

Why Use the Adult Day Assessment Tool to Measure Outcomes?

1. ASSESS NEW CLIENTS WITH AN INITIAL ASSESSMENT
 - a. Accurately document client's motor (physical), cognitive (neurological, mood) and memory status upon admission to your program.
 - b. Adult Day Assessment serves as a screening tool to help determine whether your Adult Day Program is an appropriate setting for client (vs. another type of program, SNF, etc.)
 - c. Creates a baseline assessment against which all future assessments may be compared.
 - d. Helps you determine how best to serve your client's needs
 - i. Eg. / place client in Dementia group or not?
 - ii. Determine in detail client's real need for assistance during the day ("burden of care") from staff (eg. / toileting; cutting up food, etc.)
 - iii. Pinpoint specific limitations in function so that appropriate interventions can be made in advance
 1. Safety
 2. Supervision
 - iv. Help staff formulate a client-specific Care Plan
 - e. Serves as a management tool to help ascertain staffing needs
 - f. Obtain intake demographic data
2. ONGOING PERIODIC ASSESSMENT FOR CASE MANAGEMENT
 - a. Accurately document client's motor (physical), cognitive (neurological, mood) and memory status after participation in your program
 - b. Typically, do 2nd assessment of client after 1-month, 3-months or 6-months participation in your program
 - c. Initially, it is better to do 2nd assessment sooner rather than later . . . to identify any items for "Problem alert"
 - d. After 2 assessments are completed, a client-specific outcomes report can be generated
 - i. Unique report for that client alone
 - ii. Underperforming items in the categories of motor, cognitive and memory are identified for "Problem Alert"
 - iii. Improved items (eg./ mood) are identified
 - iv. Consistent ratings are indicative of maintenance of functional abilities. MAINTENANCE OF FUNCTION IS GOOD.
 - e. Re-assess client after any significant change has occurred. For example:
 - i. After any serious illness or hospitalization
 - ii. After any fall or injury
 - iii. After any significant change in mental status (eg./ possible stroke, early dementia, etc.)
 - iv. After any long break from your program

3. INTERNAL COMMUNICATION TOOL

- a. Makes all staff aware of client's needs, safety issues, unique functional limitations and abilities
- b. Provides feedback to staff on what's working & what isn't with a client
 - i. Improves morale
 - ii. Increases pride in work
 - iii. Fosters teamwork
- c. Gives concrete information to create Care Plan

4. EXTERNAL COMMUNICATION TOOL

- a. Demonstrates benefits of your Adult Day program to target audiences including:
 - i. United Way
 - ii. Catholic Charities
 - iii. Community benefactors
 - iv. Referral sources
- b. Demonstrates value of Adult Day program to your funding sources:
 - i. City, state, county government
 - ii. Private health insurance
 - iii. LTC insurance providers
 - iv. Private payers
 - v. Foundation support
- c. Grant applications
 - i. Aggregate reports on your program's outcomes can be included in grant applications

5. FAMILY COMMUNICATION TOOL

- a. Outcomes reports can be shared with client and family
- b. Serve as communication tool for sharing information objectively
- c. Provide feedback on benefits of the program (eg./ mood improved)
- d. Provide feedback on client's functional limitations and how/what will be done to either help manage those limitations or potentially improve upon those limitations.
- e. May also be used to help objectively communicate to family when client requires greater services than the Adult Day program can provide.

6. PROGRAM EXPANSION

- a. Outcomes can be used to justify continuation of and/or expansion of your program
 - i. Documents your program's worth
 - ii. Documents your client demographics (numbers & types of clients you're serving)
 - iii. Reports on the length of time clients remain in your program
 - 1. For every day a client is served by your program, it saves society the tremendous costs associated with LTC or SNFs.

