



Level of Care Determination

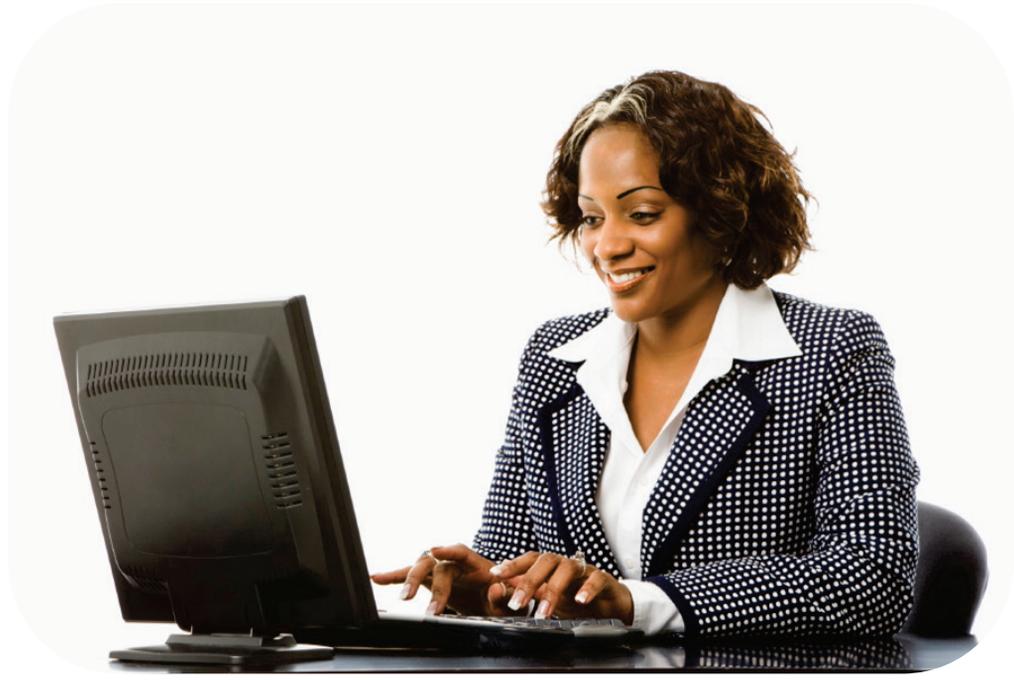


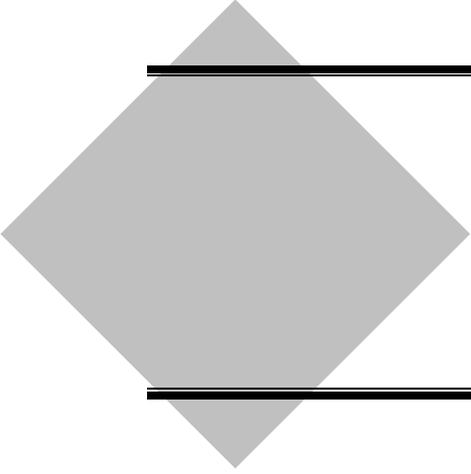


Table of Contents

Introduction.....	1
Course Description and Goals	2
Level of Care Definition	3
Level of Care Definition Overview	4
Guidelines When Determining the Level of Care	5
Tools for Conducting an Assessment	15
Conducting an Assessment	16
Boston University Assessor Training Modules	17
Assessor Roles and Responsibilities	19
Assessment Activity	20
Supervisor Roles and Responsibilities.....	27
Supervisor’s Responsibilities.....	28
Quality Assurance.....	37
Level of Care Determination Form.....	41
Overview of the LCD Form.....	42
Summary of What’s New and What’s Changed.....	56
Supervisor’s Role during Assessor Webinar	59
Supervisor’s Role during the Assessor Webinar	60
Resources	61
OBRA Target Assessments	62
OLTL Bulletin 55-12-03.....	65
Exhibit C Settlement Mosely vs. Alexander.....	69
Accessing the Boston University Center for Aging and Disability Education and Research Online Curricula	79
Mandatory Activities and Referrals.....	81
Mandatory Journal Topics	85
SAMS_80 Training Database	87
Custom Searches and Dashboard.....	89

Level of Care Determination

Quality and Compliance Unit Regions	93
On-Site Level of Care Monitoring Tool	95
SAMS Reports	97
Instructions for Completing the Level of Care Determination (LCD) Tool.....	99
Appendix.....	139
Level of Care Definition Case Study Key	140
Acknowledgements.....	146



Introduction

Course Description and Goals

Course Description

This course is designed to familiarize supervisors with the level of care definition, tools for conducting an assessment, assessor roles and responsibilities, supervisor roles and responsibilities, and the Level of Care Determination Form.

Course Goals

- ❖ Review the Level of Care Definition and important guidelines for determining the level of care.
- ❖ Discuss the tools needed to conduct an assessment.
- ❖ Review the role and responsibilities of the assessor in determining the level of care, the completion of the Level of Care Determination Form and quality assurance measures.
- ❖ Review the role of the supervisor and their responsibilities in the completion of level of care assessments, the determination of level of care and quality assurance.
- ❖ Review the new Level of Care Determination Form and instructions for completion.
- ❖ Describe the supervisor's role during the assessor training webinars.



Level of Care Definition

Level of Care Definition Overview

Under Federal and State laws and regulations, which identify the Level of Care provided in a Nursing Facility, an individual should be considered Nursing Facility Clinically Eligible (NFCE) if the following criteria are met:

<p>1. The individual has an illness, injury, disability or medical condition diagnosed by a physician, and</p>	<p>2. 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</p>
NFCE	
<p>3. A physician certifies that the individual is NFCE, and</p> <p><i>The physician's certification (MA-51 or Script) is required as part of the determination process and is used by the assessor in making a determination regarding NFCE. The certification, in and of itself, is not the final determination.</i></p>	<p>4. The care and services are either:</p> <ul style="list-style-type: none">• 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.• 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 through medical and technical personnel.

Guidelines When Determining the Level of Care

- ❖ Important criteria for determining the Level of Care
 - The individual has a diagnosis that requires treatment.
 - The individual's diagnosis and treatment impact his/her physical and/or psychological ability to manage their own care.
 - The individual's ability affects managing their care, treatments, and interventions.
 - If the individual has a diagnosis of Alzheimer's disease, dementia, traumatic brain injury, or other mental health diagnosis, the Level of Care is based on the degree to which psychological problems are affecting the individual's functioning and the ability of that individual to maintain himself or herself in their environment.
 - Deficits in Activities of Daily Living (ADLs) alone will not meet the criteria for NFCE.
 - The individual must have a medical condition that is “currently being treated” and creates a medical need that requires care and services of a health care professional.
 - Deficits in Instrumental Activities of Daily Living (IADLs) alone will not meet the criteria for NFCE.
 - The ability to perform IADL tasks can help an assessor determine the impact of physical and mental impairments, since performance of these tasks requires a combination of memory, judgment and physical ability.

- ❖ Focus on the Level of Care required (not Locus of Care)
 - An individual who is assessed in a hospital or nursing facility may present well because they are receiving total care.
 - The reverse may also be true. Because care is being provided, they are not doing what they may be capable of doing.
 - Assessors must review hospital charts/nursing facility charts, and talk with hospital staff and family members.

Level of Care Definition

- ❖ Gather information from various resources, including:
 - Medical information
 - Direct observation
 - Demonstration of ADLs and IADLs
 - Information from family and informal supports
 - Input from the primary care physician (as needed)

**The Level of Care Determination is not just a self-report
from the individual or family.**

- ❖ Documentation must include:
 - Summary of the assessor's direct observations
 - Summary of the assessor's professional judgments and conclusions
 - The basis for the judgments and conclusions that substantiate the Level of Care Determination

Level of Care Definition



Review and consider the following case studies with your small group. Record your thoughts as you discuss each case study.

Case Study #1 — Sally

Sally is a 50 year old female diagnosed with cerebral palsy. She has generalized muscular weakness and tremors (tremors and spasticity are more prevalent in upper extremities) and acid reflux. As a result of these conditions, she requires monitoring of skin for signs and development of breakdown. Sally also requires oversight, administration and monitoring for adverse side effects of medications ordered by the physician, including over-the-counter medications and supplements for pain and discomfort. Sally requires hands-on assistance with all ADLs, including bathing, dressing, transferring, and toileting. She is unable to ambulate without hands-on assistance and a walker, but usually utilizes a wheelchair which must be propelled for her. She is functionally incontinent of bowel and bladder due to mobility issues and unable to assist with personal hygiene if an incontinent episode occurs. Sally is unable to complete any IADLs without maximum hands-on assistance or total assistance.

What is the Level of Care Determination?	
What is this determination based on?	

Level of Care Definition

Case Study #2 — John

John is a 62 year old male diagnosed with poor vision, hard of hearing (HOH), history of left hip fracture, edema in his feet, gastro-esophageal reflux disease (GERD), hyperthyroidism and anxiety disorder. He requires the use of a walker when ambulating and is able to self-transfer with the use of an assistive device. John requires hands-on assistance with washing his back and hair. He is able to independently dress himself and will usually wear clothing items that do not require being pulled over his head. John requires assistance with completing laundry, as he cannot carry more than 10 pounds. He also requires assistance with grocery shopping. John is able to cook for himself and has an adaptive kitchen to address visual impairment. He manages his own medication that is pre-poured by the pharmacy in blister packs. John is alert and oriented to person, place and time and he is able to make his needs known and is able to make his own medical decisions.

What is the Level of Care Determination?	
What is this determination based on?	

Level of Care Definition

Case Study #3 — Josephine

Josephine is an 80 year old female diagnosed with dementia and arthritis in both knees. She is oriented to self and occasionally to other familiar persons only. She confuses names and the relationship of others to herself. Josephine requires monitoring of all bodily functions due to an inability to recognize impairments. She also requires monitoring of diet, encouragement to elevate lower extremities and monitoring of pain levels and complications due to pain levels in her knees. Josephine requires hands-on assistance with all ADLs. Her increased frequency of urinary incontinence, due to impaired gait and increased confusion, requires assistance 3 to 4 times per day. Josephine requires all medications to be administered. She has difficulty making her needs known and is reported and observed to be disoriented and unable to follow simple requests. Josephine requires all foods to be soft in texture to ease swallowing. She must be fed and cued to chew and swallow. She requires hands-on assistance and cueing to ambulate with a walker for a short distance inside and uses a wheelchair that needs to be maneuvered for her when outside the home. Josephine is unable to climb stairs.

What is the Level of Care Determination?	
What is this determination based on?	

Level of Care Definition

Case Study #4 — Carl

Carl is a 67 year old male and has been diagnosed with asthma, gastro-esophageal reflux disease (GERD), osteoarthritis, and severe burning in his feet. He is independent with all ADLs, but it takes a long time for bathing, dressing, and grooming due to the osteoarthritis and burning in his feet. Carl also has great difficulty getting into and out of the shower. He requires the use of a cane when ambulating indoors and outdoors. Carl is able to prepare his own meals, but it takes him a long time. He has difficulty completing his laundry. Carl requires assistance with shopping and is unable to do housework. He is able to manage his own medications, with the exception of assistance with set-up.

What is the Level of Care Determination?	
What is this determination based on?	

Level of Care Definition

Case Study #5 — Mary

Mary is an 83 year old female on dialysis 3 times a week for end stage renal disease. Dialysis leaves Mary very weak. She is retaining fluid in her legs and needs monitoring of her intake and output. She is beginning to show an onset of dementia. She requires hands-on assistance with bathing and dressing. Limited assistance is required with grooming and toileting. She is continent of bowel and bladder. Her mobility is limited due to weakness in her lower limbs. She has fallen 3 times in the past 6 months. One fall required a trip to the Emergency Room but no hospital admission. She is not bedbound but does need assistive devices for mobility. She does not walk outdoors due to her instability and weakness. She cannot perform any IADLs except money management and use of the telephone due to her weakened state. She requires set-up and verbal reminders for medications.

What is the Level of Care Determination?	
What is this determination based on?	

Level of Care Definition

Case Study #6 — Jason

Jason is a 23 year old male who was injured in a motorcycle accident in September 2005 that resulted in a diagnosis of traumatic brain injury (TBI). He has basilar skull fracture with intracranial hemorrhage and subarachnoid hemorrhage. He suffers from ambulatory dysfunction due to episodes of tingling and faint sensation when attempting to maneuver his lower extremities. He has a history of blood clots, depression and cognitive impairment as a result of the TBI. He is able to bathe, dress and groom but requires constant cueing. Jason can use the toilet himself. He is sometimes incontinent of bladder and needs some assistance with continence products. He is currently being re-trained in performing IADLs. Jason requires monitoring of medications for signs and symptoms. He can identify his medications only by color. However, if there is a change in his medication, he requires repeated explanations as to what he takes and what it is for. Therefore, he requires set-up and reminders for medication management.

What is the Level of Care Determination?	
What is this determination based on?	

Level of Care Definition

Case Study #7 — Jane

Jane is a 92 year old female diagnosed with high blood pressure, congestive heart failure, and edema which is currently being treated with diuretics. She experiences shortness of breath upon exertion, as well as a thyroid condition, bleeding ulcer, and severe back pain due to arthritis and osteoporosis. She has been diagnosed with Diabetes Mellitus Type II, macular degeneration and dementia. Jane can sponge bathe with set-up but cannot get into the shower or tub due to her back pain. She requires total assistance with getting into the tub. She dresses slowly with set-up and has to rest periodically due to her shortness of breath. She is unable to groom because of pain in her arms from arthritis. She requires assistance with all IADLs, except for telephone and money management. Her mobility is fragile when she walks with a walker. She has fallen twice in the last 6 months and suffered a broken hip. She cannot ambulate alone outdoors because she complains of dizziness and fear of falling. She requires set-up and reminders to take her medications.

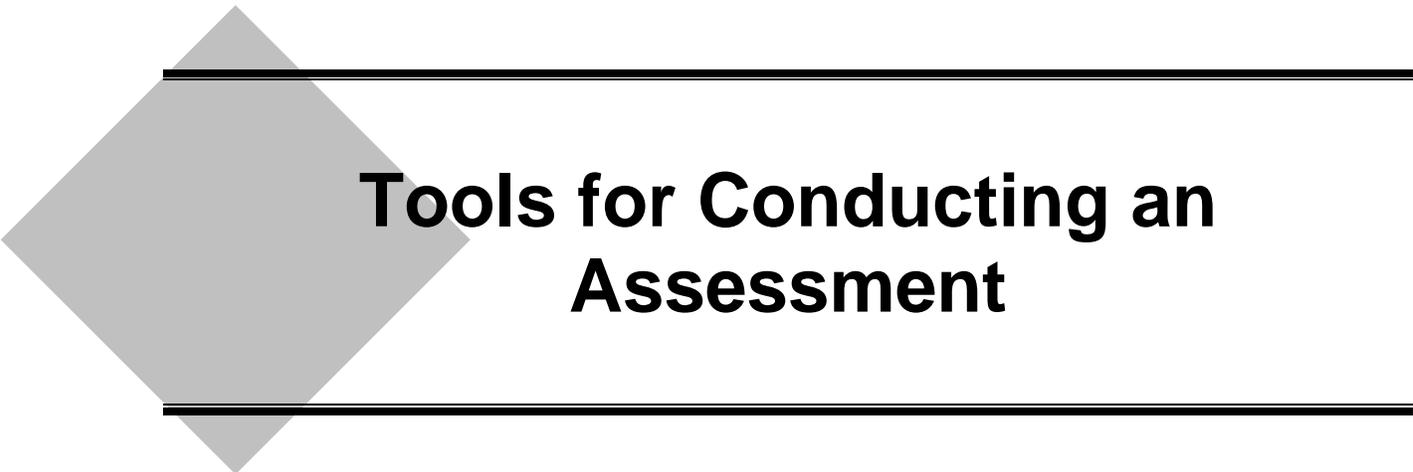
What is the Level of Care Determination?	
What is this determination based on?	

Level of Care Definition

Case Study #8 — Jake

Jake is a 60 year old male and has been diagnosed with severe depression, gastro-esophageal reflux disease, and congestive heart failure. He is alert and oriented. He has been evaluated for signs of early dementia, for which the results were negative. He is ambulatory and requires no assistance with mobility but occasionally requires total assistance with ADLs and IADLs. He is physically capable of preparing meals but does not do it. He frequently spends long periods of time in bed due to his depression and wants limited contact with others. However, infrequently and on a good day, he is physically capable of performing most tasks with cueing and coaxing. He still occasionally drives his car. Generally, he is able to manage medications unless his depression interferes with that ability. He has had in-patient psychiatric treatment once in the past year and requires adjustment in psychiatric medications from time to time.

What is the Level of Care Determination?	
What is this determination based on?	



Tools for Conducting an Assessment

Conducting an Assessment

Conducting an Assessment

- ❖ Use all of your senses
- ❖ Use your laptop onsite
- ❖ Engage the individual
- ❖ Gather information from resources, including:
 - Formal and informal supports
 - Medical resources
 - Direct observation
- ❖ Assess functional ability based on individual capability
- ❖ Know when to use consultants
- ❖ Understand executive functions. Executive functions:
 - Refer to a set of mental skills that are coordinated in the brain's frontal lobes
 - Work together to help a person achieve goals
 - Include the abilities to:
 - Manage time and attention
 - Switch focus
 - Plan and organize
 - Remember details
 - Curb inappropriate speech or behavior
 - Integrate past experience with present action
 - Anticipate outcomes and adapt to changing situations
 - Form concepts and think abstractly

Boston University Assessor Training Modules

The Boston University Assessor Training Modules are available to assist assessors with important assessment concepts. Below is a list of topics, their description and the estimated time for completion.

Overview and Time Frames

Estimated Time for Completion	Title	Description
5 min	Domains of an Assessment	Brief Introduction and Overview of the following modules
5 min	Sources of Information	Discussion of information gathering and the utilization of all available sources
15 min	Physical Health Status	Overview of physical health impacting functional ability, individual pain response and methods for obtaining physical health status
5 min	Medications and Drug Use	Information and illustration regarding how medications and/or drug use may impact an individual and methods for obtaining medication usage information
10 min	Cognitive Assessment	Introduction to the Mental Status Exam and overview of necessary executive functions for independent living
10 min	Psychological and Emotional Health Assessment	Overview of how individuals are affected by their mental and emotional health, life changes that may affect functional ability and general overview of mental health diagnosis
10 min	Psychosocial Status	Review of psycho-social elements specific to adults and discussion regarding the availability of and the need for emotional and social supports
10 min	Social Supports Network	Discussion and methodology for obtaining information regarding informal support systems and assessing the impact of support systems on an individual

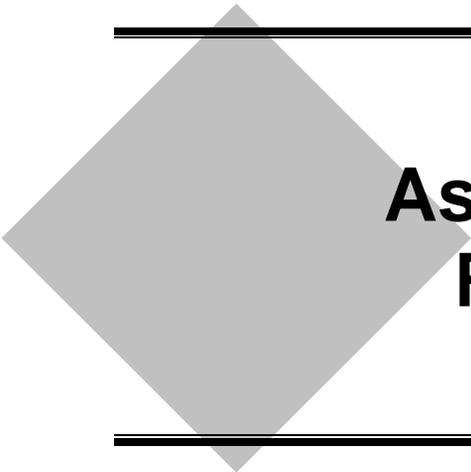
Tools for Conducting an Assessment

Estimated Time for Completion	Title	Description
15 min	Abuse and Neglect	Information regarding definitions and symptoms of abuse, assessing safety issues and review of available questionnaires
10 min	Role of Social Service Assessor	An examination of the skills necessary for completing an assessment in partnership with an individual
10 min	Skills	Information regarding the use of self-reflection and self-evaluation to identify current skill level
20 min	Conducting an Assessment	Overview of the assessment process including important tips for establishing trust and dialogue
5 min	Empathy and Sympathy	Review of definitions as they relate to the role of an assessor
15 min	Concluding an Assessment	A general overview for concluding an assessment that illustrates the impact on relationship building and future working relationships
15 min	Factors in Assessment	Review of critical assessment skills, such as addressing cultural barriers
15 min	Abuse, Neglect and Self Neglect	Further review of abuse, neglect and self-neglect to include information regarding suicide
30 min	Informed Consent, Privacy and Confidentiality and Advanced Care Directives	Overview of the legal and ethical requirements as they relate to the assessor and occur throughout the assessment process
Total Time	3 hrs. 25 min	

***See Resources section for additional information about accessing the Boston University Training Modules.*



In addition to the identified areas in the Boston University Training Modules, what other training would benefit an assessor?



Assessor Roles and Responsibilities

Assessment Activity

Pre-Assessment Activity

- ❖ When scheduling an assessment with the individual:
 - Gather basic information that will be helpful in providing insight as to the individual's current health status
 - Explain to the individual the purpose of the LCD
 - Advise the individual of informed consent
 - Assure the individual of privacy and confidentiality requirements when obtaining information necessary for completing the assessment
 - Consider various resources, such as formal and informal support systems, that may be utilized to complete an accurate assessment if cognitive impairment is apparent
- ❖ Utilize information from referral sources in the LCD prior to conducting the assessment
- ❖ Evaluate the assessment environment, including:
 - Access
 - Parking
 - Safety
 - Pets

Assessor Roles and Responsibilities

Conducting the Assessment

- ❖ As part of conducting the assessment, the assessor should engage the individual in every aspect of the completion of the LCD. It should first be discussed that the information gathered through the assessment is entered into a laptop for accuracy. It is important for the assessor to discuss with the individual the importance and content of the LCD for purposes of determining the appropriate level of care. It should also be emphasized that the level of care is in turn vital for those who will receive long-term care services.
- ❖ When the assessor and individual are actively engaged in the process, it is important for the assessor to recognize the individual's personality. This aids the assessor in how to proceed with questions and conversations during the assessment. The assessor also needs to understand the individual's needs as it pertains to education, culture, religious/spiritual beliefs, and any life-changing event that occurred in the individual's life. These may become apparent to the assessor in the initial stages of the assessment process or later in the process. Nevertheless, the assessor needs to be cognizant of these issues.

Components of the Assessment

- ❖ **Cognitive Assessment** is relevant to determine the individual's cognitive ability to respond appropriately to questions. This can impact the accuracy of the LCD as it pertains to the individual's knowledge base to report on their medical conditions, treatments, and how they function. At this point in the assessment process, the assessor will need to explore formal and informal supports.
- ❖ **Physical Health Status** is important for the assessor to understand the individual's medical conditions and treatments and their impact on the functions of daily living. It is the medical condition or prescription that may offer insight on the individual's diagnosis and treatment. Therefore, it could serve as a basis for further evaluation and probing.
- ❖ **Medications and Drug Use** is very critical to the individual's well-being, not only for purposes of knowing medications used and how they are taken but also for drug interactions/allergies that they may have encountered. It is also critical for the assessor to understand whether or not the individual has an understanding of managing their medications.
- ❖ **Supports** are important for the assessor to understand the individual's entire social support system including formal, informal and extended community involvement.
- ❖ **Abuse and Neglect** of an individual is very important in the assessment process. The assessor must be able to identify signs and symptoms of physical and emotional abuse. They must also understand the laws and requirements of reporting.

Assessor Roles and Responsibilities

Concluding the Assessment

- ❖ Conclusion of an assessment is necessary for summarizing the information obtained in the face-to-face assessment. It involves asking the individual if they have any questions pertaining to the assessment process and communicating what the individual can expect to happen next as part of the process.
- ❖ Four fundamental steps necessary for closing an assessment:
 - Summarize the assessment and discuss agreed-upon tasks, progress made, and goals
 - Indicate that you are open for questions
 - Provide an opportunity for feedback
 - Communicate the next steps and confirm contact information
- ❖ Five key guidelines of informed consent:
 - The language used to explain an assessment must be clear, unambiguous, and in the individual's natural language.
 - The details of any proposed treatment or plan must be spelled out, including the possible risks and the probable benefits.
 - Assessors must be satisfied that the individual understands the information. This means not speaking in professional jargon, or assuming that individuals understand technical language or acronyms.
 - Consent must be in writing, using appropriate agency forms.
 - Consent must be made willingly and not as a result of coercion.

Gathering All Appropriate Ancillary Paperwork

- ❖ There are various documents that are not affiliated within the SAMS database but are required to be kept in printed format. Some of these documents are:
 - MA51/Script
 - Release of Information forms
 - Medical documents that may be acquired from a physician, hospital, or nursing facility
 - Required components for the OBRA process; such as the ID Screen, PASRR Evaluation Form, Transmittal Form and all documentation provided by physicians, psychiatrist/psychologist, mental health agencies, etc.

