Introduction to the Assessment Process

COLORADO LONG-TERM SERVICES AND SUPPORTS (LTSS) ASSESSMENT TOOL

COLORADO
Department of Health Care
Policy & Financing

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Contents

Introduction to the Colorado Assessment Tool

This manual is designed to accompany the Colorado Assessment Tool for participants accessing Long Term Services and Supports (LTSS) through the Department of Health Care Policy and Financing's (the Department) Medicaid program. The manual contains instructions and guidance for completing the assessment items.

Overview of Purpose, Philosophy and Design Principles

This section provides background on the development of the Colorado Assessment Tool for participants needing LTSS.

Purpose of the Assessment and General Philosophy

The Colorado Assessment Tool helps to fulfill a number of functions necessary to ensure access to appropriate services for individuals with disabilities and older participants. The assessment tool utilizes person-centered philosophies and items to allow the participant to direct the assessment and support planning processes to the extent possible and desired. It replaces the ULTC 100.2 assessment, which was the previous tool used to determine and verify Level of Care (LOC). The new tool also replaces a number of supplemental tools used by the Department and local agencies to develop participant support plans and assign service levels.

Functions of the Colorado Assessment Tool for LTSS

- Supports a comprehensive, person-centered approach to the identification of a participant's needs, preferences and goals. This includes covering a comprehensive set of life domains that critically affect independence and quality of life.

- Contains information necessary to determine that the participant meets LOC for LTSS programs.

- Informs the development of individualized support plans by providing specific information regarding personal goals, support needs, preferences for service delivery, personal strengths, and areas for referral to obtain additional assessment information, assistance or support.

- Informs the assignment of individual budgets.

- Provides information critical to the provision of services, including but not limited to special accommodations needed, service intensity, staff competency, and participant preferences.

The design of the tool reflects the philosophy that individuals with disabilities and older participants should be supported in active involvement with family and community, maintaining control and autonomy over decisions, and achieving personal satisfaction and quality of life. A primary goal of this person-centered assessment is to assist the participant in developing personally meaningful goals in his/her support plan. In order to ensure this occurs, the participant should provide as much information during the assessment as possible.

For example, some participants need assistance from a family member (or other person) during the assessment due to cognitive or memory issues. Assessors should ensure that information and input represents the view of the participant by speaking directly to and seeking information directly from the participant. If some information is also provided by the person giving assistance during the assessment, the assessor should ask the participant to verify or respond.

The assessment tool also features person-centered approaches, reflecting that personal needs and preferences drive planning, not simply program availability. The design also reflects the strong involvement and input of stakeholders to address two other important considerations:

- **The assessment process requires people to provide very personal information. Thus, the assessment should only ask about what is necessary for support planning.**
  - ➢ Many items contained in the assessment are optional, depending on the participant's needs, circumstances, and interests, and his/her decision to provide information.
- **The assessment should include a wide array of areas that affect quality of life without overburdening participants who have no interest or need to talk about an area(s).**
  - ➢ As a result, the tool addresses interests and support needs in areas such as employment, self-direction and control of service planning, housing and environment, and personal goals for community life, using trigger items to allow participants to opt out of discussing.

Key Principles Guiding Efforts

A set of overarching values and principles guided the work of the many participating Department staff and stakeholders throughout the development process. These values and principles provide important context for understanding the design and content of Colorado's assessment approach.

A. Individual Outcomes

The Colorado Assessment Tool helps to support the goal of improved outcomes for participants by collecting critical information for matching the right services at the right time to the person needing supports. The assessment can help people take advantage of a *window of opportunity*. This window is the time between first needing help and no longer being safe at home. During this window, matching the right service to the needs of the person will more likely result in maintaining independence and quality of life, and helps to avoid unnecessary placement into a facility or hospital.

The assessment also seeks to improve outcomes through the use of *person-centered approaches*. Person-centered approaches show respect for participants and help to maintain focus on the participant

by identifying areas of greatest importance for the person and his/her family. This helps to facilitate a plan for services that is more likely to achieve personally meaningful outcomes.

- ❖ Timely and appropriate service access is critical to positive outcomes.
- ❖ The services authorized for the person will be more effective when tailored to the needs, preferences, goals and circumstances of participants.
- ❖ Person-centered approaches demonstrate respect for the person and his/her family.
- ❖ Engagement by participants/families in decisions leads to improved outcomes.
- ❖ Personal and service goals include enhancing quality of life and supporting independence to the extent possible.

