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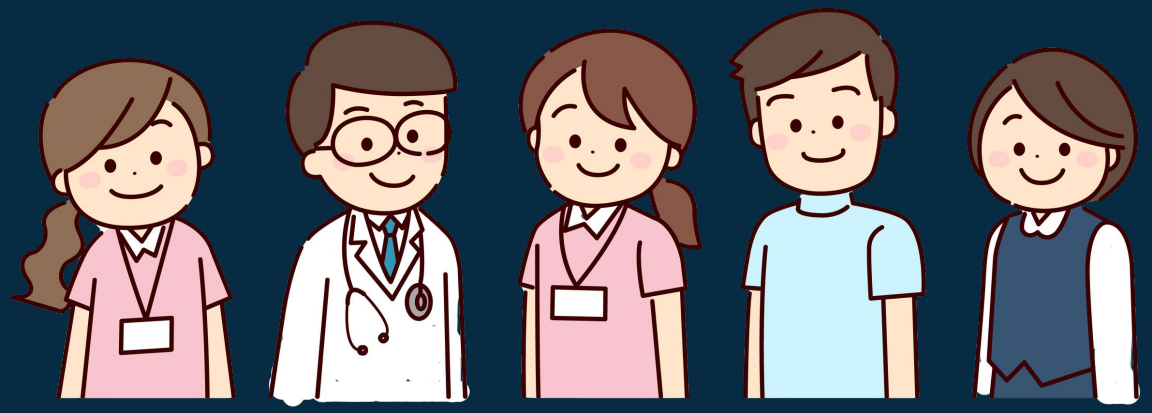
Community-Based Adult Services (CBAS)