Assessor Roles and Responsibilities

Determination of the Level of Care

- ❖ Gather input from the supervisor and registered nurse (when appropriate)
 - The RN is used for all NFCE determinations and when the assessor is struggling with making a level of care determination. At any time, the RN may be asked to make a face-to-face visit with the individual.
 - The supervisor reviews all assessments and is the last to sign off on the LCD when all are in agreement with the level of care determination.
- ❖ Use consultants available to AAA
 - Primary Care Physician
 - AAA Consulting Physician
 - Quality and Compliance Specialist(QCS)
 - OLTL/PDA Chief Medical Officer

Documentation

- ❖ Ensure completion of the LCD in OMNIA
 - The assessor must be consistent and clear in their documentation.
 - The information provided in the tool must also be consistent with information documented in Section 12.A #4 and Section 12.B. Both sections reflect the assessment narrative that summarizes the information documented in the tool.
- ❖ Ensure completion of required SAMS entries
 - SAMS entries consist of Activities/Referrals and Journal Entries. They are critical because they guide the reader through the process and time frames and convey any documentation of obstacles that may have occurred and impacted assessment requirements.
 - A reference guide of Mandatory Activities/Referrals is included in the Resources section. Assessors are not limited to this list and can use any other Activity/Referral topic.
- ❖ All LCDs are to be recorded under the Non Care-Managed Care Enrollment, except those that are completed as Annual Re-certifications for active Aging Waiver Participants.

Assessor Roles and Responsibilities

Mandatory Activities and Referrals

Mandatory	Description	Service	Care Program	Status to be used	Due Date
Date of Assessment	The date that the face-to-face visit must occur	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Waiver recertification	<ul style="list-style-type: none"> - Not Started - Scheduled - In Progress - Completed - Cancelled 	Due date is 7 calendar days from the date of Referral as noted in the Journal
RN LCD Review (Level of Care)	The date that the RN must review and sign off. This date should be equal to or less than the date level of care determined.	LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Wavier recertification	<ul style="list-style-type: none"> - Not Started - Scheduled - In Progress - Completed - Cancelled 	
Supervisor LCD Review (Level of Care Assessment)	The date that the Supervisor must review and sign off. This date should be equal to or less than the date level of care determined.	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed	<ul style="list-style-type: none"> - Not Started - Scheduled - In Progress - Completed - Cancelled 	
Date Level of Care Determined	The date that the level of care must be completed	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Wavier	<ul style="list-style-type: none"> - Not Started - Scheduled - In Progress 	

***See Resources section for more about Mandatory Activities and Referrals information.*

Assessor Roles and Responsibilities

Mandatory Journal Topics

Mandatory Topic	Description	What is to be documented – any acronyms used need to be universally understood
Referral	The date that an individual or someone on behalf of an individual makes contact with the AAA requesting an assessment from the AAA via phone, fax, e-mail or in person	The name of the person making the referral, pertinent information provided, purpose of referral if given, method of referral received
Contact Consumer Contact Family Contact Other	The date that the contact occurred	Journal should indicate what took place during the contact and the type of contact, phone, e-mail, etc. It should also include the person who was contacted, purpose of contact, what occurred during contact and any follow up. *Documentation of these contacts with the consumer/Family and Other is required for reporting compliance with the Mosley settlement requirements.
Request Medical* (If applicable)	The date the medical information was requested	The Journal note should include where and in what format the medical was requested
Date of Assessment	The date the assessment occurred (face to face visit)	The Journal note should include where and who was present for the assessment and any other pertinent information that was presented or exchanged during the visit that

**See Resources section for additional information about Mandatory Journal Topics.*

Assessor Roles and Responsibilities

Completion of Journal Entries

- ❖ Complete a journal entry not only when contact is required for a specific program, but each time there is contact throughout the life of the case
- ❖ Document all ongoing contacts and interactions with, for, or about an individual
- ❖ Use concise and accurate language
- ❖ Clearly distinguish between facts, observations, and opinions
- ❖ Do not use acronyms or abbreviations — Each entry should be able to be understood by all readers.
- ❖ Do not duplicate Journal entries and an Activity and Referral (A&R)
 - Because A&Rs can be edited, any detailed information needs to be documented in a journal note.
 - The journal entry must have the same title as the A&R.
 - The comment box of the A&R must refer the reader to the journal.



What other identified roles and responsibilities do you have for your assessors?



Supervisor Roles and Responsibilities

Supervisor's Responsibilities

Hiring and Training

- ❖ Hiring — Follow local and state requirements regarding assessor qualifications.
 - Level of Care Determinations conducted in AAAs who are part of county government and hire staff through the State Civil Service system must be completed, reviewed and signed off as required by one of the following Civil Service Job classifications.
 - Aging Program Assessor
 - Aging Care Manager 1, 2 or Aging Care Manager 3
 - Aging Care Management Supervisor 1, 2 or 3
 - Community Health Nurse 1 or 2

MET requirements for these classifications are available on the Civil Service website. They will also be placed on the PDA website when the Level of Care Chapter of the Aging Service Policy and Procedure Manual is issued.

- Determinations conducted in AAAs that do not use the PA State Civil Service system and complete, review and sign off on LCDs must meet the METs of the positions listed above. No waivers of MET requirements will be entertained by the Department.

All questions relative to the substitution of “related” education for the required experience or appropriate experience for the required education should be directed to the Department of Aging, Human Resource Division.

- ❖ Training
 - Review policy and procedures
 - Utilize the Boston University Training Modules
 - Assess understanding of the aging process (major illnesses and health conditions)
 - Review and familiarize assessor with forms and tools related to assessment
 - Examine the Level of Care Definition
 - Offer other available training (including PS principles)
 - Provide ongoing enrichment activities
 - Include SAMS and OMNIA training

Supervisor Roles and Responsibilities

❖ SAMS_80 Training Database

- Available to all SAMS users
- Contains no consumer information — All records and names are fictional.
- Is a learning tool — You cannot break anything!

***See Resources section for additional information about the SAMS_80 Training Database.*

Assignment and Tracking

❖ System for supervisor to track assessments

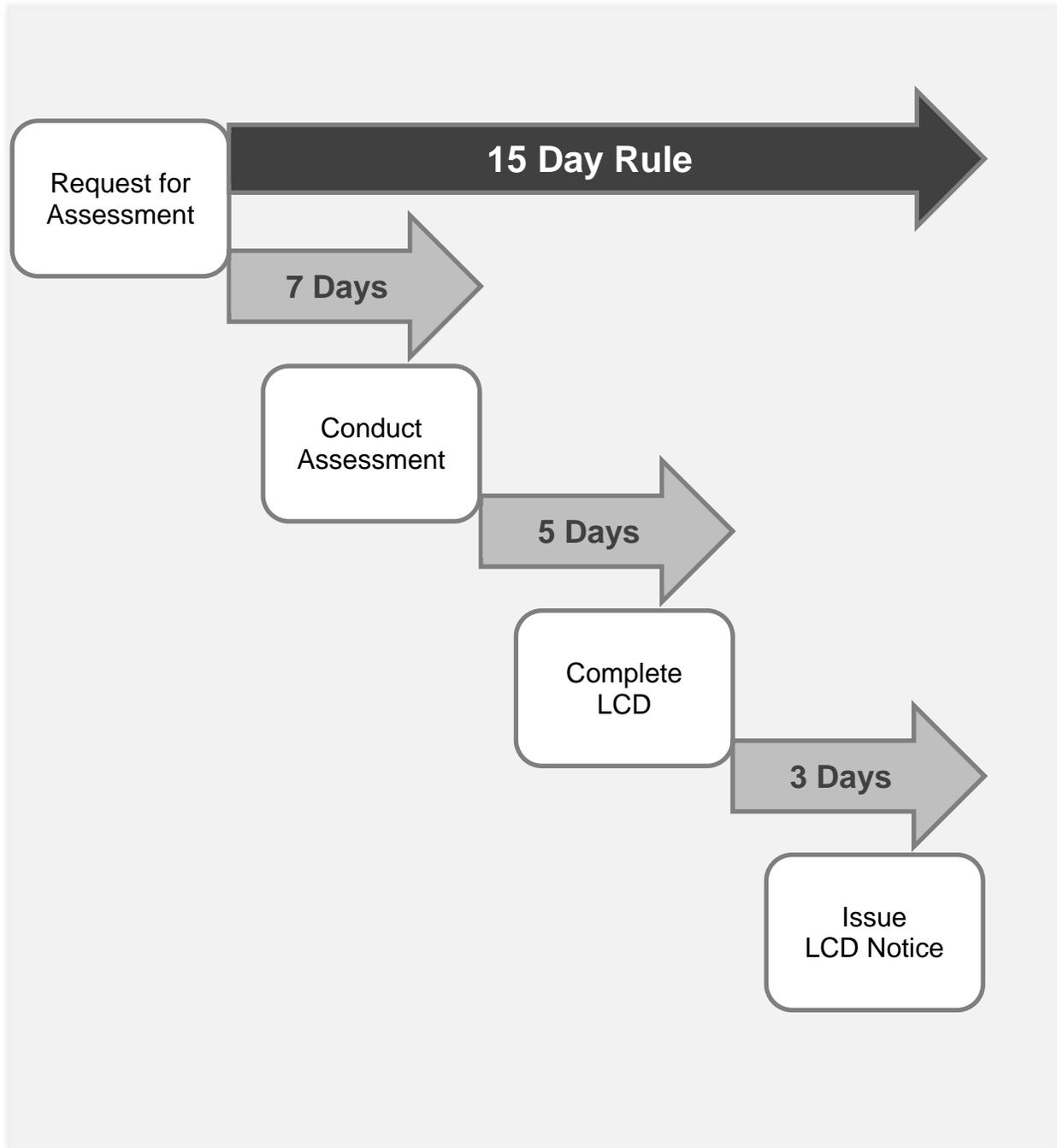
❖ Custom Searches and Dashboards

- Custom Search
 - Use the Custom Search feature in SAMS to create a report, generated by a completed Activity and Referral, to show on your Dashboard
 - Create a Custom Search from scratch or use a current Custom Search and tailor it for your specific use by simply changing its parameters, renaming it, and altering description and comments to suit your needs
 - Create a Custom Search to report information regarding all the assessors in the unit
 - Assessors can filter the Custom Search to show only their information
- Dashboards can be used for monitoring:
 - Scheduling
 - Time Management
 - Caseload Management
 - Quality Management and Improvement

***See Resources section for additional information about Custom Searches and Dashboards.*

Supervisor Roles and Responsibilities

15-Day Time Frame for Assessments Example



Supervisor Roles and Responsibilities

Level of Care Determination Time Frames

Time frames for Level of Care determinations have been impacted by the Mosley settlement. Though there are specific steps and processes that are required for individuals referred to the AAA by the Independent Enrollment Broker (IEB) (See OLTL Bulletin 55-12-03 in the *Resources* section), a 15-day time frame is required for ALL assessments.

- ❖ To meet the 15-day time frame, it is suggested that:
 - The AAA takes no more than 7 calendar days from the date of the request (phone, mail, fax, or in-person) for an assessment to conduct the face-to-face visit.

An MA-51/Rx is not required before this face-to-face visit occurs.

- The AAA completes the LCD within 5 calendar days from the face-to-face visit if the MA-51/Rx is in hand or within 5 calendar days from receipt of an MA-51/Rx.
 - Level of Care Determination Notice, (replaces Determination Report) is issued within 3 calendar days of completion of the LCD.
- ❖ Total number of days from date of request to issuance of Level of Care must not exceed **15** days.
 - ❖ Note: For OBRA assessments: **5** calendar days to completion of the LCD applies once all necessary supporting medical information, as identified on the Program Office submission checklist, is received. All OBRA target assessments require a level of care “recommendation” and all paperwork submitted to the appropriate State Program Office based on their target diagnosis.

Regardless of where the applicant is at the time of referral, the AAA will use professional judgment to evaluate an applicant’s specific circumstances in order to prioritize response time.

- ❖ For a level of care assessment to be deemed complete, the following must be met:
 - The assessor has completed the face-to-face determination of the individual.
 - The MA-51/prescription is received by the AAA.
 - The assessor has fully documented the LCD using all sources of information available as outlined above.
 - The assessor has completed detailed summary documentation for the Assessment Narrative in Section 12.B.
 - The AAA registered nurse and supervisor have reviewed, signed and dated the LCD.

Supervisor Roles and Responsibilities

Review Process

All LCDs must be reviewed in their entirety by the supervisor.

- ❖ The supervisor should assure that:
 - All sections of the LCD are completed
 - There are clear, supportive notes in the areas where required
 - All signatures and dates are completed
 - All of Section 12.B is completed and provides a detailed summary that supports an NFCE level of care determination
 - All required SAMS documentation (A&R and Journal entries) is completed

Other Supervisory Responsibilities

- ❖ Provide guidance and assistance to assessors with clarification for level of care
 - Arrange for a face-to-face visit of the individual (by supervisor or nurse) and/or consult with a physician (PCP or agency's physician consultant) when the assessor is uncertain of a level of care determination.

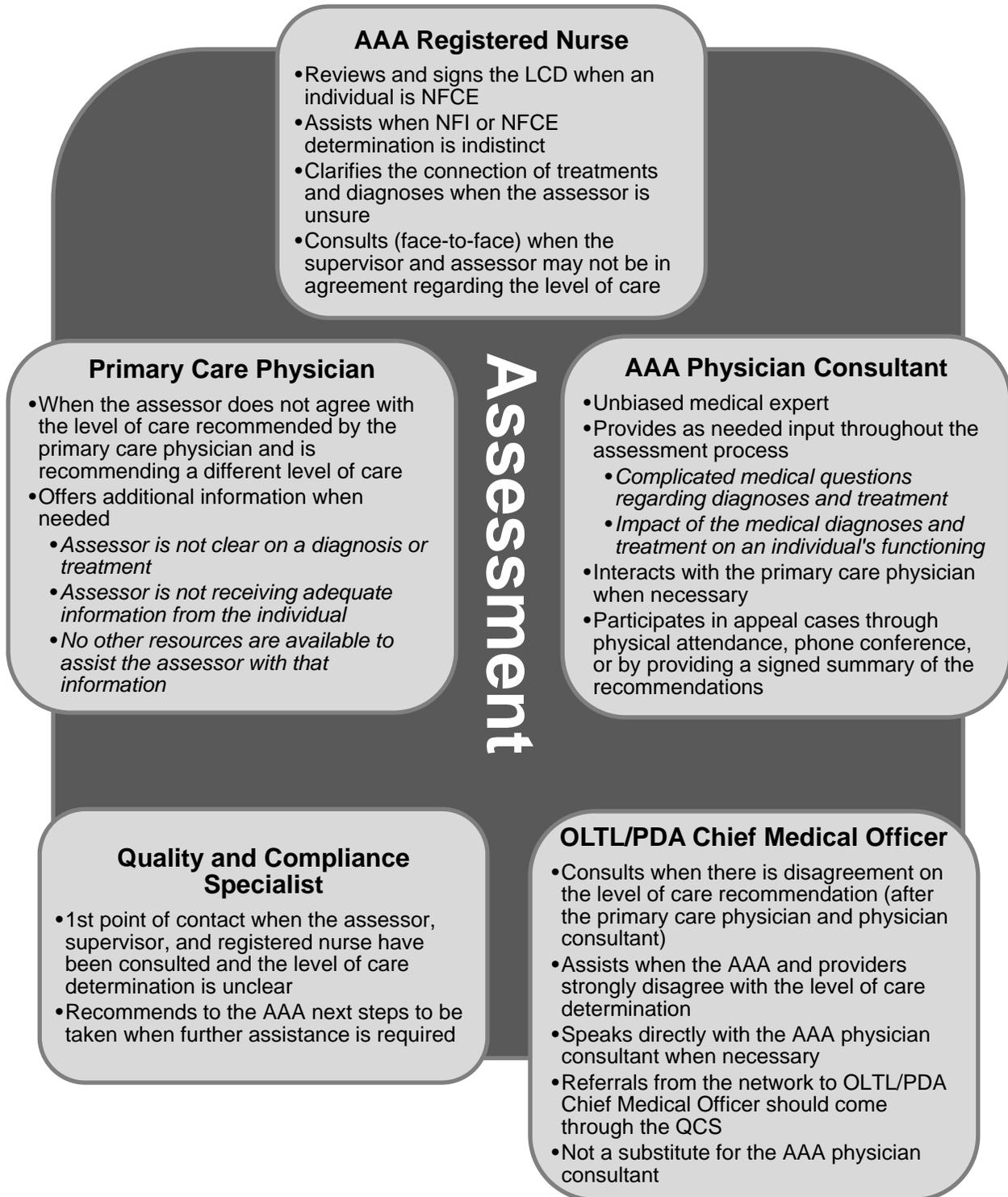


What other responsibilities related to assessment do you have for your agency?

Supervisor Roles and Responsibilities

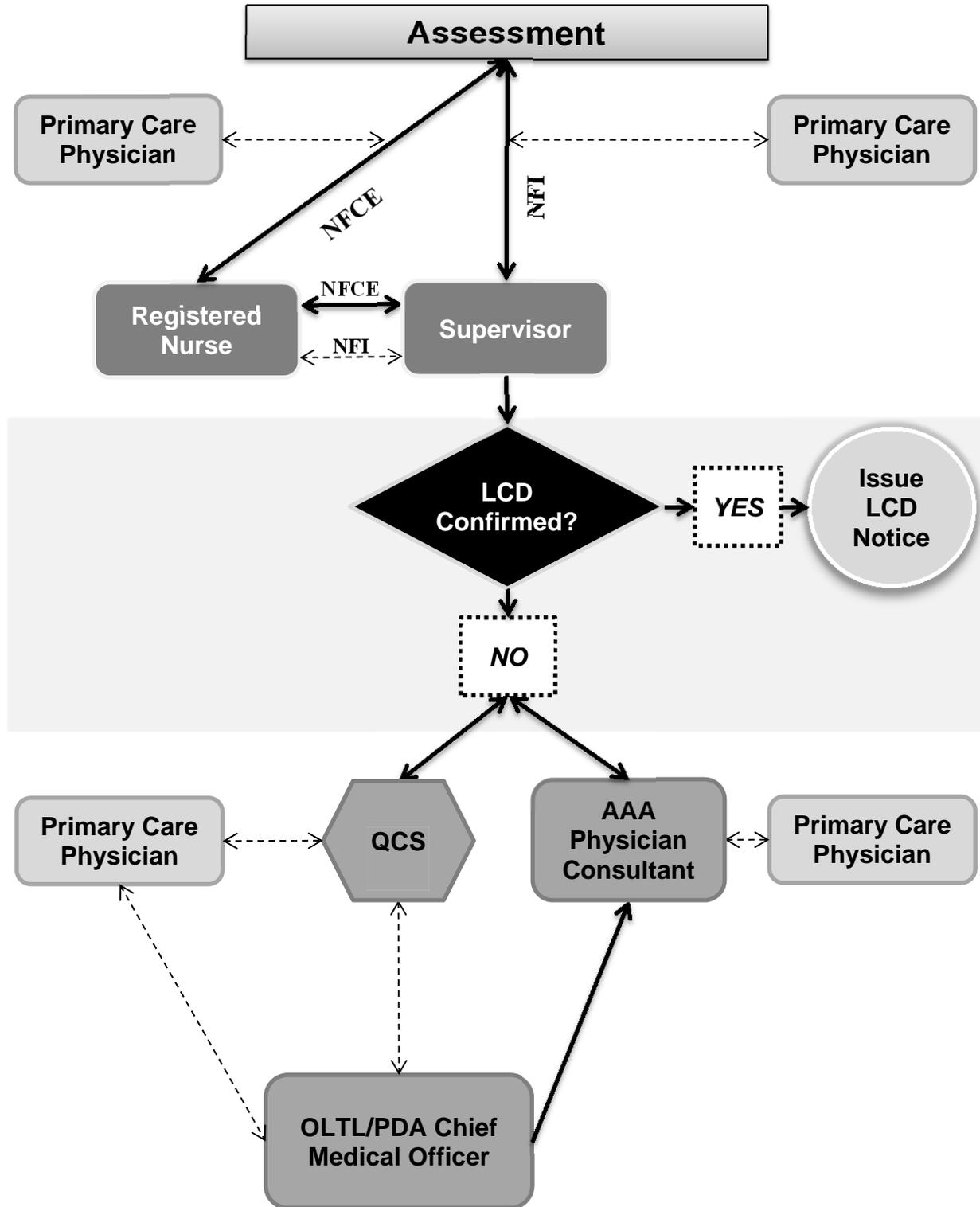
Use of Consultants

The AAA has consultants available to assist when making a level of care determination.



Supervisor Roles and Responsibilities

Assessment Protocol



Supervisor Roles and Responsibilities

PDA Monitoring of Level of Care

- ❖ The Department of Aging has administrative responsibility for the oversight of all Federal and State funding that is paid or allocated to the AAAs for the provision of level of care assessments. Monitoring of the Area Agencies on Aging for compliance with all policies and procedures set forth by the Department is conducted by the Quality and Compliance Division in the Bureau of Quality Assurance.
- ❖ The monitoring instrument is comprised of five (5) parts:
 - Time frame requirements
 - Level of Care Assessment quality contents
 - OBRA target requirements
 - Non-target requirements
 - PCH/Dom Care recertifications
- ❖ Cases are selected through various reports including but not limited to:
 - SAMS Reports for Initial/Change in Condition LCDs
 - PCH/Dom Care recertifications
 - Benchmark reports that contain statewide trends and averages
- ❖ Consumer records are reviewed electronically through SAMS/OMNIA prior to an on-site review.
- ❖ An exit interview is conducted to review the findings, provide recommendations and technical assistance and engage the agency in a collaborative discussion on program and system improvements.
- ❖ If the AAA is non-compliant in any of the requirements, the Quality and Compliance Specialist completes a “Statement of Findings” and issues the findings to the Agency. Any identified deficiencies require a CAP (Corrective Action Plan) from the agency which outlines what steps will be taken to correct the deficiency, what staff in the agency will be responsible for implementation, when the correction will be made, what the agency will do to develop a quality management process, which emphasizes ongoing quality assurance activities, to prevent further occurrences.

***See Resources section for the Quality & Compliance Specialist coverage area.*

Supervisor Roles and Responsibilities

On-site Level of Care Monitoring Tool

Level of Care Standards		
Time Frame Requirements		
The LCD was completed within 15 day time time frame		
If not within required time frames, there is documentation to support the reason in SAMS		
Based on OLTL Bulletin 55-12-03, the AAA completed LCD and submitted to the IEB in 15 days		
The AAA adhered to documentation required for delays in submission to the IEB in SAMS in accordance with the OLTL Bulletin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Level of Care Quality content review		
Physical Health		
Documentation		
Impact on LOC		
Medication Management		
Documentation		
Impact on LOC		
ADL		
Documentation		
Impact on LOC		
Mobility		
Documentation		

***See Resources section for the complete On-site Level of Care Monitoring Tool.*

Quality Assurance

Local Quality Assurance Practices



What quality assurance activities does your agency perform?



What does your quality assurance documentation look like?

Supervisor Roles and Responsibilities

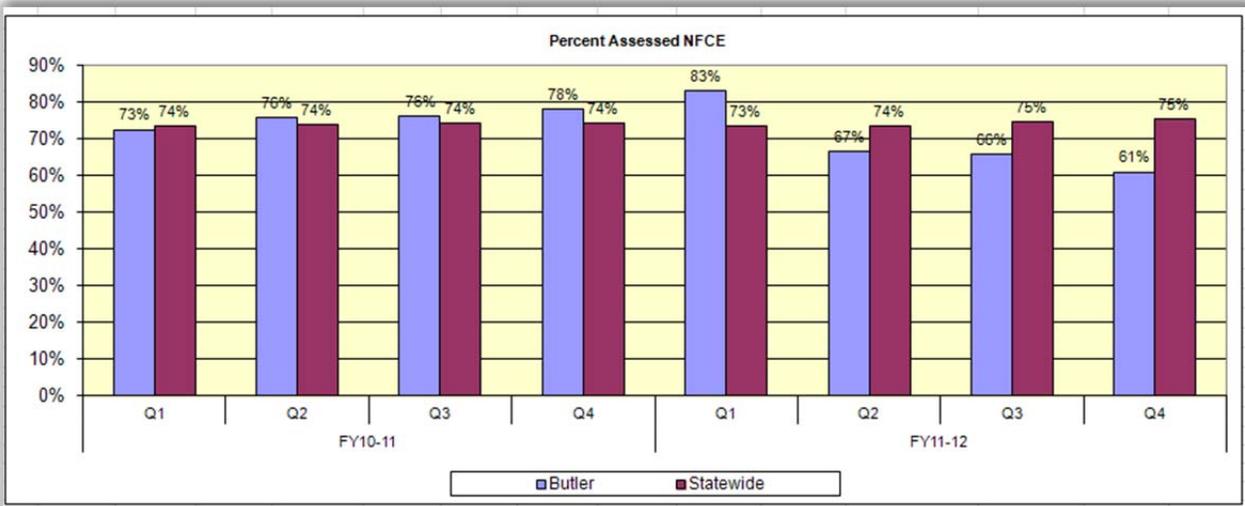
Assessment Benchmark Reports

Report	Information
Total Initial Assessments and NFCE Rates by AAA against statewide data	Gauge where the AAA NFCE rate is in relation to the statewide average Compare your rate with other AAAs of similar size <i>*In this report, some AAAs may be much higher or lower in comparison to the statewide average</i>
Assessments per 1,000 county residents	Collect for statistical purposes for all individuals assessed in the county
Age 60+ Assessments per 1,000 Assessments	Collect for statistical purposes
Age 85+ Assessments per 1,000 Assessments	Collect for statistical purposes
Assessment totals based on 4 quarters that include: <ul style="list-style-type: none"> • Community • Hospital • MH/MR Facility • Nursing Facility • PCH/Dom Care • Not identified 	Review how many assessments are completed in each location <i>*Example — it can signal that more individuals are being D/C to NF before assessment is completed</i>
Percent of assessments by ADL deficiency	
Percent of Initial assessments determined NFCE by AAA (All PSAs). <i>*All Assessment data is taken from OMNIA</i>	Compare this information to see if it matches what is in SAMS
NFCE Individuals with functional deficiencies in all reportable ADLs	

Supervisor Roles and Responsibilities

Total Initial Assessments and NFCE Rates by AAA against statewide data

Department of Aging and Office of Long-Term Living											
Assessment Report											
Based on Initial Assessments From Omnia											
1st Quarter FY 10-11 through 4th Quarter FY 11-12											
Butler											
Total Initial Assessments and NFCE Rate											
FY10-11					FY11-12						
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
		Butler	Total	204	199	169	170	173	144	229	236
			NFCE	148	151	129	133	144	96	151	144
			%NFCE	73%	76%	76%	78%	83%	67%	66%	61%
		Statewide	Total	20,115	16,297	19,678	19,899	20,714	18,735	20,257	19,056
			NFCE	14,795	12,022	14,637	14,781	15,203	13,803	15,133	14,380
			%NFCE	74%	74%	74%	74%	73%	74%	75%	75%



Supervisor Roles and Responsibilities

SAMS Reports

- ❖ Initial LOCA Assessments, NFCE with 15-day rule
 - This report is run against the denormalized OMNIA database in the PDA data warehouse using PDA Custom Reports.
 - This report is available through your QCS or on the ftp site. It is not currently available for agencies to run against the consolidated Omnia database.

