PCA, Homemaking, Chore and ICLS Training

July 25, 2023

Agenda

- PCA overview and assessment reminders
- Homemaking overview
- Chore overview
- ICSL overview
- Review of duplication of services

Personal Care Assistance (PCA)

PCA

- Is a state plan home care service
- PCA helps a person with day-to-day activities in their home and community. The goal is to help a person maximize their independence.
- The amount of PCA authorized is determined by a trained assessor completing the Legacy PCA Assessment (3428D) in conjunction with the 3428/LTCC or the MnCHOICES Assessment following DHS guidelines.

PCA services cover:

- **Activities of daily living (ADLs)**
  - Dressing, Grooming, Bathing, Eating, Transfers, Mobility, Positioning, Toileting
- **Instrumental activities of daily living (IADLs)**
  - Accompany to medical appointments, accompany to participate in the community, assist with paying bills, communicate by telephone and other media, complete household tasks integral to the PCA services, such as planning and preparing meals and shopping for food, clothing and other essential items.
- **Observation and redirection of behaviors**
  - Observe and provide redirection to the member for episodes of behavior needing redirection as identified n in the care plan
- **Health-related procedures**
  - Health-related procedures and tasks: Procedures and tasks performed by a PCA worker that can be delegated or assigned by a health care professional licensed under Minnesota state law.

PCA does not cover:

- Sterile procedures, injections of fluids and medications into veins, muscles or skin, application of restraints or similar procedures, other activities beyond the scope of PCA covered services.
- Moving the person's belongings to a new residence.
- Services that are included in the person's or caregiver's lease agreement and/or are the landlord's responsibility (e.g., snow removal, lawn care, pest control).
- Services that duplicate other Minnesota state plan or waiver services the person already receives (e.g., homemaker).

PCA Trainings – PCA Legacy Assessment (3428D) completed with the LTCC (3428)

DHS Legacy PCA Assessment Training Videos - Required

- DHS TrainLink
  - PCA Legacy Assessment (DSDPCAL)-Required
  - PCA Policy for lead agencies (PPOL2018)

OR

- youtube

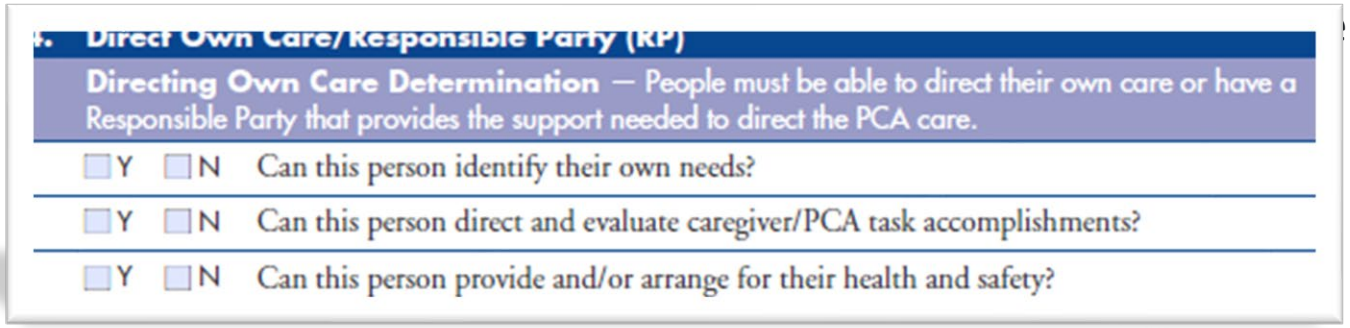
Medica Personal Care Assistance Overview Training Video and Reference Document - Required

- Adjunct to DHS PCA Trainings
- Authorizations
- Provides clarification for some areas on assessment
- Medica's documentation expectations

Required at the Assessment

Member

Responsible Party

- 
Direct Own Care/Responsible Party (RP)

Directing Own Care Determination — People must be able to direct their own care or have a Responsible Party that provides the support needed to direct the PCA care.

