdomen/bladder).*

- **Note: If option 8 is recorded (no urine output…in last 7 days), this is a potential medical emergency. Call your supervisor and 911.**

N.2 Bowel Continence

- **Bowel continence -** Refers to control of the individual's bowel movements. This item describes the individual's bowel continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the individual's ability to toilet him or herself (e.g., a person can receive extensive assistance in toileting and be continent as a result of family help).

- **Note: If option 8 is recorded (no bowel movement in last 7 days), first verify with the caregiver if this is normal for the individual, and then notify your supervisor immediately for further guidance to determine if this may or may not be a medical emergency.**

N.3 Pads/Briefs/Diapers/Pull-Ups Worn

Any type of absorbent, disposable or reusable undergarment or item, whether worn by the person (for example, a diaper or adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when the person is never or rarely incontinent.

N.4 Nighttime Incontinence (bowel/bladder) In LAST 7 DAYS

SECTION O. SLEEP

O.1 Sleep Patterns

The purpose of these questions is to determine if a lack of consistency in sleep patterns is a complication in individual's functional status and if so, to what extent. These questions look back over a 7 day time period, and any instance of the behaviours constitutes a 'yes'.

SECTION P. HABILITATION NEEDS

This section is only used for individuals authorized for or who are seeking authorization for the Community First Choice (CFC) benefit. Prior to administering Section P, the assessor must explain the CFC benefit and the requirement that an individual meet an institutional level of care (LOC) in order to receive CFC services. If the individual may meet a nursing facility level of care (called "medical necessity"), LOC may be established through the SAI. If the individual may meet the LOC for an ICF-IID or an inpatient psychiatric facility, the MCO must refer the individual for an additional assessment. The assessor should explain these additional assessments and confirm that the individual wants to pursue CFC services prior to asking these questions.

The primary difference between CFC and PCS is that CFC includes habilitation. In contrast to regular attendant care, where an attendant provides direct assistance with a task, habilitation provides the individual training in how to do a task.

P.1 Goals/Desired Outcomes for Habilitation

Clarify to the individual/caregiver once again that the purpose of habilitation is to provide training to the individual on tasks, and explain that this question is to help them determine their overall goal for such a service, as well as perhaps individual goals (e.g., "I want to be able to do my laundry," or "I want my child to be able to use the toilet"). Individual preferences for how to do various tasks and which tasks are of most importance will be discussed in the questions to follow. Use the first text box to enter any and all goals stated by the individual; use the space after the box to enter the *most important goal* to the individual, even if this goal may be duplicated from information entered in the box before.

P.2 Skill Acquisition and Training Activities Related to Attendant Care Needs

As the individual/caregiver identifies a task the individual needs help with, ask the individual/caregiver how he would like help learning to do the task and record this response on the lines/space provided.

a. Meal preparation– Helping the individual learn to: prepare meals and snacks; cook; assemble ingredients; cut, chop, grind or puree food; set out food and utensils; serve food; prepare and pour a predetermined amount of liquid nutrition; clean the feeding tube; clean area after meal; wash dishes.

b. Medication assistance or administration – Helping the individual learn to: self-administer oral medications that are normally self-administered, including how to administer medications through a permanently placed feeding tube with irrigation.

c. Telephone use or other communication – Helping the individual learn to: make or receive telephone calls; manage and set up communication devices, including augmentive communication devices.

d. Escort or assistance with transportation – Helping the individual learn to: make transportation arrangements for medical and other appointments; helping the individual learn how to use a chosen means of transportation to get to a health care appointment.

e. Laundry– Helping the individual learn to: do laundry; gather, sort, wash, dry, fold, and putt away personal laundry, bedding, and towels; remove bedding to be washed and remaking the bed; using a laundry facility.

f. **Light housework–** Helping the individual learn to perform light housework such as: cleaning and putting away dishes; wiping countertops; dusting; sweeping, vacuuming or mopping; changing linens and making bed; cleaning bathroom; taking out trash.

g. **Grocery or household shopping –** Helping the individual learn to: shop for grocery and household items; prepare a shopping list; put food and household items away; pick up medication and supplies.

h. **Money management –** Helping the individual learn to: manage their day-to-day finances; pay bills; balance a check book; make deposits or withdrawals; prepare and adhere to a budget.

i. **Locomotion or mobility –** Helping the individual learn to: move between locations; walk or use a wheelchair, walker, or other mobility equipment.

j. **Positioning –** Helping the individual learn to: position their body while in a chair, bed, or other piece of furniture or equipment; change and adjust positions; move to or from a sitting position; turn side-to-side; sit upright.

k. **Eating –** Helping the individual learn to: eat and drink; use utensils or special or adaptive eating devices; clean up after task is completed.

l. **Transferring –** Helping the individual learn to: move from one surface to another, with or without a sliding board; move from bed, chair, wheelchair or vehicle to a new surface; move to or from a standing or sitting position; use lift devices.

m. **Toileting –** Helping the individual learn to toilet; use commode, bedpan, urinal, toilet chair; transfer on and off; cleanse; change diapers, pad, incontinence supplies; adjust clothing; clean up after task is completed.

n. **Dressing–** Helping the individual learn to: get dressed; put on, fasten, and take off all items of clothing; don and remove shoes or prostheses; choose and lay out weather and situation appropriate clothing.

o. **Personal hygiene–** Helping the individual learn to manage personal hygiene, including: routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, perineum; basic nail care; applying deodorant; routine skin care; clean up after task is completed.

p. **Bathing–** Helping the individual learn to: bathe; select appropriate water temperature and flow speed; turn water on and off; lay out and put away supplies; transfer in and out of bathtub or shower; wash and dry hair and body; clean up after task is completed.

P.3 Additional Habilitation Needs

As the individual/caregiver identifies a task the individual needs help with, ask the individual/caregiver how he would like help learning to do the task and record this response on the lines/space provided. If "other" (P.3.h.) is checked "yes" (1), make sure to record what it is in the space provided; repeat for sub-items "i" and "j" if needed.

a. **Community integration –** Individual may need assistance finding, participating in and accessing community activities or community services such as free meal programs, churches, parks or self-advocacy training or events.

b. **Use of DME/assistive devices –** Individual may need assistance operating, learning to use, or accessing adaptive equipment.

c. Personal decision-making– Individual may need assistance making decisions for him or herself, including assistance in assessing what is important to that individual, pros and cons, as well as consequences.

d. Communication– Individual may need assistance in expressing his or her wants or needs at a basic level, or expressing him or herself in social situations that can lead to the development and maintenance of relationships.

e. Increase positive social encounters and engagement in preferred activities – Individual may need assistance in increasing positive social encounters and engagement in preferred activities. Individual may have challenging behaviors that can be reduced through behavior support plans, prompting, rewards, or redirection by others.

f. Socialization/relationship development – Individual may need assistance with development and maintenance of relationships or appropriate social behaviors.

g. Accessing leisure and recreational activities – Individual may need assistance identifying, finding, or accessing activities they would like to participate in during leisure time.

h-j.Other

NCAM

SECTION Q. COMPLEX CONDITIONS AND NURSING CARE

NOTE: The default look-back period for the NCAM is 30 DAYS unless otherwise specified.

Neurological

Q.1 Individual Has Seizure Disorder (MN-Req)*

**At a minimum, Item Q.1 must be asked and populated. If the answer is "No" (0) that the individual does NOT have seizures, then the sub-items may be skipped. If the answer to Q.1 is "Yes" (1), then all sub-items Q.1.a through Q.1.g must be asked and populated.*

a. Presence of new seizures since last assessment – If this is an initial assessment, ask this item from the perspective of "Any new seizures over *the last year*?"

b. Seizure is -

- **Controlled –** By any long-term method, such as daily epileptic medication, surgical intervention, vagus nerve stimulation, or deep brain stimulation. Only use this response if the answer to Sub-Item Q.1.a is "No."
- **Uncontrolled** – If the answer to Sub-Item Q.1.a is "YES" then THIS MUST BE THE RESPONSE FOR THIS SUB-ITEM.

c. Typical level of seizure intervention

1. Mild – minimal management required, including long term daily epileptic medication. *If the answer to Sub-Item Q.1.a is "NO" then THIS MUST BE THE RESPONSE FOR THIS SUB-ITEM.*

2. Moderate – medication administration required. This is NOT long term, daily epileptic medication therapy. It means rescue medication, such as DiaStat, administered to stop a seizure and given rectally, intravenously, or intramuscularly.
3. Severe – need medication, maintenance of airway, and prevention of injury. If the level of intervention requires rescue medication AND any more intensive interventions, such as use of suction, oxygen, cushioned bed rails, etc. record this response.

d. Type of seizures

i. **General -** impairs consciousness, occurs in more than one area of brain, such as grand mal, or petit mal (absence) seizures
ii. **Focal –** also called "partial seizures," no loss of consciousness, localized

Record the answer based on the diagnosis provided by the individual and/or caregiver, regardless how long it has been since a seizure has occurred, or if the seizures are controlled or uncontrolled.

e. Date of last seizure

f. Frequency of interventions – These responses apply to interventions both *during* (ictal period) and immediately *after* (post-ictal period) a seizure

i. **Ambu-bag** –a manual resuscitator or "self-inflating bag"
ii. **Rescue breaths** - mouth-to-mouth rescue breathing
iii. **Suctioning –** individual requires suctioning of trach or clearing of airway (nose and/or mouth)
iv. **Oxygen –** individual requires oxygen
v. **Medication –** rescue medication, such as DiaStat, given rectally, intravenously or intramuscularly to stop seizures; NOT long term daily epileptic medication
vi. **Vagus Nerve Stimulator (VNS)** – individual requires unscheduled activation of stimulator by special magnet
vii. **Deep Brain Stimulation (DBS) –** individual requires unscheduled activation of DBS by external means

g. Additional information on seizures, if necessary - if there is not additional information, enter "N/A"

Q.2 New or Revised Shunt Within LAST 30 DAYS (MN-Req)

Q.3 Nursing Services Related to Neurological Care (MN-Req)

The look-back period for this Question is 7 DAYS, not the default period of 30 days.

a. Neurological assessment frequency greater than once per shift (reflexes, Glascow Coma Scale, pupillary reaction, etc.) – A shift is defined as the service time one home health nurse is caring for the individual (most commonly 8 or 12 hours, depending on the home health agency's staffing policies). An example of this item might be a standing order for the individual who has multiple seizures per day to receive a neurological check of pupillary reaction and reflexes after a seizure.
b. Other – Record any additional in-home treatments, procedures, and nursing services received during the look-back period. Repeat for sub-item "c" if needed.

