Access to Long-Term Services and Supports
Self-Assessment and Planning Tool for No Wrong Door Systems
February 2023

The No Wrong Door (NWD) governing body steers the design, implementation and ongoing administration of the NWD System to streamline access to long-term services and supports (LTSS). This tool helps a NWD System governing body map the continuum of access to services at the individual and caregiver level: from initial contact with a referral source to the provision of service, with a goal of operationalizing the most efficient, easy-to-understand and accessible process possible for all populations requiring LTSS.

This self-assessment tool walks NWD governing bodies through seven key "checkpoints" of a NWD System:

This resource applies four core guiding assessment questions to each checkpoint. Additional considerations specific to each checkpoint are also listed to facilitate a comprehensive review of that checkpoint. To tailor this self-assessment tool to best fit the needs of the state's NWD System, governing bodies may decide to include more core guiding questions in their assessment, add more checkpoints or more checkpoint-specific considerations.

Assessment Questions for Each Checkpoint:

At every checkpoint, apply the core guiding questions below.

Core Assessment Questions:

1. Does this checkpoint currently work well for individuals? For caregivers?
   (What data or information supports this?)
2. What challenges do individuals face at the checkpoint? What challenges are unique to caregivers?
   (What data, information, or lack of data, indicates this?)
3. What is the role of the local NWD partner(s) at the checkpoint?
   (How do local NWD partner(s) need to improve service access for individuals? Are the needs the same or different for caregivers? Is there consistency across all NWD partners?)
4. What are the opportunities to strengthen the checkpoint?
   (Is there an opportunity to strengthen the infrastructure to support staff or resources to meet individual and caregiver needs?)

Each checkpoint also lists supplemental considerations () for discussion and review to further assess each checkpoint.

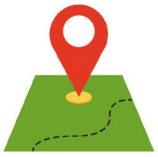
Checkpoint 1: Identifying Access Points

NWD Systems require access points to LTSS through a diverse group of entities. Entities that regularly encounter individuals eligible for LTSS (agencies, organizations, community referral platforms such as SHARPs[1], websites, 211s, hotlines, etc.) should be a pathway into a streamlined NWD System. Identifying potential and current access points to LTSS demonstrates how individuals encounter their NWD System, specifically, those involved in providing access functions listed below:

- Deliver statewide and/or local information, referral and assistance (I&R/A) programs and outreach through statewide toll-free numbers, so that staff and volunteers working for these entities can appropriately and quickly refer individuals to LTSS.

[1] Community Resource Referral Platforms aka Social Health Access Referral Platforms (SHARPs) – A technical platform enabling care coordinators to screen for social risks, needs, and protective factors, better connect members to community resources to address social health, and then understand the impacts on members' clinical health outcome – with the shared aim of enabling health care organizations to identify and refer patients to social service organizations more easily. Examples include Unite Us, Aunt Bertha (aka find help), NowPow, etc.
Source: Rise Health
Source: UCSF Social Interventions Research & Evaluation Network (SIREN), April 2019
Source: NCQA Implementing a Community Referral Platform: Recommendations From a Real-World Implementation Experience Qualitative Findings, December 2020

- Help individuals, regardless of their income or program eligibility, to avoid unnecessary placement in nursing homes and other institutional facilities, as well as to help individuals with LTSS needs who are already residing in these types of facilities to transition back to the community.
- Assist with immediate LTSS needs through efficient assessments and eligibility determination processes across multiple programs.
- Facilitate the successful transition of individuals with LTSS needs from hospitals and other health care settings back to the community.
- Facilitate the transition of youth with significant disabilities who have completed their secondary education or otherwise left school to postsecondary life.
- Encourage organizations that have formal agreements with local Veterans Administration (VA) Medical Centers to assist the VA in implementing the Veteran-Directed Home and Community-Based Services (VD-HCBS) Program and other VA HCBS programs.
- Provide Person-Centered Counseling (PCC) to ensure that the person with LTSS needs directs the PCC process. PCC may include:
    - Conducting personal conversation that includes elements of screening and assessment to confirm that the person needs LTSS and determining if they have any needs that require immediate action;
    - Recording the person's goals, preferred methods for achieving them, and a description of the services and supports needed to successfully achieve the person's goals;
    - Assisting the individual in determining how best to pay for and arrange the delivery of services, including helping the individual assess the sufficiency of their own personal resources;
    - Facilitating access to public programs for those who appear eligible for one or more public LTSS options such as Medicaid, Older Americans Act, Independent Living Programs, state revenue programs, and Veterans programs; and
    - Following-up with the individual and others as appropriate, including the case manager of relevant public program(s), to help ensure the LTSS identified in the individual's person-centered plan are initiated and meeting the individual's needs. Follow-up also involves being available to assist the individual in making adjustments to their services plan as their personal goals and preferences change.
- Conduct formal assessments and/or determining an individual's eligibility required by any state administered program that provide LTSS, including Medicaid.



