ADULT PROGRAMS DIVISION

In-Home Supportive Services (IHSS) Program Stakeholder Meeting on the Medical Certification Form

Monday, June 13, 2011, 10:00 a.m.
744 P Street, 2nd Floor Auditorium
Sacramento, CA

AGENDA

- Welcome & Introductions
- Meeting Objectives
- Overview of requirements for the Medical Certification Form (MCF)
- Presentation & discussion of the draft MCF
- Presentation & discussion of alternative forms of documentation
- Stakeholder comments & questions
- Next steps & wrap-up

MEETING OBJECTIVES

As required by Senate Bill (SB) 72 (Chapter 8, Statutes of 2011), CDSS is consulting with stakeholders on the development of the MCF.

The objectives of this meeting are to:

- Present and discuss the draft MCF developed by CDSS, and
- Provide program stakeholders an opportunity to provide input on the draft MCF.

OVERVIEW OF SB 72 REQUIREMENTS

SB 72 added Welfare and Institutions Code (W&IC) Section 12309.1, which states:

As a condition of receiving services…an applicant for or recipient of services shall obtain a certification from a licensed health care professional (LHCP)…declaring that the applicant or recipient is unable to perform some activities of daily living (ADLs) independently, and that without services to assist him or her with ADLs, the applicant or recipient is at risk of placement in out-of-home care.

SB 72 REQUIREMENTS (Cont.)

W&IC Section 12309.1(a)(1) states:

…A LHCP means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate…

Examples of a LHCP include, but are not limited to, the following:

- Physician
- Physician Assistant
- Regional Center Clinician or Clinical Supervisor
- Occupational Therapist
- Physical Therapist
- Psychiatrist
- Psychologist
- Optometrist
- Ophthalmologist
- Public Health Nurse

SB 72 REQUIREMENTS (Cont.)

Medical certification requirements apply to new applicants for IHSS as well as existing recipients.

For new applicants, the medical certification must be received before services can be authorized, unless one of the following conditions applies:

- Services are being requested on behalf of an individual being discharged from a hospital or nursing home, and services are need to enable the individual to return safely to his/her home or into the community; or
- When the ~~deterioration of the individual's health is likely to result in eviction from his/her home, homelessness, or a hazardous living environment~~ county determines that there is a risk of out-of-home placement.

SB 72 REQUIREMENTS (Cont.)

For existing recipients –

- The medical certification requirements do not apply until the date of a recipient's first reassessment following implementation.
- Recipients must be notified of the medical certification requirements in writing before or at the time of the reassessment.
- Recipients must submit the medical certification within 45 days following the reassessment.
- The 45-day period may be extended if it is determined that there is good cause for the delay in providing the certification.

OVERVIEW OF THE DRAFT MCF

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STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

In-Home Supportive Services Program
Medical Certification Form

A. Applicant/Recipient Information (to be completed by the county)	
Applicant/Recipient Name:	Date of Birth:
Address:	
County of Residence:	Case #:
Social Worker Phone #:	Social Worker Fax #:
Social Worker Name:	

B. Authorization to Release Medical Information (to be completed by the applicant/recipient)

I _____ authorize the release of my medical information to the In-Home Supportive Services program as it pertains to my need for domestic/ related and personal care services.

Signature:_____ Date:____/____/_____
Applicant/Recipient or Legal Guardian/Conservator

This release of information expires 12 months from the date above.

The above individual has requested assistance from the In-Home Supportive Services program (IHSS). IHSS is a Medi-Cal program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic and personal care services such as: housekeeping, preparing meals, meal clean up, routine laundry, shopping for food, errands, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, ambulation, transfers, assistance with bathing and grooming, rubbing skin and repositioning, care and assistance with prosthesis, accompaniment to medical appointments and alternative resources, yard hazard abatement, protective supervision, and paramedical services. The IHSS program provides hands on and/or verbal assistance (reminding or prompting) for the services described above.

This form must be completed before IHSS services can be authorized. The social worker has the responsibility to authorize service hours. However, this medical certification is used to help the social worker evaluate the individual's present condition and their need for out-of-home care if IHSS services were not provided. This form will be considered as one indicator of need for services, but the social worker will consider all relevant documentation in making the IHSS determination.

Only the Licensed Health Care Professional should complete the remainder of this form.

SOC XXX (05/11)

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

C. Medical Information (to be completed by the licensed health care professional)

1) Nature of services you provide to this individual? _____
(Examples: Medical treatment, Nursing Care, Discharge planning)

2) How long have you provided service(s) to this individual? _____

3) Frequency of contact with this individual and date last seen? _____ _____
(Monthly, Yearly, etc.) (Date Last Seen)

4) Is this individual unable to independently perform one or more activities of daily living? Yes [ ] No [ ]

5) In your opinion, is one or more IHSS services recommended in order to prevent the need for out-of-home care? Yes [ ] No [ ]

If you answered no to both question # 4 or # 5, skip the remainder of the form and complete the signature box at the bottom of the form.

