

Long-Term Care in Motion: 2007 Annual Report of Wisconsin's Managed Long-Term Care Programs



Table of Contents

Executive Summary.....	4-5
Introduction.....	6-7
Figure 1: Managed Long-term Care Service Areas, 2007	8
Services Provided by the Family Care Programs	9
Figure 2: Explanation of Benefit Packages of the Three Programs	10
Expansion of Family Care	11
Table 1: Number of Members in 2007 by County	11
Figure 3: Managed Long-Term Care Implementation, 2008.....	12
2007 Highlights.....	13
Section 1: Member Profile	14
Figure 4: Total Active Members by Target Group.....	14
Table 2: Members Active on December 31, 2007, by Target Group.....	15
Table 3: Members Active on December 31, 2007, by Age Group.....	15
Figure 5: Members by Age Range.....	15
Member Profile: Current Living Arrangements	16
Figure 6: Living Arrangement for all Members Active on December 31, 2007.....	16
Member Story: Earl and Alyce’s Story from Community Health Partnership (CHP)	17
Member Profile: Health Status.....	18
Figure 7: Multiple Health Diagnoses among Members Active on December 31, 2007	18
Table 4: Most Common Health Diagnoses for Members on December 31, 2007	19
Member Profile: Employment Status	20
Figure 8: Employment Status of Members Active on December 31, 2007	20
Member Story: “Bob’s Story” from La Crosse County Care Management Organization.....	20
Section 2: Services Provided.....	21
Table 5: Number of Members who Received Care Management Services during 2007 by MCO.....	21
Figure 9: Members who Received Care Management by Target Group during 2007.....	22
Member Story: Desiree’s Story from Community Health Partnership	23
Table 6a: Top services Provided to Family Care Members during 2007	25
Table 6b: Top services Provided to Family Care Partnership Members during 2007	25
Living Situations	26
Table 7: Use of Purchased Residential Services during 2007.....	26
Table 8: Nursing Home Stays of 90 days or Longer for Members with Low Care Needs	26
Coordination of Health Services and Long-Term Care	27
Use of Informal Supports.....	28
Table 9: Use of Informal Supports with Members who Have at Least One ADL during 2007	28
Table 10: Use of Informal Supports with Members who Have at Least one IADL during 2007	29
Self-Direction of Services within Family Care Programs	30
Member Story: “Barbara’s Story” from Community Care, Inc.	31

Section 3: Results.....	32
Figure 10: Personal Experience Outcomes of Wisconsin's Long-Term Care Programs.....	32
Indicators Related to Health Status	33
Table 11: Preventable ER visits	33
Table 12: Preventable Hospital Admissions	33
Table 13: Proportion of Members with Current Immunizations.....	34
Figure 11: Percent of Family Care Partnership Members Who Had a Flu Immunization during 2007	35
Member Story: Char's Story from Community Care of Central Wisconsin.....	35
Indicators Related to Functional Status.....	36
Table 14: One-Year Changes in Need for Assistance with Activities of Daily Living by Target Group and Program	36
Table 15: One-year changes in Need for Assistance with Instrumental Activities of Daily Living by Target Group and Program	37
Desired Living Arrangements	38
Table 16: Percent of Members by Current and Preferred Living Situation on December 31, 2007	38
Changes in Members' Employment Status.....	39
Table 17: Changes for Employed Status of Family Care Program Members during 2007	39
Members' Satisfaction	40
Satisfaction Surveys.....	40
Disenrollment for Reasons Other than Death or Loss of Eligibility	41
Table 18: Members who Left the Program during 2007	41
Appendix 1— Footnotes, Information on Data Used in Report, and Sources of Additional Information	42
Appendix 2 —Focus on the Frail Elder Target Group.....	44
Appendix 3—Focus on the Developmental Disabilities Target Group.....	51
Appendix 4—Focus on the Physical Disabilities Target Group	57
Appendix 5—Additional Data on Members with Mental Health/Substance Abuse Issues ..	65
List of Current Family Care, Partnership and PACE Managed Care Organizations	71

Executive Summary

Welcome to the first annual report to the public on the managed long-term care programs in Wisconsin. We are eager for you to read this report and learn how Family Care Programs are providing long-term care options to Wisconsin's frail elders and residents with developmental and physical disabilities. The programs described in this annual report — Family Care, Family Care Partnership and PACE — provide care management and other Medicaid-funded in-home and residential long-term care services to adults with physical or developmental disabilities and to frail elders, along with some additional Medicaid-funded health care services. The Family Care Partnership and the PACE programs also provide Medicare-funded health care and long-term care services to their members.

Wisconsin has long been recognized as a national leader in developing flexible and creative community supports for older persons and persons with disabilities. With the extensive involvement of citizens with physical disabilities, developmental disabilities or those who are elderly and their representatives, the Wisconsin Department of Health Services developed a long-term care system that was piloted and demonstrated by county and private agency Managed Care Organizations (MCOs) in a limited number of Wisconsin counties in the late 1990's. The Family Care programs were developed with four specific goals:

- Provide people with improved options from which to choose where they live and what kinds of services and supports they receive to meet their needs;
- Improve access to services
- Improve quality through a focus on health and social outcomes and
- Create a cost-effective system for the future.

2007 was the first year for Family Care expansion. The expansion goal is to have the Family Care programs available to every eligible resident of the state.

This annual report focuses on the activities and the quality care that the members of the managed long-term care programs are receiving. This report includes:

- Description of the programs' current population (members active on December 31, 2007);
- Details on the types and amounts of services delivered to Family Care members between January 1, 2007 and December 31, 2007; and
- Review of some of the key results for members during one year in Family Care.

During the development of Family Care, one of the most frequently repeated comments from advocates and people with physical disabilities, developmental disabilities or those who are elderly was that people wanted to remain in their own home as long as possible. This is consistent with current public policy that with proper supports, frail elders, people with developmental disabilities and people with physical disabilities can live in their own homes and experience an improved quality of life. The Family Care Programs have focused on providing services that enable people to remain in their own homes and allows people who are hospitalized or in a nursing home to return home more quickly. This is accomplished by the interdisciplinary team following the member wherever they are being served. The report will provide data on how the Family Care programs have provided members with improved options from which to choose where to live. The data in the reports highlights that the majority of the Family Care programs' members prefer to live in their homes and 97% of the members who are currently living in their homes, list their home as their preferred living setting. Across the Family Care programs, 82% of the members are living in their preferred living setting.

The report also highlights that the members in the Family Care programs have more access to visit their primary care physicians, allowing for prevention and early intervention health care services to be provided. Providing preventable and early intervention health care services reduces the amount of high-cost preventable emergency room visits. The available data from the Family Care programs reports that only a small percent of members went to the emergency room or were admitted into a hospital for a preventable condition for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

Along with descriptions of the programs' members, services and results, this report includes stories and quotes from actual members. The MCOs that administer Family Care programs contributed stories about their members, and the members themselves provided comments in satisfaction surveys. These stories and quotes are real, and show how Family Care programs are improving member's lives.

The 2007 year was a successful one on many levels but most importantly staff from the Department of Health Services and the Managed Care Organizations worked together to provide quality managed long-term care programs to over 13,000 members.

We expect to release the annual report describing 2008 activities and accomplishments in Spring 2009, and annually thereafter. We believe these annual reports will provide Family Care stakeholders with the information they need to remain informed participants in helping to pursue the important missions of these programs.

Introduction



Pictured left to right, Fredi-Ellen Bove, Interim DLTC Administrator; Karen Timberlake, Secretary of Department of Health Services; Sinikka Santala, former DLTC Administrator; and Judith Frye, Office of Family Care Expansion Director

The three managed-care programs included in this report—Family Care, Family Care Partnership and PACE (Program for All-Inclusive Care for the Elderly)—focus on achieving four specific goals:

Provide people with improved options from which to choose where they live and what kinds of services and supports they receive to meet their needs;
Improve access to services;
Improve quality through a focus on health and social outcomes; and
Create a cost-effective system for the future.

The Family Care programs serve members who meet the nursing home level of care. This means that a member's health care needs usually require nursing home placement, although the majority of the members were not admitted into a nursing home during 2007. Members must be eligible for Medicaid and meet one or more of Family Care's target groups. The three target groups are:

Frail Elderly (65 years or older, except in Milwaukee County¹)
Adults with Physical Disabilities (18 or older)
Adults with Developmental Disabilities (18 or older)

In the body of this report, most tables present information for the programs' membership as a whole. Information targeted specifically on each of the three target groups is included in appendices. While the Family Care programs are not designed as mental health or substance abuse treatment programs, and individuals are not eligible for the program if they do not meet statutory criteria for one of the three target groups above, a final appendix focuses on those members who also have mental health and substance abuse issues.

A short history of long-term care options in Wisconsin

Wisconsin began innovating with long-term care options in 1981, with the inception of the Community Options Program. Over the next decade, the Department created additional fee-for-service home- and community-based services programs for frail elders and adults with disabilities. This decade also saw the development of the first managed-care program of long-term care services, the Program of All Inclusive Care for the Elderly (PACE), which served frail elders in Milwaukee County. In the early 1990's, the Department worked with the University of Wisconsin and other leaders in the state's disability community to develop a demonstration program to explore the possibilities of integrating the delivery of Medicaid- and Medicare-funded long-term care and medical care for frail elders and adults with physical disabilities. This program 'Partnership,' began operations in 1995, and operated at four sites.

Still, by the early 1990's, Wisconsin was spending 50% more than the national average for each Medicaid-eligible elderly person. Access, choice and quality in the home and community-based services were not consistent from county to county, for both elders and adults with disabilities. Entitlement to nursing-facility care and long waiting lists for community care kept many eligible people inside nursing facilities or waiting with their families with inadequate care.

When individuals did obtain services, the choice of services was often dictated by a confusing and intimidating system of public programs. More than 40 public programs provide funding for long-term care, each with a different set of eligibility criteria and covered services. Responsibility and authority for the evaluation, delivery and payment of long-term care services was fragmented—resulting in inconsistency, sometimes-conflicting rules, and incentives for cost shifting. Decisions on whether to authorize individual services for individual people were often reviewed, or even made, at the state level rather than close to consumers.

To address access and information issues, the Long-Term Care Redesign Task Force in 1998 proposed the creation of Aging and Disability Resources Centers (ADRCs) to inform individuals seeking long-term care about their options and to help them get enrolled with those programs they choose. By November 2008, 28 ADRCs were operating to serve the people of 38 counties.

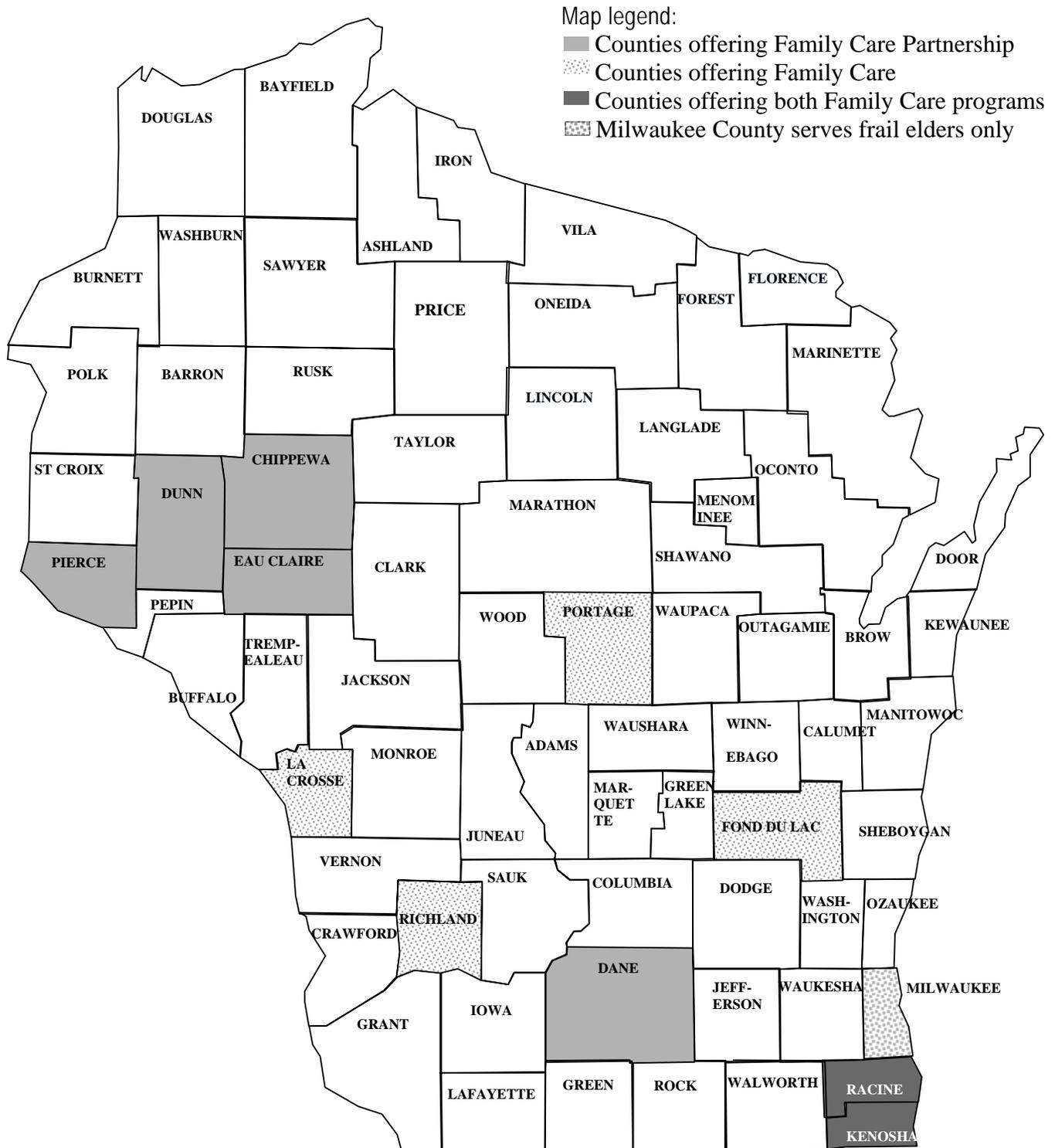
The Task Force also recommended creation of a system of managed long-term care, in which managed-care organizations (MCOs) would deliver a well-coordinated package of services, drawn from an extensive array of benefits, for every frail elder or adult with physical or development disabilities needing long-term care. This report describes the current state and performance of those programs—the Family Care Programs.

The Family Care Programs—PACE, Partnership, and Family Care—differ from traditional home and community-based long-term care programs in several ways. The Family Care Programs provide long-term care where the member lives. Members do not lose their relationship with their care management team when they enter a nursing facility. The team continues to monitor the quality of care and helps the member return to the community, if the member wants to return.

The managed-care payment arrangement is also different than the fee-for-service system. Fee-for-service programs pay providers based on the amount or cost of service provided, which creates a built-in incentive for providers to provide more, or more expensive care and which minimizes or eliminates financial incentives for preventive care, effective care, or economical services. In managed care programs, the State Medicaid program provides the MCO with a flat monthly payment for every member—or 'capitated rate.' This amount is more than the cost of some member's services, but less than the cost of other member's services, but the total amount paid to the MCO is actuarially determined to be sufficient for cost-effective care. This payment system transfers financial risk from the State, which cannot determine cost-effectiveness of each purchase decision on the basis of the member's individual circumstances, to the MCO, which can. This payment arrangement provides incentive for the MCO to create care plans that are both effective—so that the MCO can prevent the need for additional, avoidable, or unnecessary services—and economical.

¹ Milwaukee County serves frail elders, only (age 60 or older)

Figure 1: Managed Long-Term Care Service Areas, 2007



Services Provided by the Family Care Programs

The Department contracts with the Family Care MCOs to provide Medicaid-funded long-term care services arranged by an interdisciplinary care team. In addition, FC-Partnership, formerly known as the Wisconsin Partnership Program, and PACE provide their members with Medicare and Medicaid-funded health and long-term support services in a single comprehensive health plan.

Figure 2 includes information on the benefit packages of the three programs.

