

ADULT DAY HEALTH CARE TRAINING

**PRESENTED BY DEPARTMENT OF HEALTH CARE SERVICES
AUDITS & INVESTIGATIONS
MEDICAL REVIEW BRANCH**



Objectives of Training

- ❑ Participants will understand the importance of communication and the MDT as the core of all care and service provided.
- ❑ Participants will gain an understanding of medical necessity criteria.
- ❑ Participants will understand their professional documentation requirements when caring for participants in the ADHC center.



Structure of Presentation

- Background
- Role of MDT
- Medical Necessity
- Documentation requirements



Department of Health Care Services

- Health Care Services
 - Access
 - To care for Medi-Cal beneficiaries
 - Delivery
 - Medicaid/Medi-Cal
 - Child Health & Disability Prevention
 - California Children's Services
 - Safety Net
 - Rural Hospitals
 - Burn Units



Audits & Investigations

Mission

- Quality of Care
- Fiscal Integrity of publicly funded health care programs
- Goal
 - Improve
 - Efficiency
 - Economy
 - Effectiveness



Mission of Medical Review Branch

- Ensure quality of health services
- Reduce harmful outcomes
- Protect against misuse
- Protect fiscal integrity of Medi-Cal program



Mandates

- Code of Federal Regulations (CFR)
- Section 42
 - 42 CFR § 456.3
 - The Medicaid agency must implement a **statewide surveillance and utilization control** program that
 - (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
 - (b) Assesses the quality of those services;



Mandates

- California Welfare and Institutions Code
 - Contains statute relating to ADHCs

- Business and Profession Code
 - Contains statutes related to the business requirements for ADHCs

- California Code of Regulations
 - Title 22

The Role of the Multidisciplinary Team (MDT)





The Multidisciplinary Team (MDT) (W&I 14529, 54211, 78303)

- Who: MD, RN, SW, PT, OT, AC
 - When indicated by the needs of the participant, the team includes the following professional staff:
 - Psychiatrist, Psychologist, Licensed Clinical Social Worker or Psychiatric Nurse
 - Speech Therapist
 - Dietitian

