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### **Michigan Long-Term Care Supports and Services Advisory Commission Meeting of November 23, 2009 Capitol View Building, Lansing, MI**

- Agenda, Monday, November 23, 2009
- Model Act, February 14, 2005
- Legislative Draft #7 – Training and Qualifications for Certified Nursing Assistants and Hospice Aides
- PowerPoint – Profile of Publicly-Funded LTC Services, June 2009
- PowerPoint – MI Choice Waiver Update
- Instructions for Completing the Imminent Risk Assessment Tools
- Imminent Risk of Nursing Facility Placement Assessment
- 2010 Meeting Schedule

MICHIGAN LONG TERM CARE SUPPORTS & SERVICES  
ADVISORY COMMISSION  
MONDAY, NOVEMBER 23, 2009 FROM 10:00 – 4:00  
AGENDA

**I. 10:00 A.M. – Organizing Ourselves**

- A. Introductions/Roll Call
- B. Review & Approval of September Draft Minutes
- C. Review & Approval of November Agenda

**II. 10:15 A.M. – What’s Happening**

- A. Executive Committee Report
- B. Task Force Quality Management System Recommendations & The Final Report’s Model Act Component: More Recommendations or Final Report “Appendix”? -- *Mark Cody, Senior Attorney, Michigan Protection & Advocacy Services; Governor’s Medicaid LTC Task Force Member & Chair of its Legislation & Regulation Workgroup*
- C. Michigan Nurse Aide Education & Training Modernization: Emerging State Legislation Concepts -- *Commissioner Turnham*

**12:00 LUNCH BREAK**

**III. 1:00 P.M. – What Else is Happening**

- A. Public Comment
- B. State LTC Profile Tool Report -- *Jane Church*
- C. OSA/MSA Update -- *OSA Deputy Director Brey, Pamela McNab, Susan Yontz, Michael Daeschlein/Elizabeth Gallagher*

**[BREAK @ 2:45]**

**IV. 3:00 P.M. – What Needs to Happen**

- A. Commission Advisement on Final Report Recommendations’ Model Act Status
- B. Commission Action on Next Steps in State Budget Advisement & Advocacy
- C. Commission Action Related to Public Comment
- D. January 2010 Commission Needs
- E. Other Commissioner Announcements & Adjournment

**Modernizing Michigan Medicaid Long-Term Care**  
Toward an Integrated System of Services and Supports  
*Final Report of*

**The Michigan Medicaid  
Long-Term Care Task Force**

*Established by Governor Jennifer M. Granholm via Executive Order No. 2004-1*

## **Model Act**

### **MICHIGAN LONG-TERM CARE CONSUMER CHOICE AND QUALITY IMPROVEMENT ACT**

FEBRUARY 14, 2005

#### **Sec. 1 Short title**

This act shall be known and may be cited as the “Michigan Long-Term Care Consumer Choice and Quality Improvement Act.”

#### **Sec. 2 Definitions**

1) Definitions: When used in this Act, the following words shall have the following meanings:

(a) “Authority” means the entity created pursuant to section 4 of this act.

(b) “Commission” means the long-term care commission established pursuant to section 3 of this act.

(c) “Consumer” means an individual seeking or receiving public assistance for long-term care.

(d) “Department” means the department of community health.

(e) “Director” means the director of the department.

(f) “Long-term care” means those services and supports provided to an individual in a setting of his or her choice that are evaluative, preventive, habilitative, rehabilitative or health related in nature.

(g) “Medicaid” means the program for medical assistance established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, 1396g-1 to 1396r-6, and 1396r-8 to 1396v, and administered by the department under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(h) “Person-centered planning” means a process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that honors the individual’s preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

(i) “Primary consumer” means the actual user of long-term care services.

(j) “Secondary consumer” means family members or unpaid caregivers of consumers.

(k) “Single points of entry” means those entities created pursuant to section 6 of this act.

(l) "Transition services" means those services provided to assist an individual in moving from one setting to another setting of his or her choice and may include, but is not limited to, the payment of security deposits, moving expenses, purchase of essential furnishings, and purchase of durable medical equipment.

### **Sec. 3 Findings and purpose**

1) The legislature finds that long-term care services and supports are critically important for Michigan citizens, their families, caregivers and communities, that the need for long-term care services and supports is expected to increase substantially as the number of older people and people with disabilities increases, that consumers will be best served by the creation and continuing refinement of a carefully coordinated long-term care system that promotes healthy aging, consumer education and choice, innovation, quality, dignity, autonomy, the efficient and effective allocation of resources in response to consumer needs and preferences, and the opportunity for all long-term care consumers, regardless of their age or source of payment, to develop and maintain their fullest human potential.

2) Consistent with section 51 of article IV of the state constitution of 1963, which declares that the health of the people of the state is a matter of primary public concern, and as required by section 8 of article VII of the state constitution of 1963, which declares that services for the care, treatment, education or rehabilitation of persons with disabilities shall always be fostered and supported, the department is charged with the primary responsibility for ensuring the development and availability of a system of long-term care as described in this act.

3) The purpose of this Act is to ensure all of the following:

(a) That consumers have access to a well-coordinated, comprehensive, adequately funded and dynamic array of long-term services and supports including but not limited to assessment, care planning, in-home services and supports, a range of assisted living options, care management services, respite care services, nursing facility care, hospice care, primary care, chronic care management, supports coordination, and acute care. This array of services and supports must be designed through a person-centered planning process to meet existing consumer needs and preferences, be flexible and responsive to changing consumer needs and preferences, and encourage innovation and quality;

(b) That consumers are provided with sufficient education and support to make informed choices about their long-term care service and supports options;

(c) That the system is consumer focused, embraces person centered planning, and fosters the creation of innovative long-term care options;

(d) That services and supports are provided in the most independent living setting be consistent with the consumer's needs and preferences;

(e) That access to long-term care services and supports is determined by a uniform system for comprehensively assessing abilities and needs;

(f) That public resources purchase, permit, and promote high quality settings, services, and supports through:

(1) adequate and consistent monitoring of publicly funded settings, services and supports;

(2) consistent and appropriate enforcement of statutory and regulatory standards;

(3) monitoring of outcomes of long-term care for quality and adherence to the consumers' expressed preferences; and

(4) swift and effective remedies if services, supports, or settings fail to meet quality standards or to promote long-term care consumers' dignity, autonomy, and choice.

(g) The goal of the system shall be continuous quality improvement focused on consumer satisfaction and the consistent achievement of clear standards concerning the health, safety, autonomy, and dignity of long-term care managers; family members; and others when appropriate. These mechanisms shall assist regulators and policy makers in evaluating quality and consumer satisfaction and in determining necessary adaptations and improvements in the dynamic long-term care system.

(h) That long-term care services are coordinated in a way that minimizes administrative cost, eliminates unnecessarily complex organization, minimizes program and service duplication, and maximizes the use of financial resources in meeting the needs and preferences of long-term care consumers.

(i) That the state collects, analyzes, and distributes to the public on an ongoing basis complete data regarding current utilization of long-term care services and supports, unmet needs, consumer preferences, demographic data, workforce capacity, and other information that will assist the state in the continuing coordination and refinement of its long-term care system. In addition, ensure the state publishes periodic reports that assess the adequacy and efficacy of the reimbursement and enforcement systems and identify areas requiring improvement, unmet needs, successful innovations, and best practices.

(j) That state and the long-term care industry build and sustain an adequate, well-trained, highly motivated and appropriately compensated workforce across the long-term care continuum.

(k) That all stakeholders including consumers and their families and advocates, providers, representatives of the long-term care workforce, public officials and others have a continuing opportunity for meaningful input in the development and refinement of the long-term care system.

#### **Sec. 4 Long-term care commission**

1) A commission on long-term care is hereby established, to be appointed by the governor.

2) The commission shall consist of twenty-five members appointed by the governor. Commission membership shall consist of fourteen consumers, of which at least fifty percent are primary consumers and of those primary consumers at least fifty percent shall be users of Medicaid services, the remainder comprised of secondary consumers and consumer organization representatives, seven providers or provider organization representatives, three direct care workers and one member with expertise in long-term care research from a university. Overall commission membership shall also reflect the geographic and cultural diversity of the state.

3) One representative each from the single point entry network, the State Long-Term Care Ombudsman, the designated protection and advocacy system, the Department of Community Health, the Department of Human Services and the Department of Labor and Economic Growth, all of whom shall serve in non-voting supporting roles as ex-officio members. Staff from the Medical Services Administration and the Office of Services to the Aging shall serve as resources to the commission and shall assist the commission as needed.

4) Voting member terms shall be three years, staggered to ensure continuity and renewable under the appointment process. If a vacancy occurs during the term of a voting member, the governor shall appoint a replacement to serve out the remainder of the term and shall maintain the same composition for the commission as set forth in sec. 4(2).

5) Commissioners are entitled to receive a stipend, if not otherwise compensated and reimbursement for actual and necessary expenses while acting as an official representative of the commission as defined by commission policies and procedures. Commission policies and reimbursement shall establish and practice full accommodation to individual support needs of commission members, including their direct care and support workers or personal assistants, support facilitation or other persons serving them as secondary consumers.

6) The governor shall designate one person from among the consumer membership to serve as chairperson of the commission, who shall serve at the pleasure of the governor.

7) The commission shall do all of the following:

- (a) Serve as an effective and visible advocate for all consumers of long-term care supports and services.
- (b) Participate in the preparation and review, prior to the submission to the governor, of an ongoing, comprehensive statewide plan and budget for long-term care services and supports design, allocations and strategies to address and meet identified consumer preferences and needs.
- (c) Ensure the broadest possible ongoing public participation in statewide planning as part of subsection (1)(b).
- (d) Ensure broad, culturally competent, and effective public education initiatives are ongoing on long-term care issues, choices and opportunities for direct involvement by the public.
- (e) Evaluate the performance of the designated single point of entry agencies on an annual basis and make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.
- (f) Continuously monitor spending and budget implementation, including how well expenditures match policy decisions and initiatives based on consumer preferences and needs.
- (g) Meet at least six times per year.
- (h) A quorum of the commission shall consist of at least fifty percent of the voting membership, provided at least eight consumer members are present or participating. Participation may be by telephone or other means, in accordance with other statutory provisions and as determined by the commission.

**Sec. 5 Long-term care administration**

1) (Insert here language directing how the administration will be created, where it will be located, etc.).

2) The long-term care administration shall do all of the following:

- (a) Serve as an effective, visible, and accessible advocate for all consumers of long-term care supports and services.
- (b) Prepare and implement an ongoing, comprehensive statewide plan for the governor for long-term care services and supports design, administration and oversight to ensure delivery of an organized system which meets identified consumer preferences and needs.
- (c) Develop and implement an ongoing budget that ensures state financial resources follow consumer preferences under the comprehensive state plan for review by the commission prior to submission to the governor.
- (d) Ensure the broadest possible ongoing public participation in statewide planning as part of subsection (2)(b).
- (e) Recommend to the department director designations and de-designations of the state's single points of entry (SPE) network agencies under established guidelines; recommend contract awards; establish performance and review standards for SPE agencies; receive standardized annual and other reporting from the agencies.
- (f) Ensure broad, culturally competent and effective public education initiatives are ongoing on long-term care issues and choices.