The Family Care programs are Wisconsin's flexible health and long-term care programs. The programs are voluntary and offer increased consumer choice, improved access to services, and improved quality through a focus on health and personal outcomes. Long-term care consists of services and supports that people need to meet their daily needs. These services and supports include: assistance with activities of daily living such as eating, bathing, or using the telephone; home visits from nurses; home-delivered meals; home modifications; nursing home care; and case management. Many Wisconsinites take advantage of these supports and services, but over 11,000 others are waiting to receive them.

The services and supports that the members receive from the MCO are selected to help the member achieve his/her desired results, or 'outcomes.' The outcomes of long-term care can be put into three general categories: clinical outcomes, functional outcomes, and personal-experience outcomes.

Neither clinical nor functional outcomes are unique to long-term care. **Clinical outcomes** are results that can be measured in terms of improving or maintaining health. Getting high blood pressure under control, healing from a broken hip, or staying healthy through flu season are examples of clinical outcomes. **Functional outcomes** are results that can be measured in terms of improving or maintaining a person's ability to do things safely and independently. Functional outcomes include some basic activities of daily living, such as bathing and eating, and other more complex activities, such as getting and keeping a job.

Personal-experience outcomes are less familiar as the identified purpose of programs such as Family Care than are clinical or functional outcomes. Because the quality of long-term care affects people day in and day out for their entire lives, it affects nearly everything about member's quality of life—where they live, in which social activities they can participate, how and when they go to church or shopping—just about everything. Personal-experience outcomes are subjective and more difficult to measure than clinical or functional outcomes. For example, a clinician can determine by observation whether a person has achieved the functional outcome of being able independently to ride a bus, but only the person can say where he or she wants to go, when, and whether the outing contributed to the quality of his or her life.

From the *initial assessment*, in which care managers begin to understand the outcomes that each member considers important to his or her quality of life, through quality reviews that attempt to determine whether services were successful, all activities in Family Care are intended to support one or more outcomes for the members. More information on outcomes is included in Section 3 of this report, *Results*.

Figure 2: Explanation of Benefit Packages of the Three Programs

Family Care Partnership & PACE (Program of All Inclusive Care for the Elderly) (The difference between PACE & Partnership is that Partnership has a drug co-pay & PACE does not.)		
Home and Community Based	Family Care	Medicaid Card Services - LTC services
Medicaid Card Services - Acute/Primary		Medicare Card Services
Adaptive Aids (general and vehicle) Adult Day Care Care/Case Management (including Assessment and Case Planning) Communication Aids/Interpreter Services Community Support Program Consumer Education and Training Counseling and Therapeutic Resources Daily Living Skills Training Day Services/Treatment Home Modifications Housing Counseling Meals: home delivered Personal Emergency Response System Services Prevocational Services Relocation Services Residential Services: Certified Residential Care Apartment Complex (RCAC) Community-Based Residential Facility (CBRF) Adult Family Home Respite Care (for care givers and members in non-institutional and institutional settings) Supported Employment Supportive Home Care Vocational Futures Planning	Alcohol and Other Drug Abuse Day Treatment Services (in all settings) Durable Medical Equipment, except for hearing aids and prosthetics (in all settings) Home Health Medical Supplies Mental Health Day Treatment Services (in all settings) Mental Health Services, except those provided by a physician or on an inpatient basis Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease) Nursing Services (including respiratory care, intermittent and private duty nursing) and Nursing Services Occupational Therapy (in all settings except for inpatient hospital) Personal Care Physical Therapy (in all settings except for inpatient hospital) Specialized Medical Supplies Speech and Language Pathology Services (in all settings except for inpatient hospital) Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except Ambulance and transportation by common carrier) and non-Medicaid covered.	Medicare Part A (Hospital) Medicare Part B (Medical) Medicare Part D (Prescription Drugs) Ambulance services Ambulatory surgical centers Anesthesia Blood Bone mass measurement Durable medical equipment, supplies and prosthetics Cardiac rehab Chiropractic services Diabetes supplies Diagnostic tests, x-rays and lab services Physician services Emergency and urgent care services Home health care in certain situations Hospice care Inpatient hospital care Inpatient mental health care Outpatient mental health care Outpatient hospital services, including outpatient surgery Limited skilled nursing facility care Physical/speech/occupational therapy Podiatry services Prescription drugs, including drugs covered under Medicare Part A, Part B, and Part D Partnership has a small drug co-pay, PACE has no co-pay Certain preventive tests Certain dental, hearing and vision services Respite care Substance abuse treatment (outpatient)

Expansion of Family Care

Beginning in January 1999, Partnership sites offered services in Eau Claire, Dunn, Chippewa, Dane, and Milwaukee counties. The five Family Care pilot counties—Fond du Lac, La Crosse, Milwaukee, Portage, and Richland—began serving members in 2000 and 2001. In Governor Doyle’s 2006 State of the State Address, he announced his goal to expand the Family Care program statewide over the next five years. Planning for expansion began immediately; ten consortia of counties and their planning partners were awarded expansion planning grants in early 2006.

In 2007, Kenosha and Racine were the first two expansion counties; their addition increased the total number of counties in which Family Care programs operate to eleven and enrollment in the programs had grown to over 13,000 members. Table 1 shows the enrollment breakdown by county. When Family Care programs are in all 72 counties, they are expected to serve more than 53,000 members.

Since then, Family Care has steadily grown in Wisconsin. By the end of 2008, residents in 25 counties containing 46 percent of Wisconsin’s eligible people will have access to Family Care programs. As the Family Care programs expand statewide, eligible county residents will be able to enroll in a program. With each expansion county, the first priority is to provide services to existing waiver clients and then end the waitlist within the first 24 months.

Family Care programs help members live more independently and access the services and supports they need, and members tell the Department it improves their overall quality of life. We are excited to offer these programs to Wisconsin residents and look forward to the day when these programs are available statewide, without waiting, to all eligible Wisconsin residents.

Table 1: Number of Members in 2007 by County

County	Family Care	Partnership/ PACE
Chippewa		333
Dane		1,213
Dunn		301
Eau Claire		987
Fond du Lac	1,194	
Kenosha	827	15
La Crosse	2,073	
Milwaukee	7,545	1,122
Portage	1,095	
Racine	752	154
Richland	423	
Total	13,909	4,125

“Since I’ve been a member of CHP I have a calmer life, and better overall health. My seizures have been reduced to one or two in 7.5 years. I have less panic attacks.”

- Response from the 2007 Member Satisfaction Survey
-

2007 Highlights

The Family Care programs have been serving Wisconsinites for approximately 13 years. 2007 was the first year of expansion activities and brought about many quality initiatives. Kenosha and Racine were the first two expansion counties in 2007. Their addition increased the total number of counties in which Family Care programs operated to eleven. Family Care programs will serve over 53,000 members when they are operating in all 72 counties.

As the Family Care Programs expand statewide, eligible county residents will be able to enroll in a program. With each expansion county, the first priority is to provide services to existing waiver clients and then end the waitlist within the first 24 months. During the first twelve months in operation, the Managed Care Organization (MCO) in Kenosha and Racine Counties served:

- 202 individuals from the counties' waitlists;
- 1,184 individuals who were previous county waiver clients;
- 173 individuals who were Medicaid fee-for-service only clients; and
- 71 individuals who were previously not receiving any public long-term care services.

The MCO in Kenosha and Racine Counties is on target to end the county waitlist by the end of 2009.

Highlights of improvement initiatives:

- In 2006, the first Pay for Performance (P4P) initiative began. The P4P initiative attempts to reimburse or reward the managed care organizations for meeting specific quality standards. The 2006 Diabetes Pay for Performance was concluded and evaluated in 2007. The P4P concluded with all participating Family Care managed care organizations achieving the target level of hemoglobin HA1-c tests for their members with diabetes. Eighty-eight percent of all diabetics in Family Care received hemoglobin HA1-c tests, which is consistent with the rate of testing among all Wisconsin Medicaid managed care organizations. Diabetes was selected for the first P4P because diabetes is a major health issue that impacts roughly one-third of total Family Care membership. The Diabetes P4P evaluation also provided evidence that all participating Family Care managed care organizations improved the control of diabetes among their members with diabetes enrolled for two or more years. Also, three of the five participating Family Care managed care organizations saw reductions in avoidable hospitalizations and emergency room visits among their diabetic members.
- In December 2006, DHS awarded a contract to the University of Wisconsin-Madison to develop a tool for interviewing people to identify their individually-desired outcomes and for assessing whether they are present, supported and achieved. This project is known as the PEONIES Project (PEONIES stands for Personal Experience Outcomes iNtegrated Interview and Evaluation System). When completed, the PEONIES interview tool will be used by DHS' external quality reviewers and will be made available for use by managed care organizations and long-term care waiver programs.
- In May 2007, the Managed Care and Employment Task Force (MCETF) was convened by the Division of Long-Term Care and charged with recommending a comprehensive strategy to expand work options for adults who rely on the community-based, long-term care system. The Task Force, composed of 28 members representing a wide range of interests and expertise, analyzed the challenges and identified best practices from Wisconsin and elsewhere for overcoming these challenges. Among the best practices used consistently in other high-performing states is the existence of a state long-term care agency policy on employment.

Section 1: Member Profile

To be a member of a Family Care program, a person must have a disability: a significant limitation in his or her ability to perform basic activities of daily living. Eligibility for Family Care programs is limited to three ‘target groups’ or categories of people with disabilities: frail elders, adults with physical disabilities, and adults with developmental disabilities. ¹Not all people with disabilities are eligible for Family Care Programs: for example, the Program does not serve children under the age of 18. Although the Family Care Programs do not serve the mental illness target group, up to two-thirds of the Family Care members have a mental illness but their main diagnosis is within one of the three target groups.

Frail elders are individuals 65 and older who have serious and long-lasting physical health problems or dementia. Conditions that are common among Family Care’s frail elders are diabetes, disabling arthritis, congestive heart failure, cancer, Alzheimer’s, and the effects of a stroke. The person must be unable, without help from another person, to perform one or more necessary activities of daily living such as dressing, bathing, eating, toileting, mobility, ability to cook meals, manage medications or manage money.

Family Care members with **physical disabilities** are adults who have a physical problem or condition that significantly limits their ability to care for themselves. Typical disabling conditions include amputations or paralysis as a result of accidents or disease; multiple sclerosis, chronic obstructive pulmonary disease and traumatic brain injuries. As with the frail elders, the person must need help from another person to complete one or more activities necessary for daily life.

Family Care members with **developmental disabilities** are adults who had onset of the disabling condition before the age of 22 and have severe cognitive or physical functioning that significantly limits their ability to care for themselves. Some common disabling conditions include intellectual disability, cerebral palsy and epilepsy. The person must also have substantial functional limitations in at least three of the following areas: learning, use of language, self-direction, mobility, self-care (bathing, dressing, eating, etc.) or the ability to live independently without help from another person.

Finally, Family Care Program members are all financially eligible for Medical Assistance. That is, people are eligible for Family Care Programs only when they lack the financial resources to be able to afford the medical care that they need. Many Family Care Program members ‘spend down’ to Medicaid eligibility by paying for their own health and long-term care until they exhaust their private funds and became eligible for Medicaid.

²Precise requirements for functional eligibility for Family Care can be found in Wisconsin statutes s.15.197(4)(a) 2 and s.15.197(4)(a)1, and in Wisconsin Administrative Code HFS 10.13(25m).

Figure 4: Total Active Members by Target Group

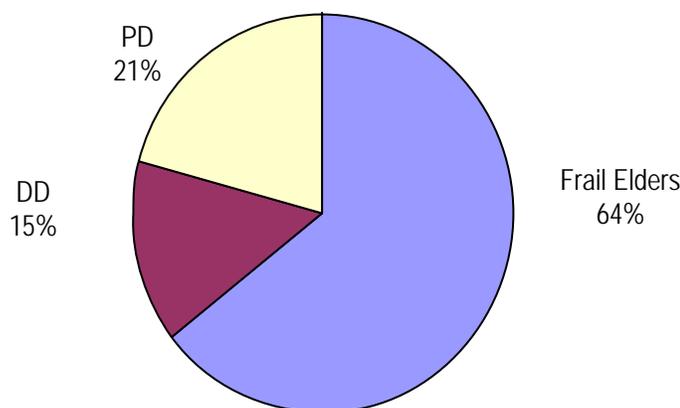


Table 2: Members Active on December 31, 2007, by Target Group

MCO and Program	Frail Elder	Members with Developmental Disabilities	Members with Physical Disabilities
Milwaukee - Family Care	5,418	203	790
Fond du Lac - Family Care	485	374	169
Portage - Family Care	472	265	215
Richland - Family Care	177	117	81
La Crosse - Family Care	696	581	543
CCI - Family Care	420	718	326
CCI - Partnership/PACE	822	19	261
Care Wisconsin - Partnership	611	7	79
CLA—Partnership	30	7	331
CHP - Partnership	878	62	473
All MCOs	10,009	2,353	3,268

Source: Each member’s most recently completed functional screen as of December 31, 2007.

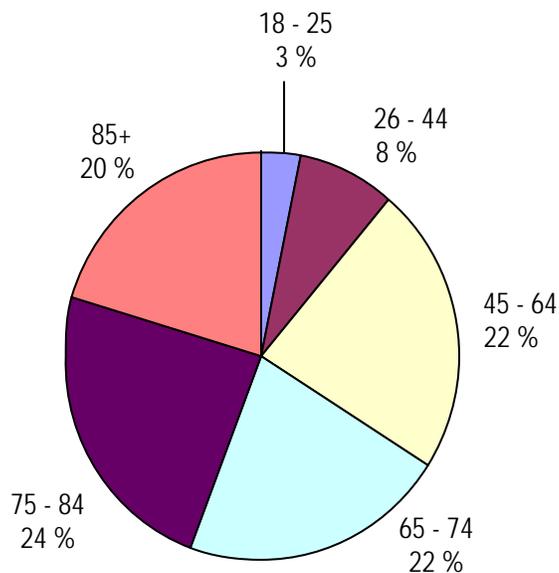
Note: The Milwaukee County Family Care Program, operated by the county’s Department of Aging, serves people with disabilities over the age of 60, while other MCOs serve adults 18 and older, considering those 65 and older to be frail elders. For comparability within this table, frail elders in all MCOs are those who are 65 and older, and Milwaukee members between the ages of 60 and 64 are reported as members with either developmental or physical disabilities.

Table 3: Members Active on December 31, 2007, by Age Group

Age Range	No. of Family Care Members	No. of Partnership Members	Total
18-25	477	27	504
26-44	1,129	166	1295
45-64	2,509	1,012	3521
65-74	2,659	727	3386
75-84	2,880	881	3761
85+	2,421	778	3199
Total	12,075	3,591	15,666

Source: DHS enrollment records.

Figure 5: Members by Age Range



Member Profile: Current Living Arrangement

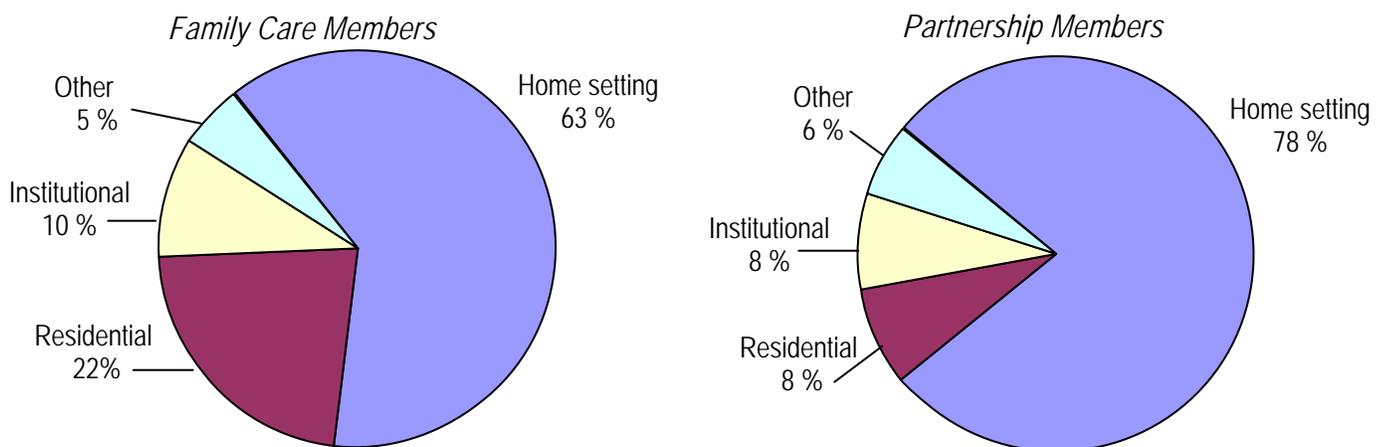
The proportion of active members who were living outside residential care facilities confirms the national and Wisconsin public policy that with proper supports, frail elders, people with developmental disabilities and people with physical disabilities can live in their own homes and experience an improved quality of life and life choices. The Managed Care Organizations work to assist members who prefer to live in a home setting by providing the right services and supports to maintain the desired living arrangement.

