Georgia Department of Human Resources Division of Aging Services Requirements for Non-Medicaid Home and Community Based Services

Section 100 Administrative Guidelines and Requirements for Area Agencies on Aging

§114 Guidelines and Requirements for Client Assessment December 2003

§114.1 Purpose

This chapter establishes the guidelines for quality service and accountability for Area Agencies on Aging, (AAAs) Area Agency contractors, and subcontracting service providers when conducting client assessments for non-Medicaid Home and Community Based Services (HCBS).[1] These are the minimum requirements to be followed if AAAs are not contracting for comprehensive HCBS case management services, of which client assessment is one component. These requirements also establish the Determination of Need-Revised as the core assessment instrument for all non-Medicaid Home and Community Based Services. In addition, this reiterates the requirement that AAAs/providers assess the nutrition risk level of all applicants for and recipients of Nutrition Program Services, using the Nutrition Screening Initiative DETERMINE Checklist and Level I Screening, when indicated. The Division will periodically review the need to establish additional assessment domains, instruments and data sets in the future. Refer to Appendix 114-A for an overview of the DON-R and NSI instruments.

§114.2 Scope and Purpose

Client assessment, a component of comprehensive Case Management, encompasses those activities which directly relate to the initial face-to-face comprehensive assessment and periodic reassessment of applicants and program participants by the Area Agency on Aging and/or its subcontractor(s). The purpose of these guidelines is to

(a) eliminate the duplication of assessment activities;

(b) assure timely completion of assessments and reassessments;

(c) assure that assessments are conducted accurately and consistently within each PSA, and statewide, and reflect change over time in clients' conditions and circumstances;

(d) assure that the services planned, ordered and provided are appropriate for a client's situation and condition on a continuous basis; and

[1] These guidelines do not apply to services provided through the Long Term Care Ombudsman Program, the Elderly Legal Assistance Program, Elder Abuse Prevention Program , Service Assistance to Victims of Abuse (SAVA), GeorgiaCares or the Senior Medicare Fraud Patrol.

(e) provide the basis for evaluating the effectiveness of service planning and measuring service quality.

§114.3 Objectives

One of the primary objectives of initial assessment is to confirm and expand upon the initial information obtained at telephone screening, through a more thorough evaluation of eligibility, functional impairment level, unmet need for care, level of nutrition risk, and other various individual needs of an applicant for services, using assessment instruments specified by the Division. The ultimate goal is the development of an individualized plan of care or service plan, in collaboration with the client, and caregivers, when present, through which care needs will be met by one or more service providers or other community resources. The primary objective of periodic reassessment is to review all criteria related to initial and subsequent assessment findings, so that any necessary adjustments in service planning and delivery may be made, based on the client's most current status and situation.

§114.4 Staffing

(a) Area agencies shall assure that staff performing assessment activities, at either the AAA or subcontract agency level, shall be competent, ethical, sufficient in number and qualified by training and/or experience to conduct face-to-face client and caregiver assessment interviews, using the instruments, tools, and data collection/management systems specified by the Division.

(b) Staff conducting assessment activities shall have specialized knowledge of older persons, with particular strength in the area of assessing the variables that affect health and functioning.

(c) Area agencies are responsible for identifying training needs of both AAA and provider staff and notifying appropriate Division staff if they need technical assistance or assistance with providing training.

§114.5 Assessment Activities

At a minimum, staff responsible for client assessment will perform the following activities:

(a) appraisal of the need for service interventions through gathering and critical, objective evaluation of relevant data. This includes assessment and documentation of the applicant/client's degree of functional impairment; unmet need for care; dietary needs; and eligibility and appropriateness for non-Medicaid Home and Community Based Services. Other domains include, but are not limited to mental/cognitive status; social/

spiritual/ emotional status; health/medical status and history; financial resources; status of primary caregiver; home environment; risk factors for abuse, neglect or exploitation; and need for assistance with advance directives or other legal issues.

