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ACL 20-16

Date: October 23, 2020

To: Community-Based Adult Services (CBAS) Center Administrators and Program Directors

From: California Department of Aging (CDA) CBAS Branch

Subject: Frequently Asked Questions (FAQ) #6, CBAS Temporary Alternative Services (TAS)

Purpose

The purpose of this All Center Letter (ACL) is to notify CBAS providers that the Department of Aging (CDA) has released a Frequently Asked Questions (FAQ) document as a follow up to the CBAS Temporary Alternative Services (TAS) Updates training on September 24, 2020. The FAQ is attached.

Questions

Please contact the CBAS branch if you have any questions: (916) 419-7545; cbascda@aging.ca.gov.

Frequently Asked Questions - #6
Guidance for Community-Based Adult Services for Temporary Alternative Services (TAS)

Released – October 23, 2020

Introduction

These FAQs respond to specific questions raised by providers about CBAS TAS required services, staffing, and documentation, many of which have been addressed in All Center Letters (ACL) in 2020 and in CDA webinars. Additionally, CBAS certification standards that may not have been addressed in recent ACLs are addressed here to ensure that providers remain aware of responsibilities for meeting statutory, regulatory, and waiver requirements that continue to be applicable to CBAS TAS.

Many CBAS certification standards are still in place and continue to be relevant to TAS and CBAS provider responsibilities. Providers must continue to make good faith efforts to comply, even during this time of TAS flexibility.

Required Services

Q.1 If a Participant needs to have more physical or occupational therapy (PT/OT) services than what we can provide through telehealth, would it be appropriate to refer them to more intensive PT/OT services such as outpatient or Home Health?

A.1 Yes, just as you would during traditional CBAS, if a participant requires therapy services beyond what can be provided at the center or by the center staff, your multidisciplinary team would make the appropriate referrals and/or work to address participant needs. If a referral is made, the center would collaborate with the referral agency to coordinate care.

Q.2 Most of our participants were authorized for five days per week before TAS. Does this mean we are required to provide telehealth services to participants five days per week, or can we provide telehealth services twice a week and provide meal delivery services on the others days?

A.2 As with traditional CBAS, your multidisciplinary team is required to assess participant needs during TAS and deliver services as appropriate to meet those needs. Services should be adapted to the specific circumstances of the participants during this time that they are unable to attend congregate center services. ACL 20-07 specifies that

at least weekly CBAS TAS providers will conduct COVID-19 wellness checks and risk assessments in addition to other services assessed and scheduled as needed to meet the goals.

Q.3 Can you clarify if we need to be available after program hours as well?

A.3 TAS approved providers are required to be available by phone and email six hours each day, Monday through Friday. Providers choose those hours and specify them in their TAS Plans of Operation. There is no requirement for services outside of those six hours.

Staffing Requirements

Q.4 If our CBAS TAS Plan of Operation states that we are not providing physical therapy, occupational therapy, speech therapy, or registered dietician services, can we still admit new participants that need only nursing and social services? Can we admit participants that need PT if we don't offer PT under TAS?

A.4 It may be possible to admit new participants during TAS in circumstances when providers may be unable to staff at traditional CBAS multidisciplinary team member levels. However, providers should do so with caution. If a provider is temporarily approved to operate below traditional CBAS staffing levels, it is the provider's responsibility to ensure that TAS requirements are still met, including assessing and addressing participant needs. Per Question 1, if a center is not able to address the assessed needs, then the multidisciplinary team would make the appropriate referrals to ensure the participant's needs are met. Reference ACL 20-11 for details regarding new participant enrollment during TAS.

As a reminder, TAS temporary staffing requirements are specified in ACL 20-07. Approved TAS providers are allowed flexibility with staffing during this time of public health emergency. At a minimum, staffing levels must include: 1) a Program director; 2) Registered nurse(s); and 3) Social worker(s). Additional staff are required based on the number and needs of participants served and to carry out TAS tasks.

Q.5 During this time, what is the acceptable staffing ratio? For example, can a registered nurse cover more than 40 participants?