Multidisciplinary Team (MDT) Process

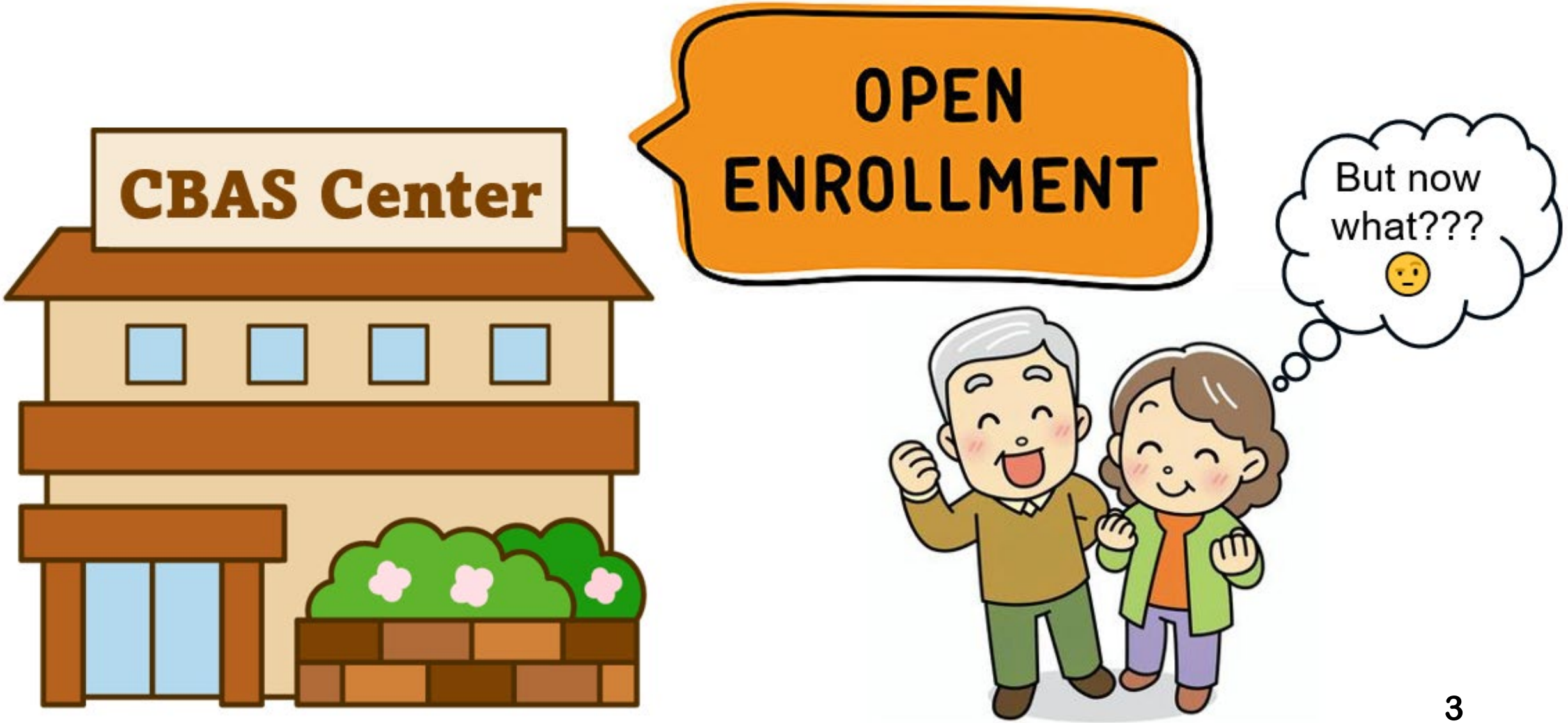


Fall 2025 CAADS Conference

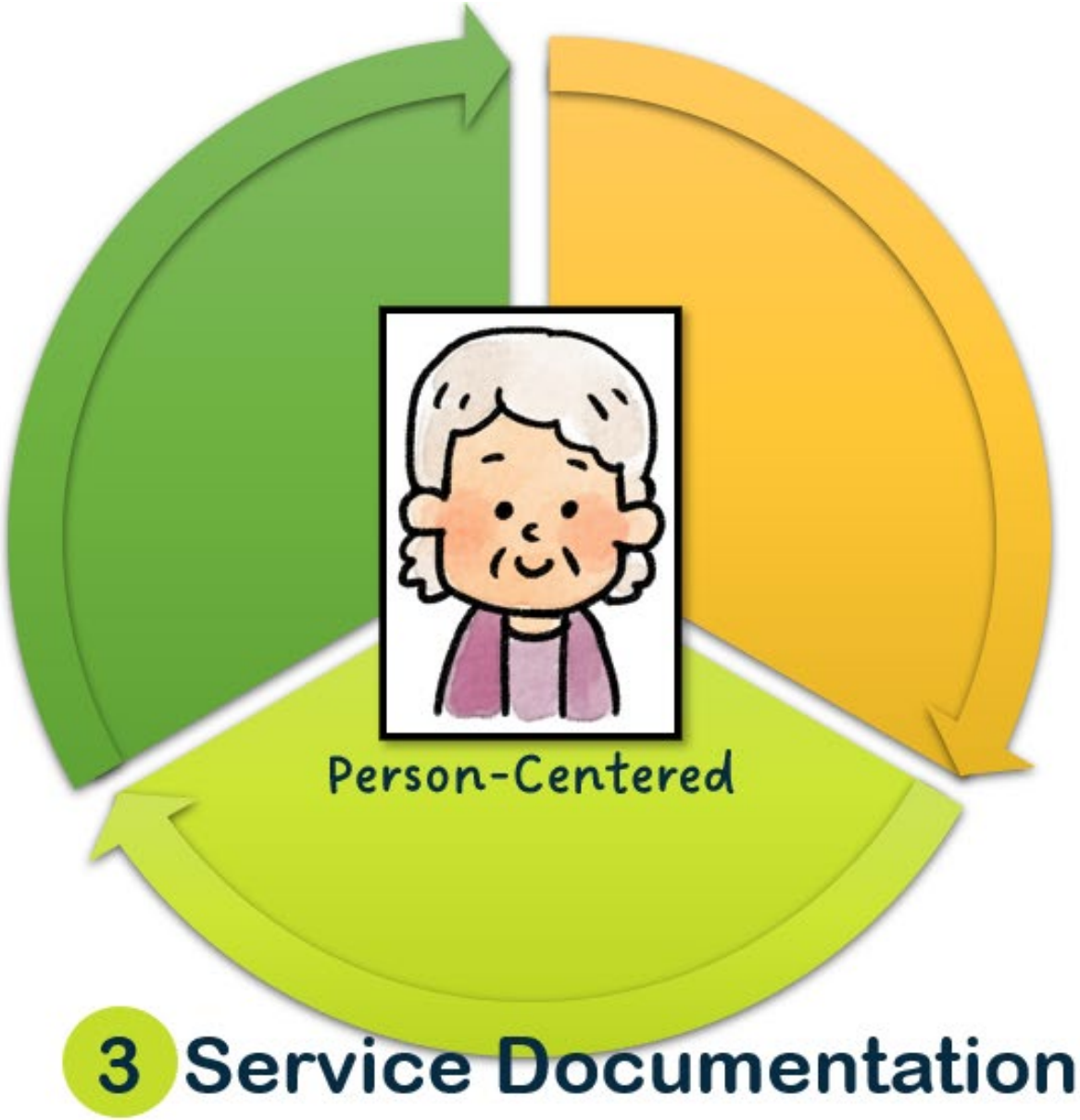
Jeanette Fong, Julia Smith & Leigh Witzke, RN
CBAS Field & Nursing Operations Teams

Target Audience

First Participant Enrolled!



Agenda


1
Assessment
2
Care Plan
Development
Person-Centered
3 Service Documentation

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Initial Assessment

WHO conducts the assessments?

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MUST

- Physician
- Registered Nurse (RN)
- Social Worker
- Activities Coordinator
- Physical Therapist
- Occupational Therapist

MAY (if needed)

- Mental Health Consultant
- Registered Dietician
- Speech Therapist

MDT Assessment

14529(a) and (b)

(a) The multidisciplinary team conducting the assessment shall consist of at least the individual's personal **physician** or a staff physician, or both, a **registered nurse**, and a **social worker**.

(b) For the initial assessment, the multidisciplinary health team shall also include a **physical therapist** and an **occupational therapist**. In addition, when the need is identified by a physician or nurse, qualified consultants with skills in **recreation therapy**, **speech** language pathology, or **dietary** assessment shall serve as team members.

54211(a) – Multidisciplinary Team

(a) The multidisciplinary team conducting the assessment pursuant to Section 54207 shall consist of at least a **physician**, **nurse**, **social worker**, **occupational therapist** and **physical therapist**. The physician may be either a salaried staff member of the adult day health care center or the participant's physician. When indicated by the needs of the participant, a **psychiatrist, psychologist, psychiatric social worker**, **speech therapist** and **dietician** shall be included as members of the assessment team and assist in the assessment.

WHEN must assessments be completed?

54209(a)(1) – Multidisciplinary Team Assessment

(a) Adult day health care services except for the initial assessment and reassessments shall require prior authorization by the Medi-Cal Consultant. The request for authorization shall:

(1) Be initiated by the center and shall include the results of an individual's multidisciplinary assessment conducted by the center within the last **30 days** and the participant's plan of care.

Physician's Assessment

78303(e) – Basic Program Services: Assessment

(e) Prior to or at the time of admission of a participant, the program director shall obtain a written health assessment of the participant which has been completed within **90 days** by the participant's **physician** or staff physician. The assessment shall be included in the participant's health record and shall include at least the following:

(1) Previous medical history.

(2) Identification of any health condition including communicable disease.

(3) Identification of physical limitations including ambulatory status.

(4) Current diagnosis of any health problem and prescribed treatment.

(5) Evidence of **tuberculosis screening**.

Home Assessment

54207(a) – Multidisciplinary Team Assessment

(2) Assessment of the home environment based on a home visit within the last **12 months**. The assessment shall include:

(A) Living arrangements.

(B) Relationship with family or other person.

(C) Facilities available such as heat, bath, toilet, stove.

(D) Existence of environmental barriers such as stairs or other features not negotiable by the impaired individual.

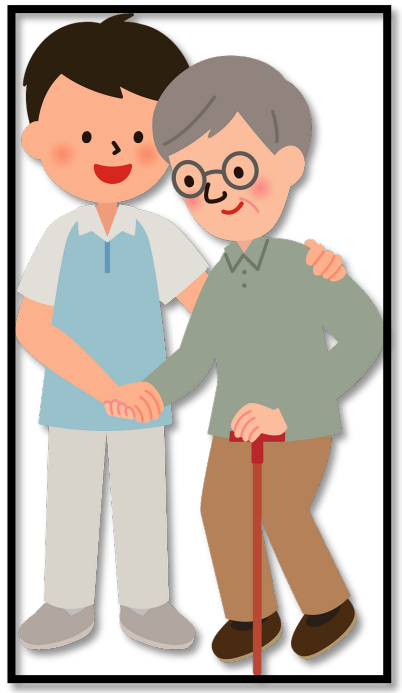
(E) Access to transportation, shopping, church or other needs of the individual.

WHAT must assessments do?

Determine Participant's Status

Medical

Psychosocial



Functional

Participant's Current Status

14529(d)(1)

(d) The assessment team shall:

(1) Determine the **medical**, **psychosocial**, and **functional** status of each participant.

54211(b) – Multidisciplinary Team

(b) The multidisciplinary assessment team shall:

(1) Determine the **medical**, **psychosocial** and **functional** status of each participant.

MDT Assessment

54207(a) – Multidisciplinary Team Assessment

(a) Each applicant shall be assessed by a multidisciplinary team **prior** to acceptance into the program. The assessment shall be conducted by the adult day health care provider in order to ascertain the individual's pathological **diagnosis**, **physical** disabilities, **functional** abilities, **psychological** status and social and **physical environment**. The assessment shall include:

(1) Contact with the applicant's physician to obtain the individual's medical history and a statement indicating the applicant's restrictions and medications and **absence of infectious disease**. If the applicant does not have a personal physician, the center shall assist the individual in finding one. An initial **physical examination** may be done by the staff physician or by a nurse practitioner under the supervision of a physician to the extent allowed under state law.