(b) assessment of past and present resource utilization; health conditions/impairment levels, past and present treatment or service plans; desired short term and long term outcomes and goals; service plans, and provider options;

(c) periodic reassessment of the client, within the standards established for each program or service, including updating information in client records, maintained in either paper or electronic form, as appropriate and necessary, to determine any changes in the client's status, situation or circumstances which impact his/her functional level and need for assistance;

(d) travel to and from the homes of applicants/clients for the purpose of assessment or reassessment;

(e) assessment, reassessment and documentation, where appropriate, of caregiver status, using criteria or instruments specified or approved by the Division;

(f) telephone follow-up with clients and caregivers, when appropriate and necessary, in accordance with program and service requirements;

(g) data collection, data entry, and programmatic reporting.

§114.6 Service Neutrality and Organizational Placement

Ideally assessment, as a component of Case Management, is service neutral; that is, performed independently by appropriately trained personnel who are not employed by an organization that also contracts with the AAA to provide supportive and other services. AAAs may elect one of the following options for provision of client assessment:

(a) the AAA provides comprehensive Case Management, including initial assessment, for those persons deemed appropriate to receive non-Medicaid HCBS and who would benefit from case management assistance, either on a short term or long term basis; *or*

(b) the AAA conducts the *initial assessment only (and 30-day follow-up contacts, if desired)* of those applicants for service who are determined appropriate for non-Medicaid HCBS, and subcontracts for the provision of comprehensive case management including care planning, service provision, periodic reassessments, record maintenance, and reporting; *or*

(c) the AAA subcontracts for the provision of comprehensive case management services, including initial assessment, with a Case Management Organization (CMO); *or*

(d) the AAA includes in its contractual expectations that subcontractors conduct comprehensive assessments for persons referred to them for services. If the AAA elects this option, it will establish procedures which assure that assessments are objective, comprehensive in addressing all components described in §114.5 (a) and (b) and yield care plans which focus on the remaining abilities of the client as well as the impairments, are goal–based, and not biased toward the services offered by the assessing entity*. AAAs shall develop protocols by which clients served by more than one organization do not receive duplicate assessments, and that services provided by several providers are coordinated through a single plan of care*. (Also see §114.9, regarding coordination with the CCSP and Appendix 114-B for the process flow for coordination of assessments.)

amended 12/ 2003

(e) Providers that conduct comprehensive assessments shall assure that they will not accept clients for whom their services are inappropriate, based on the completed comprehensive assessment. The AAA will work with providers to establish protocols for having inappropriate referrals re-screened and referred to appropriate resources.

§114.7 Initial Assessment and Reassessment Intervals.

(a) Initial Assessments. Following AAA telephone screening, and subject to the availability of services, AAAs may refer clients to appropriate providers and authorize them to begin services prior to the completion of a comprehensive initial face-to-face assessment. Either a CMO or the provider will complete the full initial assessment within ten business days of service initiation. AAAs which exercise this option must assure that providers adjust services to appropriate levels based on the full assessment and reflected by care plans developed by case management

staff/provider staff. Also see §114.5(e) above regarding arrangements/ referrals for clients who are found to be inappropriate for any reason[2] for the original service requested.

(b) Follow-up. AAA/CMO/provider staff conducting initial assessment will provide telephone follow up with clients/caregivers at the end of the first thirty (30) days of service delivery to determine client/caregiver satisfaction with services. If initial assessment is conducted independently of ongoing case management, staff performing initial assessment activities are responsible for providing and documenting 30-day follow-up and for conveying any client/caregiver concerns or necessary changes in service levels/delivery to appropriate staff of the CMO or provider agency.

(c) Reassessments. Designated staff will conduct the first complete reassessment for non-Medicaid services in accordance with standards established for each service, to confirm the client's continued eligibility and appropriateness for service, *or* whenever there is any change in client condition, status or circumstances that would affect the need for a change in service levels and/or additional services to be provided.

§114.8 Client Records and Records Management

(a) The entity conducting client assessment activities shall establish for each participant a confidential record in a form designated or authorized by the Division, which is protected from damage, theft, and unauthorized inspection, and which is made available for monitoring and audit purposes. The record shall contain, at a minimum, the following information in form and format provided by or approved by the Division:

(1) Intake and screening information;

(2) documentation of eligibility, assessment and reassessment;

(3) service/care plans;

(4) notes regarding significant client contacts, activities, including care plans; and

(4) procedures for emergency care.