Initial LOCA Assessments, NFCE with 15 day rule – Summary Only FY 12 – 13

Summary by Agency			
LOCA assessments not in compliance with 15 day rule for LOCAs between 07/01/2012 and 04/30/2013 by Agency as of 5/31/2013			
<u>AAA</u>	<u>Number of Assessments</u>	<u>Number Out of Compliance</u>	<u>Percent Out of Compliance</u>
	1,222	8	0.7%
	361	6	1.7%
	374	4	1.1%
	763	37	4.8%
	296	10	3.4%
	4,926	107	2.2%
	1,586	88	5.5%
	1,491	175	11.7%
	192	6	3.1%
	638	14	2.2%
	769	4	0.5%
	385	6	1.6%
	114	49	22.4%

Initial LOCA Assessments, NFCE with 15 day rule – Summary Only FY 11 – 12

Summary by Agency			
LOCA assessments not in compliance with 15 day rule for LOCAS between 07/01/2011 and 06/30/2012 by Agency as of 5/31/2013			
<u>AAA</u>	<u>Number of Assessments</u>	<u>Number Out of Compliance</u>	<u>Percent Out of Compliance</u>
	1,453	31	2.1%
	498	2	0.4%
	466	10	2.1%
	814	12	1.5%
	376	16	4.3%
	5,790	407	7.0%
	1,897	114	6.0%
	1,822	213	11.7%
	212	12	5.7%
	772	36	4.7%
	888	13	1.5%
	470	9	1.9%
	340	78	22.9%
	841	419	49.8%
	528	57	10.8%

***See Resources section for complete reports.*



Level of Care Determination Form

Level of Care Determination Form

Overview of the LCD Form

LCD DRAFT 6-27-13

1. INTRODUCTION

1.A. INDIVIDUAL'S IDENTIFICATION

1. DATE when AAA received the referral for the Level of Care Assessment

2. Individual's Last Name
Aaatest

3. Individual's Name Suffix (If applicable)

4. Individual's First Name
LCD

5. Individual's Middle Initial

6. Individual's Date of Birth (DOB)
10/1/1943

7. Individual's Nickname / Alias

8. Individual's Gender
 Male
 Female
Notes:

9. Individual's Ethnicity (Check only one)
 Hispanic or Latino
 Not Hispanic or Latino
 Unknown
Notes:

10. Individual's Race
 American Indian/Native Alaskan
 Asian
 Black/African American
 Native Hawaiian/Other Pacific Islander
 White-Hispanic
 Non-Minority (White, non-Hispanic)
 Unknown/Unavailable
 Other-Document in Notes
Notes:

11. Individual's Social Security Number (SSN)
345-34-5345

12a. Does the individual have a Medicaid Number?
 Yes
 No
 Pending
Notes:

12b. Indicate Medicaid Number

13a. Does the individual have Medicare?

Yes
 No
Notes:

13b. Indicate the Medicare number

14a. Does the individual have any other insurance?
 Yes
 No
 Don't know
Notes:

14b. Indicate the other insurance information

1.B. ASSESSMENT INFORMATION

1. PSA number conducting assessment
23

2. Indicate type of assessment
 Initial Assessment
 Change in Condition Reassessment
 Aging Waiver Annual Recertification
 Dom Care Annual Recertification
 PCH Annual Recertification
 Other-Document Details in Notes
Notes:

3. Where was the individual interviewed?
 AAA-Area Agency on Aging
 AL-Assisted Living Facility
 Individual Deceased
 DCH-Domiciliary Care Home
 Home
 Home of Relative /Caregiver
 Hospital
 Mental Health Facility
 Nursing Home
 PCH-Personal Care Home
 Specialized/Rehab Facility
 Other-Document Details in Notes
Notes:

4. Date of the visit/chart review
6/5/2013

5. Did the individual participate in the assessment?
 Yes
 No
Notes:

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 1 of 15

Level of Care Determination Form

6. If anyone else participated during the time of the determination, please document the Relationship.

(Document Name in Notes)

- 1 - Spouse
- 2 - Family-other than Spouse
- 3 - Legal Guardian
- 4 - Durable Power of Attorney
- 5 - Friend
- 6 - Other-Document Name and Relationship in Notes

Reworded question;
POA & Legal Guardian
included in choices

Notes:

Notes:

3. Individual's marital status

- Single
- Married
- Divorced
- Legally Separated
- Widowed
- Other-Document in Notes

Notes:

7. Identify who referred the individual

- AAA-Conducting Assessment
- AAA-Other
- Family
- Hospital
- Independent Enrollment Broker
- Nursing or Rehab Facility
- PCH-Personal Care Home
- Physician
- Self
- Social Services Agency
- Supports Coordination Agency
- Unavailable
- Other-Document Details in Notes

Notes:

4a. Is the individual a Veteran?

- Yes (Skip to 5a)
- No
- Unable to Determine

Notes:

4b. Is the individual the spouse or child of a Veteran?

- Yes
- No
- Unable to Determine

Notes:

5a. Does the individual require communication assistance?

- Yes (Complete 5b)
- No (Skip to 6a)
- Unable to Determine

Notes:

1.C. INDIVIDUAL'S DEMOGRAPHICS

1. Type of residence in which the individual resides

- Own Home
- Apartment
- Relative's Home
- AL-Assisted Living
- DC-Domiciliary Care
- PCH-Personal Care Home
- Group Home
- Nursing Home
- Homeless
- Specialized Rehab /Rehab Facility
- State Institution
- Unknown
- Other-Document Details in Notes

Incorporated homeless into
type of residence

Notes:

5b. What type of communication assistance is required?

- Assistive technology
- Interpreter
- Large print
- Picture book
- Unknown
- Unable to communicate
- Other-Document in Notes

Notes:

6a. Does the individual use sign language as their PRIMARY language?

- Yes (Complete 6b)
- No (Skip to question 7)

Notes:

2. What is the individual's PRIMARY living arrangement? (Include in the "Live Alone" category, individuals who live in an Assisted Living, Dom Care, or PCH, pay rent and have NO ROOMMATE.)

- Lives alone
- Lives with spouse only
- Lives with child(ren) but not spouse
- Lives with other family member(s)
- Unknown
- Other-Document Details in Notes

Added Primary

6b. What type of sign language is used?

- American Sign Language
- International Sign Language
- Makaton
- Manually Coded Language-English
- Manually Coded Language-Non-English
- Tactile Signing
- Other-Document in Notes

Notes:

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 2 of 15

Level of Care Determination Form

7. What is the individual's PRIMARY language?

- English
- Arabic
- Armenian
- Cantonese
- Chinese/Other
- Farsi (Persian)
- Filipino (Tagalog)
- French
- German
- Greek
- Haitian Creole
- Hebrew
- Italian
- Japanese
- Korean
- Lithuanian
- Mandarin
- Mein
- Polish
- Portuguese
- Romanian
- Russian
- Serbian-Cyrillic
- Spanish
- Thai
- Turkish
- Vietnamese
- Other-Document in Notes

Notes:

1.D. INDIVIDUAL'S RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED

1. Is the individual's Postal/Mailing address exactly the same as the Residential address?

- Yes
- No (Complete Section 1.E - Postal/Mailing address)

Notes:

2a. Residential County

Allegheny

2b. Residential Street Address

2c. Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.)

2d. Residential Municipality - REQUIRED (Usually a Township or Boro where individual Votes, Pays Taxes)

2e. Residential City/Town

2f. Residential State

PA

2g. Residential Zip Code

12345

3. Directions to the individual's home

4. Does individual reside in a Rural area?

- Yes
- No

Notes:

Changed - moved emergency contact to needs assessment; included phone numbers; required for assessment

5a. Primary Phone Number

5b. Mobile Phone Number

5c. Other Phone Number (Enter number where individual can be reached.)

5d. E-mail Address

New

6. What was the outcome when the individual was offered a voter registration form? REQUIRED

- AAA will submit completed voter registration
- Consumer declined application
- Consumer declined-already registered
- Consumer will submit completed voter registration
- Not Applicable

Notes:

Removed postal county (duplicative of 1.D.2a.)

1.E. INDIVIDUAL'S POSTAL/MAILING ADDRESS

1a. Postal Street Address

1b. Postal Address Line 2 (optional)

1c. Postal City/Town

1d. Postal State

Changed wording

1e. Postal Zip Code

2. USE OF MEDICAL SERVICES

2.A. HOSPITAL, NURSING FACILITY, ER, INPATIENT PSYCHIATRIC VISITS/STAYS

1. Has the individual stayed in the HOSPITAL in the last 12 months?

- Yes-Complete 2.A.2
- No-Skip to 2.A.3
- Unable to determine-Complete 2.A.2

Notes:

Removed # of days

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 3 of 15

Level of Care Determination Form

Removed why was consumer hospitalized

2. The **approximate number of times** the individual has stayed overnight in the HOSPITAL in the last 12 months. 1 Incorrect or not answered
Notes:

3. The **approximate number** of times the individual has visited the ER in the last 12 months and was NOT admitted. 0 Correct answer
 1 Incorrect or not answered
Notes:

4. The **approximate number** of times the individual has stayed in a NURSING FACILITY in the last 12 months. 0 Correct answer
 1 Incorrect or not answered
Notes:

5. The **approximate number** of times the individual has had Inpatient PSYCHIATRIC Visits/Stays in the last 24 months. 0 Correct answer
 1 Incorrect or not answered
Notes:

2.B. PRIMARY PHYSICIAN INFORMATION

1. Does the individual have a PRIMARY Care Physician? Changed - question wording changed; added fax and e-mail

Yes
 No
Notes:

2. PRIMARY Physician's Name

3. PRIMARY Physician's Street Address

4. PRIMARY Physician's City or Town

5. PRIMARY Physician's State

6. PRIMARY Physician's Zip Code

7. PRIMARY Physician's Business Phone Number (Requires 10 digits to transfer to SAMS, optional 1-5 digit extension.)

8. PRIMARY Physician's FAX Number

9. PRIMARY Physician's E-MAIL ADDRESS

6. Individual knows DATE OF BIRTH? 0 Correct answer
 1 Incorrect or not answered
Notes:

7. Individual knows CURRENT PRESIDENT? 0 Correct answer
 1 Incorrect or not answered
Notes:

8. Individual knows PREVIOUS PRESIDENT? 0 Correct answer
 1 Incorrect or not answered
Notes:

9. Individual knows MOTHER'S MAIDEN NAME? 0 Correct answer
 1 Incorrect or not answered
Notes:

10. SUBTRACTION TEST Subtract 3 from 20, etc. Notes:

17
 14
 11
 8
 5
 2

3. SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ) - MANDATORY

3.A. SPSMQ QUESTIONNAIRE

1. Individual knows TODAY'S DATE? New section in LCD that was in CMI; determined section is needed

0 Correct answer
 1 Incorrect or not answered
Notes:

2. Individual knows the DAY of the week?

0 Correct answer

3.B. SPMSQ RESULTS

1. Individual's Subtraction Test Results?

0 Correct
 1 Incorrect or not answered
Notes:

What was the highest grade the individual completed in school? If unknown, enter 0 and a note explaining why it is unknown.

1.00

Consumer Score on SPMSQ.

-1

Level of Care Determination Form

4. DIAGNOSES

4.A. RESPIRATORY

1. Select all RESPIRATORY diagnoses

- None
- Asthma
- COPD-Chronic Obstructive Pulmonary Dis
- Emphysema
- Respiratory Failure
- Other-Document in Notes

Notes:

2. Current treatments for RESPIRATORY diagnoses

- None
- Oxygen
- Suctioning
- Tracheotomy/Trach Care
- Ventilator/Vent Care
- Other-Document in Notes

Notes:

3. Is the individual able to self-manage care of the RESPIRATORY condition(s)?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

4.B. HEART/CIRCULATION

1. Select all HEART and/or CIRCULATORY System diagnoses

- None
- Anemia
- A-Fib and other Dysrhythmia, Bradycardia, Tachycardia
- CAD-Coronary Artery Disease: include Angina, Myocardial Infarction, ASHD
- DVT-Deep Vein Thrombosis
- Heart Failure: include CHF, Pulmonary Edema
- Hypertension
- PE-Pulmonary Embolus
- PVD/PAD (Peripheral Vascular or Artery Disease)
- Other-Document in Notes

Notes:

2. Current treatments for HEART and/or CIRCULATORY System diagnoses

- None
- Compression Device, TED Hose, Ace Bandage Wrap(s)
- Pacemaker
- Special Diet
- Other-Document in Notes

Notes:

3. Is the individual able to self-manage care of the HEART and/or CIRCULATORY System condition(s)?

- Yes
- No-Expand Details in Notes

New name in heading;
New format of terminology and questions; Removed: present, not present, consumer reported.
Focus is on diagnosis and treatments and ability to self-manage condition.

to Determine

4.C. GASTROINTESTINAL

1. Select all GASTROINTESTINAL diagnoses

- Esophagus Disease
- Diverticulitis
- Hernia
- IBS-Irritable Bowel Syndrome
- Other-Document in Notes

Notes:

2. Current treatments for GASTROINTESTINAL diagnoses

- None
- Aspiration Precautions
- Feeding Tube (Any)
- Ostomy (Any)
- TPN-Total Parental Nutrition
- Other-Document in Notes

Notes:

3. Is the individual able to self-manage care of GASTROINTESTINAL condition(s)?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

4.D. MUSCULOSKELETAL

1. Signs and symptoms of MUSCULOSKELETAL diagnoses

- None
- Ambulatory Dysfunction
- Contracture(s)
- Arthritis
- Frequent Fractures
- Joint Deformity
- Limited Range of Motion
- Osteoporosis
- Poor Balance
- Spasms
- Weakness
- Other-Document in Notes

Notes:

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 5 of 15

Level of Care Determination Form

2. Current treatments for MUSCULOSKELETAL diagnoses

- None
- Brace(s)
- Cast
- Elevate Legs
- Prosthesis(es)
- Splint
- Traction
- Other-Document in Notes

Notes:

3. Is the individual able to self-manage care of the MUSCULOSKELETAL condition(s)?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

4.E. SKIN

1. Select all SKIN diagnoses

- None
- Ulcer
- Wound
- Other-Document in Notes

Notes:

2. If any, check all affected SKIN location(s).

- Ankle(s)
- Arm(s)
- Back of Knee(s)
- Buttock(s)
- Chest
- Hip(s)
- Leg(s)
- Lower Back
- Shoulder Blade(s)
- Spine
- Tailbone
- Other-Document in Notes

Notes:

3. If Ulcer is Stageable, identify the highest known ULCER STAGE.

- 1 - Stage 1 - Redness
- 2 - Stage 2 - Partial Skin Loss
- 3 - Stage 3 - Full Thickness
- 4 - Stage 4 - Muscle and/or Bone Exposed

Notes:

4. Current treatments for SKIN diagnoses

- None
- Debridement
- Pressure Relieving Devices
- Surgery
- Unna Boot(s)
- Wound Dressing

- Wound VAC
- Other-Document in Notes

Notes:

5. Is the individual able to self-manage care of the SKIN condition(s)?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

4.F. ENDOCRINE/METABOLIC

1. Select all ENDOCRINE/METABOLIC diagnoses

- None
- Cirrhosis
- Diabetes Mellitus (DM)-Insulin Dependent
- Diabetes Mellitus (DM)-Non-insulin Dependent
- Hypoglycemia
- Thyroid Disorder
- Other-Document in Notes

Notes:

2. Is the individual able to self-manage care of the ENDOCRINE/METABOLIC condition(s)?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

4.G. GENITOURINARY

1. Select all GENITOURINARY diagnoses

- None
- Bladder Disorders, including neurogenic or overactive bladder, urinary retention
- Frequent Urinary Tract Infections (UTI)
- Renal Insufficiency/Failure (ESRD)
- Other-Document in Notes

Notes:

2. Current treatments for GENITOURINARY diagnoses

- None
- Catheter
- Dialysis
- Fluid Restrictions
- Ostomy
- Other-Document in Notes

Notes:

3. Is the individual able to self-manage care of the GENITOURINARY condition(s)?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

4.H. INFECTIONS/IMMUNE SYSTEM

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 6 of 15

Level of Care Determination Form

1. Select all INFECTION/IMMUNE System diagnoses

- None
- AIDS Symptomatic
- AIDS Asymptomatic
- Hepatitis
- HIV
- MRSA/VRE/C-Dif
- TB-Tuberculosis
- Other-Document in Notes

Notes:

2. If HIV or AIDS is indicated in 4.H.1, has the individual ever had lab results of CD4 count under 400?

- Yes
- No
- Unknown

Notes:

3. Is the individual able to self-manage care of the INFECTION/IMMUNE System conditions?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

4.I. CANCER

Added new diagnosis section

1. Does the individual have a current CANCER diagnosis?

- Yes
- No-Skip to 5.A.1

Notes:

2. If Yes, identify the Stage:

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV

Notes:

3. Select all current CANCER Diagnoses:

- Bone
- Bladder
- Brain
- Breast
- Cervical
- Colon
- Esophageal
- Gastric
- Kidney
- Leukemia
- Liver
- Lung
- Lymphatic
- Ovarian
- Pancreatic
- Prostate

- Sarcoma
- Skin
- Testicular
- Throat
- Thyroid
- Uterine
- Other-Document in Notes

Notes:

4. Current treatments for CANCER diagnoses

- Chemo/Radiation Combination
- Radiation
- Chemotherapy
- Palliative Care
- Hospice Care
- Other-Expand details in notes
- None

Notes:

5. Is the individual able to self-manage the CANCER conditions?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

Expanded this section

5. NEUROLOGICAL (Complete Section 7 if individual has a Neurological diagnosis)

5.A. Neurological

1. Select all NEUROLOGICAL diagnoses:

- None
- ALS
- Alzheimer's Disease
- Autism
- Cerebral Palsy
- CVA/TIA/Stroke
- Dementia (Include all Non-Alzheimer's Dementia)
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease
- Seizure Disorder
- TBI-Traumatic Brain Injury
- Other-Document in Notes

Notes:

2. What characteristics describe the individual's cognitive state?

- Inability to adapt to changes in routine or location
- Inability to follow commands
- Poor long term memory
- Poor short term memory
- Slow response to questions
- Other-Document in Notes

Notes:

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 7 of 15

Level of Care Determination Form

3. NEED FOR SUPERVISION: taking into account physical and psychological health, mental impairment, and behavior, how long can the consumer routinely be left alone at home safely? Explain why supervision needed in notes.

- Indefinitely
- Entire day and overnight
- Eight hours or more - day or night
- Eight hours or more - daytime only
- A few hours
- Cannot be left alone

Notes:

4. Is the individual able to self-manage care of the NEUROLOGICAL condition(s)?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

6. PSYCHOLOGICAL (Complete Section 7 if individual has a Neurological diagnosis)

6.A. Psychological

1. Select all PSYCHOLOGICAL diagnoses

- None
- Anxiety disorders
- Bipolar disorders
- Catatonic State
- Depression
- Mood disorder
- Paranoid disorder
- Personality disorder
- Psychosis
- Schizophrenia
- Other-Document in Notes

Notes:

2. Current treatments for PSYCHOLOGICAL diagnoses

- Outpatient Psychiatric Care
- ECT-Electroconvulsive Therapy
- Medication(s)
- None
- Other

Notes:

3. Is the individual able to self-manage care of the PSYCHOLOGICAL conditions?

- Yes
- No-Expand Details in Notes
- Unable to Determine

Notes:

Psychological Diagnosis

1

Neuro Supervision

1

Psychological Treatments

1

Psychological Score

1

New - additional section to accommodate TBI and OBRA requirements

7. BEHAVIOR

7.A. BEHAVIORS

1. Does the individual present with any BEHAVIORAL signs/symptoms? This Section is REQUIRED if a Neurologic or Psychological Diagnosis was noted in Section 5 or 6.

- Yes (Complete ALL of Section 7)
- No (Skip to Section 8)
- Unable to determine (Complete ALL of Section 7)

Notes:

2a. Does the individual exhibit PHYSICAL behavioral symptoms toward OTHERS?

- Yes (Complete 2b-c)
- No (Skip to 3a)

Notes:

2b. Specify ALL types of aggressive PHYSICAL behavior toward OTHERS (If not listed, Document in Notes.)

- Biting
- Hair pulling
- Hitting
- Kicking
- Picking
- Scratching
- Spitting
- Other-Document in Notes

Notes:

2c. Does the aggressive PHYSICAL behavior toward OTHERS interfere with the individual's ability to function daily?

- Yes (Comment in Notes how it interferes.)
- No (Comment in Notes why the behavior does NOT interfere.)

Notes:

3a. Does the individual exhibit aggressive PHYSICAL behavioral symptoms towards SELF?

- Yes (Complete 3b-c)
- No (Skip to 4a)

Notes:

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 8 of 15

Level of Care Determination Form

3b. Specify ALL types of aggressive PHYSICAL behavior towards SELF (If not listed, Document in Notes.)

- Biting
- Hair pulling
- Hitting
- Kicking
- Picking
- Scratching
- Spitting
- Other-Document in Notes

Notes:

3c. Does the aggressive PHYSICAL behavior toward SELF interfere with the individual's ability to function daily?

- Yes (Comment in Notes how it interferes.)
- No (Comment in Notes why the behavior does NOT interfere.)

Notes:

4a. Does the individual exhibit aggressive VERBAL behavior symptoms toward OTHERS?

- Yes (Complete 4b-c)
- No (Skip to 5a)

Notes:

4b. Specify ALL types of aggressive VERBAL behavior towards OTHERS (If not listed, document in Notes.)

- Cursing
- Screaming
- Threatening
- Other-Document in Notes

Notes:

4c. Does the aggressive VERBAL behavior toward OTHERS interfere with the individual's ability to function daily?

- Yes (Comment in Notes how it interferes.)
- No (Comment in Notes why the behavior does NOT interfere.)

Notes:

5a. Does the individual exhibit any GENERAL aggressive VERBAL behavior symptoms not specifically directed toward self or others?

- Yes (Complete 5b-c)
- No (Skip to 6a)

Notes:

5b. Select ALL GENERAL aggressive VERBAL behaviors (If not listed, Document in Notes.)

- Disruptive sounds
- Yelling out
- Other-Document in Notes

Notes:

5c. Does the GENERAL aggressive VERBAL behavior interfere with the individual's ability to function daily?

- Yes (Comment in Notes how it interferes.)
- No (Comment in Notes why the behavior does NOT interfere.)

Notes:

6a. Does the individual exhibit any OTHER behavioral symptoms?

- Yes (Complete 6b-c)
- No (Skip to 7)

Notes:

6b. Specify ALL OTHER types of behaviors reported (If not listed, Document in Notes.)

- Fecal smearing
- Hoarding
- Pacing
- Public disrobing
- Rummaging
- Sundowner's Syndrome
- Other-Document in Notes

Notes:

6c. Do the OTHER types of behaviors interfere with the individual's ability to function daily?

- Yes (Comment in Notes how it interferes.)
- No (Comment in Notes why the behavior does NOT interfere.)