☐ Y	☐ N	Can this person identify their own needs?
☐ Y	☐ N	Can this person direct and evaluate caregiver/PCA task accomplishments?
☐ Y	☐ N	Can this person provide and/or arrange for their health and safety?

nt

- It is the role of the care coordinator to assess the member's need for a responsible party (RP) at the initial assessment AND at every reassessments.

Interpreter

- If the member requires an interpreter, the interpreter must be at the assessment and sign the signature page
- The interpreter cannot be family or the PCA and must come from an interpreter agency contracted with Medica
- The interpreter is there for the member/RP but also to aide the CC in completing a thorough and accurate assessment of the member

Behaviors

Document the Description of the behavior, Frequency in which it occurs, and the Intervention needed. Additional 30 minutes/2 units added only if behavior occurs at least 4 times a week AND requires intervention of another person.

Two Examples of meeting documentation expectations:

Describe increased vulnerability due to cognitive deficits or social inappropriate behavior

Reports she has difficulty with short term memory. Requires reminders throughout the day and redirection when becomes anxious. Niece reports that she is able to redirect member but can become verbally aggressive or stubborn when she doesn't want to do something. Has a diagnosis of Alzheimer's disease.

Describe resistive to care, verbal aggression

[redacted] reported that [redacted] can get very angry, to the point where he requires being redirected and calmed down, but believes this is because "he is old, so yes, he gets mad easily". [redacted] continued saying that [redacted] tends to get very short and impatient when kids are around, because they can be loud and run around the room, which overwhelms [redacted] because he can't see where in the room they are so the loud screams scare him. CC inquired how often [redacted] gets angry and needs to be calmed down and [redacted] stated "he gets really angry every once in a while" but not on a daily or weekly basis- CC thus cannot give him time for this.

Assessment Reminders Continued

ADL's

- Member must need **cuing AND constant supervision** or **hands on assistance** to complete the task to meet dependency criteria. Documentation to include what type of assistance is needed during ADL. Supervision alone does not meet dependency criteria.

- **Eating** – Assistance cutting up food and meal prep is considered an IADL on the PCA Assessment and does **not** meet dependency criteria for eating.

- **Toileting** – if the only assistance needed during toileting is mobility and/or transfers and dependencies are already given in those ADLs, there is not a dependency in toileting. However, if assistance is needed **daily** in other areas of toileting (i.e. perineal care, managing incontinence), that would meet the dependency criteria for toileting.

- **Mobility-** If member can independently manage use of equipment safely (walker, cane, wheelchair) , mobility would not be a dependency. If the member needs assistance outside of their home but does not meet dependency criteria in their home environment, it is not considered a dependency in mobility. Independence in walking does not include mobility in the community.

- **Document the assistance** needed during the ADL task and why it is needed as well as what the member is able to do.

Examples of meeting documentation expectations to meet dependency criteria:

Activity	Y	N	Description of assistance needed	O	R
Dressing	☒	☐		☐	☒
verbally reported that due to the overall weakness and pain of arthritis & carpel tunnel in both hands-she requires physical assistance with her buttons, bra clasp and putting on and taking off her compression stockings.					
Bathing	☒	☐		☒	☒
Member states he needs hands on assistance with getting in and out of tub. Sits in shower chair. PCA has to wash back and lower half of body. Member struggles with chronic knee pain and back pain which are well documented in medical record. Member complaining of knee pain and leg pain at time of assessment.					
*Toileting	☒	☐		☐	☒
Member does struggle with urinary incontinence due to daily water pills he takes. Requires assistance getting on/off the toilet and clean up if having accidents. Declines use of bedside commode but will use urinal bottle and requires help with clean up/management.					
*Mobility	☒	☐		☐	☒
Assist needed due to pain and significant weakness/fatigue. Decline in physical health and stamina; now needs hands-on assist when ambulating. Only able to take a couple steps independently, using a cane. Needs 1 assist at all times. High fall risk and currently experiencing frequent falls. Significant weakness, fatigue, and poor balance, dizziness.					

