The University of Kansas
School of Social Welfare
Long Term Care Research Group

Expedited Service Delivery
Pilot Evaluation
Final Report

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This research was supported in part through a contract with the Kansas Departments on Aging and Social and Rehabilitation Services
Topeka, Kansas 66612

August 15, 1999
Expedited Service Delivery
Pilot Evaluation Acknowledgements

On July 26, 1999, the Expedited Service Delivery Evaluation Work Group reviewed a draft of the Expedited Service Delivery Pilot Evaluation Report. The work group’s recommended revisions have been incorporated into this final report. Appreciation is extended to the following work group members:

Sam Alvey, Jerry Brock, Rosalie Cooper, Mike Dawes, Dan Gronniger, Patricia Igo, Paul Meals, Dennis Priest, Jeanine Schieferecke, Jerry Williams, Kristy Boaz, Diana Canon, Bill Cutler, Janis DeBoer, Jennifer Hendrix, Margo Lytton, Anita Nance, Roxanne Rachlin, Debra Schwarz, Mark Wunder, Phyllis Brittain, Rosemary Chapin, Ellene Davis, Marlene Finney, Denise Hunter-Mitchell, Kelley Macmillan, Heather Phillips, Patsy Sampson, Melanie Starns

We would like to acknowledge the contributions and work of the Area Agency on Aging and Social and Rehabilitation Service staff that participated in this Pilot and ESD Evaluation. Those PSA’s are:

The Central Plains (Wichita) AAA (PSA 2)
The Northwest Kansas (Hays) AAA (PSA 3)
The Southeast Kansas (Chanute) AAA (PSA 5)
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**Expedited Service Delivery:**

Expedited Service Delivery (ESD) is a process for providing in-home services to Medicaid HCBS/FE applicants while their financial determination is being made. Through ESD, customers can receive in-home services during the Medicaid financial eligibility process.

**The Need for Expedited Service Delivery:**

Older adults who meet the appropriate level of care threshold and financial criteria for Medicaid long-term care may choose to remain in the community and have their care needs met through HCBS/FE services, instead of entering a nursing facility. However, determination of financial eligibility for Medicaid HCBS/FE services may take up to 45 days to complete, leaving the applicant without access to HCBS-FE services necessary to remain in the community during this time. Case managers have reported that by the time many older adults apply for HCBS they can not function safely more than a week without long term care. As a result of the lag time, HCBS-FE applicants may enter a nursing facility in order to receive long term care. The focus of ESD is on getting services into the home within three to five days of application.

**Pilot Background:**

During FY98, an ESD Financial Screening Worksheet (ESDFSW) was developed and tested as part of a study on ESD. It was found that the ESDFSW is accurate for determining which HCBS-FE applicants could receive expedited services pending final Medicaid determination by SRS with minimal financial risk to the state. Based on these results the 1998 Kansas legislature allocated funds to be used to conduct a pilot test of the ESD process in Kansas.

**FY99 Expedited Service Delivery Pilot:**

A workgroup made up of KDOA, SRS and KU staff was created in order to plan, design and execute the ESD pilot. Based on the results from a survey of all eleven Area Agencies on Aging (AAA) the workgroup chose three pilot sites: 1) South East Kansas (Chanute) AAA; 2) Northwest (Hays) Kansas AAA; and 3) Central Plains (Wichita) AAA, Sedgwick County only.

In preparation for the pilot the KU School of Social Welfare, in cooperation with KDOA and SRS, delivered training to both SRS staff and AAA case managers in each pilot area. KU also conducted mock runs at each pilot site the week before the pilot went live. ESD was piloted for five months from November 9th, 1998 until March 31st, 1999. During the pilot, case managers screened HCBS/F E applicants for ESD qualification after completing the functional assessment. In addition, case managers worked with direct care service providers to get in-home services started within 5 days of assessment for those older adults who qualified for ESD. Follow-up meetings, either through on-site visits or teleconferencing, were conducted with all the sites during the pilot. After the pilot concluded, KU conducted focus groups at each pilot site with AAA and SRS staff to review their experiences with ESD.
**Evaluation Results:**

The evaluation of the ESD pilot included examination of both process and outcomes. The following are highlights from the pilot evaluation.

- A total of 200 customers participated in the ESD pilot (Chanute: 103, Hays: 55, and Wichita: 42) and were screened by the ESD Intake Form. 134 of these customers were filtered out by the ESD Intake Form (Chanute: 59, Hays: 43, and Wichita: 32). Therefore, 66 customers were screened by the ESD Financial Screening Worksheet (Chanute: 44, Hays: 12, and Wichita: 10).

- 24 customers ultimately qualified for ESD (Chanute: 9, Hays: 9, and Wichita: 6). Of the 24 ESD customers, 2 were ultimately found ineligible for Medicaid HCBS/FE services. Therefore, the accuracy rate of the ESDFSW was 91.67%, and the error rate was 8.33%.

- The total cost of the two customers expedited in error, paid out of the ESD pool of funds, was $1374. This figure includes both targeted case management costs and ESD service costs.

- On average, in-home services for customers who qualified for ESD services started within 4 days of assessment.

- Case managers reported that ESD has helped consumers who would have had to enter a facility remain in the community.

- Focus group data show that 51% of the focus group participants believe ESD should be implemented statewide and an additional 30% think it should be implemented if the process was refined.

- None of the ESD recipients were in a nursing facility as of the 45th day after assessment, compared to 11 of those who did not qualify for ESD services.

**Integrated Analysis:**

This section of the report presents an examination of the costs associated with ESD followed by an analysis of the benefits and limitations of an ESD process. The purpose of the integrated analysis is to synthesize the outcomes and process evaluation data in order to identify the potential of ESD for statewide implementation.

**Cost Analysis**

The state incurred three type of costs related to expediting service delivery. One cost was based on the Targeted Case Management (TCM) time required to screen customers and get services into place when necessary. The other costs were based on the additional time customers who were found Medicaid eligible received in-home services and the cost of
services provided to customers who incorrectly received expedited services. The state saved money through an expedited service delivery process by enabling HCBS-FE applicants who if not for expedited service delivery would have entered a nursing facility. The savings are calculated based on the difference between HCBS-FE and nursing facility service costs and the length of time the customer remains in the community with services (referred to as community tenure).

- The cost analysis found that if just 5 of the 24 ESD recipients in the pilot would have actually entered a nursing facility and stayed for 7 months, if not for ESD, then the costs of assessing all 200 applicants for expedited service delivery and expediting services for all 24 would be offset.

Benefits of an ESD Process

In order to identify the benefits and limitations of ESD, the outcomes data, anecdotal records, focus group responses and cost analysis were examined and synthesized. The following highlights the benefits followed by the limitations.

- **Diversion from nursing facility placement and associated cost savings**

  The primary benefit of an ESD process is that it helps older adults avoid unnecessary nursing facility placement with minimal financial risk to the state. If only 2.5% of the older adults screened for ESD services were diverted for seven months through ESD, then the costs of the pilot program would be offset by the savings/cost avoidance.

- **Positive public relations**

  The goal of ESD, increasing service access and avoiding unnecessary nursing facility placement, is central to the mission of both KDOA and SRS. The customer-centered focus of ESD also promotes a positive image for both agencies. During the focus group, participants from both agencies reported that communication increased and improved between the AAA and SRS offices during the pilot.

- **Increased access to services**

  Data from the pilot show that on average, ESD services started within 4 days of the ESD screening. Another related benefit is that the older adult is not left in “limbo” during the time before a Medicaid determination is made. Even if the older adult does not qualify for ESD, the case manager is in the home faster to assess their needs and explore other service options with them.

- **Helps older adults in immediate need**

  Data from the pilot revealed that the customers who received ESD services showed an immediate need for services. For example, 67% of the ESD customers had not been receiving any services prior to ESD, 33% of the ESD customers were 85 years of age or older and 62%
of those who qualified for ESD lived alone. These factors have been found to correlate with a high risk of nursing facility placement and therefore demonstrate a need for timely services.

**Limitations of an ESD Process**

- **Alternative services for ESD customers ineligible for Medicaid**

  A limitation identified by the focus group participants was that there might not be any other services available for an ESD customer found ineligible for Medicaid HCBS/FE services. Therefore, the case manager would be “taking away” the HCBS/FE services without providing any other options.

- **Screening criteria too strict**

  A large proportion (67.5%) of the older adults assessed for ESD qualification that were filtered or screened out were ultimately found eligible for HCBS/FE. It was reported that some of these older adults could have benefited from ESD but did not meet the pilot criteria. It is important to note that the ESDFSW was designed to be conservative to minimize the financial risk to the state. It is likely that a larger proportion of applicants could have been expedited with minimal financial risk to the state.

**ESD Potential for Statewide Implementation:**

The data from the pilot show there are many positive benefits of ESD and staff support from both SRS and KDOA/AAA for the program. The most common suggestion from focus participants was that ESD should target high-risk groups. The majority of pilot staff that participated in the focus groups recommended that ESD should be implemented statewide. The full report contains specific recommendations based on the analysis of the pilot data and state agency staff feedback.

**Conclusion:**

The ESD pilot data, the low cost of the errors, and anecdotal information from case managers indicate that ESD can benefit older Kansans at a relatively low cost to the state. At the present time, state agency staff are faced with the immediate issue of implementing a waiting list for HCBS/FE services and how to meet the needs of older adults with limited resources. ESD could potentially be used as a mechanism to target services to older adults who are functionally and financially at the greatest risk of nursing facility placement. Based on the pilot results, ESD is a program that will benefit the state as well as older adults.
Expedited Service Delivery:  
Executive Summary

Expedited Service Delivery Pilot Project

I. Overview

Purpose

The purpose of this project was to evaluate the accuracy rate of the ESD Financial Screening Worksheet (developed during Fiscal Year 1998) and assess the effectiveness of the expedited service delivery process in order to determine the potential of ESD for statewide implementation. Expedited service delivery is a process that allows in-home services to be expedited to Medicaid home and community based services for the frail elderly (HCBS/FE) applicants while their financial eligibility is being determined. These impoverished, older adults are at high risk of entering a nursing facility. Other expected outcomes of the study include:

- A data summary, including basic demographics, and outcome information on customers assessed in the pilot project;
- Feedback from state agency field staff on expedited service delivery;
- Discussion of the benefits, risks and limitations of expedited service delivery;
- Identification of barriers to implementing a statewide expedited service delivery process;
- Cost-benefit analysis and fiscal impact of an expedited service process; and
- Recommendations on statewide implementation of an expedited service delivery process in Kansas.

It is important to note that the decision to expedite service delivery is distinct from the actual Medicaid HCBS/FE determination. Expedited service delivery is a method of using state funds to provide in-home services during the Medicaid financial eligibility determination period to customers who will most likely qualify for HCBS/FE services. It is not a process for determining Medicaid eligibility.

Background

Older adults who meet the appropriate level of care threshold and financial criteria for Medicaid long-term care may choose to remain in the community and have their care needs met through HCBS/FE services, as opposed to entering a nursing facility. However, the length of time to determine financial eligibility for Medicaid HCBS/FE services had been identified as a barrier for many older adults. In some Planning and Service Areas (PSA), case managers do not complete a Uniform Assessment Instrument (UAI) until they know the customer is financially eligible due to reimbursement concerns. The determination may take up to 45 days to complete, leaving the applicant without access to HCBS/FE services necessary to remain in the community during this time. However, this is just one step in the process. Therefore, the focus was on getting services into the home within three to five days, not the time to determine financial eligibility. Case managers have reported that by the time many older adults apply for HCBS they can not function safely more than a week without long term
care. As a result of the lag time, HCBS/FE applicants may enter a nursing facility in order to receive long term care.

One solution to this problem used in other states is to implement an expedited service financial screening tool that would allow the case manager to screen an older adult and assess the likelihood of whether they would be financially eligible for Medicaid HCBS/FE services. In 1996, staff at the University of Kansas School of Social Welfare (KUSSW) Long Term Care Project worked with the Department of Social and Rehabilitation Services (SRS) to explore the feasibility of expediting service delivery. The results of that study indicated the need for additional research and testing to refine the trigger criteria and develop an expedited service delivery financial screening worksheet and process. The 1996 Kansas Legislature directed the Secretary of Aging to “ensure statewide service access is available in a timely manner and shall adopt an application procedure for long-term care services which presumes the eligibility of persons applying for long-term care services from the date of application” (House Bill No 2047, 1996).

