CHILD HOME AND COMMUNITY BASED SERVICES NEEDS TOOL – GUIDELINES

(Use for ALTCS members aged 0-17)

Direct Care services (Attendant Care, Personal Care, Homemaker services), and Habilitation services are intended to augment and support the existing informal care and community services being provided to the member to allow the member to remain in a home setting.

The Child tab in the Home and Community Based Services (HCBS) Needs Tool (HNT), AMPM Exhibit 1620-17 is intended to evaluate the minor member's functional care needs. This document provides directions on how to use the Child HNT as well as how to document comments, feedback, and/or concerns shared by the member/family. The tool aids the case manager in assessing the need for tasks/supports that meet medically necessary and extraordinary care thresholds. While the tool will also help document which of those needs will be met by an informal support system and which parts will be provided by the formal paid caregiver, the member's needs do not change based on who provides the care and must be comprehensively assessed before determining who will provide the care. Members have a right to a comprehensive assessment, based on their unique needs and circumstances, regardless of the presence of informal supports or lack thereof. Additionally, members must receive a comprehensive care assessment at least annually, even if the member/family reports there has been no change in condition. Assessments must thoroughly document the member's needs, even if all services cannot be offered due to cost effectiveness, the member is not interested in receiving the services, and/or any other reason that may limit full-service provision.

Prior to authorizing Direct Care or Habilitation services, the ALTCS Case Manager shall complete the Person-Centered Service Plan (PCSP) AMPM Exhibit 1620-10 and the HNT.

The HNT shall be completed with direct involvement of the member/Health Care Decision Maker (HCDM); minor members may not be directly engaged in the assessment process, although they can and should be when appropriate for their age and developmental stage. Discussion shall take place about what care is needed, and the amount of time it takes to complete that care for the member. After the comprehensive needs assessment is completed, the availability of informal supports and community services that may be utilized to meet those needs can also be discussed; however, informal support and community services are not obligated to be utilized. Discussion shall include stressors the informal caregivers may be experiencing in providing care and the supports that can be provided through community resources as well as Arizona Long Term Care System (ALTCS) services.

Direct care services must be medically necessary services and based on an assessment of each member's unique needs. For minor children (members under the age of 18) care and services must also be determined to be extraordinary in nature. Extraordinary care is evaluated for each task independently and is based on the member's age, developmental milestones, and how a person of that age is generally supported by the people around them (i.e. parents, guardians). If the member is of the age where they may be assessed for a specific task using the HCBS Needs Tool, then the care needed is evaluated based on the member's ability to complete the task, the time it takes to complete the task, and the level of support needed to complete the task. If the member is not of the age to be assessed for a task, any needs,

comments or concerns from the HCDM specific to the member's needs related to those tasks shall be documented in the comment section for that task to support the extraordinary care review should the HCDM request one after completion of the assessment.

There can be no differentiation or discrimination in the types or frequencies of service authorized simply because the member's caregiver will be a family member or other live-in individual. All services the member needs shall be assessed and documented, regardless of who (paid or informal) is providing the service and/or if the caregiver resides in the home.

Times shown on the HNT are only guidelines that reflect the time that it takes to complete tasks based on general and reasonable expectations in homecare provision. Time assessed for each category shall be based on the evaluation of the member's individual needs. Comments must be documented on the HNT to support the time allotment when services are being authorized.

Time above the suggested amount in any category may be assessed, but the case manager shall provide an explanation for the amount of time needed to complete that task for the member. This shall be documented in the *Comments* section of the HNT. Comments shall also be included for any changes in assessing tasks (tasks per day and minutes each task takes) to reflect the member's current condition. If the member is not of the age to be assessed for a certain task, that shall also be included in the comment section for clarity purposes, along with any comments or concerns raised by the HCDM

Age considerations must be applied to each task. If the member is not age-appropriate for a specific task, the task shall not be assessed. There should be clear documentation regarding the member's age as rationale as well as any concerns from the HCDM regarding the assessment limit. For example, bathing shall not be assessed for a member under age 5 because it is an age-appropriate developmental milestone where parents may still engage to support their child, regardless of their child's abilities. This also applies to habilitation goals. For example, it would not be appropriate to provide paid habilitation support to teach a child under 5 years of age to brush their teeth independently as that is an age-appropriate developmental milestone where parents are actively providing that support to develop good habits; whereas if the child is 10, it would be an extraordinary care need to have support with tooth brushing. Habilitation goals shall be checked against the age-appropriateness outlined in the HNT to ensure paid habilitation is appropriate.

The time for the task to be completed shall be documented to support the extraordinary care determination and needed supports. A justification for the actual time a task requires to be completed, and the steps included in the process shall be documented in the comments along with the frequency that the task is completed. Any additional information or context supporting the assessment should also be outlined in the comments.

For minor children, if during the course of the assessment it is determined the child needs paid services during the overnight hours (between 10:00 pm and 6:00 am), the comment section must be utilized to document the specific needs that necessitate paid services provided by the parent during the overnight hours. Parents of minor children are only permitted to provide paid care between the hours of 6:00 am and 10:00 pm unless the member's needs are otherwise documented in the HNT. For authorized

overnight hours, parents being paid for care should be awake and actively engaged in member care/support during the documented time of care. The discussion regarding the various caregiver options for minors (AMPM Exhibit 1620-21, Minor Caregiver Options Discussion Guide and Decision Roadmap) occurs after the service need and hours have been assessed through the HNT. There is also a section at the end of the attendant care tasks to clearly indicate overnight needs as well as well summarize the service(s) that are needed.