Figure 6 displays the percentages of members by living arrangement on December 31, 2007.

In 2007, Partnership had a higher percentage of members in home settings because, unlike Family Care, the program could request not to enroll individuals who were currently residing in nursing homes or other residential settings. This Medicaid regulation was changed on January 1, 2008, and in future years, the mix of living arrangements used by the two programs' memberships will likely become more similar.

- A 'home setting' is the member's own home or apartment, or the home or apartment of the member's family
- 'Residential' is an adult family home, a residential-care apartment complex, or a community-based residential facility, as these facilities are defined in Wisconsin Administrative Code.
- 'Institutional' is a nursing home, an intermediate care facility for people with developmental disabilities, or a swing bed.
- The 'Other' category includes settings such as temporary living arrangements, hospices, jails, or homeless shelters. Due to uncertainty regarding the nature of certain living arrangements, occasionally screeners inflate the number of people reported to be living in these 'other' arrangements.

Figure 6: Living Arrangement for all Members Active on December 31, 2007



Source: Each member's most recently completed functional screen.

Member Story: Earl and Alyce’s story from Community Health Partnership (CHP)

Reprinted in part, with permission from Community Health Partnership’s *Empowering People to Live Independently*.



Like many farmers, Alyce and Earl figured they would rely on Social Security to pay for their medical needs in their retirement years, and use income from the sale of the land to meet other expenses.

It hasn’t worked out that way however. Alyce has diabetes, and Earl takes medications to slow the progress of his memory loss and confusion. Both have hearing problems.

“Our Social Security wasn’t covering our medical needs. We didn’t have enough to live on,” explains Alyce. In 2001, one of their daughters helped them contact Community Health Partnership representatives. “We qualified

and we joined,” says Alyce.

Although financial concerns first brought them to CHP, other services help them continue to live independently in the farmhouse they’ve shared for some 60 years. Alyce welcomes the help cleaning the house every other week. At age 84, she says she doubts she could do the job herself. CHP staff members help them coordinate their medical care and provide some in-home services, such as checks of Earl’s memory, trimming toenails, checking blood pressure, and reviewing medications. Alyce is grateful that CHP handles their medical paperwork and keeps them notified of changes in Medicare and other programs. “We don’t have to worry about it,” says Earl.

CHP also has arranged for Earl and Alyce to have access to a personal emergency alert response system. If they have a health care emergency, they can push a button and a message is relayed to personnel at a medical call center. If they are not able to communicate with a responder, their children are notified.

As Earl’s memory loss progressed, Alyce realized she needed to learn how to better care for him—and herself. She attended a caregiver’s workshop put on by CHP staff. “It was a good learning session for me,” says Alyce.

Member Profile: Health Status

The Family Care programs are entitlement programs, which means an eligible person cannot be denied enrollment into a MCO due to health reasons or capacity issues. Also a current member cannot be encouraged to leave the program due to health reasons.

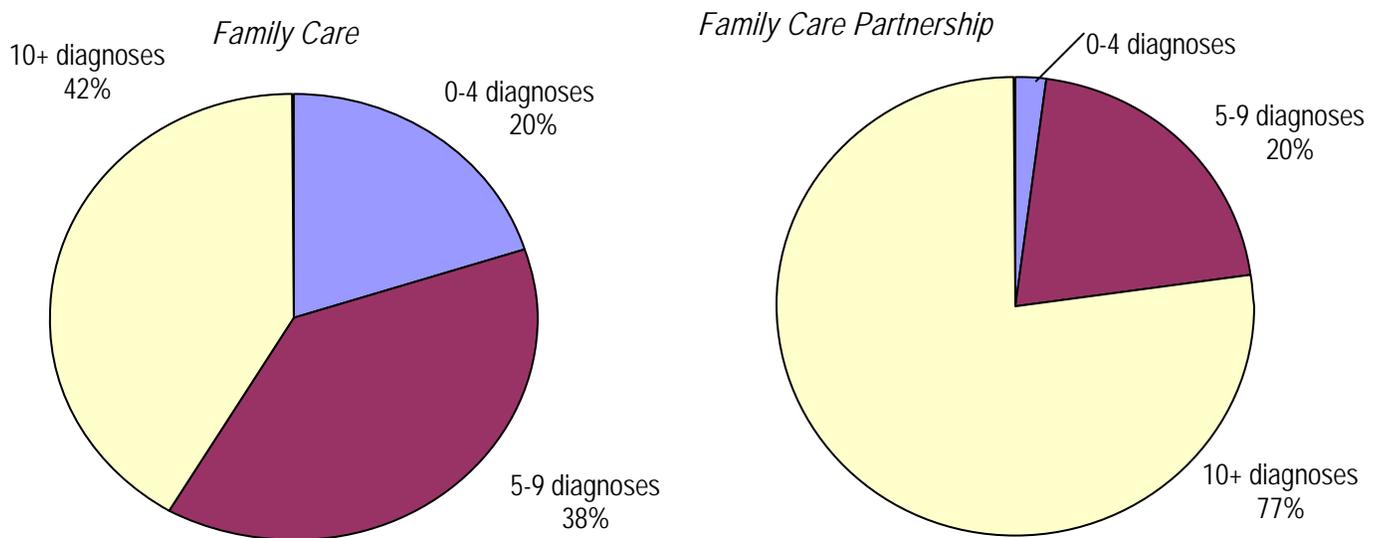
Frail elders and adults with physical or developmental disabilities present a wide variety of sometimes-complex medical conditions. While every member is unique, a few common medical conditions can be found among Family Care members. Two examples that describe members with physical disabilities include, younger adult men who experienced severe trauma from motor vehicle accidents or other mishaps. These members may have a spinal cord injury and paralysis, often conditions are accompanied with depression. The other example for members with physical disabilities are middle-aged women with a complex mix of auto-immune, metabolic, and nervous-system disorders, frequently accompanied by depression.

Two examples for members with developmental disabilities, include the middle-aged relatively physically healthy individuals with disorders such as Down's Syndrome who need continual support with the activities of daily living. Another example would include members with developmental disabilities who have very complex disabilities that significantly impair their physical health and require near-total care.

Finally, the frail elders among Family Care members include individuals of extremely advanced age—in 2007, 46 Family Care and 15 FC-Partnership members were 100 or older—whose physical health needs are continuous and often complex. Other elders in Family Care are younger—still in their 60's—but impaired by varying degrees of irreversible dementia.

The majority of member have more than one health diagnosis as detailed in Figure 7. While the diagnoses listed below were not necessarily the conditions that made the members eligible for a Family Care program, the MCOs are responsible for providing the proper services and supports to help the member control his/her health and remain as active and healthy as possible.

Figure 7: Multiple Health Diagnoses Among Members Active on December 31, 2007.



Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 4 lists the most common diagnoses for members active in December 2007. The most common diagnosis, affecting almost two-thirds of Family Care members, was hypertension. For more specific diagnosis breakdowns see the appendix for each target group.

Table 4: Most Common Health Diagnoses for Members on December 31, 2007
Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.

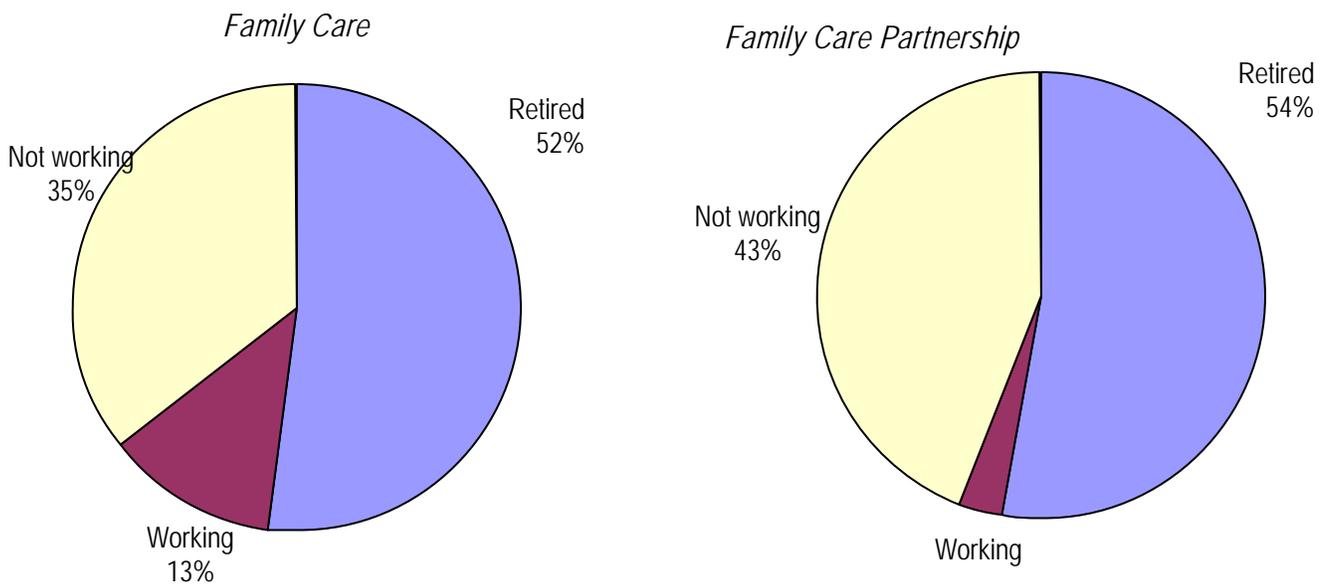
Common Health Diagnoses	FC	FC-Partnership
Allergies	17.9%	27.1%
Alzheimer Other Dementia	23.9%	26.5%
Anemia/Coagulation Defects	16.8%	33.8%
Angina/Coronary Artery Disease	23.4%	37.5%
Anxiety Disorder	19.5%	34.2%
Arthritis	55.3%	66.3%
Asthma	24.8%	38.6%
Blood/Lymph Disorders	14.8%	36.1%
Cancer	11.1%	14.4%
Cerebral Vascular Accident	16.4%	19.1%
Chronic Pain/Fatigue	35.6%	50.1%
Congestive Heart Failure	16.8%	25.1%
Dehydration/Fluid Imbalance	4.5%	12.3%
Depression	34.6%	55.2%
Diabetes Mellitus	32.7%	39.1%
Digestive Disorders ³	43.9%	72.3%
Disorders GU System	21.5%	41.8%
Heart Rate Disorders	14.4%	25.3%
Hip/Bone Fracture	28.5%	39.0%
Hypertension	62.7%	76.9%
Hypo/HyperThyroidism	16.9%	21.5%
Intellectual Disability	18.2%	1.5%
Nerve Disorders ⁴	20.8%	39.4%
Nutritional Imbalances	40.0%	65.3%
Osteoporosis	15.8%	28.7%
Other Diagnoses	19.4%	47.4%
Other Heart Conditions	11.2%	22.3%
Other Mental Illness	8.6%	12.0%
Other Sensory Disorders	14.2%	21.4%
Renal Failure/Kidney Disease	12.0%	27.0%
Respiratory Disorder	15.6%	29.5%
Skin Diseases	6.8%	20.3%
Urinary Tract Infection	8.2%	15.1%
Visual Impairment ⁵	36.0%	49.1%

Source: Each member's most recently completed functional screen as of December 31, 2007.
Footnotes on page 42.

Member Profile: Employment Status

When employment is an outcome desired by a member, the Managed Care Organization’s care teams work with the member to provide the opportunity to explore employment options and identify employment possibilities. Care plans can include a mix of employment and non-employment activities that reflect an individual’s needs and preferences. Family Care Programs include a comprehensive and integrated set of services, including vocational services for all populations, transportation, and personal care services in the workplace. The Managed Care Organizations are responsible for developing provider capacity in all service areas and have the flexibility to structure their contracts and relationships with providers in creative ways that will help expand and support integrated employment.

Figure 8: Employment Status of Members Active on December 31, 2007



Source: Each member’s most recently completed functional screen as of December 31, 2007.

Member Story: “Bob’s Story” from La Crosse County Care Management Organization

“Bob” is a young man who is cognitively delayed and has visual impairments. Bob has worked in several jobs over the last few years, but has had trouble finding a job that was the right fit. Working with a Managed Care Organization’s employment vendor, Bob was successful in gaining employment with a local chain grocery store as a bagger and cart retriever. Initially he had difficulty with bagging techniques and speed and would become overwhelmed. Job coaches supported Bob by demonstrating proper bagging or watching and offering direction. Also Bob and the coach arrived early to the shift to watch other baggers while the coach narrated proper techniques. Bob has natural supports as well, because the cashiers are always willing to help when they can.

Bob has gained confidence over the months and likes his job. His employer remarked that he is a “great employee, he is always looking for things to do.” At Bob’s three-month review he earned a \$.15 raise and was complimented for his “excellent customer service and punctuality in showing up for work.” Bob’s review also stated that he has a “great attitude and is very upbeat.” Bob now works approximately 20-25 hours a week, and has maintained his employment for eight months.

Section 2: Services Provided

The Family Care Programs are designed to provide cost-effective coordination of long-term care services and health care by providing members access to a single flexible benefit package that includes a large number of health and long-term care services, which otherwise would be available only through separate programs. Every Managed Care Organization can offer its members access to residential long-term care, the same type of long-term care services as those offered by the Home and Community-Based Waivers, and the same wide variety of supports as those offered by the state-funded Community Options Program. The Partnership and PACE Programs provide its members with acute and primary health care services, such as physician visits, emergency room services and hospital services, while the Family Care Program coordinates its members' long-term care with the health care that the members receive from fee-for-service providers. Managed Care Organizations receive a monthly per person payment, called capitation, to manage and purchase care for their members.

The Managed Care Organizations assign a care team to each member. In Family Care, the care team includes the member and anyone else the member chooses, which could be a guardian, a family member or friend, or a professional ombudsman or advocate. The team also includes at least a registered nurse and a care manager assigned by the MCO. Other professionals such as an occupational or physical therapist, or mental health specialist, may be involved, depending on the member's needs.

Table 5: Number of Members who Received Care Management Services during 2007 by MCO

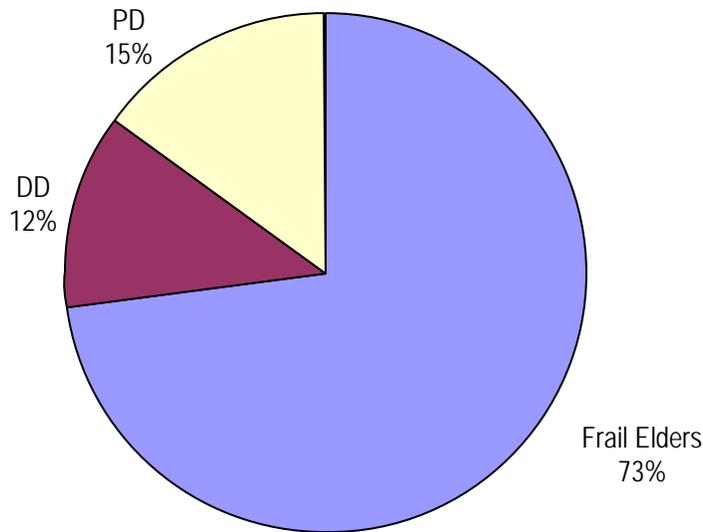
MCO and Program	Frail Elder	Members with Developmental Disabilities	Members with Physical Disabilities
Milwaukee - Family Care	6,485	214	829
Fond du Lac - Family Care	601	385	202
Portage - Family Care	564	286	244
Richland - Family Care	211	121	91
La Crosse - Family Care	836	601	629
CCI - Family Care	491	724	350
CCI - Partnership/PACE	1,101	15	165
Elder Care - Partnership	698	8	89
CLA - Partnership	28	10	374
CHP - Partnership	1,019	68	530
All MCOs	13,077	2,218	2,674

Source: Encounter data submitted by each MCO

"I receive great medical service and I'm able to stay at home with my sister. I'm able to live independently."