In 1997, the Kansas Department on Aging (KDOA) contracted with KUSSW to develop and refine a financial screening worksheet and analyze the feasibility of implementing an expedited service delivery process in Kansas. As part of the 1997 study, KUSSW contacted other states to discuss expedited service delivery in order to build upon their experiences in developing an expedited service delivery process in Kansas. In order to develop the Expedited Service Delivery Financial Screening Worksheet (ESDFS), KUSSW staff built on a preliminary screening instrument that was created as part of a 1996 student unit project entitled “Innovative Case Management in Kansas: Implications for the LIFE Program.” The “best practices” from other states were also taken into consideration in the revision and refinement of the draft financial screening worksheet. In addition, KUSSW consulted with KDOA and SRS central office and field staff in the development of the worksheet and tested the draft worksheet with four Area Agency on Aging (AAA) targeted case managers. Their recommendations were incorporated into the draft of the worksheet. Finally, the ESDFS was tested in a retrospective file review of 125 completed Medicaid HCBS/FE applications. The ESDFS was found to have a 100% accuracy rate in determining which HCBS/FE applicants could receive expedited services pending final Medicaid determination by SRS with minimal financial risk to the state.

Based on the lag time customers experience accessing HCBS/FE services, the results of KUSSW’s previous research on expediting service delivery, and the legislative interest, the 1998 Kansas Legislature appropriated state general funds to be used to conduct a pilot test of the ESD process in Kansas. KDOA and SRS contracted with KUSSW to develop, implement, and evaluate a pilot test of the Expedited Service Delivery Financial Screening Worksheet and process.
II. ESD Pilot Project

ESD Workgroup

A work group made up of KUSSW, KDOA and SRS staff was created to plan, design, and execute the ESD pilot project. KDOA staff acted as the pilot program coordinator and worked with KUSSW staff to operate the pilot. Specific duties of the work group included reviewing and approving the project timeline, developing a process for implementing the pilot, and monitoring the ESD pilot. The workgroup was divided into the following work teams:

- The survey and AAA site selection team;
- The training team;
- The payment structure team;
- The contract team; and
- The evaluation team.

Tasks involved in the implementation of the pilot are discussed below.

ESD Pilot Site Selection

One of the first tasks of the work group was the selection of pilot sites. In order to accomplish this, the work group agreed upon desired criteria for the pilot sites. Criteria included Area Agency on Aging (AAA) interest in participation, an urban/rural mix of PSA’s perceived willingness of direct care service providers to participate, and the number of HCBS/FE referrals received per month by the AAA. A survey was created to capture the needed information from each AAA. The survey was mailed to each AAA along with a letter that explained ESD, how the pilot would work, the background of the project, and the advantages and disadvantages of pilot participation.

All eleven AAAs responded to the survey and only one stated that they were not interested in participating in the pilot. The workgroup met and reviewed the results of the survey from the other ten AAA’s and chose three pilot sites. The selected sites were:

- The Central Plains (Wichita) AAA (PSA 2), Sedgwick County only;
- The Northwest (Hays) Kansas AAA (PSA 3); and
- The Southeast Kansas (Chanute) AAA (PSA 5).

Each of these three AAAs agreed to participate in the pilot and signed an AAA Provider agreement.

ESD Timeline

The start date for the pilot project was set for November 9, 1998. The pilot was scheduled to run for three months. Based on the AAA survey data it was anticipated that there would be approximately 375 new HCBS/FE applicants over the three-month period. The workgroup scheduled ESD trainings for the third week of October and a mock run for the first week of
November. In addition, deadlines were set for the creation of forms, completion of direct care service provider agreements and development of the payment structure and training curriculum.

**ESD Process**

In order to develop the flow of the ESD process, the workgroup team met on several occasions, reviewed the flowchart for the HCBS/FE program, and obtained input from state agency staff. An ESD process was designed that could be incorporated into the current system. It was decided that the ESD screening would be initiated during the in-home visit after the targeted case manager had completed the UAI. Drafts of the proposed ESD flowchart were circulated for feedback from staff. The finalized ESD flowchart is in Appendix A. KDOA designated Diana Canon, KDOA Office Specialist, as the ESD Specialist to approve all ESD plans of care during the pilot. As the flowchart shows, the majority of communication in the pilot, such as the plan of care approval process, took place via fax.

The workgroup established the following customer criteria for the ESD pilot:

- Customers who were currently receiving Supplemental Security Income (SSI) would be screened out;
- Customers who were currently receiving Medicaid would be screened out;
- Customers who had a LTC threshold score under 26 would be screened out;
- The customer’s plan of care must be determined prior to completing the ESDFSW, and those customers with a Level III cost cap exception request would be screened out;
- Customers must indicate an interest in receiving ESD services to be screened by the ESDFSW; and
- The income threshold on the ESDFSW would be set at $678 per month to qualify for ESD services.

All of the above criteria, with the exception of the last one, were “filters.” If a customer did not meet (pass through) all of them they could not be screened by the ESDFSW to receive ESD services. These criteria were designed to limit the scope of the pilot and target ESD services to those consumers who had the greatest need. Customers who were receiving SSI or Medicaid at the time of assessment did not need to be expedited since their financial eligibility could be determined very quickly. Finally, the income threshold was established at the current SRS Protected Income Limit (PIL) in order to simplify the ESDFSW and eliminate the potential of case managers having to make complex financial determinations.

The work group also made decisions regarding the length of time ESD services would be provided to a customer, deadlines for the completion of forms, and how errors would be handled. The workgroup decided that ESD services could be provided for a maximum of sixty days from the date the customer’s completed application for Medicaid HCBS/FE services was returned to the SRS Office. It was determined that once a customer qualified for ESD services they had ten days to apply for Medicaid HCBS/FE services. Failure to do so would result in the termination of ESD Services. Finally, the work group set a grace period of ten days for a consumer to continue receiving ESD services if they were found ineligible for Medicaid.
HCBS/FE services or failed to apply for Medicaid. It was also decided that if a customer received ESD services but was ultimately found ineligible for Medicaid, the cost of the ESD services would be covered by the pilot funds, rather than charging the customer or exposing the provider to financial risk.

**ESD Payment Process**

The ESD payment structure work group developed and refined the reimbursement system for the pilot. It was decided that the ESD Specialist at KDOA would track all HCBS/FE customer and provider activities using the ESD Intake Form faxed from the targeted case managers. In addition, the ESD Specialist would track all payout and recoupment activities. The work group designed a payment methodology that allowed the pilot funds (State General Funds) to cover the cost of the ESD services provided and targeted case management assessment time. Once a customer was found eligible for HCBS/FE, Medicaid would be billed for the appropriate charges. Therefore, it was anticipated that a large proportion of the pilot funds could be recouped from Medicaid. The necessary forms and protocols for the ESD payment systems were developed. A copy of the ESD payment flow chart is in Appendix B.

**ESD Direct Care Service Providers**

The work group developed an agreement to be signed by direct care service providers in the pilot areas. The agreement, ESD payment flowchart, and a letter explaining the ESD process and how it would work were sent to all providers in the pilot areas. Providers were encouraged to participate based on the fact that there was no risk to the provider of not being reimbursed, regardless of the outcome of the customer’s Medicaid determination. Providers also had a choice of submitting an ESD claim for payment through the KDOA system or waiting until the customer was found eligible for Medicaid and submitting their claims. An effort was made to secure provider agreements prior to the start of the pilot. However, due to the short time frame, if a customer chose a particular provider, it was the responsibility of the targeted case manager/AAA to secure the provider agreement prior to starting any ESD services.

**ESD Forms**

A number of forms needed to be developed and refined for the ESD pilot. The following is a description of the documents used by targeted case managers for communication, assessment, and tracking of customers during the pilot. KUSSW developed a database to house the information collected on these forms. KUSSW received the completed forms and entered them into a Statistical Package for the Social Sciences (SPSS) database for analysis.

- **ESD Intake Form**

  The work group developed the ESD Intake Form to capture demographic and functional information about customers screened in the pilot. Specific variables include the customer’s age, ethnic background, living arrangement, and level of care score. In addition, the ESD Intake Form provided information about the customer’s point of entry into the system and in-home services currently received by the customer. The ESD Intake Form served as the first
step in the ESD screening process. It included the filter criteria (e.g. LTC threshold score of 26 or above) described previously. If a customer did not meet all of the filter criteria, the case manager could not initiate the ESD Financial Screening Worksheet. The ESD Intake Form (Appendix C) was also used by KDOA as a tracking form for HCBS/FE customers.

➢ ESD Financial Screening Worksheet

The work group reviewed the existing ESDFS used in the retrospective file review in the previous year’s study. The draft ESDFS had five trigger variables, fifteen financial asset variables, and fourteen income variables. The worksheet was designed so that as information is entered onto the worksheet, decision trees prompt the case manager to make a determination to expedite or not to expedite the applicant. It was also constructed so that many people who do not qualify for expedited service delivery are eliminated from the screening process quickly by their answers to the first few questions, and thus screening time for the case manager and customer is minimized.

A number of changes to the worksheet were recommended, including the addition of a few trigger criteria. SRS suggested that customers who met any of the following criteria should be screened out because these situations would represent complex determinations:

- Customers who are not US citizens;
- Customers who are applying for HCBS at the same time as their spouse;
- Customers who are self-employed (including farming); and
- Customers who have a trust fund or account or an annuity.

As mentioned previously, the income threshold for customers to qualify for ESD was changed to $678 ($691 as of 1/99) per month. The final version of the ESDFS used in the pilot is in Appendix D.

➢ ESD Agreement Form

Since customers were not required to provide financial documentation during the ESD screening, the work group created the ESD Agreement Form to serve as a statement of attestation. The Agreement Form was the final page of the ESD Financial Screening Worksheet and was required for customers who qualified for ESD. The customer signed the form, which states that the information they have provided for the ESDFS is true and complete to the best of their knowledge. The Agreement Form also explained the following:

- The Expedited Service Delivery Financial Screening Worksheet is not an application for Medicaid benefits;
- The ESD services are only temporary;
- The customer must apply for the Medicaid HCBS services within 10 days;
- If the customer is found ineligible for Medicaid, the temporary ESD services will end following a 10 day grace period; and
- ESD services are authorized for a maximum of 60 days from the date the customer’s completed application for Medicaid HCBS services is returned to the SRS Office.

The customer initialed each of these points to signify they understood it and signed the ESD Agreement Form (Appendix E). The case manager gave a copy of the signed form to the customer.

- **ESD IM 3160**

The work group determined that customers who qualified for ESD should be identified as such in communication between the AAA and SRS office. Therefore, the IM 3160 form, a communication document between SRS and the AAA, was modified for use in the pilot. In order to create an **ESD IM-3160** the TCM would write or use a stamp to label the IM 3160 in the upper right hand corner with the letters: **ESD**. It was decided that once a customer qualifies for ESD, the **ESD-IM 3160** would be used in place of the regular IM 3160. Since a regular IM 1360 may be generated by SRS prior to a customer qualifying for ESD, the TCM would need to modify the IM 3160.

- **ESD Notice of Action**

The work group developed the ESD Notice of Action to notify customers when their ESD services were scheduled to begin or end. It was modeled after the HCBS/FE Notice of Action, but tailored to the ESD pilot program. The ESD version was used until the customer was found eligible for HCBS/FE services. The ESD customer rights and responsibilities were listed on the back of the ESD Notice of Action form (Appendix F).

- **ESD Outcomes Form**

This form was created to capture outcome data on all customers 45 days after they had been screened for ESD, regardless of qualification for ESD. Through the ESD Outcomes Form, case managers collected information such as whether the customers’ living arrangement had changed, if the customer had moved (e.g. into a nursing facility), applied for Medicaid, or received any in-home services (publicly or privately funded). KUSSW mailed the outcomes form (and return envelope) to the case manager at the time it needed to be filled out. The case manager returned the ESD Outcomes Form (Appendix G) directly to KUSSW.
ESD Training

In preparation for the pilot, KUSSW delivered a daylong training to each of the pilot sites. Both SRS and AAA staff from the pilot areas attended the training, with KDOA staff present. All attendees completed an evaluation of the training session that they attended. Results of these evaluations are presented under the Evaluation Section of this report. The morning session of the training involved both SRS and AAA staff and covered the following topics:

- Background & previous work completed on ESD by KDOA, KUSSW and SRS;
- Goals & objectives of the 1998-99 ESD Pilot ESD Project;
- The role of ESD pilot staff, including targeted case managers and Economic Assistance Specialists;
- The role of KDOA and SRS;
- The pilot timeline;
- The steps and flow of the ESD process; and
- An overview of the ESDFSW and other ESD forms.