If you answered yes to either questions # 4 and #5, please respond to questions 6 and 7, and complete the signature box at the bottom of the form.

6) Please provide a description of any condition or functional limitation that has resulted in or contributed to the need for assistance from the IHSS program (see description of services on page 1):

_____
_____
_____
_____
_____
_____

7) Is the functional impairment(s) expected to last more than 12 consecutive months? Yes [ ] No [ ]

Please be advised: the social worker may contact you to clarify the responses you provided above.

D. Licensed Health Care Professional's Certification	
By signing this form I certify I am licensed in the State of California and all information provided above is correct.	
Name:	Title:
Address:	
Phone # :	Fax # :
Signature:	**Date:**
License Number:	

SOC XXX (05/11)

MCF PART A

Part A is completed by the County.

It contains information about the applicant or recipient.

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

In-Home Supportive Services Program
Medical Certification Form

A. Applicant/Recipient Information (to be completed by the county)	
Applicant/Recipient Name:	Date of Birth:
Address:	
County of Residence:	Case #:
Social Worker Phone #:	Social Worker Fax #:
Social Worker Name:	

MCF PART B

Part B is completed by the applicant or recipient.

By signing it, the applicant/recipient authorizes the LHCP to release medical information about him/her.

B. Authorization to Release Medical Information (to be completed by the applicant/recipient)

I _____ authorize the release of my medical information to the In-Home Supportive Services program as it pertains to my need for domestic/ related and personal care services.

Signature:_____Date:____/_____/_____
Applicant/Recipient or Legal Guardian/Conservator

This release of information expires 12 months from the date above.

MCF PART B

Part B also provides information for the LHCP regarding the purpose of the MCF.

The above individual has requested assistance from the In-Home Supportive Services program (IHSS). IHSS is a Medi-Cal program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic and personal care services such as: housekeeping, preparing meals, meal clean up, routine laundry, shopping for food, errands, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, ambulation, transfers, assistance with bathing and grooming, rubbing skin and repositioning, care and assistance with prosthesis, accompaniment to medical appointments and alternative resources, yard hazard abatement, protective supervision, and paramedical services. The IHSS program provides hands on and/or verbal assistance (reminding or prompting) for the services described above.

This form must be completed before IHSS services can be authorized. The social worker has the responsibility to authorize service hours. However, this medical certification is used to help the social worker evaluate the individual's present condition and their need for out-of-home care if IHSS services were not provided. This form will be considered as one indicator of need for services, but the social worker will consider all relevant documentation in making the IHSS determination.

Only the Licensed Health Care Professional should complete the remainder of this form.

MCF PART C

Part C is completed by the LHCP.

C. Medical Information (to be completed by the licensed health care professional)

1) Nature of services you provide to this individual? _____
(Examples: Medical treatment, Nursing Care, Discharge planning)

2) How long have you provided service(s) to this individual? _____

3) Frequency of contact with this individual and date last seen? _____ _____
(Monthly, Yearly, etc.) (Date Last Seen)

MCF PART C (Cont.)

Part C is completed by the LHCP.

4) Is this individual unable to independently perform one or more activities of daily living? Yes [ ] No [ ]

5) In your opinion, is one or more IHSS services recommended in order to prevent the need for out-of-home care? Yes [ ] No [ ]

If you answered no to both question # 4 or # 5, skip the remainder of the form and complete the signature box at the bottom of the form.

If you answered yes to either questions # 4 and #5, please respond to questions 6 and 7, and complete the signature box at the bottom of the form.

MCF PART C (Cont.)

Part C is completed by the LHCP.

6) Please provide a description of any condition or functional limitation that has resulted in or contributed to the need for assistance from the IHSS program (see description of services on page 1):

_____

_____

_____

_____

_____

_____

7) Is the functional impairment(s) expected to last more than 12 consecutive months? Yes [ ] No [ ]

Please be advised: the social worker may contact you to clarify the responses you provided above.

MCF PART D

Part D is completed and signed by the LHCP.

D. Licensed Health Care Professional's Certification	
By signing this form I certify I am licensed in the State of California and all information provided above is correct.	
Name:	Title:
Address:	
Phone # :	Fax # :
Signature:	**Date:**
License Number:	

ALTERNATIVE DOCUMENTATION

W&IC, Section 12309.1(c) states CDSS, “in consultation with the Department of Health Care Services and stakeholders…shall identify alternative documentation that shall be accepted by counties to meet the requirements…, including but not limited to, hospital or nursing facility discharge plans, minimum data set forms, individual program plans, or other documentation that contains the necessary information…”

ALTERNATIVE DOCUMENTATION REQUIREMENTS

Alternative documentation must include all of the following elements to be acceptable in place of the MCF:

- An indication that the individual is unable to independently perform one or more ADLs;
- A description of the individual's condition or functional limitation that has contributed to the need for IHSS; and
- A signature of a LHCP.

