

SACHS Research Summary:
IHSS Functional Index and Alternative Assessment Tools
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IHSS ASSESSMENT TOOL: BACKGROUND

- In 1988, fifteen years after the IHSS program was created, the State legislature passed a law requiring CDSS to develop a uniform needs assessment tool “to assure that in-home supportive services are delivered in all counties in a uniform manner” (Cal. Welf. & Inst. Code § 12309(a)). In response, CDSS developed and implemented a Uniformity Assessment System. As part of the Uniformity Assessment System, the State created the Functional Index (FI) Score in 1988 to use in rating elderly or disabled individuals’ functional abilities. Each recipient is given an overall FI Score (FIS) between 1.00 and 5.00.
- There are two separate processes that produce the final FIS: first, the social worker’s assessment of the physical and mental limitations of a client; and second, a computer-generated calculation to produce an overall FIS. The social worker’s assessment provides a Functional Limitation Ranking (FLR) for each of 14 tasks in terms of need for human assistance. There are 11 separate areas of physical functioning (four household tasks: housework, laundry, shopping and meal preparation; and seven personal tasks: mobility, bathing, dressing, bowel, bladder and menstrual, transfer, eating and respiration) and three separate areas of mental functioning (memory, orientation and judgment). However, the calculation of the FIS does not include the FLRs given for the client’s mental limitations and need for protective supervision or any FLRs that indicate a paramedical need. The calculation is based solely on a weighted average of the 11 areas of physical functioning (See *Appendix A-IHSS Functional Index Score Calculation Worksheet*). (Wallace, Valentine, Smith, et al., 2009)
- IHSS employs a social model rather than a medical model. Services are determined by assessments done periodically by a county worker who rates the ability of eligible applicants to perform a range of specific living tasks considered essential to maintain independence, rather than medical criteria. The social model focuses on activities of daily living and the IHSS client’s ability to function in his or her own home. The medical model assesses clients based on medical deficits. (CWDA, 2003)
- Those who qualify for IHSS are persons “who are unable to perform the services themselves and who cannot safely remain in their homes or abodes of their own choosing unless these services are provided” (Welf. & Inst. Code § 12300(a)). The CDSS Manual of Policies and Procedures (MPP) similarly directs that IHSS “provides assistance to those eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without this assistance” (MPP § 30-700.1). Therefore by definition, an individual given a FIS of two through five in any of the functions have already been determined by the worker to need some IHSS assistance to remain safely in his or her own home.
- In 1994, a study by the Institute for Social Research addressed the question of reliability, validity, and variability in California’s IHSS functional assessments and authorized hours. The tool was found to be highly reliable by teams of independent

evaluators in a sample of 1,432 clients. Evidence clearly demonstrated that the assessment tool can be applied in a very consistent manner by a well-trained staff. As expected, assessed hours increase directly with increase in functioning rank for all tasks, indicating validity of the tool. County average FI scores varied. (Barnes, 1994)

- Since 2005, the State of California has spent \$10 million providing eight days of training to over 16,000 social workers who conduct IHSS assessments. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)

IHSS ASSESSMENT TOOL: PRESENTING ISSUES

Using the FIS to Determine Need/Eligibility for Services

- California's FI rankings and the composite FI Scores were not designed to, and do not, measure individual need or eligibility. In fact, one key argument in the federal case which enjoined the state from implementing a targeted reduction was that FI scores were an inadequate measure of impairment or risk of institutionalization (LAO, 2010). Rather, "the purpose of the ranks was to help social workers determine with uniformity the number of hours of a particular service elderly and disabled individuals needed." And the composite FI Scores were to be used for aggregate comparison of FI Scores and authorized hours on a county or statewide basis, not on an individual basis. Neither had ever been used to measure individual eligibility. Thus, using the FI rankings to determine eligibility would result in the arbitrary withdrawal of services. (IHSS Coalition, 2010)
- Key informants identify this as a poor method of identifying those with the least need and see it as too complex to implement. Appeals of the scores by those who lose benefits can slow the entire eligibility system. Those with cognitive impairments and those without family support or an outside advocate are the least likely to have the resources to appeal and may be the first to feel the service reductions. (Wallace, Benjamin, Villa, & Pourat , 2009)
- The current assessment inaccurately equates the length of time a task normally takes with the importance of the task to an individual's health and safety. The FI Scoring system favors elderly and disabled people with many different needs, especially needs for help with tasks that are particularly time-intensive, over those with fewer different needs, and needs for help with tasks that are less time-intensive, even though the unmet needs of some of the latter recipients may be equally or more life-threatening than those of the former. For example, an elderly person who needs help with tasks which on average are less time-consuming, such as mobility inside the home, transfer from sitting to standing or respiration, is more likely to receive a lower FI Score and lose all services, than is one who needs help with the kinds of tasks that tend to take more time, such as meal preparation. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)
- The FIS does not weigh the critical nature of the services recipients need and it systematically disadvantages certain groups of recipients. If a person with a particular

type of disability does not need assistance with most activities, but critically needs substantial assistance with a few, he or she will likely receive a low FI Score, and could be deprived of all IHSS services. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)

- As previously mentioned, while the FLRs do assess the physical and mental limitations of a client, the computer generated calculation of the FIS does not include the full range of disability ratings assessed. The average FIS does not include ratings of the mental limitation areas, or the most severe rating for any area. Consequently, the FIS if used to determine eligibility inadequately captures those who are limited by their mental functioning to carry out household and personal tasks. This oversight would place some older adults with impaired cognitive functioning at great risk of injury and institutionalization. In addition, an IHSS recipient may lose hours if they score too low on any of the four domestic assistance tasks. For example, a recipient who is able to reheat meals but not prepare them will lose all hours allowed for meal preparation since they need “some” but not “a lot” of assistance (3.5 to 7 hours per week). (Wallace, Benjamin, Villa, & Pourat , 2009)
- The elimination of domestic and related services for individuals with functional index ranks below 4.00 will be very detrimental. Domestic services are in some respects the “glue” that permits older people to stay in their homes. Shopping and meal preparation are especially essential, since they influence how much and how well older people eat. Weight loss is an indicator for families that a loved one is not succeeding at home, especially those living alone, and can lead to what one observer has predicted will be families thinking sooner about nursing home placement. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)
- The FIS is particularly inaccurate as a measure of the needs of children and adolescents. Because children, with or without disabilities, are not generally expected to perform such tasks as meal preparation and housecleaning, children with disabilities are automatically ranked at one on such tasks. This rank reflects, not the severity of their disabilities, but only the expectations of their age group. The dummy scores equal to “one,” carries a negative weight, which statistically impacts the client’s overall FIS. It would make more sense if this was coded instead as an N/A so during scoring it did not lower the client's FIS and services. Children’s and adolescents’ critical needs, though fewer in number, will not be met, merely because they do not have as many unmet needs as adults with the same level of disability. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)
- The “comparability” requirement of the Medicaid Act mandates comparable services for individuals with comparable needs and is violated when some recipients are treated differently than others where each has the same level of need (42 U.S.C. § 1396a(a)(10)(B); see also 42 C.F.R. § 440.240). The state may “place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.” However, the state may not “arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition” (42 C.F.R. § 440.230(c)(1-2)).

