



Instructions for
Completing the
Medical Eligibility Determination Assessment
For
Private Duty Nursing and Personal Care Services
For
Members under the age of 21
(MEDKids - PDN)

Updated June 2015

TABLE OF CONTENTS

| | |
|---|----|
| Introduction: Philosophy and Intent of MED Kids..... | 3 |
| MED Kids Tool Instructions..... | 4 |
| Section A. Identification and Background Information..... | 5 |
| Clinical Detail..... | 7 |
| Clinical Detail: Definitions..... | 7 |
| Section B. Diagnoses..... | 8 |
| Section C. Physical Functioning..... | 11 |
| Section D. Professional Nursing Services..... | 16 |
| Section E. Medication List..... | 20 |
| Section F. Medication Preparation and Administration..... | 21 |
| Section G. Cognition..... | 22 |
| Section H. Behavior..... | 25 |
| Section I. Communication, Hearing Patterns, and Vision Patterns..... | 28 |
| Section J. Height and Weight..... | 33 |
| Section K. Nutritional Status..... | 33 |
| Section L. Bladder and Bowel Continence | 35 |
| Section M. Skin Conditions..... | 36 |
| PDN Level of Care Determination..... | 38 |
| Standard Nursing Notes..... | 40 |
| Family Circumstances | 42 |

INTRODUCTION: PHILOSOPHY AND INTENT OF MEDKIDS-PDN

The Medical Eligibility Determination Tool for Children (MEDKids tool) was designed to be an objective tool that focuses on the immediate medical and symptoms and needs of children under the age of 21. The MEDKids-PDN tool is set up with 13 areas of assessment, including behavior and cognition. The MEDKids-PDN tool was launched in 2011 and is being revised after tool has been used for several years and determining areas where more information is needed to make better eligibility determinations.

These instructions provide detailed information on how to complete each section and item on the MEDKids-PDN tool. Other resources available as part of this manual include:

| | |
|---|----|
| Clinical definitions clarifying terms frequently used throughout the MEDKids-PDN tool | 7 |
| Psychiatric/Behavioral Diagnostic Categories by Age | 9 |
| Age Appropriate Activities of Daily Living – Self Performance | 14 |
| General Guidelines for Age-Appropriate Cognition | 22 |
| General Guidelines for Age Appropriate Behavior | 25 |
| General Guidelines for Age Appropriate Communication and Hearing | 29 |
| General Guidelines for Age Appropriate Social and Emotional Behavior..... | 32 |

ASSESSOR RESPONSIBILITIES

Your responsibilities as an assessor include:

Read all training materials.

Attend training sessions and make training needs known.

Complete assessments in a thorough, efficient, and timely manner in accordance with MaineCare policies.

Submit documentation to **support the scoring of the assessment**, i.e. medical information and documentation.

Maintain confidentiality. It is crucial that all information gathered is treated as confidential. **NO INFORMATION THAT WOULD IDENTIFY AN INDIVIDUAL CHILD CAN BE DIVULGED BY AN ASSESSOR.** Try to conduct interviews with people in private.

Accuracy. RN completing the assessment must attest to the accuracy of the information being provided.

MED KIDS - PDN TOOL INSTRUCTIONS

SECTION HEADERS

The information in the header connects each section of the tool and **must be completed on each page**. Information needs to be entered on page one and page two. If information is being entered electronically, the information on page two will automatically populate all subsequent pages.

The Medical Eligibility Determination Tool for Children (MEDKids) Header on the first page of the tool includes the following items:

Date of assessment
Name of person completing the assessment
Agency name
NPI number for the agency
Assessor's title
Agency telephone number

The header on page two and all subsequent pages of the assessment tool contain the following items:

Agency name
Date of the assessment
Agency's NPI number
Child's name
Child's MaineCare ID number

NAME/TITLE OF PERSON COORDINATING ASSESSMENT: This should be the name of the person responsible for the completion of the assessment tool. In the box to the right of the name, enter this person's title.

AGENCY/ORGANIZATION: Enter the name of the agency or organization that is performing his assessment. In the box to the right, enter the phone number of the agency

NPI number: enter the ten-digit National Provider Identification (NPI) number of the agency/organization.

SECTION A: IDENTIFICATION AND BACKGROUND INFORMATION

This section contains the child's demographic information as well as parent/guardian contact information. This section may follow the child to prevent repetitive questioning and verification of demographic information by every provider. The child's parent or legal guardian needs to give release of information authorization for this section to be shared with other providers.

- A.1 Child's Name:** Print applicant's legal name clearly, using capital letters for first name, middle initial and last name.
- A.2 Child's Address:** Give applicant's residential address and ten-digit phone number, including area code, at time of assessment.
- A.3**
- a. Social Security Number:** Enter the applicant's Social Security number
 - b. MaineCare Number:** MaineCare number. Check the numbers to make sure the digits were entered correctly
- A.4 Reason for Assessment:** Select the appropriate option
- 1. Initial:** First time assessment based on the consumer's need for service.
 - 2. Reassessment:** Applies to children with a current authorization for services that is due to expire, and reassessment is required to determine continued medical eligibility.
 - 3. Significant Change in Health Status:** Applies to children with a current authorization for services **and** there has been a change in the child's condition that warrants a review to determine eligibility for change in the approved services. Indicators of significant change must be met. A significant change assessment may be requested if the change is a decline or an improvement that results in a change of need for services.
 - 4. Other**
- A.5 Has this child been admitted to a hospital since the beginning of the previous authorization:** enter "0" for no hospitalizations, "1" for one hospitalization, "2" for two or three hospitalizations, "3" for four or more hospitalizations, or "4" to indicate a new admission (item A4 = 1).
- A.6 Gender:** enter "1" for male or "2" for female
- A.7 Race/Ethnicity:** Select the option that best describes the child's race or ethnic background. *This is an optional question.*
- A.8 Birth date:** For example, January 2, 2001 should be entered as 01/02/2001.
- A.9 Citizenship:** Choose one answer from "1" U. S. Citizen, "2" Legal alien, or "3" Other.
- A.10 Primary Language:** Code for the language that the child primarily speaks and/or

understands. Enter “0” for English, “1” for French, “2” for Spanish, or “3” Other for any language other than English, French, or Spanish. If the primary language is none of the three listed languages, specify the language in the space provided.

ITEMS A.10-A.12: Collect the names and telephone numbers of people who can be contacted in the event of an emergency involving the child. When no contact information is available for a person (e.g. either parent is not in the child’s life or no legal guardian), draw a line across the section of the form where the contact information would have been reported.

- A.11 Parent #1’s identifying information:** Enter Parent #1’s first and last name clearly. Indicate the residential address and enter the complete ten-digit home telephone number and work number, if applicable.
- A.12 Parent #2’s identifying information:** Enter Parent #2’s first and last name clearly. Record the residential address and enter the complete ten-digit home telephone number and work number if applicable. If the information is the same as Parent #1’s, write in “SAME.”
- A.13 Legal guardian’s identifying information:** If different from A.10 and/or A.11, enter the legal guardian’s first and last name clearly. Record the legal guardian’s residential address and enter the legal guardian’s complete ten-digit home telephone number and work number if applicable.
- A.14 No. in Household:** Specify, *including the Applicant*, the total number of people residing in the home.
- A.15 Parent Contact:** Specify who can be contacted with questions regarding the child. If the contact is someone “Other” than parent #1, parent #2, or legal guardian, make sure to include the contact’s first and last name and telephone number, including area code.
- A.16 Physician Contact:** List the name, address, and phone number of the child’s primary care physician.
- A.17 Private Insurance:** Specify whether child is currently covered under a private health insurance policy or plan. Code “0” for No and “1” for Yes. If the child is currently covered under a private health insurance policy, specify the health insurer as well as the child’s policy number. **The agency must include a copy of the member’s denied Explanation of Benefits from the primary insurance company.**

CLINICAL DETAIL

Clinical Detail is the portion of the MED Kids tool used to determine the child's level of care (Sections B-M). Upon completion of **Clinical Detail**, the assessor will be able to determine if the child is eligible for Private Duty Nursing and Personal Care Services (PDN) and the level of care. In order for a child to be eligible for PDN, he/she must require medically necessary services.

Completion of **Clinical Detail** portion of the assessment may require review of documentation, such as documentation from a physician to support the child's diagnosis and medical needs, Individual Education Plans (IEP), and a plan of care completed by the home health agency that will be providing the services. As part of a face to face assessment, the nurse completing the assessment will need to observe the child, complete this assessment tool for the child, gather information from parents and/or formal caregivers, assess the need and level of assistance with activities of daily living (ADL) that has been provided within the past 30 days, and identify the tasks that require the skills of a registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant (CNA) and/or personal support specialist (PSS).

CLINICAL DETAIL HEADER

The Clinical Detail Header includes the following items:

- Agency Name;
- Applicant Name;
- Assessment Date;
- MaineCare number; and
- NPI #

When the above information is completed on page two of the assessment, the information will be automatically completed for all subsequent pages of the assessment.

CLINICAL DETAIL: DEFINITIONS

The definitions below clarify terms that are frequently used throughout the MEDKids-PDN tool. This is not an all-inclusive list.

New/recent: is used to describe the onset of a symptom or medical condition it means presenting *within 30 days prior to the assessment date*.

Often is used to describe the frequency of a symptom it means occurring *on most days, or at least 3 days a week*.

Persistent is used to describe the intensity of a symptom it means happening on a daily or *near daily basis, at least 5 days per week*.

Continuous is used to describe the intensity of a symptom it means occurring *throughout every*

day, or 7 days a week.

Unstable: a medical condition is “unstable” when it is fluctuating in an irregular manner and/or is deteriorating and affects the child’s ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment and management is required at least once every 8 hours. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. **The loss of function resulting from a temporary disability from which full recovery is expected is not included in this definition. Unstable behavioral health conditions are also not included in this definition.**

SECTION B: DIAGNOSES

B.1 Psychiatric/Behavioral Diagnoses:

Check only if the condition has been diagnosed by a qualified mental health clinician (as defined in Section 46.01), such as a Physician, Psychiatrist, Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker, Licensed Master Social Worker Conditional Clinical (LMSW-CC), Licensed Clinical Professional Counselor (LCPC), Licensed Professional Counselor (LPC), Licensed Marriage Family Therapist (LMFT), Advanced Practice Registered Nurse Psychiatric and Mental Health Practitioner (APRN-PMH-NP), or an Advanced Practice Registered Nurse Psychiatric and Mental Health Clinical Nurse Specialist (APRN-PMH-CNS) when practicing within their scope of licensure to make a diagnosis.

