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CalAIM Dual Eligible Special Needs Plans Policy Guide

Contract Year 2024

January 2023

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Introduction

This California Advancing and Innovating Medi-Cal initiative (CalAIM) Dual Eligible Special Needs Plan (D-SNP) Policy Guide is intended to serve as a resource for D-SNPs in California, including both exclusively aligned enrollment (EAE) D-SNPs and non-EAE D-SNPs.

D-SNPs are Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal and offer care coordination and wrap-around services. All D-SNPs in California must have executed contracts with the Department of Health Care Services (DHCS), the state Medicaid agency. These contracts, referred to as the State Medicaid Agency Contract (SMAC) or Medicare Improvements for Patients and Providers Act (MIPPA) contract, must meet a number of requirements, including Medicare-Medicaid integration requirements. DHCS maintains the authority to contract or not to contract with D-SNPs.

As part of the CalAIM initiative, DHCS launched EAE D-SNPs, effective January 1, 2023, in the seven counties where the Coordinated Care Initiative and Cal MediConnect Plans were implemented: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. EAE D-SNPs are D-SNPs where enrollment is limited to D-SNP members who are also enrolled in the affiliated Medi-Cal managed care plan. Medicare Medi-Cal Plans, or MMPs, is the California-specific program name for EAE D-SNPs.

This CalAIM D-SNP Policy Guide is intended to serve as a resource for all D-SNPs in Contract Year (CY) 2024, by providing additional details to supplement the 2024 SMAC. The Policy Guide provisions that apply to all D-SNPs, and those that apply only to EAE D-SNPs, are indicated at the beginning of each section. The provisions of this Policy Guide will be part of the DHCS SMAC requirements for 2024. Updates will be published as guidance is added.

Summary of Updates and Key Changes

Date	Chapter/Section	Update/Change	Notes
1/24/23	I. Care Coordination	• Updated formatting in the disease specific criteria palliative care section	
1/19/23	I. Care Coordination	• Updated MOC submission instructions	
1/11/23	I. Care Coordination	• Initial Release	

I. Care Coordination Requirements

The purpose of this section is to provide state-specific care coordination requirements to health plans intending to operate EAE and non-EAE D-SNPs in California for contract year (CY) 2024.

The state requirements described in this section are in addition to all existing Medicare D-SNP Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual. These state requirements are part of the DHCS SMAC requirements for CY 2024.

D-SNPs that are required by CMS to submit a new Model of Care or re-submit a Model of Care for CY 2024, including those with a new D-SNP only H contract for CY 2024, must reflect these state requirements and populate and submit the California Specific Model of Care Matrix Document to DHCS email box DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager by February 15, 2023. D-SNPs should submit both the MOC and state-specific matrix to DHCS. DHCS recommends that D-SNPs submit the same MOC to both CMS and DHCS. D-SNPs are not required to submit the state-specific matrix to CMS.

For all D-SNPs in CY 2024, these requirements should be incorporated into Models of Care and implemented, regardless of prior Model of Care approval. D-SNPs that are not required by CMS to submit a Model of Care for CY 2024 should consider whether an off-cycle Model of Care update would be needed to accurately reflect their care coordination process as a result of implementing the state requirements and submit that off-cycle Model of Care update to DHCS email box DHCS_DSNP@dhcs.ca.gov, with cc to DHCS contract manager, by March 31, 2023. DHCS recommends that plans submitting off-cycle submission to DHCS also submit to CMS during NCQA off-cycle submission window. DHCS recommends that D-SNPs submit the same MOC to both CMS and DHCS. D-SNPs are not required to submit the state-specific matrix to CMS.

DHCS may provide feedback on MOC submissions, and DHCS requests any needed updated MOCs be provided to DHCS within 30 days of DHCS feedback to the plans.