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The use of numerical ranks and FI Scores to determine eligibility for IHSS services likely violates the comparability requirement of the Medicaid Act because neither reasonably measures the individual need of a disabled or elderly person for a particular service. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)

Measurements of Mental Impairment

- Numerical ranks are particularly inaccurate measures of the needs of individuals with mental impairments, such as elders with Alzheimer's disease. Individuals with cognitive and psychiatric disabilities frequently require verbal rather than physical assistance. Therefore, many of these individuals receive numerical ranks of two rather than three or four. Numerical ranks of two for recipients with mental disabilities reflect the nature of the assistance needed, not the severity of the need. Disabled and elderly individuals with numerical ranks of two have no less need for verbal assistance than individuals with severe physical impairments have for physical assistance. For example, elders may need reminders to eat on a regular basis, take medication or avoid eating foods contraindicated with certain medications. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)
- Individuals with mental disabilities may need only a few critical services, such as medication management and assistance with domestic and related tasks. But, because they do not need help with a larger number of personal care functions such as bowel/bladder, ambulation or respiration, their FI Scores will generally be below 2.0. Nevertheless, individuals with mental impairments are no less in need of IHSS services than those with physical impairments. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)

Other

- The IHSS assessment tool does not contain items that assess individual preference for living arrangement. Nor does it identify family opposition or any potential difficulties in meeting the client's preference. (Osterweil, et al., 2008)
- When documenting hours, shared living exceptions are included, which has the potential to reduce the level of household services to recipients who live with someone else. These reductions are not based on an individual's needs for service, that is, it does not consider whether a recipient lived with someone who actually would help. (V.L., et al., Plaintiffs, v. John A Wagner, 2009)
- Designed to be used by programs that target specific populations, within the context of a specific program (IHSS) and at this stage cannot reasonably be used for other populations. The information collected via the IHSS Assessment is also more difficult to share across providers. This limited-use tool can create duplication and fragmentation within a system and often subject individuals to multiple assessments to obtain needed services. (Osterweil, et al., 2008)

CA LEGISLATIVE ANALYST'S OFFICE (LAO): ALTERNATIVE PROPOSALS
FOR THE IHSS PROGRAM

Develop a Better Measure of Impairment

- The LAO (2010) believes a better assessment measure for the IHSS Program should be developed for two reasons:
 - First, it will better enable the Legislature to target services to those most at risk of institutionalization.
 - Second, it will strengthen the state's position with respect to legal challenges in federal court.
- The LAO recommends enactment of legislation requiring DSS to present the Legislature with a new system of measuring impairment and the risk of institutional placement no later than January 10, 2011.
 - In developing the new measures, DSS should be directed to convene at least two stakeholder meetings including, but not be limited to, provider organizations, consumer organizations, social workers who conduct assessments, county representatives, and legislative staff.
 - The new system for measuring impairment should require that a social worker make a specific finding whether the client needs IHSS services in order to avoid institutional placement. (Legislative Analyst Office, 2010)

Increase Minimum Threshold for Qualifying for IHSS Services

- One option the Legislature could consider to better target the program would be to raise the minimum threshold for qualifying for IHSS services. For example, each task could have a different minimum FI ranking that would be required to receive the particular task. Recipients could be required to have a FI ranking of at least 4 to receive authorization for dressing assistance, but only a 3 to receive authorization for bathing assistance.
 - By increasing the minimum ranking for qualification, services would be targeted to those with the highest impairment levels for those particular tasks.
 - The LAO notes that the use of FI rankings and scores as a method for targeting IHSS services is currently being challenged in court. However, there are other ways to target services, such as making certain services only available to recipients who are authorized to receive a certain minimum number of hours, or requiring that the client receives developmental disability services or is certified for SNF placement to qualify for particular services. (Legislative Analyst Office, 2010)

Adopt a New Service Delivery Approach for the IHSS Program

- IHSS program consists of a diverse caseload with varying levels of need. As a result, it may make sense to construct a program that recognizes the variation in the needs of different segments of the caseload, and provides different types of services accordingly to each segment.
 - For example, under this approach, the more frail recipients could continue receiving IHSS, while other recipients could instead receive funds to purchase goods and services to assist them in remaining in their own homes.

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- The LAO proposed a new three-tiered service-delivery approach to delivering IHSS which would be based on determined hours versus FIS ranking. Service levels would be correlated to the new measure of impairment and risk. Such an approach could provide a continuum of care which would help all Californians delay or avoid the need to enter an institution while better targeting services to those with the greatest impairment. The three different tiers of available services based on the recipient's overall level of need could be as follows:
 1. **First Tier:** Recipients in the first tier would be the most frail recipients (in this example, the severely impaired with over 195 authorized hours per month) for whom services would remain unchanged.
 2. **Second Tier:** Recipients in the second tier could receive a variation on cash and counseling services, with authorization to spend a set allocation of funds on the purchase of goods and services, such as in-home care or home modifications, such as a wheelchair ramp, to assist them in remaining in their own home. Tier two recipients would also receive increased case management and other assistance from their IHSS social worker.
 3. **Third Tier:** Recipients in the third tier would receive no IHSS services and no allocation of funds. Instead, these recipients would receive quarterly visits from a social worker who would monitor the condition of the recipient and provide case-management services. The intent of monitoring this group would be to transfer them to tier one or two if their condition met the qualification levels of those tiers.

	Affected Recipients	IHSS Policy Change
<i>Severely-impaired recipients</i> (195+ hours of care per month).	Tier One—Recipients with at least 195 authorized hours per month.	No Change
<i>Non-severely impaired recipients</i> (less than 195 hours of care per month).	Tier Two—Recipients with between 80 and 194 authorized hours per month.	Provide (1) cash for purchase of goods and services and (2) increased case management.
	Tier Three—Recipients with between 1 and 79 authorized hours per month.	No IHSS or cash assistance. Increased social worker case management.

- The LAO example bases the tiers on the number of authorized hours, but the Legislature could consider basing the tiers on other factors related to the level of recipient need.
- The Legislature could also consider creating additional service tiers.