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[2] Applicants may be found to be inappropriate when the need for the requested service cannot be confirmed by the full assessment or when the person's needs exceed the service organization's capacity to assure his/her safety in the home or community.

(b) Staff responsible for conducting initial client assessments for HCBS shall collect required data and initiate AIMS data entry either directly or by providing all required data to data entry staff.

(c) AAAs shall negotiate with contract providers to designate a "lead agency" to coordinate care and services when there are multiple HCBS providers involved with a client. *AAAs are to assure that only one assessment per client per assessment interval is recorded in AIMS, except as noted here:* Information about both care givers and care receivers may be indicated and recorded for the Title III-E National Family Caregiver Support Program, depending on the mix of services provided.

(d) The AAA shall develop and implement written procedures to be followed by staff performing assessment activities at any level to obtain the written consent of the client for the release of confidential information to other providers when referrals are made.

§114.9 Joint Service Provision by Non-Medicaid Providers and the Community Care Service Program.

(a) Primary Assessment: When a client receives both non-Medicaid and Community Care Service Program services, the CCSP assessment and resulting care plans are primary and should incorporate and reflect the non-Medicaid services. Non-Medicaid HCBS providers have no further responsibility under these policies for assessment/service planning in those cases, but will communicate and work with the Care Coordination Agency regarding need for adjustments in service levels and care plans based on their observations over the course of providing services. (Please note that Non-Medicaid HCBS providers that are licensed by the State Office of Regulatory Services as private home care providers may have additional requirements for assessment pursuant to those regulations.)

(b) Electronic client records and reporting: To comply with federal and state reporting requirements, AAAs or other designated entities will continue to enter any additional client data required for non-Medicaid services into AIMS to document and report each non-Medicaid service provided.

AAAs shall establish protocols and procedures for obtaining from the CMO/provider necessary data from the assessment/care plan information.

(c) Nutrition risk assessment: If a client receives services through the CCSP and home delivered meals from a non-Medicaid provider, the AAA/CMO/nutrition service provider will obtain nutrition risk scores from the CCSP Care Coordinator and enter the data in the AIMS client record.

(d) Older Americans Act Title III-E National Family Caregiver Support Program Assessments: A CCSP client may have a *caregiver* who is identified as the *client* for the NFCSP and who will be assessed using instruments identified by the Division. A separate record for the caregiver as client is established in the AIMS. DON-R or other CCSP client data may be shared, if this information is essential to develop a plan of intervention for the care receiver and is needed to provide relevant information to support service providers.

§114.10 Conditions for Referrals to Other Services.

When staff discover conditions during the assessment process which warrant referral, they shall assist clients in taking advantage of other services, whether provided through the aging network or through another community, health, medical, pastoral or legal resources. Staff shall document such referrals in the client record, and the assistance or services obtained in the care plan, if of an ongoing nature.

§114.11 Recordkeeping and Reporting.

AAAs/subcontractors shall maintain in the manner prescribed by the Division any such records, in addition to client records, as may be necessary for overall program management and report in compliance with the Division's policies and procedures.

§114.12 AAA Monitoring.

The Area Agency shall conduct periodic (at least annual) reviews of documentation in client records of assessment and reassessment activities, (including establishing procedures for self-review, if the AAA is providing assessment directly) to verify accuracy, completeness and timeliness of data collection and entry, and that activities are performed in compliance with these policies and procedures. The Division may monitor client assessment records at the AAA and subcontract provider levels, to assure compliance with all applicable requirements.

§114.13 Quality assurance. The AAA shall periodically, but not less than once annually, evaluate the effectiveness of client assessment activities (if provided as a stand alone activity, not as a part of comprehensive case management), to determine the degree of accuracy of assessment and reassessment activities and the degree of correlation of care plans to assessment data (including self-review procedures, if applicable). The AAA shall determine the degree to which the assessment component of case management contributes to the development of care plans which support maintenance or improvement of client status. The AAA will arrange for or provide training and technical assistance, when indicated, to improve assessment results.

§114.14 Integration of Client Assessment Activities The Area Agency shall assure that initial and ongoing client assessment activities are conducted in such a way as to provide maximum coordination and integration with its intake, screening, and information and assistance processes and with ongoing case management, at whatever level that activity occurs. The area agency *may*, through the negotiation of subcontracts, delegate any and all components of *case management (except for telephone screening) including client assessment.* The area agency will document that the integration of the services has occurred or will occur as a result of the agency's leadership. The Division may request documentation at the time of submission of a proposed area plan, area plan amendment or update; at the time of a program review or quality assurance review; or at any other time the information is needed as a part of program evaluation.