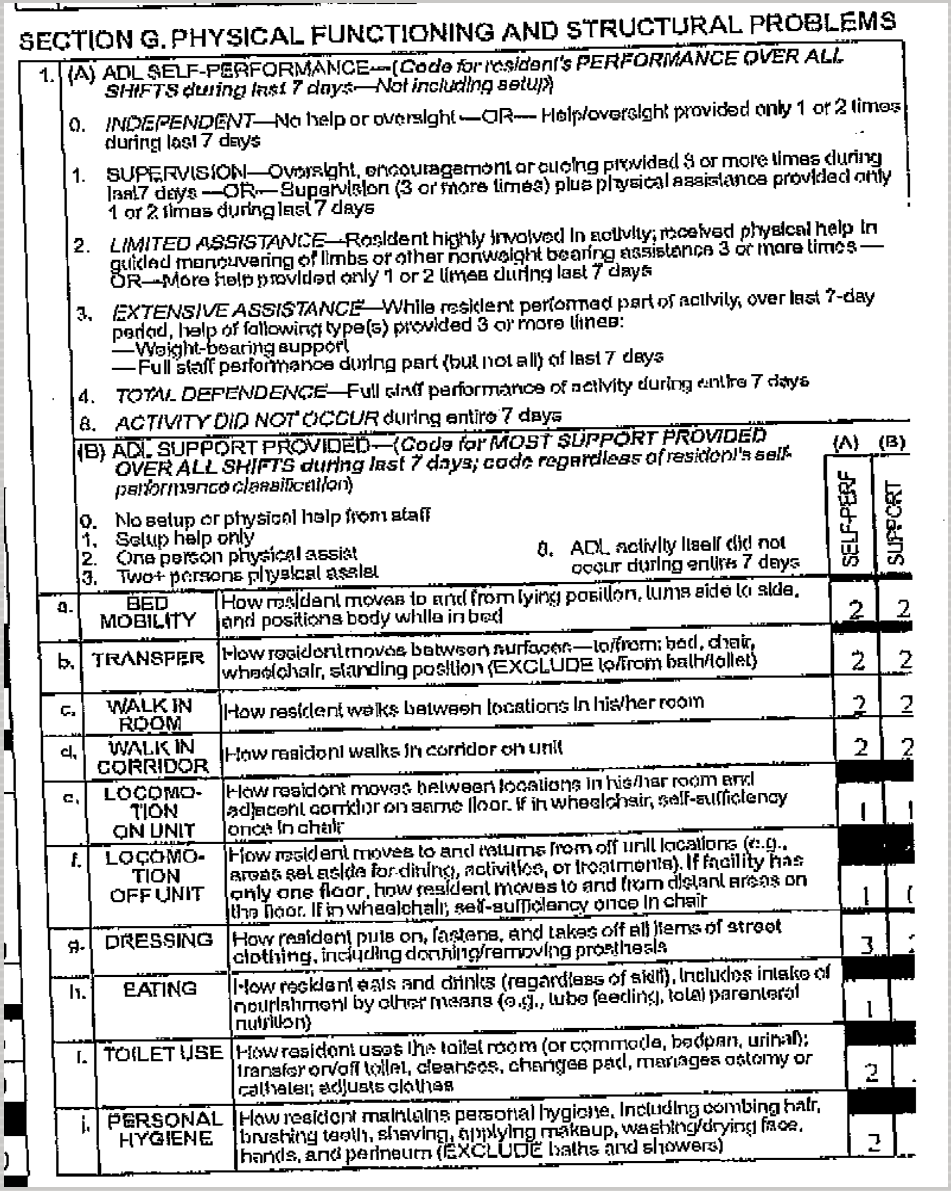
In addition, the documentation must have been completed within 60 days of the IHSS assessment or reassessment.

EXAMPLES OF ALTERNATIVE DOCUMENTATION

- Minimum Data Set (MDS) for Nursing Home Resident Assessment and Care Screening
- In-Home Operations (IHO) Case Report
- Individual Program Plan (IPP)

MDS

Section G (beginning on Page 3 and continuing to Page 4) provides information about the individual's ability to perform ADLs.



SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times — OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   —Weight-bearing support
   —Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

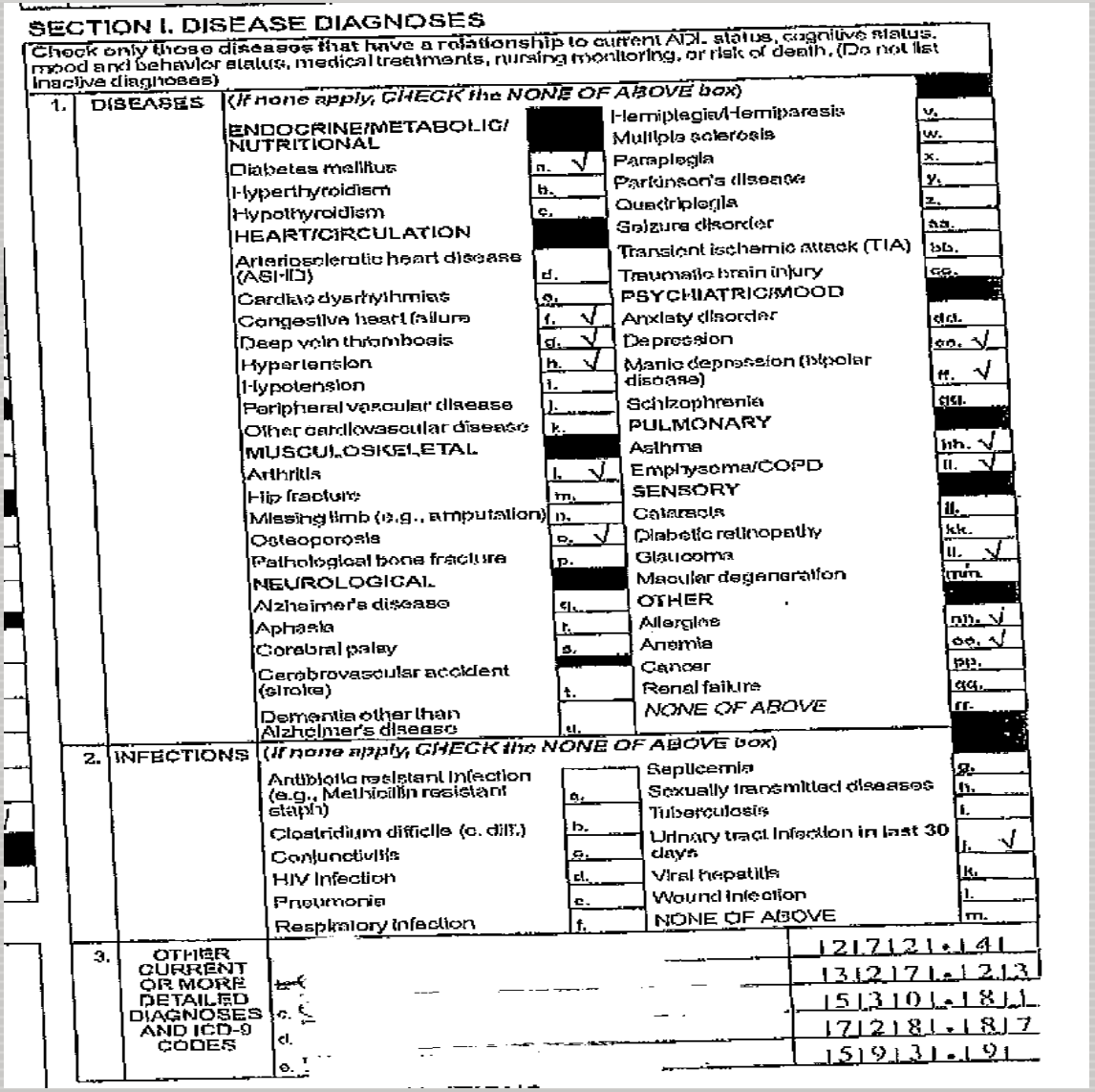
(B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	2	2
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	2	2
c.	WALK IN ROOM	How resident walks between locations in his/her room	2	2
d.	WALK IN CORRIDOR	How resident walks in corridor on unit	2	2
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	1	1
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	1	1
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	3	2
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	1	1
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter; adjusts clothes	2	2
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	2	2

MDS (Cont.)

Section I (on Page 4) provides a description of the individual's condition or functional limitation that has contributed to his/her need for IHSS.



SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1. DISEASES (*If none apply, CHECK the NONE OF ABOVE box*)

ENDOCRINE/METABOLIC/NUTRITIONAL
- a. √ Diabetes mellitus
- b. Hyperthyroidism
- c. Hypothyroidism

HEART/CIRCULATION
- d. Arteriosclerotic heart disease (ASHD)
- e. Cardiac dysrhythmias
- f. √ Congestive heart failure
- g. √ Deep vein thrombosis
- h. √ Hypertension
- i. Hypotension
- j. Peripheral vascular disease
- k. Other cardiovascular disease

MUSCULOSKELETAL
- l. √ Arthritis
- m. Hip fracture
- n. Missing limb (e.g., amputation)
- o. √ Osteoporosis
- p. Pathological bone fracture

NEUROLOGICAL
- q. Alzheimer's disease
- r. Aphasia
- s. Cerebral palsy
- t. Cerebrovascular accident (stroke)
- u. Dementia other than Alzheimer's disease
- v. Hemiplegia/Hemiparesis
- w. Multiple sclerosis
- x. Paraplegia
- y. Parkinson's disease
- z. Quadriplegia
- aa. Seizure disorder
- bb. Transient ischemic attack (TIA)
- cc. Traumatic brain injury

