Needs Assessment Tool FAQs

General

1. **Will there be a comment/narrative box at the end of the tool? How do we know how much to put in since the LOCA was always a guide?**

   Yes. There is a narrative (or assessment) summary at the end of the NAT. There are no longer any requirements as to what, if anything should be put in this section; however, it is available to you for additional supporting documentation. The LCD should not be your guide as the NAT is a needs assessment for care planning.

2. **Does a NAT need to be completed yearly and also when there are two or more changes to their care plan?**

   A NAT is required to be completed annually for OPTIONS and every 6 months for the CSP. The 6 month reassessment for CSP is expected to change with the issuance of the new CSP chapter in the Aging Policy and Procedures Manual, but remains as 6 months until then.   The "two or more changes to the care plan" was an OLTL directive. It may still apply for Aging Waiver consumers (you will need to contact OLTL to confirm), but is not a requirement for OPTIONS or CSP.

3. **Will the NAT populate to the LCD or do we have to take both out to community visits?**

   Yes, the NAT will populate into an LCD by using the Copy feature. Whenever you copy one form to another proceed with caution and review each question to ensure the response still applies.

4. **Do you need a copy of POA or just documentation you have seen proof?**

   You will need to see and retain a copy of POA/Guardianship in the case file.

5. **Would it be at all possible for OLTL/PDA to combine forms?**

   PDA has strongly encouraged OLTL to transition to the NAT for Waiver. Please contact OLTL to express your concerns.

6. **Will the NAT populate to the CMI?**

   As of July 1, 2014, the CMI is no longer to be used, <u>with the exception</u> of the Aging Waiver. The only reason a NAT would be used first is if the individual is in OPTIONS and going into Waiver. In this case, only the questions and response options that are identical will populate into the CMI.

7. **Where would it be most appropriate to document whether or not the current informal support is currently managing, but is at the point of breakdown and cannot continue at the current level or if the informal has come in from out of town and can only stay short term?**

Please document this information in Section 14B Concerns about the Helping Relationship or it can be documented in the ADL/IADL sections.

8. **In the CMI, there is a section that accounted for the time to complete the assessment in the new form this question is not asked....how do we calculate the time the worker spent on completing the assessment?**

The question regarding the time it took to complete a NAT has been removed from the assessment as it is in SAMS under service delivery-topic-time. In order to reduce repetitiveness it is no longer in the assessment but in service delivery. We are working to streamline the information in the service delivery portion of SAMS in the near future. You will be receiving new instructions on the LCD & NAT service delivery component in SAMS.

9. **Information not copying over from CMI to NAT?**

This has been tested in SAMS and is working appropriately. All questions and responses have catalog numbers attached. If the catalog numbers do not match, the information will not transfer to the new form. Please review the form in its entirety to be sure all questions are answered accurately. Remember this is an entirely different tool for care planning, it is not the CMI.

10. **If an assessor goes out on a referral and completes the LCD tool then the case is referred to care management to complete the NAT form, what happens if there is a difference in "scoring" for example the ADL/IADL sections may differ from the assessor to the care manager. How would this be addressed?**

The definitions regarding the questions and responses can be found in the NAT instructions. If there is an issue with Assessors and Care Managers disagreeing, this could be a training issue. There may be situations, depending on the amount of time between the completion of the LCD and NAT, when the individual's situation improves/declines; although, this should be a rare instance. The LCD and NAT should accurately reflect the individual situation at the time of the respective tool is completed.

11. **On question 6.A.2 on page 15, what is meant by "self-managing an I/DD condition?"**

This is a judgment call from the Care Manager. Some I/DD individuals are higher functioning and are able to handle some, if not all, self-care. This could include making their own medical appointments; making transportation arrangements; manage own medications, etc. The definition of self-care can be found in the NAT instructions.

12. **If the LOCA has no answers to asked ADL or IADL ability questions, but notes, what gets populated onto NAT?**

When the question from the LOCA does not map, you will need to assess the individual and answer the question as per the NAT instructions.

