

**Wayne County MI Choice Waiver
Wait List Study
Final Report**

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“Plain English” Summary of Study Findings

The Wayne County Wait List Study was undertaken to address three questions:

Do people on wait lists have needs comparable to current waiver participants? Yes. Among persons we assessed who met the medical eligibility standard for waiver services, we saw no substantial differences in need for personal assistance, caregiver support, cognitive ability, or health status. The assessed group did appear to use acute care services (hospitals, ERs, etc.) more frequently than did waiver participants; this may result in increased use of care manager time, or alternatively, the use of acute care services may decline if waiver services are provided.

Do people placed on wait lists have increased care needs over time? Yes. As people “age” on a wait list, their needs for personal assistance and supervision do increase modestly; however, their overall need for assistance remains slightly lower than waiver participants generally. People on wait lists for longer times also leave at accelerated rates due to death and nursing facility placement compared to those who have been on the wait list for less than six months.

Are wait lists an accurate measure of unmet need for MI Choice waiver services? No. Our best estimate is that half of the individuals on the Wayne County wait lists are either not medically eligible or not available to participate in the waiver. Because the number of persons entering and leaving wait lists fluctuates widely from quarter to quarter as well as across waiver programs, it is not possible to determine with scientific accuracy that this level of discount necessarily applies generally.

I. Methods

Purpose & Scope

People who request long term care services from the MI Choice Home and Community Based/Elderly and Disabled Medicaid Waiver Program who cannot access services because of limited program funding are required by state policy to be placed on wait lists by the waiver agent. The process was put in place in May 2005 as part of the Michigan Department of Community Health, Medical Services Administration policy bulletin MSA 05-21, April 2005 (see Appendix A). The intent is that waiver agents will provide services and supports to these individuals as funding becomes available. The Detroit Area Agency on Aging (DAAA), as part of its planning efforts for a proposed managed long term care pilot project, asked for a study about the people on wait lists.

The Wait List Study was designed to address three issues:

- Do people on wait lists have needs comparable to current waiver participants?
- Do people placed on wait lists have increased care needs over time?
- Are wait lists an accurate measure of unmet need for MI Choice waiver services?

The study period ran from April 2007 through September 2007. The study sample was comprised of individuals on wait lists of the Detroit Area Agency on Aging (DAAA), The Senior Alliance (TSA), and The Information Center (TIC), and thus represents **all** of the people seeking MI Choice waiver services in Wayne County. The study timeframe included all people who were placed on the wait lists from mid-2005 through February of 2007, although each agency's list varied in the span of time it covered.

Study Partners

A project steering committee was formed to establish the framework for the wait list study. Committee members included Faiz Esshaki from DAAA, Mary James and Brant Fries from the University of Michigan Institute of Gerontology, Mike Head, Jim Schwartz, Pam McNab, Jane Alexander, Michael Daeschlein, and Robert Orme from the Michigan Department of Community Health, and David Youngs and Marilyn Arndt from DYNS.

The project team would like to acknowledge key collaborators who contributed to the wait list study:

Detroit Area Agency on Aging (DAAA)

DAAA funded the study. Paul Bridgewater (President and CEO), Gloria Long (Deputy Director), and Faiz Esshaki (Director of Finance and Contract Management) led the initial discussions of the issues to be addressed and the scope of the project. Mary O'Neal, Waiver Director, and Bola Ojomu, Nurse Supervisor, coordinated the significant efforts of care managers assigned to contact and assess people on its wait list.

Michigan Department of Community Health, Office of Long Term Care Supports and Services (OLTCSS)

Mike Head, Director of the Office of Long Term Care Supports and Services, and his staff led the process and discussions with list study partners to make key decisions throughout the process and to interpret the study results.

Michigan Department of Community Health/Medical Services Administration (MSA)

MSA houses a Data Warehouse that includes both historical and current information on Medicaid beneficiaries. Pam McNab, Home and Community Based Waiver Specialist, assisted in the data collection by using the data warehouse to identify contact information for individuals the waiver agents were initially unable to reach.

Center for Information Management (CIM)

CIM specializes in automation tools for home and community based waivers. Carol Clifford and Doug Zimmer, owners of CIM, collaborated with wait list study team members in the study design and developed the automated tools necessary for the data collection effort. CIM provided user training on the data collection system and ongoing technical support throughout the study period.

University of Michigan, Institute of Gerontology (UM)

The UM Institute of Gerontology maintains a longitudinal Long Term Care Data Archive for MDCH. Researchers Brant Fries, PhD and Mary James, MA participated as project steering committee members. They also undertook the data analysis comparing the characteristics of the wait list study population and the MI Choice

Waiver participants.

DYNS Services, Inc. (DYNS)

DYNS managed and coordinated the data collection effort. David Youngs, CEO was a member of the steering committee. Marilyn Arndt, Project Coordinator designed and implemented the procedures for the study.

The Senior Alliance

Lydia Gold, Director of Operations at the Senior Alliance, coordinated the significant efforts of care managers assigned to contact and assess people on their wait list.

The Information Center

Ruth Sebaly, Executive Director at The Information Center, coordinated the significant efforts of care managers assigned to contact and assess people on their wait list.

Study Design and Methods

The study design called for telephone contact to persons on the wait lists to secure agreement to participate in the study, followed by a face-to-face assessment by existing care management staff from participating agencies. The wait list members were to be evaluated using an abbreviated version of the Minimum Data Set for Home Care (MDS-HC) assessment routinely collected by the waiver care managers to enable comparisons with current MI Choice waiver participants. Standard demographic information was also to be collected. The special wait list assessment was created by the Center for Information Management, using its Portable Information Collection Kit (PICK) system, a software program that collects and stores assessment data.

The original project goal was to assess 100% of the people on DAAA's wait list and 50% of the people on TSA's wait list. As the project progressed, the number of wait list members contacted was lower than expected, so the decision was made to make initial contacts to all persons on these wait lists. In July, it was decided to implement a Phase II to increase the sample size, identify more information on wait list individuals who previously could not be located, and to gather additional information regarding how each agency managed its wait list. The Information Center (TIC) joined the study, thus including all individuals in Wayne County who had expressed an interest in enrolling in the MI Choice waiver.

Communication among the waiver agents and other key stakeholders was coordinated by DYNS, including conference calls and meetings for discussions

and updates on the progress of the study. The data collection phase concluded with all data elements being reviewed for completeness by the project coordinator. At this point, data was to be sent to the University of Michigan's Institute of Gerontology for analysis.

Data Collection Activities

The project coordinator engaged the MI Choice waiver agents in Wayne County as active partners in the study. The agencies were asked to commit trained care management staff to contact wait list members, keep detailed records about attempted contacts, and, if the individual agreed to participate, to schedule and carry out a face to face assessment in the wait list member's home.

Every person on each agency's wait list was to be sent a letter about the study. Letters were to be followed up by telephone calls to discuss the study, clarify any questions the person might have, and set up an appointment for the in-home assessment.

Data collection protocols, technical tools, and the training for the assessors were produced by the project coordinator in tandem with CIM. CIM designed portable data collection software to collect the assessment information electronically. Assessors had two options to collect information during the in-home interview. For assessors previously trained in using PICK, CIM provided technical training on use of a version of CIM's portable assessment software tailored to address wait list study data collection requirements. Assessors without laptops used two specially-prepared paper forms, the Consumer Profile and the Assessment. Clerical staff at the agencies entered the paper form data into the PICK system. The project coordinator reviewed assessments once they were entered into the wait list database to assure good data quality.

All of the study data were stored in a common set of tables on the CIM server. Each person on the wait list had a record pre-loaded into a Consumer Profile table that utilized wait list data maintained at each waiver agent. Once the participant was interviewed the record was augmented with additional information and a separate record was added to the Assessment table. See Appendix B for a description of CIM's Portable Information Collection Kit (PICK) software.

Each agency's wait list was randomized to prevent any priority selection of individuals. Wait list members were assigned to care managers in groups of 5-10 people. Contact logs were used to record the number of contact attempts and to document the "reason for no assessment" if an assessment visit was not scheduled. The contact information was entered into the Consumer Profile table in PICK and became part of the record. Care managers followed the initial phone contact by making home visits to respondents who had agreed to an assessment.

To maximize participation, the invitational letter, call protocols, and interview

protocols all emphasized the importance of participation in the study. During the training sessions, assessors were presented with an overview of the project, and the significance of the study was again emphasized. Assessors, in turn, conveyed the message to wait list members that participation in the study was an avenue to contribute toward improvements in the long term care system and to achieve greater access to services and supports for people like themselves.

During Phase I, 726 people were mailed the invitational letter and 648 attempted contacts were made. By mid-June, 2007, these contacts resulted in 182 completed assessments, a 25% participation rate. This was lower than expected and was considered insufficient to provide an accurate reflection of the overall wait list population. Seeking to increase the sample size, the steering committee developed strategies to learn more about wait list individuals not participating in the Phase I in-home assessments.

At this stage of the data collection effort, Phase II was launched. A key Phase II goal was to locate and contact individuals in the “Unable to Contact” and “Other” groups. Extensive efforts were undertaken to find people who could not be contacted by phone. This included searching the MSA Data Warehouse for additional information on a wait list person’s previous addresses. The study also employed “enumerators,” that is, individuals who made “cold calls” to the home address given on the wait list to see if the person was still residing at that address or to see if information could be obtained to locate the person. Enumerators were asked to complete a short survey with the wait list person or their representative.

The intent of the enumerator surveys was four-fold:

1. to investigate what had occurred with persons in the “Unable to Contact” group;
2. to determine the person’s current health status;
3. to ask for participation in the study;
4. to determine the individual’s desire to remain on a wait list.