PSYCHIATRIC/MOOD
- dd. Anxiety disorder
- ee. √ Depression
- ff. √ Manic depression (bipolar disease)
- gg. Schizophrenia

PULMONARY
- hh. √ Asthma
- ii. √ Emphysema/COPD

SENSORY
- jj. Cataracts
- kk. Diabetic retinopathy
- ll. √ Glaucoma
- mm. Macular degeneration

OTHER
- nn. √ Allergies
- oo. √ Anemia
- pp. Cancer
- qq. Renal failure
- rr. NONE OF ABOVE

2. INFECTIONS (*If none apply, CHECK the NONE OF ABOVE box*)
- a. Antibiotic resistant infection (e.g., Methicillin resistant staph)
- b. Clostridium difficile (c. diff.)
- c. Conjunctivitis
- d. HIV infection
- e. Pneumonia
- f. Respiratory infection
- g. Septicemia
- h. Sexually transmitted diseases
- i. Tuberculosis
- j. √ Urinary tract infection in last 30 days
- k. Viral hepatitis
- l. Wound infection
- m. NONE OF ABOVE

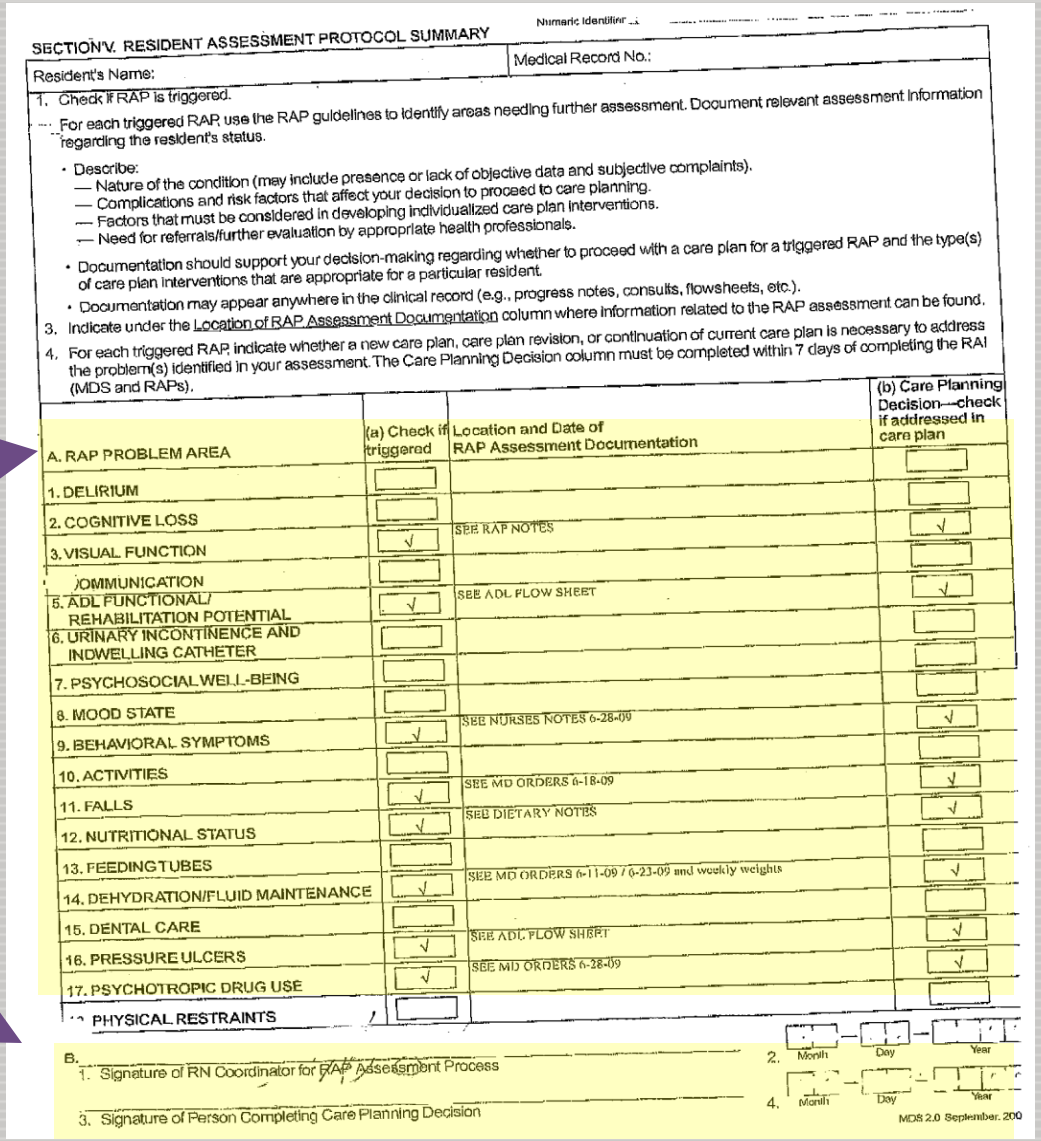
3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES

a.	I 2 I 7 I 2 I . I 4 I
b.	I 3 I 2 I 7 I . I 2 I 3
c.	I 5 I 3 I 0 I . I 8 I I
d.	I 7 I 2 I 8 I . I 8 I 7
e.	I 5 I 9 I 3 I . I 9 I

MDS (Cont.)

