Analysis of Secondary Data

A study for the Minnesota Department of Human Services of consumers, proxy decision makers, service providers, and professional long-term cared decision support staff

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Summary

In January 2008, the Minnesota Department of Human Services' Continuing Care Administration (DHS) contracted with Wilder Research to conduct a study on housing with services, assisted living, and in-home provider services. The purpose of this report and the overall study is to increase understanding of how the State of Minnesota can most effectively assist persons age 65 and older in selecting long-term care services that meet their needs, reflect their preferences, and enable them to maintain financial self-sufficiency as long as possible.

The secondary data analysis plan is designed to glean information from a variety of available sources within state government – information that bears on the key research questions included in the final research plan. Four major sources of information were identified as having information of potential value to this analysis:

- **Senior LinkAge Line**® (SLL) is a telephone information service operated by the Minnesota Board on Aging (MBA) to provide information to seniors and their representatives.

- **MinnesotaHelp.info®** (MHI) is an Internet site operated by the Minnesota Board on Aging (MBA).

- **Medicaid Management Information System (**MMIS) is the principal database used for administering Medical Assistance in Minnesota and is maintained by DHS. The system includes information on individual recipients and their health and service needs and payments made.

- **Uniform Consumer Information Guide** (UCIG). By statute, assisted living facilities in Minnesota are now required to provide information about their services and fees in a standardized format to all current and prospective residents as of January 1, 2008. This information is currently being compiled by the Minnesota Department of Health and will be incorporated into MinnesotaHelp.info®.

The findings are summarized below.

Logical next steps

The purpose of this analysis is to provide perspective on the research questions of this project and to complement the information from the literature review and the surveys of different groups. Final answers and recommendations will be synthesized after all of the data has been assembled and analyzed. However, here are some issues raised or confirmed during this secondary data analysis that warrant further consideration.

- Requiring assisted living providers to separate rent from other bundled charges to help consumers' financial planning
- Developing publicly available, standardized information on the quality and price of assisted living facilities, housing with services, and in-home services
- Expanding decision making help resources, especially financial decision making resources
- Facilitating information access for non-Internet-using consumers and non-English speaking consumers
- Education, outreach, and possibly incentives to encourage earlier investigation of housing options and financial planning by older adults and their advisors

Areas for further research

Several areas where further research would be helpful have emerged during this analysis.

- Investigating the rising percentage of first-time MA recipients who are served in assisted living in their first month of participation and consumer spend-down of assets generally
- Developing more information at the State level about private pay consumers of housing and in-home services before they come on to MA
- Exploring the relative availability of in-home services in Greater Minnesota and the Twin Cities

Long-term care decision making

Types and sources of information available

The sheer volume of raw information about housing choices and home care services in Minnesota creates a challenge for long-term care decision makers.

Much of the information on housing options, in-home services, and financial ramifications is only available over the Internet, creating a potential barrier for many older adults and their proxy decision makers.

Non-English speakers face added challenges in finding useful information to aid their long-term care choices from private sources; however, State resources provide significant help to non-English speaking seniors.

Information currently available through the State of Minnesota

The information currently available through the Minnesota Board on Aging, MinnesotaHelp.info®, and other State agencies is potentially very helpful to consumers in their long-term care decision making.

The Uniform Consumer Information Guide (UCIG) collected by the Minnesota Department of Health and being prepared for inclusion in MinnesotaHelp.info® represents an advance in information available to consumers, at least in the area of assisted living. It provides standardized, in-depth information about services. It includes limited price information.

Additional information and formats that would be helpful to consumers

More information, especially more standardized and consolidated information, on the price and quality for assisted living, housing with services, or in-home services would be extremely helpful to consumers.

Additional efforts should be made by the State to provide comparable or standardized formats across providers within a type of service or across types of services.

Further steps should be taken to ensure that information on housing choices and home-based services is updated and accurate.

Demographic differences in long-term care use

Indirect data imply that LTC decision making (and long-term care preferences and access) differs markedly by location (urban vs. rural), race/ethnicity, and gender. However, more information must be gathered to confirm these initial findings.

Paying for long-term care services

Gaps in information impacting financial self-sufficiency

Gaps in information about financial ramifications of care choices prevent consumers from using private resources, Medicare, and other third party pay in a way that maximizes financial self-sufficiency.

Demographic differences in long-term care financial planning

Over the past five years, the characteristics of persons who have depleted their private assets resulting in eligibility for public programs have changed somewhat. Compared to 2003, more new Medical Assistance recipients are male; a higher percentage are under 69; a greater number reside in assisted living; more live in the 7-county Twin cities area; and a rising number have not had a stay in a nursing home before entering MA. However, more research is needed to fully understand the trends.

Information available through the State of Minnesota regarding financial self-sufficiency

The Minnesota Department of Human Services and other State agencies provide some of the most easily accessible background information that can help older adults and others better understand long-term care choices, and in some cases, the financial self-sufficiency issue.

Characteristics of older Minnesotans receiving Medical Assistance

In recent years, an increasing proportion of new Medical Assistance recipients are approved for assisted living in their first month of eligibility for Elderly Waiver. Presumably, these people depleted their assets while paying for assisted living and then applied to the State for support through Medical Assistance. This raises the possibility that some of these older Minnesotans might have maintained financial self-sufficiency longer if they had fully understood the range of in-home services available to them.

Background

In January 2008, the Minnesota Department of Human Services' Continuing Care Administration (DHS) contracted with Wilder Research to conduct a study on housing with services, assisted living, and in-home provider services. This study was commissioned by the 2007 Minnesota Legislature (see Appendix).

The purpose of this report and the overall study is to increase understanding of how the State of Minnesota can most effectively assist persons age 65 and older in selecting long-term care services that meet their needs, reflect their preferences, and enable them to maintain financial self-sufficiency as long as possible. There are six phases included in this study:

1) A detailed research plan
2) A literature review
3) Provider and professional decision support staff web-based surveys and key informant interviews
4) Secondary data analysis
5) Consumer and friend/relative survey
6) Final report

This report provides the findings from the secondary data analysis (phase 4). This analysis of secondary data and the other reports are organized in parallel format to provide ease of comparison and use of the information from the different phases of the study. In this study, the topics fall into two general headings: information on long-term care decision making, and information on financial self-sufficiency. Under these two general headings, the findings are organized as follows.

Long-term care decision making

- Types and sources of information available
- Information currently available through the State of Minnesota
- Additional information and formats that would be helpful to consumers
- Demographic differences in long-term care use

Financial self sufficiency

- Gaps in information impacting financial self-sufficiency
- Demographic differences in long-term care financial planning
- Information available through the State of Minnesota regarding financial self-sufficiency
- Characteristics of older Minnesotans receiving Medical Assistance

Methods

While new information to answer the study's research questions was being gathered in phases 3 and 5 of this study, various data sets already produced by State agencies were identified and analyzed for this phase of the study to see how they might shed additional light on the specific research questions being considered in this project.

The secondary data analysis plan is designed to glean information from a variety of available sources within state government – information that bears on the key research questions included in the final research plan. Four major sources of information were identified as having information of potential value to this analysis:

- **Senior LinkAge Line**® (SLL) is a telephone information service operated by the Minnesota Board on Aging (MBA) to provide information to seniors and their representatives. Telephone counselors field calls, talk to callers about their concerns, and make appropriate referrals. The counselors utilize information from MinnesotaHelp.info®**,** a database maintained by the MBA. Senior LinkAge Line® maintains a database of callers, types of questions and concerns and referrals made.

- **MinnesotaHelp.info®** (MHI) is an Internet site operated by the Minnesota Board on Aging (MBA). Information from housing with services establishment registration and home care licensing collected by the Minnesota Department of Health (MDH) is included in MinnesotaHelp.info®. MBA is in the process of incorporating data from the Uniform Consumer Information Guide collected by MDH from all assisted living providers. Seniors and their helpers can sort through a large underlying database of service providers and information sources to find services and housing in any geographic area of the state. Consumers can sort through a variety of search topics including help with care, adult day services, Medicare, senior housing, and prescription drug help. There is also a "Long-Term Care Navigator" feature which leads consumers through a series of questions and then indicates appropriate types of services. The system is also a resource for senior counselors and is used by the counselors of SLL, as well.

- **Medicaid Management Information System (**MMIS) is the principal database used for administering Medical Assistance in Minnesota and is maintained by DHS. The system includes information on individual recipients and their health and service needs and payments made. Information on approximately 40,000 Elderly Waiver (EW) recipients in 2008 and 2003 was inspected and compared statistically. Information is not available on recipients prior to their eligibility for Medical Assistance. (In contrast, the State has data on all nursing home residents regardless of

their eligibility of Medical Assistance and other public programs and is, therefore, able to determine payments made and length of stay prior to spend-down to Medical Assistance.)