- Response from the 2007 Member Satisfaction Survey
-

Figure 9: Members who Received Care Management by Target Group during 2007



Source: Encounter data submitted by each MCO

Note: The number of members who received care management at any time during 2007 is larger than the number of members who were active on December 31, 2007, shown on previous tables, due to natural turnover—deaths and disenrollments.

“I have freedom from serious financial concerns and availability of medications. I have a more fulfilling life. I can get around easier with support from the program. My health has improved....”

- Response from the 2007 Member Satisfaction Survey
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In Partnership and PACE, the care team is the same as in Family Care, but also includes an assigned MCO nurse practitioner and the member’s primary care doctor. Usually the nurse practitioner communicates with the doctor, who may or may not attend the care plan meetings.

The job of the Family Care Programs care team is to work with the member to:

- Identify the clinical, functional and personal experience outcomes the member needs and wants.
- Develop a service plan that outlines the services and other help the member needs to achieve those outcomes.
- Make sure the services in the plan are actually provided.
- Make sure the plan continues to work for the member.

The first step the member’s care team completes is an assessment. The assessment is an ongoing process of identifying the real-life personal outcomes that matter to the member and his/her unique strengths and needs for support. During this process the member will tell his/her care team:

- What kind of life the member wants to live,
- Whether the member wants to live at home or in a different living situation, and
- What kind of support is needed to live the member’s desired life.

To complete the assessment, the care team must first know about the member's current situation, where the member lives, activities during the day and the health situation of the member. After the assessment is completed the care team will develop a member-centered plan and help the member move towards his/her personal outcomes. The plan must be clear about:

- What services and supports are needed to achieve the member's personal outcomes,
- Who is going to provide the member with each service or support, and
- When each service or support will be provided.

The member-centered plan should be both reasonable and effective. The care team will work with the member to find the best provider for each service or support. The provider could include a nurse, home health worker, or the member may do the activity by his/herself or with help from family or friends.

The Managed Care Organizations are responsible for helping members achieve their personal outcomes and for considering cost when deciding on services and providers. The care team and member will work through a series of questions to help identify the member's personal outcomes and to match the outcomes with the right services and supports. This process will find the most effective and cost-effective way to help the member achieve his/her personal outcomes.

The member-centered plan should be both reasonable and effective. Table 5 (on page 22) details the total number of members in 2007 that received the basic service of care management by MCO.

Member Story: Desiree's story from Community Health Partnership

Reprinted in part, with permission from Community Health Partnership's *Empowering People to Live Independently*.



It was November 20, 2001. Desiree went to bed with what she thought was the flu. When she woke up the next day, she was totally paralyzed and unable to speak. Local doctors ordered her to be air transported to Mayo Clinic in Rochester, MN, where she was a patient for approximately a month. After numerous medical tests, a specialist diagnosed her as having an autoimmune disorder of unknown case similar to only four known cases in the U.S. Following her stay at Mayo Clinic, she was in medical and rehabilitation facilities for about a year.

At age 25, Desiree is still recovering. She has trouble maintaining her balance and can lift only about 15 pounds. Her stamina is very limited. With the help of Community Health Partnership, Inc. (CHP) she lives independently in a small apartment. Without CHP's help, she says she would "probably be bankrupt and not walking." Because of CHP, she is able to get the pharmaceutical prescriptions she needs. She successfully completed a smoking cessation program and is benefiting from rehabilitation therapy. CHP helps her coordinate her health services, arranges transportation, helps her clean and maintain her apartment and serves as an information source.

Doctors have told Desiree that her recovery will take at least five years from the onset of the disorder and she's working hard to regain 100 percent of her mobility and strength. She receives physical therapy and is dedicated to a specialized exercise routine she can do in her apartment.

Members of her CHP team are accompanying her on outings so she can practice negotiating street curbs, reaching for items in a store, and pushing a shopping cart. It all works toward her goal of increasing her level of independence.

Table 6a: Top Services Provided to Family Care Members during 2007

The following tables contain information about the services provided to the 13,924 members for whom expenditures were reported for calendar year 2007.

	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care	980	7.0%	\$4,648,901	1.4%
Case Management	13,924	100.0%	\$48,472,175	15.1%
CBRF, AFH, RCAC	4,546	32.6%	\$110,827,374	34.5%
Community Support	22	0.2%	\$126,779	0.0%
Counseling and Therapeutic Resources	3,770	27.1%	\$2,365,179	0.7%
Daily Living Skills Training	803	5.8%	\$4,592,115	1.4%
Day Center Services Treatment	705	5.1%	\$5,248,450	1.6%
Day Treatment -Medical	53	0.4%	\$109,930	0.0%
Energy/Housing Assistance	330	2.4%	\$187,541	0.1%
Equipment and Supplies	9,948	71.4%	\$9,833,388	3.1%
Financial Management	2,234	16.0%	\$1,433,517	0.4%
Home Health/Nursing	2,354	16.9%	\$15,704,649	4.9%
Meals	3,008	21.6%	\$4,376,918	1.4%
Nursing Home/ICF-MR	2,452	17.6%	\$44,485,067	13.9%
Other LTC Services	795	5.7%	\$408,376	0.1%
Pre-Vocational	748	5.4%	\$4,850,526	1.5%
Recreational Activities	234	1.7%	\$58,103	0.0%
Respite	667	4.8%	\$2,067,982	0.6%
Supported Employment	654	4.7%	\$3,209,535	1.0%
Supportive Home Care	7,271	52.2%	\$50,333,821	15.7%
Transportation	6,964	50.0%	\$7,661,186	2.4%
Total unduplicated	13,924	Total	\$321,001,511	100.0%

Source: Encounter data submitted by each MCO

The distribution of services provided by Family Care Partnership from January 1, 2007 through December 31, 2007 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.

Table 6b: Top Services Provided to Family Care Partnership Members during 2007
The following tables contain information about the services provided to the 4,105 members for whom expenditures were reported for calendar year 2007.

Long-Term Care Services	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care/Day Center	1,077	26.2%	\$6,670,614	3.7%
Case Management	4,105	100.0%	\$18,767,402	10.3%
CBRF, AFH, GH	574	14.0%	\$17,327,205	9.6%
Consumer Directed Supports*	125	3.0%		
Equipment & Supplies	2,365	57.6%	\$6,047,521	3.3%
Home Health/Nursing	562	13.7%	\$1,343,993	0.7%
Meals	738	18.0%	\$303,182	0.2%
Nursing Home	875	21.3%	\$19,948,687	11.0%
Other LTC Services	4,105	100.0%	\$17,665,068	9.7%
Recreational Activities	212	5.2%	\$210,057	0.1%
Respite	14	0.3%	\$24,535	0.0%
Supportive Home Care	630	15.3%	\$1,738,543	1.0%
Transportation	3,350	81.6%	\$6,472,835	3.6%
Total LTC Service Costs			\$96,519,642	
Acute Care Services				
Anesthesia	4,009	97.7%	\$6,172,909	3.4%
Dental	2,613	63.7%	\$1,461,336	0.8%
E&M Care (Office calls, NH, Hosp Visits)	3,944	96.1%	\$5,755,232	3.2%
ER	1,853	45.1%	\$2,253,212	1.2%
Inpatient Hospital	1,298	31.6%	\$22,969,200	12.7%
Medications	4,039	98.4%	\$18,374,774	10.1%
MH & AODA Outpatient Therapy	1,184	28.8%	\$993,525	0.5%
Nutrition Intervention/Counseling	1,215	29.6%	\$471,550	0.3%
Physician Pathology & Lab	3,850	93.8%	\$1,706,142	0.9%
Physician Radiology	3,337	81.3%	\$3,133,060	1.7%
Physician Surgery	4,046	98.6%	\$10,250,411	5.7%
Physician/other medical services	4,105	100.0%	\$11,270,187	6.2%
Total Acute Care Service Costs			\$84,811,538	

Notes:

*Consumer Directed Supports started in Partnership in late 2007 & has minimal history.

A portion of some long-term care services are paid as an acute care service. A good example is a nursing home stay for rehabilitation. A portion of some acute care services are paid as long-term care services. A good example is the inpatient hospital deductible.

Living Situations

The Family Care Programs support the current public policy that with proper supports, frail elders, people with developmental disabilities and people with physical disabilities can live in their own homes and experience an improved quality of life and life choices. Living at home is not possible or preferred by all the Family Care Program members but the MCOs will work with members who have identified living at home as a personal outcome. The care team and member will work to find services and support to help the member live as independently as possible.

Table 7 details the percentage of eligible days in natural settings (non-purchased home or apartment) versus the percent of days members spent in purchased residential settings (AFH, RCAC, CBRF, ICF-MR, nursing homes and other institutions).

On average, the Family Care members spent 65% of eligible days in natural settings versus purchased residential care during 2007. There are variations between the MCOs, which can be due to the differences in members, member preferences and availability of providers in their area.

Table 8 illustrates one way that utilization of residential services can be reviewed. Members with relatively low care needs can almost always be served in community settings, and yet a small number can be observed with relatively lengthy (90 days or longer) stays in nursing facilities. Information like this helps the Department and the MCOs study and manage utilization of such services.

For all Family Care Programs, the majority of the members were never admitted into a nursing home during 2007. Nursing homes are an important part of the long-term care system for short-term stays, rehabilitation services and members who have complex needs that cannot be safely provided for at home, and people who prefer to live in a nursing home. The Family Care Programs provide wellness and prevention services and supports to reduce the need for nursing home stays or reduce the amount of days of a stay.

Table 7: Use of Purchased Residential Services during 2007
Percent of Total Member-Days Spent in Residential Settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	65.2%
Group residences	26.7%
Nursing facilities	8.2%
Total	100.0%
FC-Partnership	
Natural (non-purchased) residential settings	78.9%
Group residences	14.0%
Nursing facilities	7.1%
Total	100.0%

Source: Encounter data submitted by each MCO.

Table 8: Nursing Facility Stays of 90 Days or Longer for Members by Target Group with Low Care Needs

Family Care	Percent of Members in Target Group
Frail Elders	1.0%
Members with Developmental Disabilities	0.2%
Members with Physical Disabilities	0.5%
FC-Partnership	
Frail Elders	0.4%
Members with Developmental Disabilities	0.0%
Members with Physical Disabilities	0.3%

Source: Encounter data submitted by each MCO and member's Functional Screen data.

Coordination of Health Services and Long-Term Care

Another service provided to members by the MCOs is coordinating primary health care with long-term care.

Family Care Partnership MCOs provide both Medicare and Medicaid primary, acute, and long-term care for their members. A nurse practitioner is on every member's care-management team and provides some medical care and acts as a liaison with the primary care physician. In Family Care, which does not directly provide primary or acute medical care, nurses are assigned to each care-management team and coordinate care with the members' medical-care providers. Care team members often accompany the member to see their physician. This helps the member follow medical recommendations. In addition to assuring that people get the health and long-term care services in the Family Care benefit package, the care teams also help members coordinate all their health care, including, if needed, helping members get to and communicate with their physicians and helping them manage their treatments and medications.

An in-depth study of Family Care (not Family Care Partnership) that was conducted in 2005 compared member's health status, health care costs and long-term care costs to those of a carefully matched comparison groups of similar individuals receiving fee-for-service Medicaid services in the remainder of the state. The study, which is too costly to update every year, found that Family Care members visited their primary care physicians significantly more frequently than members of the non-Family Care comparison group. The study also found lower rates of hospitalization and nursing-home utilization, and suggested that the more frequent physician visits increased opportunities for prevention and early intervention health care services.

A good example of coordinating health care is how care teams work with the members to coordinate influenza and pneumonia vaccinations. These vaccinations are important because the members served in the Family Care Programs are at higher risk for having medical complications from influenza and pneumonia. The Family Care Partnership benefit package includes primary and acute health care services, and the doctor on the member's care team will recommend vaccinations for appropriate members. In the Family Care Partnership Program 63.7% of the members visit a dental office at least once a year and 96.1% see their primary care physician at least once a year.



"I have a team helping me with my medical problems. They are always there to answer questions or concerns that I have. They help me to stay at home and provide help with transportation, medications, and a nurse visits me often."

- Response from the 2007 Member Satisfaction Survey
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Use of Informal Supports

The member’s individual service plan includes who will provide the member needed services and supports. Providers may include the member, family, friends and other providers of informal supports. Informal supports are provided by unpaid caregivers, such as family, friends and neighbors. Informal supports services are an important part of a member’s individual service plan.

Most of us have informal supports. We have a neighbor who uses his snow blower to clear our driveway or a friend who brings a hot meal over when we do not feel well. People who provide informal supports help us feel connected to the community and add a social component to our life. However, people who provide informal supports can become “burned out” if they are not supported. The Family Care Programs’ staff monitor the informal support people and watch for signs of caregiver “burn out”. Program staff arrange respite care or increase the amount of personal care given by Program staff to ease the burden and give support to the people who provide informal supports. As the baby boomer population ages and needs more assistance, people who provide informal supports will become even more important and integral to helping people remain in their homes.

Because the arrangement and maintenance of informal supports is an objective of the Family Care and Partnership programs, observing changes in members’ reliance on informal supports over time can help to assess the success of the program in this area.

Table 9: Use of Informal Supports with Members who Have at Least One Limited ADL during 2007

Program and Target Group	No. of Members with at Least One ADL Limitation	No. of Members with at Least One ADL Limitation and at Least One ADL Informal Support	Percent of Members With at Least One Informal Support
Family Care	11,639	3,674	31.6%
Frail Elders	8,937	2,490	27.9%
Members with Developmental Disabilities	1,535	595	38.8%
Members with Physical Disabilities	1,167	589	50.5%
FC-Partnership	3,161	1,424	45.0%
Frail Elders	2,231	970	43.5%
Members with Developmental Disabilities	71	36	50.7%
Members with Physical Disabilities	859	418	48.7%

Source: Members Functional Screen data

Table 10: Use of Informal Supports with Members who Have at Least One Limited IADL During 2007

Program and Target Group	No. of Members with at Least One IADL Limitation	No. of Members With at Least One IADL Limitation and at Least One Informal Support	Percent of Members With at Least One Informal Support
Family Care	13,460	8,715	64.7%
Frail Elders	9,960	6,714	67.4%
Members with Developmental Disabilities	2,113	1,097	51.9%
Members with Physical Disabilities	1,387	904	65.2%
FC-Partnership	4,066	2,934	72.2%
Frail Elders	2,837	2,194	77.3%
Members with Developmental Disabilities	100	67	67.0%
Members with Physical Disabilities	1,129	673	59.6%

Source: Members Functional Screen data



“Our financial stress is eased. We have health care when we need it. We have support for every area of our lives. We have been able to live in a safe place and be together.”

- Response from the 2007 Member Satisfaction Survey
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Self-direction of Services within Family Care Programs

Individuals with disabilities (or their guardians, when they have guardians) can participate in the planning and directing of their services in a variety of ways. All Family Care members exercise ‘self-determination’ in that they participate in the development of the goals of the care plan, choice of the services, and evaluation of whether the services are successful. Beyond that, some prefer to exercise greater control, such as by participating in the training of newly-assigned personal care aides.

Some members or their guardians prefer to handle even more responsibility for planning and managing their services, such as by recruiting and selecting staff, handling scheduling, or even managing payroll and benefits bookkeeping and reporting. These higher levels of member control of services are called ‘self-direction,’ and within Family Care, the member can choose to self-direct only some services, while choosing to rely on the MCO to manage others. Though frequently used for in-home care, self-direction can also be used outside of the home for services such as transportation and personal care at the member’s work place. For example, a member could choose to self-direct personal-care services that help him/her to stay home or to find and keep a job, and choose to rely on the care team to manage services such as procurement and maintenance of durable medical equipment.

In 2007, the period covered by this report, Family Care MCOs (but not FC Partnership MCOs) were required to offer their members the services of a fiscal intermediary or a co-employment agency to assist them in directing the more administrative or managerial aspects of care planning. This agent assists the members in independently carrying out tasks such as the recruiting, hiring, training, supervising and firing of his/her direct care workers.