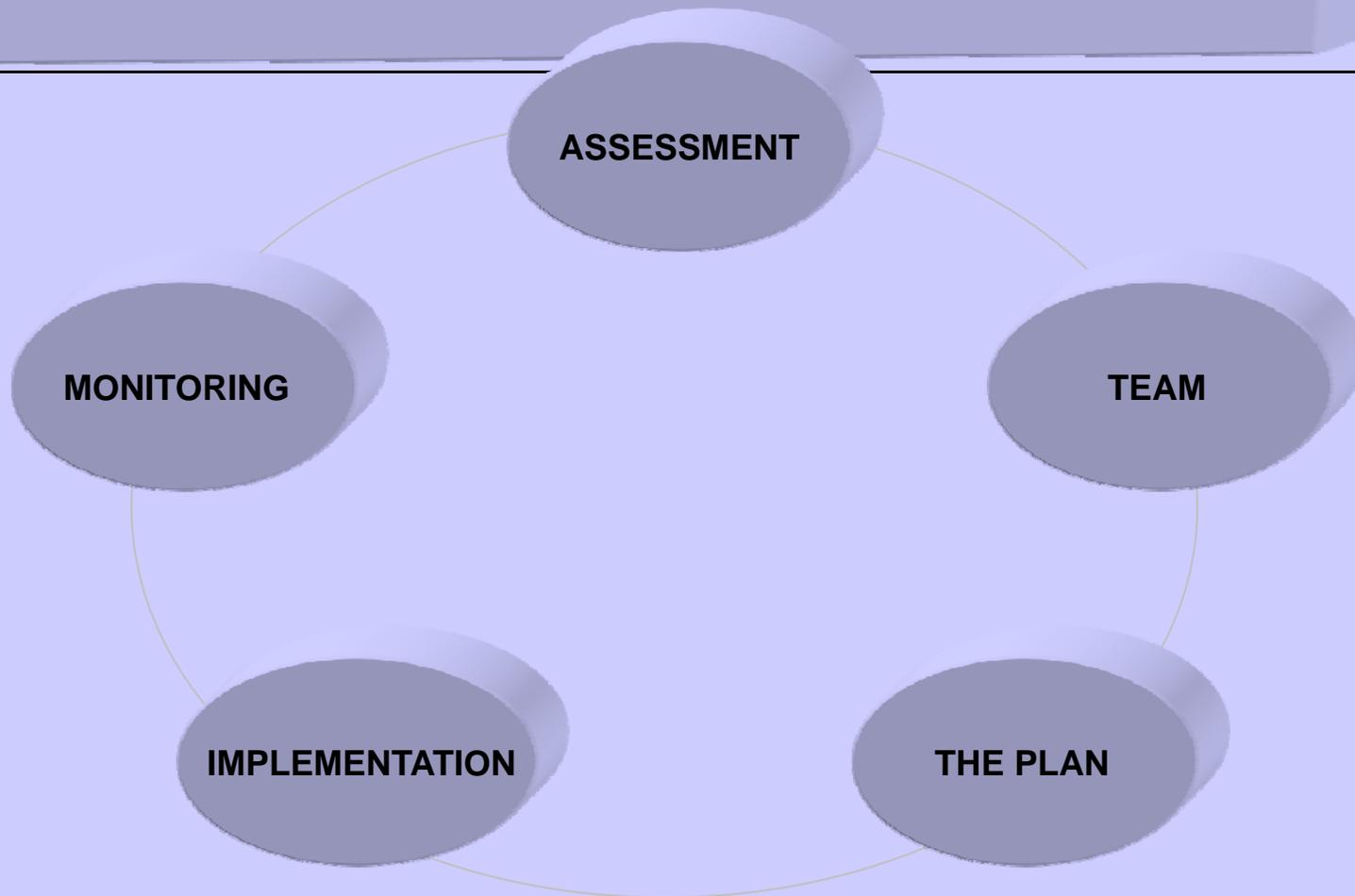


Role of the MDT

(W&I 14529, 54207, 54211)

- ❑ Assessing Participant Need
- ❑ Care Planning
- ❑ Delivering Services
- ❑ Monitoring of Participant Status,
Appropriateness of Care, Changing Needs

THE MDT LOOP





MDT – Team Process

- ❑ Laws and Regulations state that “The Team Shall”
- ❑ They don’t specify HOW
- ❑ What’s implied - Team process . . .
communicating, meeting, comparing notes,
coming to consensus
- ❑ ‘Team’ defined: “A group of people working together in a coordinated effort” – Webster’s
New World Dictionary



Characteristics of Functional MDTs

- Functional MDTs:
- These characteristics are not all inclusive but the more common characteristics found
- These are characteristics not requirements –
- They are a source for you to measure your MDT against



Characteristics of Functional MDTs

□ Characteristics:

- Meet regularly.
- Communicate routinely about meeting participant needs, both formally and informally.
- Reach consensus before acting.
- Usually available by phone
- Meet as a group at least once a week or more often as needed



Functional MDTs cont'd

- ❑ Discuss needed referrals for the participant, participant's family and/or caregiver to ensure the participant's needs are being met.
- ❑ Communicate routinely about each participant's assessment and how they plan to implement plan of care.
- ❑ Discuss discrepancies noted in each other's assessments.



Functional MDTs cont'd

- Discuss recommendations for treatment and services needed by the participant and how they may be scheduled.
- Discuss availability of formal and informal services needed by the participant.

Meeting Medical Necessity Criteria



Welfare and Institutions Code § 14526.1 (d)



Legislative Intent for Adult Day Health Care (ADHC)

- To ensure that an elderly person not be institutionalized prematurely and inappropriately
- ADHC services are identified and funded as a medical model



Before Discussing Each of the Five Medical Necessity Criteria –

**What makes a beneficiary qualify
for ADHC services?**

**Must meet all five
of the Medical Necessity Criteria (MNC)**

or

- Be a resident of intermediate care facility for the developmentally disabled-habilitative AND have disabilities and a level of functioning of such a nature that without supplemental ADHC intervention, placement to a more costly institutional level of care would be likely



A Point to Keep in Mind

- For teaching purposes, example cases will include just a few pieces of clinical information. However, when actually assessing for meeting MNC, the total medical picture must be taken into account, and the additional information could change the determination.



from Welf & Inst § 14526.1 (d) (1)

CRITERION 1

The participant has one or more chronic or post acute medical, cognitive, or mental health conditions...



from Welf & Inst § 14526.1 (d) (1)

CRITERION 1, cont.

HEALTH CONDITIONS...

...identified by the participant's personal health care provider

...requiring one or more of the following

- Monitoring**
- Treatment**
- Intervention**



from Welf & Inst § 14526.1 (d) (1)

CRITERION 1, cont.

