The Hilltop Institute

analysis to advance the health of vulnerable populations

Comprehensive Assessments in Home and Community-Based Services

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Introduction

Comprehensive assessments play an important role as states seek to provide more long-term care (LTC) in home and community-based service (HCBS) settings rather than in institutions. A well-designed assessment instrument identifies the full range of a consumer'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 (U.S. General Accounting Office, 1996):

1. Physical Health
2. Mental Health
3. Functioning
4. Social Resources
5. Economic Resources
6. Physical Environment

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. All states use one or more assessment instruments for their HCBS programs. However, states vary widely in the instruments that are used, the functions that they serve, and the depth with which each of the domains are addressed.

The purpose of this report is to identify trends and emerging best practices in comprehensive assessment for HCBS. Assessment instruments from 13 states are included in the analysis[1]. Eleven instruments were selected on the basis of information about Aging and Disability Resource Center (ADRC) and systems change grant activities and are from states that have demonstrated a commitment to provide a greater proportion of LTC services in community-based settings through active diversion programs and program expenditures. Instruments from Maryland and New Mexico also are included because of The Hilltop Institute's working relationships with these states. Eleven of the assessment tools are currently in use, and two—those from Massachusetts and Minnesota—have been piloted but not implemented. Information

[1] For a complete list of sources used, see the reference section on page 18.

for this report was obtained through review of the instruments and associated instructions or training manuals when available, interviews with state officials, and review of previously published reports and information on state websites.

Assessment Instruments Included in the Study

The assessments included in this study were obtained from state websites or provided by state officials. The assessments are, at a minimum, used for states' Medicaid HCBS waiver programs for older adults and persons with disabilities.[2] 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 reviewed are:

Colorado:	Long Term Care Eligibility Assessment (Form ULTC 100.2)—May 3, 2006
	Long Term Care Assessment for Instrumental Activities of Daily Living (Form ULTC 100.2)—November 1, 2007[3]
Florida:	Department of Elder Affairs Assessment Instrument (Form 701B)—September 2008
Maine:	Medical Eligibility Determination (MED) Version 8.0—March 1, 2007
Maryland:	Medical Eligibility Determination Form #3781B—Rev March 17, 2009
Massachusetts:	Real Choice Functional Needs Assessment—December 3, 2004
Minnesota:	Comprehensive Assessment (COMPASS)—August 2007
New Jersey:	New Jersey MI Choice Care Management Assessment—April 24, 2007
New Mexico:	Long Term Care Assessment Abstract (Form ISD 379)—July 2007
	Comprehensive Individual Assessment (Form MAD 098)—May 28, 2004
Oregon:	Client Assessment and Planning System (CA/PS)—undated
Texas:	Client Needs Assessment Questionnaire & Task/Hour Guide (DADS Form 2060)—September 2003
Vermont:	Choices for Care Clinical Assessment (Form CFC 802)—October 2005
	Independent Living Assessment (ILA)—September 2006

[2] HCBS waiver programs are authorized under § 1915(c) of the Social Security Act.
[3] These two instruments are treated as one assessment for the purposes of this report because they are both administered at the same time for consumers seeking HCBS.

Washington: Comprehensive Assessment Reporting Evaluation (Form DSHS 15-270)—November 2003

Wisconsin: Wisconsin Adult Long Term Care Functional Screen (Form LTC FS Version 3.0)—August 25, 2008

Assessment/Supplement (Form DDE 980)—August 2007

The Assessment Process

The assessment process can help to ensure accurate and consistent findings across consumers and assessors. It can also provide a mechanism for the state to ensure that only needed services are authorized. The assessment process varies across states, depending upon organizational structure and programs available within the state. Table 1 describes key features of the assessment process in each of the states studied.[4]

Table 1. Key Features of the Assessment Process

State	Organization Responsible for Assessment	Assessor Qualifications	Assessor Training	Other Responsibilities
CO	SEP agency (1 per region)	Human service degree and experience RN available	Mandatory training	Case management, develop service plan Provide services with conflict of interest waiver
FL	CARES nurses employed by state or AAAs in some areas Reassessment—Nonprofit lead agency under contract to state for case management.	RN Case management agency—4-year degree and experience in field.	Mandatory training and pass post-test	CARES nurses conduct reassessment in managed care areas and review 701B for eligibility when reassessment done by case management agency. Case management agency or MCO—case management, develop service plan
MD	Local health departments	RN or SW	In-house training	A few local health departments also case manage
ME	Private vendor	RN	Vendor trains on-the-job	Authorize services
NJ	AAAs for community residents State staff for any facility	MSW or RN	Competency training benchmarked on existing users	Some AAAs perform case management and contract out assessment or vice versa

[4] Massachusetts and Minnesota are not included in this section on the assessment process because the assessment instruments that were reviewed for this study have not been implemented at this time.