Attendant care and habilitation shall not be provided at the same time. Attendant care and habilitation shall not be provided during other service provisions, for instance during therapy sessions or during doctor appointments.

There shall be adequate documentation in the member's PCSP to support the assessment and hours authorized. There shall be consistency between the PCSP and the HNT.

After the member's needs are assessed and documented, the Cost Effectiveness Study (CES) shall be calculated to determine what can be provided within the ALTCS cost effectiveness standards. Services with total costs that are at or below 100% of the cost of institutionalization or those that are expected to be at this level within six months may be authorized.

COMPLETING THE CHILD HCBS NEEDS TOOL
TASKS

The guidelines and considerations below can be used when completing the HCBS needs tool.

LIVING SITUATION

Select the appropriate choice based on the member's situation.

HOUSEKEEPING & CLEANING

Housekeeping includes cleaning tasks necessary to attain and maintain sanitary living conditions for the member. Housekeeping and cleaning shall not be assessed for ages under 18. This task is an appropriate habilitation goal for youth age 13+ to support skill building and preparation for eventual transition to adulthood.

LAUNDRY

Laundry tasks include preparing laundry to be washed, putting the laundry in the washer, putting the laundry in the dryer or on the line, and folding/putting away the laundry, with the goal of maintaining the member's laundry in a clean manner and neat appearance. These tasks apply only to the member's clothing and linens. Laundry shall not be assessed for ages 18 and under. This task is an appropriate habilitation goal for transition age youth (age 16+) to support preparation for adulthood.

LAUNDRY EXCEPTION FOR INCONTINENCE

Incontinence laundry is specific to extraordinary care when a child aged 4 or older needs laundry support due to incontinence episodes. Laundry tasks include preparing laundry to be washed, putting the laundry in the washer, putting the laundry in the dryer or on the line, and folding/putting away the laundry, with the goal of maintaining the member's laundry in a clean manner and neat appearance. These tasks apply only to the member's clothing and linens and does not include bathing, re-dressing, or other tasks specific to member cleanliness; those needs should be assessed/documented elsewhere on the tool under the appropriate task(s). Incontinence-based laundry needs shall not be assessed for members under the age of 4.

ASSESSMENT CONSIDERATIONS

- If a member soils their clothing or bedding due to incontinence, the laundry may need to be washed more frequently (even daily) which means a single smaller load each time versus multiple larger loads once a week.

TIME GUIDE: Do not write in the gray areas.

- Incontinence Episodes: Soiled clothes and Linens
  Time Guide: 1-30 min/day
  - Time assessed is limited to active time spent on the tasks indicated above and should not include time waiting for wash/dry cycles to finish.

SHOPPING

Shopping includes grocery shopping and obtaining household items for the member. Travel time and time to put away groceries is included. Shopping shall not be assessed for ages under 18. This task is an appropriate habilitation goal for transition age youth (age 16+) to support preparation for adulthood.

MEDICATION PICK UP

Medication pick up is specific to obtaining medications for a child's chronic conditions when home delivery of medications is not an option. This would not be assessed for one-time prescriptions for acute illness. There are no age limitations on this task.

ASSESSMENT CONSIDERATIONS

- If the child has a chronic condition and ongoing need for medication is established.
- If available pharmacy does not offer home delivery (including courier or mail) of medications and pick up is the only option.
- A trip to a member/family-preferred pharmacy that is farther away than an in-network pharmacy that can meet the prescription needs shall not be considered as extraordinary care and additional time shall not be assessed.
- If a caregiver must take the bus or walk to the store more time may allotted to address the individual situation.
- Medication needs and specific considerations shall be documented on the HNT.

Time Guide: Do not write in the gray area of the assessment tool

- 1-30 min/week.

MEAL PREPARATION & MEAL CLEAN-UP

If the child has specialty meal preparation needs, do not assess this task; assess in Specialty Meal Preparation.

Meal preparation includes meal planning, preparing the foods to be cooked or served, and cooking or putting foods together.

It would not be appropriate to assess this task if the child is eating food that has been prepared as a meal for the entire family, nor would it be appropriate to assess for this task in instances where it is the child's preference to eat different food or is a selective eater (e.g. does not like vegetables or certain textures). Examples of when this support may be necessary include but are not limited to:

- The child is able to be home alone for short periods of time but is unable to prepare their own meal due to physical, behavioral, or safety limitations.
- The child may be safely home with siblings who cannot support the member with their specific needs related to food preparation.
- The child is home with a caregiver during a meal time, where a member of the family is not available to prepare a meal.

Clean up includes storing the foods utilized/left over and the cleaning of the dishes involved in the preparation and presentation of the food.

Meal preparation and meal clean-up shall not be assessed for ages under 12.

ASSESSMENT CONSIDERATIONS:

- Ask the member/family how many times a day they eat and whether the child eats the same food as the rest of the family. If they are able to eat the same meals, or mostly so, this would not be considered extraordinary care.
- Ask what the member normally eats for breakfast/lunch/dinner. This can give an idea of the complexity of meals being prepared.
- Ask if the member is able to perform any part of meal preparation such as heating or re-heating food, assembling cold foods, using appliances such as toaster, stove, etc.
- Are there meal times when the member is alone and needs assistance with preparation?
- Will the member eat more often if this support is put in place? This could help the member if there are nutritional or weight loss concerns.
- If the caregiver will not be at the residence all day and the child is able to spend some time at home unsupervised, meals can be prepared in advance and left in a convenient place for the member, such as a plate be left in the fridge to be quickly microwaved, or non-perishable foods be set out for the member to take when ready.