MONITORING, TREATMENT, INTERVENTION...

**...without which the participant's condition
will likely deteriorate and require
emergency department (ED) visits,
hospitalization, or other institutionalization**



Document the Clinical Circumstances

- ❑ How does each diagnosis affect this participant?
- ❑ What is it about each health condition that places the participant at risk?
- ❑ For a particular diagnosis, has the clinical status been changing?

- 
-
- Some patients can have the same diagnosis but have different clinical manifestations
 - One person with Chronic Obstructive Pulmonary Disease (COPD) diagnosed by CXR may be asymptomatic
 - Another person with COPD may have oxygen dependency and severe limitations in activities
 - Although each has the same diagnosis, the first is not likely to be an ADHC candidate and the second is



Example regarding Criterion 1

Proposed male participant with -

- ❑ Stroke 10 years ago with mild residual left-sided weakness
- ❑ Borderline low thyroid
- ❑ Hypertension (HTN) and diabetes mellitus (DM), on medication



Discussion of Example

- ❑ Stroke 10 years ago – unlikely to need active medical care at this late date
- ❑ Borderline low thyroid – clinic monitoring appropriate; unlikely to deteriorate and need high level of care
- ❑ HTN and DM – likely to need monitoring, treatment, and intervention; and could deteriorate and need high level of services
- ❑ In summary, this person likely meets Criterion 1 based on HTN and DM



from Welf & Inst § 14526.1 (d) (2)

CRITERION 2

Condition or conditions result in ...

- Limitations in the performance of ≥ 2 activities of daily living or instrumental activities of daily living (ADLs/IADLs), or one or more from each category**
- A need for assistance or supervision in performing ADLs, IADLs**



from Welf & Inst § 14526.1 (d) (2)

CRITERION 2

Note this caveat!

**That assistance or supervision shall be
(needed) in addition to any other non-adult
day health care support the participant is
currently receiving in his or her place of
residence**



1st Example regarding Criterion 2

A proposed participant -

- ❑ Needs assistance with ADLs
- ❑ Has full assistance provided by non-ADHC support such as family and In Home Support Services
- ❑ Therapeutic activity to keep active and involved would be of benefit



Discussion of Example

- ❑ The patient likely qualifies per the first part of Criterion 2
- ❑ The patient likely does not qualify per the second part of Criterion 2
- ❑ “Keeping active and involved” is not a recognized ADL/IADL, and so this need would not help satisfy Criterion 2
- ❑ In summary, based on the caveat, this person likely does not meet MNC 2



2nd Example regarding Criterion 2

An 80 year old female patient -

- Has hypertension and diabetes, plus has vision deficits and mild dementia; she is on a complicated medication regimen
- She has deficiencies in some ADLs and most IADLs
- She lives with her family, who provide care and support, but make errors in med administration despite their best efforts



Discussion of Example

- ❑ This patient likely meets Criterion 1
- ❑ This patient likely meets the first part of Criterion 2 regarding ADL/IADL limitations
- ❑ This patient likely meets the second part of Criterion 2 regarding needing more assistance than available at home
- ❑ In summary, this person likely meets Criterion 1 and Criterion 2



from Welf & Inst § 14526.1 (d) (3)

CRITERION 3

**Non-adult day health care center supports are
insufficient to maintain the individual in
the community**

- 
-
- For this criterion, the support services that are in place to help keep the person in the community are assessed

- 
-
- The distinction must be made between the services being beneficial versus necessary to keep the person in the community
 - The implication of Criterion 3 is that the ADHC center will provide another layer or type of support and this support will be key in keeping the individual in the community

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-
- The law goes on to say that one or more of the following three scenarios may demonstrate that the participant's network of non-ADHC center supports is insufficient



from Welf & Inst § 14526.1 (d) (3)

CRITERION 3 – Scenario I

- ❑ **The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision**

- 
-
- When a participant who lives alone may meet Criterion 3,
 - Double check to verify the participant meets Criterion 2



from Welf & Inst § 14526.1 (d) (3)

CRITERION 3 – Scenario II

- ❑ **The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant**

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-
- Scenario II of Criterion 3 typically applies to those living in private residences
 - It can apply to those living in licensed facilities with unmet medical needs



from Welf & Inst § 14526.1 (d) (3)

CRITERION 3 – Scenario III

- ❑ **The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant**

- 
-
- Respite is intended for unpaid caregivers
 - The participant's chart should address the circumstances prompting the respite request