(g) Advise the governor, the legislature, and directors of relevant agencies and department heads regarding changes in federal and state programs, statutes, and policies.

(j) As part of its ongoing planning, identify and address long-term care workforce capacity, training and regulatory issues in both the public and private sectors.

(k) Retain state approval over proposed changes in Medicaid policy and services related to long-term care before publication and comment; continually reform eligibility policy to improve timeliness and access.

(l) Develop and maintain a comprehensive state database and information collection system on long-term care service and supports capacities and utilization that is publicly accessible, while protecting individual consumer privacy, for the purposes of individual and state-aggregated planning, forecasting, and research.

(m) Ensure all necessary and vital linkages among acute, primary and chronic care management supports and services are maintained and continually strengthened to complement, leverage, and enhance services, supports and choices in the long-term care system.

(n) Develop and implement policies and procedures that will facilitate efficient and timely transition services for individuals moving from a nursing facility to home or apartment in the community. Services may include, but are not limited to payment of security deposits, moving expenses purchase of essential furnishings and durable medical equipment.

(o) Identify and implement progressive management models, culture change, and indicated administrative restructuring to maximize efficiency, optimize program design and services delivery; provide technical assistance in these areas to providers and interested members of the public.

(p) Establish a comprehensive, uniform, and enforceable consumer rights and appeals system.

## **Sec. 6 Single points of entry**

1) It is the intent of the legislature that locally or regionally based single points of entry for long-term care serve as visible and effective access points for persons seeking long-term care and promote consumer education and choice of long-term care options.

2) The director shall designate and maintain locally and regionally based single points of entry for long-term care that will serve as visible and effective access points for persons seeking long-term care and promote consumer choice.

3) The department shall monitor designated single points of entry for long-term care to:

(a) prevent bias in eligibility determination and the promotion of specific services to the detriment of consumer choice and control;

(b) Review all consumer assessments and care plans to ensure consistency, quality and adherence to the principles of person-centered planning and other criteria established by the department;

(c) Assure the provision of quality assistance and supports;

(d) Assure that quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.

(e) Assure consumer access to an independent consumer advocate.

4) The department shall establish and publicize a toll-free telephone number for those areas of the state in which a single point of entry is operational as a means of access to the single point of entry for consumers and others.

5) The department shall promulgate rules establishing standards of reasonable promptness for the delivery of single point of entry services and for long-term care services and supports.

6) The department shall require that designated single points of entry for long-term care perform the following duties and responsibilities:

(a) Provide consumers and any others with information on and referral to any and all long-term care options, services, and supports;

(b) Facilitate movement between supports, services, and settings in an adequate and timely manner that assures the safety and well-being of the consumer;

(c) Assess a consumer's eligibility for all Medicaid long-term care programs utilizing a comprehensive level of care tool;

(d) Assist consumers to obtain a financial determination of eligibility for publicly funded long-term care programs;

(e) Assist consumers to develop their long-term care support plans through a person-centered planning process;

(f) Authorize and, if requested, arrange for needed transition services for consumers living in nursing facilities;

(g) Work with consumers in acute and primary care settings as well as community settings to assure that they are presented with the full array of long-term care options;

(h) Re-evaluate consumers' need and eligibility for long-term care services on a regular basis;

(i) Perform the authorization of Medicaid services identified in the consumer's care supports plan.

7) The department shall, in consultation with consumers, stakeholders, and members of the public, establish criteria for the designation of local or regional single points of entry for long-term care. The criteria shall assure that single points of entry for long-term care:

(a) Are not a provider of direct Medicaid services. For purpose of this act, care management and supports coordination are not defined as a direct Medicaid service;

(b) Are free from all legal and financial conflicts of interest with providers of Medicaid services;

(c) Are capable of serving as the focal point for all persons seeking information about long-term care in their region, including those who will pay privately for services;

(d) Are capable of performing consumer data collection, management, and reporting in compliance with state requirements;

(e) Have quality assurance standards and procedures that measure consumer satisfaction, monitor consumer outcomes, and trigger care and supports plan changes;

(f) Maintain internal and external appeals processes that provide for a review of individual decisions;

(g) Complete an initial evaluation of applicants for long-term care within two business days after contact by the individual or his or her legal representative; and

(h) In partnership with the consumer, develop a preliminary person-centered plan within seven days after the applicant is found eligible for services.

8) Designated single points of access for long-term care that fail to meet the above criteria, and other fiscal and performance standards as determined by the department, may be subject to de-designation by the department.

9) The department shall promulgate rules establishing timelines of within two business days or less for the completion of initial evaluations of individuals in urgent or emergent situations and shall by rule establish timelines for the completion of a final evaluation and assessment for all individuals, provided such timeline is not longer than two weeks from time of first contact.

10) The department shall solicit proposals from entities seeking designation as a single point of entry and shall designate at least three agencies to serve as a single point of entry in at least three separate areas of the state. There shall be no more than one single point of entry in each designated region. The designated agencies shall serve in that capacity for an initial period of three years, subject to the provisions of Sec. 4(3).

11) The department shall evaluate the performance of the designated agencies on an annual basis and shall make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

12) No later than October 1, 2008, the department shall have a designated agency to serve as a single point of entry in each region of the state. Nothing in this section shall be construed to prohibit the department from designating single points of entry throughout the entire state prior to said date.

13) The department shall promulgate rules to implement this act within six months of enactment.

## **Sec. 7 Quality**

1) The authority shall have a continuing responsibility to monitor state agencies' performance in responding to, investigating, and ensuring appropriate outcomes to complaints and in performing its survey and enforcement functions. The Long-Term Care Administration shall issue regulations and policy bulletins, as appropriate, and take other appropriate action to improve performance or address serious deficiencies in state agencies' practices with regard to handling complaints and in performing survey and enforcement functions.

2) The authority shall establish a single toll free hotline to receive complaints from recipients of all Medicaid funded long-term care services and settings. State employees responsible for this function shall:

(a) Staff the complaint line 24 hours a day, 7 days per week;

(b) Be trained and certified in information and referral skills;

(c) Conduct a brief intake;

(d) Provide information and referral services to callers including information about relevant advocacy organizations; and

(e) Route the call to the appropriate state agency or advocacy organization to record and respond to the consumer's concern. Relevant state agencies shall ensure on-call staff is available after hours to respond to any calls that are of an emergency nature. The authority shall ensure that hotline staff are consistently informed how to contact on-call staff at all relevant state agencies to which long-term care complaints may be referred.

3) The administration shall also ensure that consumers can file complaints about any Medicaid funded long-term care setting or service using a simple, web-based complaint form.

4) The administration shall publicize the availability of the 24 hour hotline and web-based complaint system through appropriate public education efforts.

5) The administration shall form a workgroup to determine if state agencies' complaint protocols ensure a timely and complete response and to monitor for appropriate outcomes. The workgroup shall also address whether state agencies are performing their survey and enforcement functions in the most effective manner and if their practices promote quality and person-centered planning.

(a) The workgroup shall be comprised of a minimum of fifty percent consumers and/or consumer advocacy groups. The remainder of the workgroup shall include the State Long-Term Care Ombudsman and/or his/her representative, long-term care providers, a representative from the designated protection and advocacy system, and representatives from the departments that enforce the regulations in long-term care facilities.

(b) The workgroup will be charged with examining the number of consumer complaints received, the timeliness of response to these complaints, the process used by state investigators for these complaints, and the resolutions of these concerns. The workgroup will utilize existing resources such as Auditor General reports on state agencies that regulate long-term care facilities or services and any additional data it requires to perform its duties. Based on these findings, the workgroup will issue recommendations to the administration and to the director.

(c) The workgroup shall also be charged with a comprehensive review of state law and policy, including licensing laws and regulations, receivership provisions, and other mechanisms for regulating long-term care services to determine whether these laws and policies should be deleted, amended, or modified to promote quality, efficiency, and person-centered planning or to reflect changes in the long term care system. The workgroup shall issue recommendations to the authority and to the director.

6) The departments responsible for licensing of long-term care settings shall, within twelve months of the date of enactment of this statute, promulgate rules to establish a process for identifying all licensed long-term care settings which, absent intervention by the state, are likely to either close or in which care is likely to diminish or remain below acceptable standards. In promulgating these rules, the departments shall consider, but not be limited to, the facility's financial stability, administrative capability, physical plant, and regulatory history.

7) If a department has a reasonable suspicion that a licensed facility lacks administrative capability, financial stability, financial capability, or is not structurally sound, it shall have the right to request any and all relevant documentation including, but not limited to, independent audits of the facility, credit reports, physical plant inspections by appropriate professionals, and other relevant information. It may also investigate and consider factors such as whether the facility has filed for bankruptcy or whether foreclosure has been filed, consistently declining occupancy rates, chronic noncompliance, or other relevant information.

8) In the event a department identifies a facility to be nonviable, it shall take appropriate measures to protect the health and safety of the residents, which may include the following:

(a) The prompt appointment of a temporary manager or receiver with authority to take all actions necessary for the purpose of stabilizing the facility and protecting the residents, including:

1. Making all improvements necessary to ensure residents receive services that meet or exceed minimum regulatory standards; or

2. If necessary and appropriate, arranging for the safe and orderly transfer of residents out of the facility consistent with their person-centered plan and choices.

(b) Redistributing beds within the community to other facilities or making funding available in other long-term care settings, including home and community based care.

9) The State shall ensure that relevant state agencies have sufficient staff to meet all statutory or regulatory time frames for the completion of their responsibilities; effectively and expediently monitor services, supports, and facilities; respond to complaints; and enforce existing state laws and regulations regarding minimum standards for long-term care services, supports, and facilities.

## **Sec. 8 Consumer advocate**

1) No later than six months after the enactment of this act, the governor shall designate an agency with the independence and capacity to serve as an advocate for long-term care consumers, as set forth in this section. This designation shall continue indefinitely unless, for good cause shown, the agency is unwilling or incapable of performing its duties as set forth in this section.

2) The designated agency shall have the responsibility to identify, investigate, and resolve complaints concerning services provided pursuant to this act; shall assist applicants for long-term care who have been denied services and supports; and shall pursue legal, administrative and other remedies at the individual and systemic level to ensure the protection of and advocacy for the rights of long-term care consumers.

3) The designated agency shall have access at reasonable times to any consumer in a location in which services and supports are provided.

4) The designated agency shall have access to the medical and mental health records of long-term care consumers or applicants for long-term care under any of the following conditions:

(a) With consent of the consumer or applicant or his or her legal representative;

(b) Without consent, if the consumer is unable to give consent and there is no legal representative or the state is the individual's representative and the designated agency has received a complaint or has probable cause to believe that abuse or neglect has occurred; or

(c) Without consent, if the consumer is unable to give consent and the legal representative has refused or failed to act on behalf of the individual and the designated agency has received a complaint or has probable cause to believe that abuse or neglect has occurred.

5) Records requested by the designated agency shall be made available for review and copying within three business days or, in the event of death or a request made pursuant to 4(b) or (c), within 24 hours.

6) The designated agency shall maintain an office in each of the service areas of the single points of entry.