Table 1. Key Features of the Assessment Process, continued

State	Organization Responsible for Assessment	Assessor Qualifications	Assessor Training	Other Responsibilities
NM[a]	ISD 379—Third-party assessor CIA—Case management agency under contract to state	Third-party assessor—MD or RN Case management agency—4-year degree and one year of experience in field	On-the-job training	Third-party assessor—authorize services Case management agency—case management, develop service plan
TX	AAA or state/local employee MCO contractors for reassessment	SW MCO—RN	On-the-job training	AAA or MCO—case management, develop service plan State reviews for eligibility when reassessment done by MCO.
OR	AAA or state employee	None	Mandatory training	Case management, develop service plan Establish budget
VT[b]	CA—State employee ILA—HHA or AAA depending on area of state	RN	Mandatory training	HHA or AAA—case management, develop service plan. HHAs also provide services State—review assessments and service plans done by HHA or AAA and authorize services
WA	State regional field offices for residential programs AAA for in-home cases	SW RN available	Mandatory training	Case management, develop service plan, establish budget
WI[c]	FS and A/S—ADRC or county human service agencies (HSAs). Reassessment— CMOs in Family Care areas	SW or related field	Online training course and pass certification	ADRC, HSA, or CMO—case management, develop service plan

[a] New Mexico uses form ISD-379 to determine eligibility for its Disabled and Elderly HCBW program. The more in-depth Comprehensive Individual Assessment is used to establish the plan of care.
[b] Vermont uses the Choices for Care Clinical Assessment (CA) to determine initial functional eligibility and the Independent Living Assessment (ILA) for redetermination, establishing the plan of care, quality monitoring, and budgeting purposes.
[c] Wisconsin uses the Functional Screen (FS) to determine eligibility for its HCBS waiver program (the Community Options Program [COP]) and its managed LTC program (Family Care). The COP uses the Assessment/Supplement (A/S) and the Functional Screen to compose a full assessment.
Other abbreviations: Area Agency on Aging (AAA); Aging and Disability Resource Centers (ADRC); XXX (CARES); comprehensive individual assessment (CIA); care management organizations (CMOs); home health agencies (HHA); human service agencies (HSAs); independent living assessment (ILA); managed care organization (MCO); medical doctor (MD); master of social work (MSW); registered nurse (RN); single entry point (SEP); social worker (SW).

One factor that is consistent across states is that the assessment is conducted in person in the consumer's current place of residence. The current place of residence is usually the consumer's private home, but could also be a relative's home, hospital, nursing home, or residential care facility—wherever the consumer happens to be residing at the time of assessment. Most of the information needed for the assessment is obtained during this face-to-face interview, although some initial information—such as demographics or basic information about needs—may be obtained via telephone. Information obtained from the consumer is sometimes supplemented with information from caregivers or medical records. Conducting the assessment in the consumer's place of residence facilitates evaluation of the consumer's needs. For example, some assessments evaluate the condition of the home for safety issues or needs for modification, which can be directly observed using this approach.

Assessor Qualifications and Training

Assessor qualifications and training are an important component of accurate assessment. There is some level of subjectivity in all assessment. For example, the way in which a question is asked can affect the consumer's response. When caregivers also provide information, there may be conflict between responses from the consumer and the caregiver, which requires judgment on the part of the assessor to resolve. Therefore, the professionalism of the assessor contributes greatly to accurate and consistent findings on the assessment. Qualifications and training vary widely among states. The majority of states use social workers or registered nurses to conduct the assessment. Training requirements range from on-the-job training to mandatory training, with the requirement that assessors pass a certification test.