Risk Stratification

D-SNP risk stratification of members must account for identified member needs covered by Medi-Cal. At a minimum, this process must include a review of:

- Any available utilization data, including Medicaid utilization data available through the aligned Medi-Cal managed care plan (including long-term care utilization);
- Any other relevant and available data from delivery systems outside of the managed care plans such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-

and community-based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data;

- The results of previously administered Medicare or Medi-Cal Health Risk Assessments (HRAs), if available; and
- Any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).

Health Risk Assessment (HRA)

To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should identify efficiencies in their respective HRA tools and processes to minimize the burden on members. Plans must make best efforts to create a single, unified HRA to meet the requirements for both the D-SNP and Medi-Cal managed care plans. Plans have flexibility in the design of their HRA tools as long as the content specified below is included. Plans should rely on Medicare timeframes for the completion of initial and annual HRAs. To the extent that Medi-Cal and Medicare guidance for HRAs conflict, plans should follow Medicare guidance.

Non-EAE D-SNPs should coordinate with unaligned MCPs for member care, including sharing copies of their mutual member's completed HRA.

D-SNPs must ensure their HRA identifies the following elements:

(1) Medi-Cal services the member currently accesses.
(2) Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix A or similar questions. If a plan intends to use a variation of the LTSS questions provided, the question must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRA in any order.
(3) Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease. Plans should leverage Dementia Care Aware resources.
(4) Consistent with 42 CFR § 422.101(f)(1)(i), D-SNPs must include at least one question from a list of screening instruments specified by CMS in sub-regulatory guidance on each of three domains (housing stability, food security, and access to transportation).

If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. D-SNPs should use validated caregiver assessment tools, such as the Benjamin Rose Caregiver Strain Instrument, Caregiver Self-Assessment Questionnaire, and REACH II Risk Appraisal. HRAs must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.

Face-to-Face Encounters

Regulations at 42 CFR §422.101(f)(1)(iv) require that all SNPs must provide, on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the enrollee's consent, for face-to-face encounters for the delivery of health care or care management or care coordination services and be between each enrollee and a member of the enrollee's ICT or the plan's case management and coordination staff, or contracted plan healthcare providers. A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter. DHCS requires D-SNPs to provide the equivalent of Medi-Cal Enhanced Care Management (ECM) primarily through in-person contact. D-SNPs must use alternate methods (including telehealth) when in-person communication is unavailable or does not meet the needs of the member, to provide culturally appropriate and accessible communication in accordance with member choice.

Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs)

Both the ICP and ICT meeting should include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Plans must encourage participation of both members and primary care providers in development of the ICP and ICT activities. If cognitive impairment is present, caregivers should also be involved. For members with serious illness participating in a palliative care program, the D-SNP must use a palliative care ICT.

The ICP should be person-centered and, when cognitive impairment is present, family-centered, and informed by the member's HRA and past utilization of both Medicare and Medi-Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal and Medicare guidance for ICPs conflict, plans should follow Medicare guidance. The ICP should be developed and updated by, and/or shared with the member's palliative care team, as appropriate.

Non-EAE D-SNPs should coordinate with unaligned MCPs for member care, including sharing copies of their mutual member's completed ICP and participating in the ICT.

For Non-EAE D-SNP members, there must be established connections between the D-SNP and the MCP to coordinate care. The D-SNP is responsible for coordinating with the MCP and ensuring care managers are exchanging information to update the member's care plan and engage providers in care plan development and care team meetings. DHCS maintains a contact list for MCPs and D-SNPs. MCP and care coordinator contact information must be included in the D-SNP care plan.

The ICP must identify any carved-out services the member needs and how the D-SNP will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to:

- Community Based Organizations such as those serving members with disabilities (e.g., independent living centers) and those serving members with dementia (e.g., Alzheimer's organizations)
- County mental health and substance use disorder services
- Housing and homelessness providers
- Community Supports providers in the MCP network
- 1915(c) waiver programs, including MSSP
- LTSS programs, including IHSS and Community-Based Adult Services (CBAS)
- Medi-Cal transportation to access Medicare and Medi-Cal services
- Medi-Cal dental benefits

D-SNP care coordinators/managers participating in the ICT must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS programs, including home- and community-based services and long-term institutional care. The ICT should include providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports. Non-EAE D-SNPs should work with unaligned MCPs to engage Medi-Cal providers in the ICT.