- **Uniform Consumer Information Guide** (UCIG). By statute, assisted living facilities in Minnesota are now required to provide information about their services and fees in a standardized format to all current and prospective residents as of January 1, 2008. This information is currently being compiled by the Minnesota Department of Health and will be incorporated into MinnesotaHelp.info®.

In addition to these four primary sources, relevant information was received from the Office of the Ombudsman for Long-Term Care. This data consists of reports on the type of complaints received by the Office relating to housing and some additional data on the number of callers who call and receive information and consultation pertaining to home care and housing options.

A cursory investigation of some non-governmental sources of information available to consumers, chiefly through the Internet was also completed in order to better ascertain what older adults and their helpers face when contemplating long-term care choices. In particular, various searches were conducted and approximately a dozen of the most promising websites and directories available through the private sector were explored in some detail to see what information would ultimately be available to the consumer looking to make decisions about long-term care choices.

Findings

This section of the report summarizes the findings of our research on information availability, information access, and decision making using secondary sources. To the extent possible, findings within each section are prioritized with regard to importance.

The literature review that Wilder Research completed earlier in this project identified a number of key elements and problems in the long-term care decision making process. Our investigation of secondary data sources was conducted in the context provided by the literature review. The section headings in this report are aligned with the section headings in the literature review in order to facilitate ease of use.

Long-term care decision making

As context for the findings presented below, we include some of the *key relevant points on this topic that are made in our literature review:*

- Among the great ironies of the modern health care system is how poorly it delivers knowledge at a time when society enjoys unprecedented access to information.
- As with many life situations, long-term care decision making is a highly personal and at times emotional process that differs by demographic characteristics including location, race/ethnicity, gender, family situation, and type of services needed.
- Due to the complex nature of the long-term care decision making process, the information provided to older adults, family members, health care and social service professionals, and professional decision support staff is crucial to making effective and appropriate long-term care decisions.
- It is important that there be appropriate information disseminated on non-entitlement services that are offered by the State or other public programs. A study of long-term care commissioned by the Oregon Department of Human Services (2006) found that these non-entitlement services such as planning, consulting, or information gathering, are valuable to the consumer and often lead to informed choices which can save both the State and consumers money in the long-run.
- Education and information are keys to advance planning. Experts agree that increased planning is beneficial for responsible long-term care choices. Time is essential to fully take advantage of other resources such as financial planners, doctors, social workers, and geriatricians.

- One of the recurring themes throughout various strains of literature is that long-term care decisions suffer from a lack of consumer knowledge and skills, not a lack of raw information. However, this is disputable given the fact that many people in the process of making long-term care decisions cite a lack of information as a hindering factor in the decision making process.

- Regarding the question of what information is available to the State to help inform policy and programming decisions, quality assurance for home and community based long-term care services is increasingly important, due to the growing consumer demand for these services as well as increased public expenditures. However, at this point, most states rely mainly on informal mechanisms to assess and ensure quality in home and community based services.

- The health care system as a whole faces its own difficulties in implementing informed decision making because it is not well designed for this task. The system is not equipped to inform patients in a manner that is timely, easily understood, and jargon-free, nor does it encourage people to consider consequences, to ask questions, to clarify values, and to express preferences.

- Like many resources, information regarding long-term care services and supports is most readily available via the Internet. This is problematic because many older adults are not comfortable accessing information online. In addition, online information is currently more difficult for those of lower socioeconomic or education status, or those who do not speak or read English, to access. Therefore, brochures and pamphlets that provide long-term care information should be widely disseminated.

Types and sources of information available

The sheer volume of raw information about housing choices and home care services in Minnesota creates a challenge for long-term care decision makers.

With regard to housing choices, consumers can find a wide variety of information on different services as well as directories that promise to help them find the housing that is right for them. Either from Internet sources or from phone directories, consumers can quickly amass a list of senior housing providers. In fact, the volume of information can become unmanageable and overwhelming.

From our review, directories of long-term care housing options available to the public vary widely in the number of providers they list for a given geographic area. Typically, directories contain only street address, phone number and a web address if one exists. The web-based information we accessed from senior housing providers were typically marketing materials which list the amenities and services offered by different providers.

The materials we examined were often remarkably similar across providers and it was a challenge to discern differences between providers. Nevertheless, based on some comparisons of internet coverage with phone directory information, it appears that a high percentage of housing providers have a presence on the Internet.

With regard to in-home services, we also found a substantial presence on the Internet through some direct searches and through private and public directories. However, comparisons within a geographic area and additional comparisons with the number of licensees for home health care services strongly suggest that the percentage of in-home service providers represented on the Internet is smaller than than of housing providers. It is quite plausible that the in-home services field includes many smaller providers who may not establish a separate Internet presence. Therefore, to compile a complete list of providers, consumers would be more likely to need to use traditional sources like classified ads and phone books. In fact, several local online directories we identified functioned very much like a yellow pages, providing just address and phone number for many listees who did not list separate web addresses.

With such a volume of raw information available, it becomes important for individuals to have some way to sort that information to a manageable list of options to explore further. We found the Long-term Care Choices Navigator (discussed below) to be an especially useful tool in helping consumers decide which housing or services were right for them.

But even a tool such as the Navigator is hampered by three shortcomings of the existing data.

- Information on price and quality of housing and in-home services is often lacking or incomplete, making it hard to choose among competing options.
- Categories of information are not standardized, making options difficult to compare.
- Information is often not verified for accuracy or timeliness, making it hard for consumers to rely on it for decision making.

These three issues are discussed in more detail in the section on "Additional information and formats" on page 15.

Much of the information on housing options, in-home services, and financial ramifications is only available over the Internet, creating a potential barrier for many older adults and their proxy decision makers. Counselors who can access the Internet can help overcome part of this problem.

One apparent shortcoming of the long-term care information provided by the State of Minnesota is the fact that most of the information is available primarily through web-

based venues, and the Internet may not accessible to many older adults. Nevertheless, Internet use is growing among older Americans. A recent study by AARP stated that 58 percent of members log onto the Internet "from time to time." Their favored uses were getting the news and maintaining social relationships, but growing familiarity could enable more people to access Internet-based long-term care information. However, AARP is not a representative sample of all older Americans and the Internet may remain inaccessible for many lower-income older adults.

While directly accessing the Internet may not be possible for some older adults, much of the information located there can be accessed if the consumer receives help from someone with Internet access. This could be a family member or another advisor. Specifically, Senior LinkAge Line® provides seniors with live phone counselors with all of the resources of MinnesotaHelp.info® available to them.

The Internet is increasingly becoming the standard repository for consumer information across a broad spectrum of goods and services, and senior housing/in-home services are no exception. Even though there are ways for non-Internet savvy seniors to access that information indirectly, it is still likely that a portion of older adults will find this a barrier to gaining full information to inform their decisions about long-term care. Thus, the ability to access that information through Senior LinkAge Line® is very important.

Non-English speakers face added challenges in finding useful information to aid their long-term care choices from private sources; however, State resources provide significant help to non-English speaking older adults.

Based on our limited exploration of private web-based information, it appears that very little of the information available through private Internet sources is available in non-English languages. Consequently, the information available to non-English speakers must be accessed through oral communication with the use of translators, either professionals, family members, or friends and acquaintances.

However, the information resources offered by the State of Minnesota provide help for non-English speakers. With regard to access by non-English speakers, Senior LinkAge Line® utilizes translation services from an outside provider. If a caller has no or poor English language skills and the counselor can determine the language used by the caller, a translator from the outside vendor is brought so that a three-way conversation can continue. If printed information can be sent to the caller, a number of resources have been translated into the most commonly used languages of the callers, including Spanish, Hmong, Somali.[1] One limitation of this approach is that it requires literacy, and it is

[1] Additional languages available include Arabic, Cambodian, Laotian, Russian, Vietnamese, Bosnian, Amharic, and Oromo.

commonly known that some immigrant/refuge groups have low literacy rates even in their native language.

The Minnesota Department of Human Services provides content in a number of languages on its website, but the content consists mainly of essential forms that have been translated into a variety of languages. To navigate the MinnesotaHelp.info® website, users must be comfortable in English. Thus, the access of non-English speakers to the information available through the State of Minnesota is dependent on using translation through SLL, having an English-speaking helper, or access to (and literacy) for basic information and forms available in translations on the Internet.

Looking ahead, the Uniform Consumer Information Guide (UCIG) may be especially helpful to non-English speakers. Given the standardized nature of the information in the UCIG, it is possible to translate the text that surrounds the quantitative data into additional languages in a way that is not feasible or cost-effective for non-standard data.

