



Institute for Child Health Policy at the University of Florida
Texas External Quality Review Organization

Texas Medicaid Managed Care STAR+PLUS Home- and Community-Based Services Waiver Study Report

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Executive Summary

Introduction

This report describes the methodology and findings of a study conducted by the Institute for Child Health Policy (ICHP) – the External Quality Review Organization (EQRO) for Texas Medicaid – to evaluate the patient-centeredness of the Home- and Community-Based Services (HCBS) Program, which allows STAR+PLUS members who are older, chronically ill or have a disability to receive services in their home. The study examines the perceptions of STAR+PLUS service coordinators and members (both Medicaid-only and dual-eligible) about the extent to which individual service plans (ISPs) address the needs and desired outcomes of members enrolled in the HCBS Program.

The purpose of this study was to: (1) describe and categorize the types of HCBS provided to STAR+PLUS members; (2) examine perceptions STAR+PLUS members and service coordinators about the process of developing an ISP; (3) assess the involvement of members and their families in decisions regarding their care; and (4) assess members' experiences and satisfaction with the HCBS they receive.

Methodology

The EQRO adopted a mixed-methods approach to assessing patient-centered outcomes for STAR+PLUS members who had an ISP signed and implemented during fiscal year (FY) 2011 and 2012. The study included four concurrent phases: (1) a descriptive analysis of data elements present in both paper and electronic ISPs; (2) a structured telephone survey with STAR+PLUS members or their caregivers; (3) in-depth face-to-face interviews with STAR+PLUS members or their caregivers living in the Harris SA; and (4) semi-structured telephone interviews with STAR+PLUS service coordinators.

Summary of Findings

Member telephone survey

The members receiving home- and community-based services are in poor health.

- Self-ratings of general/overall health were low, with only 6.5 percent of members reporting being in very good or excellent health.
- Three-quarters to 85 percent of members reported being limited a lot in doing typical daily activities.
- Moderate to severe pain affected more than 65 percent of members in the four weeks prior to the survey.
- Daily work and accomplishments were limited most or all of the time for almost three quarters of members surveyed.
- Two-thirds of members reported depressive symptomatology and 30 percent had severe depressive symptoms occurring on a daily basis.

A majority of members are receiving paid and unpaid caregiving services.

- Ninety-one percent of members reported having a caregiver that assists with daily activities.
- Informal/unpaid caregivers provide an average of 46.8 hours of care per week on an ongoing basis with the help of paid caregivers, family members and friends.
- Family members were highly involved in putting together the members' plans for home and community based services.

A majority of members need assistance in multiple areas of daily life for multiple reasons.

- Close to 90 percent of members reported needing help with daily activities because of their physical health issues.
- Areas of highest need for assistance were for: a) looking after oneself; b) getting enough of the right type of food to eat; c) getting around inside and outside of the home; and d) assistance with daytime activities.
- On average, members needed assistance in 13 areas of daily life on a regular and consistent basis.

Members are generally satisfied with their service coordinator and the home- and community-based services they receive as part of their individual service plan

- Up to three-quarters of members reported that their plan for home- and community-based services addressed services that were important to them and were responsive to their needs.
- Most members (71 to 76 percent) reported feeling they were included in the decision-making process related to receiving home- and community-based services, including being told of the pros and cons of particular services.
- A majority of members (62 to 70 percent) felt that their service coordinator explained things well, and helped them as soon as they thought they needed assistance.

Member face-to-face interviews

Members sometimes have a need for covered services between assessments, which leads to periods of having unmet needs.

- The most common unmet needs include services that are covered by the HCBS program, such as adaptive aids, personal attendant services, nursing care, and physical therapy.
- The most important outcomes of HCBS for members include having people to look after them, outcomes specific to medical conditions such as heart disease and diabetes, independence, and mobility.

- More than one-third of members who participated in the face-to-face interviews reported having no barriers to receiving HCBS. Among those who did report barriers, poor communication was the most commonly mentioned. Poor communication leads to insufficient information about available services, which members require to make decisions about their care.

Members are not familiar with the term “ISP”, but have general knowledge of their service plans and do express a desire to be included in decisions regarding their care.

- Twenty-one out of 23 members in the face-to-face interviews were not familiar with the term “individual service plan,” although most had general knowledge of their plans to receive HCBS. More than half of the members stated they were not involved in planning as much as they wanted. Among members with family, half said their family was not involved in planning. These findings conflict with findings on similar questions from the member telephone survey, and require further exploration to determine whether revisions to the telephone survey tool are warranted.
- Members most valued being involved in cases where they experienced delays or denial of services, and when they needed information to access services.

Poor communication with providers is the most common type of negative experience that members face. Problems with transportation and victimization by vendors are also important issues.

- Poor communication with MCOs, service coordinators, and doctors – both verbal and written – was the most common negative theme. Members do not always know who to call when they have problems or questions about their care.
- Health plan transportation services were often criticized. Some members felt unsafe using health plan transportation, which often led to missed appointments.
- Victimization by personal attendants was rare, but a very salient theme for members who experienced it. Some members reported that personal attendants stole medications from them, which they found hard to replace in the short term. In one case, the member reported the theft to his home nurse, and the vendor subsequently replaced his personal attendant. These findings should be interpreted carefully, however, as they are based on member report and were not substantiated by outside sources.

Having home- and community-based services gives members a sense of independence and personal space that is important for their quality of life. Member satisfaction is greatest with providers who proactively assist them.

- Seven members of the 23 members reported being more satisfied with the HCBS they receive than services they received in prior settings, largely due to an increased sense of independence and personal space.
- Members were particularly pleased with personal attendants, nurses, and service coordinators who went “out of their way” to help them.

Members generally reported greater familiarity with personal attendants and nurses than with service coordinators. Few members reported receiving calls from their service coordinator.

- Contact with service coordinators was very infrequent. Level of familiarity increased with the level of contact, with members being more likely to know the names of their personal attendants and nurses than their service coordinator.
- Of the 23 members interviewed, only six members reported their service coordinators would call them on the phone – a finding that is inconsistent with the member telephone survey findings. This finding requires further exploration to determine whether revisions to the telephone survey tool are warranted. Only four of the 23 members reported receiving in-person visits by their service coordinator.

Service coordinator interviews

Health plans follow a systematic process to develop and reassess ISPs. However, that process does not exist without challenges, many of which may be overcome through workflow development, implementation and evaluation.

- Health plans utilize multiple strategies to identify members' needs and confirm needs claims through in-home visits. The desired needs of members are taken into consideration and services are provided if they meet minimal criteria set forth by the Texas Medicaid program. Needs not covered by services provided by the health plan are often accommodated through community resources.
- ISP development and reassessment is a dynamic process which occurs annually at minimum. Reassessment may occur prior to the annual anniversary due to a reported change in need or health status.
- The most common challenges in developing the ISP and assessing members' needs include: (1) getting the health care providers to sign documentation of medical conditions to verify medical necessity; (2) conducting in-home assessments in a timely manner; (3) issues with health plan software; and (4) making follow-up contact with members.
- Service coordinators assist with service initiation and have minimal involvement once services are initiated, unless there is: (1) a problem with a vendor; or (2) the member desires to change vendors.
- The plan provides no formal system to verify service delivery to members or to monitor the quality of services provided to members. Currently services are verified through follow-up calls by service coordinators to members, but are not required. Informal methods exist but are not utilized across the entire organization.
- Service coordinators must have at least one of the following professional qualifications: (1) a bachelor's degree in social work, human services, or a related health field; (2) a nursing degree, as a registered or licensed vocational nurse; or (3) significant experience in the medical field, social work or human services.

- Health plans provide new hire and continuous training on systems and plan related issues. However, the health plan does not offer continued education for service coordinators to maintain professional licensure.
- Caseloads are determined by geographical area and range between 200-500 cases for a service coordinator. On average, service coordinators conduct 20 new and 15 reassessment ISPs each month, which are informal thresholds used by leadership to assess caseload distribution.

Recommendations

The EQRO recommends the following strategies to Texas HHSC and STAR+PLUS MCOs for improving the delivery and quality of HCBS care for STAR+PLUS members:

Domain	Recommendations	Rationale
Service coordinator contact with members	<ul style="list-style-type: none"> • To meet the needs of members in the HCBS Program, STAR+PLUS MCOs should adopt more stringent standards regarding the frequency and means of contact between service coordinators and members. New standards may include: <ul style="list-style-type: none"> ○ In-home visits by service coordinators ○ Proactive telephone contact with members by service coordinators on a regular schedule (quarterly or monthly) ○ Use of telehealth technology to ensure that service coordination is patient-centered and tailored to members' needs.^{1,2} ○ Protocols for improving communication that involve all stakeholders – service coordinators, nurses, providers, members, and their families • Health plans should explore strategies for reducing the caseloads of service coordinators, which would allow more frequent contact with members. 	<p>Although the legal standard for in-home follow-up is an annual reassessment, the need for covered services can and does arise during the course of a year.</p> <p>Findings show that members often do not know who to call to get help. Many do not have contact information for their service coordinators, and many cannot name someone at their health plan who coordinates their care.</p> <p>For members who do not have a nurse who visits them regularly (often those with less severe conditions), low levels of contact with service coordinators translate to unmet needs for care.</p> <p>High service coordinator caseloads are a recognized barrier to improving communication with members.</p>

	<ul style="list-style-type: none"> • During points of contact, service coordinators should actively assess members' preferences and needs and inform them of available programs offered by the MCO, including disease management, exercise programs, and value-added services. 	
Vendor quality and certification	<ul style="list-style-type: none"> • STAR+PLUS MCOs should evaluate existing protocols for contracting with home health care, transportation, and other types of vendors to ensure a higher quality of vendor service. • Health plans should implement or improve upon vendor certification processes, using the following strategies: <ul style="list-style-type: none"> ○ Checking vendor ratings with local business bureaus ○ Checking vendor ratings using online resources ○ Assessing and documenting the vendor's litigation and other legal history 	<p>Many members reported negative experiences with vendors contracted by the health plan to deliver HCBS and other services.</p> <p>In particular, some members reported possible victimization by personal attendants (including theft and physical threats). Others reported dangerous situations when using health plan transportation.</p>
Future evaluation studies for STAR+PLUS	<ul style="list-style-type: none"> • Findings from this study should be examined in the context of other quality of care results for the STAR+PLUS program, including the rate of potentially preventable events such as admissions, readmissions, and emergency department visits. 	<p>Members in the STAR+PLUS program have complex health care needs and often multiple co-morbidities. Problems with service coordination can contribute to deficits in quality of care and the occurrence of potentially preventable events. While members overall were satisfied with their ISPs and care, unmet needs for care were reported that may contribute to gaps in quality of and access to care.</p>

Introduction

Over the past 20 years, state Medicaid programs have expanded coverage and services for members in need of long-term care services and supports, which account for nearly one-third of total Medicaid spending nationally.³ The most commonly reported expansion has been for new or extended waivers for home- and community-based services (HCBS), which allow members with chronic health conditions and disabilities to receive long-term care services in the home, rather than in institutional settings. The implementation of HCBS can reduce costs of institutional care in nursing facilities and intermediate care facilities, as well as improve the quality of life for members who would otherwise require institutional care.

Only 13 percent of people with chronic health conditions and disabilities receive paid help to supplement informal care, and most of the paid help comes from Medicaid and Medicare payments.^{4,5} In the Texas STAR+PLUS program – which serves Medicaid-eligible individuals who are chronically ill or have a disability in ten urban service areas (SAs) – these services are offered through the Texas HCBS Program, under the authority of a 1915(c) waiver.⁶ STAR+PLUS members who are enrolled only in Medicaid or who are dually enrolled in Medicaid and Medicare may be eligible to receive any of the following services in the home through the HCBS Program:

- Personal assistance services (PAS)
- Respite care
- Financial management services (FMS)
- Support consultation
- Adaptive aids and medical supplies
- Adult foster care
- Assisted living
- Dental treatment
- Emergency response services
- Home-delivered meals
- Minor home modifications
- Nursing services
- Specialized therapies
- Transition assistance

The services provided through the HCBS Program are identified in an individual service plan (ISP) that is developed between the member and the member's STAR+PLUS MCO service coordinator. In-depth information about the process for developing these plans and their implementation is critical for assessing health care quality in this population. However, very little is known about the extent to which enrollees receiving HCBS are included in decisions regarding their long-term care plans or in defining outcomes of importance to them. Nationally, there is an emphasis on identifying and incorporating patient-centered outcomes of care into programs because of evidence that individuals are more likely to have better health outcomes, higher satisfaction and well-being, and better treatment adherence when they are able to help define what is important to them.^{7,8}

This report describes the methodology and findings of a study conducted by the Institute for Child Health Policy (IChP) – the External Quality Review Organization (EQRO) for Texas

Medicaid – to examine the perceptions of STAR+PLUS service coordinators and members (both Medicaid-only and dual-eligible) about the extent to which ISPs address the needs and desired outcomes of members enrolled in the HCBS Program. Specifically, the purpose of this study was to: (1) describe and categorize the types of HCBS provided to STAR+PLUS members; (2) examine perceptions STAR+PLUS members and service coordinators about the process of developing an ISP; (3) assess the involvement of members and their families in decisions regarding their care; and (4) assess members’ experiences and satisfaction with the HCBS they receive.

The EQRO adopted a mixed-methods approach to assessing patient-centered outcomes for STAR+PLUS members who had an ISP signed and implemented during fiscal year (FY) 2011 and 2012. The study included four concurrent phases: (1) a descriptive analysis of data elements present in both paper and electronic ISPs; (2) a structured telephone survey with STAR+PLUS members or their caregivers; (3) in-depth face-to-face interviews with STAR+PLUS members or their caregivers living in the Harris SA; and (4) semi-structured telephone interviews with STAR+PLUS service coordinators.

Methodology

The EQRO requested copies of paper and electronic ISPs from the five managed care organizations (MCOs) participating in STAR+PLUS in FY 2011 – Amerigroup, Evercare, HealthSpring, Molina, and Superior. Among these MCOs, only Amerigroup and Molina provided ISPs during the time frame required for this study. Between April 2012 and November 2012, a total of 1,935 ISPs were collected from Amerigroup and Molina, as shown on **Table 1** below. Starting dates of the ISPs ranged from January 2011 to November 2012.