Part A of Section V (on Page 8) provides a general overview of the individuals problem areas.

Part B contains the signature of the LHCP.



Numeric Identifier

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Resident's Name: | Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     - — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     - — Complications and risk factors that affect your decision to proceed to care planning.
     - — Factors that must be considered in developing individualized care plan interventions.
     - — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

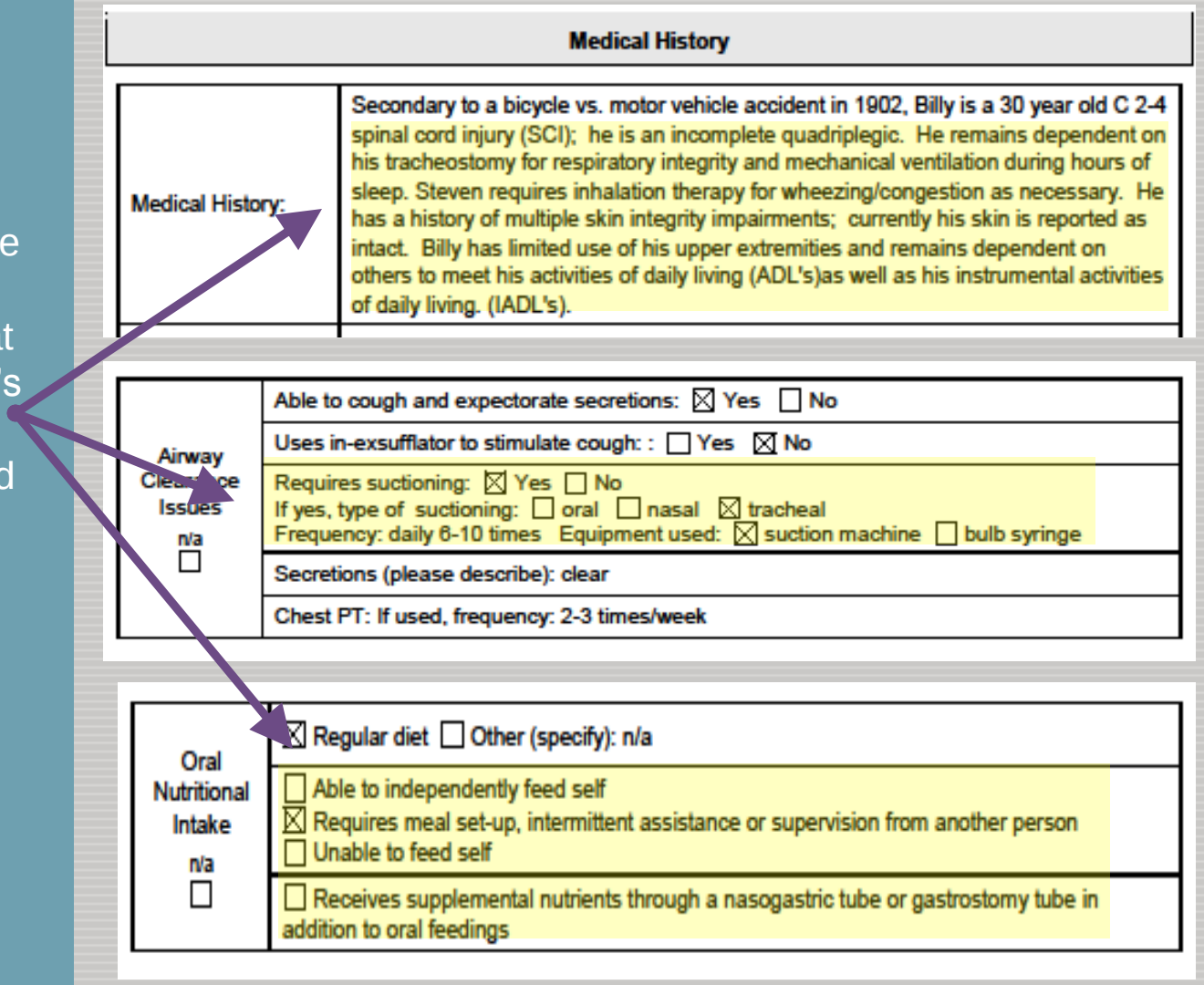
A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM			
2. COGNITIVE LOSS			
3. VISUAL FUNCTION	√	SEE RAP NOTES	√
COMMUNICATION			
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	√	SEE ADL FLOW SHEET	√
6. URINARY INCONTINENCE AND INDWELLING CATHETER			
7. PSYCHOSOCIAL WELL-BEING			
8. MOOD STATE			
9. BEHAVIORAL SYMPTOMS	√	SEE NURSES NOTES 6-28-09	√
10. ACTIVITIES			
11. FALLS	√	SEE MD ORDERS 6-18-09	√
12. NUTRITIONAL STATUS	√	SEE DIETARY NOTES	√
13. FEEDING TUBES			
14. DEHYDRATION/FLUID MAINTENANCE	√	SEE MD ORDERS 6-11-09 7 6-23-09 and weekly weights	√
15. DENTAL CARE			
16. PRESSURE ULCERS	√	SEE ADL FLOW SHEET	√
17. PSYCHOTROPIC DRUG USE	√	SEE MD ORDERS 6-28-09	√
PHYSICAL RESTRAINTS			

