California Department of Aging (CDA)

CBAS Individual Plan of Care (IPC) Webinar Training (October 3, 2018)

Frequently Asked Questions (FAQ)

General Questions

1. **Q:** When do we have to implement the new Individual Plan of Care (IPC)?

   **A:** The required implementation of the IPC will be no earlier than March 1, 2019 and shall occur after the IPC form and instructions have been published in the Medi-Cal Provider Manual. Implementation will be on a rolling basis as each participant’s IPC comes up for review and renewal, and new Treatment Authorization Requests (TARS) are submitted.

   The California Department of Aging (CDA) CBAS Branch will distribute an All Center Letter (ACL) and CBAS Updates newsletter informing providers, managed care plans, software vendors and other interested stakeholders of the official implementation date for the new CBAS IPC.

   2. **Q:** If we can capture an electronic signature for the Multidisciplinary Team (MDT) and the Primary Health Care Provider (PHCP), does the IPC still have to be printed and maintained in a paper chart?

   **A:** CBAS providers are permitted to use electronic medical records (EMRs) with electronic signatures for the IPC, Participation Agreement and other participant health records. You do not have to maintain these documents in a paper chart. However, CBAS providers must make available hard copies of any participant health records with signatures if requested by CDA or other authorized entities.

   3. **Q:** Can the IPC form be added to a Certified Electronic Medical Records system? Does it have to be exact?

   **A:** If a CBAS provider is using electronic medical records (EMRs) and wants to include the IPC form, the IPC form (which is a State form) must be exact in content and format. This applies to the Participation Agreement form too.

   4. **Q:** How often does the IPC need to be revised?

   **A:** The federal person-centered planning requirements (42 CFR 441.301) state the following: “The person-centered service plan must be reviewed and revised upon
reassessment of functional need as required by 441.365(e) at least every 12 months, when the individual’s circumstances or needs change significantly, or at the request of the individual.” However, CDA requires the IPC to be updated at least every six months or when there is a change in circumstance that may require a change in benefits. This means that reassessments are to occur every six months to coincide with the required IPC revision every six months.

5. **Q:** Does the Participation Agreement need to be submitted to managed care plans along with the IPC?

**A:** The Participation Agreement instructions indicate that a copy of the Participation Agreement (Form CDA 7000) should be filed in the participant’s health record and a copy given to the participant and/or participant’s authorized representative. **A copy of the Participation Agreement does not need to be sent with the Treatment Authorization Request (TAR) unless requested.**

CBAS providers should contact the managed care plan(s) with which they contract to determine what documents the managed care plan(s) want the CBAS center to submit and the frequency of submission.

Refer to the IPC and Participation Agreement instructions for more guidance.

6. **Q:** Where is the IPC posted?

**A:** All forms related to Eligibility and Service Authorization which include the IPC and Participation Agreement are posted on the [CDA website](https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/Eligibility_and_Service_Authorization/).

7. **Q:** Will additional pages be available for Boxes 12, 13 & 14 if we need more documentation space?

**A:** For providers NOT completing the IPC form through customized software, if more space is needed for Boxes 12, 13 and 14, additional templates will be posted along with the IPC form and instructions on the CDA [CBAS webpage](https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/Eligibility_and_Service_Authorization/).

**Boxes 1-11**

8. **Q:** In Box 2 *Diagnoses and ICD Codes*, what diagnoses should be listed? Those on the History & Physical form only, or all those noted in their health records?

**A:** All diagnoses listed on the Personal Health Care Provider’s History & Physical form as well as other health records should be documented in Box 2. This may require
reconciling diagnoses among multiple health care providers to ensure accuracy of diagnoses in the participant’s IPC and other CBAS center health records.

9. **Q:** In Box 3 *Medications*, if we list all medications but some are administered, and some aren’t administered at the center, how do we indicate that with only one Yes or No box.

**A:** The list of medications in Box 3 should include all medications (active prescriptions and over-the-counter medications and/or supplements) regardless of where the participant is taking them.

For “Participant self-administers prescribed medication(s) at the center”:

1) Check “yes” if the participant self-administers any of the participant’s prescribed medications at the center; or

2) Check “no” if the participant does not self-administer any of the participant’s prescribed medications at the center.

If both “yes” boxes are checked (which would appear to be contradictory), please provide an explanation in Box 16 *Additional Information*. For example, both “yes” boxes could be checked if a center administers a prescribed injection at the center, but the participant is able to self-administer other medications at the center.

**Please note:** The center must evaluate the participant’s ability to self-administer medications at the center as described in the instructions before permitting the participant to self-administer his/her medication(s). This evaluation is required by regulation even if the participant’s Personal Health Care Provider authorizes that the participant is able to self-administer medications.

Please refer to IPC Instructions for additional information.

