



Charting a Path Forward for Uniform Assessment of LTSS Needs

Roundtable Report

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Introduction

The Long-Term Quality Alliance (LTQA), with support from The SCAN Foundation and the assistance of The Brookings Institution, convened a Roundtable of experts and officials from state and federal programs that provide long-term services and supports (LTSS) on May 5-6, 2014. The roundtable focused on the potential for developing a core set of standardized LTSS assessment items and an action plan to gain broad adoption of the core items. This paper is the Report from the Roundtable, including proposals for follow-on activity to advance standardized LTSS assessment items.

LTQA's project on standardized assessment grew out of recommendations made by the 2013 Commission on Long-Term Care. In its Report to the Congress, the Commission called for a delivery system for LTSS "...organized to provide a comprehensive array of person- and family-centered, high-quality, financially-sustainable medical and social services and supports that meets the heterogeneous needs, preferences, and values of individuals with cognitive and functional limitations." The Commission further stated that such a system should provide "integration of LTSS with medical and health-related care, including effective management of transitions between one type or level of care and another."¹ As part of a foundation for integration, the Commission recommended "...the development and implementation of a standardized assessment tool that can produce a single care plan across care settings for an individual with cognitive or functional limitations."²

Currently, the assessment instruments and the processes used in determining eligibility and developing care plans vary from state-to-state and within states, from program-to-program. Often, programs use different assessment instruments and different processes for determining program eligibility and service needs. Most of these programs measure the same types of concepts— health status, functional status, social supports, and other factors important to supporting these populations in the community. While the concepts are common, the individual items and instruments to measure a concept vary across programs within states, and across states within common programs. These items differ either in terms of item definition or response codes.³

¹ Commission on Long-Term Care. Report to the Congress, September 30, 2013. P. 36.

² Commission on Long-Term Care, P. 43.

³ This project uses three levels of content in discussing assessment instruments: domain, concept and item. A domain is a broad conceptual topical area, such as: communication, functional status, caregiving, socio-economic status, nutrition, social network. A concept is a specific area within a domain. The domain "functional status" may include a number of concepts, including: mobility, activities of daily living (ADLs), and instrumental activities of daily living (IADLs). An item is a specific

The need for standardizing assessment items within states and across states, and the status of federal and state efforts to standardize items are detailed in two background papers prepared for use by the Roundtable.⁴ Standardizing items across a variety of assessment tools is key to sharing information across services in order to support care planning, care coordination and accountability for high quality services and outcomes.

This Report follows the format of the Roundtable. The Agenda from the Roundtable and a list of the Roundtable participants are provided in the Appendix.

Overview of Leading Federal Standardization Initiatives

The Roundtable gathered multiple stakeholders involved in individual assessment processes and reviewed key initiatives at both the state and federal levels. The Federal initiatives include the development of the standardized CARE item set, the CMS Assessment Item Library, the use of the CB-CARE in the TEFT program, and the core assessment requirement in the BIP program.

A major ongoing assessment standardization initiative at the federal level is the development of the Continuity Assessment Record and Evaluation (CARE) tool item set. The CARE item set was created by the Center for Medicare & Medicaid Services (CMS) to meet the statutory requirement for a standardized assessment approach to be used at acute discharge and post-acute admission and discharge as a part of the Medicare Post-Acute Payment Reform Demonstration (PAC-PRD). CMS worked with RTI International and a broad stakeholder community to identify items that could reliably measure individual health and functional status and be applied across acute and post-acute settings, including Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). CARE is intended to contain “best in class” items as reflected in the best science for measuring concepts common in the three Federal assessment instruments, mandated for Medicare post-acute settings: OASIS, MDS, and IRF-PAI. The CARE items have been tested extensively for validity, inter-rater reliability, and reliability across care settings. Items were also selected for their ability to explain differences in resource needs while minimizing provider burden. The CARE item set has been designed for data interoperability

question or piece of information that has a response that is coded in a database. The items for measuring ADLs are questions about ability to independently perform daily activities such as bathing, dressing, or eating. The responses to the items may be a simple “yes” or “no” or a graded scale (e.g., from 1 to 5) or some other response.

⁴ G.L. Atkins and B. Gage. The Need to Standardize Assessment Items for Persons in Need of LTSS. LTQA, April 29, 2014; and B. Gage, E. Blair, and G. L. Atkins. Standardizing LTSS Assessments for State Initiatives. LTQA, April 30, 2014.

across settings and data systems and meets the Office of the National Coordinator's standards for health data exchange.⁵

While the CARE tool items were designed to begin standardizing health, functional, cognitive, and social support items in the Medicare acute and post-acute populations, additional work has broadened this standardization effort to ambulatory settings, such as therapists' offices and LTSS populations.

