## Attachment 2: Colorado's No Wrong Door Needs Assessment

## No Wrong Door Assessment

### Introduction

Colorado is working to create a seamless entry point system, also known as a No Wrong Door (NWD) system, for Long-Term Services and Supports (LTSS). To understand what Colorado needs to do to implement NWD, it is essential to understand where Colorado's entry point system currently stands. This assessment provides an overview of the current system and compares it to the six fully functioning Aging and Disability Resource Center (ADRC) criteria identified by the Administration for Community Living (ACL). These criteria provide a framework to discuss the functions needed to create a NWD system. A recent report to the United States Congress from the Commission on Long-Term Care includes the recommendation to "Expand the 'No Wrong Door' approach to provide enhanced options counseling for individuals to navigate LTSS, and provide the support needed to make this approach effective nationally" (See Appendix A).

### Why Now

Across the country, efforts are underway with states and the federal government to prepare the LTSS system to be more responsive to increased demand and to be more person-centered. The ACL is continuing its commitment to help states redesign how people receive services. The Affordable Care Act provides funding to pilot ideas for people who are eligible for both Medicaid and Medicare. The Veterans Administration is funding projects to provide LTSS for veterans in community-based settings. With these various initiatives and funding opportunities, states are implementing innovative ways to serve people who need LTSS.

Such initiatives share a common goal: to better coordinate services and supports while reducing the burden on consumers who must navigate a complicated system during a vulnerable time in their lives. While some of these ideas have been around for years, they have recently reemerged with a new energy. In theory, more coordination will reduce unnecessary duplication of effort between publicly funded programs and community agencies, creating a higher quality experience for consumers.

The need for LTSS is increasing, which is another reason to develop a NWD system. The number of Coloradans who are 65 and older will more than double, from approximately 700,000 in 2014 to 1.5 million in 2040. Nearly three of four seniors (70 percent) will need LTSS at some point. Additionally, people with disabilities are living longer than previous generations and they continue to use services and supports as they age. The current LTSS system has neither the capacity nor the sustainable funding to handle the expected influx. It is essential to make the system more consumer friendly and efficient.

In light of these trends, Colorado has taken action. Over the past decade, several commissions have worked to redesign the LTSS system to better serve consumers. The Community Living Advisory Group (CLAG), the most recent commission, sent its report to Governor John Hickenlooper in September 2014 (see Appendix A). Recommendations in the report include creating a comprehensive LTSS entry point system. Colorado is now pursuing that goal through a NWD planning grant from the ACL.

Colorado's NWD project is also a key component to developing strategies and achieving goals in Colorado's Community Living Plan (CCLP), signed by the executive directors of the Department of Health Care Policy and Financing (the Department), the Department of Human Services (DHS) and the Department of Local Affairs (DOLA) (see Appendix A). CCLP is a comprehensive approach to meeting

the requirements of the U.S. Supreme Court ruling in Olmstead v. L.C. which ensures individuals with disabilities are served in the least restrictive environment. The report has key provisions directly related to the NWD project, such as identifying and supporting individuals in long-term care facilities who want to move to a community, preventing unnecessary institutionalization and improving communication strategies among LTSS agencies to ensure the provision of accurate, timely and consistent information about service options in Colorado.

Much of the information included in this assessment was gathered by the Colorado Health Institute and presented in "The First Step: Solving Colorado's LTSS Puzzle" (see Appendix A). The "LTSS Puzzle" was created through independent research and key informant interviews with Colorado experts as well as workers on the LTSS front lines. Each interviewee provided a unique look into the various silos that comprise the system. Further, as part of the NWD planning process, Nonprofit Impact conducted focus group discussions with over 40 consumers, advocates and caregivers, as well as 27 frontline staff workers to inform the NWD assessment and planning process. These discussions were invaluable to rounding out the NWD assessment and validating the "LTSS Puzzle."