Appendix C

Comparison of Scoring of ADLs for LTCC and PCA Assessment

Positioning

Assistance with positioning or turning a person for necessary care and comfort. Considerations include person's challenges due to their diagnosis or health status.

Determination during the assessment: Does the person meet the definition of dependency for positioning?

LTCC	PCA Assessment
00 Can move in bed without any help? 01 Need help sometimes to sit up?	Requires minimal assistance that does not meet the definition of a dependency. PCA may provide assistance to meet minimal needs.
***02 Always need help to sit up?** ***03 Always need help to be turned or change positions or person unable to help?**	***Person has a need on a daily basis for:** ■ **Cuing and constant supervision to complete the task or** ■ **Hands-on assistance to complete the task**

Complex Health-Related Need Other Congenital or Acquired Disease Reminder:

- **Must have 6-8 ADL dependencies AND requires considerable/extensive hands-on assistance in ADLs**

Complex Health Need: Other Congenital or Acquired Diseases		
Category	**Meets Criteria**	**Does Not Meet Criteria**
Need for significantly increased direct hands-on assistance related to diagnosis	6 to 8 ADL dependencies **And** requires considerable hands-on assistance in ADLs Some examples of diagnoses that may create the need for extensive assistance: spinal stenosis, muscular dystrophy, multiple sclerosis, cerebral palsy, stroke, brain injury, end stages of cancer, ALS	Less than 6 ADL dependencies Recipient has 6 or more dependencies, but not an extensive need for hands-on assistance in ADLs

Examples of documentation supporting a yes for complex health related needs:

*Other Congenital or Acquired Diseases	☒	☐	
Creates need for significantly increased direct hands-on assistance and interventions in 6 to 8 ADLs	[redacted] is on hospice and needs complete hands-on assistance with every care.		X

Comments on complex health-related needs

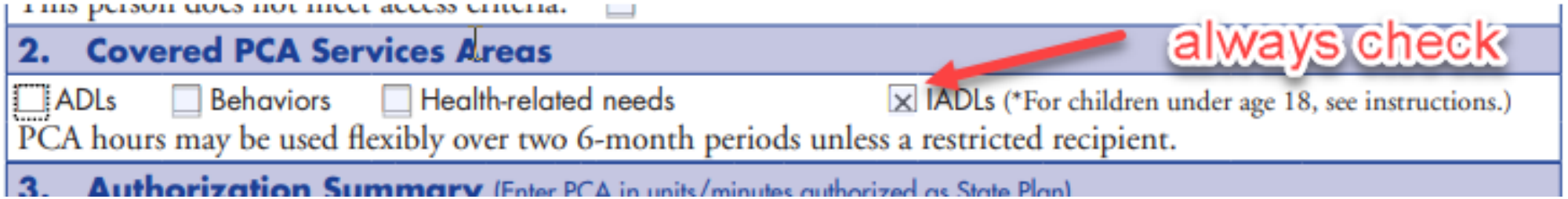
Care Coordinator was informed [redacted] most prevalent diagnoses include: severe protein malnutrition, failure to thrive, chronic kidney disease, type II diabetes, chronic heart failure, and bed bound. [redacted] is no longer walking or able to get out of bed without complete assistance of more than one person.
[redacted] needs full and complete assistance with all cares due to her current state of health/

Multiple wounds	Member has two diabetic ulcers on right foot that require daily wound care. See notes below.		X

Comments on complex health-related needs

Wounds on right foot need to be cleaned daily, have ointment put on and redressed 1x per day. [redacted] has been trained on daily wound care and member has home nurse that comes in 1x per week to check on status of wounds. PMD has been monitoring wound care and has recommended referral to wound care doctor but member declines wound care referral at this time as she does not feel it is necessary.

Completing Page 9 reminders:



Determining Home Care Rating and Units:

https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4201-ENG

Level I Behavior:

- Physical aggression towards self, others, or destruction of property that requires the *immediate response* of another person.
- *Immediate response* is intervention required at the time of the behavior episode to prevent injury to self, others or property.
- Level I behavior is the ONLY behavior that affects the **home care rating**.

