



**Attachment 2A:  
Access and Choice Design Team Assessment Tools Technical Subgroup Report  
Team Member Reviews of Selected Assessment Instruments  
August 16, 2011**

**Background and Purpose:**

According to Design Team parameters, the People First Waiver will include: “a standardized needs assessment instrument and/or tool that will be consistently applied across the People First Waiver to determine each individual’s strengths, needs, and preferences. This needs assessment tool will be used to allocate resources equitably and will be administered by an entity that is independent from service delivery.”

The Access and Choice Design Team chartered the Assessment Tools Technical Subgroup to review selected needs assessment instruments used in other state systems for people with developmental disabilities. The primary purpose of this task was to provide information on various assessment domains and factors (including administrative and other considerations) used to assess the need for supports and services. This information allowed the Access and Choice Design Team to make informed recommendations related to charter questions on needs assessment. It was not the purpose of the Assessment Tools Technical Subgroup or the Access and Choice Design Team to make a final recommendation on what assessment tool(s) should be used in the People First Waiver (see report of the Assessment Tools Technical Subgroup for further information on the team’s charge).

The following tools were reviewed by the team:

- **Developmental Disabilities Profile (DDP) adapted by other states**
- **Supports Intensity Scale (SIS) *national tool***
- **Inventory for Client Assessment and Planning (ICAP) *national tool***
- **Florida Situational Questionnaire**
- **Connecticut Level of Need (LON)**
- **Wisconsin Functional Screen**
- **the Child and Adult Needs and Strengths (CANS) assessment**
- **Health Risk Screening Tool (HRST)**

Methods for obtaining the data summarized in the chart below included the following: review of the instruments and comparison to OPWDD’s DDP; web-based research; phone calls to state officials, stakeholders, and others (see Appendix B for Resources). The chart identifies the questions that each team member was assigned to answer as part of their review of each tool. Areas left blank indicate a need for more information.



As a next step, the Assessment Tools subgroup recommends that one or more knowledgeable consultants be brought in to take the teams work to the next level by further analyzing and assessing the most efficient, person-centered, and cost-effective means to implement a systems wide needs assessment. Such an analysis should detail the costs vs. benefits (from individual and systems perspective) of revamping the current DDP tool used by OPWDD vs. adopting a different nationally recognized instrument such as the SIS with appropriate adaptations/supplements for NYS use and the CANS.



Details on Assessment Tools Reviewed by Team Members

Tool Reviewed	Background
OPWDD Developmental Disabilities Profile 2 (DDP2)	The DDP 2 was designed by OPWDD (then OMRDD) to document key characteristics of persons with developmental disabilities simply and briefly. DDP 2 initially developed over 20 years ago to inform ICF and Day Treatment rate setting methodologies.
Developmental Disabilities Profile (Kansas)	The Kansas Department of Social and Rehabilitation Services (SRS), which is the state’s DD agency, has been using the DDP (BASIS) for purposes of establishing funding levels since 1992. Kansas originally selected the DDP because of its validity and reliability at the time and because it was available at no cost. However, it appears that only the DDP information is used for purposes of establishing payment for services.
DDP (Ohio)	Ohio transitioned to the DDP based reimbursement system in 2007.
Supports Intensity Scale (SIS)	Published by the American Association on Intellectual and Developmental Disabilities to measure practical support requirements of adults with intellectual and developmental disabilities in 85 daily living and medical and behavioral areas.  Studies have been conducted comparing the SIS to other instruments and to reliability in the field. Developed over five years by experts and then field tested and it is used by over 20 states.
Inventory for Client and Agency Planning (ICAP)	The ICAP can be used to assess children and adults with developmental disabilities, people who become handicapped as adults through accident or illness, and elderly people who have gradually lost their independence often need special assistance at home, at school and at work are.
Florida Situational	The current questionnaire is a redesign of another tool they used. They developed the QSI with input from behavioral specialists, family members, self-advocates, clinicians including speech/language pathologists and occupational therapists, state workers and administrators. Upon its finalization, training was done for the assessors. They are hired by the state although they receive no full-time benefits. They receive significant training and must participate in inter-rater reliability on a regular basis. Florida assessed 30,000 individuals with disabilities in 18 months following the training of their assessors.



