Overview

The assessment process plays an important role regarding the identification of an individual's functional abilities, met and unmet needs, and the potential need for Aging Services (i.e. OPTIONS, Caregiver Support Program, Nutrition Services, etc.). Individuals who wish to enroll in and receive Aging Services shall comply with the assessment process, including verification of financial information as applicable. The Department of Aging's (hereafter referred to as "the Department") assessment tools are designed to capture essential information about an individual which forms the foundation for person-centered care plans and are used for collecting key data for federal reporting purposes. Services within person-centered care plans shall be supported by unmet needs documented in the assessment tools. Failure of an individual to comply with the assessment process may result in denial or termination of services. Assessment is also required for individuals served in the Domiciliary Care (Dom Care) Program. The Area Agency on Aging (AAA) shall follow the Domiciliary Care Services for Adults regulations cited in 6 Pa. Code Chapter 21 relating to assessment.

I. Assessment Tools

A. Needs Assessment Tool (NAT)

The NAT is a comprehensive assessment that captures information about the individual and acts as a foundation for developing the person-centered care plan for individuals enrolling in or receiving services in the OPTIONS Program. The NAT shall be completed when an individual is initially applying for services and at each reassessment. The NAT collects the following information:

- Demographic information
- Cognitive and mental status
- Medical, neurological, intellectual, and mental health conditions and how they are managed
- Need for supervision
- Medication Management
- Ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)
- Mobility
- Nutrition status

- Formal and informal supports
- Living environment
- Emergency information
- Financial information (income and assets)

Responses recorded in the NAT automatically generate a Needs Assessment Score (NAS). The NAS is used to determine placement on a wait list (when a wait list has been established) and an exception to the monthly care plan cost cap. The NAT also automatically calculates the individual's Cost Share percentage (refer to Chapter IV: OPTIONS Program).

B. Needs Assessment Tool – Express (NAT-E)

The NAT-E is a shortened version of the NAT. For the OPTIONS Program, the NAT-E shall be completed when an individual is initially applying for services and at each reassessment for individuals receiving Care Management Service alone or in combination with Emergent Services or In-Home Meal Service.

The NAT-E is also used for individuals attending and participating in services offered at a Senior Community Center or Satellite Center, including those receiving congregate meals. The NAT-E shall be completed on all new consumers and conducted annually. Only *Section 1 – Introduction* (which collects demographic information) and *Section 2 – Nutrition* of the NAT-E are required to be completed for these individuals. However, completion of the entire NAT-E is encouraged.

The NAT-E collects the following information:

- Demographic information
- Nutritional status
- Medical conditions
- Ability to perform ADLs and IADLs
- Informal supports
- Living environment
- Emergency information

C. Caregiver Assessment Tool (CAT)

The CAT is a comprehensive assessment that captures information about a Caregiver and acts as a foundation for developing the person-centered care plan for individuals enrolling in or receiving services in the Caregiver Support Program (CSP). It provides an overview of the caregiving relationship and identifies areas where support is needed. The CAT shall be completed when an individual is initially applying for services and at reassessment.

The CAT collects the following information:

- Demographic information of both the Caregiver and Care Receiver
- Expenditures by the Caregiver
- Care Receiver's household composition
- Financial information of Care Receiver's household
- Formal and informal supports
- Caregiver's general responsibilities
- Caregiver's assistance with ADLs, IADLs, and mobility
- Caregiver's well-being
- Caregiving environment

Responses in the CAT automatically generate a Caregiver Assessment Score (CAS) used to determine placement on a wait list (when a wait list has been established). The CAT also automatically calculates the Caregiver's reimbursement percentage (refer to Chapter VI: Caregiver Support Program).

II. Conducting Comprehensive Assessments

A. Who May Conduct Assessments

Assessments required for OPTIONS or CSP shall be conducted by a Care Manager or Care Management Supervisor. Consumers in OPTIONS receiving Care Management or In-Home Meal service, alone or in combination, may be assessed by a Case Aide or trained intern using the NAT-E. Case Aides or trained interns may not assess the need for Emergent Services.