Information currently available through the State of Minnesota

The information currently available through the Minnesota Board on Aging, MinnesotaHelp.info®, and other State agencies is potentially very helpful to consumers in their long-term care decision making.

The MinnesotaHelp.info® website contains links and access to a broad range of information on housing with services, assisted living, and in-home services. Moreover, it provides users with information on the vocabulary of housing to increase their understanding of the different types of services available.

For users who know what they are looking for, the site helps sort providers and facilities by geographic area and gives contact information that includes address, phone number, and web address (when available). From that point on, the user is left to seek further information directly from providers.

For users who are not sure what they are looking for, including those who may be making decisions about living arrangements, the site offers an extremely useful "Long-Term Care Choices Navigator." This is a menu-driven tool that asks a series of questions about capabilities and concerns of the consumer and then branches out to provide background information, useful web-based resources, and lists of providers with contact information. Users can save and modify a full plan for long-term care and print it out for use in contacting providers.

Another resource for consumers is the *Senior LinkAge Line*® (SLL). SLL provides another portal to the information in MinnesotaHelp.info® for those without skills to

navigate the Internet or who do not have Internet access. In 2007, SLL received 6,765 calls about housing and 7,652 calls requesting information about in-home services out of a total of roughly 100,000 calls. (The majority of the calls were on medical and healthcare insurance topics.) When surveyed by SLL, consumers say that they value the service, and usage figures back that up. Almost 20 percent of the unduplicated callers made multiple calls in 2007 and over 26,000 calls lasted over 30 minutes. On the other hand, consumers also raise concerns that they sometimes are switched to voicemail when the counselors are busy, an indication that the service is being heavily used.

For personal decision making help, MinnesotaHelp.info® users are made aware of Long-Term Care Consultants (LTCCs) provided by all Minnesota counties and they can also access a variety of other resources, such as the University of Minnesota Center on Aging, which provides a diagnostic tool to recommend the type of housing or in-home care a person should seek based on the answers to a series of diagnostic questions. In general, the site and the Navigator are quite useful to consumers who can "navigate" the Internet as a tool for identifying their needs and organizing their search for help with those needs.

The website of the Minnesota Board on Aging also provides background information that is helpful to older Minnesotans in making long-term care choices by explaining housing and in-home care options and providing a variety of tip sheets to increase understanding of the choices available.

Minnesota Office of Ombudsman for Long-term Care assists consumers with problem-solving in the areas of in-home and community services. In 2008, of the 384 complaints handled in home and community settings (housing with services including assisted living, adult foster care settings and residential hospice), 16 percent related to termination of tenancy, transfer, or moving into setting.

The Office of the Ombudsman for Long-Term Care also provides limited consultation for older adults and proxy decision makers who call with questions about long-term care choices. Data on consultation calls related to long-term care choices in the months of January and February for selected years show that the number of calls related to assisted living and in-home services rose by 68 percent between 1998 and 2008. Still, these calls are only a small fraction of the total calls received by the Ombudsman.

The State of Minnesota also provides information to consumers through the website of the Department of Human Services (DHS). On the DHS website, consumers can find information about various State programs, partnerships, and coalitions that serve to enhance long-term care. One such program that provides information to consumers via the Internet is the Minnesota Long-Term Care Partnership. This website serves a variety of needs including:

- outlining the eligibility requirements for Medical Assistance,
- providing information on determining the appropriate level of services to meet an individual's needs,
- giving guidance on how to research an insurer, and
- providing tax, relocation, and coverage information.

Also included on this website is a link to the United States Department of Health and Human Services' National Clearinghouse of Long-Term Care Information where consumers can order publications to be mailed to them.

Unlike MinnesotaHelp.info® and Senior LinkAge Line®, which are designed for use by consumers, some of the information on the DHS website was designed initially for counties or providers and then adapted or made available to consumers. Therefore, the information is sometimes focused on issues important to government and businesses rather than issues like attributes of comparative quality or price that would be important to a person shopping for care. This issue is discussed more fully in the following section.

In addition to the above mentioned resources, the DHS website offers resources on provider licensure information, grievance procedures, various provider inspection and survey findings, and Nursing Home Report Cards for nursing facilities across the state. This site also provides a mechanism for the online lodging of complaints.

The Uniform Consumer Information Guide (UCIG) collected by the Minnesota Department of Health and being prepared for inclusion in MinnesotaHelp.info® represents an advance for consumers, at least in the area of assisted living. When it becomes available in the summer of 2009, it will provide standardized, in-depth information about services. It will also provide limited price information.

This new data set presently includes over 800 separate assisted living facilities located in Minnesota. It includes a great deal of information and has been well-designed with consumers in mind. The information includes a wide range of the information that consumers currently must compile for themselves, including such detail as whether assisted living is available in the whole facility or only in a portion of it. The types of personal care, health services, and support services available are listed, along with their day-by-day availability, and whether they are included in base pricing or are available for an additional charge.

Completion of the UCIG is required of all assisted living providers by Minnesota statute. Therefore, it provides a complete database of all providers in the State. At least in the

area of assisted living, the UCIG represents a big step forward in providing standardized, useful data to consumers.

There are 43 different services for which providers can list availability and then indicate whether they are included in base packages or priced separately. They fall into three categories: 21 in support services (including meals, low sodium and diabetic diets, laundry, assistance with bills, "activities and socialization" transportation, and access to community resources), 8 in personal care (ADLs such as dressing grooming, bathing, transferring, etc.), and 14 in heath care related services (including registered nurse on-site, medication set-ups, insulin injections, wound care, and oxygen management). In addition, facilities may list "other" services in each category and indicate whether they are part of the base rate.

The UCIG data also includes price information on the basic package of services and tells the consumer what is included in the base rate it charges. Not only are the types and sizes of housing units listed, but a range of prices for each type of unit is also included. While the base rates included in the database cover a wide range, the middle half of the range showed monthly base rates between $1,775 and $3,775 per month. Our analysis of the price ranges indicates that the information will be extremely helpful to decision makers, even though they will need to have direct contact with providers to obtain the exact information necessary to make actual decisions.

Notwithstanding the improved information in UCIG, it still may be difficult for consumers and proxy decision makers to compare different providers who include different services in their base rate. In fact, our analysis showed that the number of the 43 potential services that are included in the base rates of providers varied widely. Therefore, a consumer would need to contact individual providers and get additional pricing information on specific services in order to form an accurate picture of the total cost of living at different locations.

One piece of information that is not provided by the UCIG, but should be made available to consumers and proxy decision makers in order to promote good long-term care decisions and wise financial planning. Consumers need to know the portion of the base rate payment that covers the "rent" and the portion that covers the "services." This is important because Elderly Waiver only covers services, not rent. Consumers who may spend-down to Medical Assistance after moving into an assisted living facility should understand this cost breakout before making the decision to move to that facility. Then, they and their families can decide if it is the best financial decision and if they will be able to stay in the facility (i.e., be able to afford the rent) after moving to the Medical Assistance.

The UCIG does not require that rents be delineated as a separate cost. And currently only about ten percent of the assisted living providers in the UCIG quote base rates that do not include services. This is problematic for consumers who may spend-down their assets and become eligible for Medical Assistance and reliant on Elderly Waiver (EW). EW pays for services, not for rent or raw food costs. The amount of their income that Medical Assistance (EW) recipients may keep (have available for rent and food) is limited to $860 per month currently. Should rents and raw food costs exceed the amount recipients are allow to keep, their family would have to pay the balance, or the individual would have to move. In some instances, providers offer a "down-grade" to a different apartment or room for people on EW. This information is not available within the UCIG currently. Perhaps, it could be incorporated into future iterations of the UCIG.

Additional information and formats that would be helpful to consumers

More information, especially more standardized and consolidated information, on the price and quality for assisted living, housing with services, or in-home services would be extremely helpful to consumers.

Two general classes of information were not available to consumers in the resources that were analyzed: price and quality.

Complete price information for housing with services and other in-home services is usually available only through direct contact with each provider. Occasionally, price information may be available on the provider's website. In addition, there is a lack of standardization of definitions of services and units. For example, housing with services often includes a mix of rents, meals, and personal assistance services in their base rate. The Uniform Consumer Information Guide requires that providers denote which services are included in their base rates, but not the amount of each service. This hybridization of housing and services makes cross-comparison of housing and service options and prices all but impossible except at the aggregate level. There may be a public role for eliciting more data which could help consumers to understand costs and make more informed decisions.