Table 1. Number of Individual Service Plans Collected for Study

	Amerigroup	Molina	Total
Paper ISPs	1,331	385	1,716
Electronic ISPs	96	123	219
Total	1,427	508	1,935

All data elements for paper ISPs were entered by EQRO researchers into a database, which was quality-checked at regular intervals. Data elements included member’s name and date of birth, active ISP dates, the type of authorization (whether a new or reassessed ISP), location from which the member was enrolled, and the member’s living arrangement after entering the HCBS Program. The ISPs also included a listing of the HCBS for which the member was approved, the corresponding vendor ID numbers, estimated annual service units and estimated annual cost.

Electronic ISPs were provided to the EQRO as Excel files, which were formatted and merged with the database of paper ISPs.

Phone Survey Methodology

Eligible participants for the telephone survey included all Texas STAR+PLUS members (both Medicaid-only and dual-eligible) for whom the EQRO obtained a paper or electronic ISP at the time of sampling (N = 1,207). The sampling frame included 872 members in Amerigroup and 335 members in Molina. A target sample of 290 completed surveys was set, representing the number of participants needed in order to predict the true population percentage of members whose ISPs met their needs, with a +/- 5 percent margin of error.

Participants selected for recruitment received an advance letter introducing them to the study and providing them with an opportunity to opt-out of participation. Participants following the directions in the letter had the opportunity to call the EQRO within seven days of receiving the advance letter to express their wishes not to be contacted. After the seven-day period, the Survey Research Center (SRC) at the University of Florida began calling participants to enroll them in the study. In some cases, the identified STAR+PLUS member was too sick or frail to participate in a phone survey. In these cases, an informal caregiver or other proxy who was familiar with the STAR+PLUS member's health could answer questions for the member. Interviewers obtained verbal consent from members or proxy respondents to conduct the survey.

Phone surveys were conducted using computer-assisted telephone interviewing (CATI) between September and November 2012. Each survey lasted up to 35 minutes. A total of 202 STAR+PLUS members participated in the survey, with a response rate of 46 percent and cooperation rate of 73 percent.⁹ Fifty-four percent of STAR+PLUS members in the sample could not be located. Among those located, 14 percent refused to participate.

The phone survey included questions developed by ICHP to assess members' demographic characteristics, information regarding their caregivers (both informal and paid), and their experiences and satisfaction with the development of their ISP, their service coordinator, and the HCBS delivered through their STAR+PLUS health plan. Measures of functioning and health status were included using three standardized instruments: (1) a telephone survey adaptation of the Camberwell Assessment of Need for the Elderly (CANE), which is a systematic multi-dimensional needs assessment; (2) the 10-item Center for Epidemiologic Studies Depression scale (CES-D-10); and (3) items from the Medicare Health Outcomes Survey (M-HOS) assessing self-reported health status, physical and emotional functioning. The survey instrument was sent to HHSC for review prior to pilot testing. The instrument was pilot tested with 15 Medicaid-only and 15 dual-eligible STAR+PLUS members who have ISPs, and modified based on these preliminary findings. Participants were paid an incentive (a \$25 gift card to Wal-Mart) for participation in the one-time survey.

At the end of each survey, participants in the Harris SA who met certain demographic and enrollment criteria were asked whether they would be willing to participate in a face-to-face interview at their home. Members who agreed to participate comprised the sample for the face-to-face interviews, described below.

Face-to-Face Interview Methodology

To more fully explore the experiences of STAR+PLUS members with their individual service plans and HCBS, the EQRO conducted in-depth, face-to-face interviews with a sample of members and their caregivers. Because members' experiences and perceptions may vary by race/ethnicity and eligibility status (Medicaid-only or dual-eligible), a quota sampling approach was taken to ensure that members of all groups were included. A target sample of 30 interviews was set, with half eligible for Medicaid only and half dual-eligible (15 in each group), and one-third belonging to each of three racial/ethnic groups (10 in each group) – Hispanic; White, non-Hispanic; and Black, non-Hispanic (**Table 2**).

Table 2. Face-to-Face Interview Sampling Strategy

Race/ethnicity	Medicaid-only		Dual-eligible	
	Target	Completed	Target	Completed
Hispanic	5	2	5	4
White, non-Hispanic	5	5	5	4
Black, non-Hispanic	5	4	5	5
Total	15	11	15	12

The Harris service area was selected for the face-to-face interviews because it is the largest service area in which the STAR+PLUS program operates, had been operating in STAR+PLUS the longest, and includes an ethnically diverse population. Members' experiences and perceptions may differ according to whether the member lives in an urban or rural area. To account for these differences, efforts were made to recruit members living in Matagorda and Wharton counties (which are designated as rural by the National Center for Health Statistics), in addition to the remaining counties in Harris SA, which are urban.¹⁰

Interviewers with expertise in qualitative research conducted the in-depth interviews in the members' homes during October 2012. Two interviewers were present for all interviews – one from the EQRO, and one from the National Opinion Research Center (NORC) at the University of Chicago. Topics covered in the interviews included the member's history of HCBS needs (and whether any of their needs were not being met), their experiences with shared decision-making in developing their ISP and receiving care, their perception of barriers to needed HCBS, and whether their service coordinator was meeting their expectations. Interviews were audio recorded and lasted between 30 and 90 minutes. Members (or their proxy caregivers) received an additional \$25 gift card for their participation.

Twenty-three face-to-face interviews were conducted, with all quotas having four or five completed interviews except Hispanic Medicaid-only members (as shown on **Table 2** above). Audio recordings of the interviews were transcribed and analyzed for common themes relevant to understanding members' experiences and satisfaction with the HCBS Program. The analytic

approach included an analysis of four types of narratives collected during the interviews, addressing the members' experiences with: (1) satisfactory care; (2) unsatisfactory care; (3) involvement in decisions regarding HCBS; and (4) non-involvement in decisions regarding HCBS. In addition, enough data were collected in the interviews to permit a free-list analysis of unmet needs, the "most important" outcomes of HCBS, the "most positive" aspects of HCBS, and barriers to receiving HCBS.

Service Coordinator Interview Methodology

Lastly, the EQRO planned a series of 20 semi-structured telephone interviews with STAR+PLUS service coordinators, which would allow for an understanding of the planning and delivery of HCBS from a health plan perspective, and inform the revision of other tools used in this study.

Service coordinators at the five health plans participating in STAR+PLUS during FY 2011 comprised the recruitment pool for the interviews. Appropriate contacts at each of the health plans were contacted by the EQRO via email in August 2012, explaining the purpose of the study and requesting a list of active service coordinators in the plan. Three MCOs – Amerigroup, HealthSpring, and Superior – provided complete lists of their service coordinators within the timeframe of the study. A total of 168 service coordinators were present in the combined sample.

An interview guide and protocol were developed, assessing service coordinators' understanding of the steps for creating a member's ISP, initiating home- and community-based services, follow-up and reassessment of ISP and services, and background information about service coordinators and their caseloads. The interview guide focused on the process of assessing a member's needs for services, how the member's desired health goals are identified, and the extent to which members and their families are involved in the development of their ISPs. The guide also included questions about challenges to conducting the needs assessment, common types of needs, characteristics of high-need members, and any indicators that service coordinators may use to monitor the outcomes of HCBS.

The EQRO first interviewed two service coordinator supervisors as key informants, which provided information essential for understanding the basic structure and function of the HCBS Program, and for revising the telephone survey and face-to-face interview tools. During November 2012, an additional eight telephone interviews were conducted with service coordinators. The interviews were audio recorded using web conference technology, and the recordings were transcribed for analysis.

A total of ten completed interviews were collected and analyzed – all with service coordinators in the Superior health plan.

Results

Descriptive Analysis of Individual Service Plans

As part of this evaluation, the paper and electronic versions of individualized service plans for STAR+PLUS members in Amerigroup and Molina were examined to understand the types of services utilized. A total of 1,935 individual service plans were examined. This section describes the characteristics of members with ISPs, and the type and cost of services utilized under the plans for FY 2011.

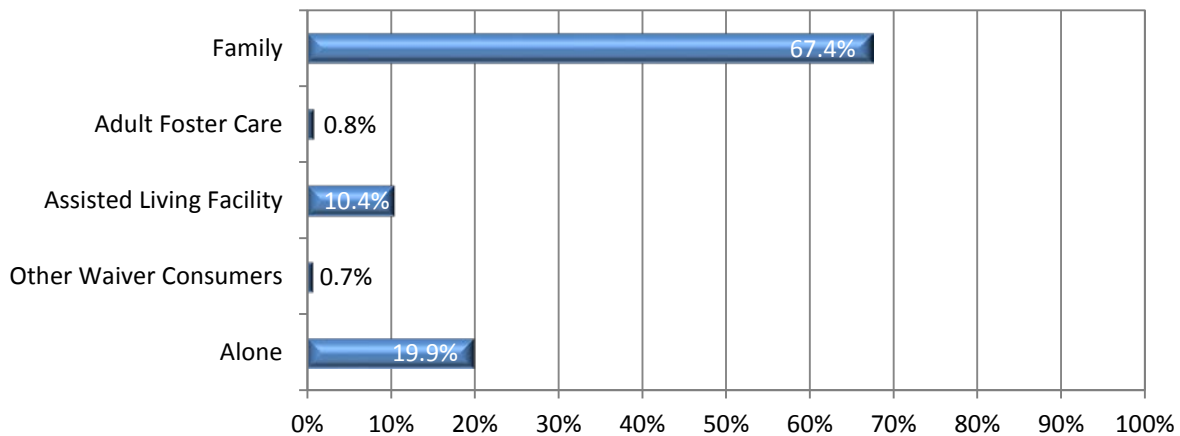
Enrollment and authorization

STAR+PLUS members can be identified for an individualized service plan (ISP) to receive home- and community-based services from multiple venues. Based on the sample of ISPs received from Amerigroup and Molina, most STAR+PLUS members were enrolled from their homes.

- 0.7 percent were enrolled from the hospital.
- 6.6 percent were enrolled from a nursing facility.
- 92.8 percent were enrolled from home.

At the time of enrollment in the HCBS Program, more than two-thirds of members were living in a community setting with a family member (**Figure 1**). More than two-thirds of members with ISPs lived with family members (68 percent), while one-fifth lived alone (20 percent). Ten percent were living in an assisted living residential care facility, five percent with other waiver consumers, and less than one percent in adult foster care.

Figure 1. Living Situation of Members at the Time of Enrollment in the HCBS Program



Most of the members with ISPs were reassessments (76.4 percent), with only 23 percent being new ISP participants and 0.6 percent having an ISP change prior to the end of the year.

Service categories

STAR+PLUS members utilized a number of different home- and community-based services. **Table 3** below provides a summary of the most utilized services and estimated costs associated with the services. Service coordinators and nurses select services for the STAR+PLUS members based on the in-home assessment and provide a cost estimate for the year for each type of service. Most members receive multiple services during the year.

Table 3. Most Utilized HCBS Program Services and Estimated Costs

	Percent of Members Utilizing the Service	Mean Cost	Minimum	Maximum
Respite Care	57.4%	\$7,254	\$1,156	\$71,568
Nursing Services	16.6%	\$3,659	\$0	\$198,831
Minor Home Modification	2.6%	\$4,085	\$150	\$7,500
Personal Assistant Services	94.8%	\$1,126	\$0	\$44,867
Assisted Living Services	7.1%	\$17	\$0	\$10,927
Emergency Response Services	89.7%	\$15	\$0	\$20,454
Adaptive Aids	5.1%	\$4,252	\$75	\$11,100
Meals	3.8%	\$1,961	\$0	\$15,912
Dental Services	4.0%	\$2,443	\$20	\$7,157

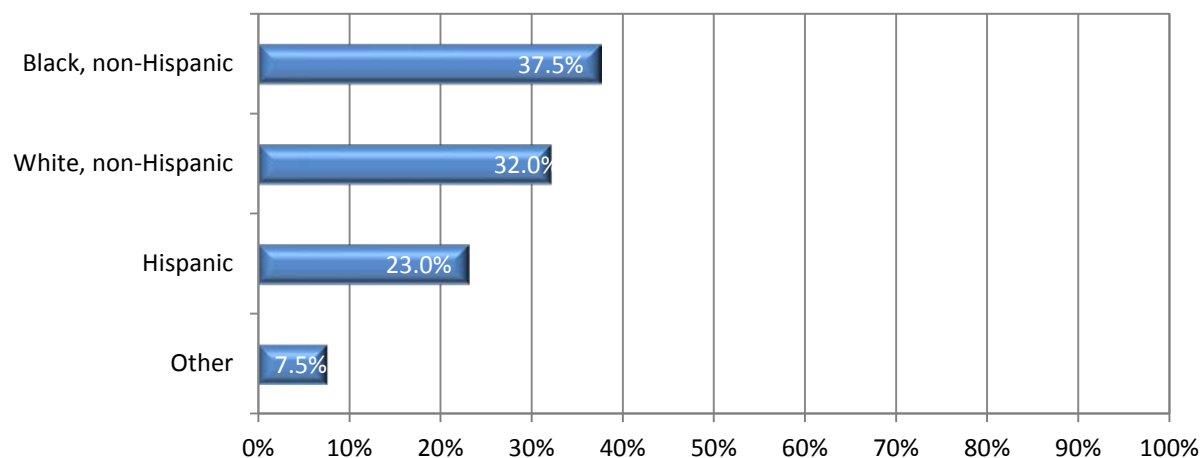
- The most common type of service used by members was personal assistant services (95 percent of members).
- The next most common services utilized by members were emergency response services (90 percent), respite care (57 percent), and nursing services (17 percent).
- Less common services were assisted living services (7 percent), adaptive aids (5 percent), dental services (4 percent), meals (4 percent), and minor home modifications (3 percent).
- The highest average cost of home- and community-based services was for respite care services, at an average yearly cost of \$7,254.
- The lowest average cost was for emergency response services (e.g., ambulance transportation for members using medical equipment that would not be appropriate for car travel) and assisted living services.

