Michigan Nursing Facility Transition Initiative

Project Evaluation Report

Transition Component

2005

Prepared for:

Michigan Department of Community Health
Division of Community Living

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Executive Summary
Michigan Nursing Facility Transition Initiative
Project Evaluation Report

People with a disability or long term illness want the option of living and participating in their communities instead of extended Nursing Facility stays. The Nursing Facility Transition Initiative (NFTI) promoted the design and delivery of home and community-based services that made that option a reality. This report is a qualitative analysis of the NFTI project; details various demographic, clinical and cost aspects of the participants in Michigan’s Nursing Facility Initiative project. The Michigan Department of Community Health (MDCH), funded by Centers for Medicare and Medicaid, 2001 Real Choice Systems Change Grant program, administered the project through a contract with DYNS Services, Inc.

Participants came from two avenues: nursing facility transition, and nursing facility diversion. The project, comprised of four components, included two additional ones; an evaluation component to analyze outcomes and cost benefit of transition services and, an education program to disseminate the methodology developed under the grant.

The Transition component used an innovative design, merging transition services with the MI CHOICE waiver in two Michigan Counties. Two MI Choice waiver agents, the Area Agency on Aging of Western Michigan (AAAWM) and the Detroit Area Agency on Aging (DAAA) delivered transition services to Kent and Wayne Counties. The goal was to develop methods and procedures to be used by agencies to transition individuals already in a nursing facility into the community. The tools used to place participants in the community include the Medicaid Home and Community Based Waiver (MI Choice) and integration of housing resources into the system. Funding was provided to cover costs for a transition supports coordinator, transition costs (deposits, furniture, transportation and so forth) and supports coordination.

A total of 112 people participated in the NFTI program during the study period from December 1, 2003 through April 30, 2005. Transition participants are evaluated by the waiver program using the MDS for home care (MDS-HC). The following scales and measures were used to group the participants: The Cognitive Performance Scale (CPS), Activity of Daily Living (ADL) Hierarchy, and RUG (Resource Utilization Group). Occurrence of these measures in the NFTI participants are compared to there occurrence in the general nursing facility population.

Cost data was obtained from actual cost data in the State of Michigan Data Warehouse (Medicaid Paid Claims data) and the MI Choice Information System, Center for Information Management, Inc. Analytical assistance was also provided by the University of Michigan, Institute of Gerontology.
The outcomes resulting from the program are of special note. Of the 112 people that participated in the NFTI project, 102 were able to transition to the community. Of these, only 56 (50%) participated in post-transition state-supported programs. Another 46 (41%) required no further state-supported services. Of those who received waiver services post transition, significant cost reduction was realized compared to costs of a nursing facility. The report gives a total of 308 participant months, for an average cost per participant month of $917. This compares to a cost of approximately $3450 per month in a nursing facility ($115 per day).

The evaluation also shows very similar characteristics across the transition population compared to the nursing facility population. This is significant in that level of acuity had very little effect on determination of which individuals could successfully transition.

Significant recommendations include: need for expanded transition services, increased housing options and supports coordination and expanded study of the long term care population and at risk populations to develop a clear picture of those most likely to return to the community.

Based on preliminary evaluation findings, the NFTI project was expanded statewide in May of 2005. This project represents a significant milestone in the transformation of Michigan’s long term care system.
The Nursing Facility Transition Initiative (NFTI) became reality under a 2001 Real Choice Systems Change Grant funded by the Centers for Medicare and Medicaid. These systems change grants represented a major new initiative to promote the design and delivery of home and community-based services that support people with a disability or long term illness to live and participate in their communities. Congress and the Administration have made $50 million available for this initiative. Funding for the Michigan NFTI grant was $770,000. The project was extended for an additional year to complete education and evaluation components.

The project had four major goals: nursing facility diversion, nursing facility transition, project evaluation, and education. The purpose of this section is to present the findings from the evaluation of the nursing facility transition component of the grant.

It is directed at the state level by the Michigan Department of Community Health, Division of Community Living. DYNS Services, Inc. was retained as a contractor to manage the evaluation process and the transition component.

As of March 2005, transition services developed by NFTI, became part of the regular Medicaid state plan services funded under the MI Choice waiver.

Brief description of models in use by NFTI:

1) **Transition Model:** Michigan’s transition model uses existing service agencies to provide housing and service plan development and implementation for relocation of individuals from nursing facilities to community living. Eligibility for the program was based solely on a person’s expressed desire to return to community living. The goal has been to promote changes within the existing home and community based service delivery network, and in particular, the MI CHOICE Medicaid Waiver program.\(^1\) By the third year of the grant, this evolved into a new model described in point 4 below.

2) **Diversion Model:** Michigan’s diversion model detects and follows persons at risk of nursing facility placement in the acute care setting of the University of Michigan Medical Center. These people are at risk of nursing facility placement based on information collected as part of the inpatient assessment process. People are either diverted directly to the community from the hospital, or followed to the nursing facility and diverted before becoming permanently institutionalized. The model is based on a hospital-community liaison person at the
University of Michigan Hospital, Turner Geriatric program. They assist in the diversion from or reduction in potential nursing facility placement consistent with the individual’s choice.

3) **Model for reduced NF stays**: This model is a sub-component of the Diversion process. Early detection and monitoring in the acute care setting allows Diversion staff to follow people released to the nursing facility (for rehabilitative services for example) and develop community care plans. The focus is on maintaining the person’s community based support network so that they can return to the community sooner.

4) **Linkage with Medicaid Home and Community Based Waiver**: The Transition component was merged with the MI CHOICE waiver in two Michigan counties. The waiver program already has a robust service planning ability, transition funds were used to develop and integrate the housing planning function into the services planning process. This resulted in a new model of care planning that includes housing services to create a successful transition plan. Specifically, the housing services added to the Waiver program are:

<table>
<thead>
<tr>
<th>Housing Service Category</th>
<th>Includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Rent, security deposit, section 8 voucher</td>
</tr>
<tr>
<td>Household supplies</td>
<td>Cleaning products, linens, towels, blanket, pillow, laundry basket, waste basket, vacuum, paper products, soap toothbrush, toothpaste, etc</td>
</tr>
<tr>
<td>Kitchen Supplies</td>
<td>Utensils, cookware, dishes, glasses, containers, small appliances, microwave, plastic wrap/foil</td>
</tr>
<tr>
<td>Utilities</td>
<td>Telephone, past due utility fees, electric, gas</td>
</tr>
<tr>
<td>Furniture</td>
<td>Dining table and chairs, sofa, chair, end table, TV stand, bed, mattress, lamp</td>
</tr>
<tr>
<td>Groceries</td>
<td>Medication management, collection of NF medications, transfer of prescriptions to community drug store</td>
</tr>
</tbody>
</table>

5) **Supportive Housing Demonstration Projects**: This model is a subcomponent of the waiver model. Housing specialists at each waiver program are responsible to develop linkages and a
resource guide listing housing resources. This model supports the housing transition plan development.

6) **Information and Referral in two counties:** The MI CHOICE Waiver programs operate an information and referral system. Nursing facility transition information was added to that system as a referral type at pre-screening using the MICIS facesheet. Attachment 1 describes the modifications made to the MI Choice Information System to accommodate data collection for this project.

7) **Evaluation using MDS RAI and HC:** Service and outcomes are evaluated using the existing assessment protocols used for Nursing facilities and the MI CHOICE waiver. Transition participants are evaluated by the waiver program using the MDS for home care (MDS-HC). Diversion participants are evaluated by the University of Michigan Medical Center using the MDS Resident Assessment Instrument. The model looks primarily at personal care (ADLs and IADLs) and nursing care needs as well as mental health issues. Examples of the MI Choice face sheet and assessment are in attachment.

**Evaluation Model:**

To meet the grant’s requirements, DYNS Services, Inc. developed an evaluation model which considered demographic and clinical aspects of the transition population in comparison to the long term care population as a whole. The second major aspect is a cost benefit analysis based on pre and post long term care costs for long term care services for grant participants. This particular aspect of the evaluation, although very important, also delayed analysis given the lag time involved in the processing of Medicaid claims.

The total universe included in the analysis is 112 people who transitioned between December 1, 2003 and April 30, 2005. There are additional participants as the project continues to operate as a regular component of the state’s Medicaid state plan services. However, complete cost data for later transitionees is not yet available. The methods used in this report can be used to analyze their data as necessary.

**Data Sources:**

The data in this report come from three major sources:

1) **MDCH/Medical Services Administration:** Data Warehouse and the Medicaid Management Information System of Approved Paid Claims. This data set provides a rich source of information on eligibility and paid claims for all Medicaid beneficiaries. The system was used to verify participant’s dates of departure from the nursing facility to the community. It also provides detailed data on all claims submitted to Michigan Medicaid for payment.
2) MI Choice Information System (MICIS): system used by all Michigan Waiver Agents to gather, store, and analyze data about participants, services, bills, and Medicaid claims.
   a. Because the MICIS system was in use at both pilot NFTI sites, and because it could be used to gather information about both participants and the community services they receive, the MICIS system was established as the system to use in gathering NFTI pilot program information.
   b. A wealth of information is available to review participant characteristics and service utilization patterns. The data presented in this report is only a small portion of information that is available in MICIS about long term care participants and services in the state.
   c. MICIS is operated by the Center for Information Management, Inc. in Ann Arbor, Michigan. The Center for Information Management, Inc. specializes in automation tools for home and community based waivers. Based on the interRAI MDS-HC, these include comprehensive, integrated tools including client assessment, Client Assessment Protocols (CAPs) and Triggers, RUGS-III/HC Individual and Agency Profile reports, Individual and Agency Quality Indicator reports.

3) University of Michigan, Institute for Gerontology: The Institute maintains a Long Term Care Data Archive which has data from Michigan, other states and nations. For the purposes of this report, they assisted by providing information from the repository of Minimum Data Set Resident Assessment Instrument (MDS-RAI) for nursing facility residents and Minimum Data Set for Home Care (MDS-HC) in the Archive. The Institute is funded by the Michigan Department of Community Health for this purpose.
Limitations of the data set:

This report is a qualitative analysis\textsuperscript{ii} of the NFTI project; details various demographic, clinical and cost aspects of the participants in Michigan’s Nursing Facility Initiative project. The instruments used to collect data, the MDS-HC and the MDS-RAI are scientifically proven as are the scales and hierarchy used in analyzing the data. All of the systems used to collect and analyze the data; the University of Michigan Long Term Care Archive, Mi Choice Information System, CMS MDS-RAI repository and the DCH Data Warehouse have a long, proven record in processing long term care data. They provided a powerful resource when linked together. This is a compelling reason for devoting resources to the creation of a Long Term Care data warehouse. The sum of the linked and interrelated systems will be greater than the sum of the systems operating independently.

The report findings can be used to formulate hypothesis for a larger research project by providing interesting indicators. For example, it could be possible to track costs by Activity of Daily Living Hierarchy sub group or to look at clinical aspects for long staying residents vs. shorter stay residents. Indeed, that is one of the reports major recommendations is that the study be expanded to include a randomized sample of the Michigan nursing facility population to develop a clear picture of those most likely to return to the community.

Program model:

The transition component operated in Kent and Wayne counties by two MI Choice waiver agents, the Area Agency on Aging of Western Michigan (AAAWM) and the Detroit Area Agency on Aging (DAAA), respectively. Both sites received grant funds to pay for transition costs and for supports coordination. Additional MI Choice waiver funds were allocated by the Michigan Department of Community Health to fund additional services for waiver eligible transitionees. Both sites were given some discretion in how they setup and organized their projects, under the oversight of the project director.