Under the Testing Experience and Functional Tools (TEFT) program, created by the Affordable Care Act, states have the opportunity to test standardized assessment items in Medicaid home and community-based (HCBS) LTSS programs. TEFT grantee states will test a modified set of functional status items from the CARE item set in community-based long-term services and support settings (CB-LTSS). Expanding the standardized assessment items to CB-LTSS settings moves states forward toward achieving person-centered care by improving transitions, establishing data exchangeability, and enabling quality monitoring across care settings.

The TEFT program provides states an opportunity to cost-effectively adopt health information technology in the LTSS systems. In addition to the standardized assessment efforts, grants also include support to develop personal health records for beneficiaries of community-based LTSS programs, and identify and develop standards for electronic LTSS records that meet the Office of the National Coordinator's (ONC) Standards and Interoperability (S&I) Framework. The S & I Framework has grown out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, which established the Electronic Health Record (EHR) Incentive Programs to encourage providers to adopt EHR technology. The Act provided financial incentives for the development and "meaningful use" of EHR technology. Although long-term care providers were not included in the HITECH Act, and therefore did not receive financial incentives for implementing EHR, there is a clear need for long-term and post-acute care providers to adopt EHR to ensure smooth care transitions between acute, post-acute and long-term services. The TEFT program provides funding to support these types of initiatives.

Nine states received TEFT grants: Arizona, Colorado, Connecticut, Georgia, Kentucky, Louisiana, Maryland, Minnesota, and New Hampshire. Of these, six are testing the CB-CARE items, and seven are demonstrating the use of electronic health records for LTSS.

⁵ B. Gage et. al. The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set, Volume 1 of 3. CMS, August, 2012.

CMS is also using the standardized CARE items in several other initiatives. B-CARE, a subset of the standardized CARE items, is being used in the national Bundled Payments for Care Improvement Demonstration (BPCI). The standardized assessment data allows populations and outcomes to be measured consistently across settings and across an episode of care. CMS and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) are also testing functional assessment items from the standardized CARE item set to develop setting-agnostic quality measures for use across the Medicare program. The CARE items are being used to consistently risk adjust more complicated populations as well as consistently measure outcomes across post-acute settings. Currently, function measures, which are collected by IRFs, SNFs, LTCHs and HHAs, are setting specific and not comparable. CMS and ASPE have led to the developed of a set of setting-agnostic, ADL/self-care and mobility measures. CARE's standardized functional items were chosen as the basis for these activities as they have demonstrated reliability and validity across care settings.

CMS is also developing an Assessment Item Library that contains items from the standardized CARE item set, the MDS, OASIS, and IRF-PAI, which would allow providers, states, and others to access a library of valid, reliable items for use in assessment tools or quality measures. The items are mapped to the common assessment domains, such as medical conditions and diagnoses, function, cognition and social supports. CMS is also identifying electronic specifications for the standardized assessment items to generate data interoperability.⁶

Another step toward standardization at the federal level is the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. This Act, recently introduced by bipartisan leadership of the Senate Finance and House Ways and Means Committees, would require post-acute care providers, defined as HHAs, SNFs, IRFs, and LTCHs, to report standardized patient assessment data, as well as standardized quality and resource use measures. The standardized assessment data will include functional status, cognitive function, special services, medical condition, impairments, prior functioning levels, and any other categories deemed necessary for assessing patient need.

Standardizing assessment items across Medicare acute and post-acute settings will provide the basic information needed to enable Medicare to compare quality across post-acute settings and improve hospital and post-acute discharge planning. Currently, there is significant variation in spending for post-acute care across settings, and the level of spending often does not correspond to better outcomes. Standardized data will allow a better understanding of these

⁶ B.Gage, E. Blair and G.L.Atkins. Standardizing LTSS Assessments for State Initiatives. LTQA, April 30, 2014.

findings. The data can also be used to reform PAC payments, such as bundled or site-neutral payments, while ensuring the beneficiary continued access to appropriate care.

Another federal initiative on standardizing assessment data is The Balancing Incentive Program (BIP), which was developed under section 10202 of the Affordable Care Act. The program is intended to provide incentives for states to shift their Medicaid LTSS spending from institutional settings to home and community-based care. The program focuses on states with lower relative use of community-based services. CMS has awarded \$2.16 billion dollars to 19 states participating in the program, the newest states being Nevada and Massachusetts.