13. **If a LOCA was done prior to 7/1/14, and we are now required to do a NAT, will the LOCA map into the NAT?**

The only questions from the LOCA that will populate into the NAT are the questions that are exactly the same.

14. **When is it appropriate for the RN to review the NAT?**

The RN may review the NAT when assistance is needed for care planning and the care manager is seeking input from the RN from a medical perspective. On reassessment, the care manager may notice that the individual's level of care has changed from NFI to NFCE. It is then required for the RN to review and sign off.

15. **Are we permitted to mention PS referral in the Journal section of the LCD and NAT?**

No. If abuse, neglect, exploitation or abandonment is suspected, the care manager must document "referred to another program".

16. **For what programs are we to use the NAT? Do we use the NAT for people in Dom Care too?**

All Aging programs are to use the NAT with the exception of Aging Waiver (OLTL/DPW program) which still uses the CMI. If a consumer is in Dom Care and they are not receiving Waiver services through an exception from the Department, they will use the NAT. If they are NFCE and have an exception with the Department and are receiving Waiver services, they will need to follow Waiver procedures and use the CMI.

17. **We are not a SCE so should we use the NAT or the CMI because we don't know which program the individual will be enrolled in?**

You should not be completing either the NAT or the CMI if you are not the Service Coordination entity for the Aging Waiver. Your agency should just complete the LCD. If this is an Aging Waiver consumer and you are the identified Enrollment Broker you must follow the requirements for the DPW enrollment entity as outlined by OLTL.

SLUMS

18. **Where can the diagrams and the narrative for the SLUMS test are found?**

All items needed for the SLUMS examination are available via the SLUMS training webinar on the PDA website under resources or on the St Louis University SLUMS exam website.

19. **Should the SLUMS should be done each time a new assessment (NAT or LCD) is done, not just use the previous results copied from the last assessment. Is this correct?**

The only time SLUMS would not be re-administered is if a NAT is completed immediately following an LCD.

20. If we are completing the first NAT on an individual who is being reassessed for a program, do we need to complete the SLUMS?

Yes, it is part of the new tool.

21. In section 3B Q4 why is that box there? Because you check off the answers in Section 3B Q7.

There is a box there because it houses the five objects the care manager is to ask the individual to remember. Nothing is recorded in this field. The correct answers will be checked off in 3B7 when the care manager asks the individual to recall the objects. PDA was requested by the aging network to place the questions on the LCD NAT exactly as on the SLUMS tool.

22. For Aging Waiver Annual Recertification, assessors are using the LCD along with the CMI. Individuals are becoming irritated with having to answer both SLUMS and SPMSQ questions.

We have informed OLTL that there will be problems between the LCD, NAT, and the CMI because the questions are different. OLTL is aware and made the decision that assessors are required to complete the LCD with the SLUMS and the CMI with the SPMSQ. Assume that they want both forms completed in full and contact OLTL to voice concerns. Remember the LCD & NAT are not question and answer tools. It is a tool for the assessor to dialogue with the consumer and engages the individual and utilize you skills (smell, feel, observations, etc.) as an assessor.

Diagnoses/Assessing

23. Why is ascites listed as a possible cancer dx?

Ascites is a common condition that goes along with cancer, including cancer of the colon, ovaries, uterus, pancreas and liver. It should not be a type of cancer. This has been corrected.

24. For Question 9B, "Are you tired?", if the client answers yes, do we need to comment or expand in the note section?

Yes. It is helpful to know the reasons the individual may be tired on a frequent basis as it could be indicative of an illness.

25. Section 9.C.5. Do you ever have feelings of worthlessness? How the consumer would interpret this question and could this effect the consumer's self-perception?

The assessor/care manager must use their skills when asking questions to determine mental health status. For example: "I know we all have some days where we are not ourselves or feel at times that we have days of feeling worthless about life, work, etc. Does this ever happen to you?

