CSHP
Rutgers Center for State Health Policy
NATIONAL ACADEMY for STATE HEALTH POLICY

March 2006

State Policy in Practice

Community Living Exchange

Funded by Centers for Medicare & Medicaid Services (CMS)

Evaluating Nursing Home Transition in Michigan

Susan C. Reinhard
Jennifer Farnham

This document was prepared by Susan C. Reinhard and Jennifer Farnham of the Rutgers Center for State Health Policy (CSHP)

Prepared for:

Rutgers Center for State Health Policy

Susan C. Reinhard & Marlene A. Walsh

Robert Mollica

The Community Living Exchange at Rutgers/NASHP provides technical assistance to the Real Choice Systems Change grantees funded by the Centers for Medicare & Medicaid Services.

We collaborate with multiple technical assistance partners, including ILRU, Muskie School of Public Service, National Disability Institute, Auerbach Consulting Inc., and many others around the nation.

This document was developed under Grant No. P-91512/2 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government. Please include this disclaimer whenever copying or using all or any of this document in dissemination activities.

STATE POLICY IN PRACTICE: EVALUATING NURSING HOME TRANSITION IN MICHIGAN

Susan Reinhard
Jennifer Farnham

March 2006

Summary

This *State Policy in Practice* brief describes Michigan's nursing home transition program and summarizes evaluation findings. The program has been sustained statewide through the addition of transition services to Michigan's 1915c waiver for the aged and disabled. This brief is intended to help state policy and program leaders, advocates, and providers learn from their peers and colleagues across the states. Similar briefs feature other states, such as Washington,[1] New Jersey,[2] Indiana[3] and Minnesota,[4] and a summary of 10 states that are working to sustain their programs.[5] Also available is a "toolbox" of information on nursing home transition.[6] These documents can be found at www.cshp.rutgers.org and www.hcbs.org.

Major Points

- Michigan was one of the first group of states to receive funding under the Nursing Home Transitions Demonstration Program in 1998.
- Michigan officials found that consumers at all acuity levels could be successfully transitioned. Influenced by the independent living movement, they focused on the resident's choice to move rather than the resident's abilities or care needs.
- Transition services are now available statewide through Michigan's 1915c waiver.
- Forty-one percent of transitionees required no government-paid services after getting assistance with the transition. Although the transitionees were not a representative sample of the nursing home population, the nursing facility transition project estimates that the prevalence of this going forward may be at least eight percent.
- Costs for transitionees who enrolled in Medicaid waiver or other service programs were 60 to 76 percent less, on average, than was paid for them to stay in the nursing facility.

[1] Gillespie & Mollica (2005).
[2] Reinhard & Petlick (2005).
[3] Reinhard & Farnham (2006, February).
[4] Auerbach & Reinhard (2005).
[5] Reinhard & Farnham (2006, January).
[6] Reinhard & Gillespie (2005).

- Challenges to successful transition, particularly access to housing, remain.

- Michigan's approach to the development of long term care programs includes a focus on data, quality, evaluation and inclusiveness, which helps to create a constructive dialogue between those emphasizing consumer freedom and those emphasizing consumer safety.

