
Frequently Asked Questions (FAQ)

from

Participant Characteristics Report (PCR) Revisions Trainings

June 2016

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SUBMISSION PROCESS

DEFINITIONS

Language

1. Q: If participants speak multiple languages (e.g., Armenian and Farsi), but are Armenian, should we mention both?

A: Enter all languages that are spoken **at the center** by participants regardless of race and ethnicity, in this case, Armenian and Farsi.

2. Q: Does the languages spoken box refer to languages staff members speak, or that of participants?

A: It refers to languages spoken by participants.

CIN

3. Q: Is the CIN the Medi-Cal number? How do we get the CIN numbers?

A: The Client Identification Number (CIN) is a participant's Medi-Cal unique identifier, available on their benefit card. This unique identifier is alphanumeric, with 8 digits and 1 single letter. See the "Instructions and Definitions" section of the Participant Characteristics Report (PCR) for further details.

Enrollment

4. Q: Please define enrollment date. Is this the first day of assessment or admission date?

A: Enrollment date refers to the first regular day of attendance at the center. See the "Instructions and Definitions" section of the form for further details.

Private Pay

5. Q: Do the centers need to include their private pay (out of pocket) participants in the form?

A: Yes, centers must include private pay participants in the report. See the "Instructions and Definitions" section of the form.

6. Q: Do the centers need to include Adult Day Program participants in the form?

A: No, centers should not report Adult Day Program participants on the PCR.

7. Q: If a participant is two days regional center and two days Medi-Cal, is Regional center considered the primary?
- A: If a participant has two payers that pay the same number of days, as in this example, report them as Medi-Cal only.

Dementia

8. Q: Can participants diagnosed with cognitive impairment, but not a dementia disorder such as Alzheimer's disease or other type of dementia, be included in the Dementia field if the Multidisciplinary Team (MDT) feels they qualify for having at least two significantly impaired core mental functions?
- A: Individuals must be diagnosed with a dementia disorder to be reported in Dementia field. Reference the "Instructions and Definition" for this field for further details.
9. Q: Can you provide further clarification which individuals we should report in this category?
- A: CDA has revised this definition to provide further clarification on which individuals to report in this field. See the "Instructions and Definitions" section of the form for further details.

Intellectually/Developmentally Disabled (ID/DD)

10. Q: Can you provide further clarification which individuals we should report in this category?
- A: CDA has revised this definition to provide further clarification on which individuals to report in this field. See the "Instructions and Definitions" section of the form for further details.

Mental Health Diagnosis

11. Q: Can you provide further clarification which individuals we should report in this category?
- A: CDA has revised this definition to provide further clarification on which individuals to report in this field. See the "Instructions and Definitions" section of the form for further details.
12. Q: Where should we report individuals with cognitive deficits that do not meet Dementia, Intellectually/Developmentally Disabled, and Mental Health Diagnosis criteria?
- A: At this time, CDA is capturing data only on individuals diagnosed with dementia disorders, intellectual or developmental disability, and mental disorders. Individuals with cognitive deficits who do not fit the definition in the "Instructions and Definitions" should not be reported in the Diagnoses fields.

13. Q: Since Dementia is considered a mental disorder in the DSM, should we report individuals with dementia in both Dementia and Mental Health Diagnosis categories?
- A: Report individuals who have only a diagnosis of dementia in the Dementia field. If they have a diagnosed dementia disorder AND diagnosed mental disorder, report them in both the Dementia and Mental Health Diagnosis fields.
14. Q: Who is permitted to provide the diagnosis for individuals reported in this field?
- A: A licensed professional can provide a diagnosis within his/her scope of practice. For PCR reporting, the diagnosis must be indicated on the IPC in Box 2 "Diagnoses and ICD Codes." The diagnosis can be either Primary or Secondary. As indicated in Box 2 of the IPC, diagnoses should be included "as provided or confirmed by the personal health care provider(s)."
- This guidance applies to reporting individuals in Fields 1, 2, and 3, all of which require a diagnosis.