Individuals attending and participating in services offered at a Senior Community Center or Satellite Center, including congregate meals, may complete the NAT-E themselves as a self-declaration tool. The Senior Center

Director or designated staff may complete the assessment with the center participant.

B. Where May Assessments Be Completed

Conducting assessments **face-to-face** in the individual's residence or living environment allows the Care Manager to accurately assess and evaluate an individual's abilities to care for themselves, safety of the home environment, and un-met needs that may not be communicated.

For individuals being assessed for the OPTIONS Program, the NAT/NAT-E shall be conducted **face-to-face** in the individual's residence or living environment.

For Caregivers being assessed for the CSP, the CAT shall be conducted **face-to-face** in the caregiving environment.

For individuals attending and participating in services offered at a Senior Community Center or Satellite Center, including congregate meals, the NAT-E may be completed by the individual as a self-declaration tool, face-to-face with Senior Community Center staff, or using a touchscreen kiosk, such as Co-Pilot or MySeniorCenter. Each Senior Community Center operates differently from center to center, and the method of completion may vary for each center.

Hybrid Assessment Process

AAAs may utilize a hybrid version of the assessment process both initially and at reassessment. AAAs have discretion to determine when the hybrid assessment process will be utilized. The Care Manager may begin the assessment with the consumer via telephone and finish the assessment **face-to-face** in the home environment. At a minimum, the following sections shall be completed during the home visit:

- NAT – Section 3: Saint Louis University Mental Status (SLUMS), Section 10: Activities of Daily Living (ADLs) through Section 19: Individual/Spouse/Household Financial Data
- NAT-E – Section 6: Activities of Daily Living (ADLs) through Section 11: Emergency Planning

- CAT – Section 6: Caregiver's Assistance, Section 7: Caregiver's Well-Being, Section 8: Care Manager Observations and Assessment Outcome

C. Who May Participate in an Assessment

Consumers may choose to have their spouse, significant other, family member, power of attorney (POA), legal guardian, or other designated representative present during the assessment. The Caregiver and Care Receiver shall both be present in the caregiving environment during the completion of the CAT.

Information obtained from the consumer is sometimes supplemented with information from other sources. When the consumer is unable to respond for themselves, other individuals present may provide information to complete the assessment. Medical records or other documents may also be used to obtain the necessary information. When this occurs, the Care Manager shall document the source of information in either the notes or narrative section of the assessment.

When assessing a consumer with limited English proficiency, the AAA shall provide an interpreter at no cost to the individual (refer to Chapter V: Care Management for detailed information).

D. How to Assess a Consumer

A thorough and accurate assessment is critical to determining program eligibility, the need for services, and the development and implementation of an individual's care plan. The Care Manager shall ensure all assessment questions are answered and provide justification for responses in the notes or narrative sections where applicable. The assessment provides insight into an individual's needs, degree to which they can care for themselves, their preferences for how they receive care or services are delivered, and the amount or degree to which other supports and resources are readily available to the individual. The assessment may also alert the Care Manager to potential medical issues or impairments in cognitive functioning that may warrant referrals to other resources or providers for follow-up. Accurate completion of the assessment tools will not only benefit the consumer but will aid the Department with federal and state reporting requirements, quality initiatives, and data integrity regarding the consumers served.

The questions in the assessment tools are not meant to be asked to the consumer word-for-word as they appear in the tool. Care Managers are to engage the individual in conversation, ask open-ended questions, and request clarification as necessary. For example, asking the consumer an open-ended question such as, “How are you managing to take a bath or shower?” will provide better insight than asking, “Are you able to manage bathing?” Equally important is what the Care Manager observes as they are in the home and conducting the assessment. In some instances, the Care Manager may notice what the consumer reports during the assessment is contrary to what the Care Manager observes. For example, a consumer may report they are able to transfer independently, but the Care Manager notices the consumer has great difficulty with transfers. The Care Manager shall document their observations in the notes section of the assessment. These observations will assist the Care Manager to develop open-ended questions to engage the consumer in dialogue related to their functional abilities, health and safety, home environment and supports, and the development of the consumer’s care plan.