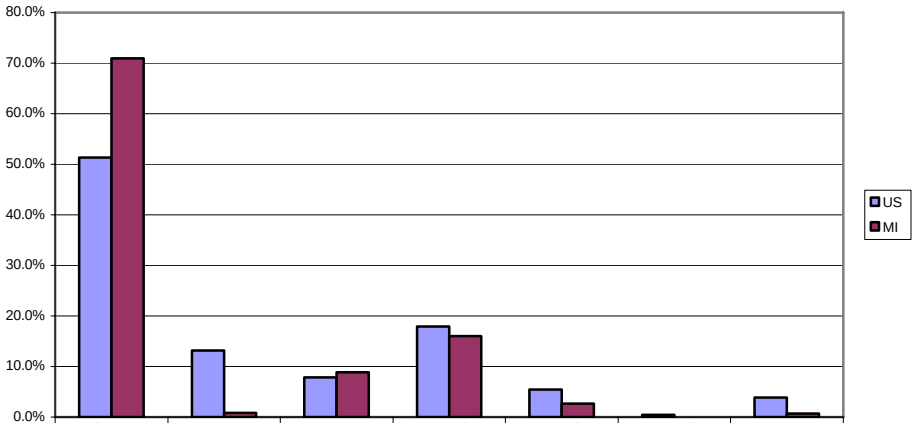
Background

Long-Term Care Spending

In 2004, Michigan spent about $2.4 billion on long term care, which was about 29 percent of its total Medicaid spending of about $8.2 billion. The majority of these funds ($1.7 billion) went to nursing facilities. The percentage of the long term care budget going to nursing facilities has decreased from 75 percent in 2000 to 71 percent in 2004.[7] Figure 1 below shows a comparison of Michigan's long term care spending in 2004 with the country as a whole. As a proportion of its budget, Michigan spends more on nursing facilities than the national average. It spends far less on average for intermediate care facilities for the mentally retarded (ICF-MR), however, and has been recognized as an innovator in community based services for the developmentally disabled (DD) population.[8] The proportion of its budget going to personal care and MR/DD waivers is similar to the national average, while the proportion going to waivers for the aged and disabled and for home health is less than the national average.

Figure 1: Composition of LTC Spending, FFY 2004

Source: Burwell et al. (2005)



	Nursing Home Services	ICF-MR Total	Personal Care	HCBS Waivers-MR/DD	HCBS Waivers-A/D	HCBS Waivers-Other	Home Health
US	51.3%	13.2%	7.9%	17.9%	5.5%	0.5%	3.9%
MI	71.0%	0.8%	8.8%	16.0%	2.6%		0.7%

[7] Burwell et al. (2005).
[8] Davis et al. (2000).

Long-Term Care Population and Program History

Michigan ranks eighth in total population among states in the U.S. with about 10.1 million residents in 2004, 1.24 million of whom are over age 65.[9] Michigan had 40,365 nursing facility residents in 2004, 67 percent paid by Medicaid, 15 percent by Medicare, and 18 percent by other (generally private) means.[10] It has the tenth highest nursing home population in the country.[11] The percent of residents 65 and older in a nursing facility is slightly lower on average than the rest of the states (3.4 percent versus four percent average across states).[12] Michigan is average with respect to the prevalence of disability in the over 65 population (about 40 percent), and slightly above average with respect to those aged 21 to 64 (13 percent, versus 12 for the country) and those aged five to 20 (eight percent, versus 6.5 percent for the country).[13] Michigan expects the non-elderly disabled to be its fastest growing population in need of Medicaid for long-term care.[14]

Michigan began operating its Care Management program for the elderly (age 60 and over) in 1983. In 1992, it began its Medicaid HCBS waiver for the elderly and disabled, known as MI Choice. In early 1998 the waiver began operating statewide.[15] The programs are under the auspices of the Michigan Department of Community Health.[16]

Nursing Home Transition Activity

Michigan was one of the first group of states to receive funding under the Nursing Home Transitions Demonstration Program in 1998.[17] This one-year grant supported a partnership with the state Department of Community Health and the Michigan Association of Centers for Independent Living (MACIL).[18] MACIL developed a set of transition planning tools that combine the philosophy of person-centered planning with practical tips regarding things that must be done in a transition.[19]

The independent living philosophy of consumer control has carried through all the transition efforts that have followed in the last eight years. In 2000 and 2001, the state Department of Community Health granted funds to MACIL to continue the transition work begun under the demonstration program. Michigan then received a Nursing Facility Transition Initiative (NFTI) grant, along with a Real Choice Systems Change (RC) Grant, in 2001. The NFTI grant focused on transition, diversion, education and evaluation, with a special emphasis on housing, which was identified in the demonstration grant as a major barrier to transition. The