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Connecticut Level of Need	<p>The state was using its own tool called the Waiting List Assessment. It was not judged as sufficiently comprehensive so CT set about a large scale instrument development effort using funds from a CMS Real Choice type (systems change) grant in 2003. This was a multi-phase, multi-year effort led by a consultant from the University of Conn. Following extensive literature review, a multi-disciplinary team was formed and started the design process qualitatively by holding focus groups and doing key informant interviews with all stakeholder types. The tool was iteratively revised and pilot tested over three phases with a cumulative case total involving over seven thousand assessments. . Reports have shown that this tool is reliable and valid.</p>
Wisconsin Functional Screen	<p>During development, stakeholders were at state meetings and many rounds of sample tests were performed. The screen was developed over years prior to implementation.</p> <p>The tool incorporates both the medical and independent living aspects in one tool. The algorithms behind the screen are predictors of need for nursing home levels of care. The state had a lot of interaction with the public and counties when this was developed. They continue to do thorough interaction with screeners about clarity and training.</p>
Child and Adolescent Needs and Strengths Assessment (CANS)	<p>A multi-purpose tool developed for children’s services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Versions of the CANS are currently used in 25 states in child welfare, mental health, juvenile justice, and early intervention applications.</p> <p>To decide on the CANS, states form a cross-system group and reviewed other tools, they then developed the CANS to meet their states needs. Development took from 7 months to 2 years.</p>
Health Risk Screening Tool (HRST)	<p>Created in 1992, The Health Risk Screening Tool (HRST) is a web-based rating instrument developed to screen for health risks associated with a wide variety of disabilities, including developmental disabilities, physical disabilities, disabilities associated with aging, and many other conditions, which specifically affect systems of the body and the person’s ability to engage in functional activities. It was field tested on 6000 individuals and is used in at least 4 states and by private providers.</p>
<b>Tool Reviewed</b>	<b>How are resources allocated based on the assessment?</b>



OPWDD Developmental Disabilities Profile 2 (DDP2)	Funding levels for the Consolidated Supports and Services program are determined using the DDP 2. The DDP 2 is still used to inform and/or determine reimbursement levels in certain programs such as ICF/DD, Day Treatment, Family Care, IRA rate appeals/price adjustments for staffing needs.
Developmental Disabilities Profile (Kansas)	<p>Score results in the assignment of an individual to one of five funding tiers. Each program or service type has a different payment amount for each tier.</p> <p>In home supports is paid entirely outside of the tier method and unrelated to the results of the DDP assessment since it was not useful for this purpose.</p> <p>Each tier also has a “super-tier” which is higher for each service based upon the need for extraordinary care. The super tier levels were established to address individuals being deinstitutionalized from state developmental centers in the process of closure, such individuals typically exhibited either high medical or high behavioral needs (or both). Since the DDP does not distinguish frequency of behavioral episodes, the super-tier designation is not driven by the DDP results. Such designation is based upon anecdotal information and negotiation between the provider and the state.</p>
DDP (Ohio)	DDP in Ohio is used to determine the funding limits or thresholds that an individual requires and is used throughout the state of Ohio for all persons served in the Options Waiver. DDP links the assessment of the individual to funding range. An Individual Service Plan is then developed. The ISP identifies the actual services needed by the individual and develops a funding level based on the funding range. Once the funding level and ISP is established, the actual funding for specific services is developed based on a “Cost Projection Tool”.
Supports Intensity Scale (SIS)	<p>Two types of methodology:</p> <ol style="list-style-type: none"> <li>1. Development method – based on the person centered plan and once completed is used to calculate the budget. Works well for individuals but does not necessarily ensure resources are distributed evenly</li> <li>2. Prospective method – relies on collection of data relating to costs incurred by each person, and determinants, including geography, support needs, regulatory factors. Formulas created to describe those relationships, Individualized Budget Allocation generated</li> </ol> <p>Two types of payments</p>



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	<ol style="list-style-type: none"> <li>1. Prospective Budget or individualized Budget Amount which sets an upper limit on funding authorized to purchase goods and services on a person behalf. Persons with similar needs have similar global budgets.</li> <li>2. Service Payments sets standardized provider payments for the delivery of particular services, taking into account differences in support needs of propel served by the provider. This is the Level Base Amount.</li> </ol>
Inventory for Client and Agency Planning (ICAP)	The ICAP was not originally developed to support rate determination or resource allocation strategies, although it has been employed in several states to do so.
Florida Situational	Florida is converting to the iBudget (Individualized Budget) over the next 10 months and will use the Florida Situational to do that.
Connecticut Level of Need	<p>The LON is used to generate a need score ranging from 1 to 8. A predetermined payment figure per score category and within program type 'bands' (day hab, supported employment, differing intensities of residential settings) is then allotted for the person's service provision. Health needs are included and the only carve outs are for transportation and respite, which are covered in a separate state waiver (Individual and Family Support Waiver).</p> <p>The instrument is used for all people in the service system for planning and DD systems analysis; however the rate setting application has been implemented gradually. At first only new entrants were incorporated into the LON financial methodology but this caused confusion and unhappiness with widely disparate payments within and between providers case mix. The state is now struggling with a phased in, FULL implementation of the methodology. All day programs have now switched to the new payment scheme, with core type residential service modules to follow sometime in 2012.</p>
Wisconsin Functional Screen	Capitated payments are provided to the managed care agencies based on the level of care. Carve outs are present (personal care is a carve out of the self-directed (IRIS) model, Medicare services are carved out of Family Care and IRIS models)
Child and Adolescent Needs and Strengths Assessment (CANS)	One state takes a base rate and then multiplies an amount by any elements that had "high" scores showing need.
Health Risk Screening Tool (HRST)	The individual ratings and overall score derived from the Health Risk Screening Tool guide the independent support coordinator and health care manager in the provision of appropriate levels and types of health care support and surveillance. Overall scores are used to assign a HEALTH CARE LEVEL, which is associated with a specific DEGREE OF