Airway Management

Q.4 Individual Uses Apnea Monitor/Pulse Oximeter (MN-Req)*

**At a minimum, Item Q.4 must be asked and populated. If the answer is "No" (0) that the individual does NOT use apnea monitor or pulse oximeter, then the sub-items may be skipped. If the answer to Q.4 is "Yes" (1), then both sub-items Q.4.a and Q.4.b must be asked and populated.*

Q.5 Individual Uses Bi-PAP or CPAP (MN-Req)*

**At a minimum, Item Q.5 must be asked and populated. If the answer is "No" (0) that the individual does NOT use Bi-PAP or CPAP, then the sub-items may be skipped. If the answer to Q.5 is "Yes" (1), then both sub-items Q.5.a and Q.5.b must be asked and populated.*

Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP). This does NOT include oxygen use which is found on Item Q.7.

Q.6 Individual Has Tracheostomy (MN-Req)*

**At a minimum, Item Q.6 must be asked and populated. If the answer is "No" (0) that the individual does NOT have a tracheostomy, then the sub-items may be skipped. If the answer to Q.6 is "Yes" (1), then all sub-items Q.6.a through Q.6.f must be asked and populated.*

a. **New or revised within last 30 days**
b. **Gauge size needed** - in mm
c. **Tracheostomy is** (cuffed/uncuffed)
d. **Appearance of site** – To determine the timeframe for this sub-item if any of these things are present (<30 days or >30 days), ask the individual/caregiver and/or check the home health records if available.
    i. **Site is red**
    ii. **Site has signs of drainage -** Site is malodorous or purulent.
    iii. **Site shows excoriation -** Any superficial loss of substance or injury to the surface of the body, such as scratching, tearing or abrasion.
    iv. **Site shows other problems**
e. **Suctioning needed** – how often?
f. **Additional information on tracheostomy, if necessary** - if there is not additional information, enter "N/A"

Q.7 Individual Uses Supplemental Oxygen (MN-Req)*

**At a minimum, Item Q.7 must be asked and populated. If the answer is "No" (0) that the individual does NOT use supplemental oxygen, then the sub-items may be skipped. If the answer to Q.7 is "Yes" (1), then all sub-items Q.7.a through Q.7.e must be asked and populated.*

a. **Needed**
b. **Oxygen has to be titrated**
c. **Oxygen administered via:** NC ("1") is a "nasal cannula."
d. **Oxygen amount (in L/min)**
e. **Oxygen saturation percentage at time of visit** – Take the readings using the individual's equipment or your own if available.

Q.8 Individual Uses Ventilator (MN-Req)*

**At a minimum, Item Q.8 must be asked and populated. If the answer is "No" (0) that the*

individual does NOT have use a ventilator, then the sub-items may be skipped. If the answer to Q.8 is "Yes" (1), then all sub-items Q.8.a through Q.8.i must be asked and populated.

Includes any type of electrically or pneumatically powered closed- system mechanical ventilatory support devices.

a. IPV - Intrapulmonary Percussive Ventilator; machine that delivers short bursts of air through a mouthpiece to help individuals to clear sputum.

b. IMV - Intermittent Mandatory Ventilation; any mode of mechanical ventilations where a regular series of breaths are scheduled but the ventilator senses patient effort and reschedules mandatory breaths based on the calculated need of the patient.

c. SIMV - Synchronized Intermittent Mechanical Ventilation; a variation of IMV where ventilator breaths are synchronized with patient inspiratory effort.

d. Negative Pressure Ventilator – such as an iron lung

e. Pressure control – note if pressure control is used on the ventilator

f. Needed – how often?

g. Used at night

h. Ventilator is on standby – record "yes" based on time of assessment

i. Additional information on ventilators, if necessary- if there is not additional information, enter "N/A"

Q.9 Nursing Services Related to Airway Management Care (MN-Req)

The look-back period for this Question is 7 DAYS, not the default period of 30 days.

Record if any of the following in-home treatments, procedures, or nursing services were received during the look-back period. If "other" (Q.9.p.) is checked "yes" (1), make sure to record what it is in the space provided; repeat for sub-item "q" if needed.

a. Apnea monitor/Pulse oximeter – devices used for cardiorespiratory monitoring. Consider all tasks related to assisting with and using the devices in the home.

b. Naso-pharyngeal suctioning - suctioning of secretions from the upper-most part of the throat, behind the nose (e.g., often used with pediatric bronchitis patients).

c. Tracheal suctioning – removing mucus and secretions from the trachea and lower airway that are unable to be cleared by coughing.

d. Oral suctioning – removal oral secretions when an individual is unable to do so themselves.

e. Bi-Pap or C-pap – machines designed to keep airways open to assist individuals with breathing problems to breathe on their own. Include any nursing care related to these machines such as assistance with, care of, or maintenance of the machines.

f. Chest vest – a vest used to loosen mucus. Code for tasks such as assistance using the device or maintenance of device.

g. Percussor – a device used to loosen mucus. Code for use of or maintenance of device in last 7 days.

h. Manual CPT – using manual (hand) percussion to loosen mucus so that the individual can cough.

i. **Tracheostomy care -** include removal of cannula and cleansing of tracheostomy site and surrounding skin with hydrogen peroxide or appropriate cleansing solution and application of ordered topical creams or ointments, as well as periodic changing of the tracheostomy tube itself.
j. **Nebulizer care –** a device driven by a compressed air machine that allows individual to take medicine in the form of a mist. Code for formal services related to use, maintenance and assistance with nebulizer.
k. **Aspiration precaution -** include any activities such as monitoring level of consciousness, monitoring swallowing ability, maintaining airway, change in diet, positional changes/head elevations, medications, etc.
l. **Cough assist (manual or use/care of cough assist machine)** – any device used to assist individual in clearing secretions from lungs and generate coughing. Code for tasks such as assistance using devices, use of manual techniques or maintenance of devices
m. **Oxygen** – giving oxygen as medical intervention.
n. **IPPB -** Intermittent positive pressure breathing (IPPB) - respiratory therapy treatment to assist individuals who are hypoventilating.
o. **Ventilator -** Includes any type of electrically or pneumatically powered closed- system mechanical ventilatory support devices. Include tasks such as assisting with use and maintaining machine.
p. **Other –** any other in-home treatments related to airway management.

Nutritional

Q.10 Enteral Feeding (e.g., NG/G tube) (MN-Req)*

**At a minimum, Item Q.10 must be asked and populated. If the answer is "No" (0) that the individual does NOT have a tracheostomy, then the sub-items may be skipped. If the answer to Q.10 is "Yes" (1), then all sub-items Q.10.a through Q.10.g must be asked and populated.*

a. **Frequency of enteral feedings**
b. **Tube specifications** –
    i. **Diameter (FR)** – width of the tube recorded in French units
    ii. **Length (cm)**

c. **Tube site care** - Any service needed to care for the tube site (e.g., cleaning, changing dressings).
d. **Appearance of tube site**
    i. **Tube site is red**
    ii. **Tube site has signs of drainage** - Site is malodorous or purulent.
    iii. **Tube site shows other problems -** Examples include pain, excoriations, edema, etc.
e. **Concerns with feeding**
    i. **Because of feeding, client experiences irritability**
    ii. **Because of feeding, client experiences distension**
    iii. **Because of feeding, client experiences vomiting**

f. Feeding over night

g. Additional information on tube feedings, if necessary- if there is not additional information, enter "N/A"

Q.11 Individual Has a Swallowing Problem (MN-Req)

Potential swallowing problems include but are not limited to: loss of liquids or solids from mouth when eating or drinking, holding food in mouth, cheek or residual food in mouth after meal, double swallow, complaints of difficulty or pain with swallowing.

Q.12 Individual Chokes with Food (MN-Req)

Indicators of choking can be coughing, gagging, turning red, labored breathing, etc. during and after a meal.

Q.13 Nutrition Nursing Services Care (MN-Req)

The look-back period for this Question is 7 DAYS, not the default period of 30 days.

Record if any of the following in-home treatments, procedures, or nursing services were received during the look-back period. If "other" (Q.13.d.) is checked "yes" (1), make sure to record what it is in the space provided; repeat for sub-item "e" if needed.

a. Parenteral/IV feeding
b. Feeding tube (e.g., NG/G tube)
c. Reflux precautions
d. Other

Medication

Q.14 Individual Receives Medication Via IV (MN-Req)*

**At a minimum, Item Q.14 must be asked and populated. If the answer is "No" (0) that the individual does NOT receive medication via IV, then the sub-items may be skipped. If the answer to Q.14 is "Yes" (1), then all sub-items Q.14.a through Q.14.c must be asked and populated.*

a. Method of IV access – if Other ("6") is noted, record the answer in the space provided

1. Peripheral – IV inserted into a peripheral vein.

2. PICC - peripherally inserted central catheter; inserted into a peripheral vein, typically the arm.

3. Broviac/hickman central line – catheter placed into a large vein by a surgeon or radiologist for longer term use.

4. Groshong central line - catheter connected through the superior vena cava by a surgeon or radiologist for longer term use. In contrast to the Hickman line, the tip of a Groshong line has a three-way valve, which is formed by a slit in the sidewall of the catheter tip

5. Port central line - a central venous catheter with a permanent port placed under the skin of the chest or arm during surgery.

6. Other – any other type of IV access

b. Appearance of IV site

- **i. IV site is red**
- **ii. IV site has signs of drainage**
- **iii. Signs of swelling**
- **iv. Signs of infiltration** – inadvertent leakage of non-vesicant infusion (e.g., normal saline) from the intended vein into surrounding tissue causing swelling. Pay careful attention for this with central venous access devices (CVADs), noted above in Sub-Item Q.14.a. as 2, 3, 4, or 5. This may occur with infection, too.
- **v. Signs of extravasation** – inadvertent leakage of a vesicant infusion (e.g., vancomycin, TPN, Doxorubicin) which can cause blisters, severe tissue injury, or necrosis. Pay careful attention for this with central venous access devices (CVADs), noted above in Sub-Item Q.14.a. as 2, 3, 4, or 5. This may occur with infection, too.
- **vi. Signs of infection** – also known as phlebitis, frequently appears as redness, pain, skin breakdown, or fever. It is possible to have extravasation or infiltration and infection at the same time.

c. Frequency of IV site care – if Other ("4") is noted, record the answer in the space provided

Q.15 Nursing Services Related to Medication Care/Administration (MN-Req)

The look-back period for this Question is 7 DAYS, not the default period of 30 days.