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- Such a major reform to the IHSS program would require legislative input on many details, and likely require significant changes to the current Medicaid State Plan and waiver agreements with the federal government. However, a tiered approach to service delivery could more effectively target resources to those with the highest risk of SNF placement. (LAO, 2010)
 - This new IHSS service-delivery proposal by LAO has similarities to Vermont's Choices for Care Program (introduced in October 2005, using a 1115 waiver) which uses a clinical assessment to prioritize clients (individuals 18 and older with disabilities, including the frail elderly) into two tiers based on their levels of need for long-term services.
 - Clients with the highest level of need are in the first tier and are eligible for a nursing facility or HCBS. People categorized as “highest need” were entitled to either nursing home or HCBS if they met the following criteria: have severe cognitive limitations or require extensive or total assistance with toileting, bed mobility, eating, or transferring; and have a monthly income of less than about \$2,000 and assets worth less than \$2,000 (for nursing home care) or \$5,000 (for HCBS).
 - Clients in the second tier, “Moderate Need” do not qualify for institutional care, as they are individuals who have been determined to need minimal assistance to remain at home, but they are eligible for limited case management, adult day services, and/or homemaker service.
 - The availability of services depends on the availability of funds, however. Similarly, the state has permission to create waiting lists for the “High Need” group if necessary for budgetary reasons.
 - Under *Choices for Care*, the state can combine HCBS funds with nursing home funds in a single capitated global budget.
 - For more information, on *Vermont's Choices for Care Program*, see: <http://www.ddas.vermont.gov/ddas-programs/programs-cfc/> (Shirk, 2009)

NATIONWIDE: ROLE OF LONG-TERM CARE (LTC) ASSESSMENT TOOLS

- *Number of Americans needing long-term care services: nearly 13 million*
- *Number of nursing home residents: 1.8 million*
- *Number receiving home- and community-based services (HCBS): 10.9 million*
- *Number of people receiving unpaid help from family and friends: 9.8 million*
- *Number of people receiving HCBS who get paid help: 1.4 million*

(Kaye, Harrington & LaPlante, 2010)

- Assessment tools can help to ensure accurate and consistent findings across clients and assessors. It can also provide a mechanism for the state to ensure that only needed

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services are authorized. The assessment process varies across states, influenced by many factors, including state organizational structures, available programs, and administrative requirements, such as level-of care determinations and authorization of services. (Shirk, 2009)

- As the Medicaid LTC programs have grown, states have examined methods for controlling LTC costs and ensuring appropriate utilization via the use of client assessment tools. Under federal Medicaid guidelines, states have flexibility in determining the need for LTC services because the minimum need criteria are not specified in statutes or regulations. (Tonner & Harrington, 2004)
- Assessment is a fundamental part of the medical care process and the social service – planning process. It provides a systematic approach to collecting information and distilling it into a coherent framework. In contrast to clinical care, the actions in LTC are often less aggressive and less directed toward the goal of cure or even rehabilitation. They are more likely to be compensatory, in the sense of helping the client adjust to reduced circumstances—restrictions created by illness and environment. (Kane & Kane, 2000)
- In addition to identifying needs for the purpose of developing service plans, assessments can serve other functions, including determining functional (sometimes referred to as “medical”) eligibility, establishing a budget for services or allocating a certain number of service hours, and monitoring quality. (Howes, 2010)
- The need for assistance with instrumental activities of daily living (IADLs), the need for supervision, and the lack of formal and informal support are measures used more frequently in evaluations for community-based services than for institutional services. (Summer, 2007)
- In their assessment tools, states use a variety of terms in addition to “level-of-care” criteria, including health and functional criteria, need criteria, targeting criteria, and service criteria. (Summer, 2007)
- Another use for assessments is to determine a client’s priority level for services. Most states have waiting lists for their HCBS waiver programs, and the assessment results can help establish where the client will fall on the waiting list. (Shirk, 2009)

COMPONENTS OF COMPREHENSIVE LTC ASSESSMENT TOOLS

- A well-designed assessment instrument identifies the full range of a client’s service needs so that they can be addressed when possible, thus preventing or delaying the need for institutionalization. Assessments are generally considered by experts to be comprehensive when they cover six domains:

1. Physical Health

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2. Mental Health

3. Functioning

4. Social Resources

5. Economic Resources

6. Physical Environment

Most state assessment instruments address all domains to some extent; however, there is wide variability in the depth to which each domain is examined.

(U.S. General Accounting Office, 1996; Shirk, 2009)

- Such an assessment must include psychological and social status, because the recommendations and decisions of case management teams are often more likely to influence psychosocial outcomes than physical health outcomes. (Kane & Kane, 2000)
- Setting level-of-care criteria poses a challenge for states. Criteria that are too broad may be problematic if the size of the population qualifying for services cannot be supported by available resources. Long waiting lists may be anticipated. On the other hand, if restrictive criteria are used, some very needy individuals may not have access at all to needed services. Some of the important questions states must consider when states establish the criteria and the process to determine functional eligibility include:
 - How should functional eligibility or “level-of-care” be determined?
 - What criteria should be used?
 - Should the same process be used to assess functional eligibility for all service settings?
 - Should states use more than one level of care?
 - Who should conduct assessments for functional eligibility?
 - What kind of training should be provided?

(Summer, 2007)

- Incorporate deliberate thoughtful assessments of both the client’s status (and implied prognosis) and the values attached to possible alternative outcomes to enhance this vital process and produce results that are as compatible as possible with client and family goals. There is a sore need for a simple, pragmatic way to allow clients and families to explore how they value alternative outcomes relative to each other. Work along these lines has shown, for example, that clients and providers do not place the same relative value on ADLs and IADLs. Clients place more importance on IADLs, whereas providers emphasize ADLs. (Kane & Kane, 2000)
- Make assessment more client-centered by incorporating more information about the person’s strengths and preferences. These types of questions are particularly important when the assessment is used for younger individuals with disabilities who want to exercise more control over their daily lives. (Shirk, 2009)
- All comprehensive assessments evaluate informal supports. Evaluating informal care giving helps ensure that services in the care plan do not duplicate services that are already being provided by someone else. (Shirk, 2009)

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- Include elements within the tool that evaluate the caregiver's status. This can be done by explicitly examining issues such as caregiver stress, health, and ability to continue providing informal supports, or including a rating or code that indicates the level of informal support that is available-which are then considered when developing the service plan. (Shirk, 2009)
- Most experts believe that adopting one standard assessment tool regardless of the client's age, disability, geographic region or services needed, encourages more objective screening of medical and functional needs and is more equitable for beneficiaries. Another argument for developing uniform assessment procedures for HCBS waiver programs and nursing facilities is that administrative efficiency improves. Duplication of effort occurs when clients must complete more than one application for different types of long-term services and multiple administrators must review applications. (Summer, 2007)
- Assessments that are designed to serve multiple functions appear to create more client friendly systems that reduce the need for repeated contacts and redundant questions. As states move toward providing more services in the community, issues such as client strengths and preferences and caregiver status have taken on more importance. (Shirk, 2009)
- It is generally easier to collect data from casual reports that summarize observations over time than from specifically structured observation or performance done in a controlled study. Moreover, these two approaches can tap different aspects of behavior. From the standpoint of enhancing reliability, there are advantages to testing clients whenever possible under standardized conditions. For example, ADL functions may be demonstrated by asking a client to actually eat something (e.g. a spoonful of raisins or water) or to dress, using a standardized garment. Occupational therapists routinely test clients in standardized kitchens and bathrooms. (Kane & Kane, 2000)
- There is some evidence to suggest that older persons with significant limitations in several IADLs, such as shopping, meal preparation, house cleaning, and transportation, have levels of disability that are comparable to those experienced by people with two or more ADL limitations so these need to be adequately assessed in the assessment tool. (Summer, 2007)
- Traditionally, the level-of-care criteria have been used as the basis for making an "either/or" decision. Applicants either do or do not qualify for care. Put another way, the level-of-care criteria serve a gate-keeping function. Proponents of a more comprehensive assessment approach that uses different sets of criteria for different levels of care believe that it gives states the opportunity to provide services to more people at different levels of intensity. Many believe that if some community-based services are made available to individuals with more modest needs, use of more costly services can be delayed or avoided later on. (Summer, 2007)