Initial Assessment

The majority of states (8 of 11) use public employees to conduct the initial assessment. These assessors may be employed directly by the state, an Area Agency on Aging (AAA), or a county. Three states use other entities to conduct the assessment, including:

- Colorado uses agencies under contract to the state as single entry point (SEP) agencies for LTC services to conduct the assessment. There is one SEP agency per geographic region. These agencies are usually public entities, such as AAAs and health or social service departments, but they can also be home health agencies (HHAs) or visiting nurse associations (VNAs).
- Maine uses a private vendor to conduct all assessments.
- New Mexico uses a third-party assessor to conduct the assessment for medical eligibility determination. A case management agency under contract to the state then conducts a second Comprehensive Individual Assessment (CIA), on which the service plan is based.

Reassessment

Policies regarding the frequency of assessment are consistent across states: Assessment is conducted annually or when there is a significant change in status. Maine and Texas also noted that some of the programs for which their assessments are used are short-term, so reassessment occurs more frequently for consumers in those programs.

Most states (9 of 11) use the same entity that conducts the initial assessment to conduct periodic reassessments in their fee-for-service HCBS programs. Florida and Vermont use a different entity to conduct the reassessment:

- In Florida, a case management agency under contract to the state conducts the reassessment using the same assessment instrument that is used for the initial assessment.
- In Vermont, an HHA or AAA (depending on the area of the state) conducts the more in-depth Independent Living Assessment (ILA) on which the plan of care is based. The ILA is subsequently used for reassessment instead of the form that is used for the initial assessment.

This arrangement facilitates coordination of services for the consumer, because these agencies also develop the plan of care and provide the ongoing case management. As a result, they have more familiarity with the consumer. In Maine and New Jersey, the same entity conducts both the assessment and reassessment and begins the service planning process; however, case management is then turned over to another agency, which completes the plan of care and coordinates services.

Reassessment is performed differently in areas of states in which there are managed LTC programs. In Florida, the state CARES staff or AAAs perform the reassessment (mainly for purposes of eligibility redetermination) and share those results with the managed care organizations (MCOs). However, each MCO then conducts its own assessment on which the plan of care is based and provides the ongoing case management. In the Texas STAR+PLUS and Wisconsin Family Care programs, managed care contractors conduct the reassessment using the same form that was used for initial assessment. The Wisconsin MCOs then conduct a second assessment on which the service plan is based, which is more comprehensive than the Functional Screen.

Although these arrangements facilitate the coordination of services for the consumer, there are several potential drawbacks. In processes in which the MCO conducts its own separate assessment for purposes of care planning, the consumer must undergo two assessments. There also is a potential for inconsistencies in the thoroughness with which needs are assessed across health plans when each MCO uses a different assessment instrument. MCOs may also have an incentive to assess an individual with a higher level of need in order to obtain a higher reimbursement rate. Texas addresses this issue by retaining the function of eligibility determination when the MCO conducts the reassessment. In Wisconsin's Family Care program,

MCO assessments must meet contract standards for areas that must be included in the assessment. The state conducts annual reviews that include a review of level-of-care determinations, a comparison of the care plan with actual services received, and an interview with the consumer. The state also compares level-of-care determinations across health plans.

All states also take other steps to ensure the integrity of the assessment process. The use of public employees or a private vendor to conduct the assessment is one such approach to ensuring objective assessment. Outside of managed LTC programs, most states (9 of 11) prohibit organizations that conduct assessments from providing services. New Jersey takes this one step further than other states by also prohibiting the entity that conducts the assessment from providing case management services. As a result, some AAAs in New Jersey retain the case management function and contract out the assessment (e.g., to the VNA), and other AAAs retain the assessment function and contract out case management. Colorado requires any SEP agency that conducts the assessment and provides case management to request a conflict of interest waiver if it will also provide services. This occurs rarely, for example, in a rural area where the public health agency conducts the assessment and also provides nursing services. Vermont staff (RNs) who conduct the initial eligibility assessment review each reassessment and plan of care performed by the AAAs and HHAs for accuracy.

The majority of states (7 of 11) also retain responsibility for authorization of services. Four states permit other entities to authorize services, but they take the following steps to ensure the accuracy of these authorizations:

- Maine allows its private vendor to authorize services, but the state reviews each of these authorizations.
- New Mexico's third-party assessor who does the medical eligibility determination reviews the assessment and service plan developed by the case management agency to authorize service.
- In Washington and Oregon, authorization for services is built into the automated system. The way the system is structured helps to reduce assessor subjectivity.