After the morning session, the training attendees had lunch and participated in a question and answer session. Immediately following lunch SRS staff presented information on Medicaid Estate Recovery and how to complete the Medicaid application. The remainder of the training was conducted with the AAA staff only.

The afternoon training session focused on how to complete the ESD forms and the steps in the ESD process. Targeted case managers were provided with written instructions (Appendix H) on how to complete the ESDFSW. Targeted case managers were given the opportunity to practice completing the ESDFSW with sample Medicaid applications. The correct responses were then shared and discussed with the case managers.

Next, the trainers reviewed the other forms and steps required in the ESD process and the follow-up process after services are initiated. An ESD Checklist (Appendix I) reflecting the steps of the process was provided to case managers. The purpose of the checklist was to help case managers keep track of the required steps/forms of the process and where they needed to be routed. The targeted case managers role-played ESD interviews and completion of ESD forms using written scenarios. Again, the correct responses were then shared and discussed with the case managers. The case managers’ written exercises were collected by KUSSW to be analyzed for areas that needed further attention. The training wrapped up with a question and answer session and dissemination of the following:

- Extra ESD forms and Medicaid applications;
- Written information on how to explain ESD and Medicaid Estate Recovery to customers;
- A technical assistance list of resource persons and phone numbers; and
- Certificates of Attendance.

Copies of the morning and afternoon agendas used in the training are in Appendix J.
During the training session at the Wichita pilot site it became apparent that the ESD process would require some modification for this area. Prior to the pilot, the Wichita SRS Office did not send the IM 3160 form to the AAA until financial eligibility was already established. Therefore, it was too late in these circumstances to screen the customer for ESD to alleviate the financial eligibility lag time. At the training, it was decided that SRS would continue to send IM 3160 forms after the financial eligibility was established, if the customer’s income was determined by the Economic Assistance Specialist to be over $678 per month. If the customer’s income was determined to be under $678, the IM 3160 form would be marked ESD and sent to the AAA prior to the financial determination being made.

**Mock Runs**

During the week prior to the pilot implementation KUSSW conducted mock run training sessions at each AAA. The purpose of the mock run was to provide a hands-on review and reinforcement of the ESD training and address any last minute issues. As part of the mock run KUSSW reviewed the finalized ESD flowchart and the case managers worked through more examples. KUSSW provided the case managers with a list of “helpful hints” for the ESD pilot. These hints were based on KUSSW’s review of the completed exercises from the training sessions. The hints highlighted areas in need of clarification such as:

- The face value of life insurance is different than the cash value, and **only the cash value** is entered on the worksheet;
- Interest income less than $50 per month is exempt; and
- The **Total Gross Income** on the worksheet pertains to the applicant only.

**Pilot Implementation**

The pilot began, as scheduled, on November 9, 1998. KUSSW conducted follow-up meetings, either through on-site visits or teleconferencing, with all the sites after the pilot began. ESD process issues were discussed and clarified during these meetings. One area of concern that arose during a follow-up visit was that some of the AAA referral sources were unaware of ESD pilot and availability of these services. Therefore, information about ESD was disseminated to hospital discharge planners, CARE Assessors and home health agencies to inform them of the ESD services. Updates on the ESD process and number of customers screened were provided through these follow-up meetings and memos sent by KDOA. The work group continued to meet as needed throughout the course of the pilot and ongoing communication was maintained with each of the pilot sites. KUSSW provided a written preliminary report on the pilot to KDOA for use during the 1999 Kansas Legislature session.

**Pilot Extension**

As the pilot progressed over time it became apparent that the number of HCBS/FE referrals, the number of ESD screening worksheets, and the number of customers receiving ESD services were less than expected. There was concern that there would not be enough customers screened to evaluate the ESDFSW and pilot. The work group decided to extend the pilot until March 31\textsuperscript{st}, 1999. The three AAA pilot sites signed amendments agreeing to extend
the pilot. Direct care service providers were also asked to sign an amendment regarding the pilot extension.

**Pilot Conclusion**

At the end of March each of the AAAs and direct care service providers were sent a memo reminding them of the pilot termination date and how to handle ESD customers after this date. The pilot concluded on March 31st, 1999. KUSSW presented their evaluation plan for the ESD pilot to the evaluation work group for review and comment. KUSSW suggested using focus groups as one method for the evaluation of the pilot. The work group reviewed and approved a draft of the proposed focus group questions. The work group also reviewed and agreed upon the elements outlined in the contract that were to be included in the evaluation report. The overall evaluation plan was approved and additional evaluation work group meetings were planned to review the evaluation report.

**ESD Focus Groups**

This method allowed pilot staff to provide detailed information about their experiences during the ESD pilot. The first portion of the focus group involved only case managers to get their feedback on the training and mock run, the ESD process and flow, the ESD forms and the effect of ESD on consumers. SRS pilot staff joined the group for lunch and to discuss the benefits and limitations of ESD, the impact of ESD for older adults, overall recommendations/concerns about the ESD process and the potential for statewide implementation. Focus group participants were given the option to record their responses on the questionnaire and/or provide them verbally. KUSSW recorded the verbal comments on flip charts. A copy of the questions used in the focus groups is in Appendix K.
III. Evaluation of ESD Pilot

The evaluation of the ESD pilot is divided into two components: 1) The outcomes evaluation and 2) the process evaluation. Data from each segment are presented followed by a section entitled “Integrated Analysis.” In this section information from the outcomes and process evaluation data are integrated to identify the benefits of an ESD process, the limitations and risks of ESD, the cost/benefit of an ESD process and the potential for statewide implementation.

Outcomes Component

The outcomes component involved collecting, analyzing and reporting the following information:

- A data summary (demographic, functional, etc.) of all customers assessed in the pilot;
- The results of the ESD screenings;
- The accuracy rate of the ESDFS;
- The costs associated with expediting services, including the cost of errors; and
- The 45 day service and residential status of all customers in the pilot.

Data for the outcomes component were collected from the various forms used in the ESD process and some follow-up with SRS, KDOA and AAA staff. All data were coded and entered into the ESD database maintained by KUSSW. The methodology used for the outcomes component was a descriptive analysis of the data collected. Comparisons between the population subgroups (e.g. urban vs. rural) were conducted.

There were 95 customers from the Wichita pilot area eliminated from the pilot results, because of an error in screening them, leaving 200 cases. This error surfaced during the focus group evaluation process. SRS and AAA staff reported a misunderstanding about the ESD Intake Form screening criterion for Medicaid recipients. The eliminated cases were filtered out as being on Medicaid when this was not necessarily the case. It was decided to eliminate these cases to preserve the methodological integrity of the results.

Outcomes Results

The following section provides a summary of data collected during the ESD pilot. Data are presented for those who qualified for ESD, those who did not qualify for ESD and a total for all participants in the ESD pilot.

Each customer was initially screened using the ESD Intake Form (See appendix C) and could be filtered out by one of five filter criteria, questions 20 through 24 on the intake form. As mentioned previously, these criteria screened out the following:

- Customers receiving SSI;
- Customers currently receiving Medicaid;
- Customers who had a LTC threshold score under 26;
Customers whose monthly plan of care cost exceeded $3000; and
• Customers who were not interested in receiving ESD services.

A summary of the results of this filtering process is be presented later on page 21 of this report. All customers who were not filtered out by the ESD Intake Form proceeded to the ESDFSW (See appendix D) to be assessed for ESD qualification.

• A total of 200 customers participated in the ESD pilot (Chanute: 103, Hays: 55, and Wichita: 42) and were screened by the ESD Intake Form.

• 134 customers were filtered out by the ESD Intake Form (Chanute: 59, Hays: 43, and Wichita: 32).

• 66 customers were screened by the ESD Financial Screening Worksheet (Chanute: 44, Hays: 12, and Wichita: 10).

• 42 customers were screened out by the ESDFSW (Chanute: 35, Hays: 3, and Wichita: 4)

• 24 customers ultimately qualified for ESD (Chanute: 9, Hays: 9, and Wichita: 6).

• On average, in-home services for customers who qualified for ESD services started within 4 days of assessment.

Accuracy and Error Rate

There were 24 customers who qualified for ESD based on the screening with ESDFSW. Ultimately 22 customers were found eligible for Medicaid HCBS/FE services and 2 were not. Therefore, the accuracy rate was 91.67%, and the error rate was 8.33%. Accuracy and error rates were calculated as follows:

\[
\text{Accuracy Rate} = \frac{\text{Number expedited and eligible for Medicaid}}{\text{Total number expedited}}
\]

\[
\text{Error Rate} = \frac{\text{Number expedited and ineligible for Medicaid}}{\text{Total number expedited}}
\]

Source of Errors

One case was an error because the customer/family provided inaccurate information regarding the resources owned by the customer. The case manager reported that a family member was the primary source of information and took the lead in answering the questions when the ESDFSW was completed. When the case manager asked about each resource listed on the ESDFSW, the family member denied that the customer had the resource. The customer and family then proceeded to complete and submit the Medicaid application. The EA Specialist at SRS verified that resources existed. The resources for the customer exceeded the resource
allowance for Medicaid HCBS/FE and the customer was denied. The EA Specialist notified the case manager who promptly discontinued the ESD services.

The second case involved a couple wherein only one was applying for services. The couple’s resource information had been destroyed in a flood so that they could only estimate the cash value of a life insurance policy. The case manager used the couple’s estimate on the ESDFSW and their total resources did not exceed the amount allowed for a couple when only one is applying for Medicaid HCBS/FE. The case manager continued to work with the couple to verify the life insurance amount and to provide that information to the EA Specialist at SRS. Once all resources were verified, the couple’s total resources still were below that allowed for a couple. However, the couple decided not to go through the division of assets process and also did not proceed because of Estate Recovery.

**Data Summary of All ESD Participants**

This section presents data on all 200 customers in the ESD pilot. The majority of the data is presented for all three pilot sites in aggregate. Data results are presented in table form with a description of the data, summary of the data, and a brief analysis of the results. There are two ways to present this data. The format in this section shows to what extent the customers who qualified for ESD mirror the total ESD applicant pool. For example, of those that qualified, 25% were male. This reflects the same gender distribution found in the applicant pool: 22%. The tables below follow this format and present a description of the ESD participants and all the customers screened for ESD. Area breakdowns are provided in Appendix L.

The other way to present this data is to show whether there are subgroup variations in qualification rates (Appendix M). For example, the rate of qualifying for ESD was 13% (6/45) for male applicants compared to 12% for females. All subgroups were tested for qualification rate differences. No substantial differences were found between the variable subgroups. The qualification rates among the subgroups for each variable are presented in Appendix M.

**Demographic Data Summary**

**Table 1. Qualification for ESD by Age.**

<table>
<thead>
<tr>
<th>Age</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>65-74</td>
<td>6</td>
<td>25%</td>
</tr>
<tr>
<td>75-84</td>
<td>10</td>
<td>42%</td>
</tr>
<tr>
<td>85+</td>
<td>8</td>
<td>33%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

It is commonly reported that advanced age (85+) is associated with higher risk of nursing facility placement. Table 1 shows that older adults age 75 to 84 comprised the largest proportion of the ESD customers and the ESD applicant pool. The table also shows that there
was a higher proportion of ESD customers age 85+ (33%) than in the ESD applicant pool (24%). Additionally, further analysis (not shown here, see Appendix M) indicates older adults age 85+ also qualified for ESD at a higher rate (17%) than the other two age groups (11% and 9%).

Table 2. Qualification for ESD by Gender.

<table>
<thead>
<tr>
<th>Gender</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>25%</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>75%</td>
</tr>
<tr>
<td>Missing Data</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

A majority of the participants in the ESD pilot were women, making up at least three-quarters of the customers. This pattern was consistent for the group who qualified for ESD and the entire ESD applicant pool.

Table 3. Qualification for ESD by Urban/Rural Setting.

<table>
<thead>
<tr>
<th>Urban/Rural</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Urban</td>
<td>8</td>
<td>33%</td>
</tr>
<tr>
<td>Rural</td>
<td>16</td>
<td>67%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

The urban/rural classification for this project was based on the US Census Bureau’s assignment of zip codes as urban and rural. The group that qualified for ESD had a slightly higher urban representation than the entire ESD applicant pool. One possible explanation for the low urban proportion is that 95 of participants from the Wichita area were eliminated from the results totals due to a referral/intake error described earlier.

Table 4. Qualification for ESD by Ethnic Status.