B.
1. Signature of RN Coordinator for RAP Assessment Process
2. Month / Day / Year
3. Signature of Person Completing Care Planning Decision
4. Month / Day / Year

MDS 2.0 September 200

IHO

Sections throughout the IHO Case Report contain information that describe the individual's condition/functional limitations and his need for assistance in performing ADLs.



Medical History

Medical History:	Secondary to a bicycle vs. motor vehicle accident in 1902, Billy is a 30 year old C 2-4 spinal cord injury (SCI); he is an incomplete quadriplegic. He remains dependent on his tracheostomy for respiratory integrity and mechanical ventilation during hours of sleep. Steven requires inhalation therapy for wheezing/congestion as necessary. He has a history of multiple skin integrity impairments; currently his skin is reported as intact. Billy has limited use of his upper extremities and remains dependent on others to meet his activities of daily living (ADL's)as well as his instrumental activities of daily living. (IADL's).

Airway Clearance Issues n/a ☐	Able to cough and expectorate secretions: ☒ Yes ☐ No
	Uses in-exsufflator to stimulate cough: : ☐ Yes ☒ No
	Requires suctioning: ☒ Yes ☐ No If yes, type of suctioning: ☐ oral ☐ nasal ☒ tracheal Frequency: daily 6-10 times Equipment used: ☒ suction machine ☐ bulb syringe
	Secretions (please describe): clear
	Chest PT: If used, frequency: 2-3 times/week

Oral Nutritional Intake n/a ☐	☒ Regular diet ☐ Other (specify): n/a
	☐ Able to independently feed self ☒ Requires meal set-up, intermittent assistance or supervision from another person ☐ Unable to feed self
	☐ Receives supplemental nutrients through a nasogastric tube or gastrostomy tube in addition to oral feedings

IHO (Cont.)

Sections throughout the IHO Case Report contain information that describe the individual's condition/functional limitations and his need for assistance in performing ADLs.

The IHO Case Report must be signed by a LHCP and be dated within 60 days of the date of the IHSS assessment or reassessment.

Function	Independent	Requires assistance	Dependent	Comments
Bathing	☐	☐	☒	None
Dressing	☐	☐	☒	None
Grooming	☐	☐	☒	None
Oral Care	☐	☒	☐	None
Toileting	☐	☐	☒	None
Telephone usage	☒	☐	☐	None
Shopping	☐	☐	☒	None
Meal Preparation	☐	☐	☒	None
Housekeeping (cooking, cleaning, laundry)	☐	☐	☒	None
Medication Administration and Management	☐	☐	☒	None
Equipment/Supply Management:	☐	☐	☒	None

Justification for Program Level of Care and Level of Case Management

Based upon the information contained in this report, Billy Bob meets the criteria for the IHO Waiver. Level of Care (LOC) determination: Adult Subacute

LOC justification: Billy is dependent on his tracheostomy and ventilator for respiratory integrity support during the hours of sleep. He requires suctioning every 4-6 hours and inhalation therapy via nebulizer for congestion and wheezing. He needs his medication administrated to him, (routine and prn), skin integrity assessment and intervention to prevent pressure sores. Billy is dependent on others for his ADL and IADL care, bowel and bladder care.