**Function 1: Information, Referral and Community Awareness**

*The LTSS entry point system must serve as a highly visible and trusted place where people of all ages, disabilities and income levels turn for unbiased information on LTSS options. The entry point system must promote awareness of options available in the community and be able to link people with needed services and supports –both public and private.*

**Information, Assistance and Referral System**

Colorado has a fragmented system for providing information, assistance and referrals. Medicaid pays some organizations to provide these services, while others are funded through federal, state and local funds. Furthermore, funding for information, assistance and referral activities often comes with specific requirements, such as clients who are eligible for assistance can only be provided to a specific population using LTSS. For example, federal funding for ADRCs through the Older Americans Act and state funding from the Older Coloradans Act must be used for people age 60 years and older. However, ADRCs also serve younger adults with disabilities. This restriction creates a funding silo within a single organization. Essentially, Colorado has created entry point systems around funding streams rather than for the people trying to access information about LTSS options.

Sixteen ADRCs provide information, assistance and referral services. However, the market penetration and quality vary. Only some of these agencies are contracted with the Department to provide entry point functions for Medicaid Home & Community-Based Services (HCBS) and nursing home admissions. As of April 2015, the Department has contracts with most of the ADRCs to provide information about HCBS for nursing home residents who request to learn more about community-based options. Ten Independent Living Centers (ILCs) provide information and referrals, peer counseling, independent living skills and advocacy for people with disabilities. They are funded through federal grants, state money, fundraising and local governmental support. Single Entry Point (SEP) agencies, Community Centered Boards (CCBs) and Area Agencies on Aging (AAAs) also provide information, assistance and referral. However, funding varies between each agency. (See Appendices A and B for more on Colorado's entry point system.) SEPs are access points for HCBS and nursing home care through Medicaid and a state-funded LTSS program called Home Care Allowance. Some of these organizations are ADRCs. CCBs provide access to HCBS specifically targeted to people with Intellectual

and Developmental Disabilities (I/DD) through Medicaid and the state general fund. AAAs are an entry point for programs and services funded by the state of Colorado and the Older Americans Act.

Most individuals with long-term behavioral health needs are connected to services through the Community Mental Health Centers, Behavioral Health Organizations (BHO), substance use disorder providers and managed service organizations. BHOs are managed care entities that contract with local mental health centers to provide mental health support and substance abuse treatment for Medicaid clients. The behavioral health crisis hotline is now serving as a new entry point for individuals and families. Many consumers are accessing services in both the Behavioral Health System and LTSS delivery system, but linkages between the systems remain tenuous.

Consumers can be further confused by fragmented responsibilities among entry point organizations. For example, each entry point also has disparate business processes for applications as well as intake and screening. These organizations are often poorly connected to each other, making it difficult to create streamlined referrals. Even when an agency refers someone for help, there is often no way to share information, forcing consumers to retell their stories. Additionally, follow-up procedures after successful referrals are inconsistent across the state, sometimes leaving consumers to navigate the system themselves after they receive a referral. Even with the fragmentation, Colorado has an extensive system of entry point agencies, each with significant expertise which can be used as a foundation for launching a statewide information, assistance and referral system. The challenge lies in increasing coordination and visibility for all individuals in need of LTSS.

**Community Awareness**

A marketing plan that clearly delineates where consumers can go for assistance will be crucial in developing a NWD system. Coloradans face a complex network of LTSS entry points. Many people do not know where to turn for information, referral and assistance resources. The lack of a statewide marketing plan to inform people of all ages, disabilities and income levels about what is available in their communities contributes to the confusion.

Some organizations do market their services to residents in their communities. These strategies vary widely in their sophistication and effectiveness and they do not always have ways to collect feedback to strengthen the message. Other organizations cannot afford marketing campaigns forcing them to rely on less sophisticated means of advertising. Branding across fragmented organizations will take significant stakeholder work. Input is needed to better understand how people access information.

Organizations across Colorado also use different formats for compiling resource lists. Some organizations use web-based platforms while others use printed materials. Colorado does not have one comprehensive database of resources. The organizations that do have resource lists also struggle to maintain the accuracy of the information.