TIME GUIDE: Do not write in the gray areas.

- Independent:
  - 0 min/day.
- Breakfast Preparation:
  - 1-30 min/day.
- Lunch Preparation:
  - 1-30 min/day.
- Dinner Preparation:
  - 1-30 min/day.

SPECIALTY MEAL PREPARATION

Meal preparation includes meal planning, preparing the foods to be cooked or served, and actually cooking or putting foods together for instances where the minor child is unable to eat the same meals as the family due to prescribed specialty diet or if the meal requires special preparation due to documented medical, physical, or behavioral limitations. Examples of specialty diet include restrictive dietary needs, having documented food aversions or inability to eat certain textures, or specific nutritional requirements such as low carb, gluten free, lactose free, food allergies, etc. Special preparation includes food modifications for the child to safely consume food such as blending, pureeing, thickening, etc. It would not be appropriate to assess for this task in instances where it is the child's preference to eat different food or is a selective eater (e.g. does not like vegetables). This task is inclusive of tasks associated with the time spent putting the meal together before it is brought to the table or is served to member. Cutting foods into appropriate size pieces for the member to eat is part of Eating/Feeding, not Meal Preparation. There is no age requirement for assessment of this task.

Clean up includes storing the foods utilized/left over and the cleaning of the dishes involved in the preparation and presentation of the food.

Alternative Meal Schedule is for members with diabetes or others that eat multiple small meals throughout the day to maintain proper nutritional intake for documented medical reasons. This can include getting the member an apple or some cheese and crackers or other small meals to help regulate the body. Adjust time to the appropriate levels based on the situation, for example, cleaning or cutting up an apple may only take two minutes, cutting and putting together cheese and crackers might only take five minutes, etc.

NOTE: If the member is being assessed for this category, all meals should be assessed here, and no time should be assessed under breakfast, lunch, or dinner.

ASSESSMENT CONSIDERATIONS

- Ask the member/family how many times a day they eat and whether the child eats the same food as the rest of the family. If they are able to eat the same meals, or mostly so, this would not be considered extraordinary care.
- Ask what the member normally eats for breakfast/lunch/dinner. This can give an idea of the complexity of meals being prepared.
- If alternative meals are being prepared for the child, ask if alternative meals are based upon member preference (would not be extraordinary care) or member necessity (e.g. a medical condition that requires specific meals or nutritional considerations).
- Does the member have any special diet/special food preparation requirements?
- Will the member eat more often if this support is put in place? This could help the member if there are nutritional or weight loss concerns.
- If the caregiver will not be at the residence all day and the child is able to spend some time at home unsupervised, meals can be prepared in advance and left in a convenient place for the member, such as a plate be left in the fridge to be quickly microwaved, or non-perishable foods be set out for the member to take when ready.

TIME GUIDE: Do not write in the gray areas.

Preparation is assessed if the member is eating a different meal than the rest of the family; Modification is assessed if the member is eating the same food but with modifications such as blended, pureed, mechanical soft, etc. In general, meal preparation and cleanup should not exceed 75 minutes per day If meals are prepared for the child while at another setting (e.g., school) by staff onsite, that time should not be considered in this needs assessment. There is not an age limit for assessment of this task.

- Independent:
  - 0 min/day.
- Breakfast Preparation and/or Modification:
  - 1-30 min.
- Lunch Preparation and/or Modification:
  - 1-30 min.
- Dinner Preparation and/or Modification:
  - 1-30 min.
- Alternative Meal Schedule:
  - 1-15 min per meal.

EATING & FEEDING

For specialty feeding needs such as G-Tube or significant choking risk associated with neuro-muscular or other conditions (e.g., dysphagia, cerebral palsy, complex dental) do not assess in this section. This should be assessed in the Specialty Eating & Feeding section.

Eating and Feeding is the process of getting oral nourishment from a receptacle (dish, plate, cup, glass, bottle, etc.) into the body after it is cooked or prepared for eating. Minimum supports include things like simple meal set up, cutting up food, and/or cueing the member to eat. Moderate support may include partial hand over hand feeding and/or ongoing cueing/supervision throughout the meal for the child to eat. Maximum support is full assistance to transfer food from a receptacle to the member's mouth. Do not assess this task for members under 5 years of age.

ASSESSMENT CONSIDERATIONS

- How many meals does the member eat per day?
- Time for the preparation of meals is calculated in the Meal Preparation category but cutting foods into appropriate size pieces for the member to eat is considered part of Eating/Feeding.
- How much support does the member need to eat?
- Does the member need more frequent meals or snacks and if so, what does that support look like?
- If the member is being assessed based on an alternative meal schedule, all meals should be assessed on that line, and no time should be assessed under breakfast, lunch, or dinner.

TIME GUIDE: Do not write in the gray areas.

- Do not assess for members aged under 5.
- Independent. Needs no assistance in eating or feeding one's self:
  - 0 min/meal.
- Breakfast Support: 1-30 min
- Lunch Support: 1-30 min
- Dinner Support: 1-30 min
- Alternative Meal Schedule Support:
  - 1-15 min/ small meal.

SPECIALTY EATING & FEEDING

This section is to be assessed only for children with a documented need for specialty assistance related to medical, physical, or behavioral conditions impacting the ability consume food. Examples include G-Tube, chewing/swallowing impairments, choking risk, etc. There is no age limit for assessment of this task.