The AAAWM scenario: The agency hired a supports coordinator who had previously worked for the Grand Rapids Center for Independent Living as a team member on the previous transition grant. She brought years of experience in working with people with disabilities to the MI Choice waiver agent. This included a working relationship with nursing facilities in Kent County. The coordinator took charge of all aspects of transition plan development and implementation. Coordination with the MI Choice waiver program resources was included for people who were eligible for the program.

The DAAA scenario: The agency assigned an existing staff person to form a transition program within the agency structure. Subcontracts were
developed with Citizens for Better Care to find participants in facilities and with a housing consultant to connect residents to community housing. As part of this, the coordinator formed a collaborative of community resources, including legal aid, home and community based service providers, volunteers and other agency staff necessary to develop and implement transition plans.

Both approaches proved successful over the course of the project.

**Characteristics of Participants**

There were a total of 112 people who participated in the NFTI program during the study period from December 1, 2003 through April 30, 2005.

Of the 112 participants in the NFTI program from December 1, 2003 through April 30, 2005, 66 were female, and 46 were male.

The average age of all participants was 64 years of age, with a range from 31 to 97 years of age. The average age of the Area Agency of Western Michigan participants (62 years) was 4 years less than the participants in the Detroit Area Agency on Aging program (66 years).

<table>
<thead>
<tr>
<th>Gender and Age Categories</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 44 and under</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>10%</td>
</tr>
<tr>
<td>Age 45 to 54</td>
<td>11</td>
<td>11</td>
<td>22</td>
<td>20%</td>
</tr>
<tr>
<td>Age 55 to 64</td>
<td>14</td>
<td>10</td>
<td>24</td>
<td>21%</td>
</tr>
<tr>
<td>Age 65 and over</td>
<td>15</td>
<td>40</td>
<td>55</td>
<td>49%</td>
</tr>
<tr>
<td>Totals</td>
<td>46</td>
<td>66</td>
<td>112</td>
<td>100%</td>
</tr>
</tbody>
</table>

As Table 1 indicates, participants were more highly represented in the older age groups, but there were 11 participants under 44 years of age, and more participants 64 and under (57) than there were participants 65 and older (55).

This shows a larger representation of younger age groups at 51% than in the State’s general waiver population at 24% as a whole. Some of this could be explained by the fact that NFTI Section 8 housing opportunities were limited to people under the age of 62, making it easier to transition those population groups. It is also possible that this is due to a lower level of long term care needs in the younger age groups, thereby making transition easier. It is particularly interesting given that the waiver agents have a longer history in working with elderly people, yet were very successful in working with younger transition candidates.

The group was clearly different from the general statewide nursing facility population, where only 11% for the residents are under the age of 65.
The number of males and females participating who were under 65 years of age was about the same, but there were over two and a half times as many females aged 65 or over (40) as males in that category (15). Again, this is significantly different from the MI Choice Waiver and nursing facility populations where 73% of the participants are female and 26% male.

Table 2

<table>
<thead>
<tr>
<th>Race</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>52</td>
<td>46%</td>
</tr>
<tr>
<td>African-American</td>
<td>56</td>
<td>50%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Amer. Indian/Eskimo/Aleut</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Totals</td>
<td>112</td>
<td>100%</td>
</tr>
</tbody>
</table>

As table 2 above shows, there was an almost even split of Caucasian (52) and African American (56) participants, with four additional people in other race categories (see Table 2). The high number of people of African American race compared to the general long term care population (23% for MI Choice and 15% for nursing facility) is the likely result of the Detroit location for the project. From the 2000 US Census, approximately 42% of Wayne County including the city of Detroit is African American compared to 14.2% for the state as a whole.

Table 3

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single / Never married</td>
<td>30</td>
<td>27%</td>
</tr>
<tr>
<td>Married</td>
<td>14</td>
<td>12%</td>
</tr>
<tr>
<td>Widowed</td>
<td>31</td>
<td>28%</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Divorced</td>
<td>21</td>
<td>19%</td>
</tr>
<tr>
<td>Not Available</td>
<td>13</td>
<td>11%</td>
</tr>
<tr>
<td>Totals</td>
<td>112</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 3 displays the marital status of participants. Of the reporting participants, only 14 were married, supporting the claim that people who are not married (and thus have no spousal support) are more likely to be in a nursing facility.
### Table 4

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th grade or less</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>Grades 9 - 11</td>
<td>19</td>
<td>17%</td>
</tr>
<tr>
<td>High School</td>
<td>30</td>
<td>27%</td>
</tr>
<tr>
<td>Tech or Trade School</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Some College</td>
<td>17</td>
<td>15%</td>
</tr>
<tr>
<td>Bachelor's Degree</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Not Available</td>
<td>30</td>
<td>27%</td>
</tr>
<tr>
<td>Totals</td>
<td>112</td>
<td>100%</td>
</tr>
</tbody>
</table>

As Table 4 indicates, the majority of reporting participants had an education level of high school or less. However, education level was not available for a significant number, 30 out of 112.

### Table 5

<table>
<thead>
<tr>
<th>Residential Setting/Svcs Rec'd Prior to NF</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing facility (NF)</td>
<td>47</td>
<td>42%</td>
</tr>
<tr>
<td>NF &amp; Rehabilitative Services</td>
<td>7</td>
<td>6%</td>
</tr>
<tr>
<td>NF &amp; Home Care (HC)</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>NF, HC, and Rehab</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>NF, HC, Rehab &amp; MH or DD Facility</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>NF &amp; Assisted Living</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Home Care</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Home Care &amp; Rehab</td>
<td>12</td>
<td>10%</td>
</tr>
<tr>
<td>None of the Above</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Not Available</td>
<td>19</td>
<td>17%</td>
</tr>
<tr>
<td>Totals</td>
<td>112</td>
<td>100%</td>
</tr>
</tbody>
</table>

At initial assessment, the residential history of participants in the five years prior to assessment included 78 people who had been in a nursing facility (some with other living settings as well), and 15 people who had home care. Of these home care recipients, 11 had rehabilitation services prior to the nursing facility. These numbers show the bulk of the participants had established nursing facility care histories, not just transitory in nature.
Table 6 presents the number and percent of the 86 participants with diseases recorded who were being treated for the indicated diseases:

<table>
<thead>
<tr>
<th>Diagnosis Description</th>
<th>Number of Participants</th>
<th>Percent of Assessed Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>33</td>
<td>38%</td>
</tr>
<tr>
<td>Depression</td>
<td>28</td>
<td>33%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>24</td>
<td>28%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>22</td>
<td>26%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>20</td>
<td>23%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>16</td>
<td>19%</td>
</tr>
<tr>
<td>Cerebral Vascular Accident (stroke)</td>
<td>15</td>
<td>17%</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>15</td>
<td>17%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>14</td>
<td>16%</td>
</tr>
<tr>
<td>Allergies</td>
<td>14</td>
<td>16%</td>
</tr>
<tr>
<td>Anemia</td>
<td>11</td>
<td>13%</td>
</tr>
<tr>
<td>Cataracts</td>
<td>10</td>
<td>12%</td>
</tr>
<tr>
<td>Other fractures</td>
<td>9</td>
<td>10%</td>
</tr>
<tr>
<td>Emphysema</td>
<td>9</td>
<td>10%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>8</td>
<td>9%</td>
</tr>
<tr>
<td>Hemiplegia/Hemiparesis</td>
<td>8</td>
<td>9%</td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>8</td>
<td>9%</td>
</tr>
<tr>
<td>Arteriosclerotic Heart Disease (ASHD)</td>
<td>7</td>
<td>8%</td>
</tr>
<tr>
<td>Missing Limb</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>Cardiac Dysrhythmia</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Other Cardiovascular Disease</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Aphasia</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Manic Depression (Bipolar disease)</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Other Psychiatric Diagnoses</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Asthma</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Diabetic Retinopathy</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Total Participants Assessed</td>
<td>86</td>
<td></td>
</tr>
</tbody>
</table>

Of the 86 participants who were assessed with the MDS-HC, all of the 88 diseases in the assessment were present and subject to treatment in at least one participant, with the exception of Parkinson’s disease, cerebral palsy and schizophrenia. One participant had only one diagnosis noted (quadriplegia), while all others had multiple diseases that were being treated. One participant who successfully transitioned to the community had eighteen different diseases that were being treated. Twenty six participants (112-86) were not assessed with the MDS-HC for several
reasons. Some residents moved out of the nursing facility shortly after contact with the NFTI case coordinator and before a full assessment could be conducted. Coordination of assessment staff schedules (one nurse and one social worker with the NFTI case coordinator) were a major contributing factor to this.

Other diseases being treated in fewer than five participants included hyperthyroidism, hypotension, deep vein thrombosis, hip fracture, pathological bone fracture, Alzheimer’s disease, dementia, multiple sclerosis, paraplegia, quadriplegia, seizure disorder, transient ischemic attack, cancer, and glaucoma.

Over 60% of the 80 participants for whom this information is available took 9 or more medications when first assessed.

<table>
<thead>
<tr>
<th>Number of Medications at Assessment</th>
<th>Number of Participants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>8%</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>11%</td>
</tr>
<tr>
<td>9+</td>
<td>51</td>
<td>63%</td>
</tr>
<tr>
<td>Totals</td>
<td>80</td>
<td>100%</td>
</tr>
</tbody>
</table>

**MDS-HC Assessment Tools**

The State of Michigan Home and Community Based Elderly and Disabled Waiver uses the MDS-HC (Minimum Data Set for Home Care) to assess all Waiver participants. This assessment tool was chosen because of the wealth of research information and measurements available from interRAI, Inc. the developers of the MDS family of assessment tools.

Because the MDS assessment instrument is used to assess all residents of nursing facilities, and therefore is available in both the nursing facility and home care settings, it is possible to review a participant both in the nursing facility and once they had returned to the community using different scales developed by interRAI.
RUG III Case Mix Groups:

An important measure of acuity in long term care participants is derived from the MDS assessment. Called RUG (Resource Utilization Group), this acuity measure is calculated using information from the MDS-RAI or MDS-HC assessments. Developed by interRAI researchers, the RUG score derived by algorithms from the MDS-RAI for nursing facility residents and MDS-HC for home care, groups participants into seven different categories of service utilization and thus presents a way to look at participant acuity. The RUG categories in order from highest to lowest acuity are: special rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical functions. Table 8 shows this distribution for the NFTI population as well as a comparison to the statewide nursing facility population.

The reduced physical function is of particular interest as a method of targeting residents with one or less ADL deficiencies and no nursing needs. The lowest two RUGs groups, Reduced Physical Functioning A1 and A2 represented or about 8% of Michigan’s nursing facility residents fall in this group or about 5,000 people statewide. However, the distribution of NFTI participants shows that a person’s RUGs group may not bear a direct relation to a person’s ability to live successfully in the community. Almost an equal number of the NFTI project participants fell into higher RUGs categories, such as special care, clinically complex and impaired cognition as they did the lowest level, reduced physical functioning. This could mean that successful transitioning is due more to other community factors, such as availability of services and supports or a supports coordinator as provided by NFTI, than a person’s level of acuity.