Dementia/Alzheimer's Care

The Dementia Care Aware training and resources may be used to support D-SNP providers when detecting cognitive impairment for D-SNP members.

Plans should encourage any providers to leverage Dementia Care Aware resources for any primary care visit to detect cognitive impairment. When detected, a full diagnostic workup should be conducted. Providers can leverage tools presented in the California Alzheimer's Disease Centers' "Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease."

Note that Medicare covers an additional Cognitive Assessment when cognitive impairment is detected. Any clinician eligible to report evaluation and management services can offer a 50-minute cognitive assessment service.

Irrespective of having a formal Alzheimer's or dementia diagnosis, if the member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage

ADLs/IADLS, the ICT must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences.

D-SNPs must have trained dementia care specialists on ICTs for members living with dementia who also have: two or more co-existing conditions, or moderate to severe behavioral issues or high utilization or live alone or lack adequate caregiver support or moderate to severe functional impairment. Dementia care specialists must be trained in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for members and caregivers. D-SNPs should leverage available training content from organizations such as Alzheimer's Los Angeles, Alzheimer's Orange County, or similar organizations when developing training content for dementia care specialists.

Dementia care specialists must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.

Care Transitions

D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and institutional long-term care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.

D-SNPs must have care transition protocols that include coordination with Medi-Cal plans for non-EAE D-SNPs. D-SNPs must have care transition protocols that reflect the State Medicaid Agency Contract and Policy Guide requirements for Information Sharing.

Medi-Cal Enhanced Care Management (ECM) and Dual Eligible Beneficiaries

DHCS' requirements for MCPs to implement ECM are contained in the ECM All Plan Letter (APL), ECM and ILOS Contract Template (ECM and ILOS Contract A), which will become part of the MCPs' contract with DHCS, and the DHCS' ECM and ILOS Standard Provider Terms and Conditions (more information and links available on the DHCS ECM and Community Supports webpage).

Some D-SNP members needing care management services through D-SNPs may also meet the criteria for ECM populations of focus. However, there is significant overlap across the D-SNP model of care and ECM requirements, which could result in duplication and confusion for members and care teams if a member receives care management from both programs. Member care management, as well as coordination across Medicare and Medi-Cal benefits, is a primary function of D-SNPs. D-SNPs must provide sufficient care management to members to ensure that members who would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP.

For members already receiving Medi-Cal ECM from their MCP, D-SNPs shall provide ongoing continuity of care with existing ECM providers, when possible, until the member graduates from ECM.

D-SNPs should review the ECM populations of focus per the ECM policy guide. D-SNPs in California must include, in addition to any other sub-populations determined by the D-SNP, four or more populations of focus from the Medi-Cal Enhanced Care Management program.

EAE and Non-EAE D-SNPs must demonstrate in the state-specific Model of Care matrix how the plan's D-SNP model of care includes and reflects the delivery of the seven ECM core services, as outlined below and in the ECM Policy Guide:

1) Outreach and Engagement
2) Comprehensive Assessment and Care Management Plan
    a. D-SNPs must engage with each Member who would otherwise qualify for ECM to receive care management primarily through in-person contact.
    b. When in-person communication is unavailable or does not meet the needs of the Member, the D-SNP must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
3) Enhanced Coordination of Care
4) Health Promotion
5) Comprehensive Transitional Care
6) Member and Family Supports; and
7) Coordination of and Referral to Community and Social Support Services

I.A. Care Coordination Requirements for Palliative Care

Palliative Care Overview

All D-SNPs are responsible for providing and coordinating inpatient and outpatient/community-based palliative care referrals and services for dual eligible members with serious illnesses that meet current Medi-Cal criteria for palliative care, including both general and disease specific criteria, or an alternate set of criteria for palliative care referral that is no more restrictive than the Medi-Cal criteria, as described in All Plan Letter (APL) 18-020 and the SB 1004 Medi-Cal Palliative Care Policy. Both EAE and non-EAE D-SNPs must leverage the Medi-Cal palliative care approach and bundle of services for their members.