However, Colorado has taken steps to creating statewide access numbers. Colorado has a new toll-free number for ADRCs. While the phone number has yet to gain traction statewide, it is a good initial effort and should receive continued support. Colorado has also recently created a statewide behavioral health crisis hotline. The hotline is an immediate connection point for many families and individuals who are seeking help and assistance for acute behavioral health care needs in communities throughout the state.

One of the stated goals of CCLP is to improve communication to ensure accurate, timely and consistent information about LTSS service options. This goal has several measurable outcomes over the next three years regarding information resources, marketing campaigns and consumer impact. Another stated strategy in CCLP is to create a statewide database of resources and programs that is searchable by consumers, families and LTSS agencies.

**Function 2: Person-Centered Counseling**

*Person-centered counseling is defined as the ability of the entry point system to provide one-on-one assistance and decision support to people and their family members, guardians and/or caregivers. The main purpose of person-centered counseling is to help people understand and assess their situation and assist them in making informed decisions about their LTSS choices.*

The first step in providing robust person-centered counseling is to ensure that entry point staff across organizations are well-versed in all options available to consumers. Unfortunately, there is a significant barrier to achieving this objective: Colorado's entry point organizations serve distinct populations characterized by age, income level and disability. As indicated above, this situation is often dictated by an organization's funding sources because the system is built around funding streams, not people. Thus a person who receives person-centered counseling from an organization that only serves Medicaid clients might learn about some Medicaid options but very little about other choices. Even within the Medicaid entry point system, clients might not receive the full range of Medicaid options.

Another challenge is that staff members of the various organizations are not required to go through the same level or kind of training, creating varying approaches to person-centered counseling. Furthermore, different organizations serve different and, in some cases, overlapping regions in Colorado, making it difficult to create a true NWD approach. (See Appendix B for a map of all entry point regions)

With all of these variables, the quality of counseling an individual receives may depend on where a person lives. Also, consumers who visit more than one entry point organization might have very disparate experiences and receive conflicting and varied information.

In addition, Colorado's entry point organizations do not share the same definition of person-centered counseling. As a result, there are no standard intake and screening forms to collect consumer information. However, Colorado is currently developing a standardized intake and screening form to use across Medicaid entry point agencies as part of an initiative to develop a new comprehensive assessment tool to use for Medicaid funded LTSS. What's more, entry point organizations cannot easily pass on what they know. Many agencies use different information management systems to capture consumer information. For example, AAAs use the Social Assistance Management System (SAMS) for care management and client tracking. But SAMS does not interface with any Medicaid systems, forcing consumers who go through both the AAA and a Medicaid entry point, which uses the Benefits Utilization System (BUS), to retell their story. The lack of integrated or shared data systems means some people may bounce around different organizations within their region or around the state and they have to go through options counseling more than once (See Appendix C for an infographic of Colorado's LTSS data systems). All of these data systems are publicly funded and require state and federal resources to maintain. Finally, entry point organizations do not have a uniform follow-up process to ensure that consumers are able to access services.

CCLP includes a goal of proactively preventing unnecessary institutionalizations of people who could successfully live in the community. Strong and coordinated person-centered counseling programs would help people learn about their options at times when it matters most, such as when they are discharged from the hospital or in times of crisis, and possibly prevent unnecessary institutionalizations.

**Function 3: Streamlined Eligibility Determination for Public Programs**

*LTSS are funded by a variety of government programs administered by an array of federal, state and local agencies, each with its own eligibility rules, procedures and paperwork requirements. An entry point system must offer a NWD to all publicly funded LTSS, including Medicaid, the Older Americans Act (OAA), the Rehabilitation Services Act and other state and federal programs and services.*

*Entry point organizations should facilitate a streamlined intake and screening and eligibility determination process for consumers accessing publicly funded LTSS.*

**Intake and Screening**

Colorado lacks a coordinated, standardized intake and screening process for public programs. Intake and screening is often disconnected from the information, assistance and referral networks, meaning consumers are left to navigate the system on their own. As noted above, several entry point organization serve only Medicaid-eligible consumers while several others have no formal interaction with the Medicaid system and cannot track the Medicaid eligibility of their clients.