7) The designated agency shall coordinate its activities with those of the state long-term care ombudsman and the designated protection and advocacy system.

8) The designated agency shall prepare an annual report and provide information to the public and to policymakers regarding the problems of long-term care consumers.

9) The legislature shall appropriate sufficient funds to enable the designated agency to perform its duties.

## Legislative Draft #7

November 2009

With Notes and changes from MHA committee meeting & November Workforce Development Workgroup meeting

This document needs lots more work and review by both the Workgroup and the Commission. Please do not assume that this draft is final.

### Article 15 of MI Public Health Code

## TRAINING AND QUALIFICATIONS FOR CERTIFIED NURSING ASSISTANTS and HOSPICE AIDES

Design issues: These are matters where the input of MDCH is important and reflected.

A. Is it better to amend the current nursing home and hospice sections of the Public Health Code by adding these provisions **or** should a brand new section that just sets up this training program for both nursing homes and hospices be created and added to the Public Health Code? Workgroup tends to lean toward a one bill approach awaiting MDCH input and guidance. *Decision—one bill to amend Article 15 (health professions) in the Public Health Code that will contain the vast majority of the language. Also, references are needed Article 17 to require licensed nursing homes and hospices to employ aides listed on the registry.*

B. Are there still nursing homes in Michigan that are not certified for Medicare or Medicaid? If so, what are their current CNA training requirements? *Decision—almost no private pay homes left; law to apply to all licensed homes and certified nursing facilities.*

C. What term is used to describe this process and the person called who is successful? Is this a “certification” process with a “certificate” at the end to a “certified aide”? Is this a “credentialing” process? Is it a “training and registry” process? *Decision—this is not a “licensing” process. This is a training and registry process. As for the person who successfully completed the training, the evaluation and is eligible to listed on the registry, it may be best to call person and the credential a new, distinct title. For purposes of this draft, the phrase “registered aide.” While the phrase “registered aide or assistant” is descriptive, inclusive, and sets a new direction for a new process and beginning, it is not warm, engaging, or great. A better title or phrase is needed and all suggestions are welcome.*

D. How much of the federal requirements that now define the program for both CNAs and hospice aides and that there are no recommendations to change need to be repeated in state law? *Decisions—*

*1. If a current CNA or hospice aide does not receive compensation for the services in 24 months, she is not eligible for renewal. How is this handled currently within hospices? Many hospice aides are CNAs, on the registry. Many hospice agencies hire only CNAs. Some hospice agencies want the aides to maintain their place on the CNA registry, others do not. An undetermined number of CNAs working for hospice agencies have let their CNA registry lapse. For those hospices that are accredited, aide core*

competencies must be re-checked every year. Otherwise, with no central registry, there is no formal renewal process for hospice aides who rely solely on passing a hospice competency evaluation.

2. *Hospice must maintain documentation that standards met. This requirement seems unnecessary if when this proposal is implemented. Rae will consult CMS.* Hospice agencies maintain aide training and competency documents and those documents are part of the survey process conducted by MDCH.

3. *Performing work prior to training, evaluation and listing on the registry. The federal provisions on this topic are different between nursing homes and hospice agencies.*

A. *For nursing homes, federal law allows them to employ a person as an aide for up to 4 months before that person takes the training and passes the testing. But the employee has to have 16 hours of training from the home before services to any resident 151(b)(1). And, there's a general provision that students do not perform any services for which they are not trained. Very few homes now employ aides before the full CNA training course; trained aides working in a home as a aide may have to wait a while for the test and the test results.*

B. *For hospices, there is no 4 month window for hospice aides to work while in training; all aides must complete evaluation prior to hire. How is this practiced by hospice agencies?* The MHHA committee confirmed that hospice agencies can only use competency evaluated aides from day one of employment. The issue of allowing an employee who is not yet evaluated can do some limited amount of work under the direct supervision of a nurse. Rae will explore this option.

These federal provisions will likely need to be referenced in Article 17 of the Public Health Code that license hospice agencies and nursing homes to preserve these federal provisions.

4. *In-service requirements are on the aide in hospice rather than on the nursing facility; see #2 directly above. Rae will consult with CMS.* Hospice agencies maintain aide training and competency documents in personnel records and those documents are part of the survey process conducted by MDCH.

5. *Hospice rules make some home health agency ineligible to be the competency evaluation organizations. (f) How is this prohibition currently handled by hospice agencies?* Part of the solution has been that many agencies use MHHA's process to do the evaluation. These prohibitions need to be part of the Department's processes for evaluation.

6. *NH rules make some homes ineligible for training or competency evaluations 151; MI has unique approach to allow locked out homes to be clinical sites. Rae/Melanie will draft some language to address current process for inclusion in the state law.*

7. *Current requirements for on-site visits by state to the CNA training programs seeking approval. 151(b)(iii) DCH recommends this be put in state law.* MHHA committee members understand and agree with the federal requirement to become an approved training program.

8. *NH training programs approved for only 2 years. 151(d). DCH recommends this be put in state law.* MHHA committee members understand and agree with the federal requirement to become an approved training program.

9. *Withdrawal of NH training program approval 151(e). DCH recommends this be put in state law for all approved training programs.* MHHA committee members understand and agree with the federal requirement to become an approved training program.

10. *In NHs, training program may be under general supervision of DON but she cannot do the actual training. What's the practice in or requirement for hospice agencies?* In hospice agencies, there is no one position identified as the "DON" with that title. MHHA committee agrees that "the nurse charged with lead responsibilities for staff and clinical operations" should not be the "primary" trainer for an approved training program.

11. *In NHs, the home cannot charge an employed aide or an aide offered employment for the CNA training 151 (c). What's the practice in hospice?* MHHA committee agencies report that they do not charge aides for training.

12. *Federal law sets a requirement of reimbursement of training costs to an aide later hired by nursing home 151(c). What's the practice or requirement in hospice?* Most agencies report that they do not reimburse aides for training costs; a few agencies report that they do reimburse aides for CNA training. Unlike nursing homes, hospice agencies do not have a direct mechanism for Medicaid reimbursement for this expense.

13. *How the competency evaluation process works is very detailed in section 154 for nursing homes and there are similar requirements for hospice. We need to compare the two and likely put components into state law.* This part of the nursing home COPs will be sent to Renee so the committee can take a look at it.

14. *Registry components: section 156 describes the CNA registry and allows that it "may include home health aides if evaluation program is approved by the state and those aides are differentiated,"* This section of federal law in the nursing home COPs was shared with the committee.

15. *Qualifying of current CNAs listed on the registry is relatively easy; since there's no list of current hospice aides how will current hospice aides be recognized to the new integrated registry?*

A. *Will there be a qualifying exam?*

B. *Need to have a time limit for getting listed on the new integrated registry*

We had a wide ranging discussion of how to get current aides working in hospice agencies on the registry. MHHA committee members pointed out the following scenarios and options:

A. Many aides currently working in hospice are active on the current CNA registry either because it is a hospice agency requirement or their personal preference.

B. Many aides currently working in hospice were on the current CNA registry but let their registration lapse.

C. Another sub-set of aides working in hospice have never been listed on the CNA registry. Some took the course but did not take the CNA test or renew that registration because of cost and registration was not a requirement of employment. Other aides are very uncomfortable with tests and sought out employment that did not require a test.

Possible options for aides described in B and C above:

1. As best as we can, find out or estimate how many aides are in B and C. The MHHA committee was asked to consider this need for information.

2. For aides in B or C who have worked X number of years successfully in hospice care, have an agency attest to the aides competency and history of employment—put the hospice aide on the new registry

3. For aides in B or C, maybe have a short evaluation process instead of or in addition to #2 directly above.

The MHHA committee was asked to think about issue and share their thoughts and preferences with the Workforce Development Workgroup (Hollis) and the Bureau of Health Professions (Rae).

F. How do we put in encouragement/authority for MDCH to use CMP money to get development the model curriculum and other enhancements called for the in the final legislation? *Decision—Melanie and Rae have some language that could work from another section of the article. The relevant section is MCLA 333.16315(6) through (9). See draft language in section 6(a) below.*

## **§ 1. Definitions.**

As used in this chapter:

(1) "Nurse aide" also means "CNA" and "CENA"

Include a reference to federal requirements

(2) Criminal background checks—define according to state laws applicable to nursing homes and hospice agencies

(3) "Department" means the Department of Community Health.

(4) Hospice – define according to state law

(5) Hospice aide

Include a reference to federal requirements

(6) "Nursing assistant"

(7) Nursing home – define according to state law, include hospital long-term care units that are certified as "nursing facilities" or "skilled nursing facilities" under federal law

(8) Primary trainer – define according to LTCSS recommendations

(9) Delegated trainer—define according to LTCSS recommendations

(10) Training support assistant—define according to LTCSS recommendations

(11) Registered aide—the new occupation that can work in both licensed nursing homes and licensed hospice agencies and meets federal standards for both employers

(12) Supervised practical training—defined in federal regs.

## **§ 2. Registered aide Training and Registry Program.**

To obtain certification as a registered aide, all trainees must successfully complete the classroom, supervised practical training, and clinical training as well as the competency evaluation process that includes both a written evaluation and observation of skills performance.

This process is meant to satisfy federal requirements for certified nursing homes to employ certified nursing aides and certified hospice agencies to employ hospice aides. This process is meant to satisfy the option in federal law that allows a state approved nurse aide training program and competency evaluation program to qualify a hospice aide to work in a certified hospice agency. 42CFR 418.76(a)(1)(iii).

Before approving training program, state must make an on-site visit to applicant training site.

Approval is for a 2 year period at which time the program must seek renewal of authority to train registered aides.

Department has authority to withdraw approval of training program for significant or substantial non-compliance with program requirements, (is this enough reasons? What are current reasons?)

Licensed nursing homes and hospices can only hire registered aides to perform the duties defined in state and federal laws ascribed to aides.

### **§ 3. Composition of registered aide training course and curriculum.**

(a) The Department shall create and oversee the delivery of Michigan model curriculum for registered aides, which will be used by all approved training programs offering training to individuals as registered aides. This curriculum shall include, but not be limited to, units of instruction or modules to teach and enhance the specific skills, knowledge, and abilities that are needed under each of the following competencies as defined here:

#### **Competency 1: Approach to Care and Role of the Assistant/Aide**

Aides will demonstrate the philosophy, values, and approaches that define person-centered care and recognize the various roles and responsibilities of a certified aide and the other members of the caregiving team in promoting the delivery of high quality person-centered care across the spectrum of individual acuity needs.

#### **Competency 2: Relational and Communication Skills**

Aides will demonstrate a wide array of effective relational and communication skills and abilities, including the use of electronic records, while interacting with residents and clients, their families, and all other members of the caregiving team.

#### **Competency 3: Knowledge and Skills**

Aides will demonstrate the knowledge and skills needed to implement individualized resident and client plans of care including personal care, restorative and rehabilitative care, nutritional needs, cognitive impairments, *mental illness* and end of life care in keeping with the resident's and client's independence, preferences, dignity, choices, and available technology.

#### **Competency 4: Well-being and Safety**

Aides will support the physical, mental, and psycho-social well-being of residents, clients, and co-workers through the use of proven health and safety workplace practices in keeping with the individual's preferences.