Assessment Contents

The contents of an assessment are determined by a number of factors, including the functions and populations for which it will be used and the way in which each state has structured its programs. For example, an assessment that is designed solely to determine functional eligibility for an elderly population will include the items that are relevant to that determination, whereas an assessment that is designed to serve as the basis for a service plan for multiple populations and/or multiple programs within the state will be more comprehensive. Some assessment instruments for HCBS programs build off tools such as the Minimum Data Set (MDS), which is federally mandated for use in licensed nursing facilities, or the Minimum Data Set–Home Care (MDS-HC), both of which have been internationally tested and validated. In this study, the instrument from Maine was developed based on the MDS, and those from Massachusetts, New Jersey, and Washington used the MDS-HC as a foundation. Despite their common beginnings, each tool has been modified to meet individual state needs, and each is structured quite differently. Other assessment instruments have been developed by individual states to meet their unique needs. As a result, no two states use the same assessment instrument for their HCBS programs, and some states use different instruments for different purposes or programs within the state.

Appendix A summarizes the elements included in each study state's assessment(s), organized by the six domains that compose a comprehensive assessment (listed above). This report looks primarily at the comprehensive assessments that are used for service planning; however, some states in the study use two assessment instruments: one for eligibility determination and another for service planning. In those cases, both assessments were reviewed to determine the extent to which there is overlap and integration of information.

Most assessment instruments address all domains to some extent; however, there is wide variability in the depth to which each domain is examined. The assessment instruments are very consistent in capturing information about functional activities of daily living (ADL) and instrumental activities of daily living (IADL) skills, which are the primary basis for eligibility for HCBS. The instruments are also similar insofar as the elements that are captured in the physical health domain. However, there are considerable differences in the extent to which the domains of mental health, social and economic resources, and physical environment are addressed. The Washington 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.

Assessments designed to both determine functional eligibility and serve as the basis for the plan of care reduce the need to collect redundant information. In states that use two assessments, there is much overlap of information, particularly in the domain of functioning, but also in the domains of physical and mental health. States that use two assessments have

addressed this issue in several ways. The Community Options Program in Wisconsin uses the Assessment/Supplement along with its Functional Screen to form the comprehensive assessment. The Supplement builds on information already collected in the Functional Screen. In Florida's nursing home diversion program, the MCOs use their own assessments to supplement information obtained during the assessment for eligibility determination. In Vermont, the Choices for Care Clinical Assessment is used for initial eligibility determination, but the Independent Living Assessment, on which the service plan is based, is subsequently used for redeterminations of eligibility, eliminating the need for two assessments.

It should also be noted that many states collect information during the intake process that is the same or similar to information obtained during the comprehensive assessment. Some states have designed their systems so that intake information—such as demographics and basic information about needs or program requests—can be integrated into the comprehensive assessment to reduce redundancy. In other states, such as Washington, intake is an integrated component of the comprehensive assessment.

All comprehensive assessments evaluate informal supports. In general, states evaluate informal care giving so that services in the care plan do not duplicate services that are already being provided by someone else. The majority of the comprehensive assessments in this study (7 of 13) include elements that evaluate the caregiver's status. Some of these assessments explicitly examine issues such as caregiver stress, health, and ability to continue providing informal supports, which are then considered when developing the service plan. Other assessments include a rating or code that indicates the level of informal support that is available. For example, 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. A different approach used in Texas assigns task hours to each area of assessed need, taking into consideration the availability of informal supports. The Washington CARE system originally automatically reduced the amount of services in a care plan by a set amount of time if the consumer lived in a household with an informal caregiver. However, as the result of a lawsuit, the state has modified its system and now evaluates each consumer individually with regard to the amount of informal support that is available.

Some assessment instruments provide more direction for assessors than others. For example, the assessment instruments from Massachusetts, Minnesota, Texas, and Vermont (the ILA) include questions for each element of the assessment. Texas noted that assessors are instructed to ask the questions exactly as written. This approach may improve consistency in assessment findings because the way questions are asked, as well as the order in which they are asked, can affect the consumer's responses.

Uses for Assessment Information

Assessments can be used to serve several different functions, including determining eligibility, developing a plan of care, monitoring quality, and establishing a budget for services or allocation of a certain number of service hours. The assessment may also be used for individuals who are members of various populations for which specific services or programs are designed, including the older adults and individuals with physical disabilities, developmental disabilities, mental health disorders, HIV, and traumatic brain disorders. The purposes for which the assessment is used often drive the assessment contents and how the assessment process is structured.