The listings for biologically based mental disorders are arranged into diagnostic categories taken directly from the Social Security Administration’s listing of mental disorders in children. These categories are: anxiety disorders; attention deficit hyperactivity disorder; autistic disorder and other pervasive developmental disorders; developmental and emotional disorders of younger infants and preschool; mental retardation; mood disorders; organic mental disorders; schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders; and somatoform, eating, and tic disorders.

These categories are separated into two age groups:

Birth to attainment of age six (6), and

Six (6) to age eighteen (18)

The category of Mental Retardation may be checked for all children with a diagnosis of mental retardation, regardless of age.

The category of “Developmental and Emotional Disorders of Younger Infants and Preschool” is designed to encompass all psychiatric/behavioral disorders (other than mental retardation) affecting children under the age of 6. It is often difficult to diagnosis specific psychiatric/behavioral disorders in young children. Developmental factors can confound the presentation of symptoms; where symptoms are exhibited, their presentation is often quite diverse and varied. Since Developmental

and Emotional Disorders of Younger Infants and Preschool is designed to be a “catch all” category, it should be checked for young children (birth to attainment of 6) who have been diagnosed with any type of psychiatric/behavioral disorder. When children reach the age of six, they will be placed in the appropriate diagnostic category for school age children (age 6 to 18) at the time of their annual reassessment.

The categories of Anxiety Disorders; Attention Deficit Hyperactivity Disorder; Autistic Disorder and Other Pervasive Developmental Disorders; Mood Disorders; Organic Mental Disorders; Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders; and Somatoform, Eating, and Tic Disorders are designed to apply ONLY to children age 6 to 18. For children falling within this age range, check the appropriate diagnosis category or categories.

Table 1. Psychiatric/Behavioral Diagnostic Categories by Age

| Birth to attainment of age 6 | 6 to 18 |
|--|--|
| Mental Retardation | Mental Retardation |
| Developmental and Emotional Disorders of Younger Infants and Preschool | N/A |
| N/A | Anxiety Disorders |
| N/A | Attention Deficit Hyperactivity Disorder |
| N/A | Autistic Disorder and Other Pervasive Developmental Disorders |
| N/A | Mood Disorders |
| N/A | Organic Mental Disorders |
| N/A | Schizophrenic, Delusional (Paranoid), Schizoaffective, and other Psychotic Disorders |
| N/A | Somatoform, Eating, and Tic Disorders |

If the child has a DSM IV Axis 1 psychiatric/behavioral diagnosis that is not captured by any of the nine diagnostic categories listed on the form, check “Other DSM IV Axis 1 Diagnoses” and write in the diagnosis and ICD code, if available, in the space provided. If the child does not have any psychiatric/behavioral diagnoses, check NONE OF THE ABOVE.

The choices for psychiatric/behavioral diagnoses are:

- a. ***Developmental and emotional disorders of younger infants and preschool (birth to attainment of 6):*** Developmental or emotional disorders of younger infants and preschoolers are evidenced by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors.
- b. ***Mental retardation:*** Characterized by significantly below average general intellectual functioning with deficits in adaptive functioning.
- c. ***Anxiety disorders:*** In these disorders, anxiety is either the predominant disturbance or is experienced if the individual attempts to master symptoms; e.g. confronting the

- dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety disorder, resisting the obsessions or compulsions in an obsessive compulsive disorder, or confronting strangers or peers in avoidant disorders.
- d. **Attention deficit hyperactivity disorder:** Manifested by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.
 - e. **Autistic disorder and other pervasive developmental disorders:** This category includes Asperger's Disorder. Characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and in imaginative activity. Often, there is markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.
 - f. **Mood disorder:** Characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psyche, generally involving either depression or elation), accompanied by a full or partial, manic or depressive syndrome.
 - g. **Organic mental disorders:** Abnormalities in perception, cognition, affect, or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate or support the presence of an organic factor judged to be etiologically related to the abnormal mental state and associated deficit or loss of specific cognitive abilities, or affective changes, or loss of previously acquired functional abilities.
 - h. **Schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders:** Onset of psychotic features, characterized by a marked disturbance of thinking, feeling, and behavior, with deterioration from a previous level of functioning or failure to achieve the expected level of social functioning.
 - i. **Somatoform, eating, and tic disorders:** Manifested by physical symptoms for which there are no demonstrable organic findings or known physiologic mechanisms; or eating or tic disorders with physical manifestations.
 - j. **Other DSM IV Axis I Diagnoses:** May include diagnoses such as psychoactive substance dependence disorder, conduct disorder, developmental delays, or any other DSM Axis 1 diagnosis that does not fall under the 9 diagnostic categories listed on the form. **Check if appropriate and fill in the diagnosis name and corresponding ICD code in the space provided.**
 - k. **NONE OF THE ABOVE.**

B.2 Medical diagnoses: Do NOT list inactive diagnoses. Check only those medical diagnoses that relate to the child's current ADL status, cognitive status, mood or behavior status, medical treatments, or need for monitoring. Do not include conditions that have been resolved or no longer affect the child's functioning. If the child does not have any medical diagnoses, check NONE OF THE ABOVE.

Check if applicable:

- a. **Allergies** (and specify allergies if checked)
- b. **Amputation**
- c. **Anemia**
- d. **Arthritis** (unspecified site)
- e. **Asthma/Respiratory disorder** (unspecified)

- f. Cancer** (unspecified as to site or stage)
- g. Cardiovascular disease**(unspecified)
- h. Cerebral palsy** (unspecified)
- i. Cleft lip and/or palate**
- j. Cystic fibrosis**
- k. Diabetes**
- l. Explicit terminal prognosis** - A physician has put in the record that the resident is terminally ill with no more than 6 months to live. This should be substantiated with a documented disease diagnosis and deteriorating clinical course.
- m. Hemophilia**
- n. HIV/AIDS**
- o. Osteoporosis** (unspecified)
- p. Paraplegia**
- q. Pathological bone fracture** (unspecified sites)
- r. Quadriplegia**
- s. Renal failure** (unspecified)
- t. Scoliosis**
- u Seizure disorder**
- v. Spina bifida** (unspecified region)
- w. Traumatic brain injury** (unspecified)
- x. Tuberculosis** (unspecified)
- y. Other Current Medical Diagnoses:** Complete if appropriate
- z. NONE OF THE ABOVE.**

SECTION C: PHYSICAL FUNCTIONING

C.1 Activities of Daily Living (ADL) Self-Performance- Activities of Daily Living (ADL) Self-Performance describes the child’s self-care performance in activities of daily living (i.e. what the child actually did alone, without assistance, and/or how much help was provided, not what he or she might be capable of doing). A child’s ADL self-performance may vary from day to day and within the day (e.g. from morning to night). There are many possible reasons for these variations, including mood, stamina, relationship issues (e.g. willing to perform for a caregiver he or she likes), and medications. The responsibility of the assessor, therefore, is to capture the total picture of the child’s ADL self-performance over the 30-day period, 24 hours a day, not only how the child is at one point in time during one day.

In order to accomplish this, it is necessary to gather information from multiple sources (i.e. discussion/observation of the child and interviews with parents and caregivers). Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Toileting with a caregiver, be sure to inquire specifically how the child moves onto and off of the toilet, how the child cleans him/herself, and how the child arranges his/her clothing after using the toilet. A child can be independent in one aspect of Toileting yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The responses in the ADL items are used to record the child’s actual level of involvement in self-

care and the type and amount of support actually received during the last 30 days. In Column 1, Self-Performance, enter the code that best describes the child's self-performance for bed mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene, not including set-up*, and walking, over a 24-hour period during the last 30 days (or 24-48 hour period if the child is in a hospital). *Exclude "Set-up" help: In evaluating the child's ADL Self-Performance, consider the type of assistance known as "set-up help" (e.g. comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the aide) within the context of the "0" (Independent) code. For example: If a child grooms independently once grooming items are set up for him, code "0" (Independent) for self-performance in Personal Hygiene.

For each ADL category, code the appropriate response for the child's actual performance during the past seven days. Enter the code in the box following the ADL and its definition, under Column 1 Self-Performance. Consider the child's performance during a 24-hour period, as functionality may vary. View each activity separately - do not blend activities together. The term "weight-bearing" pertains to the caregiver bearing the weight of the child.

Self-performance codes are:

0. Independent.

Child performed the task independently, receiving no help or oversight in self performance or receiving infrequent help/oversight defined as occurring only 1 or 2 times during the last 30 days.

1. Supervision.

Oversight, encouragement or cueing was provided 3+ times during the last 30 days, Or Supervision plus non-weight bearing physical assistance was provided only 1 or 2 times during last 30 days.

2. Limited Assistance.

Child was highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times, Or Limited assistance (3 or more times) plus weight-bearing support provided only 1 or 2 times during the last 30 days.

3. Extensive Assistance. While child performed part of activity over last 30-day period, help of the following type(s) was provided 3 or more times:

- Weight-bearing support
- Full caregiver performance during part (but not all) of last 7 days.

4. Total dependence. *Full caregiver performance* of activity during *entire* 30 days.

Complete non-participation by child in all aspects of the ADL. For example, for Self-Performance, Eating/Drinking to be coded "4", the child must be incapable of taking any food by himself/herself. Do not code "4" if the child can take finger foods or drink from a cup.

5. Cueing. Physical guidance or verbal instructions which serve as a signal to perform an activity are required during the last 30 days.

6. Needs guidance/supervision due to inability to perform without potential harm to self.

8. Activity did not occur at all during entire period. The child or the caregiver did not perform the ADL.

AA. Age Appropriate. Child performs the activity in a manner that is consistent with clinical expectations for a normally developing child at a given age or developmental stage and is age appropriate as defined in the Denver-II Developmental Screening Test or Vineland

Adaptive Behavior Scales. See **Table 2** on page 15 for select examples of age appropriate performance on ADLs.