Psychiatric Medications

15. Q: Should medications for Dementia be included in this category?
- A: Yes, they are considered psychotropic medications. You may include all participants who are prescribed psychiatric medications regardless of whether they have a psychiatric diagnosis. See the "Instructions and Definitions" section of the form for further details.

ADLs/IADLs

16. Q: It appears the ADL/IADL fields should be marked if participants require assistance. On the IPC cueing is supervision not assistance? Is this just a difference in definition between CDA and DHCS? I ask because if our software takes this information from the IPC, the answer may be different on the PCR.
- A: CDA has revised the definitions to be in sync with the IPC and the logic built in software programs that pull this information. The revised definition is as follows: Requires physical assistance with or without device or is unable to do for self, even with physical help or device.
17. Q: Can you clarify the definition of ambulation assistance? Does this include ambulation on stairs and/or flat/level surface or just flat/level surface?
- A: The definition for the "Requires Ambulation Assistance" field makes no distinction with regard to ambulation on stairs or flat/level surface. Therefore, report on participants who require physical assistance with or without a device or who are unable to do for self even with physical help or device on stairs and/or flat/level surface.

Fall Risk

18. Q: The Fall Risk definition mentions using an industry standard tool. Is there a specific

tool that we should use? Could you suggest an industry standard tool for fall risk assessment?

A: There are many fall risk assessment tools available for use that are standard practice by physical therapists and other health care professionals in a variety of settings. Each center can decide which tool to use. The following are examples of and links to some of these assessment tools:

- Tenetti Balance Assessment Tool
http://consultgerirn.org/uploads/File/Tinetti_Assessment_Balance.pdf
- Berg Balance Scale
http://www.aahf.info/pdf/Berg_Balance_Scale.pdf
- Morse Fall Scale
<http://cf.networkofcare.org/library/Morse%20Fall%20Scale.pdf>

Note that a comprehensive fall risk assessment, particularly in older adults, requires a multifactorial approach. Additional fall risk information including the multifactorial approach to assessment, prevention and intervention is available on the following websites:

- The Centers for Disease Control and Prevention (CDC)
 - <http://www.cdc.gov/homeandrecreationalafety/Falls/steady/index.html>
 - http://www.cdc.gov/HomeandRecreationalSafety/pdf/steady/fall_risk_checklist.pdf
- The American Geriatrics Society
 - http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/
- U.S. Preventive Services Task Force Recommendation Statement
“Prevention of Falls In Community-Dwelling Older Adults”
 - <http://www.uspreventiveservicestaskforce.org/uspstf11/fallsprevention/fallsprevention.htm>

19. Q: We use the Tenetti score as our standard tool. For each participant, we determine a measurement of “low, medium, or high.” With this tool, all participants have a fall risk no matter how slight. Should we mark all participants as a fall risk or should we mark participants that are medium and high risk?

A: There is variation in scoring among fall risk assessment tools. For example, the Tenetti Assessment Tool and Berg Balance Scale measure fall risk as low, medium, or high with no option for no risk. Other fall risk assessment tools such as the Morse Fall Scale measure risk as no risk, low or high.

Therefore, since centers use different fall risk assessment tools with varying risk measures, CDA asks that you report only participants with a **high** fall risk. Do **NOT**

report participants with no risk, low risk, or medium/moderate risk on the PCR.

NOTE: The standard tool is a foundation for a decision by the multidisciplinary team about the fall risk of an individual and should be interpreted in conjunction with the clinical judgment of the team.

Hearing/Vision Deficits

20. Q: Can you clarify which participants should be recorded in this field?

A: Participants appropriate for this field include:

- Those for whom IPC Box 12 "Glasses or Other Vision Aid" or "Hearing Device" is checked because they use any kind of glasses, vision aid, or hearing device
- Individuals with known hearing or vision deficits but who do not currently use any device

Please Note: Centers who generate this field in the PCR from IPC Box 12 may need to manually enter participants who do not currently use hearing or vision aids because they would not be included in Box 12 but should be reported here.