ASSESSMENT CONSIDERATIONS:

- Is there a documented need for specialty feeding supports?
- How many times per day does the child eat/receive nutrition/hydration? Note: For G-Tube feeding and hydration support, a physician will likely prescribe the frequency of occurrence throughout the day; tasks per day should reflect prescription orders

TIME GUIDE: Do not write in the gray areas.

- Member does not have a specialty eating/feeding need:
  No time assessed
- G-Tube Feeding/Cleaning as prescribed:
  - 1-30 min/feeding
- G-Tube Hydration Support (including electrolytes when appropriate) as prescribed:
  - 1-30 min/event
- Neuro-Muscular or Other Conditions requiring chewing/choking supervision (e.g. dysphagia, cerebral palsy; complex dental issues):
  - 1-30 min/meal

BATHING

Bathing is the process of washing, rinsing, and toweling the body or body parts and transferring in/out of the tub or shower. This includes the ability to get the bath water and/or equipment ready for bathing in either the shower or tub or at the sink or bedside. Use of assistive devices such as tub/shower chair, pedal/knee-controlled faucets, or long–handled brushes do not disqualify the member from being independent.

If the member needs support in getting to and from the bathroom to bathe, this should be reflected in the mobility section and not affect the score for bathing.

Transfer time into the shower/tub is included in the bathing time.

Bathing more than once per day is a personal preference and not a necessity. For instances where additional bathing may be necessary due to a member's behaviors related to toileting, please see the Specialty Toileting Task, which includes both personal and environmental cleaning and allows for multiple cleaning sessions throughout the day.

Do not assess for members under the age of 5.

ASSESSMENT CONSIDERATIONS:

- How many times per week does the member bathe (member specific, as needed)?
- A person may not need a full bath (bathtub, shower, or bed bath) every day. If a person does not want to be bathed daily, they generally need to at least have their face, underarms, and private areas washed on a daily basis.
- Sponge baths can be completed by the member or the caregiver if the member is not able to use the sponge or wash cloth to clean themselves.
- A bed bath is for members who are unable to leave their bed without maximum assistance and cannot get out of the bed to be bathed in a shower or tub.
- Clean up after incontinence episodes would generally be considered under the toileting section, as it does not usually require a full bath. If, however, the clean-up does require a bath, the frequency and time for this shall be included in bathing.

TIME GUIDE: Do not write in the gray areas. In general, bathing should not exceed 45 minutes per day.

- Do not assess for members under the age of 5.
- Independent. The member is able to bathe without any supervision or assistance:
  - 0 min/day.
- Sponge bath. The member does not bathe on these days but still wants to freshen up with water and a sponge or washcloth:
  - 1-5 min/day.
- Partial Assistance: The member needs supervision, cueing, set-up, and/or some bathing (hands on) assistance with washing/drying parts of the body. Needs some cueing or assistance getting in/out of the tub/shower:
  - 1-20 min/day
- Full Assistance: The member is dependent on others for assistance with 75% or more of the bathing process. May require one or more persons assist to get in and out of the shower/tub or requires the use of a mechanical lift or member is only able to receive bed baths:
  - 1-45 min/day.

DRESSING (AM & PM)

Dressing includes the laying out, taking off, putting on, and fastening of clothing and footwear. Do not assess for members under the age of 5.

ASSESSMENT CONSIDERATIONS

- Can the member choose their own clothes, put them on, and put on socks and shoes?
- If someone lays out the clothes, can the member put them on?
- Does the member successfully use assistive devices in dressing, such as reachers, sock pullers, shoehorns?
- While it may be faster for a caregiver to put on a member's clothes, if the member is still physically able to do this activity, then the member should be considered independent.
- Not all people get changed multiple times a day. Some people get changed once in the morning into fresh clothes and may wear and sleep in the same clothing. Examples include: shorts and tee-shirts, sweatpants, etc.

TIME GUIDE: Do not write in the gray areas. In general, dressing should not exceed 30 minutes per day.

Complete time for the AM section and, if appropriate, give additional time in the PM section. The time in the AM section is not expected to match the time in the PM section. When determining the time needed for assistance with dressing, specific tasks should be considered.

- Do not assess for members under the age of 5.
- Independent. The member does not need assistance with any part of dressing or undressing:
  - 0 min/day.
- Minimum. The member needs some supervision or reminding. Includes selecting and laying out clothes:
  - 1-5 min/dressing session (AM and PM).
- Moderate. The member needs hands-on assistance by another person, or supervision with 50% to 75% of dressing activities. Regular assistance with buttons, zippers, and buckles, socks, and shoes:
  - 1-10 min/dressing session (AM and PM).
- Maximum. The member needs hands-on assistance with 75% or more of the dressing activities. Complete assist with dressing including transfer assist if needed:
  - 1-15 min/dressing session (AM and PM).

GROOMING (AM AND PM)

Grooming includes oral hygiene, nail care, face cleaning, shaving, and fixing hair. Do not assess for members under the age of 5.

ASSESSMENT CONSIDERATIONS:

- For a member with Diabetes, nail care of the feet should only be completed by the member or a medical professional.
- For members with motor control considerations, it may be appropriate to utilize assistive supports such as electric or safety razors to foster more independence, rather than someone else completing the task for the member.
- If a member is slow to complete grooming tasks but is able to do so given appropriate time allotment, the member is considered independent.

TIME GUIDE: Do not write in the gray areas. In general time should not exceed 20 minutes a day.