Member Telephone Survey

Member Characteristics

The STAR+PLUS members responding to the survey proportionately represented the racial and ethnic breakdown of the general STAR+PLUS population (**Figure 2**). In this sample, 38 percent were Black, non-Hispanic, 32 percent were White, non-Hispanic, and 23 percent were Hispanic. Members of “other” race/ethnicity, which includes Asian and Native American, represented 7.5 percent of the survey sample.

Figure 2. Race/Ethnicity of Members Participating in Telephone Survey



- The average age of members surveyed was 60 years, with a range of 21 to 99 years.
- Female members made up 63 percent of the respondents and males made up 37 percent of respondents.
- Two-thirds of members in the survey were dual-eligible (66 percent), and one-third were eligible for Medicaid only (33 percent).
- Of the 46 STAR+PLUS respondents that were Hispanic, 83 percent identified as Mexican-American. Four percent were of Central or South American ethnicity and 11 percent identified as an “other” Hispanic ethnicity.
- A majority (79 percent) of the STAR+PLUS sample spoke English as their main language in the home. Fourteen percent spoke mainly Spanish in the home, and 7.5 percent spoke another language.
- Most of the STAR+PLUS members surveyed (86 percent) were born in the United States. Eight percent were born in Mexico and 7 percent were born in another country.
- Of the STAR+PLUS members who were born outside of the United States (28 members total), the average number of years living in the United States was 30.7 years, with a range of 11 years to 50 years.

One-third of the STAR+PLUS members surveyed were single/unmarried at the time of the survey (**Figure 3**). Twenty-two percent of members were married, three percent were unmarried but living with a partner/companion, 17 percent were divorced, 5.5 percent were separated and 19 percent were widowed.

Figure 3. Marital Status of Members in the Survey Sample

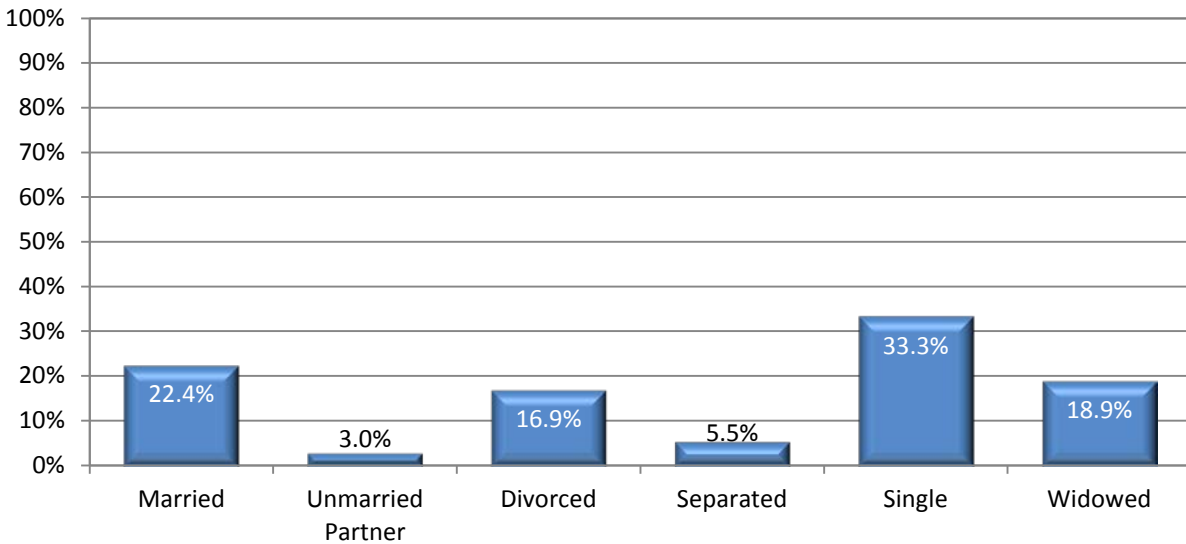
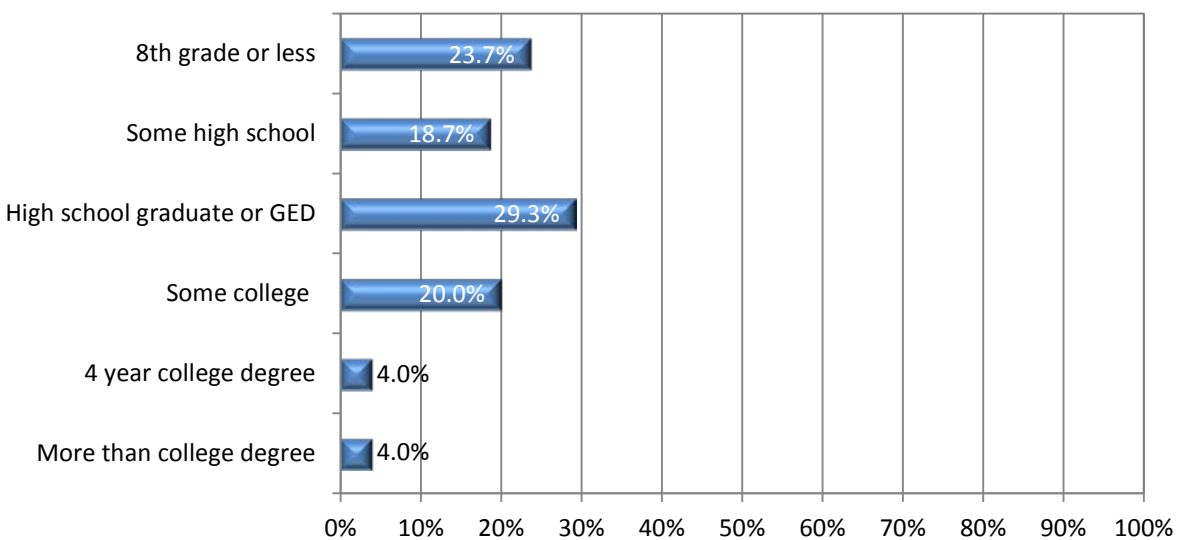


Figure 4 shows the educational level of STAR+PLUS members in the survey sample. The overall educational level in this sample was low, with 42 percent of members having less than a high school education. Nearly one-third had only a high-school diploma or equivalent (29 percent), while eight percent had a 4-year college degree or higher.

Figure 4. Educational Level of Members Participating in Survey



Caregiver Characteristics

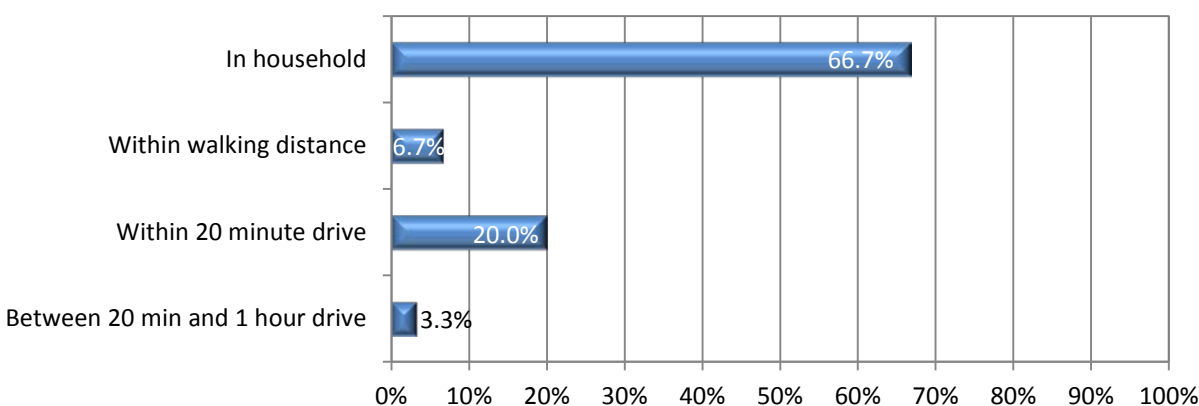
Of the 202 STAR+PLUS surveys, 38 percent were answered by a proxy for the member. Sixty-two percent of the proxies identified themselves as the person who provides care related to the member's illness or disability.

STAR+PLUS members were surveyed about the presence of a caregiver in their daily lives who assists with care related to their illness or disability. Of the 202 survey respondents, 184 (91 percent) identified a caregiver that helps them with daily activities related to their illness or disability.

Unpaid Family Caregivers

Of the STAR+PLUS members who identified a caregiver, 16 percent were unpaid family caregivers and 84 percent were caregivers who received pay in exchange for assisting members. Among the caregivers that provided unpaid assistance to the STAR+PLUS members (**Figure 5**), two-thirds lived within the same household as the member, approximately 7 percent lived within walking distance, 20 percent lived within a 20 minute drive and 3 percent lived within one hour's drive of the STAR+PLUS member's house.

Figure 5. Informal/Unpaid Caregiver Living Arrangements



- The amount of time spent in caregiving activities varied from two hours per week to a maximum of 168 hours per week (which represents 24-hour care).
- Most caregivers (77 percent) had been providing care related to the STAR+PLUS member's illness or disability for more than three years.
- Most caregivers (70 percent) had other people that provided them with assistance related to caregiving. Thirty percent had one other person to help out, 23 percent had two to three people helping out, and 17 percent had four or more other people to help with care.
- Caregiver helpers included paid caregivers (62 percent), family members (48 percent), and friends (10 percent). (The total exceeds 100 percent because respondents had the option to select more than one relationship.)

Disability Status

STAR+PLUS members identified their specific needs using the CANE tool, which assesses the level of disability of members by asking whether or not they need the assistance of other people across a number of tasks and disability related issues (**Table 4**). Members had the opportunity to identify multiple needs in this section.

Table 4. CANE Results – Self-Reported Needs and Disability Status

Percent who Currently Need the Help of Others...	
Because of problems with their physical health	88.5%
To look after themselves	82.9%
To get enough of the right type of food to eat	78.2%
To get around inside and outside their home	78.2%
With their daytime activities	78.0%
To look after their home	75.8%
To get information about their condition	64.5%
To receive the benefits they are entitled to	62.7%
Because of problems with incontinence	62.4%
Because of problems with eyesight, hearing or communication	62.2%
To keep from hurting themselves on accident	56.5%
Because of problems with medication or drugs	55.0%
To have an adequate social life	54.8%
Because of problems with mood or anxiety	54.5%
To get or have an appropriate place to live	52.8%
Because of problems with their memory	49.3%
To manage their money	44.6%
To have a close emotional or physical relationship with someone else	28.8%
Because they see or hear things that others don't	23.4%
To take care of someone else	22.6%
To keep from hurting themselves on purpose	21.3%
Because of behavioral problems	19.5%
Because of abuse or neglect from other people	7.4%
Because of a drinking problem	2.5%

The top five member needs were:

1. Assistance because of problems with physical health (89 percent)
2. Assistance to look after themselves (83 percent)
3. Assistance to get enough of the right type of food to eat (78 percent)
4. Assistance to get around inside and outside their home (78 percent)
5. Assistance with daytime activities (78 percent)

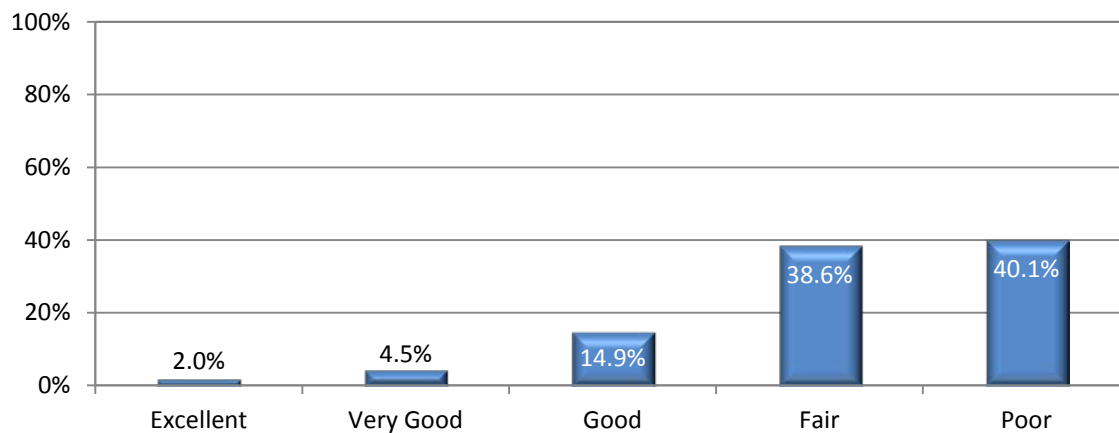
Many members had multiple needs, with a mean of 12.1 needs reported in the sample. The number of needs reported by members ranged from zero to 23 of the 24 types of needs listed in the tool.

Health and Functional Status

The next section identifies the health and functional status of the STAR+PLUS members surveyed in relation to overall health, daily activities, pain, and depressive symptomatology.

The self-reported health status of members participating in the survey was low overall, with very few members rating their health as excellent (2 percent), very good (4.5 percent) or good (15 percent) (**Figure 6**). This is to be expected within the population of STAR+PLUS members who are receiving home- and community-based services.

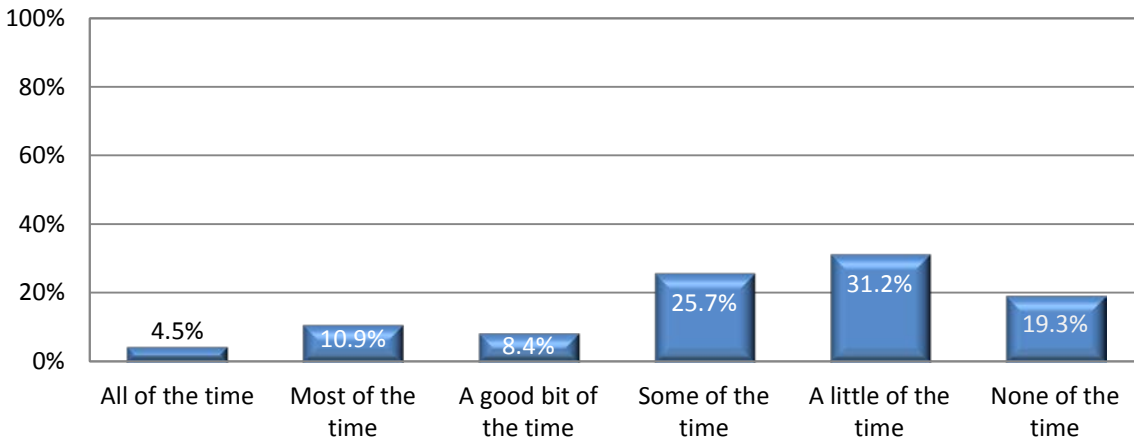
Figure 6. Self-Reported Health of STAR+PLUS Members with an ISP



A good indicator of general health and need for HCBS is the member's self-reported level of energy. STAR+PLUS members were asked how much of the time in the past four weeks they had a lot of energy (**Figure 7**).