Notes:

7. Has the individual exhibited WANDERING behavior in the past 6 months? If so, indicate the FREQUENCY.

- Daily
- Several times a week
- Several times a month
- Once a month
- Less than once a month
- Never

Notes:

8. OTHER MEDICAL INFORMATION

8.A. MEDICATION MANAGEMENT

1. Does the individual take any PRESCRIBED Medications?

- Yes
- No (Skip to 8.A.3)

Notes:

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 9 of 15

Level of Care Determination Form

No change

2. List all PRESCRIBED Medications taken by the individual

a. Name and Dose: Record the name of the medication and dose ordered.

b. Form: Code the route of administration using the following list:

- | | |
|------------------------|------------------|
| 1 = by mouth (PO) | 7 = topical |
| 2 = sub lingual (SL) | 8 = inhalation |
| 3 = intramuscular (IM) | 9 = enteral tube |
| 4 = intravenous (IV) | 10 = other |
| 5 = subcutaneous (SQ) | 11 = eye drop |
| 6 = rectal (R) | 12 = transdermal |

d. Frequency: Code the number of times per period the med is administered using the following list:

- | | |
|------------------------------|------------------------------|
| PR = (PRN) as necessary | OO = every other day |
| 1H = (QH) every hour | 1W = (Q week) once each week |
| 2H = (Q2H) every 2 hours | 2W = 2 times every week |
| 3H = (Q3H) every 3 hours | 3W = 3 times every week |
| 4H = (Q4H) every 4 hours | 4W = 4 times each week |
| 6H = (Q6H) every 6 hours | 5W = 5 times each week |
| 8H = (Q8H) every eight hours | 6W = 6 times each week |
| 1D = (QD or HS) once daily | 1M = (Q month) once/mo. |
| 2D = (BID) two times daily | 2M = twice every month |
| (includes every 12 hours) | C = Continuous |
| 3D = (TID) 3 times daily | O = Other |
| 4D = (QID) four times daily | |
| 5D = 5 times daily | |

a. Name and Dose	b. Form	c. # Taken	d. Freq	e. Comments
'epofmg;paecjm - 5	1	1	QO	
aeccearxad - 4	1	1	QO	
aecvreaef - 6	1	1	QO	
qweqxrcq - 7	1	1	QO	
trewerr - 2	1	1	QO	
wercwefacf - 3	1	1	QO	
wpoer',c'ap;s - 4	1	1	QO	

Notes:

3. List all OVER THE COUNTER (OTC) Medications taken by the individual

a. Name and Dose: Record the name of the medication and dose ordered.

b. Form: Code the route of administration using the following list:

- | | |
|------------------------|------------------|
| 1 = by mouth (PO) | 7 = topical |
| 2 = sub lingual (SL) | 8 = inhalation |
| 3 = intramuscular (IM) | 9 = enteral tube |
| 4 = intravenous (IV) | 10 = other |
| 5 = subcutaneous (SQ) | 11 = eye drop |
| 6 = rectal (R) | 12 = transdermal |

d. Frequency: Code the number of times per period the med is administered using the following list:

- | | |
|------------------------------|------------------------------|
| PR = (PRN) as necessary | OO = every other day |
| 1H = (QH) every hour | 1W = (Q week) once each week |
| 2H = (Q2H) every 2 hours | 2W = 2 times every week |
| 3H = (Q3H) every 3 hours | 3W = 3 times every week |
| 4H = (Q4H) every 4 hours | 4W = 4 times each week |
| 6H = (Q6H) every 6 hours | 5W = 5 times each week |
| 8H = (Q8H) every eight hours | 6W = 6 times each week |
| 1D = (QD or HS) once daily | 1M = (Q month) once/mo. |
| 2D = (BID) two times daily | 2M = twice every month |
| (includes every 12 hours) | C = Continuous |
| 3D = (TID) 3 times daily | O = Other |
| 4D = (QID) four times daily | |
| 5D = 5 times daily | |

a. Name and Dose	b. Form	c. # Taken	d. Freq	e. Comments
awecvraw - awcwr	1	1	QO	
crwqerwqfwe - cwewc	2	1	QO	
earzeswrdr - saefexcae	2	1	C	
se';fj;cs;dfk.m;c - fsdf	1	1	4W	
ujt@okiuolu - uiluku,	1	1	C	
werwewer - werwer	1	1	1W	
wfrcwefwfc - wcerwexrcf	1	1	QO	

Notes:

4. What is the individual's ability level to manage medication?

0. Independent
 1. Limited Assistance
 2. Total Assistance

Notes:

8.B. WEIGHT/HEIGHT

1. What is the individual's height?

68

2. What is the individual's weight?

174

3. Has the individual lost or gained 10 pounds in the past 6 months?

- Yes, gained 10 pounds
 Yes, lost 10 pounds
 No

Added weight type

Notes:

4. What is the individual's weight type?

- Normal - height/weight appropriate
 Obese
 Morbidly Obese
 Underweight

Notes:

New section

8.C. PAIN

1. Does the individual report PAIN?

- Yes (Complete Section 8.C)
 No (Skip to 9.A.1)
 Unable to determine (Skip to 9.A.1)

Notes:

2. Location(s) of PAIN site(s)

- Back
 Bone
 Chest
 Head
 Hip
 Incision site
 Joint
 Soft tissue (muscle)
 Stomach
 Other-Document in Notes

Notes:

Revised - type of assistance; will be in needs assessment

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 10 of 15

Level of Care Determination Form

3. Indicate the level of PAIN using a scale from 1-10 (1=no pain, 10=severe pain)

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Notes:

4. Indicate the frequency the individual reports the PAIN.

- Continuous
- Daily - Multiple Episodes
- Daily - One Episode
- Less than Daily
- Other-Document in Notes

Notes:

5. Does the individual report the PAIN impacting his/her daily functioning?

- Yes
- No

Notes:

Same information - different format includes definition of ADL; instead of 5 choices-> 3 choices; if limited assistance, follow up on type of assistance in subsequent question 1b

9. ACTIVITIES OF DAILY LIVING (ADLs)

9.A. ADLs

1a. BATHING Ability to bathe oneself, includes turning on the water, regulating temperature, etc.

- 0 - Independent
- 1 - Limited Assistance (verbal or non-weight bearing by another individual)
- 2 - Total Assistance

Notes:

1b. If Limited Assistance, indicate ALL types needed for BATHING

- Set-up
- Supervision
- Encouragement, cueing, or coaxing
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive devices
- Other-Document in Notes

Notes:

2a. DRESSING Ability to remove clothes from a closet/drawer; application of clothing, including shoes/socks (regular/TEDS); orthotics; prostheses; removal/storage of items; managing fasteners; and to use any needed assistive devices.

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

2b. If Limited Assistance, indicate ALL types needed for DRESSING

- Set-up
- Supervision
- Encouragement, cueing, or coaxing
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive device
- Other-Document in Notes

Notes:

3a. GROOMING/PERSONAL HYGIENE Ability to comb/brush hair; brush teeth; care for/inset dentures; shave; apply make-up (if worn); apply deodorant, etc.

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

3b. If Limited Assistance, indicate ALL types needed for GROOMING/PERSONAL HYGIENE

- Set-up
- Supervision
- Encouragement, cueing, or coaxing
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive devices
- Other-Document in Notes

Notes:

4a. EATING Ability to eat/drink; cut, chew, swallow food; and to use any needed assistive devices

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance
- 3 - Did not occur

Notes:

New question - If did not occur, sends you to question 4c

4b. If Limited Assistance, indicate ALL types needed for EATING

- Set-up
- Supervision
- Encouragement, cueing or coaxing
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive devices
- Other-Document in Notes

Notes:

4c. If response to 9.A.4a is "3-Does Not Occur", indicate type of nutritional intake. Check ALL that apply:

- IV Fluids
- NPO (nothing by mouth)
- Parenteral Nutrition
- Tube Feeding
- Other-Document in Notes

Notes:

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 11 of 15

Level of Care Determination Form

5a. TRANSFER Ability to move between surfaces, including to/from bed, chair, wheelchair, or to a standing position; onto or off a commode; and to manage/use any needed assistive devices.

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

5b. If Limited Assistance, indicate ALL types needed for TRANSFER

- Set-up
- Supervision
- Encouragement, cueing, or coaxing
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive devices
- Other-Document in Notes

Notes:

6a. TOILETING Ability to manage bowel and bladder elimination

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

6b. If Limited Assistance, indicate ALL types needed for TOILETING

- Setup
- Supervision
- Encouragement, cueing, or coaxing
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive devices
- Other-Document in Notes

Notes:

6c. BLADDER CONTINENCE Indicate the description that best describes the individual's BLADDER function

- 1 - Continent - Complete control, no type of catheter or urinary collection device
- 2 - Usually Continent - Incontinence episodes once a week or less
- 3 - Incontinent - Inadequate control, multiple daily episodes

Notes:

6d. BOWEL CONTINENCE Indicate the description that best describes the individual's BOWEL function

- 1 - Continent - Complete control, no ostomy device
- 2 - Usually Continent - Incontinence episodes once a week or less
- 3 - Incontinent - Inadequate control, multiple daily episodes

Notes:

7a. WALKING Ability to safely walk to/from one area to another; manage/use any needed ambulation devices

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

7b. If Limited Assistance, indicate ALL types needed for WALKING

- Set-up
- Supervision
- Encouragement, cueing, or coaxing
- Guided maneuvering of limbs
- Assistance with the use of equipment
- Other-Document in Notes

Notes:

10. MOBILITY

10.A. CONSUMER'S MOBILITY

1. BEDBOUND Is the individual bedbound and non-ambulatory? Indicate in Notes any help needed, comments or relevant information.

- Yes (Skip to Section 11)
- No
- Unable to determine

Notes:

2a. INDOOR MOBILITY Ability of movement within INTERIOR environment

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

2b. If Limited Assistance, indicate ALL types needed for INDOOR MOBILITY

- Set-up
- Supervision
- Encouragement, cueing, or coaxing;
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive devices
- Other-Document in Notes

Notes:

3a. OUTDOOR MOBILITY Ability of movement OUTSIDE living arrangement

- 0 - Independent
- 1 - Limited Assistance
- 2 - Extensive/Total Assistance

Notes:

3b. If Limited Assistance, indicate ALL types needed for OUTDOOR MOBILITY

- Set-up
- Supervision
- Encouragement, cueing, or coaxing;
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive devices
- Other-Document in Notes

Notes:

Same information - different format, including definition of mobility; instead of 5 choices-> 3 choices; if limited assistance, follow up on type of assistance in subsequent question 2b

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 12 of 15

Level of Care Determination Form

4a. STAIR MOBILITY Movement safely up and down

STEPS

- 0 - Independent
- 1 - Limited Assistance
- 2 - Extensive/Total Assistance

Notes:

Replaces "climb" on LOCA

4b. If Limited Assistance, indicate ALL types needed for STAIR MOBILITY

- Set-up
- Supervision
- Encouragement, cueing, or coaxing
- Guided maneuvering of limbs
- Assistance with the use of equipment or assistive devices
- Other-Document in Notes

Notes:

5. What is the individual's weight bearing status?

- Full weight bearing
- Non-weight bearing;
- Partial weight bearing
- Toe touch weight bearing
- Unable to determine

Notes:

New question

6. Select all that affect the individual's mobility.

- None
- Ambulation Dysfunction
- Fatigues Easily
- Muscle Stiffness
- Pain
- Poor Balance
- Rigidity
- Shuffling Gait
- Spasms
- Tremors
- Other-Document in Notes

Notes:

New question

10.B. FALLS

1. Is the individual at risk of falling?

- Yes
- No
- Unable to determine

Notes:

2. Select the number of times the individual has fallen in the last 6 months.

- None
- 1
- 2
- 3 or More

Notes:

New question

11. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

11.A. IADLs

Same information - instead of 5 choices-> 3 choices with definitions included

1. MEAL PREPARATION Ability to plan/prepare meals, use of kitchen appliances, heat/prepare meals. List any needed Adaptive Equipment/ Assistive Devices in Notes.

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

2. HOUSEWORK Ability to maintain living space, includes tasks such as dishwashing, making the bed, dusting, running the vacuum or sweeping an area. List any needed Adaptive Equipment/ Assistive Devices in Notes.

- 0 - Independent
- 1 - Limited assistance
- 2 - Extensive/Total Assistance

Notes:

3. LAUNDRY Ability to gather clothes, place clothes in washing machine, turn on appliance, remove clothes and place in dryer, or hand wash items and hang to dry.

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

4. SHOPPING Ability to go to the store and purchase needed items, includes groceries and other items. List any needed Adaptive Equipment/ Assistive Devices in Notes.

- 0 - Independent
- 1 - Limited assistance
- 2 - Total Assistance

Notes:

5. TRANSPORTATION Ability to travel on public transportation or drive a car.

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

6. MONEY MANAGEMENT Ability to manage financial matters, writing checks, paying bills, going to the bank.

- 0 - Independent
- 1 - Limited assistance
- 2 - Total Assistance

Notes:

7. TELEPHONE Ability to obtain phone numbers, dial the telephone and communicate with person on the other end. List any needed Adaptive Equipment/ Assistive Devices in Notes.

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013

Page 13 of 15

Level of Care Determination Form

8. HOME MANAGEMENT Ability to perform heavier household tasks such as taking out the trash, completing minor repairs around the living space, yard work and/or snow removal.

- 0 - Independent
- 1 - Limited Assistance
- 2 - Total Assistance

Notes:

Changed - RN assessment removed; section streamlined; Questions 4, 5, 6, are new questions

12. LEVEL OF CARE (LOC) ASSESSMENT DATA

12.A. ASSESSMENT OUTCOME

1. What is the date the individual's MA-51 or Rx Script, signed by a physician was received by the AAA?

5/29/2013

2. What Level of Care did the physician recommend?

- Nursing Facility Clinically Eligible (NFCE)
- Nursing Facility Ineligible (NFI)
- Evaluation not required

Notes:

3. What is the Level of Care determination for this individual?

- Nursing Facility Clinically Eligible (NFCE)
- Nursing Facility Ineligible (NFI)

Notes:

4. Does the functional limitation(s) of the individual's medical condition(s) support the level of care determination?

- No
- Yes - Requires Completion of 12.B

Notes:

Algorithm will provide a recommendation: True/False

5. Consumer is recommended NFCE:

6. Are the assessor and the model clinical eligibility results the same? If False, document reasons in Section 12B.

12.C. Consumer Place of Service Preference

1. Does the individual want to be in community?

- Yes
- No

Notes:

Removed locus/location of care information, except for NFI consumers

Having been determined NFI, what is the individual's PREFERRED residential setting?

- Home
- DC-NFI (Domiciliary Care)
- PCH (Personal Care Home)
- Other-Document in Notes

Notes:

3. Having been determined NFI, what is the individual's PREFERRED Community Service Program?

- ACT 150
- FCSP-NFI (Family Caregiver Support Program)
- OPTIONS-NFI
- Other-Document in Notes

Notes:

New - completing this form will be the electronic signature

12.D. Level Of Care Determination Authentication

1. Name of the Assessor completing this assessment

James Burd

2. Date of Assessor's Signature

3. Name of Registered Nurse reviewing the assessment for Clinical Eligibility

4. Date of Registered Nurse review

5. Name of assessment Supervisor who reviewed and approved the Level of Care

6. Date assessment Supervisor approved the assessment

7. Date the Level of Care is being issued

12.B. Provide DETAILED SUMMARY documentation for the Assessment Narrative based for each of the following:

Diagnoses and Treatments

Functional limitations to managing their own care needs

If Assessor outcome differs from Model Recommendation, document reasons why.

Yellow highlights indicate change

Blue highlights indicate NAPIS information REQUIRED

6/26/2013
Page 14 of 15

Summary of What's New and What's Changed

- ❖ All information contained in the LCD is essential to determine a level of care.
- ❖ Information previously found in the LOCA has been moved to the needs assessment tool because the information was found to be most appropriate when developing a service plan.
- ❖ Federal reporting requirements necessitate retention of some information that may not appear relevant.
- ❖ There is no longer any reference to locus of care.
- ❖ The tool also has an algorithm to assist with clinical eligibility determinations.
- ❖ Certain responses on the tool will facilitate the appropriate clinical eligibility determination to trigger further thought processes for the assessor.
- ❖ The tool will improve documentation and the results can be utilized by the Department for quality initiatives and general data collection regarding the people that are served.
- ❖ Use of the LCD will improve consistency with documentation in the assessments by decreasing text entries.
 - Medical conditions now display drop down boxes for each type of diagnosis.
 - The category of “Other” is available in each section for selection of diagnoses not provided and a notes section is included for expanded documentation.
 - Each section also contains a question on the individual’s ability to manage their care based on the functional limitations of their diagnosis.
- ❖ The Short Portable Mental Status Questionnaire has been placed before the medical condition section and must be completed.
 - This enables the assessor to determine the cognitive ability of the individual to answer questions pertaining to medical diagnosis and functional ability.
 - In the event of cognitive impairment, the assessor must contact the primary care physician, as well as any formal and informal support systems of the individual.
 - If the AAA chooses to utilize another cognitive test, they can do so but only in addition to the SPMSQ.

Level of Care Determination Form

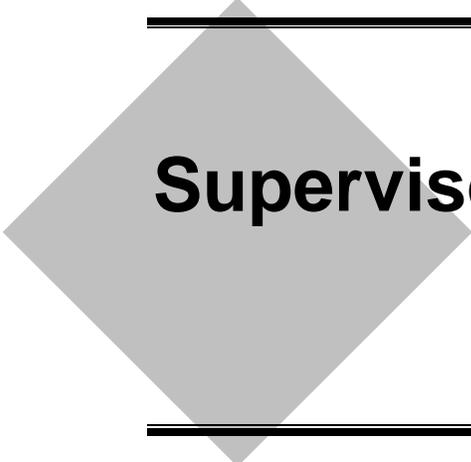
- ❖ The Decision Narrative has been removed.
 - Summary documentation to support the level of care determination is now included in Section 12.B.
 - The assessor will answer the question then document all information in the notes section to support the level of care.



In your small groups, review the Level of Care Determination form(s) from a supervisor's perspective. Identify what has not been completed correctly.

Level of Care Determination Form

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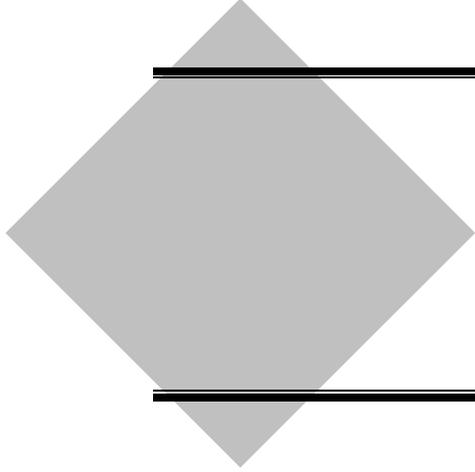
Supervisor's Role during Assessor Webinar

Supervisor's Role during the Assessor Webinar

- ❖ Ensure prerequisites are completed
- ❖ Facilitate exercises and discussions on site
- ❖ Take attendance
- ❖ Keep your microphone on "MUTE"
- ❖ Assign a "reporter" for each activity



In what other ways can you assist with the Assessor Training Webinar?



Resources

OBRA Target Assessments

Federal laws governing nursing facilities were revised, effective January 1989, by *Public Law 100-203*, the Omnibus Budget Reconciliation Act (OBRA) of 1987 (Nursing Home Reform Act), and [42 Code of Federal Regulations \(CFR\) Sections 483.100 - 483.116](#). These laws require Pre-Admission Assessments for all individuals initially entering Nursing Facilities to determine if they are Mentally Ill (MI), Mentally Retarded (MR), or diagnosed with an Other Related Condition (ORC). If an individual is found to be mentally ill or mentally retarded, or diagnosed with another related condition the screening helps determine whether nursing facility care is appropriate or whether the individual needs specialized services.

The Department designates the AAAs as the evaluation agencies responsible for the pre-admission screening under the OBRA statute. The AAA must complete a level of care determination (LCD) and a PASRR-EV on all individuals who are identified as a target and seeking admission to a Pennsylvania nursing home irrespective of funding.

1. Forms completed in the OBRA process are:
 - a. Medical Evaluation form (MA-51) - This form is completed by the physician as part of the level of care determination.
 - b. PASRR-ID Identification Form (PA-PASRR-ID) - This form is designed to evaluate whether an individual, requesting admission to a nursing facility, is subject to the determination requirements of the OBRA or document the basis for exempting the individual from the process. The form is a screening assessment and is done for all individuals entering a nursing facility, regardless of diagnosis or payment status. All referrals for a level of care determination for individuals who are applying for nursing home admission) must include a completed PA-PASRR-ID for individuals with a target diagnosis. The OBRA process will address individuals identified as part of one or more of the target group(s), (diagnosis of mental illness, mental retardation or other related conditions).
 - c. Pre-Admission Screening Instrument (PASRR-EV) - This form is designed to enable the AAA to gather additional information and confirm an individual's target diagnosis.
 - d. Level of Care Determination (LCD) - This is the standardized instrument that is used to assess all individuals seeking nursing facility placement. The Level of Care Determination is forwarded to the appropriate Program Office with the assessment packet.

OBRA Target Assessments

- e. Transmittal Form –This form provides the AAA’s recommendation regarding the individual’s level of care and recommendation for the need for specialized services. There are two Transmittal Forms currently being used:
 - o The Transmittal Form Evaluation Agency to Program Office is completed and sent with assessment packets going to OMHSAS and OLTL.
 - o The Transmittal – Preliminary Evaluation Report Recommendation for the MR Target Population form is completed and sent with the assessment packets to the Regional Developmental Disabilities Program Office.
- f. Program Office Letter of Determination – This is generated by the Program Office to notify the individual and the AAA of the final determination. The form letter identifies whether the individual requires a nursing facility level of care and if specialized services for either mental illness, mental retardation or other related conditions is required.
- g. Your Right to Appeal and to a Fair Hearing– Along with the Program Office Letter of Determination, the Right to Appeal and to a Fair Hearing is sent to an individual by the Program Office as a notification to their hearings and appeals rights under the OBRA process.

Once the AAA has completed the level of care determination (LCD) and the PASRR-EV, the following information is to be included in the assessment packet that is sent to the Program Office. Please refer to the link for specifics by Program Office (Program Office submission packet checklist):

- LCD with the Decision Narrative page.
- PASRR-ID and if applicable the Out of State ID.
- MA-51 (unsigned).
- PASRR-EV.
- Include any information/consultations obtained to document the need for specialized services on the PASRR-EV.
- Transmittal form with recommendation.
- Any other relevant information.

The OBRA process is complete when the AAA receives the Letter of Determination from the Program Office.

NOTE: The AAA should review each case individually and contact the appropriate Program Office with any questions about what information should be included in the transmittal.

OBRA Target Assessments

2. OBRA Special Circumstances

a. Exceptional Admission

An individual with a target diagnosis that enters a nursing facility based on a [PA-PASRR-ID](#) exemption, as indicated in Section V of the form, represents an exceptional admission. There are four exceptions for identified individuals that require nursing facility services:

- Exempted hospital discharge for convalescent care (not more than 30 days);
- Respite care (not more than 14 days);
- Persons requiring emergency placement as certified by the AAA Protective Services Unit (not more than 30 days);
- Persons in a coma or functioning at a brain stem level.

b. Dual and Multiple Target Diagnoses

The assessment may identify individuals who could be appropriately served by more than one Program Office. If an individual is identified who could be served by more than one Program Office, **all** applicable Program Offices are to review the assessment packet. The AAA is responsible to send out only one packet.

If the individual is a dual target for OMHSAS and ODP, the order of Program Office review is OMHSAS first and then ODP. Similarly, if the individual is a dual target for ORC and OMHSAS, the order of Program Office review is OMHSAS first and then ORC. If the individual is a target for all three, the order for review is: OMHSAS, ODP second, and then ORC.

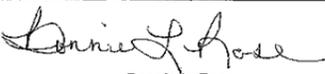
c. Out of State Admissions

The Program Offices cannot accept an ID from another state to make and issue the Letter of Determination. The AAA can make a determination on an individual's targeted status using the Out of State ID if the AAA determines they have sufficient supporting documentation and completes the PA-PASRR-EV. It is the responsibility of the in-state nursing facility to complete and send to the AAA office a PA-PASRR-ID before or by the day of the individual's admission to the facility. In these circumstances the AAA is to send the entire packet including the Out of State ID, PA-PASRR-ID, and the PA-PASRR-EV to the appropriate Program Office.

d. Current Nursing Facility Residents

In these circumstances, the AAA can at the time of the level of care determination (LCD) complete the PASRR-EV. The AAA should coordinate with the appropriate Field Operations Unit for completion of the PASRR-EV for those individuals who are a target, already residing in a nursing home due to exceptional admission, and now applying for MA funding.

OLTL Bulletin 55-12-03

 Pennsylvania DEPARTMENT OF PUBLIC WELFARE DEPARTMENT OF AGING www.dpw.state.pa.us	OFFICE OF LONG-TERM LIVING BULLETIN	
ISSUE DATE December 31, 2012	EFFECTIVE DATE December 31, 2012	NUMBER 55-12-03
SUBJECT: Procedures and Timeframes Related to Performance of Level of Care Assessments and Independent Enrollment Broker Responsibilities		 Bonnie L. Rose Deputy Secretary, Office of Long-Term Living

PURPOSE

This bulletin establishes uniform procedures and timeframes for Area Agencies on Aging (AAAs) to follow to complete Level of Care Assessments (LOCAs), and sets forth the responsibilities of the Independent Enrollment Broker (IEB). This bulletin supercedes and replaces the Office of Long-Term Living (OLTL) bulletin issued on November 21, 2012 (#55-12-02).

SCOPE

This Bulletin applies to LOCAs performed by AAAs for the Office of Long-Term Living's waiver programs.