Delivery/Processing of the Assessment Tool

- Implement single-points-of-entry for persons seeking long-term care services, whether in nursing homes or community settings and regardless of age and disability, where case managers, using uniform automated assessment tools and processes, will determine eligibility, assess need and help recipients develop a plan for care in the setting of their choice. (Summer, 2007)
- Assessment tool training efforts are more likely to be successful if they teach not only about the mechanics of the process, but also about how the assessment process fits into the broader goals for delivering long-term services and supports effectively. Researchers note that when assessors do not understand or do not agree with the underlying rationale, they tend to regard the assessment as add-on work rather than as an important part of the process to provide quality services. In such instances the assessment forms tend to be completed after the fact. (Summer, 2007)
- Some researchers note that assessment tools are only as good as their users and that assessors' preferences, priorities, values, and beliefs can influence the outcome of an assessment. There is evidence also that some subjectivity may be associated with standard protocols. For example, in states that use structured assessment tools which generate scores, the qualifying scores are usually well known and some reviews have shown that many scores cluster just above the cut-off score. Experts caution that standard assessment tools should not be viewed as a substitute for clinical judgment. (Summer, 2007)
- Recommendations to improve the assessment process have included the use of systems that use scores as a guide, but allow professionals to use their own judgment and over-ride the scores on occasion. (Summer, 2007)
- An assessment's administration can be automated or paper-based. For best results, the assessment information should be gathered electronically. Automated assessments allow for the use of a standardized algorithm to synthesize responses. Assessment information housed in a single database reduces duplicative data collection and facilitates information sharing across programs. (Osterweil, et al. 2008)
 - Automation also helps ensure that the assessment is conducted in a consistent and thorough manner. Automation also greatly enhances the ability to perform administrative functions, such as authorizing service, tracking case management, and monitoring service delivery outcomes. Data from these assessments also can be easily displayed in graphs or analyzed for quality improvement purposes. (Shirk, 2009)

NATIONWIDE BEST PRACTICES: ASSESSMENTS FOR DETERMINING FUNCTIONAL ELIGIBILITY OR LEVEL-OF-CARE

Based on the research, the four most promising Nationwide LTC assessment tools identified (Hyperlinks are provided for more information) include:

1. Washington-Comprehensive Assessment and Reporting Evaluation (CARE) System (<http://www.aasa.dshs.wa.gov/professional/care/>)
 - CARE Tool (Paper Form-49 Pages)¹:
http://www2.hsri.org/quality/QF_CAREAssmtTool.pdf
 - WA State Fact Sheet: CARE System:
http://www.srskansas.org/hcp/css/SystemsTransformation/LOC_Documents/F5_Wash_CARE_Fact_Sheet.pdf
 - Orientation to Washington CARE Tool/Assessment Process (Includes PDF Screenshots)
<http://www.adrc-tae.org/documents/washcare.pdf>
2. Oregon- Client Assessment and Planning System (CA/PS) (<http://oregon.gov/DHS/spwpd/ltc/main.shtml>)
 - CA/PS Tool (Paper Form-39 Pages)
http://www.oregon.gov/DHS/spd/mfp/dd/bi/docs/paper_tool_071113.pdf
3. Wisconsin-Adult Long Term Care Functional Screen System (<http://dhs.wi.gov/ltcare/FunctionalScreen/Index.htm>)
 - LTC FS Version 3 (Paper Form-21 Pages):
<http://dhs.wi.gov/ltcare/FunctionalScreen/PaperFormV3.pdf>
 - Testing the Reliability and Validity of the Wisconsin LTC Functional Screen:
<http://dhs.wi.gov/ltcare/FunctionalScreen/1915bAttachmentAIatt3c1.pdf>
 - PowerPoint Presentation: An Orientation to Wisconsin's Long-Term Care Functional Screen (Includes screen shots and explanations of each page):
<http://dhs.wi.gov/ltcare/FunctionalScreen/LTCFSSlideShow.HTM>
4. California-San Mateo County Division of Aging and Adult Services Uniform Assessment Tool (<http://www.co.sanmateo.ca.us/>)

More information on the above assessment tools, in addition to other LTC assessment tools for consideration are outlined in the below research studies.

¹ The CARE assessment tool has received routine updates since the paper version of the tool was created in November 2003. WA no longer uses the paper version of the tool all assessments are completed on a laptop. The laptop has a full version of the tool on it and a case manager is able to download up to 20 client assessments onto the lap top at any given time. The assessment is done in the client's home on the lap top. When the case manager returns to the office the assessments are synchronized with the server database.

SOURCE: Shirk, C. (July, 2009). *Comprehensive Assessments in Home and Community-Based Services*. Baltimore, MD: The Hilltop Institute, UMBC.
www.adrc-tae.org/tiki-download_file.php?fileId=28348

Shirk (2009) performed a review of 13 state assessment instruments and associated instructions or training manuals when available, interviews with state officials, and review of previously published reports and information on state websites to determine the most comprehensive assessment tools for HCBS.

The assessments are, at a minimum, used for states' Medicaid HCBS waiver programs for older adults and persons with disabilities. In many cases, they are also used for Medicaid state plan services, Section 1115 demonstration projects, and/or state-funded LTC services. The assessment instruments Shirk (2009) analyzed included:

1. *Colorado: Long Term Care Eligibility Assessment; Long Term Care Assessment for Instrumental Activities of Daily Living*
2. *Florida: Department of Elder Affairs Assessment Instrument*
3. *Maine: Medical Eligibility Determination (MED) Version 8.0*
4. *Maryland: Medical Eligibility Determination*
5. *Massachusetts: Real Choice Functional Needs Assessment*
6. *Minnesota: Comprehensive Assessment (COMPASS)*
7. *New Jersey: New Jersey MI Choice Care Management Assessment*
8. *New Mexico: Long Term Care Assessment Abstract; Comprehensive Individual Assessment*
9. *Oregon: Client Assessment and Planning System (CA/PS)*
10. *Texas: Client Needs Assessment Questionnaire & Task/Hour Guide*
11. *Vermont: Choices for Care Clinical Assessment; Independent Living Assessment*
12. *Washington: Comprehensive Assessment Reporting Evaluation*
13. *Wisconsin: Adult Long Term Care Functional Screen-Version 3.0; Assessment/ Supplement*

All states except Texas use the same assessment instrument for people applying for both institutional (e.g., nursing home) care and HCBS.