- Only 4.5 percent of members indicated that they had a lot of energy “all of the time.”
- 19 percent of members indicated that they had a lot of energy “none of the time.”
- The most common responses were “some of the time” (26 percent) and “a little of the time” (31 percent).

Figure 7. Member Reports of How Often They Had “A Lot” of Energy

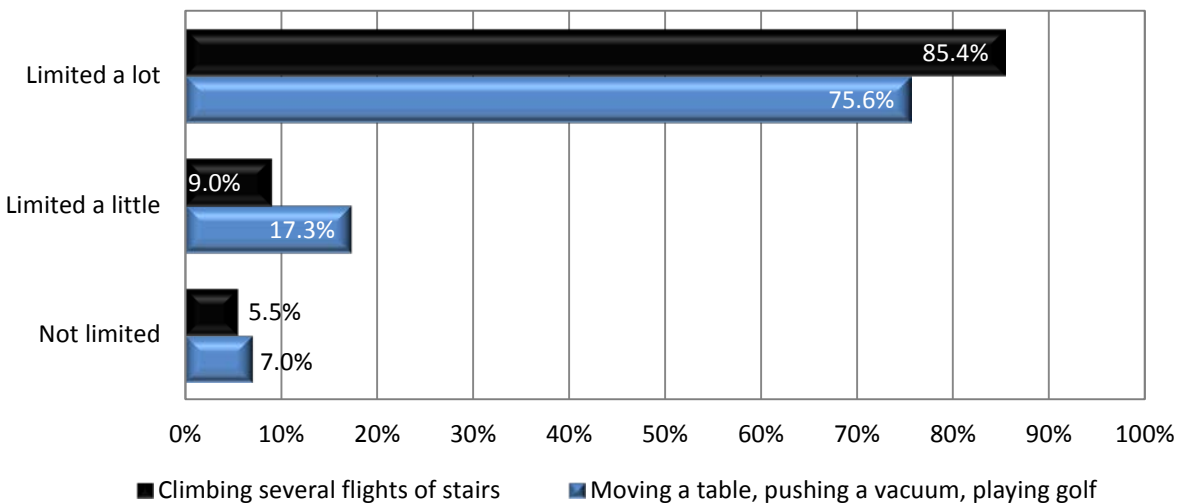


Activity Limitations

A majority of STAR+PLUS members reported activity limitations. Very few members surveyed reported having no limitation (less than seven percent of the sample). **Figure 8** displays the activity limitations for two common types of activities in which members might engage – moderate activities such as moving a table, pushing a vacuum cleaner, or playing golf, or more strenuous activities such as climbing several flights of stairs.

- 76 percent of members reported being “limited a lot” in doing daily activities like moving a table, pushing a vacuum, playing golf or bowling.
- 85 percent of members reported being “limited a lot” in climbing several flights of stairs.

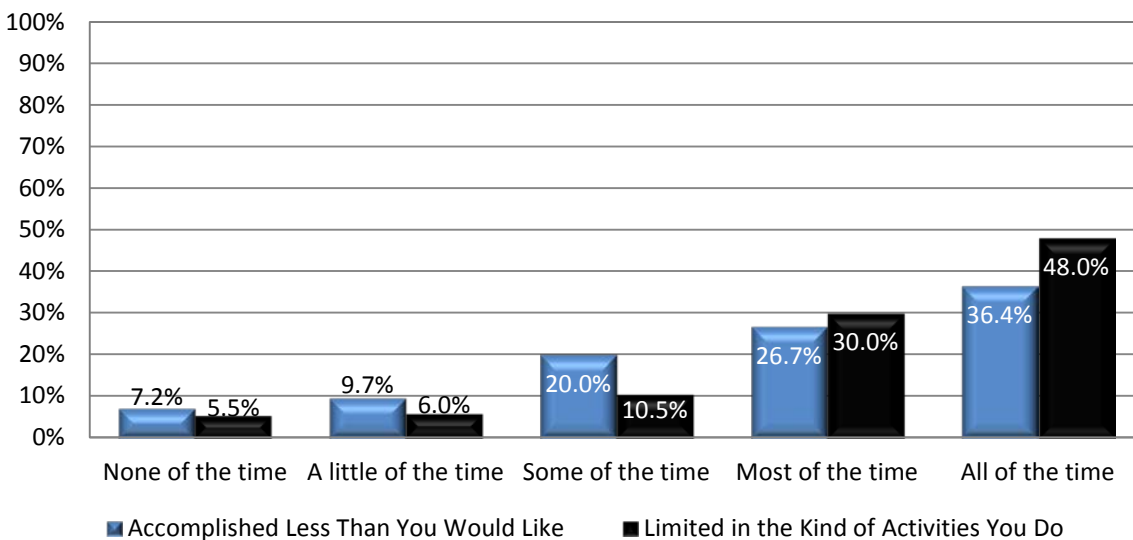
Figure 8. Member Reports of Activity Limitations



STAR+PLUS members were also asked how much of the time their physical health: (1) limited them in the kind of work or other activities they could do; and (2) prevented them from accomplishing as much as they would like in the past four weeks (**Figure 9**).

- 48 percent of members reported being limited all of the time in their work or other activities.
- Only 5.5 percent of members reported having activity limitations none of the time.
- Only 7 percent of members reported never accomplishing less than they would like as a result of their physical health.
- 63 percent of members reported accomplishing less most or all of the time.

Figure 9. Accomplishment and Activity Limitations Due to Poor Health

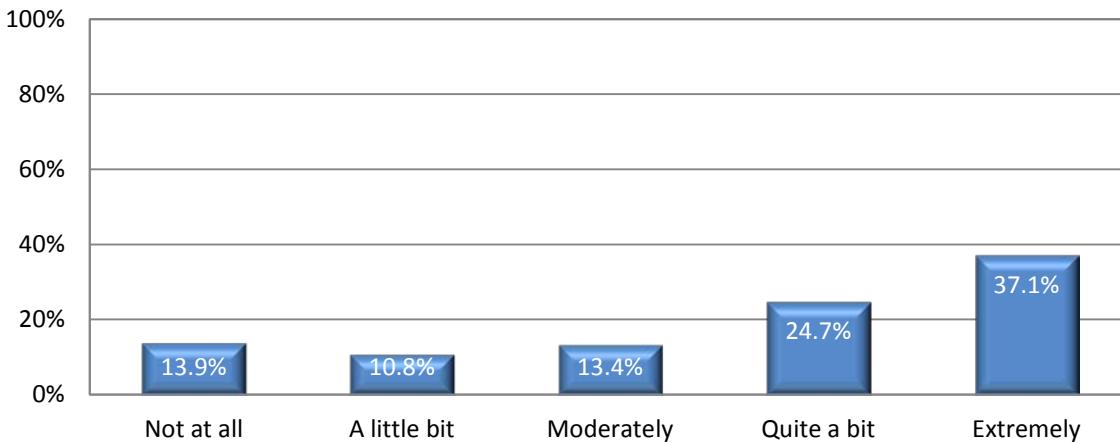


Pain

Many STAR+PLUS members deal with chronic and often debilitating pain. In order to understand how pain limits work and daily activities, a series of questions were asked of members to understand how different types of pain affect daily life. When asked how much pain interferes with normal work (including both work outside the home and housework), a majority of STAR+PLUS members were affected (**Figure 10**).

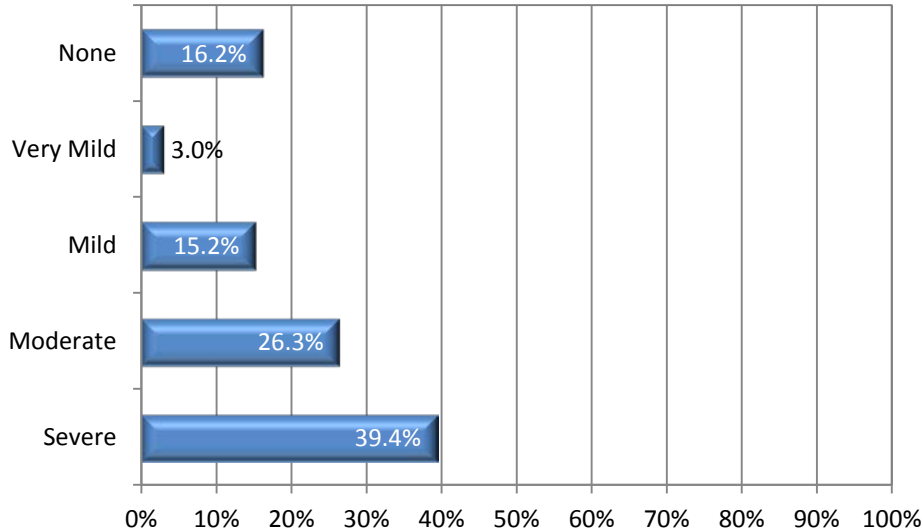
- Very few (14 percent) members were able to do normal work without interference from pain.
- Close to 62 percent of members were extremely affected or affected quite a bit by pain in their normal work activities.

Figure 10. Member Reports of the Degree to Which Pain Interferes with Normal Work



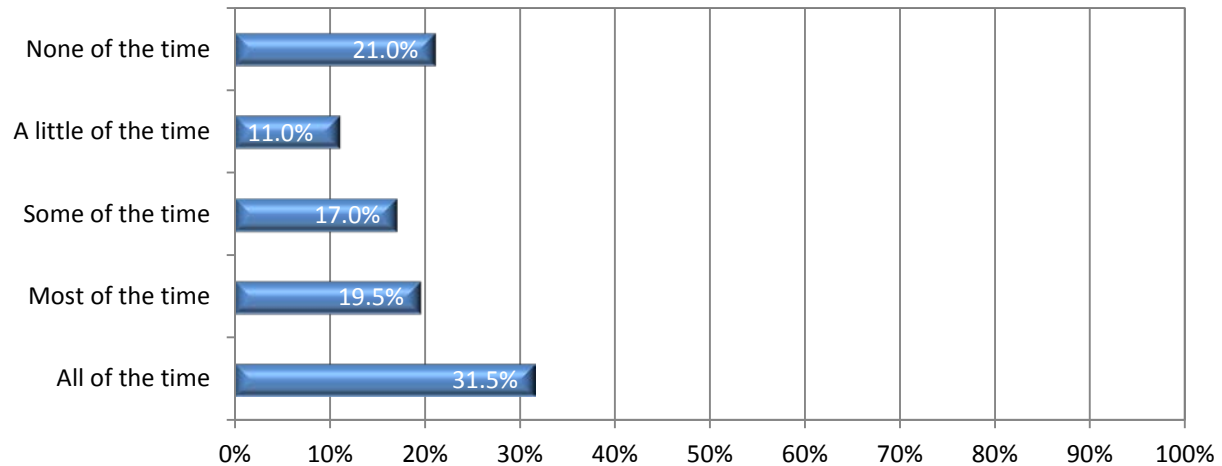
STAR+PLUS members also indicated the severity of any arthritis pain they had felt in the past 4 weeks (**Figure 11**). Nearly 40 percent of members reported severe arthritis pain and 26 percent reported moderate levels of arthritis pain. Only 16 percent of members had no arthritis pain in the past four weeks.

Figure 11. Member Reports of Arthritis Pain Severity



Lower back pain is a common complaint among people with physical disabilities. STAR+PLUS members were asked to indicate how often low back pain interfered with their usual daily activities including work, school or housework (**Figure 12**).

Figure 12. Member Report of Frequency of Activity Limitations Due to Low Back Pain



- 31.5 percent of members were troubled by low back pain all of the time in their daily activities.
- An additional 19.5 percent of members were troubled most of the time by low back pain.
- Only 21 percent reported no interference in their daily activities by low back pain.

Depressive Symptomatology

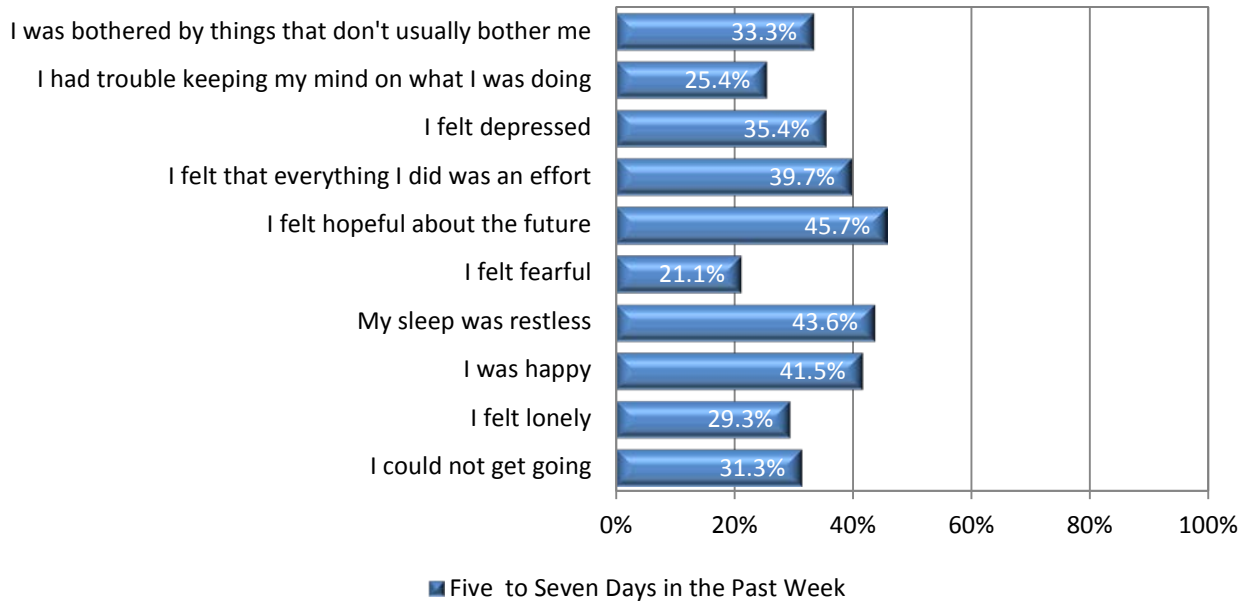
STAR+PLUS members were asked to report how they have felt or behaved during the past week in order to gauge their level of depressive symptomatology. Because how a person feels cannot be assessed by anyone else, these items were only asked if the STAR+PLUS member answered for themselves. Proxy respondents did not complete these items.