#### **Competency 5: Consumer Rights, Ethics, and Confidentiality**

Aides will provide resident and client supports and services in a manner that upholds ethical and legal standards and practices while respecting the dignity, spirituality, preferences, *culture* and individuality of each person.

#### **Competency 6: Self-Care**

Aides will identify ways to maintain their own physical and emotional health to address grief and loss as well as the stress and burnout associated with high quality caregiving.

(b) The registered aide model curriculum developed by the Department shall conform to the following requirements:

**(1) Requirement 1: Adult Learner-centered Instruction**

CNA/HA programs and the model curriculum will facilitate application of new skills by students with the least delay possible to foster comprehension and retention. The approved training programs will be guided by student needs, facilities, and comprehension.

**(2) Requirement 2: Person-centered planning**

Use the Commission created and Department approved definition, at least, and require its use in creating the new model curriculum.

**(3) Requirement 3: Meet federal minimum standards**

Both for nursing homes and hospice agencies

**(4) Requirement 4: Evaluations of students completing the curriculum shall be based on these competencies.**

These competencies shall be used by the Department to design, oversee or administer evaluations and testing of skills, knowledge, and abilities of students in approved training programs.

**(5) Requirement 5: Length of the training program**

The model curriculum shall be designed with sufficient classroom, laboratory (supervised practical training), and clinical hours and experience to meet minimum federal requirements and effectively convey the materials to students. *[Public policy makers may want a cap on the number of hours for budget reasons.]*

**§ 4. The registry of registered aides**

(a) Authorize MDCH to create one registry of folks who pass the evaluation that meets federal minimum standards and this state law.

(b) Look at 42 CFR 483.156 for minimum standards on who, required content, and disclosure of the people listed on the registry.

(c) Authorize MDCH to add information about successful completion of other training and/or credentials such as a federally registered apprenticeship, licensed occupation or other substantive training recognized by nursing homes or hospice agencies.

(d) Require nursing homes and hospices to hire aides listed on the registry.

(e) Need to discuss fees. Current CNA fees are an application fee of \$25 and \$20 for 2 year renewal.

## § 5. Approved training programs

(a) Create authority for MDCH to require entities training CNAs and hospice aides to get to meet federal and state standards.

(b) Prohibit entities from advertising or offering training without MDCH approval.

(c) All approved training programs must have the following student to instructor ratio:

Class/Lecture – not to exceed *24 trainees:1 instructor*, Lab Practice – not to exceed *12 trainees:1 instructor* and Clinical Practicum – not to exceed *8 trainees:1 instructor*.

(d) Other staffing requirements—program coordinators

(e) Require use of new “model curriculum” by approved programs

(f) Give MDCH authority to conduct training sessions for the new model curriculum, approved trainers, and to provide a sufficient number of ongoing classes to produce enough primary trainers.

(g) Criminal background checks (Need to raise the differences the federal government sees searching criminal records for educational purposes, licensing purposes, and for employment purposes. It gets complicated.

- i. We recommend that all CNA/Hospice Aide approved training programs be required to conduct both the state and federal criminal background checks on all applicants required by PA 26-29 of 2006 and that all applicants for training must be eligible to work under PA 26, 27, 28 and 29 of 2006 before enrollment.
- ii. The costs of the criminal background checks shall be covered by state revenues and not be paid by the students or the approved training program.
- iii. We recommend that the State Legislature amend relevant sections of PA 26, 27, 28, and PA 29 of 2006 to include a process that allows an individual who is ineligible to work because of criminal conviction(s) to show rehabilitation and worthiness for employment in long-term care. The evidentiary burden of demonstrating rehabilitation should be the responsibility of the applicant or job seeker.

## § 6. Authority for MDCH to take necessary administrative steps to implement legislation.

(a) The Department shall (put in language needed to authorize department to get the work done within a year months.) The civil monetary penalty fund created and mandated by federal law is established in the state treasury, cite federal law. The Department shall use a portion of that civil monetary penalty to hire consultants and/or additional staff to complete within the year the administrative rules, model curriculum, training of approved trainers, approved of training programs, updates to the online registry, and other functions authorized and required by this section

(b) In order to get the work done, the Department is encouraged to use funds from the CMP fund to complete aide in development of the model curriculum, to conduct educational programming to

about the new curriculum and registry updates. [There's language in other parts of Article 15 that we can use.]

(c) The design of the model curriculum shall be done in collaboration with nursing homes, hospice agencies, currently approved CNA training programs including community colleges, ISDs, high schools, and proprietary schools, advocacy organizations representing the interests for nursing home residents and hospice clients, the State Long-Term Care Ombudsman program, worker associations and organized labor who represent CNAs or hospice aides, the Department of Energy, Labor, and Economic Growth, the Office of Services to the Aging, the Michigan Alliance of Person-Centered Community, and other interested groups as identified by the Department.

(d) MDCH should notify or post the process and criteria for how a "locked out" nursing home can be a host for clinical training.

**§ 7. CNA/Hospice Aide Registry and Renewal Process** (this section needs more input from the Bureau of Health Professions on how to accomplish this efficiently and effectively)

(a) Initial registry of applicants—

- i. Registry applicants should be required to respond to a series of questions at the time of application including information regarding misdemeanors and felony convictions as well as any substance abuse problems the individual has had prior to application for the registry.
- ii. Positive responses to the questions would result in further review of the applicant's credentials by the Bureau of Health Professions. Individuals who are not eligible for work would be denied the ability to test and become registered.

(b). Disciplinary Process for CNA/Hospice Aide Registrants – Recommend that certified nurse aides be added to Article 15 of the Michigan Public Health Code so that the same disciplinary process used for other regulated health professionals can be applied to certified nurse aides. *(Rae is reviewing how to work this section without a board; one other health profession does not have an overseeing board that plays a large role in discipline.)*

- i. After the applicant is registered, felony and misdemeanor convictions as well as actions or complaints filed with the Department will be reviewed. The Department would review the allegation and determine if a complaint should be filed and investigated against the registrant.
- ii. Registrant should be formally notified of the investigation and given an opportunity to participate in an informal compliance conference or an administrative hearing.
- iii. Disciplinary actions that could be assessed against the registrant would include reprimand, probation, fine, limitations on employment, suspension and revocation (flag). The disciplinary actions, other than the "flag" would be for a limited time period. It would also be possible for registrants to ask for reconsideration of actions taken against them if evidence justified review.

(c) Continue the State's current practice of allowing verification of 8 hours of RN-supervised work to be accepted from a wide variety of long-term care health settings.

## **Article 17 of the MI Public Health Code**

Relevant sections will be added the licensing sections for nursing homes and hospices require these organizations to train aides according to the requirements, to operate training programs if eligible and desired according to the requirements, and/or hire aides from the registry.

DRAFT

*PROFILE OF  
PUBLICLY-FUNDED  
LTC SERVICES  
JUNE, 2009*

*PREPARED AND SUBMITTED BY:  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF LTC SUPPORTS AND SERVICES*

*Ongoing SPT Grant activities are now managed by  
Office of Services to the Aging*

## Context

Michigan received one of ten State Profile Grants to develop a profile of its publicly-funded LTC system and to assist CMS in developing national benchmarks for all states to use to assess their progress in balancing LTC services.

## State Profile Tool Grant Goals

- Better integration of planning/management
- Development of integrated reporting
- Dementia services recommendations and action plans.
- Meaningful stakeholder participation

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## Michigan's Profile

- A snapshot of the LTC support system.
- Acknowledges success and identifies gaps.
- Includes recommendations for improved coordination and collaboration.
- Provides a framework for comparing change

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## Participating Stakeholders

- Partnership of OLTCSS and a Stakeholder Advisory Council.
- Culturally and geographically diverse group.



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5

## Methods

- Data collected through interviews
- Standardized interview template
- Basis of the report narrative
- Content expert review and approval



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6

## Grant-Required Target Populations

- Older adults
- People with physical disabilities
- People with developmental disabilities
- People with mental illness
- Children

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## Other Valued Populations Included

- People with dementia,
- People with substance abuse problems,
- Native American tribes and off-reservation natives
- Veterans
- People exiting correctional facilities

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## Required Key System Components

- Consolidated state agencies
- Single access points
- Institutional supply controls (CON)
- Transition from institutions
- The array of residential options
- HCBS infrastructure development
- Person-Centered Planning and Self-Direction
- Quality management

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## Factors that Drive Systems Change

- Legacy of HCBS for people with DD
- Commitment to PCP and Self-Determination
- Success of managed care & other programs
- Eager lawsuit settlement
- Olmstead Coalition
- Medicaid LTC Task Force Recommendations

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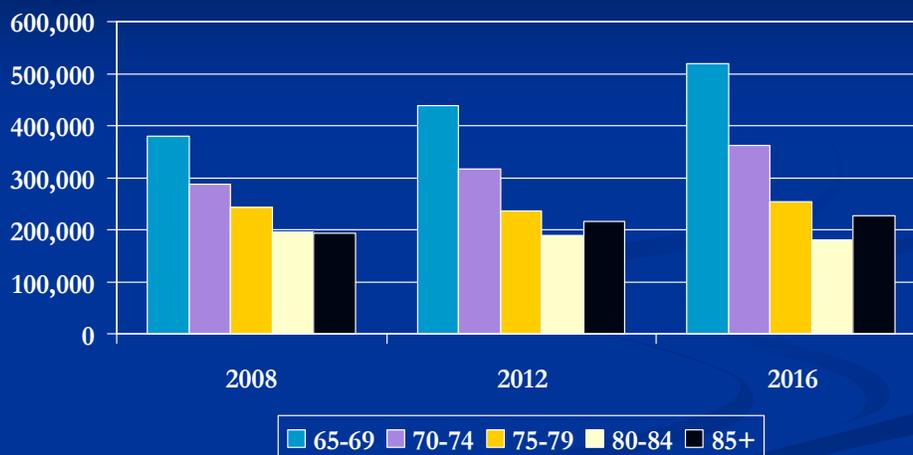
## Systems Change Initiatives

- Independence Plus
- Money Follows the Person
- Cash and Counseling
- Nursing Facility Transition Initiative
- Single Points of Entry
- Self determination in Home Help and MI Choice programs
- Increased funding for HCBS

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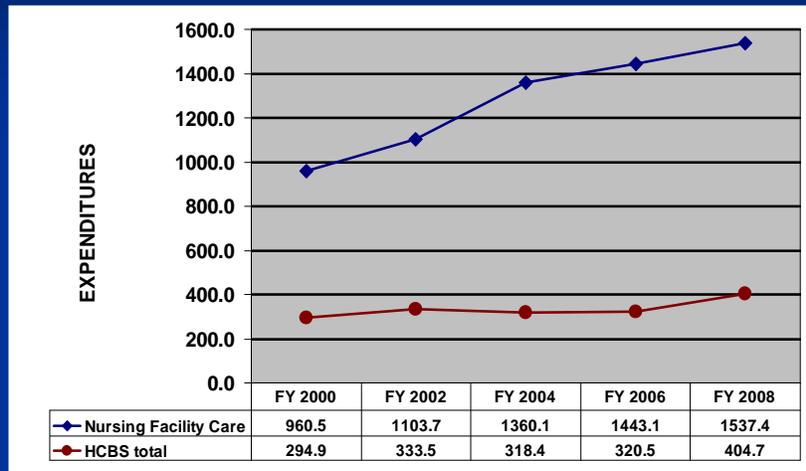
## Aging Demographics in Michigan