§114.15 Implementation Date This chapter incorporates and amends policies originally transmitted as DAS Procedural Issuance 146, "Client Assessment for Non-Medicaid Home and Community Based Services," April 21, 2001, which took effect July 1, 2001 for SFY 2002. These policies and procedures supercede Procedural Issuance 146 in its entirety and take effect upon issuance. Area Agencies shall have adequate time to develop protocols and implement any changes in the client assessment process as may be necessary.

Appendix 114-A

Core Assessment Instruments for Non-Medicaid Home and Community Based Services

114-A-1.1 About the DON-R

The Determination of Need-Revised (DON-R) assessment instrument was developed during 1987 through 1989 by a team of researchers at the Gerontology Center of the University of Illinois at Chicago for use by the Illinois Department on Aging's statewide network in determining eligibility for home and community based services, including its Medicaid waiver program. The DON not only provides the basis for determining program eligibility, but also provides sufficient information for case managers to evaluate care needs and develop plans of care.

The DON is used as a basic individual needs assessment to determine where there are deficits in functioning and where there are remaining strengths, including the presence or absence of a support system. The DON provides documentation of the need for assistance across a range of impairments and is a true ordinal scale. An ordinal scale provides clearly defined meanings for each level of impairment, each level of unmet need for care and each functional activity. Thus changes in score represent actual changes in capacity and/or need for assistance and the scoring can be used to track changes over time.

When originally field tested, the DON was normed to a nursing home population on the impairment scale. People in the community with impairment level scores of 15 or higher are similar in their degree of impairment to the upper two-thirds of a nursing home population. However, it is the unmet need for care which has more bearing on the actual potential for placement outside the home. The availability of a continuous range of scores means that staff responsible for planning or assisting others with planning for care are able to develop plans to order only the actual amount of service needed and can provide the basis for controlling costs. The DON can assist in developing a plan of care which promotes independence in the community, or if assessing the strengths of someone already in a nursing home, to help the resident remain as independent as possible in that setting.

114-A-1.2 Summary of the Determination of Need-Revised (DON-R) Assessment of Functional Impairment and Unmet Need for Care

	Column A	Column B	
Function	Level of Impairment	Unmet Need for Care	Comments
1. Eating	0 1 2 3	0 1 2 3	
2. Bathing	0 1 2 3	0 1 2 3	
3. Grooming	0 1 2 3	0 1 2 3	
4. Dressing	0 1 2 3	0 1 2 3	
5. Transferring	0 1 2 3	0 1 2 3	
6. Continence	0 1 2 3	0 1 2 3	
7. Managing Money	0 1 2 3	0 1 2 3	
8. Telephoning	0 1 2 3	0 1 2 3	
9. Preparing Meals	0 1 2 3	0 1 2 3	
10. Laundry	0 1 2 3	0 1 2 3	
11. Housework	0 1 2 3	0 1 2 3	
12. Outside Home	0 1 2 3	0 1 2 3	
13. Routine Health	0 1 2 3	0 1 2 3	
14. Special Health	0 1 2 3	0 1 2 3	
15. Being Alone	0 1 2 3	0 1 2 3	
Box A: Subtotal Col. A, Items 1-6	**Box A**	**Box B**	Box B: Subtotal Col. B, Items 1-6
Box C: Subtotal Col. A, Items 7 - 15	**Box C**	**Box D**	Box D: Subtotal Col. B, Items 7- 15
Box E: Subtotal Box A and Box C	**Box E**	**Box F**	Box F: Subtotal Box B and Box D
		Box G	Box G: Subtotal Box E and Box F

Score:	**Interpretation:**
0	No Impairment or no unmet need for care
Greater than 1 and less than or equal to 1.5	Mild impairment or mild unmet need for care
Greater than 1.5 and less than or equal to 2	Mild to Moderate impairment or mild to moderate unmet need for care
Greater than 2 and less than or equal to 2.5	Moderate impairment or moderate unmet need for care
Greater than 2.5	Severe impairment or unmet need for care