The BIP states must implement three structural changes: a No Wrong Door/Single Entry Point (NWD/SEP) system, a core standardized assessment, and conflict-free case management.

- The NWD/SEP system is a virtual single point-of-entry for assessing LTSS needs of older adults and individuals with disabilities for a wide range of programs via one entry point with a single intake assessment.
- The core standardized assessment (CSA) requirement directs participating states to design a uniform assessment system for determining eligibility for all Medicaid-funded LTSS. The assessment is also intended to identify individuals' support needs and inform their service and support planning. This core data set includes background information on the person, activities of daily living (ADLs), instrumental activities of daily living (IADLs), the person's medical conditions and diagnoses, their level of cognitive function, behavioral concerns, and financial information. Although caregiving information is not a required domain in the CSA, the BIP guidance from CMS also states that family caregiver needs should be considered⁷. States can choose to utilize and adapt components of preexisting tools through lists on the BIP website, create their own tools, or a combination of both.
- Conflict free case management ensures that there are different agencies determining eligibility than those who are providing the services.

⁷ E. Kako, R. Sweetland, K. Melda, E. Coombs, M. Smith, and J. Agosta. The Balancing Incentives Program: Implementation Manual. Mission Analytics Group, Acumen LLC, and Human Services Research Institute, February, 2013.

Other BIP requirements include collecting service, quality and outcomes data, meeting either the 25 percent or 50 percent expenditure benchmark, and spending program funds for the enhancement and expansion of community LTSS.

Overview of Current State LTSS Initiatives

Roundtable participants who have been involved in state efforts to develop uniform assessment instruments provided information on the status of assessment standardization activities in their states' initiatives. Participating states were motivated to work on uniform assessment instruments for a variety of reasons, including receipt of BIP or TEFT grants. States also reported differences in assessment processes, the approach taken to uniform assessment, and the status of these efforts.

Colorado

Colorado has a uniform assessment instrument they currently use across their Medicaid programs although they are in the process of revising these tools and approaches to support three structural changes they are making in their Medicaid HCBS waiver programs. Although they are making some of the same structural changes called for in BIP, they are doing it with a grant from the Colorado Health Foundation since they already shifted much of their LTSS into community-based initiatives, and therefore, did not qualify for BIP. The structural changes are:

- Waiver simplification— to consolidate waivers and reduce the number of different diagnosis and disability-specific programs;
- Expansion of consumer direction— to extend the opportunity to manage individual service budgets beyond the current older adult, physical disability and mental illness populations to other populations, such as I/DD (intellectual and development disabilities); brain injury and
- Employment support— to identify more individuals who could benefit from employment opportunities.

Colorado is using a modular approach to designing a core assessment tool. They have completed a crosswalk of several major assessment instruments: interRAI, Minnesota, Washington CARE, and the Federal CARE items, and are exploring ways to enhance and customize these tools. They will initiate a four-phase process for rolling out the new tools for their adult populations, starting with a pilot to ensure that the new tools do not result in different eligibility results than current tools.

Virginia:

Virginia was one of the first states to develop a preadmission screening process to determine functional eligibility for Medicaid-funded long-term services and supports. The Universal Assessment Instrument (UAI) was created in 1994 and mandated for use statewide as a critical component to better manage individuals in need of long-term services and supports. It is used across health and human services agencies with populations at risk for institutionalization (including nursing homes and long-stay hospitals), PACE programs, and Medicaid HCBS waivers. Approximately 27,000 screenings are performed per year. It is also used for other human services programs in the Commonwealth.

The UAI has been updated over the last ten years to address the needs of individuals with mental illness and to provide guidance when screening children. The UAI is not used to determine eligibility for those individuals in need of intermediate care facilities, for individuals with developmental disabilities (ICF/IDs) or for those individuals being served in the Intellectual/Developmental Disabilities HCBS Waivers. There has been some interest within human service agencies to revise and update the UAI. This will likely occur within the next two years.

California

The California legislature mandated development of a universal assessment process for home and community-based services as part of its Coordinated Care Initiative of 2012. California has a diverse population and one of the largest HCBS populations in the country. Over half of the state's long-term Medicaid expenditures are in HCBS, with the largest HCBS program being the In Home Supports and Services (IHSS) program.