- Do not assess for members under the age of 5.
- Independent. The member does not need assistance with any part of grooming:
  - 0 min/day.
- Minimum. The member needs some supervision or reminding. May include setting out grooming materials (e.g. hair brush, tooth brush/tooth paste):
  - 1-5 min/grooming session (AM and PM).
- Moderate. The member needs hands-on assistance by another person, or supervision with 50% to 75% of grooming activities:
  - 1-8 min/grooming session (AM and PM).
- Maximum. The member needs hands-on assistance with 75% or more of the grooming activities. Complete assistance with grooming, including transfer assist if needed:
  - 1-10 min/grooming session (AM and PM).

TOILETING

For specialty toileting needs including catheter, ostomy, toileting schedule, or medical and/or behavioral needs impacting toileting, do not assess in this section. This should be assessed in the Specialty Toileting section.

Toileting tasks include reminders, the taking off and putting on of clothing and/or diapers, post-toilet hygiene, and use of equipment such as a urinal. Do not assess for ages under 4.

ASSESSMENT CONSIDERATIONS

- It is not healthy/safe to use suppositories or laxatives to have more than one bowel movement per day. If this is occurring, notify the member's PCP.
- If the member is incontinent but is able to manage their own incontinence supplies and change themselves, then the member is still independent.

TIME GUIDE: Do not write in the gray areas.

- Do not assess for members under the age of 4.
- Independent. The member does not need assistance in any part of toileting or is able to manage own incontinence with use of briefs or pads that the member is able to change on their own:
  - 0 min/task.
- Minimum. The member needs reminders to go to the restroom, standby assist, or supervision with toileting:
  - 1-5 min/task.
- Moderate. The member needs moderate assistance with clothing, diapers, post-toilet hygiene, and/or equipment for either continent or incontinent members:
  - 1-10 min/task.
- Maximum. Total assist with clothing, diapers, post-toilet hygiene and/or equipment for either continent or incontinent members:
  - 1-15 min/task.

SPECIALTY TOILETING NEEDS CONSIDERATIONS

Specialty toileting includes care needed when a member has a catheter bag and/or ostomy bag, demonstrates digging/smearing behaviors that require personal and/or environmental cleaning, demonstrates chronic constipation/holding behaviors, or follows a prescribed formal toileting schedule. This does not include standard toilet training activities/scheduling. A formal toileting schedule should be developed by a physician, occupational therapist, or behavioral therapist. There is no age limitation on this task.

ASSESSMENT CONSIDERATIONS

- The time to pour out the urine from a catheter bag should generally not require more than 15 minutes/day.
- The time to take care of a member's ostomy bag (even when twice a day) should generally not require more than 20 minutes/day.
- If the member is able to manage catheter and/or ostomy care without assistance, time should not be assessed.
- It is not healthy/safe to use suppositories or laxatives to have more than one bowel movement per day. If this is occurring, notify the member's PCP. Administering suppositories or laxatives should not be part of assessed time, as this is symptom management, not toileting.
- Number of toileting events per day for those whose specialized needs do not involve catheter/ostomy.
- If the member is on a toileting schedule, it must be prescribed by a clinician.
- If the member demonstrates constipation or holding behaviors, what assistance is being provided during the toileting routine, and how much time do those interventions take

TIME GUIDE

- Independent: The member has a specialty toileting need but has the ability to self-manage.
- Catheter: The member has catheter and needs assistance to pour out the urine and clean or change the bag:
  - 1-15 min/day.
- Ostomy: The member has an ostomy and needs assistance to pour out the feces and clean or change the bag:
  - 1-20 min/day.
- Smearing behaviors that require personal and/or environmental cleaning:
  - 1-30 min/event
- Chronic Constipation/Holding Behaviors:
  - 1-15 min/event
- Formal Toileting Schedule in Place due to medical and/or behavioral needs:
  - 1-10 min/event

MOBILITY

Mobility is the extent of the member's purposeful movement within their residence. The use of assistive devices such as a wheelchair, walker, or quad cane does not disqualify the member from being independent, nor does it guarantee an increase in the need for assistance by another individual.

Transfer time is not counted in the mobility section but in the transfer section below. Do not assess for ages under 2.

ASSESSMENT CONSIDERATIONS:

- Can the member purposely move about his/her residence independently with or without the use of assistive devices? A member that can propel themselves in a wheelchair should be considered independent.
- Is the member unsafe without the assistance of another person in ambulating?
- Does the member have weakness, unsteady gait, or unstable balance?

TIME GUIDE: Do not write in the gray areas.

The number of times a member is assisted with mobility per day is Not counted; rather an approximate amount of time spent per day in mobility assistance shall be assessed.

- Do not assess for members under the age of 2.
- Independent. The member is independent in mobility with or without assistive devices:
  - 0 min/day.
- Minimum. The member needs some supervision, standby, or reminders for safety. This may include adjusting of assistive devices or safety restraints:
  - 1-15 min/day.

- Moderate. The member needs hands-on assistance for safety. One-person assist, with or without assistive devices:
  - 1-30 min/day.
- Maximum. May need one or more persons or may be totally dependent on others for mobility:
  - 1-60 min/day.

TRANSFERRING

Transferring is the member's ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc. Do not assess for ages under two.

ASSESSMENT CONSIDERATIONS:

- Is the member able to use any mechanical devices such as a walker, cane, or handrails of wheelchair to assist with transfers? Use of assistive devices does not disqualify the member from being independent.
- Is the member unsafe without the assistance of another person in transferring?
- Can the member physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver?

If a mechanical lift is needed, then all transfer time shall be noted in the lift section and not in the other min-max assistance sections.