D-SNP Sub-populations of most vulnerable enrollees must include members with serious illness eligible for palliative care referral.

Referral to and effective coordination of palliative care services should be a priority for D-SNPs. D-SNP care plans should reflect any changes resulting from palliative care consultation. Members of the palliative care team should be included in the member's care team meetings and the palliative care coordinator should serve as lead care manager for the member. For members with serious illness participating in a palliative care program, the D-SNP must use a palliative care ICT. D-SNPs should ensure that the provider network includes sufficient palliative care providers and home- or community-based organizations offering palliative care services.

The DHCS Medi-Cal Palliative Care Policy specifies the minimum types of palliative care services that must be authorized when medically necessary for members who meet the eligibility criteria.[1] D-SNPs must either adopt the DHCS minimum eligibility criteria for palliative care, or they may submit broader eligibility criteria to DHCS for approval.

Palliative Care Eligibility Criteria

Members are eligible to receive palliative care services if they meet all of the criteria outlined in the General Eligibility Criteria below, and at least one of the four requirements outlined in the Disease-Specific Eligibility Criteria.

General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.

2. The member has an advanced illness, as defined in section

[1] DHCS' SB 1004 Medi-Cal Palliative Care Policy, dated November 2017, is available at: http://www.dhcs.ca.gov/provgovpart/Documents/SB1004PalliativeCarePolicyDoc11282017.pdf

I.B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.

3. The member's death within a year would not be unexpected based on clinical status.

4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.

5. The member and, if applicable, the family/member-designated support person, agrees to:
    a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    b. Participate in Advance Care Planning discussions.

Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher;[2] and
    b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
    a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

[2] NYHA classifications are available at: http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.WefN7rpFxxo

3. Advanced Cancer: Must meet (a) and (b)
    a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone
    a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.[3]

If the member continues to meet the above minimum eligibility criteria palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.[4]

D-SNPs must have a process to identify members who are eligible for palliative care, including a provider referral process.[5] D-SNPs must periodically assess the member for changes in the member's condition or palliative care needs. D-SNPs may discontinue palliative care that is no longer medically necessary or no longer reasonable.

Palliative Care Services

When a member meets the minimum eligibility criteria for palliative care, D-SNPs must authorize palliative care. Palliative care must include, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

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[3] The MELD score calculator is available at: https://optn.transplant.hrsa.gov/resources/allocation- calculators/meld-calculator
[4] CMS Letter #10-018 is available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10018.pdf
[5] D-SNPs may receive referrals from in-network or out-of-network providers, such as primary care providers, specialty providers, and Specialty Care Centers. D-SNPs must review all referrals received to make medical necessity determinations for palliative care services.

A. Advance Care Planning: Advance care planning for members enrolled in palliative care includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

B. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
    - Treatment plans, including palliative care and curative care
    - Pain and medicine side effects
    - Emotional and social challenges
    - Spiritual concerns
    - Patient goals
    - Advance directives, including POLST forms
    - Legally-recognized decision maker

C. Plan of Care: A plan of care should be developed with the engagement of the member and/or the member's representative(s) in its design. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care.

D. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a member and of the member's family and are able to assist in identifying the member's sources of pain and discomfort. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. DHCS recommends that the palliative care team include, but is not limited to the following team members: a doctor of medicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner

(NP) (Primary Care Provider if NP); and a social worker. DHCS also recommends that D-SNPs provide access to chaplain services as part of the palliative care team.