<table>
<thead>
<tr>
<th>Ethnic Status</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Black</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>White</td>
<td>19</td>
<td>79%</td>
</tr>
<tr>
<td>Native</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>
The largest percent of ESD applicants in all groups were white. There was slightly less ethnic diversity representation in the group that qualified for ESD compared to the entire ESD applicant pool. In part, this is because all of the customers screened in one ESD pilot site were white. Because this is not a random sample, caution must be exercised about drawing any inferences about diversity representation.

Table 5. Qualification for ESD by Marital Status.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Married</td>
<td>5</td>
<td>21%</td>
</tr>
<tr>
<td>Never Married</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Widowed</td>
<td>15</td>
<td>63%</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

A majority, at least 61%, in both groups were widowed. Those who were married comprised the next largest group. A slightly higher percent of those who qualified for ESD were married compared to the entire ESD applicant pool. A smaller percent were divorced and qualified for ESD when compared to the entire ESD applicant pool.

Table 6. Qualification for ESD by Living Arrangement.

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Own home/apt</td>
<td>9</td>
<td>37%</td>
</tr>
<tr>
<td>Rent home/apt</td>
<td>10</td>
<td>42%</td>
</tr>
<tr>
<td>Assisted Living/Residential Care</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

The majority in both groups rented a home or an apartment, followed by those who owned a home or apartment. A larger percent of applicants that qualified for ESD either lived in their own home or apartment, or in an assisted living/residential care facility than the entire ESD applicant pool.
Access Data Summary

Table 7. Qualification for ESD by Initial Contact Person.

<table>
<thead>
<tr>
<th>Initial Contact</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Customer</td>
<td>4</td>
<td>17%</td>
</tr>
<tr>
<td>Family</td>
<td>13</td>
<td>54%</td>
</tr>
<tr>
<td>Discharge Planner</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>21%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing Data</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 7 illustrates who made the initial contact for HCBS/FE services on behalf of the customer. A larger percent of family members of those customers who qualified for ESD initiated the contact compared to the entire ESD applicant pool. Family members may have been instrumental in helping the older adult access ESD services.

Table 8. Qualification for ESD by Point of Access.

<table>
<thead>
<tr>
<th>Point of Access</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>AAA</td>
<td>14</td>
<td>58%</td>
</tr>
<tr>
<td>SRS</td>
<td>10</td>
<td>42%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing Data</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

The proportion of ESD applicants who accessed SRS or AAA as their first contact for HCBS/FE services is consistent for both groups. The ESD pilot utilized the already existing referral and intake system to identify customers for participation in the ESD pilot. It is interesting to note 40% of individuals used SRS as the initial point of access for HCBS/FE.
High Risk & Functional Status Data Summary

Table 9. Qualification for ESD by Whether Applicant was Living Alone.

<table>
<thead>
<tr>
<th>Living Alone</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>62%</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>38%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

Since living alone may be considered a risk factor of nursing facility admission, this information was collected about the applicant. The majority of both groups lived alone, highlighting their need for support. As the table illustrates, a slightly higher proportion of the ESD customers lived alone, 62%, compared to the entire ESD applicant pool, 57%.

Table 10. In-Home Services* Received at Time of ESD Application.

<table>
<thead>
<tr>
<th>In-home service</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>HCBS/PD</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>SCA</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Meals</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Income Eligible</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Home health</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Private pay</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Hospice</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Volunteer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No Services</td>
<td>16</td>
<td>122</td>
</tr>
<tr>
<td>Missing Data</td>
<td>0</td>
<td>11</td>
</tr>
</tbody>
</table>

*Services received information was gathered from the ESD Intake Form

Among the individuals who qualified for ESD, prior to the pilot, only three types of services were received. In addition, the majority of both those who qualified for ESD (67%) and the total applicant pool (61%) were not receiving any in-home services.

Home health service was the most frequently utilized service. Home health services are skilled services that are received under the Medicare Benefit and are short-term services only. The ending of these services may have prompted the application for HCBS/FE. For the total ESD pool, meals were the second most frequently utilized in-home service; however, those who did qualify for ESD were not using meal services at all.
Table 11. Qualification for ESD by Whether the Applicant was in a Nursing Facility in the Last 12 Months.

<table>
<thead>
<tr>
<th>In NF in the last 12 months</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>83%</td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>17%</td>
</tr>
<tr>
<td>Missing Data</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

Overall, approximately 16% of the ESD applicants were in a nursing facility within the 12 months preceding the assessment for ESD. Prior nursing facility stays can be an indication of potential risk factors for older adults in need of services. There were no differences in the incidence of nursing facility admissions in the last 12 months for those who qualified for ESD and the entire ESD applicant pool.

Table 12. Qualification for ESD by Whether the Applicant was in a Hospital in the Last 30 days.

<table>
<thead>
<tr>
<th>In hospital in last 30 days</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>58%</td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>42%</td>
</tr>
<tr>
<td>Missing Data</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

Recent hospitalization may be viewed as a potential risk factor for older adults needing services. The customers that qualified for ESD showed a higher proportion of recent hospitalizations, 42% compared to 30% for the entire ESD applicant pool.

Table 13. Qualification for ESD by UAI-Memory Score.

<table>
<thead>
<tr>
<th>UAI/Memory Score</th>
<th>ESD Qualified Customers</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>0</td>
<td>10</td>
<td>42%</td>
</tr>
<tr>
<td>1</td>
<td>9</td>
<td>38%</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Missing data</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>
The UAI-Memory Score is part of the CARE Assessment and is an indicator of short-term memory, long-term memory, memory/recall, and decision-making skills. A score of 4 indicates memory difficulty in all four areas and a lower memory score indicates less impaired memory skills. Memory skills can be considered a proxy for cognitive impairment and therefore a potential risk factor. A low memory impairment score may be an indicator of ability to live safely at home.

For the group that qualified for ESD, 80% of their memory scores were between 0 and 1, compared to 62% for the entire group. Only 4% of those who qualified for ESD had a memory score of 4, compared to 11% for the entire group.

**Data on Customers who Received ESD Services**

**Plan of Care Costs of Customers Who Received Expedited Services**

In order to calculate the in-home costs for the 22 customers who were correctly expedited, data were needed on the duration of the ESD services received by these customers and the associated plan of care (POC) costs. Customers who were correctly expedited received ESD services for an average of 11 days before being found eligible for HCBS/FE services. This was calculated by measuring the length of time from the ESD service start date to the date SRS made the financial Medicaid determination. The amount of time ranged from 0 to 40 days. Some customers had completed their Medicaid applications prior to being screened for ESD, therefore the Medicaid determination may have been made close in time to the ESD service start date. Approximately 40% of the ESD customers received services for 13 days or longer before the final Medicaid determination was made.

The POC costs were calculated for the 22 customers who were correctly expedited. The aggregate and pilot areas POC cost data are presented in Table 14. As the table shows, the average monthly POC costs were $609.81 per customer, with a range of $70.00 to $2,335.75 per month. As presented above, the average length of time these customers received ESD services before being found eligible for Medicaid was 11 days. Therefore, the total estimated plan of care costs for these customers before the Medicaid determination was made was $4919.13 ($609.81/30 days × 11 days × 22 customers). It is important to note that these POC costs were recouped from Medicaid because these customers were found eligible for HCBS/FE services.
Table 14. Average Monthly Plan of Care Costs for Customers* Correctly Expedited.

<table>
<thead>
<tr>
<th></th>
<th>Chanute</th>
<th>Hays</th>
<th>Wichita</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Range</td>
<td>$70.00 - $1,590.00</td>
<td>$161.00 - $596.25</td>
<td>$397.50 – $2,335.75</td>
<td>$70.00 – $2,335.75</td>
</tr>
<tr>
<td>Individual Mean</td>
<td>$620.06</td>
<td>$312.11</td>
<td>$941.75</td>
<td>$609.81</td>
</tr>
<tr>
<td>Aggregate POC Costs</td>
<td>$5,580.50</td>
<td>$2,184.75</td>
<td>$5,650.50</td>
<td>$13,415.75</td>
</tr>
<tr>
<td>Standard Dev.</td>
<td>$476.35</td>
<td>$153.70</td>
<td>$712.36</td>
<td>$524.48</td>
</tr>
</tbody>
</table>

POC Costs of the Errors

The plan of care (POC) costs and the amount of time services were received before the Medicaid determination were also calculated for the two customers who were incorrectly expedited. The average length of time these two customers received ESD services before being found ineligible for HCBS/FE services was 34 days, 29 days for one customer and 39 for the other. In both cases SRS received the customer’s application after the ESD service start date. The monthly POC cost was $120.00 for one customer and $386.25 for the other. Therefore, the aggregate monthly POC cost for the 2 customers was $506.25.

The targeted case management costs for the two customers expedited in error were $990: $440 for one customer and $550 for the other (a portion of these costs was for the time required to conduct the UAI). The claims for in-home ESD services for the two customers found Medicaid ineligible totaled $384. Therefore, the total cost of the two customers expedited in error, paid out of the ESD pool of funds, was $1374 ($990 + $384).

Data on Customers Who Did Not Receive ESD Services

Reasons customers did not receive ESD services

Customers could be filtered or screened out of the ESD process at two different points. First, a customer must meet the filter criteria on the ESD Intake Form in order to proceed to the ESDFS. The ESD customer, once through the intake process, could be screened out by the ESDFS. The reasons customers did not receive ESD are described in detail below.

As previously explained, a total of 200 customers participated in the ESD pilot. The ESD Intake Form filtered out 134 customers, leaving 66 customers to proceed to the ESDFS. Table 15 highlights the 134 customers who did not make it past the ESD Intake Form. Data are presented in aggregate and by pilot area.
Table 15. Reasons Customers were Filtered Out by the ESD Intake Form.

<table>
<thead>
<tr>
<th>Reason Filtered out by ESD Intake Form</th>
<th>Chanute</th>
<th>Hays</th>
<th>Wichita</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI Recipient</td>
<td>9</td>
<td>3</td>
<td>27</td>
<td>39</td>
</tr>
<tr>
<td>Medicaid Recipient</td>
<td>32</td>
<td>30</td>
<td>1</td>
<td>63</td>
</tr>
<tr>
<td>Level of Care &lt;26</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Not Interested</td>
<td>16</td>
<td>10</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>43</td>
<td>32</td>
<td>134</td>
</tr>
</tbody>
</table>

A total of 39 customers were receiving SSI and 63 were receiving Medicaid. These individuals did not need to be expedited because of a process already in place at SRS and the AAA that could result in quick determinations for these groups. Two customers had a LTC Threshold Score that was less than 26 and were filtered out by the ESD Intake Form. A total of 30 customers chose not to participate in ESD for reasons presented below in Table 16.

Table 16. Reasons Customers were Not Interested in ESD.

<table>
<thead>
<tr>
<th>Reason not interested in ESD</th>
<th>Chanute</th>
<th>Hays</th>
<th>Wichita</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other services/ No need</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Spenddown concerns</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Prefers to wait</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Didn’t think they’d Qualify for Medicaid</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>10</td>
<td>4</td>
<td>30</td>
</tr>
</tbody>
</table>

A total of seven customers already had some services and did not believe they needed expedited services. A total of seven customers self-selected out of the ESD process because of concerns about the spend down process and rules. A total of nine customers chose to wait for services to start because they did not have an urgent need and may have already submitted their Medicaid application. A total of five customers were not screened for ESD out of their concern that they would not qualify for Medicaid.

There were 66 customers that were screened by the ESD Financial Screening Worksheet. Data on the 42 customers screened out by the ESDFSW are presented in Table 17 below.
Table 17. Reasons Customers were Screened Out by the ESDFSW.

<table>
<thead>
<tr>
<th>Reason Not Qualified for ESD</th>
<th>Chanute</th>
<th>Hays</th>
<th>Wichita</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applying with Spouse</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Transferred Assets</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Assets too high</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Income too high</td>
<td>16</td>
<td>1</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>3</td>
<td>4</td>
<td>42</td>
</tr>
</tbody>
</table>

Two customers were screened out because they were part of a married couple applying for Medicaid-HCBS/FE at the same time. A total of 9 customers were screened out because they had transferred assets within the last five years (a trigger criterion). Twelve customers were screened out by the ESDFSW because their resources exceeded the resource threshold for Medicaid. Nineteen customers were screened out by the ESDFSW because their income exceeded the income threshold. This left 24 individuals who qualified for ESD.