Special Diet

21. Q: Can you clarify the definition of special diet? Is a cut-up diet considered altered texture?

A: CDA has further defined this field as follows: A therapeutic diet prescribed by a physician and provided at the center to help manage chronic illness or other medical conditions. Includes portion control, high/low calorie, low sodium, low cholesterol/low fat, no concentrated sweets, diabetic, and renal. Also includes modified textures when the modified texture alters the nutritional content of the food such as mechanical soft, pureed, or tube feeding diets.

Does not include the following:

- Diets to prevent chronic disease such as a "heart healthy" diet (no added salt, no added fat)
- Cut up, chopped with no alteration of the nutritional content
- Tube feeding that is not formulated for a specific medical condition
- Enteral (TF)/Parenteral Nutrition (IV)

Group/Individual Psych Services

22. Q: Does this field include the 1:1 and group counseling done by the MSW and assistants, or only the LCSW?

A: The Group/Individual Psych Services field refers to mental health services scheduled in Box 22 of the center's IPC provided by the center's mental health consultant. These services meet the requirements specified in the Medi-Cal Manual, Community IPC

Section, p. 30, Box 22 Instructions for Additional Services. Do not report in this field services provided by the center's social worker and social work assistant which are scheduled in Box 21 Social Services of the IPC.

Prescribed Medications Administered by Center

23. Q: Can you clarify what medications should be reported in this field?

A: Report medications prescribed by the physician and administered by the center nurse on a routine medication order, not PRN (as needed). The most common type of medication order is defined as medication that is administered until a discontinuation order is written or until a specified date is reached. An example is Hydrochlorothiazide 50 mg qd, or Amoxicillin 500 mg tid x10 days.

This could include over-the-counter (OTC) medications, so long as they are prescribed by the physician on a routine order and are administered by the center's nurse.

- Do not report a PRN order. PRN orders are conditional and are to be administered only upon the occurrence of a certain clinical event.
- Do not report standing orders. A standing order is generally facility wide, not written for a specific patient.
- Do not report self-administered medications.

To summarize, report medications prescribed by a physician on a routine order (including OTC) that are administered by the center's nurse.

24. Q: If a participant needs reminders to take medication, do we report it in this field?

A: Yes, **if** the medication meets definition #23 above.

To clarify, if an individual requires any help to take medication (including cueing or reminders); they are not independent for self-administering medications at the center. This individual requires reminders to take medications, therefore the CBAS center nurse must adhere to the Title 22 medication administration guidelines for nursing services (see Title 22, CCR, Section 54323(a)(6)(A)(B)(C)(D)) and report under the "Prescribed Medications Administered by Center" field.

If the medication does not meet the definition #23 above, do not report it in this field.

Self-Administered Medications at Center

25. Q: Are participants who self-administer OTC medication included in this field?

A: Yes, if the medication is prescribed by the physician and is administered independently by the participant on a routine medication order, not PRN. Note, the participant must meet the criteria for medication self-administration per Title 22, CCR, Sections 54319(e) and 78317(f)(1)(2)(3).

If the medication does not meet this definition, do not report it in this field.

Restorative OT/PT

26. Q: Does the "Restorative OT/PT" services field include OT/PT maintenance classes?

A: No, it does not. Report only restorative services provided.

Skilled Nursing

27. Q: Can you provide further clarification about this field? Why are some professional nursing services excluded from this category?

A: Skilled nursing services include:

Professional Nursing services listed under Welfare and Institutions Code, Section **14550.5(a)(5)**, and refer to direct one to one care provided by a licensed nurse, per physician's order and the participant's care plan. Such care includes but is not limited to: 1) catheter insertion; 2) injections; 3) ostomy care; 4) complex wound care; 5) blood glucose testing.