Assessments should identify…

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MDT's

Assessed
Primary Problems

+

Participant's

Expressed Needs, Goals
& Desired Outcomes

Validated Screening Tools

FALL RISK

- Berg Balance Scale
- Hendrich II Fall Risk Model
- Morse Fall Scale
- Tinetti Balance & Gait Assessment

MEDICATION SELF-ADMINISTRATION

- Medi-Cog
- MedMalDE

Assessment of Medication Regimen

Medication Reconciliation

- **<u>Medication Reconciliation</u>:**
  Brown bag, home visit, History & Physical, pharmacy list, caregiver information
- **<u>Liaison</u>:**
  Clarify discrepancies, indications for use, diagnoses
- **<u>Center Pharmacist</u>:**
  Polypharmacy, interactions, scheduling

Home Situation

- Living situation
- In-Home Supportive Services (IHSS) hours
- Current medication schedule
- Who is at home when assistance is needed?
- Medications prescribed as needed (PRN) or multiple times per day (BID/TID) or those that need to be taken with meals
- Supervision/reminders/prompting/ cueing received from caregivers or family

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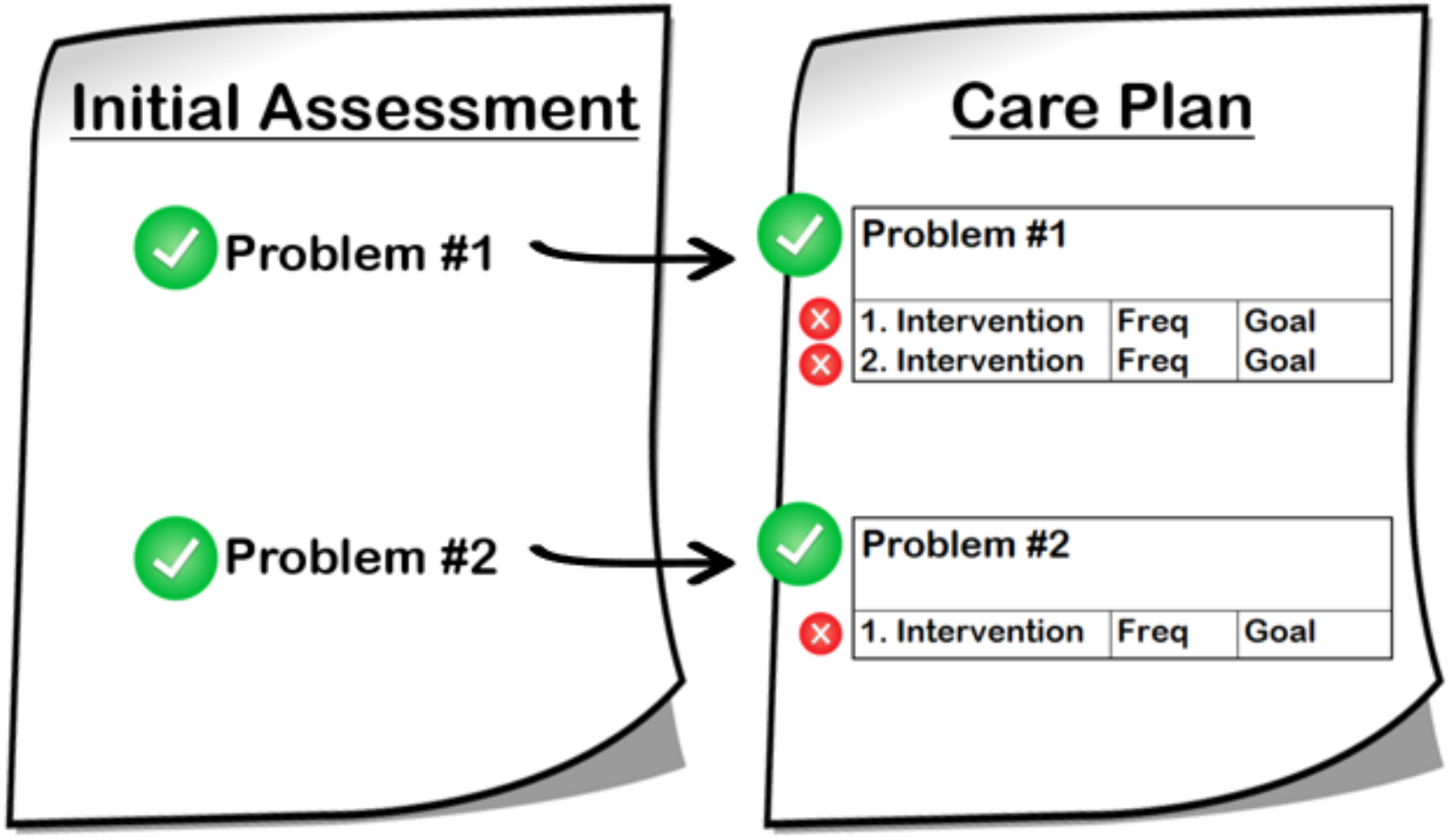
Care Plan Development



Meeting the Participant's Needs

14529(d)(2)

(d) The assessment team shall:

(2) Develop an individualized plan of care, including goals, objectives, and services designed to **meet the needs of the person**, which shall be signed by each member of the multidisciplinary team, except that the signature of only one physician member of the team shall be required.

Frequencies & Individualized Goals

54211(b)(2)(A)(4) and (5) – Multidisciplinary Team

(b) The multidisciplinary team shall:

(2) Develop an individualized plan of care including goals, objectives and services designed to **meet the needs of the person**. The plan shall be signed by each member of the team, except that the signature of only one physician member of the team shall be required.

(A) The individualized plan of care shall include:

(4) Specific type, number of units of service and **frequency** of individual services to be given on a monthly basis.

(5) The specific elements of the services which need to be identified with **individual objectives**, therapeutic **goals** and **duration** of treatment.

Individual Plan of Care (IPC)

(13) CORE SERVICES		
PROFESSIONAL NURSING SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s)** _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Need / Problem

- Describe the symptom or demonstrated behavior, **not the diagnosis**
- Be related to the medical or mental health diagnosis or condition
- Be something that can be realistically addressed by interventions available at the center
- Be specific to the **individual** participant (not “cookie cutter”)
- Provide a **measurable starting point**

Treatment(s) / Intervention(s)

- Propose a way to resolve or mitigate the problem (may reflect how the participant, family, and/or caregiver will be engaged)
- Be supported by the MDT assessments and History & Physical
- Be related to the need/problem
- Be **specific to the individual** participant (not a group of participants)

Frequency

- Indicate specific type and frequency (e.g., days/week)
- Include the planned time (e.g., minutes) and duration (e.g., number of weeks)
- Ensure the provision of medically necessary core services on each day of attendance

Goal(s)

- Reflect the assessments completed by the personal health care provider and the MDT, and the **desired outcome** expressed by the participant, family, and/or caregiver
- Be related to the intervention
- Be **attainable** by the participant
- Be **measurable**
- Include timelines for achievement if the timeframe is more or less than six months

Cheat Sheet

(13) CORE SERVICES

PROFESSIONAL NURSING SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

- ☑ How the condition affects the **individual** (not group)
- ☑ Is **NOT** the diagnosis
- ☑ Description of symptom/behavior
- ☑ Baseline for **measurement**
- ☑ **ONE** problem per box
- ☑ Plain language

Treatment(s)/Intervention(s)	Frequency	Goal(s)
☑ Addresses/mitigates the problem ☑ Specific to the **individual** (not group) ☑ Practical ☑ Multiple interventions per problem okay	☑ Days/Wk ☑ Duration ☑ Time *Ensure daily core services	☑ Desired Outcome ☑ **Measurable** ☑ Attainable ☑ Multiple goals per intervention okay

Example: Nursing Services

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(13) CORE SERVICES

PROFESSIONAL NURSING SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

Unstable BP. Checked 5x/week for past 6 months. Range: 204/96 to 130/78. Required PRN medication administration x3 with PHCP liaison.

