Final Report

The Minnesota Live Well At Home Program: Performance Evaluation

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Executive Summary

The Minnesota Live Well at Home Program (LWAHP) focused on the private-pay individual, or the client who may be close to the Medical Assistance (MA) eligibility cut-off but ineligible for traditional state- or federally-reimbursed service programs. In contrast to more generalized case management principles, the extended support service component of the LWAHP was firmly grounded in a risk management approach that directly linked clients to evidence-based interventions, emphasized self-direction, and targeted consultation based on the identification of risk factors with the hope of facilitating private purchase of appropriate community-based support. Specifically, if extended support services of the LWAHP worked as anticipated, clients would develop a flexible service plan and budget with the help of the LWAHP provider to mitigate risk factors and purchase services on their own (via private funds or other income sources) with ongoing oversight to ensure effective fiscal management that sustains community living. The primary objective of this performance evaluation which included a small controlled study was to determine whether the LWAHP led to reductions in nursing home admission (NHA) or assisted living entry (ALE) and was well-received by older adults and family caregivers in all seven Minnesota Area Agencies on Aging (AAAs) regions.

Participants were identified during regular contact via private provider service delivery (e.g., caregiver consultant and memory care assessments, homemaker services, home delivered meals), routine calls to the Senior LinkAge Line®, or similar contacts. Once these individuals were identified, basic study procedures commenced. As part of the controlled study process, baseline, 3- and 6-month telephone interviews were conducted by University of Minnesota Research Coordinator, Mary Boldischar, with participants following the initial Rapid Screen Service. These interviews collected detailed information on service utilization (i.e., community-

based service use, long-term care utilization), MA spend-down patterns, satisfaction with the LWAH Rapid Screen© and extended support service, perceptions of facilitators or barriers encountered with the LWAHP, and other key variables identified by the LWAHP team. The goal of these follow-up surveys was to determine if the LWAHP is feasible, if it delivers its extended support services successfully, and if it is well-received by private-pay clients, caregivers, and the aging network providers. The follow-up surveys with "control" group participants provided the basis for determining the efficacy of the LWAHP services.

A total of 50 participants (25 in a LWAHP "treatment" condition, recruited from one AAA site; and 25 in a usual care control condition, recruited from a separate AAA site) were enrolled in the 6-month controlled evaluation. In addition, 471 older persons or their proxies participated in an "evaluation" study that only collected data from the LWAH Rapid Screen© and service use.

Enrollment of participants in the performance evaluation which included the controlled study and evaluation appeared to target individuals at sufficient risk for subsequent health service utilization. Higher risk scores predicated two types of service use: services related to the supportive components of the LWAHP initially and over time (e.g., risk action planning, caregiver services, memory programs, self-directed services, and Title III services) and, following re-screening, high intensity health service use such as nursing home admission or hospital stays. Satisfaction data in the controlled study sample emphasized that participants were highly satisfied with LWAH-RS sessions overall, and that this general satisfaction was maintained over a 6-month period. Open-ended data collected from LWAHP providers implied that the LWAH-RS is the strength of the LWAHP; providers consistently praised the length and content of the tool, so much so that translation of the tool into everyday assessment has already

begun. The extended support service component of the LWAHP, however, did not take hold as well, which suggests the need for more expansive implementation work to embed the principles in AAAs and among other community providers. The overall lack of placement data did not allow for any conclusions related to extended support services actually delaying costly residential transitions. One finding that was contrary to expectation was that the frequency and duration of contact in the control site was significantly greater at the control site when compared to the LWAHP treatment site. The significant difference may have been due to variations in income at baseline, as almost all participants from the control site were under the 200% income threshold while significantly fewer were from the treatment site; this variation may have led to greater access and service delivery at the control site. Interestingly, no treatment group LWAHP provider had any participants who used LWAHP grant funds for a self-directed service budget. This could be because the treatment group provider offered like or similar services through her agency or perhaps there simply was no interest from participants.

The Fiscal Support Entity contracted to handle the self-directed service (SDS) budgets reported that 21 participants enrolled in SDS with 50% cost-share, with 1 of these participants converting to 100% private pay during the project period. Seven additional participants were referred to SDS but for various reasons did not enroll. In reports from LWAHP providers, the topic of cost-sharing, private pay purchasing, and people using their own money to pay for services can be very challenging as many older adults are saving money for their children to inherit.

In considering the results of the current LWAHP performance evaluation in Minnesota, our recommendations are consistent with our pilot LWAHP evaluation. What is evident at this stage of pilot implementation is that the LWAH-RS is a flexible, easy-to-use tool and offers key

information to service providers to inform care planning. This conclusion is further bolstered by the results here, which suggest the LWAH-RS was the most successful component implemented. Areas that require continued attention in future evaluations include a more viable controlled comparison that includes more sites and a larger sample to ensure feasible statistical analysis. A variable or data collection element that is critical to understanding the process of the LWAHP as well as whether it achieves its outcomes is to determine the number of clients who actually purchase services using private funds due to extended support services. Future evaluation efforts should clearly assess whether this occurs. Subsequent implementation and evaluation of the LWAHP should also consider longer-term follow-up to demonstrate efficacy or effectiveness of the intervention to delay NHA, ALE, or similar outcomes. The shift in service delivery paradigm from case management to risk management requires greater operationalization of the LWAHP, particularly extended support services. While this is to some degree a culture shift and disciplinary training issue, it is also critical for future administrators or providers of the LWAHP to be specific as to what the functioning tasks of the extended support services provider are, how they are implemented as clearly as possible, and how such service delivery builds upon (and does not duplicate) existing services. The sensitivity and specificity of the LWAH-RS should also be tested prospectively; as the LWAH-RS is the most successful component of the LWAHP, bolstering its validity would go to great lengths to establish its replicability for regions beyond Minnesota.