Record if any of the following in-home treatments, procedures, or nursing services were received during the look-back period. If "other" (Q.15.h.) is checked "yes" (1), make sure to record what it is in the space provided; repeat for sub-item "i" if needed.

a. IV medication

b. Injectable medication – intramuscular (IM) or subcutaneous (SC), such as flu shot, insulin, or Epi-Pen

c. Enteral (tube feed) medication

d. Lab draw

e. Finger Stick – for example, blood glucose check

f. Complex medication administration and/or RX>q2hr intervals – A "complex medication administration" example might be a medication that must be crushed and mixed with juice and thickening agent before orally administering to the individual in small doses over 15 minutes. Also notate "Yes" here if any medication must be administered more often than every 2 hours.

g. Medication requiring post-administration monitoring (e.g., vital signs, notating effects on condition, etc.)

h. Other

Elimination

Q.16 Individual Has Constipation (MN-Req) *

**At a minimum, Item Q.16 must be asked and populated. If the answer is "No" (0) that the individual does NOT have constipation, then the sub-items may be skipped. If the answer to Q.16 is "Yes" (1), then all sub-items Q.16.a through Q.16.e must be asked and populated.*

a. **Average bowel movement frequency -** If no bowel movement has occurred in the last 7 days ("3"), first verify with the caregiver if this is normal for the individual, and then notify your supervisor immediately for further guidance to determine if this may or may not be a medical emergency.
b. **Individual is on high fiber diet (may include fiber supplement).**
c. **Number of medications taken for constipation (oral stool softener, laxative, suppositories, etc.) – code for the number of times any constipation medication was used**
d. **Enemas used**
e. **History of dis-impaction –** Record how often manual/digital dis-impaction has occurred

Q.17 Individual Has Urinary Catheter (MN-Req) *

**At a minimum, Item Q.17 must be asked and populated. If the answer is "No" (0) that the individual does NOT have a urinary catheter, then the sub-item may be skipped. If the answer to Q.17 is "Yes" (1), then Q.17.a must be asked and populated.*

a. **Type of catheter**
    1. **Indwelling (Foley) -** A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by suprapubic incision.
    2. **Intermittent** – Coated, uncoated, sterile, or clean inserted for one-time use or multiple uses to void.
    3. **External (condom) - Condom catheter** - A urinary collection device worn over the penis.

Q.18 Nursing Services Related to Elimination Care (MN-Req)

The look-back period for this Question is 7 DAYS, not the default period of 30 days.

Record if any of the following in-home treatments, procedures, or nursing services were received during the look-back period. If "other" (Q.18.e.) is checked "yes" (1), make sure to record what it is in the space provided; repeat for sub-item "f" if needed.

Integumentary

Q.19 Individual's Skin Status (MN-Req)

Make your best effort to assess the individual's skin across their body. It may be helpful to examine the easily visible portions of the skin. *However, do NOT remove any existing dressings to determine the status of wounds, burns, ulcers, etc.* Instead, assess visually and

by asking the individual/caregiver the status, as well as consulting a home health chart if available. For ulcers, pay particular attention to areas of the body most often affected, such as the sacrum, buttocks, feet, and other bony prominences.

a. Skin color

0. Pink/WNL – skin color is within normal limits

1. Pale – lighter than normal skin color

2. Jaundice – a yellowish tint to the skin

3. Cyanotic – a blue or gray tint to the skin

b. Current skin condition

i. **Warm**
ii. **Hot**
iii. **Cool**
iv. **Cold**
v. **Dry**
vi. **Diaphoretic -** perspiring profusely

c. Current number of pressure ulcers at each stage

- **Pressure ulcer -** Any localized area of tissue damage caused by shearing, friction or excess pressure impairing circulation of oxygen and nutrients. Pressure ulcers usually occur in individuals with limited mobility or nerve damage over bony prominences. Pressure ulcers are staged to classify the degree of tissue damage observed.

Ask if the individual has been examined for the presence of pressure ulcers or other skin conditions. Consult with the individual and family about the presence of an ulcer. Review any home health notes available in order to stage the ulcer if unable to visualize due to dressings. It could be difficult to examine the individual's entire skin, as you are a guest in the individual's home. For individuals who are cognitively able, you can get good information about their skin condition without conducting a skin examination.

If a non-removable dressing or device impairs the view, or if it otherwise impossible to be certain it is a pressure ulcer or other wound, record as another wound type, instead.

It is sometimes difficult to determine the presence of a reddened area (a Stage 1 ulcer) in individuals with darker skin tones. To recognize Stage 1 ulcers, look for:

- Any change in the feel of the tissue in a high-risk area; may feel boggy or indurated
- Any change in the appearance of the skin in high-risk areas, such as an "orange-peel" look or a subtle purplish hue; and
- Extremely dry crust-like areas that, upon closer examination, are found to cover a tissue break.

i. **Stage I: any area of persistent skin redness –** Redness does not disappear when pressure is relieved and there is no break in the skin.
ii. **Stage II: partial loss of skin layers -** A partial-thickness loss of skin that presents clinically as an abrasion, blister, or shallow crater.

iii. **Stage III: deep craters in the skin -** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining of adjacent tissue. Depth of pressure ulcer can be measured.

iv. **Stage IV: breaks in skin exposing muscle or bone -** A full thickness of skin and subcutaneous tissue is lost, exposing muscle, tendon or bone.

v. **Not stageable (e.g., slough and/or eschar predominant) -** *Slough tissue* is Necrotic/avascular tissue in the process of separating from the viable portions of the body; usually light colored, soft, moist, stringy (at times). *Eschar tissue* is thick, leathery, frequently black or brown necrotic (dead) or devitalized tissue that has lost its usual physical properties and biological activity; eschar may be loose or firmly adhered to the wound.

d. Pressure ulcer site or additional information – if there is not a pressure ulcer or any additional information, enter "N/A"

e. Prior pressure ulcer(s) in the last 30 days

Ask the individual or caregiver if he or she has ever had a pressure ulcer that is now healed.

f. Total number of venous and arterial ulcers currently present

- **Venous ulcer –** wound on the leg or ankle caused by abnormal or damaged veins
- **Arterial ulcer –** ulcers that can appear anywhere on the extremities; usually have a "punched out" appearance

g. Other skin problems currently present

i. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesion)
ii. Surgical wound(s)
iii. Burn(s) (second or third degree)

Q.20 Nursing Services Related to Integumentary Care (MN-Req)

The look-back period for this Question is 7 DAYS, not the default period of 30 days.

Record if any of the following in-home treatments, procedures, or nursing services were received during the look-back period. If "other" (Q.20.j.) is checked "yes" (1), make sure to record what it is in the space provided; repeat for sub-item "k" if needed.

a. Pressure reducing device for chair- Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water, gel or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices.

b. Pressure reducing device for bed - Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water, gel or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices.

c. Turning/repositioning program - Includes a consistent program for changing the individual's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the individual's needs.

d. Nutrition or hydration intervention to manage skin problems - Dietary measures received by the individual for the purpose of preventing or treating specific skin conditions, e.g., wheat free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.

e. Pressure ulcer care - any intervention for treating pressure ulcers. Examples may include the use of topical dressings, chemical or surgical debridement, wound irrigations, wound vacuum assisted closure (VAC), and/or hydrotherapy.

f. Surgical wound care - any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application. Do not include post-operative care following eye or oral surgery.

g. Application of nonsurgical dressings (with or without topical medications) other than to feet. - This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include Band-Aids.

- Do NOT code application of non-surgical dressings for pressure ulcer(s) other than to the feet in this item; use Pressure ulcer care item (M1200E).
- Do not code application of dressings to the ankle. The ankle is not part of the foot.
- Dressings do not have to be applied daily in order to be coded on the assessment. If any dressing meeting the assessment definitions were applied even once during the seven-day look-back period, the assessor should check that item.

h. Applications of ointments/medications other than feet. - may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).

- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.

This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

i. Skin treatment every four hours or more often

j. Other

Other Nursing Services

Q.21 Other Nursing Services (MN-Req)

The look-back period for this Question is 7 DAYS, not the default period of 30 days.

Record if any additional in-home treatments, procedures, or nursing services were received during the look-back period that did not fit under any of the other body systems or criteria above. USE THIS ITEM SPARINGLY. If “yes” (1) is indicated, make sure to record what it is in the space provided; repeat for any additional sub-items “b” through “j” if needed.

MDCP

Note: This module is used ONLY to gather information used to calculate and assign a Resource Utilization Group (RUG), which is used to determine the MDCP cost limit, or budget, for the individual. **NONE OF THESE ITEMS IN THIS SECTION OF THE SAI ARE USED FOR MEDICAL NECESSITY DETERMINATION.** The assessor should explain to the individual that these questions may seem duplicative of items in the Core, PCAM, and NCAM, but that the timeframes for the questions are different. The assessor should also explain the different purpose of this module. The default look-back period for the MDCP module is 7 days, unless otherwise specified.

SECTION R. MDCP RELATED ITEMS

R.1 Reason for Assessment

Copy answer from Core Item A.12.

Cognitive Patterns

R.2 Individual Has No Discernable Consciousness, is in A Persistent Vegetative State, Or Is in A Coma

Copy answer from Core Item D.2.

R.3 Making Self Understood (Expression)

Copy answer from Core Item F.5 EXCEPT if answer was “9” then enter “-“ dash here.

R.4 Individual Is Under 7 Yrs, At Least 7 But Rarely/Never Understood, Or Unable to Be Assessed (Expression)

If the answer to Question R.3 is “-“dash, or "3" then the answer to this item is “Yes” (1). Also, if the child is less than seven years old the answer is "yes" (1).

NOTE: If the answer to R.4 is "yes" (1) then the individual cannot be assessed for mental status independently. Skip to R.9, bypassing the Individual Assessment of Mental Status items and instead perform the Caregiver Assessment of Mental Status items (R.9 Short Term Memory and R.10 Cognitive Skills).

NOTE: Questions R.5 through R.8 make up the Brief Interview for Mental Status (BIMS). They are to be addressed to the INDIVIDUAL and NOT the caregiver. If the BIMS is *successfully* administered, then R.9 and R.10 are SKIPPED as they address the caregiver.

R.5 - R.8 GENERAL GUIDELINES FOR CONDUCTING BIMS

- The individual may respond using any means of communication (e.g., speaking, writing, augmentive communication device, picture book, etc.).