When assessing Checkpoint 1, also consider:

- Who offers information and referral services at the state level? At the local level? Are they the same entities for caregivers? Do the information and referral service entities all refer to NWD System partners?
- What entities should be added as a critical pathway but are not currently a partner? Are these entities the same or different for caregivers?

Checkpoint 2: Initial Contact and Intake of Basic Information

There are wide variations in the quality of existing systems of information and assistance. Therefore, NWD partners must evaluate how best to strengthen the provision of basic information so that individuals get the information they need. Assess the initial contact to a NWD partner, which is the critical first engagement an individual, family member or caregivers has with the NWD System. Person-centered philosophy and principles should be embedded into the first point of contact and be carried throughout the NWD System.

When assessing Checkpoint 2, also consider:

- How many ways can an individual make initial contact with the NWD partner? Do caregivers make initial contact the same ways or in other ways?
- How is information captured? Are standardized questions used to handle the initial intake? Are staff assessing for unexpressed needs, urgent needs, and future needs? Is there a universal intake used by all or most NWD partners?
- What person-centered training do intake staff receive to perform this function?
- Is information presented in a way that is easily understood by individuals and caregivers? Does information include private pay options?
- Are warm transfers across partner agencies considered so individuals and caregivers can receive assistance with one call, email or contact?
- Are there staff training needs or opportunities at this checkpoint? Are the staff training needs different when serving caregivers? If training needs are identified, who offers that training?

Checkpoint 3: Screening(s) & Comprehensive Assessment of Needs & Existing Supports

Screening(s) and comprehensive assessments in a NWD System should identify a client's needs across multiple domains (environment, social and social determinants of health, functional, cognitive/behavioral, health, caregiving and informal supports). These assessments are essential to supporting person-centered recommendations about the range service options to support the person's identified needs. Screening(s) and comprehensive assessments should also incorporate the state's programmatic assessment for state and federal programs including nursing facility level of care or Medicaid waivers.

When assessing Checkpoint 3, also consider:

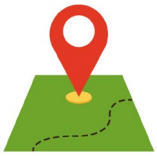
- Are assessments offered in-person to individuals, families or caregivers?
- Are individuals and caregivers able to complete the assessment online? Are there IT system functions that would assist in collecting and processing assessment information?
- Is there a standardized assessment tool for all populations or a specialized assessment tool for each population? How are caregivers included or involved? If different tools are used for multiple populations, are there a core set of questions being asked across tools?
- Do NWD partners have access to state IT systems, such as Medicaid enrollment systems to perform standardized assessments? Is there duplication across other agencies conducting similar assessments?
- Is there an upfront screening tool to identify risk areas that feeds into the comprehensive assessment? How can the screening(s) and comprehensive assessments processes be more standardized or streamlined to ease burden individuals and caregivers?
- Has individual or caregiver feedback been applied to the assessment tool design?

Checkpoint 4: Person-Centered Counseling (PCC)

Through PCC, NWD empowers individuals and caregivers to make informed choices about their LTSS options to be consistent with their personal goals.[2] Furthermore, PCC allows individuals to successfully navigate the various organizations, agencies and other resources in their communities that provide LTSS. Because the PCC process is centered on the individual and their personal goals, it is much broader in scope than any formal assessment or eligibility determination process tied to a public or private program. For example, a PCC process provides meaningful access to participants and/or their representatives with limited English proficiency with low literacy materials and interpreters. If the person does not have LTSS needs, the counselor should help the individual address his or her immediate needs or seek a referral. For more information on PCC activities, competencies, and opportunities to streamline access, please see the PCC Schematic in the NWD Key Elements document.

[2] Person-centered counseling, thinking and practice empowers individuals to make informed choices about their LTSS options, consistent with their personal goals and needs, and assists individuals with navigating the various organizations, agencies, and other resources in their communities. The skills and knowledge base of person-centered counseling includes: 1) A personal interview to discover strengths, values, and preferences and the utilization of screenings and assessments necessary to determine potential program eligibility; 2) A facilitated decision-making process which explores resources and support options and provides tools to the individual in weighing pros and cons; 3) Developing action steps toward a goal or a long-term support plan and assistance in applying for and accessing support options when requested. 4) Quality assurance and follow-up to ensure supports are working for the individual.