A.5 Traditional CBAS staffing ratios serve as a guide for considering appropriate staffing levels. But ultimately, providers must staff at a level required to address the number and needs of participants served and to deliver TAS required services.

Q.6 Should a center continue accepting new participants during this pandemic time and without increasing staff?

A.6 Providers should staff at levels required by ACL 20-07 and specified in their approved TAS Plan of Operation, which includes serving continuing CBAS participants and new TAS participants. Reference Question 4 above.

Q.7 Given that many centers have assigned participant contacts to a lead who does wellness checks, risk assessments, etc., is it a problem if a social worker is the lead and they ask for vital sign readings?

A.7 A social worker may gather information such as the vital sign readings. However, an assessment of the vital sign readings as they relate to the participant's condition is not within the social worker's qualifications.

Q.8 Language barriers are big issues when making phone calls. We are using staff such as the PT and RD who speak the participant's language. They report to the RNs and SWs as needed. Are we on the right track?

A.8 The staff member who speaks the participant's language may make phone calls, conduct assessments *within their scope of practice*, and share the outcome of those assessments with the MDT. To complete an assessment when the MDT member does not speak the language of the participant, the MDT member would need to conduct the assessment using an interpreter.

Documentation Requirements

Q.9 Can we complete IPC Box 13 for TAS?

A.9 Yes. Reference slide #26 from CDA's TAS training on September 24, 2020 for an example of how IPC Box 13 could be used during TAS.

Q.10 If we use Box 13 on the IPC, do we leave the pre-TAS IPC care plan in place and add the TAS care plan to show continuity in the IPC?

A.10 Yes. Be sure to leave pre-TAS Box 13 information intact for continuing participants. Reference slide #26 from CDA's TAS training on September 24, 2020 for an example of how IPC Box 13 could be used during TAS.

Q.11 Can we still use just IPC Boxes 15 and 16 or is it recommended to start using box 13? We have not been updating Boxes 13 and 14, only using 15 and 16.

A.11 Yes, providers may continue to use Box 15 and 16 in lieu of providing TAS care plans in Boxes 13 and 14. (Also refer to Question 24)

***Box 15**: Medi-Cal Manual instructions specify that Box 15 should include:*

- *Significant changes in participant's condition and/or care plan since last IPC*
- *Changes that may have or likely have a considerable influence or effect on the participant's quality or quantity of life*

***Box 16**: Medi-Cal Manual instructions specify that Box 16 should include:*

- *Critical history/information not included elsewhere in the IPC*
- *Information that is relevant to authorization*

In addition *to the Medi-Cal Manual instructions, the following TAS-relevant details shall be included in Boxes 15 and/or 16 at time of completion:*

- *Any changes to the participant's health status*
- *Any changes to the participant's living arrangements*
- *Significant needs that are identified by the CBAS team and services being provided during TAS*
- *Date that center-based services ended, and the date participant began receiving CBAS TAS*

Q.12 Are flowsheets required in TAS?

A.12 As with traditional CBAS, flowsheets are not required in TAS. Flowsheets are a method that many providers choose to use, including during TAS, to document services provided. The format providers choose to document services – either narrative notes or flowsheets – is entirely their choice. The requirements for documentation of services is that any service provided is documented, on the day the service was provided, including the date, type of service, outcome/result, and name/signature of person providing.

Q.13 Flowsheets are required for the RN and SW, correct? What about for the other departments, such as OT, PT, Activity?

A.13 Reference Question 12 above. Additionally, just as with traditional CBAS, any discipline providing services must document services on the day it was provided.

Q.14 Is it still required that the provider obtain an updated history and physical form every six months? Some participants have not been able to see their personal care physician (PCP) because they either closed or are only conducting telehealth. Some PCPs just put in an order to renew their meds monthly and have not scheduled to see the participant.