2. For every day a client is served by your program, family members are able to remain gainfully employed with piece of mind.
- b. Outcomes help document the demand for *particular* services
 - i. Eg./ Increased demand for dementia specific Adult Day program
 - ii. Eg./ Increased demand for early memory loss program

7. ACCREDITATION

- a. Outcomes measurement is required for accreditation of programs. While accreditation is not mandated today for Social Model Adult Day programs, it could be in the future.
- b. Accreditation serves as a “seal of approval” and is a recognized measure of quality.
- c. Accreditation can be a powerful marketing tool for your program.

Time: Arrival _____ Departure _____

DOCUMENTATION OF ENCOUNTERS: DAY HAVEN TRANSITIONS

Participant: _____ Date: _____
Site: () 2210 Smithtown Avenue, Ronkonkoma, NY 11779 () 400 Sheep Pasture Road, Port Jefferson, NY 11779

Other _____

Goal/Milestone:
Staff Action/Service Provided
Participant's Response: Initial _____

Goal/Milestone:
Staff Action/Service Provided
Participant's Response: Initial _____

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Staff Action/Service Provided
Participant's Response: Initial _____

Goal/Milestone:
Staff Action/Service Provided
Participant's Response: Initial _____

Supervisor Signature _____

Date: _____

ASSESSMENT PART III: Detailed Plan for Day Haven Transitions Participant

Initial care and service plans are developed within 30 days of start date and whenever a change in participant status requires. Care and service plans are developed in consultation with the participant and / or caregiver. At a minimum, care and service plans are reviewed and updated annually. The plan will be designed to attain and maintain the highest practicable physical, mental and psychological well being of the participant, including an optimal capacity for independence and self-care. Furthermore, the plan shall encourage the participant to use his / her existing capacities, develop new capacities and interests, and compensate for existing or developing impairments in capacity.

Name: _____ D.O.B: _____ Start Date: _____

Care Plan: Original Event Based Annual Other

Caregiver Name: _____ Relationship: _____

Service Coordinator: _____ Agency: _____

Objectives of program: _____

Diagnosis: _____ Participant Strengths: _____

Program / Staff support required for: _____

Has the plan been discussed and accepted by participant and / or informal supports? Yes No Is the participant self-directing / able to direct staff? Yes No

What type of diet is the participant on? Regular Vegetarian Ethnic Religious (type: _____) Texture Modified Calorie Controlled
 Sodium Restricted Fat Restricted High Calorie Renal Other (specify: _____)

Has the participant been placed on a waiting list for any service need? If yes, specify service and date: _____

Has a referral been made for a service? Yes No Service type: _____ Program: Regular Dementia-Specific Blended

Plan Approved By: _____ Title: _____ Date: _____

****DETAILED PLAN ON REVERSE SIDE**

Participant Outcome Statement (upon termination): _____

Termination Date: _____ Reason for termination: _____ By whom: _____

Terminated By: _____ Date: _____ Phone: _____

Core Service Area or Concern	Milestones	Intervention	Planned Outcome/Time Frame	Dates/ Initial	Comments/Notes/Updates
<u>Socialization:</u> Structured Activities using participant's skills, responding to interests, capabilities, needs and to minimize impairments...					
<u>Supervision:</u> Need to observe and be aware of whereabouts, activities, and needs; protect safety and welfare...					
<u>Personal Care:</u> Toileting, mobility, transfers, eating, medication reminders...					
<u>Nutrition:</u> Dietary concerns...					
<u>Referrals to other services and/or benefits/entitlements info. and/or assistance</u>					
<u>Use of Assistive / Adaptive Devices</u>					

Structured Day Program Services

Definition

Structured Day Program services are individually designed services, provided in an outpatient congregate setting or in the community, to improve or maintain the waiver participant's skills and ability to live as independently as possible in the community. Services may include assessment, training and supervision to an individual with self-care, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills, and skills to maintain a household.

Structured Day Program services may be used to augment some aspects of other NHTD services and Medicaid State Plan services when reinforcement of skills is necessary. This is permitted due to the difficulty many individuals have with transferring or generalizing skills learned in one setting to other settings and the need for consistent reinforcement of skills. The SP should address how the services are complimentary but not duplicative and ensure consistency. This service is intended to provide an opportunity for the waiver participant to continue to strengthen skills that are necessary for greater independence, improved productivity and/or increased community inclusion.

