

Assisted Living Program (ALP)
Questions and Answers

04/25/96

This Question and Answer document is the fifth one developed by the Department in response to frequently asked questions pertaining to the ALP. Four earlier sets of Questions and Answers were dated October 15, 1992, April 26, 1994, October 4, 1994 and October 16, 1995. We encourage you to continue to identify issues and to ask questions about the ALP. The questions inform and support the implementation process and contribute to the effective operation of the ALP. General ALP questions may be referred to the Office of Housing and Adult Services (OHAS) at (518) 432-2991. Additional questions related specifically to a Certified Home Health Agency (CHHA), a Licensed Home Care Services Agency (LHCSA) or a Long Term Home Health Care Program (LTHHCP) may be referred to the Department of Health's (DoH) Bureau of Home Health Care Services at (518) 271-2741. Additional questions pertaining to Medical Assistance (MA) may be referred to the Department's Division of Health and Long Term Care (DH<C) at (518) 473-5563 or 473-5569.

1. Q. Will an ALP receive Medicaid (MA) reimbursement when an MA recipient is away from the facility for a few days, a week or a couple of weeks visiting family or friends?

A. No. As stated in the ALP Question and Answers dated 4/26/94, an ALP will not receive any MA reimbursement for a resident who is away from the facility for more than two days. For example, if a resident is away for a week, the ALP will not receive reimbursement for any days of the absence. Reimbursement will only be made if the absence is no more than two days in duration and if the following conditions are met:

- o the recipient has resided in the ALP for at least 30 days;
- o the recipient's physician has approved the absence in writing;
- o the ALP assures that the recipient's health care needs will be met during the absence;
- o the visit is limited to two days duration for any single absence;
- o the ALP obtains prior authorization from the fiscally responsible social services district if the recipient total days of absence exceeds 18 days in a 12 month period;
- o the ALP is fiscally responsible for the provision of any home care services included in the MA rate which are required by the recipient during the absence which the family members or friends are unwilling to provide, and;
- o the ALP documents all absences on an ALP-Medicaid Recipient Absence Roster (DSS-4455). A copy of the form must be maintained in the resident's record and included in transfer records. In addition to documenting absences, this form must be used to document the prior authorization of the social services district.

2. Q. May an ALP contract with the social services district (the district) to conduct the initial and periodic nursing assessments for ALP applicants and residents?
- A. According to Social Services Law 461-1 and to 18 NYCRR 494.4(b), nursing assessments of ALP residents must be conducted by a certified home health agency (CHHA) or a long term home health care program (LTHHCP). Unless a district is either a CHHA or a LTHHCP, it is ineligible to conduct these assessments. In addition to the prohibition by statute and regulation, the capitated rate paid to the ALP by Medicaid (MA) includes payment of the reassessments.
3. Q. Do all applicants for admission to an ALP have to obtain a Medical Evaluation (DSS 4449 C 1-4) within 30 days prior to admission as required by 18 NYCRR 494.4(f)(1)?
- A. This regulation is being waived in certain circumstances. All applicants for admission to an ALP need to obtain a Medical Evaluation (DSS 4449 C 1-4) prior to admission. If, however, the applicant is an adult home or enriched housing program resident and the Medical Evaluation (DSS 4449 C 1-4) becomes out-of-date, i.e., more than 30s days old, while a district is reviewing it, a new one does not have to be obtained as long as the applicant's condition remains the same. The reason for this is that as a resident in an adult home or enriched housing program, the applicant already has a current Medical Evaluation (DSS 3122) reflecting the resident's condition accurately and completely.

Therefore, as long as the condition of the adult home or enriched housing program resident remains the same, the ALP Assessment Medical Evaluation (DSS 4449 C1-4) sent to the district will be considered current until the district determines whether or not the applicant is appropriate for admission to the ALP or for up to 90 days from the date of the Medical Evaluation (DSS 4449 C1-4). If the applicant is admitted to the ALP, an updated Medical Evaluation (DSS 4449 C1-4) is needed whenever the resident's condition changes so that the RUG category changes or within 45 days of admission, whichever comes first.

4. Q. Must the person who signs an adult care facility medical evaluation form (e.g., physician, nurse practitioner, physician's or specialist's assistant) be the same person who completes the form, i.e., fills in the data in response to the questions or items on the form?
- A. No. By signing the form, the licensed individual is considered to be certifying that the information on the form is, in the professional opinion of that licensed individual, complete and accurate. It is not necessary for that person to be the same person to complete (i.e., fill-in or type-up) the form.

The intent of the regulations and of statute is to have a medical professional conduct a physical examination of an individual and to document accurate results or findings of that examination on a medical evaluation form. While the medical professional who conducts the examination must also sign the medical evaluation form, the regulations do not require that same medical professional to physically complete the form.

Any system established whereby the medical evaluation form is completed by someone other than the professional who conducted the physical examination and who is signing the form must be appropriate under all professional acts and guidelines. If a licensed individual signs a medical evaluation that contains erroneous and misleading information, then the matter should be referred to the attention of the entity that provides legal oversight to the individual's practice or licensure.

5. Q. Where is documentation of a resident's condition and services provided by CHHA or LTHHCP staff to be maintained? Must it be maintained in both the CHHA or LTHHCP office and in the ALP?