(The remainder of this page has been left intentionally blank to accommodate table 8 in its entirety on the page 9)
Table 8

<table>
<thead>
<tr>
<th>Resource Utilization Group (RUG)</th>
<th>NFTI Number of Participants</th>
<th>NFTI Percent of Participants</th>
<th>Nursing Facility*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Rehabilitation</td>
<td>18</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Extensive Services</td>
<td>3</td>
<td>13%</td>
<td>3%</td>
</tr>
<tr>
<td>Special Care</td>
<td>10</td>
<td>33%</td>
<td>9%</td>
</tr>
<tr>
<td>Clinically Complex</td>
<td>11</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>Impaired Cognition</td>
<td>11</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>7</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>Reduced Physical Functions</td>
<td>44</td>
<td>48%</td>
<td>41%</td>
</tr>
<tr>
<td>Reduced Physical Functions - E</td>
<td></td>
<td></td>
<td>9%</td>
</tr>
<tr>
<td>Reduced Physical Functions - D</td>
<td></td>
<td></td>
<td>19%</td>
</tr>
<tr>
<td>Reduced Physical Functions - C</td>
<td></td>
<td></td>
<td>2%</td>
</tr>
<tr>
<td>Reduced Physical Functions - B</td>
<td></td>
<td></td>
<td>3%</td>
</tr>
<tr>
<td>Reduced Physical Functions – A2</td>
<td></td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>Reduced Physical Functions – A1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RUG assessments</td>
<td>79</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Unavailable*</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Participants</td>
<td>112</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The RUGs grouper relies on elements in the MDS-HC assessment to calculate a score. If the MDS-HC assessment is not completely filled out or not completed (as was the case for twenty-six, previously mentioned) a RUGs score will be unavailable.

ADL Hierarchy

The Activity of Daily Living (ADL) Hierarchy is a measure developed by interRAI researchers to determine different levels of physical functioning using the MDS-HC data. The ADL hierarchy was derived from assessment items that conceptually measure early ADL loss (dressing, hygiene), intermediate ADL loss (transfer, locomotion, and toileting), and late ADL loss (bed mobility, eating). The Hierarchy combines these ADLs into a comprehensive scale based on the degree of losses and performance level coding.

The NFTI participants for whom this measure could be calculated at initial assessment were arrayed across the categories, with most participants falling in the Limited or Extensive 1 categories. Only one
participant was independent, while three were classified in the total dependence category.

### Table 9
**NFTI ADL Scores compared to Nursing Facility - Michigan**

<table>
<thead>
<tr>
<th>ADL Hierarchy</th>
<th>NFTI Number of Participants</th>
<th>NFTI Percent of Participants</th>
<th>Nursing Facility*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>1</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>Supervision</td>
<td>10</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Limited</td>
<td>26</td>
<td>33%</td>
<td>16%</td>
</tr>
<tr>
<td>Extensive 1</td>
<td>21</td>
<td>27%</td>
<td>26%</td>
</tr>
<tr>
<td>Extensive 2</td>
<td>11</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>Dependent</td>
<td>7</td>
<td>8%</td>
<td>18%</td>
</tr>
<tr>
<td>Total Dependence</td>
<td>3</td>
<td>4%</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Unavailable*</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Participants</td>
<td>112</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*see discussion in table 8.

This table shows difference in the ADL scores for NFTI transitionees and nursing facility residents. While significant differences appear in ADL scores for the two groups, NFTI was able to find and transition people who were medically needy. This profoundly underscores the desire and hopes that residents with physical disabilities have to return to the community. Recently, in 2004 data, when asked to respond to MDS-RAI question Q1a, “Do you wish to return to the community?” 64% of the residents in Michigan’s Kent and Wayne Counties responded affirmatively.iii

**Cognitive Performance Scale**

The Cognitive Performance Scale (CPS) is a measure developed by InterRAI researchers to determine different levels of cognitive performance using the MDS-HC data, from intact to very severe impairment. The CPS is a hierarchical index used to rate cognitive status. The CPS has been validated against the Mini Mental State Examination. The nursing facility CPS scales uses comatose to identify the most impaired group. Because these types of persons are rarely seen in home care settings, a modified CPS for waiver participants based on four assessment items: memory, cognitive skills for daily decision making, expressive communication, and eating.
Using the first assessment conducted for NFTI participants, the highest numbers of participants were in the intact category, with fewer participants in each category as the impairment increases.

**Table 10**  
NFTI CPS Scores compared to Nursing Facility - Michigan

<table>
<thead>
<tr>
<th>Cognitive Performance Scale</th>
<th>NFTI Number of Participants</th>
<th>NFTI Percent of Participants</th>
<th>Nursing Facility*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact</td>
<td>32</td>
<td>38%</td>
<td>11%</td>
</tr>
<tr>
<td>Borderline Intact</td>
<td>20</td>
<td>24%</td>
<td>9%</td>
</tr>
<tr>
<td>Mild Impairment</td>
<td>14</td>
<td>17%</td>
<td>14%</td>
</tr>
<tr>
<td>Moderate Impairment</td>
<td>11</td>
<td>13%</td>
<td>33%</td>
</tr>
<tr>
<td>Moderately Severe Impairment</td>
<td>4</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>Severe Impairment</td>
<td>2</td>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td>Very Severe Impairment</td>
<td>1</td>
<td>1%</td>
<td>11%</td>
</tr>
<tr>
<td>Total</td>
<td>84</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>CPS unavailable</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Participants</td>
<td>112</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Remainder of page left intentionally blank)
Transition Outcomes

Of the 112 people that participated in the NFTI project from December 1, 2003 through April 30, 2004, 102 were able to transition to the community. Of these, only 56 (50%) participated in post-transition state-supported programs. Another 46 (41%) required no further state-supported services.

Table 11

NFTI Participant Transition Status

<table>
<thead>
<tr>
<th>Category</th>
<th>Program/Status</th>
<th>Total Participants</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post Transition Community Programs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Transition Community Programs</td>
<td>HCBE/ED Waiver</td>
<td>43</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td>OSA Care Management</td>
<td>8</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>OSA Targeted Care Management</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Transferred to DHS Program</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Local Agency Funds</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>56</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td><strong>Transition Only</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transition Only</td>
<td>NFTI Program Only; No Further Services</td>
<td>32</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>No Further Contact</td>
<td>14</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>46</strong></td>
<td><strong>41%</strong></td>
</tr>
<tr>
<td><strong>Still in Nursing Facility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Still in Nursing Facility</td>
<td>Stayed in Nursing Facility; Closed NFTI</td>
<td>5</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Still in Nursing Facility; may transition</td>
<td>5</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>10</strong></td>
<td><strong>8%</strong></td>
</tr>
<tr>
<td><strong>Total Participants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>112</strong></td>
<td></td>
</tr>
</tbody>
</table>
Current Status of Participants in Community Programs (as of September 13, 2005)

Of the 56 participants who transitioned to community programs, 38 are still open in those programs.

Table 12

<table>
<thead>
<tr>
<th>NFTI Community Programs Post Transition Status</th>
<th>Total Participants</th>
<th>Still Open as of 9/13/2005</th>
<th>Percent Still Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Transition Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCBE/ED Waiver</td>
<td>43</td>
<td>33</td>
<td>77%</td>
</tr>
<tr>
<td>OSA Care Management</td>
<td>8</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>OSA Targeted Care Management</td>
<td>2</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>Transferred to FIA Program</td>
<td>2</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>Local Agency Funds</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56</strong></td>
<td><strong>38</strong></td>
<td></td>
</tr>
</tbody>
</table>

Waiver Services Provided to NFTI Participants After Transition

The HCBS/ED Waiver provides a core set of services for people in the program that allow them to remain in the community. These services include personal care, private duty nursing, Homemaker services, home delivered meals, personal emergency response systems, respite care, chore services (e.g. snowplowing), home modifications, medical equipment and supplies, and adaptive items to assist with necessary activities. These services were provided as needed to waiver participants who had transitioned from nursing facilities. Table 13 indicates the number of NFTI participants who received waiver services post-transition.
Table 13
Distribution of Post Transition Waiver Services for 51 participants

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Participants Receiving each Service</th>
<th>Percent of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care</td>
<td>41</td>
<td>80%</td>
</tr>
<tr>
<td>Homemaker</td>
<td>37</td>
<td>73%</td>
</tr>
<tr>
<td>Emergency Response Systems</td>
<td>24</td>
<td>47%</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>20</td>
<td>39%</td>
</tr>
<tr>
<td>Special Waiver Service*</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>10</td>
<td>20%</td>
</tr>
<tr>
<td>Specialized Medical Equipment</td>
<td>9</td>
<td>18%</td>
</tr>
<tr>
<td>Personal Care Item</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>Tub Stool or Bench</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>Home Modifications</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>Chore Services</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>Enteral Formulae</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>Raised Toilet Seat</td>
<td>6</td>
<td>12%</td>
</tr>
</tbody>
</table>

* Includes security deposit, initial rent payment, appliances, furniture, etc.

In the Home Modifications category, one NFTI participant required to have a ramp installed, and three needed specialized door locks. In the Special Waiver Service category, four participants needed to have a security deposit or initial rent paid, and a few need appliances and furniture. One participant required an over tub sliding bath system, the most expensive item was purchased for these NFTI participants. Since the start of the program through May, 2005, the total cost of HCBS/Ed Waiver services for all participants was $282,479. This total covers 308 participant months, for an average cost per participant month of $917. This compares to a cost of approximately $3450 per month in a nursing facility ($115 per day).
Waiver Service Costs for ADL Hierarchy Groups

The following table presents HCBS/ED Waiver costs for NFTI participants by ADL Hierarchy groupings. There were 51 participants who were scored on this scale who had service codes during the period from January 1, 2004 through May 31, 2005. The average cost per service month is highest for those in the Extensive 1 category, and range from $493 to $893 for the other groups.

Table 14

<table>
<thead>
<tr>
<th>Waiver Service Costs For NFTI Participants by ADL Hierarchy</th>
<th>Number of Participants</th>
<th>Number of Service Months</th>
<th>Average Cost per Service Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>0</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Supervision</td>
<td>2</td>
<td>18</td>
<td>$493</td>
</tr>
<tr>
<td>Limited</td>
<td>17</td>
<td>98</td>
<td>$775</td>
</tr>
<tr>
<td>Extensive 1</td>
<td>11</td>
<td>81</td>
<td>$1,406</td>
</tr>
<tr>
<td>Extensive 2</td>
<td>5</td>
<td>41</td>
<td>$716</td>
</tr>
<tr>
<td>Dependent</td>
<td>5</td>
<td>33</td>
<td>$893</td>
</tr>
<tr>
<td>Total Dependence</td>
<td>1</td>
<td>4</td>
<td>$821</td>
</tr>
<tr>
<td>No ADL, not classified</td>
<td>10</td>
<td>33</td>
<td>$657</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>308</strong></td>
<td><strong>$917</strong></td>
</tr>
</tbody>
</table>
Waiver Service Costs for Cognitive Performance Scale Groups

The following table presents HCBS/ED Waiver costs for NFTI participants by CPS groupings. There were 51 participants who were scored on this scale who had service codes during the period from January 1, 2004 through May 31, 2005. The average cost per service month is highest for those in the “Intact” category, which is also the category with the most participants. The other monthly costs range from $575 to $821 for the other groups.