Since then, the services of fiscal intermediaries and co-employment agencies have been added to the FC Partnership benefit package and are offered to all members. However, since they were not a required service in 2007, the FC Partnership MCOs did not report them in the data they submitted to the Department, and so no information is available to include in this report. (The annual report for 2008 will include this information.)

In addition, 2008 saw the creation of a separate program, IRIS (Include, Respect, I Self-direct), for individuals who prefer to exercise the greatest degree of self-direction, with no involvement of an MCO at all. IRIS is not a managed-care program, and will not be covered in this report.

“My father is able to stay with me, because of Care WI. He goes to day care, has socialization, excellent health care and I have a support team to help with the increasing needs of my dad, making sure he's as happy and healthy as possible.”

- Response from the 2007 Member Satisfaction Survey
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Member Story: “Barbara’s Story” from Community Care, Inc.

Meet Barbara, a member of Community Care’s Family Care program. For a woman who cannot use her arms and has very limited use of her legs, she is amazingly independent. Barbara attributes her upbringing and the services she receives with empowering her to live on her own.

Although Barbara has lived with cerebral palsy her entire life, her parents never let it be an excuse or an obstacle. “I was never treated differently from my brother. They didn’t deny things were more challenging for me, but it didn’t make a difference. When I needed or wanted to do something, my mom would figure out how I could do it on my own.”

Barbara’s family owned a hardware store in Racine County. Her job was to take care of the accounts’ receivable. “Mom would put it all out in front of me. I would type with a stick in my mouth.” Barbara’s dad had a house designed and built with her in mind. She lived there with her parents while they were living, and it is still her home today.

After an illness in 2002, Barbara spent ten months in a nursing home, where she was evaluated as a good candidate to live at home. Barbara moved back into the home with her mother. Upon her return home, Barbara began receiving long-term care services through Racine County and its service provider.

Barbara’s mother died in 2006, the year Barbara turned 60, and Barbara found herself on her own with many new responsibilities to learn. “I had to learn to be a homeowner and all that entails,” she says.

Community Care, as the state’s new contracted managed long-term care provider, began providing Family Care services in Racine in 2007. County clients like Barbara began receiving services through Community Care. Barbara became a Community Care participant in July and was able to continue working with the service provider she had been working with since 2002. “The transition has been very smooth,” says Barbara. “The people I’m working with are all wonderful,” she says.

During the day, Barbara receives help in the morning to get ready for the day and throughout the day with her meals.

Through Community Care, Barbara was also able to tackle a major obstacle to independence – nighttime. “I need extra help at night because in bed I’m a prisoner. I have no ability to move. If I get cold, I can’t put on an extra cover. If I’m hot, I can’t kick off the sheets. I can’t get up to get a drink of water.”

Community Care helped Barbara develop a care plan that used the Self-Directed Supports option through which she could pay friends to stay overnight. She chose three friends who all have nursing home experience. Two of them are certified nursing assistants. “I’m an employer now,” she says.

“With support, I can live on my own,” says Barbara. “Everything may take a little longer when I’m on my own, but it will get done.” When life looks challenging and Barbara needs courage, she tells herself, “You know you can do it.” And she has proven that she can.

Section 3: Results

Family Care services are provided not because there is a ‘slot’ available, but because the services are expected to achieve or support results—or outcomes—that are desired by the member. The program measures quality and success through three types of member outcomes:

Clinical outcomes, such as recovering from a specific illness, getting a medical condition under control, managing risk and preventing deterioration, and other health and safety outcomes;

Functional outcomes, such as developing or recovering the ability to perform certain activities of daily life, or finding and keeping desired employment; and

Personal experience outcomes, which are quality-of-life circumstances unique to each member. When working on members’ care plans or assessing performance, care managers and quality reviewers explore personal-experience outcomes with the member in twelve general areas, shown in Figure 10.

Figure 10: Personal Experience Outcomes of Wisconsin Long-Term Care Programs

I decide where and with whom I live.
I make decisions regarding my supports and services.
I decide how I spend my day.
I have relationships with family and friends I care about.
I do things that are important to me.
I am involved in my community.
My life is stable.
I am respected and treated fairly.
I have privacy.
I have the best possible health.
I feel safe.
I am free from abuse and neglect.

Indicators related to Health Status

Ambulatory care sensitive conditions (ACSCs) are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. These conditions provide insight into the quality of the health care system outside the hospital setting. Some common ACSCs include asthma, bacterial pneumonia, urinary tract infection and long- and short-term complications from diabetes. The list of ACSC's was developed by the federal Department of Health and Human Services' Agency for Healthcare Research & Quality and is used nationwide as an indicator of quality of healthcare.

The tables below detail the percent of members by target group that either went to an emergency room or were admitted into a hospital due to a preventable health issue. An example of a preventable event is when a person with diabetes is admitted into the hospital for an unexpected toe amputation. If a person with diabetes receives regular care, preventive education and maintains good blood sugar control can reduce an individual's risk of serious health complications.

Table 11: Preventable Emergency Room (ER) Visits

Family Care	Percent of Members in Target Group with Preventable ER Visit
Frail Elders	1.9%
Members with Developmental Disabilities	1.4%
Members with Physical Disabilities	4.6%
FC Partnership	
Frail Elders	17.6%
Members with Physical Disabilities	20.5%

Source: MMIS claims data.

The Medicare admissions are included only in the FC Partnership numbers.

Table 12: Preventable Hospital Admissions

Family Care	Percent of Members in Target Group with Preventable Hospital Admission
Frail Elders	5.5%
Members with Developmental Disabilities	0.9%
Members with Physical Disabilities	5.4%
FC Partnership	
Frail Elders	
Members with Developmental Disabilities	
Members with Physical Disabilities	

Source: MMIS claims data for Family Care.

Not Available at time of production

Table 13: Immunizations – Influenza and Pneumonia Vaccinations for Active Family Care Members on December 31, 2007

Family Care MCOs	Frail Elders	Members with Developmental Disabilities	Members with Physical Disabilities
Milwaukee			
Influenza Immunization	75.6%		
Pneumonia Immunization	70.7%		
Fond du Lac			
Influenza Immunization	84.6%	64.1%	64.3%
Pneumonia Immunization	53.2%	12.8%	36.2%
Portage			
Influenza Immunization	78.2%	58.3%	60.7%
Pneumonia Immunization	45.5%	20.3%	31.8%
Richland - Family Care			
Influenza Immunization	88.1%	69.3%	81.3%
Pneumonia Immunization	69.1%	39.6%	57.8%
La Crosse - Family Care			
Influenza Immunization	64.0%	52.3%	55.3%
Pneumonia Immunization	69.9%	34.6%	57.8%
CCI - Family Care			
Influenza Immunization	34.3%	36.9%	26.2%
Pneumonia Immunization	9.2%	8.1%	12.0%
All Family Care MCOs			
Influenza Immunization	73.9%	52.4%	53.9%
Pneumonia Immunization	66.2%	22.1%	43.7%

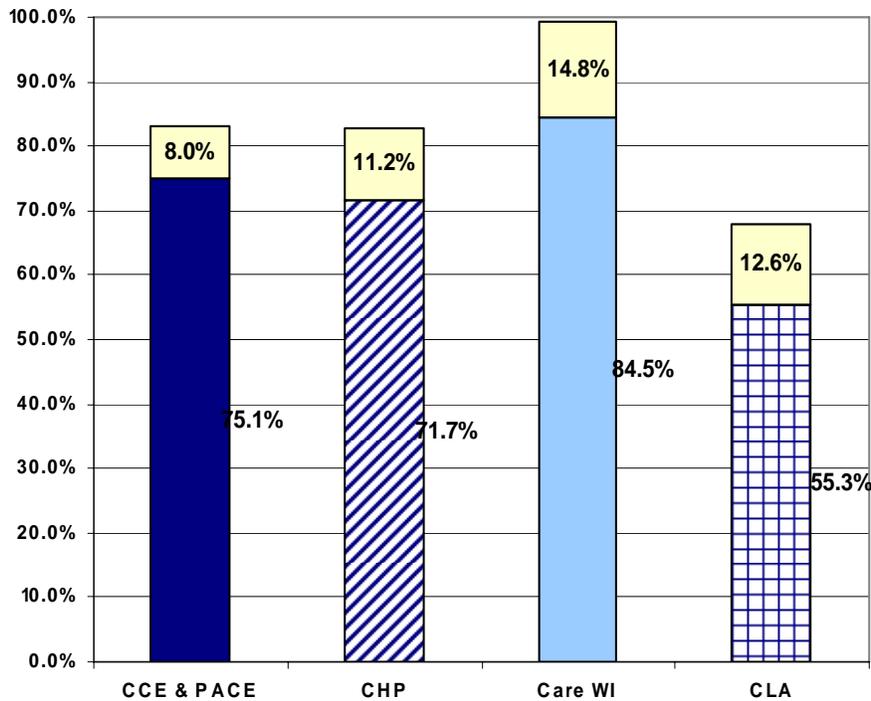
Source: Data compiled by External Quality Review Organization



“My team has helped me through some of the hardest times I have ever had to deal with, and I don't know if I would be here, if they were not helping me to overcome my physical and emotional problems at the times.”

- Response from the 2007 Member Satisfaction Survey
-

Figure 11: Percent of Family Care Partnership Members Who Had a Flu Immunization during 2007



Source: Event data submitted by MCOs.

Note: The lower portion of each box shows those members who were immunized; the upper portion shows those who refused the shot or that the immunization was medically contraindicated.

Member Story: Char's Story from Community Care of Central Wisconsin

Char is taking life one day at a time. In December, 2001 she was severely injured in an automobile accident that left her comatose for over a month. She was transferred from the local hospital intensive care unit to a coma recovery program for three months, and finally entered an intensive brain injury recovery facility in the Milwaukee area. Almost every weekend her husband rented a care to make the three-hour drive to see her. He has been her strongest supporter, always encouraging her to do her best.

Thanks to her husband's help and Char's determination, she made steady gains in her physical and psychological functioning, exceeding the expectations of the rehab staff. In November 2002, just two weeks before the one-year anniversary of her accident, Char returned home to her husband and two teenage children. She also has a son who is in college.

Family Care provides help with physical and occupational therapy, and her care provider assists with shopping, errands and home management. This support allows Char's husband to continue his full-time job.

Although Char misses activities like fishing with her husband and shopping on her own, she is gaining independence. She now has some movement in her left hand and has been able to make her own meals and do her own bathing. Char also finds time to play cards, work on her computer and spend quality time with her family. She is excited about her progress and eventually would like to gain some vocational skills but she knows she still has a way to go.

Char has some words of wisdom for other who may be facing similar challenges—"Don't give up, take one day at a time, and do the best of your ability."

Indicators related to Functional Status

Every Family Care member enters the program with a certain number of impaired activities of daily living (ADLs) or instrumental activities of daily living (IADLs. ADLs are:

- Bathing
- Dressing
- Eating
- Moving around in one’s home
- Using the toilet
- Moving between surfaces, such as from a chair to a bed.

IADLs are:

- preparing meals
- managing and taking medications
- managing money

The MCOs’ services are intended to reduce or delay any unavoidable deterioration in each member’s functional abilities and to, whenever possible, help members to recover or improve their abilities. Tables 14 and 15 show the proportion of Family Care members whose abilities improved during 2007 and the proportion whose abilities deteriorated.

Table 14: One-Year Changes in Need for Assistance with Activities of Daily Living by Target Group and Program
ADLs (Eating, bathing, toileting, dressing, transferring and mobility)

Program and Target Group	Percent of Members with Fewer ADLs Limitations	Percent of Members with No Change in ADLs Limitations	Percent of Members with More ADLs Limitations
Family Care	14.7%	61.0%	24.3%
Frail Elders	16.0%	55.9%	28.1%
Members with Developmental Disabilities	8.3%	77.8%	13.9%
Members with Physical Disabilities	17.1%	64.9%	18.0%
FC-Partnership	18.9%	53.5%	27.6%
Frail Elders	17.2%	53.5%	29.4%
Members with Developmental Disabilities	14.5%	61.8%	23.7%
Members with Physical Disabilities	24.0%	52.7%	23.3%

Source: Functional screens submitted for each member during 2007, compared with functional screens from one year earlier.

Table 15: One-Year Changes in Need for Assistance with Instrumental Activities of Daily Living by Target Group and Program.

IADLs (Meals, medications and money)

Program and Target Group	Percent of Members with Fewer IADLs Limitations	Percent of Members with No change in IADLs Limitations	Percent of Members with More IADLs Limitations
Family Care	6.8%	83.8%	9.4%
Frail Elders	6.9%	83.5%	9.6%
Members with Developmental Disabilities	4.5%	89.8%	5.8%
Members with Physical Disabilities	10.7%	75.4%	13.9%
<hr/>			
FC-Partnership	10.5%	76.4%	13.1%
Frail Elders	9.3%	80.2%	10.5%
Members with Developmental Disabilities	9.2%	72.4%	18.4%
Members with Physical Disabilities	14.2%	66.6%	19.3%

Source: Functional screens submitted for each member during 2007, compared with functional screens from one year earlier.



“It is a great organization--as a child of an older mom, it has allowed us to have mom at home longer.”

- Response from the 2007 Member Satisfaction Survey
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Desired Living Arrangements

A primary goal of the Family Care programs is giving people better choices about where they want to live. As stated earlier, the current public policy is that most people can remain living in their homes if provided with the proper services and supports. The membership of the Family Care programs reflect the trend that most people would like to remain in their home. Table 16 shows the current and preferred living arrangements of active members in the Family Care programs.

The table includes data on where the member is currently living and the member preferred living setting. The shaded boxes designated that percent of member who are currently living in their preferred living setting for each residence choice. Overall, 83.2% of the Family Care members and 82.3% of the FC-Partnership members are living in their preferred living arrangement.

Table 16: Percent of Members by Current and Preferred Living Situation on December 31, 2007

Family Care Current Residence	Preferred Residence			
	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting
Currently lives in Home Setting	97%	1%	0%	2%
Currently lives in Group Setting	13%	74%	0%	13%
Currently lives in Nursing facility	29%	12%	38%	21%
Currently lives in Other setting	30%	29%	0%	40%
Total Percent of members currently living in preferred setting	97%	74%	38%	40%

Family Care Partnership Current Residence	Preferred Residence			
	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting
Currently lives in Home Setting	97%	0%	0%	3%
Currently lives in Residential	24%	64%	0%	11%
Currently lives in Institutional	35%	9%	28%	27%
Currently lives in Other setting	24%	19%	0%	57%
Total Percent of members currently living in preferred setting	97%	64%	28%	57%

Source: Each member's most recently completed functional screen, as of December 31, 2007.

Changes in Members' Employment Status

The Managed Care Organization's care teams provide services to help members achieve their employment objectives. Services such as daily living skills training, day treatment, pre-vocational services and supported employment are included in the Family Care benefit package. Other Family Care services such as transportation and personal care also help people meet their employment goals.

Supporting frail elders and adults with physical and developmental disabilities with their employment goals is a challenge to long-term care programs, and there is room for improvement in the employment rates among members. Historically, in Wisconsin and across the nation, participation in employment and particularly integrated employment, among working age adults with disabilities has been limited. Currently, most working age adults with disabilities served by the public long-term care system in Wisconsin are unemployed or employed in non-integrated settings.

The Wisconsin's Medicaid Infrastructure Grant (MIG) program "Pathways to Independence", is working to develop alternative strategies and better practices that strengthen and add capacity to the rehabilitation, workforce, education, and Medicaid systems.

Table 17: Changes for Employment Status of Family Care Program Members during 2007

Year-later Employment Status of Retired Members on Earlier Screen	Family Care Total (N=4077)	FC-Partnership Total (N=1259)
No Change: Still Retired and Satisfied	99.1%	99.1%
Now Have Employment and Satisfied	0.1%	0.2%
Not Satisfied: Still Retired but Desiring Employment	0.8%	0.7%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care Total (N=342)	FC-Partnership Total (N=113)
Now Have a Job, Satisfied	14.6%	1.8%
No Longer Desire Employment, Satisfied	21.9%	23.9%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	63.5%	74.3%
Total	100.0%	100.0%

Year-later Employment Status of Members who were Employed and Satisfied With Job on Earlier Screen	Family Care Total (N=929)	FC-Partnership Total (N=56)
No Change: Still Employed in Desired Job	87.1%	69.6%
Now Retired or Unemployed but Satisfied	5.9%	23.2%
Now Out of a Job or Desiring a Different One	7.0%	7.1%
Total	100.0%	100.0%

Source: Functional screen created for each member during 2007, compared with functional screens from one year earlier.