ESDFSW Screening Data

The following is a summary of the asset and income amounts reported by customers screened in the pilot. Appendix N contains the asset and income data in table format by pilot area and in aggregate. Highlights include:

- The reported total asset amounts of all customers screened by the worksheet averaged $3157, with a range from $0 to $41,900.
- Approximately 74% of the customers had less than $2000 in total assets.
- The reported monthly income amounts of the customers screened by the worksheet ranged from $170 to $1490, with an average of $704. Approximately 54% of the customers who made it to this point of the worksheet had income below $678 per month. 75% of the customers screened had incomes less than $805 per month.

Case Manager Time to Complete the ESDFSW

In order to address concerns regarding the length of time required to complete the ESDFSW, during the pilot case managers were asked to report the amount of time they spent completing the ESDFSW. This information was recorded by the case manager on the ESD Intake Form and was entered into a database by KUSSW. The ESDFSW completion times ranged from 1 minute to 3 hours. Additional highlights from this analysis are listed below.

* These data do not include the incorrect income and asset amounts reported initially by the two individuals that received ESD services, but were found ineligible for Medicaid.
• On average, the ESD Financial Screening Worksheet took case managers approximately 29 minutes to complete.

• Approximately 10% of the ESD Financial Screening Worksheet screenings took longer than an hour to complete.

**ESD Outcomes Data for all ESD Pilot Participants**

Case managers completed an ESD Outcomes Form (see Appendix G) for all participants in the ESD pilot 45 days after the customer had been initially assessed for ESD. The following tables have missing data because there were twelve ESD Outcomes Forms not received.

**Number of Medicaid Applicants and Determination Status**

Table 18. Applications for Medicaid HCBS/FE and Determination Status.

<table>
<thead>
<tr>
<th>Applied for Medicaid HCBS/FE</th>
<th>ESD Qualified Customers</th>
<th>DID not qualify for ESD</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied for Medicaid HCBS/FE</td>
<td>100% (24/24)</td>
<td>91% (161/176)</td>
<td>92% (185/200)</td>
</tr>
<tr>
<td>Approved for Medicaid HCBS/FE*</td>
<td>92% (22/24)</td>
<td>84% (135/161)</td>
<td>85% (157/185)</td>
</tr>
</tbody>
</table>

*This row does not include the 15 customers that did not apply for Medicaid.

Table 18 shows that while the ESD Intake Form assessed 200 older adults, 185 applied for Medicaid HCBS/FE services. All 24 ESD customers applied for HCBS/FE services, as required by the pilot. Of the 185 older adults that applied for Medicaid HCBS/FE services, 157 (85%) were approved. These data illustrate the conservative nature of the ESDFSW. 135 older adults who were filtered or screened out of the ESD pool ultimately qualified for HCBS/FE services.

**Number of ESD Applicants Receiving Public, Private & Informal Services**

The Outcomes Form inquired about whether the individual had, within 45 days after the ESD assessment, received public services, received private-pay services, and received informal services from family, friends, church, etc. These results are presented in Tables 19 through 21.
Table 19. In-Home Service Outcomes for All Customers Screened.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>ESD Qualified Customers</th>
<th>DID not qualify for ESD</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Services</td>
<td>95.8% (23/24)</td>
<td>79.0% (139/176)</td>
<td>81.0% (162/200)</td>
</tr>
<tr>
<td>Privately Funded</td>
<td>0% (0/23)</td>
<td>4.3% (7/162)</td>
<td>3.8% (7/185)</td>
</tr>
<tr>
<td>(15 missing data)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal Services</td>
<td>26.1% (6/23)</td>
<td>21.5% (35/163)</td>
<td>22.0% (41/186)</td>
</tr>
<tr>
<td>(14 missing data)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As Table 19 shows, 96% of the ESD customers were receiving public services as of 45 days after the ESD assessment, compared to 79% of those that were filtered/screened out. 4% of the older adults that were filtered/screened out were receiving privately funded services, compared to none of the ESD customers. A similar proportion of both groups reported receiving informal services.

Table 20. Public Service Outcomes.
(Customers could receive more than one service)

<table>
<thead>
<tr>
<th></th>
<th>ESD Qualified Customers</th>
<th>DID not qualify for ESD</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS/FE</td>
<td>22</td>
<td>135</td>
<td>157</td>
</tr>
<tr>
<td>Home Health</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Hospice</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Senior Care Act</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Meals</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Income Eligible</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 20 shows that ESD applicants received a small number of publicly funded services, besides HCBS/FE. As mentioned previously, ESD qualified customers, on average, received in-home services within four days of ESD assessment. The most common services received besides HCBS/FE were home health or meals.
Table 21. Informal Service Outcomes.
(Customers could receive more than one service)

<table>
<thead>
<tr>
<th></th>
<th>ESD Qualified Customers</th>
<th>DID not qualify for ESD</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Care</td>
<td>3</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Meals</td>
<td>2</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Transportation</td>
<td>3</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Shopping</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Day Care</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medication Management</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Financial Management</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No Informal Services</td>
<td>17</td>
<td>128</td>
<td>145</td>
</tr>
</tbody>
</table>

Table 21 presents the data collected on informal services received. Case managers reported that the majority of older adults screened for ESD were not receiving any type of informal support as of the 45th day after assessment. Individuals often continue to receive informal services even after they begin to receive publicly funded services.

Change in Residential Status

The ESD Outcomes Form asked the case manager to supply information regarding the residential status of all older adults assessed for ESD services. Information was gathered regarding whether, as of the 45th day after ESD assessment, the older adult had moved in with family, entered a nursing or assisted living facility, entered a hospital, etc. The results are presented in Table 22.

Table 22. Changes in Residential Status Outcomes.

<table>
<thead>
<tr>
<th>Change in Residence</th>
<th>ESD Qualified Customers</th>
<th>DID not qualify for ESD</th>
<th>Total ESD Applicant Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moved in with family</td>
<td>2</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Entered a Nursing Facility</td>
<td>0</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Entered a Hospital</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Entered Assisted Living</td>
<td>3</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Entered a Senior Apartment</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
• It is interesting to note that none of the ESD customers has entered a nursing facility as of the 45th day, compared to 11 of those who did not qualify for ESD services.

In fact, the most common change in residential status for those adults who did not qualify for ESD was entrance to a nursing facility. The most common change for the ESD customers was entering an assisted living facility.
Process Component

The process evaluation includes data regarding staff experiences with ESD, including their perceptions of the following:

- The training and mock runs;
- The ESD forms and process;
- The impact on older adults; and
- The potential for statewide implementation.

The methodology used for the process component of the evaluation included evaluation surveys, anecdotal records and focus groups.

A. Training Evaluations

AAA and SRS staff were asked to evaluate the ESD training that they attended. Staff from both agencies attended a morning session to provide background and an overview of the ESD pilot. SRS staff completed an evaluation at the end of the morning session. AAA staff attended an afternoon session to be trained on tasks specific to the case managers’ role in the ESD pilot. AAA staff completed an evaluation for the morning and afternoon session. The following is a summary of the written ESD training evaluations.

- Evaluation of Morning ESD Training Session

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Yes</th>
<th>No</th>
<th>Did Not Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was material presented clearly?</td>
<td>34</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Do you have concerns not addressed?</td>
<td>1</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>

Overall, SRS and AAA staff reported the material was presented clearly and their concerns were addressed.

<table>
<thead>
<tr>
<th>Areas needing more attention</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESD Process</td>
<td>4</td>
</tr>
<tr>
<td>ESD qualification issues</td>
<td>3</td>
</tr>
<tr>
<td>Local Processes</td>
<td>3</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Forms clarified or improved</td>
<td>1</td>
</tr>
<tr>
<td>None specified</td>
<td>31</td>
</tr>
</tbody>
</table>
The majority of attendees did not answer this question on the evaluation questionnaire. Four training attendees commented that the ESD process needed more attention in training. An equal number commented that qualification issues and local processes needed more attention.

Table 25. Morning ESD Training Session: Most Helpful Component of Training.

<table>
<thead>
<tr>
<th>What was most helpful?</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed materials</td>
<td>13</td>
</tr>
<tr>
<td>Roxanne &amp; Kelley’s instructions</td>
<td>12</td>
</tr>
<tr>
<td>Having SRS/outside staff at training</td>
<td>5</td>
</tr>
<tr>
<td>Question and answer sessions</td>
<td>4</td>
</tr>
<tr>
<td>Did not answer</td>
<td>9</td>
</tr>
</tbody>
</table>

When asked what was most helpful in the morning training, attendees reported the printed instructions and KUSSW staff instruction were the most helpful, followed by SRS staff attendance at the training and questions answered at the training session.

➢ Evaluation of the Afternoon ESD Training Session

Table 26. Afternoon ESD Training Session: Training Content Feedback.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Yes</th>
<th>No</th>
<th>Did Not Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was material presented clearly?</td>
<td>20</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Do you have concerns not addressed?</td>
<td>10</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Are you comfortable implementing ESD?</td>
<td>26</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Were the exercises helpful?</td>
<td>27</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Overall, AAA staff reported the material was presented clearly and they were comfortable implementing the ESD Pilot. The afternoon session included numerous role-plays and written exercises. The most common concern of AAA staff at the conclusion of training was the time it would take to complete the ESDFS.
Table 27. Afternoon ESD Training Session:
Areas Needing More Attention.

<table>
<thead>
<tr>
<th>Areas needing more attention</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>6</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Forms clarified/improved</td>
<td>1</td>
</tr>
<tr>
<td>Rural issues</td>
<td>1</td>
</tr>
<tr>
<td>Billing/payment</td>
<td>1</td>
</tr>
<tr>
<td>Provider participation</td>
<td>1</td>
</tr>
<tr>
<td>Eligibility issues</td>
<td>1</td>
</tr>
<tr>
<td>None specified</td>
<td>20</td>
</tr>
</tbody>
</table>

At the conclusion of the afternoon training, six AAA staff still had concerns about the ESD process. Some AAA staff also expressed concerns about the availability of services for those customers not eligible for Medicaid.

Table 28. Afternoon ESD Training Session:
Most Helpful Component of Training.

<table>
<thead>
<tr>
<th>What was most helpful?</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hands on practice/examples</td>
<td>16</td>
</tr>
<tr>
<td>Roxanne &amp; Kelley’s instructions</td>
<td>8</td>
</tr>
<tr>
<td>Printed materials</td>
<td>3</td>
</tr>
<tr>
<td>Answering questions</td>
<td>1</td>
</tr>
<tr>
<td>Did not answer</td>
<td>4</td>
</tr>
</tbody>
</table>

AAA staff reported that the role-plays and examples were the most helpful component of the ESD training. The second most helpful item was KUSSW staff instruction. As noted earlier, the afternoon session was designed to be highly interactive.

B. Anecdotal Records

The anecdotal record methodology involved reviewing the field notes and records that were kept during the implementation and the pilot. These notes and records helped identify areas that need refinement or additional training/clarification. They served as a record of issues that were encountered and how they were resolved. Additional elements of the anecdotal records segment included correspondence during the pilot, feedback received during the mock run and follow-up meetings as well as the written training evaluations.

ESD Pilot Records/Notes

Throughout the ESD Pilot, records of planned steps, questions and issues that arose, and action to address variations in the plan were maintained. This section highlights these written records.
The planned steps of the ESD Pilot included the mock run to be conducted approximately one week before the pilot went live, and two follow-ups with each pilot site around the 30th day and 60th day following implementation of the pilot. Contact by telephone with AAA case management supervisors by the end of the first week of the ESD Pilot was done by KUSSW staff to identify issues, problems, answer questions, and find out how many ESD screenings had been done.

Mock Run

The mock run included the case managers who attended the ESD training. As a result of the ESD training, revisions in the ESD Flowchart were made and this was an agenda item for the mock run. The specific change was that all people screened, regardless of the outcome of the ESD screening must have an ESD Intake Form completed and then faxed to the ESD Specialist so that payment of the case managers’ time could be processed. The entire ESD Flowchart process was reviewed with case managers during the mock run. In addition, the ESD Checklist was revised to reflect the changes in the ESD Flowchart, and the revised checklist was handed out.

Case managers received a written copy of “Helpful Hints” that was developed based on analysis of the role-plays and ESD forms completed by case managers during the ESD Training. Problem areas and errors were identified in the training materials: how to identify, evaluate and calculate burial/funeral plans as resources, and a review of the difference between life insurance cash value and face value.