114-A-1.3 Overview of Scoring the Impairment Level

Table 1

Impairment Level Score	And If …
Score "0" if the client performs or can perform all essential components of the activity, with or without assistance…	- no significant impairment level remains; - the activity is not required by the client (refers to these IADLs only: medication management, routine health and special health); and/or - the client may benefit from but does not require verbal or physical assistance
Score "1" if the client performs or can perform all essential components of the activity, with or without assistance, but some impairment of function remains which requires verbal or physical assistance in some or all components of the activity …	- client experiences *minor, intermittent fatigue* in performing the activity; - client *takes longer* than would be required for an unimpaired person to complete the activity; - client must perform the activity *more often* than an unimpaired person; and/or - client requires *some* verbal prompting to be able to complete the task.
Score "2" if the client cannot perform most of the essential components of the activity, with or without assistance, but some impairment of function remains which requires verbal or physical assistance in some or all components of the activity …	- client experiences *frequent or rapid fatigue or minor exertion* in performing the activity; - client takes an *excessive amount of time* to perform the activity; - client must perform the activity *much more frequently* than an unimpaired person; or - client requires *frequent* verbal prompting to complete the task.
Score "3" if the client cannot perform the activity and requires someone else to perform the task, although s/he may be able to assist in small ways; or requires constant verbal or physical assistance.	

Note: A score of "0" in functional impairment will automatically yield a score of "0" for unmet need.

114-A-1.4 Overview of Scoring Unmet Need for Care

Table 2

Unmet Need for Care Score	**And If …**
Score "0" , regardless of the impairment level if the client's need for assistance is met to the extent that the client is at no risk to health or personal safety…	- client has no need for assistance; and/or - additional assistance would not benefit the client.
Score "1" if the client's need for assistance is met most of the time…	- there is minimal risk to health or personal safety if additional assistance is not provided.
Score "2" if the client's need for assistance is *not* met most of the time….	- there is moderate risk to health or personal safety if additional assistance is not provided
Score "3" if the client's need for assistance is seldom or never met or there is severe risk to health and safety….	- the client would require acute medical intervention if additional assistance is not provided.

In-depth training is available upon request to the Division.

114-A-2 The Nutrition Screening Initiative DETERMINE Checklist

The Nutrition Screening Initiative (NSI) Checklist is a scored checklist aimed at developing the nutritional awareness of older adults living in the community. The checklist was developed to be either self-administered by the older adult, or used by professionals to rate the potential or actual nutrition risk status. The Checklist has been psychometrically tested and found to have acceptable levels of reliability and validity. The checklist does not provide a clinical diagnosis but does provide an effective initial screen of nutrition risk. It has also proven to be an excellent indicator of chronic depression, since depression has a major impact on nutrition status and chronic disease. Often, people who score high on the checklist have multiple problems, which can be addressed once identified.