The code “8” is limited to situations where the ADL activity was not performed and is primarily applicable to full bed-bound children who were neither transferred nor moved between locations. When an “8” code is entered for self-performance, also enter an “8” code for support.

****Note:** The self-performance definitions are mutually exclusive. They do not overlap. Moving from one level of self-performance to the next step requires a change in the number of times that help is provided. To move a child’s scoring from Independent to Supervision, for example, oversight or help must increase from 1 or 2 times up to 3 or more times. To move from Supervision to Limited Assistance, non-weight bearing supervision or physical assistance must increase from 1 or 2 times up to 3 or more times.

C.2 Activities of Daily Living (ADL) Support Provided: determines the intensity of ADL support, focusing on the time or episode when the highest level of support was provided during the last 30 days.

For each ADL category, code the highest amount of support given in Column 2, Support, irrespective of the frequency over the specific period of time. Code regardless of the child’s self-performance classification (e.g. if child was independent but received a 1- person physical assist one or two times during the period). Code at the level of assistance needed to do the activity.

Support codes are:

- 0. No setup or physical help.**
- 1. Setup help only.** Child is provided with materials or devices necessary to perform the activity of daily living independently. Examples of ‘setup help only’ include:
 - Locomotion:** handing child a walker or locking wheels on wheelchair;
 - Dressing:** retrieving clothes from closet and laying out on child’s bed;
 - Eating:** cutting food and opening containers at meals; **personal hygiene:** providing wash basin or grooming articles; **bathing:** placing bathing articles at tub side within child’s reach.
- 2. One-person physical assist.**
- 3. Two + persons physical assist.**
- 5. Cueing** support required 7 days per week, .
- 6. Needs guidance/supervision** due to inability to perform without potential harm to self.
- 8. Activity did not occur** during the entire period- when an “8” code is entered for support, also enter an “8” code for self-performance.
- AA. Age Appropriate.** Child requires support in a manner that is consistent with clinical expectations for a normally developing child at a given age or developmental stage.

These codes are mutually exclusive. They do not overlap. Moving from one level of support to the next requires a change in the amount of assistance provided.

Table 2. Age-Appropriate Activities of Daily Living-Self Performance

| Activities of Daily Living (ADL) | Child's Age | | | | | | | |
|----------------------------------|--|--|---|--|---|--|-----------------------------|-----------------------|
| | 0 to 4 months | 4 to 8 months | 8 months to 1 year | 1+ year to 2 years | 2+ years to 3 years | 3+ years to 4 years | 4+ years to 5 years | More than 5 years |
| Bed mobility | Dependent on caregiver | Rolls from to back; supports head | Stomach to sitting position | Independent | → | | | |
| Transfer | Dependent on caregiver | Supports weight with legs | Pulls up to stand; stands momentarily | Independent | → | | | |
| Locomotion | Moves arms, stretches and kicks legs | Creeps or crawls (7 to 9 months); sits with or without support | Crawls; walks holding onto furniture; two or three steps with support | Walks alone (12 to 15 months); running (18 months) | Runs well; walks up and down stairs one step at a time | Independent | → | |
| Dressing | Dependent on caregiver | Dependent on caregiver | Dependent on caregiver | Helps to undress and put on some clothing (18 months) | Helps to undress and put on some clothing | Helps in dressing; unbuttons clothing; puts on shoes | Dresses without supervision | Dresses and undresses |
| Eating and Drinking | Nurses or feeds from bottle; spoon fed solids (4 to 6 months); moves hand to mouth | Holds bottle (6 months); reaches hand | Picks up bottle | Weaning from bottle; holds and drinks from cup; picks up food with fingers | Handles spoon well; feeds self | Feeds self; diet is similar to that of the family | Independent | → |
| Toilet use | Dependent on caregiver | Dependent on caregiver | Dependent on caregiver | Dependent on caregiver | Beginning to toilet train; day time bowel and bladder control (average 30 months) | Goes to toilet alone | Independent | → |
| Personal Hygiene | Dependent on caregiver | Dependent on caregiver | Dependent on caregiver | Dependent on caregiver | Brushes teeth | Washes hands | Independent | → |

C.2h Bathing: **Note: Bathing is coded independently of the other ADLs because it can be done less frequently; bathing is not necessarily a daily activity for many children. The frequencies used to define the other ADLs are not appropriate for an activity that might occur only once or twice a week.

In **Column 1, Self-Performance**, enter the **special bathing self-performance code** that best describes the child's *most dependent level of self-performance*. When coding, apply the bathing self-performance code that reflects the highest amount of assistance that the child received during any bathing episode. Enter "8" if bathing did not occur. Bathing self-performance codes are:

- 0. Independent.** No help provided
- AA. Age Appropriate.**
 - 1. Supervision.** Oversight help only
 - 2. Physical help limited to transfer only.**
 - 3. Physical help in part of bathing activity.**
 - 4. Total dependence.**
 - 5. Cueing.** Cueing support required 7 days per week, during the last 30 days.
 - 6. Needs guidance/supervision** due to inability to perform without potential harm to self.
 - 8. Activity did not occur** during the last 30 days.

In **Column 2, Support**, enter the ADL support codes defined in **Section C.2**.

**Note: See Appendix A for examples of scoring ADLs.

C.3 Walking: Code the child's self-performance in walking, as well as the intensity of support needed. In **Column 1, Self-Performance**, enter the ADL self-performance codes defined in **Section C.1**. In **Column 2, Support**, enter the ADL support codes defined in **Section C.2**.

C.4 Mode of locomotion: Code the primary means by which the child moves from place to place. The choices are:

- 0. Walking.**
- 1. Wheelchair.**
- 2. Walker.**
- 3. Splints or braces.**
- 4. Prosthetics.**
- 5. Orthopedic shoes.**
- 6. Cane/crutch.**
- 7. Scooting board.**
- 8. Other.** Please specify.
- 9. NONE OF ABOVE**

SECTION D: PROFESSIONAL NURSING SERVICES AND TREATMENTS

Code for each condition/treatment for which the child will need care that is or otherwise would be provided by or under the supervision of a licensed nurse. Use the following codes for Section D.1 - D.11. Every block must be coded with a response. If a treatment or procedure is administered by the child, do not score as a nursing need to be done by another person. Score with a '0' for independent when professional nursing monitoring is not required. If the treatment or procedure is administered by the parent/guardian, then assume that the child would need licensed nursing care in the parent/guardian's absence and score according to the frequency of treatment required.

0. Conditions/treatment not present in the last 30 days.
1. 1-2 days a week.
2. 3-4 days a week.
3. 5-6 days a week.
4. 7 days a week.
5. Once a month
6. At least once every 8 hours; 7 days a week
7. Twice a month.
8. More than once per day; 7 days a week
9. As needed (PRN)

- D.1 Injections/IV feeding.** Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for injections (intra-arterial, intravenous, intramuscular or subcutaneous) or IV feeding for the treatment of an unstable condition requiring medical or licensed nursing intervention, excluding daily insulin injections for a child whose diabetes is under control. A diabetic's condition is considered to be controlled when his/her blood sugar is maintained at a level that is considered within normal limits for that individual and requires no adjustment of the maintenance dose of insulin. **Every box must be coded with a response.**
- D.2 Feeding tube.** Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for nasogastric tube, gastrostomy or jejunostomy feeding for a new/recent (within 30 days) or an unstable condition. Please specify the date of insertion of the feeding tube. **Every box must be coded with a response.**
- D.3 Suctioning and/or Tracheostomy care.** Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for nasopharyngeal suctioning or tracheostomy; however, care of a tracheostomy tube must be for a new/recent (within 30 days) or an unstable condition. Please specify the date of insertion of the tracheostomy tube. **Every box must be coded with a response.**
- D.4 Treatment/Dressing.** Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for the treatment and/or application of dressings when the physician has prescribed irrigation, application of prescribed medication, or sterile dressings of stage 3 or 4 decubitus ulcers, other widespread skin disorders (except psoriasis or eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including but not limited to ulcers, 2nd or 3rd degree burns, open

surgical sites, fistulas, tube sites and tumor erosions). Physician ordered daily chest physical therapy, by the licensed nurse, to support respiratory status for an acute episode of disease process. If the chest physical therapy is provided by a respiratory therapist, code in E.3a Following are examples of treatments that are EXCLUDED from this category: perineal rash, reddened coccyx, non-barrier dressings for Stage 1 and 2 ulcers, steri-strips, and healed tube sites. **Every box must be coded with a response.**

- D.5 Oxygen.** Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for administration of oxygen on a regular and continuing basis when his/her condition warrants professional observation for a *new/recent* (within 30 days) condition. **A response must be coded.** Please specify start date of oxygen administration.
- D.6 Assessment/management.** Child has an **unstable** medical condition (see previous definition on page 9) that requires professional nursing intervention for assessment, and management due to exacerbations or severity of the condition. **A response must be coded.**
- D.7 Catheter.** Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse for the insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition. The need for the catheter must be documented and justified in the medical record. If a child at home has a catheter, the assessor will need to check with the child, family, MD, or home health agency to determine why the catheter is being used. For example, if a bedridden child with a bedsore has a catheter to prevent further skin breakdown, the skin breakdown prevention and treatment qualifies as a medical need, but the use of a catheter to manage incontinence for the convenience of the caregiver does not qualify as an adjunct to active treatment of disease or medical condition. **A response must be coded.**
- D.8 Comatose.** Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse to manage a comatose condition. A child is considered comatose when in a state of unconsciousness from which he or she cannot be aroused; i.e. **persistent vegetative state**, or has a neurological diagnosis of **coma**. **A response must be coded.**
- D.9 Ventilator/Respirator.** Child will need care that is or otherwise would be performed by or under the supervision of a licensed nurse to manage the ventilator/respirator equipment. A Ventilator or Respirator assures adequate ventilation in a child who is, or who may become, unable to support his/her own respirations. Include any type of electrically or pneumatically powered closed system mechanical ventilatory support device. **(Note: CPAPS and BIPAPS are not ventilators.) A response must be coded.**
- D.10 Uncontrolled Seizure Disorder.** Direct assistance that would be performed by or under the supervision of a registered professional nurse is required for the safe management of an uncontrolled seizure disorder (i.e. grand mal). An “uncontrolled seizure disorder“ is defined as a “diagnosed seizure disorder that cannot be managed by medications.“ The physician is the best person to make this judgment. **A response must be coded.**

