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INFORMATION MEMORANDUM **Number: 99-IM-20**

DATE: May 11, 1999

TO: Area Agency on Aging Directors

SUBJECT: Questions and Answers #4--Community Based Long Term Care Assessments--Minimum Data Set

PURPOSE:

This Information Memorandum transmits the fourth in a series of frequently asked questions received from the network regarding the Minimum Data Set (MDS). MDS data elements are now required when assessing older persons for community based long term care services that are provided with state and federal funds that flow through SOFA to the AAAs. The community based long term care services are case management, homemaking/personal care, housekeeping/chore, home delivered meals, social adult day care and home health aide.

BACKGROUND:

The first three sets of questions and answers were transmitted in 97-IM-32 (June 13, 1997), 97-IM-36 (June 30, 1997) and 97-IM-54 (November 17, 1997).

Questions and answers in this transmittal are grouped by topics: Assessments, Reassessments and Care Planning (questions 1 - 8), Provider Data System (PDS) and Automation (questions 9 - 13) and Reporting (questions 14 - 19).

PROGRAMS AFFECTED:

	[x] Title III-B	[] Title III-C-1	[x] Title III-C-2	
[x] Title III-D	[] Title III-F	[x] CSE	[x] SNAP	[] Energy
[x] EISEP	[] Cash-in-Lieu	[] Title V	[] HIICAP	[] LTCOP

[] Other:

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Attachment

MINIMUM DATA SET QUESTIONS AND ANSWERS #4 MAY 1999

ASSESSMENT, REASSESSMENT, CARE PLANNING

Question #1: If a client is receiving more than one community based long term care service, must each provider have a completed copy of the assessment instrument?

Answer #1: The short answer is "no." The State Office for the Aging (SOFA) has not mandated procedures for the sharing of information from the assessment with community based long term care (CBLTC) service providers. However, we strongly encourage area agencies on aging (AAAs) to work with providers in determining local procedures that meet the needs of all concerned. Information should be shared with providers on a "need-to-know" basis. Certainly, different providers will need to have different levels of information. For example, if the client is receiving case management, the case manager should have the full assessment as he/she is coordinating care and needs to have a complete picture of the client's situation. However, for other providers, less information may be required. Clearly the information that a home care agency needs to know is different from what the home delivered meal (HDM) provider needs to know. The level and type of involvement the provider is expected to have with the client should dictate what information is shared with that provider.

Question #2: What if during the initial screening for services it is determined that only home delivered meals are needed? Can the MDS (Minimum Data Set) be modified, e.g., to include only the nutrition sections or the short term home delivered meal questions?

Answer #2: Even though the screening process provides information that home delivered meals are the only service needed, the full MDS must be administered. The purpose of instituting a comprehensive assessment process is to eliminate fragmented intake and service gaps; therefore it is important that prospective clients are assessed for the full array of services. The exception is if the area agency has implemented a system for short term home delivered meal assessments and, based on the AAA's criteria, the person needs meals for 45 or fewer calendar days. (Also see 97-IM-32, Page 1, Question #4 for related information.)

Question #3: What action(s) are recommended when an assessment shows that an older individual is at high nutritional risk?

Answer #3: The assessor should share relevant information on the older individual with the Registered Dietitian (RD). The RD will then determine whether further assessments of risk are necessary and/or whether specific follow-up activities such as nutrition counseling, referrals to congregate meal services or benefit programs should be considered for inclusion in the care plan.

Question #4: Can an AAA that has been using an assessment instrument that is not MDS compliant meet the MDS requirements by instructing assessors to include MDS required elements under general sections of their instrument? For example, the instructions to the instrument tell the assessor to note if the client has "swallowing problems" under comments for the section on health.

Answer #4: The information may be collected in any format the AAA chooses. However, the answer to each item must be recorded and available for use during care planning, ongoing service delivery and program monitoring. Thus every MDS item must be addressed and the answer recorded (on paper and/or electronically) in such a way that it is clear what MDS item the answer pertains to.

Also, SOFA reporting and data collection standards, as well as the National Aging Programs Information System (NAPIS), will require that certain data elements within the MDS be retrievable for reporting purposes. Narrative information may be less useful for reporting than information in a database system.

Question #5: How much information can be missing from an assessment (because it wasn't asked or the person refused to provide the information) and still be counted as a completed assessment?

Answer #5: Every item in the MDS must be addressed with the client and/or his/her representative. However, as noted in the COMPASS (Comprehensive Assessment for Aging Network Community-Based Long Term Care Services) instructions, a client can refuse to provide any of the information. Such refusal to provide information can result in their not receiving the most appropriate service(s) or the service(s) preferred. A client's refusal to provide information should be so noted next to the item.