When answering questions requiring the Care Manager to document details in the notes, the Care Manager shall provide as much detail as possible to elaborate on the response to the question. For example, when completing the NAT and responding to the question “What concerns does the individual have about any of the non-paid helpers? Document Details in Notes”, if the consumer reports they are concerned about their non-paid helper’s physical health as the non-paid helper provides transportation to medical appointments but is currently hospitalized due to a recent fall, the Care Manager shall indicate this in the notes.

III. Timeframes

Care Managers and Care Management Supervisors shall follow required timeframes when completing the NAT, NAT-E, and CAT at initial assessment and re-assessment.

A. Initial Assessments

Initial assessment timeframes are the same for OPTIONS and CSP regardless of the assessment tool used (refer to Section I. Assessment Tools for a description of the NAT, NAT-E, and CAT). Care Managers shall complete the

home visit within 10 business days of receiving the initial referral for services. When scheduling the home visit, the Care Manager shall review with the consumer the documents the consumer is required to provide for the assessment and encourage the consumer to gather the documents to provide during the home visit. During the home visit, the Care Manager shall complete the appropriate assessment tool to identify the consumer's unmet needs. The assessment is not considered complete until financial verification is received and recorded in the NAT or CAT. Care Management Supervisors shall review and sign-off on the initial assessment within 10 business days of the home visit. If a case aide or trained intern completes the NAT-E, a review and sign-off by the supervising Care Manager within 10 business days of the home visit is sufficient and meets the timeframe requirement (refer to Section II.A Who May Conduct Assessments).

For the provision of Emergent Services, Care Managers and Care Management Supervisors shall make every effort to complete the assessment as quickly as possible.

For individuals who wish to attend and participate in services offered at a Senior Community Center or Satellite Center, including congregate meals, a NAT-E shall be completed within the individual's first five visits to the Senior Community Center/Satellite Center. Only *Section 1 – Introduction* and *Section 2 – Nutrition* of the NAT-E are required to be completed; however, completion of the entire NAT-E is encouraged.

B. Reassessments

1. OPTIONS

The purpose of a reassessment is to determine ongoing program eligibility, reevaluate the consumer's needs and level of functioning, and review the appropriateness of the current care plan. Consumers receiving OPTIONS services shall be assessed annually or any time the AAA becomes aware the consumer has a significant change in condition, a change in income and/or assets, or a change in living environment impacting the needs of the consumer. The Care Manager shall complete the reassessment during a home visit with the consumer and/or their designated representative. When scheduling the home visit, the Care Manager shall review with the consumer the documents the consumer is required to provide for the reassessment

and encourage the consumer to gather the documents to provide during the home visit.

The Care Manager may select the most recently completed assessment and copy it into the new NAT or NAT-E (refer to Chapter IV: OPTIONS Program Appendix D). The Care Manager shall review all sections of the assessment and update the NAT or NAT-E accordingly to ensure the collected information accurately reflects the consumer's current functional needs, preferences, supports, and resources.

The annual reassessment shall occur by the end of the last month of the 12-month care plan period. In instances when changes to the care plan are necessary, the Care Management Supervisor shall review and sign-off on the assessment tool and revised care plan within 10 business days of the home visit. In instances when the current care plan remains the same for the next care plan period, the Care Management Supervisor shall review and sign-off on the assessment tool and approve the care plan within the first month of the new care plan period. When a reassessment NAT-E is completed by a Case Aide or trained intern, the Care Manager supervising the Case Aide or trained intern may sign-off on the NAT-E.