Note: Employment information collected from the screener may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Members' Satisfaction

Although it is not an 'outcome' in the same sense as the clinical or functional well-being of the members, members' satisfaction with the program is an important indicator of the programs' success. Member satisfaction can be observed in at least two measures: satisfaction surveys and the rate at which members choose to leave the program. Beginning in 2008 a member satisfaction survey will be conducted in both Family Care and Family Care Partnership.

Satisfaction Surveys

DHS staff randomly selected and mailed surveys to more than 1100 Partnership and PACE members with at least 6 months enrollment during 2007. 662 surveys were returned, resulting in a 60% return rate. The survey had 23 questions.

Overall the responses were very positive. More than 95% of those who answered the survey were "always/very" or "usually" satisfied in the following areas:

- The services of the member's main physician;
- Team treats member with respect;
- Team involves the member in making decisions;
- The member's health related concerns are addressed to the extent that the member wants;
- The member is able to live where and with whom the member wants;
- The member has people who care about and are involved in the member's life;
- The member has privacy when they want it;
- The member knows whom to contact for questions;
- Team listens and understands the member's concern;
- Team follows through with questions or requests, and
- Team answers questions promptly.

90 to 95% of those who answered the survey were "always/very" or "usually" satisfied with the following services:

- Access to the member's main physician;
- Care from the dentist;
- Day Center;
- In-home services;
- Transportation, and
- Over all experience with the Partnership or PACE Programs.

The only two questions that received below a 90% satisfaction score included:

- 75% of the members were "always" or "usually" able to see their dentist as often as they thought they should, and
- 89% of the members "always" or "usually" had opportunities for social and recreational activities in the community as often as they wanted.

The full survey and summary is posted on the Department's website at:

<http://dhs.wisconsin.gov/wipartnership/pdf-wpp/2007membrsatsurvey.pdf>

Disenrollment for Reasons Other than Death or Loss of Eligibility

Table 18 details the number of Family Care program members who chose to leave the program during 2007. There are a variety of reasons for a member to leave the program, such as, they moved out of State, or they have chosen another program to receive their services from. Overall there is a small percent of eligible members who choose to leave a Family Care program.

Table 18: Members who chose to leave the program during calendar year 2007

Left the program means members who left the program and did not come back within a 3-month time period.

MCO and Program	Members Served in Calendar Yr. 2007	No. of Members who chose to leave program	% of Members who chose to leave program
Milwaukee - Family Care	7,528	243	3.2%
Fond du Lac - Family Care	1,188	52	4.4%
Portage - Family Care	1,094	44	4.0%
Richland - Family Care	423	11	2.6%
La Crosse - Family Care	2,066	103	5.0%
CCI - Family Care	1,565	27	1.7%
CCI - Partnership/PACE	1,281	23	1.8%
Care Wisconsin - Partnership	795	12	1.5%
CLA - Partnership	412	13	3.2%
CHP - Partnership	1,617	25	1.5%
All MCOs	17,969	553	3.1%

Source: MMIS eligibility data.

"I got involved with the program before I was released from the care facility I was in after I had a stroke. So since my stroke I've always had their help. Without a doubt, they have made my life a lot easier. I have independence and can stay in my home!"

- Response from the 2007 Member Satisfaction Survey
-
-

Appendix 1

Footnotes:

¹ Milwaukee County serves frail elders, only (age 60 or older)

² Precise requirements for functional eligibility for Family Care can be found in Wisconsin statutes s.15.197(4)(a) 2 and s.15.197(4)(a)1, and in Wisconsin Administrative Code HFS 10.13(25m).

³ Digestive disorders: examples of common diagnoses include dysphagia (difficulty swallowing), gallstones, gastroesophageal reflux (GERD), gastroenteritis, GI bleed, hernia, hemorrhoids, irritable bowel syndrome (IBS), soft palate deformity, pancreatitis, ulcers.

⁴ Nerve disorders: examples of common diagnoses include anoxic brain syndrome (lack of oxygen at birth), apraxia (disorder of movement planning), bacterial meningitis, brain aneurysm, brain tumor, cerebellar ataxia, cerebral aneurysm, encephalitis, fetal alcohol syndrome, hydrocephalus.

⁵ Visual impairment: examples of common diagnoses include cataracts, diabetic Retinopathy, glaucoma, lens implant, macular degeneration, retinal keratosis.

Information on the data:

The following pages provide a description of the program's current members. The data that were used to produce the information that is included in this section came from the Department's administrative data systems, primarily MMIS. Another major source for information presented here is the Long-Term Care Functional Screen, which provides a wide range of data on member demographics, functional needs and health status.

Most of the data used here resides on several universes in the MEDS data warehouse. These universes are databases, or logical configurations of Oracle tables that were designed to meet specific research needs and purposes.

In comparing several tables, readers may note that the total number of cases varies amount tables, even sometimes when it seems as if the 'N' should be the same. This variation results from several factors:

- Missing data. Most tables presented in this report are the products of matching and analyzing multiple administrative data sources. When certain data are missing from any of the data sources used in such analysis, any attempt to offer different views of even a similar phenomenon will frequently result in a somewhat different population size (N), or in a different count of the characteristics being analyzed.
- Reporting lag and database updates. Late reporting (lag) effects data completeness at any given point in time. Since the analyses presented here were performed over several months, some discrepancies in the number of cases and the data associated with them can occur. The same holds true for the updating of the administrative databases in the MEDS data warehouse. Since these databases are updated on different schedules, certain discrepancies are possible as well.
- Data instability. The correction and adjustment of various data on the administrative database is common and can result in certain data fluctuations over time. The eligibility data, which are the primary source for identifying Family Care members and is the starting point to form any analysis, is a primary example of data instabilities. On different days the eligibility databases can yield different numbers of eligible members for the same focal date.

List of Acronyms/Abbreviations:

ADL – Activities of Daily Living

ADRC – Aging and Disability Resource Center

DHS – Department of Health Services

EQRO – External Quality Review Organization

IADL – Instrumental Activities of Daily Living

Family Care Programs – refers to Family Care, Family Care Partnership and PACE

MCO – Managed Care Organization

Sources of Additional Information

- For additional information specific to a MCO, contact the MCO. Contact information is listed on page 75.
- External Quality Review Reports by State Fiscal year are located on the MetaStar website: <http://www.metastar.com/web/>
- In 2008, public fiscal reporting will be available on the Family Care Programs.
- In 2008, the public report will feature articles about the MCO's Program Improvement Projects (PIPs) and other quality improvement projects.

Comments and suggestions regarding the content of this report can be submitted to Karen McKim, Quality/Research Team Manager (Karen.McKim@dhs.wisconsin.gov).

Appendix 2—Focus on the Frail Elder Target Group

Table 19: Frail Elder Membership by MCO on December 31, 2007

MCO and Program	Frail Elder	Proportion of Total MCO Membership
Milwaukee - Family Care	5,418	84.5%
Fond du Lac - Family Care	485	47.2%
Portage - Family Care	472	49.6%
Richland - Family Care	177	47.2%
La Crosse - Family Care	696	38.2%
CCI - Family Care	420	28.7%
CCI - Partnership & PACE	822	74.6%
Care Wisconsin - Partnership	611	87.7%
CLA - Partnership	30	8.2%
CHP - Partnership	878	62.1%
All MCOs	10,009	64.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Note: *The Milwaukee County Family Care program, operated by the county's Department of Aging, serves people with disabilities over the age of 60, while other MCOs serve adults 18 and older, considering those 65 and older to be frail elders. For comparability within this table, frail elders in all MCOs are those who are 65 and older, and Milwaukee members between the ages of 60 and 64 are reported as members with either developmental or physical disabilities.*

Table 20: Current and Preferred Living Situation for Frail Elder Members
All Members Active on December 31, 2007.

Family Care		Preferred Residence			
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	98%	1%	0%	1%	
Currently lives in Group Setting	13%	78%	0%	9%	
Currently lives in Nursing facility	28%	11%	39%	22%	
Currently lives in Other setting	29%	29%	1%	42%	
Total Percent of members currently living in preferred setting	98%	78%	39%	42%	

Family Care Partnership		Preferred Residence			
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	96%	0%	0%	4%	
Currently lives in Residential	22%	65%	0%	13%	
Currently lives in Institutional	31%	8%	30%	30%	
Currently lives in Other setting	19%	19%	1%	61%	
Total Percent of members currently living in preferred setting	96%	65%	30%	61%	

Source: Each member's most recently completed functional screen, as of December 31, 2007.

Table 21: Most Common Health Diagnoses Among Frail Elder Members on December 31, 2007
Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.

Common Health Diagnosis	FC	FC-Partnership
Allergies	30.2%	18.0%
Alzheimer's Disease	10.6%	31.7%
Anemia/Coagulation Defects	38.0%	21.2%
Angina/Coronary Artery Disease	44.2%	30.3%
Anxiety Disorder	31.4%	19.7%
Arthritis	74.9%	69.9%
Asthma	36.1%	28.1%
Blood/Lymph Disorders	41.6%	18.4%
Cancer	17.3%	14.3%
Cerebral Vascular Accident	21.0%	20.7%
Chronic Pain/Fatigue	46.4%	41.3%
Congestive Heart Failure	29.9%	21.9%
Dehydration/Fluid Imbalance	13.7%	5.6%
Depression	50.8%	35.9%
Diabetes Mellitus	37.8%	38.2%
Digestive Disorders ³	77.1%	50.1%
Disorders GU System	46.4%	26.0%
Heart Rate Disorders	31.0%	18.5%
Hip Fracture/Replacement	10.7%	34.2%
Hypertension	83.5%	77.4%
Hypo/HyperThyroidism	23.4%	18.6%
Nerve Disorders ⁴	38.9%	22.8%
Nutritional Imbalances	69.6%	47.9%
Osteoporosis	34.8%	19.9%
Other Diagnoses	44.3%	19.9%
Other Heart Conditions	25.2%	13.3%
Other Sensory Disorders	25.7%	17.0%
Pneumonia/Bronchitis/Flu	10.5%	NA
Renal Failure/Kidney Disease	32.5%	14.6%
Respiratory Disorder	16.7%	17.8%
Skin Diseases	21.5%	6.9%
Urinary Tract Infection	16.7%	10.2%
Visual Impairment ⁵	60.6%	45.8%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 22: Multiple Diagnoses Among Frail Elder Members on December 31, 2007

MCO and Program	Family Care	FC-Partnership
0-4 Diagnoses	16.0%	1.2%
5-9 Diagnoses	38.3%	18.2%
10+ Diagnoses	45.7%	80.6%
Total	100.0%	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 23: Employment Status Among Frail Elder Members on December 31, 2007

Family Care	No. of Frail Elder Members	Percent of Frail Elder Members
Retired	6,133	70.8%
Working	163	1.9%
Not Working	2361	27.3%
FC-Total	8,657	100.0%
FC-Partnership		
Retired	1,854	74.9%
Working	31	1.3%
Not Working	589	23.8%
FC-Partnership Total	2,474	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 24a: Top Services Provided to Frail Elder Family Care Members during 2007

	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care	888	8.7%	\$4,264,905	1.9%
Case/Care Management	10,172	100.0%	\$36,598,365	15.9%
CBRF, AFH, RCAC	3,329	32.7%	\$75,032,536	32.6%
Community Support Program	8	0.1%	\$27,298	0.0%
Counseling and Therapeutic Resources	2,768	27.2%	\$1,481,261	0.6%
Daily Living Skills Training	150	1.5%	\$1,083,878	0.5%
Day Center Services	197	1.9%	\$1,564,348	0.7%
Day Treatment Medical	21	0.2%	\$65,954	0.0%
Energy/Housing	272	2.7%	\$152,785	0.1%
Equipment and Supplies	7,765	76.3%	\$7,054,061	3.1%
Financial Management services	1,466	14.4%	\$1,193,324	0.5%
Home Health/Nursing	1,647	16.2%	\$9,960,313	4.3%
Meals	2,663	26.2%	\$4,101,278	1.8%
Nursing Home/ICF-MR	2,035	20.0%	\$40,506,230	17.6%
Other LTC Services	575	5.7%	\$240,041	0.1%
Pre-Vocational Training	89	0.9%	\$260,160	0.1%
Recreational Activities	51	0.5%	\$14,289	0.0%
Respite	202	2.0%	\$547,921	0.2%
Supported Employment	95	0.9%	\$736,469	0.3%
Supportive Home Care	5,758	56.6%	\$40,549,564	17.6%
Transportation	5,196	51.1%	\$4,611,608	2.0%
Total Unduplicated	10,172		\$230,046,600	

Source: Encounter data submitted by each MCO

The distribution of services provided by Family Care Programs from January 1, 2007 through December 31, 2007 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.

Table 24b: Top Services Provided to Frail Elder Family Care Partnership Members during 2007

Long-Term Care Services	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care/Day Center	1,062	32.9%	\$6,573,962	4.3%
Case Management	3,225	100.0%	\$16,220,957	10.7%
CBRF, AFH, GH	545	16.9%	\$16,460,845	10.8%
Consumer Directed Supports*				
Equipment & Supplies	2,002	62.1%	\$5,030,149	3.3%
Home Health/Nursing	418	13.0%	\$588,557	0.4%
Meals	571	17.7%	\$252,992	0.2%
Nursing Home	792	24.6%	\$18,211,855	12.0%
Other LTC Services	3,225	100.0%	\$13,878,159	9.1%
Recreational Activities	108	3.3%	\$176,763	0.1%
Respite	11	0.3%	\$16,535	0.0%
Supportive Home Care	547	17.0%	\$1,439,921	0.9%
Transportation	2,795	86.7%	\$5,605,684	3.7%
Total LTC Service Costs			\$84,456,379	
Acute Care Services				
Anesthesia	3,225	100.0%	\$4,872,843	3.2%
Dental	2,291	71.0%	\$1,146,110	0.8%
E&M Care (Office calls, NH, Hosp Visits)	3,225	100.0%	\$4,983,416	3.3%
ER	1,495	46.4%	\$1,817,891	1.2%
Inpatient Hospital	1,065	33.0%	\$18,279,888	12.0%
Medications	3,225	100.0%	\$13,887,430	9.1%
MH & AODA Outpatient Therapy	869	26.9%	\$666,799	0.4%
Nutrition Intervention/Counseling	1,199	37.2%	\$464,238	0.3%
Physician Pathology & Lab	3,225	100.0%	\$1,450,870	1.0%
Physician Radiology	2,803	86.9%	\$2,674,100	1.8%
Physician Surgery	3,225	100.0%	\$8,290,503	5.4%
Physician/other medical services	3,225	100.0%	\$7,530,863	4.9%
Total Acute Care Service Costs			\$66,064,951	
Total Acute & LTC Service Costs			\$150,521,330	

Notes:

*Consumer Directed Supports started in Partnership in late 2007 & has minimal history.

A portion of some long-term care services are paid as an acute care service. A good example is a nursing home stay for rehabilitation. A portion of some acute care services are paid as long-term care services. A good example is the inpatient hospital deductible.

Table 25: Use of Purchased Residential Services for Frail Elders during 2007
Percent of total member-days spent in residential settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	63.2%
Group residences	26.8%
Nursing facilities	10.0%
Total	100.0%

FC-Partnership

Natural (non-purchased) residential settings	77.5%
Group residences	15.0%
Nursing facilities	7.5%
Total	100.0%

Source: Encounter data submitted by each MCO.