For the above instruments Shirk (2009) provided a summary of elements covered in each state's assessment(s), organized by the six domains that are generally considered to compose a comprehensive assessment. This summary is included in *Appendix B: HCBS Assessment Tools-Content Comparison*.

As shown in Appendix B, Shirk concluded that Washington's CARE instrument appears to be the most comprehensive in terms of the number of elements captured across all six domains. Washington uses CARE for a number of different functions, including financial eligibility, and for all populations, which contributes to its comprehensiveness.

Additionally, of the above assessments some of the major best practices Shirk (2009) identified include:

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- Maine's Medical Eligibility Determination instruction manual includes task time guidelines for use in developing the plan of care. The assessment instrument contains a care plan summary page that outlines the support services the individual will receive, including both formal and informal care and the amount of services based on the task and time guidelines.
- Minnesota's Comprehensive Assessment (COMPASS) begins with a person-centered interview that includes questions about areas such as personal history, preferences and strengths, life satisfaction, planning for the future, losses, risk factors, and who makes decisions about the client's choices.
- Oregon noted that they had recently revised their assessment to put the ADL skills that determine functional eligibility at the beginning of the assessment, which saves time if the client is ineligible. This revision has decreased assessment time from 1.5 hours to 15 minutes for individuals who are found ineligible.
- Three assessments in the study (from Minnesota, Oregon, and Washington) do not use "scores" per se, although assessors do indicate the consumer's level of independence in each area. These assessments are fully automated, and logic built into the computer determines functional eligibility without the need for scores. In automated assessments, eligibility determinations are made instantaneously, so there is no need to wait before proceeding with the plan of care development.
- Two assessments in the study (Oregon and Washington) use systems with internal logic that indicate the potential programs and hours of service to meet the consumer's identified needs. The case manager then works with the consumer to select appropriate services from those available. In addition, certain data elements or combinations of data elements that are selected in the assessment trigger a critical indicator that recommends a referral.
- Payment algorithms are used to establish individual budgets in Oregon and Washington. In this approach, consumers are placed into groups based on their assessed characteristics and projected relative resource use as determined through time study. There are currently 18 levels in Oregon and 17 levels in Washington. The level in which the individual is placed then drives the maximum payment rate to meet the care plan needs. The results of the eligibility and payment algorithms programmed into the computer are displayed on the care plan page of the computerized assessment to assist with service planning.
- Washington's automated system prevents assessors from proceeding if relevant fields are left blank.
- The Washington CARE system now evaluates each client individually with regard to the amount of informal support that is available (instead of automatically reducing the amount of services in a care plan by a set amount of time if the client lives in a household with an informal caregiver)

- Wisconsin codes each ADL and most IADLs to indicate whether an unpaid caregiver will continue to provide assistance. The Assessment/Supplement then looks more closely at the level of assistance already in place and whether additional assistance is needed.
 - Periodic reviews conducted by states generally examine issues such as the timeliness of assessment and service initiation and whether the services included in care plans match identified needs and services rendered. *Wisconsin* includes an interview with the client as part of its review and compares data across health plans.
 - The *New Jersey Choice* assessment results in trigger care assessment protocols (CAPS) that identify areas needing special assessment and guide care and service planning. When its new assessment is fully implemented, New Jersey will base its payments on resource utilization groups (RUGS). Originally developed by InterRAI, an international collaborative of researchers, as part of its suite of assessment instruments that includes the MDS-HC, the RUGS system groups participants into categories of service utilization based on their unique characteristics as identified in the assessment. New Jersey is currently working with an actuary to develop financial levels for these categories.
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SOURCE: Osterweil, D., et al. (2008). *California Pathways/Money Follows the Person: Final Report*. Department of Medicine David Geffen School of Medicine-University of California, Los Angeles: Los Angeles, CA.
http://www.dhcs.ca.gov/services/ltc/Documents/CA_Pathways_MFP_FinalRpt.pdf

Osterweil, et al. (2008) selected 13 LTC Assessment Protocols: National; Statewide California; Local (California); and Models from Other States for review (he obtained copies of the assessments and their instruction manuals from either the Internet or administrators from each state or program), which are listed below:

1. National Assessments:
 - *Minimum Dataset (MDS) 2.0*
(<http://www.cms.gov/NursingHomeQualityInits/downloads/MDS20MDSAllForms.pdf>)
 - *Minimum Dataset for Home Care (also known as RAI-HC)*
 - *Outcome and Assessment Information Set (OASIS)*
2. Statewide California Assessments from:
 - *Multipurpose Senior Services Program (MSSP)*
 - *In-home Supportive Services (IHSS)*
3. Local California Assessments from:
 - *California Assisted Living Pilot Project*
 - *San Mateo's Uniform Assessment Tool*
 - *Santa Rosa's Nursing Facility Transition Tool*

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4. Model Assessments from Other States:

- *Michigan's MI-Choice Waiver Program assessment*
- *Texas's Inventory of Community Service and Support Needs for Nursing Facility Transition*
- *Oregon's Client Assessment and Planning System tool*
- *Wisconsin's Long-term Care Functional Screen*
- *Washington's CARE uniform assessment*

The *Minimum Data Set (MDS)* was selected for review because of its reported reliability and validity. Additionally, data collected from MDS assessments are widely used by the Medicare program and many state Medicaid programs to determine provider reimbursements as well as to monitor the quality of care provided to nursing facility residents and home care clients. Similarly, the *OASIS* instrument is widely used by home health agencies to meet CMS's standardized reporting requirements.

MSSP and *IHSS* assessments were included because they are used throughout California by many aging and disability programs and services. *San Mateo*, *Santa Rosa*, and the *California Assisted Living Pilot Project* have developed innovative assessment tools that foster system integration, nursing facility transition, and the determination of level of need, respectively. The five state assessments (used in *Michigan*, *Texas*, *Oregon*, *Wisconsin*, and *Washington*) were selected because they are recognized by the literature as exemplary. *Appendix C* presents a description of each of the above assessment protocols.

Osterweil, et al. (2008) consulted a 2005 report written by Jennifer Gillespie of the National Academy for State Health Policy entitled *Assessment Instruments in 12 States* (http://www.hcbs.org/moreInfo.php/state/177/doc/844/Assessment_Instruments_in_Twelve_States) which facilitated their selection of the following evaluation criteria:

- Context and Purpose of the Assessment Tool: How is the tool used?
- The Assessment Process: How are the data gathered and used?
- System Integration: Is the tool used within the context of a system? Is that system integrated across populations and programs?
- Content: Are the following key elements covered?
 - Individual Preference
 - Memory/Cognition
 - Social Support/Living Arrangements
 - Physical Functioning
 - Diseases/Conditions
 - Medications
 - Housing/Home Environment
 - Transportation
 - Service Utilization

All the assessment tools were found to cover similar domains and potential problem areas, including functioning, cognition, health status, medications, social support, and service use. Few tools address issues related to current employment, activity pursuit

patterns. Although the assessment tools examine similar domains, they vary in their measurement and coding of responses.

