Fact Sheet
Community Alternatives Program
IHA/PNA to Cover unstaffed PDN

A Medicaid Home and Community-Based Service

The Community Alternatives Program for Children (CAP/C) is for children ages 0 to 20 years old who have physical health conditions. These health conditions are on-going and severe. The goal of the program is to reduce unplanned urgent, or emergency care and extended hospital stays. This is done through services and supports.

USING IN-HOME AIDE (IHA) OR PEDIATRIC NURSE AIDE (PNA) WITH PRIVATE DUTY NURSE (PDN) WHEN HOURS ARE REGULARLY UNSTAFFED

When PDN hours are routinely unstaffed because of a health care shortage, IHA or PNA services can be used with PDN to cover the unstaffed hours.

Hours are based on the identified needs of the child, parent, primary caregiver or legally responsible person to fill unmet needs in activities of daily living (ADLs), instrumental activities of daily living (IADLs), or hands-on support that can be assigned to a certified nurse assistant I or II (CNA I or CNA II).

REQUIREMENTS

- Must have assigned nurse hours missed at least weekly.
- Documented attempts by a hiring agency to recruit a nurse without success for two or more months.
- Ongoing recruitment efforts by the nurse agency to hire a nurse.
- Unstaffed hours are because of a healthcare shortage or unsuccessful recruitment of staff and not because of rejection of staff.
- The combinned hours of IHA or PNA and PDN may not exceed the approved nurse hours.
- IHA/PNA and PDN hours may not overlap during a course of a day/night.
- IHA/PNA cannot be used at school. PDN hours that are separate from IHA/PNA can be used at school.

ELIGIBILITY FOR CONSIDERATION

- Have a completed and approved individual risk agreement (IRA).
  - An IRA is a document made with the CAP participant or their legally responsible party. It allows them to take on risk while planning to meet their needs.

- It includes:
  - How risks will be addressed.
  - Who will perform tasks and how.
  - How the CAP participant will be protected from harm.
- Have submitted a plan of care (POC) that includes:
  - Why IHA or PNA is being used instead of PDN.
  - Safeguards used to ensure the health, safety, and well-being of the CAP participant.
  - The monitoring plan to assess the safety of the CAP participant.
  - The IHA or PNA service provider's name.
  - The days and times IHA or PNA will be used.

HIRING REQUIREMENTS

- IHA or PNA hours can be provided through provider-led or consumer-directed services.
- The direct care worker must meet all hiring requirements.
- Parents or a legally responsible person can be hired to work no more than 40 hours per week when:
  - They meet the hiring requirements and have at least 1 of the 5 extraordinary conditions.
    - The 5 extraordinary conditions are listed in the CAP/C waiver.

REQUIRED DOCUMENTS

1. Individual Risk Agreement (IRA)
   - DHB form completed by the beneficiary/legally responsible person and case manager.
2. Documented Uncovered Hours
   - Case management notes and supporting documentation from the nurse agency
3. Documented Attempts to Link to PDN
   - Case management notes, freedom of choice selection forms, and supporting documentation from nurse agency.

If the participant is using consumer-directed services, the following additional forms are required:

4. Self-assessment Questionnaire
   - DHB form completed by the beneficiary/legally responsible person.
5. Consumer Direction Training
   - Certificate or confirmation email received by EOR after completing training.

6. Competency Validation Form
   - DHB form completed by the EOR.
7. Employer/Employee Agreement
   - Submitted by FMS provider to case manager to upload in e-CAP

Copies of documents 1, 4, and 6 are attached behind this page.

INDIVIDUAL RISK AGREEMENT

The risk(s) [situation, conditions, circumstances that impact health, safety and well-being] that have been identified below have been determined and the CAP beneficiary has chosen to assume responsibility in addressing the risk. The details of the risk(s) have been explored and the beneficiary understands how the specified risks may impact the beneficiary's health, safety and well-being. The CAP beneficiary has negotiated an agreement with measurable time frames. Risks that have been identified will be continuously monitored and re-evaluated throughout the length of the agreement. The beneficiary is aware of the possible consequences of not addressing risks as outlined in their agreement. Individuals under the age 18, the parent or legally responsible party assume the risk for the CAP beneficiary.