Table 26: Changes in Employment Status during 2007 (*Refers to Table 17 in main report*)

Year-later Employment Status of Retired Members on Earlier Screen	Family Care FE (N=3992)	FC-Partnership FE (N=1215)
No Change: Still Retired and Satisfied	99.1%	99.1%
Now Have Employment and Satisfied	0.1%	0.2%
Not Satisfied: Still Retired but Desiring Employment	0.8%	0.7%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care FE (N=36)	FC-Partnership FE (N=11)
Now Have a Job, Satisfied	5.6%	0.0%
No Longer Desire Employment, Satisfied	33.3%	27.3%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	61.1%	72.7%
Total	100.0%	100.0%

Year-later Employment Status of Members who were employed and satisfied with job on Earlier Screen	Family Care FE (N=125)	FC-Partnership FE (N=18)
No Change: Still Employed in Desired Job	82.4%	77.8%
Now Retired or Unemployed but Satisfied	15.2%	22.2%
Now Out of a Job or Desiring a Different One	2.4%	0.0%
Total	100.0%	100.0%

Source: Functional screen completed for each member during 2007, compared with functional screens from one year earlier.
 Note: The information is collected from the screener and may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Appendix 3—Focus on the Developmental Disabilities Target Group

Note: Partnership data is not included in all tables because the Partnership MCO's served less than 100 members with developmental disabilities during 2007.

Table 27: Members with Developmental Disabilities by MCO on December 31, 2007

MCO and Program	Members with Developmental Disabilities	Proportion of Total MCO Membership
Milwaukee - Family Care	203	3.2%
Fond du Lac - Family Care	374	36.4%
Portage - Family Care	265	27.8%
Richland - Family Care	117	31.2%
La Crosse - Family Care	581	31.9%
CCI - Family Care	718	49.0%
CCI - Partnership/PACE	19	1.7%
Care Wisconsin - Partnership	7	1.0%
CLA - Partnership	7	1.9%
CHP - Partnership	62	4.4%
All MCOs	2,353	15.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Note: *The Milwaukee County Family Care Program, operated by the county's Department of Aging, serves people with disabilities over the age of 60, while other MCOs serve adults 18 and older, considering those 65 and older to be frail elders. For comparability within this table, frail elders in all MCOs are those who are 65 and older, and Milwaukee members between the ages of 60 and 64 are reported as members with either developmental or physical disabilities.*

Table 28: Current and Preferred Living Situation for Members with Developmental Disabilities
All Members Active on December 31, 2007.

Family Care		Preferred Residence			
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	92%	1%	0%	7%	
Currently lives in Group Setting	11%	65%	0%	25%	
Currently lives in Nursing facility	27%	27%	19%	27%	
Currently lives in Other setting	36%	43%	0%	21%	
Total Percent of members currently living in preferred setting	92%	65%	19%	21%	

Family Care Partnership		Preferred Residence			
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	96%	0%	0%	4%	
Currently lives in Residential	43%	57%	0%	0%	
Currently lives in Institutional	67%	0%	33%	0%	
Currently lives in Other setting	100%	0%	0%	0%	
Total Percent of members currently living in preferred setting	96%	57%	33%	0%	

Source: Each member's most recently completed functional screen, as of December 31, 2007.

Table 29: Most Common Health Diagnoses Among Members with Developmental Disabilities on December 31, 2007

*Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.*

Common Health Diagnosis	FC	FC-Partnership
Allergies	17.6%	16.9%
Anemia/Coagulation Defects	2.9%	20.2%
Angina/Coronary Artery Disease	1.3%	12.4%
Anxiety Disorder	15.3%	42.7%
Arthritis	8.0%	33.7%
Asthma	9.1%	29.2%
Behavioral Diagnoses	10.6%	9.0%
Blood/Lymph Disorders	2.1%	15.7%
Brain Injury Onset age 22	5.5%	11.2%
Cerebral Palsy	16.7%	19.1%
Chronic Pain/Fatigue	7.1%	38.2%
Contractures/Connective Tissue	4.1%	12.4%
Depression	16.8%	57.3%
Diabetes Mellitus	9.2%	30.3%
Heart Rate Disorders	2.2%	13.5%
Digestive Disorders ³	20.7%	51.7%
Disorders GU System	5.9%	32.6%
Hip/Bone Fracture	10.5%	3.4%
Hypertension	13.4%	50.6%
Hypo/HyperThyroidism	10.9%	16.9%
Intellectual Disability	81.6%	32.6%
Nerve Disorders ⁴	7.7%	36.0%
Nutritional Imbalances	11.9%	51.7%
Osteoporosis	3.2%	16.9%
Other Brain Disorders	5.7%	20.2%
Other Diagnoses	12.5%	58.4%
Other Heart Conditions	5.4%	18.0%
Other Mental Illness	13.9%	21.3%
Other Sensory Disorders	6.7%	11.2%
Otherwise Meets State/Fed DD	9.9%	34.8%
Respiratory Disorder	6.4%	10.1%
Seizure Disorder After age 22	2.8%	11.2%
Seizure Disorder Onset age 22	23.9%	30.3%
Skin Diseases	6.9%	21.3%
Urinary Tract Infection	1.6%	10.1%
Visual Impairment ⁵	8.5%	20.2%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 30: Multiple Diagnoses Among Members with Developmental Disabilities on December 31, 2007

MCO and Program	Family Care	FC-Partnership
0-4 Diagnoses	50.4%	4.5%
5-9 Diagnoses	33.6%	37.1%
10+ Diagnoses	16.0%	58.4%
Total	100.0%	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 31: Employment Status Among Members with Developmental Disabilities on December 31, 2007

Family Care	No. of Members with Developmental Disabilities	Percent of Members with Developmental Disabilities
Retired	31	1.5%
Working	1,199	58.3%
Not Working	825	40.1%
FC-Total	2,055	100.0%
FC-Partnership		
Retired	5	5.6%
Working	13	14.4%
Not Working	72	80.0%
FC-Partnership Total	90	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 32: Top Services Provided to Family Care Members with Developmental Disabilities during 2007

	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care	49	2.3%	\$246,094	0.4%
Case/Care Management	2,129	100.0%	\$6,310,383	9.6%
CBRF. AFH, RCAC	955	44.9%	\$30,575,138	46.7%
Community Support Program	4	0.2%	\$20,359	0.0%
Counseling and Therapeutic Resources	407	19.1%	\$347,864	0.5%
Daily Living Skills Training	534	25.1%	\$3,008,772	4.6%
Day Center Services	486	22.8%	\$3,629,144	5.5%
Day Treatment Medical	15	0.7%	\$22,550	0.0%
Energy/Housing	15	0.7%	\$8,083	0.0%
Equipment and Supplies	932	43.8%	\$1,073,170	1.6%
Financial Management services	521	24.5%	\$171,670	0.3%
Home Health/Nursing	262	12.3%	\$2,635,862	4.0%
Meals	54	2.5%	\$39,799	0.1%
Nursing Home/ICF-MR	146	6.9%	\$1,407,666	2.2%
Other LTC Services	102	4.8%	\$71,484	0.1%
Pre-Vocational Training	610	28.7%	\$4,357,521	6.7%
Recreational Activities	126	5.9%	\$30,354	0.0%
Respite	398	18.7%	\$1,316,097	2.0%
Supported Employment	533	25.0%	\$2,409,374	3.7%
Supportive Home Care	558	26.2%	\$5,327,419	8.1%
Transportation	1,115	52.4%	\$2,434,602	3.7%
Total Unduplicated	2,129		\$65,443,413	

Source: Encounter data submitted by each MCO

The distribution of services provided by Family Care Programs from January 1, 2007 through December 31, 2007 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.

Table 33: Use of Purchased Residential Services for Members with Developmental Disabilities during 2007
Percent of Total Member-Days Spent in Residential Settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	61.2%
Group residences	37.4%
Nursing facilities	1.4%
Total	100.0%

Source: Encounter data submitted by each MCO.

Table 34: Changes in Employment Status for members with Developmental Disabilities during 2007
(Refers to Tables 17 in main report)

Year-later Employment Status of Retired Members on Earlier Screen	Family Care DD (N=25)	FC-Partnership DD (N=1)
No Change: Still Retired and Satisfied	100.0%	100.0%
Now Have Employment and Satisfied	0.0%	0.0%
Not Satisfied: Still Retired but Desiring Employment	0.0%	0.0%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care DD (N=182)	FC-Partnership DD (N=13)
Now Have a Job, Satisfied	24.7%	15.4%
No Longer Desire Employment, Satisfied	13.2%	23.1%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	62.1%	61.5%
Total	100.0%	100.0%

Year-later Employment Status of Members who were employed and satisfied with job on Earlier Screen	Family Care DD (N=718)	FC-Partnership DD (N=5)
No Change: Still Employed in Desired Job	88.9%	20.0%
Now Retired or Unemployed but Satisfied	3.8%	40.0%
Now Out of a Job or Desiring a Different One	7.4%	40.0%
Total	100.0%	100.0%

Source: Functional screen completed for each member during 2007, compared with functional screens from one year earlier.

Note: The information is collected from the screener and may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Appendix 4—Focus on Physical Disabilities Target Group

Table 35: Members with Physical Disabilities by MCO on December 31, 2007

MCO and Program	Members with Physical Disabilities	Proportion of Total MCO Membership
Milwaukee - Family Care	790	12.3%
Fond du Lac - Family Care	169	16.4%
Portage - Family Care	215	22.6%
Richland - Family Care	81	21.6%
La Crosse - Family Care	543	29.8%
CCI - Family Care	326	22.3%
CCI - Partnership/PACE	261	23.7%
Care Wisconsin - Partnership	79	11.3%
CLA - Partnership	331	89.9%
CHP - Partnership	473	33.5%
All MCOs	3,269	21.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Note: *The Milwaukee County Family Care Program, operated by the county's Department of Aging, serves people with disabilities over the age of 60, while other MCOs serve adults 18 and older, considering those 65 and older to be frail elders. For comparability within this table, frail elders in all MCOs are those who are 65 and older, and Milwaukee members between the ages of 60 and 64 are reported as members with either developmental or physical disabilities.*

Table 36: Current and Preferred Living Situation for Members with Physical Disabilities
All Members Active on December 31, 2007.

Family Care Current Residence	Preferred Residence			
	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting
Currently lives in Home Setting	99%	0%	0%	0%
Currently lives in Group Setting	26%	67%	0%	7%
Currently lives in Nursing facility	54%	11%	28%	7%
Currently lives in Other setting	57%	25%	0%	18%
Total Percent of members currently living in preferred setting	99%	67%	28%	18%

Family Care Partnership Current Residence	Preferred Residence			
	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting
Currently lives in Home Setting	99%	0%	0%	1%
Currently lives in Residential	31%	62%	3%	5%
Currently lives in Institutional	69%	14%	10%	7%
Currently lives in Other setting	54%	18%	0%	29%
Total Percent of members currently living in preferred setting	99%	62%	10%	29%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 37: Most Common Health Diagnoses Among Members with Physical Disabilities on December 31, 2007
Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.

Common Health Diagnosis	FC	FC-Partnership
Alcohol or Drug Abuse	12.0%	16.5%
Allergies	18.4%	20.5%
Anemia/Coagulation Defects	10.5%	24.9%
Angina/Coronary Artery Disease	13.3%	23.4%
Anxiety Disorder	25.7%	40.3%
Arthritis	34.5%	48.6%
Asthma	27.9%	45.5%
Blood/Lymph Disorders	10.8%	24.6%
Brain Injury After age 22	5.6%	2.7%
Cerebral Vascular Accident	11.9%	15.7%
Chronic Pain/Fatigue	42.7%	60.3%
Congestive Heart Failure	7.6%	14.7%
Depression	54.5%	65.9%
Diabetes Mellitus	33.5%	43.0%
Digestive Disorders ³	40.5%	62.5%
Disorders GU System	16.4%	31.5%
Heart Rate Disorders	7.1%	12.3%
Hip/Bone Fracture	19.3%	3.8%
Hypertension	44.6%	63.2%
Hypo/HyperThyroidism	15.3%	17.1%
Nerve Disorders ⁴	28.1%	41.1%
Nutritional Imbalances	33.0%	56.3%
Osteoporosis	9.0%	14.7%
Other Diagnoses	27.7%	54.3%
Other Heart Conditions	7.0%	15.8%
Other Mental Illness	12.0%	18.5%
Other Sensory Disorders	7.4%	11.7%
Renal Failure/Kidney Disease	10.7%	15.3%
Reproductive System Disorders	3.7%	10.0%
Respiratory Disorder	16.5%	25.1%
Skin Diseases	6.5%	17.2%
Urinary Tract Infection	5.3%	11.8%
Visual Impairment ⁵	15.1%	23.4%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 38: Multiple Diagnoses Among Members with Physical Disabilities on December 31, 2007

MCO and Program	Family Care	FC-Partnership
0-4 Diagnoses	33.6%	7.3%
5-9 Diagnoses	32.8%	32.0%
10+ Diagnoses	33.6%	60.7%
Total	100.0%	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 39: Employment Status Among Members with Physical Disabilities on December 31, 2007

Family Care	No. of Members with Physical Disabilities	Percent of Members with Physical Disabilities
Retired	93	7.0%
Working	163	12.0%
Not Working	1082	81.0%
FC-Total	1,338	100.0%
FC-Partnership		
Retired	85	8.4%
Working	62	6.1%
Not Working	869	85.5%
FC-Partnership Total	1,016	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 40a: Top Services Provided to Family Care Members with Physical Disabilities during 2007

	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care	39	2.5%	\$111,777	0.5%
Case/Care Management	1,544	100.0%	\$5,375,799	22.0%
CBRF, AFH, RCAC	251	16.3%	\$4,891,778	20.0%
Community Support Program	10	0.6%	\$79,120	0.3%
Counseling and Therapeutic Resources	591	38.3%	\$526,637	2.2%
Daily Living Skills Training	119	7.7%	\$494,228	2.0%
Day Center Services	37	2.4%	\$72,499	0.3%
Day Treatment Medical	17	1.1%	\$21,519	0.1%
Energy/Housing	42	2.7%	\$26,512	0.1%
Equipment and Supplies	1,220	79.0%	\$1,693,687	6.9%
Financial Management services	236	15.3%	\$61,194	0.2%
Home Health/Nursing	437	28.3%	\$3,019,663	12.3%
Meals	284	18.4%	\$229,048	0.9%
Nursing Home/ICF-MR	260	16.8%	\$2,397,516	9.8%
Other LTC Services	111	7.2%	\$92,063	0.4%
Pre-Vocational Training	49	3.2%	\$218,490	0.9%
Recreational Activities	56	3.6%	\$13,410	0.1%
Respite	66	4.3%	\$198,016	0.8%
Supported Employment	22	1.4%	\$47,369	0.2%
Supportive Home Care	917	59.4%	\$4,316,930	17.6%
Transportation	633	41.0%	\$599,694	2.4%
Total Unduplicated	1,544		\$24,486,959	

Source: Encounter data submitted by each MCO

The distribution of services provided by Family Care Programs from January 1, 2007 through December 31, 2007 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.

Table 40b: Top Services Provided to Family Care Partnership Members with Physical Disabilities during 2007

Long-Term Care Services	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care/Day Center	15	1.7%	\$96,652	0.3%
Case Management	880	100.0%	\$2,546,445	8.9%
CBRF, AFH, GH	29	3.3%	\$648,653	2.3%
Consumer Directed Supports*				
Equipment & Supplies	363	41.3%	\$1,017,372	3.5%
Home Health/Nursing	144	16.4%	\$755,436	2.6%
Meals	167	19.0%	\$50,190	0.2%
Nursing Home	83	9.4%	\$1,736,832	6.1%
Other LTC Services	880	100.0%	\$3,786,909	13.2%
Recreational Activities	104	11.8%	\$33,294	0.1%
Respite	3	0.3%	\$8,000	0.0%
Supportive Home Care	171	19.4%	\$757,744	2.6%
Transportation	555	63.1%	\$867,151	3.0%
Total LTC Service Costs			\$12,304,678	
Acute Care Services				
Anesthesia	636	72.3%	\$1,300,066	4.5%
Dental	322	36.6%	\$315,226	1.1%
E&M Care (Office calls, NH, Hosp Visits)	621	70.6%	\$771,816	2.7%
ER	358	40.7%	\$435,321	1.5%
Inpatient Hospital	233	26.5%	\$4,689,312	16.3%
Medications	643	73.1%	\$4,487,344	15.6%
MH & AODA Outpatient Therapy	315	35.8%	\$326,726	1.1%
Nutrition Intervention/Counseling	16	1.8%	\$7,312	0.0%
Physician Pathology & Lab	588	66.8%	\$255,272	0.9%
Physician Radiology	534	60.7%	\$458,960	1.6%
Physician Surgery	633	71.9%	\$1,959,908	6.8%
Physician/other medical services	880	100.0%	\$3,739,324	13.0%
Total Acute Care Service Costs			\$18,746,587	
Total Acute and LTC Service Costs			\$31,051,265	

Notes:

*Consumer Directed Supports started in Partnership in late 2007 & has minimal history.

