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Wisconsin's Family Care Long-Term Care Pilot Program: Care Managers' Perspectives on Progress and Challenges

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EXECUTIVE SUMMARY

This report is part of an ongoing study of Wisconsin's Family Care pilot long-term care program, focusing on the perspective of care managers working in the Family Care program in four Family Care counties implementing Care Management Organizations (Fond du Lac, La Crosse, Milwaukee, and Portage). A previous report in 2001 focused on the early experiences of Family Care care managers (CMs) during the first year of implementation. The current report updates those findings, addressing care managers' views after completing early implementation years of Family Care.

The goals of this report were (1) to examine whether and how Family Care has changed the services provided to people with long-term support needs, (2) to describe some specific service issues that will need attention to improve Family Care, (3) to describe care managers' overall views of Family Care at the end of its early implementation phase, and (4) to describe care managers' suggestions for change to Family Care. This research was based on structured phone surveys conducted at two times. Wave 1 included 64 Family Care CMs interviewed in fall/winter 2000–01. Wave 2 included 119 Family Care CMs interviewed in spring/summer 2002. A comparison sample of 62 care managers working in the long-term support system across the rest of the state was interviewed in winter 2001.

Our six major conclusions are presented below.

1. Family Care has improved the service environment for people with long-term support needs by (1) making Family Care an entitlement and (2) creating a more flexible and responsive system to tailor services and supports to the particular needs of participants.

2. Family Care has been responsive to improving availability, access, and choice of services to better meet needs of consumers. At Wave 1, Family Care CMs reported that personal care/supportive home care, transportation, and residential options were the top three service areas needing the most development. There is evidence that the Family Care counties made improvements in each of these areas as well as in other areas by Wave 2.

3. Despite improvements in the service environment under Family Care, all counties reported both shared and unique service areas that need improvement. For example, in terms of shared areas, all four counties need to develop additional residential alternatives. In terms of county-specific needs, Family Care CMs in Milwaukee reported particular needs in the areas of personal care (50 percent), transportation (19 percent), and care management (15 percent). Portage care managers reported particular needs for transportation (38 percent), respite (38 percent), and residential options (38 percent). Fond du Lac care managers reported needs for residential options (50 percent), transportation (18 percent), respite (18 percent), and mental health services (18 percent). La Crosse care managers mentioned needs for residential options (33 percent), personal care/supportive home care (20 percent), and employment services (17 percent).

4. Most Family Care CMs felt positive about Family Care's ability to serve consumers well. When asked about their general views regarding Family Care, care managers agreed that Family Care increased services to some participants who were not getting enough services under the old system. Almost all care managers agreed that Family Care allows them to provide some types of services not allowed before, and that consumers now have increased choice in types of services and service providers. When asked whether Family Care should be expanded to the rest of the state, 72 percent of Wave 2 Family Care CMs responded that it should, while 18 percent were unsure and 12 percent did not support expansion.

5. Care managers cited challenges to effectively fulfilling their care management roles. Although Family Care CMs reported that program participants receive good care under Family Care, they stressed that improvements need to be made to the care management role itself in order for them to continue providing optimal care to participants.

6. Care managers' recommendations for changes to Family Care focused primarily on organizational and administrative issues. When care managers were asked to make three recommendations for improving Family Care, about half of their suggestions were aimed at changing the

amount and type of work required of care managers (e.g., reducing paperwork, improving pay, reducing caseloads). About one-quarter of responses were aimed at changing administrative processes, such as developing or improving policies and procedures. About 15 percent of the suggestions focused on improving specific services to participants, such as expanding housing options and transportation.

Wisconsin's Family Care Long-Term Care Pilot Program:
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1. INTRODUCTION

A. Brief Description of Family Care

Wisconsin recently began a pilot long-term care initiative called Family Care in nine Wisconsin counties. One of the primary goals of Family Care is to increase access to long-term support services for frail older adults and adults with physical or developmental disabilities. The Family Care initiative created two new types of organizations. Nine Family Care counties have developed *Aging and Disability Resource Centers*, designed to provide "one-stop shopping" for information about and access to long-term support resources. Five of the Family Care counties have also created *Care Management Organizations* (CMOs) that coordinate long-term support benefits in those counties.

Under Family Care, the county CMOs coordinate all the long-term care services—home- and community-based services as well as institutional services—for those eligible for and desiring publicly funded long-term care services in Family Care CMO counties. In the Family Care scheme, a county, through its CMO, now bears the financial risk for coordinating and providing for all the long-term care (LTC) needs of eligible and participating county residents. The state combines multiple funding streams from a number of programs such as the Home and Community-Based Waiver programs, the Community Options Program, and some Medicaid card services. The state then pays county CMOs a capitated rate for each Family Care enrollee. In non-Family Care counties throughout Wisconsin, the LTC system is a fee-for-service system rather than a capitated system, and it separates nursing home care from home- and community-based LTC both financially and organizationally. Another important change is that the Family Care benefit has been made an entitlement—people functionally and financially eligible for the program in these five counties are enrolled and served. Although each of the five Family Care counties had waiting

lists for LTC services before Family Care, their wait lists were eliminated by the end of 2002, while the wait lists in non-CMO counties continue to climb.

By combining funds from multiple programs, and by loosening complicated rules about the provision of services, it is hoped that Family Care will provide a more flexible benefit to better meet the individual needs of participants in the long-term support system in the five Family Care counties. If so, Family Care eventually might be expanded to other counties.[1]

Wisconsin has been a national leader in creating long-term support programs that serve people in home and community settings. However, one of the reasons for initiating Family Care is that the long-term support system in Wisconsin has become increasingly complex over the last decades. Multiple funding streams each have different eligibility criteria for access to services and different rules about which services are covered, in what amounts, at what cost, and by whom. Such complexity can result in inadequate and inequitable provision of services. Services that may best meet a consumer's needs may not be allowable, resulting in a consumer's needs going unmet. Or services may be provided that are not most appropriate or efficient for meeting the need. For example, in some cases, expensive services may be provided because the more appropriate and less costly alternatives are not allowed under program funding rules. In other cases, services to meet a particular need may be denied entirely, potentially leading to poor consumer outcomes. Such outcomes are both socially undesirable and fiscally inefficient.

Under Family Care, changes in both program goals and organizational rules and structures should result in changing patterns of service use. Some Family Care program goals include a renewed emphasis on consumer-directed care, consumer needs, and consumer outcomes. This emphasis may lead to improved identification of informal and formal supports that will best meet the particular needs of individual consumers. Family Care is also changing organizational rules to increase flexibility in funding of services so that services can be provided to best meet the needs of consumers. Improved identification

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[1]See a more detailed description of Family Care at <http://www.dhfs.state.wi.us/LTCare/>.

of consumer needs and preferences combined with increased flexibility in how those needs can be met may lead to changes in the types and amounts of formal services provided.

B. Goals of the Report

As Family Care is implemented, it needs to be examined to determine whether the initiative as a whole, or some of its components, is successful at improving the long-term support system. Family Care research projects are being conducted by the state and the counties, as well as by external research organizations.[2] Taken together, these various projects will provide a more complete picture of the Family Care program.