To provide more clarity about the reasons for non-contact, the categories in the Contact Log were expanded from 6 to 10 options. (The added categories are identified by a *):

- Death
- Nursing Facility Placement
- In Hospital*
- In Waiver*
- In Other Program*
- No Longer Needs Help*
- Other
- Moved
- Unable to Contact
- Refused Study Participation

In August, 2007, The Information Center was engaged to contact and interview people on its wait list. TIC initiated the same procedures and protocols used by DAAA and TSA in Phase I but followed through immediately with Phase II protocols, sending out enumerators to locate potential study participants whom care managers were unable to contact by phone. Across all agencies, 123 enumerator visits were made and 67 surveys completed. These visits significantly reduced the percentage of persons categorized in the Unable to Contact category from 30% in Phase I to 8% at the end of Phase II. Through the enumerators' efforts, 34 additional people were located who agreed to an assessment. Individually, the percentage of DAAA wait list members participating in an assessment increased from 36% in Phase I to 43% in Phase II; TSA's rate went from 23.5% to 26%. TIC had a 44% participation rate.

The surveys carried out by the enumerators reflected that respondents most often characterized their health status as poor and in decline since being placed on the wait list. Many of them had experienced hospitalizations but were able to return to their homes. While very few faced a nursing facility placement and were choosing to remain in their homes, the accounts told to the enumerators were of people struggling with their illnesses and disabilities but fierce in their determination to remain independent. Several vignettes of persons waiting for assistance are provided in Appendix C.

University of Michigan Institute of Gerontology received the final set of study data from CIM in November 2007. During the course of cleaning these data and merging the various files, UM identified 10 duplicate study members, for a total of 870 unduplicated individuals across the three agencies' wait lists. Of this group, 106 individuals had only received the initial letter inviting them to participate in the study but had not had any further follow-up. This left a final study sample of 764 people. Thus, at the end of the data collection, nearly 88% of the original study sample target had been met, in that participants were either interviewed or the reason they were no longer on the wait list had been determined. Of this group, 258, or 33.8%, had participated in an in-home assessment.

II. Study Findings

State of the Art

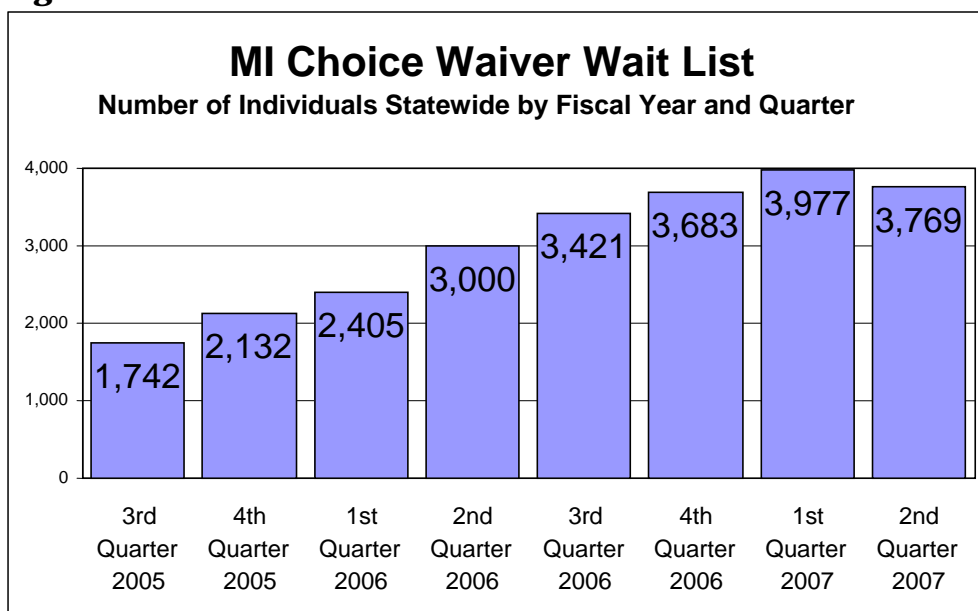
In order to interpret the study findings, it may be helpful to review what is already known about people on wait lists. Nationally, the literature on wait lists for home and community based waiver programs is very sparse. Twenty-two states kept wait lists for their home and community-based waivers in 2002 (Kitchener, 2004) A literature review of both peer-reviewed journals and the extensive holdings of www.hcbs.org found only one article comparing policy

and/or operation of wait lists across states or programs (Auerbach and Reinhard, 2006). The review did not identify any studies that examined the feasibility of wait lists for measuring unmet need for home and community based services.

Apparent Demand for Waiver Services

Within Michigan, ongoing budget constraints have restricted statewide MI Choice waiver enrollments for a number of years. The number of people statewide reported on wait lists has grown steadily since inception of the policy in May 2005, rising from 1,742 by the end of the third quarter of FY 05 to a high of 3,977 at the end of the first quarter of FY 07.

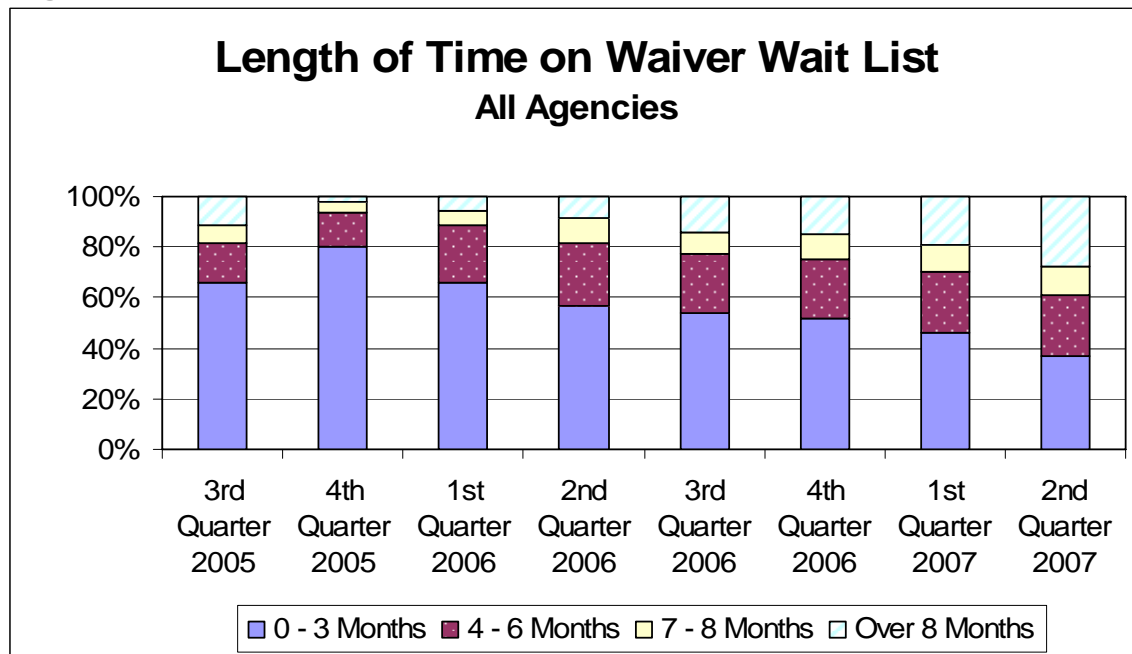
Figure 1.



Source of Data: OLTCCS

Reported time spent on the wait list has also increased. While 66% of the individuals on the wait list at the end of the third quarter 2005 had waited less than three months, this number had shrunk to 37% by the end of the second quarter of 2007.

Figure 2.



Source of Data: OLTCCSS

Although these trends are often cited as proof of the need for more waiver funding, the quality of the wait list data itself—whether the lists are current or “stale,” whether people on the lists meet medical eligibility criteria for the waiver-- has also been challenged. One of the goals of this study was to determine the accuracy of reported wait list information.

Representativeness of Study Findings

The UM review of the longitudinal wait list data, both at the state and individual agency level, found wide variations from quarter to quarter in the number of persons being placed on or removed from wait lists. Over the four quarters preceding this study, DAAA added 165, 150, 102, and 159 people to its wait list. In that same timeframe, TSA added 67, 74, 39, and 42 people, and TIC added 4, 2, 1, and 6 people. During the same timeframe, DAAA removed 129, 97, 78, and 81 people from its wait list, TSA removed 51, 15, 14, and 4 people, and TIC removed 5, 10, 4, and 8 people (source of data: OLTCCSS).

Beyond these observed wide variations in individual agency reports, discussions with waiver agent staff revealed that agency-level practices for maintaining the lists are different among sites and also vary over time within a site. Each of the waiver programs in the study had unique practices for screening waiver seekers. Each program had different protocols for how often people on the lists are contacted, when individuals are removed from the lists, and the amount of information and referral provided to a waiver seeker. Other factors that

appeared to influence the size and variation of the lists include the number of waiver slots available to a given waiver agent, or even the relative success of a local nursing facility transition effort.

Given the constantly changing nature of the wait lists themselves, we wish to emphasize that it is not possible to determine a “representative” wait list population. Thus, the wait list profile derived from the study is best considered as an illustrative snapshot of people on wait lists in the summer of 2007 in Wayne County. Caution should be taken in generalizing these results or using them to predict the status of future wait list populations.