A portion of some long-term care services are paid as an acute care service. A good example is a nursing home stay for rehabilitation. A portion of some acute care services are paid as long-term care services. A good example is the inpatient hospital deductible.

Table 41: Use of Purchased Residential Services for Members with Physical Disabilities during 2007
Percent of total member-days spent in residential settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	84.8%
Group residences	10.7%
Nursing facilities	4.6%
Total	100.0%
FC-Partnership	
Natural (non-purchased) residential settings	92.7%
Group residences	3.1%
Nursing facilities	4.2%
Total	100.0%

Source: Encounter data submitted by each MCO

Table 42: Changes in Employment Status for Members with Physical Disabilities during 2007
(Refers to Table 17 in main report)

Year-later Employment Status of Retired Members on Earlier Screen	Family Care PD(N=60)	FC-Partnership PD (N=43)
No Change: Still Retired and Satisfied	98.3%	100.0%
Now Have Employment and Satisfied	1.7%	0.0%
Not Satisfied: Still Retired but Desiring Employment	0.0%	0.0%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care PD (N=124)	FC-Partnership PD (N=89)
Now Have a Job, Satisfied	2.4%	0.0%
No Longer Desire Employment, Satisfied	31.5%	23.6%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	66.1%	76.4%
Total	100.0%	100.0%

Year-later Employment Status of Members who were employed and satisfied with job on Earlier Screen	Family Care PD (N=86)	FC-Partnership PD (N=33)
No Change: Still Employed in Desired Job	79.1%	72.7%
Now Retired or Unemployed but Satisfied	10.5%	21.2%
Now Out of a Job or Desiring a Different One	10.5%	6.1%
Total	100.0%	100.0%

Source: Functional screen completed for each member during 2007, compared with functional screens from one year earlier.

Note: The information is collected from the screener and may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Appendix 5—Additional Data on Members with Mental Health/ Substance Abuse Issue

While the statutes governing Family Care programs limit eligibility to frail elders and to those adults who have a physical disability or a developmental disability, many individuals with these disabilities, just like people without disabilities, also experience issue with mental health or with substance abuse.

Some mental health or substance abuse issues are more prevalent among people with disabilities than in the general population. For example, major depressive disorder affects approximately 6.7 percent of the U.S. population age 18 and older at any given time, but 19.2 percent of the individuals who enrolled in Family Care during 2007 reported a diagnosis of depression at the time of their enrollment.

In addition to the disabilities that qualified them for Family Care membership, more than six percent of the new enrollees had relatively manageable chronic mental illnesses such as schizophrenia and bipolar disorder, while 10.5 percent had harder-to-manage diagnoses such as personality disorders or serious substance abuse issues.

For these reasons and others, it is sometimes useful to look specifically at the subgroup of Family Care members with mental health or substance abuse issues. Table 43 show the number of members in each programs' three target groups who also have mental health (MH) or substance abuse (SA) issues.

Table 43: Family Care Members by Target Group with Mental Health and Substance Abuse Diagnoses on December 31, 2007

	Frail Elder	Members with Developmental	Members with Physical
Anxiety	2,480	348	750
Depression	4,366	392	1,393
Bipolar	316	72	177
Schizophrenia	698	139	135
Other MH	812	301	348
SA	614	56	326
Behavioral	140	223	71
All	9,426	1,531	3,200

Note: Members are counted in the totals for each diagnosis they have, and members may have more than one listed diagnosis.

Table 44: Current and Preferred Living Situation for Members with Mental Health/Substance Abuse
All Members Active on December 31, 2007.

Family Care		Preferred Residence			
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	98%	1%	0%	1%	
Currently lives in Group Setting	15%	66%	0%	18%	
Currently lives in Nursing facility	27%	12%	39%	21%	
Currently lives in Other setting	77%	8%	0%	14%	
Total Percent of members currently living in preferred setting	98%	66%	39%	14%	

Family Care Partnership		Preferred Residence			
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	97%	0%	0%	3%	
Currently lives in Residential	22%	45%	0%	34%	
Currently lives in Institutional	38%	9%	27%	26%	
Currently lives in Other setting	64%	18%	9%	9%	
Total Percent of members currently living in preferred setting	97%	45%	27%	9%	

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 45a: Most Common Health Diagnoses Among Members with Mental Health/Substance Abuse on December 31, 2007

*Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.*

Common Health Diagnosis	FC	FC-Partnership
Allergies	19.8%	29.1%
Alzheimer Other Dementia	28.6%	28.0%
Anemia/Coagulation Defects	18.0%	35.3%
Angina/Coronary Artery Disease	24.4%	37.9%
Arthritis	55.8%	67.4%
Asthma	28.5%	42.8%
Blood/Lymph Disorders	15.6%	36.0%
Cancer	10.9%	14.6%
Cerebral Vascular Accident	16.3%	19.3%
Chronic Pain/Fatigue	38.4%	55.1%
Congestive Heart Failure	16.8%	24.6%
Dehydration/Fluid Imbalance	5.3%	13.6%
Diabetes Mellitus	33.4%	38.5%
Digestive Disorders ³	49.8%	76.7%
Disorders GU System	23.8%	43.9%
Heart Rate Disorders	14.9%	24.7%
Hip/Bone Fracture	30.3%	40.6%
Hypertension	63.4%	76.2%
Hypo/HyperThyroidism	18.9%	21.7%
Intellectual Disability	17.0%	1.6%
Nerve Disorders ⁴	23.2%	42.0%
Nutritional Imbalances	42.8%	66.0%
Osteoporosis	17.4%	29.7%
Other Heart Conditions	11.3%	22.7%
Other Infectious Diseases	4.0%	10.5%
Other Sensory Disorders	13.8%	21.7%
Renal Failure/Kidney Disease	11.4%	25.5%
Reproductive System Disorders	4.6%	10.1%
Respiratory Disorders	17.5%	31.5%
Skin Diseases	7.7%	21.4%
Urinary Tract Infection	9.4%	16.4%
Visual Impairment ⁵	34.5%	48.2%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 45b: Percentage of Family Care Members with Mental Health and Substance Abuse Diagnoses on December 31, 2007

MCO and Program	Anxiety	Depression	Bipolar	Schizophrenia	Other MH	Substance Abuse	Behavioral
Milwaukee - Family Care	19.8%	36.0%	3.0%	7.7%	7.8%	6.1%	1.3%
Fond du Lac - Family Care	24.8%	35.6%	2.6%	5.5%	9.5%	5.0%	5.1%
Portage - Family Care	19.0%	38.6%	4.4%	3.9%	6.4%	3.6%	5.9%
Richland - Family Care	22.4%	37.2%	5.4%	4.3%	8.1%	5.9%	1.6%
La Crosse - Family Care	18.8%	37.4%	3.7%	4.8%	11.1%	6.5%	3.9%
CCI - Family Care	15.8%	22.4%	4.0%	7.7%	9.7%	2.9%	5.6%
CCI - Partnership/PACE	27.3%	52.7%	4.0%	7.5%	9.3%	11.4%	2.5%
Care Wisconsin - Partnership	34.9%	54.6%	4.0%	3.7%	5.7%	7.8%	1.1%
CLA - Partnership	28.5%	59.0%	4.6%	3.0%	10.9%	15.2%	1.1%
CHP - Partnership	40.8%	56.6%	4.8%	3.7%	17.6%	7.5%	3.4%
All MCOs	23.0%	39.5%	3.6%	6.2%	9.4%	8.8%	2.8%

Note: Members are counted in the totals for each diagnosis they have, and members may have more than one listed diagnosis.

Table 46: Multiple Diagnoses Among Members with Mental Health/Substance Abuse on December 31, 2007

MCO and Program	Family Care	FC-Partnership
0-4 Diagnoses	10.4%	1.3%
5-9 Diagnoses	41.7%	17.3%
10+ Diagnoses	47.9%	81.5%
Total	100.0%	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 47: Employment Status Among Members with Mental Health/Substance Abuse on December 31, 2007

Family Care	No. of Members with MH/SA	Percent of Members with MH/SA	FC-Partnership	No. of Members with MH/SA	Percent of Members with MH/SA
Retired	3222	49.9%	Retired	1194	50.5%
Working	686	10.6%	Working	68	2.9%
Not Working	2552	39.5%	Not Working	1103	46.6%
FC-Total	6,460	100.0%	FC-Partnership Total	2,365	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2007.

Table 48a: Top Services Provided to Family Care Members with Mental Health/Substance Abuse during 2007

	Number of Members Served	Percent of Members	Expenditures	Percent of Expenditures
Adult Day Care	521	7.1%	\$2,488,243	1.3%
Case/Care Management	7,330	100.0%	\$28,207,778	14.8%
CBRF, AFH, RCAC	2,821	38.5%	\$72,747,626	38.2%
Community Support Program	18	0.2%	\$98,477	0.1%
Counseling and Therapeutic Resources	2,251	30.7%	\$1,512,872	0.8%
Daily Living Skills Training	435	5.9%	\$2,576,010	1.4%
Day Center Services	372	5.1%	\$2,750,155	1.4%
Day Treatment Medical	51	0.7%	\$109,214	0.1%
Energy/Housing	192	2.6%	\$105,399	0.1%
Equipment and Supplies	5,235	71.4%	\$5,118,835	2.7%
Financial Management services	1,496	20.4%	\$1,025,168	0.5%
Home Health/Nursing	1,201	16.4%	\$6,629,644	3.5%
Meals	1,510	20.6%	\$2,230,699	1.2%
Nursing Home/ICF-MR	1,503	20.5%	\$31,756,357	16.7%
Other LTC Services	503	6.9%	\$292,628	0.2%
Pre-Vocational Training	370	5.0%	\$2,114,672	1.1%
Recreational Activities	131	1.8%	\$24,432	0.0%
Respite	332	4.5%	\$1,071,210	0.6%
Supported Employment	293	4.0%	\$1,265,199	0.7%
Supportive Home Care	3,596	49.1%	\$24,625,104	12.9%
Transportation	3,851	52.5%	\$3,808,479	2.0%
Total Unduplicated	7,330		\$190,558,212	

Source: Encounter data submitted by each MCO

The distribution of services provided by Family Care Programs from January 1, 2007 through December 31, 2007 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.

Table 48b: Top Services Provided to Family Care Partnership Members with Mental Health/Substance Abuse during 2007

Not Available at time of production

Table 49: Use of Purchased Residential Services for Members with Mental Health/Substance Abuse during 2007
Percent of Total Member-Days Spent in Residential Settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	57.6%
Group residences	31.6%
Nursing facilities	10.7%
Total	100.0%

FC-Partnership

Natural (non-purchased) residential settings	
Group residences	
Nursing facilities	
Total	100.0%

Not Available at time of production

Source: Encounter data submitted by each MCO

Table 50: Changes in Employment Status for Members with Mental Health/Substance Abuse during 2007
 (Refers to Table 17 in main report)

Year-later Employment Status of Retired Members on Earlier Screen	Family Care MH/SA (N=2093)	FC-Partnership MH/SA (N=780)
No Change: Still Retired and Satisfied	98.9%	99.0%
Now Have Employment and Satisfied	0.1%	0.1%
Not Satisfied: Still Retired but Desiring Employment	0.9%	0.9%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care PD (N=210)	FC-Partnership MH/SA (N=81)
Now Have a Job, Satisfied	12.4%	2.5%
No Longer Desire Employment, Satisfied	26.7%	23.5%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	61.0%	74.1%
Total	100.0%	100.0%

Year-later Employment Status of Members who were employed and satisfied with job on Earlier Screen	Family Care MH/SA (N=420)	FC-Partnership MH/SA (N=37)
No Change: Still Employed in Desired Job	81.4%	64.9%
Now Retired or Unemployed but Satisfied	9.3%	24.3%
Now Out of a Job or Desiring a Different One	9.3%	10.8%
Total	100.0%	100.0%

Source: Functional screen completed for each member during 2007, compared with functional screens from one year earlier.
 Note: The information is collected from the screener and may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

List of Current Family Care, Partnership and PACE Managed Care Organizations and Contact Information
Listed alphabetically by managed care organization corporate name.
Information compiled on November 7, 2008

Care Wisconsin, Inc.	
2802 International Lane Madison WI 53704	
Corporate:	608-240-0020
General Info:	800-963-0035
Member Services:	800-963-0035
TTY:	WI Relay 711
24-Hour:	800-963-0035
www.carewisc.org	
Counties served:	Columbia, Dane, Dodge, Jefferson, Green Lake, Marquette, Sauk, Walworth, Washington, Waukesha, Waushara

Community Care of Central Wisconsin	
3349 Church Street Suite 1 Stevens Point WI 54481	
Corporate:	715-345-5968
General Info:	877-622-6700
Member Services:	
TTY:	715-344-2140
24-Hour:	715-345-5968
www.communitycareofcentralwisconsin.org	
County served:	Portage

Community Care, Inc.	
1555 S. Layton Blvd Milwaukee WI 53215	
Corporate:	414-385-6600
General Info:	866-992-6600
Member Services:	866-992-6600
TTY:	866-288-9909
24-Hour:	866-992-6600
www.cco-cce.org	
Counties served:	Kenosha, Milwaukee, Ozaukee, Racine, Washington, Sheboygan and Waukesha

Community Health Partnership	
2240 East Ridge Center Eau Claire WI 54701	
Corporate:	715-838-2900
General Info:	800-842-1814
Member Services:	800-842-1814
TTY:	715-838-2900
24-Hour:	800-842-1814
www.communityhealthpartnership.com	
Counties served:	Chippewa, Dunn, Eau Claire, Pierce, St Croix

Creative Care Options of Fond du Lac County	
50 North Portland Street Fond du Lac WI 54935-3412	
Corporate:	920-906-5100
General Info:	877-227-3335
Member Services:	920-906-5100
TTY:	800-947-3529
24-Hour:	920-906-5177
www.fdlco.wi.gov	
County served:	Fond du Lac

Milwaukee County Department of Aging	
310 W. Wisconsin Avenue, 6th Floor East Milwaukee WI 53203	
Corporate:	414-289-5950
General Info:	866-229-9695
Member Services:	
TTY:	414-289-8584
24-Hour:	414-289-6874
www.county.milwaukee.gov/Familycare	
County served:	Milwaukee

Southwest Family Care Alliance (previously Richland County)	
1900 Hwy. 14 East PO Box 111 Richland Center WI 53581	
Corporate:	608-647-4729
General Info:	608-647-4729
Member Services:	
TTY:	800-947-3529
24-Hour:	
www.familycarealliance.org	
County served:	Richland

Western Wisconsin Cares	
1407 Saint Andrew St., Suite 100 La Crosse WI 54603	
Corporate:	608-785-6266
General Info:	608-785-6266
Member Services:	
TTY:	608-785-9787
24-Hour:	
www.wwcared.org	
County served:	La Crosse

Family Care Vision

The result of Family Care expansion will be a complete rebalancing of Wisconsin's long-term care system.

Aging and disability resource centers will endeavor to keep individuals financially independent and physically healthy by informing people of the long-term care service options available to them, providing healthy aging and prevention programs and if they need assistance, informing them of the publicly-funded long-term care programs that can help them.

The resource centers will help people through eligibility and enrollment in those programs.

Every Wisconsin citizen who needs long-term care will have equal access to in-home services and institutional care and everything in-between with no waiting.

For every eligible person, self-directed options will be available – either within a managed care organization or through IRIS, our self-directed supports waiver.

Our contracts with managed care organizations and our monitoring will focus on performance in achieving enrollees' quality of life outcomes, including health and safety, community integration and self-determination and choice as well as fiscal integrity and cost effectiveness.



Wisconsin Department of Health Services
Division of Long Term Care
Office of Family Care Expansion
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Madison, Wisconsin 53707-7851
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December, 2008