The current report is part of an ongoing study of the Family Care initiative, and of the long-term support system in Wisconsin more generally, being conducted at the UW–Madison School of Social Work. This research focuses specifically on the perspective of care managers in the Family Care program, based on structured phone surveys with care managers in each of the Family Care counties. A previous report in 2001 focused on the early experiences of Family Care care managers (CMs) during the first year of Family Care CMO implementation.[3] The current report updates findings from the earlier report, addressing care managers' views after completing the early implementation years of Family Care.

In Family Care, care/case managers are defined as follows:

> The care manager initiates and oversees the initial comprehensive assessment process and reassessment process, the results of which are used by the care management team, participant and his/her informal supports in identifying the service needs of the participant and developing the individual's plan of care. The care manager also carries out activities that help participants and their families identify their needs and manage and gain access to necessary medical, social, rehabilitation, vocational, educational and other services.[4]

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[2]See reports at <http://www.dhfs.state.wi.us/LTCare/ResearchReports/>.

[3]"Early Evidence from Wisconsin's Family Care Long-Term Care Pilot Program: Continuity and Change in the Provision of Formal Services," by Stephanie Robert (2001), at <http://www.ssc.wisc.edu/irp/sr/sr80.pdf>.

[4]"Wisconsin Family Care Final Evaluation Report," by The Lewin Group (2003), at <http://www.legis.state.wi.us/lab/reports/03-0FamilyCare.pdf>.

Care managers serve as the bridge between consumers and the LTC service system. As such, they have a unique view of both the experiences of consumers and the perspective of the organization and service system. For example, although each program participant is most knowledgeable about how Family Care serves his/her own needs, care managers can identify trends or patterns in the quality of care expressed by multiple program participants. Simultaneously, care managers have to respond to the changing organizational environment of Family Care. For example, they have to understand changes in system priorities and processes in order to implement the program. Being most familiar with the complex details of how the long-term support system is run, care managers are able to identify specific aspects of the system that provide opportunities and constraints in meeting program participants' needs.

Even before changes in trends in service utilization can be recognized in administrative data, care managers are likely to recognize these changes. In addition, although changes in patterns may be described using administrative data, those data provide no information about *why* those changes have occurred. Care managers can provide such insight.

Moreover, understanding the experiences and needs of care managers should help the state and counties improve the quality of care management. Since care managers serve as the bridge between consumers and the Family Care program, the quality of care management likely affects both consumer and program outcomes.

The four main goals of this report are:

1. to examine whether and how Family Care has changed the services provided to people with long-term support needs;
2. to describe some specific service issues that will need attention to improve Family Care;
3. to describe care managers' overall views of Family Care at the end of its early implementation phase;
4. to describe care managers' suggestions for change to Family Care.

2. SUMMARY OF RESEARCH METHODS

This report is based on phone surveys conducted with care managers in four Family Care counties (Fond du Lac, La Crosse, Milwaukee, and Portage) and a comparison sample of care managers working in the long-term support system across the rest of the state. After about 1 year of Family Care implementation (fall/winter 2000–01), 64 Family Care CMs were interviewed in Wave 1. Also at Wave 1, telephone interviews were conducted with a sample of 62 CMs from the non-Family Care counties across the state (one care manager from each non-Family Care county). Over a year later (spring/summer 2002), a second round of interviews was conducted with Family Care CMs (Wave 2). Among these 119 Wave 2 Family Care CMs, 44 percent were "follow-up" CMs (those interviewed at both Waves 1 and 2) and 56 percent were new care managers. This report sometimes focuses on the subset of Wave 2 CMs who worked in the previous long-term support system before Family Care, calling this subgroup "transition care managers," and asking their opinions about differences between the two programs. Table 1 presents a summary of CM characteristics across the two waves and samples. A more detailed description of the sample and survey methods can be found in the Appendix.

3. RESULTS

A. Stability and Change in Services with the Introduction of Family Care

The first goal of this report is to examine whether and how Family Care has changed the services provided to people with long-term support needs.

(1) Perceived Changes in Specific Services

To begin answering this question, we identified the subset of 66 Family Care CMs (from Wave 2) who had also worked in the previous long-term support system. We asked these "transition care managers" to compare Family Care to the old long-term support system on a number of dimensions.

TABLE 1
Summary of Care Manager Characteristics

Characteristics	Wave 1		Wave 2	
	Statewide CMs (n=62)	Family Care CMs (n=64)	Follow-up Family Care CMs (n=52)	New Family Care CMs (n=67)
Women	90%	91%	90%	91%
Median Years in Long-Term Support System	11 years	10 years	10 years	2.5 years
Educational Background				
Social work degree	44%	25%	27%	43%
Nursing degree	2%	17%	19%	22%
Other human service degree	55%	58%	54%	34%
Population Served				
Older adults	84%	73%	69%	88%
Nonelderly people with physical disabilities	58%	58%	71%	42%
People with developmental disabilities	34%	48%	58%	33%
People in need of protective services	13%	3%	12%	13%
Transition CMs*	NA	69%	77%	39%

Note: Percentages may not add to 100% due to rounding.
*Transition CMs are those who worked in the previous long-term support system before working for Family Care.

Transition care managers were provided a list of specific services and were asked to indicate whether Family Care participants receive fewer, equal, or more of these services than participants in the previous long-term support system. Table 2 demonstrates that transition care managers perceive both continuity and change in service use between the previous system and Family Care.

Transition care managers who reported changes in use of a particular service under Family Care (reporting either "fewer" or "more") were asked *why* they thought service use had changed. We summarize below the main themes in their explanations, and point out some county differences in responses.

Personal care. Half of transition care managers reported an equal use of personal care services between the old system and Family Care. Almost one-third of transition care managers reported that Family Care participants receive more personal care services, noting that personal care services are easier to authorize now and that there is more flexibility in who can be hired to provide care. The 22 percent of transition care managers reporting fewer personal care services were from two counties. In Milwaukee and Fond du Lac counties, 38 percent and 27 percent of transition care managers, respectively, reported fewer personal care services. Some of these care managers felt that there are now more restrictions on service allocations for personal care, and that there are insufficient personal care providers in the county. However, some saw the reduction in personal care as appropriate, explaining that "under Community Options Program, many participants were getting excessive care and there wasn't a lot of accountability."

Respite care. Most transition care managers reported that the amount of respite care services has remained the same overall (53 percent), with over one-third of care managers citing increases in the use of respite care. Primary reasons given for the increases were an easier and more flexible authorization process under Family Care. Some care managers reported decreases in respite care services in Fond du Lac (25 percent) and Milwaukee (12 percent) counties, explaining that the RAD (Resource Allocation

TABLE 2
Transition Care Managers' Perceptions of the Amount of Specific Services Family Care Participants Receive Compared with Services in the Previous Long-Term Support System

Type of Service	Fewer	Equal	More	n*
Personal care	22%	49%	30%	64
Respite care	10%	53%	38%	61
Home modifications	24%	36%	40%	62
Skilled nursing services	7%	57%	37%	62
Transportation services	3%	51%	46%	65
Durable medical equipment	20%	41%	39%	64
Adaptive aids	13%	41%	46%	63
Daily living skills training	6%	61%	33%	51
Employment services	13%	50%	38%	40
Consumer directed supports	3%	32%	65%	62

Note: Percentages may not add to 100% due to rounding.
*****Total number of transition care managers in Wave 2 is 66; n's and percentages presented for each item exclude missing or "don't know" responses.