Quality information on home and community based services available to consumers is limited and not provided in a user-friendly fashion. Quality measures on Medicare Certified home care agencies (those with Class A licenses) are available on the Centers for Medicare and Medical Assistance Services (CMS) website. These quality measures focus on health outcomes such as percentages of patients who improve at getting around, percentage who improve at daily life skills, percentage who stay in their homes after service ends, and the percentage who have medical emergencies. While these objective measures are used in the assessment of providers by Medicare and Medical Assistance, they do not answer many of the questions consumers would have about dimensions of care.

The survey results from Class F home care providers (non-Medicare Certified) are available on the Minnesota Department of Health website. This information includes the letter indicating licensing status, including a list of any deficiencies that need to be corrected and a copy of the licensing survey form filled out by a registered nurse who has visited the provider. These copies of official forms would be hard for consumers to interpret since they refer to Minnesota statue numbers in some cases and they deal mainly with formal compliance with those statues.

Far more detailed quality information is available in the nursing home industry, where the Minnesota Department of Health and the Minnesota Department of Human Services provide information through its Nursing Home Report Card. The Nursing Home Report Card allows consumers to select three of seven areas of quality to compare nursing homes by geographic area. The quality dimensions include resident quality of life ratings, Minnesota quality indicators, hours of direct care, staff retention, use of temporary staff, proportion of single rooms, and State inspection results.

Figure 1 presents a side-by-side comparison of the criteria used in the CMS ratings, the Nursing Home Report Card and the Class F Survey. As the information in the table indicates, these three rating systems take very different approaches. Moreover, only the Nursing Home Report Card presents information in a manner that consumers would be expected to process and understand.

1. Comparison of criteria reported in three different quality ratings for long-term care services in Minnesota

CMS ratings	Class F Survey	Nursing Home Report Card
In-home health services	Assisted living housing	Nursing homes
Objective health outcomes	Compliance assessment	Consumer-focused quality
12 health outcomes	7 indicators of compliance	7 categories of quality
Percentages of success or improvement	Written valuations of each factor	1 to 5 stars for each category
Improvement in getting around	Meets client service plan	Resident quality of life
Improvement in getting in and out of bed	Promotes clients' rights	Minnesota quality indicators
Less pain when moving	Protects health and safety of clients	Hours of direct care
Bladder control improves	Client confidentiality maintained	Staff retention
Better at bathing	Employs qualified staff	Temporary staffing agency use
Better at taking medicines	Recognizes changes in condition/ stores medications safely	Proportion of single rooms
Short of breath less often	Has a current license	State inspection results
Stay at home aftercare ends		
Wounds improve or heal		
Admitted to hospital		
Need urgent, unplanned medical care		
Need unplanned care for a new or infected wound		

Sources: *Mn Dept. of Health, Mn Dept. of Human Services, CMS website.*

In addition, there is an on-line model of consumer-satisfaction from the private sector. Angie's List is a national information-sharing resource with user-submitted reviews on providers of home services such as house cleaning, lawn mowing, and roof repair. Subscribers can access the information and are encouraged to submit reviews to build the breadth and accuracy of the database. In this case, the information is shared among private citizens and the data is only as accurate as the input from private users. Over time, as more people join the network and submit reviews of their experience with different providers, the information has become more comprehensive and reliable. Just recently, Angie's List in the Twin Cities began to carry listings for several categories of "elder care," including assisted living, adult day care, and in-home services, but there are only a couple of listings and a small number of reviews. Over time, this information source could develop, but its potential is still limited because the service will only work where there is a sufficient population density, and with groups that have sufficient access to and comfort in using the Internet. Therefore, areas of Greater Minnesota and

consumers who do not use the Internet would remain uncovered by this kind of service even in the most optimistic case.

Nevertheless, Angie's List or similar services could be a useful complement to other resources, both public and private. In particular, in the area of in-home services in large and medium-sized cities, it could provide very useful information on small providers for whom no other quality information might be available. Moreover, its ratings are organized in a way that is easy for consumers to understand and use, and the rating elements are tailored to consumer needs. Figure 2 compares the criteria reported by Angie's List in its ratings of in-home health services and assisted living providers.

2. Comparison of criteria reported use in Angie's List ratings of in-home service and assisted living

Angie's List	Angie's List
In-home health services	Assisted living housing
Quality for consumers	Quality for consumers
5 indicators plus an overall grade	3 indicators plus an overall grade
Grades A-F	Grades A-F
Price	Price
Quality	Quality
Responsiveness	NA
Punctuality	NA
Professionalism	Professionalism
Overall grade	Overall grade

***Source**: Angie's List website.*

With regard to housing providers, private market resources exist that might provide a clue as to what type of quality information might be attainable in the future. In some cases, private marketing firms help providers to compare themselves to a peer group of other services with which they compete. One such service is utilized by the Wilder Foundation to assess its senior housing facilities. Using this system, each provider administers a customer satisfaction questionnaire provided by the market research company and then receives its tabulated results compared to a group of other facilities surveyed by the company. This information is kept private and facilities are not given the names of the other facilities in their peer group, but they are able to view their organization's results to a "benchmark" of similar providers. It is likely that such private information will remain inaccessible to consumers, but public sources can take cues from the type of information collected and analyzed by such sources.

Additional efforts should be made by the State to provide comparable or standardized formats across providers within a type of service or across types of services.

One ongoing challenge in the housing area is that there is a continuum of services available. By Minnesota statute, providers that advertise as assisted living must meet some minimum standards. However, there is still a great deal of variability in the type and scope of services offered in different facilities that use the same title. For example, different providers did not list the details of "memory care" or "medical assistance" in many instances, leaving consumers to inquire in detail in order to see if the offerings meet their individual needs. We did not find information in standardized or easily comparable formats about housing services currently available from private sources, nor did we find any standardized information available about in-home services.

Further steps should be taken to ensure that information on housing choices and home-based services is updated and accurate.

There is no way for consumers to make sure that information in web-based sources or other more traditional media is either accurate or current. While, in some abstract sense, it is in the best interests of providers with Internet presences to keep their information relatively up-to-date, there is no mechanism that ensures this. Moreover, over time conditions or practices at specific housing sites may change or the services offered by in-home providers may vary. Especially if the changes have been toward less services, there may even be an incentive for businesses to leave their information unchanged in order to attract more inquiries.

A major challenge of services like MinnesotaHelp.info® and the UCIG is keeping provider information up-to-date. Currently, the burden is placed on providers to update the information they list on these sites, but without any funding or regulatory mechanism to ensure this, it is likely that the information on individual providers is only accurate for a short time from the original posting. In another portion of this study, Wilder Research conducted surveys with providers who were sampled from the MinnesotaHelp.info® database. A number of providers indicated that they no longer offer the services that were listed in the database, suggesting that the database is easily out-dated.

There is a portal through which providers can update their information in MinnesotaHelp.info®. Though it may be in the providers' interest to make sure their information is current, there is no formal mechanism to ensure accuracy or timeliness. Perhaps it would be in everyone's best interest if providers could be required to update their information in order to renew their licenses.

Demographic differences in long-term care use

Indirect data imply that long-term care decision making (and long-term care preferences and access) differs markedly by location (urban vs. rural), race/ethnicity, and gender. However, more information must be gathered to confirm these initial findings.

Secondary data sources provide little information on how decisions about long-term care are actually made or how those decisions vary among different groups of older Minnesotans. However, there are some clues in the data about the context in which those decisions are made and some of the results of those decisions can be seen. In particular, we analyzed data from the Minnesota Medicaid Information System, the database that tracks all Medical Assistance recipients, including Elderly Waiver recipients. Our analysis highlights some comparisons that can be used to draw inferences about decision making by these older Minnesotans.

The percent of people using assisted living were compared with those using home-based services across different demographic groups of Elderly Waiver (EW) recipients. People were sorted into groups based on their level of dependency in four categories of need: activities of daily living (ADLs), instrumental activities of daily living (IADLs), medical needs, and cognitive challenges.[2] Then, we sorted recipients into 16 different groups based on the number and combination of different types of dependencies they had. Finally, we compared the usage of assisted living for each diagnosis group.

We found that, on average, a larger proportion of female EW recipients compared with male EW recipients were using assisted living (32.2% versus 26.9% in 2008). This greater use held true across 11 of the 16 diagnosis groups and was especially pronounced in the group that had dependencies in all four categories, 49.6 percent versus 41.2 percent, and in three of the four groups that had three categories of dependency. The difference in assisted living between the genders appears to have widened a bit between 2003 and 2008 for these higher-needs individuals. All of these differences were statistically significant, though we have not investigated the reasons for the differences. One potential explanation is that older men are more likely to have a family (female) caregiver than older women who may be more likely to be living alone.