It is up to the AAA staff, or subcontractor staff if this responsibility is delegated, to determine if enough of the necessary information has been provided to develop a care plan and authorize service. To some extent it will depend on the needs identified and the services needed/desired.

Question #6: Does SOFA have any recommendations for the conduct of a reassessment when using a paper document? For example, can we use the previously completed assessment and just make changes where appropriate?

Answer #6: We have no specific recommendation to make at this time. Each AAA must set up its own system based on what would work best for them given the needs of its staff, the organizational structure of the agency and the operations of each program. The example noted, making changes to the previously completed assessment, is acceptable as long as the reassessment includes a comprehensive review of the client's situation and it is clear what the client's situation is at the time the reassessment is completed (i.e., the current information for each item is clear).

Staff could photocopy the previously completed assessment and use that during the reassessment interview. During the reassessment interview, the assessor would review each item but would only write something when the client's information had changed. This would save writing time and acknowledge the client's situation at the time of the assessment, while not compromising the comprehensiveness of the reassessment.

Question #7: If a problem can't be addressed because the service needed does not exist, would this be noted in the care plan? If so, how?

Answer #7: Any problem that is not already being addressed in some way must be recorded. Where and how it is recorded depends on the nature of the problem. A problem that would, if unaddressed, put the client's health or safety in jeopardy must be included in the care plan, whether or not the most desirable service is available. Actions to ameliorate this type of problem would be included among services authorized or arranged or referrals made. Additional notes may be added in the care plan, either in the margins or on an attached page.

When a problem poses no danger to the person's health or safety, and there are no services available to address the unmet need (or the services that are available are not acceptable to the person) it may be noted in the care plan that the problem remains unaddressed. Alternately, it could be noted in the client case record. An example of this type of problem is:

> A person feels isolated and alone and would, among other things, like to visit her sister who is 20 miles away in a nursing home. The client no longer drives, and there is no public transportation. The only available transportation is a very expensive taxi.

In addition, we recommend that there be a system in place to keep track of any unmet needs for action in the future, for instance,

when the service needed by a specific client becomes available, or when data on unmet needs in the community are being collected to document the need for new services and to support advocacy.

Question #8: What is the difference between care planning and case management?

Answer #8: Care planning is the process of analyzing the findings of the assessment or reassessment, establishing goals and objectives and developing a plan of action to address the problems identified during the assessment or reassessment. Depending on client needs and the structure of the AAA, the care plan may be developed by the assessor as the concluding step of an assessment or reassessment, by a case manager or by another staff person. After the care plan is developed it is implemented, usually by arranging for formal or informal services and/or making appropriate referrals. The involvement of staff in plan implementation, which staff and to what extent, will depend upon the organizational structure of the agency and the needs of the client.

Case management is a comprehensive service consisting of several components -- assessment/reassessment, care planning, service authorization/referral, services follow-up/client monitoring and service termination/client discharge. Care planning is one component of case management. When a client is receiving case management, the staff are involved in the implementation of the care plan and additional follow-up -- authorizing or arranging services, carrying through on referrals, checking on the provision of services and the client's situation to assure that services continue to meet client needs and terminating services/discharging the client as appropriate.

PDS AND AUTOMATION

Question #9: Is SOFA considering any changes to the Provider Data System (PDS), MDS and/or COMPASS?

Answer #9: Our intent is to continue to review and improve the software and the standards and to make modifications as necessary based on user feedback. Version 4.0 of PDS was developed, in concert with the New York City Department for the Aging, to reflect many of the comments we received from case managers and others actually using the software. As this recently released version of the software gains more exposure, we anticipate that other suggestions for useful features and functions will emerge and will be evaluated. We expect that CD-ROM updates for the software will be available on approximately an annual basis, with interim minor changes distributed as necessary.

Our plan is to similarly review and, where feasible and

necessary, revise the MDS. However, since the requirement for full implementation of these data collection standards statewide commenced on April 1, 1999, we want to be sure that the network has enough experience with these requirements before beginning a process to actively solicit suggestions for changes. Any modifications to the MDS would, of course, be incorporated into PDS as well as into COMPASS.

We have also received a number of comments and suggestions for format and content modifications to COMPASS. Since the COMPASS was developed as a technical assistance effort to provide an optional tool for AAAs to use in conducting MDS compliant assessments, please note that the COMPASS may be modified locally to meet local preferences, so long as the MDS standards are met.

However, we will incorporate the COMPASS into the overall reviews noted above and make changes based on consensus and "best practice." Also, AAAs using PDS may find that the format of the assessment instrument as printed out by the software is more convenient for data entry purposes.

Question #10: In PDS does reassessment information override previous assessment information so that only current client information is available?