A.14 CDA addressed this issue in part in ACL 20-08, FAQ #3 as follows below. Additionally, providers are required to make good faith efforts to liaison with the participants' PCPs and obtain updated health information, but there is no six-month requirement for doing so at this time. ACL 20-8 FAQ #3 addressed the following:

Q. *What can we do if we cannot obtain a history and physical (H&P) from a participant's personal physician because they are not prioritizing physicals right now?*

A. *CDA recognizes that providers may not be able to obtain customary paperwork and complete regular CBAS processes at this time. We have been instructed to be flexible to ensure service delivery to and protection of our CBAS participants, who are the most at risk during this COVID-19 emergency. ACL 20-07 specifies that CBAS providers admitting and serving new participants at this time must conduct at least a telehealth assessment and develop a care plan. Providers should work with your contracting managed care plan(s) regarding how to proceed with authorization in such instances.*

Q.15 Do we need to obtain a physical signature on the Participation Agreement (CDA 7000) for new participants or when there are increased days scheduled due to their emerging needs?

A.15 No, a physical signature of the participant or caregiver on the CDA 7000 is not required at this time. ACL 20-11 specifies that providers may obtain verbal or electronic authorization for services from the participant/caregiver at this time and note it in the participant's health record.

Q.16 Does there need to be more than one quarterly progress note? For instance, one from the RN, one from the SW, etc.?

A.16 ACL 20-09 specifies two options for completing quarterly progress notes during TAS: 1) having each discipline that provides the services document quarterly progress; or 2) writing a single quarterly progress note that summarizes a participant's progress based on daily notes of services provided. The ACL specifies that providers choosing Option 2 may have the quarterly progress note completed by the individual team member most familiar with the services provided to the participant during this period, and the program director signs the note to certify the note's content.

Providers choosing to document quarterly progress under Option 2 must ensure that the single summary progress note is derived from the health record and reflects the participant's status and services provided. Therefore, any discipline (nurses, social workers, etc.) that provides services must ensure that assessment information regarding the participant's health status is documented in the health record so that no scope of practice issues occur when another staff member completes the summary.

Q.17 We're not clear whether the nurses and social workers must complete their traditional CBAS reassessment paperwork during TAS (every 6 months).

A.17 The six-month quarterly progress note forms the basis of the IPC update at the time of reauthorization. For providers choosing to document quarterly progress as described in ACL 20-09 under Option 1 (and addressed in Question 16 above), multidisciplinary team members providing services may use their traditional reassessment document or use a narrative format. However, the quarterly progress note must include, at a minimum: the participant's current status, progress achieved toward the most significant goals addressed through TAS, and whether the plan of care will be continued or revised.

Q.18 Under quarterly notes, if the social worker added relaxation sessions over the phone to help but no frequency is addressed, is that a problem?

A.18 Quarterly notes do not necessarily need to address frequency. Each identified need or problem that the center is addressing under TAS has a corresponding intervention and goal that is individualized, and person centered. The frequency of the intervention is determined by accepted standards of care and the MDT members estimation of how often it would be needed to meet the goal. This information is contained in the plan of care on the IPC.

Under quarterly notes, required documentation includes how the participant has responded to those interventions, and progressed toward the goal.

Q.19 I have been documenting the COVID screening on the progress note for nursing. Does the form also have to be filled out for each participant contact?

A.19 There is no specific form required for recording COVID screening. Documentation may be recorded in a variety of ways, including in progress notes.

Q.20 Do you have an example of the weekly wellness check risk assessment documentation? Are most nurses documenting their interaction in progress notes in Turbo Tar?

A.20 CAADS has developed a sample COVID-19 screening form for providers to use if they choose. Some providers are using this form or other forms they have developed, and some providers are documenting in their progress notes the standardized questions they have developed for their centers. How providers choose to document the weekly COVID-19 checks is their discretion.

Q.21 Please clarify the difference between the quarterly note and what goes into Box 15?

A.21 The quarterly progress note is an evaluation of how the participant has responded to the interventions provided with progress achieved toward plan goals, an assessment of their current status, and whether the interventions will be continued as written or revised. This information forms the basis of the IPC update to be described in Box 15.

ACL 20-09 specifies that Box 15 shall include significant changes in the participant's plan of care. This includes what the center may or may not be providing under TAS as stated in a continuing participant's pre-TAS IPC under Boxes 13 and 14. In addition, Box 15 shall include significant changes in the participant's condition since the last IPC.