Skilled nursing services do not include:

Professional Nursing services listed under Welfare and Institutions Code, Section **14550.5 (a)(1-4)**, such as observation and monitoring, administration of medications, routine blood pressure monitoring, liaison with other health care providers, or supervision of or assistance with personal care services. Services provided by a certified nursing assistant or program aide do not qualify as skilled nursing services. Do not report such services in this category.

At this time, CDA is collecting information specifically for the skilled nursing services component of professional nursing services. This will allow us to better understand the acuity level of participants at CBAS centers.

FORM ACCESS AND FORMATTING

Access

28. Q: Where can I find the form and webinar recording?

A: Both are available on the CDA website at:

Form - <http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/Default.asp>

Webinar Recording - http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/CBAS_Training/Default.asp

29. Q: I am unable to print or open the form on the CDA website.

A: If you are unable to access the form, you may contact the CBAS Branch for assistance.

30. Q: Which version of the form should I be using?

A: Participant Characteristics Form (CDA CBAS 293) (Rev. 05/14)

Formatting

31. Q: Is it possible to combine the last name and first name in one column, separated by a comma? Currently, we have both fields in one column.

A: Do not modify or compile fields. The form must be completed as it appears (i.e., separate column for first name and last name), in order for CDA to be able to upload it into our database.

32. Q: Form appears to be in the latest version of Excel (xlsx). Can CDA send it in an older version (xls)?

A: You may contact the CBAS Branch to obtain this form in another version of Excel.

33. Q: Does the new form have a way to make sure that the categories carry onto the next page so the person completing form does not have to count Xs?

A: There are formulas built into the spreadsheet to count each 'X,' even as you add or delete rows. Since you will be completing this form electronically, there is no need to manually count these.

34. Q: I am unable to add/delete rows from the Excel form. Can I receive some technical assistance with this issue?

A: If your version of Excel does not allow you to add/delete rows from the Excel form, or for any other technical issues, please contact CDA. We will work with each provider on a case-by-case basis to provide a form that works with your system.

SUBMISSION PROCESS

35. Q: When we submit the report in July and January, is it data for June and December?
- A: Yes, that is correct. If a participant is enrolled for any portion of the month (e.g., June or December), then report them in the PCR.
36. Q: Do we need to submit a monthly report?
- A: No, you do not need to submit the PCR monthly. Do not confuse the PCR with the Monthly Statistical Summary Report (MSSR), which is due monthly. The PCR is due semi-annually - by July 31 and January 31.
37. Q: Where do I send the completed report?
- A: Submit the report via the CBAS File Drop Web Portal at <https://cbasfiledrop.aging.ca.gov>. Do not submit it via email as it contains confidential participant information. See the "Instructions and Definitions" section of the report for further details.
38. Q: When will the PCR be available in our software (e.g., CADCare, Correlink, TurboTAR, etc.)?
- A: Check with your respective software provider for specifics.
39. Q: Is the PCR a snapshot of participants on one particular date or all participants who were enrolled during the six month reporting period?
- A: The PCR is a "point in time" report on participants enrolled in a center during the months of June (to be reported by July 31) and December (to be reported by January 31).
40. Q: Are there any specific periods defined to be carried unto the PCR form? For example, skilled nursing services, any wound dressings in the history in center or within six months entering the PCR form?
- A: For the semi-annual PCR, report data that is current in the months of June or December as reflected in the participant's care plan. If you have made adjustments

to the participant care plan, but your system generates the PCR based on the participant's Individual Plan Of Care (IPC) that does not yet contain this new information, CDA will accept the data that is generated through your system. You may also make manual changes to the report to more accurately reflect the participant status should you choose to do so. You may wish to discuss this further with your software vendor.

For providers who are manually completing the PCR in Microsoft Excel, the reported data should be what is current for the months of June or December as reflected in the participant's care plan.

41. Q: What if CDA requests a PCR for a month other than June or December?
- A: Centers should be prepared to make a report available to CDA upon request, as stated in the "Instructions and Definitions" section of the form.