Answer #10: Yes, the reassessment information overrides the previous assessment information in the client module. Thus only the current client information is available in the client module. However, some of the information from previous assessments is maintained in PDS under its history function. For example, information on Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL) status, medications, living arrangements and financial situation is maintained over time. The history function records the date of the original entry, the date of the change and the information before it was modified. Thus, this information remains available to the AAA and could be used to monitor changes in clients over time.

Question #11: What about protecting client confidentiality? What steps need to be taken when using PDS?

Answer #11: While automation has made this a somewhat more complex and multifaceted issue, protecting client records from unauthorized access has been the policy and practice of the aging network for many years. As with paper files, it is necessary to insure that electronic data is not altered, except by people authorized to do so and in accordance with properly established procedures. Similarly, AAAs should ensure that confidential data is available only to authorized personnel who need that data in order to do their jobs.

The PDS software, whether running on a Local Area Network (LAN) server, a desktop computer, or a laptop computer, requires every

user to enter a user identification (ID) and password. AAAs and provider agencies using PDS should determine who needs to have access to what data and then set up the ID and password code security features within PDS to control access to client records accordingly.

Also, note that where PDS data is transmitted from one computer to another over any channel other than an agency's internal LAN (e.g., the Internet, cellular modems, conventional phone lines), the data is automatically encrypted.

Finally, any desktop computer containing a PDS database should be kept in a location that is not accessible to the general public, and any portable computer containing a PDS database should be kept in a secure location when not in use. Users of portable computers should take reasonable precautions to protect them from loss or theft.

Question #12: How can an AAA get a client signature when the assessment is done on a laptop?

Answer #12: SOFA does not require a client signature on the assessment or care plan. At this time, the only signature required is for Expanded In-home Services for the Elderly Program (EISEP) clients and Community Services for the Elderly (CSE) clients receiving EISEP-like services. It is currently required on the client agreement part of the financial assessment. When the client signs the agreement, he/she is actually signing off on several things -- the level of his/her cost sharing, the accuracy of the financial information, understanding that he/she must inform the program if there is a change in his/her financial situation, that he/she has reviewed the care plan and that he/she has been informed of his/her rights, including the right to request a hearing or settlement conference. On the other hand, we know that many AAAs have been requiring clients to sign off on assessments that are conducted for HDM and that many of these AAAs have added a client signature to the care plan section of the COMPASS. This is allowable, but it is local decision.

For an AAA that plans to conduct assessments using laptop computers and where either EISEP or CSE EISEP-like services will be provided, probably the easiest thing an AAA could do is have staff bring two paper copies of the client agreement so the client can sign off. (An AAA could use the section in the "Cost Share Determination and Client Agreement" or the "Financial Information and Client Agreement" form or a local equivalent.) One copy of the signed agreement would be left with the client and the other copy would be placed in the client file.

An AAA that wants to have a client sign off on a care plan that doesn't include either EISEP or EISEP-like services will need to develop a form for this purpose. Please note that as we work on revising the case management regulations and develop regulations covering assessments, we will include requirements on what must

be given to the client when an assessment is completed and a care plan developed. The document that an AAA develops to meet this requirement would be a logical place for a client signature if the AAA chooses to require such.

Question #13: What's the relationship between PDS and COMPASS in terms of format and data entry? Will they ever line up precisely?

Answer #13: Since the COMPASS is a paper form developed by SOFA as an optional instrument that may be used (as is or reformatted) by assessors to capture the MDS, and PDS is an automated tool with screens that flow differently than a paper based system, it would be difficult and perhaps counterproductive to force either to exactly correspond with the other.

However, although the system was designed to facilitate data entry into PDS directly as the assessment is being conducted, it will also accommodate data that is entered later from a paper record. Therefore, beginning with Version 4.0, released in April, 1999, PDS has the capacity to print out blank (or completed) assessment forms that match the screens in PDS, contain all the necessary MDS information and can be taken into the field for assessments and reassessments. After the data is entered on the PDS printed assessment form by the assessor, it can be taken back to the office for entry into the system.

REPORTING

Question #14: How does PDS address our current reporting needs and how will annual/future changes in SOFA's reporting requirements be handled?

Answer #14: PDS has three different ways of retrieving/reporting data from the system:

1) a variety of standard management reports,
2) a separate module that uses the PDS database to generate the Consolidated Area Agency Reporting System (CAARS) Quarterly Report and
3) a separate statistics module to allow ad hoc querying of the data.

As SOFA reporting requirements are revised, we will work with the software developer to modify the CAARS module accordingly. For example, as NAPIS based modifications to our reporting requirements are implemented, corresponding changes will be made to PDS to ensure the requisite data will be captured and available. We will also seek input from AAAs to improve the

standard management reports noted above and to ensure that the "ad hoc" reporting feature is responsive to local needs.