In the event a reassessment is completed due to a change in the consumer's circumstances, the Care Manager shall document in a journal entry the details of the home visit, change in circumstances, and any updates to the care plan. In instances when changes to the care plan are necessary, the Care Management Supervisor shall review and sign-off on the assessment tool and approve the increased or additional service(s) within 10 business days of the home visit. To align the assessment date and care plan period, the Care Manager shall enter the increased or additional service(s) to the existing care plan for the remainder of the month in which the change in service occurred and end date the care plan as of the last day of the month. The updated care plan shall be copied in SAMS for the next 12-month care plan period. A decrease in services shall not occur until the Care Management Supervisor approves the changes unless the consumer has requested a decrease in service(s) or termination of service(s). When the AAA determines the units of service in a care plan need to be reduced or the service be terminated, the Care Manager shall follow the guidance outlined in Chapter II: Hearings and Appeals.

How to Determine When a Reassessment is Needed

At a minimum, a reassessment is needed annually for individuals enrolled in the OPTIONS Program. A reassessment shall also be completed any time the Care Manager becomes aware the consumer has a **significant change impacting the needs of the consumer**. This may include a change in condition, a change in income and/or assets, or a change in living environment impacting the needs of the consumer. A change in condition is any significant decline or improvement in a consumer's health status, physical or cognitive ability, ability to manage their conditions or care for themselves, or need for supervision since the last assessment that is expected to have a long-term impact.

Examples of significant changes which impact the needs of the consumer may include, but are not limited to:

- New conditions such as stroke, heart attack, or onset of other acute illness or condition
- Unplanned hospitalization
- Falls resulting in broken bones, hospitalization, head trauma, limited use of extremities, etc.
- Changes in cognition
- Changes observed during the home visit, concerns noted during phone contacts, or reports by family, neighbors, or designated representative
- Relocation to a new place of residence
- Changes in household composition
- Changes in income which affect the consumer's cost share or eligibility for another program

Examples of when a reassessment is not required include:

- Instances when the initial units of service are not sufficient to complete the tasks identified in the care plan and there has not been a change in the consumer's condition.
- Short-term illnesses such as a cold or virus
- Planned vacation or temporary changes to living situation

- Instances when the provider was only able to partially fulfill the requested hours in the care plan but is now able to fulfill all requested hours
- Change in provider payment model (ex. consumer chooses to switch to consumer reimbursement model from agency model)

2. Caregiver Support Program

The purpose of a reassessment is to determine ongoing program eligibility, reevaluate the Caregiver's needs, and review the appropriateness of the current care plan. The Care Manager shall reassess the Caregiver every six months or anytime there is a significant change in the caregiving relationship or a change in household income/composition. A Care Manager shall complete the reassessment during a home visit with the Caregiver and Care Receiver in the caregiving environment. When scheduling the home visit, the Care Manager shall review with the consumer the documents the Caregiver and Care Receiver are required to provide for the reassessment and encourage them to gather the documents to provide during the home visit. While reassessment for the Caregiver Support Program is required every six months, financial verification is only required on an annual basis or when there has been a significant change in countable income or household composition that may affect the Caregiver's reimbursement percentage.

The Care Manager may copy the most recently completed assessment and copy it into the new CAT (refer to Chapter VI: Caregiver Support Program Appendix D). The Care Manager shall review all sections of the assessment and update the CAT accordingly to ensure the collected information accurately reflects the caregiving relationship and identifies areas where support is needed.

The six-month reassessment shall occur within the last month of the six-month care plan period. In instances when changes to the care plan are necessary, the Care Management Supervisor shall review and sign-off on the assessment tool within 10 business days of the home visit. In instances when the current care plan remains the same for the next care plan period, the Care Management Supervisor shall review and sign-off on the assessment tool and approve the care plan within the first month of the new care plan period.

NOTE: For grandparents/older relative Caregivers of children, a new CAT shall be completed with the Caregiver when a Care Receiver turns age 18, if other Care Receivers who are children remain in the home.

