

**Functional Assessment Team Summary
(Mental Health, Mental Retardation, Developmental
Disabilities, Brain Injury Commission)
September 19, 2007**

2004:

During the 2004 Legislative session, Iowa's Mental Health, Mental Retardation, Developmental Disabilities, Brain Injury Commission was given the following direction:

"Propose functional assessment tools and process to be used for establishing eligibility, integrated with chapter 249A eligibility tools and process 2(d)."

The Functional Assessment Team, composed primarily of county CPCs, provider staff, representatives of Magellan, legislative staff, DHS, and faculty and staff from the University of Iowa met for the first time on May 13, 2004. A consumer representative joined the team in spring 2005. Initial tasks identified at the first meeting were: 1) Define scope of work; 2) Define the processes related to clinical eligibility determination, case rate determination, and service authorization; 3) Determine the feasibility; 4) Test the proposed process; and 5) Describe the method for transitioning the state to the new process.

By July 2004, the team had reviewed numerous assessment tools and reviews compiled by the Iowa Consortium for Mental Health and reached some early conclusions:

- While the process of functional assessment should be common across disability populations (e.g., mental illness, mental retardation, brain injury across in adults and children respectively), the specific tools used will likely need to differ across disability groups. Global assessment tools do not capture the individual needs that contribute to each type of diagnosis.
- Developed the concept of "levels of assessment" which included:
 - Level I—Clinical Eligibility (individuals meets current diagnostic guidelines)
 - Level II—Functional Assessment (determines intensity of service needs)
 - Level III—Individual Service Plan (specifies services based on person-centered plan with direct consumer input)

While the legislation called for functional assessment to determine clinical eligibility, the group quickly came to the consensus that this should not be the case. The concern is that individuals may be doing well in part because of the services they receive, and if someone is indeed doing well, they should not run the risk of losing necessary services. There are tools that ask the rater to judge how the person would be doing without services, but these introduce significant reliability and validity disadvantages. As such, the group recommended that clinical eligibility for services should continue to be

determined by diagnoses and assessments generated via routine clinical processes, rather than by any kind of cut-off score from a functional assessment measure.

The group decided that we should focus on the Level II process. The Level III assessment (person-centered plan) is also mandated by rules although no single tool is specified. Through establishment of a single Level II assessment, the system would be able to look at matching an individual's level of need with a level of service option.

There was substantial discussion about the role of functional assessment in case rate determination. Other state systems (e.g., Wyoming) have looked at this issue closely and have been able to quantify the degree to which functional level predicts costs across various disability populations. It turns out that functional level contributes a very small portion of the overall variance in costs – so even a highly reliable and valid method of functional assessment would not add a lot of information to case rate determination.

The team conducted some preliminary analyses of relationships between functional assessment and costs – and found essentially no correlation. However, this analysis looked only at county dollars, and it is possible that if all payer information had been included, a more robust relationship might have been found. Conceivably, as the data warehouse becomes fully functional, this is something that can be looked at again.

2005:

During the 2005 Legislative session, the commission was given the following direction:

“During the fiscal year beginning July 1, 2005, develop uniform functional assessment tools and processes for adult persons receiving disability services funded by the state or counties.” (HF 876, Section 1, D)

Throughout the rest of the fiscal year, the team discussed and reviewed processes around how best to implement an assessment process. By taking advantage of work that was done through Iowa's first “Real Choices Systems Change” grant from CMS, the group was able to review a wide variety of functional assessment instruments for individuals with mental illness and MR/DD across the age spectrum. The group agreed to pilot some of these instruments to determine feasibility, face validity, and practical utility.

The functional assessment team selected the LOCUS (Level of Care Utilization System for Psychiatric and Addiction Services) assessment for persons with mental illness for this pilot. It was tested in six counties (Polk, Webster, Linn, Allamakee and Winneshiek) primarily by case managers, involving more than 100 cases. The result of this was that it was found to be highly feasible – taking approximately 10 minutes per patient when completed by someone familiar with the case. More importantly, it was felt to be a useful addition in

terms of treatment planning. It was decided after this to go forward with the LOCUS. By August 2005, DHS purchased licenses for LOCUS pilot projects and staff was trained. Through a contract with the Iowa Consortium for Mental Health, LOCUS is available for data entry and analysis online. There were numerous technical problems with this pilot that caused loss of momentum.

A similar effort was undertaken with the ICAP (Inventory for Client and Agency Planning for Mental Retardation and Developmental Disabilities Services) and SIS (Supports Intensity Scale). The SIS was recognized to be very useful in terms of a level III assessment, but too detailed and time-consuming to make it feasible for a level II assessment.

2006:

In late 2006, the team chose to move forward with the ICAP tool as the assessment for persons with mental retardation and developmental disabilities. The above-mentioned counties also participated in piloting this tool.

The Functional Assessment Team has spent significant time discussing a tool that would best capture the needs of persons with brain injury. There is no known standardized reliable tool in existence. Staff from brain injury associations has been involved in meetings and research. There has been discussion about developing a LOCUS-type assessment in conjunction with Deerfield & Associates but this has been put on hold until the process for the other disability fields is more standardized.