**Financial and Functional Eligibility Processes**

Public programs lack a seamless process for eligibility determination. County departments of social and human services determine a person's financial eligibility independent of organizations that assess the person's functional eligibility for Medicaid LTSS. Even within the Medicaid program, different organizations determine functional eligibility depending on a consumer's type of disability. For example, a CCB determines functional eligibility for people with I/DD while SEP agencies determine eligibility for consumers with other types of disabilities.

Consider, for example, the fragmentation that can occur in determining functional eligibility for Medicaid LTSS and the impact that it can have on consumers. Colorado's Medicaid program uses a uniform tool, the ULTC 100.2, to assess all Medicaid clients for functional eligibility. The ULTC 100.2 has relatively few questions and they are broad in scope. Therefore, each entry point organization must create individual care plans and staff members must make subjective determinations of a person's needs. Consequently, care plans can vary widely, even for people with similar functional statuses. A more comprehensive and rigorous assessment tool, currently being developed and anticipated to be piloted in 2015, will reduce the subjectivity in eligibility decisions and could direct people to options inside and outside of the Medicaid program for services that are tailored to their specific needs.

As part of the functional eligibility determination, certain required processes may actually delay enrollment in a HCBS program or interrupt the continuity of care for regular redeterminations. For example, Medicaid HCBS programs require a primary care physician to complete a professional medical information page to verify targeting criteria for an HCBS waiver. Medicaid entry point agencies spend

an inordinate amount of time following up with primary care physicians to complete the paperwork. The Department could consider other approaches to streamline the process to verify targeting criteria.

There is no data system that connects needs, service plans and service utilization for most Medicaid clients. Additionally, the data system used in determining financial eligibility for Medicaid does notinterface with the systems used for functional eligibility determination. The lack of data system integration means agencies are not automatically notified when a client receives an eligibility determination. This, in turn, can result in delays in enrollment.

In many instances, Medicaid clients who are functionally eligible may wait up to 45 days or longer for financial eligibility determination. Entry points and county agencies do not have a consistent approach, if any, to triage clients so those most at risk might have an expedited financial eligibility determination. Because entry point organizations are not automatically notified upon determination of financial eligibility, some have developed manual internal tracking systems to monitor applications.

With all of the difficulties, there are processes that work well in Colorado. Some county departments of social services, which conduct the financial eligibility determinations, are also SEPs. Some of these counties have practices that improve the coordination of the financial and functional eligibility determinations. Colorado is one of the few states in the country that requires an entry point agency to determine eligibility for a nursing home admission. Involving the entry point agency in the admissions creates an opportunity for the entry point to have a conversation with a consumer about community-based options. In many cases, the entry point approves the admission for a short period of time and reassesses the consumer and discusses community-based options if appropriate.

**Function 4: Person-Centered Transition Support**

*To effectively deliver person-centered transition support, the entry point system must be able to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program to another. The entry point system can play a pivotal role in these transitions to ensure that people understand their options and receive LTSS in the setting that best meets their needs and preferences.*

Some entry point organizations have developed partnerships on the local level with critical pathway providers such as hospitals, nursing homes and rehabilitation centers to smooth transitions between settings. However, without a clear statewide approach, relationships between entry point organizations and critical pathway providers vary widely across Colorado.

Promoting formal and robust partnerships would go a long way towards meeting the objective of comprehensive and consistent person-centered transition support. An initiative to do just that is the Colorado Choice Transitions (CCT) initiative, supported by the federal Money Follows the Person grant. Under CCT, Medicaid provides transition services to clients residing in long-term care facilities through ILCs, SEPs, CCBs and other community-based agencies. To better support this effort, the Department is contracting with the 16 ADRCs in Colorado to provide person-centered counseling to nursing home residents who request information about community-based services. If the client is interested in transitioning, the ADRCs refers to CCT or other community transition services to help coordinate a return to community living.