B. Administrative Outcomes

The new assessment tool is intended to complement other initiatives aimed at improving service delivery in Medicaid waivers, such as waiver simplification and No Wrong Door, aimed at improving overall service administration. The Department must ensure responsive and flexible service delivery that is capable of meeting diverse, personal circumstances. At the same time, Colorado must also ensure the wise and efficient use of funds.

PRINCIPLES RELATING TO ADMINISTRATIVE OUTCOMES

- ❖ Timely, sufficient and reliable information is essential to effective management and administration.
- ❖ The Department must have a reliable and valid approach for determining LOC, waiver eligibility, and the need for services.
- ❖ The design and content of the tool should complement other efforts, such as individual budget approaches and expansion of consumer-directed options.
- ❖ Public accountability and transparency are critical to sustaining services and programs.
- ❖ The Department must operate and administer programs within all federal and state requirements.

C. Successful Implementation

Successful implementation of the new assessment tool depends on a good design and implementation approach. In order to achieve the outcomes desired for a new tool, it was necessary to make assumptions about what changes to infrastructure the Department would seek to make.

Three critical assumptions were made: 1) the caseloads for assessors/case managers would be reduced so that a more comprehensive and person-centered approach to assessment can occur; 2) amounts paid for each assessment would need to reflect the increased time necessary to complete the assessment; and 3) automation of the assessment tool and its related materials (such as the training manuals) will occur. Absent these, the new tool will not be able to be implemented as designed.

Given these assumptions, the following design principles guided development.

DESIGN PRINCIPLES FOR SUCCESSFUL IMPLEMENTATION

- ❖ The new assessment process must help the Department meet changing state and federal policies/regulations regarding person-centered design approaches.
- ❖ The design of the tool must be feasible for use by existing agencies and staff.
- ❖ The design must be efficient and lend itself to automation.
- ❖ The tool must be useful for developing support plans which include the needs, preferences and goals of participants.
- ❖ The tool applies to all participants needing LTSS and to multiple programs managed by the Department.

Overview of the Assessment Tool and Process

The Colorado Assessment Tool contains necessary items to determine LOC, waiver eligibility, and to develop the support plan. Information documented in the assessment is designed to be gathered from a variety of sources. These sources include:

- The participant through the use of a personal interview
- Proxies, family or significant other people with information about the participant
- Medical, school, or other assessments and/or records
- Observation by the assessor

Collecting and integrating information from all of the above sources requires skill, content knowledge and an ability to work with others to interpret information. The Department has an automated system to record the information, but assessor training and access to helpful tools that assist in the collection and understanding of information is critical.

In designing the assessment, much emphasis was placed on a tool that would provide a well-rounded picture of the participant and his/her situation and would also support increased opportunities for participants to actively engage in the process of assessment and service planning. The assessment protocol and items:

- Provide an opportunity for the assessor to "get to know" the person using an interview to allow the person to tell his/her story and to talk about what is most important to him/her.
- Identify strengths and preferences as well as needs of the person.

- Provide a complete set of information to inform service planning across multiple areas.
- Speed up the assessment process by using: technology to document and prefill areas of the assessment; trigger questions to indicate if more information is needed; and items to help the assessor identify when referrals are needed.
- Reduce burden on the participant through the use of participant-driven optional items within the assessment.
- Improve accountability by supporting the ability to track assessment results to the support plan.

The Assessment Tool Contents

The assessment tool is divided into modules covering a range of areas. These modules are broken up into sections to help track various aspects of the module. Some items in the modules are mandatory. Mandatory items are indicated in the paper tool with the symbol ⚠. Other items are optional based on the needs presented, personal circumstances, and the preferences of the participant to address the item.

The following table (**Table 1**) includes a summary of all the modules available in the assessment tool. This table includes the name of the module, a brief summary of the contents, whether the module is mandatory or is administered based on the answers provided by trigger items designed to elicit need and interest, and brief comments to provide a further description of the module.