D.11 Treatments for Chronic Conditions. This section would be coded for those post-operative or chronic conditions that require licensed nursing care and monitoring for administration of treatments, procedures, or dressing changes which involve prescription medications, in accordance with physician orders. Code for the number of days care would be performed by or under the supervision of a licensed nurse. Please specify the treatments, procedures, or dressing changes for which there are physician's orders. These orders should be reflected on the plan of care. Each box must be coded with a response.

a. Medications via tube. Any medication ordered by a physician that can only be administered via a gastrostomy, jejunostomy or nasogastric tube (enteral tube) for a child who cannot do this for themselves. This must be performed by a licensed nurse or a family/friend who has been taught to perform this skill.

b. Feedings via tube. Any formula, breast milk, or other nutritional supplement intake that is administered via an enteral tube. This must be done by a licensed nurse or a family/friend that has been taught to perform this skill.

c. Tracheostomy care for a stable tracheostomy more 30 days old. Includes cannula care, tracheostomy dressing changes and suctioning related to the routine daily tracheostomy care for children who cannot do this for themselves. This must be done by a licensed nurse or a family/friend who has been taught to perform this skill.

d. Inhalation medications. A medication that is administered by having the child breathe in medications delivered via nebulizer or hand-held inhaler. Administration of these medications may require prior assessment by a licensed nurse or other individual who has been trained to determine if this type of medication is needed. The assessment and medication administration must be done by a licensed nurse or a family/friend that has been taught to perform this skill.

e. Chest PT. This is chest physical therapy for a chronic condition where the PT provides preventative/maintenance airway clearance such as in the case of a child afflicted with cystic fibrosis. This must be done by a licensed nurse or a family/friend that has been taught to perform the PT that would otherwise require the skills of a licensed nurse. *Do not code use of a percussion vest the use of a vest does not require the skills of a licensed nurse.*

f. Oxygen therapy for chronic condition. This is the treatment of a condition where the child has been receiving oxygen therapy for more than 30 days and continues to need assessment by a licensed nurse to adequately maintain respiratory function. This must be done by a licensed nurse, or a family/friend that has been taught to assess and monitor oxygen therapy.

g. Venipuncture. This is the drawing of blood from a child to be sent to a lab for physician-ordered lab studies to monitor the child's condition or response to treatment. PDN policy allows venipuncture by a Licensed Practical Nurse or Registered Professional Nurse who has been trained to perform this procedure.

h. Monthly injections. The administration of a physician-ordered medication on a monthly basis via an intramuscular route. This must be done by a licensed nurse or a

family/friend that has been taught to perform the injection. If the child performs this task independently, it cannot be counted and would be coded “0” -- professional nursing care and monitoring not required.

i. Urinary catheter insertion. Removal and reinsertion of a new indwelling urinary, suprapubic, or straight catheter for children who are unable to perform this task independently. This must be done by a licensed nurse or family/friend that has been taught to perform this skill. If the child performs this task independently every time, it cannot be counted and would be coded “0” -- professional nursing care and monitoring not required. Do not code for insertion of catheter to obtain a urine specimen.

j. Urinary catheter irrigation. This includes the “flushing” of a urinary catheter to prevent or remove a deposit that prevents the drainage of urine. This must be done by a licensed nurse or a family/friend that has been taught to perform this skill. If the child performs this task independently, then it cannot be counted and would be coded “0” -- professional nursing care and monitoring not required.

k. Barrier dressings for Stage I or II ulcers. These are occlusive dressings used to treat and/or debride Stage I or II decubitus ulcers. The skills of a licensed nurse are required to assess the effects of the treatment and to adjust or change the treatment plan as needed, in consultation with a physician. This must be done by a licensed nurse or a family/friend that has been taught to perform this skill. If the child performs this task independently, then it cannot be counted and would be coded “0” -- professional nursing care and monitoring not required.

l. Observation and Assessment for a chronic condition. This would be assessment for a condition that has not had an exacerbation of symptoms or required new treatment within the past 60 days.

m. Other Physician-ordered treatment. Please specify other condition(s) for which treatment is required by a licensed nurse or a family/friend who has been taught to perform this skill.

n. Teach/train. Refers to teaching and/or training done by a licensed nurse related to the child’s medical condition, disease process, or treatment. Specify the training required.

* Supporting documentation is required for injections, intravenous treatments, feeding tubes, suctioning, tracheostomy care, treatments and dressings, new or recently prescribed oxygen therapy, assessment and management of an unstable medical condition, ventilator care, seizure disorder, treatments for chronic conditions or any procedure required more than once per day.

The following are EXCLUDED as Treatments:

- proper positioning of children in bed,
- wheelchair or other accommodations;
- bed baths;
- prevention and treatment of skin irritations and non-barrier dressings for Stage I and II decubitus ulcers;
- observation of vital signs and detailed recordings of findings in child’s record;

- assistance and training in self-care as required for feeding, grooming, ambulation, toilet activities and other activities of daily living;
- assistance and training in person transfer techniques,
- administration of routine medications,
- performance of routine care for a person, (i.e. incontinence; prophylactic and palliative skin care including bathing and applications of creams and/or treatment of minor skin problems; routine care in connection with casts, braces, and other devices; instruction in basic health needs; and change of dressings for non-infected post-operative or chronic conditions.)

SECTION E: MEDICATION LIST

List all medications given during the last 60 days including prescription and over-the-counter medications. Include medications used regularly, but less than weekly if these medications are part of the child’s treatment regimen. If the child does not receive any medications, specify “N/A” for “Not Applicable” in Column 1.

For each medication listed provide the following information in the columns provided:

- 1. List the medication name, dosage, and frequency.**
- 2. Indicate if medications are New (N), changed (C), or discontinued (D) within the past 60 days. Include all prescription, PRN, and over-the-counter medications prescribed in the last 60 days, including antibiotics. Do not include nutritional supplements.**
- 3. Date of new, changed, or discontinued medication.**
- 4. Route of Administration:** choose the appropriate code, 1 through 10 from list at the top.
- 5. Times of Administration:** indicate the specific times of administration, i.e. 08:00am is written as 8A and 8:00 PM would be written as 8P.
- 6. PRN-number of times:** If the frequency is “as needed” (PRN), record the number of times during the past 30 days that each PRN medication was given. Do not use this column for scheduled medications.

Note: There are three pages designated for listing medications. If the second page (page 10 of 29) or the third page (page 11 of 29) is not used, place an “X” in the box to indicate the page is intentionally left blank.

SECTION F: MEDICATION PREPARATION AND ADMINISTRATION

F.1 . Preparation /Administration: Record whether the child prepared and administered any of her/his own medications in the last 30 days. Code a response from the following list that describes preparation and administration of medications for child.

0. Child prepared and administered **All** of his/her own medications
 1. Child prepared and administered **Some** of his/her own medications.
 2. Child prepared **None** of his/her own medications.
 3. Child had no medication in the last 30 days.
 4. Child did not prepare, but administered **Some** of his/her own medications.
 5. Child requires administration of medications due to severe and disabling mental illness.
- AA = it would not be age-appropriate for the child to prepare and/or administer medications.

F.2. Compliance: Determine if there are specific or potential problems with the way the child's medications are administered or taken. Review the child's medication, question the child and his or her family and/or caregivers to assess how well the child complies with the medications ordered by a physician/psychiatrist and how well the family or caregivers administer the medications as ordered. Code a response from the following list that represents the level of compliance during the last 30 days. Non-compliance could be due to the child refusing to take medications or due to parents/caregiver not administering medications as ordered.

0. 100% of prescribed medications were given.
1. 75% of prescribed medications were given
2. 50% of prescribed medications were given
3. 25% of prescribed medications were given
4. 0% of prescribed medications were given.

*Supporting documentation required if less than 100% of prescribed medications were given, documentation will clarify the reason for coding.

SECTION G: COGNITION

Children will have varying cognitive abilities depending on their ages and stages of development. When scoring items in the Cognitive Section, it is important to assess the child in relation to normal cognitive expectations for that age or developmental level. Although children develop at their own pace (and it's impossible to tell exactly when a child will learn a given skill), the examples of cognitive milestones listed below in Table 3 are meant to give a general idea of changes that may be expected at different points in a child's development. Assessors are expected to apply their clinical expertise and knowledge of normal stages of child development when scoring infants and pre-verbal or nonverbal children on this section.

Table 3. General Guidelines for Age-Appropriate Cognition

| CHILD'S AGE | EXAMPLES OF SOME SIGNIFICANT COGNITIVE MILESTONES |
|-----------------------------------|--|
| By the End of 7 mos. | <ul style="list-style-type: none">• Finds partially hidden objects• Explores with hands and mouth• Struggles to get objects that are out of reach |
| By the End of 2 years (24 months) | <ul style="list-style-type: none">• Finds objects even when hidden under covers• Begins to sort by shapes and colors• Begins make-believe play |
| By the End of 3 yrs. (36 months) | <ul style="list-style-type: none">• Makes mechanical toys work• Matches an object in his/her hand or room to a picture in a book• Plays make-believe with dolls, animals, and people• Sorts objects by shape and color• Completes simple puzzles |
| By the End of 4 yrs. (48 months) | <ul style="list-style-type: none">• Correctly names some colors• Understands the concept of counting and may know a few numbers• Tries to solve problems from a single point of view• Begins to have a clearer sense of time• May follow three-part commands• Recalls parts of a story• Understands the concepts of "same" and "different"• Engages in fantasy play |
| By the End of 5 yrs. (60 months) | <ul style="list-style-type: none">• Can count a handful of objects• Correctly names some colors• Better understands the concept of time• Knows about things used every day in the home (money, food, appliances) |

Shelov Source: Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5 by Steven, Robert, E. Hammermann © 1991, 1993, 1998, 2004 by the American Academy of Pediatrics

G.1 Memory- the child's capacity to remember both recent and past events.

Use the following codes for section G.1a. and G.1.b. Each box must be coded with a response.

0. Memory OK
 1. Memory problems
 2. Nurse unable to determine
- AA= age appropriate

G.1.a Short-term memory- Ask the child to describe a recent event that you both had the opportunity to remember or use a more structured short- term memory test.