Comparing the Wait List and MI Choice Waiver Populations

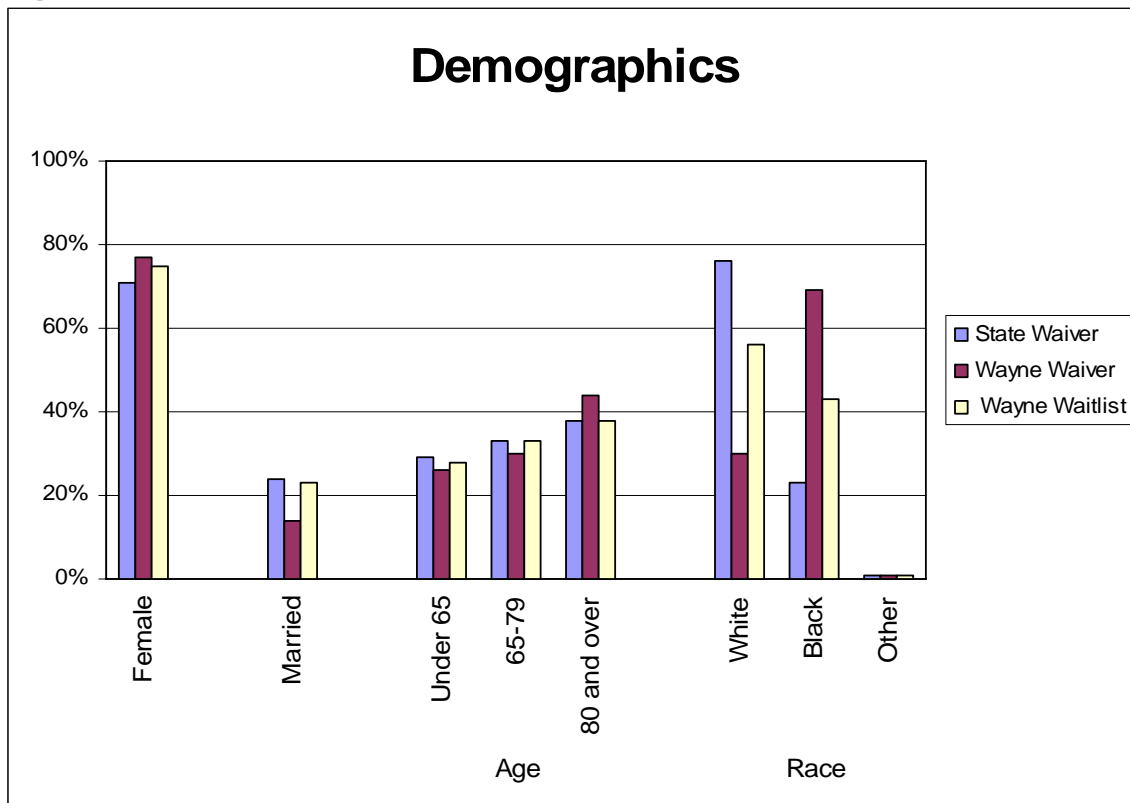
UM prepared an initial version of the “Profile” report found in Appendix D using the MDS-HC study data and FY 2006 data in the UM Michigan Long Term Care Data Archive. This report compared a variety of functional, cognitive, and health status indicators using the study group and persons newly enrolled in the MI Choice waiver during FY 2006. Two presentations (with DCH and waiver site staff, respectively) were held to discuss these initial findings.

In February 2008 the Profile was updated with participant data for all persons served by the waiver over the course of FY 2007 (not only new enrollees). A more detailed version of the Profile that breaks out the data by agency was provided to DCH and the participating waiver agents but is not included here. Additional analyses were run to address issues raised in the presentations.

Key findings from the comparison are summarized below. Unless otherwise stated, comparisons are between the study sample and FY 2007 participants in the three Wayne County waiver programs. Only those differences meeting statistical tests of significance ($p \leq .05$) are reported here. Greater detail on the measures discussed is available in the complete Profile.

Demographic Characteristics (p. D-5): The three groups were similar in gender and age. The study sample had significantly more white individuals (56%) than did the waiver (30%), reflecting the greater number of out-Wayne participants in the study. The wait list sample had more married couples (23%) than did the waiver (14%). More wait list study individuals either lived with a spouse or with a spouse and other family members (23%) than did the Wayne waiver group (14%).

Figure 4.



Caregiver Support (p. D-7): All groups reported high levels of caregiver assistance. The wait list sample was more likely to have a spouse (17%) or child (54%) as the main caregiver, compared to waiver participants (10% and 28%, respectively); waiver participants were significantly more likely to have “other relative” as the main caregiver (53% vs. 18%). Despite these differences, the percentage of caregivers providing 30+ hours of assistance per week did not vary substantially (44% for study members, 40% for waiver).

Health/Mental Health Status (p. D-9 to D-12): Disease diagnoses showed no significant differences among the groups. The study sample had recently used more acute care services than had persons on the waiver. Study members had high rates of hospital use in the last 90 days (25% vs. 19%), more emergency room visits in the last 90 days (12% vs. 8%) and higher rates of emergent (non-routine) physician visits (15% vs. 7%). Study members also had higher rates of weight loss of at least 5% in the last 90 days (13% vs. 4%). 35% of the study sample had experienced five or more falls in the last 90 days, compared to 24% of the waiver population. Although the overall use of skilled services was low in both groups, more of the study group had used skilled care (5% vs. 2%). Study group members reported feeling depressed more often than did waiver participants (35% vs. 14%).

Nursing Facility Use (p. D-11): Both groups reported similar rates of previous nursing facility use in the last five years (14% for study group, 18% for

waiver).

Function (p. D-13): Although one third of the study sample had extensive late loss ADL deficits (bed mobility, eating), the study sample overall was less functionally impaired than persons in the waiver. This is reflected in the percentage of study members who were classified independent or only needing supervision in late-loss ADLs (37% vs. 26%).

Cognition (p. D-13): About 9% of both groups had severe or very severe cognitive deficits. However, overall the study sample was less cognitively impaired than persons in the waiver; 48% of the study group was assessed as cognitively intact, vs. 33% of the waiver group.

Case Mix (p. D-15): A third of the study members assessed (32.6%) did not meet the DCH medical eligibility threshold for the waiver. The average RUG-III/HC case mix index among study members (1.16) was 8.6% lower than the average case mix index among waiver participants (1.26). After removing study members who did not meet the DCH medical eligibility criteria, the average case mix index rose 11.1% (to 1.40) among study members. However, the functional and cognitive status among study group members who met the medical eligibility threshold did not appear substantially different from that of study members who did not meet it, suggesting that the difference in case mix index is the result of the greater use of skilled care services among wait list study members.

Time on Wait List: UM calculated the duration of time each person in the study sample had been on a wait list. Results are shown in Table 1. While nearly three quarters had been on the wait list for a year or less, 4.5% (34 people) had been on the list for over two years. Very few people had received help; 2.1%, (16 people) were found to be on the waiver, and 2.7% (21 people) had been enrolled in another program. 3.3% of the study group (25 people) reported they no longer needed help. 18% of the study group (138 people) could not be contacted. One in ten (76 people) had died; one in thirteen (57 people) had been placed in a nursing facility.

Table 1. Outcomes by Time on Wait List

	Months on Wait List				Missing	Total
	0 - 6	7 - 12	12 - 18	18 - 24		
Death	12	33	18	13	0	76
Nursing Facility Placement	13	27	7	9	1	57
In Hospital	3	11	5	2	0	21
In Waiver	1	3	6	6	0	16
In Other Program	3	6	5	6	1	21
Refused Participation	41	82	19	7	3	152
No Longer Needs Help	3	9	9	4	0	25
Other	6	12	6	0	0	24
Moved	4	21	21	7	0	53
Unable to Contact	16	27	10	8	0	61
Assessed	103	127	20	7	1	258
Total	205	358	126	69	6	764

Outcomes over Time: UM also examined the relationship between time on the wait list and several study outcomes of interest. Six percent of the people with a wait list duration under six months had died; this rate accelerated to 19% of the persons with a wait list duration of 18+ months. Among persons with a wait list duration of under six months, 6% had been placed in a nursing facility; this rate went up to over 13% among persons with a wait list duration of 18+ months. Half the people who had a wait list duration of under six months had been assessed; this rate dropped to about 3% of persons who had a wait list duration of over two years. The refusal rate among persons who had declined to participate in an assessment went down among persons with the longest duration on the wait list, from 20% of persons with six months' duration to 10% of persons with 18+ months' duration.

A final set of analyses was done to compare the rate of change in key health status indicators over time for persons on the wait list and persons enrolled in the waiver. For this effort, we looked at three standard measures derived from the MDS-HC, the ADL Hierarchy (ADLH) (see p. D-13), the Cognitive Performance Scale (CPS) (see p. D-13), and the average RUG-II/HC Case Mix Index (see p. D-15). Note: the analysis timeframes were truncated at 18 months due to the small sample sizes in the ensuing out-months for wait list study members.

Table 2. Rates of Change in Key Health Status Indicators

	Months on List			Total
	0--6	7--12	13--18	
Sample Sizes				
State waiver	2260	811	768	3839
Wayne waiver	181	221	142	544
Wayne wait list	103	127	20	250
Average Cognitive Performance Scale				
State waiver	1.79	1.59	1.83	
Wayne waiver	1.71	1.56	1.89	
Wayne wait list	1.21	1.33	1.55	
Average ADL Hierarchy				
State waiver	1.96	2.12	2.12	
Wayne waiver	2.23	2.49	2.54	
Wayne wait list	1.92	2.02	2.00	
Average RUG-III/HC Case Mix Index				
State waiver	1.32	1.27	1.31	
Wayne waiver	1.31	1.37	1.36	
Wayne wait list	1.11	1.2	1.23	

From the data in the Wait List Study Profile, it has already been established that a smaller proportion of waitlist study participants had cognitive impairments than did the comparison groups. This information shows that as time on the waitlist increases, the average CPS among waitlist members rises, while the average CPS in the statewide and Wayne County groups dips slightly, then rises slightly as time in these programs increase. These differences in CPS are not substantial. Thus, it is reasonable to expect that if all waitlist members were to be enrolled in a managed long-term care arrangement at once, the persons who have been on the list for the longest time would have a slightly higher level of cognitive impairment than wait list members with shorter durations, but their degree of cognitive impairment would remain lower than that of persons already served in the Wayne (or statewide) waivers.