The assessment instrument is used for all populations in 7 of 13 states. Table 2 illustrates the fact that the trend among states appears to be toward designing the assessment instrument to capture uniform information for all populations. For example, the newer instruments developed for Massachusetts and Minnesota adopt a modular approach that includes areas relevant for all populations. New Jersey's new assessment tool is also designed for all populations. When using instruments for all populations, some states reported that additional information is obtained for certain of those populations. For example, Minnesota's COMPASS is designed to flag mental health needs, and the person is then referred for a more in-depth assessment and development of a service plan. Similarly, Colorado collects some additional information for populations other than older adults and persons with physical disabilities, and anticipates modifications to provide better direction on assessing children that takes their developmental age into consideration. The Minnesota COMPASS addresses this issue by including a special module for children. Wisconsin uses a separate instrument for children and individuals with mental health needs. All states except Texas use the same assessment instrument for people applying for both institutional (e.g., nursing home) care and HCBS.

Table 2. Populations Assessed

All Populations	Older Adults and Persons with Physical Disabilities only	Older Adults and Persons with Physical and Developmental Disabilities
Colorado	Florida	Wisconsin
Maine (limited use for children)	New Mexico	
Maryland	Oregon	
Massachusetts	Texas	
Minnesota	Vermont	
New Jersey		
Washington		

Most states (10 of 13) use a single assessment for multiple purposes. As Table 3 shows, this approach helps to limit the need to conduct multiple interviews with a consumer. Three states (New Mexico, Vermont, and Wisconsin) reported using two assessment instruments: one to determine functional eligibility and a second, more in-depth assessment on which the plan of care is based. All states use the same instrument for both initial and redetermination of eligibility, except Vermont, where the ILA (the instrument used to develop the plan of care) is

used for redetermination. In most states, assessment for financial eligibility is conducted separately from that for functional eligibility. Only Washington uses the same instrument for financial eligibility determination.

Table 3. Uses for Assessment Information

Uses	CO	FL	MD[a]	ME	MA[b]	MN[c]	NJ	NM[d]	TX	OR	VT[e]	WA	WI[5]
Functional eligibility	✓	✓	✓	✓	✓	✓	✓	ISD-379	✓	✓	CFC or MDS	✓	✓
Financial eligibility												✓	
Redetermination of eligibility	✓	✓	✓	✓	✓	✓	✓	ISD-379	✓	✓	ILA	✓	FS
Develop plan of care	✓	✓	✓	✓	✓	✓	✓	CIA	✓	✓	ILA	✓	FS + A/S
Monitor quality	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	ILA	✓	✓
Establish budget		✓			✓	✓	✓		✓	✓		✓	✓

[a] Technically, Maryland uses a separate form (DHMH 4286) to determine eligibility for the elderly and physically disabled populations; however, this statistical form contains information about ADL scores that is transferred directly from the comprehensive assessment; therefore, it is not considered separately for purposes of this study.
[b] Massachusetts' and Minnesota's assessments have not been implemented, but they are intended to serve all of these purposes.
[c] New Mexico uses form ISD-397 to determine medical eligibility for its Disabled and Elderly HCBS waiver program. The more in-depth Comprehensive Individual Assessment (CIA) is used to establish the plan of care.
[d] Vermont uses the Choices for Care Clinical Assessment (CFC) to determine initial functional eligibility and the Independent Living Assessment (ILA) for other functions. The Minimum Data Set (MDS) may also be used for individuals already in nursing home placement.
[e] Wisconsin uses the Functional Screen (FS) to determine eligibility for its HCBS waiver program (the Community Options Program [COP]), and for its managed LTC program (Family Care). The COP uses the Assessment/Supplement (A/S) in conjunction with the Functional Screen to complete the full assessment on which the plan of care is based. Family Care MCOs conduct their own assessments for service planning purposes.