In order to assess depressive symptomatology the Center for Epidemiologic Studies Depression Scale (CES-D-10) was administered. This is a 10-item scale designed to gauge depressive symptoms that might be indicative of depression. This tool is used as a screening measure and was developed to identify current depressive symptomatology related to major or clinical depression among adults. Items include depressed mood, feelings of worthlessness and helplessness, psychomotor difficulties, and sleep difficulties. Respondents were asked to indicate the number of days in the past week they were behaving or feeling a certain way.

Many STAR+PLUS members reported depressive symptoms 5, 6, or 7 days in the past week (**Figure 13**).¹¹

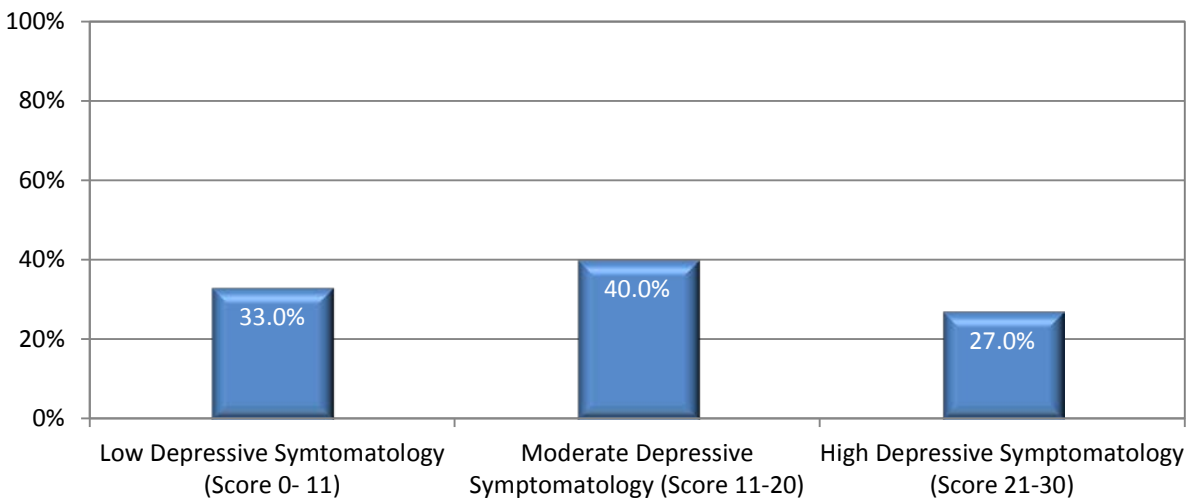
- Restless sleep was experienced by 43 percent of members.
- Fear and loneliness was reported by 20 percent and 29 percent of members respectively, 5 to 7 days out of the last week.
- More than one-third of members reported feeling depressed 5 to 7 days out of the past week.

Figure 13. Percent of Members Reporting Depressive Symptoms Five to Seven Days in the Past Week



The CES-D-10 items were summed to create a score that would provide some indication of depressive symptomatology (**Figure 14**). According to the Center for Epidemiologic Studies, a score of less than 11 indicates a low level of depressive symptomatology consistent with normal everyday life. A score of at least 11 is consistent with moderate levels of depressive symptomatology. A score of 11 or greater is equivalent to experiencing six symptoms for most of the previous week or a majority of symptoms on one or two days. Higher scores on this scale indicate greater symptoms.

Figure 14. STAR+PLUS Member CES-D (Depression) Scores



Members that score a 21 or higher on this scale are experiencing high levels of depressive symptoms.

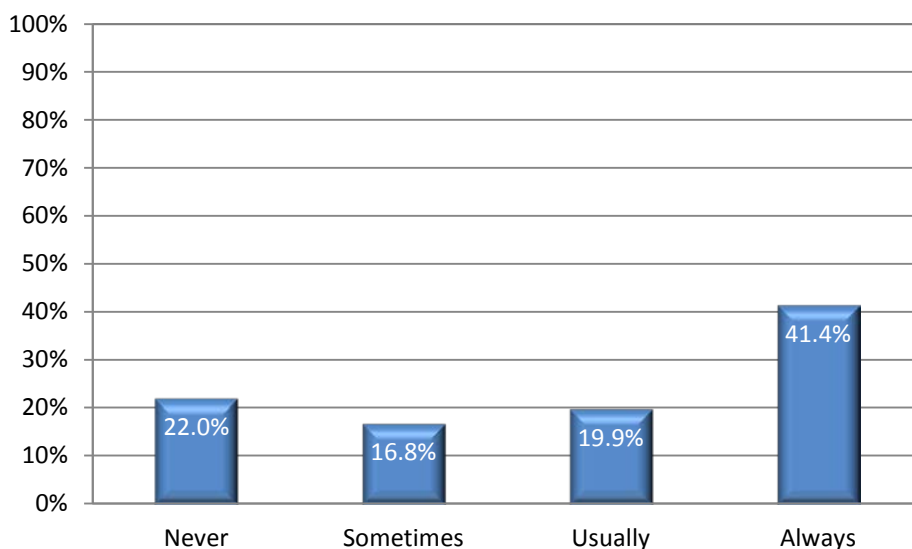
- 33 percent of members experienced low or normal levels of depressive symptoms.
- 40 percent of members reported experiencing moderate levels of depressive symptoms.
- 27 percent of members reported experiencing high levels of depressive symptoms.

STAR+PLUS Service Coordinator

Members were asked about their experiences with their service coordinator specific to receiving home- and community-based services. Service coordinators normally contact their STAR+PLUS clients one time per year to follow up on their home- and community-based services. STAR+PLUS members may contact their service coordinator as often as they would like related to the services they receive as part of their individual service plan.

More than half (55 percent) of STAR+PLUS members reported being contacted by their service coordinator within the past 6 months. Nearly two-thirds of members (61 percent) reported usually or always receiving help from their service coordinator as soon as they thought they needed it (**Figure 15**). This item comprises the HHSC Dashboard Indicator for STAR+PLUS health plans – *Good Access to Service Coordination*. There were no significant differences in results for this indicator by health plan (Amerigroup = 61 percent; Molina = 62 percent) or by eligibility status (Medicaid-only = 62 percent; dual-eligible = 61 percent). These results are comparable to the CY 2012 Dashboard standard of 63 percent for this measure.

Figure 15. Member Reports of How Often They Received Help from Service Coordinator as Soon as They Felt They Needed It



Members' experiences with communication and overall satisfaction with their service coordinators was high. Among STAR+PLUS members who had contact with their service coordinator in the last six months:

- 70 percent reported that their service coordinator usually or always explained things in a way they could easily understand.
- 84 percent reported being satisfied or very satisfied with the help they received from their service coordinator in the past six months.

Individual Service Plan

The next section provides insight into STAR+PLUS members' experiences with ISPs related to the HCBS Waiver program. Based on face-to-face interviews conducted with members, it became clear that many members do not know the term individual service plan (ISP), even though this term is used among service coordinators and nurses. In order to reduce confusion, members were provided a definition of a service plan prior to being asked specific questions about the services they received under the plan.

In the survey, the ISP was defined as: "something that you completed with your service coordinator to receive services in your home, like having someone deliver meals, having someone drive you to the doctor's office or having a nurse come to the house." Despite the definition of the service plan, 13 percent of surveyed STAR+PLUS members reported they did not have a service plan.

Members were asked who helped them develop their service plan for HCBS (**Figure 16**). Most members (61 percent) had help from only one source. Eleven percent reported help from two sources, five percent reported help from three sources, and one person reported having help from 10 different sources. Thirteen percent of members said they had no help developing their service plan.

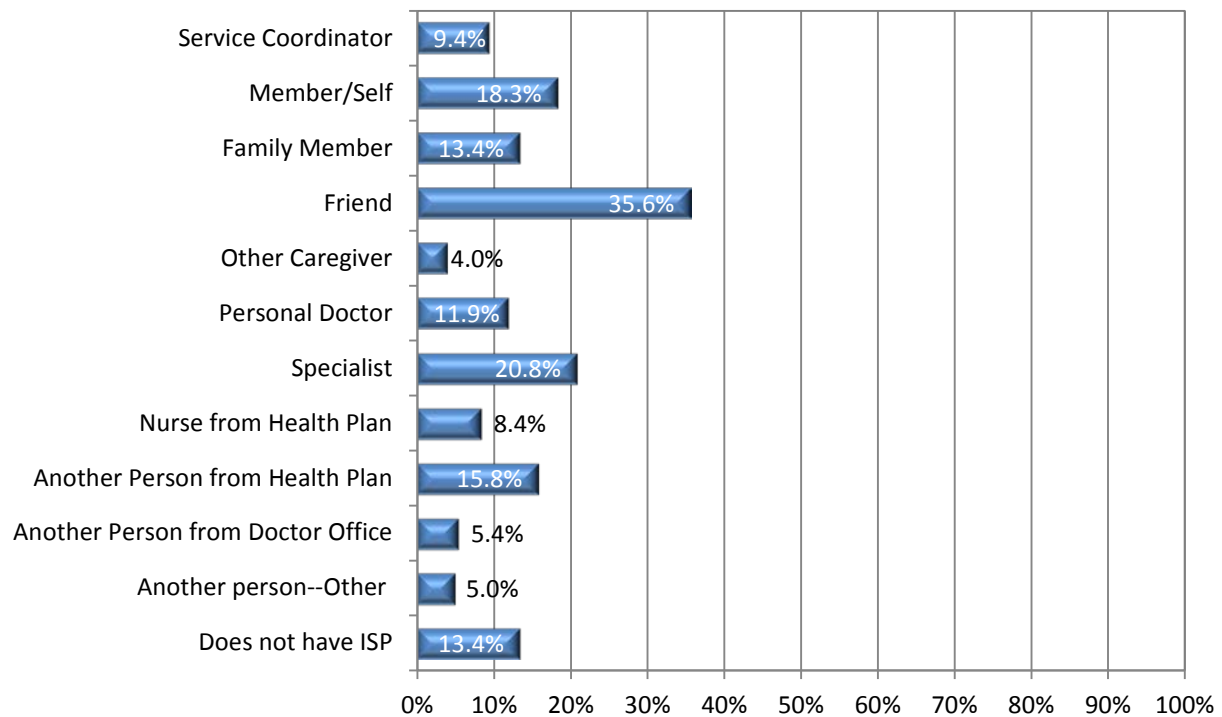
Help with ISPs from non-health professionals was relatively common, mentioned by 76 percent of members.

- Help from friends was the most common (36 percent), followed by the member him or herself (18 percent), family members (13 percent), and other caregivers (4 percent).

Help from health professionals and/or health plan workers was less common than expected, mentioned by 66 percent of members.

- The most common source of assistance was a physician specialist (21 percent), followed by a person from the health plan (16 percent), personal doctor (12 percent), and a nurse from the health plan (8 percent).
- Only 9 percent of members reported receiving help from their service coordinator.

Figure 16. People Who Helped STAR+PLUS Members Develop Their ISP



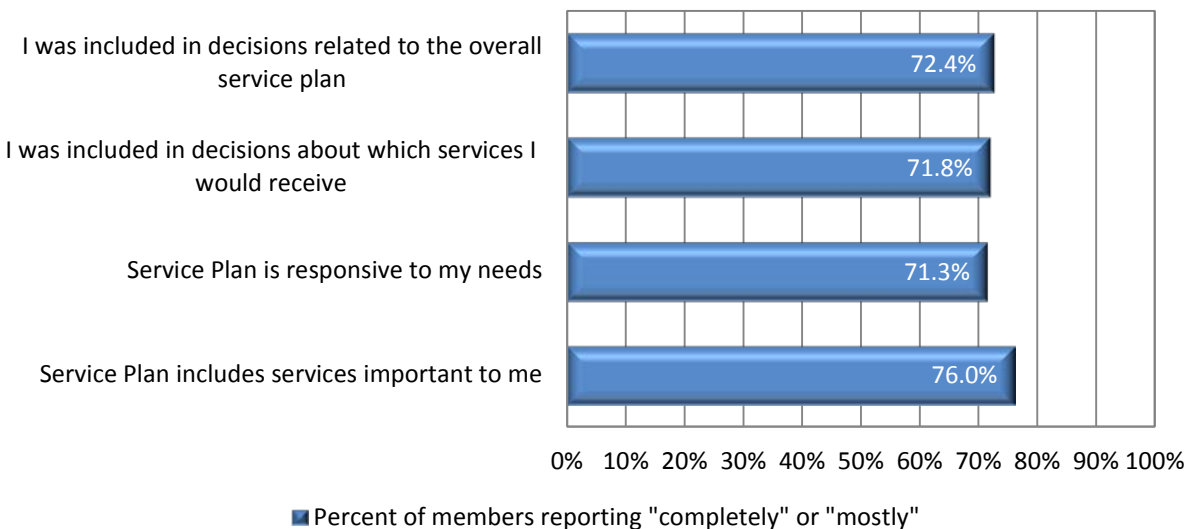
*Percentages add up to greater than 100% because members could select more than one option

As part of developing an ISP, the service coordinator sends a nurse or other health professional to the member's home to assess the member's current need for services. Once the home visit is complete, the nurse recommends which home- or community-based services the member will receive. To ensure that service plans are patient-centered, the nurse should engage the member in a conversation about his or her preferences and needs. STAR+PLUS members were asked a number of questions about their experiences with this process.