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HEALTH RISK.								
Tool Reviewed	Domains							
OPWDD Developmental Disabilities Profile (DDP) 2	Disability description/ diagnosis	Medical	Sensory Motor	Cognitive/ communication	Behaviors	Self Care/Daily Living/ADLs	Clinical Services	
DDP (Kansas)	Same as above							
DDP (Ohio)	Same as above							
Supports Intensity Scale (SIS)	Community Living	Exceptional medical	Employment	Social Activities	Exceptional Behavioral	Lifelong Learning	Health/ Safety	Protection & Advocacy
Inventory for Client and Agency Planning (ICAP)	Community Living		Motor skills	Social and communication	General maladaptive behavior index	Personal Living Skills		
Florida Situational	Community inclusion and fulfillment	Physical status	Functional status		Behavioral intervention and support status	Essential living skills		
Connecticut Level of Need	Unpaid Support	Health & Medical	Social Life, Recreation, and Community Activities	Comprehension and understanding, and Communication	Behavioral and Mental Health	Home or Residence and Day, school, job or vocational level of Support	Transportation	Overnight support, monitoring or assistance



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Wisconsin Functional Screen	Demographics & living situation	Diagnoses (with medical diagnoses)	Risk	Communication and Cognition	Behaviors/Mental health	ADLs	Health Related Services	Overnight Care & Employment
Child and Adolescent Needs and Strengths Assessment (CANS)	Life domain functioning	Strengths (individual & environmental)	Risk behaviors	Acculturation	Behavioral / emotional needs	Developmental needs	Co-morbidities	Caregiver strengths & needs
Health Risk Screening Tool (HRST)	Functional Status	Physiological	Frequency	Safety	Behaviors			
<b>Tool Reviewed</b>	<b>How is person-centered planning and individual life goals integrated with needs assessment?</b>							
OPWDD Developmental Disabilities Profile 2 (DDP2)	No consistent process that connects the DDP information with the individual’s person-centered service plan.							
Developmental Disabilities Profile (Kansas)	--							
DDP (Ohio)	--							
Supports Intensity Scale (SIS)	A functional needs assessment tool that when used in conjunction with a person-centered planning process leads to a plan that addresses the individual’s hopes and dreams by identifying areas of support.							
Inventory for Client and Agency Planning (ICAP)	--							
Florida Situational	Assessor meets with a nurse, a waiver support coordinator, and a behavior support coordinator. From there another support coordinator meets with the individual and family and determines an individualized budget and life goals.							



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Connecticut Level of Need	The individual and family are part of the team that provides input to the case manager completing the tool. And this tool drives development of the plan.
Wisconsin Functional Screen	Long Term Care program focuses on individual requested outcomes correlating to the screened assessment of needs.
Child and Adolescent Needs and Strengths Assessment (CANS)	Tool does not use “diagnostic” or “medical” language and looks at the functioning level and strengths of the individual.
Health Risk Screening Tool (HRST)	Typically used in conjunction with an assessment tool.
<b>Tool Reviewed</b>	<b>How does the needs assessment process lead to a comprehensive care plan?</b>
OPWDD Developmental Disabilities Profile 2 (DDP2)	---
Developmental Disabilities Profile (Kansas)	--
DDP (Ohio)	--
Supports Intensity Scale (SIS)	SIS is designed to identify needs and updates will show how those needs might fluctuate. It can be the basis and reference point for a person-centered plan.
Inventory for Client and Agency Planning (ICAP)	--
Florida Situational	Score helps to determine a support level and the assessment is then used by “service coordinators” to develop the comprehensive care plan.
Connecticut Level of Need	The individual and family are part of the team that provides input to the case manager completing the tool. And this tool drives development of the plan.