Table 15

<table>
<thead>
<tr>
<th>Service Costs For NFTI Participants by CPS</th>
<th>Number of Participants</th>
<th>Number of Service Months</th>
<th>Average Cost per Service Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact</td>
<td>17</td>
<td>131</td>
<td>$1,231</td>
</tr>
<tr>
<td>Borderline Intact</td>
<td>8</td>
<td>56</td>
<td>$ 763</td>
</tr>
<tr>
<td>Mild Impairment</td>
<td>10</td>
<td>53</td>
<td>$ 642</td>
</tr>
<tr>
<td>Moderate Impairment</td>
<td>6</td>
<td>36</td>
<td>$ 787</td>
</tr>
<tr>
<td>Moderately Severe Impairment</td>
<td>1</td>
<td>4</td>
<td>$ 821</td>
</tr>
<tr>
<td>Severe Impairment</td>
<td>1</td>
<td>7</td>
<td>$ 575</td>
</tr>
<tr>
<td>Very Severe Impairment</td>
<td>0</td>
<td>0</td>
<td>$ 0</td>
</tr>
<tr>
<td>Not Classified</td>
<td>8</td>
<td>21</td>
<td>$ 417</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>308</td>
<td>$ 917</td>
</tr>
</tbody>
</table>

Comparison of Pre and Post Nursing Facility Costs

It was possible to compare Nursing Facility six month pre-transition costs and six month post-transition costs for six NFTI participants. Others had not been in either the Nursing Facility or the Waiver long enough for a six-month comparison. Overall, community services for participants cost about 25% of what was charged by the nursing facility in the six months before transitioning. For the largest group, who saw a 90% reduction in cost, include people who returned to the community with a minimum of Medicaid supports and who did not enroll in any ongoing long term care services and supports program. The other programs group includes people who chose a variety of programs for people with service and supports needs outside the Medicaid long term care programs such as the Department of Human Services Home Help program, Office of Services to the Aging Care Management Program and Targeted Care Management.
### Table 16
Summary Costs by Population Group Served/Medicaid Paid Claims
6 months pre transition vs. 6 months post transition

<table>
<thead>
<tr>
<th>Population</th>
<th>Number of Participants</th>
<th>Total Claims</th>
<th>Cost Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>All NFTI</td>
<td>112</td>
<td>$1,797,258</td>
<td>$441,918</td>
</tr>
<tr>
<td>MI Choice Waiver</td>
<td>43</td>
<td>$736,239</td>
<td>$293,261</td>
</tr>
<tr>
<td>Other Programs</td>
<td>19</td>
<td>$331,927</td>
<td>$79,852</td>
</tr>
<tr>
<td>NFTI in Community</td>
<td>46</td>
<td>$729,092</td>
<td>$ 68,805</td>
</tr>
<tr>
<td>Still in NF</td>
<td>4</td>
<td>$103,421</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 17 shows examples from the project of transition costs for individual participants. Waiver costs include all costs for the thirteen MI Choice waiver services: personal care, home maker, home delivered meals, medical supplies, home modifications, transportation, chore, respite, counseling, private duty nursing, personal emergency response, personal care supervision, and adult day care. Medicaid costs include other state plan services such as pharmacy, therapies, and hospital.

### Table 17
Sample Pre and Post Transition Total Medicaid and Waiver Costs
Sept. 15, 2005

<table>
<thead>
<tr>
<th>Person</th>
<th>Six Mo. Cost Nursing Facility</th>
<th>Total Six Month Medicaid Costs for:</th>
<th>Cost</th>
<th>Community Costs as % of NF Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Other Medicaid Total Difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person A</td>
<td>$18,788</td>
<td>$3,444 $2,072 $5,516 $13,272</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Person B</td>
<td>$14,363</td>
<td>$10,260 $1,464 $11,724 $2,639</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Person C</td>
<td>$25,547</td>
<td>$8,944 $863 $9,807 $15,740</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Person D</td>
<td>$12,261</td>
<td>$4,629 $1,410 $6,039 $6,222</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Person E</td>
<td>$27,869</td>
<td>$7,682 $3,066 $10,748 $17,121</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Person F</td>
<td>$26,498</td>
<td>$8,162 $8,303 $16,467 $10,031</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td>Person G</td>
<td>$24,170</td>
<td>$21,369 $12,028 $33,397 $9,227 Hosp*</td>
<td>138%</td>
<td></td>
</tr>
<tr>
<td>Person H</td>
<td>$10,050</td>
<td>$2,905 $847 $3,752 $6,298</td>
<td>37%</td>
<td></td>
</tr>
</tbody>
</table>

Total $159,546 $67,397 $30,053 $97,450 $62,096 61%

* NFTI costs are inclusive of a hospital stay.
Transition Barriers:

Comments from both sites have been combined in the list.

1) Lack of person centered community supports and community supports coordinator. Residents in facilities for more than a few weeks start to lose their connections to the community. Once these connections are lost, it becomes nearly impossible for a person to orchestrate their own transition. A surrogate or community supports coordinator is required to reconnect the individual to the community supports and services. Funds are required to pay for transition expenses. Availability of both these were reasons for NFTI’s success. This barrier results from a set of false biases commonly held by the general population of citizens and health professionals:
   a. Often people do not consider community living a “safe” or “appropriate” living arrangement for people with significant long term care health needs for services and supports. Because of this bias, people are not even offered the option of community living. Many NFTI participants were placed in nursing facilities with no discussion or explanation of other options for community living.
   b. Person centered, consumer driven decisions are not the “norm” for providers in the long term care health area, more often decisions are driven by the medical professionals or family members, not the person.

2) Lack of an information source to receive information about long term care and community living options. Residents reported not being able to access a telephone, fax or internet to assist in this effort.

3) Lack of funds to pay for services and supports due to the state’s budget crisis. During the first two years of the NFTI project the MI Choice Waiver was closed to new enrollments. This made it very difficult to transition people with significant health needs.

4) Housing Issues: This is the single most difficult barrier for residents to tackle once they have lost community supports.
   a. More subsidized housing, for all ages. The limitation of vouchers to age 62 and younger was a barrier to placing older residents in the community.
   b. Education for landlords on the special needs of the long term care population and how to accommodate them in a successful housing arrangement.
   c. Lack of a directory of housing options and availability. When the need arises to locate housing that is acceptable to the participant, there is not a web site or housing resource directory containing information on publicly and privately funded housing including assisted living, apartments, condominiums, single family homes.
d. MI Choice Medicaid waiver cannot pay for services in licensed assisted living.
e. Current Medicaid waivers for home and community based services cannot include housing costs (rent or purchase) while the nursing facility rate does.

5) Services and person centered planning and direction:
Residents encounter a grinding mass of paperwork, forms, conflicting program instructions and assessments that often become barriers in themselves. People should be put first, with a focus on their hopes and desires for a better more productive life.

6) Financial assistance and financial planning: Many residents, particularly younger people with disabilities, may have not had the opportunity to manage their own finances and require assistance to take on this responsibility.
   a. lack ability to save funds to transition: after nursing facility expenses, residents are left with about $60 per month. This is not enough to save towards transitioning to the community.
   b. Poor credit history: For a variety of reasons do to poor health, lack of planning, guardianship issues, and no job or income, most NFTI participants had serious credit problems. These had to be resolved before a landlord would consider renting an apartment.

7) Lack of support from corporate guardians

8) Nursing facilities do not keep resident data up to date. This makes transition planning difficult because key elements about the person’s supports and care needs are missing and/or not current.

9) Residents are reluctant to share personal and financial information with supports coordinator.

NFTI Transition Accomplishments:

- Established ability to provide independence to persons who previously had no hope of returning to the community
- Transitioned 112 people to the community
- Demonstrated ability of MI Choice Waiver program to be a strong partner in long term care services, supports and transition
- Demonstrated MI Choice waiver programs commitment to person centered planning for younger persons with disabilities and elderly persons
- Savings established in long term care costs
- Community outreach activities, i.e., permanently expanded number of contacts available to assist in relocation of nursing facility residents back to the community
- Outreach efforts have created a heightened awareness of housing challenges, especially for disabled participants under 55 years of age.
- Outreach activities have created new opportunities for long term care residents
NFTI project informed MDCH, DAAA and AAAWM and participating agencies regarding barriers and cost savings.

Helped define and develop statewide policies and procedures for transition expansion.

Future Actions to NFTI Challenges, Conclusions and Discussion:

1) Many people residing Michigan nursing facilities can return to the community. In the NFTI group, 41% of the people transitioned with no further service needs. The remainder had moderate to high needs similar to all nursing facility residents but still chose to live in the community. This represents a significant expense to the state that should be reduced as soon as possible by expansion of transition and diversion models statewide using NFTI techniques, including:
   a. Providing supports coordination to nursing facility residents who wish to develop transition plans to move back to the community
   b. Funding for transition costs (rent deposits, household furnishings, transportation), including funding for non Medicaid and non medically eligible residents

2) People requiring long term care can live successfully in the community. Most of the people who did need long term care services were still living in the community at the end of the project.

3) The MI Choice Waiver agents can provide effective and less costly alternative to institutional care. Service costs were less than one third the cost of a month in an institution.

4) Build local collaborative whose focus is to assist people to move out of nursing facilities and wish to live in the community.

5) Encourage communities to develop local consortia that combine Centers for Independent Living, Mi Choice Waiver and other service/housing providers to develop and implement transition plans
   a. Develop discussion groups to work out special issues that would aid in transition such as pain management, arranging transportation, substance abuse, and employment counseling.
   b. Use consortia to mobilize local resources and create a climate of change to educate people on person centered planning, choice and control and the appropriateness of community home based care.

6) Develop an information and referral function to provide people with up to date information on alternatives to institutions.
   a. Develop state level money follows the person model, as people shift from one care system to another the long term care funds would follow them.
   b. Develop an ongoing transition and diversion program by redirecting funds previously used for people in institutions who now reside in the community.
7) Close nursing facility beds and/or waiver slots as people transition to community based care  
8) Fund advanced research to refine NFTI findings  
9) Annually rebase long term care funds to follow person directed care settings  
10) Revise long term care quality management plan to include transition and diversion status and measurement indicators.  
11) Include housing, in addition to home modification, as a core long term care service  
12) Provide financial counseling services: poor credit history is one of major barriers to finding a place to live outside of the institution  
13) Develop and education and training program to raise community awareness to the appropriateness of home and community based services for people with long term care needs.  
14) Work with nursing facilities to develop new models of care that more closely resemble community living.

In closing, the NFTI transition program demonstrated that most people in nursing facilities who have long term care supports and services can live in the community successfully. Some need extensive services but an equal number really only need housing and supports. Nursing facility residents should be helped at all cost to regain community living in a setting that achieves their wishes and desires for a better life.
Nursing Facility Transition Project Data Collection: MI Choice Face Sheet

**MI CHOICE Participant Information**

Section A: Identifying Information

1. Client Name
   - Last
   - First
   - Middle Initial

2. Date of Birth
   - / / 

3. Gender
   - Male
   - Female

4. Marital Status
   - Single/NA
   - Married
   - Widowed
   - Divorced
   - Other

5. Spouse Last Name
   - First Name
   - Middle Initial

6. Race (If only one)
   - White
   - Asian/Pacific Islander
   - Black
   - American Indian/Alaska Native
   - Other

7. Hispanic (If applicable)
   - Yes
   - No

8. Client Address
   - 

9. City

10. Client Phone
    - 

11. Has SSN Been Verified?
    - No
    - Yes

Directions to Home

12. Primary Language

13. Education: Highest level completed
    - Grade(s)
    - High School
    - College

14. Religious Affiliation
    - Contact
    - Phone

15. Cultural issues that pertain to care plan
    - No
    - Yes

16. Client Rights and Responsibilities explained
    - No
    - Yes

17. Reason for Referral
    - Post hospital care
    - Community chronic care
    - Home placement
    - Day care
    - Other

18. Where lived at time of referral
    - Private home
    - Home care service care
    - Group home
    - Residential facility

19. Who lived with at referral
    - Alone
    - With only
    - With both
    - With relatives in group setting

20. Referral Name

21. Referral Date
    - / / 

22. Referral Agency Code

23. Referral Agency Name

24. Referral Type

25. Family Contact Name

26. Contact Phone

27. Residential History and Services 5 Years Prior to Referral
    - Lived in a nursing home
    - Home care client prior to this episode
    - Documented services prior to this episode
    - None of the above

28. Surrogate Decision Maker
    - Has legal guardian
    - No
    - Pending
    - DPOA
    - No
    - Pending
    - Conservator
    - No
    - Pending
    - Rep. Payee
    - No
    - Pending

This form will be processed using a scanner. The best results in interpreting your handwriting will be achieved if you use a fine or medium black or dark blue ink pen and attempt to keep letters and numbers inside the boxes provided for entry. Use all uppercase letters when possible. Circled represent field responses where only one should be chosen, square boxes represent fields which may include multiple responses. Please fill in circles completely and use "x" instead of check marks in the squares.

