Agency Nurse Instructions:
Adult Nursing Services Eligibility Parameter Tool

Adult Nursing Services (ANS) are detailed on the 2018 New Mexico DD Waiver Standards, Chapter 13 – Nursing Services. Please refer to: https://nmhealth.org/about/ddsd/pgsv/ddw/ . You may also contact your Regional Office Nurse or Clinical Services Bureau, 1-505-841-2948, for technical assistance.

Adult Nursing Services (ANS) are designed to meet a variety of health conditions experienced by adults receiving services on the DD Waiver program. These services are intended to support the highest practicable level of health, functioning and independence for persons age 21 years and older who;

1. Reside in a Family Living setting;
2. Receive Customized In-home Supports(CIHS);
3. Require ANS but who do not receive any Living Supports; or
4. Require ANS during participation in Customized Community Supports -Individual (CCS-I) or Customized Community Supports - Small Group (CCS-Small Group) and /or Community Integrated Employment (CIE).

ANS are also available for young adults, age 18-20, who reside in Family Living and are at aspiration risk and who are required to have Aspiration Risk management (ARM) supports.

Several elements of ongoing Adult Nursing Services are required and some may be optional. Refer to the Standards and the parameter tool.

Part 1: Overview of Nursing Assessment and Consultation Process

1- This core nursing service provides an initial and annual comprehensive health assessment (e-CHAT, MAAT and ARST) and subsequent consultation from the nurse to the person and their guardian. It is the first step in determining the person's health needs and possible eligibility for additional services. The nurse notifies the Case Manager to budget up to 12 hours or 48 units of nursing time each ISP year to provide this service. No additional documentation, review or authorization is needed. The nurse does not need to use the entire original amount before seeking added hours for change of condition and/or Ongoing Adult Nursing. These hours are part of the available balance of nursing time and should be sufficient for assessment activities for the subsequent ISP cycle. Refer to the Standards for specific requirements regarding this service.

2- Based on the results of the nursing assessment, the nurse completes the Adult Nursing Services Parameter Tool and identifies those ongoing nursing services for which the person meets the criteria.

*3- The directions for completing the Adult Nursing Services (ANS) Parameter Tool and requesting ongoing nursing hours are listed in **Part 2 and Part 4** below.*

4- Once the ANS Parameter Tool is completed, the nurse meets with the person, guardian and CM regarding the results of the nursing assessment and identifies those nursing services that are required and those may be considered. Time for the assessment, consultation meeting and development/training of any initial care plans are billed against the originally budgeted nursing hours.

5- After the consultation meeting, the final number of ANS hours are identified and sent to the Case Manager with all pertinent documents that justify the request.

Part 2: Completing the ongoing Adult Nursing Services Eligibility Parameter Tool

The ANS Parameter Tool is a multipage document that the nurse completes based on their knowledge of the person's needs and circumstances. The tool is used to identify required or needed nursing services and identify

the number of nursing hours that will be submitted to the Case Manager for the person's budget. The nurse reviews each Assessment Factors and circles the section that best describes the person's circumstances and needs. The pages of the Parameter Tool and the Assessment Factors are listed below.

Page 1: Complete demographic information. Enter your agency name, your name, contact information and date tool was completed. General instructions are provided on page 1.

Page 2: Assessment Factor 1- Health Care Planning and Coordination

The nurse will determine the number of hours needed for creating, training and monitoring Health Care Plans and Medical Emergency Response Plans based on a review of the eCHAT summary sheet; the overall acuity rating (Low, Moderate or High) and the number of triggered required and considered HCPs and MERPs. The nurse may combine any HCPs as clinically appropriate. Note that the Comprehensive Aspiration Risk Management Plan (CARMP) is considered to be a HCP and should be included in the total count of HCPs.

Page 2: Assessment Factor 2- Aspiration Risk Management (ARM)

The nurse will determine the number of hours needed for ARM activities based on the aspiration risk level; if a new CARMP needs to be developed or an existing CAMP is in place, or if they have been treated in any setting for pneumonia events in the last year. In addition to collaborative assessment, CARMP development, revisions and training, ARM activities also include monitoring, reassessment as needed and ongoing communication with team, guardian and Primary Care Practitioner.