---

[9] Statistical Abstract of the U.S. (2006), Tables 18 & 21.
[10] Harrington et al. (2005).
[11] Ibid. Ranking is using 2004 data.
[12] Gibson et al. (2004).
[13] American Community Survey (2004), Tables R1801, R1802 & R1803.
[14] Michigan Department of Community Health (2000, June).
[15] Fries et al. (2002).
[16] See http://www.michigan.gov/mdch; http://www.miseniors.net for senior services.
[17] Unless otherwise noted, all grants were given by the federal government via the Centers for Medicare & Medicaid Services (CMS).
[18] See Eiken et al. (2002) for a report on this grant.
[19] Michigan Disability Rights Coalition (2001). Online at http://www.macil.net/issues/NHtransplan.php

RC grant focused on evaluation of outcomes and on workforce issues, another area identified by the demonstration as a transition barrier.[20] Results of these grants are discussed below.

Michigan has demonstrated significant efforts to reform its system for long term care and supports and continues to secure grants and marshal stakeholders to help drive this reform.[21] In 2003, Michigan received a Money Follows the Person grant. In 2004, Michigan received a Cash and Counseling grant from The Robert Wood Johnson Foundation. Also in 2004, the Long Term Care Task Force was created as part of an Olmstead lawsuit settlement.[22] The task force issued its final report in May of 2005.[23] Shortly thereafter, the governor issued an executive order implementing key task force recommendations, including creating the Office of Long-Term Care Supports and Services and the Michigan Long-Term Care Supports and Services Advisory Commission within the Department of Community Health. The order also mandated the department to establish at least three single point of entry demonstration programs and to evaluate their effectiveness for the state.[24] Also in 2005, Michigan received an Aging and Disability Resource Center (ADRC) grant to augment these efforts. In addition to working on rebalancing and alternatives to institutions, Michigan is also working to change the design and atmosphere of long term care facilities.[25]

Program Practices

Nursing Facility Transition

As of April, 2005 NFTI is a statewide waiver service through the MI Choice program. The program is delivered through 22 waiver agents (Area Agencies on Aging and others) divided among 14 regions in the state.[26] Those who do not qualify for waiver services may be able to access transition assistance through other programs offered through Centers for Independent Living.[27]

Nursing facility transition initiative

In the transition initiative project, funded by CMS in 2001, two waiver agents participated. The Area Agency on Aging of Western Michigan (covering a nine county area including Grand Rapids) hired a supports coordinator to handle transition plan development and

---

[20] Centers for Medicare & Medicaid Services. (2005, March).
[21] Michigan officials note that their leadership in the developmental disabilities arena has been more significant than their work on behalf of older adults and persons with disabilities, where they are moving from a more preliminary stage of development. See Davis et al. (2000) for a discussion of Michigan's DD program.
[22] Granholm, J. (2004, April 1).
[23] Michigan Medicaid Long-Term Care Task Force (2005).
[24] Granholm, J. (2005, June 9).
[25] See http://www.michigan.gov/mdch/0,1607,7-132-27417-119666--,00.html or http://www.michigan.gov/documents/bhs_guidelines_fids_128309_7.pdf for details of the Long Term Care Facility Innovative Design Supplemental Program (accessed February 22, 2006).
[26] See http://www.michigan.gov/mdch/0,1607,7-132-2943_4857_5045-16263--,00.html (accessed February 13, 2006).
[27] These programs are funded through Civil Monetary Penalty collections, among other sources (Daeschlein, M., comments at Nursing Home Transition Summit, September 2005). For a summary of recent research on the use of such funds, see http://www.nccnhr.org/govpolicy/51_164_1849.cfm (accessed February 23, 2006).

implementation. This coordinator had a working relationship with nursing facilities in her area as she had worked with an area Center for Independent Living on a previous transition grant. The Detroit Area Agency on Aging (DAAA) utilized subcontractors to identify participants and match participants with housing in the community. DAAA staff pulled together the resources in the community to carry out transition plans.[28]

Nursing facility diversion initiative

The diversion project, also part of the 2001 CMS grant, was carried out by The Geriatrics Center, Turner Geriatric Clinic-Social Work and Community Programs at the University of Michigan. The Center hired two social workers (1.5 full-time equivalents). The part-time social worker enrolled participants, and the full time social worker worked with nursing facilities, consumers and their families to return the consumers to the community.