Most members felt that they were completely or mostly involved in the development of their ISP and decisions related to receiving their home-based services (**Figure 17**).

- 72 percent of members were included in the decision-making process related to the overall development of the ISP.
- 72 percent of members felt they were included in the decisions related to the types of services they were to receive under the ISP.
- 71 percent of members felt that their ISP was responsive to their needs.
- 76 percent of STAR+PLUS members felt that their service plan included services that were important to them.

Figure 17. Members' Report of Their Involvement in their ISP and HCBS Decisions



Members were also asked whether they were told that there was more than one choice for services in their ISP, and if so, what the pros and cons of those choices were. Two-thirds of members reported they were told there was more than one choice for their HCBS (66 percent). Among these members, the vast majority (90 percent) said that they were informed about the pros and cons of the different choices.

Member Face-to-Face Interviews

Face-to-face interviews were conducted with 23 STAR+PLUS members with ISPs for home- and community-based services who had also participated in the telephone survey. **Table 5** shows member demographic and program-related characteristics of the face-to-face interview participants. Overall, participants were more likely to be female (61 percent), between 41 and 60 years old (52 percent), living in an urban area (83 percent), living alone (57 percent), and English-speaking (91 percent). Face-to-face interview participants were evenly distributed among the three racial/ethnic groups. The majority of participants lived in either a single-family home (48 percent) or an apartment (26 percent).

More than half of interview participants were dual-eligible (57 percent). The majority of participants were members of Amerigroup (70 percent). Four members reported experiences of switching MCOs and were able to report experiences with both Amerigroup and Molina. With regard to caregiving, most members reported having only personal attendant services (PAS) provided by the health plan (39 percent) or PAS along with caregiving by live-in family members (35 percent).

Table 5. Face-to-face Interviews – Member Characteristics

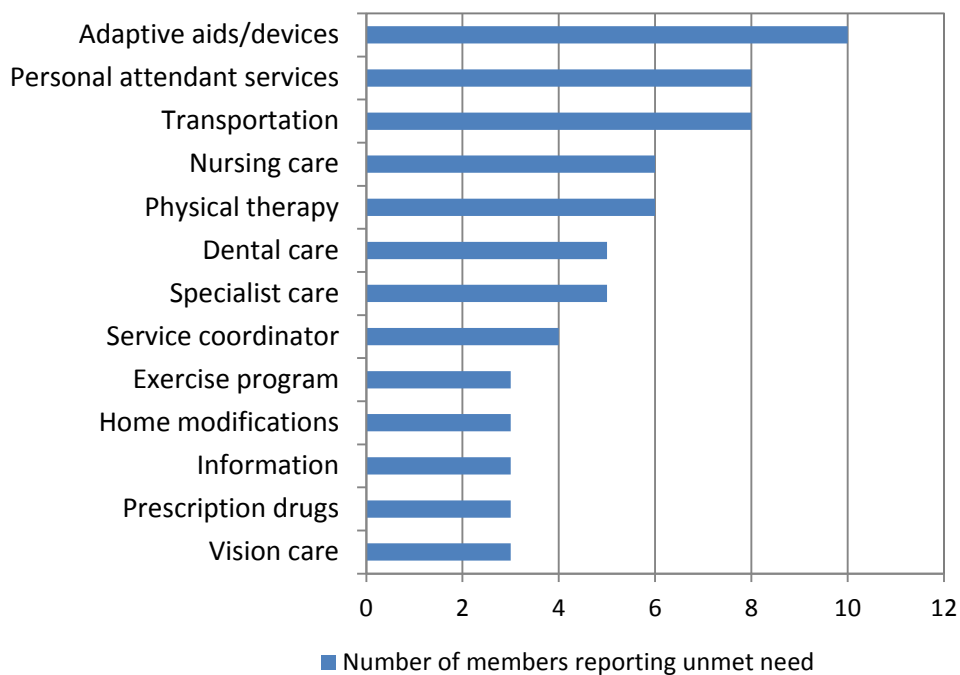
Characteristic		N	%
Sex	Male	9	39%
	Female	14	61%
Age	21 – 40	1	4%
	41 – 60	12	52%
	61 – 80	9	39%
	81+	1	4%
Race/ethnicity	Hispanic	7	30%
	White, non-Hispanic	8	35%
	Black, non-Hispanic	9	39%
Residence	Urban	19	83%
	Rural	4	17%
Housing	Single-family home	11	48%
	Assisted/Independent living	3	13%
	Apartment	6	26%
	Housing project	2	9%
	Trailer	1	4%
Lives alone	Yes	13	57%
	No	10	43%
Caregiver	Personal attendant only (PAS)	9	39%
	PAS and live-in family	8	35%
	PAS and outside family/friend	4	17%
	Live-in family only	1	4%
	Outside family/friend only	1	4%
Proxy respondent	Yes	5	22%
	No	18	78%
Language	English	21	91%
	Spanish	2	9%
Eligibility	Medicaid-only	10	43%
	Dual-eligible	13	57%
Health plan	Amerigroup	16	70%
	Molina	7	30%

Five interviews were conducted with proxies for members who were physically or mentally unable to participate (22 percent). In four cases, the proxy was the spouse of the member. One interview was conducted with the member's sister. In many cases, other family members or paid caregivers were also present during the interviews and provided valuable input.

Unmet Needs

Twenty-one members participating in the face-to-face interviews mentioned having at least one HCBS need that was not being met through their ISP. Among these members, the number of unmet needs ranged from one to 14, with an average of 4.4 unmet needs per member. **Figure 18** shows the most commonly mentioned unmet needs (those mentioned by at least three members).

Figure 18. Most Common Unmet Home- and Community-Based Service Needs



Unmet needs falling into the category of adaptive aids and medical devices were the most common, having been mentioned by ten members.

- Four members reported needing equipment to assist with mobility, such as a wheelchair or scooter.
- Three members reported needing a toileting chair.
- Three members reported needing to have devices repaired.

The two next most common unmet needs were for personal attendant services (PAS) and transportation, cited by eight members each.

- In most cases where PAS was mentioned, members were already receiving these services through their ISP, but felt they needed more time approved for their personal attendant to reduce strain on family caregivers or reduce the amount of time the member is left home alone. Two members, who felt their health problems posed a danger to them when they were left alone, reported needing continued PAS through the night.
- Unmet needs for transportation were cited for a variety of reasons. In some cases, members reported that existing transportation services offered by their health plan were not sufficient. Four members reported that their health plan would not cover transportation to certain locations, such as the grocery store, the bank, or the drug store.

It is important to note that six of the most common unmet needs are also services that are covered by the HCBS Program – adaptive aids, personal attendant services, nursing care, physical therapy, dental care, and home modifications. For many members, changes to their health status or living situation occur during the year between their in-home assessments, which would make them eligible for receiving additional services covered by the HCBS Program. In cases where communication between the member and service coordinator is lacking, these changes result in unmet needs for members that will not be addressed until their next in-home assessment.

“Most Important” Outcomes and “Most Positive” Aspects of HCBS

Seventeen members participating in the face-to-face interviews were asked what outcomes of their home- and community-based services were the most important to them. Some members offered more than one outcome as the “most important” (up to four outcomes).

- Having a personal attendant and other providers to “look after” or “take care of” members was the most frequently cited outcome, mentioned by five members.
- Four members cited outcomes that were specific to their medical conditions, such as having good medical care for heart disease or diabetes.
- Independence and mobility, which emerged as common themes in the interviews generally, were each mentioned by three members.

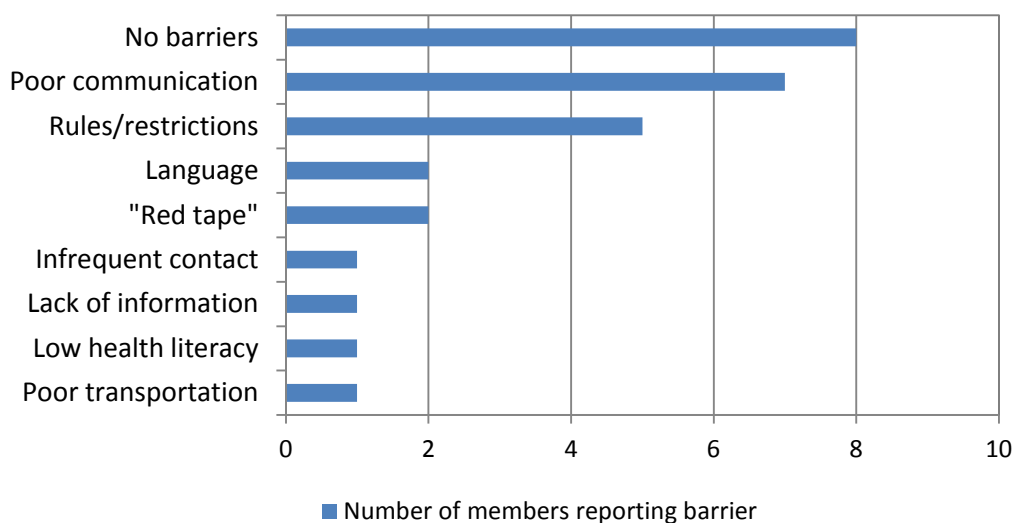
Members were also asked what they thought were the “most positive” aspects of the care they received in the home, or the “most positive” qualities of their service coordinators and home providers. This question was related to the most important outcomes of care, and responses generally followed the same pattern – focusing on the quality of personal attendant services, independence, comfort, and security.

When asked specifically about the positive qualities of their home providers, members focused on personal attendants, service coordinators, and nurses who were attentive, responsive, proactive, communicative, friendly, timely, patient, and professional.

Barriers to Receiving HCBS

Twenty-one members provided responses to the question, “What would you say are the different types of barriers to getting services you need?” Members mentioned up to three different barriers to care, with an average of one barrier per member. **Figure 19** shows the barriers mentioned by members, in order from most- to least-frequent. Eight members reported they experienced no barriers to receiving HCBS, which was the most common response to this question.

Figure 19. Member-Reported Barriers to Home- and Community-Based Services



Among members who did report barriers, poor communication was the most common, mentioned by seven members.

- Four barriers in this category dealt specifically with phone communication, including unreturned phone calls by service coordinators and providers, and phone systems that were difficult for members to navigate.
- One member mentioned infrequent communication with his service coordinator.
- One member mentioned poor communication with her house call doctor.
- One member mentioned poor communication more generally, stating that people at the health plan were not telling her “how to do things”, and that she was not “clear” on what services were available to her.

The barrier of poor communication is related to lack of information (mentioned by one member). Members who reported problems communicating with their health plan, providers, and vendors also typically reported not having the information they needed to make decisions about their care. In many cases, information on available network providers was lacking, as many members reported that their health plan provider directories were unavailable, inaccessible, or out-of-date.

The second-most common type of barrier fell in the category of “rules” and “restrictions”, mentioned by five members. These generally pertained to restrictions by health plans or vendors on what services were available and covered by the HCBS Program. One member focused on the need for his doctor to authorize services, which led to delays and sometimes denial of treatment he felt was necessary. Another member, who could not afford rent for an apartment and was living with a member from her church, expressed this barrier in terms of “politics” and her need for adequate housing, stating:

If [the health plan] will help me get from a nursing home into independent living, why not help me maintain a place to stay with my name on it that don't have all those stipulations?... As many people that need jobs in America today, you can create a job for somebody to help people who are on Medicaid get their own person space.

Shared Decision-Making for Individual Service Plans

A substantial portion of the face-to-face interview guide covered issues of shared decision-making in regard to the development of members’ ISPs. Members were asked to relate their experiences with joining the HCBS Program and planning their home- and community-based services. Specifically, interviewers asked members: (1) whether someone from their health plan helped them set goals for their health and services; (2) whether anyone asked them what their preferences were; and (3) whether they and their families were involved as much as they wanted to be in the planning of services.

First, it is important to note that the vast majority – 21 of the 23 members interviewed – were not familiar with the term *individual service plan*, and most claimed they did not know they had an ISP. Most members were shown blank copies of the ISP form that was in use during the measurement period (Form 3671-1). Among these members, only one recognized the form, despite the fact that all members (or their caregivers) had signed the form prior to the implementation of their HCBS Program services.

However, most members were able to talk about their involvement in decisions about their services – including decisions made at the time of enrollment in the HCBS Program and decisions made regarding ongoing care.

- Twenty-one members discussed their own involvement in planning for their services. Among these members, 13 stated that they were not involved in the planning as much as they wanted to be. Two members offered mixed opinions about their own involvement. One member stated that he had not been asked about his goals or preferences. But at the same time, he was happy with his level of involvement in decision-making, stating that when he needs help, “I just call, and that’s it... They fix it.” Another member also stated that, while he had not been asked about his preferences when his ISP was developed, his service coordinator did actively involve him in ongoing decisions about his care.

- Sixteen members who had family members living with or near them also discussed their family's involvement in planning for their services. Among these members, nine stated that their family members were not involved in planning. Some members had no desire to involve their family members in planning – in some cases out of concern for stress on their family members, and in other cases because they were estranged from their families.

These findings conflict with those from the member telephone survey regarding member involvement in planning for HCBS, which showed that members were generally satisfied with shared decision-making (see **Figure 17**). It is likely that the more in-depth approach in the face-to-face interviews – which allowed the topic to be addressed from multiple perspectives (e.g., goals, preferences, family involvement) – provided members the opportunity to reflect more closely on the topic.

Involvement and Non-involvement Narratives

Members were also asked to relate one or more specific experiences in which they felt they were involved (or not involved) in planning for their services. These narratives reveal the context in which members experience shared decision-making, and implicitly highlight the aspects of care for which involvement is most salient to members.