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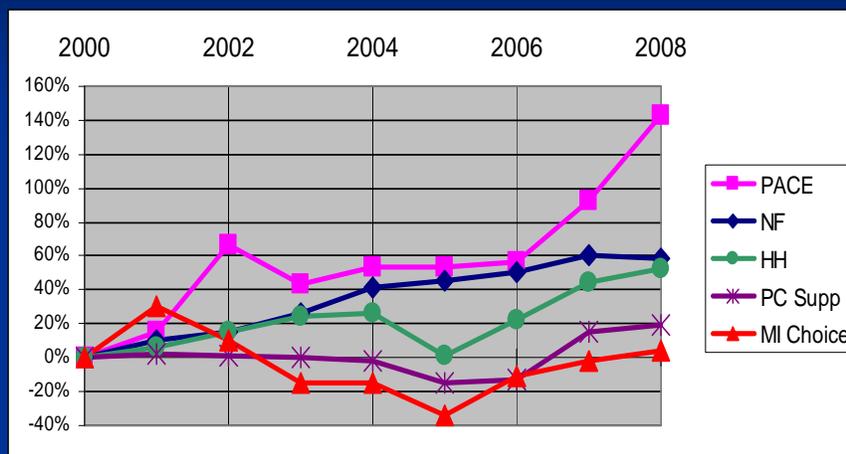
## Michigan LTC Expenditures 2000-2008



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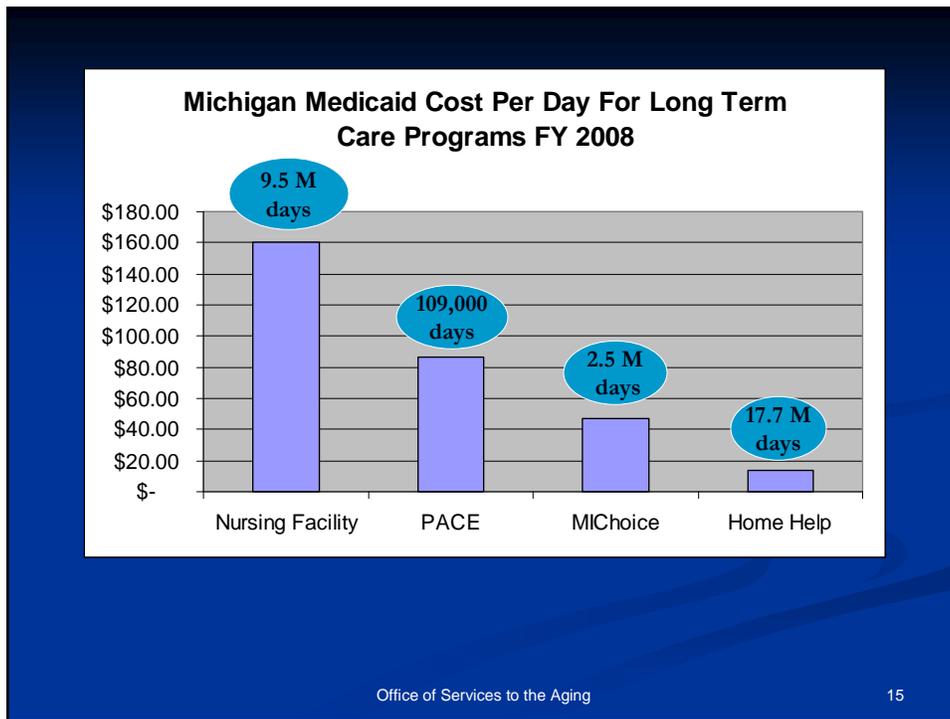
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## Michigan LTC Expenditures % Increase 2000-2008



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## Continuing LTC Supports Reform

- MI Choice offers AFC and HFA options
- Collaboration with MSHDA on affordable assisted living
- Changes in reimbursement methodologies
- Continued work on an integrated care waiver
- Improving quality of life outcomes measures

## Profile Findings - Strengths

- Extensive service delivery system
- Growth of HCBS
- Evidence of progress in creating options
- Growing PCP throughout the array
- Closing of final ICF-MR
- Attention to workforce needs



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## Profile Findings – Challenges

- Need for improved coordination and collaboration
- Lack of consistent approach to ensuring quality
- Lack of rolled-up budget line item

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## Profile Findings – Challenges

- Lack of state level collaboration
- Providers regulated by separate bureaus
- Need to build capacity and infrastructure
- High case-loads impact access to quality of care

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## What's Happened Since July?

- New grants
- OLTCSS dissolved and staff integrated into other parts of the department
- Substantial cuts to Medicaid, mental health, aging and disability services

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## State Profile Tool Grant – Next Steps

- Participate in the development of national balancing indicators
- Share results, get the message out, create a buzz
- Conduct activities necessary to achieve Michigan-specific goals
- Keep stakeholders engaged in the process.





# **MI Choice Waiver Update**

**Long-Term Care  
Supports and Services Commission  
November 23, 2009**

**Elizabeth Gallagher, Waiver Program Manager  
Home and Community-Based Services Section  
Michigan Department of Community Health**

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## **2009-2010 Initiatives**

- **SCORE replaces administrative reimbursement**
- **MI Choice in licensed settings**
- **Nursing facility transitions and diversions**
- **MI Choice and Quality**

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## Support Coordination and Operations Reimbursement

Purpose:

- Separate supports coordination funding and make it sensitive to:
  - Participant acuity
  - Quality assurance measures
  - Nursing facility transition outcomes
  - Service mix
- Remove counter-productive incentives
- Provide specific funding for operating the MI Choice program

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## SCORE

- Administration no longer dependent upon participant days
  - Removes incentive to maximize participant days and minimize amount of services
  - Creates incentives to increase quality
  - Create incentives to increase service mix
  - Creates incentives to enroll NFTs
- Operations funding based upon amount of MI Choice services claims

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## MI Choice in Licensed Settings

### Service definition:

Residential services include enhanced assistance with activities of daily living and supportive services. MI Choice participants who receive this service must reside in licensed homelike, non-institutional settings. These settings include continuous on-site response capability to meet scheduled or unpredictable resident needs and provide supervision, safety, and security. Third parties may only furnish this service with the approval of the participant, licensee, and waiver agent. Payment excludes room and board, items of comfort or convenience, and costs of facility maintenance, upkeep, and improvement.

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## Other MI Choice services available to participants in licensed settings:

- Non-Medical Transportation
- Adult Day Health
- Counseling
- Specialized DME and supplies
- NFT
- Private Duty Nursing
- Training
- Fiscal Intermediary
- Goods and Services

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## Likely candidates for MI Choice in licensed settings:

- Nursing facility residents who want to return to community living and whose needs can best be met in a group living arrangement.
- Current AFC or HFA residents whose needs have increased beyond the home's capacity support them.
- Current MI Choice participants residing in a home or apartment who could benefit from the additional services offered in a licensed setting.

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## Imminent Risk Assessment

- Tightened policy regarding how to qualify as a diversion participant
- Based on algorithm developed by interRAI research
- Qualified applicants are moved up on the waiting list – between NFTs and community referrals (same category as APS referrals)

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## Residential Services Implementation Strategies

### Nursing Facility Outreach and Training

- Meet with NF staff to explain this option
- Meet with NF residents and families to inform them of MI Choice options
- Individual planning with NF residents (and their family members) interested in transitioning
- Facilitate NF transitions

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## Residential Services Implementation Strategies, cont.

### AFC/HFA Provider Development

- Meet with local DHS staff to inform them of this option available through MI Choice and their roles
  - Adult Services Staff
  - Eligibility Staff
- Research AFC/HFA homes in service area
- Meet with AFC/HFA home staff/management
- Enroll AFC/HFA as MI Choice providers
- Conduct Webinars with MALA to inform providers across the state of this option

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## Nursing Facility Transitions

	MI Choice	Other Community	Totals
FY 2005	37	5	42
FY 2006	221	60	281
FY 2007	337	115	452
FY 2008	408	190	598
FY 2009	642	228	870
FY 2010 to date	98	25	123

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## Issues for FY 2010

- Continue the state's commitment to wait list reduction through an increase in the 2011 budget
- Conduct sufficient outreach and transition services to meet the legislative target for savings
- Improve access by Native American Tribal members

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## MI Choice and Quality

- Hired 5 RNs and one SW for Clinical Reviews
  - All have years of hands-on experience with MI Choice
  - Preliminary data suggests much better reviews
- Conducting Administrative Reviews
  - HCBS Section staff participate
  - Will complete all Waiver Agents by 7/2010
  - Quality piece of SCORE will include Administrative reviews for FY 2011
- Working with CMS to better define our Quality Improvement Strategy for MI Choice.

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## Contact Information

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# Instructions for Completing the Imminent Risk Assessment Tool

## 1. Purpose and Background

The purpose of this assessment is to determine if an applicant would qualify for nursing facility diversion priority status on the MI Choice waiting list. An applicant is eligible for diversion status if they are living in the community or are being released from an acute care setting and are found to be at imminent risk of nursing facility admission using this assessment.

The supports coordinator must complete this instrument in person for applicants seeking MI Choice program enrollment who indicate that without MI Choice services, they will be admitted to a nursing facility in the very near future. **Once completed, the supports coordinator must forward the Imminent Risk Assessment (IRA) form with a completed Nursing Facility Transition Exception Request form to MDCH, HCBS Section, 400 S. Pine Street, Lansing MI 48909-7979 for final approval and authorization.** The supports coordinator must include an explanation of the reason the diversion is being requested in the Nursing Facility Transition Exception Request form.

MDCH expects that the supports coordinators will complete the interRAI for Home Care (iHC) assessment instrument at the same time the IRA tool is completed. If this is not possible, and the applicant scores an 8 on the IRA, the waiver agent should schedule and complete a full iHC within 7 days of completing the IRA. All approved diversion request forms are subject to retrospective reviews. The retrospective reviews will include an examination of the IRA tool and the corresponding MI Choice assessment.

The scoring for some items on the assessment differs depending upon the type of residence in which the participant currently lives. The basis for the difference in scoring is that licensing rules require licensed Adult Foster Care (AFC) homes and Homes for the Aged (HFA) to minimally provide basic personal care and supervision to all residents of their facilities. Therefore, persons in these settings who only require minimal assistance for activities of daily living (ADLs) are not at risk of nursing facility admission. Additionally, some questions on the IRA are not applicable to persons residing in licensed settings.

## 2. Fields on the Tool and Instructions For Completion

### **Agency Information Section:**

<b>Field</b>	<b>Instructions for Completion</b>
<b>Waiver Agent</b>	Fill in the waiver agency that you represent.
<b>Supports Coordinator</b>	Provide your name and contact information.
<b>Date</b>	Indicate the date that the Imminent Risk Assessment was completed.