TIME GUIDE: Do not write in the gray areas.

- The number of times a member is transferred per day is NOT counted (except when transferred by Lift); rather an approximate amount of time spent per day on transfer assistance shall be assessed.
- Do not assess for members under the age of 2.
- Independent. The member is independent in transfer with or without assistive devices:
  - 0 min/day.
- Minimum. The member needs some supervision, standby, or reminders for safety. This may include adjusting of assistive devices or restraints:
  - 1-10 min/day.
- Moderate. The member needs hands-on assistance for safety. One-person assist, with or without assistive devices. The member may be able to bear weight and pivot:
  - 1-15 min/day.
- Maximum. May need two or more persons or may be totally dependent on others for transfers:
  - 1-30 min/day.
- Person Who is Unable to Leave Their Bed: requires frequent turning and repositioning in bed:
  - 1-90 min/day.
- Mechanical Lift: Member requires the use of a mechanical lift. If member transferred by Lift, time for transfer will be counted in this area only and not in any of the min-max areas above:
  - 1-60 min/event.

GENERAL SUPERVISION

Supervision will be assessed based on safety concerns related to each child's specific medical and/or behavioral needs and limitations and must be clearly documented. Supervision is not intended to replace general monitoring of children who, due to age alone, cannot be left unattended. Supervision needs must be supported by the presence of extraordinary care needs and medically necessary care interventions.

- Complex medical conditions requiring consistent monitoring for safety can include concerns such as frequent seizure activity, high risk for choking, ventilator dependence, etc.
- Behavioral needs can include elopement, putting inappropriate items in mouth/eating non-food items, self injurious behaviors, aggressive behaviors, etc.
- A member may be supervised through the night if the member has sleep issues due to a documented medical or behavioral condition that makes it unsafe for the member to be left unattended.
- Environmental modifications shall be considered to lessen the need for paid supervision. If environmental modifications are being evaluated to mitigate the need for supervision, supervision shall be authorized until the necessary modification(s) is in place.
- Paid general supervision shall not be authorized for a member requiring active or direct supervision whose legally responsible person works from the home, unless supervision is provided by a non-legally responsible person or by a legally responsible person not working during the hours requiring supervision.
- The caregiver must be awake to be paid for general supervision.
- Paid supervision is not intended to replace childcare obligations; supervision shall be a medically necessary service and be based on a member's unique care needs to maintain the member's health and safety.
- Attendant care supervision services shall not be authorized by the Contractor or Tribal ALTCS while the member is engaging in, participating in, or receiving provided privately or publicly funded K-12 educational services, programs or grants.

Paid supervision through the attendant care service shall always be a last resort. Supervision must be based on needs that result in the member requiring active or direct supervision.

TYPES OF SUPERVISION	
ACTIVE SUPERVISION	A responsible adult within arms reach of child at all times.
DIRECT SUPERVISION	A responsible adult is readily and easily accessible in the home at all times.

QUESTIONS AND CONSIDERATIONS

What does the school day look like?
If the child attends a school program, supervision and other Home and Community Based Services (HCBS) may be provided directly by the school. The school may also offer before and after school care to ensure supervision until the parent can collect their child. It is typical for parents to use these services and pay any associated fees directly.

What does the child's sleep schedule look like? How does the adult in the home need to intervene?
It is typical for children under the age of 2 to wake up multiple times during the night. In this situation, it is also typical for the parent or guardian to help the child return to sleep. It would be considered extraordinary if an older child is not able to sleep through the night or the child requires multiple hours with adult supervision because of sleep issues during the night. It may also be considered extraordinary if the child requires active supervision during sleeping hours due to a documented medical or behavioral condition that makes it unsafe for the child to be unattended. Caregivers must be awake during overnight care hours to be paid; time spent sleeping even if there is a monitor or other alarm process present does not translate to active supervision/paid support.

If the parent is in the home, what prevents them from supervising the child?
If the parent works from home and the child requires direct or active supervision, it may be appropriate for supervision to be provided by a non-parent provider or another parent/guardian. A parent provider cannot work from home for an employer and simultaneously be paid through ALTCS to provide services to their child.

Does the child have a documented medical need that requires 24-hour eyes on supervision (e.g., multiple daily seizures, non-verbal, medical needs like feeding tubes, pulsometer monitoring, autism driven eloping)?
Case Managers should assess each member holistically to determine the service(s) that may best support the member in maintaining their health and wellbeing, including skilled and non-skilled supports. The case manager should also consider if attendant care tasks that may have been assessed include a supervisory component (e.g. feeding includes monitoring the member to ensure they are eating safely).

Does the child have a physical limitation that would prevent them from safely leaving the home in the event of an emergency (e.g., house fire, flood)?
If so, paid supervision may be appropriate if there are no natural supports that can provide informal supervision.

In determining if a child may be left alone for a short period of time, determine if they are able to feed themselves. Are they able to call someone in case of an emergency? Do they understand how to safely respond if someone knocks on the door? Can the child take necessary medication by themselves?
If the child is unable to be safely left alone for a short period of time, supervision either paid or informal may be appropriate.

Are there nearby childcare centers willing and able to care for the child and their extraordinary needs?
It is typical for parents to pay for childcare for their children. Understanding a child eligible for ALTCS may have extraordinary needs, there may be childcare centers available that can meet the needs of the child. If not paid or informal supervision may be appropriate.

Can environmental modifications mitigate the risks requiring paid attendant care supervision (e.g., safe sleep bed, high door locks the child cannot reach, alarms on the windows and doors)?
If so, environmental modifications shall be a priority to lessen the need for paid supervision.