For questions that are general in nature about an individual's mental health status, we may say: "I know you probably know the answers to these questions, but they are a part of the assessment tool and we need to ask them." (Even if the assessor/care manager knows the individual may not be able to answer the questions, this is a good way to approach those questions.)

26. **Are assessors & care managers required to view and stage wounds & skin conditions in order to categorize on the LCD & NAT? Will we receive further training to do so?**

    No. You do not need to see the ulcer. Please gather as much information as possible from the individual, their formal/informal supports, any available charts, or as a last result, contact the PCP. If staging is not known, select Unknown in section 4E3 and document in Notes section.

27. **At the LCD webinar, the staff was told that if someone could only transfer into a wheelchair with full assistance - they should be considered bedbound.**

    The LCD instructions have been corrected. We have updated the definition for bedbound; it is as follows:

    <u>Bedbound</u> is defined as an individual who is bedridden and <u>never leaves the bed</u>. When the individual is able to be transferred from bed to chair with assistance (by an individual/s or with an assistive device), they are not considered bedbound.

28. **Do meds go in the medication section only?**

    Yes. There is no need to document the medications with the diagnosis. That is why a drop down box has been placed under treatments in the diagnosis section because all that is required is the mediation that is used as treatment for the diagnosis.

29. **Sometimes consumers don't know whether they are admitted to the hospital or were there for observation. How do we address this?**

    The social worker is usually helpful when contacting Aging about an individual in for observation. If not, the care manager may contact medical personnel in the hospital or ER.

30. **If, for example, someone has Type I Diabetes – they are seen by a specialist every three months, their daughter fills their insulin syringe, and the participant themselves does accu-checks and self-injects. Who manages this condition? Are we to assume that if the participant is knowledgeable and is doing most of the maintenance (besides regular checkups and med set up) that they are managing themselves?**

You would answer the question by indicating who all is involved in managing the care. In this scenario you would select Specialty Physician, Informal Support and self. If they need any assistance, answer accordingly in the following question and document additional information in the Notes section.

31. **Regarding mobility in Question #6, how would aphasia affect an individual's mobility?**

Aphasia affects the ability to communicate the need for assistance to ambulate.

32. **Is a review by an RN required for all NFCE consumers? For example: an NFCE CSP consumer?**

Yes. An RN must review all NFCE individuals and sign and date. This information will be included in the Care Management chapter which is currently in development.

33. **If a consumer is in a nursing home temporarily, for rehab for example, would you document permanent address still as their home?**

Yes.

34. **Regarding the frailty scale, if someone is wheelchair bound, they automatically have two out of five on the frailty scale due to their inability to ambulate. But some wheelchair bound individuals are not frail. How do we reconcile this?**

The assessor should document the situation in the Notes section.

35. **What is morbid obesity and how do we calculate it?**

This is addressed in the instructions. There is a link to the BMI index that will calculate this.

36. **Question 17.A.3. on the NAT asks what type of Emergency Response System (ERS) is in place for consumers but there are no definitions for these on the instructions.**

We will be making adjustments to this question in the next version of the NAT. Until that time, please answer the question as best as you can with the information you are given by the consumer/family.

Medication

37. **NAT question 13.B.8 asks about over the counter medications. Medications are already listed in 9.D. If the individual indicates they do take 3 or more prescribed or OTC meds, should we just document in Notes to see Medication list in 9D?**

13B.8 is part of the Nutritional Risk assessment score mandated by ACL/AOA. This question needs to be answered so the appropriate score can be added up. Answer the question with the appropriate response. It is not necessary to re-list all of the medications in the Notes.

ADLS/IADLS

38. In terms of ADLs, do we need to note WHO is assisting? How is it documented if assistance is provided by OPTIONS or another program?

Yes. You must document who is assisting and what they are doing for the individual. If assistance is being provided by a program, answer Other –Document Details in Notes and describe what services are being provided.

39. Is the individual considered independent for ADL if assistive devices are used?

It depends on if the individual requires assistance of another person in addition to an assistive device. If they use an assistive device but can perform the ADL using it without help, then they should this should be documented as independent.