NE II completing the review: _____ signature NEII printed name

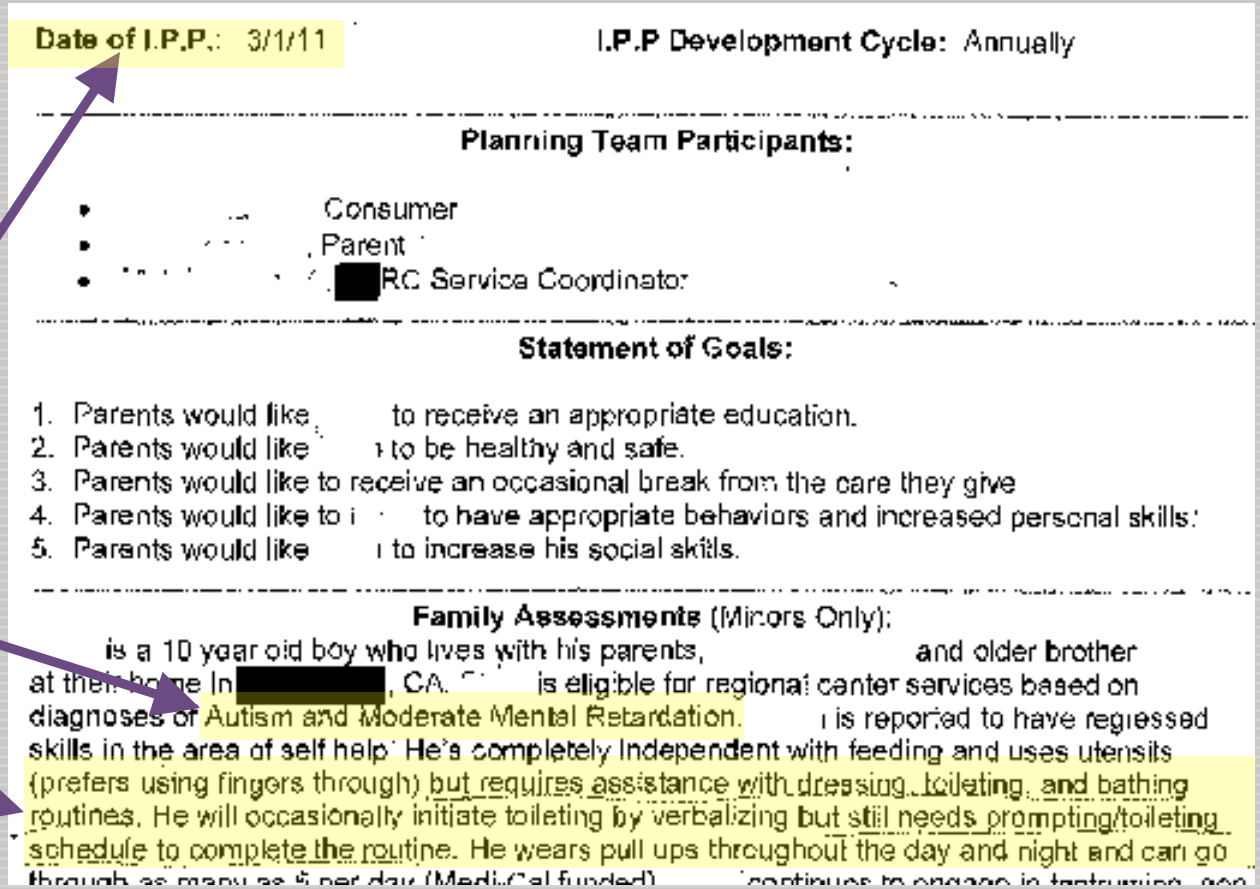
Date report completed: 04-28-2011

IPP

This IPP contains several of the elements required for valid alternative documentation, including:

- Date completed;
- Applicant's/ recipient's condition or functional limitation; and
- His need for assistance in performing ADLs.

However, it is NOT acceptable because it has NOT been signed by a LHCP.



Date of I.P.P.: 3/1/11 **I.P.P Development Cycle:** Annually

Planning Team Participants:

- Consumer
- Parent
- [redacted]RC Service Coordinator

Statement of Goals:

1. Parents would like to receive an appropriate education.
2. Parents would like to be healthy and safe.
3. Parents would like to receive an occasional break from the care they give
4. Parents would like to to have appropriate behaviors and increased personal skills.
5. Parents would like to increase his social skills.

Family Assessments (Minors Only):

is a 10 year old boy who lives with his parents, and older brother at their home in [redacted], CA. is eligible for regional center services based on diagnoses of Autism and Moderate Mental Retardation. is reported to have regressed skills in the area of self help. He's completely independent with feeding and uses utensils (prefers using fingers through) but requires assistance with dressing, toileting, and bathing routines. He will occasionally initiate toileting by verbalizing but still needs prompting/toileting schedule to complete the routine. He wears pull ups throughout the day and night and can go through as many as 5 per day (Medi-Cal funded) continues to engage in [illegible]

QUESTIONS & COMMENTS

SUBMITTING COMMENTS ON THE DRAFT MCF

- **Deadline for submitting comments:**

  Friday, June 24, 2011

- **Submit comments to:**

Operations & Technical Assistance Unit

Marshall Browne, Manager
marshall.browne@dss.ca.gov

&

Victoria Rodriguez, Analyst
victoria.rodriguez@dss.ca.gov