In the event a reassessment is completed due to a significant change in the caregiving relationship or Care Receiver's household income/composition, the Care Manager shall document in a journal entry the details of the home visit, change in circumstances, and any updates to the care plan. In instances when changes to the care plan are necessary, the Care Management Supervisor shall review and sign-off on the assessment tool and approve the increased or additional service(s) within 10 business days of the home visit. To align the assessment date and care plan period, the Care Manager shall enter the increased or additional service(s) to the existing care plan for the remainder of the month in which the change in service occurred and end date the care plan as of the last day of the month. The updated care plan shall be copied in SAMS for the next 6-month care plan period. A decrease in the Caregiver's monthly care plan cost cap shall not occur until the Care Management Supervisor approves the changes unless the Caregiver has requested a decrease or termination. In cases where the AAA has taken action to reduce a Caregiver's monthly care plan cost cap or terminate services, the Care Manager shall follow the guidance outlined in Chapter II: Hearings and Appeals.

C. Financial Verification Timeframe

In instances when the consumer is required to provide financial verification, the Care Manager shall contact the consumer prior to the home visit and encourage the consumer to gather financial verification to provide during the home visit. In rare instances when the consumer is unable to provide financial verification during the home visit, the consumer shall be permitted to provide financial verification within 30 calendar days of the date of the home visit. The AAA may choose to grant a timeframe extension in instances when the consumer is unable to obtain the financial verification within 30 calendar days. AAAs shall establish a written financial verification timeframe policy to outline when a timeframe extension will be granted and determine a reasonable timeframe to allow additional time for the consumer to provide the financial verification. The extended timeframe established by the AAA shall not exceed 90 calendar days.

D. Timeframe Extensions

In rare instances where a timeframe is exceeded, a journal entry documenting the reason(s) for the exception shall be entered in the consumer's record in SAMS. For example, the consumer requests to reschedule the assessment, the consumer is hospitalized at the time of the assessment, an individual the consumer requests be present for the assessment is unavailable, or the consumer is granted additional time to provide financial verification. Workload and staffing issues are not considered valid reasons for exceeding timeframes for assessments. The journal entry shall be titled, "Timeframe Extension."

IV. Saint Louis University Mental Status (SLUMS)

The SLUMS helps to identify signs and symptoms of mild cognitive impairment or dementia and can be used to identify changes in cognition over time. Results of the SLUMS allows individuals to seek early medical intervention and treatment. The SLUMS consists of 11 questions that evaluate memory, attention span, visual-spatial function, orientation/level of awareness, and executive functioning, with items such as calculations, naming of animals, clock drawing, and recognition of geometric figures. The SLUMS produces a score ranging from 0-30 points and has two different scoring structures based on the consumer's level of education.

The SLUMS is contained within the NAT, and its completion is required as part of the initial and subsequent reassessments. (Refer to Appendix C.7 and the NAT Instructions for detailed information on completing the SLUMS). The score for the SLUMS is automatically calculated in the NAT. The SLUMS is a screening tool and is not a substitute for a full diagnostic assessment or diagnosis.

V. Creating New Assessments and Reassessments In SAMS

Depending on the process established in each AAA, the Care Manager enters information into SAMS or Mobile Assessment (refer to Appendix D for specific detailed instructions).

For initial assessments and reassessments, the Care Manager shall ensure all required questions have been answered. When completing a reassessment, the Care Manager may copy the most recently completed assessment into the new

assessment as a starting point. The Care Manager shall review all assessment information and make updates as necessary.

The Care Manager shall ensure a service delivery is entered for each assessment. The Care Manager shall service deliver the initial assessment under a non-Care Managed care enrollment and service deliver the reassessment under the care enrollment for the appropriate program.

VI. Level of Care Determinations

A. Levels of Care

When referring to long-term care services, a “level of care” is used to describe how much assistance an individual needs with ADLs and management of health conditions, as well as the setting in which the amount, or kind of care, is provided. Long-term care can be provided in a variety of settings. This may range from facility-based care (i.e., skilled nursing homes, intermediate care facilities), community-based care (i.e., assisted living residences, personal care homes, adult day care centers), and home-based care (i.e., home health/home care agencies, paid/unpaid caregivers).

Levels of care are differentiated by the scope of care provided, where the care is provided, and by whom the care is provided. The higher the level of care, the more intense the effort to treat or maintain an individual’s health or functional status. More intense efforts require treatment or care from a provider with more training and expertise.