Treatment(s)/Intervention(s)	Frequency	Goal(s)
1. Monitor BP daily upon center arrival. Administer PRN medication per PHCP order: HCTZ 25 mg for BP >150/90. Recheck BP after 1 hour to monitor medication effectiveness. 2. Report BP range to PHCP q 3 months and PRN if >150/90 or medication effectiveness not achieved.	1. 5x/wk 2. q3mos/ PRN	1. Ptp will have prompt med administration for elevated BP with BP maintained at <150/90. 2. Will maintain liaison w/ PHCP for unresolved BP exacerbations and use of PRN medication.

Example: Personal Care Services

PERSONAL CARE SERVICES

Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

Ptp requires supervision for ambulation, transfers, and supervision/assist with clothing management (dressing) based on nursing and PT assessment. PT recommends use of cane 100% of time but ptp occasionally forgets it at the table while ambulating in the center.

Treatment(s)/Intervention(s)	Frequency	Goal(s)
1. Provide supervision during ambulation, transfers to seat, toilet, and bus. Supervise clothing management during toileting for need to assist. 2. Note any change in functional level or need that would indicate higher level of assistance is needed. Provide assistance if need is observed. Note when assistance is provided for clothing management. 3. Observe for use of cane 100% of time. Promptly provide cane when left at table. Note when ptp forgets cane to develop baseline and indicator of functional status change.	1. QD 2. QD 3. QD	1. Ptp will maintain safe ambulation and transfers, avoid falls, use cane 100% of time, and receive prompt assistance if need is identified through supervision. 2. Maintain clothing management needs 100% of time. 3. Ongoing sustained assessment of functional status and needs to provide prompt changes to interventions if needed.

Example: Therapeutic Activities

THERAPEUTIC ACTIVITIES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

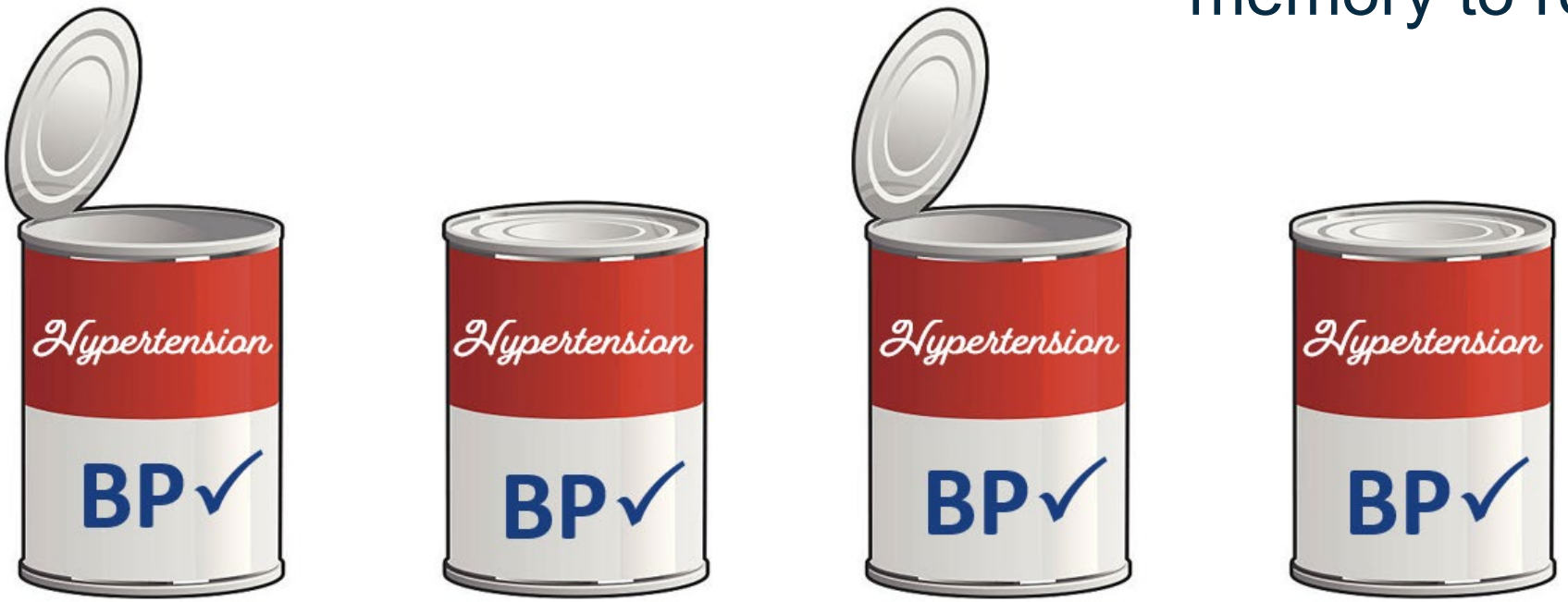
1. Need/Problem

Ptp has limited ability to initiate and sustain interest in activities independently. Enjoys helping others and folding/sorting activities. Will sit without engagement and looking lost if activity is not facilitated in small cluster of ptps with similar functional abilities.

Treatment(s)/Intervention(s)	Frequency	Goal(s)
Schedule individualized activities specific to the interests and abilities of ptp to include: 1. Reminiscence small group 2. Music Appreciation sing-along in large group w/ facilitated small group cluster 3. Bingo in large group w/ facilitated small group cluster 4. Daily "helping activities" – fold napkins/paper sacks, roll yarn, sort beads/other items, wipe tables, decorate paper place mats, etc.	1. 3x/wk 2. 1x/wk 3. 1x/wk 4. QD	1. Ptp will maintain engagement with successful completion of activities and avoid sitting without engagement looking lost.