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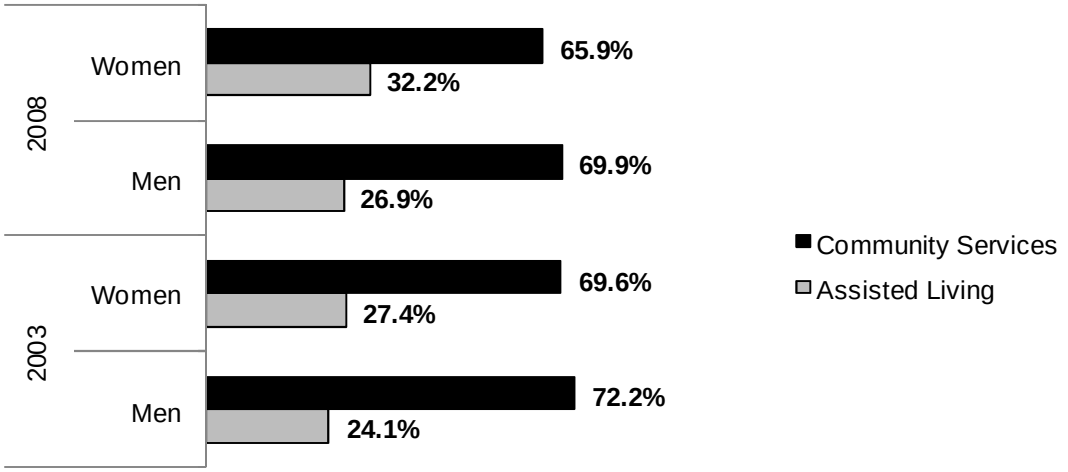
[2] Residents were rated as dependent or not in each of four categories according to the following method:

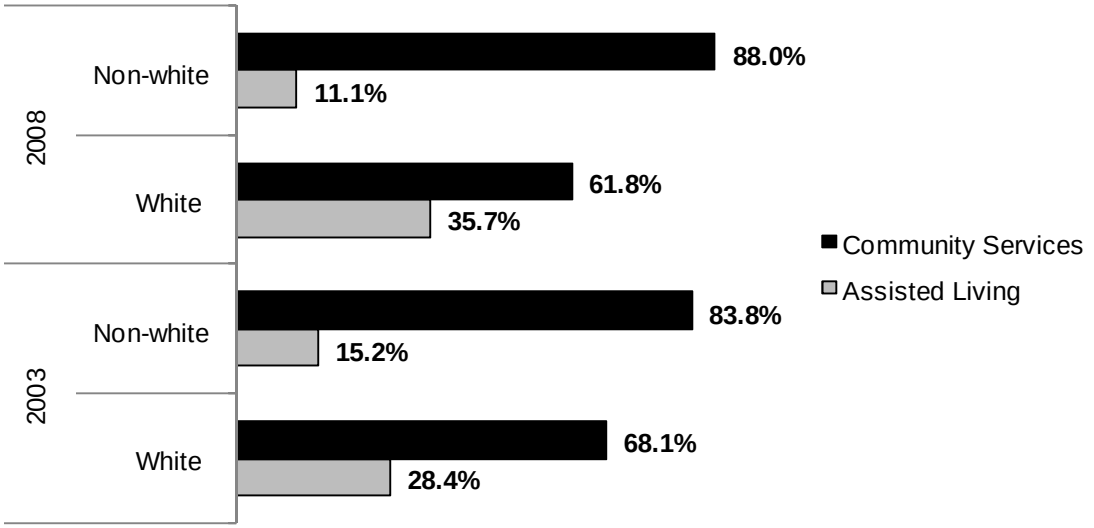
- Activities of daily living – one or more scores of 2 or higher in dressing, grooming, eating, bed mobility, transferring, or walking OR a score of 3 or higher on bathing OR a score of 1 or higher on toileting
- Instrumental activities of daily living – on ore more scores of 3 or higher on shopping, meal preparation, light housekeeping, heavy housekeeping, or laundry
- Medical – a score of 2-4 on medication management OR a yes on complex care OR a score of 1 or higher on clinical monitoring or special treatment
- Cognitive – a score of 2 or higher on orientation, self preservation, or behavior

3. All EW recipients by gender



When assisted living use of non-Hispanic whites was compared with the use of all other ethnic and racial groups, the contrast was especially striking. Overall, 35.7 percent of whites receiving EW were using assisted living in 2008 compared with only 11.1 percent of minority groups receiving EW. This result held across all but 2 of the 16 diagnostic groups, and was the most apparent for the highest-needs individuals. Fully 55.1 percent of whites in the group with dependencies in all four areas were in assisted living compared with only17.8 percent of the minorities. Curiously, the percentage of whites using assisted living increased from 2003 to 2008 while the percentage of minorities declined over the same period. All of the differences were statistically significant.

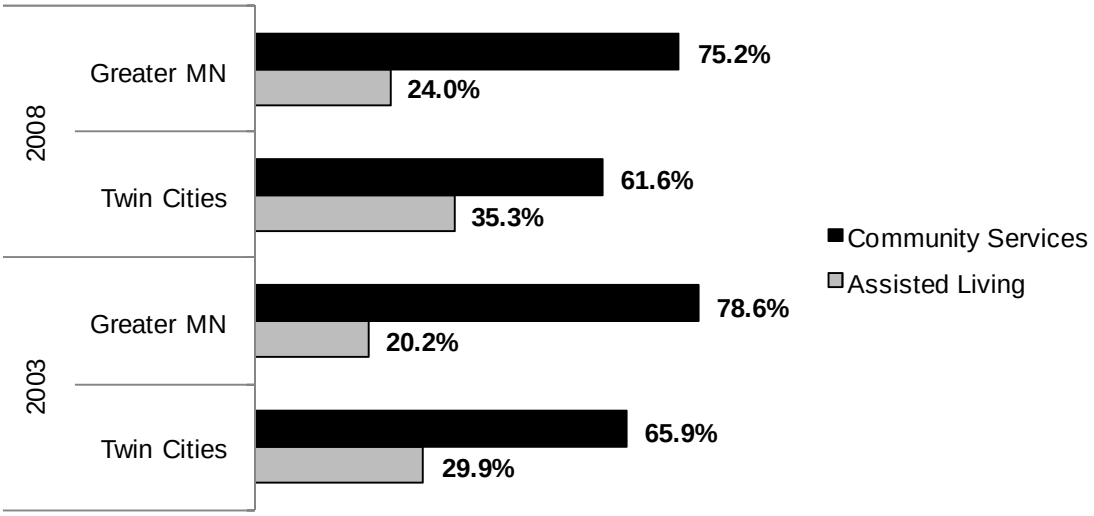
4. All EW recipients by race/ethnicity



When EW recipients in Greater Minnesota were compared to those in the 7-county Twin Cities metropolitan area, greater usage of assisted living outside the Twin Cities was found. Over one-third (35.3%) of recipients in Greater Minnesota were being served in assisted living settings compared with less than one-quarter (24.0%) in the Twin Cities. This result held across all 16 groups from low-needs to high-needs individuals. Part of the explanation for this contrast could be a relative shortage of in-home services in Greater Minnesota relative to the Twin Cities. While we do not have definitive information on this point, a count of the number of professional home health agencies holding Class A licenses shows that 73 percent are registered in the 7-county metro area which is home to 61 percent of Minnesota's residents. However, the majority of home health providers holding Class F licenses, a larger group than Class A licensees, are located outside of the metro area.

An alternative possibility is that people in rural areas may have access to fewer family caregivers. Hence, they might be more likely to go to assisted living than similar persons in urban areas where more informal caregivers might live nearby. So, more investigation is necessary to explain this disparity.[3]

5. All EW recipients by location



It is important to note that differences in use of EW among different demographic groups does not necessarily indicate a "disparity" that should be addressed by the State in order to ensure all groups are using EW-related services at the same rates. For example, the lower use of assisted living among EW recipients of color compared with white recipients may

[3] In fact, data from 2008 show that 96.5 percent of EW recipients living with a family member or a friend used home based services, up slightly from 95.4 percent in 2003. This compared to 81.2 percent of EW recipients who lived alone and 13.0 percent of those who were reported as living in congregate settings.

indicate a preference for minorities for long-term care options other than assisted living, rather than a lack of access to information. However, these differences could also be attributed to differences in access to financial resources and lack of access to information. More research is needed to tease out the reasons for differences by demographic groups.

Data from the different call centers of Senior LinkAge Line® (SLL) also show different proportions of calls related to housing and in-home services. As mentioned earlier, about 6 percent of all of the calls received by SLL statewide were about housing and another 7 percent were about in-home services. However, only about 1 percent of the calls received in the Warren region related to housing while 12 percent of the calls to the St. Cloud region were on housing topics. Similarly, the calls regarding in-home services ranged from a low of roughly 3 percent in Slayton to a high of almost 12 percent in Warren. The extreme difference in the mix of calls to the Warren center may indicate a difference in long-term choices or preferences of American Indians, who represent a higher percent of the residents served by that SLL call center compared with other regions.