Page 3: Assessment Factor 3- Delegation

The nurse will determine the number of nursing hours needed for oversight, monitoring and training based on the type of delegated tasks, the number of delegation relationships that exist, the stability of those relationships and prudent nursing practice. Refer to the Standards to review the nurse and provider responsibilities for delegation.

Page 4: Assessment Factor 4- Medication Oversight

Medication Oversight is required if the person lives with a host/surrogate Family Living provider, are a Jackson Class Member, or if non-related DSP provide Assistance with Medication Delivery (AWMD) at home or in the community. Medications include all prescription and over the counter (also known as "comfort") medications. This service includes response and follow up to calls related to the use of PRN medications. Medication Administration Records (MARs) are needed if any non- related DSP provide AWMD supports.

Medication Oversight is optional if the person lives independently and can self-administer their medication or resides with their biological family (affinity or consanguinity). Refer to DDW Standards, Chapter 13 for additional information.

Page 5: Assessment Factor 5- Medication Administration by a Licensed Nurse The nurse will determine the number of hours requested based on the current orders for frequency of administering the medication, the need for monitoring and addressing the person's response; communication

with the ordering practitioner and interactions with the MCO or pharmacy as needed. This service requires submission of an additional typed report. Nurses are advised to complete a health report in Therap with all pertinent information and save under the title "Justification Report for Administration of Medication by a Licensed

Nurse m/d/year ". The report must include the reason(s) why medications must be administered by a DD Wavier licensed nurse instead of another entity. This service must be billed at the LPN rate. If used, these hours must be listed on page 7 as LPN time.

Page 6: Assessment Factor 6- Coordination of Complex Conditions

The nurse will determine the number of hours based on person's eCHAT acuity level, the complexity of the medical condition, need for nursing visits, consultation and health care coordination. If clinical criteria are met, this service is required in family living for surrogate/host families and all JCMs.

When requesting more than 25 hours, nurses must complete a health report in Therap with all pertinent information and save under the title "Justification Report for Coordination of Complex Conditions m/d/year ".

Part 3: Meeting to discuss Ongoing ANS

The nurse will meet with the person, guardian, CM (and if requested with the IDT) regarding the ANS assessment results. At that meeting, the nurse will review where the person met the ANS criteria and discuss the nursing services the person is eligible to receive and those services that are required for Jackson Class Members, for persons living with non- related Family Living providers, and for persons who receive AWMD supports from non- related DSP at home or in the community. Guardians may choose to opt out of some services but may not opt out if the service is required.

Part 4: Finalizing the ANS budget request and submitting paperwork to the Case Manager, *Page 7*

1- The nurse will check the box for the appropriate budget request either annual or budget revision.
2- Insert the hours needed for Nursing Assessment and consultation.
3- If appropriate, insert the hours needed for Change of Condition/OOHP follow up. Insert the date of discharge or the condition change. Supporting documentation will be required.
4- The nurse will total the number of hours from each section of the parameter tool. Nurses are advised that the amount of hours listed in each section of the tool are a guide and are likely sufficient to meet the person's annual needs if only one assessment factor is triggered. For persons who meet criteria for multiple services, the nurse must review the total number of hours and adjust the actual number of hours in the budget request to a logical, "doable" amount that will likely meet the person's general nursing needs in the ISP year. The final budget request may be equal to or less than the original total amount of hours. All nursing services provided will be billed against the Adult Nursing Services budget.
5- Please refer to the current DD Waiver Clinical Criteria for a description of required supporting documentation that must be sent to the Case Manager. Additional supporting documents may be provided if deemed critical to support the request, but should not be excessive.
6- The completed ANS Parameter Tool, pages 1 - 7 and all supporting documentation should be submitted to the Case Manager in a HIPAA compliant manner.
7- If there are no required services and optional Adult Nursing Services are not selected, limited nursing consultation will be provided as requested, but will not exceed the remaining balance of the original 12 hours/48 units for ANS.
8- Additional hours may be requested to address any change of condition as needed. When a Budget Revision is needed, complete the parameter tool and submit with additional justification to the Case Manager.

Part 5: Billing for services

The nurse must document all services in detailed, dated and timed progress notes. This documentation must support the billing for services. Submit billing and documentation as required in Chapter 21 of the Standards.