The changes in ADL function over time are slightly different, but again are not substantial. The Profile indicates that waitlist study group was less functionally impaired overall, but as time on the waitlist increases the ADLH score for all groups rises, although the average score among the study group rises less than do the ADLH scores in the comparison groups. Given this, in the event of a managed care enrollment for all persons on the waitlist, those who have been on the list for the longest time would continue to be somewhat less impaired functionally than their counterparts in the Wayne or statewide waivers.

As regards the average Case Mix Index, the Profile shows that the average Case Mix Index among waitlist study participants was lower than that of the

comparison groups. As time on the waitlist increases, the average Case Mix Index among the waitlist study group rises steadily while the Case Mix Index in the comparison groups remains essentially flat. In the event of a future managed care enrollment, those who have the longest wait list duration could be expected to use about 10% more formal and informal care than persons with a short waitlist stay.

Estimating future demand: As previous discussion has indicated, the study found many people in need of ongoing assistance. The study also found an extremely low number of persons who actually enrolled in the waiver from the wait list over a two+ year period. Nor did the study identify many people who had found other ways to address their needs. However, the study also found a substantial number of persons who did not meet the medical eligibility threshold for the waiver (11% of the entire wait list sample, and 32.6% of persons assessed). As well, the study identified a number of other individuals who had died, moved, or reported they no longer needed help.

The table below provides UM's estimate of the "realized demand", that is, the net number of wait list members who could be expected to become enrolled in the waiver if slots were to become available. Categories of persons whose outcome status renders them unlikely or unable to use waiver assistance have been highlighted in grayscale and subtracted from the final tally of net eligible persons. As can be seen, these subtractions reduce the wait list size by half.

Table 3.

Final Wayne Co WL Study Results: Realized Demand						
Revised February 07						
	ALL		DAAA		OUT WAYNE	
All Persons on Wait List	764	100.0%	223	29.2%	541	70.8%
Completed In Home Assessments	258	33.8%	95	42.6%	163	30.1%
Ineligibles per LOCD Algorithm	84	11.0%	19	8.5%	65	12.0%
Net Eligibles	174	22.8%	76	34.1%	98	18.1%
Persons Not Assessed						
Death	76	9.9%	17	7.6%	59	10.9%
Nursing Facility Placement	56	7.3%	8	3.6%	48	8.9%
In Hospital	21	2.7%	10	4.5%	11	2.0%
In Waiver	16	2.1%	0	0.0%	16	3.0%
In Other Program*	21	2.7%	2	0.9%	19	3.5%
No Longer Needs Help	25	3.3%	8	3.6%	17	3.1%
Other*	24	3.1%	10	4.5%	14	2.6%
Moved	53	6.9%	18	8.1%	35	6.5%
Unable to Contact	61	8.0%	15	6.7%	46	8.5%
Refused Study Participation*	153	20.0%	40	17.9%	113	20.9%
Probable Ineligibles in * Groups	64	8.4%	17	7.6%	48	8.8%
Total Probable Persons No Longer Seeking Services	379	49.7%	94	42.1%	286	52.8%
Net Eligibles	385	50.3%	129	57.9%	255	47.2%

III. Wait List Management Issues & Recommendations

The Michigan Department of Community Health policy bulletin MSA 05-21 implemented a process “for persons who request participation in the MI Choice Program when requests for participation exceed program capacity.” This represented a significant improvement over the contact log process in place at that time. The process set up a “first come first served” system based on the date services were requested. Priority groups were also clearly identified.

This study revealed a number of differences in the management of the wait lists maintained by the three agencies, including the amount of screening done before a person is added to the wait list, the scope of information collected about a person’s needs, the frequency of follow up contacts, the basis for decisions to remove individuals from the list, and the consistency of data reported quarterly to the state. The different “cleaning” practices among the study programs are

illustrative. Shortly before the study began, DAAA made some corrections to its list, eliminating duplicate names and addressing other inconsistencies. This review reduced the DAAA wait list by approximately 65 names. TSA worked with a wait list that did not get reviewed prior to the study and did not follow a practice of removing people routinely. TIC began the collection effort with a “cleaned” wait list after removing individuals who were also on TSA’s list. This adjustment trimmed the TIC wait list by half. Clearly, these differences among waiver agents challenge the accuracy of current forecasts about the number of people seeking assistance from the MI Choice program.

Wait list practices also appear likely to affect access to the waiver. Per state policy, people are routinely placed on a wait list if there is insufficient waiver capacity available to assist them. Currently there is no system to maintain a list that could support coordination with other waiver agents serving the same regional communities. This has serious implications for people hoping for equitable access to their preferred mode of long-term care. A person who has been waiting for months may miss a service opportunity with a waiver agent in their area because the wait list information is not available across agencies. The current wait list policy requires prioritization of each person based on established categories of need. However, the lack of an overarching common wait list structure among agents serving the same area, and the lack of consistent follow-up, effectively negates the MDCH priority system.

Waiver agency staff involved in screening individuals for the wait list expressed frustration with the Telephone Intake Guidelines required for use by the wait list policy. Staff held that the guidelines were identifying many “false positives,” that is, people who did not meet the medical eligibility standard when later assessed in person. The study results show that nearly one third of wait list members assessed did not meet this threshold. Whether this reflects design problems in the TIG, inadequate training of screening staff, or is perhaps the result of individuals’ improved health and function over time cannot be ascertained, as TIG data is not recorded electronically and thus is not available for analysis.

It is troubling that nearly 7% of the wait list members had moved, and another 8% could not be located, despite concerted efforts to do so. Given the overall frailty of the persons in the study sample, there is ample reason to suspect that these individuals did not experience improved health or function. The fact that no one could be found who was familiar with their whereabouts serves as a harsh reminder of the isolation often experienced among the urban elderly and disabled population.

It is obvious that a responsive information system is a logical first step in enhancing access to waiver services and supports. Automated tools can facilitate the ability to obtain statewide information about persons seeking assistance and can assist waiver agents to meet future performance standards. Such tools will be used in the Single Point of Entry pilot programs and their performance can be further evaluated in these settings.

Our other recommendations for improvements to current wait list practices include:

1. Develop an information system that is user-friendly, allowing people to have knowledge of their placement on the wait list and the probable date of access to the waiver program.
2. Improve the accuracy of wait list data by requiring standardization and uniformity of data collected.
3. Create standard maximum wait times that correspond to a person's situational urgency.
4. Undertake performance-based quality assurance audits of wait lists.

References:

Kitchener, M., Ng, T., & Harrington, C. (2004). Medicaid 1915(c) home and community-based services waivers: a national survey of eligibility criteria, caps, and waiting lists. *Home Health Care Services Quarterly*, 23(2), 55-69.

Auerbach, R., & Reinhard, S. (2006). *Challenges Posed by Waiver Waiting Lists*. Rutgers Center for State Health Policy.

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APPENDICES

A. Policy Bulletin

B. PICK Overview

C. Vignettes

D. Profile of Wait List Study Participant Characteristics

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APPENDIX A: Policy Bulletin

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Bulletin: MSA 05-21

Distribution: Medicaid MI Choice Home and Community Based Program for Elderly and Disabled (MI Choice Program - Provider Type 77)
Nursing Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Care Units (Provider Type 63)
Centers for Independent Living

Issued: April 1, 2005

Subject: MI Choice Program Nursing Facility Transition Services and Waiting List Policy

Effective: May 1, 2005

Programs Affected: Medicaid

Purpose

The Michigan Department of Community Health (MDCH) is implementing a procedure for the utilization of Waiting Lists for persons who request participation in the MI Choice Program when requests for participation exceed program capacity. MDCH is also initiating a new MI Choice Program covered service, Nursing Facility Transition Services, that will allow reimbursement for specific costs associated with transitioning individuals from nursing facilities to the MI Choice Program.

Waiting Lists

Based on annual budget appropriations for the MI Choice Program, individual agencies are provided a maximum budget for services. Effective May 1, 2005, a Waiting List procedure will be implemented should the number of participants receiving and applying for MI Choice Program services exceed program capacity.

Any person who expresses interest in the MI Choice Program must be evaluated by telephone using the Telephone Intake Guidelines (TIG) at the time of his or her request. If the person is seeking services for another, the MI Choice Program agent shall either:

- Contact the person for whom services are being requested, or
- Complete the TIG to the extent possible using information known to the caller

Applicants to the program who are determined presumptively eligible based on financial criteria and the TIG must be offered a face-to-face evaluation within seven days if the MI Choice Program is accepting new participants. Applicants who are determined presumptively eligible when new participants are not being accepted must immediately be placed on the MI Choice Program Waiting List. If an applicant who is determined presumptively eligible through the TIG screening process does not receive a face-to-face evaluation within seven days, the person shall be placed on the Waiting List based on the priority category, chronologically by date of the original request for services. Contact logs will no longer be used.

Applicants who are determined ineligible based on telephonic screen information may request a face-to-face evaluation using the Michigan Medicaid Nursing Facility Level of Care Determination and financial eligibility criteria. MI Choice Program agents must issue an adverse action notice and advise applicants of his or her appeal rights when the applicant has been determined ineligible either through telephonic screening or face-to-face evaluation.

When an applicant appears to be eligible based on the TIG, but does not appear to meet financial eligibility requirements, the MI Choice Program agent must allow the applicant a place on the waiting list if it appears that he or she may become financially eligible within 60 days.