6. Comparison of Senior LinkAge Line call center calls by region, total unduplicated, housing related, and in home services related in calendar year 2007

Region	Total unduplicated calls	Housing calls	In home services calls
Warren	4,488	49	531
		1.1%	11.8%
Duluth	6,892	216	217
		3.1%	3.1%
Fergus Falls	8,880	234	536
		2.6%	6.0%
Metro	38,284	2,827	2,743
		7.4%	7.2%
Rochester	15,099	641	1,219
		4.2%	8.1%
Slayton	10,981	290	284
		2.6%	2.6%
St. Cloud	20,241	2,428	2,061
		12.0%	10.2%
Statewide totals	104,865	6,685	7,591
		6.4%	7.2%

Sources: *Minnesota Board on Aging data and Wilder Research calculations.*

Paying for long-term care services

A review of the literature on the topic indicates that:

- Older adults are frequently forced into long-time care as a response to some sort of crisis such as illness or a fall.
- Individuals are not necessarily unwilling to consider different long-term care options, but research has shown that most older adults prefer no services first, then community based services, and only select institutional care as a last resort.
- Financial self-sufficiency is not regarded as a stand-alone decision, rather a factor in making long-term care plans and a consequence of health status, prior income and savings, and the availability of informal service providers.
- We found no studies that specifically addressed the issue of consumer awareness of the financial implications of long-term care choices. Given the research on financial literacy, we expect that few elders or long-term care decision makers have more than an intuitive sense of a risk to future housing choices when spending assets.

Gaps in information impacting financial self-sufficiency

Gaps in information about financial ramifications of care choices prevent consumers from using private resources, Medicare, and other third party pay in a way that maximizes financial self-sufficiency.

Our review of resources for consumers of long-term care services turned up little information that could help families plan for financial self-sufficiency. And, given the paucity of information about pricing and lack of standardization of services, it is not surprising that we could find detailed information on Medical Assistance eligibility but only general advice on financial planning. Moreover, our literature search confirms that decisions about long-term care are often made on short notice in response to a medical crisis. Therefore, detailed financial calculations are often not possible in the time frame in which decisions are required.

Adequacy of information on financial issues has profound implications for the financial self-sufficiency of seniors and the financial projections for the State as increasingly large cohorts of older adults move through their 60s and 70s. Decisions about financial issues for older Minnesotans are inherently more complicated and more individualized than decisions about long-term care. The latter are essentially shopping decisions while the former are strategic decisions with many more variables.

This issue will be addressed chiefly through the information being collected in another phase of this project, the survey of consumers. Analysis of the sources considered here

and general investigation into information did not reveal resources that were sufficient to enable older Minnesotans and their helpers to maximize financial self-sufficiency. A challenge intrinsic in the current long-term care system is that it is so complex that even if complete information were available, the lack of consistency of terms coupled with the multiplicity of variables results in a maze consumers are unable to navigate on their own. The complexity of the system itself results in difficulty for the consumer, even if "complete" basic information could be made available.

Resources to educate and support informed choices need to be expanded and redesigned to better fit the needs of decision makers, especially in the areas of financial self-sufficiency and advance planning.

In our review of Internet-based financial resources, we did not find decision making tools that could take consumers all the way to a financial plan. Rather, we found retirement planning tools that can help younger people anticipate their future financial needs in a general way. We found referral sources that directed consumers to planning professionals. And we found sites which would sort through information and determine mixes of services that fit a person's situation.

One example was the Long-Term Care Planning Tool at www.medicaid.gov. In many ways similar to the Navigator at MinnesotaHelp.info®, it produced both a long-term care plan and a long-term care finance plan. However, the finance plan just laid out some general options for service and what the potential costs would be, referenced to the consumer's geographic location. Therefore, this tool falls far short of what a consumer needs to form an effective financial plan. The inherent complexity of the calculations required probably limits how much help a freestanding decision tool could be. Nevertheless, additional resources could be fruitfully devoted to this problem given the current state of financial information and the task that most consumers face in maintaining financial self-sufficiency.

Demographic differences in long-term care financial planning

Over the past five years, the characteristics of persons who have depleted their private assets resulting in eligibility for public programs have changed somewhat. However, more research is needed to fully understand the trends.

We compared data on all of the recipients of the Elderly Waiver contained in the MMIS database in 2003 and 2008. As explained earlier in this report, some of the comparisons were made by sorting recipients into 16 groups, reflecting their having been diagnosed as having a dependency in one of the four areas: activities of daily living, instrumental activities of daily living, medical needs, and cognitive challenges.

First, we analyzed the *changing composition* of all recipients by comparing the overall distribution of individuals by total dependency levels. The 2008 data show the greatest increase in the number of people who had dependencies in all four categories since 2003, from 43.2 percent to 46.3 percent. In other words, a greater percentage of recipients showed dependency in all four categories of possible need.

Other changes were evident from the MMIS data (see the Appendix for data tables):

- The overall proportion of EW recipients who are in assisted living rose from 26.6 percent in 2003 to 30.9 percent in 2008.
- The age distribution shifted, with distinctly more people in the youngest category, up to 69 years old.
- The gender mix of recipients shifted toward more males, 25.8 percent in 2008 versus 23.6 percent in 2003.
- A greater proportion of EW recipients were located in the 7-county Twin Cities area, 39.0 percent in 2008, up from 33.9 percent in 2003.
- A greater proportion of recipients had not had a stay in a nursing facility in the last three years before entering MA, 75.4 percent in 2008 versus 73.6 percent in 2003.
- Slightly more of the MA recipients self-rated their own health as good or excellent in 2008 than did so in 2003, 44.2 percent versus 42.6 percent.

Information available through the State of Minnesota regarding financial self-sufficiency

The Minnesota Department of Human Services and other State agencies provide some of the most easily accessible background information that can help seniors and others better understand long-term care choices, and in some cases, the financial self-sufficiency issue.

The DHS website includes an eligibility calculator that can help older adults figure out if or when they might qualify for Medical Assistance. The "Advisor" section of the website of the Minnesota Board on Aging provides some useful questions and answers about financing long-term care and refers people to Senior LinkAge Line® if they have additional questions.

The current navigation feature on MinnesotaHelp.info® cannot provide detailed financial guidance due to lack of standardization of features/service definitions and also the lack of price information for most services. At the present time, the tool can create a service plan for an individual but does not provide support to consumers in projecting their continued

financial self-sufficiency based on different housing and service scenarios. Software and programming that would make this possible within MinnesotaHelp.info® would be extremely valuable to consumers.

Characteristics of older Minnesotans receiving Medical Assistance

In recent years, an increasing proportion of new Medical Assistance recipients are approved for assisted living in their first month of eligibility for Elderly Waiver. Presumably, these people depleted their assets while paying for assisted living and then applied to the State for support through Medical Assistance.

Minnesota is able to ascertain how long people live in nursing homes before spending-down to Medical Assistance, what amount was paid, and the services that were provided. However, the State has no comparable data on housing with services, assisted living or other in-home services. This is problematic because it is virtually impossible to predict where older adults are in their trajectory toward financial dependency. Spend-down to Medical Assistance in housing with services settings is further complicated as the consumer's housing is potentially at-risk if they are unable to pay the rent portion of provider' fees.

One potentially important change in recent years is the proportion of new Medical Assistance (MA) recipients who are authorized for assisted living in their first month of eligibility. This bears on the question of how older adults plan long-term care because, most, if not all, of these consumers were in assisted living at the time they became eligible for MA. If some of these people moved into assisted living when their needs could have been met at a lower cost, they could have maintained their financial self-sufficiency longer.

As the following figure shows, the number of first time recipients of MA in Minnesota tripled from 2003 to 2007. (This is in part due to the growth of the older adult population due to the aging of the baby boomer generation.) Moreover, the proportion of those new MA recipients who are authorized for assisted living during their first month on MA grew from 46 percent in 2003 to 64 percent in 2006 and has stayed above 60 percent in 2007 and so far in 2008.

7. Number and percent of new recipients of Medical Assistance authorized for assisted living in their first month, 2003, 2006, 2007, and 2008 YTD

	First time MA recipients	Authorized assisted living first month	Percent of all new MA recipients
2003	583	271	46%
2006	996	635	64%
2007	1,425	868	61%
2008 (through Aug)	687	450	66%

***Source**: DHS MMIS data and Wilder Research calculations.*

These data suggest that these EW recipients may be spending down their assets faster in assisted living than they would if they used home-based services. However, when the consumers' needs reach a certain level, home-based care can become more expensive than assisted living. Therefore, more information is needed to confirm this speculation. Such information would be extremely helpful to the State in its financial planning.