The diversity in assessment tools is apparent in the purpose and usage of each tool. Some tools address a narrow purpose, for example, facilitating nursing facility transitions (i.e., Santa Rosa, Texas) or determining eligibility for a waiver program (i.e., ALWPP, MI-Choic. Other tools are employed within the context of a specific program (e.g., MSSP, IHSS).

Study Findings/Recommendations:

- Ideal is uniform assessment tool employed within the context of an integrated system. This tool applies to more than one population and to multiple programs within the state of California. Through the use of this tool, an individual would have a single entry into a system of needed programs and services. For best results, the assessment information should be gathered electronically using a single tool and translated into care plans and reimbursement levels via standardized algorithms. Assessment information would be housed in a single database to reduce duplicative data collection and to facilitate information sharing across programs.
- Of the 13 instruments Osterweil, et al., 2008 reviewed, they found only three met the above criteria: those used in Washington, Oregon, and Wisconsin.
 - Washington, Wisconsin, and Oregon have each developed their own statewide, uniform assessment, which determines eligibility, provides authorization, and creates a single point of entry into each state's long-term care system. Findings from these tools are used to develop care plans and are automatically linked to reimbursement levels.
 - The tools used in Washington and Wisconsin, feature detailed interview protocols and scripts to follow to ensure standardized approaches to interviewing and probing clients and therefore, inter-rater reliability.
- Of the three top instruments cited, Osterweil, et al., 2008 recommend that policymakers closely examine the Washington CARE tool, because:
 1. It has been administered extensively throughout the state and is used within an integrated system.
 2. Washington has evaluated the tool's inter-rater reliability and empirically tested its algorithms, which are used to predict resource allocation.
 3. Washington's assessment process allows data to be scanned or entered directly into a computer and includes software programs that use standardized algorithms to convert raw assessment data into usable information for care planning and reimbursement.
 4. Contacts in Washington have willingly shared their experiences with the tool and have even offered technical assistance.
 5. Although the programming costs of developing a similar instrument for use in California are unknown, the Washington tool can be modified to suit California's needs, which include both nursing facility diversion and transition.

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- Osterweil, et al., 2008 also recommend policymakers examine the *San Mateo UAT* because it is a single assessment that has integrated requirements of several specific California programs and therefore may be adaptable for statewide use as well as use in nursing facility diversion and transition programs.
 - Builds off the MDS-HC instrument, but has been tailored to incorporate specific requirements for the MSSP and AIDS programs.
 - Furthermore, the MDS-HC has been psychometrically tested for reliability.
 - The UAT instrument is housed in a single information system to reduce duplication of data collection and to ensure that data is easily shared across programs
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SOURCE: Shugerman, L. & Mack, K. (May 2009). *Evaluation of the Uniform Assessment Tool (UAT): Final Report*. Prepared for the County of San Mateo Aging and Adult Services. Rand Corporation.

The RAND Corporation was asked to develop and conduct an evaluation of the *County of San Mateo Aging and Adult Services Universal Assessment Tool (UAT)* pilot in an effort to provide feedback to AAS about the prospects of the UAT to support service integration and planning.

Background:

- In 2003, the California State Legislature passed AB 786, which designated San Mateo County as the first pilot county for the UAT in an effort to move toward long-term care integration following a larger effort to consolidate existing HCBS with acute and institutional long-term care for eligible populations in San Mateo County through the Long-Term Supportive Services Project (LTSSP).
 - The LTSSP was developed by the Health Plan of San Mateo, the Health Services Agency, AAS, and the Hospital Consortium of San Mateo County. One of the essential components of the project is to establish a uniform assessment tool to identify the needs of vulnerable populations.
- AB 786 identified the interRAI-HC as the core assessment instrument of the UAT after an extensive search of existing assessment instruments used in HCBS programs across the country. The interRAI-HC was combined with San Mateo County Aging and Adult Services (AAS), a division of the San Mateo County Health System program-specific assessment items to create what is now the AAS UAT. Software was developed to integrate the UAT into the 'Q Continuum' (Q), an automated case management software used across California counties for standard reporting on selected HCBS programs to the state and federal governments.
- The legislation paved the way for AAS to finalize the UAT and test the tool's efficacy with clients. In accordance with AB 786 (2003), San Mateo County piloted a Uniform Assessment Tool (UAT) to test the tool's efficacy with clients in May, 2008 within Aging and Adult Services (AAS).

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- The UAT was launched as a pilot with several case management programs run by AAS: Adult Protective Services (APS), Healthier Outcomes through Multidisciplinary Engagement (HOME) Team, In-Home Supportive Services (IHSS), Linkages, Meals on Wheels, Multipurpose Senior Services Program (MSSP), and the Public Guardian program.

Conclusions:

- Overall results indicate a strong potential for the UAT to be used in an integrated system within San Mateo County.
- Specifically, the UAT was perceived as a comprehensive assessment tool that could support care planning, with the primary goal to unify information across programs and move away from several independent systems for assessment under the same division umbrella.
 - The UAT can be viewed as both a uniform assessment system as well as a vehicle for the introduction of a uniform language with which to speak about client need.
- Other counties have expressed interest in the AAS UAT.
 - AAS will share information on the UAT with those who are interested in the hopes of promoting widespread adoption
- RAND outlined five lessons are derived from San Mateo's experience implementing the UAT:
 - Of primary importance to the further implementation of the UAT or any other uniform assessment tool is the resolution of technical issues prior to broad implementation of the assessment.
 - Optimal testing of the assessment will require that the case managers who use the tool be exempt from completing other assessment tools.
 - Select carefully the programs in which the UAT will be piloted or be clear about what elements of the assessment must be completed and which are optional, depending on the program.
 - Train case managers well on the use of the UAT, how to complete all data elements, and how to interpret the reports produced for care planning.
 - Consider using technology that limits interference with relationship building with clients but increases speed in completing the assessment and reduces duplication of efforts.
- The San Mateo UAT pilot was an important step towards realization of the LTSSP model. The pilot of a uniform assessment tool across AAS programs that serve clients with different needs moves the field closer to the goal of integrating long-term care and health care services.

Also see: BASSC Review-Uniform Assessment Tool:

http://cssr.berkeley.edu/bassc/cases/2007/Marilyn_Remark.pdf

SOURCE: Summer, L. (June 2007). *Community-based long term care services financed by Medicaid: managing resources to provide appropriate Medicaid services*. Washington, DC: Georgetown Public Policy Institute, Long term Care Financing Project. <http://lrc.georgetown.edu/pdfs/summer0607.pdf>

- The Wisconsin Family Care Program uses a valid web-based functional screen:
 - Social workers and registered nurses may become certified screeners after they take an on-line training course and pass an exam.
 - The assessment tool was developed with input from a variety of stakeholders and looks not only at ADLs and IADLs, but at an array of measures including cognition and behavior, indicators for mental health problems, substance abuse and other conditions that put a person at-risk of institutionalization, and the need for assistance with medically-oriented tasks, transportation and employment.
 - Eligibility logic, based on previous state experience, is built into the system so that eligibility determinations can be made immediately.
 - The functional eligibility screen is seen as an objective and consistent tool, having been systematically tested for reliability and validity.