A. According to Section 763.7 of 10 NYCRR, the CHHA or LTHHCP must maintain a confidential clinical record for each patient to include identifying patient data, physician orders, patient assessment, plan of care, signed and dated progress notes following each patient contact, and supervisory notes. The original of these documents should be maintained at the CHHA or LTHHCP office while a copy of the documents pertaining to the resident's on-going care, to include the plan of care, progress notes and aide supervisory notes should be maintained at the ALP, either separately or incorporated into the adult home or enriched housing program record.

The ALP must also maintain all records that are a part of the ALP Assessment process such as the ALP Screen and Summary, Identifying Data, Medical Evaluation and Social/Nursing/Functional Assessment forms in the DSS 4449 package.

6. Q. Must the services of all professional staff be documented in the resident's ALP clinical record.

Yes. The resident's ALP clinical record must include signed and dated progress notes following each patient visit by all professional personnel providing care which include a summary of the patient status and response to the patient's plan of care.

7. Q. How much documentation is required and how often must it be documented for the ALP nurse to verify the resident's plan of care and an on-going assessment of the resident's condition?

A. The amount of documentation required in an ALP resident's record should be sufficient to comprehensively describe the resident's current and ongoing status. The ALP nurse must verify the

resident's plan of care and on-going assessment of condition as frequently as required to reflect the changing care needs of the resident but no less frequently than every six months.

8. Q. How often do the Home Health Aide care plans need to be reviewed?
- A. Home Health Aide care plans need to be reviewed at times of change in the resident's condition, at times of reassessments and, at least, every 62 days.
9. Q. Are photocopies of the nurse's CHHA or LTHHCP records acceptable in the ALP?
- A. Yes, CHHA or LTHHCP records may be photocopied.
10. Q. If the CHHA or LTHHCP conducts an incomplete assessment will the ALP receive a deficiency?
- A. Yes. The assessments are to be jointly completed by the CHHA or LTHHCP and the ALP (LHCSA). This configuration places responsibility on the ALP nurse as well as the CHHA or LTHHCP nurse to ensure that the assessments are complete and accurate. If the ALP receives a deficiency for an incomplete assessment, the ALP should involve the CHHA or LTHHCP to obtain a complete and accurate assessment.
11. Q. Does the ALP Medical Evaluation (DSS 4449 C1-4) serve as the physicians' orders?
- A. Yes. The Medical Evaluation (DSS 4449 C 1-4) may serve as the physician's orders as long as the orders are appropriately signed and dated.
12. Q. How often must the LHCSA nurse evaluate an ALP staff member and document the evaluation?
- A. Each staff must receive a complete evaluation of his or her performance, at least annually. These evaluations are maintained in the employee's file.
13. Q. How often must supervisory visits be made by the nursing supervisor when overseeing the care and services provided to residents by personal care and home health aides?

Nursing supervisory visits to personal care aides must be provided, at a minimum, every 90 days. Documentation of these visits is maintained in the resident's record. Nursing supervisory visits must be made more frequently when the resident's medical condition requires more frequent visits or when the aide providing personal care services needs additional or more frequent on-the-job training to perform assigned functions and tasks competently and safely.

Supervision of care is on-going and the frequency of supervision to home health aides is based on the resident's condition and changing care needs which must be individualized. Nursing supervising visits to home health aides must be provided, at a minimum, every two weeks.

14. Q. Part 494.4(c)(5) states that a resident of an ALP must voluntarily choose to participate in the ALP after being provided with sufficient information to make an informed choice. What does this mean?

A. Discharge planners and ALP operators must assure that an individual considering participating in an ALP is provided with sufficient information to inform the individual what an ALP is, the services it provides as well as other residential and service options. It is the individual's choice to participate in an ALP.

Complaints concerning involuntary admissions or the provision of insufficient information will be investigated by the Department of Social Services' regional office.

15. Q. If a resident in receipt of public benefits were to unexpectedly inherit a sum of money disqualifying the resident from receipt of the public benefits for a short period, will the operator be penalized for not meeting the commitment to having a certain percentage of residents in receipt of public benefits in the ALP?

A. As long as the resident remains appropriate for the ALP level of care, the Department would not seek to penalize an ALP operator, with respect to compliance with a public pay condition, in situations which were not reasonably foreseeable by the operator at the time of admission.

16. Q. If an emergency occurs when the LHCSA nurse is not on duty, e.g., during the night, must the ALP staff call the CHHA or LTHHCP nurse supervisor before calling for any other service or care such as an ambulance or emergency medical technicians?

A. Each ALP has policies and procedures governing management of emergencies. These procedures should be implemented in any emergency and the facility's LHCSA nurse on call should be consulted. If the emergency necessitates that an ambulance or other emergency service be called for first, then that should be included in the ALP's policies and procedures for emergency situations. In addition, any CHHA or LTHHCP involved in the resident's care, needs to be notified of the situation.

17. Q. How do operators obtain ALP forms from the Department of Social Services?

A. New York State Department of Social Services forms are available by writing to:

New York State Dept. of Social Services
Bureau of Forms and Print Management
Box 1990
Albany, NY 12201

You must state the name of the form and its DSS number, e.g., Assisted Living Program (ALP) Medicaid (MA) Recipient Absence Roster, DSS 4455, and how many forms you are requesting.