Examples: If considered to be age-appropriate, ask the child to describe the meal or activity just completed, or, to name 3 items (e.g. book, watch, table). Immediately after you state the items, have child repeat them to verify understanding. Continue conversation with the child. After 5 minutes, ask child to repeat the names of the items again. If s/he cannot, code “1.” Code “2” if child is non-verbal or unable to answer questions. Do not rely on family or caregivers to determine if they believe the child can recall.

G.1.b. Long-term memory- Engage the child in a conversation that is meaningful to him or her. Ask questions for which you already know the answers (e.g. from your review of record, general knowledge, family).

Examples: As the child’s age and development allows, you may use questions such as the following. What country do you live in? What is your address? Do you have any brothers or sisters? How many? When is your birthday? If child cannot answer these types of question, code “1.” Code “2” if child is non-verbal or unable to answer questions. *Do not rely on family or caregivers to determine if they believe the child can recall.*

G.2 Memory/Recall Ability- Ask the child about items **a** through **d**. For example, “What is the current season? “What is the name of this place?” “What kind of place is this?” If the child is not in his or her room, ask “Will you show me to your room?” Observe the child’s ability to find his/her way.

- a. **Current season-** able to name the current season (e.g. correctly refers to weather for the time of year, legal holidays, religious celebrations).
- b. **Location of own room-** able to locate and recognize own room. He or she should be able to find the way to the room.
- c. **Names and faces-**able to distinguish family members, friends, caregivers, and strangers.
- d. **Where he/she is-** able to distinguish where child is (e.g. home, hospital, nursing home).
- e. **Nurse unable to determine** if child is unable to respond; do not rely on family or caregivers to determine if they believe the child can recall.
- f. **NONE OF THE ABOVE** was recalled.

For each item that the child can recall, check the corresponding answer box. Assessor can confirm with a parent or caregiver if the responses have been consistent for the past 30 days.

G.3 Cognitive Skills for Daily Decision Making- determines the child’s ability to make everyday decisions about the tasks or activities of daily living. Consult with family, formal and informal caregivers. Observe the child during the assessment interview. The inquiry should focus on whether the child is actively making these decisions, and not whether a family member or caregiver believes the child might be capable of doing so. Remember, the intent of this item is to record what the child is capable of doing. When a family member or formal caregiver does not allow the child decision-making responsibility regarding tasks of everyday living, or if the child does not participate in decision-making, regardless of his/her capability, the child should be considered to have impaired performance in decision- making. This item is especially important for care planning as it can alert providers to a mismatch between a child’s abilities and his/ her level of

performance, or that the family and/or caregiver may be inadvertently fostering the child's dependence.

Examples:

Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g. clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g. asks for help when necessary); making the correct decision concerning how to get to the dining room or bathroom; acknowledging need to use a walker or other device, and using it faithfully.

Enter one number that corresponds to the most correct response, using the following codes:

- 0. Independent-** decisions consistent, reasonable and safe (reflecting lifestyle, culture, values); child organizes daily routine and makes decisions in a consistent, reasonable and organized fashion.
- 1. Modified Independence-** child organizes daily routine and makes safe decisions in familiar situations, but experiences some difficulty in making decisions when faced with new tasks or situations.
- 2. Moderately Impaired-** child's decision-making skills are poor; child requires reminders, cues, and supervision in planning, organizing and conducting daily routines.
- 3. Severely Impaired-** child's ability to make decisions is severely impaired; child never or rarely makes decisions or the nurse is unable to determine as the child is non-communicative.
- AA. Age Appropriate-** child makes decisions in a manner that is consistent with clinical expectations for a normally developing child at a given age or developmental stage.

G4. Memory and Use of Information: Enter the number that best describes child's ability to remember and use information appropriately, within the last 30 days:

- 0.** The child does not have difficulty remembering and using information; does not require directions
- 1.** Has minimal difficulty remembering and using information; requires direction and reminding from others 1 – 3 times per day. Can follow simple written instructions.
- 3.** Has difficulty remembering and using information; requires direction and reminding from others 4 or more times per day. Cannot follow written instructions.
- 4.** Cannot remember or use information; requires continual verbal reminding.

AA=Age Appropriate inability to recall information

G5. Communication: Enter the number that best describes child's ability to convey information within the last 30 days:

- 0.** Speaks normally
- 1.** Minor difficulty with speech or word-finding difficulties

2. Able to carry out only simple conversations
 3. Non-verbal
 4. Able to make needs known
 5. Sign language or gestures
 6. Communication device
- AA. Age appropriate inability to communicate**

SECTION H: BEHAVIOR

Children develop at their own pace, and it’s impossible to tell exactly when a child will learn a given skill. The examples of social and emotional milestones listed below in Table 4 are meant to give a general idea of behavioral changes one may expect at different points in a child’s development.

Table 4. General Guidelines for Age-Appropriate Behavior

| CHILD’S AGE | Examples of Some Significant Social and Emotional Milestones for Behavior |
|-----------------------------------|---|
| 0 to 3 mo. | <ul style="list-style-type: none"> • Begins to develop a social smile • Enjoys playing with other people and may cry when playing stops • Becomes more expressive and communicates more with face and body • May imitate some movements and facial expressions |
| By the End of 7 months | <ul style="list-style-type: none"> • Enjoys social play • Interested in mirror images • May respond to other people’s expressions of emotion and appears joyful often |
| By the End of 2 years (24 months) | <ul style="list-style-type: none"> • May imitate behavior of others, especially adults and older children • More aware of herself/himself as separate from others • More excited about company of other children • Often demonstrates increasing independence • May begin to show defiant behavior • Separation anxiety may increase toward midyear than fade |
| By the End of 3 years (36 months) | <ul style="list-style-type: none"> • Imitates adults and playmates • May spontaneously show affection for familiar playmates, may express affection openly • Can take turns in games • Understands concepts of “mine” and “his/hers” • May express a wide range of emotions • By 3, begins to separate more easily from parents • May object to major change in routine |
| By the End of 4 years (48 months) | <ul style="list-style-type: none"> • Interested in new experiences • Cooperates with other children • May play “Mom” or “Dad” • Increasingly inventive in fantasy play • Dresses and undress • Begins to negotiate solutions to conflicts • More independent • May imagine that many unfamiliar images may be “monsters” • Views self as a whole person involving body, mind, and feelings • Often cannot tell the difference between fantasy and reality |

| | |
|---|---|
| By the End of 5 years (60 months) | <ul style="list-style-type: none"> • Wants to please friends; may want to be like his/her friends • More likely to agree to rules • Often likes to sing, dance, and act • Shows more independence and may even visit a next-door neighbor by himself/herself • Aware of gender • Able to distinguish fantasy from reality • Sometimes demanding, sometimes eagerly cooperative |
|---|---|

Source: Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5 by Steven Shelov, Robert E. Hammernann © 1991, 1993, 1998, 2004 by the American Academy of Pediatrics

When assessing children for **problem behavior**, assessors should consider not only the presence of a behavior or symptom but the degree to which it is present and may interfere with normal day-to-day functioning.

H.1 Problem Behavior - Identifies the presence of problem behaviors in the last 30 days that cause disruption; include behaviors that are potentially harmful to the child or disruptive in the environment, even though friends, family members, and/or caregivers may appear to have adjusted to the behaviors.

- a. **Wandering:** movement with no rational purpose, seemingly oblivious to needs or safety. A wandering child may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g. a hungry child moving about in search of food). Wandering may occur by walking or by wheelchair. Note: Do not include pacing as wandering behavior.
- b. **Verbally abusive:** the child may scream or curse at others; others may feel threatened by the child.
- c. **Physically abusive:** others were hit, shoved, scratched or sexually abused
- d. **Socially inappropriate / disruptive behavior:** disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared or threw food/ feces, hoarding, rummaging through others' belongings
- e. **Resists care:** resists medications, injections, ADL assistance or eating. Signs of resistance may be verbal and/or physical (e.g. verbally refusing care may appear as pushing a caregiver away or scratching a caregiver). This category does **not** include instances where child has made an informed choice not to follow a course of care (e.g. child has exercised his or her right to refuse treatment, and reacts negatively as caregivers try to reinstitute treatment.)

For each disruptive behavior use one of the following codes to indicate frequency. Report the occurrence of disruptive behavior over the past 30 days. **Every box must be coded 0, 1, 2, or 3 for frequency.**

Frequency codes: code for the frequency of behavior in the last 30 days.

0. Behavior not exhibited in last 30 days.
1. Behavior of this type occurred 1 to 3 days per week in last 30 days
2. Behavior of this type occurred on 4 to 6 days per week, but not every day.
3. Behavior of this type occurred daily .
4. Nurse unable to determine

AA=Age Appropriate

H.2. Sleep patterns: Enter the number that best describes child’s sleep patterns within the last 30 days:

- 0. Unchanged from “normal” for the child
 - 1. Sleeps noticeably more or less than “normal”
 - 2. Restless, nightmares, disturbed
 - 3. Up wandering for all or most of the night, unable to sleep.
 - 4. Nurse unable to determine
- AA = age appropriate**

H.3. Wandering: Enter the number that best describes child’s wandering behavior within the last 30 days:

- 0. Does not wander, or child is chair or bedbound
 - 1. Wanders within residence and may wander outside, but does not jeopardize health and safety
 - 2. Wanders within residence. May wander outside. Health and safety may be jeopardized. Does not have a history of getting lost and is not combative about returning.
 - 3. Wanders outside and leaves grounds. Has a consistent history of leaving grounds, Getting lost, or being combative about returning.
 - 4. Exit seeking
- AA = age appropriate**

H.4 Behavioral Demands on Others: Enter the number that best describes the effect of child’s behavior on their living arrangement within the last 30 days:

- 0. Attitudes, habits and emotional states do not create stressors, or the condition does not place behavior demands on others.
 - 1. Attitudes, habits, and emotional states DO create stressors within the individual’s living environment and with companions
 - 2. Attitudes, disturbances, and emotional states create consistent difficulties that are modifiable to manageable levels with services in place.
 - 3. Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels with services in place.
- AA= age appropriate behavioral demands**

H.5 Danger to Self and Others: Enter the number that best describes the extent to which the individual has been dangerous to self or others within the last 30 days:

- 0. Child is not disruptive or aggressive and is not dangerous.
- 1. Child is not capable of harming self or others because of mobility limitations (i.e. chair- or bedbound)
- 2. Child is disruptive or aggressive, either physically or verbally, 1 to 3 times per week or is extremely agitated or anxious even after evaluation and treatment.
- 3. Child is disruptive or aggressive, either physically or verbally, 4 to 6 times per week or is frequently agitated or anxious and professional judgment is required to determine if prescription medication needs to be administered.
- 4. Child is dangerous or physically abusive; even with proper evaluation and treatment the child may require additional physician intervention.