To initiate the process of developing a universal assessment process, California undertook a review of external standards and universal assessment activities in four comparison states. The evaluation found:

- A lack of common vocabulary for the components of a comprehensive assessment process
- A concern by states that any change is costly and disruptive and requires careful planning
- Diversity in the populations and the programs with regards to the assessment process, and the defined levels of care

- Formation of constituencies and program activities around particular item sets
- Potential unreliability of uniform items
- A trade-off between comprehensiveness and feasibility

The planned California redesign was initiated with a set of shared goals and values for the assessment process and items. The assessment should:

- Be person-centered
- Focus on strengths rather than deficits
- Aim at determining need to support care planning for independent living in the community
- Balance burden and equity –not be so lengthy and cumbersome as to adversely affect recipients.

The project is developing two draft sections for the assessment instrument: a Core Item Set (CIS) and Candidate Supplement and Replacement Items (CSRI). The next stage of the process is to develop the items and pre-test them within the state.

Arizona

Arizona has separate, statewide assessment tools for level-of-care determination and needs assessment for care planning. All plans in the state (Arizona provides all Medicaid through MCOs) are required to use the uniform needs assessment tool and are not permitted to use their own assessment instruments. The plans use their own assessment tools for developing member care plans.

Texas

Texas is a grantee in the BIP program. To meet the BIP requirements for a Core Standardized Assessment, it is using its current functional assessment instrument and adding a page with additional CSA domains. The tool will be used with the disabled and aging population, but not the I/DD population. Managed care organizations will use the BIP assessment instrument with all their enrollees using LTSS. Texas is also adding additional domains to the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) tools, for populations with behavioral health and substance abuse issues.

Illinois

In Illinois, several agencies are involved in serving LTSS populations. Long-term services and supports, skilled nursing and supportive living are managed by the Medicaid agency. However, the Department on Aging also serves these populations. Illinois is in the process of putting together a Section 1115 waiver to consolidate its LTSS programs. While Illinois' budget constraints drove the state to review its Medicaid programs and focus on coordinating its eligibility tools, the BIP grant provided an incentive to move to a core standardized assessment. This initiative dovetails with Illinois' effort to consolidate multiple HCBS waivers. Illinois will also fold behavioral health into this effort.

Illinois differentiates Level 1 and Level 2 assessments. The Level 1 screening is an extension of No Wrong Door— it allows people to access the system, but it is not a functional assessment. For the Level 2 assessment, they have issued an RFP to develop a uniform assessment tool to replace their existing instrument. They intend to fold in as many programs and populations as possible, with an interest in moving toward longitudinal assessment. They would like assessment items that are nationally comparable and are seeking an off-the-shelf solution, if one exists. Illinois is moving quickly into managed LTSS and is looking at how MCOs will interact with a uniform tool.

Louisiana

Louisiana initiated the process of long-term care reform in 2004 in response to a governor's mandate to reform the administration and delivery of long-term supports and services, and address the substantial backlog of people on the waiting list for home and community-based services. They are currently using three well-recognized assessments with their long-term care populations, a different instrument for each group. The state Office of Aging and Adult Services implemented an interRAI instrument in 2005. Between 2008 and 2011 they implemented a process for resource allocation, certification for assessors and monitoring processes. In addition, the state Office for Citizens with Developmental Disabilities evaluated both the interRAI and the Supports Intensity Scale (SIS) for the I/DD population, but adopted the SIS instrument. They also added a supplement to provide additional data elements for resource allocation. And the State Office of Behavioral Health is utilizing the Level of Care Utilization System/Child and Adolescent Level of Care Utilization System (LOCUS/CALOCUS) for need assessment and care planning for the behavioral health population. Following the award of the BIP grant the three program offices began work to develop a core standardized assessment instrument. Louisiana is also a TEFT grantee state. Understandably, the three programs are vested in their current instruments and systems, which took tremendous time and resources to

develop. This is viewed as the biggest challenge to cross-population standardization for the state.

Minnesota

Minnesota has had an integrated Medicare-Medicaid program through its non-profit managed care and special needs plans since 1997. The state has built common assessment processes and instruments into the managed care program. Plans have been successful at increasing the proportion of beneficiaries served in the home and community settings, and have become experienced in assessing social service needs, but continue to work on incorporating more of the medical information into the LTSS assessment.

Minnesota is in the process of rolling out its automated single assessment tool, MnCHOICES, which is active in six counties now, and will be used by managed care organizations in 2015. The assessment instrument is designed to be administered before a person is assigned to a program (unlike many other states) in order to determine which program would best meet the person's needs. This tool will be used to develop an electronic community support plan for each participant. In addition, Minnesota is establishing an assessor certification program to provide the training to use the tool successfully. Minnesota also has received a TEFT grant, which they are using to help finance portions of the new infrastructure of the state's HCBS system and to test the standardized CB-CARE items.