Beyond CCT, the Denver-region AAA has partnered with hospitals to provide transition support for patients discharging from the hospital in an effort to reduce hospital readmissions. This effort, as with CCT, is currently unsustainable because funding is grant-funded and uncertain. To implement a fully functional NWD system, the state needs to implement sustained efforts to support transitions.

However, CCT continues to build the infrastructure and foster partnerships between local agencies to support transitions. Lessons learned from CCT can provide a foundation for informing how person-centered transition support can work in a NWD system.

Transitions between care settings are important, as are transitions between public programs. For example, there is a process in place for people who are on the waitlist for the HCBS-for the Developmentally Disabled (HCBS-DD) Medicaid waiver to enroll in the HCBS-Elderly, Blind and Disabled (HCBS-EBD) waiver in the meantime. However, this option is not always presented to consumers nor does a consumer always meet targeting criteria for both waivers. Furthermore, transitions from school-based or foster care services to adult-related services and supports are also not seamless. The NWD system would be able to provide comprehensive options counseling for people on the waitlists for certain programs or people in life transitions.

CCLP addresses the need for transition services. The plan suggests ways to identify qualified individuals who are interested in moving from institutional care and calls for a person-centered approach to meet their needs. The plan also suggests systems and supports to help people avoid being reinstitutionalized and to increase housing options and appropriate community services and supports.

**Function 5: Consumer Populations, Partnerships and Stakeholder Involvement**

*Entry point systems must serve persons with all types of disabilities regardless of age and income. To achieve this outcome, a wide variety of stakeholders, including consumers, LTSS programs and providers and state agencies must actively participate in not only designing and refining the entry point system but also in providing the services.*

Under the current entry point system, competency varies in serving all ages, types of disabilities and different cultures and ethnicities. Certain organizations only serve certain populations, a niche approach that results in a series of right and wrong doors for consumers. In addition, staff at some organizations are trained in cultural and disability sensitivity. However, there is no requirement for such training.

Colorado statutes designate some entry point organizations to conduct Medicaid assessments and eligibility determinations only for certain populations. These organizations, along with other non-Medicaid entry point organizations, are expected to work together on behalf of people trying to access LTSS. However, formal service standards, protocols for information sharing and cross-training across entry point organizations are ad hoc. Very few partnerships are formalized through contracts or memorandums of understanding. Advisory councils for all of the different entry point organizations vary in structure and governance responsibilities. The disparate advisory councils do not always bridge the service and communication gaps between organizations.

At the state level, departments are beginning to work together to bridge networks and breakdown silos, as evidenced by the creation of the CCLP and the CLAG Report to the Governor. State Agencies are coordinating and collaborating together on shared interests and priorities that impact people who

use LTSS. While coordination with the Department of Veterans Affairs (VA) and other federal programs is limited, four ADRCs are working with the VA and ACL to implement the veteran-directed HCBS program.

**Function 6: Quality Assurance and Continuous Improvement**

*Quality assurance and continuous improvement must be a part of every entry point system to ensure services are available, are of high quality and meet the needs of individuals and are sustained statewide. Entry point systems should use integrated information technology (IT) systems to track customers, services, performance, costs and to continuously evaluate and improve on the results.*

Colorado faces significant challenges in constructing a standard, high-quality entry point system. Quality assurance and continuous improvement depend on adequate coordination and staff capacity as well as an integrated IT solution or interoperability to support data sharing.

Because funding varies and different state agencies have authority over different community entry point organizations, there is no overall quality improvement strategy for entry point activities. The Department oversees Medicaid, while offices within DHS oversee state aging services, behavioral health services and vocational rehabilitation services. This means that entry point organizations are responding to different quality measurements and reporting requirements. Some streamlining of entry point efforts have already occurred within the Medicaid system. Medicaid programs for people with I/DD were moved from DHS to the Department which has improved coordination of the oversight of the different Medicaid entry points and waivers.