Table 1: Summary of Assessment Modules – Comprehensive Assessment

Module Name	Contents	Mandatory	Comments
Introduction and Decision Supports	Overview of assessment process for participant, information about decision supports, such as guardians	Trigger items and select information about decision maker/ guardian if applicable	Information may populate from Intake Screen if guardianship/ decision maker was collected
Level of Care Screen (LOC)	Contains items and protocol to verify that the participant meets LOC prior to proceeding with entire assessment.	Yes	Assessor only completes enough of module to verify LOC, then can move onto assessment.
Personal Story	Personal interview items which allow participant to "tell his/her story."	Trigger items should be asked to determine interest in completing entire module or sections of the module	Can complete all, some or none of the module. Participant controls where information can be shared. Online capability for independent completion being planned.
Case Manager Introduction	The Case Manager introduces the assessment tool and informs the participant	Yes	Core decision point on which assessment path to follow.

Module Name	Contents	Mandatory	Comments
	about completing the Brief or Comprehensive Assessment		
Memory & Cognition	Items to document cognition or memory issues.	Trigger items	Contains some duplicate items from LOC Screen. These are designed to prefill based on Eligibility module.
Functioning	ADL and IADL	Trigger items	Also includes items to document strengths, needs, preferences, and other information for support planning. Includes information about assistive devices needed or used for ADLs and IADLs. Contains some duplicate items from LOC Screen. These are designed to prefill based on LOC module.
Health	Medical information and needs	Trigger items	Purpose is to identify the participant's health and safety risks.
Sensory and Communication	Vision and hearing, other sensory related items, needs related to functional communication	Trigger items	Includes information about sensory processing disorders
Psychosocial	Behavior needs, and behavioral health screens	Trigger items	Purpose is to identify any behavior concerns that could impact functioning.
Safety and Self-Preservation	Emergency and supervision needs	Trigger items	Purpose is to identify whether the participant is able to act appropriately in an emergency, if he/she has concerns about personal safety, and whether he/she is able to live safely in community.
Housing and Environment	Housing status, environmental safety, housing needs including needs for transition	Trigger items	Has specific mandatory items for participants who are (or desire to) transition residences (including one community residence to another)
Employment, Volunteering, and Training	Discusses interest in employment, volunteering or training/education	Trigger items	Items are interest based.

Module Name	Contents	Mandatory	Comments
Participant Engagement	Capacity for active decision making and engagement in planning and directing service delivery; interest in self-advocacy training and information	Trigger item	Purpose is to identify opportunities to maximize engagement in planning and service provision. Also identifies interest in referral for training or information.
Caregiver	Use of unpaid caregivers and caregiver interview	Trigger item and some caregiver information items	Contains an optional section that includes an interview of primary caregiver. This is intended to help identify caregiver needs for continuing support (e.g., respite, equipment or other community based resources).
Assessment Summary	Used by case manager after the assessment to document additional areas not covered by the assessment and identify supervision needs	Specific Sections	Also the point for completing the Hospital Level of Care Supplement

The Colorado Assessment Tool also offers a condensed version, designed for participants who only want to complete the mandatory items. In general, this would include participants who are familiar with the supports and services desired and can direct the provision of services.

Training Material – Chapter Set-Up

Each training manual is set up to provide guidance for the assessment modules. The format is similar in each module and provides the following:

- Describes the purpose of the module.
- Provides an overview of the module, including identification of the main sections and subsections.
- Describes the general instructions relevant to the module. In some cases this includes a brief background and discussion about the general approach to be taken.
- Provides specific item by item instructions. For many items, the guidance provides examples to help the assessor.

Special Instructions for Children and Age-Specific Items

Modules contain items that may be skipped for or only asked of participants of a specified age. Items and response options in orange font in the paper version of the tool and the corresponding training manuals are intended for children (age 0-18).

For some areas within the assessment, such as Functioning and Memory & Cognition, assessors should respond based upon the level of support needed that is beyond what is required for a child of a similar

age without a disability. It is anticipated that children will need varying levels of support that is consistent with their chronological age. *For example, a four-year-old participant may need supervision while bathing or a twelve-year-old participant may need assistance with laundry.* This would correspond to the response option "Age Appropriate Dependence."

The assessor should include the child to the maximum extent possible throughout the assessment. This includes directing items and questions to the child and consulting the parent, guardian, and/or other legal representative as necessary. Where possible, document both the participant and parent/guardian's responses. If there are conflicting reports from the child and parent/guardian, the assessor should use the training guidance and his/her expertise in selecting a response.