40. Since there are now only three options for ADL deficiencies, what number of ADL deficiencies will determine eligibility for CSP?

ADL deficiency is now "limited assistance" or "total assistance". If someone requires limited assist or total assist, they have a functional deficiency. Document in the Notes section for limited assistance as it is important to reflect the functional need. The number of ADL deficiencies required for CSP is unchanged and a selection of either limited assistance or total assistance will meet the previous required score of 3 or more.

41. In the health sections, there doesn't seem to be a place to document previous history of health issues such as health condition or cancer?

No, unless the illness affects the current functional ability of the individual it should not be documented. For example, if a person had a stroke two years ago and is still paralyzed, this affects their functioning and this diagnosis would need to be documented.

Depression/Life Satisfaction/Mental Health

42. Under suicide screening Section 7B, it implies there is an Aging Suicide Risk Assessment- where is this located?

Completing section 7B, questions 1-3, is considered the risk assessment. If the answer to question 1 is yes, then the care manager must complete questions 2 & 3.

43. **Section 7 refers to Mental Health and the term Psychiatric is used throughout the section except for the last question, #6, which then uses Psychological in the question, is this correct? Or should it be referred to as psychiatric as indicated in the other questions?**

   It has been noted and the question has been revised on the NAT.

44. **I believe determining ability to do the task vs. someone doing it for a person is subjective. Mental health often affects this as a variable. Any suggestions on how to better screen for ability? (ADL and IADL sections).**

   The NAT instructions indicate the Care Manager is to document what the individual is capable of doing on their own not what is being done for them. This may require further probing by the Care Manager. For example, a consumer may not prepare meals because someone else has always prepared meals for them. Because someone else is preparing the meal, does not mean that they cannot do this. This would need to be determined and documented in the Notes. If a mental health diagnosis is affecting their ability to perform ADL/IADLs, this too would need to be documented in the Notes section.

45. **Under 7B Suicide Screening, shouldn't there be a follow up question about needing additional services or who will be assisting the consumer with this process?**

   Please document any referral services in the Notes and any additional details in the Journal.

Functional Needs Score (FNS)/Functional Needs Measurement (FNM)

46. **Where will the new FNS score populate?**

   The FNS will be automated into the NAT creating a score that is to be utilized in the event of a wait list. The FNS algorithm is currently being tested and is expected to be available soon. Until it is released, please use the paper copy of the FNM to calculate the score. The instructions on how to calculate the FNM were recently sent out to the LCD agency contacts.

47. **Is the tier from the LCD going to be used for the FNS score?**

   Yes, that is part of the FNS.

48. **If we are going to use the FNS score from the CMI, what if there are changes in the individual's level of care or additional diagnoses that are not on the CMI but on the NAT, then the previously generated FNM score is not really a reliable number?**

   You will need to recalculate the FNM based on the information you have in the NAT.

Nutritional Risk Assessment

49. **Does the NAT tell us if an individual is eligible for meals (Nutritional Risk Score)?**

    It is not currently in this version of the NAT but will be available in the next version that is put out.

CSP

50. **If we use the NAT for CSP, then must we do the caregiver stress separately on paper too? In addition to the FNM?**

    No. Additional information needed for CSP is to be documented in the Journal.

51. **I was in the NAT pilot. We were only using the NAT for OPTIONS. Is this to be used for CSP also?**

    NAT is to be utilized for CSP until the development/implementation of the Caregiver Assessment Tool (CAT) is complete. Document additional needed for CSP in the Journal.

52. **For CSP cases, where does the care manager document other family members' income in the NAT since other household income is considered for the program?**

    Until the implementation of the CAT, document additional financial information in the Journal section.

53. **Is the NAT used for the care receiver in CSP?**

    Yes.   Until the Caregiver Assessment Tool (CAT) is released and the CSP chapter is complete, the NAT needs to be used on the care receiver.