### **Applicant Information Section:**

<b>Field</b>	<b>Instructions for Completion</b>
<b>Name (Last, First)</b>	Provide the applicant's name in the format specified.
<b>Type of Residence</b>	Check "Private" if the participant lives in a home, apartment, or unlicensed assisted living. Check "Licensed AFC/HFA" if the participant lives in a licensed setting. If the participant is currently in an acute care setting (i.e. hospital) check the type of residence the participant lived at just prior to the acute setting admission.
<b>Date of Birth</b>	Provide the applicant's date of birth.
<b>Social Security #</b>	Provide the applicant's social security number
<b>Medicaid ID#</b>	Provide the applicant's Medicaid identification number, if known.

## Instructions for Completing the Imminent Risk Assessment Tool

### Imminent Risk Assessment Section:

Item/Field	iHC item	Instructions
1.a. In the last three days, has the person required ANY help (including set-up or supervision more than two times in that period) to bathe, shower, or take a sponge bath?	<b>Section P:</b> Functional Status, ADL Self-Performance, Bathing	<b>Coding:</b> Consider all episodes over 3-day period. <ul style="list-style-type: none"> <li>■ Code “No” if the participant always performed this activity independently, or required setup help or supervision only once in the last three days.</li> <li>■ Code “Yes” if the participant required setup help or supervision at least two times, or additional assistance at any time in the last three days.</li> <li>■ Code “Activity did not occur” if the person did not bathe at all in the last three days.</li> </ul>
1.b. What kind of bathing help was provided?	<b>Section P:</b> Functional Status, ADL Self-Performance, Bathing	<b>Coding:</b> Consider all episodes over 3-day period. If <b>all</b> episodes are performed at the same level, score ADL at that level. If <b>any</b> episodes at level 6, and others less dependent, score ADL as a 5. Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2 - 5. <p><b>0 = Independent</b> - no physical assistance, setup, or supervision in any episode</p> <p><b>1 = Independent setup help only</b> - article or device provided or placed within reach, no physical assistance or supervision in any episode</p> <p><b>2 = Supervision</b> - oversight/cuing</p> <p><b>3 = Limited assistance</b> - guided maneuvering of limbs, physical guidance without taking weight</p> <p><b>4 = Extensive assistance</b> - weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks</p> <p><b>5 = Maximal assistance</b> - weight-bearing support (including lifting limbs) by 2+ helpers -OR- weight-bearing support for more than 50% of subtasks</p> <p><b>6 = Total dependence</b> - full performance by others during all episodes</p> <p><b>8 = Activity did not occur during entire period</b></p> <ul style="list-style-type: none"> <li>■ Code “No help” if all episodes are performed at level 0.</li> <li>■ Code “Set-up help” if most dependent episodes are performed at level 1.</li> <li>■ Code “Supervision” if most dependent episodes are performed at level 2.</li> <li>■ Code “Physical assistance more than three times” if most dependent episodes are performed levels 3, 4, 5, or 6.</li> <li>■ Code “Bathing did not occur” if answer is 8.</li> </ul>
<b>SCORING Item 1</b>	<b>Not Applicable</b>	For persons residing in <b>private home/apartment</b> score one (1) point if answer to 1.a. is “ <b>yes</b> ” or “ <b>activity did not occur.</b> ” <p>For persons residing in a <b>licensed setting (AFC/HFA)</b>, score one (1) point if answer to 1.b. is “<b>physical assistance more than three times</b>” or “<b>activity did not occur.</b>”</p> <p>Otherwise, score zero (0).</p>

## Instructions for Completing the Imminent Risk Assessment Tool

Item/Field	iHC item	Instructions
2.a. In the last three days, has the person required ANY help (including set-up or supervision more than two times in that period) to dress themselves (including laying out of clothes, putting them on, and taking them off)?	<b>Section P:</b> Functional Status, ADL Self-Performance, Dressing lower body and Dressing upper body	Consider all episodes over 3-day period. <ul style="list-style-type: none"> <li>■ Code “No” if the participant always performed this activity independently, or required setup help or supervision only once in the last three days.</li> <li>■ Code “Yes” if the participant required setup help or supervision at least two times, or additional assistance at any time in the last three days.</li> <li>■ Code “Activity did not occur” if the person did not dress at all in the last three days.</li> </ul>
2.b. What kind of dressing help was provided?	<b>Section P:</b> Functional Status, ADL Self-Performance, Dressing lower body and Dressing upper body	Consider all episodes over 3-day period. If <b>all</b> episodes are performed at the same level, score ADL at that level. If <b>any</b> episodes at level 6, and others less dependent, score ADL as a 5. Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2 - 5. <p><b>0 = Independent</b> - no physical assistance, setup, or supervision in any episode</p> <p><b>1 = Independent setup help only</b> - article or device provided or placed within reach, no physical assistance or supervision in any episode</p> <p><b>2 = Supervision</b> - oversight/cuing</p> <p><b>3 = Limited assistance</b> - guided maneuvering of limbs, physical guidance without taking weight</p> <p><b>4 = Extensive assistance</b> - weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks</p> <p><b>5 = Maximal assistance</b> - weight-bearing support (including lifting limbs) by 2+ helpers -OR- weight-bearing support for more than 50% of subtasks</p> <p><b>6 = Total dependence</b> - full performance by others during all episodes</p> <p><b>8 = Activity did not occur during entire period</b></p> <ul style="list-style-type: none"> <li>■ Code “No help” if all episodes are performed at level 0.</li> <li>■ Code “Set-up help” if most dependent episodes are performed at level 1.</li> <li>■ Code “Supervision” if most dependent episodes are performed at level 2.</li> <li>■ Code “Physical assistance more than three times” if most dependent episodes are performed levels 3, 4, 5, or 6.</li> <li>■ Code “Dressing did not occur” if answer is 8.</li> </ul>
<b>SCORING Item 2</b>	<b>Not Applicable</b>	For persons residing in <b>private home/apartment</b> score one (1) point if answer to 2.a. is “ <b>yes</b> ” or “ <b>activity did not occur.</b> ”  For persons residing in a <b>licensed setting (AFC/HFA)</b> , score one (1) point if answer to 2.b. is “ <b>physical assistance more than three times</b> ” or “ <b>activity did not occur.</b> ”  Otherwise, score zero (0).

## Instructions for Completing the Imminent Risk Assessment Tool

Item/Field	iHC item	Instructions
<p><b>3.a.</b> In the last three days, has the person required ANY help (including set-up or supervision more than two times in that period) to move in bed, including turning side to side and moving to and from a laying position?</p>	<p><b>Section P:</b> Functional Status, ADL Self-Performance, Bed Mobility</p>	<p>Consider all episodes over 3-day period.</p> <ul style="list-style-type: none"> <li>■ Code “No” if the participant always performed this activity independently, or required setup help or supervision only once in the last three days.</li> <li>■ Code “Yes” if the participant required setup help or supervision at least two times, or additional assistance at any time in the last three days.</li> <li>■ Code “Activity did not occur” if the person did not move in bed at all in the last three days.</li> </ul>
<p><b>3.b.</b> What kind of help was provided to move in bed?</p>	<p><b>Section P:</b> Functional Status, ADL Self-Performance, Bed Mobility</p>	<p>Consider all episodes over 3-day period. If <b>all</b> episodes are performed at the same level, score ADL at that level. If <b>any</b> episodes at level 6, and others less dependent, score ADL as a 5. Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2 - 5.</p> <p><b>0 = Independent</b> - no physical assistance, setup, or supervision in any episode  <b>1 = Independent setup help only</b> - article or device provided or placed within reach, no physical assistance or supervision in any episode  <b>2 = Supervision</b> - oversight/cuing  <b>3 = Limited assistance</b> - guided maneuvering of limbs, physical guidance without taking weight  <b>4 = Extensive assistance</b> - weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks  <b>5 = Maximal assistance</b> - weight-bearing support (including lifting limbs) by 2+ helpers -OR- weight-bearing support for more than 50% of subtasks  <b>6 = Total dependence</b> - full performance by others during all episodes  <b>8 = Activity did not occur during entire period</b></p> <ul style="list-style-type: none"> <li>■ Code “No help” if all episodes are performed at level 0.</li> <li>■ Code “Set-up help” if most dependent episodes are performed at level 1.</li> <li>■ Code “Supervision” if most dependent episodes are performed at level 2.</li> <li>■ Code “Physical assistance more than three times” if most dependent episodes are performed levels 3, 4, 5, or 6.</li> <li>■ Code “Activity did not occur” if answer is 8.</li> </ul>
<p><b>SCORING Item 3</b></p>	<p><b>Not Applicable</b></p>	<p>For persons residing in <b>private home/apartment</b> score one (1) point if answer to 3.a. is “<b>yes</b>” or “<b>activity did not occur.</b>”</p> <p>For persons residing in a <b>licensed setting (AFC/HFA)</b>, score one (1) point if answer to 3.b. is “<b>physical assistance more than three times</b>” or “<b>activity did not occur.</b>”</p> <p>Otherwise, score zero (0).</p>

## Instructions for Completing the Imminent Risk Assessment Tool

Item/Field	iHC item	Instructions
4. In the last three days, what assistive devices has the person used to move around indoors?	<b>Section P:</b> Locomotion/ Walking, Primary Mode of Locomotion	<p><b>Intent:</b> To record the primary mode of locomotion and type of appliances, aids or assistive devices the person used over the last 3 days.</p> <p><b>Definitions:</b>  <b>Cane</b> — A slender stick held in the hand and used for support when walking.  <b>Crutch</b> — A device for aiding a person with walking. Usually it is a long staff with a padded crescent-shaped portion at the top that is placed under the armpit.  <b> Scooter</b> — Motorized vehicle operated by a person for use in getting from one location to another.  <b>Walker</b> — A mobile device used to assist a person with walking. Usually consists of a stable platform made of metal tubing that the person grasps while taking a step. The person then moves the walker forward and makes another step.</p> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code for the primary mode of locomotion used by the person indoors within the last 3 days.</li> <li>■ Code “Cane, walker, scooter” for persons who walk by pushing a wheelchair in front of them for support, or if they use a Meri-Walker device as a walker-type device.</li> </ul>
<b>SCORING Item 4</b>	<b>Not Applicable</b>	Score one (1) point if answer is “ <b>wheelchair</b> ” or “ <b>activity did not occur,</b> ” regardless of type of residence. Otherwise, score zero (0).
5. In the last three days, has the person been left alone in the mornings or afternoons?	<b>Section B:</b> Social Functioning, Length of Time Alone During the Day (morning and afternoon)	<p><b>Intent:</b> To identify the actual amount of time the person is alone.</p> <p><b>Definition:</b>  <b>Length of time alone during the day (morning and afternoon)</b>  -- The amount of time the person is literally alone without any other person in the home. If the person is residing in a board and care facility, congregate housing, or other situation where there are other persons in their own rooms, count the amount of time the person spends alone in his or her room by him/herself as time alone.</p> <p><b>Process:</b> First ask the person how much time he or she spends “alone”. Be clear about what is defined as “being alone”. Confirm with caregivers the amount of time the person spends “alone”.</p> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code for the most appropriate category.</li> </ul>
<b>SCORING Item 5</b>	<b>Not Applicable</b>	Score one (1) point if answer is “ <b>no – person is never or hardly ever left alone,</b> ” regardless of type of residence. Otherwise, score zero (0).