Assessment Process: Initial Assessment

The initial assessment occurs after an intake and screening process that identifies if the participant is potentially in need of LTSS and likely meets LOC. The intake process will attempt to identify if there are any substitute decision-makers or others the participant wants to have participate in an assessment, and contact information for setting up the assessment time and location. Information from the intake, such as demographic information, should flow forward to the assessment so that the assessor does not need to re-collect this information.

1. Explain the Process

The assessment process should be explained so that the participant understands the process and can be prepared. The overview should include a discussion of the purpose of the assessment and the mandatory vs. voluntary items. For the latter, it will be important for participants to know that many of the items may either not apply or may not be of interest (e.g., employment items). A sample script for this conversation is included in the training manual for the Introduction module. Existing state and local agency policies should continue to be observed regarding the involvement of substitute decision makers (e.g., guardians).

2. Verify Participant Meets Level of Care (LOC)

The next step in the process is to verify that the participant meets the LOC. This includes addressing activities of daily living (ADLs), behaviors, and cognition and memory. The assessor will only ask about items up to the point that the participant's needs are sufficient to meet LOC. Once the threshold is met, the assessor can stop with LOC Screen and move onto other modules in the assessment.

The level of care criteria can be met in any of the following ways:

- Partial/moderate assistance or higher on 2 or more ADLs
- Presence of one or more substantial behavior issues, which include self-harm and physical and/or verbal behaviors directed at others;
- Presence of one or more substantial cognition and/or memory issues.

3. Complete the Assessment
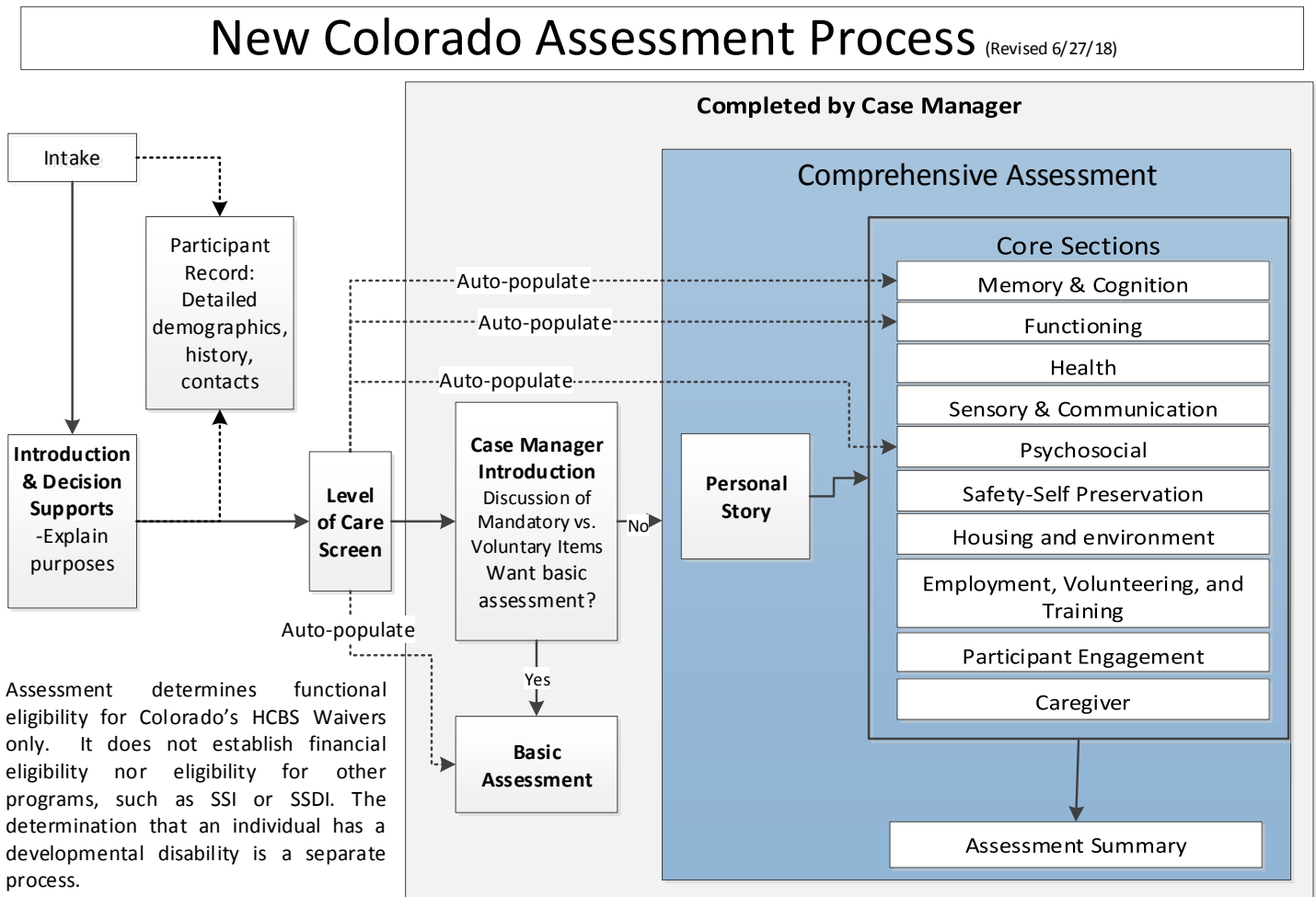
Once LOC is verified, the assessor will move on to the remaining modules. Not all items are required to be completed. There are trigger items contained in the modules. These trigger items determine whether the module or section of the module should be completed. The tool is also designed with "skip patterns," meaning the number and order of items to be completed in a section will be dependent