Decision) method led care managers to examine all other alternatives and support within a family before turning to formal respite care.

Home modification. About one-quarter of transition care managers reported fewer home modifications with Family Care. Most of these care managers described how the previous long-term support system had been excessive in providing home modifications in their county, and that declines in utilization with Family Care were due to *appropriate* reductions. Some reported that using the new RAD method helped them better evaluate whether home modifications provide the most appropriate way to achieve consumer outcomes. In Wave 1, only 24 percent of care managers had noted an increase in home modifications (see footnote 3), whereas 40 percent noted an increase in Wave 2. This increase is reportedly due to both an easier authorization process and a greater need among Family Care consumers. Some care managers noted that because Family Care is taking more people out of nursing homes, and because more consumers are choosing home care over nursing home care, there are increased levels of need among these community residents, resulting in greater demand for home modifications to accommodate community living.

Skilled nursing. The greatest percentage (57 percent) of care managers reported the same level of skilled nursing services. Of the care managers who reported an increase in skilled nursing services (37 percent), most interpreted this increase as a positive outcome of nurses' increased involvement in interdisciplinary care management teams. In our previous report, we noted that some transition care managers without nursing backgrounds reported that they had little nursing support in the old system and that the addition of nurses to the team was improving their ability to attend to participants' medical needs.

Transportation. About half of care managers reported that transportation services were about the same under Family Care. In Wave 1, only 20 percent of care managers had reported an increase in transportation services under Family Care (see footnote 3), whereas almost one-half reported an increase at Wave 2. Wave 2 care managers perceived greater flexibility in the types of vehicles available under Family Care (e.g., taxi for nonmedical transportation) and increases in the number of service providers.

Since transportation services had been one of the top three services that care managers thought needed improvement overall at Wave 1 (see footnote 3), this reported increase in transportation use at Wave 2 suggests that Family Care has been somewhat successful at responding to the need for this particular service.

Durable medical equipment and adaptive aids. Increases in use of durable medical equipment (DME) and adaptive aids were identified by 39 percent and 46 percent of transition care managers. The 20 percent and 13 percent of care managers reporting fewer DMEs and adaptive aids came from two counties, with almost half of Fond du Lac care managers and over a quarter of Milwaukee care managers reporting fewer DMEs.

Explanations for both increases and decreases were somewhat complicated. Some transition care managers reported increased flexibility in providing DME and adaptive aids but, simultaneously, more scrutiny involved in making the decision to provide them. As a result, some Family Care participants receive less equipment than they would have in the old system while some receive more. Some transition care managers suggested that the previous system provided equipment too easily, even if people didn't really need it. In such cases, providing less equipment under Family Care was viewed as appropriate and positive. One transition care manager explained "some clients may need physical therapy or occupational therapy rather than adaptive aids" and "we urge them to follow through with their exercises and take responsibility." This means, according to another care manager, "the team is being more creative in doing what needs to be done." Others claimed that some participants in the old system were not able to access what they needed, so that perceived increases in providing equipment in Family Care was viewed as appropriate.

Issues regarding DME were raised in many instances during the interviews. Before Family Care, most care managers did not have to directly arrange for DME. Medicaid paid for DME, Medicaid participants could arrange for this equipment themselves with a physician's order, and vendors billed Medicaid directly. Under Family Care, care managers are responsible for authorizing DME purchases,

requiring an understanding of detailed billing codes. This change has not been smooth, with many care managers complaining that the authorization process for DME is unclear and overly burdensome, with care managers in some counties experiencing more frustration with DME than care managers in other counties.

Daily living skills training. About one-third of transition care managers reported increases in daily living skills training, with most care managers reporting that use of such training has stayed about the same. Those reporting increases suggested that interdisciplinary teams have led to an increase in this service because of the focus on meeting consumer needs. The involvement of nurses in daily living skills training was cited as a new positive approach under Family Care as well.

Employment services. Not all care managers responded to this question because some serve only older adults who generally do not use employment services. Among those who responded, the greatest percentage (50 percent) replied that this service remained about the same, while 38 percent noted an increase and 13 percent noted a decrease. Among those noting an increase, many perceived more flexibility in this service as well as more immediate access to it when necessary. Some care managers indicated that some employment services have been terminated because increased scrutiny led care managers to conclude that there were some cases where employment services were not truly needed by the clients.

Consumer-directed supports. An increase in consumer-directed supports was reported by two-thirds of transition care managers. An increased focus on consumer-defined needs and consumer choice is a primary goal of Family Care. However, this aspect of the program has been developed more slowly and counties continue to struggle with how best to structure policies to implement this goal.

In sum:

- *Many transition care managers report that Family Care participants receive* more *services than participants in the previous long-term support system.*

One-third or more of transition care managers reported an increase in each service listed (except for personal care where only 30 percent reported an increase). Most care managers described increases in

funding and/or more flexible rules as the reasons for increases in use of these services. Almost all of the increases were portrayed as appropriate and beneficial increases for program participants. There were notable increases between Waves 1 and 2 in the percentage of transition care managers perceiving increases in transportation services, with some reported increases between waves in home modifications and adaptive aids as well.

- *Some transition care managers report that Family Care participants receive* fewer *services than participants in the previous long-term support system.*

Some care managers noted that there were fewer services provided under Family Care, primarily in Fond du Lac and Milwaukee counties. However, most of these care managers noted that the reductions were *appropriate*. For example, some felt that the previous long-term support system was providing expensive equipment and home modifications when they were unnecessary, and that Family Care was decreasing these services in appropriate ways in some cases. Very few transition care managers reported that Family Care decreased services to participants who they felt truly needed the services.

- *Care managers report much continuity between the new and the old system in terms of the overall amount of specific services provided.*

For all services but three, the greatest percentage of transition care managers reported that Family Care participants receive *equal* services compared to participants in the previous long-term support system. However, this does not mean that there were no changes, as some transition care managers reported "equal" services while commenting that some Family Care participants receive more while others receive fewer services under Family Care. A perceived increased flexibility under Family Care means that not all participants get the same package of services but rather participants get services that are appropriate to meet their particular needs.

(2) Organizational and Structural Barriers to Formal Service Use—Comparisons between Family Care CMs and Statewide CMs

Another way to examine whether service access and use have changed under Family Care is to compare the experiences of care managers in Family Care counties to those in non-Family Care (statewide) counties. We asked both Family Care CMs (at Waves 1 and 2) and statewide CMs (at Wave

1) about specific organizational or structural barriers to formal services. Family Care is supposed to reduce some of the formal barriers to services, allowing more flexibility in what *kinds* of services are provided, as well as where, when, how, and by whom they are provided. We examine whether Family Care CMs perceive fewer organizational or structural barriers to services than do the Statewide CMs.