The Structured Day Program may be provided within a variety of settings and with very different goals. Waiver participants may choose to participate in a Structured Day Program that emphasizes basic work skills, such as punctuality, problem solving and effectively communicating with co-workers and supervisors. Other Structured Day Programs may focus on specific job skills, such as computer operation, cooking, etc. Other participants, for whom employment is not an immediate or long-term goal, may be more interested in community inclusion or improving their socialization skills.

The Structured Day Program is responsible providing appropriate and adequate space to meet the functional needs of those served. The Program must provide adequate protection for the personal safety of the program participants, including fire drills twice a year and maintain documentation of those drills. The Structured Day Program must be located in a building that meets all provisions of the New York State Uniform Fire Prevention and Building Codes. In addition, access to the Program must meet and adhere to the requirements of the Americans with Disabilities Act. If the RRDS or DOH identifies questionable situations, appropriate referrals will be made for necessary corrective action. The RRDS or DOH may determine the appropriateness of the physical space for the NHTD waiver participants.

Whatever type of Structured Day Program(s) the participant chooses it is essential that there be coordination between providers, assuring consensus in the type of supports and structures that are used in all settings and avoiding duplication of services. This is particularly important when the participant is receiving waiver services such as ILST, PBIS, and HCSS.

Provider Qualifications for the Director of Structured Day Programs

Structured Day Programs may be provided by any not-for-profit or for profit health and human services agency. All Structured Day Programs must be identified in the SP and provided by agencies approved as a provider of this waiver service by DOH.

The Structured Day Program Director must be:

1. Registered Occupational Therapist - Licensed by the NYS Education Department;
2. Registered Physical Therapist - Licensed by the NYS Education
3. Licensed Speech-Language Pathologist - Licensed by the NYS Education Department;
4. Registered Professional Nurse - Licensed by the NYS Education
5. Certified Special Education Teacher - Certified by the NYS
6. Certified Rehabilitation Counselor - Certified by the Commission on Rehabilitation Counselor Certification;
7. Master of Social Work; or
8. Master of Psychology.

Structured Day Program Directors must have, at a minimum, one (1) year of experience providing

functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with disabilities and/or seniors; OR

- B. Individual with a Bachelor's degree and two (2) years of experience providing functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with disabilities and/or seniors.

In addition to a required Program Director, a Structured Day Program may employ program staff. Program staff must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service. It is expected that Structured Day Program staff will be available to provide hands-on assistance to participants, and therefore, must have previous training as a PCA.

Reimbursement

Structured Day Program services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Structured Day Program services are reimbursed on an hourly basis. Participation in Team Meetings organized by the SC is reimbursed at the hourly rate.

The provision of Structured Day Program services must not occur in a sheltered workshop environment. If a participant decides to make use of the services of a sheltered workshop, the reimbursement for that service must be provided through VESID.

Revised: September 2008

NHTD Waiver Eligibility Criteria

To be a NHTD waiver participant, the individual must:

1. Be eligible for admission to a nursing home
2. Have Medicaid coverage for Community Based Long Term Care services
3. Be at least 18 years of age or older (must have a physical disability for those between 18 and 64)
4. Be able to live in the community with assistance from family, friends, community members, etc., non-Medicaid supports and/or Medicaid State Plan services and be in need of one or more waiver service per month
5. Be part of the group of NHTD waiver participants whose average cost of Medicaid services is less than what it would cost for the same group to live in a nursing home
6. Choose to live in the community as a participant in this waiver rather than in a nursing home; and
7. Not participate in another Home and Community Based Services waiver

NHTD Waiver Philosophy

The dignity of risk and right to fail are integral parts of the waiver's philosophy.

The philosophy of the waiver supports the participant's right to choose:

Where to live,
Who to live with
Who to socialize with
What goals and activities to pursue.