Each MI Choice Program agent will maintain a Waiting List for its service area. Applicants will be placed on the Waiting List chronologically (by the date of request for services) by priority category (when known). Available slots are then assigned on a first come/first served basis using the following categories, listed in descending order of priority.

- **Persons no longer eligible for Children's Special Health Care Services (CSHCS) because of age**
This category includes only persons who continue to need Private Duty Nursing care at the time coverage ended under CSHCS.
- **Nursing Facility Transition participants**
A given number of program slots will be targeted by MDCH each year to accommodate nursing facility transfers. Nursing facility residents are a priority only until the enrollment target established by MDCH has been reached.
- **Current Adult Protective Services (APS) clients**
When an applicant who has an active APS case requests services, priority should be given when critical needs can be addressed by MI Choice Program services. It is not expected that MI Choice Program agents seek out and elicit APS cases, but make them a priority when appropriate.
- **Chronological Order by Date Services Were Requested**
This category includes potential participants who do not meet any of the above priority categories and those for whom prioritizing information is not known.

Each Waiting List identifies applicants who have been presumed eligible based on the Telephone Intake Guidelines (or the Michigan Medicaid Nursing Facility Level of Care Determination) by priority category, and then in chronological order by date of service request. A service request date is defined as a contact by a person requesting services, or someone on his or her behalf, to the Waiver Agent voicing an interest in MI Choice Program services.

MI Choice Program agents will advise applicants on Waiting Lists of all alternative options for assistance, such as other MI Choice Program openings in a given area, Home Help service options, or paying privately for care until a MI Choice Program slot becomes available.

Applicants who have an established place on a waiting list and who want to move or apply to another MI Choice Program agency, may transfer to the new agency waiting list using the original service request date.

An adverse action notice must be provided to any applicant at the time they have been placed on the Waiting List. Required language for these notices is on the MDCH website at www.michigan.gov/mdch, select "Providers," select "Information for Medicaid Providers," select "Michigan Medicaid Nursing Facility Level of Care Determination."

Applicants listed on agent contact logs on May 1, 2005, and who have been presumed Medicaid eligible, will be contacted to determine their continued interest in the program and placed on the Waiting List based on their first service request date and priority category.

MI Choice Program agents must submit a report including the following summary information from Waiting Lists to MDCH LTC Program Development Section staff on a quarterly basis.

- Number of persons waiting in each category by number of months, i.e., the number of persons new to the list this month, waiting one month, two months, three months, etc.;
- Number of persons enrolled into the MI Choice Program from each category in the past quarter;
- Number of persons by category eliminated from the waiting list for any reason (except enrollment) during the last quarter, and the reason for removal.

The report must be e-mailed to Elizabeth Aastad (AastadL@michigan.gov) no later than the fifteenth of the month following the end of the quarter, as identified below:

Period	Due Date
October - December	January 15th
January - March	April 15th
April - June	July 15th
July - September	October 15th

The first report, due July 15, 2005, will include information from May 1, 2005 through June 30, 2005. A suggested format for the quarterly report is included as an attachment to this bulletin.

Nursing Facility Transition Services

Nursing Facility Transition Services are reimbursable as a MI Choice Program service. MDCH will reimburse MI Choice Program agents for coordination and support services over a six-month period of nursing facility stay. In addition, MDCH will reimburse allowable transition expenses incurred over the same six month period for potential program participants who intend to transfer into the MI Choice Program.

MDCH must pre-approve any plans projected to total more than \$3,000, which includes transition and support/coordination costs. No payments will be made to the MI Choice Program agent for Nursing Facility Transition Services until the applicant has been enrolled into the MI Choice Program.

MDCH annually allocates a specific portion of funds for Nursing Facility Transitions coordinated by MI Choice Program agents. This amount is identified in the annual MDCH/MI Choice Program Agency contract.

The MI Choice Program agent must develop a nursing facility transition plan that includes all projected transition costs (except support and coordination). The plan must be based on individual goals and needs. The transition plan must be included within the participant's medical record and updated to reflect any changes.

When a transition plan has been initiated, the MI Choice Program agent must ensure that sufficient funding is available in its current contract to absorb the service costs for the potentially transitioned participant. MDCH will issue Nursing Facility Transition Practice Guidelines to assist MI Choice Program and other transition agents in developing transition plans. Draft guidelines will be released for public comment prior to implementation.

In addition, the MI Choice Program agent must notify MDCH of its intention to transition a nursing facility resident to the MI Choice Program when initiating a nursing facility transition plan. Procedures for notification can be obtained from the MI Choice Program contract manager.

When nursing facility residents have been effectively transferred to the MI Choice Program, claims for transition services may be submitted for reimbursement. Waiver agents should contact their contract manager when nursing facility residents, who were provided transition services, expire or will not be enrolled in the MI Choice Program for other reasons.

As an approved MI Choice Program service, Nursing Facility Transition Services may be coordinated by a registered nurse or clinical social worker (BSW or MSW). Staff who qualify as care managers may also coordinate nursing facility transition services.

Allowable transition costs include the following:

- Housing deposits: A one-time expense to secure housing or obtain a lease.
- Utility hook-ups and deposits: A one-time expense to initiate and secure necessary utilities (cable is not included).
- Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (TVs and VCRs are not included).
- Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and overall cleaning.

Nursing Facility Transition Services – Other Than MI Choice Program Participants

MDCH will annually allocate additional alternative funds to further support Long Term Care Nursing Facility Transitions in the following ways:

- **Category 1:** Provide reimbursement for MI Choice Program agents who, on good faith, attempted to transition a Nursing Facility resident into their program using MI Choice Program services but failed related to the resident's death, resident's refusal of MI Choice Program services, or for other reasons.
- **Category 2:** Provide MI Choice Program agents with transition gap-filling funds for those nursing facility residents who have identified transition costs that are not reimbursable under Medicaid, such as a limited amount of delinquent debt.
- **Category 3:** Provide reimbursement to assist in transition of nursing facility residents who do not meet the level of care requirements for the MI Choice Program (resident does not meet the NF LOC criteria or qualifies only under Door 7).

Use of these alternative funds will require the same guidelines, notification, and approval processes as does MI Choice Program Nursing Facility Transition Services. MDCH will accept requests for Category 3 use of the funds from MI Choice Program agents and the Michigan Association of Centers for Independent Living (MACIL).

MI Choice Program and Centers for Independent Living (CIL) transition agents will work with nursing facilities to identify residents appropriate for transfer and submit their requests to the MDCH Administrative Support and Contract Development Section (telephone 517-335-5068 or 517-241-9937). Section staff will evaluate requests for transition services funding on a first come/first served basis.

In addition, the Transition agent must notify MDCH of its intention to transition a nursing facility resident to the community and gain pre-approval for use of funds when initiating a transition plan. No funds should be expended until MDCH has approved the individual projected expenses for a resident. Requirements for notification can be obtained by contacting the MDCH Administrative Support and Contract Development Section.

Claims for transition services may be submitted for reimbursement as they occur. MDCH will reimburse MI Choice Program agents and the MACIL as noted above for transitions of nursing facility residents who are not intended for enrollment into the MI Choice Program. Individual Centers for Independent Living may perform these services, but must coordinate and bill through MACIL.

Transition agents should contact the MDCH Administrative Support and Contract Development Section staff when nursing facility residents who were provided transition services expire, or who will not be transferring to the community for other reasons.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual or the MDCH website.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Michigan Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may telephone toll-free 1-800-292-2550.

Approved

A handwritten signature in black ink that reads "Paul Reinhart". The signature is written in a cursive style with a large initial "P" and a long, sweeping underline.

Paul Reinhart, Director
Medical Services Administration

MI Choice Program Waiting List Quarterly Summary Report

Agent: _____

Quarter: _____ Submission Date: _____

		Categories			
		CSHCS	NFT	APS	Others
A.	Persons enrolled this quarter				
B.	Persons eliminated from waiting list due to:				
	o Death				
	o Move from region				
	o Other (describe)				
	o Other (describe)				
	o Other (describe)				
C.	Persons Waiting				
	o Less than one month (new)				
	o One Month				
	o Two Months				
	o Three Months				
	o Four Months				
	o Five Months				
	o Six Months				
	o Seven Months				
	o Eight Months				
	o Over eight months				

Instructions

This report is due from each MI Choice Program agent quarterly. The report must be submitted to Elizabeth Aastad (AastadL@michigan.gov) on the following schedule.

Period	Due Date
October - December	January 15th
January - March	April 15th
April - June	July 15th
July - September	October 15th

- A.** Number of persons enrolled into the MI Choice Program from each category in the past quarter
- B.** Number of persons by category eliminated from the waiting list for any reason (except enrollment) during the last quarter, and reason for removal.
- C.** Number of persons waiting in each category by number of months; i.e., the number of persons new to the list this month, waiting one month, two months, three months, etc.

APPENDIX B: Portable Information Collection Kit (PICK) Overview

Center for Information Management, Inc. created a portable information management system, called PICK to improve the productivity and effectiveness of long term care supports coordinators when working outside of the office. Powerful assessment software and other case management tools are included in the PICK systems, depending on the data collection needs of the customer.

Work Objectives Addressed by PICK

PICK was developed to address the following objectives, as identified by our customers:

- Collect in-home assessments without paper forms
- Develop a system that is easy to use for even the least experienced computer user
- Allow use of remote data entry tools that do not require assessments to be “locked” at the central office
- Automate progress notes for recording anytime/anywhere
- Capture key additional details on caregivers, medical providers, and pharmacies
- Capture and store key additional details on medications
- Provide a summary of progress notes and medications history for quick review

Portable Caseloads

Remote users will download all data for selected participants to their portable computers. Users will have the option to select an entire caseload and/or individual participants (by the person’s name). Information for these case files will be entered on their portable computer, as their daily work requires, throughout the day. Periodically, users will sync data to the central server, allowing access by all appropriate staff.