AA= age appropriate need for supervision to prevent danger to self

H.6 Awareness of Needs and Use of Judgment: Enter the number that best describes the child's awareness of their needs and level of cooperation in meeting those needs within the last 30 days:

0. Child understands the need for care.
1. Child has difficulty understanding the need for care, 1 to 3 times per week, but will cooperate when given direction or explanation.
2. Child has difficulty understanding the need for care, 4 to 6 times per week, but will cooperate when given direction or explanation.
3. Child does not understand the need for care.
4. Child will not cooperate even though given direction or explanation.
5. Nurse unable to determine.

AA=age appropriate unawareness of needs

Total Behavior Score: Add the answers to questions 1-6 and enter this number in the box provided. The total score is a point of reference; the higher the score, the greater the degree of behavioral impairment. The score can also be used to compare behaviors from one assessment to the next.

SECTION I: COMMUNICATION, HEARING, and VISION PATTERNS

There are many possible causes for communication problems. Usually a communication problem is caused by more than one factor. For example, a child might have aphasia as well as a long-standing hearing loss. The child's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can affect opportunities for effective communication.

Deficits in the child's ability to understand (receptive communication deficits) can be caused by impairments in hearing, impaired comprehension (spoken and/or written), or inability to recognize facial expressions. Deficits in ability to make oneself understood (expressive communication deficits) can be caused by reduced voice volume, and difficulty producing sounds, difficulty in finding the right word, or difficulty making sentences, writing, and/or gesturing.

The assessor should interact with the child. Observe and listen to the child's efforts to communicate. Observe the child's interactions with others. Consult with caregivers and family members. Be alert to what you have to do to communicate with the child. For example, you have to speak more clearly, use a louder tone, speak more slowly, use gestures, the child may need to see your face to know what you are saying, or you have to take the child to a more quiet area to conduct the interview. If any of these interventions are used it may indicate a hearing problem.

Although children develop at their own pace (and it's impossible to tell exactly when a child will learn a given skill), the examples of communication/hearing milestones listed below in Table 5 are meant to give a general idea of changes one may expect at different points in a child's development.

Table 5. General Guidelines for Age-Appropriate Communication and Hearing

| CHILD'S AGE | Examples of Significant Milestones – Communication and Hearing |
|-----------------------------------|---|
| 0 to 3 mos. | <ul style="list-style-type: none"> • Smiles at sound of voice • Begins to babble • Begins to imitate some sounds • Turns head towards direction of sound |
| By the End of 7 mos. | <ul style="list-style-type: none"> • Responds to own name • Begins to respond to “no” • Can tell emotions by tone of voice • May respond to sound by making sounds • Uses voice to express joy and displeasure • Babbles chains of sounds |
| By the End of 2 years (24 months) | <ul style="list-style-type: none"> • Points to object or picture when it’s named for him/her • Recognizes names of familiar people, objects, and body parts • Says several single words (by 15 to 18 months) • Uses simple phrases (by 18 to 24 months) • Uses 2 to 4 word sentences • Follows simple instructions • May repeat words overhead in conversation |
| By the End of 3 yrs. (36 months) | <ul style="list-style-type: none"> • Follows a two and three part command • Recognizes and identifies almost all common objects and pictures • Understands most sentences • Understands placement in space (“on,” “in,” “under”) • Uses 4 to 5 word sentences • Can say name, age, and sex • Uses pronouns (I, you, me, we, they) and some plurals (cars, dogs, cats) • Strangers may be able to understand most of child’s words |
| By the End of 4 yrs. (48 months) | <ul style="list-style-type: none"> • Has mastered some basic rules of grammar • Speaks in sentences of 5 to 6 words • Speaks clearly enough for most strangers to understand • Tells stories |
| By the End of 5 yrs. (60 months) | <ul style="list-style-type: none"> • Recalls part of a story • Speaks sentences of more than 5 words • Uses future tense • Tells longer stories • Says name and address |

Source: Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5 by Steven Shelov, Robert E. Hammermann © 1991, 1993, 1998, 2004 by the American Academy of Pediatrics

I.1 Hearing: Code for the child’s ability to hear. If hearing appliance is used, code child’s ability to hear with hearing appliance.

- 0. Hears adequately.** The child hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.
- 1. Minimal difficulty.** The child hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-to-one situations.
- 2. Hears in special situations only.** the child appears to hear when the speaker adjusts tonal quality and speaks distinctly, or the child can hear only when the speaker’s face is clearly visible.

- 3. **Highly impaired - absence of useful hearing.** There appears to be no comprehension of conversational speech, even when the speaker makes maximum adjustments.
- 4. **No response to auditory stimuli**

I.2 Communication: Check the methods by which the child has communicated during the last 30 days. Remember to check all that apply.

- a. **Speech.**
 - b. **Written messages** to express or clarify needs.
 - c. **American or other sign language, Braille.**
 - d. **Communication device.** For example, picture exchange, special computers, augmentative and alternative communication devices (AAC).
 - e. **Eye gaze.**
 - f. **Gestures.** Includes pointing, leading, head nods, hand squeezes, etc.
 - g. **None of above.**
- AA= age appropriate communication skills**

I.3 Communication Devices or Techniques: Check all that apply during last 30 days:

- a. **Hearing aid, present and used.** A hearing aid or other assistive device is available to the child and is used regularly.
- b. **Hearing aid, present and not used regularly.** The hearing aid is used only occasionally or is broken.
- c. **Other receptive communication techniques used.** (e.g. lip reading) A mechanism or process is used by the child to enhance interaction with others, e.g. touching to compensate for hearing deficit, writing is done by another child, use of a communication board.
- d. **None of above.**

I.4 Speech clarity: Code the child's ability to speak clearly.

- 0. **Clear speech.** Child's speech is distinct and intelligible enough to be understood by most people most of the time.
 - 1. **Unclear speech.** There are enough errors in speech so that child's speech is unintelligible to people who are not familiar with the child or when no context is provided.
 - 2. **No speech.** Absence of spoken words
- AA=Age Appropriate**

I.5 Making self understood: Code the child's ability to communicate with others in articulating requests and needs, whether in speech, writing, sign language, or a combination of these (including use of word or key board). Enter 0, 1, 2, or 3 depending on the appropriate response.

- 0. **Understood.** When communicating with others, child uses nouns, names objects, and can give first and last names.
- 1. **Usually understood.** Child has difficulty finding words or finishing thoughts.
- 2. **Sometimes understood.** Child's ability to communicate with others is limited to making concrete requests.

3. Rarely or never understood. Child's ability to communicate with others is limited to highly individual, child-specific sounds or body language/gestures.

AA=Age Appropriate inability to communicate with others

I.6 Ability to Understand Others: Code for the child's ability to understand others. Enter 0, 1, 2, or 3 depending on the appropriate response.

0. Understands. The child understands a speaker's age-appropriate message and demonstrates comprehension by words or actions/ behaviors.

1. Usually understands. The child may miss some part or intent of the message but comprehends most of it.

2. Sometimes understands. The child demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions.

3. Rarely or never understands. The child demonstrates very limited ability to understand communication. Or, the child can hear sounds but does not understand messages.

4. None of the above or unable to determine

AA=Age Appropriate inability to understand others

I.7 Vision: Code 0, 1, 2, 3, or 4 depending on the appropriate response.

0. Adequate. No documented visual abnormality.

1. Adequate with corrective device

2. Impaired. Documented visual abnormality.

3. Eyes do not appear to follow objects

When scoring infants on this item, refer to Table 6 as a general guide on what constitutes "adequate" and/or age-appropriate vision.

I.8. Visual Appliances: Code "0" if No, "1" if Yes.

a. Glasses and/or contact lenses.

b. Artificial eye.

c. Other: specify.

Table 4. General Guidelines for Age-Appropriate Behavior

| CHILD'S AGE | Examples of Some Significant Social and Emotional Milestones |
|-----------------------------------|---|
| 0 to 3 mo. | <ul style="list-style-type: none"> • Begins to develop a social smile • Enjoys playing with other people and may cry when playing stops • Becomes more expressive and communicates more with face and body • May imitate some movements and facial expressions |
| By the End of 7 mos. | <ul style="list-style-type: none"> • Enjoys social play • Interested in mirror images • May respond to other people's expressions of emotion and appears joyful often |
| By the End of 2 years (24 months) | <ul style="list-style-type: none"> • May imitate behavior of others, especially adults and older children • More aware of herself/himself as separate from others • More excited about company of other children • Often demonstrates increasing independence • May begin to show defiant behavior • Separation anxiety may increase toward midyear than fade |
| By the End of 3 yrs. (36 months) | <ul style="list-style-type: none"> • Imitates adults and playmates • May spontaneously show affection for familiar playmates, may express affection openly • Can take turns in games • Understands concepts of "mine" and "his/hers" • May express a wide range of emotions • By 3, begins to separate more easily from parents • May object to major change in routine |
| By the End of 4 yrs. (48 months) | <ul style="list-style-type: none"> • Interested in new experiences • Cooperates with other children • May play "Mom" or "Dad" • Increasingly inventive in fantasy play • Dresses and undress • Begins to negotiate solutions to conflicts • More independent • May imagine that many unfamiliar images may be "monsters" • Views self as a whole person involving body, mind, and feelings • Often cannot tell the difference between fantasy and reality |
| By the End of 5 yrs. (60 months) | <ul style="list-style-type: none"> • Wants to please friends; may want to be like his/her friends • More likely to agree to rules • Often likes to sing, dance, and act • Shows more independence and may even visit a next-door neighbor by himself/herself • Aware of gender • Able to distinguish fantasy from reality • Sometimes demanding, sometimes eagerly cooperative |

Source: Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5 by Steven Shelov, Robert E. Hammernann © 1991, 1993, 1998, 2004 by the American Academy of Pediatrics

SECTION J: HEIGHT AND WEIGHT

J.1. Height. Record the applicant's current height in inches. Specify the date the measurement was taken.