BACKGROUND/DISCUSSION

This bulletin will ensure compliance with the 90-day federal requirement for Medicaid waiver eligibility determination. See 42 CFR 435.911. It establishes the requirement that LOCAs be completed within a fifteen (15) calendar day period and provides for additional timeframes for the completion of tasks. This bulletin provides for corrections in the letters attached to the previous bulletin issued by OLTL on November 21, 2012. Changes are underlined.

PROCEDURE

When a AAA receives a request from the IEB for a LOCA to be performed, the AAA shall perform the LOCA within fifteen (15) calendar days, in accordance with the following procedure:

1. When a referral is received by a AAA from the IEB for a LOCA and the AAA makes contact with the applicant by phone or mail, the AAA must send a confirmation letter to the applicant (SEE ATTACHED SAMPLE LETTER #1) within three (3) business days confirming the date and time of the scheduled LOCA.
2. When a referral is received by a AAA from the IEB for a LOCA and the applicant has a valid telephone number but cannot be reached on the first call, the AAA shall:

OLTL Bulletin 55-12-03

- Initiate three phone contacts (including the initial call) with the applicant to schedule their LOCA. Calls must be made not less than two days apart and cannot extend more than five (5) business days. If contact has not been made via phone by the third call, a letter is to be sent by the AAA to the applicant informing them of a date by which the applicant must contact the AAA to schedule their LOCA. The date by which the applicant must respond should be no more than five (5) business days from the date on the letter. The letter may be sent on the day that the last call was placed to the applicant by the AAA and will inform the applicant that their application will be terminated if they do not call to schedule a LOCA by the required date. (SEE ATTACHED SAMPLE LETTER #2.)

If the applicant does not respond, the AAA will inform the IEB no later than twenty (20) days after receiving the referral to terminate the application by faxing the LOCA request form back to the IEB, noting 'incomplete LOCA' on the form.

3. When a referral is received by a AAA from the IEB for a LOCA and the applicant does NOT have a valid telephone number, the AAA shall:

- Send a letter to the applicant requesting that the applicant contact the AAA to schedule their LOCA no more than five (5) business days from the date on the letter. (SEE ATTACHED SAMPLE LETTER #3.)

If the applicant does not respond, the AAA will inform the IEB no later than twenty (20) days after receiving the referral to terminate the application by faxing the LOCA request form back to the IEB, noting 'incomplete LOCA' on the form.

4. If, after a LOCA has been scheduled, the applicant calls to reschedule his or her appointment, the AAA must offer to reschedule the appointment and must inform the applicant that if they do not appear for the rescheduled appointment, their application will be terminated and they will have to reapply, thus delaying possible services.

If the applicant does not respond, the AAA will inform the IEB no later than twenty (20) days after receiving the referral to terminate the application by faxing the LOCA request form back to the IEB, noting 'incomplete LOCA' on the form.

If a LOCA is not completed and submitted to the IEB within fifteen (15) calendar days from the date on which it was requested, the IEB will send a reminder to the AAA, with a copy to OLTL fifteen (15) calendar days after requesting the LOCA. The IEB shall provide a AAA with a second reminder within five (5) calendar days after the first reminder if the LOCA has not been received by the IEB.

The fifteen (15) calendar day requirement for completion of LOCAs also applies to the Aging Waiver.

Questions concerning this bulletin should be directed to the Bureau of Individual Support at 717-787-8091

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Department of Aging/Office of Long-Term Living
Bureau of Individual Support
P.O. Box 2675
Harrisburg, PA 17105
(717) 787-8091

LETTER #1

Dear _____:

This letter is to confirm that you have scheduled an appointment on _____, 20__, at _____ for a Level of Care Assessment by the (insert agency name) to be conducted at (insert location LOCA to be done).

This assessment is a step in the eligibility determination process to determine whether or not you qualify for long-term living services provided under the medical assistance program. It is important, therefore, that you not miss this appointment.

If, however, an emergency arises and you must reschedule this appointment, please contact _____ at () _____ as soon as possible.

Sincerely,

LETTER #2

Dear _____:

The (insert agency name) recently received a referral for you to receive a Level of Care Assessment for long-term living services. This assessment is a step in the eligibility determination process to determine whether or not you qualify for long-term living services provided under the medical assistance (MA) program. It is important, therefore, that you schedule an appointment.

We have attempted, but been unable to reach you by phone. Please call us at () _____ by _____ (insert date which is 5 business days from the date you are sending this letter to the applicant) to schedule your appointment.

If you do not respond by the date above, your application for MA funded long-term living services will be terminated, which means that you will have to reapply for services.

Sincerely,

LETTER #3

Dear _____:

The (insert agency name) recently received a referral for you to receive a Level of Care Assessment for long-term living services. This assessment is a step in the eligibility determination process to determine whether or not you qualify for long-term living services provided under the medical assistance (MA) program. It is important, therefore, that you schedule an appointment.

We have attempted to reach you by phone but the number we were given is not correct. Please call us at () ____-____ by _____ (insert date which is 5 business days from the date you are sending this letter to the applicant) to schedule your appointment.

If you do not respond by the date above, your application for MA funded long-term living services will be terminated, which means that you will have to reapply for services.

Sincerely,

Exhibit C Settlement Mosely vs. Alexander

EXHIBIT C

All signed applications and other documentation, if any, gathered by the IEB under the process specified below must be submitted to the CAO no later than 40 calendar days from the Application Date. When a deadline under this process falls on a Saturday, on a Sunday or on a Pennsylvania legal holiday, then the deadline shall be the next business day.

A. SCOPE

- (1) For purposes of the Ongoing Process, "Applicant" means:
- An individual who signs or, on whose behalf the individual's representative signs a PA 600LWP; or
 - An MA recipient who expresses or whose representative expresses an intention to the IEB that the MA recipient be considered for participation in an OLTL Waiver

B. INITIAL CONTACT

- (1) When a potential consumer or consumer's representative calls the IEB, the IEB will determine whether the caller is making an "inquiry" or a "request to apply" for services. If the call is a "request to apply," the IEB proceeds to the step in subsection (2) below.
- (a) A contact is an inquiry if the individual is only requesting general information regarding OLTL Waivers or Waiver services or in-home services generally, but is not expressing any intention to be considered for participation in a Waiver. If any question exists as to whether a contact is an inquiry or a "request to apply," the contact should be treated as a request to apply.
- (b) The IEB must keep a record of the name, address and telephone number of each person making an inquiry and the date of the inquiry.

Exhibit C Settlement Mosely vs. Alexander

- (2) If the call is a request to apply, the IEB will follow a "Script," which is attached as Appendix A.
- (3) If, during the Initial Contact, the potential consumer decides not to proceed with the application process, the IEB will note that in its records and the case will be closed.
- (4) If the potential consumer says he/she wants to continue with the application process, the IEB will schedule an in-home Intake Visit, which **must** be conducted within seven (7) calendar days of the Initial Contact unless the potential consumer requests that the visit take place at a later date or there are other circumstances beyond the control of the IEB.
 - (a) If the Intake Visit does not occur within seven (7) calendar days of the Initial Contact, the IEB will note the reason for the delay in its records.
- (5) The IEB will check CIS prior to the Intake Visit to determine whether the potential consumer is an MA recipient.

C. INTAKE VISIT

- (1) The IEB will bring the following forms to all Intake Visits:
 - (a) Care Management Instrument (CMI)
 - (b) Freedom of Choice Form
 - (c) Service Provider Choice Form
 - (d) Authorization of Release of Information (PA4)
 - (e) Information about the Estate Recovery Program
 - (f) Citizenship Form
 - (g) Notice of Privacy Practices, includes Acknowledgement Form
 - (h) Waiver Participant's Rights and Responsibilities
 - (i) A flow chart entitled "PA Enrollment Broker (IEB) Application Process for Home and Community Based Service"

Exhibit C Settlement Mosely vs. Alexander

- (j) Notice of Right to Timely Eligibility Determination
- (2) If a potential consumer is not an MA recipient, in addition to the forms specified in subsection (1) above, the IEB will bring the following forms to the intake visit:
 - (a) 0192 Waiver Application (for the AIDS Waiver)
 - (b) PA 600L or PA 600WP (12 Community Choice counties)
- (3) The IEB will complete the CMI.
 - (a) If the CMI indicates that the consumer may not be programmatically or clinically eligible, the IEB will explain that a person must meet certain eligibility requirements to get waiver services, but the consumer has the right to file an application and continue with the application process.
 - (b) If the consumer or his/her representative wants to continue the application process:
 - (i) If consumer is an MA recipient, the IEB will proceed to the step in Section D. below.
 - (ii) **If consumer is an MA recipient, the date of the Intake Visit is the Application date.**
 - (c) If the consumer is not an MA recipient, the IEB will explain to the consumer or his/her representative that in order to begin the application process, the consumer or his/her representative must sign a PA 600L/WP and that the consumer or representative will have to complete the form and submit supporting documentation.
 - (i) If the consumer signs the PA 600L/WP at the Intake Visit, the consumer is an "Applicant."
 - (ii) If for some reason the consumer does not want to sign the PA 600L/WP form at the Intake Visit, the IEB will leave the form and explain to the consumer that the application process will not start until the form is signed and returned to the IEB.

Exhibit C Settlement Mosely vs. Alexander

(iii) **The date the consumer returns a signed PA 600L/WP to the IEB is the Application Date. In most cases, the Application Date will be the date of the Intake Visit.**

(4) The IEB will review the application process, including the need for a Physician Certification and a LOCA, and assist the consumer or his/her representative as necessary to complete the forms identified in (1) and (2) above.

D. POST-INTAKE VISIT PROCESS FOR APPLICANTS:

(1) **An Applicant must receive an eligibility determination within 90 days of the Application Date.**

(a) **If consumer is an MA recipient, the Application Date is the date of the Intake Visit.**

(b) **If the consumer is not an MA recipient, the Application Date is the date on which the consumer returns a signed PA 600L/WP to the IEB. In most cases, the Application Date will be the date of the Intake Visit.**

(2) For each Applicant, the IEB will:

(a) Within seven (7) calendar days of the Application Date, send a Physician Certification form (see OLTL Bulletin # 05-10-04, 51-10-04, 55-10-04, 59-10-04 (July 6, 2010)) to the Applicant's physician to be completed, unless the Applicant decides to get the form completed him/herself. The IEB will request the physician complete and send the form so that it is received by the IEB no later than ten (10) calendar days after the date the IEB sent the form to the physician.

(b) Within fifteen (15) calendar days of the Application Date, request the AAA to conduct and submit a LOCA to the IEB within fifteen (15) calendar days of the date of the request.

(i) The IEB will notify the AAA of the deadline which the IEB gave for submission of the Physician Certification.

Exhibit C Settlement Mosely vs. Alexander

- (ii) If the Physician Certification is received before the AAA submits the LOCA to the IEB, the IEB will forward the Physician Certification to the AAA.
 - (iii) If the Physician Certification is not received before the AAA conducts the assessment and completes the LOCA, then the AAA will complete the LOCA, but will note on the LOCA that the Physician Certification was not submitted and that the consumer is, therefore, NFI.
- (3) If LOCA is not completed and submitted to the IEB within fifteen (15) calendar days from the date on which the IEB requests the LOCA:
 - (a) Starting on the fifteenth (15th) day, the IEB will send two reminders to the AAA with a copy to OLTL, with the second reminder sent five (5) calendar days after the first reminder.
 - (b) If the LOCA is not received by the IEB within five (5) calendar days of the second reminder, the IEB will refer the case to OLTL for follow-up.
- (4) For each Applicant that the IEB refers to OLTL because it has not received a LOCA, within ten (10) calendar days of the IEB referral, OLTL will contact the AAA to determine why the LOCA has not been completed.
 - (a) If the AAA has been unable to complete the LOCA because the Applicant has refused to cooperate, or is no longer interested, OLTL will instruct the IEB to complete and submit a PA 1768 Form or an updated PA 1768 Form to the CAO verifying that the individual does not qualify for waiver services. In the comment section, the IEB will note whether the Applicant did not cooperate and, if so, the nature of the lack of cooperation or whether the Applicant is no longer interested in receiving OLTL waiver services.
 - (b) For all other Applicants, OLTL will set a deadline for completion of the LOCA, which will be no later than ten (10) calendar days after the contact with the AAA.

Exhibit C Settlement Mosely vs. Alexander

- (i) If the LOCA is not completed by the deadline, then OLTL will arrange for an assessment to be conducted and the LOCA completed by staff or designee of OLTL within five (5) calendar days. Subsection (6) will apply.
- (5) If the Physician Certification is not received by the deadline for completion of the LOCA, the assessor will conduct the assessment and complete the LOCA, but will note on the LOCA that the Physician Certification was not received and that the Applicant is therefore NFI.
- (6) If the IEB does not receive the physician cert within ten (10) calendar days from the date on which the IEB sent the Physician Certification form to the physician:
 - (a) Starting on the tenth (10th) day, the IEB will make a total of two (2) reminder calls to the physician, with the second call made five (5) calendar days after the first call, and at least one (1) call to the Applicant during that period, explaining that the application will be denied if the Physician Certification form is not received.
 - (b) If the IEB does not receive the Physician Certification form within seven (7) calendar days of the last reminder call, the IEB will send a written notice to the Applicant advising that, unless a Physician Certification is received within ten (10) calendar days of the notice, the Applicant may be determined ineligible for OLTL Waiver services.
- (7) For each Applicant for whom a LOCA has been completed by the AAA:
 - (a) If the Applicant is NFCE, within seven (7) calendar days of the date the LOCA is completed, the IEB will refer the Applicant to OLTL to determine whether the Applicant is Program Eligible for the OLTL Waiver identified by the IEB or another OLTL Waiver.
 - (i) Within seven (7) calendar days of receiving the referral, OLTL will notify the IEB whether the Applicant is Program Eligible for an OLTL Waiver.

Exhibit C Settlement Mosely vs. Alexander

- (ii) Within seven (7) calendar days of the date that OLTL determines whether the Applicant meets the Program eligibility criteria for an OLTL Waiver, the IEB will complete and submit a PA 1768 form to the CAO.
- (b) If the Applicant is NFI because the LOCA was completed without a Physician Certification, within seven (7) calendar days of the date of the LOCA determination, the IEB will complete and submit a PA 1768 to the CAO, along with the signed PA 600LWP and whatever supporting documentation has been provided to the IEB. The IEB will note in the comment section of the PA 1768 that the Applicant is NFI because the physician did not submit a Physician Certification. The IEB will also note whether the assessor's recommended level of care for the consumer is NFCE.
 - (i) If a Physician Certification is received by the IEB before the CAO issues a Notice of Eligibility/Ineligibility, and the physician recommends or orders nursing facility level of care, the IEB will complete and submit an updated PA 1768 Form noting that the Applicant is NFCE **provided that**, on the LOCA, the assessor's recommended level of care for the Applicant is NFCE.
- (c) If the Applicant is NFI based upon the LOCA, within seven (7) calendar days of the date of the LOCA determination, the IEB will complete and submit a PA 1768 to the CAO, along with the signed PA 600LWP and whatever supporting documentation has been provided to the IEB.
- (8) Whether or not the LOCA has been received, no later than forty (40) calendar days after the Application Date, the IEB must forward to the CAO the PA1768, the PA600WP/L, and all supporting documentation received by that date.
 - (a) If the LOCA has not been received as of the date the IEB forwards the application package to the CAO, the IEB will leave the ELIGIBILITY/PROGRAM ASSESSMENT INFORMATION section of the PA 1768 blank and note in the comment section that the LOCA is pending.

Exhibit C Settlement Mosely vs. Alexander

- (b) Once the LOCA is received, the IEB will send an updated PA 1768 Form to the CAO in accordance with section D.6.(c).
- (9) For each Applicant for whom the CAO receives an application package from the IEB, the CAO will:
 - (a) If the application includes all needed supporting documentation upon receipt, make a financial eligibility determination and Issue a Notice of Eligibility/Ineligibility no later than forty-five (45) calendar days from the date the CAO receives the application package; or
 - (b) If the application is missing needed supporting documentation, request that the Applicant provide additional supporting information within ten (10) calendar days and issue a Notice of Eligibility/Ineligibility no later than forty-five (45) calendar days from the date the CAO receives the application package.
 - (c) If the individual was marked NFI because the physician did not submit a Physician Certification, but the assessor's recommended level of care for the consumer is otherwise NFCE (see subsection D.(7)(b), above), the CAO will not issue the Notice of Ineligibility/Eligibility prior to receipt of the Physician Certification or prior to forty-five (45) days of receipt of the application package, whichever occurs first.

E. POST INTAKE PROCESS FOR NON APPLICANTS:

- (1) If the individual, who is not an MA recipient, does not sign the PA 600L/WP at the Intake Visit, the individual is not considered an "Applicant."
- (2) For each such individual, the IEB will:
 - (a) Within thirty (30) calendar days of the Intake Visit, contact the individual by written correspondence that includes a PA 600L/WP asking if he/she is still seeking OLTL Waiver services and offering to assist the individual to complete the form;

Exhibit C Settlement Mosely vs. Alexander

- (b) If the individual requests assistance, the IEB will schedule an Intake Visit, which must occur within seven (7) calendar days of the individual's request.
- (c) If the Applicant submits a signed PA 600LWP in response to the IEB's inquiry, the steps in Section D. (1) through (9) will apply.
- (d) If the IEB does not receive a signed PA 600LWP form within thirty (30) days, the IEB will notify the individual that no further action can be taken because the form has not been signed and that his/her case is closed but can be reopened when the signed form is received.

Exhibit C Settlement Mosely vs. Alexander

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Accessing the Boston University Center for Aging and Disability Education and Research Online Curricula

1. Go to the Long Term Living Training Institute of Pennsylvania home page. The web address is <http://www.ltltrainingpa.org>.
2. Select the Boston University Center for Aging and Disability Education and Research link.

The screenshot shows the homepage of the Long Term Living Training Institute of Pennsylvania (LTLTI). The header includes the LTLTI logo and the text "LONG TERM LIVING TRAINING INSTITUTE OF PENNSYLVANIA". Navigation links include HOME, ABOUT US, ONLINE RESOURCES, CAREGIVER INFORMATION, TECHNOLOGY, LINKS, CONTACT, and CAREERS. A "1" is placed over the "HOME" link. Below the navigation bar are three images: a woman and a man talking, a bridge over a river, and an elderly man. The main content area is titled "WELCOME TO LTLTI" and contains a welcome message, a note about browser zooming, and contact information. A "2" is placed over the "Affordable Housing for Older Adults and People with Disabilities" link in the "NEWS & ANNOUNCEMENTS" section. On the right side, there is a "LTLTI PORTAL" section with a "LOG IN TO YOUR TRAINING ACCOUNT" button and a "Register your training account" link. Below that is an "OTHER TRAINING RESOURCES" section with links to "Boston University Center for Aging and Disability Education and Research", "Brain Injury Association of Pennsylvania", and "Centers for Medicare and Medicaid Services".

Boston University Training Modules

3. Follow the instructions on the screen, and in the links, to create your account and access the courses.

The screenshot shows the LTLTI website interface. At the top, there is a header with the LTLTI logo and the text 'LONG TERM LIVING TRAINING INSTITUTE OF PENNSYLVANIA'. To the right of the header are links for 'register Account' and 'dashboard login'. Below the header is a green navigation bar with links for 'HOME', 'ABOUT US', 'ONLINE RESOURCES', 'CAREGIVER INFORMATION', 'TECHNOLOGY', 'LINKS', 'CONTACT', and 'CAREERS'. The main content area features three images: a man at a computer, the Pennsylvania State Capitol building, and two men in wheelchairs. Below the images is the text 'BOSTON UNIVERSITY CENTER FOR AGING AND DISABILITY EDUCATION AND RESEARCH'. A red 'BOSTON UNIVERSITY' logo is present. A callout box with the number '3' points to the 'Online Course Catalog for PA Long Term Care Professionals' section. This section contains a paragraph about the online curricula, followed by several links: 'Instructions for Setting up a BU Web Account', 'Instructions for Enrolling in the LTLTI Program', 'Instructions for Accessing the LTLTI Program', 'Link to Course Access Page', 'Frequently Asked Questions', and 'Technical Assistance'. Below these links is the BU IGSW Website Home URL: <http://www.bu.edu/phpbin/registration-manager-catalogs/cader-agency-23/app/catalog.php>. Other links include 'Core Training - User Guide', 'Core Training - Supervisor Guide', 'Assessor Training - User Guide', and 'Assessor Training - Supervisor Guide'. To the right of the main content is the 'LTLTI PORTAL' section, which includes a paragraph about account registration, a 'LOG IN TO YOUR TRAINING ACCOUNT' button, and a link to 'Register your training account'. Below this is the 'OTHER TRAINING RESOURCES' section with links to 'Boston University Center for Aging and Disability Education and Research', 'Brain Injury Association of Pennsylvania', 'Centers for Medicare and Medicaid Services', 'PCMI', 'Pennsylvania Homecare Association', and 'Take Charge'. At the bottom right is the 'UPCOMING EVENTS' section with details for 'Tier One Training' at the Delaware County Office of Services for the Aging (COSA) in Eddystone, PA, on 07/11/2013 from 8:00AM.

Mandatory Activities and Referrals

Mandatory Activities and Referrals

Mandatory	Description	Service	Care Program	Status to be used	Due Date
Aging Waiver Annual Recertification	The date that the annual recertification is due next	LCD – Level of Care Recertification	PDA Waiver	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	Indicate the date that the next recertification is due to be completed
PCH/Dom Care Annual Recertification	The date that the annual recertification is due next	LCD – Level of Care Recertification	Non-Care Managed	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	Indicate the date that the next recertification is due to be completed
Contact Consumer Contact Family Contact Other	The date that contact must be made with either the participant/applicant, family or other	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Waiver recertification	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	Indicate the date that this activity is due
Request Medical (If applicable)	The date the request for the medical needs to be sent, faxed or e-mailed to the physician (PCH and Dom Care annual recertification only)	LCD – Level of Care (Initial/Change)	Non-Care Managed	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	

Mandatory Activities and Referrals

Mandatory	Description	Service	Care Program	Status to be used	Due Date
Date of Assessment	The date that the face-to-face visit must occur	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Waiver recertification	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	Due date is 7 calendar days from the date of Referral as noted in the Journal
RN LCD Review (Level of Care)	The date that the RN must review and sign off. This date should be equal to or less than the date level of care determined.	LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Wavier recertification	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	
Supervisor LCD Review (Level of Care Assessment)	The date that the Supervisor must review and sign off. This date should be equal to or less than the date level of care determined.	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	
Date Level of Care Determined	The date that the level of care must be completed	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Wavier recertification	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	
Level of Care Determination prepare and distribute	The date that the Level of Care Determination Notice must be issued to the individual and/or their responsible party, the referral source and the CAO if applicable	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Wavier recertification	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	

Mandatory Activities and Referrals

If follow up is going to be scheduled for the medical or with the individual, their family or other, the Actions and Journal Topics below are to be completed.