Canned Interventions

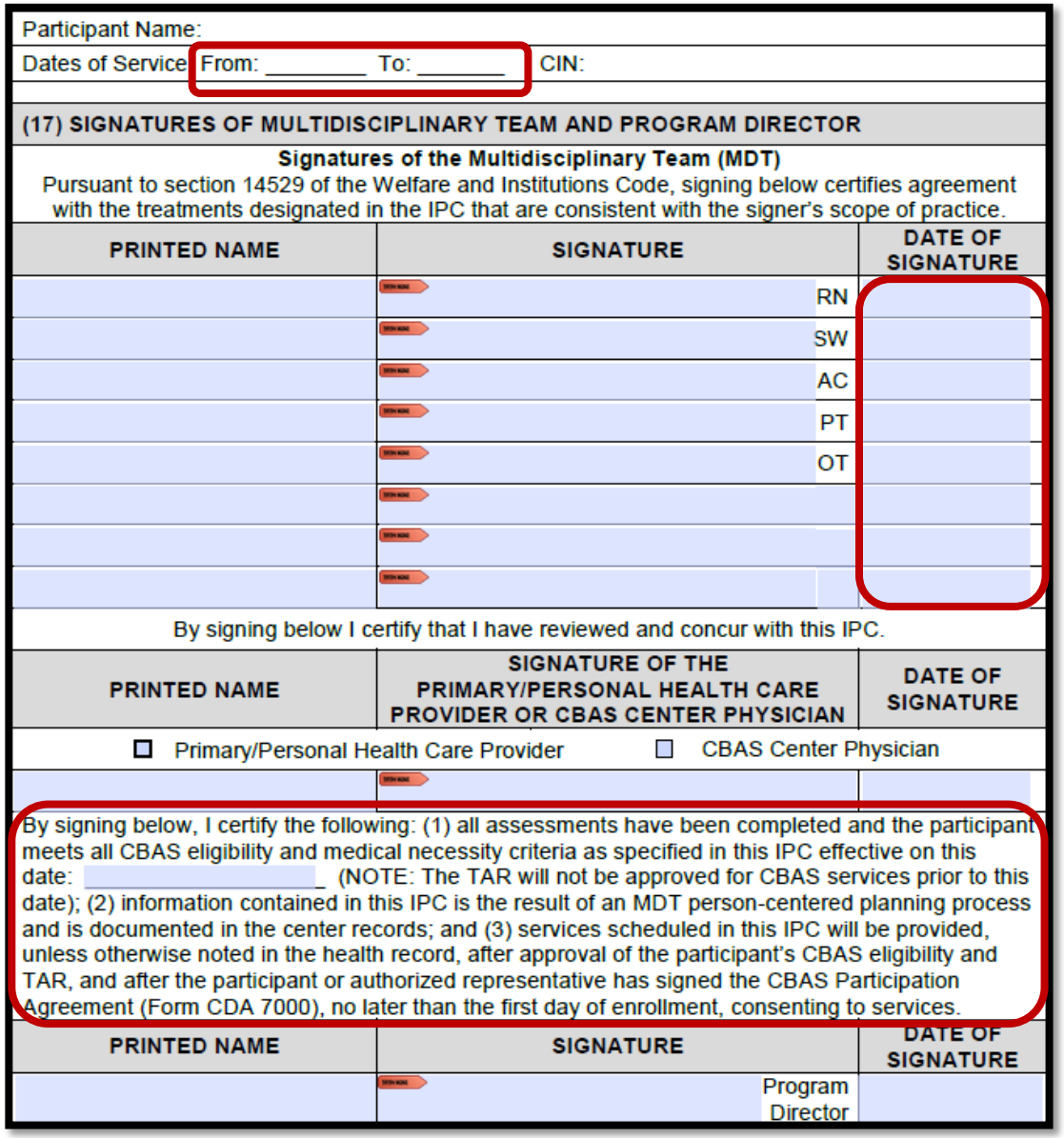
- Not everyone with **hypertension** requires diet education or blood pressure monitoring every day. Many are stable with medication compliance and diet interventions.
- Not everyone with **depression** would benefit from education on coping skills. Those with concurrent cognitive impairment may not have the short-term memory to retain new information.



Box 17 – Signature Page

Program Director must attest that:

1. All assessments are completed prior to the IPC effective date.
2. The participant meets CBAS eligibility and medical necessity criteria as specified in IPC.
3. The IPC is the result of an MDT person-centered planning process that is documented in the center's records.
4. Services scheduled in the IPC will be provided.



Participant Name:

Dates of Service From: _____ To: _____ CIN:

(17) SIGNATURES OF MULTIDISCIPLINARY TEAM AND PROGRAM DIRECTOR

Signatures of the Multidisciplinary Team (MDT)

Pursuant to section 14529 of the Welfare and Institutions Code, signing below certifies agreement with the treatments designated in the IPC that are consistent with the signer's scope of practice.

PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	RN	
	SW	
	AC	
	PT	
	OT	

By signing below I certify that I have reviewed and concur with this IPC.

PRINTED NAME	SIGNATURE OF THE PRIMARY/PERSONAL HEALTH CARE PROVIDER OR CBAS CENTER PHYSICIAN	DATE OF SIGNATURE
☐ Primary/Personal Health Care Provider ☐ CBAS Center Physician		

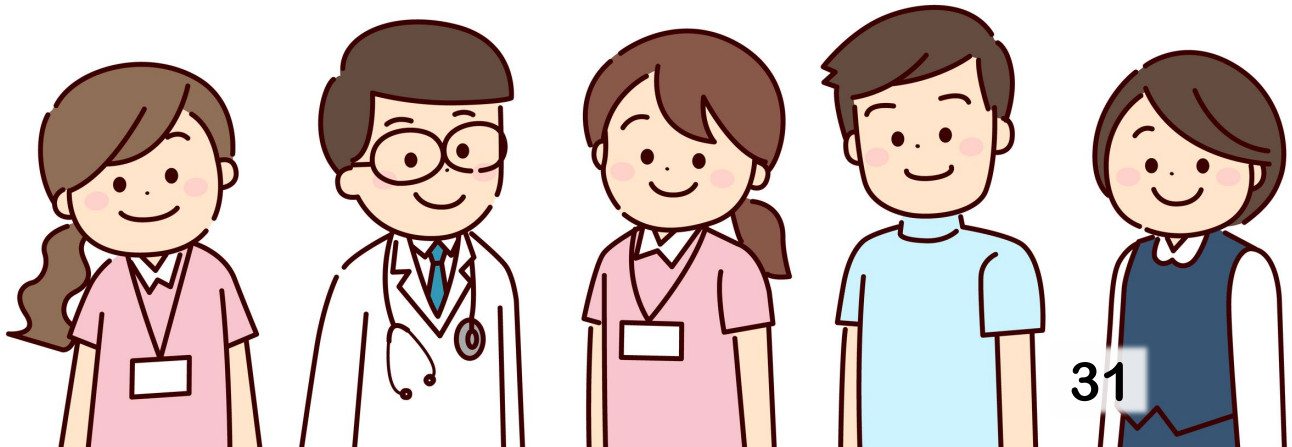
By signing below, I certify the following: (1) all assessments have been completed and the participant meets all CBAS eligibility and medical necessity criteria as specified in this IPC effective on this date: _____ (NOTE: The TAR will not be approved for CBAS services prior to this date); (2) information contained in this IPC is the result of an MDT person-centered planning process and is documented in the center records; and (3) services scheduled in this IPC will be provided, unless otherwise noted in the health record, after approval of the participant's CBAS eligibility and TAR, and after the participant or authorized representative has signed the CBAS Participation Agreement (Form CDA 7000), no later than the first day of enrollment, consenting to services.

PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	Program Director	

MDT Process

A well-functioning MDT:

- Shares information
- Makes coordinated decisions on treatment
- Communicates routinely (formally and informally)
- Has open discussions
- Meets regularly
- Documents the process



MDT Best Practices

- MDT meetings are separate from regular staff meetings.
- The nurse, social worker, activity coordinator, physical therapist, and occupational therapist are in attendance.
- Each MDT member summarizes the participant's status.
- Discrepancies between MDT assessments are identified and resolved.
- A consistent format for discussing participants **due for reassessment** exists.
- A consistent format for discussing participants **NOT due for reassessment** exists (e.g., change in condition, Emergency Remote Services, etc.).
- The MDT process is documented.