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### MI CHOICE Participant Information

#### Section B: Benefits & Insurance

<table>
<thead>
<tr>
<th>1. Client has Advance Medical Directives in place</th>
<th>Name</th>
<th>Telephone</th>
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</thead>
<tbody>
<tr>
<td>(Be sure to do a hospitalization order)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] Pending</td>
</tr>
<tr>
<td>2. Living Will</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] Pending</td>
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</table>

<table>
<thead>
<tr>
<th>3. Client has Medicare</th>
<th>Medicare ID</th>
<th>Part A Effective</th>
<th>Part A Effective To</th>
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</thead>
<tbody>
<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
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<thead>
<tr>
<th>4. Medicaid Status</th>
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<th>MA Effective To</th>
<th>MA Spend Down</th>
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<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
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<tr>
<td>[ ] MA Active</td>
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<thead>
<tr>
<th>5. QMB</th>
<th>6. Medicaid ID</th>
<th>7a. MA Case Number</th>
<th>7b. Medicaid Re/Certification Date</th>
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<tbody>
<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
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<thead>
<tr>
<th>8. FA/Case Worker/Phone</th>
<th>9. Patient Pay Amt</th>
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<tbody>
<tr>
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<tr>
<th>10. Veterans ID</th>
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<thead>
<tr>
<th>11. Insurance Resource</th>
<th>[ ] No other insurance</th>
<th>[ ] Private insurance</th>
<th>[ ] Blue Cross/Blue Shield</th>
<th>[ ] Other</th>
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<tbody>
<tr>
<td>[ ] Worker's disability compensation</td>
<td>[ ] Eligible for Medicare</td>
<td>[ ] Employer/Union</td>
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<table>
<thead>
<tr>
<th>12. Health Insurance (Client)</th>
<th>Company Name</th>
<th>Phone</th>
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<tr>
<th>Address</th>
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<table>
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<th>Service Code</th>
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</table>

| Group # | |
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<table>
<thead>
<tr>
<th>13. Health Insurance (Spouse)</th>
<th>Company Name</th>
<th>Phone</th>
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| Group # | |
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| [ ] | |

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<thead>
<tr>
<th>14. Life Insurance (Client)</th>
<th>Company Name</th>
<th>Phone</th>
<th>Term</th>
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<tbody>
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<td>[ ]</td>
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<td>[ ] No</td>
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<thead>
<tr>
<th>Address</th>
<th>Face Value $</th>
<th>Whole Life</th>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ] No</td>
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<tr>
<th>Contract #</th>
<th>Cash Value $</th>
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<tr>
<th>15. Life Insurance (Client)</th>
<th>Company Name</th>
<th>Phone</th>
<th>Term</th>
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<tbody>
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<tr>
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<table>
<thead>
<tr>
<th>16. Life Insurance (Spouse)</th>
<th>Company Name</th>
<th>Phone</th>
<th>Term</th>
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<td>[ ]</td>
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<tr>
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<th>Face Value $</th>
<th>Whole Life</th>
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<table>
<thead>
<tr>
<th>Contract #</th>
<th>Cash Value $</th>
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</tr>
</tbody>
</table>

| 17. Client or representative can describe health benefits correctly | [ ] No | [ ] Yes |

| 18. Client or representative can interpret explanation of benefits correctly | [ ] No | [ ] Yes |
### MI CHOICE Participant Information

**Section C: Financial Information**

1. **Gross Monthly Income**
   - Social Security
   - Railroad Retirement
   - VA Benefits
   - Pensions
   - Annuity
   - Estate or Trust Fund
   - Interest Income
   - Dividends
   - Employment
   - SSI
   - Other
   - Subtotals
   - Total Household Income

   *IfHouseholdIncomeLessThanSpecialIncomeLimit: Yes
   *ClientorRepresentativeIsEffectivelyManagingFinancialAffairs: Yes

2. **Assets**
   - Savings
   - Checking
   - Equity Value/Real Estate
   - Stock/Securities
   - CD/IRA/Money Market
   - Cash Value Life Insurance
   - Trade-In With Second Car
   - Subtotals
   - Total Countable Assets

3. **Current Monthly Household Expenses**
   - Rent/Property Tax
   - Heat
   - Water/Sewer
   - Telephone
   - Cable TV
   - Food
   - Trans Expenses
   - Car Payment
   - Install Payments
   - Home Insurance
   - Car Insurance
   - Life Insurance
   - Other
   - Household Total

4. **Current Monthly Medical Expenses**
   - Prescriptions
   - Health Insurance
   - Medical Transport
   - Personal Care
   - Over Counter Meds
   - DME
   - Medical Bills
   - Medicare Premium
   - Medicare Supplement
   - Others
   - Medical Subtotal
   - Total Monthly Expenses
   - Variance

5. **Protected Spousal Amount (Worksheet)**
   - Total Asset Amount divided by 2
   - Enter the lower amount: Line A or the minimum PSA (If A is lower than the minimum PSA, enter the minimum PSA)
   - Add Individual Asset Limit to B
   - Note: C = the maximum amount of countable assets the couple can have for the client to be asset eligible.
Attachments 2

Nursing Facility Transition Project Data Collection: MI Choice Assessment

(Rest of this page is left blank)
SECTION A: IDENTIFYING INFORMATION

1. Screen Date (mm/dd/yyyy)

2. Date of Assessment (mm/dd/yyyy)

3. Place of Assessment
   - Home
   - Hospital
   - PHI/Institution
   - Other

4. Assessment Reason
   - Initial assessment/Appropriate placement
   - 45 day follow-up assessment
   - 90 day follow-up assessment
   - Discharge assessment (45 days after initial assessment)
   - Death assessment (45 days after initial assessment)
   - Other

5. Client Last Name

6. Client First Name

7. Date of Birth (mm/dd/yyyy)

8. Date Case Opened / Reopened (mm/dd/yyyy)

9. Has SSN Been Verified?  No  Yes

Comments, Section A

SECTION B: SOCIAL FUNCTIONING

1. Involvement
   a. Clients not communicating with others (e.g., has to spend time with others)
   b. Openly expresses conflict or anger with family/beneficial

2. Change in Social Activities
   - As compared to 180 days ago, decline in the client's level of participation in social, religious, occupational, or other preferred activities, if there was a decline, client distressed by this fact

3. Isolation
   a. Length of time client is alone during the day (morning/afternoon)
   b. Client says or indicates that he/she feels lonely

4. Change in Social Activities

Comments, Section B

SECTION C: INFORMAL SUPPORT SERVICES

<table>
<thead>
<tr>
<th>Relationship Code</th>
<th>0. Child or child's own</th>
<th>1. Spouse</th>
<th>2. Other relative</th>
<th>3. Friend or neighbor</th>
</tr>
</thead>
</table>

1. Primary Helper
   - First Name
   - Last Name
   - Phone
   - Relationship
   - Tasks (check all that apply)
   - Days/Hours Avail

2. Secondary Helper
   - First Name
   - Last Name
   - Phone
   - Relationship
   - Tasks (check all that apply)
   - Days/Hours Avail

This form will be processed using a scanner. The best results in interpreting your handwriting will be achieved if you use a medium black or dark blue ink pen and attempt to keep letters and numbers inside the boxes provided for entry. Use all uppercase letters when possible. Circles represent field responses where only one should be chosen. Boxes represent fields which may include multiple responses. Please fill in digits completely and use "X" instead of checkmarks in the squares.
### MI-CHOICE CARE MANAGEMENT ASSESSMENT

**Participant SSN**

<table>
<thead>
<tr>
<th>3. Other Helper</th>
<th>Phone</th>
<th>Relationship</th>
<th>Tasks</th>
<th>Days/Hours Avail.</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>4. Other Helper</th>
<th>Phone</th>
<th>Relationship</th>
<th>Tasks</th>
<th>Days/Hours Avail.</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>5. Other Helper</th>
<th>Phone</th>
<th>Relationship</th>
<th>Tasks</th>
<th>Days/Hours Avail.</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Primary and Secondary Helpers Only:**

6. Lives with Client
   - 0. No
   - 1. Yes
   - 2. No such help available (skip remaining items in this section)

7. Areas of Help
   - a. Advice on emotional support
   - b. IADL Care
   - c. ADL Care

8. If Needed, Willingness (with ability) to Increase Help
   - 0. No
   - 1. 1-2 Hours/day
   - 2. More than 2 hours
     - a. Advice on emotional support
     - b. IADL Care
     - c. ADL Care

9. Caregiver Status
   - a. Caregiver unable to continue in caring activities (e.g., decline institutionalization, caregiver smoker/illness/disability)
   - b. Primary caregiver not satisfied with support received from family and friends (e.g., other children of client)
   - c. Primary caregiver expresses feelings of distress, anger, or depression
   - d. None of the above

**Comments, Section C**

---

**SECTION D: ENVIRONMENTAL ASSESSMENT**

1. Home Environment
   - Check any of the following that make home environment hazardous or inhospitable.
   - Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridor)
   - Flooring and carpeting (e.g., worn, loose, bowing, or no carpet in living room)
   - Bathroom and toilet (e.g., non-operating toilet, leaking pipe, no sink, or broken toilet, or outside toilet)
   - Kitchen (e.g., dangerous stove, inadequate refrigerator, no hands-free faucet, or no toilet)
   - Heating and cooking (e.g., too hot in summer, too cold in winter, wood stove in home with asthmatics)
   - Personal safety (e.g., fear of violence, safety problems going to mailbox or visiting neighbors, heavy traffic in street)
   - Access to home (e.g., difficulty entering or leaving home)
   - Access to rooms in home (e.g., unable to climb stairs)
   - None of above

2. Living Arrangement
   - a. Adult carbohydrate ongoing need: client will live with other persons (e.g., moved in with another person, other moved in with client)
   - b. Client has many caregivers and the client should be better staffed

3. Housing Assessment
   - Client lives in:
     - House
     - Apartment
     - Residential Group Home
     - Other

4. Neighborhood Usability
   - Client report of problems: client lives in high crime neighborhood, difficult to get to neighborhood, difficult to get to shopping, etc.