upon responses to key items contained in that section. The design for the automated system will account for these skip patterns so that assessors do not need to continually track these "skips."

The time needed for the Initial Assessment will typically be longer than a Reassessment. Assessors should also expect the time required for assessment to be longer during initial implementation.

Exhibit 1 provides a recommended flow for the assessment process.

Exhibit 1: Recommended Flow for the Assessment Process

New Colorado Assessment Process (Revised 6/27/18)

Completed by Case Manager

Intake

Participant Record: Detailed demographics, history, contacts

Introduction & Decision Supports -Explain purposes

Level of Care Screen

Case Manager Introduction Discussion of Mandatory vs. Voluntary Items Want basic assessment?

Auto-populate

Yes

Basic Assessment

No

Personal Story

Auto-populate

Auto-populate

Auto-populate

Comprehensive Assessment

Core Sections

Memory & Cognition

Functioning

Health

Sensory & Communication

Psychosocial

Safety-Self Preservation

Housing and environment

Employment, Volunteering, and Training

Participant Engagement

Caregiver

Assessment Summary

Assessment determines functional eligibility for Colorado's HCBS Waivers only. It does not establish financial eligibility nor eligibility for other programs, such as SSI or SSDI. The determination that an individual has a developmental disability is a separate process.

Assessment Process: Reassessment

Reassessment can occur at any time. Minimally the assessor must re-verify LOC annually and should talk with the participant to determine if there needs to be a reassessment of specific areas. Modules and sections, except for LOC Screen, do not need to be completed again except under the following circumstances:

- There has been a change in status resulting in a change in the needs of the participant.
- The participant wants to revisit all or a portion of the assessment.
- There is a desired or planned change in the delivery of services that is significant, such as transition from a facility to a community home.
- Other events, such as critical incidents, indicate the need to re-evaluate the needs of the participant.

The automated system should allow the assessor to make updates to the most recent assessment, which will minimize the need to re-collect data that does not meet the criteria listed above. This should substantially decrease the time required to complete the Reassessment.

Basic Assessment

If the participant prefers, he/she can forego the Comprehensive assessment and elect to complete only the items related to LOC, waiver eligibility, and establishing budgets that the designated mandatory items within the assessment. This process is called the Basic assessment, and all mandatory items MUST be completed. These mandatory items are a subset of items from the other modules. While the Basic assessment is a simplified and shorter version of the Colorado Assessment Tool, the items flagged as mandatory still provide sufficient information for person-centered support planning.

Participants unfamiliar with service options and those going through an initial assessment should be encouraged to complete the Comprehensive assessment. Case managers should explain to participants the value of the Comprehensive assessment, emphasizing that it provides valuable in-depth information for developing an effective service plan and allows the assessor to better understand the participant's strengths, needs, and preferences.

Participants who may be appropriate to forego the Comprehensive assessment include:

- Participants who are currently receiving services and are familiar with the spectrum of LTSS offered in Colorado
- Participants who are only looking for specific services and are not interested in any additional supports.