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Wisconsin Functional Screen	The assessment correlates to outcomes on the Person Centered Plan. To the degree possible, individuals choose their level of requested assistance. There is a level of risk when choosing no assistance in a needed area.
Child and Adolescent Needs and Strengths Assessment (CANS)	The tool is designed for communicating with the individual and other stakeholders so that a comprehensive plan can be developed. In certain states, it is helps develop treatment planning and any areas identified as high need are required to be addressed in the plan.
Health Risk Screening Tool (HRST)	Tool used as a preliminary measure before the plan is developed, the score and outcome is shared with the team that is responsible for the care plan.
<b>Tool Reviewed</b>	<b>How are changes in life circumstances taken into account after the assessments are completed and resources, supports and services allocated, i.e. what triggers a reassessment? How often are needs assessed?</b>
OPWDD Developmental Disabilities Profile 2 (DDP2)	<ol style="list-style-type: none"> <li>1. Within thirty days of when an individual moves to a new program/service,</li> <li>2. Whenever a significant change occurs to an individual's characteristics,</li> <li>3. At least every two years</li> </ol>
Developmental Disabilities Profile (Kansas)	<ol style="list-style-type: none"> <li>1. When entering the system</li> <li>2. Every year</li> </ol>
DDP (Ohio)	--
Supports Intensity Scale (SIS)	<ol style="list-style-type: none"> <li>1. When entering the system</li> <li>2. Every four to five years</li> <li>3. Recommended when there is a significant change</li> </ol>
Inventory for Client and Agency Planning (ICAP)	--
Florida Situational	<ol style="list-style-type: none"> <li>1. Within months of entering the system</li> <li>2. When there is a change in health (physical, behavioral and mental) or unpaid caregiver support and when there is interaction with the criminal justice system.</li> </ol>



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	3. Every 3 years		
Connecticut Level of Need	<ol style="list-style-type: none"> <li>1. Completed Annually</li> <li>2. Whenever there is a significant change in service that needs to be addressed.</li> </ol>		
Wisconsin Functional Screen	<ol style="list-style-type: none"> <li>1. Completed Annually</li> <li>2. Whenever there is a significant change, such as a new diagnosis, living arrangement, or a change in ability/independence</li> </ol>		
Child and Adolescent Needs and Strengths Assessment (CANS)	<ol style="list-style-type: none"> <li>1. Completed within 30 days of placement or before authorization of services</li> <li>2. Flexibility</li> <li>3. Some states require an update every six months</li> </ol>		
Health Risk Screening Tool (HRST)	1. Usually annually and whenever there is a significant change (dependent upon the policies in each state).		
<b>Tool Reviewed</b>	<b>Which organizations administer the tool?</b>	<b>What are the qualifications of the organizations &amp; assessors?</b>	<b>What is the role of the state?</b>
OPWDD Developmental Disabilities Profile 2 (DDP2)	Agencies delivering the service	A staff member who knows the person best and consults with clinical staff or family members, as necessary.	Aggregate DDP-2 data is to be used to describe, plan, and manage the system of services. State also completes DDP2s as it delivers services.
Developmental Disabilities Profile (Kansas)	Not-for-profit agencies or local governmental units, which may be service providers.	A person, who is not a case manager, but is a professional that receives quarterly training.	Assigns level of payment based on an individual's score.
DDP (Ohio)	County level government, which may be service providers.	A county staff person who is trained and certified.	--
Supports Intensity Scale (SIS)	States can decide. Counties, state staff, contracted employees, does not appear to be	Human service professional with a four-year degree	--



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	direct service providers when it is implemented in a state-wide fashion		
Inventory for Client and Agency Planning (ICAP)	--	Professional who has known the person for at least three months and sees the person on a daily basis.	--
Florida Situational	State.	Bachelor's degree and 4 years of professional experience with individuals with developmental disabilities. Preference given to those with 2 years experience in working in direct services. Staff cannot be employed by an agency that provides services to individuals with DD. Must pass a two- day training.	The state administers the assessment
Connecticut Level of Need	State agency	Qualifications are similar to a Medicaid Service Coordination (Associates Degree in a social services field and one year experience working with individuals with DD)	The state processes the assessment and assigns a level of need category.
Wisconsin Functional Screen	Initial screening is done by a state regional office. Agencies and MCOs perform updates.	Bachelor's degree in a human services field and 2 years of online certification	
Child and Adolescent Needs and Strengths Assessment (CANS)	Providers of service, county and state workers	Flexible. Although some states require a bachelor's. Online certification that lasts 6 months to two years.	Quality oversight and assignment of base level payment.
Health Risk Screening Tool			



(HRST)  <b>Tool Reviewed</b>	<b>How is quality of the needs assessment determined?</b>
OPWDD Developmental Disabilities Profile 2 (DDP2)	Not Applicable
Developmental Disabilities Profile (Kansas)	There is quarterly training for assessors as well as assessor reviews to test for inter-rater reliability.  Assessors may also be service providers but must have a separate supervisory structure for the contracted assessment function.
DDP (Ohio)	Administered by trained, certified county professionals.
Supports Intensity Scale (SIS)	Developed over five years by experts and then field tested. Studies have been conducted comparing the SIS to other instruments and to reliability in the field.
Inventory for Client and Agency Planning (ICAP)	Designed to be administered by a professional who has known the person for at least 3 months and sees the person day to day.
Florida Situational	Assessors have distinct educational and experience requirements and then they are trained for a minimum of 2 days in the classroom. They also are given an online test that gives them potential situations to consider. They engage in inter-rater reliability testing to ensure consistency.
Connecticut Level o f Need	When contested, assessments may be formally reviewed by a Program Review Administrative Team that may revise items that result in changing funding scores. Any supplemental rate awarded has a utilization review.
Wisconsin Functional Screen	Quality assurance includes the assessor completing an online certification course, inter-rater reliability testing, random sampling for accuracy and consistency, and new assessors have monitoring and mentoring, State staff review screens and quality assurance methods and agencies must correct and amend screens that are done incorrectly.
Child and Adolescent Needs and Strengths	Reviews that include how the CANS has been integrated into the plan. Auditors score the CANS against the information in an individual's record to see if they arrive at the original score. And recertification training includes inter-reliability testing.