- Nonsensical responses should be coded as zero ("0"). A nonsensical response is any response that is unrelated, incomprehensible, or incoherent and is not informative with respect to the item being rated.
- Rules for stopping the interview before it is complete (i.e., "Unable to Assess"):
  --Stop the interview after completing Question R.6.c "Day of the Week" if:
  1. All responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated); OR
  2. There has been no verbal or written response to any of the questions up to this point; OR
  3. There has been no verbal or written response to some questions up to this point and for all others, the individual has given a nonsensical response.
- If the interview is stopped, do the following:
  1. Code a "-" dash in Question R.7.a, R.7.b, and R.7.c.
  2. Code "99" in the summary score in Question R.8.
  3. Complete Question R.9 (Caregiver Assessment of Short Term Memory) and R.10 (Caregiver Assessment of Cognitive Skills).
- Examples of Incorrect and Nonsensical Responses:
  1. It is 2016. Interviewer asks 10-year-old Kylie to state the year. She replies "2006." This answer is incorrect but related to the question.
     Coding: This answer is coded "0" but would NOT be considered nonsensical.
     Rationale: The answer is *wrong*, but it is *logical* and relates to the question.
  2. Interviewer asks 7-year-old Jackson to state the year. He says, "Second grade." The interviewer acknowledges this is his year in school and then asks him to try to name the year again. Jackson shrugs.
     Coding: This answer is coded "0" but would NOT be considered nonsensical.
     Rationale: The answer is *wrong* because *refusal* is considered a wrong answer, but the individual's comment about school year is *logical* and clearly relates to the question.
  3. Interviewer asks 11-year-old Maddie to name the day of the week. She answers, "Mama!"
     Coding: The answer is coded "0"; the response is *illogical and nonsensical*.
     Rationale: The answer is *wrong*, and her comment clearly *does not relate* to the question; it is *nonsensical*.

R.5 Repetition of Three Words by Individual (BIMS)

Say to the individual: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed."

Use the word and related category cues as indicated. If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues. Immediately after presenting the three words, say to the individual: "Now please tell me the three words."

After the individual's first attempt to repeat the items:

- If the individual correctly stated all three words, say, "That's right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture" [category cues].
- Category cues serve as a hint that helps prompt individuals' recall ability. Putting words in context stimulates learning and fosters memory of the words that individuals will be asked to recall in item R.4, even among individuals able to repeat the words immediately.
- If the individual recalled two or fewer words, say to the individual: "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words." If the individual still does not recall all three words correctly, you may repeat the words and category cues one more time.
- If the individual does not repeat all three words after three attempts, re-assess ability to hear. If the individual can hear, move on to the next question. If he or she is unable to hear, attempt to maximize hearing (alter environment, use hearing amplifier) before proceeding

Record the maximum number of words that the individual correctly repeated on the first attempt. This will be any number between 0 and 3.

- The words may be recalled in any order and in any context. For example, if the words are repeated back in a sentence, they would be counted as repeating the words.

- Do not score the number of repeated words on the second or third attempt. These attempts help with learning the item for C0400, Recall, but only the number correct on the first attempt goes into the total score. Do not record the number of attempts that the individual needed to complete.

- Code 0, none: if the individual did not repeat any of the 3 words on the first attempt.
- Code 1, one: if the individual repeated only 1 of the 3 words on the first attempt.
- Code 2, two: if the individual repeated only 2 of the 3 words on the first attempt.
- Code 3, three: if the individual repeated all 3 words on the first attempt.

R.6 Temporal Orientation (orientation to year, month, and day) by Individual (BIMS)

If applicable, start by asking the individual what date they wrote on their papers at school that day. Then ask the individual each of the 3 questions separately. Allow the individual up to 30 seconds for each answer and do not provide clues.

a. **Able to report correct year** - Note that a partial year value is not acceptable. For example, if the individual responds "16" when the year is 2016, that does not count as a valid response. The interviewer may ask again for the full year and use an example, such as "Can you please tell me the full year, like nineteen-seventy-five?"

b. **Able to report correct month** - Count the current day as "day one" when determining the accuracy of the response for the month (i.e., was it within five days or missed by six days to one month). For example, if the date of the interview is December 3, 2016 and the individual responds that the month is "November," code the response as "2" (Accurate within 5 days). The month of November was less than 5 days beforehand (December 3 is day one minus 3 more days = 4 days, so November is within 5 days of the interview, even though the current month is December).

c. Able to report correct day of the week - Code any answer other than the correct day of the week as "0." For example, if the individual says "It's pizza day!" the code is still "0."

R.7 Recall by Individual (BIMS)

Ask individual: “Let’s go back to an earlier question. What were those three words that I asked you to repeat?” Allow individual up to 5 seconds for spontaneous recall of the word. For each word that is not correctly recalled after 5 seconds, provide a category cue (e.g., "One word was something you wear"). Allow up to 5 seconds after category cueing for each missed word to be recalled.

If on the first try (without cueing), the individual names multiple items in a category, one of which is correct, they should be coded as correct for that item. If, however, the interviewer gives the individual the category cue and the individual then names multiple items in that category, the item is coded as "0" (No - could not recall), even if the correct item was in the list, since the assumption is that the individual is guessing and likely named it by chance.

a. Able to recall “sock”
b. Able to recall “blue”
c. Able to recall “bed”

R.8 Summary Score (BIMS)

The BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all possible aspects of cognitive impairment. The final determination of the level of impairment should be made by the individual’s physician or mental health care specialist; however, these practitioners can be provided specific BIMS results.

The total possible BIMS score ranges from 00 to 15, or 99 for an incomplete interview.

- If the individual chooses not to answer a specific question(s) that question is coded as incorrect ("0") and the item(s) counts in the total score. If, however, the individual chooses not to answer four or more items, then the interview is coded as incomplete ("99" in the summary score) and Questions R.9 and R.10 (the Caregiver Assessments) are completed.
- To be considered a completed interview, the individual had to attempt to provide relevant answers to at least four of the questions included in Questions R.5 through R.7. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. If an interview is complete and a number 00 to 15 is obtained, then skip to Question R.11 for the Individual Assessment of Mood (PHQ-9©).

Occasionally, an individual can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview. Code “99” for a summary score and proceed to Question R.9.

R.9 Short Term Memory (Caregiver Assessment)

This question should ONLY be asked if it is not possible to perform or successfully complete the BIMS on the Individual. That is, if the answer to Question R.4 is “Yes” (1) or the answer to Question R.8 is "99." Copy answer from PCAM Item J.1.a. if populated EXCEPT if

answer was “9” then enter “-“ dash here. If Question J.1.a. is not populated (i.e., the PCAM was never triggered), the assessor should ask this Question R.9 instead, but again, only if the BIMS could not be performed or successfully completed.

R.10 Cognitive Skills for Daily Decision Making (Caregiver Assessment)

Copy answer from Core Item F.4. EXCEPT if answer was “9” then enter "-" dash here. This question should ONLY be asked if it is not possible to perform or successfully complete the BIMS on the Individual. That is, if the answer to Question R.4 is “Yes” (1) or the answer to Question R.8 is "99."

Mood

R.11 Individual Mood Interview (PHQ-9©)

Complete this question only if the child is 7 years old or greater and able to respond to the questions. That is, if the answer to Question R.4 is “No” (0) and the BIMS (Questions R.5 through R.8) was completed successfully (see Question R.8 for what makes a BIMS successful). You can get parent/caregiver input to this question and its sub-items even when interviewing the child, especially for "f," "g," "h," "i," and for "Symptom Frequency."

NOTE: If *50% or more* of the information is obtained from the parent/caregiver, record a score of "99" under "Total severity score," and then switch to item R.12 (Caregiver Assessment of Individual Mood (PHQ-9-OV©)).

If symptom is present, enter “1” (yes) in column 1. Then move to column 2 and indicate symptom frequency in last 14 days. Some sub-items (e.g., sub-item f) contain more than one phrase. If an individual gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.

If symptom frequency is blank for 3 or more items, the interview is deemed NOT complete. Total Severity Score should be coded as “99” and the Caregiver Assessment of Individual Mood (PHQ-9-OV©) should be conducted found in Question R.12.

Interview the individual.

- **Suggested language:** “Over the last 2 weeks, have you been bothered by any of the following problems?”
- Then, for each question in **Individual Mood Interview**
    - Read the item as it is written in bold, or *use the recommended language for the items below*. The rest of the words on each item are extra descriptors if the individual needs help understanding the question better. However, the item should be scored based on the individual’s interpretation and not on the assessor's definition.
    - Each question **must be** asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
    - Enter **code "9"** for any response that is unrelated, incomprehensible, or incoherent or if the individual’s response is not informative with respect to the item being rated; this is considered a nonsensical response (e.g., when asked the question about “poor appetite or overeating,” the individual answers, “I always win at video games”).

- For a "yes" (1) response to symptom presence, ask the individual to tell you how many days he was bothered by the symptom over the last two weeks. Record as close a response as possible to the answers listed for Column "2. Symptom frequency" in the chart.

a. **Little interest or pleasure in doing things.** Try asking the child, "Do you still love to do your favorite things like you used?"
b. **Feeling down, depressed, or hopeless.** Try asking the child, "Do you feel sad a lot lately?"
c. **Trouble falling or staying asleep, or sleeping too much**
d. **Feeling tired or having little energy**
e. **Poor appetite or overeating**
f. **Feeling bad about yourself.** Try asking the child, "Do you like yourself?"
g. **Trouble concentrating on things - problems thinking/concentrating; distractibility**
h. **Moving or speaking so slowly that other people could have noticed. Or the opposite** – being so fidgety or restless that you have been moving around a lot more than usual. You can simplify this item by asking: "How often have you had problems with moving or speaking so slowly that others have noticed?" (Pause for response) Then: "How often have you felt so fidgety you move around a lot more than normal?"
i. **Thoughts that you would be better off dead or of hurting yourself in some way.** Consider asking the child, "Do you ever feel like hurting yourself on purpose?"

- **Total severity score** – the sum of all frequency response in column 2. The sum should be a number (00-27). A score of "99" indicated the individual was unable to complete interview (i.e. Symptom frequency is blank for 3 or more items.) If any of the items in Column 2 have "-" dashes (i.e., the corresponding item in Column 1 is equal to "9"), then count their values as zero in computing the sum. Remember, three or more "-" in Column 2 means the value should be a "99" and Question R.12 conducted.