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Appendix A

IHSS Functional Index Score Calculation Worksheet

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Functional Index Score Calculation Worksheet					
FI Task Areas	Rank	Minus 1	Total	Multiplied by weight	New Total
Housework/Domestic (can be ranked 1-5)		-1 =		X .038 =	
Laundry (can be ranked 1-5)		-1 =		X .037 =	
Shopping and Errands (can be ranked 1-5)		-1 =		X .040 =	
Meal Preparation and Clean Up (can be ranked 1-5)*		-1 =		X .222 =	
Mobility Inside/Ambulation (can be ranked 1-5)		-1 =		X .079 =	
Bathing and Grooming (can be ranked 1-5)		-1 =		X .095 =	
Dressing (can be ranked 1-5)		-1 =		X .057 =	
Bowel, Bladder and Menstrual (can be ranked 1-5)		-1 =		X .129 =	
Repositioning (can be ranked 1-5)		-1 =		X .094 =	
Eating (can be ranked 1-5)*		-1 =		X .127 =	
Respiration (can be ranked 1-5)**		-1 =		X .082 =	
Sum of above →					
+1 =					
Round off number to 2 decimal points. The total is the FI Score					

*If recipient receives tube feeding, rank as "1" and provide paramedical services.

**If recipient receives tracheostomy care and suctioning, rank as "1" and provide paramedical services.

Appendix B

HCBS Assessment Tools-Content Comparison

The following tables show the full spectrum of elements evaluated in Shirks (2009) analysis of 13 state HCBS assessment(s), organized by the six domains that are generally considered to compose a comprehensive assessment.

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Table A1. DOMAIN: Functioning

	CO ¹	FL	MD	ME	MA	MN	NJ	NM		OR	TX	VT		WA	WI
								ISD379	CIA			CFC	ILA		
ADLs															
Hygiene	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Eating	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bathing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dressing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Toileting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Transfer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mobility	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bed mobility				✓	✓	✓	✓					✓	✓	✓	✓
Uses adaptive devices		✓		✓		✓						✓	✓	✓	✓
Overnight supervision															✓
IADLs															
Medication management	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Transportation	✓	✓		✓	✓	✓	✓		✓	✓			✓	✓	✓
Money management	✓	✓	✓	✓	✓	✓	✓		✓	✓			✓	✓	✓
Shopping	✓	✓		✓	✓	✓	✓		✓	✓	✓		✓	✓	
Meal preparation	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Laundry	✓			✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Housework	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Phone use		✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Accessing resources	✓														
Wood supply														✓	
Pet care		✓				✓				✓			✓	✓	
Household maintenance										✓			✓		
Care for equipment													✓		
Child care		✓											✓		

¹Colorado's assessment notes reasons for functional deficits that include a variety of physical impairments, supervision, and mental health issues.



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Table A2. DOMAIN: Physical Health

	CO	FL	MD	ME	MA	MN	NJ	NM		OR	TX ¹	VT		WA	WI
								ISD379	CIA			CFC	ILA		
History									✓	✓				✓	A/S
Diagnoses		✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Treatments		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Therapies		✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓
Health-related services			✓		✓										✓
Medications		✓		✓		✓	✓	✓	✓	✓			# only	✓	
Vision		✓	✓	✓	✓	✓	✓	✓		✓				✓	A/S
Hearing		✓	✓	✓	✓	✓	✓	✓		✓				✓	A/S
Communication		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓
Nutrition/weight loss		✓		✓	✓	✓	✓	Diet only	✓	✓		✓	✓	✓	A/S
Skin				✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Pain					✓	✓	✓			✓		✓	✓	✓	
Continence			✓	✓	✓	✓	✓		✓			✓	✓		A/S
Balance/falls				✓	✓		✓		✓	✓	✓			✓	A/S
Foot care				✓		✓				✓				✓	
Vitals														✓	
Allergies						✓			✓	✓					
Dental				✓	✓	✓	✓								A/S
Medical equipment					✓		✓			✓					

¹In Texas, the AAAs that perform the assessment conduct a separate assessment of physical health needs.



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Table A3. DOMAIN: Mental Health

	CO	FL	MD	ME	MA	MN	NJ	NM		OR	TX	VT		WA	WI
								ISD379	CIA			CFC	ILA		
Wandering		✓	✓	✓	✓					✓		✓	✓		✓
Self-injury			✓	✓		✓	✓		✓	✓					✓
Behavior	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Mental illness diagnosis/history			✓						✓						✓
Alcohol/substance abuse					✓	✓	✓		✓	✓			✓	✓	✓
Mental status/orientation		✓	✓	✓	✓	✓		✓		✓			✓	✓	
Physically resistive to care				✓	✓				✓				✓		✓
Memory		✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Mood/depression/suicide		✓		✓	✓	✓	✓			✓	✓		✓	✓	
Losses						✓	✓			✓					
Sleep pattern				✓		✓				✓			✓	✓	
Decision making	✓			✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Awareness (of needs)				✓						✓					
Risk	✓				✓	✓			✓	✓			✓		✓

Table A4. DOMAIN: Social Resources

	CO	FL	MD	ME	MA	MN	NJ	NM		OR	TX	VT		WA	WI
								ISD379	CIA			CFC	ILA		
Employment					✓	✓								✓	✓
Community involvement		✓			✓			✓							A/S
Caregiver status		✓		✓	✓	✓			✓				✓	✓	A/S
Relationships		✓				✓	✓	✓					✓	✓	
Interests						✓				✓				✓	
Client goals					✓	✓								✓	
Legal issues	✓			✓	✓	✓			✓	✓			✓	✓	✓
Isolation		✓					✓								
Change in social activities							✓								
Social history						✓									A/S
Personal independence															A/S



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Table A5. DOMAIN: Economic Resources

	CO	FL	MD	ME	MA	MN	NJ	NM		OR	TX	VT		WA	WI
								ISD379	CIA			CFC	ILA		
Income		✓		✓	✓								✓	✓	
Resources		✓											✓	✓	
Expenses					✓								✓	✓	
Insurance				✓	✓	✓			✓				✓	✓	✓
Trade-offs				✓	✓		✓								

Table A6. DOMAIN: Physical Environment

	CO	FL	MD	ME	MA	MN	NJ	NM		OR	TX	VT		WA	WI
								ISD379	CIA			CFC	ILA		
Housing					✓	✓	✓							✓	A/S
Living situation	✓	✓		✓	✓	✓	✓		✓				✓	✓	✓
Condition of home		✓		✓	✓	✓	✓		✓	✓			✓	✓	A/S
Accessibility														✓	
Home modifications													✓		A/S
Emergency plans							✓								A/S
Location														✓	A/S
Fire safety														✓	



Appendix C

Description of LTC Assessment Protocols-National; Statewide and Local (CA); and Models From Other States

Appendix C presents a description of the 13 National, Statewide (California), and Local LTC Assessment protocols which were selected and reviewed by Osterweil, et al. (2008)

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Minimum Data Set 2.0 – (RAI)

The Resident Assessment Instrument (RAI) helps NF staff gather information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff in revising care plans by enabling the facility to track changes in the resident's status. The MDS features a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. MDS items standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

Minimum Data Set for Home Care (also known as RAI-HC)

The MDS-HC is a client assessment system that informs and guides comprehensive care planning in the home care environment. Elderly clients of home care agencies benefit from this instrument because it identifies their needs, strengths, and preferences. The RAI-HC is compatible with the MDS 2.0 assessment used in nursing facilities. Clinical assessment protocols are included for further assessment and individualized care planning for clients who have problematic trigger conditions.