5. Cooking facilities and refrigerator on premises
   - No
   - Yes

6. Microwave on premises
   - No
   - Yes

7. Telephone accessible and usable
   - Private line
   - No
   - Yes
   - Touch tone service
   - No
   - Yes

8. Home requires modifications to remove barriers or home repairs are needed (roof leaks, unsafe flooring, heating, etc.)
   - No
   - Yes

9. Tub/shower/hot water accessible
   - No
   - Yes

10. Pets
    - No
    - Yes

11. Smoke detector
    - No
    - Yes

12. Washer/dryer accessible
    - No
    - Yes

13. Emergency plan in place
    - No
    - Yes

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MI-CHOICE CARE MANAGEMENT ASSESSMENT

Comments, Section D

SECTION E: COGNITIVE PATTERNS

1. Memory
   a. Short-term memory OK - seems to have memory difficulty recalling after 3 minutes
      o Memory OK o Memory Problem
   b. Long-term memory OK - seems to have memory difficulty recalling long past
      o Memory OK o Memory Problem

2. Cognitive Skills for Daily Decision Making: How well client makes decisions about daily life (e.g., when to get up or how many meals, clothes to wear, or activities to do)
   o Independent - decisions consistently reasonable
   o Modified independence - some difficulty in new situations
   o Moderately impaired - decisions more careful/assistance required
   o Severely impaired - never really made decisions

3. Indicators of Delirium
   a. Sudden or new onset change in mental function (including ability to pay attention, awareness of surroundings, being coherent, unpredictable fluctuations over course of day)
      o No o Yes
   b. In the past 20 days, client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others
      o No o Yes

Comments, Section F (Discuss orientation to surroundings, date, time, place, and reliability of information)

SECTION F: COMMUNICATION / HEARING PATTERNS

1. Hearing (with hearing appliance if used)
   o Hears adequately - normal talk, TV, phone, doorbell
   o Minimal difficulty when not in quiet setting
   o Hears in normal conversations only - speaker has to adjust loudness quality and speak distinctly
   o Highly impaired - absence of useful hearing

2. Making self understood (Expressing information content - however able)
   o Understood
   o Usually understood - difficulty finding words or finishing thoughts
   o Sometimes understood - difficulty limited to making concrete requests
   o Rarely/never understood

3. Ability to understand others (understands verbal information - however able)
   o Understands
   o Usually understands - may miss some part or intent of message
   o Sometimes understands - responds inadequately to simple, direct communication
   o Rarely/never understands

4. Hearing aid
   o Yes
   o No
   o Does not use regularly
   o Needed, but not available
   o Does not need/want

SECTION G: MOOD AND BEHAVIOR PATTERNS

1. Drinking / Smoking
   a. In the past 30 days, client left the need or was told by others to cut down on drinking, or others were concerned with client's drinking
      o No o Yes
   b. In the past 30 days, client had to have a drink last thing in the morning to steady nerves (e.g., an "eye opener") or had been in trouble over drinking
      o No o Yes
   c. Smoked or chewed tobacco daily
      o No o Yes
   d. Over a typical week in the last month, record the number of days (0-7) client had one or more drinks
      o 2 o 3 o 4 o 5 o 6 o 7
   e. On days client had a drink, record the number of drinks usually consumed per day (0 oz or no drinking, 1 oz or more drinking)
      o 1 o 2 o 3 o 4 o 5 o 6 o 7

2. Indicators of Depression, Anxiety, Sad Mood
   (Code for indicators observed in last 30 days, irrespective of the assessed cause)
   0. Indicator not exhibited in last 30 days. 1. Indicator of this type exhibited up to 3 days/week. 2. Indicator of this type exhibited daily or almost daily (4+ days/week)
   a. Feeling of sadness or being depressed, that life is not worth living, that nothing matters that he or she is of no use to anyone, or would rather be dead
      o 0 o 1 o 2
   b. Persistent anger with self or others (e.g., easy annoyed, anger at being alone)
      o 0 o 1 o 2
   c. Depressive or anxious complaints, concerns, e.g., persistent feelings of uneasiness regarding personal safety, school, work, family, friends
      o 0 o 1 o 2
   d. Sad, overly worried facial expressions, e.g., frown, droopy mouth
      o 0 o 1 o 2
   e. Recurrent crying, tears
      o 0 o 1 o 2
   f. Withholding love or affection (e.g., no interest in long lasting activities or being with family/friends)
      o 0 o 1 o 2
   265 36
3. Behavioral Symptoms: In the last 7 days, instances when the client exhibited following behavioral symptoms. If exhibited, code of occurring symptom when it occurred:
   a. Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)
   b. Visibly obsessional behavioral symptoms (threatened, screamed at, cried all night)
   c. Physically abusive behavioral symptoms (hit, shoved, scratched, sexually abused others)
   d. Socially inappropriate/disruptive behavioral symptoms (disruptive sounds, noises, screaming, self-abusive acts, sexual behavior, disturbing in public, smears/throws food/urine, rummaging, repetitive behavior, runs away and causes disruption)
   e. Aggressive resistance of care (e.g., throw medications, pushed caregivers)
   4. Changes in Behavioral Symptoms: Behavioral symptoms have become worse or are less well tolerated by family or compared to 30 days ago.
   5. Mental Health: Problem conditions in last week (check all present at any point during last 7 days)
   a. Delusions
   b. Hallucinations
   c. None
   6. Number of prior lifetime mental health admissions
   a. None
   b. 1-3
   c. 4-6
   d. 7 or more
   7. Self Injury: Self-inflicted attempt (code for most recent instance)
   a. None
   b. Attempt to kill oneself
   c. Attempt in last 6 months
   d. Considered self-injury behavior in last 30 days
   e. Family/caregiver/nurse/doctor expresses concern that patient is at risk for self-injury
   8. Violence: Code for most recent instance
   a. History of violence to others
   b. Attempted violence to others
   c. Violent reaction
   d. Police intervention for violent behavior
   e. Sexual violence
   9. Mental Health Interventions (specify)
   10. Mental Retardation: Diagnosis
   11. Developmental Disability: Diagnosis
   12. Significant Life Changes within the Last Six Months (check all that apply)

 Comments, Section G: Discuss history of mental health impairment

 SECTION II: SUMMARY - SOCIAL WORKER

 SW Signature: [signature]
 Date: [day]

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### MI-CHOICE CARE MANAGEMENT ASSESSMENT

**Participant SSN** [Redacted]

#### SECTION I: DISEASE DIAGNOSIS, DISABILITIES

1. **Primary Physician**
   - Address
   - Phone
   - Data last seen

2. **Specialist**
   - Address
   - Phone
   - Data last seen

3. **Specialist**
   - Address
   - Phone
   - Data last seen

4. **Specialist**
   - Address
   - Phone
   - Data last seen

5. **Specialist**
   - Address
   - Phone
   - Data last seen

6. **Most recent (MM/DD/YYYY)**
   - a. Hospitalization
     - Admission Date
     - Discharge Date
     - Hospital Phone
   - b. Emergency Room date of visit

7. **Diseases**
   - Include all diseases that affect the client’s status, require treatment, or require symptom management. Also include if disease is being monitored by a home care professional or is the reason for hospitalization in last 90 days.
   - **Codes**
     - a. Not present
     - b. Present not subject to focused treatment or monitoring by home care professional
     - c. Present monitored or treated by home care professional

#### NEUROLOGICAL
- M. Multiple sclerosis
- N. Parkinson’s disease
- O. Transient ischemic attack (TIA)
- P. Traumatic brain injury

#### PSYCHIATRIC / MOOD
- Q. Major depression (bipolar disorder)
- R. Schizophrenia
- S. Other psychiatric diagnosis

#### RESPIRATORY
- T. Asthma
- U. Emphysema/COPD

#### SENSORY
- V. Glaucoma
- W. Macular degeneration

#### OTHER
- X. Renal failure
- Y. Cancer (in past 5 years - not including skin cancer)

#### INFECTIONS
- Z. Antibiotic resistant infection (e.g., Methicillin-resistant Staphylococcus aureus)
- A. Chlamydia trachomatis (C. trachomatis)
- B. Gonorrhea
- C. HIV infection
- D. Herpes
- E. Hepatitis
- F. Invasive fungal infection
- G. Nipah virus
- H. Varicella zoster virus

#### OTHER CURRENT OR MORE DETAILED DIAGNOSIS and ICD-9 Codes

10. **Source of medical information**

11. **AWARE OF DIAGNOSIS**
   - Client: No / Yes
   - Family: No / Yes

**Comments, Section II (Include Medical History)**

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## SECTION J: HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

### 1. Preventive Health
- [ ] Blood pressure measured
- [ ] Received influenza vaccination
- [ ] Health assessment and physical exam by health care provider in the last 90 days
  - If MALE:
    - [ ] Prostate exam
    - [ ] Toxinscreen exam (self or health provider)
    - [ ] PSA blood test (Prostate-specific antigen)
  - If FEMALE:
    - [ ] Pap smear
    - [ ] Received breast examination or mammography
  - None of the above

### 2. Client needs medication to control pain
- [ ] No
- [ ] Yes

### 3. Falls Frequency
- Number of times fell in last 30 days (or since last assessment):
  - Comparison: Change from previous falls

### 4. Danger of Fall
- Unstable Gait
  - [ ] No
  - [ ] Yes

- [ ] Client limit going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)
  - [ ] No
  - [ ] Yes

### 5. Problem Conditions Present on 3 or more days:
- (check all that were present on all at least 2 of last 7 days)
  - Diarrhea
  - Frequent vomiting
  - Loss of appetite
  - Difficulty initiating or maintaining 3 or more times at night
  - Fever
  - None of the above

### 6. Problem Conditions in last week
- (physical health check at present at any point in last 7 days)
  - Change in usual symptoms
  - Chest pain of exertion or chest pain/presure at rest
  - Constipation in 4 of last 7 days
  - Diarrhea or light-headedness
  - Edema
  - Shortness of breath
  - None of the above

### Comments, Section J

## SECTION K: NUTRITIONAL / HYDRATION STATUS

### 1. Weight Change
- [ ] Unintended weight loss of 5% or more in last 30 days, or 10% or more in last 180 days
- [ ] No
- [ ] Yes

### 2. Consumption
- [ ] At least 4 of the last 7 days, client ate one or fewer meals a day
- [ ] No
- [ ] Yes

- [ ] In the last 7 days, noticeable decrease in the amount of food client ate or usual eating patterns
- [ ] No
- [ ] Yes

- [ ] Insufficient fluids - client did not consume all fluids during last 3 days
- [ ] No
- [ ] Yes

### Nutritional Approaches
- [ ] Parenteral / IV feeding
- [ ] Mechanicalized tube feeding
- [ ] Synthetic oral feeding
- [ ] Therapeutic diet
  - [ ] None of the above
  - [ ] Yes

### 3. Type of Diet
- [ ] Regular
- [ ] Mechanical soft
- [ ] Sodium Restricted
- [ ] Blended, low residue
- [ ] Tube controlled
- [ ] Colonos restricted
- [ ] Diabetic
- [ ] Other

### 4. Nutritional Treatments
#### A. Management Codes
- [ ] 0. Total parenteral nutrition
- [ ] 1. Intravenous
- [ ] 2. Enteral tube feeding

#### B. Number of days formal care received in last week
- [ ] Management
- [ ] Number of days

### 5. Other Status Indicators
- (check all that apply)
  - Faints and/or dizziness
  - Unusual, sudden, or severe pain
  - General weakness, fatigue
  - Seizures
  - Nausea, vomiting, diarrhea
  - None of the above

---

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5. Ability to Access Food/Drink
   a. Physically capable to purchase or prepare food at times needed: (on a scale of 1-10, 10 being the highest, 10 indicates the highest degree of capability)
   o No o Yes
   b. Able to chew, swallow foods prepared or presented: (on a scale of 1-10, 10 being the highest, 10 indicates the highest degree of capability)
   o No o Yes

4. Describe what client actually consumed during last three meals. Include snacks between meals:
   Breakfast:
   Lunch:
   Dinner:
   Snacks consumed during the last 24 hours:

Comments, Section K

SECTION L: DENTAL STATUS (ORAL HEALTH)

1. Oral Status: Check all that apply
   o Problem chewing or swallowing (e.g., pain while eating)
   o Mouth is "dry" when eating a meal
   o Problem brushing teeth or dentures
   o None of the above

2. Dental Care
   a. Client needs dental care
   o No o Yes
   b. Client has dentures
   o No o Yes
   c. If Yes, insert dentures

3. Describe condition of mouth

Comments, Section L

Date dental last seen: / /

SECTION M: VISION PATTERNS

1. Vision: (ability to see in adequate light and with glasses if needed)
   o Adequate - sees fine detail, including regular print in newspapers or books
   o Impaired - sees large print, but not regular print in newspapers or books
   o Moderately impaired - limited vision; not able to see newspaper headlines, but can identify objects
   o Highly impaired - object identification in question, but eyes appear to follow objects
   o Severely impaired - no vision or sees only light, color, or shapes; eyes do not appear to follow objects

2. Visual Limitations/Difficulties
   o Sees but does not recognize objects, such as lights, curtains, or shapes
   o Does not recognize colors
   o Glare
   o Even in low light, difficulty seeing
   o Light sensitive

3. Visual decline
   o Worsening of vision as compared to status of 30 days ago
   o No o Yes

Comments, Section M
### SECTION N: SKIN CONDITION

1. **Skin Problems:** Any noticeable skin condition or changes in the last 30 days (e.g., burns, bruises, rash, redness, body lice, scabies): No ❌ Yes ☑