R.12 Caregiver assessment of individual mood (PHQ-9-OV©)

Do not complete if Individual Mood Interview (PHQ-9©) was completed (Question R.11). This question should only be asked if it is clear that the individual cannot participate in the mood survey process--and previously did not complete the BIMS (i.e., Questions R.9 and R.10 were completed for caregiver assessment of cognitive function instead of Questions R.5 through R.8).

Read the item as it is written in bold. The rest of the words on each item are extra descriptors if the caregiver needs help understanding the question better. Some sub-items (e.g., sub-item f) contain more than one phrase, and these may be simplified if needed into separate questions. However, if a caregiver gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.

For a "yes" (1) response to symptom presence, ask the caregiver to tell you how many days he believes the individual was bothered by the symptom over the last two weeks. Record as close a response as possible to the answers listed for Column "2. Symptom frequency" in the chart.

NOTE: Unlike Question R.11, "9. No response" is NOT an option for "Symptom Presence" since the assessor is asking the caregiver.

a. **Little interest or pleasure in doing things**
b. **Feeling down, depressed, or hopeless**
c. **Trouble falling or staying asleep, or sleeping too much**
d. **Feeling tired or having little energy**
e. **Poor appetite or overeating**
f. **Feeling bad about yourself**
g. **Trouble concentrating on things–** problems thinking/concentrating; distractibility
h. **Moving or speaking so slowly that other people could have noticed. Or the opposite –** being so fidgety or restless that you have been moving around a lot more than usual
i. **Thoughts that you would be better off dead or of hurting yourself in some way**
j. **Being short-tempered, easily annoyed**

- **Total severity score** – the sum of all frequency response in column 2. The sum should be a number (00-30). Note that "99" is NOT an option as it is for Question R.11.

Behavior

R.13 Potential Indicators of Psychosis

a. **Hallucinations** (auditory or visual) **-** The perception of the presence of something that is not actually there. It may be auditory or visual or involve smell, tastes or touch. Consider asking the child, "Do you hear people talk to you in your head?"
b. **Delusions -** A fixed, false belief not shared by others that the individual holds even in the face of the contrary.

NOTE: These two sub-items may be directed to the caregiver rather than the child if appropriate. Use your best clinical judgment.

R.14 Behavior Patterns in LAST 7 DAYS

Count the number of days' behavior was exhibited regardless of the number or severity of episodes occurring on any of those days.

Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause, or the assessor's judgment that the behavior can be explained or should be tolerated. Code where a behavior is present, even if caregivers have become used to the behavior or view it as typical or tolerable.

a. **Physical abuse**
b. **Verbal abuse**
c. **Other behavioral symptoms not directed toward others**
d. **Rejection of care**
e. **Wandering/elopement -** *Wandering* is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering individual may be oblivious to his/her physical or safety needs. The individual may have a purpose such as searching to

find something, but he/she persists without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when an individual believes he/she must find his/her mother, who caregivers know is deceased). Pacing (repetitive walking with a driven/pressured quality) within a constrained space is not included in wandering. *Elopement* is an attempt to exit or leave home/school/etc. at an inappropriate time without permission or notice.

Functional Status

R.15 ADL Self-Performance

- **ADL Self-Performance** – Measures what the individual actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.

The responses for R.15 and R.16 can be coded simultaneously. The codes for this item are recorded in the same chart as item R.16.

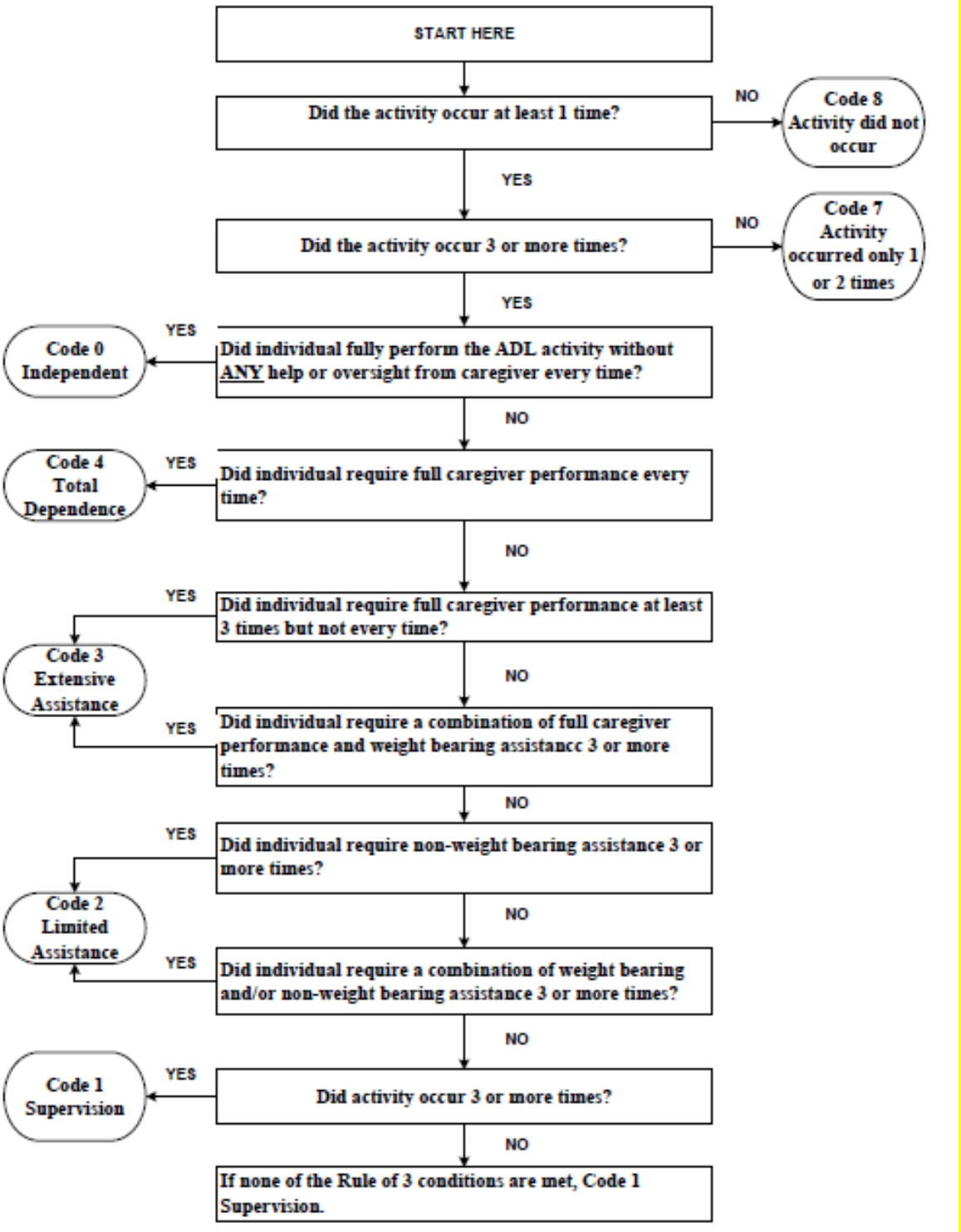
Code based on the individual's level of assistance when using special adaptive devices such as a walker, device to assist with donning socks, dressing stick, long-handle reacher, or adaptive eating utensils.

An individual's ADL self-performance may vary from day to day. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a caregiver that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the individual's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the nurse assessor sees the individual, but how the individual actually performs).

Differentiate between guided manoeuvring and weight-bearing assistance by determining who is supporting the weight of the individual's extremity or body. For example, if the caregiver supports some of the weight of the individual's hand while helping the individual to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the individual, this is "weight-bearing" assistance for this activity. If the individual can lift the utensil or cup, but the caregiver's assistance is needed to guide the individual's hand to his or her mouth, this is guided maneuvering. **NOTE: This Question has a different scale for coding performance than Core F.3 and PCAM M.2.**

ADL Self-Performance Coding Flow Diagram

Instructions: Follow arrows on flowchart to determine correct coding, starting at the "Did Activity Occur" box.



R.16 ADL Support Provided

- **ADL Support Provided** – Measures the highest level of support provided by caregivers over the last 7 days, even if that level of support only occurred once.

The responses for R.15 and R.16 can be coded simultaneously. The codes for this item are recorded in the same chart as item R.15.

Some examples for coding for ADL Support Provided when the activity involves the following:

a. **Bed mobility** - handing the individual the bar on a trapeze, the caregiver raises the ½ rails for the individual's use and then provides no further help. Code 1. Setup help only.
b. **Transfers** - giving the individual a transfer board or locking the wheels on a wheelchair for safe transfer. Code 1. Setup help only.
c. **Eating** - cutting meat and opening containers at meals; giving one food item at a time. Code 1. Setup help only.
d. **Toilet use** - handing the individual a bedpan or placing articles necessary for changing an ostomy appliance within reach. Code 1. Setup help only.

NOTE: This Question has a different scale than Core F.3 and PCAM M.2 where the focus was *effect*. For Question R.16, the emphasis is *support.*

Bladder and Bowel

R.17 Urinary Toileting Program

- **Bladder Rehabilitation/Bladder Retraining** - A behavioral technique that requires the individual to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than the urge to void.
- **Prompted Voiding** - Prompted voiding includes (1) regular monitoring with encouragement to report consistence status, (2) using a schedule and prompting the individual to toilet, and (3) praise and positive feedback when the individual is continent and attempts to toilet.
- **Habit Training/Scheduled Voiding** - A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the individual's voiding habits or needs.

R.18 Bowel Continence Program

Review the medical record, if available, for evidence of a bowel toileting program being used to manage bowel incontinence during the seven-day look-back period. Code "0," no, if the individual is not currently on a toileting program targeted specifically at managing bowel continence.

Diagnoses and Conditions

R.19 Problem Conditions

Review the medical record, if available, interview caregivers, and observe the individual for any indication that the individual had vomiting, fever, potential indicators of dehydration, or internal bleeding during the seven-day look-back period.

a. Fever - is defined as a temperature 2.4 degrees F higher than baseline. Typically, temperatures higher than 100.4 degrees constitute fever in children.

b. Vomiting - Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).

c. Dehydrated – Code 1 "Yes" for this item if the individual has two or more of the following indicators:

- Individual or caregiver reports that the individual usually takes in less than the recommended amount of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups) according to the following:

Pediatric Drinking Water Requirements (Institute of Medicine, Dietary Reference Intakes Tables, reviewed May 2015)

Age Range	Gender	Total Water (Cups/Day)
4 to 8 years	Girls and Boys	5
9 to 13 years	Girls	7
	Boys	8
14 to 18 years	Girls	8
	Boys	11

- Individual or caregiver reports that the individual's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).
- The nurse assessor identifies that the individual has one or more potential clinical signs (indicators) of dehydration, including, but not limited to: dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).

d. Internal bleeding - Bleeding may be frank (such as bright red blood) or occult (such as guiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds", hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily

controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded in internal bleeding.