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Assessment (CANS)	
Health Risk Screening Tool (HRST)	Scores that identify potential health and safety risk issues are reviewed by nurses and medical professionals. Reports and results can be shared with auditing and reviewing parties. There is ongoing training and technical assistance for providers who need it.
<b>Tool Reviewed</b>	<b>What is the involvement of families i.e. is it transparent and how are families apprised of the tool?</b>
OPWDD Developmental Disabilities Profile 2 (DDP2)	--
Developmental Disabilities Profile (Kansas)	--
DDP (Ohio)	--
Supports Intensity Scale (SIS)	All states reviewed have a mandatory requirement that the individual and their family be shown how SIS works (or have information sites and booklets). Individuals and families can be trained on the instruments.
Inventory for Client and Agency Planning (ICAP)	--
Florida Situational	Families can access the website to learn more about the assessment.
Connecticut Level of Need	Self-advocates and families were involved in the development of the assessment. Through outreach and education, transparency and family understanding have grown in the last five years ago.
Wisconsin Functional Screen	Individuals and families are told about the process and shown the screen in paper format (they can have a copy if they wish). The screen, instructions for the screen and all webcast training are online for anyone to view. All eligibility determinations from the screen are formally appealable; individuals can request a 2nd screening by a different screener.
Child and Adolescent Needs	Tool is made available online and agencies performing assessments are to tell families about the tool.



and Strengths Assessment (CANS)		
Health Risk Screening Tool (HRST)	The tool can be shared with the family and individual. The HRST does not need the family and individual present, as it can sometimes be completed through a record review.	
<b>Tool Reviewed</b>	<b>Strengths</b>	<b>Weaknesses</b>
OPWDD Developmental Disabilities Profile 2 (DDP2)	<ul style="list-style-type: none"> <li>• Past studies have indicated that the DDP can successfully predict support staffing needs.</li> <li>• The DDP is relatively simple and quick to complete and score.</li> <li>• It can be completed by direct support professionals</li> <li>• OPWDD has heavily invested in the infrastructure of the DDP as the Tracking and Billing System (TABS) is built on DDP fields. In addition, data from the instrument has been used for research and planning functions over the last 20+ years so there is availability of a large quantity of data from which to use as a baseline for future comparisons.</li> </ul>	<ul style="list-style-type: none"> <li>• The instrument is deficit based instead of strengths-based</li> <li>• the DDP does not include sufficient information on natural supports and community safety needs</li> <li>• Inconsistent results depending upon who is administering the instrument</li> <li>• Duplicative processes—required too many times in too many settings</li> <li>• Insufficient training on how to administer it</li> <li>• Since DDP results may relate to provider reimbursement levels, it could be construed that incentives exist to skew results</li> <li>• The DDP is outdated and has not kept up with advances in the field of developmental disabilities</li> <li>• Instrument does not assess individual’s preferences.</li> </ul>
Developmental Disabilities Profile (Kansas)	<ul style="list-style-type: none"> <li>• Originally selected because of its validity and reliability at the time and because it was available at no cost.</li> </ul>	<ul style="list-style-type: none"> <li>• The DDP fails to account for depth of need in behavioral supports, medical conditions and physical disabilities</li> <li>• Does not truly weight needs across the system or uniformly weight needs</li> <li>• Individuals felt that they were not assigned to the</li> </ul>



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		<p>appropriate tier</p> <ul style="list-style-type: none"> <li>• Important adaptive behaviors such as the ability to see, hear and walk without assistance have no weighted value</li> <li>• Not appropriate for children</li> </ul>
DDP (Ohio)	--	<ul style="list-style-type: none"> <li>• Uses additional assessment tools to make up for the limitations of the DDP.</li> </ul>
Supports Intensity Scale (SIS)	<ul style="list-style-type: none"> <li>• SIS is rationally rooted and due to its high inter-rater reliability is likely to be equitable</li> <li>• SIS was developed through rigorous process that incorporated current best practice</li> <li>• Been used in over 20 states, and has built a substantial body of data and ability to compare needs and costs across states. Data can be used to acquire and order data at a granular level</li> <li>• While not endorsed by CMS it appears to be aligned with their view of best practice</li> <li>• SIS methodology is transparent and directly involves the person with I/DD</li> <li>• SIS allows for personal growth and development and potential reduction of support needs</li> <li>• SIS has multiple options for access including web based or static</li> <li>• Nationally organized with ability to assist states in comparing services and cost to other states and insulated from established political arrangements and the provider industry.</li> <li>• Supports need based rather than deficit based and is based on employment first perspective</li> </ul>	<ul style="list-style-type: none"> <li>• Initial and ongoing costs to use as it is a proprietary, copyrighted instrument</li> <li>• There is substantial training required, which is ongoing</li> <li>• SIS may need to be supplemented (e.g. HRST) for certain health and behavioral areas in addition to being modified to take into account regulatory requirements</li> </ul>