Waiver services are provided based on the participant's unique:

Strengths
Needs
Choices
Goals
Health and welfare.

The individual is the primary decision-maker
and works in cooperation with providers to develop a plan for services.

The process leads to:
Personal empowerment,
Increased independence
Greater community inclusion
Self-reliance and
Meaningful and productive activities.

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NEW YORK STATE DEPARTMENT OF HEALTH

Nursing Home Transition and Diversion Medicaid Waiver

Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion

The Home and Community-Based Services (HCBS) Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is one of the options available to New Yorkers with disabilities and seniors so they may receive services in the most appropriate, least restrictive setting. This summary provides a general overview of the NHTD waiver.

I. Philosophy

The NHTD Medicaid waiver was developed based on the philosophy that individuals with disabilities and/or seniors have the same rights as others to:

- Be in control of their lives.
- Encounter and manage risks and learn from their experiences.

II. What is an HCBS Medicaid Waiver?

A waiver:

- Is an opportunity for comprehensive services to be available in the community rather than in an institution.
- Allows states to assemble a package of carefully tailored services to meet the needs of a targeted group in a community-based setting.
- Maintains the waiver participant's health and welfare through an individualized service plan.
- Assures the overall cost of serving waiver participants in the community is less than the cost of serving a similar group in an institution.

III. Why did New York State Develop the NHTD Medicaid Waiver?

- State legislation authorized a new HCBS Medicaid waiver to provide a cost-effective community-based alternative to nursing facility care, reflecting the State's commitment to serve all persons in the least restrictive setting, appropriate to their needs.
- Individuals with disabilities and seniors, their families and other interested persons advocated for additional options for community-based services and supports.
- Otherwise existing Medicaid services and other supports may not be sufficient or most efficient to meet the needs of some individuals with disabilities and seniors to transition into or remain in the community.

IV. What are the Expected Outcomes?

- Participants will have an additional community-based choice.
- Participants will have opportunities to live meaningful and productive lives in their communities.
- Families and other informal caregivers will have access to additional supports to assist them in their caregiver roles.

V. To be Eligible for the NHTD Medicaid Waiver an Individual Must:

- Be capable of living in the community with needed assistance from available informal supports, non-Medicaid supports and/or Medicaid State Plan services and be in need of one or more waiver service;
- Be eligible for nursing home level of care;
- Be authorized to receive Medicaid Community Based Long Term Care;
- Be at least 18 years of age or older;
- Be considered part of an aggregate group that can be cared for at less cost in the community than a similar group in a nursing home;
- Choose to live in the community as a participant in this waiver rather than in a nursing home; and
- Not participate in another HCBS waiver.

VI. Regional Resource Development Centers (RRDC)

The NHTD waiver is administered through a network of Regional Resource Development Centers (RRDC), each covering specific counties throughout the State. The contact person at the RRDC is the Regional Resource Development Specialist (RRDS). Additionally, the RRDC employs a Nurse Evaluator (NE).

Responsibilities of the RRDS include:

- Interviewing potential waiver participants;
- Assisting participants to access approved providers for Service Coordination;
- Reviewing Service Plans for approval;
- Determining whether an applicant participant meets all non-financial eligibility requirements for the waiver;
- Maintaining regional budgets for waiver services; and
- Issuing Notice of Decision forms to applicants to approve or deny waiver participation and to participants as necessary for ongoing participation.

Responsibilities of the NE include:

- Utilizing clinical expertise to review medically complex Service Plans;
- Providing technical assistance to the RRDS and waiver service providers; and
- Resolving issues associated with level of care determinations.

VII. Quality Management Specialists (QMS)

The NHTD waiver relies on a network of Quality Management Specialists (QMS) throughout NYS, each covering specific regions. The primary responsibility of the Specialists is to assure quality under the waiver through a range of functions, including:

- Assisting in the retrospective review of Service Plans;
- Reviewing Service Plans over \$300 per day;
- Overseeing the incident reporting process;
- Conducting participant satisfaction surveys; and
- Performing trend analysis in their regions with recommendations for improvements.