Other behaviors (i.e., vulnerability and verbal aggression) do not affect the home care rating but if the behavior meets criteria, it will affect the total number of daily units

Assessment Reminders Continued

General Comments:

Reminder to use this section to document what has changed from the previous assessment that results in an increase or decrease from the previous PCA assessment.

Home Care Rating and PCA units

Always double check your work and calculations to assure the home care rating is correct and the total number of units is correct. If a yes is given in a Complex Health Related Need, this will affect the home care rating and the additional time that is added to the base rate.

If you have questions or need to consult on a PCA Assessment, please reach out to MedicaCCSupport@medica.com.

PCA DTRs

- Submit a DTR to Medica as soon as you determine there will be a reduction in PCA from the previous assessment (unless #2 is initialed on Signature Page)
    - Must include in the Rationale section what has changed from the previous assessment (i.e. no longer dependent in transfers, does not meet criteria for Complex health Related need – wounds, etc.) and include the previous years assessment

- If after discussing with member of the results of PCA assessment, member wants more PCA time, provide member with appeal rights by completing a DTR with a denial for increased PCA time.

- A DTR for PCA services must include the PCA Assessment

- If a DTR is processed and the member states they want a new assessment, the member must go through the appeal process. The CC should not complete a new assessment.

Care Coordination Hub

ON THIS PAGE

- Manuals, policies + processes
- Guidelines
- Templates, tools, and additional resources

Sign in →

Manuals, policies + processes

- Care Coordination Manuals
- Policies and Processes

Guidelines

- Benefit and Clinical Guidelines
- Transition of Care
- Personal Care Assistance (PCA)
- Denial, Termination, Reduction (DTR's) and Benefit Exceptions

Elderly Waiver Reminders

- All members receiving EW services must first access Medical Assistance home care services to the highest extent before adding Elderly Waiver services to the support
- Be the least costly alternative to meet the members assessed needs
- Be within the allowable case mix budget

Not Covered

- Recreational or diversional purposes
- Duplicates other services available
- Substitutes for informal supports that appropriately meet the member's needs
- Are available through another funding source (i.e., Medical Assistance state plan, longer term care insurance,)

Homemaking

Chore

Chore Services

Chore services: Assistance provided to a person or their primary caregiver to help maintain a clean, sanitary and safe environment.

Chore services cover:

- Dumpster rental or refuse disposal.
- Extermination and pest control, *limited to a reasonable number of treatments required to alleviate the pest problem*.
- General indoor and outdoor home maintenance (e.g., lawn care, snow removal).
- Grocery delivery when the delivered products meet the majority of the person's total grocery needs for at least seven days.
- Heavy household chores (e.g., securing loose rugs, washing floors, windows and walls).
- Moving or removing large household items and heavy appliances to provide safe access to and exit from the home.
- Packing the person's belongings.
- Rearranging or securing household items to prevent injuries or falls.

Chore services do not cover:

- Moving the person's belongings to a new residence.
- Services that are included in the person's or caregiver's lease agreement and/or are the landlord's responsibility (e.g., snow removal, lawn care, pest control).
- Services that duplicate other Minnesota state plan or waiver services the person already receives (e.g., homemaker).

Individual Community Living Supports (ICLS)

Individual Community Living Supports

ICLS: Bundled service that includes six service components. ICLS services offer assistance and support for older adults who need reminders, cues, intermittent/moderate supervision or physical assistance to remain in their own homes.

ICLS covers assistance and support for eligible people age 65 and older enrolled in the Alternative Care (AC) program or the Elderly Waiver (EW). It includes the following service components:

- Active cognitive support.
- Adaptive support service.
- Activities of daily living (ADLs) support.
- Household management assistance.
- Health, safety and wellness.
- Community living engagement.

Components:

- **Active Cognitive Support:** Provides support for members with cognitive challenges such as: Helping problem-solve activities of daily living, providing reassurance, observing and redirecting the member with cognitive, orientation or other behavioral concerns, providing check-ins for problem solving & resolution.
- **Adaptive support service:** Helping the member learn to use adaptations to increase independence including providing verbal, visual, &/or touch support for a member during task completion; developing helpful tool such as reminders & lists; assisting the member with safe assistive technology use; and developing other strategies to promote independence.