Weight. Record the applicant's current weight in pounds. Specify the date the measurement was taken.

BMI measurement can be added, if available.

J.2. Weight Change

0= No weight change

1=Unintended weight **gain** of 5% or more in the last 30 days **or** 10% or more in the last 180 days.

2=Intended weight **gain** of 5% or more in the last 30 days **or** 10% or more in the last 180 days.

3=Unintended weight **loss** of 5% or more in the last 30 days **or** 10% or more in the last 180 days.

4=Intended weight **loss** of 5% or more in the last 30 days **or** 10% or more in the last 180 days. Specify the previous weight and the date of measurement.

SECTION K: NUTRITIONAL STATUS

The intention of this section is to provide a complete view of the child's nutritional status including methods and complications. Code to accurately identify the child's needs.

K.1. Nutritional approach - oral: *At least one box must be checked.*

a. Oral diet (specify regular or therapeutic): enter the specific prescribed diet orders, including alterations in texture. A mechanically altered diet alters the consistency of foods in order to facilitate oral intake. For example: regular, pureed, allergies, etc. A *therapeutic* diet is not about the consistency as much as it is about the reason for the specialized diet.

b. Oral supplement (specify): A supplement is a food or liquid that is administered to increase the daily intake of calories or other nutrients, such as vitamins. Enter the specific supplements that are administered to the child. Include frequency and amounts, as appropriate.

c. Thickened liquids: check the box to the right, as appropriate and include the consistency, i.e. nectar, honey, or pudding. This is for persons who can take only liquids that have been thickened to prevent choking.

d. NPO: check this box if the child takes nothing by mouth.

K.2. Nutritional approach – enteral: *At least one box must be checked.*

a. Enteral diet (specify formula, frequency, amount, schedule and whether the feedings are administered via pump or gravity).

b. Enteral supplements (specify): A supplement is a food or liquid that is administered to increase the daily intake of calories or other nutrients, such as vitamins. Enter the specific supplement, the frequency, and the amounts that are administered. Include frequency and amounts, as appropriate.

- c. **Hydration bolus:** indicate additional water that is administered and the times of administration; specify times and/or frequency.
- d. **Enteral diet provides less than 50% of daily calories:** check this box, as appropriate.
- e. **Enteral diet provides 50% or more of daily calories:** check this box, as appropriate.
- f. **TPN (total parenteral nutrition):** check this box if the child receives intravenous nutritional through a centrally inserted intravenous line.
- g. **Not applicable:** check this box, if other approaches in K2 do not apply

K.3. Nutritional problems - oral: *At least one box must be checked*

- a. **Complains about the taste and texture of many foods:** the sense of taste or ability to manage various food textures can change as a result of health conditions or medications
- b. **Chewing and/or swallowing are a problem:** Inability to chew food easily and without pain or difficulties, unless due to teething
- c. **Gagging and/or vomiting** due to any reason
- d. **Regular or repetitive complaints of hunger:** On most days, the child asks for more food or complains of feeling hungry, even after eating a meal.
- e. **Noncompliance with diet:** Child eats less than 75% of food, even when substitutes are offered at least 2 out of 3 meals per day.
- f. **Aspiration risk**
- g. **Food allergies:** specify food and reaction
- h. **Restrictions:** specify any dietary restrictions and reason
- i. **None of the above:** check this box if other selections in K3 do not apply

K.4. Nutritional Problems – enteral: *At least one box must be checked.*

- a. **No complications**
- b. **Aspiration risk**
- c. **Gagging**
- d. **Vomiting**
- e. **Diarrhea**
- f. **Venting of tube:** This procedure involves removing excess gas from the stomach. Specify frequency and reason.

SECTION L: BLADDER AND BOWEL CONTINENCE

Control of bladder and bowel function is a sensitive subject. Children with poor control may try to hide their problems out of embarrassment or fear of retribution. Validate continence patterns with family members or caregivers who know the child well. Remember to consider continence patterns over the last **30 day period, 24 hours** a day.

L.1 Urinary Continence in the past 30 days: Control of urinary function, including dribbling with an insufficient volume to leak through clothing. If appliances, as described in M.1, are used, document the level of incontinence with the use of the appliance.

- a. **Continent** – complete control
- b. **Usually continent** – incontinent episodes once a week or less
- c. **Occasionally incontinent** – incontinent episodes 2 or more times per week but not daily
- d. **Frequently incontinent** – tends to be incontinent daily, but some control present.
- e. **Incontinent** – incontinent all or almost all of the time.
- f. **Age appropriate urinary incontinence**

L.2 Bowel Continence in the past 30 days: Control of bowel function, with the use of an appliance or program, if used.

- a. **Continent** – complete control
- b. **Usually continent** – incontinent episodes less than weekly
- c. **Occasionally incontinent** – incontinent episodes once a week
- d. **Frequently incontinent** – tends to be incontinent 2-3 times per week.
- e. **Incontinent** – incontinent all or almost all of the time.
- f. **Age appropriate bowel incontinence**

L.3 Appliances and Programs for Urinary Management: Be sure to ask about any items that are usually hidden from view because they are worn under street clothing.

- a. **External (condom) catheter.** A urinary collection appliance worn over the penis.
- b. **Catheter.** A catheter that is inserted within the bladder for the purpose of continuous or intermittent drainage of urine. Includes catheters inserted through the urethra or by supra- pubic incision. Please indicate the frequency of insertion.
- c. **Pads, briefs used.** Any type of absorbent, disposable or reusable undergarment or item, whether worn by the child (e.g. diaper) or placed on the bed or chair for protection from incontinence. Does NOT include the routine use of pads on beds where child is never or rarely incontinent.
- d. **Ostomy present.** Any type of ostomy of the gastrointestinal or genitourinary tract.
- e. **Scheduled toileting program.** Timed/ scheduled toileting of the child or any other program such as bladder retraining.
- f. **Age appropriate toilet training.** Child uses age appropriate toileting appliances and/or programs. See Table 2. on Age-Appropriate Activities of Daily Living-Self-Performance for clinical expectations for age appropriate toilet use.
- g. **Age appropriate incontinence.**
- h. **None of the above is applicable.**

L.4 Appliances and Programs for Bowel Management: Be sure to ask about any items that are usually hidden from view because they are worn under street clothing.

- a. **Pads, briefs used.** Any type of absorbent, disposable or reusable undergarment or item, whether worn by the child (e.g. diaper) or placed on the bed or chair for protection from incontinence. Does NOT include the routine use of pads on beds where child is never or rarely incontinent.
- b. **Ostomy present.** Any type of ostomy of the gastrointestinal or genitourinary tract.
- c. **Scheduled toileting program.** Timed/ scheduled toileting of the child or any other program such as bladder retraining.
- d. **Age appropriate toilet training.** Child uses age appropriate toileting appliances and/or programs. See Table 2. on Age-Appropriate Activities of Daily Living-Self-Performance for clinical expectations for age appropriate toilet use.
- e. **Age appropriate incontinence.**
- f. **None of the above is applicable.**

SECTION M: SKIN CONDITIONS

M.1 Ulcers: Record the number of pressure and/or stasis ulcers at each of the four ulcer stages, or “unstageable”. Code all occurrences of ulcers, whether caused by pressure or circulation, within the **last 30 days**. If no ulcers are present at a stage, record “0”. If one ulcer is present at a stage, record “1.” If an ulcer cannot be staged (i.e. covered with eschar or area of discoloration), code as “Unstageable.”

The four stages are:

- a. **Stage 1** - A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- b. **Stage 2** - A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
- c. **Stage 3** - A full thickness of skin is lost, exposing the subcutaneous tissues, presents as a deep crater with or without undermining adjacent tissue.
- d. **Stage 4** - A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.
- e. **Unstageable** - due to non-removable dressing, slough, eschar, or suspected deep tissue injury

The types of ulcers are:

Pressure ulcer - any lesion caused by pressure resulting in damage of underlying tissue.

Stasis ulcer - open lesion caused by poor circulation in the lower extremities. MaineCare covers RN care for Stage 3 or 4 ulcers.

M.2 Skin problems: Document presence of skin conditions or changes, other than ulcers. Check all that apply in the last 30 days.

- a. **Abrasions** (scrapes) or cuts - Includes skin that has been scraped or rubbed away, such as skin tears.
- b. **Burns** (second or third degree) - Includes burns from any cause (e.g. heat, chemicals) in any

stage of healing. This category does not include first-degree burns, which results in changes in skin color only.

- c. **Bruises.** Includes ecchymosis, localized areas of swelling, tenderness and discoloration.
- d. **Rash**
- e. **Body lice or scabies**
- f. **Itchiness**
- g. **Irritation related to yeast, skin fold issues, or incontinence.**
- h. **Surgical wound**
- i. **Surgical drain**
- j. **Cast** (specify type and location)
- k. **Infection** (specify location and type)
- l. **Other** (specify)

M.3 Foot Problems and Care: Code “0” No or “1” Yes for Questions

- a. foot problems or infections such as corns, calluses, hammer toes, overlapping toes, pain, structural problems, gangrene of the toes, foot fungus, or onychomycosis.

Describe the condition if the response is coded with a “1”

PDN Level of Care Determination (page 22 and 23 of the MEDKids-PDN assessment)

Continue scoring each section until there is a “no” as a final score in any section. The appropriately scored level would be the last section with a “yes” as a final response.

PDN Level I:

In level I, the child must require cueing in eating, toilet use, dressing, and bathing, OR limited, extensive, or total assistance in one of the seven ADLs identified in Section C, OR , any of the items (D1 through D5 or D7 through D11) must be coded to indicate nursing services are needed at least one time per month. **This does not include assessment of a medical condition, whether the condition is chronic or unstable.**

A. In Clinical Detail, Section C, Physical Functioning, were d, e, f, and h (eating/drinking, toilet use, dressing, and bathing) all coded with a ‘5’ (cueing) in Self-Performance AND Support? **OR**

B. In Clinical Detail, Section C, Physical Functioning, were 2 of the following ADL’s (bed mobility, transfer, locomotion, eating/drinking, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in Self-Performance AND a 2 or 3 in Support? **OR**

C. In Clinical Detail, Section D, were any of the items I-5 or 7-II coded to indicate nursing services were needed at least one time per month?