When assessing Checkpoint 4, also consider:



- Is standardized PCC training offered to a broad range of entities (both public and private) to coordinate person-centered approaches?
- How is the PCC program evaluated? Are individuals and caregivers surveyed about their experiences with PCC services?
- Are there PCC staff training needs or opportunities identified through this checkpoint? Are the staff training needs different when serving caregivers? If training needs are identified, who offers that training?
- Is there a standard person-centered plan used to share with individuals as they develop their goals and action steps? Is the plan used to enhance follow-ups?

Checkpoint 5: Eligibility Determination (Functional & Financial)

NWD governing bodies should strive for a single NWD System where anyone can be seamlessly connected to the full range of community-based options. The NWD System provides states with an approach to coordinate and integrate the multiple access functions associated with various state administered programs that pay for LTSS. The NWD System provides all payers a vehicle for better coordinating assessments, PCC plans, service plans, eligibility determinations, data collection, and reporting for all LTSS populations.

When assessing Checkpoint 5, also consider:

- With how many entities must an individual or caregiver interact to apply for public benefits?
- Are application or assessment forms user-friendly for the individual? For the caregiver?
- Are applicants or application status tracked by NWD staff?
- Are written agreements (MOU/MOAs) in place for coordination among agencies? Can management information systems (MIS) accommodate electronic transfer of information between agencies?

(Questions continued…)

When assessing Checkpoint 5, also consider:

- Financial eligibility considerations
  - Can NWD staff collect preliminary financial information?
  - Are there regular meetings between NWD partners and financial eligibility staff to facilitate coordination? Are NWD staff co-located with financial eligibility staff?
  - Does the agency determining financial eligibility have designated staff for the programs targeted in streamlining plans (i.e., Medicaid HCBS waivers)?
  - Does the state have self-declaration of income policies?
  - Is presumptive eligibility used for Medicaid HCBS waivers or Medicaid funded programs?
- Functional eligibility considerations
  - Is a physician signature needed for the functional level of care determination? Can that requirement be eliminated?
  - Who can perform the functional assessment? Can NWD staff perform this role? If not, how does NWD staff coordinate this process for the individual or caregiver?

Checkpoint 6: Service Access / Initiation

In a NWD System, service access/initiation is either when the individual or caregiver makes an informed decision about LTSS or when they transition into environments providing more intensive LTSS such as assisted living, residential or nursing facility care. This checkpoint may be carried out by the entities outside of the NWD System, such as waiver case management, private case management, or home health, but the NWD System should help ensure a smooth transition into the chosen LTSS.

When assessing Checkpoint 6, also consider:

- What are the processes to maintain waitlists or manage resource allocation for available services in the community?
- How is communication and/or information exchanged between NWD partners and case management functions, if separate?
- Is there a lag between eligibility determination and when services start (e.g., shortage of workers, waiting lists)?
- How do private pay individuals access services?
- Are referral types tracked to understand current and future demand (i.e., demand for number of people in need of services, demand for funding, and/or populations serviced, etc.)

Checkpoint 7: Ongoing Monitoring/Follow-up

Ongoing monitoring allows the NWD partners to assess what people do with the information provided and resources provided to them. It also offers NWD partners and staff the opportunity to reflect on operational successes and areas for improvement. Continuous quality improvement strategies (e.g., Plan, Do, Study, Act or root cause analyses) should be regularly conducted.

When assessing Checkpoint 7, also consider:

- What kind of quality measures are in place?
- How are learnings from monitoring and evaluative processes applied?
- Is information collected on the individual's experience, through written or telephone surveys? Are individual satisfaction surveys conducted?
- How do individuals or caregivers report complaints/ problems?
- What IT system is used for client tracking?
- Have NWD staff provided the information needed for individuals and families to make informed decisions?

Analyze Findings and Create Action Steps

Following these assessments of NWD System checkpoints, governing bodies should organize the information to map the current access system. This may be through a visual diagram, a report, charts, tables or another preferred method. The mapped access system should address themes identified through this assessment. This may include: themes across the four core guiding questions, addressing caregivers' role in LTSS and opportunities for increased support from existing NWD governing body partners or potential partners. Once complete, NWD governing bodies should use their mapped NWD System to identify how to address gaps and more effectively serve all populations.