Can habilitation goals be used to teach/improve skills to mitigate risks and lessen the need for paid attendant care supervision?
If so, habilitation shall be used in place of paid supervision to teach those skills and lessen the need for paid supervision.

ASSESSMENT CONSIDERATIONS

Do not assess under age 10. Children under age 10 must be assessed in specialty supervision category.

For those needing supervision time, the time assessed should cover the time between the specific ADL/IADL tasks the caregiver is performing and the time the child is engaged in other activities/programs where supervision is provided (school, therapies, etc.).

For example: A member who is a minor that experiences multiple seizures daily. The school aged child receives supervision during the day at school, but nighttime supervision hours may be needed.

Another example would be a member who is a minor child who is an elopement risk due to limited capacity to understand risks. The child receives attendant care in the morning to help with toileting, bathing, dressing, grooming, and eating breakfast before school. The parent is unable to provide supervision during that time due to helping other children get ready. The supervision need would be assessed only for the time between and after the assessed tasks. So, if the needs assessed for all tasks total 60 minutes, and an additional 20 minutes is needed until the bus arrives, the supervision need would be 20 minutes.

- Informal Supports (IFS) hours shall be clearly noted on the tool in the IFS column if they have agreed and are available and willing to cover supervision time.
- For those receiving supervision time, the caregiver may need to assist with the self-administration of medications (as applicable), monitoring of the member's medical condition, monitoring the member's level of functioning, oversight of decision making and activities of daily living, and documentation of the same during this supervision time.

  Reminder: Only licensed medical professionals are allowed to be paid to administer or use discretion/judgment in the dispensing of medications to another person. Family members working as caregivers who choose to administer medications or set up med-boxes are allowed to do so but they *cannot be paid* to do so.

TIME GUIDE:

Varies upon the needs of the individual member to fill in the period of time between functional assistance being provided and when family/IFS is able to supervise the member.

SPECIALTY SUPERVISION:

Specialty Supervision for children under the age of 10 shall only be assessed when the child requires active supervision (a caregiver within arm's reach at all times) to meet the need for immediate response or intervention from a caregiver, to ensure member health/safety due to documented medical or behavioral risks such as the following: Environmental risk-taking (e.g. pica/eating of non-food objects, unsafe climbing, property destruction, mouthing electrical cords, unsafe interaction with electrical outlets despite use of reasonable safety precautions including outlet covers, elopement risk despite use of reasonable safety precautions including door locks), frequent, severe self-injurious behavior (e.g. head banging, self-biting, or other forms of self-harm/potential self-harm), physical aggression towards others (siblings, pets, etc.), uncontrolled seizures that require caregiver to physically intervene to prevent harm, high airway risk due to trach/ventilator-dependence, severe choking risk.

- A member may be supervised through the night if the member has sleep issues due to a documented medical or behavioral condition that makes it unsafe for the member to be left unattended.
- Environmental modifications shall be considered to lessen the need for paid supervision. If environmental modifications are being evaluated to mitigate the need for supervision, supervision shall be authorized until the necessary modification(s) is in place.
- Paid specialty supervision shall not be authorized for a member requiring active supervision whose legally responsible person works from the home, unless supervision is provided by a non-legally responsible person or a legally responsible person not working during the hours requiring supervision.
- The caregiver shall be awake to be paid for specialty supervision.
- Paid supervision is not intended to replace childcare obligations; supervision shall be a medically necessary service and be and based on a member’s unique care needs to maintain the member’s health and safety.
- Attendant care supervision services shall not be authorized by the Contractor or Tribal ALTCS while the member is engaging in, participating in, or receiving provided privately or publicly funded K-12 educational services, programs or grants.

Paid supervision through the attendant care service shall always be a last resort. Supervision must be based on needs that result in the member requiring active supervision.

ASSESSMENT CONSIDERATIONS:

- For those needing supervision time, the time assessed should cover the time between the specific tasks the caregiver is performing and the time the child is engaged in other activities/programs where supervision is provided (school, therapies, etc.).

  For example: A member who is a minor that experiences multiple seizures daily. The school aged child receives supervision during the day at school, but nighttime supervision hours may be needed.

  Another example would be a member who is a minor child who is an elopement risk due to limited capacity to understand risks. The child receives attendant care in the morning to help with toileting, bathing, dressing, grooming, and eating breakfast before school. The parent is unable to provide supervision during that time due to helping other children get ready. The supervision need would be assessed only for the time between and after the assessed tasks. So, if the needs assessed for all tasks total 60 minutes, and an additional 20 minutes is needed until the bus arrives, the supervision need would be 20 minutes.

- If extraordinary care needs are documented for nighttime hours, paid supervision time assessed must indicate the person supervising is awake. The Case Manager shall not authorize for a paid caregiver to sleep and be paid for supervision.

- Informal Supports (IFS) hours shall be clearly noted on the tool in the IFS column if they have agreed and are available and willing to cover supervision time.

- For those receiving supervision time, the caregiver may need to assist with the self-administration of medications (as applicable), monitoring of the member's medical condition, monitoring the member's level of functioning, oversight of decision making and activities of daily living, and documentation of the same during this supervision time.

  Reminder: Only licensed medical professionals are allowed to be paid to administer or use discretion/judgment in the dispensing of medications to another person. Family members working as caregivers who choose to administer medications or set up med-boxes are allowed to do so but they *cannot be paid* to do so.