## Instructions for Completing the Imminent Risk Assessment Tool

Item/Field	iHC item	Instructions
6. In the last three days, has the person experienced a flare up of a recurrent or chronic health problem?	<b>Section J:</b> Health Conditions and Preventative Health Measures, Instability of Conditions, second item	<p><b>Definition:</b> The person is symptomatic for an acute health condition (e.g., new myocardial infarction; adverse drug reaction; influenza) or recurrent acute condition such as aspiration pneumonia or a urinary tract infection. This item also includes those people who are experiencing an exacerbation or flare-up of a chronic condition (e.g., new onset shortness of breath in someone with a history of asthma; increased pedal edema in a person with congestive heart failure). This type of acute episode is usually of sudden onset, has a time-limited course, and requires evaluation by a physician.</p> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code “No” if person has not experienced a flare up of a recurrent or chronic health problem.</li> <li>■ Code “Yes” if the person has experienced a flare up of a recurrent or chronic health problem.</li> </ul>
<b>SCORING Item 6</b>	<b>Not Applicable</b>	Score one (1) point if answer is “ <b>yes</b> ,” regardless of type of residence. Otherwise, score zero (0).
7. In the last seven days, has the person received prevention/care of a wound or skin ulcer, such as dietary treatments, moving/turning treatments, or use of pressure relieving devices?	<b>Section Q:</b> Service Utilization, Treatments: Wound Care and/or Programs: Turning/repositioning program	<p><b>Intent:</b> To review prescribed treatments. This item includes special treatment, therapies and programs for the prevention or care of a wound or skin ulcer received or scheduled during the last 7 days, either in the home or on an outpatient basis.</p> <p><b>Definitions:</b> <b>Wound care</b> — Includes the application of bandages (e.g. dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles); wound irrigation; application of ointments and topical medications to treat skin conditions (e.g. cortisone, antifungal preparations, chemotherapeutic agents, etc); debridement (chemical or surgical) to remove dirt or dead tissue from a wound; suture removal.</p> <p><b>Turning/repositioning program</b> — The person is periodically turned from side to side and onto his or her back while in bed. Once the person has been turned to the new side, staff ensures that the head, torso and limbs are positioned to minimize pain, promote function, and minimize pressure on bony prominences.</p> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code “No” if person has not received treatments or programs for the prevention or care of a wound or skin ulcer.</li> <li>■ Code “Yes” if the person has received treatments or programs for the prevention or care of a wound or skin ulcer.</li> </ul>
<b>SCORING Item 7</b>	<b>Not Applicable</b>	Score one (1) point if answer is “ <b>yes</b> ,” regardless of type of residence. Otherwise, score zero (0).

## Instructions for Completing the Imminent Risk Assessment Tool

Item/Field	iHC item	Instructions
8. In the last seven days, has the person received or been scheduled for treatment with peripheral intravenous medication?	<b>Section Q:</b> Service Utilization, Treatments: IV Medication	<p><b>Intent:</b> To review prescribed treatments. This item includes peripheral intravenous medication treatments received or scheduled during the last 7 days, either in the home or on an outpatient basis.</p> <p><b>Definition:</b> <b>IV medication</b> — Includes any drug or biological (e.g. contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication.</p> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code “No” if person has not received peripheral intravenous medication treatments in the last seven days.</li> <li>■ Code “Yes” if the person has received peripheral intravenous medication treatments in the last seven days.</li> </ul>
<b>SCORING Item 8</b>	<b>Not Applicable</b>	Score one (1) point if answer is “ <b>yes</b> ,” regardless of type of residence. Otherwise, score zero (0).
9. In the last three days, how well did the person make decisions about organizing the day (e.g., when to get up or have meals, what clothes to wear, what to do)?	<b>Section E:</b> Cognitive Patterns, Cognitive Skills for Daily Decision Making	<p><b>Intent:</b> To record the person's actual performance in making everyday decisions about the tasks or activities of daily living (e.g., when to get up or have meals, which clothes to wear, or activities to do.)</p> <p><b>Definitions:</b>  <b>Independent</b> - decisions consistent, reasonable, safe  <b>Modified independence</b> - some difficulty in new situations only  <b>Minimally impaired</b> - in specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times  <b>Moderately impaired</b> - decisions consistently poor or unsafe; cues/supervision required at all times  <b>Severely impaired</b> - never/rarely made decisions  <b>No discernible consciousness</b> - coma</p> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code “Person made decisions that were consistently reliable without difficulty” if independent.</li> <li>■ Code “Person made decisions, even if he/she had difficulty, or decisions were poor and required supervision” if modified independence, minimally impaired, or moderately impaired.</li> <li>■ Code “Persons rarely or never made decisions” if severely impaired or no discernible consciousness.</li> </ul>
<b>SCORING Item 9</b>	<b>Not Applicable</b>	Score one (1) point if answer is “ <b>person rarely or never made decisions</b> ,” regardless of type of residence. Otherwise, score zero (0).

## Instructions for Completing the Imminent Risk Assessment Tool

Item/Field	iHC item	Instructions
10. In the past 90 days, has the person become agitated or disoriented such that the person's safety was endangered?	<b>Not Applicable</b> (was in MDS-HC under Indicators of Delirium)	<p><b>Intent:</b> To record changes in behavior in the past 90 days such that the person's safety is endangered. Consult the participant, family members, medical professionals, formal caregivers, and others familiar with the person. Ask them to think about the person's behavior over the past 90 days.</p> <p><b>Definitions:</b> <b>Agitated:</b> marked by restlessness and increased activity intermingled with anxiety, fear, and tension</p> <p><b>Disoriented:</b> the loss of proper bearings, or a state of mental confusion as to time, place, or identity.</p> <p><b>Coding:</b> Based on interaction with and observation of the person, code based on what you see or is reported to you, regardless of what you believe the cause to be.</p> <ul style="list-style-type: none"> <li>■ Code "No" if the person has not become agitated or disoriented to the point that the persons' safety was endangered over the last 90 days.</li> <li>■ Code "Yes" if the person has become agitated or disoriented to the point that the persons' safety was endangered over the last 90 days.</li> </ul>
<b>SCORING Item 10</b>	<b>Not Applicable</b>	Score one (1) point if answer is "yes," regardless of type of residence. Otherwise, score zero (0).
11. In the last three days, how well has the person been able to make him/herself understood?	<b>Section F:</b> Communication/ Hearing	<p><b>Intent:</b> To document the person's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or key board).</p> <p><b>Definitions:</b></p> <ol style="list-style-type: none"> <li><b>0. Understood</b> — The person expresses ideas clearly without difficulty.</li> <li><b>1. Usually Understood</b> — The person has difficulty finding the right words or finishing thoughts (resulting in delayed responses), BUT if given time, little or no prompting is required.</li> <li><b>2. Often Understood</b> — The person has difficulty finding words or finishing thoughts, AND prompting is usually required.</li> <li><b>3. Sometimes Understood</b> — The person has limited ability, but is able to express <b>concrete</b> requests regarding at least basic needs (e.g., food, drink, sleep, toilet).</li> <li><b>4. Rarely or Never Understood</b> — At best, understanding is limited to interpretation of highly individual, person-specific sounds or body language (e.g., caregiver has learned to interpret person signaling the presence of pain or need to toilet).</li> </ol> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code "Person is understood even if he/she has difficulty in finding words or finishing thoughts" if defined as 0, 1, or 2.</li> <li>■ Code "Person is limited to making concrete requests or is rarely or never understood" if defined as 3 or 4.</li> </ul>

## Instructions for Completing the Imminent Risk Assessment Tool

Item/Field	iHC item	Instructions
<b>SCORING Item 11</b>	<b>Not Applicable</b>	Score one (1) point if answer is “ <b>person is limited to making concrete requests or is rarely or never understood.</b> ” regardless of type of residence. Otherwise, score zero (0).
<b>12.</b> In the last three days, has the person threatened, cursed at, or screamed at others?	<b>Section G:</b> Mood and Behavior Patterns, Behavior Symptoms, Verbal Abuse	<p><b>Intent:</b> To identify the frequency of verbal abuse symptoms during the last three days that cause distress to the person, or are distressing or disruptive to others with whom the person lives. Such behaviors include those that are potentially harmful to the person or disruptive to others. This item is designed to pick up verbal abuse exhibited by the person that may be considered “combative or agitated” by some health professionals.</p> <p><b>Definition:</b> <b>Verbal abuse</b> — e.g., others were threatened, screamed at, or cursed at.</p> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code “<b>No</b>” if the person has not threatened, cursed at, or screamed at others in the last three days.</li> <li>■ Code “<b>Yes</b>” if the person has threatened, cursed at, or screamed at others in the last three days.</li> </ul>
<b>SCORING Item 12</b>	<b>Not Applicable</b>	Score one (1) point if answer is “ <b>yes</b> ,” regardless of type of residence. Otherwise, score zero (0).
<b>13.</b> In the last 90 days, has the person moved in with others, or have others moved in with the person?	<b>Section D:</b> Environmental Assessment, Living Arrangement	<p><b>Intent:</b> To record the duration of the current living arrangement.</p> <p><b>Coding:</b> A person who used to live with someone 90 days ago (e.g., a spouse who has since died) and now lives alone should be coded “yes” since their living situation has changed.</p> <ul style="list-style-type: none"> <li>■ Code “<b>No</b>” if the person’s living arrangement has not changed in the last 90 days.</li> <li>■ Code “<b>Yes</b>” if the person’s living arrangement has changed in the last 90 days.</li> </ul>
<b>SCORING Item 13</b>	<b>Not Applicable</b>	For persons residing in <b>private home/apartment</b> score two (2) points if answer is “ <b>yes</b> .” Otherwise, score zero (0).
<b>14.</b> In the last 14 days, has this person permanently lost an essential caregiver who provided necessary care (e.g., death of a spouse, child moved away, serious and permanent health decline of informal supports)?	<b>Not Applicable</b>	<p><b>Intent:</b> To record the whether the person has lost an essential caregiver in the last 14 days.</p> <p><b>Coding:</b></p> <ul style="list-style-type: none"> <li>■ Code “<b>No</b>” if the person has not lost an essential caregiver in the last 14 days.</li> <li>■ Code “<b>Yes</b>” if the person has lost an essential caregiver in the last 14 days.</li> </ul>
<b>SCORING Item 14</b>	<b>Not Applicable</b>	For persons residing in <b>private home/apartment</b> score one (1) point if answer is “ <b>yes</b> .” Otherwise, score zero (0).
<b>Total Score</b>	<b>Not Applicable</b>	Add the scores from items 1 through 14 to obtain the total score for the Imminent Risk Assessment.

## Instructions for Completing the Imminent Risk Assessment Tool

### **3. Determining if the Person Meets the Imminent Risk Assessment Criteria**

Persons with a total score of eight (8) or more may qualify for diversion status. Supports Coordinators should forward completed Imminent Risk Assessments with a score of 8 or more **AND** a completed Nursing Facility Transition Exception Request form to MDCH at the address indicated above for final approval. The Nursing Facility Transition Exception Request form must include a detailed explanation of why the Supports Coordinator is requesting diversion status for each applicant. MDCH will notify the waiver agent if the person qualifies for diversion status. Persons deemed eligible for diversion status can be moved to the third category (**Current Adult Protective Services (APS) Clients and Diversion Applicants**) on the MI Choice waiting list.