Example regarding Criterion 3 –

A 42 year old female patient -

- ❑ Has multiple mental and medical problems (schizophrenia, depression, traumatic brain injury, seizures) and is on multiple meds
- ❑ She has problems with emotions and behavior
- ❑ She marginally performs ADLs, she has social service support for most IADLs; she needs help with hygiene, meds, and accessing resources
- ❑ She is living alone at this time



Discussion of Example

- This person likely meets Criterion 1
- She lives alone but probably meets Criterion 2
- She also likely meets Criterion 3
 - ADHC services may be able to play a key role in keeping her out of an institution
- In summary, she likely meets Criteria 1, 2, and 3



from Welf & Inst § 14526.1 (d) (4)

CRITERION 4

A high potential for deterioration of the participant's condition



likely to result in emergency department visits, hospitalization, or other institutionalization



without adult day health care services



High potential for deterioration...

The Medi-Cal Provider Manual has defined “high potential for deterioration” as $> 50\%$ chance of needing ED visits, hospitalization or institutionalization within 6 months



Do these clinical circumstances meet the level of risk needed for Criterion 4?

- ❑ HTN, controlled on home meds
- ❑ HTN, fluctuating BPs
- ❑ SOB on exertion
- ❑ DM, OA, GERD
- ❑ Old age
- ❑ History of depression



HTN

- Hypertension – If generally well-controlled, HTN does not represent high short-term risk and is appropriate for management in a medical office. Significantly low blood pressures (BPs) or high BPs may be appropriate for monitoring in an ADHC center.



SOB

- Shortness of breath on exertion – More information would be needed to make an assessment of this risk. For example, the underlying problem could be de-conditioning (low risk) to severe congestive heart failure (high risk).



DM, OA, GERD

- Diabetes mellitus, osteoarthritis, gastroesophageal reflux disease – Although carrying different long-term risks, in the typical case, each of these diagnoses would not qualify as high short-term risk. However, in the extreme case or when there are extenuating circumstances, such as significant co-morbidities, they might.



Old Age

- ❑ Old age – An advanced age is not a qualifier in and of itself, since it follows from the requirement that ADHC services have to be able to reduce the risk.
- ❑ However, there may be accompanying conditions that put the person at high risk which the ADHC services can address.



Depression

- Depression – A distant history of depression typically would not be an indicator of high short-term mental health risk.



from Welf & Inst § 14526.1 (d) (5)

CRITERION 5

Condition(s) require ADHC *specified services* -

- ❑ On each day of attendance**
- ❑ That are individualized**
- ❑ That are designed to maintain the ability of the participant to remain in the community and avoid ED visits, hospitalizations, or other institutionalization**



Key Words and Phrases

- Require the specified services
- On each day of attendance (ie, meaningful service at the frequency of planned attendance)
- That are individualized (tailored to the individual, not leaving out elements that are needed)



from Welf & Inst § 14550.5

Specified Services

- One or more of the listed professional nursing services**
- One or both of the listed core personal care services or social services**
- At least one of the listed therapeutic activities**
- One meal per day of attendance**

- 
-
- On the Specified Services list, the first reference is to nursing services. Since the medical services are what set ADHC centers apart from Adult Day Care centers, the details regarding these services are highlighted on the next slide.



from Welf & Inst § 14550.5

Professional Nursing Service

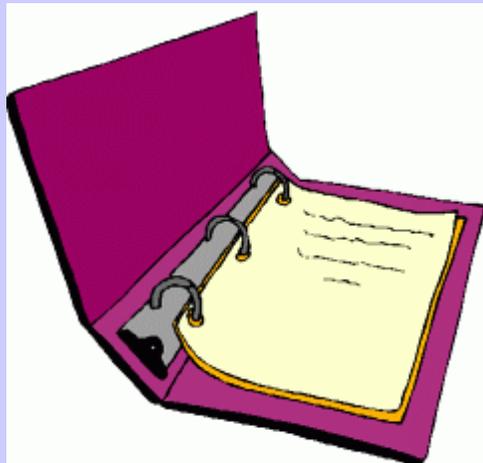
- ❑ Observation, treatment, and monitoring of health status and changes
- ❑ Medication administration, monitoring, and assessment
- ❑ Communication with care providers regarding medical changes
- ❑ Supervision of provision of personal care services
- ❑ Provision of skilled nursing care



Treatment Authorization Request

- ❑ Meeting MNC is required for the granting of a treatment authorization request for ADHC services.
- ❑ Authorization does not guarantee qualification for payment.
- ❑ Documentation must substantiate the delivery of services consistent with the services and the rationale for medical necessity detailed in the request for authorization.