If A or B or C is checked as yes the child appears to be eligible for PDN Level I.

PDN Level II:

In level II, the child must require cueing in eating, toilet use, dressing, and bathing **OR** limited, extensive, or total assistance in one of the seven ADLs identified in Section C, **AND** at least one of the items in Section D must be coded to indicate nursing services are needed at least one time per month. The level may include assessment of an unstable medical condition.

A. In Clinical Detail, Section C, Physical Functioning, were d, e, f, and h (eating/drinking, toilet use, dressing, and bathing) all coded with a ‘5’ (cueing) in Self-Performance AND Support? **OR**

B. In Clinical Detail, Section C, Physical Functioning, were 2 of the following ADL’s (bed mobility, transfer, locomotion, eating/drinking, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in Self-Performance AND a 2 or 3 in Support? **AND**

C. In Clinical Detail, Section D, were any of items 1 — 11 coded to indicate nursing services are needed at least one time per month?

If A or B is checked as yes AND C is coded yes, the child appears to be eligible for PDN Level II

PDN Level III:

In level III, two of the five shaded ADL (bed mobility, transfer, locomotion, toilet use, and eating) must be coded as requiring limited, extensive, or total assistance, **AND**, at least one of the items in Section D must be coded to indicate nursing services are needed at least one time per month. The level may include assessment of an unstable medical condition.

A. In Clinical Detail, Section C, Physical Functioning, were 2 of the following 5 Shaded ADLs (bed mobility, transfer, locomotion, eating/drinking, toilet use) coded with a 2, 3, or 4 in Self-Performance **AND** a 2 or 3 in Support?

AND

B. In Section D, were any of items 1 — 11 coded to indicate nursing services are needed at least one time per month?

*If A **AND** B are checked as yes, the child appears to be eligible for PDN Level III.*

PDN Level IV:

In level IV, coding in Section C must indicate that three (3) or more of the shaded ADL (bed mobility, transfer, locomotion, toilet use, and eating) must be coded as requiring limited, extensive, or total assistance, **OR** Section D must indicate that any of the items 1 through 8 were coded to indicated services were needed seven (7) days per week, **OR** Section D must indicate that item 9 was coded indicate ventilator services were needed at least three (3) days per week, **OR** Section D was coded to indicate an uncontrolled seizure disorder required direct assistance by a registered nurse (RN) or under the supervision of a RN at least one time per week.

A. In Section D, Professional Nursing Services, items 1-5, 7, or 8, did you code any of the responses with a 4 (i.e., services needed 7 days per week)? **OR**

B. In Section D, Professional Nursing Services, item 6, did you code a response of 6 (i.e., services needed at least every eight (8) hours)? **OR**

C. In Section D, item 9 (Ventilator/Respirator) did you code this response with a 2, 3, or 4 (care needed at least three (3) days per week)? **OR**

D. In Section D, item 10 (Uncontrolled Seizure), did you code this response with a 1, 2, 3, or 4 (care needed at least one time per week)? **OR**

E. In Section C (Physical Functioning), were 3 or more *shaded* ADLs coded with a 3 (extensive assistance) or a 4 (totally dependent) in self performance? (This does not include the “AA” code.)

If the answer to any of these questions is “YES”, then the child appears eligible for PDN Level IV.

PDN Level V:

To qualify for PDN level V, at least one item (1 through 4, 8, or 10) in Section D must be coded to indicate nursing services were needed at least one time every eight (8) hours **AND** two items in Section D must be coded to indicate nursing services were needed daily, seven (7) days per week; OR coding in Section D must be coded to indicate nursing services were needed at least daily for an individual who was ventilator dependent.

1a. In Section D, was one of the items from 1-4, 8, or 10 coded with a 6 indicating service needed at least once every 8 hours, 7 days a week? **AND**

1b. In Section D, were two (2) items from 1-4, 8, or 10 coded with a 4 indicating service needed 7 days per week.

If the answer to BOTH 1a, and 1b is YES, then the child appears to be eligible for PDN Level V.

OR:

2. In Section D, was item 9 (ventilator/respirator) coded with a 4 (nursing services needed 7 days a week)?

If the answer to 2 is YES, then the child appears to be eligible for PDN Level V.

STANDARD NURSING NOTES

This section provides space to report any supplemental information that describes and supports scoring decisions, and provides space to include documentation required, as coded by a "*" in Section D, Professional Nursing Services. The nurse completing the assessment may complete the areas he/she feels is pertinent to the child.

Who provided the clinical details: *check all that apply*

- Parent #1
- Parent #2
- RN direct caregiver
- LPN direct caregiver
- CNA direct caregiver
- Agency RN
- Care manager
- Guardian
- Other (specify)

This question documents how the information was obtained to complete the assessment

Who was present for the assessment: *check all that apply*

- Parent #1
- Parent #2
- Child
- RN direct caregiver
- LPN direct caregiver
- CNA direct caregiver
- Agency RN care manager
- Guardian
- Other (specify)

This question documents who participated in the assessment and if the child was present for direct observation and assessment to occur.

The remaining items are numbered, in order to allow for continuation of documentation, as needed, on addendum pages that follow.

1. Description of child: (age, diagnosis, characteristics, whether the child attends school, etc.):

Any information included by the nurse completing the assessment assists the Department in making a decision regarding medical necessity that is required in order to authorize nursing and/or personal care services. A complete description creates a “picture” of who is the child and what are his/her needs.

2. Adaptive equipment: include all equipment used by the child to enhance functional abilities

3. ADL abilities: space to provide further clarification of coding in Section C, Physical Functioning.

4. Nursing Services: space to provide information about nursing services that may be required.

5. Brief history of current condition: include information that would be helpful to the person reviewing the request for services.

6. Behavior problems: This information is helpful when reviewing the case in its entirety, but PDN covers nursing and personal care services and does not cover care for behavior problems. Services to address behavioral problems can be obtained through another section of policy and by contacting Office of Child and Family Services.

7. Required documentation from Section D and Section G: Professional Nursing Services and Medication Administration and Compliance. Documentation to support the coding of starred (*) items in Section D and Section G.

8. Activities (school/home): provides information about the child’s interests and abilities

9. Reasons for location of services other than home: Use this space to describe the need for services at other locations such as school, escort assistance to medical appointments, daycare, etc. All services must be medically necessary.

10. PDN Level of Care: Document the PDN level of care, as determined by the nurse completing the assessment. Scoring tool is located on pages 22 and 23 of the MEDKids-PDN assessment tool.

11. Copies of Documents included: there is a pre-populated list, including Plan of care, IEP, Nurse notes, Task Time Allowance worksheet, Seizure logs, Physician notes, and Medication Administration Records. There is additional space to add any additional documents that are being sent for consideration.

Family Circumstances:

This section of the assessment provides space to include information about the family. While approvals are based on the medically necessary needs of the child, it is helpful to have information on circumstances within the family that may impact the needs of the child.

12a. List all members of the household and their relationship to the child

12b. Describe how parents and others have been trained to meet the child's complex care needs: include information on parents' ability to meet the needs of the child when there are no paid caregivers, such as RN, LPN, CNA, or PSS, present in the home.

13. Describe the training that is needed for family members to care for the child: what training is needed to enable to family to provide the necessary care. There is a requirement for a contingency plan to be in place in the event that staffing is not available (Chapter 119: Regulations Governing the Licensing and Functioning of Home Health Care Services).

14. Indicated reasons family members are unable to care for the child: MaineCare does not cover respite or custodial care. Services are approved to provide care at times parents are not available or to provide teaching and training that will enable parents to provide the necessary care.

15. What are the parents expressing that they need help with, specifically, to support them in providing care for their child? Please be as descriptive as possible. The more information that is provided, the easier it is to make a decision regarding authorization of services.

16. Are there times when the family is unavailable to provide care when assistance is needed? Please be as descriptive as possible. The more information that is provided, the easier it is to make a decision regarding authorization of services.

17. Indicate hours of work: indicate if hours include travel time

MaineCare does not cover services to a child simply because a parent is working. While it is important for parents to have time away from their children, MaineCare does not cover respite care. This section provides space to indicate times when parents are unavailable to provide medically necessary care due to a work schedule.

18. Services being requested, RN, LPN, CNA, and/or PSS:

On each line, provide the start and end date for the service being requested.

RN per week: enter the start and end dates, complete the number of hours required each day, Sunday through Saturday.

LPN per week: enter the start and end dates, complete the number of hours required each day, Sunday through Saturday.

CNA per week: enter the start and end dates, complete the number of hours required each day, Sunday through Saturday.

PSS per week: enter the start and end dates, complete the number of hours required each day, Sunday through Saturday.

RN per month: enter the start and end dates, complete the total hours per month.

When this section is completed electronically, the grid is set up to calculate the total cost column, the total cost per week, total cost per month, and grand total per month. If additional lines or space is needed, continue on the addendum page. Note: any information included on the addendum page will not be automatically included in the calculations.

19. Location of services: check all that apply

Check Home, school, medical appointments, and/or other. Please specify location if other is checked.

Plan of care must indicate the location of services, hours per day and days per week. If the cost of services exceeds the annual cap for the selected PDN level, documentation to justify exceeding the cap must be submitted.

20. Attestation Statement: The RN completing the assessment must sign and date to attest that the information contained in the assessment is correct to the best of his/her knowledge and he/she and the agency may be subject to penalties for submitting false information.

Policy References regarding timeliness and request by the Department for additional information:

The MEDKids-PDN assessment tool shall be submitted to Office of MaineCare Services, via portal, within 72 hours of completion of the MED form, for initial assessments or reassessments. MaineCare payment ends with the reassessment date, also known as the eligibility end date. (MaineCare Benefits Manual, Chapter II, Section 96.07-2.B)

The Department reserves the right to request additional information to evaluate medical necessity. (MaineCare Benefits Manual, Chapter II, Section 96.03.D)

Addendum Pages (pages 29 and 30):

Use this space to document information that exceeds the space provided in any item throughout the MEDKids-PDN assessment tool. Number each item by section and/or item number so the reviewer can

clearly identify the section of the assessment being referenced. All information submitted must be legible, accurate, and submitted in a timely manner.

Questions may be directed to the PDN Nurse Reviewer at Office of MaineCare Services by telephone or submitted via email to HomeHealth-PDN.dhhs@maine.gov