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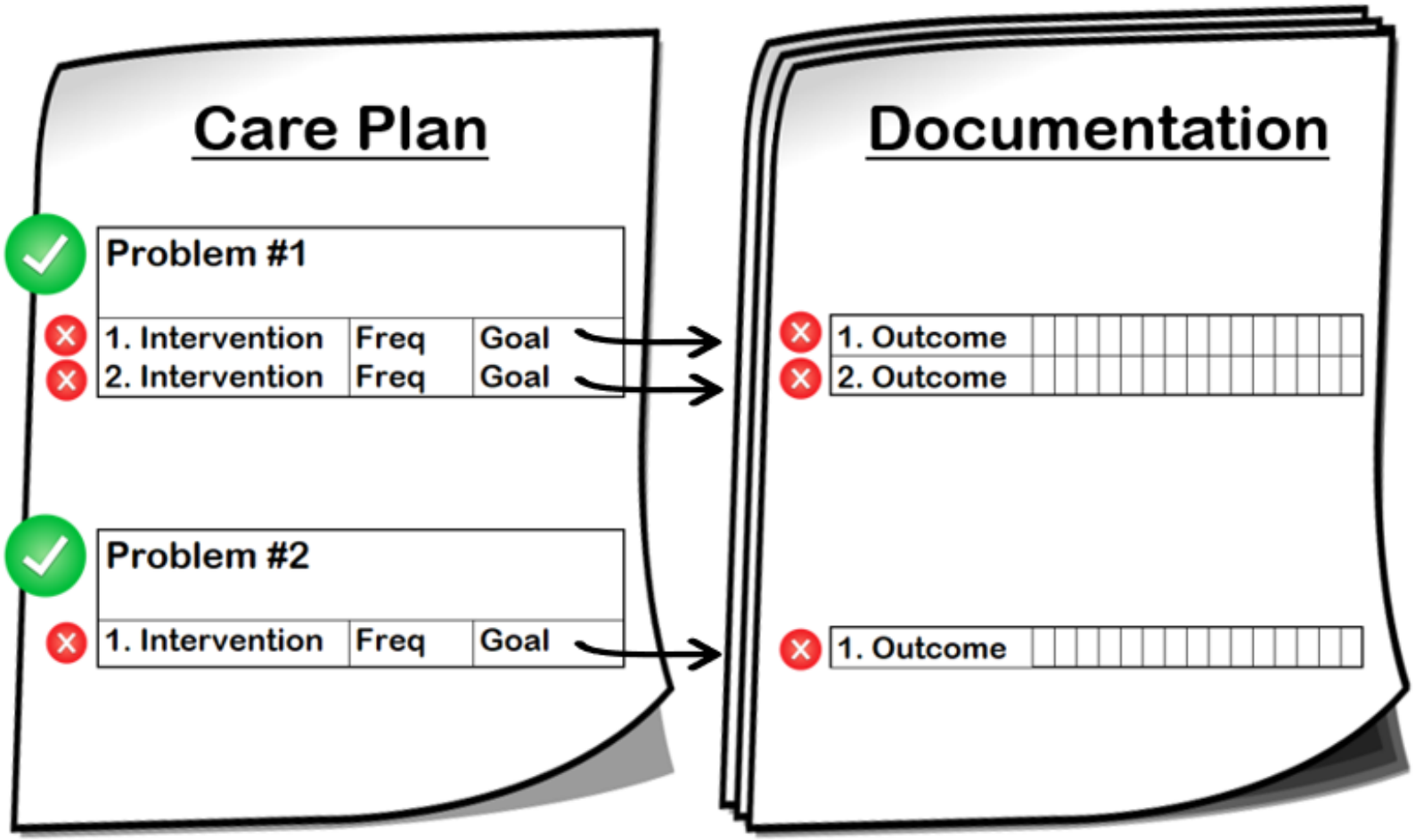
Service Documentation



Provision & Documentation of Services

14530(a)

(a) Individual plans of care shall be submitted to the department. Services for each participant shall be **provided as specified in the individual plan of care** approved pursuant to Section 14526.

54425(a)(4) – Participant Records

(a) Each center shall maintain a complete health record for each participant in the program in the **format established by the Department**. Each medical record shall include, but is not limited to:

(4) **Daily records** of participant's attendance and services utilized, including transportation.

What does CDA want to see?

Providers ask us this all the time but it's not about **us**!

- Of course, documentation must be sufficient to demonstrate that services are being provided.
- What's more important is what do **YOU** want or need from your documentation to ensure quality services? How can you determine whether prior IPC **goals** have been met?

Example: Physical Therapy Maintenance

THERAPEUTIC ACTIVITIES – PHYSICAL THERAPY MAINTENANCE PROGRAM
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

Ptp demonstrated FAIR endurance with 5 minutes of moderate exertion, affecting endurance for functional mobility such as ambulation. GAIT: Tinetti Gait Score 12/12 with no deviations increasing risk for falls during ambulation.

Treatment(s)/Intervention(s)	Frequency	Goal(s)
1. Treadmill: 10 mins, 1.8-2.0 mph, 0.0% incline. NOTE: gym staff to implement, assist, and cue PTP, nursing to supervise.	1. 5x/wk	1. Increase endurance to GOOD with 10 mins of moderate exertion, improving endurance for functional mobility (e.g., ambulation at community level with undue fatigue). 2. GAIT: Maintain Tinetti Gait Score in the 9-12/12

Checkmark Charting

INTERVENTION	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Treadmill (5x/wk) 10 mins, 1.8-2.0 mph, 0% incline	✓	✓	✓	✓			✓	✓	✓	✓	✓			✓	✓	✓	✓	✓			✓	✓	✓	✓	✓			✓	✓	✓	✓
PTM Aide Initials																															
OT or PT or RN Initials																															

Meaningful Documentation

INTERVENTION	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Treadmill (5x/wk) 10 mins, 1.8-2.0 mph, 0% incline																															
Participation (mins)	10	10	10	10			10	10	10	10	10			10	10	10	10	5			10	10	2	10	10			10	10	10	10
Response	1	1	1	1			1	1	1	1	1			1	1	1	1	2			1	1	S	1	1			1	1	1	1
Assistance	C	C	C	C			C	C	C	C	C			C	C	C	C	B			C	C	A	C	C			C	C	C	C
PTM Aide Initials																															
OT or PT or RN Initials																															

LEGEND	PARTICIPATION
	# = Minutes
	A = Participant Absent
	SC = Schedule Conflict
	TA = Therapist Absent
	O = Out of Town

RESPONSE	
1 = Tolerated Well	6 = Low Endurance
2 = Didn't Tolderate Well	7 = Improving
3 = C/O Pain	8 = Regressing
4 = S.O.B.	9 = Sick
5 = Weakness / Fatigued	R = Refused

ASSISTANCE NEEDED	
A = Maximum	75%-99% Assist
B = Moderate	50%-74% Assist
C = Minimal	25%-49% Assist
D = Supervised	5%-24% Assist
E = Independent	In a Structured Setting 1%-4%