TABLE 3
How Often Does Availability of Certain Types of Services or Service Providers Limit the Types or Amount of Formal Services That Participants Get?

	Never	Sometimes	Frequently	Always	% (n)
Wave 2 Family Care CMs	8% (10)	64% (76)	27% (32)	1% (1)	100% (119)
Statewide CMs	0% (0)	49% (30)	49% (30)	2% (1)	100% (61)

Missing = 0
Chi-square 12.65, df=2, p=0.002; calculated after combining "frequently" and "always" responses.

- Statewide CMs cited availability of certain types of services or service providers as a more frequent barrier to formal services than did Family Care CMs. About half (49 percent) of statewide CMs reported that availability of certain types of services or service providers was a *frequent* barrier to formal services, compared to only 27 percent of Family Care CMs.

- According to 8 percent of Family Care CMs, availability of certain types of services or service providers *never* limits the types or amount of formal services that participants get. In contrast, all statewide CMs reported this barrier at least sometimes.

- The percentage of Family Care CMs reporting that availability of certain types of services or service providers was a *frequent* barrier to formal services decreased from 39 percent in Wave 1 (see footnote 3) to 27 percent in Wave 2. This suggests perceived improvements in service availability under Family Care.

TABLE 4
How Often Do Restrictions on the Types of Services That Are Allowable or Reimbursable Limit Formal Services That Participants Get?

	Never	Sometimes	Frequently	Always	% (n)
Wave 2 Family Care CMs	34% (40)	62% (72)	3% (4)	0% (0)	99%* (116)
Statewide CMs	18% (11)	72% (44)	10% (6)	0% (0)	100% (61)

*Percentage does not add to 100% due to rounding.
Missing = 3
Chi-square 7.26, df=2, p=0.027; calculated after combining "frequently" and "always" responses.

- Statewide CMs cited restrictions on the types of services that are allowable or reimbursable as a more frequent barrier to formal services than did Family Care CMs.
- According to 34 percent of Family Care CMs, but only 18 percent of statewide CMs, restrictions on the types of services that are allowable or reimbursable *never* limit formal services that participants get.
- Most care managers in both groups (62 percent of Family Care CMs and 72 percent of statewide CMs) reported that restrictions on the types of services that are allowable or reimbursable *sometimes* limit formal services.

TABLE 5
How Often Do Limits or Rules Regarding Residential Options Affect the Types or Amount of Formal Services That Participants Get?

	Never	Sometimes	Frequently	Always	% (n)
Wave 2 Family Care CMs	31% (36)	60% (70)	6% (7)	3% (3)	100% (116)
Statewide CMs	18% (11)	48% (29)	30% (18)	3% (2)	99%* (60)

*Percentage does not add to 100% due to rounding.
Missing = 4
Chi-square 17.57, df=2, p=0.000; calculated after combining "frequently" and "always" responses.

- Statewide CMs cited limits or rules regarding residential options as a more frequent barrier to formal services than did Family Care CMs.
- According to 31 percent of Family Care CMs, but only 18 percent of statewide CMs, limits or rules regarding residential options *never* affect the types or amount of formal services that participants get.
- According to 33 percent of statewide CMs, but just 9 percent of Family Care CMs, limits or rules regarding residential options *frequently* or *always* affect the types or amount of formal services that participants get.

In sum, there are many similarities and some differences between Family Care and statewide CMs regarding specific perceived barriers to formal services in long-term support programs. Most care managers in both systems reported that the types or amount of formal services that participants receive are *at least sometimes* affected by (1) availability of certain types of services or service providers, (2) restrictions on the types of services that are allowable or reimbursable, and (3) limits or rules regarding residential options. However, Family Care CMs perceive these three barriers as occurring significantly less frequently than do statewide CMs.

It is unclear how much of the difference in responses between these two groups of care managers represents *change* in the Family Care counties, or how much is due to differences in the long-term support systems between the Family Care and non-Family Care counties that existed before Family Care was implemented. However, as demonstrated earlier, many transition care managers reported that use of services under Family Care has increased. Therefore, it is likely that some of the differences between Family Care and non-Family Care counties are due to changes under Family Care.

B. Suggested Changes to Long-term Care Services under Both Family Care and the Statewide System

The second goal of this report is to describe some of the specific service issues that will need attention to improve Family Care. All care managers were asked an open-ended question: What services need to be developed or be more available to better meet the needs of participants? Table 6 presents a summary of the most frequent responses provided by statewide CMs at Wave 1 and by Family Care CMs at both Waves 1 and 2.

Table 6 demonstrates a shared sense among Wisconsin care managers that personal care/supportive home care services need to be further developed or more available. Statewide CMs cited this as the number one service needing to be developed or more available (40 percent of statewide CMs). Between Waves 1 and 2, the percentage of Family Care CMs who mentioned personal care and/or

TABLE 6
What Services Need to Be Developed or More Available to Better Meet the Needs of Family Care Participants?

Type of Service	Wave 1 Statewide CMs (n=61)	Wave 1 Family Care CMs (n=62)	Wave 2 Family Care CMs (n=116)
Personal care/supportive home care services	40%	45%	28%(32)
Transportation	26%	23%	18%(21)
Respite	5%	5%	*
Residential options	28%	24%	28%(33)
Home health	7%	5%	*
Employment services	8%	11%	9%(10)
Adult day care centers	5%	16%	5%(6)
Care management (e.g., smaller caseload)	*	8%	11%(13)
Socialization options	10%	*	9%(10)
Volunteers	7%	*	*
More mental health services	*	*	7%(8)

Note: Care managers could list more than one service, so percentages do not add up to 100%.
*Only responses mentioned by 5% or more of care managers are listed above. Fewer than 5% of s*tatewide CMs* cited the following services as *the most difficult* to access or provide: homemaker/chore, adult day care center services, providers for high-need participants, home companion, snow removal, hospice, and DME/S. Fewer than 5% of Family Care CMs at Wave 1 cited homemaker/chore, adult day care center services, socialization and recreational opportunities, major clean-up help, approving things previously acquired directly through Title XIX (Medicaid), bilingual personal care, natural supports, mental health services, expensive items, home modifications, and therapies (OT/PT/speech). Fewer than 5% of Family Care CMs at Wave 2 cited respite, home health, volunteers, none are difficult, more options, more providers, dental care, caregiver support network for Spanish-speaking caregivers, drug coverage for consumers not on Medicaid, and rural medication delivery services.

supportive home care declined from 45 percent to 28 percent. This reduction is consistent with results presented earlier suggesting that personal care services have increased under Family Care.

Comparing responses of statewide CMs to those of Family Care CMs in Wave 2, we note that statewide CMs are more likely to cite needs in the areas of personal care/supportive home care services, transportation, respite, home health, and volunteers. Both statewide CMs and Wave 2 Family Care CMs were about equally likely to list residential options, employment services, adult day care centers, and socialization options as needing further development/availability. Wave 2 Family Care CMs were more likely than statewide CMs to list care management services and mental health services as those needing further development or availability.