The ESD Intake Form was reviewed to emphasize that case managers are given specific instructions on the next step for questions 20-28. This was important because the outcomes could vary and hence the action by the case manager would vary as a result. The ESDFS was reviewed to emphasize recording asset amounts in the correct column (gross income, not net income) and how to use the decision boxes for assets and income.

During the mock run in Central Plains AAA, staff identified the need for a Notice of Action for ESD participants. A call was made to KDOA to discuss this issue. KDOA decided to develop a NOA for ESD customers and noted that it would be delivered to the AAAs by the start of the ESD Pilot. Finally, case managers also received a revised ESD Technical Assistance List because of a change in the phone and fax number for the ESD Specialist at KDOA.

Follow-up call within first week of the ESD Pilot

KUSSW staff contacted case management supervisors and found that there were not any problems with the ESD implementation. One question arose in the Southeast Kansas AAA about the UAI. Staff had completed a UAI as part of a Senior Care Act annual review and thought the person should be screened for ESD. Staff were reminded that only UAI’s completed for HCBS/FE applicants would trigger the ESD screening. Northwest Kansas AAA and Southeast Kansas AAA held receptions for service providers and reported the service providers were very positive about the ESD Pilot.
In the ESD contract between KUSSW, KDOA and SRS it was specified that each pilot site would have a site visit within 30 days of the start of the pilot. However, the number of ESD customers screened within the first 30 days was very low and the few problems or issues that emerged were resolved quickly without a site visit. All three pilot sites were in agreement that a site visit was not necessary.

60 Day Follow-up

On-site visits were conducted in January at the Northwest Kansas AAA, Central Plains AAA, and Southeast Kansas AAA. The staff were given an update on the number of ESD customers to-date at each pilot site and in aggregate. The AAAs were advised that the ESD work group had discussed and agreed to an extension of the ESD Pilot because of the low number of ESD customers. The AAAs were supportive of the extension.

AAA staff discussed provider availability for ESD customers, and the AAAs reported they were able to get services into place easily and quickly. One AAA commented that some providers had not received the provider contracts before ESD went live, and this caused extra work for the case managers to get a contract in place. The same was true for service providers who had received the provider contract but had not signed and returned it.

AAA staff asked if the Qualified Medicare Beneficiary (QMB) Program indicated a person was already on Medicaid. Following the site visit, a call was made to Dennis Priest, SRS, to get an answer to that question. Mr. Priest stated that a person on QMB was not necessarily on Medicaid and could be identified as QMB because he/she would have a red Medical card. A person with full Medicaid Benefits has a green Medical Card. The case management supervisor in each Pilot area was informed that ESD customers with a red Medical card should be processed as not being on Medicaid.

AAA staff were also reminded that the Medicaid-HCBS/FE income threshold was $691.00 effective January 1, 1999. Revised ESDFS forms were given to the case management supervisors for distribution to all case managers involved in the ESD pilot.

Unplanned actions and variations in the ESD pilot

There were three primary unanticipated actions taken during the ESD Pilot. First, during the ESD Training, staff at the Central Plains AAA (Wichita) became concerned that the number of ESD participants would be greater than what the agency could handle. A manager with KDOA, the Central Plains AAA case management supervisor, and the local SRS Income Maintenance Chief negotiated an agreement on how to deal with the concern. This decision was announced during that training session and only affected the Central Plains pilot site. The decision was if a customer used the SRS office, as the initial point of access, SRS would screen the Medicaid HCBS/FE applicant’s income. If the applicant’s income was below the ESDFS income threshold ($678/month), the case would be referred to the AAA office for
the functional assessment and ESD screening. If the income was above the ESDFSW income threshold, the case would only be referred for the functional assessment after the Medicaid determination was final and if the person was Medicaid eligible. This modification raised concern over the ability to test the accuracy of the ESDFSW in this pilot area. In addition, it also affected the comparability of data between the pilot areas.

Second, it was noted that referral sources were unaware of the ESD pilot, so AAA staff worked with KUSSW staff to develop an announcement of the ESD pilot for distribution to hospital discharge planners, home health agencies, and CARE Assessors. This announcement was developed by KUSSW staff and approved by KDOA before distribution to AAAs. AAAs sent out the announcement in December 1998.

Third, the number of ESD customers was lower than expected, so the ESD work group agreed to extend the Pilot from the original termination date of February 9, 1999 to March 31, 1999. This issue was discussed at a work group meeting held December 23, 1998 and the final decision was made immediately after the first of the year. Considerations for an extension included: 1) Would the AAAs agree to continue the pilot; 2) Would service providers agree to continue the pilot; 3) Would there be budgetary problems as a result of extending the pilot. No negative consequences of extending the pilot were identified.

An issue that arose during the ESD Pilot, which occurs during any research project, involved the completeness and accuracy of the data collected. Where necessary, KUSSW staff contacted AAA case managers to request completion of missing or unclear information on forms.

One major problem area was the completion of the ESD Outcome Form. The ESD process included follow-up on all ESD participants within 45 days of their initial ESD screening/assessment. KUSSW staff routinely mailed the ESD Outcomes Form to the case manager in time for completion at the 45th day. However, many ESD Outcome Forms were incomplete and required some type of follow-up.

➢ Technical notes

A question arose regarding how to handle the assets in the ESD screening of an older adult who was married but separated. This question was referred to the SRS office where it was subsequently addressed.

Another question was how to know if a Medicaid number was active. First, it was pointed out that when a person applies for Medicaid they are assigned a benefit identification number, but the number is not active until the person is approved for Medicaid. Likewise, a person may have been on Medicaid but failed to re-apply according to pre-determined requirements and therefore the Medicaid number becomes inactive. Case managers were advised to make every effort to verify that the Medicaid number was active when in doubt and that the best source of that information was the SRS office.
C. Focus Groups

As mentioned previously, the focus groups allowed pilot staff to provide detailed information about their experiences during the ESD pilot. A focus group was conducted at each pilot site. All of the case managers in the Hays and Wichita pilot areas and SRS staff who were involved in the pilot were invited to participate in the focus group. In the Chanute area, the large number of case managers made it necessary to draw a purposive sample for the focus group. The case management supervisor was asked to identify targeted case managers who should participate in the focus group, based on their experience or knowledge of ESD.

Focus group participants provided written as well as verbal comments in response to specific questions. A draft of the focus group questionnaire was reviewed by KDOA staff and approved by the evaluation work group prior to the focus groups. The first portion of the focus group involved only case managers to get their feedback on the training and mock run, the ESD process and flow, the ESD forms and the effect of ESD on consumers. SRS staff joined the group to discuss the benefits and limitations of ESD, the impact of ESD for older adults, overall recommendations/concerns about the ESD process and the potential for statewide implementation. The focus group questions were divided into separate sets by topic area and went from specific to general questions. Each set was completed before moving on to the next one. A copy of the final questionnaire used in the focus groups is in Appendix K.

KUSSW recorded the verbal comments on flip charts at each focus group. The flip chart comments were transcribed by KUSSW and mailed to the AAA and SRS office at each pilot site to verify that KUSSW had accurately captured the participants’ verbal comments. There were no comments or revisions received. KUSSW then collated all the written and verbal focus group responses and organized them by category. The data were analyzed for thematic content in aggregate as well as by pilot area.

Focus Group Themes

The following section is a summary of the common themes identified in the written and verbal focus group responses. It is organized by topic area and generally follows the questions asked in the focus group sessions. Appendix O contains detailed responses to each focus group question that were common to all pilot areas and notes responses that were specific to a pilot area. The complete data set of responses is available upon request from the KU School of Social Welfare.

➢ Training

Case managers were asked to evaluate the training in terms of how well it prepared them for the actual ESD process. The focus group feedback about the training was positive, which was consistent with the written evaluations received at the training. The scenarios with role-plays and the question and answer sessions were reported as the most helpful elements of the training. Case managers also reported that the mock run was useful in “putting it all together” and increased their confidence. Some areas that staff believe needed more emphasis were complicated situations having to do with life insurance and funeral plans, and an explanation
of QMB and SLMB. Staff also wanted to know more about how to explain estate recovery and spend down. It should be noted that the ESD training was not intended to prepare case managers to be Economic Assistance workers, but to provide an overview of the Medicaid application process. Complex and unusual situations should be referred to SRS. Additional highlights of the focus group feedback regarding the training are listed below.

- The training should have allowed more time for reviewing the Medicaid Application.
- The training should have included more information on how to handle home ownership when the customer was in an unusual living circumstance (e.g. AL).
- The training should have included instructions on how to complete ESD-NOA.
- More information on how to prepare for the customer interview would have been helpful.
- Future training should include more practice opportunities, rotation of partners for role-plays and an ESD experienced case manager to provide support.

➢ Process Issues

Overall, staff reported that the ESD process flowchart as developed before implementation was well designed. Staff reported the need for more information about the billing process, which could be done separately from case manager training. Staff reported that not having provider contracts in place was problematic because the CM had to get the contract signed before services could start. Additional highlights from the focus group responses are below.

- Although the flowchart was congested, it was helpful and matched what happened in the field.
- Provider contracts should have been in place before implementation.
- During the pilot providers responded quickly to requests for services.
- In the future, a separate training, including providers, on how to do provider billing would be helpful.

➢ Customer Orientation

The focus group participants identified ideas on how to help older adults understand the ESD process. One recommendation was to provide written information so that the older adult has something to refer to after the case manager leaves. This document could include information that helps the customer understand estate recovery.

➢ ESD Forms

Overall, the feedback about the ESD paperwork was positive. Staff found the ESD Checklist helpful and the ESD Intake Form and ESDFSW easy to use and not time consuming to complete. Additional common responses about the forms used in the ESD process are listed below.

- The ESD Checklist was useful because it helped to track steps as they were taken.
- The step “enter the POC into the MMIS” should be added to the checklist.
• A line for marking the date when each step is completed should be added to the ESD Checklist.
• The ESD Intake Form was easy to use, although it may duplicate some of AAA Intake Form information.
• The ESDFS was not too difficult or time consuming to use.
• The ESD process required too much faxing of forms.

➢ Communication

Staff reported that ESD related communication was good and that interaction between SRS and AAA was positive. Staff would like to see SRS staff communication loops built into the ESD process. Additional common responses are listed below.

• SRS and AAA staff need to know who the contact person is for a customer at each agency.
• Communication with KUSSW and KDOA about ESD was good and helpful.
• The ESD Specialist was very quick with turn around times and positive to work with.
• It would be helpful if SRS would let the case manager know if the Medicaid Application was received in 10 days.
• There should have been more publicity about ESD, for example, to discharge planners, physicians, home health agencies, etc.

Case managers were provided with written instructions and examples for completion of the ESDFS, which were intended to help with questions in the field. Staff did not mention referring to the instructions during the focus group sessions, so it is impossible to assess the instruction's effectiveness and usefulness.

➢ Impact of ESD on Older Adults

Since the ultimate test of the efficacy of ESD is the impact it has on older adults, focus group participants were asked to identify the positive and negative consequences of ESD on older adults. The following are the common responses identified.

Negative Consequences

• It can be difficult to explain ESD and the purpose of it to older adults.
• The ESD process may be confusing to older adults.
• Older adults may not realize there is more work to getting the Medicaid application done after the ESD screening.
• There may be no other services available if the customer is found ineligible for Medicaid. Also, taking away services hurts the case manager’s reputation and breeds distrust.
Positive Consequences

- ESD helps prevent premature nursing facility placement.
- Through ESD, services arrive quickly and help preserve quality of life.
- ESD helps get a professional in the home quickly to assess the situation.
- Services are delivered faster and provide more options for older adults.
- ESD helps older adults maintain their independence.
- Through ESD, case managers helped older adults gather documentation for the Medicaid application.

ESD criteria refinements and recommendations

Focus group participants provided valuable feedback about the ESD filtering and screening criteria. Staff recognized the benefit of ESD; however, they recommend that ESD be targeted only for high-risk older adults who are at risk of NF placement, or who are recent hospital discharges. Risk factors such as the availability of a caregiver could be used to conduct this targeting. Other recommendations received by staff are detailed below.

- The ESD filter and trigger criteria should be loosened. For example:
  - Allow more case manager discretion;
  - Increase the income threshold;
  - Include couples when both are applying for HCBS-FE services;
  - Do not filter out current Medicaid recipients or SSI recipients; and
  - Decrease the LOC threshold to 15 for ESD.
- Self-directed customers should be screened out.
- An ESD process should be developed to include other services (e.g. Senior Care Act).
- Qualification for ESD should not be tied to only assets and income.
IV. Integrated Analysis

This section of the report presents an examination of the costs associated with ESD followed by an analysis of the benefits and limitations of an ESD process and the barriers to statewide implementation. The purpose of the integrative analysis is to synthesis the outcomes and process evaluation data in order to identify the potential of ESD for statewide implementation.