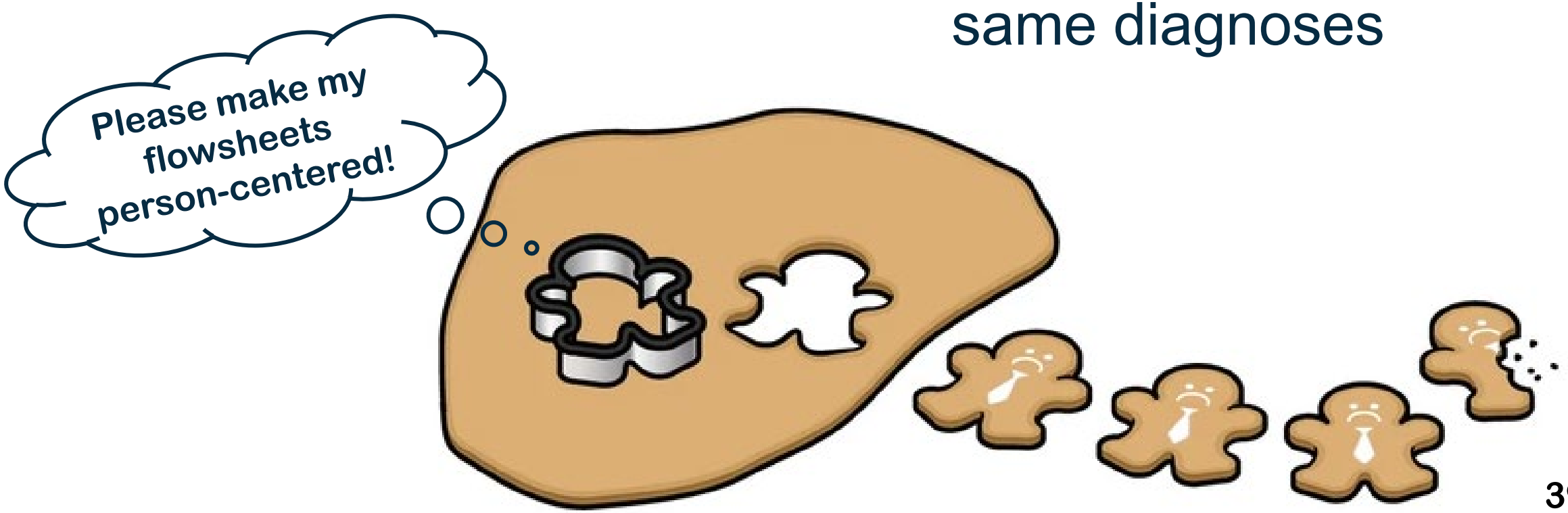
COMMENTS

10/18/25: Today participant was depressed. See SW notes for details.

10/23/25: Today participant complained of not feeling well and experiencing weakness/fatigue/headache/dizziness. Participant was escorted to nursing station by OT/PT aide for assessment and intervention. See RN notes for details.

Cookie Cutter Flowsheets

- Avoid **diagnosis** driven, one size fits all flowsheets
- Avoid standard interventions provided to all participants with the same diagnoses



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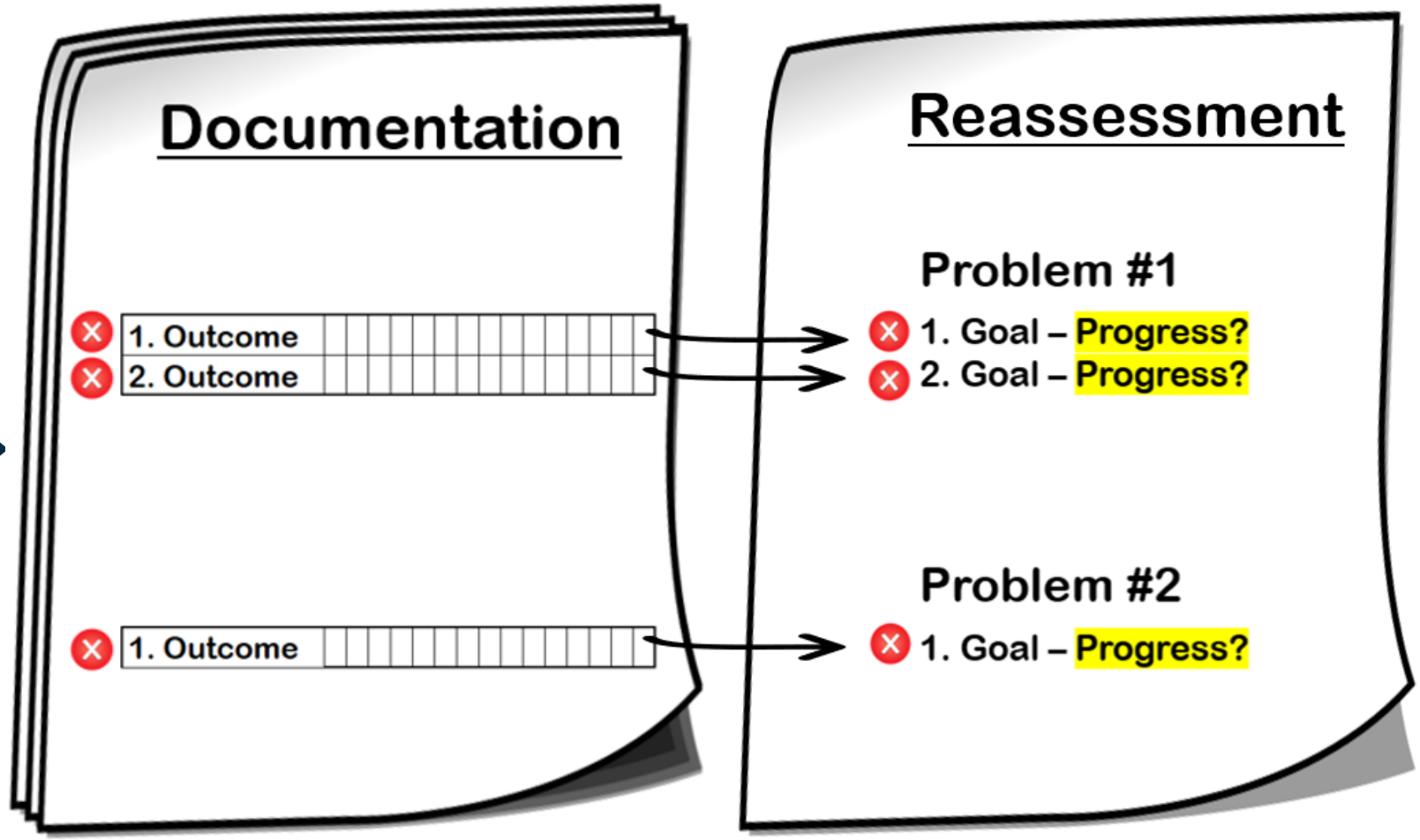
Reassessment



WHO conducts the reassessments?

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MUST

- Physician
- Registered Nurse (RN)
- Social Worker
- Activities Coordinator
- Physical Therapist
- Occupational Therapist

MAY (if needed)

- Mental Health Consultant
- Registered Dietician
- Speech Therapist

Initial Assessment Vs. Reassessment

14529(b) and (c)

(b) For the **initial assessment**, the multidisciplinary health team shall also include a **physical therapist** and an **occupational therapist**. In addition, when the need is identified by a physician or nurse, qualified consultants with skills in recreation therapy, speech language pathology, or dietary assessment shall serve as team members.

(c) The multidisciplinary team described in subdivision (b) shall conduct an initial assessment. At the time of **reassessment**, if an individual plan of care has been developed by the physical therapist or the occupational therapist, they shall reassess the participant to determine any ongoing or different needs for physical therapy or occupational therapy services. **If it is determined that no further physical therapy or occupational therapy is needed, the physical therapist and the occupational therapist shall not be required to sign the treatment plan. For further reassessments the nurse or physician shall determine if the physical therapist or occupational therapist is needed.**

Restorative Vs. Maintenance

14529(d)(4) and (5)

(d) The assessment team shall:

(4) If the initial assessment or any subsequent reassessment shows that **restorative therapy** is needed, acute rehabilitative treatment shall be provided by the appropriate licensed or certified personnel.