First Work Session: Prioritization of Domains and Concepts

Developing and implementing a person-centered care plan for someone in need of LTSS begins with knowing the person and requires an investment in understanding the person's life experiences, values, personal and family situation, and functional needs. This information becomes the core set of individual data around which other information needed for developing and managing services can be wrapped. Communication among health and social services professionals and family caregivers is essential for effectively executing a single person-centered care plan. Effective communication and coordination depends on a common set of standardized items to enable data sharing across the individual's entire team, including their providers, family, and other caregivers.

Identifying the domains and concepts central to LTSS assessments is an important first step in developing standardized assessments. Participants noted that the decision about which

domains and concepts to include in an assessment should be driven by the purposes and processes that the assessment serves. Assessments and assessment data serve a variety of functions, including eligibility determination, level-of-care determination, care planning, resource allocation, plan and provider payment, and quality measurement.

Assessment approaches vary across state programs and populations, both within a state and across states. Many states use separate instruments to determine eligibility, level-of-care needs, and develop care plans. Eligibility screening or determination is usually the first stage of interaction with a person seeking assistance. Individuals determined eligible may then be assessed for the level-of-care needed and be referred to a program for services. The program will often administer its own assessment instrument and develop a care plan for the individual on the basis of that assessment. Information from the assessment may also be used to establish benchmarks for individual outcomes and for provider performance.

Participants discussed the challenges of developing a single standardized assessment instrument that could serve the full range of LTSS programs and populations, given the number and variety of programs within a state and the vast differences between states in available programs. The lack of a common definition of unmet need across programs presents an additional challenge for standardization.

Participants urged that a parsimonious approach be taken to selecting data elements for inclusion in assessment tools. It was noted that data should be restricted to only the information needed to properly develop a care plan for an individual. The assessment and data collection should be minimized and focus only on those concepts that have the most direct bearing on an individual's functioning and quality of life. For each item added, the question should be: "How will this data be used?"

A Tiered Assessment Approach

Participants were concerned about the potential for overly long and burdensome assessments if states moved in the direction of a single comprehensive assessment instrument to meet the information needs across every setting, program, and population. Participants agreed with the need to standardize at minimum a critical subset of items likely to be used in every assessment, and possibly standardize a larger core set of data items.

An approach that was broadly supported was to design a single person-centered record that could accumulate data from a tiered set of assessment tools as the person is served across the care system. The tools might use a core set of standardized items but vary in additional content

depending on the settings, programs, or services an individual may use. The information would be accessible through various program portals that would allow the data to travel with the individual from program-to-program and be linked with the individual's electronic medical records.

- The first tier of assessment would support initial contact with the individual and eligibility screening for LTSS services. The initial interview would collect an individual's contact information, goals for care and preferences, and basic demographic and economic data. This information could generate an electronic record for the individual and populate the front end of the record.
- The second tier of assessment might support a level-of-care determination and referral for services. The information collected at this tier would populate the functional assessment section of the individual's record and might contribute to an initial care plan.
- The third tier of assessment might support service- or program-specific need assessments, which might contribute to modifications in the individual's care plan.
- Finally, modules could be developed for specific subpopulations or programs that would capture essential information unique to the population or program that would not need to be shared with other programs and could be uniquely tailored to a specific program. The modules would be incorporated in the individual's total electronic record.

This tiered approach would achieve multiple goals, including:

- Eliminate redundancy in data collection that occurs from multiple interviewers collecting the same information;
- Facilitate data sharing and interoperability by using a core set of standardized items and building a cumulative record around them; and
- Preserving program- and population-specific assessment information by permitting each program to append its own module to the cumulative record.

High Priority Domains

If a core set of universal standardized items were developed, what domains should be at the center and selected to be developed and implemented first?

Participants emphasized that a person-centered system of care should start with a conversation with the person (and family members if present) to understand their values and what they want in life – creating a narrative that would reveal a person's goals and preferences rather than starting from clinical measurements. The person's own goals for care are too often missing in assessments, and as a result, the assessment focuses first on matching up a list of

possible services with a person’s objective “needs” rather than asking a person how they would like to live, what is important to them, and what types of assistance might help. Assessments that do not start with an understanding of a person’s life and their own goals and preferences are at risk of specifying services for people that are neither desired nor helpful.