TIME GUIDE:

Varies upon the needs of the individual member to fill in the period of time between functional assistance being provided and when family/IFS is able to supervise the member.

HABILITATION:

Habilitation is designed to facilitate the learning of new skills and foster greater independence for the member. It is to be assessed when it is believed that the child has the capacity to increase their independence in the completion of a task with the help of instruction and assistance. Habilitation goals are not limited to ADLs and may include various skills to promote/support health, home, and community skills.

ASSESSMENT CONSIDERATIONS:

- Do not assess for members under the age of 3.
- Habilitation goals should not be considered for age-appropriate learning. Use the age indicators ("Do not assess for children under") indicated above and in the HNT to determine if the member is appropriate for habilitation for that particular task. If they cannot be assessed for attendant care, then it is not appropriate to assess for habilitation unless specifically noted as allowable.
- The amount of time to be assessed for habilitation must consider the member's capacity to learn, practice, and retain information. Time assessed should not exceed the outlined time indicated on the HNT.
- Ongoing assessment/monitoring of the member's progress should occur for each habilitation goal to ensure it remains appropriate.
- Members may not receive attendant care during the same day/time that habilitation is being delivered.
- Habilitation goals may not be educational in nature (something that would be part of a school/home school curriculum).
- Habilitation services can be provided in the home or in the community, based upon where the skill is most likely to be used.

TIME GUIDE:

- Members aged 0-2: Do not assess.
- Members aged 3 and older: Not to exceed 14 hours in a 7-day period

INFORMAL SUPPORTS:

The discussion regarding who the member wants engaged in their care shall occur AFTER the needs of the member have been identified. The member is generally able to choose the caregiver(s) that they want, including family members and friends although neither are obligated to provide care if unable and/or unwilling to do so. Case managers should also explore how care will be received such as formal (paid) caregivers, informal (unpaid) supports, or a combination of both.

- If the member/family wants an agency to identify and hire all caregivers for their minor child, that is appropriate.
- If the parent wants to provide paid care to their minor child, they may do so as long as they meet all the requirements outlined in the Parents As Paid Caregiver service model.

- If the member/family wants known family members or friends to be the paid caregiver, that is allowable as long as the person(s) meet the Direct Care Worker (DCW) requirements established by the provider agency.

Discuss formal and informal supports with the member. Ask the member/family what their preference is in terms of who provides the assessed care to the minor child. It is commonplace for parents to reach out to family, friends and other trusted adults to help with supervision if they have local connections who may be willing to assist. If the member/family has informal supports that they intend to use, list the individuals who are available to provide informal support. Family members and/or friends shall not be pressured to provide care/services (whether formal or informal) if they are not interested and/or able to do so. Also, the member/family shall not be made to feel that they are obligated to identify caregivers for the member; this is a responsibility of the provider agency.

If informal supports are being used, this must be documented on the HNT. Enter the time(s) that informal supports will be able to assist as well as the specific task(s) for which the informal supports will be engaged; this should be entered in the IFS Hours column.

Listing the IFS information is mandatory, as it is always necessary to clearly document what care is already being provided to the member in order to demonstrate what needs remain unmet. This should be completed even if there are no IFS being provided.

In addition to informal supports, if the member is receiving care from another source, such as Medicare home health or hospice, be sure to document this.

EXTRAORDINARY CARE REVIEW *(EXCEPTION)* PROCESS

Members under the age of 18 may be eligible for an Extraordinary Care Review (ECR) or exception process if the HCDM disagrees with the hours assessed (or lack thereof) due to the age or habilitation service hour limitations outlined in the HNT. The case manager shall educate the HCDM about the ECR process and ensure information as well as any concerns regarding the assessment process are documented on the HNT.

If the HCDM does want to receive more information, they also need to acknowledge two things:

- That receiving written information regarding ECR does not mean that the member is automatically eligible for an ECR; eligibility is outlined in Rule and the ECR Policy (ACOM Policy 450).
- That the HCDM will be required to submit a formal request if they wish to pursue an ECR for the member and they may submit supporting documentation for the ECR within the timelines required. They may also choose to complete an additional assessment called the PEDI-CAT on behalf of the member.

If the HCDM does not want to receive written information about the ECR process, that should be documented with the HCDM name and signature as well as the date of the decision.

The HCDM can elect to pursue an ECR at the time of completion of the HNT or anytime following the completion of the HNT if concerns arise later.

The HCDM shall be made aware that requesting an ECR does not mean that their child is automatically eligible for an ECR; eligibility is outlined in Rule and the ECR Policy (ACOM Policy 450).

If the HCDM elects not to pursue an ECR, the CM shall document this, while also educating the HCDM that they may request an ECR at a later date in the manner prescribed by the health plan.

The HCDM shall be made aware that choosing not to pursue an ECR at that time does not prevent them from doing so at a later date and/or if the member has a change in condition and their care needs also change.

HCDMs shall be educated about the annual limits of the ECR process, with an ECR occurring once every 12 months, unless the child has a change in condition and/or the child receives a service assessment/review of a task that was not previously reviewed as an ECR.

SIGNATURES

Upon completion, the Case Manager is required to sign and date the HNT and must attest that *"I have contacted the IFS/s named above and s/he voluntarily agree/s to provide the services indicated, with no compensation"* by checking the box above the signature line.

If a member's assessed units/hours exceed the number of units/hours that the Case Manager is allowed to approve, the supervisor's signature line can be used as a way to indicate that the supervisor has reviewed the HNT and is in agreement with the assessed units/hours. With the exception of Tribal ALTCS Programs, supervisor signatures are optional.