Staff capacity, which is crucial for implementing continuous improvement activities, varies across organizations. Some organizations are understaffed given their workload and limited funding for entry point services and turnover is high. Local organizations are largely responsible for staff training but there is no common set of qualifications or training protocols. The lack of a trained workforce overseen at a state level may lead to significantly different experiences for consumers trying to access LTSS.

Information Technology systems that are used to track clients within the Medicaid system are not integrated and have limited ability to share information. Many systems are also dated and lack flexibility and interoperability. Separate systems exist for financial and functional eligibility and only the financial system communicates with the Medicaid Management Information System (MMIS), which tracks utilization information. However, the Department is in the process of replacing its current MMIS system and the BUS (the LTSS case management software system) with an integrated information management platform over the next few years.

That effort will help. However, data systems used outside of Medicaid by AAAs, ILCS and other agencies are not connected to each other or to Medicaid. Integrating these data systems will be a challenge as many organizations have invested significant resources in their own software solutions to track and report entry point activity.

State agencies overseeing the entry point organizations do not use a uniform set of metrics to evaluate entry point services. The metrics they do have are not linked to assessment or case management in a meaningful way or only include process measures but do not assess the impact on the consumer experience. Few publicly available quality indicators on entry point providers exist.

LTSS organizations carry out consumer satisfaction evaluations and surveys voluntarily, but the results are not collated to provide a big picture look at how well the system is working. The Department does an annual satisfaction survey of Medicaid entry point agencies in Colorado although this data is not necessarily used in a meaningful way to drive quality improvement. The Department is in the process of piloting different quality of life tools to assess the impact of the community services on a consumer's quality of life, but these tools do not have measures to necessarily evaluate entry point operations.

**Conclusion**

As Colorado works toward creating a NWD system of LTSS entry points, it is important to understand the current status of the LTSS entry point system.

Colorado has numerous types of LTSS entry point organizations. However, the system is uncoordinated and confusing for consumers. It is hobbled by disconnected IT systems, disparate training requirements for entry point staff, fragmented service delivery and funding that promotes the status quo.

To overcome these challenges, consumers, advocates, LTSS entry point staff, LTSS providers, state departments and other stakeholders must work collaboratively to create a system that is not only inclusive of all ages, disability types, income levels and pay sources but is also easy to navigate for people at vulnerable points in their lives.

## Appendix A

**United States Senate, Commission on Long-Term Care; Report to the Congress, September 30, 2013**

The Commission on Long-Term Care was established to develop a plan for implementing comprehensive, coordinated, high-quality long-term services and supports system. Their report to Congress was written after six months of meetings, public hearings and soliciting comments from the general public. The recommendation to expand the No Wrong Door approach can be found on page 45.

The report can be found at

http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf.

**Colorado's Community Living Plan; Colorado's Response to the Olmstead Decision**

This July 2014 report details Colorado's efforts to ensure the people with disabilities and older adults have the resources they need to live independent lives.

The report can be found at

https://www.colorado.gov/pacific/sites/default/files/Colorado%20Community%20Living%20Plan-July%202014.pdf.

**Colorado Health Institute, The First Step; Fixing Colorado's System of Long-Term Services and Supports**

This September 2013 report provides the framework for understanding why Colorado needs a No Wrong Door system. It explains how Colorado's LTSS puzzle was developed over the years and its implications for clients. It also discusses some of the state's efforts to redesign the fragmented LTSS system.

The report can be found at

http://www.coloradohealthinstitute.org/uploads/downloads/LTSS_First_Step_publication_for_web.pdf
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## Appendix B

Maps of Colorado's LTSS Entry Points

## Appendix C

LTSS Data Systems Flow Chart

http://www.adrc-tae.acl.gov/gp_uploads/Colorado/Data_Systems_Flow_Chart_Appendix_C.pdf.