	<ul style="list-style-type: none"> <li>• Readily adaptable as a budgeting tool</li> <li>• Can apply to spectrum of peoples’ needs as the approach permits access to services from multiple perspectives and providers of health services</li> <li>• Already translated into many languages</li> </ul>	
Inventory for Client and Agency Planning (ICAP)	<ul style="list-style-type: none"> <li>• According to Colorado report, strengths include the following:             <ul style="list-style-type: none"> <li>○ Reliable for measuring adaptive and problem behavior</li> <li>○ Acceptably differentiates among individuals with respect to extent of adaptive and maladaptive behavior</li> <li>○ May be applied to both children and adults</li> <li>○ Exhibits psychometric properties</li> <li>○ Supports compiling robust information concerning people receiving services</li> <li>○ Scoring is relatively straightforward</li> <li>○ Is in relatively wide-use among states in various applications</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Initial and ongoing costs to use as it is a proprietary, copyrighted instrument</li> <li>• Minimal information is collected on the individual’s health status and health status is not considered in calculating the Service Level Index score.</li> <li>• Tool is not widely used to support the development of individual service plans.</li> <li>• Adaptive behavior scoring does not directly measure the frequency or intensity of the support necessary to assist the person.</li> <li>• Tool does not collect info about the extent to which non-paid caregivers are available to meet individual needs</li> <li>• Does not have much on employment/vocational supports</li> <li>• Is deficit based rather than strengths based</li> <li>• May have inherent biases based on the type of individual completing it</li> <li>• The same behavior can be rated again in several categories. Allowing for errors in scoring.</li> </ul>
Florida Situational	<ul style="list-style-type: none"> <li>• Allowed the state to have good data collection for placement issues.</li> <li>• The tool helps to identify extraordinary needs; this is useful for individualized budgeting.</li> <li>• The tool assists the support coordinator to get to know new people.</li> </ul>	<ul style="list-style-type: none"> <li>• Does not specifically address subpopulations (i.e., dual diagnosed, aging, children, hearing impaired, individuals with seizures, individuals in residential settings)</li> <li>• There should be more questions regarding the continued availability of care providers. An example would be to understand the physical capabilities and condition of care</li> </ul>



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	<ul style="list-style-type: none"> <li>• Research supports that the tool is reliable and that it measures what it is intended to measure.</li> </ul>	<p>providers.</p> <ul style="list-style-type: none"> <li>• Scales are built on the expectations of deficits and levels of interventions. Deficiency – based approach.</li> <li>• It does not address individual interests or related needs for support.</li> <li>• Based on the “medical model.”</li> <li>• Not consistent with individual choice, self-determination.</li> <li>• Self advocate experts do not consider the language used in the targeted scales to be respectful of the people they are intended to assess. For example, item 23 is titled “self-protection”, yet the supports described in the rating scale are what others can do to the person rather than what the person can do to protect him or herself.*</li> <li>• Since 72% of individuals served in Florida live at home while another 8% live on their own, question about whether the scale truly reflects people who need group living. Level of supports determined by the tool did not truly correspond to the level of supports needed for an individual. For example: supervision in the community was difficult to score on this tool.</li> </ul>
Connecticut Level of Need	<ul style="list-style-type: none"> <li>• The instrument is short but covers a large amount of different domains.</li> <li>• The LON does not necessarily require supplemental assessments for rate setting purposes</li> <li>• The assessor requires advanced clinical training.</li> <li>• And though the form is copyrighted, CT’s view is that the tool is largely public domain as it was devised with federal money.</li> </ul>	<ul style="list-style-type: none"> <li>• The form is relatively new and has not been adopted by other states; thereby the validation data is not large.</li> <li>• There are questions about sensitivity to extreme ‘outlier’ needs or characteristics. This is attended to partially by way of open ended text fields and the ‘appeals’ process.</li> </ul>
Wisconsin	<ul style="list-style-type: none"> <li>• Can be completed by non-medical staff</li> </ul>	<ul style="list-style-type: none"> <li>• Individuals don’t always understand that their self-report</li> </ul>