10. **Q:** If a participant’s personal health care provider has prescribed PRN meds to be administered by the center as needed, does the center list them in the prescribed medication section of Box 3 *Medications*, but not check the “yes” box for “Center administers participant’s prescribed medication(s)”?

**A:** Correct. All active prescriptions and over-the-counter medications and/or supplements are listed in Box 3 *Medications*. These include medications prescribed on a routine medication order and as a PRN (as needed.) If a center administers a PRN medication at the center, then this would be documented in the participant’s health record.

However, when completing the “yes” and “no” questions in Box 3 (e.g., if the center administers participant’s prescribed medications or if the participant self-administers prescribed medications at the center), only check yes for prescribed medications taken on a routine medication order at the center, (not PRN medications).

As mentioned during the IPC webinar training, although not specific to Box 3, PRN medications prescribed by the participants personal healthcare provider for a condition that’s based on the participants eligibility for admission to the program may need to be
addressed in the treatment plan in Box 13 Core Services under Professional Nursing Services.

11.  Q: In Box 5 ADL/IADLs Status, are we rating their ‘worst performance’ at home AND at the center, just at the center, or just at the home?

A: The CBAS center’s assessment should reflect the participant’s ADLs/IADLs as they are on the participant’s worst or lowest functioning day regardless of setting. In addition to the MDT assessment, this information may be obtained through discussions with the participant and/or the participant’s family/caregiver(s)/authorized representative.

12. Q: In Box 9 Living Arrangement/Household Composition and Non-CBAS Long Term Support Services, the IPC form does not allow space for indicating case management services other than MSSP or CVRC. However, some participants have case managers through county behavioral health. Should this be included on the IPC?

A: Yes. There was a formatting problem on the IPC form which we corrected so there is now a space to identify “Other” care management programs.

For additional information, please refer to the IPC Instructions for Care Management Program in Box 9.

13. Q: In Box 11 Risk Factors, do we have to care plan for all risk factors indicated?

A: No. Refer to the IPC Instructions for Box 11 Risk Factors for additional instruction.

14. Q: In Box 11 Risk Factors under ADL Functional Limitations (3+), how should we define “limitations”? Using the definitions for Box 5 ADL/IADL Status would limitations be defined as “Needs Supervision” and higher?

A: Refer to the following IPC Instructions for defining “limitations” using the categories identified on the IPC form for Box 5 ADL/IADL Status:

*ADL Functional Limitations (3+)* means limitations in three or more ADLs listed in Box 5 ADL/IADL Status. Referring to definitions in Box 5, “limitations” would include ADL’s checked in the following categories: *Needs Supervision, Needs Assistance, and Dependent.*
Box 12: Needs/Goals/Desired Outcomes

15. Q: Box 12 Needs/Goals/Desired Outcomes Expressed by Participant or Authorized Representative During Assessment Process has space for five needs/goals. Will there be additional templates available if the participant identifies/communicates more than five?

A: Yes. Box 12 includes space for five participant-expressed needs/goals/desired outcomes. It is not necessary to complete all five, however the center must complete at least one. If the provider is NOT completing the IPC through customized software and the participant expresses more than five, document additional needs/goals/desired outcomes using the Box 12 template available on the CDA website.

16. Q: Do all services provided in Boxes 13 Core Services and 14 Additional Services need to refer to at least one need/goal identified in Box 12?

A: If the participant expresses a need, goal or desired outcome in Box 12, then the appropriate discipline within his/her scope of practice should care plan to that need, goal, desired outcome if possible. The care plan should reflect both the participant’s expressed needs/goals/desired outcomes and the MDT’s assessed needs of the participant.

The MDT’s assessed needs of the participant may or may not correlate directly with all of the participant’s needs/goals/desired outcomes in Box 12. However, if any participant needs, goals, desired outcomes identified in Box 12 are relevant to a particular discipline’s scope of practice, then that discipline should care plan to that participant-expressed need, goal, desired outcome.

17. Q: What if participants are unable to state a need or goal due to their diagnoses such as Intellectual Disability, Alzheimer’s dementia or are non-verbal. Would interviewing family or a caregiver be acceptable to obtain a goal/need for participant?

A: Regardless of a participant’s diagnoses, impaired cognition, being non-verbal, forgetful or whatever the reason, the MDT should try to engage the participant in a person-centered manner to express or communicate in some way his/her desires, needs, interests that could help the center identify what the participant might need or enjoy doing while at the center or at home. Refer to the IPC instructions for Box 12 for examples of questions/ways the center might elicit this information from the participant.

If despite center efforts the participant is unable to articulate, communicate or provide this information, the center should communicate with the participant’s family/caregiver, authorized representative, personal health care provider and/or anyone else involved in the participant’s care who may be able to speak for the participant and identify the participant’s needs, goals, or desired outcomes based on their knowledge of the participant.
18. Q: Working with participants with severe/profound intellectual disabilities, the needs/goals for the participants become very repetitive/cookie cutter. Is this acceptable? If not, how do we address the fact that most severe/profound participants with intellectual disabilities have the same needs/goals?