E. Care Coordination: A member of the palliative care team must provide coordination of care, ensure continuous assessment of the member's needs, and implement the plan of care.

F. Pain and Symptom Management: The member's plan of care must include all services authorized for pain and symptom management. Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address a member's pain and other symptoms.

G. Mental Health and Medical Social Services: Counseling and social services must be available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate.

D-SNPs must have a process to determine the type of palliative care that is medically necessary or reasonable for eligible members. D-SNPs must have an adequate network of palliative care providers to meet the needs of their members.

D-SNPs may authorize additional palliative care not described above, at the plan's discretion. Examples of additional services offered by many community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/7 days a week.

Palliative Care Providers

D-SNPs may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. D-SNPs must utilize qualified providers for palliative care based on the setting and needs of a member. DHCS recommends that D-SNPs use providers who possess current palliative care training and/or certification to conduct palliative care consultations or assessments.

D-SNPs may contract with hospitals, long-term care facilities, clinics, hospice

agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care. D-SNPs may contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services facilities may be considered palliative care partners for facilitating advance care planning or palliative care referrals. Palliative care provided in a member's home must comply with existing requirements for in-home providers, services, and authorization, such as physician assessments and care plans. D-SNPs must inform and educate providers regarding availability of palliative care.

IX. Appendices

Appendix A: LTSS Questions for Inclusion in EAE D-SNP HRA

The questions are organized in the following two tiers and EAE D-SNPs must take a holistic view of questions in both tiers to identify beneficiaries in need of follow-up assessments:

- Tier 1 contains questions directly related to LTSS eligibility criteria and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
- Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.

The headings in bold are not part of the questions but provide the intent of the questions.

Tier 1 LTSS Questions:
Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living

Limitations / Functional Supports (Functional Capacity Risk Factor)
Question 1: Do you need help with any of these actions? (Yes/No to each individual action)
a) Taking a bath or shower
b) Going up stairs
c) Eating
d) Getting Dressed
e) Brushing teeth, brushing hair, shaving
f) Making meals or cooking
g) Getting out of a bed or a chair
h) Shopping and getting food
i) Using the toilet
j) Walking
k) Washing dishes or clothes
l) Writing checks or keeping track of money
m) Getting a ride to the doctor or to see your friends
n) Doing house or yard work
o) Going out to visit family or friends
p) Using the phone
q) Keeping track of appointments

If yes, are you getting all the help you need with these actions?

Housing Environment / Functional Supports (Social Determinants Risk Factor)
Question 2: Can you live safely and move easily around in your home? (Yes/No)
If no, does the place where you live have: (Yes/No to each individual item)
a) Good lighting
b) Good heating
c) Good cooling
d) Rails for any stairs or ramps
e) Hot water
f) Indoor toilet
g) A door to the outside that locks
h) Stairs to get into your home or stairs inside your home
i) Elevator
j) Space to use a wheelchair
k) Clear ways to exit your home

Low Health Literacy (Social Determinants Risk Factor)
Question 3: “I would like to ask you about how you think you are managing your health conditions”
a) Do you need help taking your medicines? (Yes/No)
b) Do you need help filling out health forms? (Yes/No)
c) Do you need help answering questions during a doctor’s visit? (Yes/No)

Caregiver Stress (Social Determinants Risk Factor)
Question 4: Do you have family members or others willing and able to help you when you need it? (Yes/No)

Question 5: Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)

Abuse and Neglect (Social Determinants Risk Factor)
Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No)
Question 6b: Is anyone using your money without your ok? (Yes/No)

Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)
Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)

Tier 2 LTSS Questions:
Fall Risk (Functional Capacity Risk Factor)
Question 8a: Have you fallen in the last month? (Yes/No)
Question 8b: Are you afraid of falling? (Yes/No)

Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)

Isolation (Social Determinants Risk Factor)
Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one)
None – I never feel lonely
Less than 5 days
More than half the days (more than 15)
Most days – I always feel lonely