Where data exist, benefits, limitations, and risks of ESD will be substantiated. Then, the perceived barriers to implementing ESD will be reported and addressed, drawing on the preceding summaries and synthesis of the ESD report. The integrated analysis permits the reader to critically examine the facts and separate them from previously held perceptions about ESD.

The ESD pilot and evaluation were completed in order to provide information to the state concerning the feasibility of statewide implementation. As delineated in the contract between KUSSW, KDOA, and SRS, criteria that should be used to analyze the potential of ESD for statewide implementation include:

- Cost to the state;
- Benefits and limitations for the state and older adults; and
- Feasibility of implementation.

The integrated analysis provides the information and data needed to evaluate these elements.

Cost Analysis

A major consideration in evaluating ESD focuses on the overall cost of ESD. A cost-benefit analysis was conducted as part of the Fiscal Year 1998 Expedited Service Delivery project. It utilized a number of assumptions to examine the costs of an expedited service delivery process incurred by the state (as one of the payers of HCBS-FE services). The analysis was developed using cost data provided in the Client Assessment Referral and Evaluation (CARE) Program Annual Report. The State Fiscal Year (SFY) 1998 ESD cost analysis estimated that if approximately 6% of the HCBS-FE applicants assessed for expedited service delivery, or 9% of the expedited service delivery recipients per year were diverted through expedited service delivery, then the costs of providing ESD would be offset by the savings.

The methodology developed for the SFY1998 ESD project was used to conduct a cost analysis of the ESD process tested in the pilot. It is important to point out that since the pilot did not represent a random sample and the actual number of customers expedited in error was small (2), the results of the following cost analysis should not be generalized to the state as a whole. However, specific elements of the pilot data can be used to refine the assumptions employed in the previous years’ cost analysis. The following section provides a cost analysis of the pilot.
The state incurred three types of costs related to expediting service delivery. The first cost is based on the Targeted Case Management (TCM) time required to screen older adults for ESD. This first cost is broken into the following components:

- For those older adults found eligible for HCBS/FE, the TCM cost is the additional amount of time required to process the customer as compared to a regular HCBS/FE screening; and
- For those customers found ineligible for HCBS/FE services, the cost is the total amount of the TCM services provided.

The second cost is based on the additional time customers who are found Medicaid eligible will receive in-home services because of ESD. The third expense is the cost of the in-home services provided to customers who incorrectly received expedited services.

The financial analysis focused primarily on the State General Fund share of Medicaid dollars for Targeted Case Management, HCBS-FE and NF services. In order to conduct the analysis, cost data from the SFY 1998 Client Assessment Referral and Evaluation (CARE) Program Annual Report were used. Appendix P provides the plan of care and nursing facility cost data used for this analysis. The figures used in the cost analysis are as follows:

- The hourly state Medicaid share of Targeted Case Management is $16.40;
- The daily (monthly) per customer, State General Fund and federal Medicaid share of HCBS-FE services is $22.09 ($672.00);
- The daily (monthly), per customer, State General Fund share of HCBS-FE services is $9.06 ($275.52);
- The daily (monthly) per customer, State General Fund and federal Medicaid share of nursing facility services is $57.40 ($1746.00); and
- The daily (monthly), per customer, State General Fund share of nursing facility services is $23.54 ($715.86).

**Costs to The State By Expediting Service Delivery**

**ESD-Related TCM Costs**

- The total TCM costs related to ESD incurred during the pilot is: **$12,967.60** ($10,032 + $2,214 + $721.60) (Please see explanation and tables below)
TCM Costs of ESD applicants found ineligible for HCBS/FE

The ESD pilot data show that the cost to the state of the TCM time spent on customers that were not found eligible for Medicaid, including the two customers expedited in error, was $10,032. This represents the amount spent during the pilot that could not be recouped from Medicaid.

TCM Costs of ESD applicants found eligible for HCBS/FE

As mentioned previously, the TCM costs of ESD for applicants found eligible for HCBS/FE, is based on the additional amount of time required to process the customer as compared to a regular HCBS/FE screening. For the older adults who did not qualify for ESD, it is the time spent completing the ESD Intake Form, ESDFSW, ESD Outcomes Form and any additional time related to ESD such as explaining the ESD process. In other words, it is the TCM time that would not have been spent if there were not a pilot. The pilot-related TCM costs for the older adults who qualified for ESD are the same as those described above with the addition of the time spent getting the ESD POC approval and setting up the ESD services.

The amount of ESD-related TCM time spent on older adults who did not qualify for ESD but were found eligible for HCBS/FE is estimated to be one hour. This figure is based on the following: 1) On average, it took case managers 29 minutes to complete the ESDFSW and 2) Based on discussions with ESD pilot staff, completion of the additional ESD forms for these older adults would not take more than a half hour. (See Table 29)

The amount of ESD-related TCM time spent on older adults who qualified for ESD and were found eligible for HCBS/FE is estimated to be two hours. This estimate is based on the reasons listed above, and the additional time needed to set up the ESD services and complete the ESD process steps. (See Table 30)

The ESD cost calculations do not include SRS staff time. When the ESD pilot was planned, it was not anticipated that SRS would incur costs since it was expected that HCBS/FE applications would be processed as usual. SRS staff from one pilot area reported that additional time was expended on their part in processing the ESD customers, regardless of whether they qualified for ESD. Future ESD work will need to track the amount of and need for extra SRS staff time expenditures.
### Tables 29 and 30. Targeted Case Management Costs Related to ESD for Persons Found Eligible for HCBS/FE Services.

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons who did not qualify for ESD and were found eligible</td>
<td>135</td>
</tr>
<tr>
<td>for HCBS/FE Services</td>
<td></td>
</tr>
<tr>
<td>Hours of ESD-related TCM required, per customer</td>
<td>x 1</td>
</tr>
<tr>
<td>Total hours of TCM required</td>
<td>135</td>
</tr>
<tr>
<td>The hourly state share of TCM costs</td>
<td>x $16.40</td>
</tr>
<tr>
<td>Total state share of the ESD-related TCM costs for persons who did</td>
<td>$2,214</td>
</tr>
<tr>
<td>not qualify for ESD and were found eligible for HCBS/FE Services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons who qualified for ESD and were found eligible</td>
<td>22</td>
</tr>
<tr>
<td>for HCBS/FE Services</td>
<td></td>
</tr>
<tr>
<td>Hours of ESD-related TCM required, per customer</td>
<td>x 2</td>
</tr>
<tr>
<td>Total hours of TCM required to expedite services</td>
<td>44</td>
</tr>
<tr>
<td>The hourly state share of TCM costs</td>
<td>x $16.40</td>
</tr>
<tr>
<td>Total state share of the ESD-related TCM costs for persons who qualified</td>
<td>$721.60</td>
</tr>
<tr>
<td>for ESD and were found eligible for HCBS/FE Services</td>
<td></td>
</tr>
</tbody>
</table>

**ESD-Related In-Home Service Costs**

- The total cost to the state of in-home services related to ESD incurred during the pilot is **$2,576.52**. ($384 + $2,192.52) (Please see discussion and table below)

**ESD service costs for ESD applicants found HCBS/FE ineligible**

As reported earlier on page 21, the total in-home ESD service costs incurred by the state for the customers expedited in error was **$384**.

**ESD service costs for ESD applicants found HCBS/FE eligible**

Customers who were expedited received in-home services sooner than they would have if they had to wait for the Medicaid determination to start services. The state share of this additional service time is one of the costs of an ESD program. Data from the pilot showed that on average ESD customers received services for 11 days before the Medicaid HCBS/FE determination was made. Therefore, 11 days is used as the estimate for the additional amount of time Medicaid eligible customers will receive services under ESD as compared to without it. (See Table 31)
Table 31. State Share of the Cost of Providing an Additional 11 Days of Service to Customers Found Eligible for Medicaid HCBS-FE Services

<table>
<thead>
<tr>
<th>Number of persons correctly receiving expedited service delivery</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>The daily state share of HCBS-FE service costs, per customer</td>
<td>$9.06</td>
</tr>
<tr>
<td>State cost per day of persons receiving expedited service delivery</td>
<td>$199.32</td>
</tr>
<tr>
<td>Multiply by number of additional days services are received through ESD</td>
<td>11</td>
</tr>
<tr>
<td>Total service-related cost of persons receiving expedited service delivery</td>
<td>$2,192.52</td>
</tr>
</tbody>
</table>

- Therefore, the total cost to the state of providing expedited service delivery through the pilot is $15,544.12 ($12,967.60 + $2,576.52).

Savings to the state by expediting service delivery

The state will save money through an expedited service delivery process by enabling HCBS-FE customers who, if not for expedited service delivery, would have entered a nursing facility. The savings are based on the difference between HCBS-FE and nursing facility service costs for these customers.

In order to calculate costs, an estimate of the length of time a customer, who if not for expedited service delivery would have entered a nursing facility, remains in the community receiving HCBS-FE services is needed. Since Kansas does not collect data regarding the community tenure of customers diverted from nursing facility placement, statistics from Missouri were utilized. After discussion with Missouri Care Options staff about diversion rates and services available in Missouri (see note 1 below) it was determined we should use 213 days as the average amount of time a customer remains in the community receiving services in Missouri. Therefore, for the following analysis an estimate of seven months is used.

Table 32: State Share of Cost Savings Per Customer, Based on Community Tenure

<table>
<thead>
<tr>
<th>(A) The monthly state share of NF services, per customer</th>
<th>(B) The monthly state share of HCBS-FE services, per customer</th>
<th>(C) Difference between state cost of HCBS-FE and NF (Subtract Column B from A)</th>
<th>(D) Months of community tenure</th>
<th>(E) State savings (Multiply Columns C by D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$715.86</td>
<td>$275.52</td>
<td>$440.34</td>
<td>7 months</td>
<td>$3082.38</td>
</tr>
</tbody>
</table>

- If the length of community tenure is seven (7) months, then the state cost savings per customer is $3082.38.

1 Source: Missouri CARE Options Data. This included all in-home services funded by the HCBS Waiver, Social Service Block Grant Funds, and Older American Act Funds.
Therefore, if 5 of the ESD customers would have entered a nursing facility if not for ESD, then the costs of the pilot would be offset. This represents 21% of those who qualified for ESD or 2.5% of all the applicants screened for ESD.

Calculations:

During the pilot 200 persons were screened for ESD and 24 customers qualified for ESD services. 2 of these customers received services in error, and 22 customers received services “correctly.” Of these 22 customers, assume just 5 are diversions and 17 would not have entered a nursing facility.

The calculations below use these diversion figures to estimate the costs and savings/cost avoidance of the pilot expedited service delivery process. The costs are presented first and are followed by the savings/cost avoidance.

**Expedited service delivery costs:**

- Total Cost \((12,967.60 + 384 + 1,694.22) = $15,045.82\)  
(Please see calculations below)

- **TCM Costs:** TCM costs of screening all 200 customers = $12,967.60

**HCBS service costs:**

- The ESD in-home service costs incurred for the 2 persons expedited in error were $384.
- Costs of expediting services to the 17 “non-diversions” = $1,694.22  
(17 persons \(\times\) $9.06 (HCBS daily state share) \(\times\) 11 days)

**Minimum number of diversions necessary to begin to realize cost savings:**

- Cost avoidance of expediting services to 5 diversions: \(5 \times \$3082.38 = \$15,411.90\)  
(See Table 32. This is the difference between the cost of NF and HCBS-FE services for these 5 customers)

Therefore, if just 5 of the ESD recipients in the pilot would have actually entered a nursing facility and stayed for 7 months, if not for ESD, then the costs of assessing all 200 applicants for expedited service delivery and expediting services for all 24 would be offset.

As of the 45th day after the ESD assessment, none of the customers who received ESD services had entered a nursing facility compared to 11 of those who did not qualify for ESD.

This difference suggests that ESD helped older adults in the pilot avoid nursing facility placement. Outcomes and focus group data reflect that ESD was instrumental in helping older
adults remain in their own home. For example, one case manager noted on the ESD Outcomes Form “[the customer] was able to remain at home thanks to Expedited Service Delivery.” Another case manager reported that “ESD provided service for an elderly man who was virtually bedbound. He had skilled nursing from home health, but that was ending soon. ESD started before he lost that service. Client was able to stay in his home, which he strongly preferred.”