Mandatory	Description	Service	Care Program	Status to be used	Due Date
Follow up with physician		LCD – Level of Care (Initial/Change)	Non-Care Managed	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	
Contact Consumer/ Contact Family Contact Other	The date that contact must be made with either the individual, family or other	LCD – Level of Care Recertification or LCD – Level of Care (Initial/Change)	Non-Care Managed unless Aging Wavier recertification	<ul style="list-style-type: none"> – Not Started – Scheduled – In Progress – Completed – Cancelled 	

Mandatory Activities and Referrals

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Mandatory Journal Topics

Mandatory Journal Topics

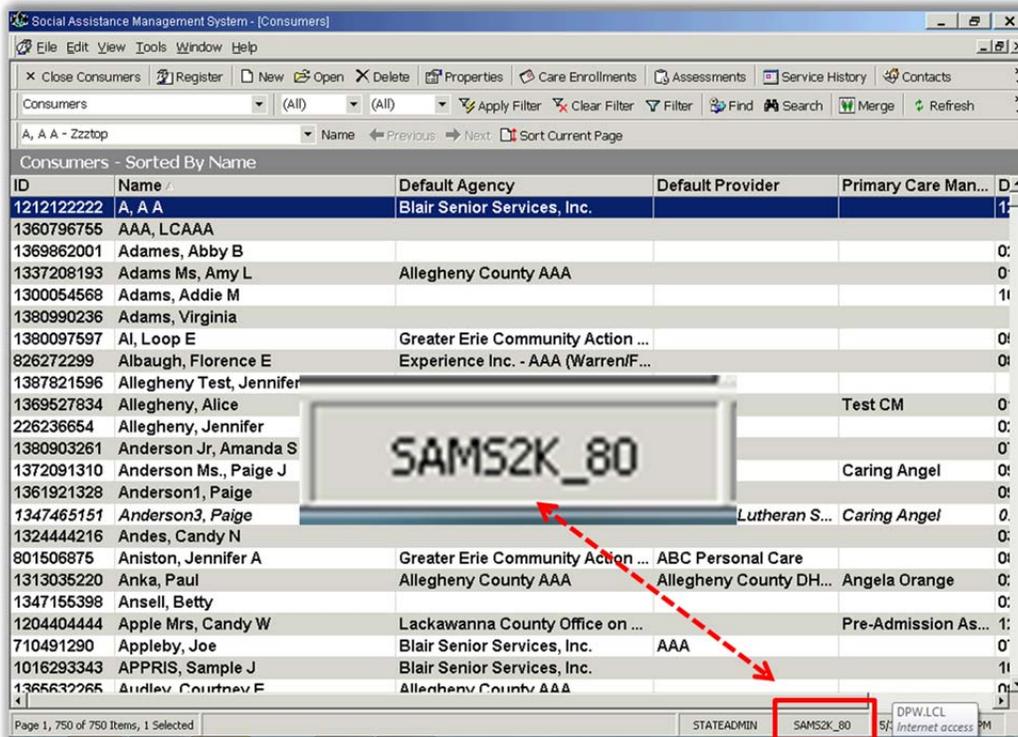
Mandatory Topic	Description	What is to be documented – any acronyms used need to be universally understood
Referral	The date that an individual or someone on behalf of an individual makes contact with the AAA requesting an assessment from the AAA via phone, fax, e-mail or in person	The name of the person making the referral, pertinent information provided, purpose of referral if given, method of referral received
Contact consumer Contact family Contact other	The date that the contact occurred	Journal should indicate what took place during the contact and the type of contact, phone, e-mail, etc. It should also include the person who was contacted, purpose of contact, what occurred during contact and any follow up. <i>Documentation of these contacts with the individual/Family and Other is required for reporting compliance with the Mosley settlement requirements.</i>
Request medical (If applicable)	The date the medical information was requested	The Journal note should include where and in what format the medical was requested
Date of Assessment	The date the assessment occurred (face-to-face visit)	The Journal note should include where and who was present for the assessment and any other pertinent information that was provided or exchanged during the visit that is not already documented in the LCD

Mandatory Journal Topics

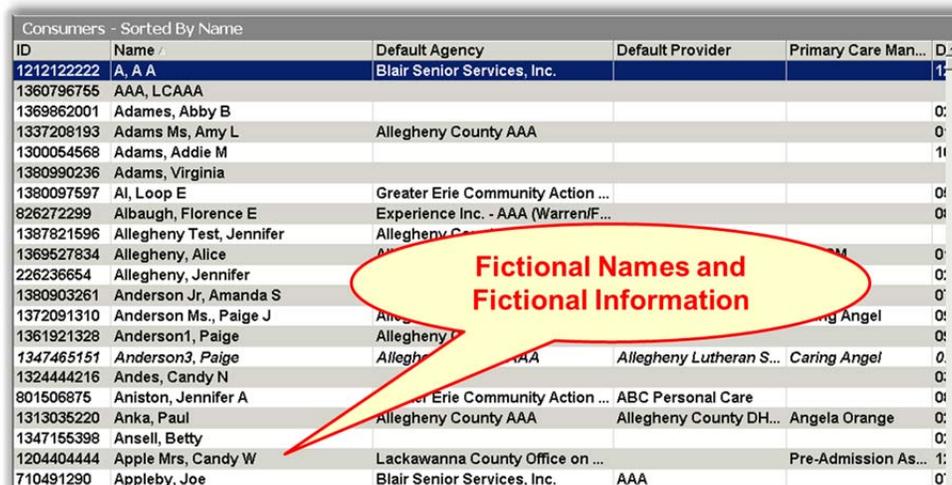
Mandatory Topic	Description	What is to be documented – any acronyms used need to be universally understood
Date level of Care Determined	the date that the level of care was completed	This Journal topic is to be entered for the date that the LCD is signed off by the Assessor, AAA RN (if applicable) and the Supervisor
Level of Care Determination prepare and distribute	The date that the Level of Care Determination Notice was issued	The Journal should include how and to whom the notice was sent, ie, via e-mail, mail, fax
Follow up with physician	The date that the follow up for the medical occurred	The Journal should indicate type of contact, who the AAA contacted, what occurred during the contact and outcome

SAMS_80 Training Database

The SAMS_80 Training Database is available to all SAMS users.



It contains no consumer information (all fictional information) and can be used as a learning tool.



SAMS_80 Training Database

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Custom Searches and Dashboard

Use Custom Search to build a customized report for your Dashboard.

Comments	Custom Search Title	Description
Custom Search	Activity Search	A list of activities with attribute and consumer demographic filters.
Custom Search	Consumer Search	A list of consumers with demographic filters.

Title	Description	Shared W...	Create User	Last ...	Last ...	Comments
#2 ISP Review	JAB 2012	Agency	Judy Beck	Judy ...	4/29/2...	
#2 ISP SUP REVIEWS	ISP SUBMI...	Agency	Tawnya Burke	Sean ...	1/24/2...	ISP REVIEWS/APPROVALS 1/23/2013
000 Activity & Referral-Bairl		Provider	Julie Bair	Julie ...	5/3/20...	
0000-Activity/Referral Status- Williard		Provider	Nathan Williard	Natha...	3/12/2...	
000-Activity/Referral- Miller		Provider	Nathan Williard	Shee...	5/3/20...	
01 - Adam's ISP Review		Agency	Adam Fetty	Adam...	6/13/2...	
01 - Alicia Master Approved ISP		Agency	Alicia Master	Alicia ...	6/13/2...	
01 - Alicia Master ISP Review		Agency	Alicia Master	Alicia ...	6/13/2...	
01 - Amy Hromek Approved ISP		Agency	Amy Hromek	Amy ...	6/13/2...	
01 - Amy Hromek ISP Review		Agency	Amy Hromek	Amy ...	6/13/2...	
01 - AR LOCA due dates		Agency	Amanda Trenn	Aman...	4/22/2...	
01 - Chianti Thomas Approved ISP		Agency	Chianti Thomas	Chian...	6/13/2...	
01 - Courtney Tome Approved ISP		Agency	Courtney Tome	Court...	6/14/2...	
01 - Courtney Tome ISP Review		Agency	Courtney Tome	Court...	6/14/2...	
01 - Initial ISP Review Approvals		Agency	Leslie Demaske	Leslie...	8/13/2...	
01 - ISP Review Approvals		Agency	Leslie Demaske	Leslie...	8/13/2...	
01 - ISP Reviews		Agency	Leslie Demaske	Leslie...	6/12/2...	
01 - Joanna Activities due		Agency	Joanna Ream	Joan...	1/25/2...	
01 - Joanna Approved ISP		Agency	Joanna Ream	Joan...	4/23/2...	
01 - Joanna ISP Review		Agency	Joanna Ream	Joan...	6/14/2...	
01 - Kanchana Approved ISP		Agency	Kanchana Matson	Kanc...	8/10/2...	
01 - Kanchana ISP Review		Agency	Kanchana Matson	Kanc...	5/8/20...	
01 - Kim Hutzelman Approved ISP		Agency	Kim Hutzelman	Kim ...	1/9/20...	
01 - Kim Hutzelman ISP Review		Agency	Kim Hutzelman	Kim ...	1/9/20...	
01 - Kim Huyck's ISP Approvals		Agency	Leslie Demaske	Kim ...	6/13/2...	
01 - Kim Huyck's ISP Reviews		Agency	Leslie Demaske	Leslie...	3/13/2...	
01 - Lana Approved ISP		Agency	Lana Locanto	Lana ...	1/20/2...	
01 - Lana Approved ISP		Agency	Lana Locanto	Lana ...	1/20/2...	
01 - Lana Approved ISP		Agency	Lana Locanto	Lana ...	1/20/2...	

Custom Searches and Dashboard

Use Filters to specify the information you want to view from that report. Save the filtered Custom Search and create a Saved Widget to view on your Dashboard.

The screenshot displays the 'Social Assistance Management System - [DDS Assessment Report - Activity Search]' window. The interface includes a menu bar (File, Edit, View, Tools, Window, Help) and a toolbar with options like 'Close Search', 'Save Search', 'Clear All Filters', 'Print Results', 'Preview Search', 'Refresh Search', and 'Export Results'. The main content area is titled 'DDS Assessment Report - Activity Search' and is divided into two sections: a filter panel on the left and a data table on the right.

The filter panel on the left contains the following sections and options:

- Search Title:** DDS Assessment Report
- Comments:**
- Description:**
- Shared With:** (All)
- Modifications Allowed:** (All)
- (Search Results):** (8 Items)
- Choose Columns:** (8 Items)
- Activity/Referral:**
 - Action: (3 Items)
 - Status: (6 Items)
 - Reason: (5 Items)
 - Date Filter Type: (None)
 - Date Filter Range: Any
 - Followup Status: (Any)
 - Agency: (Any)
 - Provider: (Any)
 - Service: (Any)
 - Subprovider: (Any)
 - Action Level of Care: (Any)
 - Action Service Program: (Any)
 - Action Care Program: (Any)
- Care Enrollment:**
- Care Managers:**
 - Care Manager: Hawah Konneh
 - Apply Today Filter? (Effective As of Today): No
 - Primary Care Manager Designation: Yes
 - Date Filter Type: (None)
 - Date Filter Range: All
- Consumer Details:**
- Providers:**
- Search Header:**
 - Subtitle:

The data table on the right has the following columns: Client Id, Reason, and Primary Care Manager. The table contains 8 rows of data, all with 'Hawah Konneh' as the Primary Care Manager. The first row is highlighted in blue.

Client Id	Reason	Primary Care Manager
1400225933	Additional information requested/required	Hawah Konneh
1400225639	Additional information requested/required	Hawah Konneh
1400225381	Additional information requested/required	Hawah Konneh
1400215287	Additional information requested/required	Hawah Konneh
1400214756	Additional information requested/required	Hawah Konneh
1400214756	Additional information requested/required	Hawah Konneh
1400214756	Additional information requested/required	Hawah Konneh
1400214756	Additional information requested/required	Hawah Konneh

A red callout bubble with a yellow background and red border points to the filter panel. The text inside the bubble reads: "Filter to specific parameters to show the information you want to see on your Dashboard".

The status bar at the bottom of the window shows: 11 Rows, STATEADMIN, SAMS2K_PA_STATE, 5/30/2013, 3:45 PM.

Custom Searches and Dashboard

Saved Widgets allow you to select the reports viewed on your Dashboard. Choose a Custom Search to create a Saved Widget for your Dashboard.

Social Assistance Management System - [Dashboard]

File Edit View Tools Window Help

Dashboard Consumers Activities & Referrals Rosters Routes Reports Custom Search

New Call Call Log Search for Services

Dashboard Consumers Test, A-Margo - Consumer Custom Searches DDS Assessment Report - Activity Search

State Admin's Dashboard

Saved Search Widget

Choose the saved search you would like this widget to display:

- DDS - 3 Month Contact [Activity Search]
- DDS - follow up contacts [Activity Search]
- DDS - NHT Follow Up Contacts [Activity Search]
- DDS - Track Consumer Record Status re: Enrollment Services [Activity Search]
- DDS Assessment Report [Activity Search]**
- DDS-Service Plan Review [Activity Search]
- DDS-Two Week Follow Up Contact [Activity Search]
- Decreases for Central Region [Activity Search]

Choose your Custom Search

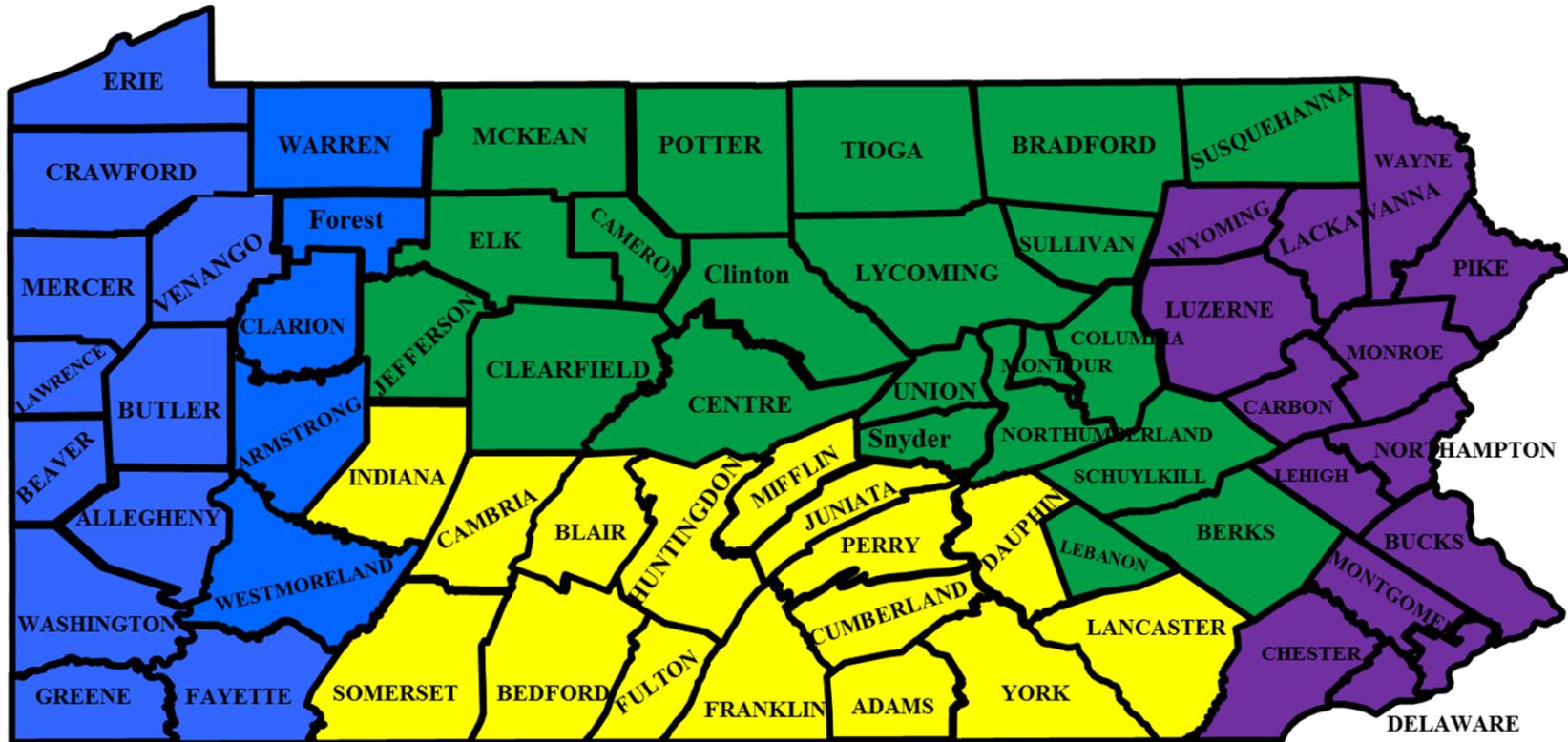
Custom Searches and Dashboard

View that report (Saved Widget) on your Dashboard. Create several Saved Widgets to view multiple reports on your Dashboard.

The screenshot shows the 'Social Assistance Management System - [Dashboard]' interface. The main content area is titled 'State Admin's Dashboard' and features a 'DDS Assessment Report [Activity Search]' table. The table has columns for Subject, Start Date, End Date, Due Date, Action, Full Name / Reason, and Primary Care Manager. A red box highlights the last two rows of the table.

Subject	Start Date	End Date	Due Date	Action	Full Name / Reason	Primary Care Manager
annual recert	03/10/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Ashford, Melanie V Additional information requested/required	Hawah Konneh
annual recert	03/09/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Ashford, Melanie V Additional information requested/required	Hawah Konneh
annual recert	03/10/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Carter, Arlene Additional information requested/required	Hawah Konneh
annual recert	03/09/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Davidson, Rita Additional information requested/required	Hawah Konneh
annual recert	03/09/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Gallagher, Theresa M Additional information requested/required	Hawah Konneh
Annual Recert (late entry)				Annual Recert w/MA-51/PDA Waiver	Gregg, Sarah D Additional information requested/required	Hawah Konneh
annual recert	03/10/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Johnson, Mary Additional information requested/required	Hawah Konneh
annual recert	03/10/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Johnson, Mary Additional information requested/required	Hawah Konneh
annual recert	03/10/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Pitts, Josephine E Additional information requested/required	Hawah Konneh
annual recert	03/10/2009		01/15/2009	Annual Recert w/MA-51/PDA Waiver	Reed, Octavia H Additional information requested/required	Hawah Konneh
MA-51 Requested				Annual Recert w/MA-51/PDA Waiver	Robinson, Helen L Additional information requested/required	Hawah Konneh
Assessments Due				Annual Recert w/MA-51/PDA Waiver	Test, A-Margo Pending Approval-Supervisor	Hawah Konneh

Quality and Compliance Unit Regions



Anna Marie Cename

George Diamond

Dana Ehrhart

Kathryn Skrinak

QCS Coverage Area

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On-Site Level of Care Monitoring Tool

Level of Care Standards	
Time Frame Requirements	
The LCD was completed within 15 day time frame	
If not within required time frames, there is documentation to support the reason in SAMS	
Based on OLTL Bulletin 55-12-03, the AAA completed LCD and submitted to the IEB in 15 days	
The AAA adhered to documentation required for delays in submission to the IEB in SAMS in accordance with the OLTL Bulletin	
Level of Care Quality content review	
Physical Health	
Documentation	
Impact on LOC	
Medication Management	
Documentation	
Impact on LOC	
ADL	
Documentation	
Impact on LOC	
Mobility	
Documentation	
Impact on LOC	
IADL	
Documentation	
Impact on LOC	
Section 12 Assessment Outcome Question #4 summarizes the LCD Tool content	
The LCD supports the level of care determination	

On-Site Level of Care Monitoring Tool

OBRA Target requirements	
Completed LCD and Section 12 Assessment Outcome question #4 except for LOC Determination	
PASARR-EV completion	
Transmittal Form completion	
Transmittal indicates recommended level of care and Specialized or non-specialized services	
Ancillary Documentation as required by Program Office submitted to Program Office	
PASARR Y/N Form from Program Office received	
Non-target requirements:	
Completed LCD and completion of Section 12 Assessment Outcome Question #4	
Supervisory Review	
RN review	
RN home visit conducted to address LOC discrepancy	
Required signatures	
LOC determination to CAO	
PCH/Dom Care Recertification only	
Notification to PCH/Dom Care 60 days prior to recertification date to obtain an MA51/Script	
Recertification occurs 365 days from date of assessment	
PA 1768 and PA 745 forwarded to CAO	
Determination Report to CAO	

SAMS Reports

Initial LOCA Assessments, NFCE with 15 day rule – Summary Only FY 12 – 13

Summary by Agency
LOCA assessments not in compliance with 15 day rule for LOCAs
between 07/01/2012 and 04/30/2013 by Agency as of 5/31/2013

<u>AAA</u>	<u>Number of Assessments</u>	<u>Number Out of Compliance</u>	<u>Percent Out of Compliance</u>
	1,222	8	0.7%
	361	6	1.7%
	374	4	1.1%
	763	37	4.8%
	296	10	3.4%
	4,826	107	2.2%
	1,586	88	5.5%
	1,491	175	11.7%
	192	6	3.1%
	638	14	2.2%
	769	4	0.5%
	385	6	1.6%
	214	48	22.4%
	691	307	44.4%
	423	31	7.3%
	364	49	13.5%
	216	6	2.8%
	260	120	46.2%
	449	147	32.7%
	253	24	9.5%
	649	7	1.1%
	60	10	16.7%
	638	140	21.9%
	534	12	2.2%
	1,526	168	11.0%
	1,198	284	23.7%
	483	61	12.6%
	1,580	48	3.0%
	1,014	13	1.3%
	922	25	2.7%
	3,220	335	10.4%
	1,013	68	6.7%
	1,164	25	2.1%
	567	6	1.1%
	20	2	10.0%
	419	22	5.3%
	1,440	383	26.6%
	678	340	50.1%
	153	3	2.0%
	541	7	1.3%
	334	25	7.5%
	234	7	3.0%
	290	18	6.2%
	234	8	3.4%
	262	2	0.8%
	358	4	1.1%
	367	113	30.8%
	274	5	1.8%
	138	6	4.3%
	436	9	2.1%
	99	2	2.0%
	129	1	0.8%
	3	0	0.0%
	11	0	0.0%
Statewide	36,761	3,356	9.1%

SAMS Reports

Initial LOCA Assessments, NFCE with 15 day rule – Summary Only FY 11 – 12

Summary by Agency			
LOCA assessments not in compliance with 15 day rule for			
LOCAS between 07/01/2011 and 06/30/2012 by Agency			
as of 5/31/2013			
<u>AAA</u>	<u>Number of Assessments</u>	<u>Number Out of Compliance</u>	<u>Percent Out of Compliance</u>
	1,453	31	2.1%
	498	2	0.4%
	466	10	2.1%
	814	12	1.5%
	376	16	4.3%
	5,790	407	7.0%
	1,897	114	6.0%
	1,822	213	11.7%
	212	12	5.7%
	772	36	4.7%
	888	13	1.5%
	470	9	1.9%
	340	78	22.9%
	841	419	49.8%
	528	57	10.8%
	395	200	50.6%
	257	7	2.7%
	246	86	35.0%
	531	85	16.0%
	317	16	5.0%
	835	5	0.6%
	110	16	14.5%
	673	222	33.0%
	490	19	3.9%
	1,822	158	8.7%
	1,364	267	19.6%
	722	257	35.6%
	2,330	211	9.1%
	1,192	14	1.2%
	1,185	127	10.7%
	5,660	1,426	25.2%
	1,139	137	12.0%
	1,502	43	2.9%
	663	8	1.2%
	51	3	5.9%
	471	14	3.0%
	1,751	305	17.4%
	756	392	51.9%
	177	2	1.1%
	702	12	1.7%
	436	40	9.2%
	344	14	4.1%
	360	48	13.3%
	265	47	17.7%
	304	11	3.6%
	481	3	0.6%
	478	65	13.6%
	330	7	2.1%
	164	1	0.6%
	464	114	24.6%
	116	3	2.6%
	160	4	2.5%
	2	0	0.0%
	85	11	12.9%
Statewide	46,497	5,829	12.5%

Instructions for Completing the Level of Care Determination (LCD) Tool

PREAMBLE

The previous tool known as the LOCA (Level of Care Assessment) has now been replaced by the LCD (Level of Care Determination) tool. All information contained in the LCD is essential to determine a level of care. Information previously found in the LOCA has been moved to the new Needs Assessment Tool (NAT) because the information was found to be most appropriate when developing a service plan, not when determining a level of care. Use of the LCD will improve consistency with documentation in the assessments by decreasing text entries.

Medical conditions now display drop down boxes for each type of diagnosis. The diagnosis section lists common diagnoses and the category of “other” for selections of diagnoses not provided. Each question has a notes section for expanded documentation. Each diagnosis section contains a question on the individual’s ability to manage their care based on the functional limitations of their diagnosis. This is instrumental in determining a level of care.

Federal reporting requirements necessitate the retention of some information that may not appear relevant. There is no longer any reference to locus of care and placement preferences with the exception of Personal Care Home (PCH) information.

The Short Portable Mental Status Questionnaire has been added, placed before the medical condition section, and must be completed. This enables the assessor to determine the cognitive ability of the individual to answer questions pertaining to medical diagnoses and functional ability. In the event of a cognitive impairment, the assessor must contact formal and informal support systems of the individual and the primary care physician to assist with accurate information for the level of care determination. If the AAA chooses to utilize another cognitive test, they can do so but only in addition to the SPMSQ.

The Decision Narrative has been removed. Summary documentation to support the level of care determination is now included in Section 12.B. If Section 12.A. Assessment Outcome, Question 4 is answered “yes”, the assessor will be required to complete Section 12.B. by providing detailed documentation to support level of care.

Level of Care Determination Tool Instructions

The LCD is recorded in OMNIA and can be transferred to the Needs Assessment Tool (NAT) using the SAMS copy feature (refer to SAMS instructions). Therefore, it is important that information documented in the LCD is accurate; numbers and spelling must be correct.

The assessment tool also has an algorithm to assist with clinical eligibility determinations. Certain responses on the tool will facilitate the appropriate clinical eligibility determination. The assessor's professional judgment, with justification thoroughly documented, can differ from the outcome of the algorithm. The LCD tool will improve documentation and the results can be utilized by the Department for quality initiatives and general data collection regarding the people that are served.

The assessors, registered nurses, and supervisors must ensure that when logging into OMNIA/SAMS that they use their individually assigned User IDs and passwords. The data recorded must be entered by the logged in user. This ensures the accuracy and integrity of the data entered. OMNIA will use the User ID to record an electronic signature for the individual completing their portion of the assessment tool. The electronic signature replaces the need for hard copy signatures. Failure to follow these instructions could be considered fraudulent documentation.

Level of Care Determination Tool Instructions

1. INTRODUCTION

NOTE: *Refers to Federal NAPIS (National Aging Program Information Systems) reporting requirements. These questions MUST be completed for each individual.

1.A. Individual's Identification

Question 1. Date of Referral:

Using the MM/DD/YYYY format, document the date that the agency received a referral for a level of care assessment.

Question 2. Individual's Last Name:

Document the last name of the individual as it appears on his/her birth certificate or social security card.

Question 3. Individual's Name Suffix (if applicable):

Document name suffix (e.g. Sr. or Jr.).

Question 4. Individual's First Name:

Document the first name of the individual as it appears on his/her birth certificate or social security card.