Name – CAP Waiver Beneficiary:

Name – CAP Case Management Entity:

Name(s) – Individuals involved in risk identification and reduction discussion (list all who contributes and supports the agreement):

1. **Describe the risk(s) identified by multidisciplinary team (MDT)** [e.g., exhibited behavior that is deemed to be verbally/physically abusive to others, non-compliance of the Plan of Care; or risk/hazard(s) in the person's environment (pest infestation, lack of sufficient water supply, etc.), unstaffed hours, use of lower acuity services]. Specifically state each area and the responsible person:

2. **Describe the adverse outcome/harm that may result from failure to address the risk(s)** (e.g., decline in physical/emotional health, injury to self or others):

3. **Describe the beneficiary's understanding of identified risk(s) and his/her plan for addressing it.** (Include the assumed risks, training oversight and emergency procedure):

4. **What alternative measures may be used by the local lead agency, the beneficiary, or by his/her informal supports to minimize risk, reduce adverse outcome(s) identified in #2 above?** (e.g., durable medical equipment, adaptive equipment; increased personal care hours, improve network of informal supports):

5. Briefly describe the agreement reached including consequences of failure to work toward a solution:

The risks identified by the agency have been explained to me. I accept the risk(s) associated with my choice, decision or preferred course of action.

SIGNATURE – Beneficiary / Legal Representative: X_____ Date Signed:

SIGNATURE – Local Lead Agency Case Manager: X_____ Date Signed:

Consumer-Direction Self-Assessment Questionnaire

The self-assessment questionnaire is used to determine your readiness to direct your care in the consumer-direction option of the Community Alternatives Program. The tools in the self-assessment questionnaire will identify areas that you are knowledgeable and areas that you may need additional help. These tools will also assist you in identifying your personal care needs and the required skills your hired employee will need to assure your health, safety, and well-being. Once you complete the self-assessment questionnaire; you will make it available to your case management entity. The self-assessment questionnaire includes the following sections:

- Is Consumer-Direction Right for Me?
- What Areas Do I Need Help?
- Task List and Employee Competency Validation

Beneficiary name:

Person completing form:

Individual acting as employer:

Self-Assessment Questionnaire Completion Guide

PURPOSE

The self-assessment questionnaire is used to determine your readiness to consumer direct. The self-assessment will also be used to identify your training needs and confirm the ability of your employee(s). This tool will provide guidance to you, as the individual acting as the employer, in completing the self-assessment questionnaire.

WHO COMPLETES THE SELF-ASSESSMENT?

The self-assessment questionnaire shall be completed by the individual acting as the employer.

Beneficiaries 0-17 years old: to be completed by the parent or responsible party

Beneficiaries 18 years old and older: to be completed by the beneficiary

Beneficiaries 18 years old and *older requiring a representative*: to be completed by the representative

Sections of the Self-Assessment

IS CONSUMER-DIRECTION RIGHT FOR ME?

- Complete section during consumer-direction orientation.
- Answer questions related to health care needs from the perspective of the beneficiary.
- Answer questions related to managing care, finances, and employer responsibilities from the perspective of the individual acting as the employer.

WHAT AREAS DO I NEED HELP?

- Complete section after consumer-direction orientation.
- Place a check by the appropriate response to indicate your current knowledge level of each topic.

TASK LIST AND EMPLOYEE CHECKOFF

- Complete section for all employees.
- Circle the tasks that are required to address the beneficiary's health care needs.
- Provide a response detailing how the employee(s) should complete the selected task.
- Check the response to indicate the employee's ability to complete the selected task.
    - *Previous caregiver: individual has previously provided services to the beneficiary*
    - *Health/personal care experience: individual has health/personal care work experience*
    - *Training provided: employer will provide training to employee on selected task*

Is Consumer-Direction Right for Me?

Consumer-direction offers freedom and independent thinking. Complete this section below during your orientation session to help decide if consumer-direction is right for you.

Date consumer-direction enrollment process initiated:

Why do you wish to participate in the consumer-direction option of CAP?

1. Do you want to appoint someone as your representative for consumer- direction?
   - If yes, allow representative to complete the remaining sections of the questionnaire on your behalf.
     ☐ Yes ☐ No

2. Do you want to be an employer?
   - Registering with the Internal Revenue Service as an employer of record is a requirement.
     ☐ Yes ☐ No

3. Are you able to dedicate approximately 2-4 hours per year for consumer- direction education?
   - NC Medicaid provides annual training to consumer-direction participants.
     ☐ Yes ☐ No

4. Are you able to dedicate time daily and weekly for managing your employee and completing employer related tasks?
   - Managing employee schedules, tasks, and approving timesheets is a requirement.
     ☐ Yes ☐ No

5. Will you allow a financial management agency to manage your waiver services' expenses and employee payroll?
   - Financial management services through an NC Medicaid CAP provider is a requirement.
     ☐ Yes ☐ No

6. Do you feel comfortable telling an individual what you like and don't like about the services he or she provides?
   - An employer is required to give directives independently to an individual on the services provided.
     ☐ Yes ☐ No

7. Do you plan to hire a family member as your employee?
   - A parent, step-parent, or a parent's significant other may not be the employee of a minor child.
     ☐ Yes ☐ No

8. Do you know how to provide step-by-step instructions to someone to assist in meeting your health care needs?
   - An employer is required to independently provide clear instructions to an employee.
     ☐ Yes ☐ No

9. Are you able to identify signs of abuse, neglect, or exploitation?
   - Any occurrence of abuse, neglect, or exploitation must be reported to the local DSS immediately.
     ☐ Yes ☐ No

10. Are you able to store confidential employment documents in a secure location?
    - An employer must have the ability to safely store employment documents to ensure privacy.
      ☐ Yes ☐ No

What Areas Do I Need Help?