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<p>Functional Screen</p>	<ul style="list-style-type: none"> <li>• Easy to administer and is not intimidating for individuals to answer questions</li> <li>• The training is available on-line</li> <li>• Computerized model enables quicker eligibility determinations</li> <li>• The functional screen and the individualized assessment process capture social and medical data in one place for care planning and provide consistency statewide.</li> </ul>	<p>isn't the only determinant in their eligibility and that medical verification is used as well as financial need for the service. This is especially true of people who might not understand the difference between services available for people whose service needs are due to mental health disabilities rather than physical/developmental disabilities.</p>
<p>Child and Adolescent Needs and Strengths Assessment (CANS)</p>	<ul style="list-style-type: none"> <li>• Takes into account where those needs are already being met by a natural support. In these instances, "formal" supports would not be offered or required unnecessarily.</li> <li>• It is a public domain tool. That means that it can be modified to meet the needs of a population or of the system. It also does not have proprietary costs and will be cheaper to use in the long run.</li> <li>• This tool does not require certain qualifications of the assessor. States can have the flexibility to mandate them.</li> <li>• OMH is already using this tool and OCFS is using the tool in their Bridges to Health Waiver.</li> <li>• Has been tested for reliability and validity</li> </ul>	<ul style="list-style-type: none"> <li>• Focuses on Children although there are variations that have been created for adults.</li> <li>• Would require modifications to address needs of subpopulations (e.g., medically frail, forensic, dually diagnosed)</li> <li>• May not be a weakness but a major difference between the CANS and the DDP-2 is that this tool is not specific (e.g. DDP-2 asks "can pick up a small object). As the CANS is a planning tool,</li> <li>• The idea is that where a person has needs, the actual plan would give the specifics to this.</li> <li>• Time would be needed to develop the tool to fit OPWDD's specific population</li> <li>• An algorithm would need to be developed to use as reimbursement.</li> </ul>
<p>Health Risk Screening Tool (HRST)</p>	<ul style="list-style-type: none"> <li>• According to contractor, CMS will reimburse 50% of cost of tool. CMS cited tool in Quality HCBS report for Georgia.</li> <li>• HRST comes with a software package with built in logic and decision trees. The software also makes</li> </ul>	<ul style="list-style-type: none"> <li>• This is a health risk screening tool; it is not an assessment tool and therefore would be a supplement to any assessment tool chosen.</li> </ul>



	<p>training and care planning recommendations based on responses.</p> <ul style="list-style-type: none"> <li>• The training is available on-line</li> <li>• Ability to aggregate health outcomes based on individual and trend over time as well as statewide aggregation or aggregation by specific categories such as DDSO or region.</li> <li>• Comes with a variety of aggregated reports. Company willing and available to write new reports upon request.</li> <li>• The electronic software package can interface with most other systems. For example, the HRST works well with the Supports Intensity Scale (SIS) in states such as Georgia that are using both instruments.</li> <li>• Web-based system allows individual information to be shared with a team of professionals and assists with the monitoring of health care needs. The tool was also developed to diminish incorrect results by detecting errors.</li> <li>• In general, the tool allows a proactive approach which results in decreased health crises which results in decreased costs.</li> </ul>	
<b>Tool Reviewed</b>	<b>Other Comments</b>	
OPWDD Developmental Disabilities Profile 2 (DDP2)	DDP could be revised to be strengths based and enhanced to include missing components from other instruments, however, revisions would need to be undertaken by trained professionals and tested for validity and outcome attainment.	



Developmental Disabilities Profile (Kansas)	--
DDP (Ohio)	--
Supports Intensity Scale (SIS)	<p>Other states:</p> <ul style="list-style-type: none"> <li>• Hawaii is currently using ICAP but switching to SIS for a more responsive tool to assess support needs</li> <li>• North Carolina switched from ICAP to NC SNAP to SIS</li> <li>• Oregon adopted SIS via ReBAR redesign process</li> <li>• Colorado adopted under pressure from CMS to create more equity in waiver spending</li> <li>• Georgia reformed its approach to services around IBA principles and adopted SIS</li> <li>• Missouri adopted SIS in response to growing HCBS waiver costs</li> <li>• Rhode Island using SIS to move to IBA environment</li> <li>• Utah went from ICAP to SIS statewide as PC policy and to control cost</li> <li>• There is some feedback that CMS has favored IBA adoption and is comfortable with SIS</li> </ul> <p>Populations: The SIS does not define need by disability or degree of illness, but instead assesses degree of support required, allowing for changed in conditions either internal to the person or exogenous</p>
Inventory for Client and Agency Planning (ICAP)	--
Florida Situational	<p>Discrete assessors complete the document. They use a number of tools including assessments, observation and interviews to gather their information.</p> <p>Florida assessed 30,000 individuals with disabilities in 18 months following the training of their assessors.</p> <p>Lessons learned:</p> <ul style="list-style-type: none"> <li>• Better marketing of the program – make sure individuals and their families understand the process.</li> <li>• Create additional buy-in from the field.</li> <li>• Be sure not to create unrealistic expectations for individuals and their families. There are still over 19,000</li> </ul>