Comparing Family Care CMs over time between Waves 1 and 2, there was a large reduction in the percentage who reported needs in the area of personal care/supportive home care, and a slight reduction in the percentage who reported needs in the areas of transportation, respite, home health, and adult day care centers. This suggests that Family Care has made some modest improvements in these areas over just a couple of years. Between waves, similar percentages of Family Care CMs reported needs in the areas of residential options, employment services, and care management services. Family Care CMs were more likely to list socialization options and mental health services as needing further development/availability in Wave 2.

Despite differences between Family Care and non-Family Care counties, and despite apparent improvements in service availability under Family Care, care managers across the long-term support system in Wisconsin listed the following three services as those that most need to be developed or be more available: personal care and supportive home care services, transportation, and residential options.

However, looking at Wave 2 Family Care CM responses by county, we see that counties vary in the services that need further attention. Table 7 shows that 50 percent of Milwaukee care managers believe that personal care/supportive home care needs further development, versus 0 percent in Portage, 9 percent in Fond du Lac, and 20 percent in La Crosse. Looking at the most frequently mentioned services

TABLE 7
County-Specific Responses (Wave 2): What Services Need to Be Developed or More Available?

Type of Service	Milwaukee (n=48)	Portage (n=16)	Fond du Lac (n=22)	La Crosse (n=30)
Personal care/supportive home care	50% (24)	0% (0)	9% (2)	20% (6)
Transportation	19% (9)	38% (6)	18% (4)	10% (3)
Respite	0% (0)	38% (6)	18% (4)	10% (3)
Residential options	8% (4)	38% (6)	50% (11)	33% (10)
Home health	6% (3)	6% (1)	0% (0)	0% (0)
Employment services	0% (0)	13% (2)	14% (3)	17% (5)
Adult day care centers	2% (1)	13% (2)	5% (1)	7% (2)
Care management	15% (7)	13% (2)	0% (0)	7% (2)
Socialization options	6% (3)	19% (3)	5% (1)	10% (3)
Volunteers	4% (2)	0% (0)	5% (1)	3% (1)
Mental health services	4% (2)	6% (1)	18% (4)	3% (1)
Other	23% (11)	19% (3)	14% (3)	23% (7)
None	6% (3)	0% (0)	5% (1)	3% (1)

within each county, Family Care CMs report that Milwaukee has particular needs in the areas of personal care (50 percent), transportation (19 percent), and care management (15 percent). Portage CMs report particular needs in the areas of transportation (38 percent), respite (38 percent), and residential options (38 percent). Fond du Lac CMs report needs in residential options (50 percent), transportation (18 percent), respite (18 percent), and mental health services (18 percent). La Crosse CMs mentioned needs for residential options (33 percent), personal care/supportive home care (20 percent), and employment services (17 percent).

C. Care Managers' Views of Family Care

The third goal of this report is to describe care managers' overall views of Family Care at the end of its early implementation phase.

(1) Overall Views of Family Care

We provided a number of statements and asked Family Care CMs to indicate whether they strongly disagreed, somewhat disagreed, somewhat agreed, or strongly agreed with each statement. Table 8 presents responses of "follow-up" Family Care CMs' (those interviewed in both Waves 1 and 2) to statements related to service provision and utilization.

Table 8 demonstrates that most Family Care CMs interviewed at both waves had positive views of Family Care's accomplishment or progress on some of the major program goals. All agreed that Family Care increases services to some participants who weren't getting enough services under the old system, with about half strongly agreeing with that statement. Almost all follow-up CMs agreed that Family Care allows some types of services not allowed before, and that it offers more choices to consumers regarding both types of services and service providers. However, about two-thirds reported that the lack of care providers in their communities means that people are not served well. This concern decreased between Wave 1 and Wave 2. At Wave 1, 81 percent agreed with this statement whereas at Wave 2, 66 percent agreed with this statement.

TABLE 8
Views Regarding Family Care by Follow-up Care Managers at Wave 2

	Percentage of Family Care Follow-up Care Managers Who…				
Statement	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Total (n=52)
Family Care increases services to some participants who weren't getting enough services under the old system.	0%	0%	51%	49%	(51)
Family Care allows us to provide some types of services that weren't allowed before.	0%	6%	37%	58%	(52)
Family Care offers more choices to consumers in the types of services they can get.	0%	10%	42%	48%	(52)
Family Care offers more choices to consumers in who provides services to them.	2%	15%	50%	33%	(52)
Even if Family Care serves more people, the lack of care providers in my community means that people are not served well.	4%	31%	54%	12%	(52)

(2) Views Regarding Care Management under Family Care

Table 9 summarizes follow-up CMs' responses to statements about their care management experience with Family Care.

Table 9 demonstrates that care managers' views about the care management role under Family Care are not as positive as their overall view of the program. Virtually all follow-up care managers disagreed that Family Care has reduced the amount of time care managers spend on paperwork, with 88 percent *strongly* disagreeing. Few agreed that Family Care allows care managers more time to work with each consumer (12 percent) or with families (16 percent), with about half *strongly disagreeing* that there is more time for such work. Despite the Family Care goal of reducing caseloads, and despite reports of some success in reducing caseloads (see footnote 4), 63 percent of follow-up care managers strongly disagree, 24 percent somewhat disagree, and 14 percent either somewhat or strongly agree that caseloads have been reduced for care managers. Indeed, at Wave 1, care managers were more optimistic about whether Family Care would improve care management than they were at Wave 2, where the reality of improvements in the care management roles did not meet expectations.

Concerns about workload issues were noted throughout the interviews. For example, we asked "Do you ever have to balance the needs of a client with the needs of other clients on your caseload?" Among Wave 2 care managers, 78 percent responded that they either sometimes or frequently (as opposed to never) have to balance needs among clients. We asked them to describe the ways in which they had to balance needs among clients, and we examined whether responses referred to allocation of care manager time and attention or allocation of services or resources. Most care managers referred to dilemmas regarding allocation of their own time, with only 8 percent clearly reporting dilemmas over allocating resources among clients. An example of a resource dilemma was provided by a care manager who reported that "there was a choice between a couple of consumers for a (residential placement) that might have worked for either of them." But most of the examples had to do with care manager time, such

TABLE 9
Follow-up Care Managers' Views of Care Management under Family Care

Statement	Percentage of Family Care Follow-up Care Managers Who…				
	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Total (n=52)
Family Care has reduced the amount of time care managers spend on paperwork.	88%	10%	2%	0%	(51)
Family Care has reduced caseloads for care managers.	63%	24%	8%	6%	(51)
Family Care provides a care manager more flexibility in the service plan that can be put together.	0%	12%	50%	38%	(52)
Family Care allows care managers to spend more time working with each consumer.	52%	36%	12%	0%	(50)
Family Care allows care managers to spend more time doing direct work with families.	49%	35%	14%	2%	(51)

as "not enough hours in the day to meet everyone's needs" or "when clients have emergencies, I need to drop other things on my agenda and spend a lot of time with them."