In this section, you will rate your knowledge and experience of each listed item to identify what areas you need help in understanding. Check the response that applies to your current knowledge and experience level.

KNOWLEDGE AND EXPERIENCE LEVELS DEFINED

No knowledge/experience:

I have no knowledge or experience in this area; extensive training needed.

Minimal knowledge/experience:

I have some knowledge and experience in this area; substantial training needed.

Substantial knowledge/experience:

I have advanced knowledge and experience in this area; minimal training needed.

Extensive knowledge/experience:

I have expert knowledge and experience in this area, little training needed.

ITEMS TO RATE

Deciding how to set a fair pay rate for an employee(s)

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Setting job standards/responsibilities for an employee(s)

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Completing an employee performance review

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☑ Extensive knowledge or experience

Reviewing an employee(s) work tasks and timesheets

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Creating a job description

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Resolving issues/conflict with an employee

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Finding other available services/resources in the community

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Planning for back-up or emergency care

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Medicaid fraud, waste, and abuse

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Tracking/monitoring use of Medicaid services

☐ No knowledge/experience ☐ Minimal knowledge/experience

☐ Substantial knowledge/experience ☐ Extensive knowledge or experience

Self-Assessment Questionnaire/Training Completion Signature Page

My signature indicates that I have participated in a consumer-direction orientation session and completed the self-assessment questionnaire. I will follow the recommendations presented to me that may include: additional training, re- completion of the self-assessment questionnaire, and requests of other items that are needed to move forward in consumer-direction enrollment. I understand that compliance with NC Medicaid, case management entity, and financial management agency requirements is necessary for continued participation in the consumer-direction model of care. Failure to comply with consumer-direction requirements will result in my removal from the consumer-direction model of care and I will receive CAP services in the traditional provider managed model of care.

Individual acting as employer name:

Beneficiary name:

Individual acting as employer signature: X _____ Date signed:

The care advisor's signature indicates that he or she has reviewed the self- assessment questionnaire, evaluated the responses to determine the consumer- direction abilities of the beneficiary/individual acting as the employer, and provided necessary training.

Training/education completed:

Following the completion of training the beneficiary/individual acting as the employer displays the ability to consumer direct.

☐ *Yes* ☐ *No*

If no; further evaluation and consult with NC Medicaid will be completed to determine beneficiary/employer's readiness to consumer direct.

Care advisor name:

Care advisor signature: X _____ Date Signed:

Task List and Employee Competency Validation

Beneficiary name:

Name of individual acting as employer:

Name of direct care employee:

Directions to complete: Circle the skill that is needed to address the beneficiary's care needs. Provide instructions on how the employee(s) shall complete the task. Provide the appropriate response to indicate the employee's ability to complete the task. Complete for each employee.

Note: Tasks should align with needs identified in the comprehensive assessment.

Bathing

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Toileting

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Incontinence care

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Dressing

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Personal hygiene

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Transfer/ambulation positioning

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Fall prevention

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Feeding/meal prep

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Vital signs/monitoring

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Therapy reinforcement

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

G-tube/J-tube care

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

IV fluids/site check

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Administration/monitoring of medication

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Seizure management

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Apnea monitoring

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Catheter care

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Wound care

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Housekeeping

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Shopping

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Meal Preparation

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Transportation

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Other

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Other

Instructions to employee:

Employee's ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Other

Instructions to employee:

Employee’s ability to complete task:

Previous caregiver: ☐ Yes ☐ No

Health or personal care experience: ☐ Yes ☐ No

Training provided: ☐ Yes ☐ No

Task List and Employee Competency Validation Signature Page

My signature indicates that I have completed the task list and confirmed the skill set of the employee(s) that I intend to hire. I understand that an employee(s) is not required to be a licensed health care professional to provide my care needs. I have determined that my employee(s) has the competencies to complete the tasks required for my care and I take full responsibility of hiring, training, and supervising the employee(s) I hire and ensuring that he/she maintains the requirements needed to provide my care.

Individual acting as employer name:

Beneficiary name:

Individual acting as employer signature: X _____ Date signed:

The care advisor's signature indicates that he or she has reviewed the completed task list and employee competency validation.

Care advisor name:

Care advisor signature: X _____ Date signed:

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