VIII. Available NHTD Waiver Services

NHTD waiver services are used to complement already available sources of support and services. The following provides general definitions. More specific information will be provided to applicants and participants as part of the service planning process. Others may access on the DOH web under Long Term Care http://www.nyhealth.gov/facilities/long_term_care/.

1. Service Coordination
Assistance with the development and implementation of a person-centered individualized Service Plan that will lead to the waiver participant's independence, integration into the community, health and welfare.
2. Assistive Technology
Equipment that will improve the participant's independence, decrease reliance on staff and be a cost effective aid for community integration. This service supplements Durable Medical Equipment provided through the general Medicaid program.
3. Community Integration Counseling
Counseling service provided to waiver participants who are coping with altered abilities and skills, revisions in long term expectations and/or changes in their roles in relation to significant others.
4. Community Transitional Services
Assistance in transitioning from a nursing home back to the community, including the cost of moving, essential furnishings, deposits for utilities, security deposits or one-time cleaning services prior to occupancy.
5. Congregate and Home Delivered Meals
Meals for waiver participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation.
6. Environmental Modifications Services

Internal and external physical adaptations to the home necessary to assure the waiver participant's health and welfare in that setting. Environmental modifications may be made to a residence owned by the participant or to rental units with permission received from the landlord.

7. Home and Community Support Services
Oversight and/or supervision as a discrete service or in combination with assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL).
8. Home Visits by Medical Personnel
Services provided by a physician, nurse practitioner or physician's assistant to diagnose, treat and monitor wellness to preserve the waiver participant's functional capacity to remain at home. An evaluation of the caretaker's ability to maintain his/her role is conducted, as well as an assessment of the living environment to identify if it can support the participant's medical needs.
9. Independent Living Skills Training Services
Training to improve or maintain the waiver participant's ability to live as independently as possible by focusing on essential community living skills such as task completion, money management, interpersonal skills, sensory/motor skills, problem solving skills and the ability to maintain a household.
10. Moving Assistance
Transport of the participant's possessions and furnishings when moving from an inadequate or unsafe housing situation or to a location where more informal supports will be available.
11. Nutritional Counseling/Educational Services
Assessment, planning, education and counseling for the waiver participant's nutritional needs and eating patterns.
12. Peer Mentoring
Improvement of the waiver participant's self-sufficiency, self-reliance, and ability to access needed services, goods and opportunities in the community accomplished through education, teaching, instruction, information sharing, and self-advocacy training, provided by a "peer" (with similar disabilities).
13. Positive Behavioral Interventions and Supports (PBIS)
Services intended to decrease the frequency or intensity of the waiver participant's significant behavioral difficulties that may jeopardize his/her ability to remain in the community of choice due to inappropriate responses to events in his/her environment.
14. Respiratory Therapy
Services providing preventive, maintenance and rehabilitative airway-related techniques and procedures to the waiver participant in his/her home.

15. Respite Services

Relief for non-paid primary caregivers of a waiver participant provided in a 24 hour block of time in the home.

16. Structured Day Program Services

Outpatient congregate setting providing services designed to improve or maintain waiver participants' skills and abilities to live as independently as possible within the community. Services may include a wide array of interventions and supports ranging from pre-vocational skill building to socially-oriented activities.

17. Wellness Counseling Service

Intermittent evaluation visits to waiver participants who are medically stable to assist them in maintaining optimal health status.

IX. The Use of a Regional Aggregate Budgeting System

Federal rules require cost neutrality, which is the assurance that the overall Medicaid costs for waiver participants is less than the Medicaid costs for a similar group of Medicaid recipients residing in a nursing home.

The NHTD waiver will use a regional aggregate cap to maintain cost neutrality. This will permit the waiver to serve individuals with a wide range of needs.

For further information, please contact a local Regional Resource Development Center (see attached list).