Participants confirmed that functional assessment, including mobility, Activities of Daily Living (ADLs), and Instrumental Activities of Daily Living (IADLs), is a core domain that appears in nearly every assessment tool. Participants noted that functional status should be considered a “vital sign” on a par with blood pressure or temperature because of its centrality to the determination of level-of-care and care planning. States are increasingly using functional limitations to assess eligibility for programs and to develop care plans. Many states also use functional limitations in case-mix adjustments to determine the level of funds for home and community-based services.

Participants raised the question of whether eligibility screening and level of need determination should be done in one stage or two. For example, should the initial eligibility screening simply ask who the participant is, what services he/she wants, determine his/her financial eligibility and then, based on that information, refer them to a separate interview to assess their level-of-care needed, or should functional assessment be part of the eligibility determination and be used to determine where to direct them for care?

There was broad agreement that family caregiving assessment should be a key domain in assessment tools. Family caregiving is the largest source of LTSS in the United States today. Family caregivers not only assist with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), but almost half conduct medical tasks that they may not be qualified or trained to do. An assessment of an individual’s social supports, including available family caregiving, is critical in determining the amount and type of additional care needed. Assessments should also ask about the training and support needs of the family caregiver, if the plan of care depends upon that family caregiver. Family caregiving information is more appropriately a factor in assessing the need for services and supports than in determining eligibility, since conditioning eligibility on an absence of family caregiving would create a disincentive for families to continue providing care. While all states say they assess caregiver needs, according to AARP Public Policy Institute’s 50-state study of waiver programs, every state means something different by this, and no state spoke extensively with caregivers⁸.

⁸ K. Kelly, N. Wolfe, Gibson, M.J., and L. Feinberg. Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid Home-and Community-Based Service Waiver Programs. AARP Public Policy Institute, December 2013.

Other domains identified as being significant were cognitive function, environmental safety, health status, poly-pharmacy, oral health and substance abuse.

These domains should serve as the starting point in developing a core of standardized items. Later, additional domains can be brought in to expand the items that would be collected uniformly and entered into a single, standardized, exchangeable record of the person's LTSS needs and personal and family resources.

Second Work Session: Development of Standardized Items

The first step is to identify the core set of items that need to be standardized to enable data sharing and interchangeability. The core set should be based on the person- and family-centered conversation on values and preferences – focusing on self-determination. Objective measures of needs and available resources can be built on that base. One approach might be to develop a simple, standardized tool that could be used across programs within states, and across states, for all persons with LTSS needs.

There are a few instruments that have been or are being developed that will have interoperability and data exchangeability and might serve as a source for core standardized items. The CARE tool, which is designed as a comprehensive data set for use across Medicare post-acute care settings, is being modified and tested under TEFT grants for use in home and community-based settings. The standardized items are designed to be exchangeable using electronic standards such as Clinical Document Architecture (CDA) or the Continuity of Care Document (CCD) that have been designed to create interoperability and data exchangeability.

CMS is building an Assessment Item Library that is taking the “best-in-class” items from the CARE tool and other sources to develop quality measures. The Library will be a repository for a standardized set of items that will be available in the public domain for use in developing assessment tools.

The most important place to start in developing standardized items is in the domains related to functioning: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) are used in both eligibility and functional assessment. There are common concepts used in measuring both ADLs and IADLs: ADLs include a person's ability to bathe, groom, dress, and feed themselves, as well as their ability to use a toilet. IADLs include the necessary tasks of managing money, shopping, meal preparation, and using the telephone, among other tasks. Despite using common concepts, there is no consistency in the language used in questions or in the structure of the coded answers.

A comparatively easy first step in standardizing assessment items would be to develop a core set of standardized ADL and IADL questions and answers. Work on this is underway at CMS and is expected to produce standardized items that will be tested for use with HCBS by state TEFT grantees.