**Cost Implications of Expediting Service Delivery**

In summary, this cost analysis demonstrates the potential cost avoidance/savings of the pilot ESD process. The pilot data shows that if only 2.5% of the older adults screened for ESD, or 21% of the ESD recipients in the pilot were diverted for seven months through ESD, then the pilot costs were offset by the savings. These figures can be considered the “break-even” point for the expedited service delivery pilot. It is the point at which the state’s costs equal the savings of conducting an expedited service delivery process. If ESD were implemented statewide, any changes in the filtering or screening criteria would result in different costs and potential savings to the state. This illustration is made to point out how few people have to be actually diverted to make this effort a success. In addition, expedited service delivery has many benefits for the customer and the state that are not cost related.

**Benefits and Limitations**

In order to identify the benefits and limitations of ESD, the outcomes data, anecdotal records, focus group responses and cost analysis were examined and synthesized. The following section details the benefits followed by the limitations.

**Benefits of an ESD Process**

- **Diversion from nursing facility placement and associated cost savings**

  *Changes in home health reimbursement from Medicare have increased the need for services, especially in rural areas. People are sometimes reluctant to ask for help, but getting services quickly can keep them from nursing facility admission. (Focus Group Written Comment)*

  The primary benefit of an ESD process is that it helps older adults avoid unnecessary nursing facility placement with minimal financial risk to the state. Case managers reported on the ESD Outcomes Form and in the focus group that ESD helped consumers who would have had to enter a facility remain in the community. As presented earlier, if only 2.5% of the older adults screened for ESD services were diverted for seven months through ESD, then the costs of the pilot program would be offset by the savings/cost avoidance.
Positive public relations

I expedited one client who lived with her husband...She maintained independence and gained confidence through ESD. She and her husband were very grateful, as were her daughters who lived some distance away. (Focus Group Written Comment)

The customer-centered focus of ESD promotes a positive image for both SRS and KDOA. It also increases communication between the agencies. During the focus group, participants from both agencies reported that communication increased and improved between the AAA and SRS offices during the pilot. Staff also reported that the goal of ESD, increasing service access and avoiding unnecessary nursing facility placement, is central to the mission of both KDOA and SRS.

Increased access to services

A very frail man recovering from cancer had recently moved from a different state. He weighed only 89 lbs., and we were able to help him in only 2 days. (Focus Group Written Comment)

Another benefit of the ESD process is that it helped get the case manager into the older adult’s home quickly. The case manager could assess the customer and complete the UAI without the concern of not being reimbursed. Data from the pilot show that on average, ESD services started within 4 days of the ESD screening. Another related benefit is that the older adult is not left in “limbo” during the time before a Medicaid determination is made. This reduces the stress on the older adult during what may be an emotional and difficult time. Even if the older adult does not qualify for ESD, the case manager is in the home faster to assess their needs and explore other service options with them. In addition, it was reported that ESD helped to reduce the Medicaid determination lag time because the case manager aided the older adult in gathering the needed documentation for the application. This was true for customers that qualified for ESD and those that did not.

Helps older adults in immediate need

A frail 80-year-old female with alcoholism was recently hospitalized due to a head injury and was living in unsafe and unsanitary housing. ESD allowed immediate alternate living arrangement in a residential health care facility. (Focus Group Written Comment)

Focus group participants at all three pilot sites discussed the benefits of providing ESD to older adults who were in dire need of in-home services and were under-served. The data from the pilot also highlight that the customers who received ESD services showed an immediate need for services. For example, 67% of the ESD customers had not been receiving any services prior to ESD. 33% were 85 years of age or older. In addition, 42% of the customers had been in the hospital within the 30 days prior to their ESD assessment. Finally, 62% of those who qualified for ESD lived alone and 79% were widowed, divorced, separated, or had never married. These factors often relate to a risk of nursing facility placement and therefore demonstrate a need for services.
Limitations of an ESD Process

- **Alternative services for ESD customers ineligible for Medicaid**

  A limitation identified by the focus group participants was that there might not be any other services available for an ESD customer found ineligible for Medicaid HCBS/FE services. Therefore, the case manager would be “taking away” the HCBS/FE services without providing any other options. This action could jeopardize the safety and well being of the older adult and have a negative impact on the image of the state agency with the older adult.

  There were two individuals that qualified for ESD, but were found to be Medicaid HCBS/FE ineligible. The following summary details what happened when these ESD customers were found Medicaid HCBS/FE ineligible.

  One customer was eligible for Income Eligible Services and they were put into place when ESD was discontinued. The second customer was living with family and had identified family members to provide self-directed care. In addition, the reason the individual was Medicaid HCBS/FE ineligible was because of significant resources. Therefore, this customer had the resources to pay privately for help that was available.

- **Screening criteria too strict**

  *Client did not qualify for ESD due to income. This prevented the client from receiving needed services quickly. Health is declining, and client is at risk for nursing facility placement.*  
  *(Focus Group Written Comment)*

  *I had several clients who didn’t qualify b/c of client obligation. One had to go to a hospital b/c wait was too long. They certainly could have had to enter a nursing facility.*  
  *(Focus Group Written Comment)*

  Another limitation of the ESD pilot process is that the screening criteria were very strict. A large proportion (67.5%) of the older adults assessed for ESD qualification that were filtered or screened out were ultimately found eligible for HCBS/FE. It was reported that some of these older adults could have benefited from ESD but did not meet the pilot criteria. It is important to note that the ESDFSW was designed to be conservative to minimize the financial risk to the state. However, many case managers stated that the ESD criteria should have focused more on risk factors for nursing facility admission rather than the older adult’s financial disposition. For example, some case managers felt that self-directed customers who had family to provide care should not have been expedited since they were not at imminent risk of nursing facility admission. They also pointed out that even a $125 increase in the income threshold for ESD qualification would have allowed a number of additional older adults to qualify for ESD. The income threshold was set at the Protected Income Limit (PIL) to avoid the complex issue of client obligations.
Feasibility of Statewide Implementation

Potential Barriers

Both AAA and SRS staff identified potential barriers to statewide implementation of ESD that were examined in the course of the pilot. The following section describes and analyzes these perceived barriers using data from the pilot.

➢ ESD Costs

One of the primary barriers to statewide implementation identified by staff was the cost of statewide implementation, including training costs. The pilot demonstrated that the costs associated with ESD were low. As presented earlier, the savings may offset these costs if only a small proportion (21%) of the customers who received expedited services would have entered a nursing facility for seven months, if not for ESD. For example, one concern was the time and hence the cost for case managers to do the ESDFS. Overall, the average time for case managers to complete the ESDFS was 29 minutes. In addition, the cost of training case managers exists, but training could be accomplished in a four-hour block of time. Since this was a pilot, the training included elements that would not be needed if ESD were to be implemented statewide. Based on the training evaluation and focus group feedback, training was effective as presented and could be incorporated into other staff training.

➢ ESD Impact

*In the past, as a supervisor, I have had case managers ask me how they can expedite services while waiting for Medicaid determination. We used to use home health for gap-filling, but these services are now very limited and reluctant to take referrals. Many older adults do not have natural support systems and need formal services. The numbers may not be great, but the level of need often is.* (Focus Group Written Comment)

Another barrier identified is that the ESD process, in its current form, does not benefit enough older adults because only 24 customers were expedited. Although the obvious benefit of ESD is for those who qualify, ESD can also benefit those older adults who do not qualify. Since ESD allows in-home services to start for the older adults who qualify, SRS could prioritize Medicaid applications from non-ESD customers since they have no services. Through ESD, case managers could help all older adults who were screened for ESD, not just those who qualified for ESD, with their Medicaid application.

Additionally, one focus group participant pointed out, that even if a program impacts only a small number of older adults, it is important to those it does benefit. Finally, if the number of customers correctly expedited is extrapolated out to a year and included all areas of the state, the result is approximately 194 customers receiving ESD services. As mentioned previously, the ESDFS was designed to be conservative in nature. Based on the pilot data, it appears that the trigger criteria could be loosened to allow a greater number of older adults to qualify for ESD without compromising the accuracy of the tool.
Potential Provider Barriers

Another potential barrier identified prior to implementing the ESD pilot was whether providers would be willing to participate. However, case managers in the focus groups did not identify the lack of providers as a problem during the ESD pilot. On a statewide basis there could be isolated problems, but even in sparsely populated areas like Northwest Kansas, providers were available.

The provider cooperation and willingness to work with ESD can be demonstrated by the fact that providers waited until ESD customers were Medicaid eligible before billing for services. This eliminated staff time and energy for recoupment that was previously anticipated. (Providers did not bill up front to ESD and preferred to wait for Medicaid determination.)

Interagency complexities

Customer needed 24-hour care and chose assisted living. She had a life estate and a home not lived in. She was screened out, but the process was expedited by the EES worker to get estate information and a sale set up. (Focus Group Written Comment)

Staff attitude and the lack of cooperation between SRS and AAA was also identified as a possible barrier to going statewide. Involving AAA and SRS staff in the ESD training was intended to open up communication and cooperation for the ESD project. During the focus groups, case managers reported that knowing more about the Medicaid application and process did help them appreciate and understand the work of Economic Assistance workers. Both groups also reported that the amount of communication between them increased because of ESD. As in all interagency interactions, communication difficulties arise and all players need to work to keep communication open. One of the benefits of the ESD pilot identified by focus group participants is that it facilitated interagency staff relationships that will continue after the pilot.

Waiting lists for HCBS/FE

A final barrier to statewide implementation identified by focus group participants is the potential of waiting lists for HCBS/FE services. If there are not any services available, there does not seem to be a purpose for ESD. It is interesting to note, however, that some staff commented that ESD was needed even more because of the waiting list issue. ESD could be used to target services to older adults that are in imminent danger of nursing facility placement. The data presented earlier show that ESD did benefit customers considered to be at high-risk (e.g. living alone).

ESD potential for statewide implementation

The barriers that were identified do not represent obstacles that are insurmountable. In addition, the pilot demonstrated that the costs associated with ESD were low and that ESD is a cost-effective process with little financial risk to the state.
The data from the pilot show there are many positive benefits of ESD and staff support from both SRS and KDOA/AAA for the program. Focus group data show that 51% of the participants believe it should be implemented statewide and an additional 30% think it should be implemented if the process was refined. The most common suggestion was that ESD should target high-risk groups. Only 19% did not believe ESD should be implemented statewide. Therefore, the majority of pilot staff that participated in the focus groups recommended that ESD should be implemented statewide.

In considering statewide implementation of ESD, it would be helpful to have data on the average length of time customers wait from their initial contact to the start of services. The following specific recommendations for statewide implementation are based on the analysis of the pilot data and state agency staff feedback.

- Risk factors of nursing facility placement (e.g. recent hospital stay, lack of informal support, etc.) should be incorporated into the ESD screening. Other states have developed ESD screening criteria to target customers in imminent danger of nursing facility placement. Doing so enables those older adults who are at the greatest risk of nursing facility placement and financially lack the resources to pay for in-home services to receive ESD services.

- The filtering criteria on the ESD Intake Form should be loosened to allow more customers to be assessed by the ESDFSW for ESD qualification. One possibility is to not filter out all current Medicaid consumers. Case managers reported that some of the current Medicaid consumers could have still benefited from ESD. Further exploration into this criterion is needed.

- Training would be improved by devoting time to the Medicaid application process, utilizing ESD experienced case managers as trainers, including providers and referral sources (i.e. CARE assessors, hospital discharge planners, etc.) in training, and conducting a separate training for the billing system.

- ESD customer input should be sought in order to refine the ESD process.

- The ESD process should be reworked to minimize the amount of faxing required between the agencies.

- Direct care service provider contracts should be in place prior to ESD being implemented. Case managers reported that having to secure these agreements slowed down the start of services.

V. Conclusion

In summary, the ESD pilot data, the low cost of the errors, and anecdotal information from case managers indicate that ESD can benefit older Kansans at a relatively low cost to the
state. Staff feedback also indicates that the ESD process could be integrated into the current case management process and state agency functions. Therefore, ESD has the potential to aid state agencies in their quest to provide cost effective services that enhance customer preferences and independence. At the present time, however, state agency staff are faced with the immediate issue of implementing a waiting list for HCBS/FE services and how to meet the needs of older adults with limited resources. As discussed previously, ESD could potentially be used as a mechanism to target services to older adults who are functionally and financially at the greatest risk of nursing facility placement. Based on the pilot results, ESD is a program that will benefit the state as well as older adults.
References