Documentation for ADHCs





Purpose of Medical Record Documentation

- Clinical Care
- Claims Payment
- Risk Management



Documentation Standards

- Professional medical record documentation standards do not change with the setting
- Established by professional board, professional organizations and oversight agencies
- Licensed professional practice acts and accompanying regulations
- Title 22 §51476 and other areas of Title 22



Primary Purpose

- Good clinical care requires good documentation.
- Good documentation contains pertinent facts, findings, and observations about participant. It tells the “whole story.”



Documentation of services is related to IPC

- ❑ Individualized
- ❑ Patient-centered
- ❑ Measurable
- ❑ Specific
- ❑ Consistent with services scheduled on the IPC



Documentation

- Facilitates continual evaluation, assessment, and changes in the care plan

- Vehicle for communication among providers
 - Within the multidisciplinary team
 - In coordinating care with participant's PCP and other healthcare professionals



Purpose: Claims Payment

- Good, thorough, and detailed documentation is advantageous to ensure claims are paid on a timely basis.
- When a question exists about delivery of care not being documented, payment of claims may be withheld.



Purpose: Risk Management

- Provider Agreement

- make, keep and maintain records
- systematic and orderly manner
- readily retrievable
 - For 3 years



Purpose: Risk Management

- Provider Agreement

□ Title 22 § 51476

- Such records as are necessary to **fully disclose the type and extent of all services**
- Such records shall be made **at or near the time at which the services, goods, supplies, and merchandise are delivered or rendered**
- Such records shall include the **identification of the person rendering services**



Purpose: Risk Management

- Legal Documents

- Remember the following:
 - Put the participant's full name on every page
 - Use complete dates
 - Use ink
 - No white-out
 - No erasing
 - No covering entries
 - Keep records for seven years (78435)
 - Protect Their Confidentiality (54439)



Legibility

- Documentation must be legible
 - To someone from outside the center
 - May be typed
 - Must be signed at the time it is written/typed



WHAT'S IN A FORM?

- When documentation is evaluated or a claim adjudicated, we look for information required by regulations and the law, not a specific format unless specifically indicated.



Flow Sheets

- Individualized
 - Be created to meet the individualized needs for each beneficiary
 - One size may not **fit** all
- Legend
 - Reflect services provided
 - Reflect participant's response to services as needed
 - Reflect interventions needed as result of monitoring/observations, etc.
 - Each symbol must stand for only **one** thing
- Information
 - Must contain information about services, participant's response, and any interventions provided
 - If not clear on the flow sheet you will need a progress note



When do I write a progress note?

- When is flow sheet documentation not enough?
 - Whenever something you don't want to happen happens even if it is an expected problem – SOB, chest pain
 - Include physical assessment as appropriate for complaint
 - Include all interventions accomplished
 - Include outcome as result of interventions
 - Evaluate effectiveness of interventions
 - Plan for prevention of recurrence of symptoms
 - Plan for intervention if complaint persists/reoccurs
 - Communicate with PCP and/or caregiver



When do I write a progress note?

- Continued refusal to participate in planned PT/OT or a planned activity, nursing service or social service
- Individual one-on-one counseling
- Whenever you don't think that mark on the flow sheet accurately reflects the services you provided the participant that day



Principles of Medical Record Documentation

- ❑ Legible
- ❑ Complete and thorough
- ❑ Past and current diagnoses easily understood
- ❑ Identifies health risk factors
- ❑ Includes assessment
- ❑ Outlines plan of care
- ❑ Provides reasons for the interventions in the care plan
- ❑ Identifies/describes interactions and treatment with date
- ❑ Records participant progress, response to and changes in treatment, revision of diagnosis/condition/treatment/plan of



Minimum Requirements: IPC

The problems, treatments/interventions, and objectives/desired outcomes must

- relate back to the conditions for medical necessity
Wel. & Inst 14526.1
- (current regulations and the law)
- reflect the assessment
- include interventions that can be documented and relate to
- measurable/defined goals



Problem Statements

- ❑ Are specific and provide a measurable starting point (baseline).
- ❑ Reflect assessment by the team and the referring physician.
- ❑ Are related to the diagnosis but are NOT the diagnosis.
- ❑ Are problems the ADHC is capable of addressing.
- ❑ Are individualized.