During the 2006 legislative session, DHS was appropriated funds to move the assessment process farther:

“...is allocated to the department for development of an assessment process for use beginning in a subsequent fiscal year as authorized specifically by a statute to be enacted in a subsequent fiscal year, determining on a consistent basis the needs and capacities of persons seeking or receiving mental health, mental retardation, developmental disabilities, or brain injury services that are paid for in whole or in part by the state or a county. The assessment process shall be developed with the involvement of counties and the mental health, mental retardation, developmental disabilities and brain injury commission.”

Iowa's 2006 legislative session allocation supported the purchase of additional site licenses to use the LOCUS software. As of June 2007, a small sample from Polk, Webster, Allamakee & Winneshiek counties had been collected.

2007:

In Spring 2007, an additional Level III feature was added (LOCUS M-POWER Service Planner) that allows practitioners to use the LOCUS assessment as a basis for service planning, to guide service planning/clinical treatment across

levels of care. This feature was examined to see if it could be used as an Individual Plan under Chapter 24 of the Iowa Code. The preliminary results were that there would have to be changes made in the Iowa Code.

As of June 2007, approximately 3,000 persons in Polk County have been assessed using the ICAP or LOCUS. Many of the 3,000 people have multiple assessments. Initial ICAP assessments have been conducted for in Webster, Winneshiek, and Allamakee Counties. At the present time, aggregate data for all counties is not available.

In 2007, Iowa was named as a recipient of one of the Money Follows the Person grants that allow flexible use of Medicaid funds for consumers who choose to transition from an institutional to a community setting. DHS/MHDS has started to implement a statewide assessment of all ICF/MR residents using the ICAP. MHDS is in the planning stages of this project and hopes to create an RFP for a vendor entity to begin assessments in the next 12 months. This project can be funded through a combination of sources including Medicaid, Money Follows the Person grant, and the MHDS functional assessment allocation.

Recommendations:

Functional assessments should be considered an integral part of the Continuous Quality Improvement system process at the program, county, and statewide levels to assist in determining progress and service priorities.

1. The following tools are recommended for the following populations:
 - LOCUS (Level of Care Utilization System for Psychiatric and Addiction Services) assessment for persons with mental illness
 - ICAP (Inventory for Client and Agency Planning for Mental Retardation and Developmental Disabilities)
 - CAFAS (Child and Adolescent Functional Assessment Scale) or CA-LOCUS (Child/Adolescent LOCUS) or other SAMHSA-recommended tool for children's mental health.
 - Brain injury tool to be determined.
2. Statewide implementation of the ICAP should be rolled out, initially over the next few months in conjunction with the Money Follows the Person initiative, in order to provide assistance in determining community capacity and individual service needs. The ICAP should be mandated for all publicly funded individuals with MRDD on a statewide basis by July 1, 2008. The CAFAS and CALOCUS or other SAMHSA-recommended tool should be considered as tools that may be piloted as an early part of the Systems of Care grant and one of those should be incorporated in the ongoing project based on that initial pilot. The LOCUS is used currently in several counties (including the two largest

Polk and Linn), and should be supported by DHS for statewide implementation (e.g., technical support for web-based system).

3. Any mandated implementation of new functional assessment tools by DHS (both level II or III) should be introduced only in conjunction with efforts to eliminate any other mandated tools (by any part of DHS, including IME) with which they appear redundant, so as not to unnecessarily increase administrative and paperwork burden on providers, consumers and families. This will likely require review and changes in administrative code. This effort needs to be supported and implemented as soon as possible within DHS.
4. Ideally, web-based assessment tools should be preferred to reduce paperwork demand on providers, provide immediate feedback and reports, and to increase consistency for the purpose of aggregate data reporting capacity. This will provide an ongoing process to inform the system of care to identify gaps in the system and to optimally allocate funds to those services that are most needed.
5. In analyses of other state's disability systems, functional assessment has been shown to contribute relatively little to the overall variance in costs as compared to other more easily measurable factors. Therefore functional assessment should not be used as a major determinant of case rate.
6. Due to the likelihood that other client and service-management issues will arise, the Functional Assessment Team recommends proceeding with the above-mentioned tools recognizing the need for possible "add-on" supplements to enhance data collection that is not captured on the original tools.
7. Implementing a standardized functional assessment must be based on, and consistent with a clearly stated set of statewide values that incorporate an emphasis on individualized supports that promote full consumer and family involvement at all levels and community participation.
8. Analyses of data from ongoing functional assessment must be integrated, at the local and state level, with standardized outcomes. At the state level, there must be adequate ongoing funding to support the data infrastructure capacity within the department to do so.
9. The resulting data should be made available to the commission (and other stakeholders as appropriate), to meaningfully inform the commission's annual report to the legislature on the quality of, and access to mental health and disability services.

10. Funding must also be available on an ongoing basis to support a process to optimize quality assurance of functional and outcomes assessments.
11. The commission should continue to monitor efforts and results of implementation of statewide functional assessment and outcomes and make recommendations regarding how this monitoring and oversight process should proceed on an ongoing basis.