A: Even though a participant may have severe/profound intellectual disabilities, his/her needs/goals should still be person-centered. Persons with profound disabilities may have the same basic needs – personal care, assistance with eating, needing physical help from someone to engage in an activity, but that does not mean their goals can’t be person-centered. For example, just because persons are classified as severe/profound, they may be totally different in their social interactions or the music they like, or have different ways of letting someone know their needs by sounds, gestures, etc. It is up to the center to talk with the participant’s family, the regional center case manager, or anyone who knows the participant well to determine what they like. For example, if someone is non-verbal but responds to pictures, the center may show them different pictures of things to see what they like. Maybe they want to go to the park but can’t verbalize that, but with a picture and a possible eye gaze or point, they can choose an activity. Most times their goals are very small, but even the smallest step can be huge. Persons with profound disabilities have hopes and desires which person-centered planning is to identify. If the participant has a Regional Center care manager, this person would be an important care planning resource to the MDT.

Box 13: Core Services

19. Q: Do we have to write a care plan for each diagnosis?

A: The “Need/Problem” statement on the IPC for Boxes 13 Core Services and 14 Additional Services should not state solely the diagnosis but what the participant’s assessed and/or expressed needs/problems are that may be related to a diagnosis. The “Need/Problem” should not be “Depression” or “Alzheimer’s Disease” or “Diabetes” but rather the participant’s assessed needs/problems related to these diagnoses that puts them at risk for an adverse health event or are limiting the participant’s ability to function as independently as possible or to enjoy life.

20. Q: If professionals from the MDT identify some problems/issues, like poor safety awareness, poor balance, but those are not the participant’s goals, do we include them in the IPC?

A: Yes. The MDT should develop a care plan based on their assessment within his/her scope of practice and discuss this with the participant even though the participant hasn’t identified that need/problem. However, it is important that the participant agrees with the care plan since he/she needs to engage in the treatment interventions to achieve the identified goals/outcomes. The IPC must be developed in a person-centered way that engages the participant in his/her own treatment plan at the center.
Box 14: Additional Services

21. Q: Mental Health intervention is not identified under core or additional services. Where would we insert a mental health intervention, i.e., LCSW sessions?

A: “Mental Health Services” has been changed to “Behavioral Health Services” in Box 14 to align with the Waiver. There was a change in terminology only, so instead of being referred to as mental health services, it is now referred to as behavioral health services.

22. Q: In Box 14 Additional Services - Transportation Services, do we need a transportation care plan for all participants who are using center transportation?

A: Yes. Centers are required to care plan transportation for all participants for whom the center is providing or arranging for transportation to and from the participant’s place of residence and the center.

23. Q: If a participant desires to walk/drive to the CBAS center, do we need a doctor's approval, and do we have to care plan that?

A: No, a doctor's approval is not needed. The center is only required to care plan transportation if the center provides or arranges the transportation to and from the participant’s place of residence and the center. The center may decide to document transportation arrangements for participants who are independent in walking or driving to and from the center, but it is not required.

24. Q: If a participant uses ACCESS, Dial-A-Ride, family or other method of transportation that is not the center’s transportation, do we care plan for that?

A: The center would care plan for transportation if the center is providing or arranging transportation to and from the participant’s place of residence and the center. If the social worker is arranging ACCESS transportation or some other method of transportation, this would be documented on the IPC in Box 14 Transportation Services. The center is not required to care plan transportation if the family is providing it.

25. Q: Which staff person is responsible for assessing participant transportation needs and completing the transportation section of the IPC?

A: The center shall decide which discipline should assess participants' transportation needs and complete Box 14 Transportation Services.
26. Q: Do we need a separate assessment form for transportation services?

A: The center can decide how to operationalize care planning for the transportation service, including if the transportation assessment is to be included on the assessment form of one of the center’s disciplines, or to develop a new form.

**Box 17: Signatures of Multidisciplinary Team and Program Director**

27. Q: Do we need a signature on the IPC for transportation services?

A: Whoever completes the assessment and care plans for transportation on the IPC should sign the IPC. This will likely be one of the center’s disciplines who are already signing the IPC. However, the center will determine the assessment and care planning process for documenting transportation services in Box 14 and thus determine who signs the IPC for transportation.

28. Q: The signature page only has space for 8 MDT members. What do we do if we have more than 8?

A: There are 8 spaces for signatures by the registered nurse, social worker, activity coordinator, physical therapist, occupational therapist, registered dietician, speech therapist, and mental health consultant. If you are using an electronic IPC, adding more signatures will not be a problem. However, if you are using a hard or paper copy, you can make an extra copy of Box 17 if more signature lines are needed. However, a signature from one discipline representative would be acceptable, preferably the person who has completed the assessment and developed the care plan.