Functional Eligibility

Most assessment instruments assign "scores" to certain elements of the assessment. Usually these elements are the ADL and IADL skills, but a few states also assign scores or ratings to other elements. Rating scales vary but usually produce ratings of 0 to 3, 4, or 5, with the higher number representing a higher level of need. One use for these scores is to establish functional eligibility. A consumer must have a particular score or level of need in order to qualify for placement in an institutional setting and, as a result, Medicaid HCBS waiver programs.[5] For example, Colorado requires a score of 2 or greater in two out of six ADL skills for its HCBS programs. Some states also permit individuals with lower scores to qualify for state-funded services. 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

[5] The federal Medicaid statute requires that an individual must be eligible for institutional placement in order to qualify for HCBS waiver programs.

consumer is ineligible. This revision has decreased assessment time from 1.5 hours to 15 minutes for individuals who are found ineligible. The assessment in Texas computes a total score that indicates for which programs the consumer is eligible.

Another use for scores is to determine a consumer's priority level for services. Most states have waiting lists for their HCBS waiver programs, and the score establishes where the consumer will fall on the waiting list. Vermont's Choices for Care Clinical Assessment prioritizes consumers into two tiers: Consumers with the highest level of need are eligible for a nursing facility or HCBS. Consumers in the second tier may also be eligible for those services based on availability of funding, and they are placed on a waiting list in order of greatest need. Waiting lists are also one reason that states do not always initially conduct the complete assessment. For example, Florida uses a separate assessment form (Form 701A) to establish prioritization for services. This form collects a subset of the same information as the comprehensive assessment (Form 701B), but it is potentially done several months earlier if there is a waiting list. In Wisconsin's Community Options Program, the Functional Screen for eligibility is usually conducted at the same time as the Assessment/Supplement, but the assessments may be done separately if the consumer's level of care is in doubt or there is a waiting list in the county. In those cases, the Assessment/Supplement is conducted at a later time, and the Functional Screen is also updated at that time.

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.[6] In automated assessments, eligibility determinations are made instantaneously, so there is no need to wait before proceeding with the plan of care development.

Developing the Plan of Care

The plan of care (also known as the service plan) flows from the assessment. Like the assessment itself, there is some level of subjectivity involved in developing the plan of care. Assessors and case managers need to be knowledgeable about the range of available services. In addition, input from the consumer is important in determining which services are included in the plan.

Some assessments provide more direction in establishing the plan of care than others. In states with highly automated systems, identified needs are automatically carried forward onto the service plan to ensure that they are addressed. For example, Minnesota's COMPASS is designed to be automated and includes a module for developing the plan of care that auto fills based on the

[6] Minnesota's assessment has not been implemented; however, the intent is for it to be fully automated.

needs identified. 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.

New Jersey's new assessment, NJ Choice, is based on Michigan's MI Choice assessment and the MDS-HC, which have been extensively tested. The NJ Choice assessment results in trigger care assessment protocols (CAPS) that identify areas needing special assessment and guide care and service planning. The assessor in the home completes the community care counseling regarding client choice, thus beginning the care plan and the client service selection. The care manager assigned to the client completes the care plan based on the final selection of services. Maine uses a similar system in which the care plan is generated during the assessment process and then turned over to the case management agency to arrange for and coordinate services.

Another way that the assessment directs the service plan is through the use of task and time guidelines. These guidelines help to determine the amount of services that will be included in the service plan. For example, the Texas assessment instrument includes columns that indicate the maximum number of service minutes per day for each ADL and IADL skill. The assessor then fills in the amount of service time that will be available based on the consumer's needs. Maine's assessment 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.

Budget and Rate Setting

Some states (Colorado, New Mexico, and the Wisconsin Community Options Program) indicated that an individual's funding is based on the care plan rather than assessment information. In these fee-for-service systems, the maximum allocation for each individual is limited based on cost neutrality requirements for Medicaid HCBS waiver programs; that is, the cost of services provided through the HCBS waiver program cannot exceed the costs of services in an institutional setting. Maine also indicated that each program for which an individual qualifies has a capped amount of funding. The Medicaid rate for the units of service the consumer will receive is entered on the care plan summary to determine the total cost of the individual's plan of care. Texas and Vermont use a similar approach in their HCBS programs.

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.

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.

In managed LTC programs, a monthly capitation rate is established that is based on actuarial analysis. For example, in Florida, information from the assessment is used to develop actuarial rates that are based on frailty levels and cost of providing services. A set rate is paid to each MCO, which varies depending upon the costs of providing care in a particular area of the state. In Wisconsin's Family Care program, the monthly capitation rate is based on two levels of functional need, each with a different level of funding.