In general, the following areas are commonly considered when determining an individual’s “level of care”:

- Functional ability – physical and cognitive
- Health issues and medical needs
- Behavioral issues

In Pennsylvania, eligibility for Medical Assistance Long-Term Services and Supports (MA LTSS) available through the Community HealthChoices (CHC) Program or the Living Independence for the Elderly (LIFE) Program is based on meeting income and asset requirements and needing a nursing facility level

of care. The level of care is determined by an assessment called the Functional Eligibility Determination Tool (FED) and a certification from the individual's physician of the level of care needed. The FED is administered by an Independent Assessment Entity under contract with the Department of Human Services (DHS). The outcome of the FED assessment determines an individual to be either Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI).

NFCE is defined as:

- The individual has an illness, injury, disability, or medical condition diagnosed by a physician; **and**
- As a result of that diagnosed illness, injury, disability or medical condition, the individual requires care and services above the level of room and board; **and**
- A physician certifies that the individual is NFCE; **and**
- The care and services are **either**
    - a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or
    - b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services, but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.

Individuals who do not meet the definition of NFCE are considered NFI.

B. Levels of Care for Aging Programs

1. Caregiver Support Program (CSP)

A level of care determination/assessment is not required or needed for a Caregiver or Care Receiver in the CSP. However, if a Care Receiver appears to be eligible for MA LTSS and might benefit more from enrollment in CHC or the LIFE Program, the Care Manager may make a referral to the DHS Independent Enrollment Broker (IEB).

2. OPTIONS Program

Individuals are eligible for enrollment into the OPTIONS Program if they meet the eligibility criteria identified in Chapter IV: OPTIONS Program. While individuals eligible or enrolled in OPTIONS may meet NFCE criteria, a level of care determination/FED assessment is not required or used for OPTIONS enrollment or receipt of services.

Consumers shall be directed to appropriate program(s) that will best meet their needs. All applicants for OPTIONS services, or existing OPTIONS consumers, whose income and assets are under the financial thresholds noted in Appendix F.4 of Chapter IV: OPTIONS Program **and** who appear to meet the definition of NFCE shall be referred to the IEB to apply for MA LTSS (refer to Mandatory MA Eligibility Determination Process in Chapter IV: OPTIONS Program).

A referral to the IEB begins the application and eligibility determination process. The IEB is responsible for requesting the completion of the FED from the Independent Assessment Entity.

Resources:

Appendix A - Definitions and Service Standards

- Refer to Chapter IV: OPTIONS Program Appendix A
- Refer to Chapter VI: Caregiver Support Program Appendix A

Appendix B - Documentation Requirements

- Refer to Chapter V: Care Management Appendix B.1 The Department-Approved Acronyms and Abbreviations

Appendix C – Forms

- Appendix C.1 Caregiver Assessment Tool (CAT)
- Appendix C.2 Caregiver Assessment Tool (CAT) Instructions
- Appendix C.3 Needs Assessment Tool (NAT)
- Appendix C.4 Needs Assessment Tool (NAT) Instructions
- Appendix C.5 Needs Assessment Tool Express (NAT-E)
- Appendix C.6 Needs Assessment Tool Express (NAT-E) Instructions
- Appendix C.7 SLUMS Examination (contained within the NAT)

Appendix D - SAMS Data Entry Requirements

- Refer to Chapter IV: OPTIONS Program Appendix D
- Refer to Chapter VI: Caregiver Support Program Appendix D

Appendix E - Regulations and Citations

- Appendix E.1 6 Pa. Code Chapter 21 – Domiciliary Care Services for Adults
- Refer to Chapter VI: Caregiver Support Program Appendix E

Appendix F - Other Resources

- Refer to Chapter IV: OPTIONS Program Appendix F
- Refer to Chapter V: Care Management Appendix F
- Refer to Chapter VI: Caregiver Support Program Appendix F
- National Institute of Mental Health Brochures and Fact Sheets: https://www.nimh.nih.gov/health/publications