Question 5. Individual's Middle Initial:

Document the individual's middle initial as it appears on his/her birth certificate or social security card.

***Question 6. Individual's Date of Birth(DOB):**

Using the MM/DD/YYYY format, document the individual's date of birth.

Question 7. Individual's Nickname/Alias:

Document the individual's nickname or alias (e.g. Josephine, alias – Jay).

***Question 8. Individual's Gender:**

Document if the individual is a male or female.

Level of Care Determination Tool Instructions

***Question 9. Individual's Ethnicity:**

Document the individual's ethnicity as described by the individual. Select only one response (box).

***Question 10. Individual's Race:**

Document the individual's race as described by the individual. Select only one response (box).

Question 11. Individual's Social Security Number (SSN):

Enter the individual's SSN. The individual must present their SSN to apply for services in the community or nursing facility.

Question 12a. Does the individual have a Medicaid number?

Answer "Yes", "No", or "Pending".

"Pending" would be used when an individual is being assessed for enrollment in an MA Waiver or has otherwise indicated that they have completed or are in the process of completing a PA 600 for MA benefits.

Question 12b. Indicate Medicaid Number:

Enter the individual's Medicaid number, if applicable.

Question 13a. Does the individual have Medicare?

Answer "Yes" or "No".

Question 13b. Indicate the Medicare Number:

Enter the individual's Medicare number.

Question 14a. Does the individual have any other insurance?

Answer "Yes", "No", or "Don't Know".

Question 14b. Indicate the other insurance Information:

Document the name of the individual's supplemental insurance.

Level of Care Determination Tool Instructions

1.B. Assessment Information

Question 1. Indicate the PSA number of the agency conducting the assessment:

Document the agency PSA (Planning and Service Area) number.

Question 2. Indicate type of assessment:

Document the type of assessment completed. Select only one response (box).

Question 3. Where was the individual interviewed?

Document the location where the individual was interviewed. Select only one response (box).

Question 4. Date of visit/chart review:

Using the MM/DD/YYYY format, enter the date of the visit/chart review. A chart review should only be utilized if the individual is deceased. All other assessments should be face-to-face, except in rare instances, such as out of state individuals looking to transfer to Pennsylvania. Documentation of any situation where a face-to-face visit did not occur is required.

Question 5. Did the individual participate in the assessment?

Answer "Yes" or "No".

Question 6. If anyone else participated during the time of the determination, please document the relationship (document name in notes):

Document all present at the interview. Select all response boxes that apply.

List names and relationships in the notes section.

Question 7. Identify who referred the individual for assessment:

Document all referral sources. Select all response boxes that apply, as there may be more than one referral source.

Level of Care Determination Tool Instructions

1.C. Individual's Demographics

***Question 1. Type of residence in which the individual resides:**

Document type of residence the individual lives in. Select only one response (box).

***Question 2. What is the individual's PRIMARY living arrangement? (Include in the "Lives Alone" category, individuals who live in an Assisted Living, Dom Care, or PCH, pay rent and have no roommate:**

Document the appropriate primary living arrangement. If the individual lives alone but lives in Assisted Living, Dom Care, or PCH, pays rent and has no roommate, check the "lives alone" box and indicate in the notes section the type of living arrangement.

***Question 3. Individual's Marital Status:**

Document the marital status of the individual. Select one response (box).

***Question 4a. Is the individual a Veteran?**

Select "Yes", "No", or "Unable to Determine". Select one response (box). If "Unable to Determine", describe in notes section.

Question 4b. Is the individual the spouse or child of a Veteran?

Select "Yes", "No", or "Unable to Determine". Select one response (box). If "Unable to Determine", describe in notes section.

***Question 5a. Does the individual require communication assistance?**

Select "Yes", "No", or "Unable to Determine". Select one response (box). If "Unable to Determine", describe in notes section.

Question 5b. What type of communication assistance is required?

Document the type of assistance that the individual requires for communication.

If the individual is unable to communicate, the care manager should check the response (box) entitled "Unable to Communicate".

Use the notes section to clarify the type of language assistance used, such as an interpreter, or mechanical assistance (e.g. letter board).

Level of Care Determination Tool Instructions

Question 6a. Does the individual use sign language as their PRIMARY language?

Indicate “Yes” or “No”. Select one response (box).

Question 6b. What type of sign language is used?

Document the type of sign language the individual uses. Select one response (box). If “Other”, describe in notes section.

***Question 7. What is the individual’s PRIMARY language?**

Document the primary language understood and used by the individual. If not listed, indicate “Other” and describe in notes section.

1.D. Individual’s Residential Address Information

***Municipality Required**

Question 1. Is the individual’s postal/mailing address exactly the same as the residential address?

The purpose of this section is to document the individual's postal/mailing address which may not be the same as their residential address.

Indicate “Yes” or “No”. If “No”, complete section 1E – Postal/Mailing Address.

Question 2a. Residential County:

Indicate the county where the individual resides.

Question 2b. Residential Street Address:

Indicate the address where the individual resides.

Question 2c. Residential Address Second Line (Apartment, Room Number, Building, or Complex Name, etc.):

Document the apartment number or room number and the name of the building or complex (if applicable) where the individual resides (Ex: Apt #3, Independence Court).

***Question 2d. Residential Municipality- Required:**

This is the township or borough where the individual votes and pays taxes.

Level of Care Determination Tool Instructions

Question 2e. Residential City/Town:

Document the city/town where the individual resides.

Question 2f. Residential State:

Document the state where the individual lives.

Question 2g. Residential Zip Code:

Document the zip code where the individual lives.

Question 3. Directions to the individual's home:

Document the driving directions to the individual's home.

***Question 4. Does the individual reside in a rural area?**

Indicate "Yes" or "No".

Question 5a. Primary Telephone Number:

Document the PRIMARY phone number of the individual.

Question 5b. Mobile Phone Number:

Document the individual's mobile phone number.

Question 5c. Other Phone Number:

Document any other ancillary phone number where an individual may be reached.

Question 5d. Email Address:

Document the individual's email address.

***Question 6. What was the outcome when the individual was offered a Voter Registration Form? – Required:**

Select one response (box).

Level of Care Determination Tool Instructions

1.E. Individual's Postal/Mailing Address Information

Question 1a. Postal Street Address:

Document the street address of the individual's residence.

Question 1b. Postal Address Line 2 (optional):

Document the building number (if applicable) of the individual's residence.

Question 1c. Postal City/Town:

Document the city or town where the individual resides.

Question 1d. Postal State:

Document the state where the individual resides.

Question 1e. Postal Zip Code:

Document the zip code of the individual.

2. USE OF MEDICAL SERVICES

2.A. Hospitals, Nursing Facilities, ER, and Inpatient Psychiatric Visits/Stays

Question 1. Has the individual stayed in the HOSPITAL in the last 12 months?

Select one response (box) – “Yes”, “No” or “Unable to Determine”. If “Unable to Determine,” describe in notes section.

Question 2. The approximate number of times the individual stayed overnight in the HOSPITAL in the last 12 months:

Indicate in the box the number of times the individual stayed in the hospital in last 12 months.

Level of Care Determination Tool Instructions

Question 3. The approximate number of times the individual has visited the ER in the last 12 months and was not admitted:

Indicate in the box the number of times the individual visited the ER and was not admitted.

Question 4. The approximate number of times the individual has stayed in a Nursing Facility in the last 12 months:

Indicate in the box the number of times the individual stayed in a Nursing Facility in the last 12 months.

Question 5. The approximate number of times the individual has had Inpatient Psychiatric visits/stays in the last 24 months:

Indicate in the box the number of times the individual has had Inpatient Psychiatric visits or stays in the last 24 months.

2.B. Primary Physician Information

Question 1. Does the individual have a Primary Care Physician?

Answer "Yes" or "No".

Question 2. Primary Physician's Name:

Enter the name of the primary physician in the space provided.

Question 3. Primary Physician's Street Address:

Enter the primary physician's street address in the space provided.

Question 4. Primary Physician's City or Town:

Enter the primary physician's city or town in the space provided.

Question 5. Primary Physician's State:

Enter the primary physician's state.

Question 6. Primary Physician's Zip Code:

Enter the primary physician's zip code.

Level of Care Determination Tool Instructions

Question 7. Primary Physician's Business Phone Number. (requires 10 digits to transfer to SAMS, optional 1-5 digit extension):

Enter the primary physician's 10 digit telephone number in the space provided. It is optional to enter an extension.

Question 8. Primary Physician's Fax Number:

Enter the primary physician's fax number in the space provided.

Question 9. Primary Physician's Email Address:

Enter the primary physician's email address in the space provided.

3. SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE

A 10-item Short Portable Mental Status Questionnaire (SPMSQ), easily administered by any clinician in the home, office, or in a hospital has been designed, tested, standardized and validated. There was a high level of agreement between the clinical diagnosis of Organic Brain Syndrome and the SPMSQ scores that indicated moderate or severe organic impairment.

Assessors should note that these are only guidelines. The SPMSQ should not be used to make a definitive diagnosis of cognitive impairment, dementia or Organic Brain Syndrome (OBS), etc. However, poor performance on the SPMSQ is highly correlated with the presence of a cognitive disorder. Therefore, high SPMSQ error scores suggest a possible need for further medical and/or psychiatric evaluation.

If scored poorly, this should prompt the assessor that the individual may be a poor resource for medical conditions and treatments, and that the assessor must seek other collateral resources.

3.A. SPMSQ Questionnaire

Question 1. Individual knows TODAY'S DATE?

The answer is correct if the individual provides the exact month, day, and year. If the person offers only the month and date, the interviewer should ask, "And what is the year?" Select one response only.

Level of Care Determination Tool Instructions

Question 2. Individual knows the DAY of the week?

The correct day, Monday, Tuesday, etc., must be given. Select one response only.

Question 3. Individual knows LOCATION?

Any accurate description of the location is considered correct. For example, if the interview is taking place in the individual's home, and the individual says "my home," this is considered correct. The name of the town or city, or (if institutionalized) the name of the hospital or nursing facility can also be accepted as correct answers. Choose one response only.

Question 4. Individual knows TELEPHONE NUMBER (street address, if no telephone)?

The individual's telephone number can be considered correctly answered when the assessor can verify the number the individual offers. The assessor can verify the number via the phone console, the phone book, or other records. If none of these methods are possible, the phone number can be checked by asking the individual to repeat his/her phone number later during the interview. If the individual repeats the same number as earlier, the assessor should consider this correct. Choose one response only.

Question 5. Individual knows AGE?

There is only one correct answer. The individual must state their exact age. Select one response only.

Question 6. Individual knows DATE OF BIRTH?

Score correctly if the individual gives the correct month, day and year. The assessor should be able to verify this date based on Intake data, report of significant other, or hospital/medical records. Choose one response only.

Question 7. Individual knows CURRENT PRESIDENT?

The correct last name of the current president is required. Select one response only.

Question 8. Individual knows PREVIOUS PRESIDENT?

The correct last name of the previous president is required. Select one response only.

Level of Care Determination Tool Instructions

Question 9. Individual knows MOTHER'S MAIDEN NAME?

Score the person correct if a female first name is given with a last name other than the individual's last name. Select one response only.

Question 10. SUBTRACTION TEST- Subtract 3 from 20:

Read this question exactly as printed. You may repeat it if necessary or you may offer the probe, "Can you subtract three from 20?"

And can you subtract three from that?" The individual must get the entire series correct to be scored correct (17, 14, 11, 8, 5, 2).

3.B. SPMSQ Results

Question 1 .Individual's subtraction test results:

Record whether the individual correctly answered the test. Choose one response only.

Question 2. What was the highest grade the individual completed in school? If unknown, enter 0 and a note describing why it is unknown.

Before determining the SPMSQ score, be sure to ask the individual what is the highest grade completed in school.

Question 3. Consumer score on SPMSQ.

Document the score utilizing the following information:

Add up the total number of errors. Subtract one point from the number of errors if the individual has had a grade school education (up to an 8th grade education or less).

Add one point to the error score if the subject has had education beyond high school (e.g., one or more years of college or professional school). For example, an individual with 3 errors on the SPMSQ who had received one year of college education would be given a score of 4. An Individual with 3 errors who dropped out of school in the 5th grade would be given a score of 2. This scoring technique adjusts in the SPMSQ for the biasing effects of educational background.

This adjusted score can be compared to the recommended scoring guidelines provided:

- 0 -2 errors: intact intellectual functioning
- 3 -4 errors: mild intellectual impairment
- 5 -7 errors: moderate intellectual impairment
- 8 -10 error: severe intellectual impairment

Remember that these are only guidelines.

Level of Care Determination Tool Instructions

4. DIAGNOSES

The purpose of this section is to document three important questions:

- The individual's diagnoses or conditions as specified in each question
- If the individual is being treated for the medical diagnose/conditions
- If the individual is able to self-manage the care of their medical diagnoses/conditions

All questions must be answered. There may be more than one diagnosis in each section. Select the appropriate boxes for each and document in notes section any additional information about the diagnosis. In the event that there is a section with no diagnosis present, select the "None" box.

The LCD tool contains common diagnoses and in no way is meant to be all inclusive. If a diagnosis is not present, check "Other" and document the diagnosis in the notes section.

4.A. Respiratory

Question 1. Select all Respiratory diagnoses:

Select the appropriate responses for all diagnoses. Use the notes section for additional information. If the current diagnosis is not listed, select the "Other" box and document the diagnosis in the notes section.

Question 2. Current treatments:

Select appropriate responses for all treatments the individual is receiving. Use the notes section for additional information. If a current treatment is not listed, select the "Other" box and document the treatment in the notes section.

Question 3. Is the individual able to self-manage care of the Respiratory condition(s)?

Answer "Yes", "No" or "Unable to Determine". If "No" or "Unable to Determine", you must document why in the notes section.

Level of Care Determination Tool Instructions

4.B. Heart/Circulation

Question 1. Select all Heart and Circulatory System diagnoses:

Select the appropriate responses for each diagnosis. Use the notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Question 2. Current treatments:

Select appropriate responses for all treatments the individual is receiving. Use the notes section for additional information. If a current treatment is not listed, select the “Other” box and document the treatment in the notes section.

Question 3. Is the individual able to self-manage care of the Heart and Circulatory System condition(s)?

Answer “Yes”, “No” or “Unable to Determine”. If “No” or “Unable to Determine”, you must document in the notes section.

4.C. Gastrointestinal

Question 1. Select all Gastrointestinal diagnoses:

Select the appropriate responses for all diagnoses. Use the notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Question 2. Current treatments:

Select appropriate responses for all treatments the individual is receiving. Use the notes section for additional information. If a current treatment is not listed, select the “Other” box and document the treatment in the notes section.

Question 3. Is the Individual able to self manage care of Gastro-intestinal disorders?

Answer “Yes”, “No” or “Unable to Determine”. If “No” or “Unable to Determine”, you must document why in the notes section.

Level of Care Determination Tool Instructions

4.D. Musculoskeletal

Question 1. Musculoskeletal Diagnoses and/or signs and symptoms of Musculoskeletal diagnoses:

Select the appropriate responses for all diagnoses/signs and symptoms. Use the notes section for additional information. If the current diagnosis/sign and symptom is not listed, select the “Other” box and document the diagnosis in the notes section.

Question 2. Current treatments:

Select appropriate responses for all treatments the individual is receiving. Use the notes section for additional information. If a current treatment is not listed, select the “Other” box and document the treatment in the notes section.

Question 3. Is the individual able to self-manage care of Musculoskeletal disorders?

Answer “Yes”, “No” or “Unable to Determine”. If “No” or “Unable to Determine”, you must document in the notes section.

4.E. Skin

Question 1. Select all skin diagnoses:

Select the appropriate responses for all diagnoses. Use the notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Question 2. If any, check all affected skin locations:

Select all appropriate boxes.

Question 3. If ulcer is stageable, identify the highest known ulcer stage:

Select appropriate box. The assessor may have to refer to a medical professional to get correct stage of ulcer. If no stage-able ulcer, skip this section.

Level of Care Determination Tool Instructions

Question 4. Current treatments for skin diagnoses:

Select appropriate responses for all treatments the individual is receiving. Use the notes section for additional information. If a current treatment is not listed, select the “Other” box and document the treatment in the notes section.

Question 5. Is the individual able to self-manage care of the skin condition?

Answer “Yes”, “No” or “Unable to Determine”. If “No” or “Unable to Determine”, you must document why in the notes section.

4.F. Endocrine/Metabolic

Please note that in this section there are no treatments listed for Endocrine/Metabolic diagnoses. The Endocrine/Metabolic System has numerous disorders and very different treatments; therefore, answer Questions 1 and 2 and document any additional information needed in the notes section.

Question 1. Select all Endocrine/Metabolic diagnoses:

Select the appropriate responses for all diagnoses. Use the notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Question 2. Is the individual able to self-manage care of the Endocrine/Metabolic diagnosis?

Answer “Yes”, “No” or “Unable to Determine”. If “No” or “Unable to Determine”, you must document why in the notes section.

4.G. Genitourinary

Question 1. Select all Genitourinary diagnoses:

Select the appropriate responses for all diagnoses. Use the notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Level of Care Determination Tool Instructions

Question 2. Current treatments for Genitourinary diagnoses:

Select appropriate responses. There may be more than one box selected. Use notes section for additional information. If a current treatment is not listed, select the “Other” box and document the treatment in the notes section.

Question 3. Is the individual able to self-manage care of the Genitourinary condition?

Answer “Yes”, “No” or “Unable to Determine”. If “No” or “Unable to Determine”, you must document why in the notes section.

4.H. Infections/Immune System

Please note that in this section there are no treatments listed for Infections/Immune System diagnoses. The Infection/Immune System has numerous disorders and very different treatments; therefore, answer Questions 1 and 2 and document any additional information needed in the notes section.

Question 1. Select all Infection/Immune System diagnoses:

Select the appropriate responses for all diagnoses. Use the notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Question 2. Current treatments for Infection/Immune diagnoses

Select appropriate responses. There may be more than one box selected. Use notes section for additional information. If a current treatment is not listed, select the “Other” box and document the treatment in the notes section.

Question 3. Is the individual able to self-manage care of the Infection/Immune condition?

Answer “Yes”, “No” or “Unable to Determine”. If “No” or “Unable to Determine”, you must document why in the notes section.

Level of Care Determination Tool Instructions

4.I. Cancer

Question 1. Does the individual have a Cancer diagnosis?

Select “Yes” or “No”. **NOTE:** This question has a skip pattern. If “No”, skip to question 5.A.1.

Question 2. If yes, identify the stage:

Select appropriate box. The assessor may have to refer to a medical professional to get correct stage of cancer. If unable to identify the correct stage of cancer, leave blank.

Question 3. Select all current Cancer diagnoses:

Select appropriate responses for all diagnoses. There may be more than one box selected. Use notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Question 4. Current treatments for Cancer diagnoses:

Select appropriate responses. There may be more than one box selected and these listed are not meant to be all inclusive. Use notes section for additional information. If a current treatment is not listed, select the “Other” box and document the treatment in the notes section.

Question 5. Is the individual able to self-manage the Cancer conditions?

Answer “Yes”, “No” or “Unable to Determine”. If “No” or “Unable to Determine”, you must document why in the notes section.

5. Neurological

NOTE: If the individual has a neurological diagnose you must complete Section 7: Behavioral.

Question 1. Select all Neurological diagnoses:

Select the appropriate responses for all diagnoses. Use the notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Level of Care Determination Tool Instructions

Question 2. What characteristics describe the individual's cognitive state?

Select the appropriate responses. Use the notes section for responses that are not included in the list and for additional information. If the current characteristic of an individual's cognitive state is not listed, select the "Other: box and document the characteristic in the notes section.

Question 3. Need for supervision

Select the appropriate response that indicates how long the individual can routinely be left alone safely. Take into account physical and psychological health, mental impairment and behavior. Use notes to explain why supervision is needed.

Question 4. Is the individual able to self-manage care of the Neurological condition?

Answer "Yes", "No" or "Unable to Determine". If "No" or "Unable to Determine", you must document why in the notes section.

6. Psychological

NOTE: If the individual has a neurological diagnoses you must complete Section 7: Behavioral.

Determine whether or not the individual has any type of psychological disorders/mental illness. Mental illness is defined as a mental or bodily condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological functioning of the individual. The illness may result in a disruption in a person's thinking, feeling, moods and ability to relate to others.

Prompting questions: Have you ever seen a psychiatrist? Have you ever been told that you have any psychiatric problems? Did you receive treatment?

If the individual does not have these problems, check the appropriate box. If the answer is "No" in question 7.A.1, skip to section 8. If the individual does have these problems, continue with the remaining questions and note the skip pattern in each question. Check the appropriate box in each question and use the notes section to document.

Level of Care Determination Tool Instructions

Question 1. Select all psychological diagnoses:

Select the appropriate responses for all diagnoses. Use the notes section for additional information. If the current diagnosis is not listed, select the “Other” box and document the diagnosis in the notes section.

Question 2. Current treatments for psychological diagnosis:

Select appropriate responses. There may be more than one box selected and this list is not meant to be all inclusive. Use notes section for additional information. If a current treatment is not listed, select the “Other” box and document the treatment in the notes section.

Question 3. Is the individual able to self-manage care of the psychological condition?

Answer “Yes,” “No” or “Unable to Determine.” If “No” or “Unable to Determine,” you must document why in the notes section.

7. Behavior

This section is to document behaviors issues that impact the individual’s functional level.

Question 1. Does the individual present with any behavioral signs/symptoms? This section is required if a Neurological or Psychological diagnosis was noted in Neurologic or Psychological Sections 5 or 6.

Select the correct response. **NOTE:** This question has a skip pattern. If “Yes”, complete ALL of Section 7. If “No”, skip to Section 8. If “Unable to Determine” document explanation in the notes section and determine the need to complete all of Section 7.

Question 2a. Does the individual exhibit physical behavioral symptoms toward others?

Select the correct response. **NOTE:** This question has a skip pattern. If “Yes”, complete 2b. and 2c. If “No”, skip to question 3a.

Level of Care Determination Tool Instructions

Question 2b. Specify all types of aggressive physical behavior toward others (if not listed, document in notes):

Select the appropriate responses for all types of aggressive physical behavior. If the behavior is not listed, select the “Other” box and document the behavior in the notes section. Use the notes section for additional information.

Question 2c. Does the aggressive physical behavior toward others interfere with the individual’s ability to function daily?

Select the appropriate response and document in notes section how the behavior interferes or why the behavior does not interfere with the individual’s daily function. Include any other pertinent additional information.

Question 3a. Does the individual exhibit aggressive physical behavioral symptoms towards SELF?

Select the correct response. **NOTE:** This question has a skip pattern. If “Yes”, complete 3b. If “No”, skip to question 4a.

Question 3b. Specify all types of aggressive physical behavior towards self (If not listed, document in notes):

Select the appropriate response and document in notes section the additional information. If the behavior is not listed, select the “Other” box and document the behavior in the notes section.

Question 3c. Does the aggressive physical behavior toward self interfere with the individual’s ability to function daily?

Select the appropriate response and document in notes section the additional information.

Question 4a. Does the individual exhibit aggressive verbal behavior symptoms toward others?

Select the correct response. **NOTE:** This question has a skip pattern. If “Yes”, complete 4b and 4c. If “No”, skip to question 5a.

Question 4b. Specify All types of aggressive verbal behavior toward others (if not listed, document in notes):

Select the appropriate response and document in notes section the additional information.

Level of Care Determination Tool Instructions

Question 4c. Does the aggressive verbal behavior toward others interfere with their ability to function daily?

Select the appropriate response and document in notes section how the behavior interferes or why the behavior does not interfere with the individual's daily function. Include any other pertinent additional information.

Question 5a. Does the individual exhibit any general aggressive verbal behavior symptoms not specifically directed toward self or others?

Select the correct response. NOTE: This question has a skip pattern. If yes, complete 5b. and 5c. If No, skip to question 6a.

Question 5b. Select all general aggressive verbal behaviors (if not listed, document in notes):

Select the appropriate response and document in notes section the additional information.

Question 5c. Do the general aggressive verbal behaviors interfere with the individual's ability to function daily?

Select the appropriate response and document in notes section how the behavior interferes or why the behavior does not interfere with the individual's daily function. Include any other pertinent additional information.

Question 6a. Does the individual exhibit any other behavioral symptoms?

Select the correct response. NOTE: This question has a skip pattern. If "Yes", complete 6 b. and 6 c. If "No", skip to question 7.

Question 6b. Specify all other types of behaviors reported (if not listed document in notes):

Select the appropriate response and document in notes section the additional information.

Question 6c. Do the other types of behaviors interfere with the individual's ability to function daily?

Select the appropriate response and document in notes section how the behavior interferes or why the behavior does not interfere with the individual's daily function. Include any other pertinent additional information.

Level of Care Determination Tool Instructions

Question 7. Has the individual exhibited wandering behavior in the past 6 months? If so, indicate the frequency.

Select the appropriate response and document in notes section the additional information.

8. OTHER MEDICAL INFORMATION

8.A. Medication Management

The purpose of this section is to document the name of the medication prescribed, the dose, the route, and the frequency. It also describes the individual's ability level to manage medication.

Question 1. Does the individual take any prescribed medications?