Tables 8 and 9 demonstrate well a theme we noted throughout our interviews with Family Care CMs at both Waves 1 and 2. Care managers generally believe that Family Care is a program that works well for consumers. However, they have concerns regarding organizational issues that make it challenging for them to provide quality care management.

D. Suggested Changes to Family Care

The fourth goal of this report is to describe care managers' suggestions for changes to Family Care. Care managers were asked the open-ended question, "What three major changes would you make to Family Care to improve it?" We categorized responses for Wave 2 Family Care CMs, and Table 10 summarizes the suggestions provided most frequently.

The most frequently suggested change to Family Care was to reduce the amount of or inefficiency of paperwork, suggested by two-thirds of care managers. Reducing caseload sizes was suggested by 41 percent of care managers. More resources for clients was suggested by 16 percent of care managers. Their resource suggestions ranged from general ("more providers") to more specific suggestions such as improved transportation, supportive home care, chore services, and incentives to community providers to expand choice of providers for consumers. More training and education was suggested by 15 percent of care managers. Of these, over half requested more care management training (on topics such as Medicare, DME, and a more thorough Family Care orientation), and under half suggested more education for the community (e.g., for politicians and for acute care and other providers). The other three suggestions mentioned by at least 5 percent of care managers were (1) improving the computer systems, (2) changing the way durable medical equipment (DME) is accessed, and (3) increasing the amount of one-on-one contact between care managers and clients (which presumably is one of the goals of suggesting reduced paperwork and caseload as well).

TABLE 10
What Three Major Changes Would You Make to Family Care To Improve It?

Change	% of CMs (n=116)
Reduce amount and/or inefficiency of paperwork	66% (77)
Reduce caseload size	41% (48)
Increase resources for clients	16% (19)
Increase training and education	15% (17)
Improve computer systems	9% (11)
Change DME funding/access system	8% (9)
Increase the amount of 1:1 contact with clients	7% (8)
Other*	55% (64)
Unclear response	11% (13)

* 55% of care managers provided a suggestion which fell outside of the above categories and which was cited by fewer than 5% of other care managers.

About half of care managers also made specific suggestions that were not shared by 5 percent or more other care managers. This does not mean that these other responses would not be helpful to the program, but they may be lower-priority suggestions since they were not shared by a critical mass of care managers as being the most important issues.

Table 11 further classifies all responses by whether the suggestions were care manager-focused, administration-focused, or service-focused. About half of all suggestions were aimed at changing the amount and type of work required of care managers (e.g., reducing paperwork, improving pay, reducing caseloads). About one-quarter of responses were aimed directly at changing administrative processes, such as developing or improving policies and procedures. Only 15 percent of the suggestions focused on improving the manner in which clients are served, such as improving housing or transportation options, increasing the number of home care providers, or expanding the eligibility criteria to include a broader range of consumers. However, it is clear from care managers' requests for less paperwork and smaller caseloads that their concern is about the impact on the consumer. For example, one care manager suggested streamlining paperwork as one of the top three suggested changes, elaborating further, "It's getting to be a monster. Face-to-face time is shrinking due to paperwork." Another suggested, "Less paperwork. It deters us from developing a better relationship with the member, getting to know them and serve them better."

E. Should Family Care Be Expanded to the Rest of the State?

One test of care managers' overall attitudes toward Family Care is whether they believe it should be expanded to the rest of the state. The majority of care managers in Wave 2 (72 percent) support the expansion of Family Care to the rest of Wisconsin, with 18 percent unsure, and 12 percent not supporting expansion. Table 12 summarizes their reasons for support or lack of support of Family Care expansion.

Among those supporting expansion, the reasons most often cited included the ability to serve more consumers and to provide more services/options for consumers. "It gets people off waiting lists and we can serve more people," explained one care manager. Others suggested that "it is better for people to

TABLE 11
Suggested Changes to Family Care: Types of Change Suggested

Type of Change Suggested	% of Responses (n=290)*
CM-focused suggestions	53% (154)
Administration-focused suggestions	26% (75)
Service-focused suggestions	15% (44)
Other	5% (15)

*Percentages do not add up to 100% due to rounding; n=290 rather than 357 (119 CMs X 3) because not all care managers provided three responses to this question.

TABLE 12
Why Do You Think Family Care Should/Should Not Be Expanded to the Rest of the State?

Reasons why it *should* (n=84) 72%	
Ability to serve more consumers	(22) 26%
More services/options for consumers	(18) 21%
More cost-effective	(13) 15%
More uniformity	(12) 14%
Better consumer outcomes	(10) 12%
Improved consumer participation in care plan	(6) 7%
Other	(16) 19%
Reason why it *should not* (n=14) 12%	
All the bugs haven't been worked out yet	(7) 50%
Not enough known about Family Care yet	(5) 36%
Too costly	(4) 29%
Enrollment process too cumbersome	(2) 14%
Other	(1) 7%

Note: Case managers could list more than one reason, so percentages do not add up to 100%.

live where they want to live," and "we are keeping more people in their homes." Other reasons for expanding the program included that Family Care is more cost-effective, would provide more uniformity across the state and across target groups, provides better consumer outcomes, and improves consumer participation in the care plan. "We are maintaining care and watching out how taxpayers' dollars are spent," explained one care manager. "Funding should be standard between counties so that (consumers) can move if they want to," suggested another.

Among the 12 percent of care managers not supporting expansion, half (7 CMs) said that the "bugs" have not been worked out yet. "The program has too many glitches/problems. It hasn't been fine tuned yet," believed one care manager. Over a third of care managers not supporting expansion (5 CMs) said that not enough is known yet about Family Care. Four care managers thought that Family Care is too costly, two found the enrollment process too cumbersome, and one said that the only good thing about the program is the increased participation of nurses. However, these care managers were in the minority.

4. MAJOR CONCLUSIONS AND DISCUSSION

There were four main goals of this report:

1. to examine whether and how Family Care has changed the services provided to people with long-term support needs;
2. to describe some specific service issues that will need attention to improve Family Care;
3. to describe care managers' overall views of Family Care at the end of its early implementation phase;
4. to describe care managers' suggestions for change to Family Care.

This report examined these issues from the perspective of care managers, focusing on responses by care managers working in four Family Care pilot counties. Six major conclusions of this study are presented below.

Conclusion #1: Family Care has improved the service environment for people with long-term support needs.

Family Care has improved the service environment for people with long-term support needs by (1) making Family Care an entitlement and (2) creating a more flexible and responsive system to tailor services and supports to the particular needs of program participants.

Making the Family Care program an entitlement improves access to supports and services for people with long-term support needs by eliminating waiting lists. Whereas the Family Care CMO counties had eliminated waiting lists by the end of 2002, waiting lists continue to climb in non-Family Care counties (see footnote 4). This results in insufficient and inequitable service access across Wisconsin.

It appears that Family Care is better at meeting service and support needs of consumers who participate in Wisconsin long-term support programs. The results of this study suggest that Family Care has improved the amount, type, and quality of services and supports available to consumers.