R.20 Active Diseases/Conditions

You may be able to populate answers to this question based on your experience with the individual during the SAI to this point, such as from previous responses to various questions (e.g., Core Item D.1 Diseases), so you may not actually have to ask this question directly. However, remember this applies only to the LAST 7 DAYS, unlike elsewhere in the SAI.

a. Aphasia
b. Cerebral palsy
c. Diabetes Mellitus (e.g., diabetic retinopathy, nephropathy, and neuropathy)
d. Hemiplegia or Hemiparesis
e. Multiple Sclerosis
f. Pneumonia/lower respiratory infection
g. Quadriplegia
h. Septicemia

Skin Conditions

R.21 Current Number of Pressure Ulcers at Each Stage

Copy the answers from NCAM Sub-Item Q.19.c.

i. Stage I: any area of persistent skin redness
ii. Stage II: partial loss of skin layers
iii. Stage III: deep craters in the skin
iv. Stage IV: breaks in skin exposing muscle or bone
v. Not stageable (e.g., slough and/or eschar predominant)

- **Slough tissue-** Necrotic/avascular tissue in the process of separating from the viable portions of the body; usually light colored, soft, moist, stringy (at times).
- **Eschar tissue-** Thick, leathery, frequently black or brown necrotic (dead) or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound.

R.22 Total Number of Venous and Arterial Ulcers Present

Copy the answer from NCAM Sub-Item Q.19.f.

- **Venous Ulcers**- Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.
- **Arterial Ulcers**- Ulcers caused by peripheral artery disease, which commonly occur on the tips of toes, top of the foot or distal to the medial malleolus.

R.23 Other Skin Problems

Copy the answers from NCAM Sub-Item Q.19.g.

a. **Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion) - Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis.
b. **Surgical wound(s) -** Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body.
c. **Burn(s) –** second or third degree burns

R.24 Foot Problems

a. **Infection of the foot** (e.g., cellulitis, purulent drainage)
b. **Diabetic foot ulcer(s) -** Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.
c. **Other open lesion(s) on foo**t – e.g. cuts, fissures

R.25 Skin and Ulcer Treatments

Copy answers from NCAM Sub-Items Q.20.a through Q.20.h. respectively into sub-items "a" through "h." Sub-item R.25.i is unique and must be examined and asked separately.

a. **Pressure reducing device for chair-** Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water, gel or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices.
b. **Pressure reducing device for bed -** Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water, gel or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices.
c. **Turning/repositioning program -** Includes a consistent program for changing the individual's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the individual's needs.
d. **Nutrition or hydration intervention to manage skin problems -** Dietary measures received by the individual for the purpose of preventing or treating specific skin conditions, e.g., wheat free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.
e. **Pressure ulcer care -** any intervention for treating pressure ulcers. Examples may include the use of topical dressings, chemical or surgical debridement, wound irrigations, wound vacuum assisted closure (VAC), and/or hydrotherapy.
f. **Surgical wound care -** any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application. Do not include post-operative care following eye or oral surgery.

g. **Application of nonsurgical dressings** (with or without topical medications) other than to feet. - This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include Band-Aids.
   - Do NOT code application of non-surgical dressings for pressure ulcer(s) other than to the feet in this item; use Pressure ulcer care item (M1200E).
   - Do not code application of dressings to the ankle. The ankle is not part of the foot.
   - Dressings do not have to be applied daily in order to be coded on the assessment. If any dressing meeting the assessment definitions were applied even once during the seven-day look-back period, the assessor should check that item.

h. **Applications of ointments/medications** other than feet. - may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
   - Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
   - This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

i. **Applications of dressings to feet** (with or without topical medications) - Includes interventions to treat any foot wound or ulcer other than a pressure ulcer. For pressure ulcers on the foot, use Pressure ulcer care item.

Nutritional Status

R.26 Nutritional Status

a. **Individual uses parenteral/IV feeding** – Copy answer from NCAM Item Q.13.a.
b. **Individual uses feeding tube-nasogastric or abdominal (PEG or G-button)** – Copy answer from NCAM Item Q.13.b**.**
c. **Proportion of total calories the individual received through parenteral or tube feeding during entire 7 days –** Only ask if sub-item "a" or "b" is "Yes" (1)
d. **Average fluid intake per day by IV or tube feeding during entire 7 days –** Only ask if sub-item "a" or "b" is "Yes" (1)

R.27 Weight Loss of 5% Or More In LAST 30 DAYS or 10% Or More In LAST 180 DAYS

NOTE: This Question is more specific than Core Item G.2. on Nutrition, so it must be asked separately.

- **Physician-Prescribed Weight-Loss Regimen-** A weight reduction plan ordered by the individual's physician with the care plan goal of weight reduction. May employ a calorie restricted diet or other weight loss diets and exercise. When a physician has ordered diuretics and weight loss is expected to occur, it is included under this definition. It is important that weight loss is intentional.

Physician Care

R.28 Number of days the physician (or authorized assistant or practitioner) examined the individual in LAST 14 DAYS

Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician. Examination (partial or full) can occur in the community setting or in the physician's office. Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.

R.29 Number of days the physician (or authorized assistant or practitioner) changed the individual's orders in LAST 14 DAYS

Includes written, telephone, fax, or consultation orders for new or altered treatment. Does not include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. Do not count orders written by a pharmacist.

Special Treatments, Procedures and Programs

R.30 Record the Number of Days That Injections of Any Type Were Received During the Last 7 Days

NOTE: This Question is different and more specific than Core Item H.4 on Injections, so it must be asked separately.

Count the number of days that the individual received any type of injection (subcutaneous, intramuscular or intradermal). Record the number of DAYS that any type of injection (subcutaneous, intramuscular or intradermal) was received.

Ex: If in the one week look-back period a flu vaccine was received on Monday, followed by two allergy shots on Thursday, and then an Epi-Pen on Sunday, code "03" in the box since this is about *number of days* (Monday, Thursday, Sunday) and NOT total injections received.

R.31 Formal Treatments in The LAST 14 DAYS

Include formal treatments that may have occurred once or more during the time period.

NOTE: The look-back period for this question is NOT THE SAME as Core Item H.5, so you may NOT copy those responses here. Please re-ask to verify if these treatments have occurred in the last 14 days.

a. Chemotherapy - Includes any type of chemotherapy (anticancer drug) given by any route.

b. Radiation - Code intermittent radiation therapy, as well as radiation administered via radiation implant, in this item.

c. Oxygen therapy - Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to an individual to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the individual places or removes his/her own oxygen mask, cannula.

d. Suctioning - *Code only tracheal and/or nasopharyngeal suctioning in this item.* Do NOT code oral suctioning here (**NOTE:** This differs from Core Item H.5.f. which allows for

oral suctioning). This item may be coded if the individual performs his/her own tracheal and/or nasopharyngeal suctioning.

e. Tracheotomy care - Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the individual performs his/her own tracheostomy care.

f. Ventilator or respirator - Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the individual who is, or who may become, unable to support his or her own respiration in this item. An individual who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here. This does not include CPAP/BiPAP.

g. IV medication - Code any drug or biological (e.g., contrast material) given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do not code saline or heparin flushes to keep a heparin lock patent, or IV fluids without medication here. Record the use of an epidural pump in this item. Epidural, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do not code subcutaneous pumps in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy.

h. Transfusion - Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), which are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy.

i. Dialysis - Code peritoneal or renal dialysis that occurs in the community setting (e.g. outpatient setting or in an individual's residence) in this item. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure. This item may be coded if the individual performs his/her own dialysis.

R.32 Restorative Nursing Programs

A restorative program refers to nursing interventions that promote the individual's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

An individual may be started on a restorative program when he or she has restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise. Generally, restorative nursing programs are initiated when an individual is discharged from formalized physical, occupational, or speech rehabilitation therapy. Persons qualified to perform rehabilitation/restorative care include, but are not limited to: family members, caregivers and attendants specifically trained in these techniques/practices. This section does not include procedures carried out by the qualified therapist.

The following criteria for restorative care must be met:

- Measurable objectives and interventions must be documented in the plan of care. If a restorative nursing program is in place when a plan of care is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care

planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the record.

- Evidence of periodic evaluation by the licensed nurse must be documented. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
- Nursing assistants/aides must be skilled in the techniques that promote individual involvement in the activity.
- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program.
- Restorative nursing does not require a physician's order.

Days - For each type of nursing program, enter the number of days restorative nursing programs were provided in the last 7 days. *A day of restorative nursing is defined as treatment for 15 minutes or more during the day.* Enter "0" if none was provided OR if it was provided for less than 15 minutes on that day.

a. Range of motion (passive) - provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be planned, scheduled, and documented in the medical record.

b. Range of motion (active) - exercises performed by the individual, with cueing, supervision, or physical assist by caregivers that are planned, scheduled, and documented in the medical record. Include active ROM and active-assisted ROM.

c. Splint or brace assistance - provision of (1) verbal and physical guidance and direction that teaches the individual how to apply, manipulate, and care for a brace or splint, or (2) a scheduled program of applying and removing a splint or brace. These sessions are planned, scheduled, and documented in the medical record.

d. Training/skill practice in bed mobility - activities provided to improve or maintain the individual's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed.

e. Training/skill practice in transfer - activities provided to improve or maintain the individual's self-performance in moving between surfaces or planes either with or without assistive devices.

f. Training/skill practice in walking -activities provided to improve or maintain the individual's self-performance in walking, with or without assistive devices.

g. Training/skill practice in dressing and/or grooming - activities provided to improve or maintain the individual's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

h. Training/skill practice in eating and/or swallowing - activities provided to improve or maintain the individual's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the individual's ability to ingest nutrition and hydration by mouth.

i. Training/skill practice in amputation/prostheses care - activities provided to improve or maintain the individual's self-performance in putting on and removing prosthesis,

caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item.

j. Training skill practice in communication - activities provided to improve or maintain the individual's self-performance in functional communication skills or assisting the individual in using residual communication skills and adaptive devices.