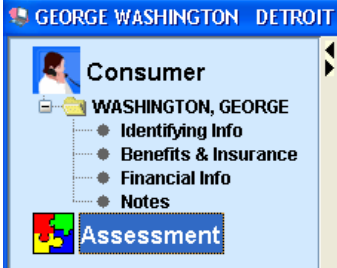
Data Storage and Access

All data collected using PICK is securely stored on HIPAA-compliant centralized database servers. Once data is synced to the server, it can be accessed by anyone with the appropriate data permissions. Office-based users either use the PICK software on desktop computers for full access to all information, or can implement a web-based direct data access system.

Data Collection Software Used in Wait list Study

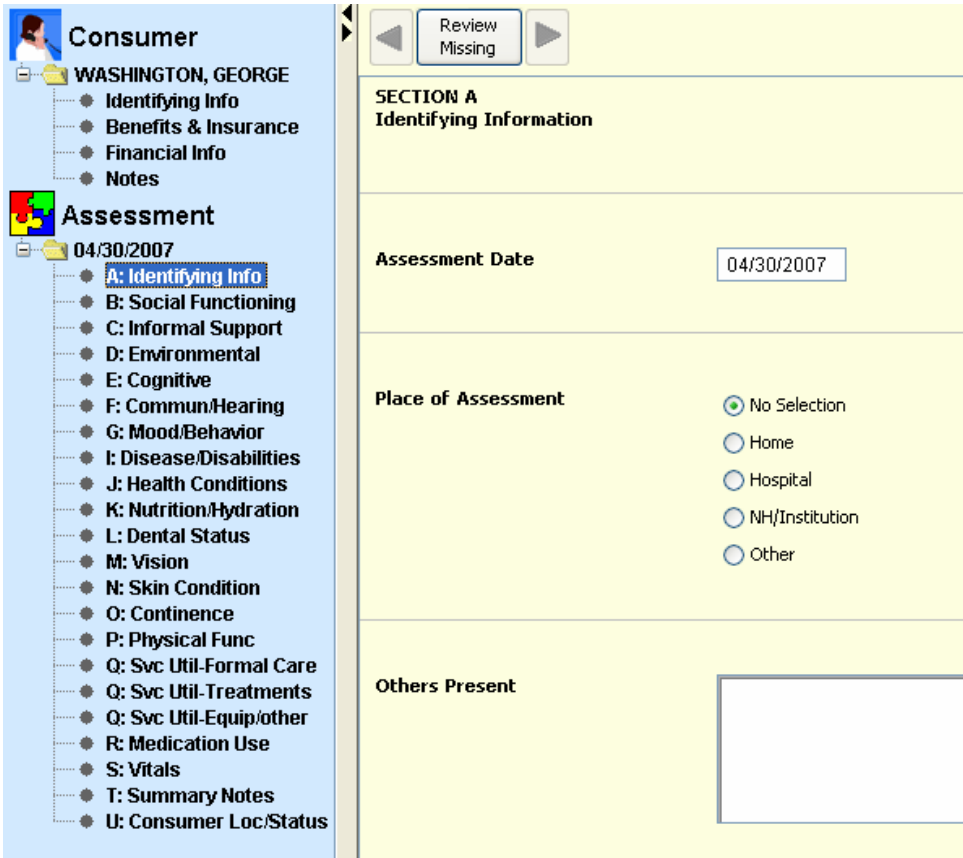
A version of CIM’s PICK software was customized to collect in-home interviews of people on wait lists. Each person on the wait lists was pre-loaded into a Consumer table with information from spreadsheets maintained at each waiver agent. This baseline Consumer record was augmented with additional information (including demographics and financials) once the person is interviewed. A separate record was added to store the Assessment data. The following presents screen shots from the PICK software.

The **Consumer Profile** was divided into three sections, similar to the participant information form used for MI Choice participants, plus a section for notes. The section names are displayed under the name of the individual in the navigation panel, as follows:



To enter data, users click on each section name and a data panel displayed a place for entering information. Users completed as many data items as possible and appropriate.

Care managers added an **Assessment** in a separate folder. The Assessment was divided into 21 sections. A [Review Missing] function allowed users to identify any important data items that were omitted.



APPENDIX C. VIGNETTES

I.

This person lives in a single family home with her husband. Her husband is the primary caregiver. She has a history of dementia and has had several strokes. She is unable to do anything for herself. She requires personal bathing, diapering, feeding and dressing.

Her spouse has been her primary caregiver for the past 18 years. He retired after working 32 years for a corporation that went bankrupt, and he lost his pension plan. He only receives \$847.00 each month through social security. The wife receives \$400.00 in social security benefits.

In the process of losing his retirement benefits, he also lost his home. The spouse has tried all avenues to get help for his wife but has been unsuccessful. Because they can barely make ends meet with the amount of money they receive, he has stopped giving her medications. He states he also has a difficult time paying for her diapers. The two of them eat day old bread and he plants a garden and cans food for the winter.

This wait list person would benefit greatly from the help of the MI Choice Waiver program. The spouse could benefit with the help of respite services.

II.

This is a case profile of a 46 year old female, with a long history of disability related to Progressive Multiple Sclerosis, Seizure Disorder and Hypertension. She resides in deplorable conditions in a mobile home infested with flies and other vermin. She cannot exit her residence due to steps and her wheelchair bound status.

She lives with her 17 year old son who attends high school during the day and functions as her primary caregiver. The son has had to repeat 11th grade because his caregiving activities has caused him to miss too much school to pass to the next grade level.

She receives \$600.00 per month; she is not certain if this benefit is SSI or Social Security Disability. She states she doesn't receive any support for her son and doesn't understand why. She does receive \$100.00 in food stamps each month but her rent is \$400.00 which doesn't allow enough income to meet all expenses.

This individual is unable to enter the bathroom area and therefore is unable to shower or bathe. She has difficulty getting from bed to chair without assistance, and therefore spends long hours in bed. Her safety is at risk because she would not be able to exit her home during the time her son is away.

She has difficulty swallowing and chewing as well, and she is in desperate need of dental care. Her friends help out with providing some food and her son does some of the meal preparation.

She does have a daughter who is either a Power of Attorney or Guardian but wasn't sure of the designation. This wait list member's issues are many and are extremely complex.

III.

A wait list member that was interviewed for the study has Dementia and is currently being cared for by family members. Her son had to leave his home in the Upper Peninsula to move in with her due to her need for constant supervision.

Family members are burned out with the responsibility of 24 hour care and constant supervision. They are requesting respite services to provide them some relief with their caregiving duties. They will not abandon her and will continue to care for her in her home but are just asking for some assistance through the MI Choice program.

IV.

An assessment was conducted on a Mrs. S who has been on the wait list with her spouse. The spouse is now deceased while waiting on the list for help.

The daughter commented that her father really needed help and had to be placed in a nursing home. This had a negative impact on Mrs. S who once was his primary caregiver; he had advanced Alzheimer's disease. She fell once when caring for him which triggered a hospitalization for her. She was exhausted and in need of help herself.

Mr. S was then admitted to the nursing home and Mrs. S would visit him daily. One time she was rushed to the hospital from the nursing home due to elevated blood pressure and stress. She continued to visit him and as he declined was at his bedside daily.

The family convinced her to go home and rest one night and he died while she was at home. Mrs. S has many regrets and wishes he could have been at home during his declining illness. She feels this would have been possible if they had been able to receive some assistance for his care. The couple had been married for over 60 years.

**APPENDIX D: Profile of Wait List Study
Participant Characteristics**

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About This Report

This report is designed to compare the characteristics of persons waiting to enroll into the MI Choice Home and Community Based Waiver program with persons already enrolled in this waiver in Wayne County. Data were recorded using a slightly abbreviated version of the Minimum Data Set for Home Care (MDS-HC) version 1.10. The data were analyzed at the University of Michigan under contract to the Michigan Department of Community Health.

The report displays three columns of data:

Column 1: cross-sectional data on all persons served statewide in the MI Choice Waiver program during FY 07.

Column 2: cross-sectional data on all persons served by the three Wayne county waiver agents during FY 07.

Column 3: data on Wayne county Wait List members who participated in this study.

The assessment record closest to April 1, 2007 was selected to create columns 1 and 2. All records were unduplicated. Statistically significant differences between the data in Columns 2 (Wayne County waiver) and 3 (Wayne County waitlist) are reported on the far left-hand side of each data page; one star = $p < .05$, two stars = $p < .01$, three stars = $p < .001$). For multi-category items, statistical differences across all categories are indicated by a star next to the grey category label, while differences between individual categories are indicated by a star adjacent to the category.

How the Report Is Organized

The report displays information on selected assessment items, as well as a variety of scales and indices. Explanations for items/scales are found on the page opposite the data. The report contains nine topic areas: Demographics, Caregiver Status, Health/Mental Health Status, Disease Diagnoses, Prior Service Use, Summary Status Measures, Resource Use Measures, Screening Algorithms, and Clinical Assessment Protocols.

Demographics

This section captures a general picture of the persons in each sample.