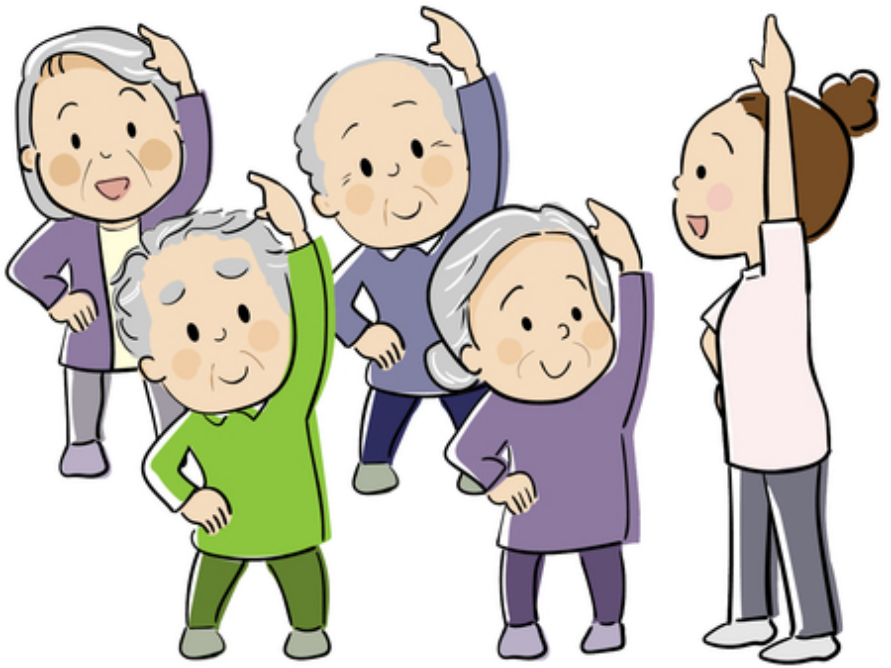
(5) If the initial assessment or any subsequent reassessment shows that **restorative therapy is not needed**, the multidisciplinary team shall determine whether the participant requires **maintenance program** services and if the team finds that the participant requires those services, the multidisciplinary team shall develop an **individual maintenance program** as part of the plan of care.

Therapy Maintenance Program

1570.7(l)

(l) “Maintenance program” means procedures and exercises that are provided to a participant, pursuant to Section 1580, in order to generally **maintain existing function**. These procedures and exercises are:

- Planned by a licensed or certified therapist and are
- Provided by a person who has been **trained** by a licensed or certified therapist and who is
- **Directly supervised** by a nurse or by a licensed or certified therapist.



Direct Supervision = Supervisor shall be present in the same building and available for consultation and assistance (54141)

Training

- The therapist must train both the **RN supervisor** and all **staff** providing maintenance therapy services.
- The specific elements of the training must be documented and signed by both the therapist and RN supervisor/staff.
- Training must include:
    1. Initial instruction and demonstration
    2. Observation of staff
    3. Provision of **on-going** training as often as necessary to ensure therapy maintenance services are being correctly provided.

WHEN must reassessments be completed?

14529(d)(1)(3)

(d) The assessment team shall:

(3) At least **biannually** reassess the participant's individualized plan care and make any necessary adjustments to the plan.

WHAT must reassessments show?

14529(d)(1)(3)

(d) The assessment team shall:

(1) Determine the **medical, psychosocial, and functional status** of each participant.

54215(a)(1)(2)(3) – Reassessment

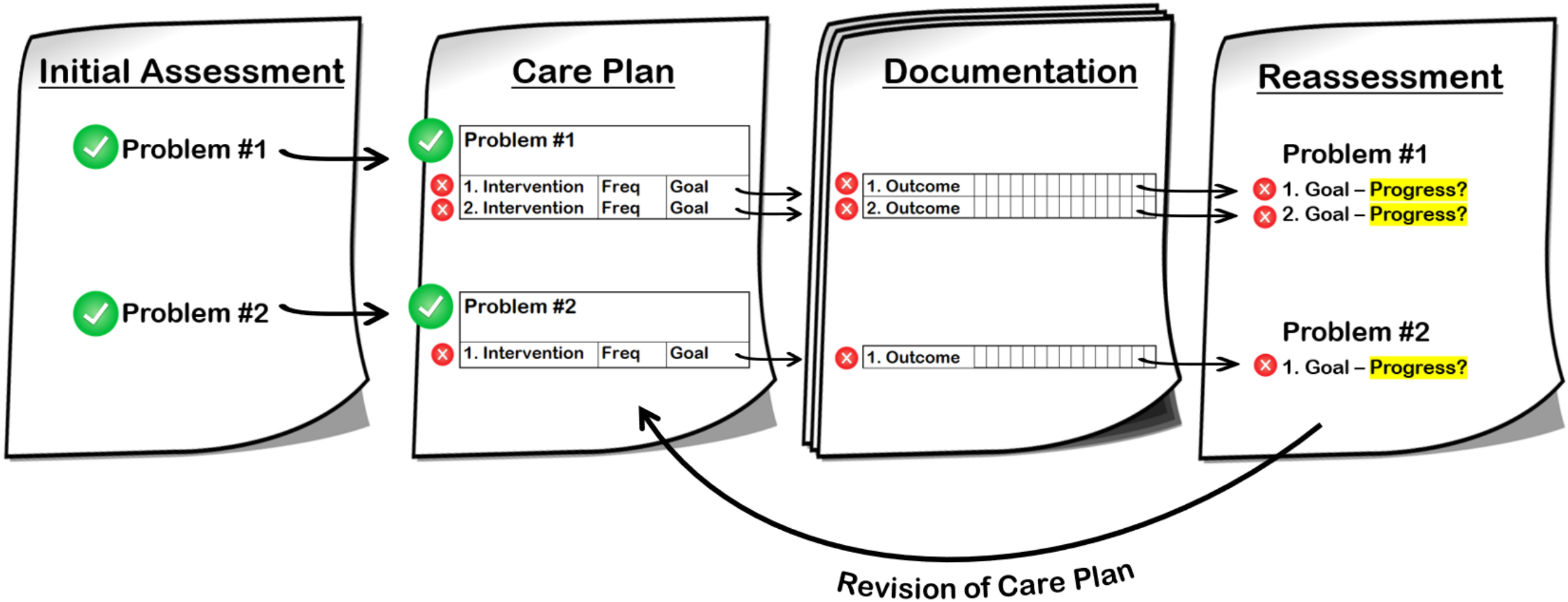
(a) Reassessment, at least quarterly, shall include:

(1) **Progress achieved**.

(2) Review and revision of **goals and objectives**.

(3) Revision or continuation of the **individual plan of care**.

Putting It All Together



CBAS Hokey Pokey!

Assess the problems first
Pop ‘em in the care plan next
Document the outcomes in the health record

Review all flowsheets for progress made
Reassess as needed
But at least quarterly

Put some new goals in
Take the old goals out
If the interventions ain’t working, switch ‘em all about

Document the outcomes
All over again
That’s what it’s all about!

California Department of AGING

CBAS Team
Phone: (916) 419-7545
Email: cbascda@aging.ca.gov