Involvement

Seven members offered narratives describing instances when they felt their providers (personal attendants, nurses, service coordinators, or doctors) involved them in decisions about their care. Among nine involvement narratives collected from these members, seven pertained to the member's service coordinator, and two pertained to the member's home nurse. Two common themes included: (a) helping the member get through delays or denial of services, and (b) providing the member with information they needed to access services.

In one notable example, a 50-year-old White female related that her service coordinator “took an interest” in helping relieve her teenage son from the stress of caregiving:

My son, he was just starting to really get off on a wrong track, because he was doing everything for me at that point in time. He had no life. He'd go to school and come home and help me clean and help me cook. I mean he had no life, literally... And when I explained to her [service coordinator] about my son starting to get in trouble, you know his grades were going down, it was just... because he's the only one here with me. He's the only one to help me. That's when she said, "Well, I'll tell you what. I can send you somebody that can come in and take some of that off"... So I really feel like she did take an interest. And he has upped his grades and he's doing a lot better.

Non-involvement

Four members offered narratives describing situations when they felt their providers could have involved them more in decisions about their care. Denial of services by the STAR+PLUS MCO was a common theme among the narratives collected from these members. One member – a 52-year-old Black female – described two separate instances in which her health plan denied services she considered necessary, without her involvement. The member sensed unfairness in the denial of service, since it was made by people who had never met her:

My scoliosis specialist ordered some tests and they were denied. I got a letter from Amerigroup stating that it had went before some board and the board decided it wasn't necessary. Then less than a year later I was having the same issues and basically [the doctor] just told the people – “Do the x-ray. Do the MRI.”... That's when I found out I had cervical radiculopathy and lumbar radiculopathy and then [the doctors] ordered the scooter 'cause I could barely walk. They just kind of pushed it and said, “Look, this patient needs these services and you all are steady saying ‘no’ based on some board, board of doctors who read some stuff and they make a decision.” They don't even know me. They have never met me. It's just an obsolete decision that has been made.

In this case, the member felt she had no opportunity to advocate for herself before receiving the letter from the health plan denying her tests – a decision that was made by people she believed were out of touch with her personal situation. The health plan's decision not to approve the member's tests resulted in a delay of diagnosis, and was overturned only after the advocacy of the member's doctors.

Member Experiences with Home- and Community-Based Services

Experiences with HCBS were a primary focus for members who participated in the face-to-face interviews – largely because they reflect topics that are both current (representing ongoing care) and personal (representing health-related topics in which members are personally invested). A number of important themes regarding experiences with HCBS emerged in the interviews. These were coded and separated broadly into “negative” and “positive” categories.

Negative experiences

Poor communication with various types of providers was the most common negative theme overall. In particular, the ten most common themes included poor communication with the MCO, poor communication with the service coordinator, and poor communication with doctors. Problems with both verbal and written communication were included in this category, and in most cases, the member associated poor communication with not having or getting the information they needed about their services. Knowing who to call at the health plan when a member has questions is one of the most critical pieces of information members need to ensure they are receiving good patient-centered care.

Ten most common negative themes	N
• Poor communication with MCO	10
• Poor communication with SC	10
• Delays in care	9
• Denial of services by MCO	9
• Poor phone experience	9
• Red tape/paperwork	7
• Discrimination/stigma	7
• Poor quality transportation	7
• Poor quality dental care	7
• Poor communication with doctors	7

One member who had switched health plans (from Molina to Amerigroup) reported different experiences in communicating with the health plans over the phone, stating: “Through Molina it was just a recording...and you have to stay on the phone listening to all those recordings... When I switched to Amerigroup it was a different story. I mean, I had a live person talking to me. There wasn’t no machine, no recording, no nothing. And actually, she gave me her name and her number and said, “If you ever have any problems or any questions, this is the person you need to talk to.”

Seven members reported having poor quality transportation, which is offered by the health

plans for members who need transportation to their doctor’s appointments. Although transportation is not a service provided through the HCBS Program, this service is critical for ensuring integrated and timely care for members who have no other reliable means of transport. Although members said that MCO transportation generally got them to their appointments on time, many of these members reported having to wait hours after their appointments to be picked up and taken home.

Furthermore, some members reported feeling unsafe while using health plan transportation – due to problems with the condition of the vehicles (e.g., worn out CV joints, missing seats) as well as the behavior of the drivers. One member described being frightened by drivers who exceeded the speed limit, in one case, driving 70 miles per hour in a 35-mile-per-hour zone. Because of these experiences, the member stated that she would sometimes cancel her doctor’s appointments if her only option was to take the health plan transportation.

Two members reported being victimized by their personal attendants. In both cases, the member believed the personal attendants assigned to them had stolen their property – in particular, their prescription medications. One 60-year-old dual-eligible member stated that she no longer had a personal attendant because her previous three attendants had stolen from her and she chose to dismiss them; in the last case, the member reported that her personal attendant threatened her if she tried to notify the authorities. The member subsequently filed charges against the individual. Another member reported that his personal attendants had stolen his prescription pain medicines, arrived at his home drunk, and brought other people into his home. The member went for a period without his medication because his doctors refused to order replacements, stating: “Doctors have heard those stories over and over... ‘Somebody stole my pills.’ When in fact they’ve taken them all themselves or sold them or whatever they do with them. Just about all the doctors have the same policy. If you run out or you use them, that’s on you.” This member subsequently notified his nurse of these problems, and the PAS vendor immediately replaced his personal attendant. While member reports of victimization by their

personal attendants are troubling, it is important to note that vendors take timely corrective action when notified of such instances. These findings should be interpreted carefully, as they are based on member report and were not substantiated by outside sources.

In general, negative experiences with HCBS and other health plan services frequently led to under-utilization of needed services by members – many of whom would prefer to forego their health care to avoid future negative experiences.

Unsatisfactory care narratives

Members were also asked to describe an occasion or provide an example of a time when the services they received were unsatisfactory. Nine members provided between one and four narratives each – for a total of 17 unsatisfactory care narratives. No single, cohesive theme emerged in these narratives. Rather, the members' negative experiences dealt with a variety of provider types, services and situations, including:

- Inattentive and unfriendly medical supply vendors.
- Denied or delayed services such as dental care, prescription medicines, vision care, and personal attendants.
- Unsatisfactory MCO transportation.
- Insufficient services such as physical therapy or personal attendant services.
- Poor experiences communicating with doctors.

In one interview with the sister of a 24-year-old Hispanic man with a disability, the proxy respondent related a story in which the member was initially denied emergency dental care by his health plan – likely the result of poor communication of the member's medical history between his providers and MCO:

He is suffering a lot right now with his teeth. In two occasions the insurance here has covered emergency dental. We have had times that we've had to threaten, to fight with the person that we communicate with at the insurance... In the first occasion it was almost a six-month wait for them to give him treatment. In this [second] occasion she [the service coordinator] said, "No, it's that the dentist hasn't sent me the papers that I need." When we called the dentist, the dentist said that they already sent it to her...Amerigroup didn't approve it because they didn't send the x-rays. So we told them, "You know he can't take x-rays. It's not the first time that we're discussing the subject with you."

Positive experiences

Overall, members reported fewer positive experiences than negative experiences in the face-to-face interviews. The most commonly reported type of positive experience emerged when members were asked how the home- and community-based services they currently receive compare with similar services they had received in other settings in the past. The past experiences typically involved the members' stays in hospitals or nursing homes.

Seven members reported that they were more satisfied with the services they currently received in the home than in prior settings. One dual-eligible Hispanic member stated that, in reference to the care he received in the nursing home, the care he was receiving at home “doesn’t compare”. In particular, the member reported better food, friendlier people, more personal space, and better “scenery” in his own home than in the nursing home. Underlying the member’s statements is the high value placed on independent living. The concept of independence recurred throughout the face-to-face interviews, was a commonly mentioned “most important” outcome, and intersected numerous other themes.

Ten most common positive themes	N
• Better services than before	7
• Good communication with SC	6
• Good communication with doctor	5
• Good communication with nurse	5
• Good quality nursing care	4
• Good quality PAS	4
• Good attitude from nurses	3
• Good communication with MCO	3
• Good quality transportation	3
• Good attitude from PAS	2

Satisfactory care narratives

Eleven members described an occasion of a time when the services they received were satisfactory. Each member provided one or two narratives, for a total of 13 satisfactory care narratives. Almost all of these narratives dealt with care provided through the member’s personal attendant (six narratives), nurse (three narratives), or service coordinator (two narratives). One common element involved these providers “going out of their way” for the members or doing more than what was expected of them.

One dual-eligible Black member related that her home care nurse expressed a personal interest in her life, in an effort to understand changes in the member’s health status, and then advocated for the member in the interest of her health:

She was here and she took my blood pressure and it was high. She said, “What did you do over the weekend? Did you go to church?” I said, “No, I didn’t go this Sunday.” I said, “I was upset.” So she wanted to know why I was upset.

What happened was... I was getting my pictures together. I’m going to make a poster and put pictures on it how I celebrate my birthday through the years. I had given my mother a picture when I was 32 and I wanted the picture. So I asked my brother would he bring it to me... And instead of him bringing it, he takes it and put it on the Photostat copy machine and have a picture made off. I tried to explain to him I was going to have the picture restored. “Well the picture tore up,” [her brother said]. I was so disgusted with it ‘til it run my blood pressure up.

So the nurse called him and told him that she want him to bring me my picture because he had really upset me. So that really tickled me.

Familiarity with nurses and service coordinators

All STAR+PLUS members who receive home- and community-based services through the HCBS Program have two individuals assigned to them who work for the health plan – a nurse who makes annual home visits to assess their need for HCBS, and a service coordinator who helps arrange services and is available for the members to contact when they have questions.

However, despite the role of the service coordinator, members participating in the face-to-face interviews reported overwhelmingly that contact with their service coordinators was infrequent. When asked whom they would call if they had questions about their services, only seven members cited their service coordinator. Other members stated that they would contact the health plan directly (using the health plan’s 1-800 number) or the vendors with whom the health plans contract to deliver HCBS.

In fact, members’ level of familiarity and comfort increased with the level of contact they had with individuals. Members were most likely to know the first names of their personal attendants and nurses than their service coordinators. While the majority of members who participated in the face-to-face interviews recognized that they had someone at their health plan who helped them arrange services, most members did not recognize the title “service coordinator”. They instead referred to service coordinators as their “caseworkers” or “social workers”.

While many members had the phone number of their service coordinator and knew to call them with questions, only six members reported that their service coordinators would call them – whether proactively or simply returning phone calls. Inconsistencies were observed when these responses were compared to the members’ response to the telephone survey item – “Has a service coordinator contacted you in the last six months?” Among 12 members who said “yes” to the telephone survey item, only four also related in the face-to-face interviews that their service coordinators would call them, while three said their service coordinators would not call them, and five could not answer the question.

In-person visits by service coordinators were even less frequent – reported by only four members. Furthermore, it is likely that these members were referring to someone other than their actual service coordinator. Ten members had trouble identifying the roles of the various individuals who coordinated and provided their HCBS, and were unable to distinguish between their MCO nurse and their service coordinator. In a few cases, members thought that the term “service coordinator” applied to their personal attendants. These findings have implications for the validity of the service coordination items used in EQRO telephone surveys for the STAR+PLUS population.

Service Coordinator Interviews

ISP Development

Qualitative analysis of interviews with service coordinators revealed the following three main themes of significance to the development and implementation of ISPs: 1) assessing members' needs; 2) the ISP development and reassessment process; and 3) challenges to this process.

Assessing Member Needs

Effective ISP development hinges on an accurate and thorough assessment of a member's health care needs. Findings suggest that health plans utilize multiple strategies to identify members' needs, including self-identification by the member, needs assessment conducted by health plan staff (i.e., nurses, service coordinators, intake department), family members, caregivers, and health care/service providers. Service coordinators described the process of identifying needs, which is typically initiated by a telephone call to a service coordinator. One respondent stated:

It's through either a phone conversation – because a lot of times what we have is either the member themselves call in saying “I have diabetes. I'm having trouble doing my own insulin. Is there any way I can get a nurse?”... Also you have agencies that call in; they're the ones providing the actual hands-on care in the home. They'll also call in to let us know, “Hey, this is what's going on.”

Service coordinators rely heavily on the findings from in-home assessments to get an accurate and complete perspective of the members' needs. Most respondents described home visits as a critical step in the needs assessment and ISP development process. The in-home assessment not only verifies reported needs and associated health conditions; it provides an opportunity to identify additional needs not detected through the initial phone notification process. One respondent described the process, stating:

We send one of our nurses out to do an actual in-home assessment because you can't tell everything over the phone when you first get that contact. There's a lot of, I wouldn't say the wrong word is “pride” but it's being able to tell the full story and the full of your condition. Because when you used to be able to do something and now you can't, you don't always subscribe to the fullest how much you can't do it.

STAR+PLUS members present with a diverse spectrum of needs, some of which are not covered by services offered by the health plan. Service coordinators reported that the most common member needs are: 1) personal attendant services; 2) respite care; 3) dental services; and 4) adaptive/mobility equipment. Furthermore, service coordinators reported that a greater need for services exists among members who: 1) are male; 2) live alone; 3) have low literacy; and 4) do not speak English as their primary language.

Many service coordinators stated they go beyond the requirements of their job functions to accommodate the needs of members, as well as those covered under service plan. Although a member may request a service by indicating a need, a minimal score generated by the in-home assessment, as well as verification of medical necessity by the health care provider, is required before a desired service can be approved on the ISP. One respondent described a type of situation in which members may request a service for which they do not qualify:

We do have a lot of males. They're either single or they divorce or they're widowed and they cannot perform the cooking, the cleaning. And that's basically what they want and need, but sometimes they don't fall under the category for the provider. But they have to fall in the functional score of, let's just say, 24. So, if that's all that they want is the cleaning, the laundry and meals, and they don't fall in that category... it is hard to tell them, "No, I'm sorry, you didn't qualify".

All respondents indicated that, although services are not always available to meet the members' needs, service coordinators attempt to accommodate shortfalls through the use of community resources and charitable organizations, such as United Way and Catholic Charities. Most respondents indicated that the service coordinator will often provide members with information to obtain the community resources and, in some cases, initiate contact with the organizations on behalf of the member.