Family Care CMs who worked in the long-term support system prior to Family Care (transition care managers) were asked to compare Family Care and the previous program. Their responses suggest that overall there are both appropriate increases in services and appropriate decreases in services. Attention to the particular needs of participants, combined with increased flexibility in how those needs are met, has meant that some services and supports have increased, particularly consumer-directed supports, home modifications, adaptive aids, and transportation services. Transition care managers reported some increases in services not only between the old system and Family Care, but over time within the Family Care program as well (between Waves 1 and 2). Some transition care managers also reported that there have been decreases in services. However, most of these care managers reported that some of the services provided in the past were not appropriate to best meet participants' needs, therefore viewing some of the decreases as appropriate.

We also compared Family Care CM responses to responses of care/case managers in long-term support programs across the state. Our results showed that Family Care is generally better than long-term

support programs statewide in terms of providing options for meeting the service needs of program participants. Family Care has greater availability of services and service providers, more flexibility in the types of services allowable, and fewer limits and rules regarding residential options.

Conclusion #2: Family Care has been responsive to improving availability, access, and choice of services to better meet needs of consumers.

At Wave 1, Family Care CMs reported that personal care/supportive home care, transportation, and residential options were the top three service areas needing the most development. There is evidence that the Family Care counties made improvements in each of these areas as well as in other areas over the subsequent 2 years. For example, a recent evaluation of Family Care by the Lewin Group (see footnote 4) suggests that between 2001 and 2003, La Crosse significantly expanded its personal care services, and both Fond du Lac and Portage expanded their respite care options. All three of these counties reported significant increases in alternative residential options as well (comparative data were not available for Milwaukee County).

Our data show that at Wave 1, 40 percent of statewide CMs and 45 percent of Family Care CMs listed personal care/supportive home care services as needing further expansion and improvement. By Wave 2, only 28 percent of Family Care CMs listed this issue, and these were primarily care managers in Milwaukee County. Improvements in transportation were noted as well. At Wave 1, only 20 percent of transition care managers had said that there were increases in transportation services under Family Care, whereas 46 percent of care managers noted increases in transportation at Wave 2.

Quarterly reports submitted by each Family Care county describe many efforts to increase or improve services and supports. For example, in response to Family Care participant requests for privacy, Fond du Lac decreased the size of its community-based residential facilities to four beds to allow for private rooms. La Crosse increased the number of Hmong homes certified as adult family homes to provide culturally acceptable care to Hmong older adults. The design of Family Care allows for flexibility in service options. During the first few years of Family Care, counties have been receptive to using this increased flexibility to expand and improve service options.

Conclusion #3: Despite improvements in the service environment under Family Care, all counties report both shared and unique service areas that need improvement.

In terms of shared areas, it appears that all four counties need to develop additional residential alternatives. Further development of residential options was listed as a priority among 50 percent of care managers in Fond du Lac, 38 percent in Portage, 33 percent in La Crosse, and 8 percent in Milwaukee. Although our study shows that Family Care CMs reported problems with residential alternatives less frequently than did statewide CMs, a large percentage of Family Care CMs cited limits or rules regarding residential options as a problem. For example, care managers were asked how often "limits or rules regarding residential options affect the types or amount of formal services that participants get." Although Family Care CMs reported this problem less frequently that statewide CMs, a large percentage of Family Care CMs reported that this is at least sometimes a problem (60 percent sometimes, 6 percent frequently, and 3 percent always).

Counties also have unique needs for service development due to county differences in caseload composition, organizational strengths, and community service environment. Family Care CMs in Milwaukee reported particular needs in the areas of personal care (50 percent), transportation (19 percent), and care management (15 percent). Portage CMs reported particular needs in the areas of transportation (38 percent), respite (38 percent), and residential options (38 percent). Fond du Lac CMs reported needs in residential options (50 percent), transportation (18 percent), respite (18 percent), and mental health services (18 percent). La Crosse CMs mentioned needs for residential options (33 percent), personal care/supportive home care (20 percent), and employment services (17 percent).

Service and support needs in the Family Care counties have been shifting over time, and we expect this to continue. As these four counties began implementing Family Care, they recognized and mobilized around particular gaps in their service and support options. For example, most counties needed to further develop their personal care networks right away. They also used the new program flexibility to improve transportation options and to meet the particular needs of different ethnic groups among their participants. Then counties found that they had to develop more alternative housing options to meet the

needs of growing caseloads and changing profiles of people on the caseloads. We anticipate that as counties continue developing their consumer-directed care option, they will need to make further changes to support consumer choice. We also anticipate that counties will have to continue to improve how they address the mental health needs of consumers, a theme starting to arise among care managers.

Conclusion #4: Most Family Care CMs feel positive about Family Care's ability to serve consumers well.

When asked about their general views regarding Family Care, all follow-up care managers agreed that Family Care increases services to some participants who weren't getting enough services under the old system. Almost all care managers agreed that Family Care allows them to provide some types of services not allowed before, and that consumers have increased choices in types of services and service providers. When asked whether Family Care should be expanded to the rest of the state, 72 percent of Wave 2 Family Care CMs responded that it should, while 18 percent were unsure and 12 percent did not support expansion. This summarizes well Family Care CMs' general sense that this program meets the needs of consumers.

Conclusion #5: Care managers report challenges to effectively fulfilling their care management roles.

Although Family Care CMs reported that program participants receive good care under Family Care, they felt that improvements need to be made to the care management role itself in order for them to continue providing optimal care to participants. In our first report 2 years ago (see footnote 3), we summarized:

> Although Family Care CMs report that program participants have equal or greater access to services under Family Care, those services are often harder for the care manager to arrange. In the short term, increased barriers to access might not be experienced by program participants, with care managers buffering the effects of inevitable organizational change. However, if care managers continue to bear the brunt of organizational change, this may ultimately affect both the quantity and quality of their work with program participants. Family Care CMs' generally positive expectations for Family Care are no doubt helping them get through a challenging period of early organizational change, but those positive expectations may begin to dwindle if attention is not paid to addressing many of the issues faced by care managers.

Indeed, the current report demonstrates that Family Care CMs continue to have concerns about their care management role, particularly (1) the amount of time they spend on paperwork, (2) large caseloads, and (3) lack of time to spend with program participants. In fact, between Waves 1 and 2, Family Care CMs demonstrated *growing* concern over Family Care's ability to structure the care management role effectively.

Conclusion #6: Care managers' recommendations for changes to Family Care focused primarily on organizational and administrative issues.

Family Care CMs made many recommendations throughout the interviews regarding improving specific services and supports to Family Care consumers. However, when asked to make three recommendations for improving Family Care, their primary recommendations focused on organizational and administrative issues. About half of their suggestions were aimed at changing the amount and type of work required of care managers (e.g., reducing paperwork, improving pay, reducing caseloads). About one-quarter of responses were aimed at changing administrative processes, such as developing or improving policies and procedures. Only 15 percent of the suggestions focused on improving specific services to participants, such as expanding housing options and transportation.