Issues to consider

Logical next steps

The purpose of this analysis is to provide perspective on the research questions of this project and to complement the information from the literature review and the surveys of different groups. Final answers and recommendations will be synthesized after all of the data has been assembled and analyzed. However, here are some issues raised or confirmed during this secondary data analysis that warrant further consideration.

- Requiring assisted living providers to separate rent from other bundled charges to help consumers' financial planning
- Developing publicly available, standardized information on the quality and price of assisted living facilities, housing with services, and in-home services
- Expanding decision making help resources, especially financial decision making resources
- Facilitating information access for non-Internet-using consumers and non-English speaking consumers
- Education, outreach, and possibly incentives to encourage earlier investigation of housing options and financial planning by older adults and their advisors

Areas for further research

Several areas where further research would be helpful have emerged during this analysis.

- Investigating the rising percentage of first-time MA recipients who are served in assisted living in their first month of participation and consumer spend-down of assets generally
- Developing more information at the State level about private pay consumers of housing and in-home services before they come on to MA
- Exploring the relative availability of in-home services in Greater Minnesota and the Twin Cities

Appendix A

For all tables:

Sources: *DHS MMIS data and Wilder Research calculations.*

Note: *All 2008 data are for the period January through August and, thus, totals should not be compared to prior years*

Note: *Total percentages may not add to 100 due to rounding.*

Note: ** indicates statistical significance (p ≤ 0.05)*

Note: *"Moderate needs" indicates that no individual service need rose to the level used to sort dependencies*

A1. Elderly Waiver recipients: comparison of percentage of persons with dependencies, 2003 and 2008

	Jan – Aug		
	2003	**2008**	**Change**
ADL	74.8%	74.5%	-0.3%
IADL	96.1%	94.0%	-2.1%*
Medical	72.8%	76.5%	+3.7%*
Cognitive	57.7%	56.9%	-0.8%
N	**21,995**	**18,990**	**-**

Note: *In this and succeeding tables, residents were rated as dependent or not in each of four domains according to the following method:*

*Activities of daily living **(ADL)** – one or more scores of 2 or higher in dressing, grooming, eating, bed mobility, transferring, or walking OR a score of 3 or higher on bathing OR a score of 1 or higher on toileting*

*Instrumental activities of daily living **(IADL)–** on ore more scores of 3 or higher on shopping, meal preparation, light housekeeping, heavy housekeeping, or laundry*

***Medical** – a score of 2-4 on medication management OR a yes on complex care OR a score of 1 or higher on clinical monitoring or special treatment*

***Cognitive** – a score of 2 or higher on orientation, self preservation, or behavior.*

A2. Elderly Waiver recipients: distribution of persons by number of dependencies, 2003 and 2008

		Jan – Aug	
	2003	**2008**	**Change**
No domain	1.3%	2.8%	+1.5%*
1 domain	9.7%	10.2%	+0.5%
2 domains	18.5%	15.9%	-2.6%*
3 domains	27.2%	25.0%	-2.2%*
4 domains	43.2%	46.3%	+3.1%*
N	**21,995**	**18,990**	

A3. Elderly Waiver recipients: distribution of persons by dependencies, 2003 and 2008

		Jan – Aug	
	2003	**2008**	**Change**
Moderate needs	1.3%	2.8%	+1.5%*
Cognitive only	0.3%	0.3%	-
Medical only	0.8%	1.1%	+0.3%*
Medical & cognitive	0.3%	0.3%	-
IADL only	8.3%	8.0%	-0.3%
IADL & cognitive	2.3%	1.5%	-0.8%*
IADL & medical	7.3%	7.1%	-0.2%
IADL & medical & cognitive	4.7%	4.6%	-0.1%
ADL only	0.4%	0.8%	+0.4%*
ADL & cognitive	0.2%	0.1%	-0.1%
ADL & medical	0.4%	0.5%	+0.1%
ADL & medical & cognitive	0.3%	0.2%	-0.1%
ADL & IADL	8.0%	6.4%	-1.6%*
ADL & IADL & cognitive	6.5%	3.7%	-2.8%*
ADL & IADL & medical	15.8%	16.5%	+0.7%
ADL & IADL & medical & cognitive	43.2%	46.3%	+3.1%*
N (all service types included)	**21,995**	**18,990**	

A4. Elderly Waiver recipients: distribution of persons by housing type, 2003 and 2008

	Jan – Aug		
	2003	**2008**	**Change**
Housing with services	26.6%	30.9%	+4.3%*
Home based services	70.2%	66.9%	-3.3%*
Other residential	3.2%	2.2%	-1.0%
N	**21,995**	**18,990**	**-**

A5. Elderly Waiver recipients: comparison of percentage of persons by service type for each dependency category, 2003 and 2008

	Housing with services Jan – Aug			Home-based services Jan – Aug		
	2003	**2008**	**Change**	**2003**	**2008**	**Change**
Moderate needs	0.3%	0.1%	-0.2%*	1.7%	4.1%	+2.4%*
Cognitive only	0.2%	0.2%	-	0.3%	0.3%	-
Medical only	0.4%	0.2%	-0.2%*	1.0%	1.5%	+0.5%*
Medical & cognitive	0.3%	0.2%	-0.1%*	0.3%	0.3%	-
IADL only	3.3%	1.3%	-2.0%*	10.5%	11.3%	+0.8%*
IADL & cognitive	1.0%	0.5%	-0.5%*	2.9%	1.9%	-1.0%
IADL & medical	5.7%	3.3%	-2.4%*	8.1%	9.0%	+0.9%*
IADL,medical & cognitive	6.0%	5.7%	-0.3%	4.2%	4.0%	-0.2%
ADL only	0.1%	0.1%	-	0.5%	1.1%	+0.6%*
ADL & cognitive	0.1%	0.1%	-	0.2%	0.1%	-0.1%
ADL,& medical	0.3%	0.1%	-0.2%	0.5%	0.7%	+0.2%*
ADL, medical & cognitive	0.3%	0.3%	-	0.3%	0.2%	-0.1%
ADL & IADL	3.5%	2.0%	-1.5%*	10.1%	8.7%	-1.4%*
	3.6%	2.0%	-1.6%*	7.7%	4.6%	-3.1%*
ADL & IADL & medical	15.8%	12.8%	-3.0%*	16.1%	18.5%	+2.4%*
ADL & IADL & medical & cognitive	59.2%	71.2%	+12.0%*	35.6%	33.6%	-2.0%*
Total percentage of all services	**26.6%**	**30.9%**	**+4.3%**	**70.2%**	**66.9%**	**-3.3%**
N	**5,847**	**5,864**		**15,440**	**12,709**	

Note: *Since only 2-3 percent of all EW recipients are in residential programs other than housing with services, these individuals are not included in this table.*

A6. Elderly Waiver recipients: comparison of percentage of persons for each dependency category, by gender, 2003 and 2008

	Female			Male		
	2003	Jan – Aug 2008	Change	2003	Jan – Aug 2008	Change
Moderate needs	1.2%	2.6%	+1.4%*	1.5%	3.3%	+1.8%*
Cognitive only	0.3%	0.3%	-	0.3%	0.2%	-0.1%
Medical only	0.7%	0.9%	+0.2%*	1.1%	1.6%	+0.5%
Medical & cognitive	0.3%	0.2%	-0.1%	0.4%	0.4%	-
IADL only	8.5%	8.1%	-0.4%	7.5%	7.8%	+0.3%
IADL & cognitive	2.3%	1.3%	-1.0%*	2.2%	1.9%	-0.3%
IADL & medical	6.2%	6.0%	-0.2%	10.7%	10.1%	-0.6%
IADL & medical & cognitive	4.2%	3.9%	-0.3%	6.2%	6.5%	+0.3%
ADL only	0.4%	0.9%	+0.5%*	0.3%	0.4%	+0.1%
ADL & cognitive	0.2%	0.1%	-0.1%	0.1%	0.1%	-
ADL & medical	0.4%	0.5%	+0.1%	0.4%	0.5%	+0.1%
ADL & medical & cognitive	0.3%	0.2%	-0.1%	0.2%	0.1%	-0.1%
ADL & IADL	9.4%	7.4%	-2.0%*	3.7%	3.5%	-0.2%
ADL & IADL & cognitive	7.1%	4.1%	-3.0%*	4.3%	2.6%	-1.7%*
ADL & IADL & medical	16.1%	16.9%	+0.8%	14.9%	15.3%	+0.4%
ADL & IADL & medical & cognitive	42.4%	46.6%	+4.2%*	46.0%	45.5%	-0.5%
N	**16,794**	**14,095**		**5,201**	**4,895**	