Select the correct response. NOTE: This question has a skip pattern. If "Yes", continue to question 2. If "No", skip to question 8.A.3.

Question 2a. List all prescribed medications taken by the individual:

Record the name of the medication and the dose.

Question 2b. Code the route of administration using the codes 1-12:

Document the code (1-12) designated for the route of administration.

- 1 = by mouth (PO)
- 2 = sub lingual (SL)
- 3 = intramuscular (IM)
- 4 = intravenous (IV)
- 5 = subcutaneous (SQ)
- 6 = rectal (R)
- 7 = topical
- 8 = inhalation
- 9 = enteral tube
- 10 = other
- 11 = eye drop
- 12 = transdermal

Level of Care Determination Tool Instructions

Question 2c. Code the number of times per period the medication is administered using the following list:

Document the number of times each medication is administered using the designated coding system.

PR = (PRN) as necessary	OO = every other day
1H = (QH) every hour	1W = (Q week) once each week
2H = (Q2H) every 2 hours	2W = 2 times every week
3H = (Q3H) every 3 hours	3W = 3 times every week
4H = (Q4H) every 4 hours	4W = 4 times each week
6H = (Q6H) every 6 hours	5W = 5 times each week
8H = (Q8H) every eight hours	6W = 6 times each week
1D = (QD or HS) once daily	1M = (Q month) once/mo.
2D = (BID) two times daily (includes every 12 hours)	2M = twice every month
3D = (TID) 3 times daily	C = Continuous
4D = (QID) four times daily	O = Other
5D = 5 times daily	

Question 3a. List all over the counter (OTC) medications taken by the individual:

Record the name of the medication and the dose.

Question 3b. Code the route of administration using the codes 1-12:

Code the route of administration using the codes 1-12.

- 1 = by mouth (PO)
- 2 = sub lingual (SL)
- 3 = intramuscular (IM)
- 4 = intravenous (IV)
- 5 = subcutaneous (SQ)
- 6 = rectal (R)
- 7 = topical
- 8 = inhalation
- 9 = enteral tube
- 10 = other
- 11 = eye drop
- 12 = transdermal

Level of Care Determination Tool Instructions

Question 3c. Code the number of times per period the medication is administered using the following list:

Document the number of times each medication is administered using the designated coding system.

PR = (PRN) as necessary	OO = every other day
1H = (QH) every hour	1W = (Q week) once each week
2H = (Q2H) every 2 hours	2W = 2 times every week
3H = (Q3H) every 3 hours	3W = 3 times every week
4H = (Q4H) every 4 hours	4W = 4 times each week
6H = (Q6H) every 6 hours	5W = 5 times each week
8H = (Q8H) every eight hours	6W = 6 times each week
1D = (QD or HS) once daily	1M = (Q month) once/mo.
2D = (BID) two times daily (includes every 12 hours)	2M = twice every month
3D = (TID) 3 times daily	C = Continuous
4D = (QID) four times daily	O = Other
5D = 5 times daily	

Question 4. What is the individual's ability level to manage medications?

This question addresses the individual's ability to manage their medications.

- Independent – describes the ability to completely manage medication administration
- Limited Assistance – describes an individual who may require assistance with one or more of the following:
 - set-up/pre-packaged
 - verbal reminders
 - coaxing
 - medication dispenser
 - assist with self-injections but independent with oral medications
- Total Assistance – the individual cannot administer medications independently and requires hands-on assistance with all aspects of medication administration

Select the correct response. Choose one response only. Document in the notes section any additional information.

Level of Care Determination Tool Instructions

8.B. Weight/Height

An individual's weight and height are important factors for an assessor to know especially if the individual has lost 10 or more pounds in the past 6 months. This could be indicative of a medical issue/ illness/ eating disorder.

Document if the individual has lost or gained ten pounds in the past six months without attempting to do so.

Prompting questions: Have you recently (last six months) lost or gained weight without any changes to your diet or exercise? Do you know why your weight has gone up or down?

Question 1. What is the individual's height?

Enter height in notes section.

Question 2. What is the individual's weight?

Enter weight in notes section.

Questions 3. Has the individual lost or gained 10 pounds in the last 6 months?

Select the appropriate box that describes the individual's weight loss or gain. If either "Yes, gained 10 pounds" or if "Yes, lost 10 pounds are selected, provide specific details in notes section.

Question 2. What is the individual's weight type?

Select the appropriate box that describes the individual's weight type. The assessor should use the reference guide (<http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm>) to determine the individual's weight type.

8.C. Pain

This section will address if the individual is experiencing pain, the location of the pain, the level of pain, the frequency of pain, and whether or not the individual's pain is impacting their ability to function daily.

Question 1. Does the individual report pain?

Select the correct response. **NOTE:** This question has a skip pattern. If "Yes", complete section 8C. If "No", skip to question 9.A.1. If "Unable to determine", describe in notes section and skip to question 9.A.1.

Level of Care Determination Tool Instructions

Question 2. Location of pain:

Select the appropriate box (boxes) for location of pain. There may be more than one box selected. If the pain location is not listed choose "Other "and explain in the notes section.

Question 3. Indicate the level of pain using a scale from 1-10 (1= no pain, 10= severe pain)

Select the appropriate box to indicate the level of pain the individual is experiencing with 1 as no pain and 10 as the worst imaginable pain. This pain level should be the pain level prior to medication prescribed for pain. Choose only one response.

Question 4. Indicate the frequency the individual reports the pain:

Select the appropriate box to indicate how frequent the individual has pain and document in the notes section any additional information.

Question 5. Does the individual report that the pain impacts his/her daily functioning?

Select the box indicating "Yes" or "No".

If "yes" describe in notes section. If individual reports improved function after pain medication administration or treatments indicate in notes.

9. ACTIVITIES OF DAILY LIVING (ADLs)

9.A. ADLs

The assessor must rate the individual's ability to perform their ADLs and the ability to manage ADLs with reasonable safety. There may be instances when the individual has no opportunity to perform ADL tasks because they are in a facility/hospital or family members are assisting. Therefore, in order to accurately assess the individual's ability to perform any ADLs, the assessor is required to review facility charts in addition to assessing and asking the individual about their abilities.

Level of Care Determination Tool Instructions

ADLs include:

- Bathing
- Dressing
- Grooming
- Eating
- Transferring
- Toileting
- Bladder/Bowel Incontinence
- Walking

Walking was added to the ADL section because it is a tool to accurately measure the individual's capability of performing ADLs.

The following questions address the individual's ability to complete the ADL. Select the correct response.

- Independent- describes the ability to completely manage the ADL.
- Limited Assistance- describes an individual who may require some assistance with the ADL. Select the response(s) in the drop down menu that best describe what assistance is being provided.
- Total Assistance- describes the inability of the individual to complete the ADL in full or in part.

Question 1a. Bathing: ability to prepare a bath and wash oneself, includes turning on the water, regulating temperature, etc.

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 1b. If limited assistance, indicate all types needed for bathing:

Select the appropriate responses. There may be more than one box selected.

Question 2a. Dressing: ability to remove clothes from a closet/drawer, application of clothing including shoes/socks (regular/TEDS), orthotics, prosthesis, removal/storage of items, managing fasteners, and to use any needed assistive devices

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Level of Care Determination Tool Instructions

Question 2b. If limited assistance, indicate all types needed for dressing:

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

Question 3a. Grooming/Personal Hygiene: ability to comb/brush hair, brush teeth, care for/inset dentures, shave, apply make-up (if worn), apply deodorant, etc.

Select the appropriate response. Check one box only.

Question 3b. If limited assistance, indicate all types needed for grooming/personal hygiene:

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

Question 4a. Eating: ability to eat/drink, cut, chew, swallow food, and to use any needed assistive devices

Select the appropriate response. Check one box only.

Question 4b. If limited assistance, indicate all types needed for eating:

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

Question 4c. If response to 9A.4.a. is “3-Does not occur”, indicate type of nutritional intake.

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

Question 5a. Transfer: ability to move between surfaces, including to/from bed, chair, wheelchair, or to a standing position, onto or off a commode, and to manage/use any needed assistive devices

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 5b. If limited assistance, indicate all types needed for transfer:

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

Level of Care Determination Tool Instructions

Question 6a. Toileting: ability to manage bowel and bladder elimination

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 6b. If limited assistance, indicate all types needed for toileting:

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

Question 6c. Bladder Incontinence: Indicate the description that best describes the individual’s bladder function.

Select the appropriate response. Check one box only. Describe additional information in notes section.

Question 6d. Bowel Incontinence: Indicate the description that best describes the individual’s bowel function.

Select the appropriate response. Check one box only. Describe additional information in notes section.

Question 7a. Walking: ability to safely walk to/from one area to another, manage/use any needed ambulation devices

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 7b. If limited assistance, indicate all types needed for walking:

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

10. MOBILITY

The assessor will choose the appropriate response(s) for each question that best describes the individual’s ability to perform each task.

A bed bound individual is defined as an individual who cannot get out of the bed/chair without the assistance of another person. Without this assistance, the individual would remain in the bed/chair. This definition should not be confused with how the individual transfers or moves about once the individual is out of the bed/chair.

Level of Care Determination Tool Instructions

Non-ambulatory means the individual, after rising from the bed/chair (assisted or non-assisted), cannot walk without the assistance of another person.

The assessor can evaluate an individual's mobility through observation and questioning. If the individual is willing, the assessor must ask for a demonstration of walking or wheeling ability across a room and back.

The following questions address the individual's mobility. Select the correct response.

- Independent - describes the ability to completely manage the ADL.
- Limited Assistance - describes an individual who may require some assistance with the ADL. Select the response(s) in the drop down menu that best describe what assistance is being provided.
- Total Assistance - describes the inability of the individual to complete the ADL in full or in part.

“Other” is to be used if the above choices do not accurately reflect the individual's mobility. The notes section should be used to fully describe what is occurring

10.A. Consumer's Mobility

Question 1. Bedbound - Is the individual bedbound and non-ambulatory? Indicate in notes any help needed, comments or relevant information.

Select the correct response. NOTE: This question has a skip pattern. If the response is “Yes”, skip to section 11. If “Unable to Determine”, describe in notes.

Question 2a. Indoor Mobility: Ability of movement within interior environment

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 2b. If limited assistance, indicate all types needed for needed for indoor mobility:

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

Question 3a. Outdoor Mobility: Ability of movement outside living arrangement

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Level of Care Determination Tool Instructions

Question 3b. If limited assistance, indicate all types needed for outdoor mobility:

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes.

Question 4a. Stair Mobility: Movement safely up and down steps

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 4b. If limited assistance, indicate all types needed for stair mobility.

Select the appropriate responses. There may be more than one box selected.

If “Other”, describe in notes

Question 5. What is the individual’s weight bearing status?

You may use the following information/prompting questions to clarify weight bearing status with the individual:

Note: Putting weight on your legs is called “weight bearing “.

Full weight bearing (FWB) - You may place your full body weight on your affected leg(s) when you stand or walk. No limitations.

Non-weight bearing (NWB) - You do not /cannot place any weight on your affected leg(s). You do not touch the floor with your affected leg(s). If only one leg is affected while you stand or walk, you must hold your affected leg off the floor.

Partial weight bearing (PWB) - When you stand or walk you may place XX percent of your body weight (## pounds) on your affected leg. Note: these numbers are designated by your physician or therapist.

Toe-touch weight bearing (TTWB) - When you stand or walk, you may touch the floor only for balance. You do not place actual weight on your affected leg.

Select the correct response. If “Unable to Determine”, describe in notes.

Level of Care Determination Tool Instructions

Question 6. Select all that affect the individual's mobility.

Select the appropriate responses. There may be more than one box selected. If the individual has other identified issues that affect mobility, please choose "Other" and describe in notes.

10.B. Falls

The assessor must document if the individual is at risk of falling.

Factors that may render an individual at risk for falls include, but are not limited to, poor health or declining health, impaired balance, decreased strength and/or flexibility, decreased vision, and medications. This item requires the assessor to make a judgment regarding the individual's risk for falls, based on observations or information provided by the individual or significant others.

NOTE: An individual is a fall risk as a result of environmental barriers as well. However; that is not relevant in determining a level of care and will be part of the Needs Assessment Tool only.

In the Notes section, document what functional deficit related to their diagnoses puts them at risk of falls. Provide as much information as possible, including whether or not the individual has fallen recently. "Recently" is defined as within the last six months.

Prompting questions: Have you fallen during the past six months? How often? Where did you fall? What were you doing at the time? Did you faint or lose consciousness? Were you injured in the fall(s)? Could you get back up by yourself? Did a physician see you or did you go to the emergency room to be evaluated after your fall? Do you do/use anything special to prevent falls?

Utilize the notes section to provide details if the individual has fallen.

Question 1. Is the individual at risk of falling?

Select the correct response. If "Unable to Determine", describe in notes.

Question 2. Select the number of times the individual has fallen in the last 6 months.

Select the correct response and document additional information in the notes section.

Level of Care Determination Tool Instructions

11. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

NOTE: Deficits in IADLs alone will not meet the criteria for nursing facility clinically eligible.

IADLs include tasks which are not necessarily done every day, but are important to independent living. These tasks include preparing meals, doing housework, laundry, shopping, using transportation, managing money, using the telephone and doing home maintenance. The ability to perform IADL tasks can help an assessor determine the impact of physical and mental impairments, since performance of these tasks requires a combination of memory, judgment and physical ability.

There may be instances in which the individual has no opportunity to perform IADL tasks. For example, some individuals do not prepare meals because a spouse or other relative (who lives with them) routinely does this task. In the same way, individuals who are in an institution at the time of the assessment have no regular opportunity to cook, clean, do laundry or shop. Therefore; when administering the IADL questions, it is very important for the assessor to stress the ability of the individual to perform the task. The following questions address the individual's ability to complete the IADL. Select the correct response.

- Independent- describes the ability to completely manage the IADL.
- Limited Assistance- describes an individual who may require some assistance with the IADL.
- Total Assistance- describes an individual who cannot complete the IADL in full or in part.

The assessor is to choose one response for each IADL that best describes the individual's ability to perform each task. In the notes section, record any additional information including assistive devices uses by the individual.

11.A. IADLs

Question 1. Meal Preparation: ability to plan/prepare meals, use of kitchen appliances, heat/prepare meals.

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Level of Care Determination Tool Instructions

Question 2. Housework: ability to maintain living space, includes tasks such as dishwashing, making the bed, dusting, running the vacuum or sweeping an area.

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 3. Laundry: Ability to gather clothes, place clothes in washing machine, turn on appliance, remove clothes and place in dryer, or hand wash items and hang to dry

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 4. Shopping: ability to go to the store and purchase needed items

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 5. Transportation: ability to travel on public transportation or drive a car

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 6. Money Management: ability to manage financial matters, writing checks, paying bills, going to the bank

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 7. Telephone: ability to obtain phone numbers, dial the number and communicate with the person on the other end.

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Question 8. Home Management: ability to perform heavier household tasks such as taking out the trash, completing minor repairs around the living space, yard work and/or snow removal

Select the appropriate response. Check one box only. Describe additional information in the notes section.

Level of Care Determination Tool Instructions

12. LEVEL OF CARE (LOC) ASSESSMENT DATA

This section addresses the level of care outcome based on the information obtained in the LCD. All questions must be completed and follow the order in which they are listed. The assessor must be the first to complete the LOC Determination. If the individual is determined NFCE, the RN must review and enter the appropriate information in this section. The assessment supervisor is the last to review the assessment. The date the Level of Care is being issued (Question 9) is the date when the supervisor has made the final determination.

12.A. Assessment Outcome

Question 1. What is the date the individual's MA51 or RX Script, signed by a Physician, was received by the AAA?

Using the MM/DD/YYYY format, document the date the MA51 or RX Script was received.

NOTE: Only individuals requesting MA payment for nursing facility care, the Personal Care Home and Domiciliary Care Supplement and those referred for enrollment in a Medical Assistance Home and Community Based Waiver program require a MA51/Script.

Question 2. What Level of Care did the Physician recommend?

Select the correct response. Check one box only.

Question 3. What is the Level of Care Determination for this individual?

Select the correct response. Check one box only.

Question 4. Do the functional limitation(s) of the individual's medical condition(s) support the level of care determination?

Indicate if the functional limitations of the individual's medical diagnoses/conditions as documented in this assessment tool support the need for the care that an individual would receive in a nursing facility.

Select the appropriate response. Check one box only. If "Yes", the assessor is required to complete Section 12.B. If "No", the assessor may provide documentation to support the answer.

Level of Care Determination Tool Instructions

Question 5. Consumer is recommended NFCE:

The response to this question will be computer generated and will be a True or False response. A True response means the decision logic of the model found the consumer is NFCE. A False response means based on the models decision logic the individual did not follow typical characteristics of NFCE definition and requires documentation of the NFCE rationale in 12.B.

Question 6. Are the assessor and the model's clinical results the same?

This will self populate "True" or "False". If "False" it means that the assessor and the model do not agree. If "False", then Section 12.B must be completed.

A True response indicates agreement, proceed to 12.B.

12.B. Provide detailed summary documentation for the Assessment Narrative based on each of the following:

If the individual is NFI this question is optional. If the individual, is NFCE this question must have a response.

Provide detailed **summary** documentation to support the Level of Care Determination based on the following:

- Diagnoses and treatments that impact the functional capabilities of the individual and/or how they limit the ability to manage their own care.
- If assessor outcome (question 12.A.3) differs from model recommendations (False algorithm response in Question 5), document summary of justification on why the recommendation is different.

12.C. Individual Place of Service Preference

Question 1. Does the individual want to be served in the community?

Select the appropriate response. Check one box only.

Note: If the individual has a NFCE level of care the assessment is completed.

If the individual has a NFI level of care, complete Section 12, questions 2 and 3.

Level of Care Determination Tool Instructions

Question 2. Having been determined NFI, what is the individual's PREFERRED residential setting?

Select the appropriate response. Check one box only.

Question 3. Having been determined NFI, what is the individual's PREFERRED Community Service Program?

Select the appropriate response. Check one box only.

12.C. Level of Care Determination Authentication

Note: The individual(s) who complete questions in this section are considered to have provided an electronic signature attesting to who they are, that they completed this assessment and entered ALL of the information contained in the assessment (assessor); that they reviewed the assessment in its entirety (RN when required) and supervisor.

Question 1. Name of the Assessor completing the assessment

Document the assessor's first and last name.

Question 2. Date of Assessor's signature

Using the MM/DD/YYYY format, document the date the assessor signed the LCD.

Question 3. Name of Registered Nurse reviewing the assessment for Clinical Eligibility

Document the name of the Registered Nurse who reviewed the assessment for NFCE clinical eligibility.

Question 4. Date of Registered Nurse review

Using the MM/DD/YYYY format, indicate the date the RN reviewed the assessment.

Question 5. Name of supervisor who reviewed and approved the Level of Care

Document the name of the supervisor who reviewed and approved the final Level of Care determination.

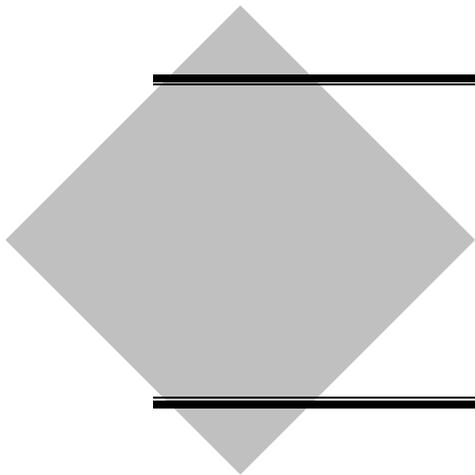
Level of Care Determination Tool Instructions

Question 6. Date the supervisor approved the assessment

Using the MM/DD/YYYY format, indicate the date the supervisor reviewed and approved the assessment.

Question 7. Date the Level of Care is being issued

Using the MM/DD/YYYY format, indicate the final date the Level of Care is being issued. This addresses the date the supervisor determines that all final components to the assessment are received, completed and ready for submission.



Appendix

Level of Care Definition Case Study Key

Case Study #1 Sally is NFCE because:

- ❖ Sally has a medical condition diagnosed by a physician, that includes:
 - Cerebral palsy
 - Generalized muscular weakness
 - Spasticity in upper extremities, with tremors
 - Acid reflux

- ❖ Sally requires a level of care above room and board because:
 - She requires care and services that are both skilled and inherently complex due to the need of monitoring her skin for breakdown.
 - She needs oversight and monitoring of medications for side effects.
 - She requires hands-on assistance with a wheelchair/walker.
 - There is bladder and bowel incontinence and the risk of breakdown since she is not able to manage her incontinence.
 - She needs total assistance with ADLs and IADLs.

Appendix

Case Study #2 John is NFI because:

- ❖ John has a medical condition diagnosed by a physician, that includes:
 - Hard of hearing
 - Edema in his feet
 - Gastro-esophageal reflux disease
 - Hyperthyroidism
 - Anxiety disorder

- ❖ John does not require a level of care above room and board because:
 - He ambulates with a walker and no assistance.
 - He needs minimal assistance with bathing, such as washing his back and hair.
 - He dresses himself if clothing items do not need pulled over his head.
 - He requires assistance with IADLs, such as laundry and grocery shopping.
 - He manages his own medications.
 - He is continent of bladder and bowel.

Case Study #3 Josephine is NFCE because:

- ❖ Josephine has a medical condition diagnosed by a physician, that includes:
 - Dementia
 - Arthritis in both knees

- ❖ Josephine requires a level of care above room and board because:
 - She requires care and services that are both skilled and inherently complex due to her dementia diagnosis.
 - Her dementia prevents her from recognizing impairments or making her needs known.
 - She requires direction, such as monitoring of diet, prompting to elevate legs, and monitoring regarding her pain levels.
 - She needs hands-on assistance with all ADLs and IADLs.
 - She has an increase in incontinence and requires assistance.
 - She requires assistance with medication management.
 - She is wheelchair bound and needs assistance propelling.

Appendix

Case Study #4 Carl is NFI because:

- Carl has a medical condition diagnosed by a physician, that includes:
 - Asthma
 - Gastro-esophageal reflux disease
 - Osteoarthritis
 - Severe burning in his feet

- ❖ Carl does not require a level of care above room and board because:
 - He is independent with his ADLs, other than being slow and needing assistance with getting in and out of shower/bath.
 - He walks independently with a cane.
 - He can do some IADLs, such as preparing his meals.
 - He needs assistance with housework and shopping.
 - He manages his own medications.

Case Study #5 Mary is NFCE because:

- ❖ Mary has a medical condition diagnosed by a physician, that includes:
 - End stage renal disease
 - Dementia

- ❖ Mary requires a level of care above room and board because:
 - She requires care and services that are both skilled and inherently complex.
 - She requires monitoring of fluid retention, including intake and output.
 - She needs hands-on assistance with bathing and dressing.
 - She needs limited assist with toileting and grooming.
 - She requires hands-on assistance with ambulating.
 - She needs total assistance with IADLs, except money management.
 - She requires set-up and verbal reminders of medications, including monitoring of diuretics.

Appendix

Case Study #6 Jason is NFCE because:

- ❖ Jason has a medical condition diagnosed by a physician, that includes:
 - Traumatic Brain Injury
 - Complications, such as hemorrhaging and fracture

- ❖ Jason requires a level of care above room and board because:
 - He requires care and services that are inherently complex.
 - He has some ambulatory dysfunction and requires assistance with ambulation.
 - He requires monitoring for blood clots.
 - He requires limited assist with bathing, dressing and toileting.
 - He needs assistance with continence products due to occasional bladder incontinence.
 - He requires total re-training in IADLs.
 - He requires set-up and verbal reminders of medications due to his inability to differentiate between medications.

Appendix

Case Study #7 Jane is NFCE because:

- ❖ Jane has a medical condition diagnosed by a physician, that includes:
 - High blood pressure
 - Congestive heart failure with extreme shortness of breath
 - Edema
 - Thyroid condition
 - Bleeding ulcer
 - Pain due to arthritis and osteoporosis
 - Diabetes Mellitus Type II
 - Macular degeneration
 - Dementia

- ❖ Jane requires a level of care above room and board because:
 - She requires care and services that are inherently complex.
 - She sponge bathes with set-up but requires total assistance getting into tub.
 - She dresses herself but slowly due to shortness of breath.
 - She needs total assistance with grooming due to pain in her arms.
 - She requires assistance with all IADLs, except telephone and money management.
 - She uses a walker and her mobility is fragile.
 - She needs assistance with a walker due to falling and a broken hip.
 - She requires set-up and verbal reminders of medications.

Appendix

Case Study #8 Jake is NFI because:

- ❖ Jake has a medical condition diagnosed by a physician, that includes:
 - Depression
 - Gastro-esophageal reflux disease
 - Congestive heart failure

- ❖ Jake does not require a level of care above room and board because:
 - His depression appears to be the only diagnosis that would prevent him from functioning well enough to manage his needs.
 - The incidents may be isolated or may be occurring frequently, which would signal that more information about treatments is needed.
 - The assessor may not have enough information to accurately determine his level of care.
 - This would be a good case to consult with the Primary Care Physician and/or Psychiatrist/Psychologist if he has been diagnosed with his depression by either.

This would be a good case to consult the Primary Care Physician and/or Psychiatrist/Psychologist if either diagnosed his depression.



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