Treatments/Interventions

- ❑ Take into consideration culture, gender, likes and dislikes.
- ❑ Maximize participant independence and dignity
- ❑ Include group and individual.
- ❑ Can include more than one treatment for a problem and more than one disciplinary approach.



Treatments/Interventions

- ❑ Always include frequency.
- ❑ Reflect physicians orders and MDT assessments.
- ❑ Relate to the problem.
- ❑ Are practical for implementation in an ADHC setting.



Goals and Objectives

- ❑ Are specific and measurable.
- ❑ Use measurement consistent with problem statement.
- ❑ Reflect MD and MDT assessment.
- ❑ Relate to problems and treatments.
- ❑ Are achievable.
- ❑ Include timelines (if other than six months).



Licensed Staff

- Expectation that licensed staff will practice their profession as required by law and regulation in order to maintain their licensure.
- Center administration will be aware of these requirements and understand the practice acts are the final determination what staff can or can not do.
- References for these requirements are in handout



Participant Health Records (Title 22 § 54425 and 78431)

- Required documentation
 - Identifying information
 - Physician's request and health assessment.
 - Health clearance (**TB**)
 - Attendance and services
 - Initial assessment



Participant Health Records (Title 22 § 54425 and 78431)

- Required documentation
 - IPC
 - TAR
 - Method of transportation
 - Participation agreement



Participant Health Records (Title 22 § 54425 and 78431)

- ❑ Referrals to other providers
- ❑ Dates and substance of communications with the physician, family members, other service providers
- ❑ Medication records
- ❑ Progress notes by involved personnel



Documentation ‘Musts’

- The health record must reflect:
 - Services provided as scheduled (on the IPC)
 - If services not provided, an explanation of why
 - The participant’s progress or lack of progress toward goals and objectives
 - The participant’s medical, functional, psychosocial status



Required Signatures

- ❑ The person providing the service needs to sign/initial at the time the service is provided
- ❑ The supervising staff needs to sign at least once a month if not more often
- ❑ Everyone who initials needs to sign and print name/initials on form
- ❑ Remember the initials on a flow sheet are in lieu of a signature
 - Need to be written by the person providing the service



Examples/Important Points

- Inconsistent information
- Source documents need to support assessments/summary notes
 - Participant nursing flow sheet documented pain at 1/10 for entire month
 - 6 month reassessment covering this month described it as 7-8/10 relieved to 5-6/10 with Tylenol.



Examples/Important Points

- ❑ Nursing
- ❑ Intervention - Monitor obstacle free center is not a nursing intervention
- ❑ That is a liability responsibility for the center for everyone – participants, staff and visitors
- ❑ Intervention - Obs for s/s of change – much too vague – observing what? change in what?
- ❑ Observations need to be specific



Examples/Important Points

- PT
- Vague pain measurements a check for “yes” or “no” that you did it is not sufficient. What did you find with your pain measurement using scale 1-10?
- Need the measurement and symptoms/behaviors as appropriate
 - IF measurement doesn’t match symptoms/behaviors, describe symptoms/behaviors the participant exhibits for the measurement
- If a service is determined to be needed and placed on the IPC, it needs to be done – not “refused due to another activity”
- Individual schedules need to be developed for each participant so all needed services can be provided



Important Points

- Social Services one-on-one counseling needs a progress note with what is discussed and the participant's response to the counseling
 - Just a letter or a number on a flow sheet doesn't accurately reflect what was accomplished during the counseling session
 - This is especially important for those participants that attend because of psychiatric conditions
 - Summary notes covering several days don't accurately reflect individual counseling



Important Points

- Activities
- Need documentation of all activities provided to each beneficiary per the IPC
 - Needs to be done by person providing services
 - Supervised by Activities Coordinator
- Need to reflect individual interventions and goals from the IPC
- Need to be scheduled so as not to interfere with other therapeutic services provided by licensed staff at the center



Important Points

- ❑ Activities
- ❑ Need to document participant's response to services – how they are progressing toward goals
- ❑ Problem – needs to describe the participant's particular problem - be individual not the same for everyone
- ❑ Interventions – also need to be individual
- ❑ Goals- also need to be individual not the same for everyone – measurable



Important Points

- If summary notes are written there needs to be support documents to support the summary
 - Flow sheets/progress notes need to contain clear information that supports what is written in the summary note
 - Without support documents/ the summary notes are of little value