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	<p>individuals waiting for services, some since 2003.</p>
<p>Connecticut Level of Need</p>	<p>The state was using its own ‘homegrown’ tool called the Waiting List Assessment. It was not judged as sufficiently comprehensive so CT set about a large scale instrument development effort using funds from a CMS Real Choice type (systems change) grant in 2003. This was a multi-phase, multi-year effort led by a consultant from the University of Conn. Following extensive literature review, she formed a multi-disciplinary team and started the design process qualitatively by holding focus groups and doing key informant interviews with all stakeholder types. The tool was iteratively revised and pilot tested over three phases with a cumulative case total involving over seven thousand assessments</p>
<p>Wisconsin Functional Screen</p>	<p>The initial screen is conducted independent of the MCO by county resource centers. MCOs cannot be involved with the screen prior to enrollment but can perform “rescreens”</p> <p>Training for the screen is conducted on-line. The online approach is more efficient and environmentally conscious. Easier to conduct calculations on-line and easier to transfer/share data. By using computerized model, eligibility determinations are prepared instantaneously upon completion of the functional screen.</p> <p>The LTC Functional Screen replaced another screening assessment. The new screen incorporates both the medical and independent living aspects in one tool. The LTC functional screen is correlative to the MDS in the Nursing Home setting. The algorithms behind the screen are predictors of need for nursing home levels of care. The old system was too open to screener bias to the outcomes.</p> <p>The state had a lot of interaction with the public and counties when this was developed. They continue to do thorough interaction with screeners about clarity and training.</p>
<p>Child and Adolescent Needs and Strengths Assessment (CANS)</p>	<p>The original CANS is for children and adolescents only, but ANSA (Adult Needs and Strengths Assessment) has been developed and it is specifically for adults. The tool is not specific to individuals with DD, but other states have modified the tool to incorporate this population.</p> <p>Some variations include the CAANS-DD developed for OPWDD IB Services and was modified to include individuals with dual diagnoses and the ANSA-T was modified to focus on individuals transitioning from school.</p> <p>All of the states included John Lyons (the creator of the CANS) as a consultant when deciding to implement the CANS in</p>



	<p>their state.</p> <p>The variations on the CANS have decision trees. Every person has a core of questions that are asked and then depending on other needs additional questions are included (e.g. if there is a history of addiction or criminal activity, more questions are asked).</p> <p>Lessons learned:          Do not implement statewide right away. Implement it regionally to better ensure that it is being integrated into the planning.          Do assessments of everyone before setting rates, as reimbursement may have to be reestablished otherwise). They wish they had a baseline using the CANS and then used it. They have found that most push back is due to the rates. They offered us to use any of their materials online and hoped we would share anything as well, if we chose to use this. They also felt that nothing was being asked of staff to do anything that they shouldn't already be doing (i.e. integrating the assessment and addressing the needs into a plan).          Wisconsin: They are still rolling it out and making changes. However, they wished they had done assessments of everyone before setting rates (they may have to reestablish the rates). They wish they had a baseline using the CANS and then used it. They have found that most push back is due to the rates. They offered us to use any of their materials online and hoped we would share anything as well, if we chose to use this. They also felt that nothing was being asked of staff to do anything that they shouldn't already be doing (i.e. integrating the assessment and addressing the needs into a plan).</p>
<p>Health Risk Screening Tool (HRST)</p>	<p>This type of tool could help providers be pro-active and prevent destabilization especially for more vulnerable populations. Direct care staff are typically non-medical, therefore, this screening could allow support staff to be aware of risks and prevent the probability of more intensive intervention. Identification of red flags allows for better planning.</p> <p>With the move to care management and care coordination with a managed care structure, this tool could provide preliminary health information in a useable way to establish baseline performance data. In addition to use at the individual level, it seems that the tool could be used to determine effectiveness of integrated care coordination/care management.</p> <p>Other States:</p>



- Oklahoma Developmental Disabilities uses the HRST as part of their health care policy.
- Louisiana uses it as part of the children’s waiver.
- State of Georgia uses it for their state DD waiver and it is integrated with the states electronic case management system. Georgia first used the tool in 1997 when a group of developmentally disabled individuals were being transitioned from a congregate care setting into the community. The HRST was used to indicate the level of nursing needs, services and supervision required.
- Kentucky is using the tool for 3,500 people with dd. Southern California used it to transition 390 individuals out of a developmental center and into the community.
- Tennessee, Oklahoma, and Florida use it to determine the type and extent of professional support and training and its use is mandated by policy.
- Tennessee’s Division of Mental Retardation Services (DMRS) requires that all recipients of residential services in the department receive a health care level determination using the Health Risk Screening Tool.
- In Illinois, people are re-rated within 3 - 6 months to determine if their health care status is stable.