Other areas identified by Roundtable participants as important for early item standardization for LTSS included:

- Social participation, including the person's level of interaction with others.
- Ability to communicate, including the use of telephones and Internet. This category can also be expanded to include a person's capacity to communicate, particularly in an emergency.
- Self-ratings of health status.⁹
- Ability to transfer, including differentiating between transferring with assistance from one person versus transferring with assistance from two people.
- Falls risk, including the person's tendency for falling, and their concerns about falling within their present environment.
- Delirium, both the person's history with and current state regarding experiencing delirium. Delirium has been linked to falls and hospital stays.
- Post-Traumatic Stress Disorder (PTSD), both the person's history with and current state experiencing PTSD.
- Medication management including both understanding of prescribed medications and ability to take them correctly.
- The person's level of pain.
- Skin conditions, including the presence of pressure ulcers and wounds.
- Oral health, including the identification of the most recent dental visit. Poor oral health has been linked to cancer and preventable infections.
- Safety in the home and experience with and risk of abuse and exploitation by family members, partners, or others, or living in fear of abuse, particularly with the I/DD and elderly populations. Partner abuse should include physical, mental, and financial abuse. Often, admittance to partner abuse depends upon where the assessment takes place and how many times the assessor asks the questions.
- Substance abuse, both the person's current and historical experience of substance abuse. The relevance of the person's response to this question will lead to important follow-up questions regarding nature of substance, how often it is used, etc. Various

⁹ F.D. Wolinsky, P. Ayyagari, F. Ullrich. Identifying Rehospitalization Trajectories and Their Antecedents. CMS and RTI, August 2012.

kinds of substance abuse have been shown to be risk factors for hospital readmission, depression, and suicide, particularly for female populations.

- If applicable, caregiver’s reported stress, and available respite services, as well as other family caregiver services and supports, such as information about managing chronic conditions, education and training on direct care skills, and counseling for the family caregiver. Caregiver strain and burden has been shown to affect the outcome of their client. Sample questions include: “How often in the last month have you gone out of the house on your own?”, “How would you rate your health?”, and brief depression screenings.

Third Work Session: Development of Next Steps

The discussion about next steps in advancing the use of standardized assessment items needs to start with the understanding that much has already been accomplished at both the state and federal level. A few states have designed and, in some cases, implemented standardized assessment items for use statewide across programs and/or population groups. At the same time, the federal government, largely through CMS, has worked on standardizing assessment items for the Medicare program and is working on adapting some of these items to serve Medicaid purposes.

The federal government will not impose specific standardized items on state programs— even those programs with partial federal funding. Instead, the Federal government is making resources available to states to use to build interoperable data systems for the LTSS program populations. These efforts to advance the use of standardized items can be strengthened by work through national organizations of state officials (such as the National Association of Medicaid Directors) to develop approaches that have broad acceptance by the states. For states that have recently implemented, or are in the process of implementing comprehensive uniform assessment systems, an approach may be needed to encourage a smooth transition. It may also be necessary to provide financial support or some incentive as in the BIP program to enable those states to modify their instruments and data systems.

The collaborative process coming out of this Roundtable should provide a framework for the states to approach the use of standardized items. As a first product, the Roundtable discussion should generate a Concept Paper that presents the tiered approach to the assessment process and assessment instruments (e.g., pre-eligibility, level-of-care eligibility, program-specific assessments) that was discussed in the Roundtable, and provides a checklist for states to use in considering the components that should be incorporated in an overall system of assessments.

Several efforts are under way to document inconsistencies in items in different assessment instruments and to suggest approaches to developing standardized items and encouraging use of these items. As a follow-up activity to the Roundtable, those working on these various activities should meet and pool their efforts to develop a single document that states can use as a resource in determining how to move forward on developing and incorporating standardized assessment items.

The CARE tools provide one set of items that have been standardized for use across Medicare acute and post-acute settings. States have raised questions about the extent to which the CARE tools should be considered in developing assessment tools for Medicaid LTSS. There is some concern about the differences between the interRAI instrument, which many states now use for Medicaid waiver assessments, which is based on Medicare's MDS 2.0 version of the mandated assessment instrument for SNFs, and the CARE instrument that was designed in relation to Medicare's MDS 3.0 instrument. CMS is not proposing to apply CARE per se to Medicaid, but CARE does include standardized items that would be appropriate for states to use in Medicaid assessments. CMS is currently testing in the TEFT demonstration initiative a set of CARE items that have been modified for home and community-based services. This demonstration may lead to a core set of items for use with the Medicaid HCBS waiver program in the future and that would be exchangeable with the Medicare-participating providers serving those individuals.

A useful next step following the Roundtable would be to convene a small expert group to prepare a guide for states that would include a vision for tiered assessment tools using standardized items that would enable person- and family-centered assessments, interchange of data across settings, sparing and efficient interview and assessment processes, care coordination around a single shared care plan, and monitoring of care delivery and accountability for outcomes. The guide would identify sources for standardized, reliable, assessment items and a pathway for states to follow in moving toward a common core of shared assessment data and comprehensive approach across state programs to person- and family-centered assessment of LTSS needs.