DEMOGRAPHICS			
	State Waiver	Wayne Waiver	Wayne Waitlist
Sample Size	8,785	1,368	258
Persons Served			
Gender (% female)	71%	77%	75%
*** Marital Status (% married)	24%	14%	23%
*** Referred/Admitted From			
*** Private Home w/ No Home Health Services	28%	46%	59%
*** Private Home w/ Home Health Services	65%	46%	34%
Board & Care/Assisted Living/Group Home	1%	2%	3%
** Nursing Facility	4%	5%	1%
*** Living Arrangement			
Lived Alone	42%	42%	41%
** Lived With Spouse Only	17%	10%	16%
* Lived with Spouse and Other(s)	7%	4%	7%
Lived with Child (Not Spouse)	19%	24%	23%
Lived with Other(s) (Not Spouse or Children)	12%	14%	13%
*** Lived in Group Setting With Non-Relatives	4%	6%	0%
Age			
Under 65	29%	26%	28%
65-79	33%	30%	33%
80 and over	38%	44%	38%
*** Race			
*** White	76%	30%	56%
*** Black	23%	69%	43%
Other	1%	1%	1%

Caregiver Status

Caregiver status identifies the types of unpaid support and assistance received by each person.

Participants with 1+ caregiver

This describes whether the person has one or more family members, friends, or neighbors who do or would provide assistance.

Areas of Assistance

This subsection reports whether or not help was given for either emotional support (listening, “being there” for the person), IADL care such as housework, shopping, or transportation, or ADL care, such as dressing, bathing or assistance with eating.

The last two items in this section summarize (1) the proportion of people who received more than 30 hours of informal help with ADLs or IADLs over the last seven days and (2) the proportion of informal helpers who were unable to continue in caregiving activities.

CAREGIVER STATUS			
	State Waiver	Wayne Waiver	Wayne Waitlist
*** Primary caregiver/participant relationship			
Participants with 1+ caregiver	95%	97%	96%
Primary caregiver lives with participant	46%	43%	46%
*** Child or Child-in-Law	42%	28%	54%
** Spouse	19%	10%	17%
*** Other Relative	28%	53%	18%
Friend/Neighbor	10%	9%	11%
Areas of Assistance			
*** Advice or Emotional Support	98%	99%	95%
IADL Care	92%	92%	93%
ADL Care	58%	64%	60%
Extent of Help			
Greater than 30 Hours/Week	36%	40%	44%
Caregiver Unable to Continue Care	10%	13%	16%

Health/Mental Health Status

End-stage Disease: person has six or fewer months to live.

Falls: five or more in the last 90 days.

Pain: one or more periods of pain each day over the last seven days.

Weight Loss: either 5% unintended weight loss in the last 30 days or 10% in the last 180 days.

Pressure Ulcers: presence of one or more stage 1 or higher pressure ulcers.

Bladder Incontinence: daily episodes of incontinence with some control, e.g., during the day, or always incontinent.

Bowel Incontinence: incontinent two or three times a week, or always incontinent.

Indicators of Depression: behavior was exhibited at least once in the last 30 days.

Behavioral Symptoms: behavior occurred daily or almost daily within the last seven days.

Changes in Behavior Symptoms: symptoms have worsened as compared to 30 days ago.

Disease Diagnoses

Data in this section document the presence of diseases/infections that have a relationship to the individual's current ADL status, cognitive status, behavior status, medical treatments, nurse monitoring, or risk of death. Conditions that have been resolved or no longer affect the individual are not included.

Prior Service Use

Hospital Admissions: any overnight hospitalization in the last 90 days.

Emergency Room Visits: any ER use without an overnight stay in the last 90 days.

Emergent Care Visits: any visit to a health provider that was unscheduled in the last 90 days.

Prior Nursing Facility Placement: any nursing facility stay within the last five years.

DISEASE DIAGNOSES			
	State Waiver	Wayne Waiver	Wayne Waitlist
Sample Size	8785	1368	258
Heart/Circulation			
* Cerebrovascular Accident (stroke)	27%	31%	25%
Congestive Heart Failure	32%	26%	24%
Neurological			
Alzheimer's	8%	11%	12%
Dementia other than Alzheimer's	19%	19%	18%
Parkinson's Disease	4%	4%	2%
Head Trauma	4%	2%	4%
Multiple Sclerosis	6%	5%	6%
Hemiplegia/Hemiparesis	13%	14%	16%
Musculo-Skeletal			
Hip Fracture	5%	4%	5%
Osteoporosis	26%	16%	17%
Other Diseases			
Cancer (not including skin cancer)	11%	10%	11%
Diabetes	40%	38%	38%
Emphysema/COPD/Asthma	24%	17%	20%
Renal Failure	10%	8%	7%

PRIOR SERVICE USE			
	State Waiver	Wayne Waiver	Wayne Waitlist
* Hospital Admissions	21%	19%	25%
* Emergency Room Visits	12%	8%	12%
*** Emergent Care Visits	8%	7%	15%
Prior Nursing Facility Placement	24%	18%	14%

Summary Status Measures

ADL Hierarchy

The ADL Hierarchy was derived from the ADL items in the assessment that conceptually measure early ADL loss (dressing, hygiene), intermediate ADL loss (transfer, locomotion, and toileting), and late ADL loss (bed mobility, eating) (Morris, Fries, and Morris, 1999). For each of the loss areas, potential difficulty is scored using the 0-4 scale from independence to total dependence. The Index combines these ADLs into a single comprehensive hierarchical scale (from 0 to 6) based on the degree of losses and performance level coding:

- Independent
- Supervision required
- Limited impairment
- Extensive assistance required (I)
- Extensive assistance required (II)
- Dependent
- Total dependence

Cognitive Performance Scale (CPS)

The CPS is a hierarchical index used to rate cognitive status. The CPS has been validated against the Mini Mental State Examination. The nursing facility CPS scale uses comatose to identify the most impaired group. Because these types of persons are rarely seen in home care settings, we use a modified CPS for people at home based on four assessment items: memory, cognitive skills for daily decision making, expressive communication, and eating.

- | | |
|----------------------------|----------------------|
| Intact | (average MMSE of 25) |
| Borderline intact | (average MMSE of 22) |
| Mild impairment | (average MMSE of 19) |
| Moderate impairment | (average MMSE of 15) |
| Moderate/severe impairment | (average MMSE of 7) |
| Severe impairment | (average MMSE of 5) |
| Very severe impairment | (average MMSE of 1) |

Communication Scale

The communication scale is a cognitive functioning outcome and assesses the person's ability to understand and make self understood. Each item in the communication outcome variable is scored 0-3. Combined, this summated scale has a range of 0-6, with increasing values indicating poorer communication ability.

- Clear
- Adequate
- Minimal Difficulty
- Some Difficulty
- Moderately Difficulty
- Highly Impaired
- Severely Impaired

Pain Scale

The pain scale is used to examine prevalence of pain. It has been validated against the Visual Analogue Scale (VAS). The pain scale examines the frequency and intensity of pain shown by an individual.

- No Pain
- Mild Pain
- Moderate Pain
- Severe Pain

Depression Rating Scale (DRS)

The DRS (Burrows, Morris, Simon, Hirdes, Phillips 1998) is a scale used to screen depression. It has been validated against the Hamilton Depression Rating Scale and the Cornell Scale for Depression.

- No Depression
- Mild Depression
- High Depression

SUMMARY STATUS MEASURES			
	State	Wayne	Wayne
	Waiver	Waiver	Waitlist
Sample Size	8785	1368	258
*** ADL Hierarchy			
*** Independent	22%	13%	32%
*** Supervision	14%	13%	5%
Limited Assistance	29%	34%	30%
Extensive Assistance I	14%	17%	15%
Extensive Assistance II	10%	10%	6%
Dependent	7%	8%	7%
Total Dependence	3%	6%	5%
*** Cognitive Performance Scale			
*** Intact	33%	33%	48%
Borderline Intact	17%	18%	15%
* Mild Impairment	21%	21%	16%
Moderate Impairment	19%	16%	11%
Moderately Severe Impairment	2%	3%	2%
Severe Impairment	5%	5%	7%
Very Severe Impairment	2%	4%	2%
*** Communication Scale			
*** Clear	62%	62%	80%
*** Adequate	16%	13%	5%
Minimal Difficulty	13%	12%	9%
Somewhat Difficulty	4%	4%	2%
* Moderate Difficulty	4%	5%	2%
Highly Impaired	1%	1%	0%
Severely Impaired	1%	2%	2%
Pain Scale			
No Pain	26%	31%	30%
Mild Pain	22%	27%	21%
Moderate Pain	27%	24%	25%
Severe Pain	26%	18%	24%
*** Depression Rating Scale			
*** No Depression	55%	65%	55%
Mild Depression	27%	24%	27%
*** High Depression	17%	11%	17%

Resource Use Measures

Resource Utilization Groups

The RUG-III/HC system classifies people into groups with similar needs and use of services and supports. It was designed to be compatible with the parallel system used in nursing facilities called Resource Utilization Groups – Version III (RUG-III). The system identifies seven distinct clinical categories. These major categories, listed in order of generally decreasing intensity of services and supports use, are described briefly below. Individuals are placed in the most resource-intensive category for which they qualify (i.e., closest to the beginning of the list). Sub-groups within the major clinical categories are created based on the person's degree of functional impairment for a total of 23 sub-groups.

- **Special Rehabilitation:** includes individuals who at the time of their assessment are receiving short term skilled therapies, including speech, occupational, and physical therapy.
- **Extensive Services:** includes individuals who receive very expensive and extensive medical services: those who have tracheostomies, are using a ventilator or respirator, or are getting parenteral feeding.
- **Special Care:** includes individuals with complicated care needs, including those who are quadriplegic, have multiple sclerosis, have stage 3 or 4 pressure ulcers, are receiving tube feeding, etc.
- **Clinically Complex:** includes individuals with a variety of somewhat less significant medical conditions under active treatment, including pneumonia, dehydration, urinary tract infections, chemotherapy, transfusions, and terminal illness.
- **Impaired Cognition:** includes individuals with cognitive loss.
- **Behavior Problems:** includes individuals who have challenging behavior, such as wandering, hallucinations, or physical abuse of others.
- **Reduced Physical Functions:** includes individuals with varying degrees of functional impairment who do not have any of the substantial medical, behavioral or cognitive problems that would qualify them for the other categories.