Under TAS each identified need or problem that the center is addressing should include a corresponding intervention, including an estimation of how often an intervention would be needed to meet stated goals and prevent decline. This information would be included in Box 15 of the IPC for each discipline providing services under TAS.

Q.22 What if we are now bringing in our participants to meet with the appropriate disciplines to do their reauths - do we still need to complete IPC Box 15?

I was under the impression that we should not change Box 13 to the TAS treatment, and put it in Box 15. Is this correct?

A.22 Regardless of whether providers bring participants to the center to conduct assessments by various disciplines, the provider is required to document on the IPC as specified in ACL 20-09. In the early days of the COVID-19 public health emergency in May 2020, CDA developed documentation policy in ACL 20-09 to flexibly accommodate TAS IPC completion. We now see that some providers and managed care plans prefer to document TAS care plans in Boxes 13 and 14.

Providers may choose to complete TAS care plans in IPC Boxes 13 and 14, so long as all the TAS-related information described in ACL 20-09 that is not addressed in Box 13 is addressed in Boxes 15 and 16. Providers who choose to complete TAS care plans in Boxes 13 and 14 should leave pre-TAS Box 13 care plans intact for continuing participants. Reference slide #26 from CDA's TAS training on September 24, 2020 for an example of how IPC Box 13 could be used during TAS.

Q.23 Are providers allowed to maintain documentation (progress notes, flow sheets, quarterly progress notes, assessments, etc) electronically? Our EMR makes it possible to complete and maintain documentation electronically, which is very efficient for multi-disciplinary approach and instant updating other staff on participant status changes.

A.23 Yes, providers may continue using their electronic medical records. Additionally, ACL 20-07 specified that "Providers should maintain existing processes with MCPs and DHCS for electronic health records and signatures."

Q.24 We were originally told to leave the CBAS IPC alone and not place TAS treatments in Boxes 13 and 14 but reflect everything in Boxes 15 and 16. Has this changed?

A.24 Documentation policy outlined in ACL 20-09 has not changed. Providers are to complete IPC Boxes 15 and 16 consistent with ACL 20-09. Since the beginning of CBAS TAS in March 2020, some providers have found that they prefer documenting TAS care plans in Boxes 13 and 14. Also, some managed care plans have stated a preference for this approach as well. Please be aware that if you update Boxes 13 and 14 with TAS care plan information, you need to leave pre-TAS care plans in tact and clearly note TAS care plans that you are adding. Additionally, you'll need to ensure that Boxes 15 and 16 include the required information specified in ACL 20-09. Reference Questions 9, 10,11 and 22 above for additional information.

Relevant CBAS Standards

Q.25 If participants refused to receive any type of service, such as wellness check calls and food delivery, and the center cannot talk to participants and their responsible party at all regardless of multiple attempts to contact, what can the center do?

A.25 ACL 20-07 specifies the following regarding participants who refuse services at this time:

"If a participant or caregiver requests to be disenrolled from the program or refuses all services after attempts to reengage them in CBAS TAS during this period, they may be considered on hold until the return of traditional CBAS or discharged, as appropriate, based on existing discharge requirements. The provider may not bill for those individuals unless services are provided."

Q.26 If a provider is not serving participants in person at the center, is the quarterly pharmacy review still required?

A.26 Medication requirements under Title 22, CCR, Section 78317(L), which include pharmacy services, have not specifically been waived by CDPH Licensing at this time. Providers should make good faith efforts to meet traditional ADHC/CBAS requirements that continue to be relevant during TAS and document when requirements can not be met.

All Facilities Letter 20-34.2 indicates that the following regulations have been waived:

Title 22 CCR sections 78301, 78305, 78307, 78309, 78311, 78313, 78319, 78337, 78339, 78341: ADHCs shall not be required to provide all services at the center and will have flexibility in how they provide basic services to participants. Basic services include: occupational therapy, physical therapy, speech therapy, medical services, nursing services, nutrition services, psychiatric or psychological services, social services, and recreation or planned social activities. Services may be provided via telehealth or other remote methods. This will allow for, but is not limited to, check-in calls, health screening calls, video conferencing, and meal delivery. ADHCs that provide in-person services should follow the mitigation guidance provided in AFL 20-27.1

Q.27 Does the LCSW need to provide supervision hours to SW staff who are working under a program flexibility and have supervision as a condition of approval?