ISP Development and Reassessment

The process of ISP development and reassessment is systematic and can involve a variety of stakeholders, including the member, the Texas Medicaid program, health plan staff (e.g., service coordinators and nurses), the member's family or caregivers, and health care providers. Respondents described the process as one that is guided primarily by regulation, with the health plan staff acting as a sort of liaison between the member and other stakeholders. As the health plan does not establish the guidelines that govern the approval process, respondents described their role in the ISP development/reassessment process as information gathering.

However, the efficiency of this process is dependent upon the cooperation and responsiveness of all involved stakeholders. Communication between the service coordinator and the member is essential during the entire ISP development and reassessment process to ensure timely approval of the ISP. Nearly all respondents indicated that service coordinators make at least one contact with members prior to the finalization of the ISP. During the ISP development and reassessment process, family members are welcome to provide input; however, the member must provide permission for family members to speak with service coordinators in compliance with HIPAA regulations.

All respondents described the ISP development process as one that allows for expedited assessment and reassessment of members' needs, with the ability to make adjustments to services as needed. After initial approval, the ISP is reassessed annually by the health plan if no change in need or health status is reported. Members are contacted 60 to 120 days prior to their

renewal date to initiate the reassessment process. This is done to allow sufficient response time from other stakeholders. Some service coordinators described exceptions where ISPs were approved without prior contact with the member; however, these exceptions occurred in an effort to prevent a lapse in service. Reassessment may take place prior to the annual renewal date if a change in needs or health status is reported. In this instance, the health plan will initiate a needs assessment to confirm the report and adjust the ISP as needed.

Development of the ISP involves the use of standardized forms and tools, such as the ISP Form 3671-1. All respondents described the form as a decision-making tool to estimate annual service units based upon pre-determined spending limits, referred to as “Resource Utilization Group (RUG) limits.” Other standardized forms, such as the functional needs assessment, the Medical Necessity and Level of Care Assessment (MNLOC), and the Consumer Needs Assessment Questionnaire (Form 2060), are typically completed during the in-home needs assessment process. Respondents generally reported that the ISP Form 3671-1 can be completed in approximately 30 minutes.

Challenges to ISP Development and Implementation

Service coordinators encounter a number of challenges in assessing the needs of members and developing ISPs, many of which are out of their control. The most common challenges described by respondents are: 1) getting health care providers to sign documentation of medical conditions to verify medical necessity; 2) conducting in-home assessments in a timely manner; 3) issues with health plan software; and 4) making follow-up contact with members. Nearly all of the respondents described situations in which health care providers delayed the medical necessity verification process by not returning documentation in a timely manner. In addition, some respondents indicated that the health plans are overwhelmed with an influx of new members and are not adequately staffed to meet the demand. One respondent described challenges related to insufficient health plan nursing staff:

Well, one of the things is we were so inundated by so many people that I'm not sure we have enough staff in place to have the nurses get out there in a timely manner. So that's kind of been a long process for people and they've become anxious at times, wanting to know when the nurse is coming to assess them. It seems to be getting a little bit better, but that has definitely been a challenge.

All of the respondents described challenges associated with making contact with members due to non-responsiveness and inconsistent telephone contact information. Respondents described situations where members refused to answer the door when nurses came to conduct home visits, or refused to answer calls from unfamiliar phone numbers. In some cases, service coordinators reported that members' telephone numbers were no longer in service. One respondent described challenges with making follow-up contact with members:

I guess the most challenging part is making contact with the member... making sure that it's completed. Because one of the biggest things that

we find is that you may receive a call from a member one day and you try calling them the next day and they've already lost their phone service or whichever... We've had a couple of people where maybe they wake up on the wrong side of the bed that morning "I don't want anybody in my house" type of deal. Then those assessing nurses will either make arrangements to go back or we have had instances where the member just refused. "I don't want to do this." I don't think the members realize that this is part of the protocol.

Home- and Community-Based Services

Qualitative analysis of interviews with service coordinators revealed the following two main themes of significance to implementing a member's plan for HCBS: 1) coordinating services; and 2) service delivery.

Coordinating Services

Most service coordinators assist members in initiating services, and this process is typically carried out in a timely manner. In addition, service coordinators reported that members enjoy a great deal of autonomy in the service coordination process. Members can begin receiving services shortly after an ISP is approved, usually a time frame of two to five days. The health plans maintain a listing of vendors with whom they contract to provide services approved in the ISP, and which they provide to members to help facilitate the selection process. All of the respondents described a similar process for initiating services after an ISP has been approved. The process begins after the member has selected a vendor to provide a specific service.

Next, the service coordinator makes contact with the agency and provides them with written authorization to begin services. After the agency receives authorization to provide services, the burden of service delivery rests solely with the vendor agency. The agency will contact the member to initiate services and may conduct a separate assessment process. All of the respondents stressed that service coordinators do not select or refer vendor agencies for members. When asked about vendor referral for services, one service coordinator stated:

As far as referrals, we cannot suggest a provider agency to a member. I can't say to them, "Girling Healthcare is really good." I cannot. We'll send them a list; we encourage them to talk to neighbors and friends, maybe their doctor, to find a company that they want to work with.

A general consensus among respondents was that the time period between ISP approval and service initiation varies based upon the service and service delivery mechanism the member selects. For example, with home attendant services, members may utilize the consumer directed services (CDS) or service responsibility (SR) option, which allows members to have more autonomy in selecting the specific attendant who will be providing care in their home. In this case, the member identifies a specific individual, trains them, and acts as their immediate supervisor. This option allows a family member, close friend, or neighbor (excluding spouses) to serve in the capacity as the home care attendant and receive payment from the health plan.

Completing the requirements for this process takes longer and exceeds the normal time frame for service initiation following ISP approval. Employment qualifications that are set by the agency must be met before services can begin, which typically includes a background check.

All service coordinators reported having experienced issues with vendors, although it appeared to more of an exception than a common occurrence. The types of problems varied, and included problems related to miscommunication between the vendor agency and the health plan, as well as issues between the member and the agency. However, if the member is not completely satisfied with the services provided by the vendor, service coordinators reported that they can change vendors at any time.

There appeared to be no consensus regarding how members received self-care or disease management services. When asked about self-care and disease management, most respondents indicated that the health plan follows a process for providing these services through home health agencies, who train members in self-care and medication management if their functioning level permits, or by contacting the member's primary care provider. Only one respondent indicated they did not know how self-care fits into the context of the ISP. Most often respondents indicated that their greatest challenge to service coordination is working with vendor agencies that do not have the capacity to provide services in a timely manner.

All respondents indicated that there is not a waiting list for members to receive services under the STAR+PLUS program. Many of respondents described the system prior to the implementation of STAR+PLUS, where members could be on a waiting list for periods as long as five to six years. In addition, service coordinators clarified the difference between a waiting list and an "interest list", which is for individuals who are not enrolled in a managed care plan. Health plans are notified of a "potential member", which triggers a nursing assessment and a 45-day time frame to complete the eligibility requirements, which may include financial verification and medical necessity. Once all of the eligibility requirements have been met, the case is assigned to a service coordinator who begins the ISP development and service coordination.

Service Delivery Monitoring

The findings suggest that no formal system exists to verify service delivery or monitor service delivery outcomes. None of the respondents indicated a specific system to verify service delivery or monitor service outcomes. The general consensus among respondents was that once the health plan notifies the selected agency of the member's service need and provides an authorization, the burden to provide the service falls on the agency. None of the respondents could describe a specific process that the health plan follows to verify whether services are actually being conducted. Many respondents indicated that the health plan may not be aware that a member is not receiving services unless the member contacts the health plan. One respondent stated:

If they do not let us know that they're not receiving the services, there's no way of us knowing that they're not receiving the services.

Many respondents described an informal verification process in which service coordinators conduct follow-up calls with members to determine if they are receiving services, and to assess their level of satisfaction with the services being provided by the vendor. This usually occurs one to two weeks after services have been initiated. However, when asked about monitoring of HCBS outcomes, none of the respondents could describe a formal list of measures that the health plans use to monitor service outcomes. One service coordinator supervisor described an informal process of measuring service outcomes between annual assessments:

Well, there's two things that I personally look at, and one is on the annual reviews. If there is not a change in that ISP where they're keeping the same nursing hours, that's usually a good indicator that they're not deteriorating... Two, I hear it from my nurses all the time when they do that initial home visit, [is] just the actual physical appearance, condition, the mentality, the way their voice is over the phone from the first time you talk to them to three months later when they've been receiving that service.

Service Coordinators

Service coordinators dually serve as advocates and liaisons to ensure that ISPs are developed and services are received by members. Qualitative analysis of interviews with service coordinators revealed the following three central themes of significance to understanding the role of service coordinators: 1) professional qualifications; 2) training; and 3) caseloads.

Professional Qualifications

Health plan service coordinators have varied professional backgrounds in health, human and/or social services obtained through education or extensive work experience. The interviews revealed a consensus regarding the minimum professional qualifications for service coordinators. All respondents indicated the following three main types of professional qualifications that service coordinators must have: 1) a bachelor's degree in social work, human services, or a related health field; 2) a nursing degree, as a registered or licensed vocational nurse; or 3) significant experience in the medical field, social work or human services. One respondent described a diversity of professional qualifications among service coordinators:

Some of us are nurses. Some of us are social workers. I think some of us have had the experience or come from the DADS [Texas Department of Aging and Disability Services] or the training from DADS. We're a little bit of everything.

Although all respondents indicated that service coordinators with degrees in social work meet the minimum professional qualifications, consensus was not reached regarding social work licensure requirements. Some respondents indicated that a degree in social work was sufficient; however, others suggested that those with social work degrees must also have a state license as a social worker to work as a service coordinator. Previous work experience was named as a

minimum professional qualification; however, some respondents indicated that the health plan was moving toward hiring only applicants with either a bachelor's or nursing degree.

Most of the service coordinators who were hired without bachelor's or nursing degrees were hired when the health plan started a department or division devoted to servicing STAR+PLUS members. Many of these service coordinators had previously worked for the Texas Department of Aging and Disability Services (DADS) in some capacity. Although all agreed that previous experience with DADS would serve as an acceptable professional requirement, service coordinators did not clearly articulate the minimum number of years of experience that would be required. Some respondents indicated that service coordinators have previous experience working in medical facilities, such as hospitals, doctor's offices, or non-profit service organizations. Most respondents also indicated that service coordinators should be knowledgeable of community resources and services for the underserved.

Training

The overall consensus among respondents was that the health plan provides adequate training for service coordinators when newly hired to the organization, as well as continuing education and procedural updates. All respondents indicated that service coordinators complete four weeks of training when newly hired. The new hire training for service coordinators generally includes, but is not limited to, training on the computer systems, available health plan programs and services for members, and needs assessment techniques and procedures. The classes are led by trainers and typically last for two weeks. One respondent described the health plan's training for service coordinators:

We have quite a bit of training. First of all, just our systems; we have several different systems that we work in within the computers. The other is all of these processes we're talking about. We have work processes for initial waiver assessments and SNAs and for reassessments, and we do quite a bit of training. Just the computer training alone can take a week. And then the other training, depending on the groups, the waiver module can take two to three days to get through; it's quite lengthy. And then we have ongoing training as well, especially if there's a new process or new expectation. We have monthly meetings amongst our staff to introduce any new issues or any new developments or processes.

As a part of the training provided by the health plan, respondents indicated that service coordinators-in-training receive a mock caseload and the opportunity to shadow an experienced service coordinator. In addition, the respondents who were supervisors indicated that the health plan offers subject matter and policy update trainings as changes to regulations, programs, or systems are introduced. None of the respondents mentioned continuing education training provided by the health plan for individuals with professional licenses, such as licensed or registered nurses or licensed social workers.

Caseloads

Caseloads for service coordinators varied based upon zip codes, and generally ranged from 200 to 500 cases. Many of the service coordinators could not provide an exact number of cases, as their caseload assignment is based upon zip codes. When asked to provide an estimate of the number of cases under their management, one respondent stated, "I wish I knew. It's difficult for me to determine that. I don't know. I just know that I'm busy."

Although the caseload each service coordinator maintains is high, most respondents indicated that the number is not unrealistic, as each case does not require attention each month. Furthermore, the nurses provide a significant amount of information required to complete the ISP during the home visit.

Respondents indicated that service coordinators complete between 15 to 20 new assessments and 10 to 15 reassessments each month as a result of their caseload distributions. These numbers are not set based upon health plan policy or mandated regulation, but are informal measures used by the health plan's leadership (i.e., team leads or supervisors) to gauge workload. Leadership within the health plan is careful to ensure that service coordinators maintain realistic caseloads, and that caseloads are adjusted if service coordinators are approaching or exceeding these thresholds. One supervisor described how caseloads are monitored by health plan leadership:

If I see someone getting towards that mark, I redistribute that workload to have someone else assist them, to make sure everything is done in a timely manner.

Endnotes

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- ⁶ CMS (Centers for Medicare and Medicaid Services). 2012. "1915(c) Home and Community-Based Waivers." Available at: <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html>.
- ⁷ PCORI (Patient-Centered Outcomes Research Institute). 2012. *National Priorities for Research and Research Agenda*. Available at: <http://www.pcori.org/assets/PCORI-National-Priorities-and-Research-Agenda-2012-05-21-FINAL.pdf>.
- ⁸ Rathert, C., M.D. Wyrwich, S.A. Boren. 2012. "Patient-Centered Care and Outcomes: A Systematic Review of the Literature." *Medical Care Research and Review*, Nov. 20, 2012.
- ⁹ These rates are slightly lower than response and cooperation rates in the FY 2012 STAR+PLUS Member Survey (55 percent and 81 percent, respectively).
- ¹⁰ CDC (Centers for Disease Control and Prevention). 2012. "NCHS Urban-Rural Classification Scheme for Counties." Available at: http://www.cdc.gov/nchs/data_access/urban_rural.htm.
- ¹¹ It should be noted that two of the CES-D-10 items are reverse coded – meaning that their absence (rather than presence) is indicative of depression. These items are: (1) Feeling hopeful about the future; and (2) Feeling happy.