Outcome and Assessment Information Set (OASIS)

OASIS is a federally mandated assessment administered to patients of all Medicare-reimbursed home health agencies (HHAs). OASIS is not a comprehensive assessment instrument, but rather a set of data items necessary for assessing patients and measuring patient outcomes. HHAs can augment OASIS data as they deem necessary. Overall, the OASIS items are useful for outcome monitoring, clinical assessment, care planning, and other internal agency-level applications.

In-Home Supportive Services (IHSS)

The IHSS Program enables individuals who are elderly (over 65 years of age), blind, or disabled to receive in-home assistance as an alternative to institutionalization. IHSS services include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), transportation to medical appointments, and protective supervision for the mentally impaired.

Multipurpose Senior Services Program (MSSP)

MSSP provides social and healthcare management for frail older adults who are deemed nursing facility certifiable, but who can remain at home if offered certain services. MSSP arranges and bundles necessary community services that help delay institutionalization. Services include care management, meal services, home health aid, personal care aid, transportation, and home modifications. MSSP is a cost neutral program in that all services must be provided at a lower cost than care within a nursing facility.

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The MSSP assessment is comprised of four components: 1) the initial psychosocial assessment; 2) the initial health assessment; 3) the reassessment; and 4) deinstitutional care management (DCM) assessment. This last component is used for clients who are nearing the end of a lengthy nursing facility stay and need services to facilitate a successful discharge back to the community. After a year-long pilot test, the DCM assessment is now being introduced to all MSSP sites. The responses in our assessment grid consider all components of the MSSP assessment, including the DCM component.

CA Assisted Living Waiver Pilot Project (ALWPP)

This Medicaid benefit program targets individuals aged 21 years or older who meet an NF level of care but can be served outside a skilled nursing or intermedicare care facility if offered adequate support services. The program was created to provide services to individuals who reside in licensed residential care facilities for the elderly (RCFEs) or in publicly subsidized living arrangement. It also offers services to eligible individuals who want to transition from a NF into any of these living arrangement options.

ALWPP participants have access to six waiver benefits:

- The Assisted Living Waiver Service – a bundled benefit
- Care Coordination
- Translation and Interpretation Services
- Consumer Education
- Environmental Accessibility Adaptations
- Community Transition Services

The ALWPP assessment tool determines the tier of assisted living services needed by participants from among four tiers of reimbursement. The ALWPP tool determines a participant's level of care, assists in care planning, and is linked to reimbursement levels.

San Mateo, California- Uniform Assessment Tool

San Mateo is developing a uniform assessment tool that can be used by the San Mateo County Division of Aging and Adult Services. This division is an integrated agency with multiple programs, including IHSS, APS, MSSP, Linkages, and AIDS case management. A draft of the tool is completed. It was adapted from the MDS for Home Care (MDS-HC, now known as the InterRAI-HC) to incorporate specific requirements for the MSSP and AIDS programs. All case managers will complete core sections of the assessment while those engaged in complex case management (e.g., for the MSSP program) will complete the entire assessment.

Santa Rosa, California

Community Resources for Independence (CRI), with locations in Santa Rosa, Ukiah, and Napa, is a non-profit corporation established in 1976 by a group of disabled and non-disabled individuals to advance the rights of persons with disabilities to equal justice, access, opportunity, and participation in their communities.

CRI's Transitions Project has developed processes for relocating individuals with disabilities from nursing facilities into the community. Working with physicians, social workers, discharge planners, nursing facilities, and family members, Transitions Project staff and the client develop a plan,

SACHS Summary: IHSS Functional Index and Alternative Assessment Tools

set goals, and explore options. Clients are actively involved in daily decision making, reviewing choices in living arrangements, and interviewing and choosing a personal assistant.

Michigan – MI Choice Assessment

Michigan's Medicaid Waiver Program, MI Choice offers 13 in-home supportive services to eligible adults. Services include durable medical equipment and supplies, home health aides, private duty nursing, adult day care, and respite care. The program's primary goal is to maintain participant independence and prevent or avoid costly institutionalization.

Oregon- Client Assessment and Planning System

Oregon's State Department of Human Services, Seniors and People with Disabilities Division developed a statewide, comprehensive method of resident screening called the Client Assessment Planning System (CAPS). The automated tool is completed annually by case managers for each client seeking residential services. The assessment is used to provide a single point of entry into the state's long-term care system and access to a range of home and community-based and institutional care.

Texas- Inventory of Community Service and Support Needs

The Texas Independent Living Partnership is a cooperative effort of the Texas Association of Centers for Independent Living (TACIL), the Texas Health & Human Services Commission (HHSC), and the Texas Department of Human Services (TDHS). The Independent Living Partnership developed an "Inventory of Community Service and Support Needs," which is used by centers for independent living to develop a profile of the individuals who have been identified as wanting to leave the NF. The document is designed for persons of all ages who reside in nursing facilities and consolidates information on a range of services and supports.

Washington's Comprehensive Assessment Reporting Evaluation (CARE) Tool

Washington's CARE tool is used to assess and develop service plans for clients who receive long-term care services. CARE is an interactive tool that is computer-based and user friendly. This comprehensive and objective tool represents a single point of entry for a wide range of services. The CARE assessment tool evaluates a person's health and living situation. Eligibility for department-paid home and community programs and level of reimbursement is automatically determined through a standardized algorithm. The tool boasts high inter-rater reliability and is integrated with a payment method that more closely ties allocated resources to client needs.

Wisconsin- Long-term Care Functional Screen

Wisconsin's Long-Term Care Functional Screen is an automated, objective assessment used to identify the long-term care needs of elders and individuals with physical or developmental disabilities. The functional screen has multiple uses, including determination of level of care eligibility and care planning.

The screen is an "inventory of needs" that gathers information about whether a person needs help with certain activities and if so, how much help is needed. Stakeholders, consumers, and clinical practitioners all contributed to the screen's development. Several studies have tested its validity and reliability. Upon completion of the tool, the assessor can instantly see the applicant's level of care and eligibility for Family Care as well as other home and community-based waiver programs in Wisconsin.