2. **Ulcers (Pressure/Stasis):** Presence of an ulcer anywhere on the body.
   - Ulcers include any area of persistent skin redness (Stage 1)
   - Partial loss of skin layers (Stage 2)
   - Deep ulcer(s) in the skin (Stage 3)
   - Necrosis in skin exposing muscle, fat or bone (Stage 4)
   - (Code "O" if no ulcer, otherwise record the highest ulcer stage (1-4))
   - a. Pressure ulcer found on bone.
   - Effect of pressure, resulting in damage to underlying tissue
   - b. Skin ulcer - open ulcer caused by poor circulation in the lower extremities

3. **Other Skin Problems:** (Including infection)
   - Burns (second or third degree)
   - Open lesions other than ulcers, rash, cuts (e.g., cancer)
   - Skin tears or cuts
   - None of the above

4. **Surgical Wound Sites:** (Check all that apply)
   - Thorax
   - Abdomen
   - None of the above

5. **History of Resolved Pressure Ulcers:** Client previously had at any time or an ulcer anywhere on the body.
   - No ❌ Yes ☑

### Comments, Section N

---

### SECTION O: CONTINENCE IN LAST 14 DAYS

1. **Bladder Continence:** In the last 14 days, control of urinary bladder (including use of appliances such as catheters or incontinence program employed) (Note: it debilitates, volume insufficient to soak through undergarments)
   - Continent: Complete control
   - Incontinent: Incidents episodes once a week or less
   - Occasionally incontinent: Incidents episodes 2 or more times a week but not daily
   - Frequent incontinence: Incidents episodes daily, but some control present
   - Continence: Inadequate control multiple daily episodes

2. **Bladder Devices:** (In last 14 days)
   - External device (self care)
   - Indwelling urinary catheter (self care)
   - Ostomy (self care)
   - External device (not self care)
   - Indwelling urinary catheter (not self care)
   - Ostomy (not self care)
   - Use of pads or briefs to protect against wetness
   - None

3. **Urgency, frequency or other problems**

---

4. **Bowel Continence:** In the last 14 days, control of bowel movement (with appliance or bowel continence program employed)
   - Continent: Complete control
   - Occasionally incontinent: Bowel incontinent episodes less than weekly
   - Occasionally incontinent: Bowel incontinent episode once a week
   - Frequent incontinence: Bowel incontinent episodes 2-3 times a week
   - Incontinent: Bowel incontinent all (or almost all) of the time

5. **Bowel Function**
   - Ostomy (self care)
   - Ostomy (not self care)

6. **Type of Ostomy**
   - Endostomy
   - Colostomy
   - None

7. **Define usual elimination pattern or problems**

---

Comments, Section O

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1. ADL Self-Performance - Code for functioning in routine activities around the home or in the community during the last 7 days.

(A) ADL Self Performance Code (Code for client's performance during the last 7 days. 8 Independent= does it on own. 1 Some help= help at some of the time. 2 Full help= performed with help all of the time)

1. Bathing
2. Dressing
3. Eating
4. Grooming
5. Mobility in bed
6. Mobility out of bed
7. Toileting
8. Transferring

(B) ADL Difficulty Code (How difficult it was to do that activity) 0 = No difficulty 1 = Some difficulty 2 = Great difficulty 3 = Not possible

1. Meal preparation: How meals are prepared (e.g., planning meals, cooking, serving food, washing etc.)
2. Ordinary House Work: How ordinary work around the house is performed (e.g., cleaning, cooking, serving food)
3. Medications: How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct doses, giving injections, applying ointments)
4. Phone Use: How telephone is used, received, ordialed
5. Shopping: How shopping is performed for food and household items (e.g., selecting items, managing money)
6. Transportation: How client gets around by vehicle (e.g., walks places) or by other means (e.g., gets around using public transportation, carpooling)

Note: Refer to the following codes when answering the ADL portion of this assessment.

2. ADL Self-Performance - Code for functioning in routine activities around the home or in the community during the last 7 days.

(A) ADL Self Performance Code (Code for client's performance during the last 7 days. 8 Independent= does it on own. 1 Some help= help at some of the time. 2 Full help= performed with help all of the time)

1. Bathing
2. Dressing
3. Grooming
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6. Transferring
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Note: Refer to the following codes when answering the ADL portion of this assessment.

3. ADL Self-Performance - Code for functioning in routine activities around the home or in the community during the last 7 days.

(A) ADL Self Performance Code (Code for client's performance during the last 7 days. 8 Independent= does it on own. 1 Some help= help at some of the time. 2 Full help= performed with help all of the time)

1. Bathing
2. Dressing
3. Grooming
4. Mobility in bed
5. Mobility out of bed
6. Transferring
7. Toileting

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6. Transportation: How client gets around by vehicle (e.g., walks places) or by other means (e.g., gets around using public transportation, carpooling)

Note: Refer to the following codes when answering the ADL portion of this assessment.

4. ADL Self-Performance - Code for functioning in routine activities around the home or in the community during the last 7 days.

(A) ADL Self Performance Code (Code for client's performance during the last 7 days. 8 Independent= does it on own. 1 Some help= help at some of the time. 2 Full help= performed with help all of the time)

1. Bathing
2. Dressing
3. Grooming
4. Mobility in bed
5. Mobility out of bed
6. Transferring
7. Toileting

(B) ADL Difficulty Code (How difficult it was to do that activity) 0 = No difficulty 1 = Some difficulty 2 = Great difficulty 3 = Not possible

1. Meal preparation: How meals are prepared (e.g., planning meals, cooking, serving food, washing etc.)
2. Ordinary House Work: How ordinary work around the house is performed (e.g., cleaning, cooking, serving food)
3. Medications: How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct doses, giving injections, applying ointments)
4. Phone Use: How telephone is used, received, ordialed
5. Shopping: How shopping is performed for food and household items (e.g., selecting items, managing money)
6. Transportation: How client gets around by vehicle (e.g., walks places) or by other means (e.g., gets around using public transportation, carpooling)

Note: Refer to the following codes when answering the ADL portion of this assessment.

5. ADL Self-Performance - Code for functioning in routine activities around the home or in the community during the last 7 days.

(A) ADL Self Performance Code (Code for client's performance during the last 7 days. 8 Independent= does it on own. 1 Some help= help at some of the time. 2 Full help= performed with help all of the time)

1. Bathing
2. Dressing
3. Grooming
4. Mobility in bed
5. Mobility out of bed
6. Transferring
7. Toileting

(B) ADL Difficulty Code (How difficult it was to do that activity) 0 = No difficulty 1 = Some difficulty 2 = Great difficulty 3 = Not possible

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2. Ordinary House Work: How ordinary work around the house is performed (e.g., cleaning, cooking, serving food)
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4. Phone Use: How telephone is used, received, ordialed
5. Shopping: How shopping is performed for food and household items (e.g., selecting items, managing money)
6. Transportation: How client gets around by vehicle (e.g., walks places) or by other means (e.g., gets around using public transportation, carpooling)

Note: Refer to the following codes when answering the ADL portion of this assessment.
### MI-CHOICE CARE MANAGEMENT ASSESSMENT

**Participant SSN**

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#### 7. Stair Climbing
- In the last 7 days, how client went up and down stairs:
  - [ ] Up and down stairs without help
  - [ ] Up and down stairs with help
  - [ ] Does not go up and down stairs, code client's capacity for stair climbing.
  - [ ] Up and down stairs without help
  - [ ] Up and down stairs with help
  - [ ] Does not go up and down stairs-can do without help
  - [ ] Does not go up and down stairs—no capacity to do it
  - [ ] Unknown — did not climb stairs and assessor is unable to judge whether the capacity exists

#### 8. Stamina
- a. In a typical week, during the last 30 days, code the number of days client usually went out of the house or building in which client lives (for matters for which he/she is responsible):
  - [ ] Every day
  - [ ] 2-6 days a week
  - [ ] 1 day a week
  - [ ] No days
- b. Hours of physical activities in the last 7 days (e.g., walking, cleaning house, exercised):
  - [ ] Two or more hours
  - [ ] Less than two hours

#### Comments, Section P

---

#### SECTION Q: SERVICE UTILIZATION

<table>
<thead>
<tr>
<th>Nature of Surgery</th>
<th>Date</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

#### 1. Recent Impending Surgery within last six months
- Nature of Surgery
- Date
- [ ] No
- [ ] Yes

#### Treatments (continued)

<table>
<thead>
<tr>
<th>g. Continuous positive airway pressure (CPAP)</th>
<th>h. Dialysis-peritoneal (CAPD)</th>
<th>i. Dialysis-initiated (CAPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 2. Formal Care (minutes recorded to even 10 minutes)
- Extrinsic care or care management during 14 days involving this or other agencies
- a. Home Health aides
- [ ] Hours
- [ ] Minutes
- b. Volunteer services
- c. Homemaking services
- d. Meals
- e. Linen services
- f. Physical therapy
- g. Occupational therapy
- h. Speech therapy
- i. Day care or day hospital
- j. Social Worker in home

#### 3. Special Treatments, Therapies, Programs
- a. Alcohol/drug treatment program
- b. Blood transfusions
- c. Chemotherapy
- d. Cardiac rehabilitation
- e. Dialysis
- f. Diuretic
- g. Incontinence control
- h. Management by injection
- i. Oxygen therapy (continuous, fractionated, nasal)
- j. Postural therapy
- k. Rehabilitation
- l. Respiratory therapy (including oxygen, FMH)
- m. Vestibular
- n. k. Therapists
- o. Exercise therapy
- p. Occupational therapy
- q. Physical therapy
- r. Respiratory therapy

#### Programs
- w. Day Care
- x. Day Hospital
- y. Hospice care
- z. Physician or clinic visit
- aa. Portable care

#### Special Procedures Done In Home
- ab. Daily urine monitoring (e.g., EKG, urinary output)
- ac. None monitoring less than daily
- ad. Medical care (vasculation) or electronic security client
- ae. Skilled treatment
- af. Special diet
- ag. Other

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### MI-CHOICE CARE MANAGEMENT ASSESSMENT

**Participant SSN**

**SECTION A: MANAGEMENT**

1. **Management of Equipment**
   - [ ] 1. Managed on own
   - [ ] 2. Managed on own if left out or with verbal reminders
   - [ ] 3. Partially performed by others
   - [ ] 4. Fully performed by others

2. **Visits in Last 90 Days**
   - (Code 10 if none, code 1 if more than 9)
   - Number of times client visited social worker or other professionals
   - Number of times client visited home

3. **Overall Change in Care Needs**
   - [ ] No change
   - [ ] Improved, e.g., receives fewer supports
   - [ ] Deteriorated, e.g., receives more support

### SECTION B: MEDICATIONS

1. **Number of Medications**
   - Record the number of different medications prescribed over the course, including eye drops.
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] 5
   - [ ] 6
   - [ ] 7
   - [ ] 8
   - [ ] 9
   - [ ] 10
   - [ ] 11
   - [ ] 12
   - [ ] 13
   - [ ] 14
   - [ ] 15
   - [ ] 16
   - [ ] 17
   - [ ] 18

2. **Receipt of Psychotropic Medications**
   - [ ] Antipsychotic
   - [ ] Antidepressant
   - [ ] Other
   - [ ] Antianxiety
   - [ ] Hypnotic

3. **Medical Oversight**
   - [ ] Discussed with at least one physician (or no medication taken)
   - [ ] No single physician reviewed all medications

4. **Compliance/Adherence with Medications**
   - [ ] Always compliant
   - [ ] Compliant 80% or more
   - [ ] Compliant less than 80%
   - [ ] No medications prescribed