Question #15: Could SOFA provide a hypothetical example of how PDS will provide outcome based data?

Answer #15: One example of how PDS might provide outcome data comes from the Elderly Nutrition Program.

> Scenario: During a comprehensive assessment, it is learned that Mrs. Jones is underweight as a result of her inability to obtain food and prepare meals for herself. She is subsequently referred to the home delivered meals program. One of the goals of her participation in that program is to increase her weight by 10 pounds.
>
> The PDS system will aid the nutrition program in assessing its progress toward this goal by providing data on Mrs. Jones' weight at the time of the initial assessment and subsequent re-assessments. The program will then be able to judge whether the goal of increasing Mrs. Jones' weight has been achieved over a period of time.

In addition to looking at individual outcomes, PDS will be able to assist AAAs in tracking program-wide progress. For instance, one of the desired outcomes of the Elderly Nutrition Program may be to help older people in stabilizing weight and coming into healthy Body Mass Index (BMI) levels. If that is the case, PDS will be modified to enable the AAA to create special reports to review information collected over time on how many overweight and underweight individuals receiving HDMs stabilized their weights and/or achieved healthier BMIs.

More information on creating outcome reports using PDS will be made available as more specific methods for measuring outcomes are developed.

Question #16: What happens in terms of CAARS Reporting and PDS at the end of a State Fiscal Year (SFY)? That is, how will client data be transitioned from one year to the next? Will we have to "search and delete" in order to remove/archive clients who are no longer receiving services?

Answer #16: Because the PDS CAARS module first looks at whether a client ACTUALLY RECEIVED a service to determine who should be included in the quarterly report, it is not necessary to "start over" with a new database. Clients who have died, moved or are otherwise terminated can remain in the active database, or they can be archived after the end of the SFY in which they were last served to insure that they are counted properly during that last year.

Question #17: Can assessments and reassessments be charged under SNAP and IIIC-2 and how does this get reported?

Answer #17: Both SNAP and Title IIIC-2 have always been able to pay for the conduct of client assessments and reassessments. This continues to be true with the implementation of the MDS. However, there is a difference when it comes to reporting the activity. As noted in 97-PI-20, as of April, 1997, the case management cell in the CAARS quarterly report was opened under SNAP to allow AAAs to report assessment and reassessment activities, as well as expenditures, under the case management category, separate from the actual meal. (Please note that clients are not reported. Also, ongoing case management is not an allowable activity and cannot be charged or reported under SNAP.)

We are hoping to do the same thing for Title IIIC-2. However, we have not yet received approval from the Administration on Aging (AoA). In the meantime, AAAs using Title IIIC-2 to conduct client assessments and reassessments must include these costs as part of the meal costs. The actual activity does not generate any units that get reported to SOFA.

Question #18: How do we charge and report the costs of inputting client data from a paper assessment into an electronic data system?

Answer #18: The costs of inputting the client data should be charged to and reported under the same service and funding stream as the assessment.

In the context of the previous question regarding the charging and reporting of assessments when the client is receiving home delivered meals and not case management:

- If the client is/will be receiving a SNAP-funded home delivered meal only (i.e., and not case management also), the costs for inputting the client data should be charged to case management (since that is where the assessment costs and time are reported) and the activity supports the assessment. The time it takes to input the data is not to be translated and reported as units.

- If the client is/will be receiving a IIIC-2-funded home delivered meal only (i.e., and not case management also), the costs for inputting the client data should be charged to home delivered meals (since that is where the assessment costs and time are reported because we do not yet have permission from AoA to open up the assessment cell) and the activity supports the assessment. Here too, the time it takes to input the data is not be to be reported as units.

If the client is/will be receiving case management, the costs for inputting the client data should be charged to case management

under the appropriate funding stream, (e.g. Title IIIB, EISEP, CSE) (since that is where the assessment costs and time are reported) and the activity supports case management. Here too, the time it takes to input the data is not to be reported as units.

Alternatively, and applicable in all three instances, since the inputting of client information is a support activity, the AAA could choose to charge and report these costs under program administration/implementation instead.

Question #19: How should an AAA report six-month contacts for HDM clients who do not receive case management?

Answer #19: Actually, this contact is not reported to SOFA. Six-month contacts for HDM clients who do not receive case management are performed to ensure that client needs are being addressed and that the client continues to be eligible for the program. These contacts are considered part of the HDM service and, as such, are not reported as a separate unit from the meal. As noted in 97-IM-32 Minimum Data Set Questions and Answers #1, Page 4, Question #1, the six-month contact must be documented.