### **4. Where to Send Completed IRA and Nursing Facility Transition Exception Request Forms**

Mail to: MDCH, MSA, Home and Community Based Services Section  
400 S. Pine Street, 7<sup>th</sup> Floor  
P.O. Box 30479  
Lansing, MI 48909-7979

Facsimile: (517) 241-7816

### **5. Questions**

Please direct any questions related to this document to either Ellen Speckman-Randall ([SpeckmanE@michigan.gov](mailto:SpeckmanE@michigan.gov) or 517.373.9532) or Elizabeth Gallagher ([GallagherE@michigan.gov](mailto:GallagherE@michigan.gov) or 517.335.5068).

## Imminent Risk of Nursing Facility Placement Assessment

The purpose of this assessment is to determine if an applicant would qualify for nursing facility diversion priority status on the MI Choice waiting list. An applicant is eligible for diversion status if they are living in the community or are being released from an acute care setting and are found to be at imminent risk of nursing facility admission using this assessment.

The supports coordinator must complete this instrument in person for applicants seeking MI Choice program enrollment who indicate that without MI Choice services, they will be admitted to a nursing facility in the very near future. **Once completed, the supports coordinator must forward the form with a completed Nursing Facility Transition Exception Request form to MDCH, HCBS Section, 400 S. Pine Street, Lansing MI 48909-7979 for final approval and authorization.**

Agency Information	
<b>Waiver Agent:</b>	
<b>Supports Coordinator:</b>	
<b>Date:</b>	

Applicant Information	
<b>Name (Last, First):</b>	
<b>Type of Residence (check one)</b>	<input type="checkbox"/> Private home/apartment (includes unlicensed assisted living) <input type="checkbox"/> Licensed AFC/HFA
<b>Date of Birth:</b>	
<b>Social Security #:</b>	
<b>Medicaid ID #</b>	

Imminent Risk Assessment
<p>Supports coordinators should answer the questions based on all information available at the time of the assessment. This includes observations, answers to questions obtained from the applicant or other knowledgeable individuals, and medical records. Supports coordinators may ask probing questions when necessary to determine the most appropriate answer. More detailed instructions for completion of each item are available.</p>

Item	Answer (check one)	Score
<b>1. Bathing</b>		
1.a. In the last three days, has the person required ANY help (including set-up or supervision more than two times in that period) to bathe, shower, or take a sponge bath?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Activity did not occur	
1.b. What kind of bathing help was provided?	<input type="checkbox"/> No help <input type="checkbox"/> Set-up help <input type="checkbox"/> Supervision <input type="checkbox"/> Physical assistance more than three times <input type="checkbox"/> Bathing did not occur	
<p><b>SCORING for Item #1:</b></p> <p>➤ For persons residing in <b>private home/apartment</b> score one (1) point if answer to 1.a. is “<b>yes</b>” or “<b>activity did not occur.</b>”</p> <p>➤ For persons residing in a <b>licensed setting (AFC/HFA)</b>, score one (1) point if answer to 1.b. is “<b>physical assistance more than three times</b>” or “<b>activity did not occur.</b>”</p> <p>➤ Otherwise, score zero (0).</p>		

## Imminent Risk of Nursing Facility Placement Assessment

<b>Date</b>	<b>Applicant Name</b>	<b>MA ID #</b>

Item	Answer (check one)	Score
<b>2. Dressing</b>		
2.a. In the last three days, has the person required ANY help (including set-up or supervision more than two times in that period) to dress themselves (including laying out of clothes, putting them on, and taking them off)?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Activity did not occur	
2.b. What kind of dressing help was provided?	<input type="checkbox"/> No help <input type="checkbox"/> Set-up help <input type="checkbox"/> Supervision <input type="checkbox"/> Physical assistance more than three times <input type="checkbox"/> Dressing did not occur	
<b>SCORING for Item #2:</b> ➤ For persons residing in <b>private home/apartment</b> score one (1) point if answer to 2.a. is <b>“yes”</b> or <b>“activity did not occur.”</b>  ➤ For persons residing in a <b>licensed setting (AFC/HFA)</b> , score one (1) point if answer to 2.b. is <b>“physical assistance more than three times”</b> or <b>“activity did not occur.”</b>  ➤ Otherwise, score zero (0).		
<b>3. Moving in Bed</b>		
3.a. In the last three days, has the person required ANY help (including set-up or supervision more than two times in that period) to move in bed, including turning side to side and moving to and from a laying position?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Activity did not occur	
3.b. What kind of help was provided to move in bed?	<input type="checkbox"/> No help <input type="checkbox"/> Set-up help <input type="checkbox"/> Supervision <input type="checkbox"/> Physical assistance more than three times <input type="checkbox"/> Activity did not occur	
<b>SCORING for Item #3:</b> ➤ For persons residing in <b>private home/apartment</b> score one (1) point if answer to 3.a. is <b>“yes”</b> or <b>“activity did not occur.”</b>  ➤ For persons residing in a <b>licensed setting (AFC/HFA)</b> , score one (1) point if answer to 3.b. is <b>“physical assistance more than three times”</b> or <b>“activity did not occur.”</b>  ➤ Otherwise, score zero (0).		
4. In the last three days, what assistive devices has the person used to move around indoors?	<input type="checkbox"/> No assistive devices <input type="checkbox"/> Cane, walker, scooter <input type="checkbox"/> Wheelchair <input type="checkbox"/> Activity did not occur	
<b>SCORING for Item #4:</b> ➤ Score one (1) point if answer is <b>“wheelchair”</b> or <b>“activity did not occur,”</b> regardless of type of residence.  ➤ Otherwise, score zero (0).		

## Imminent Risk of Nursing Facility Placement Assessment

<b>Date</b>	<b>Applicant Name</b>	<b>MA ID #</b>

Item	Answer (check one)	Score
<b>5. In the last three days, has the person been left alone in the mornings or afternoons?</b>	<input type="checkbox"/> No – person is never or hardly ever left alone <input type="checkbox"/> Yes – person is left alone, even if only for about an hour	
<b>SCORING for Item #5:</b> ➔ Score one (1) point if answer is “no – person is never or hardly ever left alone,” regardless of type of residence. ➔ Otherwise, score zero (0).		
<b>6. In the last three days, has the person experienced a flare up of a recurrent or chronic health problem?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>SCORING for Item #6:</b> ➔ Score one (1) point if answer is “yes,” regardless of type of residence. ➔ Otherwise, score zero (0).		
<b>7. In the last seven days, has the person received prevention/care of a wound or skin ulcer, such as dietary treatments, moving/turning treatments, or use of pressure relieving devices?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>SCORING for Item #7:</b> ➔ Score one (1) point if answer is “yes,” regardless of type of residence. ➔ Otherwise, score zero (0).		
<b>8. In the last seven days, has the person received or been scheduled for treatment with peripheral intravenous medication?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>SCORING for Item #8:</b> ➔ Score one (1) point if answer is “yes,” regardless of type of residence. ➔ Otherwise, score zero (0).		
<b>9. In the last three days, how well did the person make decisions about organizing the day (e.g., when to get up or have meals, what clothes to wear, what to do)?</b>	<input type="checkbox"/> Person made decisions that were consistently reliable without difficulty <input type="checkbox"/> Person made decisions, even if he/she had difficulty, or decisions were poor and required supervision. <input type="checkbox"/> Person rarely or never made decisions.	
<b>SCORING for Item #9:</b> ➔ Score one (1) point if answer is “person rarely or never made decisions,” regardless of type of residence. ➔ Otherwise, score zero (0).		
<b>10. In the past 90 days, has the person become agitated or disoriented such that the person’s safety was endangered?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>SCORING for Item #10:</b> ➔ Score one (1) point if answer is “yes,” regardless of type of residence. ➔ Otherwise, score zero (0).		

## Imminent Risk of Nursing Facility Placement Assessment

<b>Date</b>	<b>Applicant Name</b>	<b>MA ID #</b>

Item	Answer (check one)	Score
<b>11. In the last three days, how well has the person been able to make him/herself understood?</b>	<input type="checkbox"/> Person is understood even if he/she has difficulty in finding words or finishing thoughts. <input type="checkbox"/> Person is limited to making concrete requests or is rarely or never understood.	
<b>SCORING for Item #11:</b> ➤ Score one (1) point if answer is <b>“person is limited to making concrete requests or is rarely or never understood,”</b> regardless of type of residence. ➤ Otherwise, score zero (0).		
<b>12. In the last three days, has the person threatened, cursed at, or screamed at others?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>SCORING for Item #12:</b> ➤ Score one (1) point if answer is <b>“yes,”</b> regardless of type of residence. ➤ Otherwise, score zero (0).		
<b>13. In the last 90 days, has the person moved in with others, or have others moved in with the person?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>SCORING for Item #13:</b> ➤ For persons residing in <b>private home/apartment</b> score two (2) points if answer is <b>“yes.”</b> ➤ Otherwise, score zero (0).		
<b>14. In the last 14 days, has this person permanently lost an essential caregiver who provided necessary care (e.g., death of a spouse, child moved away, serious and permanent health decline of informal supports)?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>SCORING for Item #14:</b> ➤ For persons residing in <b>private home/apartment</b> score one (1) point if answer is <b>“yes.”</b> ➤ Otherwise, score zero (0).		
<b>TOTAL SCORE (add scores from items 1 through 14):</b>		

Persons with a total score of eight (8) or more may qualify for diversion status. Supports Coordinators should forward completed Imminent Risk Assessments with a score of 8 or more **AND** a completed Nursing Facility Transition Exception Request form to MDCH at the address indicated above for final approval. The Nursing Facility Transition Exception Request form must include a detailed explanation of why the Supports Coordinator is requesting diversion status for each applicant.

**Michigan Long-Term Care Supports and Services  
Advisory Commission  
2010 Schedule of Meetings**

<b>DATE</b>	<b>TIME</b>	<b>PLACE</b>
January 25, 2010	10:00 a.m. to 3:30 p.m.	Capitol View Building 201 Townsend Street Lansing, MI 48913 1st Floor, Conference Rooms A-C
March 22, 2010	10:00 a.m. to 3:30 p.m.	Capitol View Building 201 Townsend Street Lansing, MI 48913 1st Floor, Conference Rooms A-C
May 24, 2010	10:00 a.m. to 3:30 p.m.	Capitol View Building 201 Townsend Street Lansing, MI 48913 1st Floor, Conference Rooms A-C
July 26, 2010	10:00 a.m. to 3:30 p.m.	Capitol View Building 201 Townsend Street Lansing, MI 48913 1st Floor, Conference Rooms A-C
September 27, 2010	10:00 a.m. to 3:30 p.m.	Capitol View Building 201 Townsend Street Lansing, MI 48913 1st Floor, Conference Rooms A-C
November 22, 2010	10:00 a.m. to 3:30 p.m.	Capitol View Building 201 Townsend Street Lansing, MI 48913 1st Floor, Conference Rooms A-C

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