5. **Client Needs Reminding Several Times a Day to Take Medications**
   - [ ] No
   - [ ] Yes

6. **Preparation of Medications Needed**
   - [ ] No
   - [ ] Yes

7. **Medications Must Be Administered to Client**
   - [ ] No
   - [ ] Yes

8. **Pharmacy Use**
   - [ ] Phone #: 
9. Current Medications (Rx & OTC)  

<table>
<thead>
<tr>
<th>Name / Strength</th>
<th>Frequency (e.g., BID, PRN)</th>
<th>Purpose</th>
<th>Prescribed By:</th>
<th>Prescriber's Name</th>
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</table>

10. Allergies/Sensitivities (specify including reaction)

Pharmacological:

Environmental:

Comments, Section R

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### SECTION 5: VITAL SIGNS AND SYSTEMS

1. **Vital Signs**
   - **BP (sitting) Left arm**: [ ] [ ]
   - **BP (sitting) Right arm**: [ ] [ ]
   - **BP (standing) Left arm**: [ ] [ ]
   - **BP (standing) Right arm**: [ ] [ ]
   - **Temperature**
     - [ ] [ ]
     - [ ] [ ]
   - **Respiration**: [ ] [ ] [ ]
   - **Pulse-Apical**: [ ] [ ] [ ]
   - **Pulse-Radial**: [ ] [ ] [ ]

2. **Height**
   - [ ] [ ] [ ] [ ]

3. **Weight**
   - [ ] [ ] lbs

4. **Grips (hands)**
   - [ ] [ ]

5. **Sleeping Problems**
   - That occurred within the last 7 days reported by client:
     - [ ] [ ]

6. **Numbness/Tingling**
   - That occurred within the last 7 days reported by client:
     - [ ] [ ]

7. **Functional Limitation in Range of Motion**
   - (Code for limitations during the last 7 days that interfered with daily functions or placed client at risk of injury)
   - **A. Range of Motion**
     - [ ] [ ]
   - **B. Voluntary Movement**
     - [ ] [ ] [ ]
   - **Range (0-2)**
     - [ ] [ ] [ ] [ ] [ ]
   - **Voluntary (0-2)**
     - [ ] [ ] [ ] [ ]

8. **Comments, Section 5**

### SECTION 6: NURSING NOTES

All issues identified during assessment requiring intervention:

---

IN Signature: [ ]

Date: [ ] [ ]
SECTION U: CLIENT LOCATION RECOMMENDATION

1. a. CM recommends:
   - Community based care
   - Institutional care

   b. Client choice:
   - Community based care
   - Institutional care

2. Confirm client medically eligible for MI Choice.  No  Yes

Comments, Section U

Care Manager 1
Initials

Care Manager 2
Initials

SECTION V: STATUS

1. Opened
   - Presumed Status:
     - CM Aging
     - WA-Funding
     - WA
     - Others

2. Not Opened
   Check EITHER CM reason OR DCH reason:

   Choose CM reason not opened:
   - Death
   - Moved
   - Not eligible
   - NH placement
   - Refused Service
   - ICF/MR
   - Institutional Placement
   - Others:

   OR

   Choose DCH reason not opened:
   - Hearing Decision
   - For Cause

Comments, Section V
Nursing Facility Transition Initiative (NFTI) participants will be tracked using MICIS. This document outlines MICIS data collection requirements and options for NFTI participants.

I. NFTI Screen

Potential NFTI participants are screened using the MICIS screen, which must be entered to MICIS as a first step in data collection.

Once the screen is entered, a facesheet and assessment are generated to use in conducting the assessment interview.

II. NFTI Facesheet and Assessment Data Collection

A. Participant Identification by Referral Type

All participants served in the NFTI program must be entered using “NFTI” (Referral Type code 14) as the Referral Type in the MICIS Facesheet. This is the data item that will be used to identify NFTI participants across all agencies.

B. Other facesheet and assessment data collection for NFTI participants is handled as with all other participants.

C. All NFTI participants need to be entered to MICIS, whether or not they will receive ongoing services.

III. NFTI Status Data Collection

A. Waiver Status: Client Type

During the time that a person is receiving transition services, including housing plan development, they will be designated as a NFTI participant (using the NFTI Client Type in the MICIS Waiver status table) as long as they are not being served in another program such as the Waiver or Care Management. If a NFTI participant comes directly into another program at the agency (e.g. the Waiver), they will be designated as a Waiver Client Type from the beginning. It is not necessary to assign the NFTI Client Type unless the participant is served in NFTI before becoming eligible for another program. Some persons may remain in the NFTI program and not be
moved to a different program. These persons will remain in MICIS with the NFTI Client Type (and the mandatory NFTI Referral Type) until they are closed.

Persons can move to and from the NFTI Client Type as required within a given episode.

B. MOU Status Agents can apply for MOU status for NFTI participants if appropriate.

C. Movement from MICIS Program to Nursing Facility and Back to Program

A person who is in MICIS (in one of the existing programs) who then moves to a nursing facility would typically be kept open (in Care Management or Waiver Ineligible) in anticipation of the return. However, if the person is transitioned back to the agent using the NFTI program, the only way to appropriately track the NFTI participant is to create a new episode, using the NFTI Referral Type code.

IV. Care Plans: Housing Plan Development and Transition Services

A. Tracking NFTI Services in Care Plans

NFTI services will be tracked during the time a housing plan is being developed and transition is occurring.

A special list of service codes (Attachment A) has been created to identify NFTI transition services. Care plans should be created for these services as required by the person’s transition plan.

B. NFTI Fund Sources

NFTI Housing Plan and Transition services should be entered using the fund source code 972, NFTI Transition Funds. This code should be used for all purchased NFTI services identified in Attachment A.

A donations fund source code (703) can be used for donated items.

C. Movement from NFTI to Another Agency Program

When (and if) the person enters another program, such as the Waiver or Care Management, the services delivered in this program will be tracked as they are with any other
agency client. New care plans should be created with the appropriate fund sources for these services.

V. Tracking Care Manager Time

A. At the Agent discretion, Care Manager time spent in NFTI activities can be tracked in MICIS. Care Managers would need to keep track of time spent on behalf of each NFTI participant, including assessment time, housing negotiations, phone calls, shopping, client contacts, etc.

B. The Care Manager service would be entered to MICIS Care Plans using service T1016 (Case Management), and fund source 972 (NFTI transition). An appropriate template can be created to use in posting bills.

C. “Bills” can be posted using this care plan to indicate the number of 15-minute units spent on behalf of the client. These “bills” can be posted daily as they occur, or in aggregate weekly or monthly.

D. As an option, more detailed services could be created to differentiate services (for example, housing work, shopping, phone calls, travel time, etc), using standard remarks. This means that separate care plans would need to be created for each of these services. If necessary, CIM will add standard remarks for these additional services.

VI. NFTI Bills and Waiver Claims

A. Bills will be posted against care plans for NFTI participants in the same way that bills are posted for regular MICIS participants.

B. If a NFTI person is moved into the Waiver, the normal data collection rules are required (Waiver Client Type, Waiver-funded care plans and bills). The Medicaid claims for these services will be generated in the same way as all other Waiver participants.

VII. NFTI Reporting

A. NFTI Participants in Other Agency Programs

Once in another program like the Waiver, NFTI participants will be handled as any other Waiver participant. They will:

1. Use Waiver days like any other Waiver participant
2. Be included in the Waiver Enrollment report
B. DCH Identification of NFTI Participants

DCH will identify NFTI participants and remove their costs from Cost Reconciliation processing. These costs will need to be monitored against the $100,000 NFTI grant.

C. NFTI Service Days and Service Costs

Service costs for NFTI participants who never move to another Agency program will need to be tracked by participant. The NFTI referral source will be used to identify all participants transitioned, and service costs for this referral source will be presented in a report by fund source and service.

Service costs for NFTI participants who do move to another Agency program (like the Waiver) will also need to be tracked by participant. Agents will need to be able to identify both days and service costs for NFTI participants; this will allow the calculation of administrative costs for each day, and service costs (both detail by participant and summary by service) to count against the $100,000 grant. CIM will develop scripts to provide these reports.

D. Individual RUG Reports for NFTI Participants

The RUG Reports are available by specifying a Client ID, so they could be run for NFTI participants. The current version of RUG cost reports can only be run by Client Type, and since NFTI participants may include different type of clients it is not currently possible to run them as a group for only NFTI participants.

E. Individual Quality Indicator Reports

QI reports are available by Client Type, but since NFTI will be tracked using a referral source, the current version of QI reports cannot be run as a group for only NFTI participants. These reports can be run for individual NFTI participants.
The Nursing Facility Transition Initiative (NFTI) provides special services to participants who are establishing residence in the community after a nursing home stay. The NFTI programs need to be able to track both the traditional in-home services provided to participants, and the more specialized NFTI services. The following HCPCS codes and standard remarks will enable NFTI Agents to collect information about the specialized services in the MICIS Care Plan and Billing modules. Some of these codes have been added for the NFTI program, and others were already available for other programs.

<table>
<thead>
<tr>
<th>HCPCS Category</th>
<th>HCPCS Code</th>
<th>Standard Remark</th>
<th>Includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>99199</td>
<td>9908</td>
<td>Rent</td>
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<tr>
<td></td>
<td></td>
<td>9909</td>
<td>Security deposit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9910</td>
<td>Section 8 voucher</td>
</tr>
<tr>
<td>Household Supplies</td>
<td>99199</td>
<td>9009</td>
<td>Cleaning products, linens, towels, blanket, pillow, laundry basket, waste basket, vacuum, paper products, soap, toothbrush, toothpaste, etc.</td>
</tr>
<tr>
<td>Kitchen Supplies</td>
<td>99199</td>
<td>9009</td>
<td>Utensils, cookware, dishes, glasses, containers, small appliances, microwave, plastic wrap/foil</td>
</tr>
<tr>
<td>(same code as Household supplies)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td>99199</td>
<td>9013</td>
<td>Telephone, past due utility fees, electric, gas, cable</td>
</tr>
<tr>
<td>Furniture</td>
<td>99199</td>
<td>9014</td>
<td>Dining table and chairs, sofa, chair, end table, TV stand, bed, mattress, lamp</td>
</tr>
<tr>
<td>Groceries</td>
<td>99199</td>
<td>9015</td>
<td>Medication management, collection of NF medications, transfer of prescriptions to community drug store</td>
</tr>
<tr>
<td>Pharmacy Transfer</td>
<td>H2010</td>
<td>2000</td>
<td>Medication management, collection of NF medications, transfer of prescriptions to community drug store</td>
</tr>
</tbody>
</table>
The MI Choice Waiver Program is a 1915c Medicaid Waiver Program funded under Title 19 of the Social Security Act. Through this program, eligible adults who meet income and asset criteria can receive Medicaid-covered services like those provided by nursing homes, but can stay in their own home or another residential setting. Each participant can receive the basic services Michigan Medicaid covers, and one or more of the following services unique to the waiver: Homemaker services, Respite services, Adult day care, Environmental modifications, Transportation, Medical supplies and equipment not covered under the Medicaid State Plan, Chore services, Personal emergency response systems, Private duty nursing, Counseling, Home delivered meals, Training in a variety of independent living skills, Nursing Facility Transition Services.

It is not intended to be generalized to the larger nursing facility population given the relatively small number of participants in the program. It is limited to people in a select number of nursing facilities who indicated a desire to return to community living in two Michigan counties, Wayne and Kent. An expanded sample size of at least 300 participants would be necessary to present qualitative comparison data for the entire state of Michigan.

Frequency of Q1a in CY 2004 for only Kent and Wayne counties, July 2005, Michigan MDS repository, special report from the University of Michigan. Note that this includes both Medicare and Medicaid residents of Michigan nursing facilities.