Monitoring Quality

All states report that they monitor quality using data from the assessments. 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.

States also utilize data from assessments for quality assurance activities. For example, Maine monitors assessments when they are uploaded to the server for data accuracy, and that data is later aggregated and analyzed by the Muskie School of Public Service at the University of Southern Maine for quality monitoring purposes. New Jersey will use assessment data to monitor consumer outcomes and timeframes. The state is also incorporating CMS' quality paradigm into its monitoring plan. Washington's automated system allows it to generate reports based on assessment data and validate algorithms against the care plan.

Trends in Assessment

The newest assessment instruments examined in this study are those from Massachusetts, Minnesota, and New Jersey. These assessments offer some insights into current trends. All three instruments are designed to assess all populations, serve multiple functions, and be fully automated.

Modular Format

The assessment instruments from Massachusetts and Minnesota use a modular format. The format is intended to reduce the redundancy that occurs when multiple forms and tools are used across programs within a state. The assessments begin with a core set of questions that are asked of all consumers, regardless of the program(s) for which they are applying. The core set of questions triggers further assessment using only those modules that are relevant for the individual who is being assessed.

Person-Centered Process

The Minnesota assessment tool 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 consumer's choices. Several other states indicated that they were considering revisions to their instruments that would make them more consumer-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.

The MDS-HC

As discussed earlier, New Jersey's assessment instrument is based on the Michigan MI Choice assessment instrument, which uses the MDS-HC as its foundation. The MDS-HC and the MI Choice tools were developed by Inter-RAI researchers, and the Michigan tool has been extensively tested. The use of the MDS-HC foundation has several advantages: Core elements across all settings can be examined to determine whether there have been changes, providing evidence-based data for offering choices in service selection. Client outcomes can be measured for quality improvement purposes. Main drawbacks include that it takes up to two hours and requires extensive training to administer. The instrument also does not capture consumer strengths and preferences.

Mental Health Assessment

Mental health is an area that many states have been working to address in their assessment instruments. Several informants for this study reported that there had been changes to the assessment instrument in recent years to better address mental health needs and/or that they

anticipated such changes in the near future. All of the assessment instruments reviewed include elements in the mental health domain; however, some examine specific behaviors, moods, and symptoms more thoroughly than others.

Automation

The level of automation of the assessment instrument is an important key to integrating the various functions involved in assessment. Several states included in this study, including Maine, New Jersey, Oregon, and Washington, have highly automated systems. Other states reported that they are working toward more automated systems. Automation can help to ensure that the assessment is conducted in a consistent and thorough manner. For example, Washington's system prevents assessors from proceeding if relevant fields are left blank. Automation also greatly enhances the ability to perform administrative functions, such as authorizing service, tracking case management, and monitoring service delivery and quality outcomes. Although the high cost of developing these systems has been a barrier for many states, the investment in automated systems may pay off in the long run as programs are able to operate more efficiently.

Conclusion

Comprehensive assessments in HCBS programs are influenced by many factors, including state organizational structures, available programs, and administrative requirements, such as level-of-care determinations and authorization of services. Although no two instruments are alike, assessments that are designed to serve multiple functions appear to create more consumer-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 consumer strengths and preferences and caregiver status have taken on more importance. It appears likely that the development of new assessment instruments and revisions to existing instruments will place greater emphasis on these areas in the future.

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Appendix A. Content Comparison

The following tables show the elements covered in each state's assessment(s), organized by the six domains that are generally considered to compose a comprehensive assessment. Several important caveats should be considered when reviewing these tables. First, states do not necessarily categorize elements included in their assessments within the same domains as in these tables. For example, some assessments include vision and hearing as functional skills, whereas others include them as physical health issues. Second, although a particular element is indicated as included in several assessment instruments, this does not necessarily mean that it is addressed in the same depth by each instrument. For example, depression can be assessed as a single item (e.g., asking whether the consumer feels sad) or as multiple items that examine more closely the various symptoms of depression. Third, these tables do not include demographic information (such as contact information) or elements specific to a particular state (such as for which programs the consumer is applying), which is collected by most states as part of the assessment. Finally, some minor elements of assessment instruments have been omitted in order to capture key elements in a concise manner.

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		✓											✓		

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

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					✓		✓			✓					

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

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

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														✓	

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