Associated with each RUG-III/HC group is a “case mix index” (“CMI”), a relative measure of the cost of caring for individuals in that group. Case Mix Index values express ratios; a person in the RUG-III/HC group with the highest CMI will use about 8 times more resources than a person in the lowest CMI group. The “average case mix index” across all categories of persons served in a population can also be calculated, as has been done here. The average CMI can also be used to compare the resource use among different HCBS populations or of the same population across time.

RESOURCE USE MEASURES				
		State	Wayne	Wayne
		Waiver	Waiver	Waitlist
Sample Size		8785	1368	258
***	RUG III-HC			
	Special Rehabilitation B	2%	1%	1%
	Special Rehabilitation A2	2%	1%	3%
*	Special Rehabilitation A1	2%	2%	5%
	Extensive Services 3	0%	0%	0%
	Extensive Services 2	0%	0%	0%
	Extensive Services 1	2%	2%	0%
	Special Care B	3%	3%	3%
	Special Care A	4%	4%	2%
	Clinically Complex C	3%	2%	3%
	Clinically Complex B	8%	6%	7%
	Clinically Complex A2	7%	6%	9%
*	Clinically Complex A1	5%	2%	5%
	Impaired Cognition B	7%	8%	6%
	Impaired Cognition A2	8%	6%	5%
	Impaired Cognition A1	1%	0%	0%
	Behavior Problems B	0%	1%	0%
*	Behavior Problems A2	0%	0%	1%
	Behavior Problems A1	0%	0%	0%
*	Reduced Physical Functions D	9%	11%	7%
	Reduced Physical Functions C	5%	5%	5%
***	Reduced Physical Functions B	13%	18%	6%
	Reduced Physical Functions A2	10%	14%	18%
***	Reduced Physical Functions A1	8%	7%	14%
Average Case Mix Index				
***	Average CMI (formal care only)	1.07	1.06	1.05
***	Average CMI (formal and informal care)	1.27	1.29	1.16

Screening Algorithms

Institutional Risk Screen

This screen identifies persons with impaired functioning who are at high risk of hospital or nursing facility use in the ensuing three-month period. The screen is triggered when the individual exhibits four or more of eleven risk factors. The algorithm was developed by Hebrew Rehabilitation Center for Aged in Boston as a Clinical Assessment Protocol.

Self-Reliance Screen

This screen, also developed by Hebrew Rehabilitation Center for Aged, is designed to differentiate persons who are able to function independently. For such persons, a short version of the MDS-HC, the Community Health Assessment, may be used to identify opportunities to promote the individual's health and reduce risks.

MI Choice Screen

This system, developed by the University of Michigan (Fries et al, 2004, 2002), predicts the care needs of persons seeking long term care assistance. The five "levels of care" roughly correspond with the following care modalities: nursing facility, home care, intermittent personal care, homemaker, and information and referral.

Physical A Screen

This screen, also developed by the University of Michigan, employs the RUG-III/HC algorithm logic to identify the "least impaired" group of persons served in a given setting. "Least impaired" is defined as those persons who use the fewest staff resources in either a nursing facility or in home care, and thus fall into the lowest acuity case mix category. A slightly modified version of this screen has been adopted for use by DCH in the Nursing Facility Level of Care Determination process. The screen works as a series of "doors" that sequentially measure ADLs, cognitive performance, changes in physician orders, selected treatments/conditions, skilled therapies, and behavior. (Note: this output does not reflect a seventh door (service dependency) which DCH added to its LOCD algorithm, as this calculation requires a more time-consuming process of linking longitudinal records).

MAPLe Screen

MAPLe, or Method for Assigning Priority Levels, was developed by researchers at the University of Waterloo, Ontario, Canada, to differentiate individuals into five priority levels. Research demonstrated that the five priority levels are predictive of relative risk of adverse outcomes. Persons in the high priority level are nearly 9 times more likely to be admitted to a long term care facility than are persons in the low priority group (Hirdes et al, publication pending). MAPLe also predicts caregiver stress. Angela: Hirdes says there is a paper out now about MAPLe: if it's in the bib, please add a reference to it here.

SCREENING ALGORITHMS				
		State	Wayne	Wayne
		Waiver	Waiver	Waitlist
Institutional Risk				
***	% who are At Risk	25%	29%	28%
Self-Reliance				
***	% who are Not Self-Reliant	84%	92%	74%
MI Choice				
	Nursing Facility	6%	8%	6%
***	Home Care	58%	70%	44%
***	Intermittent Personal Care	28%	19%	31%
***	Homemaker Services	4%	2%	11%
***	Information & Referral	4%	2%	7%
Physical A				
***	% who are PA	18%	20%	33%
MAPLE				
***	Very High Risk	4%	1%	7%
**	High Risk	5%	3%	7%
	Moderate Risk	56%	61%	57%
	Mild Risk	29%	27%	21%
	Low Risk	6%	7%	9%

Clinical Assessment Protocols

The assessment system includes Clinical Assessment Protocols (CAPs) developed by interRAI. These protocols address major topics of concern and are designed to alert the assessor to consider the issue in care planning activities with the individual and family. Basically, CAPs promote understanding of WHAT should be addressed in care planning, WHY it should be addressed, and HOW it should be addressed.

CAP “triggers” are specific combinations of items from the assessment that identify potential problems and existing health risks. The protocols and the health risks or concerns which they identify are listed below. In the accompanying chart, the data reflect the percentage of persons who triggered on each CAP. Triggering a CAP does not mean that the person will actually have a given problem; rather, the trigger indicates a need for further evaluation.

Functional Performance

ADL/Rehabilitation Potential: Identifies individuals with the potential for greater independence in self care.

Instrumental Activities of Daily Living: Identifies interventions for restoring impaired IADL function.

Health Promotion: Identifies individuals who may benefit from increased exercise or smoking cessation.

Institutional Risk: Identifies individuals at high risk of hospital or nursing facility use.

Sensory Performance

Communication Disorder: Detects problems in receiving/sending verbal/nonverbal messages.

Visual Function: Guides the evaluation of individuals with vision problems.

Mental Health

Alcohol Abuse and Hazardous Drinking: Evaluates alcohol use, abuse, or dependence.

Cognition: Identifies presence of acute or chronic cognition problems.

Behavior: Identifies individuals with behavioral symptoms distressing to themselves or to others.

Depression and Anxiety: Detects people who experience anxiety and/or depression.

Elder Abuse: Detects situations of abuse, neglect or significant risk of abuse.

Social Function: Detects loneliness, decline in preferred activities.

Health Problems

Cardio-Respiratory: Identifies cardiovascular/respiratory systems requiring medical management.

Dehydration: Detects dehydration or factors which could lead to dehydration.

Falls: Detects risk of falling and provides guidance to minimize risk and limit injury.

Nutrition: Detects malnutrition and risk of malnutrition.

Oral Health: Detects oral health problems that cause pain, inability to eat or speak, etc.

Pain: Identifies individuals for whom pain limits ability to function.

Pressure Ulcers: Identifies individuals at risk of developing skin breakdown.

Skin and Foot Conditions: Detects skin and foot problems or risk of developing problems.

Service Oversight

Non-Adherence Risk: Identifies individuals at risk of not following medical advice re treatments and therapies.

Brittle Support System: Identifies families who may have difficulty dealing with impaired person’s needs.

Medication Management: Establishes a complete list of medications.

Palliative Care: Identifies the need for comprehensive care to terminally ill persons who wish to stay home.

Preventive Health Measures: Identifies individuals with unmet needs for screenings/immunizations.

Psychotropic Drugs: Identifies individuals taking psychotropic drugs who need a medical review.

Reduction in Formal Services: Evaluates formal services delivered, with the goal of service reduction.

Environmental Assessment: Detects hazardous conditions in and around the home.

Continence

Bowel Management: Detects problems associated with bowel function and GI system disorders.

Urinary Incontinence: Detects potentially reversible causes of incontinence.

CLINICAL ASSESSMENT PROTOCOLS (CAPs)			
	State	Wayne	Wayne
	Waiver	Waiver	Waitlist
Sample Size	8785	1368	258
Functional Performance			
ADL/Rehab Potential	51%	43%	45%
*** IADL Intervention	97%	97%	92%
Health Promotion	69%	71%	75%
*** Institutional Risk	25%	29%	28%
Sensory Performance			
*** Communication Disorder	52%	52%	36%
*** Visual Evaluation	46%	70%	52%
Mental Health			
Alcohol Dependence/Hazard Drinking	1%	1%	1%
*** Cognition	54%	54%	43%
Behavior	7%	11%	10%
*** Depression/Anxiety	29%	18%	29%
Elder Abuse/Neglect	3%	1%	3%
*** Social Function	24%	21%	33%
Health Problems			
Cardio-Respiratory	51%	38%	39%
** Dehydration Risk	4%	4%	8%
Falls Risk	28%	33%	30%
*** Nutrition	16%	16%	25%
* Oral Health/Dental Care	25%	22%	29%
Pain	74%	70%	70%
Pressure Ulcer Risk	46%	42%	39%
Skin/Foot Condition	39%	29%	29%
Service Oversight			
Nonadherence Risk	6%	4%	6%
* Brittle Support System	70%	76%	69%
*** Medication Management	50%	39%	42%
Palliative Care	2%	1%	2%
Preventive Health Measure	89%	94%	95%
Psychotropic Drugs	57%	43%	44%
*** Reduction in Formal Services	12%	8%	19%
Environmental Hazards	11%	17%	18%
Continence			
Bowel Management	33%	37%	40%
Urinary Incontinence	57%	59%	52%