Another aspect of sharing assessment information around a core of standardized items is integrating the assessment tools with an IT platform that enables assessment data to be exchanged across sectors. This information exchange capability is critical to enabling community providers to communicate with clinical providers and participate in coordinating care around a single care plan. The work that is underway at the Office of the National Coordinator (ONC) on data interchangeability and health information exchanges is critical to

developing the mechanisms for information exchange. In addition, work underway at the National Quality Forum on person- and family-centered measures of LTSS quality should be factored into the overall discussion on assessment instruments. As a follow-up to the Roundtable, LTQA should convene a working group to map and describe the activities in these three dimensions: assessment instrument content, the health information exchange platform, and quality measures. This work should also be documented in materials for states to reference in bringing these dimensions together in their own assessment development work.

Finally, LTQA needs to follow-up the Roundtable, and the post-Roundtable work, by maintaining and growing the community of individuals working on common assessment items and comprehensive assessment systems in federal and state government and in the research community. LTQA should build an Internet platform that members of this community can use to share information with and solicit information from others working on these issues and to access best practices and the latest and most helpful documents and tools to further their work in this area. As part of this community, it will be important to ensure that a full array of relevant stakeholders, including medical and community providers, caregivers, and individual and family consumers are engaged in the community and participating in the dialogue and working committees advancing standardized assessment items and the development of integrated clinical and community delivery systems.

The work of the Roundtable is hereby presented to the Board of the LTQA with the understanding that the Board will take responsibility for developing and advancing a more specific work plan for the Alliance and for the community of individuals and organizations working to advance the data, IT, and care planning and care coordination infrastructure that needs to be in place to support person-and family-centered LTSS integration and improved quality and choice of services and supports.



Charting a Path Forward for Uniform Assessment of LTSS Needs

The Brookings Institution • Washington, DC
May 5 & 6, 2014

Agenda

Monday, May 5

Dinner

Saul/Zilkha Room - 1st Floor

- 7:00 pm** **Welcome and Overview**
Rene Seidel, The SCAN Foundation
- 7:15 pm** **Introductions**
- 7:45 pm** **Discussion of Agenda for the Meeting**
Larry Atkins, Long Term Quality Alliance
- 8:15 pm** **Background Discussion -- State of Assessment Standardization**
Barbara Gage, Engelberg Center for Health Care Reform, The Brookings Institution

Tuesday, May 6

Roundtable

Stein Room - 2nd floor

- 8:00 am** **Opening Remarks**
Larry Atkins
- 8:15 am** **Overview of leading Federal standardization initiatives**
Federal Development of Assessment Item Library
Stella Mandl, Centers for Medicare & Medicaid Services
CMS Initiative to Assist States in LTSS Item Standardization
Anita Yuskas, Centers for Medicare & Medicaid Services
Balancing Incentives Program (BIP) Core Assessments
Kerry Lida, U.S. Department of Health and Human Services
- 9:15 am** **Overview of Current State LTSS Initiatives**
Participant Presentations on State Activities
State Attendees
Initiating reasons
Stage of development
Extent of standardization

- 10:30 am Break**
- 10:45 am First Work Session: Prioritization of Domains and Concepts**
 Overview of Domains and Concepts Common across States
 Barbara Gage
 Selection of Priority Concepts for Initial Standardization
 Across Programs within State (No Wrong Door)
 Across States to Allow Comparability of Costs/Outcomes
 Tabling of Concepts for Further Work on Resolution
 Determination of Potential for Consensus on Selected Concepts
- 12:15 pm Lunch**
 Mark McClellan, Initiative on Innovation and Value in Health Care, The Brookings Institution
- 12:30 pm Second Work Session: Development of Standardized Items**
 Barbara Gage – *Moderator*
 Overview of Differences among States on Items Measuring a Concept
 In-depth Discussion of Certain Concepts Common across Programs
 Recommendations for Specific Work to be Done to Develop Standard Language
- 2:15 pm Break**
- 2:30 pm Third Work Session: Development of Next Steps**
 Larry Atkins– *Moderator*
 Identification of Barriers to Widespread Adoption of Standardized Core Items
 Strategy for Overcoming Barriers, Implementing Standardized Core Items
 Proposal to the LTQA Board
 Growing the Community Engaged in Assessment Instrument Issues
 Using the Community to Further Resolve Issues with the Items or Their Widespread Adoption.
- 3:30 pm Closing Remarks: Next Steps**
 Larry Atkins



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Participant List

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