A.27 Yes. Providers who have approved program flexibility for their social work staff must continue to meet conditions of their approval.

Q.28 When the participant's blood pressure is running high are we as nurses responsible to let their providers know or are they responsible?

A.28 As with traditional congregate CBAS, when a participant is symptomatic of a disease or illness and the center is aware of their condition, it is the nurse's responsibility to notify the participant's personal health care provider or, in urgent cases, emergency medical services.

Miscellaneous

Q.29 Do we have to do home visits in person? Do you accept virtual/phone home evaluation?

A.29 ACL 20-11 notes that at this time the assessment of the home environment may take the form of a doorstep "check-in," drive by, and/or be completed telephonically. If other sources of information are available, such as past home assessments by other agencies, they can be substituted or supplement the provider's assessment.

Q.30 Tell us about TB clearance requirements in TAS while there are no congregate services.

A.30 ACL 20-11 specifies that evidence of TB clearance is required before participants may be served in person inside their home or in the center.

Q.31 We are having trouble getting MDs to sign off on medication reconciliation and return our requests via fax as they usually do. Our response rate has dropped to almost zero. We think one reason may be that the participants are often being seen remotely and may not be in-person to bring in their meds for reconciliation at their MD appt. What is CDA's expectation for medication reconciliation during TAS?

A.31 Nurses should make good faith efforts to monitor participants' medication use and liaison with personal health care providers as possible. Approximately 30 percent of hospital admissions of older adults are drug related. Monitoring of participants' medication use is an important component of CBAS and CBAS TAS services. Centers may use telehealth to gather medication information from the participant or caregiver. We have heard that some centers use the participant's pharmacy to obtain a list of medications filled by the participant as well as doing a "Brown Bag Review" of medications at the doorstep.

Q.32 If the participant is receiving telehealth and food 5x/week, we are billing for 5x/week. Insurance companies have repeatedly told us that they will NOT accept increases in days unless the participant's health has declined and that the participant's need for food is not sufficient by itself to increase days. How can we remedy this?

A.32 Determinations regarding authorization of services are the purview of the managed care plans (MCP) for their members and DHCS for fee-for-service participants. When authorizing services, the MCPs and DHCS evaluate medical necessity for services. Any clarification providers need regarding a particular TAR/IPC decision should be addressed with either the MCP or DHCS. In cases where a participant is not authorized for needed services, providers should refer participants to other sources to get their needs addressed and/or coordinate referral with the participant's MCP. In the case of meal deliveries, social service agencies in the community that provide food and meals would be the source for referral.

Q.33 What is the time frame for medical records that will be requested during the recertification process?

A.33 CDA asks the center to provide the medical records for Medi-Cal participants who have been enrolled in the program less than two years and whose most recent reauthorization periods were effective June 1, 2020 or later.

Q.34 What is the best way for nursing to get accurate blood pressure and blood sugar readings from participants during TAS?

A.34 Obtaining a blood pressure measurement and/or blood sugar reading during TAS includes ensuring the participant has a means to take it themselves or has a reliable caregiver to take it for them. Some centers report they have provided participants with the tools necessary to ensure readings can be obtained. Nursing services provides the education in the proper use of the glucometer or blood pressure monitor. Other centers are providing doorstep blood pressure checks or in-center blood pressure monitoring by appointment. CAADS and ALE have provided numerous resources and webinars on this topic which providers may want to access.

Q.35 How do we provide services to those in ICF/DD homes? Isn't that double dipping services?

A.35 ICF/DD-H residents have long been eligible for ADHC/CBAS. It is not considered a double dip.

WIC 14525(e) states:

Notwithstanding the criteria established in subdivisions (a) to (d), inclusive of this section, any person who is a resident of an intermediate care facility for the developmentally disabled-habilitative shall be eligible for adult day health care services if that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.