To provide quality care management, care managers need to have three things: knowledge of how to do their jobs well, time to put that knowledge into practice, and enthusiasm to sustain their efforts in this challenging job. Regarding knowledge, Family Care can address additional care manager training needs in two general categories: (1) Family Care training, such as procedures to follow, rules and regulations regarding Medicare and Medicaid, and (2) professional care management training, such as more training on consumer-directed care, implementing the RAD method, dealing with participants' mental health issues, and addressing the needs of different populations (e.g., gerontological training for care managers with no background in working with older adults).

However, even the most knowledgeable care managers cannot provide quality supports to consumers if they do not have enough time to do so. Family Care needs to attend to increasing the amount

of time that care managers have available to spend with participants by (1) reducing care manager time on administrative tasks (such as paperwork) and/or (2) reducing caseloads.

Although caseloads are smaller under Family Care (see footnote 4), the tasks required of care managers under Family Care in comparison to the previous long-term support program are arguably greater. There is always a tension over quality versus cost. Caseloads that are too high can result in poor-quality care. Yet spending resources on additional care managers often reduces the amount of money available to provide other direct services to consumers. Family Care counties clearly need to continue improving the efficiency of their systems to free up care managers from excessive paperwork, as well as examining what caseload balance is optimum under Family Care.

Finally, care managers need to maintain their enthusiasm to provide creative, high-quality care to consumers. Some care managers have asked for additional workshops on time management and on stress reduction. Although these are important to maintaining care manager enthusiasm and reducing turnover, enthusiasm will best be maintained if care managers have a sense of competence and pride in their work. If Family Care addresses care managers' knowledge-development needs, this will promote their sense of competence. If Family Care increases the time care managers have available to provide high-quality care, this will sustain pride in their work. Moreover, in an organizational environment where change is the norm, such as with Family Care, continuing to integrate care managers in the development of the program involves them as agents of change. Involving care managers as agents of change will likely result not only in more satisfied care managers but also in a program that better meets the needs of consumers.

APPENDIX

FULL DESCRIPTION OF RESEARCH METHODS

Phone surveys were conducted with care managers working in Wisconsin's long-term care system at two time points. Wave 1 was conducted in fall/winter 2000–01 with 126 care managers in Wisconsin. About half (n=64) were care managers working with Family Care in four counties, and the other half (n=62) were care managers in the long-term support system in non-Family Care counties across the state. Wave 2 was conducted in spring/summer 2002 with Family Care CMs in four counties. Under half (n=52) of Wave 2 care managers had also been interviewed at Wave 1, and are referred to as "follow-up care managers," while 67 were interviewed for the first time at Wave 2.

The Wave 1 Family Care Sample and Survey

The study targeted all care managers who worked with Family Care participants in the four counties that began enrolling Family Care participants by fall 2000. These counties and the dates they began enrollment are Fond du Lac (February 2000), Portage and La Crosse (April 2000), and Milwaukee (July 2000). Richland did not begin Family Care enrollment until later, and Richland's program progress will be discussed in a later report.

Lists of Family Care CMs were obtained from each of the four county CMOs. CMO administrators were informed about the study and were told that care managers would be asked to participate. In three counties, Family Care CMs work directly for the county in the CMO. However, in Milwaukee, most Family Care CMs work in agencies that contract with the county rather than working directly for the county. In Milwaukee, supervisors at each contract agency were informed that their care managers would be asked to participate in the study. All Family Care CMs received letters telling them about the study and notifying them that an interviewer would call them to see whether they were willing to participate, and if so, to set up a time to conduct a phone interview. In some instances, care managers who were contacted had no Family Care clients yet, had just started with Family Care, or had only one

case. In these instances, the care managers were not considered eligible to participate in Wave 1 of this study.

Of those care managers who were eligible, most were willing to participate, resulting in an overall response rate across the four Family Care counties of 85 percent. Fond du Lac had an 89 percent response rate (16 participants), La Crosse 84 percent (16 participants), Milwaukee 75 percent (18 participants), and Portage 100 percent (14 participants). We were unable to contact all of the Milwaukee care managers listed (phone calls were not answered or returned), and anyone not contacted was considered a refusal. Therefore, it is possible that the Milwaukee response rate might actually be higher than 75 percent if some of those we were unable to contact were not yet serving Family Care clients, were serving only one client, or had just begun with Family Care.

The telephone survey was conducted after receiving oral consent from study participants. The survey contained both closed- and open-ended questions on a number of topics related to Family Care and to the broader long-term support system in Wisconsin. Surveys were conducted primarily in October and November 2000, with a handful conducted in December 2000 and February 2001. The length of the survey ranged from 35 to 100 minutes, with a median of 57 minutes.

The Wave 1 Statewide Sample and Survey

We drew a "statewide" sample of care managers (Statewide CMs) by selecting one care manager from each Wisconsin county not currently implementing Family Care CMOs (all counties except La Crosse, Fond du Lac, Portage, and Richland). We also randomly sampled one Milwaukee care manager from the pool of Milwaukee care managers who do not work in the Family Care program (Milwaukee continues to run both Family Care and the previous long-term support system). We obtained a list of care managers for each county from The Management Group, with permission from the Department of Health and Family Services. We randomly selected one care manager from each county and sent introductory letters to both the selected care managers and their supervisors or directors. Care managers were then called to determine whether they were willing to participate. If the selected care manager was no longer

working in the position, was on maternity leave, etc., another care manager on the list for that county was selected. If a selected care manager refused to participate, or if the supervisor/director would not allow the care manager to participate, that county was counted as a refusal.

We conducted 62 interviews and had six refusals, resulting in a response rate of 91 percent for the statewide CM sample. The statewide CM survey was similar to the survey conducted with Family Care CMs, with both closed- and open-ended questions related to the long-term support system in Wisconsin. This survey was shorter because it excluded questions specific to Family Care. Most phone interviews with statewide CMs took place in January and February 2001, with a handful conducted in November 2000 and in March and April 2001. The length of the interviews ranged from 30 to 75 minutes, with a median of 45 minutes.

The Wave 2 Family Care Sample

The Wave 2 sample included 119 Family Care CMs: 52 follow-up interviews and 67 interviews with care managers who were new to the Family Care system since the first wave.

Wave 2 Follow-Up Care Managers

We tried to contact all Family Care CMs interviewed at Wave 1. Among the 56 previous participants who were still available, 52 were willing to participate in Wave 2, for a 93 percent response rate among follow-up CMs. Milwaukee County had an 85 percent response rate (11 participants), Portage 85 percent (11 participants), Fond du Lac 100 percent (14 participants), and La Crosse 100 percent (16 participants). The survey was conducted from February 2002 through May 2002. The length of the interviews ranged from 25 to 124 minutes, with a median of 55 minutes.

Wave 2 New Care Managers

Among 124 available new care managers (from county lists), 67 were contacted and willing to participate in the study (54 percent). Milwaukee County had a 42 percent response rate (38 participants),

Portage 100 percent (6 participants), Fond du Lac 75 percent (9 participants), and La Crosse 88 percent (14 participants). The survey for new participants was conducted from March 2002 to September 2002. The length of interviews ranged from 30 to 120 minutes, with a median of 55 minutes.