

## Level of Care (LOC)/Plan of Care (POC) Review Process

### MDS-HC Assessment Review

#### I. Complete, Correct, and Correlated

- Is the assessment **Complete**?
  - Review every item of the MDS-HC and ensure that all fields are filled in.
    - Exceptions: Refer to the updated MDS-HC Assessment Frequently Asked Questions (FAQs).
- Is the Assessment **Correct** and Coded According to Guidelines?
  - Review assessment to ensure that the assessor coded correctly: Did the assessor use accurate information and observations?
  - Were look back periods used (i.e. look at last 3 days for ADLs, except bathing which is in the last 7 days, or unless otherwise specified such as 30 days, 90 days, etc.)?
  - Coded ADLs measuring what participant actually did or was not able to do within each ADL category; measures performance and episodes.
  - Coded IADLs measuring the participant's ability to complete a task; what could they do regardless of current involvement with informal support? Look at the entire process; including all tasks/subtasks.
- Does the MDS-HC **Correlate** to MDS-HC Notebook entries and other Sections of the MDS-HC?
  - Review the assessment to determine if all sections correlate:
    - The MDS-HC, scales, and notebook entries correlate.
    - Does the entire MDS-HC paints a mental picture of the participant?
    - The MDS-HC matches the MDS-HC Notebook. If not, review notebook documentation for clarification of items that do not correlate.

#### II. Level of Care Determination

- Transitioning out of a Nursing Facility to Home and Community-Based Services (HCBS):

- Refer to Level of Care (LOC) Eligibility Manual - Transitioning Out of a Nursing Facility to HCBS.
- Individuals leaving a nursing facility are deemed, by their presence in the nursing facility, to meet the nursing facility level of care. The assessment is to determine if the participant can transition safely.
- Transitioning from HCBS Program to HCBS Program:
  - Refer to OAAS LOC Eligibility manual - Transitioning from One HCBS Program to Another HCBS Program.
  - If an individual wishes to transition from one OAAS operated long-term care program to another, he/she must meet on at least one of the LOC pathways or meet via use of the DDQ process described in the LOC Eligibility manual.
- Determining if LOC is Met for Initial and Annual Assessment Reviews:
  - Step 1: Does the participant meet Activities of Daily Living (ADL); Cognitive Performance; and/or Behavior pathways?
    - If the participant has triggered in at least one of the LOC pathways noted above, the assessor stops the LOC Review process and continues on with the Care Planning process. **Skip Steps 2-4 and refers to Plan of Care Review section.**
  - Step 2: Does the participant meet using Degree of Difficulty Questions (DDQs)?
    - If the participant has not triggered in at least one of the LOC pathways noted above, the assessor continues on to the DDQs process described in the LOC Eligibility manual.
    - If the participant meets the DDQ criteria the assessor must document in the MDS-HC Notebook that the participant has met the ADL LOC pathway per application of the DDQs and continues with the Care Planning process. **Skip Steps 3-4 and refers to Plan of Care Review section.**
    - If the participant does not meet the DDQ criteria or the assessor determines that the participant does not meet the criteria for application of the DDQ he/she must document in the MDS-HC Notebook and continue evaluating for LOC using the remaining pathways. (Refer to OAAS LOC Eligibility manual)
  - Step 3: Does the participant meet LOC using Physician Involvement, Treatments & Conditions, and/or Skilled Rehabilitation Therapies pathways?

- The assessor continues on to determine if LOC is met by review of Physician Involvement, Treatments & Conditions, and Skilled Rehabilitation Therapies pathways as outlined in the LOC Eligibility manual.
- If the assessor determines that the participant may qualify for approval in the Physician Involvement, Treatments and Conditions, and/or Rehabilitation Therapies pathways, he/she must provide additional supporting documentation, as described in the LOC Eligibility manual.
- If the documentation supports that the Physician Involvement, Treatments and Conditions, and/or the Skilled Rehabilitation pathways are met (Refer to the OAAS LOC Eligibility manual) then the Care Planning process continues. **Skip Step 4 and refer to Plan of Care Review section.**
- Step 4: Does the participant meet LOC using the Service Dependency pathway?
  - The Service Dependency pathway is used to identify participant who are currently enrolled and receiving services prior to 12/01/2006 with no break in service to the present day.
  - If the participant continues to meet LOC based on Service Dependency pathway, there must be documentation in the MDS-HC Notebook, and care planning can continue. (Refer to the LOC Eligibility manual)

## Plan of Care Review

- Review the Plan of Care (POC) to ensure:
  - All required demographic sections of the POC have been completed.
  - The Participant Profile clearly summarizes the participant's status in each of the four categories.
  - All components of the 4 CAPs Issues Categories (Social Life, Cognitive/Mental Health, Physical/Functional, and Clinical Issues) are comprehensive and correct using the CAP Summary Instructions:
    - Triggered CAPs are identified.
    - Related CAPs are identified.
    - Short term goals that can be resolved within 3 months are identified.

- Short term goals can incorporate the intervention within the goal.
  - Long term goals are identified.
  - All needed assistance/interventions are identified if applicable.
    - Exception: The CAPs that are identified as “A” will not have interventions.
  - All Interventions address **EITHER** the individual items that caused the CAP to trigger **OR** the overall objective of the Triggered CAPs. Assessor will need to use professional judgment to determine which approach is the most appropriate.
  - Person specific preferences are incorporated: Who, What, When and Where.
  - Interventions that are specific to formal and informal supports are addressed in the appropriate sections.
    - The combination of formal and informal supports described in the POC address all identified needs.

**NOTE:** Interventions addressed by both formal and informal supports do not have to be repeated.
  - Personal goals and preferences are addressed in the appropriate issue categories.
  - Community resources and services that meet the participant’s needs are identified.
- The MDS-HC matches the POC.
  - The snapshot picture of the MDS-HC, notebook entries, scales, and POC make sense.
- The POC includes evidence that the participant’s needs for medication administration and health-related tasks have been identified with interventions developed to meet those needs.
- The POC includes evidence that the participant’s risk factors/critical incident reports (CIRs) have been identified and interventions developed to reduce those risks. Refer to Clinical Assessment Protocols Summary Instructions.
- The Flexible Schedule is completed correctly.

- The Budget worksheet is completed correctly.
  - Budget worksheet should match the Flexible Schedule.
- All appropriate signatures are on the correct pages.
  - Have all required individuals signed in the appropriate places?
  - Review Cognitive Performance Scale (CPS) to determine whether a Responsible Representative signature is required.
- The Plan of Care Action section is completed correctly.
- Notice of Approval and Fair Hearing Rights is completed correctly (if applicable).
- The Emergency Plan form identifies responsible parties and their roles with appropriate signatures and/or verbal agreements.
- The Back-Up Staffing Plan form identifies responsible parties and their roles with appropriate signatures and/or verbal agreements.
- The date the approved POC was mailed to participant and applicable providers is documented.