R.33 Speech-Language Pathology and Audiology Services

a. Individual minutes - Enter the total number of minutes of therapy that was provided on an individual basis in the last 7 days. Enter "0" if none were provided. Individual services are provided by one therapist or assistant to one individual at a time.

b. Concurrent minutes – Enter the total number of minutes of therapy that was provided on a concurrent basis in the last 7 days. Enter "0" if none were provided. Concurrent therapy is defined as the treatment of 2 individuals at the same time, when the individuals are performing two different activities.

c. Group minutes – Enter the total number of minutes of therapy that was provided in a group in the last 7 days. Enter "0" if none were provided. Group therapy is defined as the treatment of 2 to 4 individuals who are performing similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.

d. Days - Enter the number of days therapy services were provided in the last 7 days. *A day of therapy is defined as treatment for 15 minutes or more during the day.* Enter "0" if none was provided OR if therapy was provided for less than 15 minutes on that day.

R.34 Occupational Therapy

a. Individual minutes - Enter the total number of minutes of therapy that was provided on an individual basis in the last 7 days. Enter "0" if none were provided. Individual services are provided by one therapist or assistant to one individual at a time.

b. Concurrent minutes – Enter the total number of minutes of therapy that was provided on a concurrent basis in the last 7 days. Enter "0" if none were provided. Concurrent therapy is defined as the treatment of 2 individuals at the same time, when the individuals are performing two different activities.

c. Group minutes – Enter the total number of minutes of therapy that was provided in a group in the last 7 days. Enter "0" if none were provided. Group therapy is defined as the treatment of 2 to 4 individuals who are performing similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.

d. Days - Enter the number of days therapy services were provided in the last 7 days. *A day of therapy is defined as treatment for 15 minutes or more during the day.* Enter "0" if none was provided OR if therapy was provided for less than 15 minutes on that day.

R.35 Physical Therapy

a. Individual minutes - Enter the total number of minutes of therapy that was provided on an individual basis in the last 7 days. Enter "0" if none were provided. Individual services are provided by one therapist or assistant to one individual at a time.

b. Concurrent minutes – Enter the total number of minutes of therapy that was provided on a concurrent basis in the last 7 days. Enter "0" if none were provided. Concurrent therapy is defined as the treatment of 2 individuals at the same time, when the individuals are performing two different activities.

c. **Group minutes –** Enter the total number of minutes of therapy that was provided in a group in the last 7 days. Enter "0" if none were provided. Group therapy is defined as the treatment of 2 to 4 individuals who are performing similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.
d. **Days -** Enter the number of days therapy services were provided in the last 7 days. *A day of therapy is defined as treatment for 15 minutes or more during the day.* Enter "0" if none was provided OR if therapy was provided for less than 15 minutes on that day.

R.36 Respiratory Therapy

a. **Days -** Enter the number of days therapy services were provided in the last 7 days. *A day of therapy is defined as treatment for 15 minutes or more during the day.* Enter "0" if none was provided OR if therapy was provided for less than 15 minutes on that day.

SECTION Z. ASSESSMENT SUMMARY

Z.1 Individual or Caregiver Has Urgent Concerns (SAI-Req)

Use this space to note any concerns that should be addressed immediately

Z.2 Individual Receives Services That Are Helpful (SAI-Req)

This space is to record any services that the individual or caregivers deem to be particularly effective to assist in the individual's care. Examples include personal care services, particular therapies, specific assistance provided at school, nursing care, etc.

Z.3 PCS needed (SAI-Req)

a. **PCAM triggered** – Record "Yes" (1) if the PCAM was performed.
b. **Recommended PCS hours** – Do NOT ask if the answer to Sub-Item Z.3.a. is "No" (0). Recommended hours should be based on information gathered through the SAI. The assessor may use worksheets to aid in creating a recommendation. Task/hour guides, such as those published by DADS, should not be used.

Z.4 Nursing Needs (SAI-Req)

a. **NCAM triggered** – Record "Yes" (1) if the NCAM was performed.
b. **Recommended nursing hours** – Do NOT ask if the answer to Sub-Item Z.4.a. is "No" (0). Recommended hours should be based on information gathered through the SAI. The assessor may use worksheets to aid in creating a recommendation. Task/hour guides, such as those published by DADS, should not be used.

MDCP and CFC Determinations

Z.5 MN (CFC or MDCP) and MDCP RUG Requirements (SAI-Req)

a. **MN determination needed?** ***(MN-Req)*** – **Note:** This item serves as an indicator for HHSC's Administrative Services Coordinator that this assessment will need to be evaluated to make a MN determination for either MDCP or CFC program eligibility. For a complete description of submission scenarios, please see the SAI Business Rules.
b. **MDCP RUG calculation required?** – **Note:** This item serves as an indicator for HHSC's Administrative Services Coordinator that this assessment will need to be evaluated to make a RUG value calculation for MDCP. For a complete description of submission scenarios, please see the SAI Business Rules.

ERS - Emergency Response Services

Z.6 Does the client require ERS?

If yes, describe in the box below how the individual will benefit from ERS. For example, an individual could benefit from this service if he or she lives alone or is left alone for long periods of time. ERS is only available to individuals approved to receive CFC services.

NOTE: If the individual requires ERS and is not a client requiring either a level of care assessment for ICF-IID or inpatient psychiatric facility, then verify that items labelled "MN-Req" have been completed, as the individual will need to have a medical necessity determination for CFC services.

Support Management

Z.7 Is the individual currently receiving support management?

- **Support management** includes training on how to select, manage and dismiss attendants. Support management is a service available to all CFC recipients. It is not restricted to those using the consumer-directed services option.
- NOTE: This question only applies if the individual/caregiver has requested CFC.

Z.8 Would the individual like to receive support management?

- **Support management** includes training on how to select, manage and dismiss attendants. Support management is a service available to all CFC recipients. It is not restricted to those using the consumer-directed services option.
- NOTE: This question only applies if the individual/caregiver has requested CFC.

Z.9 If Z.7 or Z.8 is "yes," identify any needs, requests, or considerations specific to this service that are necessary for the CFC provider to know when supporting the individual in achieving his/her outcomes.

Service Delivery Options

- **NOTE: These Questions Z.10 through Z.14 only apply if the individual/caregiver has requested CFC or is currently receiving CFC.**

For initial assessment:

Z.10 Is the individual/legally authorized representative (LAR) interested in self-directing CFC services?

For renewal:

Z.11 What service delivery option is the individual currently using?

Z.12 Does the individual want to change their service delivery option?

1. Agency – Agency Directed Services. Where the home health agency provides the services in their entirety.
2. CDS – Consumer Directed Services. Where the individual/LAR hires and manages staff on their own with the assistance of a Financial Management Services Agency.
3. SRO – Service Responsibility Option. A hybrid option between the Agency model and CDS where the individual/LAR selects and supervises the staff but the agency handles all of the paperwork, including timesheets, payroll, and employment records.

Z.13 If "yes" to Z12, what service delivery option would the individual/LAR want to use?

Z.14 Summary of recommended CFC Services

a. **CFC PCS/HAB recommended Total Hours per week –** Recommended hours should be based on information gathered through the SAI. The assessor may use the Section Y worksheets to aid in creating a recommendation. Task/hour guides, such as those published by DADS, should not be used.
b. **Support management total recommended hours** – Code yes if support management is required
c. **ERS -** Code yes if ERS is required

Z.15 Further Assessment is Needed (SAI-Req)

Code based on instructions on the assessment which identifies items for further assessment. These are also known as flags for further follow up by the MCO.

a. **Behavioral Health** (Code "Yes" if B.6.f., H.2, I.1., or I.2 are "1", or any of I.3.a-d are not "0", OR any of I.4.a-k or I.5.a-j are not "0")
b. **Assistive Devices/DME** (Code "Yes" if D.13 is "1" OR any of D.14.a-j are not "1")
c. **Physical Therapy** (Code "Yes" if B.6.c, D.3.a, OR H.6.g are "1")
d. **Occupational Therapy** (Code "Yes" if B.6.b, D.3.a, OR H.6.h are "1")
e. **Speech Language Pathology** (Code "Yes" if B.6.d, D.3.b, or H.6.i are "1", OR F.5. is not "0")
f. **Respiratory Therapy** (Code "Yes" if H.6.f is "1")
g. **ECI** (Code "Yes" if D.3.a or D.3.b is "1", OR D.4 is "2")
h. **Nutrition** (Code "Yes" if any of G.3.b-f are "1")
i. **IDD** (Code "Yes" if D.5 is "6")
j. **Education** (Code "Yes" if B.9 OR D.3.c. are "1")
k. **Medical Provider evaluation**; i.e., longer than one year since office visit (Code "Yes" if A.24.e. is greater than 12 months ago)
l. **Blind Services for Children** (Code "Yes" if B.6.e. is "1")
m. **Deaf and Hard of Hearing Services** (Code "Yes" if B.6.i. is "1")
n. **Employment Services**; e.g., supported employment, employment assistance, vocational rehabilitation (Code "Yes" if B.11 is "3", or B.12 is "1", OR B.14 is "1-3")
o. **Medical care supplies requested** (Code "Yes" if D.15 is "1")
p. **Medical Emergency Plan required** (Code "Yes" if D.16 is "2")
q. **ISP required** (Code "Yes" if C.5 is "3")
r. **ISP update requested** *(Code "Yes" if C.5. is "2")*

Z.16 Additional Information/Referrals Recommended by Assessor (SAI-Req)

This is the last opportunity for the assessor to use their professional judgment and make recommendations on their own as to what programs or services the individual might benefit from. **Note:** This list is meant to provide examples of the services and programs an individual may be eligible for. The descriptors and eligibility requirements for these programs are subject to change. Further information should be sought out after completing the SAI to determine benefits, eligibility requirements and other protocols.

a. **MCO Disease Management –** programs provided by the MCO that provide education and disease management for chronic or complex conditions.
b. **In-Home and Family Support Program –** a program that provides direct grant benefits to people with physical disabilities and/or their families to choose and purchase services

that help them to remain living in their own homes. Services include access to counseling and training programs, attendant care, assistance with medical transportation or special equipment, and respite care.
Who can get services:

a. 4 years old or older
b. must have a physical disability substantially limiting one or more major life activities.
c. A copayment begins at 105 percent of the state median income for household size.