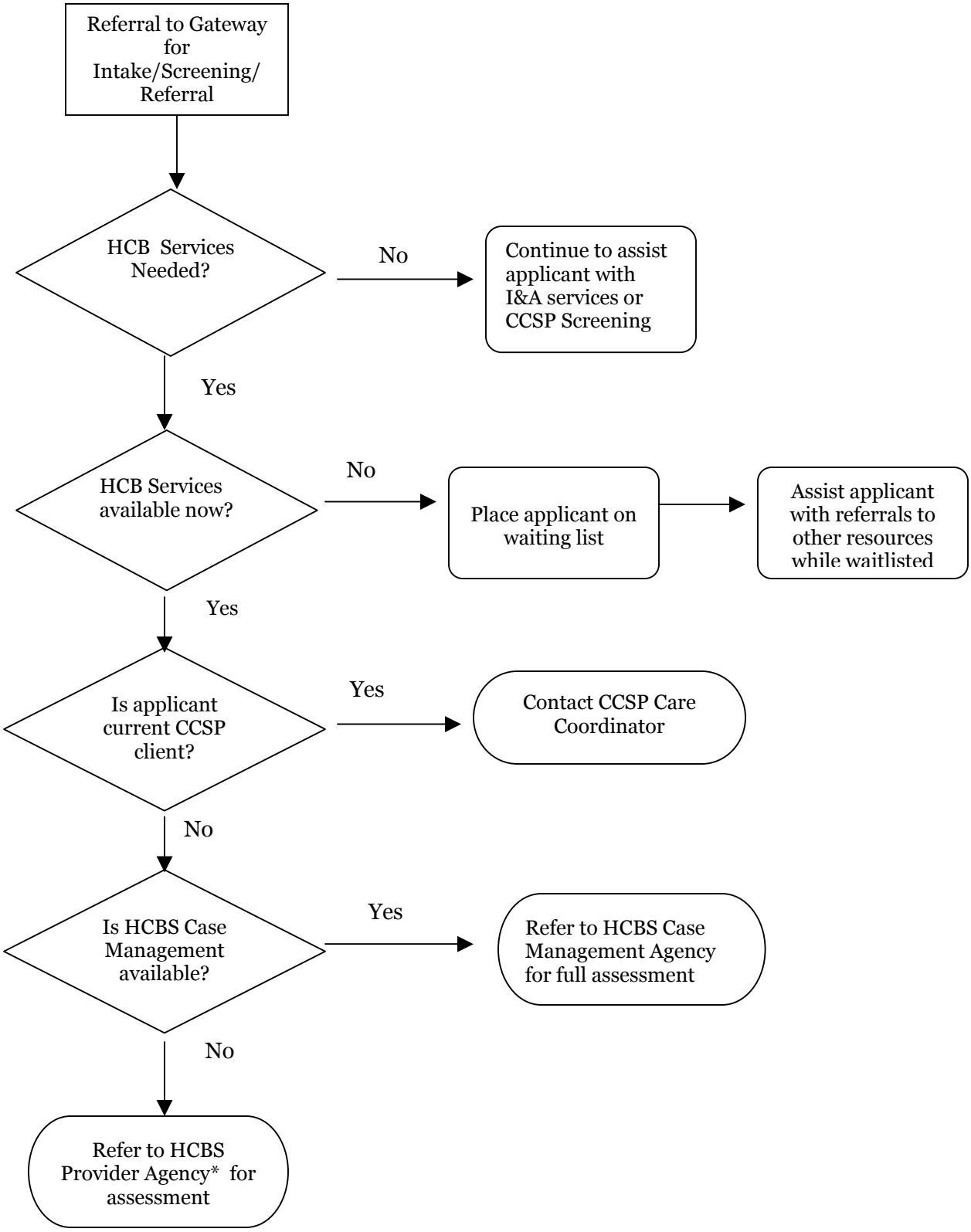
The Nutrition Screening Initiative is a project of the American Academy of Family Physicians, The American Dietetic Association and the National Council on the Aging. Following is a summary of the instrument.

NSI-DETERMINE Checklist	**YES**
I have an illness or condition that made me change the kind and/or amount of food I eat.	**2**
I eat fewer than 2 meals per day.	**3**
I eat few fruits or vegetables or milk products.	**2**
I have 3 or more drinks of beer, liquor or wine almost every day.	**2**
I have tooth or mouth problems that make it hard for me to eat.	**2**
I don't always have enough money to buy the food I need.	**4**
I eat alone most of the time.	**1**
I take 3 or more prescribed or over-the-counter drugs a day.	**1**
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	**2**
I am not always physically able to shop, cook and/or feed myself.	**2**
Scoring **0-2 Good; not at risk. Recheck in 6-12 months.** **3-5 Moderate risk. Refer for Level I/II Screening. Recheck in 3 months.** **6 + High risk. Refer for Level I/II screening and to health care professional.** **TOTAL**	

For additional information on planning interventions using the NSI Checklist and related materials, refer to The Nutrition Interventions Manual for Professionals Caring for Older Americans, 1992, Greer, Margolis, Mitchell, Grunwald and Associates, for the Nutrition Screening Initiative, 2626 Pennsylvania Avenue, N.W., Suite 301, Washington, D.C., 20037, or visit websites at http://www.aafp.org/x16081.xml and http://www.eatright.org/images/nsifinal.pdf

Appendix 114-B

Process Flow for Coordination of HCBS Assessment



*If 2 or more HCBS providers are involved, AAA designates primary provider to conduct all assessments.