A7. Elderly Waiver recipients: comparison of percentage of persons for each dependency category, by race/ethnicity, 2003 and 2008

	White (non-Hispanic)			Non-white		
	2003	Jan – Aug 2008	Change	2003	Jan – Aug 2008	Change
Moderate needs	1.4%	2.9%	+1.5%*	0.6%	2.2%	+1.6%*
Cognitive only	0.3%	0.3%	-	0.2%	0.1%	-0.1%
Medical only	0.8%	1.0%	+0.2%	0.5%	1.3%	+0.8%*
Medical & cognitive	0.3%	0.3%	-	0.3%	0.2%	-0.1%
IADL only	8.6%	8.3%	-0.3%	5.9%	6.7%	+0.8%
IADL & cognitive	2.4%	1.5%	-0.9%*	1.5%	1.3%	-0.2%
IADL & medical	7.4%	6.9%	-0.5%	6.8%	7.6%	+0.8%
IADL & medical & cognitive	4.6%	4.8%	+0.2%	5.1%	3.4%	-1.7%*
ADL only	0.4%	0.9%	+0.5%*	0.2%	0.3%	+0.1%
ADL & cognitive	0.2%	0.1%	-0.1%	0.1%	<0.1%	-
ADL & medical	0.4%	0.6%	+0.2%	0.2%	0.3%	+0.1%
ADL & medical & cognitive	0.3%	0.2%	-0.1%	0.3%	0.2%	-0.1%
ADL & IADL	8.5%	6.8%	-1.7%*	5.1%	5.0%	-0.1%
ADL & IADL & cognitive	6.4%	3.9%	-1.5%*	7.0%	2.8%	-4.2%*
ADL & IADL & medical	16.5%	15.5%	-1.0%*	12.0%	20.5%	+8.5%*
ADL & IADL & medical & cognitive	41.5%	45.9%	+4.4%*	54.2%	48.1%	-6.1%*
N	**18,948**	**15,258**		**3,047**	**3,732**	

A8. Elderly Waiver recipients: comparison of percentage of persons for each dependency category, by location, 2003 and 2008

	Twin Cities 7-county metro area			Greater Minnesota		
		Jan – Aug			Jan – Aug	
	2003	2008	Change	2003	2008	Change
Moderate needs	0.4%	1.6%	+1.2%*	1.8%	3.5%	+1.7%*
Cognitive only	0.1%	0.2%	+0.1%	0.4%	0.3%	-0.1%
Medical only	0.2%	0.8%	+0.6%*	1.1%	1.3%	+0.2%
Medical & cognitive	0.3%	0.2%	-0.1%	0.3%	0.3%	-
IADL only	4.5%	6.2%	+1.7%*	10.2%	9.1%	-1.1%*
IADL & cognitive	2.2%	1.4%	-0.8%*	2.4%	1.5%	-0.9%*
IADL & medical	4.8%	5.7%	+0.9%*	8.6%	8.0%	-0.6%
IADL & medical & cognitive	5.0%	4.5%	-0.5%	4.5%	4.6%	+0.1%
ADL only	0.2%	0.5%	+0.3%*	0.5%	1.0%	+0.5%*
ADL & cognitive	0.1%	<0.1%	-	0.2%	0.1%	-0.1%
ADL & medical	0.2%	0.3%	+0.1%*	0.5%	0.6%	+0.1%
ADL & medical & cognitive	0.3%	0.2%	-0.1%	0.2%	0.2%	-
ADL & IADL	5.3%	5.5%	+0.2%	9.4%	7.0%	-2.4%*
ADL & IADL & cognitive	8.7%	4.0%	-4.7%*	5.3%	3.5%	-1.8%*
ADL & IADL & medical	10.3%	15.9%	+5.6%*	18.7%	16.8%	-1.9%*
ADL & IADL & medical & cognitive	57.3%	53.1%	-4.2%*	36.0%	42.0%	+6.0%*
N	**7,464**	**7,398**		**14,531**	**11,592**	

A9. Elderly Waiver recipients: distribution of persons by age group, 2003 and 2008

		Jan – Aug	
	2003	**2008**	**Change**
65-69 years	9.8%	14.1%	+4.3%*
70-74 years	13.3%	14.9%	+1.6%*
75-79 years	18.4%	17.2%	-1.2%*
80-84 years	23.5%	20.2%	-3.3%*
85-89 years	20.1%	19.1%	-1.0%*
90-94 years	11.4%	10.7%	-0.7%*
95-99 years	3.0%	3.3%	+0.3%
100 years+	<0.1%	<0.1%	-
N	**21,995**	**18,990**	

A10. Elderly Waiver recipients: distribution of persons by gender, 2003 and 2008

		Jan – Aug	
	2003	**2008**	**Change**
Female	76.4%	74.2%	-2.2%*
Male	23.6%	25.8%	+2.2%*
N	**21,995**	**18,990**	

A11. Elderly Waiver recipients: distribution of persons by location, 2003 and 2008

		Jan – Aug	
	2003	**2008**	**Change**
7-county metro area	33.9%	39.0%	5.1%*
Greater Minnesota area	66.1%	61.0%	-5.1%*
N	**21,995**	**18,990**	

A12. Elderly Waiver recipients: distribution of persons by number of nursing facility stays within 3 years, 2003 and 2008

	Jan – Aug		
	2003	**2008**	**Change**
0	73.7%	75.4%	+1.7%*
1	22.2%	20.0%	-2.2%*
2	3.2%	3.4%	+0.2%
3	0.7%	0.8%	+0.1%
4+	<0.1%	<0.1%	-
N	**21,994**	**18,990**	

A13. Elderly Waiver recipients: distribution of persons by health self evaluation, 2003 and 2008

	Jan – Aug		
	2003	**2008**	**Change**
Excellent	2.9%	3.3%	+0.4%*
Good	42.6%	44.2%	+1.2%*
Fair	44.3%	42.0%	-2.3%*
Poor	10.2%	10.5%	+0.3%
Valid N*	**20,580**	**17,684**	

***Note:** *Data were not available for all consumers on this item.*

Appendix B

This report card shows how Minnesota nursing homes scored in seven quality measures. Each nursing home is scored from 1 (lowest) through 5 (highest) on each of the seven measures. For additional information about the report card go to the nursing home report card fact sheet *(pdf, 5 pages, 53k).*

First, you can focus your search by choosing your preferred area of the state by zip code, or *click here to see the report card for an individual nursing home*.

I am looking for a nursing home within [ ] miles of zip code [ ].

Second, select the quality measures that are most important to you.

- 1, for the most important quality measure.
- 2, for the second most important quality measure.
- 3, for the third most important quality measure.

[ ] Resident quality of life ratings More

[ ] Minnesota quality indicators More

[ ] Hours of direct care More

[ ] Staff retention More

[ ] Temporary staffing agency use More

[ ] Proportion of single rooms More

[ ] State inspection results More

[1] *2008 Minnesota Statutes*

Resources

Topics

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256B.439 LONG-TERM CARE QUALITY PROFILES.

Subdivision 1.**Development and implementation of quality profiles.**

(a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement a quality profile system for nursing facilities and, beginning not later than July 1, 2004, other providers of long-term care services, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. The system must be developed and implemented to the extent possible without the collection of significant amounts of new data. To the extent possible, the system must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, and other entities. The system must be designed to provide information on quality to:

(1) consumers and their families to facilitate informed choices of service providers;

(2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The system must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

Subd. 2.**Quality measurement tools.**

The commissioners shall identify and apply existing quality measurement tools to:

(1) emphasize quality of care and its relationship to quality of life; and

(2) address the needs of various users of long-term care services, including, but not limited to, short-stay residents, persons with behavioral problems, persons with dementia, and persons who are members of minority groups.

The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond current state and federal requirements.

Subd. 3.**Consumer surveys.**

Following identification of the quality measurement tool, the commissioners shall conduct surveys of long-term care service consumers to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioners, surveys may be conducted by telephone or by provider staff. Surveys must be conducted periodically to update quality profiles of individual service providers.

Subd. 4.**Dissemination of quality profiles.**

By July 1, 2003, the commissioners shall implement a system to disseminate the quality profiles developed from consumer surveys using the quality measurement tool. Profiles may be disseminated to the Senior LinkAge line and to consumers, providers, and purchasers of long-term care services through all feasible printed and electronic outlets. The commissioners may conduct a public awareness campaign to inform potential users regarding profile contents and potential uses.

History:

1Sp2001 c 9 art 5 s 29; 2002 c 220 art 14 s 12,13; 2002 c 379 art 1 s 113