Individual Community Living Supports - continued

Components continued

- **Activities of Daily Living:** Supporting the member with supervision, cues or intermittent hands-on assistance for completion of ADLs including providing reminders & cues, cues or intermittent physical assistance with dressing, grooming, eating, toileting, mobility, transferring and positioning (not appropriate if the member requires constant supervision or physical assist except for bathing). ICLS provider can provide cueing &/or constant supervision and physical assistance for bathing.
- **Household management:** Assistance managing their home such as: Help with cleaning, meal planning/preparation and shopping for household and personal needs. Help with budgeting and money management. Help with communications (e.g., sorting mail, accessing email, making phone calls, scheduling appointments).Provide transportation when it is integral to ICLS household management goals and when community resources and/or informal supports are not available.
- **Health, safety and wellness:** Helping member to maintain their overall wellbeing such as: identifying health changes or needs and notifying appropriate individuals, coordinating & implementing changes to reduce environmental risk, provide reminders about health & safety, medication assistance, monitoring according to written plan, and use of medical equipment or adaptive technology as instructed.
- **Community engagement:** Assisting the member with participation in their community such as: assisting the member access activities and services in the community, helping the member develop and informal support system, & providing transportation when included on the community engagement goals.

ICLS can be authorized up to 12 hours per day. ICLS can be provided remotely but must meet the requirements for remote support. Face-to-face in-person support must be scheduled at least weekly.

Once eligibility is determined, the Care Coordinator must complete ICLS Planning Form DHS-3751 which outlines instructions and supports needed for the provider.

Individual Community Living Supports

ICLS was developed to allow a person to receive multiple service categories from one provider, thus eliminating the need for multiple providers coming to a person's home. In our next Elderly Waiver renewal, DHS is requesting that the requirement be changed to require a person to receive at least two service categories, but DHS cannot enforce that until we receive CMS approval, most likely next Summer or Fall.

The ICLS service requires the person to receive ICLS services in a single-family home or apartment the person or their family owns or rents, as demonstrated by a lease agreement. Living with the child in the child's home is allowed if the person is receiving ICLS services from a different person (not the child who has a financial interest). The child could provide ICLS to the mother if the mother lived in a separate home she rented/owned or was owned or rented by a different family member.

If the policy quest answer is more than two years old, it is irrelevant.

Duplication of Services

Duplication of Services

Utilizing PCA, homemaking, chore and ICLS interchangeably

- It is imperative that CC's know the definition and difference between each of the above listed services.
- It is the responsibility of the CC to authorize the appropriate service(s) to meet the assessed needs of the member.
- CC's need to assure they are NOT duplicating services
- It is the CC's professional judgment per the assessment to arrange for services accordingly.
- The CC needs to be prepared to explain to the member and/or family/representative that some services may not be appropriate to meet the member's needs according to the assessment and understand it may be a difficult conversation.
- The member and assessment drive the service plan; not the family or provider.
- If we are denying, terminating or reducing a service the member can follow the appeal process. Services do not need to be increased or added because you are DTR'ing another service.

Resources

CBSM-Individual community living supports (ICLS)

DHS-ICLS-and-PCA-ADL-Assistance-Tool

PCA Program Manual

PCA Overview Training

Homemaking Benefit Guideline

Duplication of Services

Case Examples

1. CC had authorized 6.25 hours of PCA per day, 3 days of ADC and 33 units per week of ICLS.

2. Member lives with family, receives 10 hours of PCA and 5 hours of homemaking per week. Member potentially qualifies for VA services. Family was providing informal services, to what extent was difficult to determine.

3. Member was receiving 13 hours of ICLS per week for cleaning and shopping. Is this the most appropriate service to meet the member's needs?

4. Member was receiving 6 hours of ICLS on Mondays, attending ADC 4 days per week one of which included Mondays. Member was also receiving companion services.

THANK YOU