For more information - https://www.dads.state.tx.us/services/faqs-fact/ifs.html

c. Children with Special Healthcare Needs (CSHCN) – program helps clients with health care, drugs, therapies, family support services, transportation
The program is available to anyone who:

a. lives in Texas
b. is under 21 years old (or any age with cystic fibrosis)
c. has a certain level of family income
d. has a medical problem that
    i. is expected to last at least 12 months
    ii. will limit one or more major life activities
    iii. needs more health care than what children usually need
    iv. has physical symptoms. (This means that the Program does not cover clients with only a mental, behavioral or emotional condition, or a delay in development.)

For more information - https://www.dshs.texas.gov/cshcn/

d. STAR+PLUS Waiver (for members nearing age 21) – managed care program for people with disabilities for those 21 years old or older.
To get services through STAR+PLUS you must: (1) be approved for Medicaid, (2) live in a STAR+PLUS service area (now statewide) and (3) be one or more of the following:

a. Age 21 or older, getting Supplemental Security Income (SSI) benefits, and able to get Medicaid due to low income.
b. Not getting SSI and able to get STAR+PLUS Home and Community-Based Waiver Services.
c. Age 21 or older, getting Medicaid through what are called "Social Security Exclusion programs" and meet program rules for income and asset levels.
d. Age 21 or over residing in a nursing home and receiving Medicaid while in the nursing home.

For more information - http://www.hhsc.state.tx.us/medicaid/managed-care/starplus/client-information.shtml

e. Waiver Interest List (MDCP, YES, CLASS, HCS, TxHmL, DBMD) - Because the demand for HHSC community-based services and supports often outweighs available resources, applicant's names may be placed on an interest list until services are available. Applicants are placed on interest lists on a first-come, first-served basis. When a person's name comes to the top of the list, he or she will be contacted by a caseworker. When the caseworker determines that someone is eligible, that person will need to choose a provider to deliver services, if he or she has not already done so. For more information -

https://hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care or https://hhs.texas.gov/services/list-all-dads-programsservices

f. **State Supported Living Center crisis diversion slot** - state supported living centers serve people with intellectual and developmental disabilities who are medically fragile or who have behavioral problems. A crisis diversion slot may be used if an individual is at imminent risk of admission to SSLC. For more information - https://www.dads.state.tx.us/services/sslc/

g. **PASRR crisis diversion slot** - is a federally mandated program that is applied to all individuals seeking admission to a Medicaid-certified nursing facility, regardless of funding source. PASRR must be administered to identify: individuals who have a mental illness, an intellectual disability or a developmental disability (also known as related conditions),the appropriateness of placement in the nursing facility, and the eligibility for specialized services. A crisis diversion slot may be used if an individual is at imminent risk of admission to a nursing facility. For more information - https://www.dads.state.tx.us/providers/pasrr/

h. **Medicaid Medical Transportation Program (MTP)** - non-emergency rides for people who have no other way to get to their Medicaid health-care visits. For more information - http://www.hhsc.state.tx.us/medicaid/mtp/

i. **Blind Children's Program –** provides training, education and resources for children under 22 years old who have vision impairment. For more information - http://www.dars.state.tx.us/dbs/bcp.shtml

j. **Deaf and Hard of Hearing Services –** communication and education services for those who are deaf or hard of hearing. For more information- http://www.dars.state.tx.us/dhhs/index.shtml

k. **Autism Program –** behavior and support services for children with autism spectrum disorder. For more information - http://www.dars.state.tx.us/autism/

l. **Comprehensive Rehabilitation Services Program –** provides services to those who have experience traumatic brain injuries and/or traumatic spinal cord injuries to improve ability to function independently in home and community.
Who is eligible for Services?
(a) To meet the basic eligibility criteria for the Comprehensive Rehabilitation Services (CRS) program, there must a reasonable expectation that services will benefit the person by improving his or her ability to function within the home environment or within the community, and the person must:
   - have a traumatic brain injury or traumatic spinal cord injury that constitutes or results in a substantial impediment to the person's ability to function within the home environment or the community;
   - be at least 15 years of age;
   - be a U.S. citizen or lawful permanent resident, and a Texas resident (as defined in §107.705(52) of this subchapter (relating to Definitions));
   - not be participating in, or be eligible for and able to access, another rehabilitation program offering similar rehabilitation treatment or therapy services; however the person may participate in rehabilitation programs that offer complementary rehabilitation services;
   - be willing to participate in services; and

- be medically stable, including no progression of deficits, no deterioration of physical and cognitive status, or both; not be in imminent need of any acute care; and be functioning at a Level IV of the Rancho Los Amigos Levels of Cognitive Functioning Scale or equivalent.

(b) The person's continued eligibility for the CRS program will be reviewed and, if he or she no longer meets all criteria in subsection (a) of this section, program services may be discontinued.
For more information - https://hhs.texas.gov/services/disability/comprehensive-rehabilitation-services

m. Independent Living Services – a program that may provide counseling, training, adult basic education and assistive devices to promote self-sufficiency for those with one or more significant disabilities.
To be eligible for the ILS program, a person must be certified by staff at a Center for Independent Living (CIL):

a. to have a significant disability that results in a substantial impediment to their ability to function independently in the family and/or in the community, and
b. there must be a reasonable expectation that ILS assistance will result in the ability to function more independently.

For more information - https://hhs.texas.gov/services/disability/independent-living

n. Other Non-Medicaid, Non-State, Community Services – e.g., family or client housing, community transportation, respite. If other services are recommended, specify the service in the space provided.

Appendix: Revision Table

Revision (Date)	Change
2.05 (9/19/16)	1. Aligned item names, numbers, and look-back periods with SAI version 2.05. 2. Changed references throughout the Manual from SK-SAI to SAI. 3. Added an Appendix: Revision Table to track these and future changes to the Manual (not unlike the MN/LOC Manual). 4. Updated assessor requirements throughout the Manual, clarifying sections that specifically require RN assessors (NCAM, MDCP). 5. Explained more thoroughly the look-back periods for modules globally and for individual items where they differed from a module's standard look-back period. 6. Added "(SAI-Req)" and "(MN-Req)" notations to items that are mandatory for the SAI itself and for those requiring an MN determination and corrected the explanation of the process for skipping items that are not mandatory. 7. Provided additional "Helpful Hints" on items such as Care Transition Planning (D.17), ADLs/IADLs (F.2, F.3, M.1, M.2), Pain Control and Physical Function Improvement (H.7, H.8), and Introducing the MDCP (Section R). 8. Clarified use and function of PCAM Section P for CFC purposes only in the "Section Breakdown" Section. 9. Clarified in Core Item A.9 that Interpreters may sign a separate form developed by the MCO, rather than the SAI itself. 10. Defined "Major" and "Minor" corrections in Core Item A.12. 11. Clarified in Core Item A.18 that a child under the age of 18 living with his/her parent(s) at home should be coded as "Yes" (1) for A.18b (Own home or apartment with family). 12. Clarified Core Items A.20 through A.22 that these questions on Community Living should only be asked if age appropriate (individual 18 or older). 13. Clarified Core Item A.24 that the assessor does NOT have to ask the individual the provider's NPI/API number but rather will populate that field at a later time. 14. Clarified Core Items A.25 and A.26 on the role of Guardians/LAR for those 18 and over and those under 18. 15. Noted in Core item B.1 that if the individual attends Private school, it should be recorded under B.1.j "Other" and clarified scenario where B.1.k "Not Applicable" would be coded "Yes." 16. Expanded instructions for Core Items B.3 through B.5 by providing definitions for IEP and special education settings.

	17. Added an example of a preferred learning style to Core Item B.8. 18. Clarified Core Items C.1 and C.2 on coding of goals and primary goal, noting that a primary goal may be duplicated from the goals list above it. 19. Removed 90 day look-back period in instructions for Core Item C.3 and clarified how to code for an initial assessment. 20. Instructed assessors NOT to use "Not Applicable" (8) on Core Item C.6 as it is essentially redundant to "Does not receive" (2). 21. Clarified in D.1 that the assessor does NOT have to ask the individual the ICD code but rather will populate that field at a later time; provided examples of different diagnoses for primary and other. 22. Expanded and clarified how to manage the DME conversation in items D.13 and D.14, including that if no concerns are expressed in D.13, the assessor should still record and code each piece of DME in D.14, and if a DME need exists in D.14 but no equipment, the assessor should write the need instead that must be addressed. 23. Provided examples and coding clarification for the following Core Items: D.5 through D.12, D.15 though D.17; E.1 through E.4, E.8; F.1 through F.6; G.1, G.3, G.5; H.1 through H.5, H9; I.1 through I.3, I.6 and I.7. 24. Expanded on examples of acceptable forms of communication and response types in PCAM Section J (Cognition and Executive Functioning). 25. Clarified purpose of PCAM Item M.3 (Individual Needs Cueing/Redirection During ADLs…) and provided new example. 26. Added notes in PCAM Section N (Continence) for what may constitute a medical emergency regarding lack of urine output or bowel movement and how to proceed. 27. Provided explanation for PCAM Item P.1 as it relates to CFC overall, as well as clarified instructions for the individual tasks in items P.2 and P.3. 28. Addressed the seizure issues in NCAM Item Q.1 by clarifying the definition of "controlled" in Q.1b and the role of long-term anti-epileptic medication for seizure intervention versus rescue medication in Q.1c. 29. Improved definition of "neurologic assessment frequency greater than once per shift" for NCAM Item Q.3a. 30. Provided examples of IV site appearance for NCAM Q.14b and complex medication administration for NCAM Q.15f. 31. Clarified skin assessment concerns in NCAM Item Q.19 by explaining that assessor should make best effort to examine the body without removing existing dressings and when necessary

	ask the individual/caregiver and consult home health chart if available. 32. Provided definitions and examples of integumentary care nursing services for NCAM Item Q.20 (copied and aligned with MDCP Item R.25). 33. Clarified the role of the MDCP Module as RUG-only for cost ceiling (budget) purposes in the waiver and not used for MN. 34. Highlighted in the MDCP Module that many items are similar to the rest of the SAI but with different look-back periods--and then specifically noted the individual items that are. 35. Notated which items in the MDCP Module can copy values from items in other modules. 36. Provided more detailed examples and coding clarification for the following MDCP Module items: R.4 through R.13, including new section of general guidelines for conducting BIMS (R.5 though R.8); and R.32 through R.36, defining "days." 37. Section Z updates: Item Z.11 (defined service delivery options), Item Z.16 (updated program web links).
2.06 (9/27/16)	1. Version and date updated throughout Manual to conform with SAI version 2.06 release.