The diversion project targeted clients at the University Hospital, University of Michigan Health System (in Ann Arbor), who were likely to be admitted to a nursing facility upon hospital discharge. These individuals were judged as likely nursing facility admissions if they were impaired physically and had at least one other "complicating" variable with respect to their mental or social status (e.g., cognitive ability, housing, social support). Individuals who had been in a nursing home for more than two years prior to hospital admission were considered transition, rather than diversion, cases. The social workers worked with 34 nursing facilities that received hospital discharges, and acquainted themselves with community resources in a ten county area.[29]

Education

Part of the NFTI grant included an educational component to develop materials to help expand the program, as well as materials to educate the public. A training curriculum was developed to assist with statewide implementation. Brochures and other information were developed for community distribution.[30] A DVD entitled "A Better Choice" was created to raise awareness about the realities of transition among care managers, consumers and their families. The title reflects the fact that community living was a better choice for the consumers featured in the DVD, and is not meant to imply that it is a better choice for everyone.[31]

Evaluation

Evaluation was the fourth component of the NFTI grant. An evaluation was commissioned to compare the demographic and clinical characteristics of transitionees with the overall long term care population, and to do a cost analysis of the pre and post long term care costs for transitionees, based on Medicaid claims data.[32] A separate evaluation was prepared for the diversion component that examined participant characteristics and the challenges for them with respect to living in a community setting.[33] Michigan has been focusing on quality

[28] Youngs et al. (2005).
[29] Supiano et al. (2004).
[30] Youngs (2005).
[31] Comments of Youngs, D. in phone interview, March 9, 2006.
[32] Youngs et al. (2005).
[33] Supiano et al. (2004).

initiatives with the Real Choice Systems Change grant, and building evaluation into many of its long term care activities.[34]

Program Results

> *"the NFTI transition program demonstrated that many people in nursing facilities who have long term care supports and services can live in the community successfully. Some need extensive services but others only need housing and supports"*[35]

Characteristics of Transitioned Consumers

There were 258 consumers who transitioned during the NFTI 2001 grant,[36] 112 of whom were transitioned during the evaluation period (ten people were still working on the transition at the conclusion of the evaluation).[37] When combined with the numbers transitioned earlier, the total is 456 consumers transitioned since 1998.[38] The waiver was closed to new enrollments during the first two years of the NFTI 2001 grant, which made it difficult to transition those with medical needs.[39]

Of the 112 transitionees included in the evaluation, 51 percent were under age 65. Forty-one percent of the participants were male, half were African American (nearly all the rest were Caucasian), and 12 percent were married. Of the 93 residents for whom evaluators could determine residential history in the five years prior to assessment, 78 (84 percent) had been in a nursing facility for all or part of the time, and 15 had received home care services. Three-quarters were taking eight or more medications at the time of their assessment.[40] Figure 2 below shows the distribution of Activity of Daily Living (ADL) measures in the transition population compared to the Michigan nursing facility population. Transitionees were concentrated in the lower to mid ADL hierarchy, and were less likely than the nursing facility population to be classified as dependent.[41] Still, there were transitionees in every category. Program staff noted that the consumer's choice was more important than their abilities or service needs with respect to being able to transition.

---

[34] Daeschlein (2005a).
[35] Youngs et al. (2005), p.27.
[36] Youngs, D. (2005).
[37] Youngs et al. (2005).
[38] Eiken et al. (2002).
[39] Youngs et al. (2005).
[40] Michigan was one of the states that helped develop the MDS-HC, and uses it to track its transitionees. See Fries et al. (2002) for a discussion of the development of Michigan's assessment.
[41] Note: ADL data was available for 79 of the 112 transitionees. Some participants left the nursing facility before a complete assessment was done.

Figure 2: ADL Categories, Transitions vs. NF population
Source: Youngs et al., (2005)

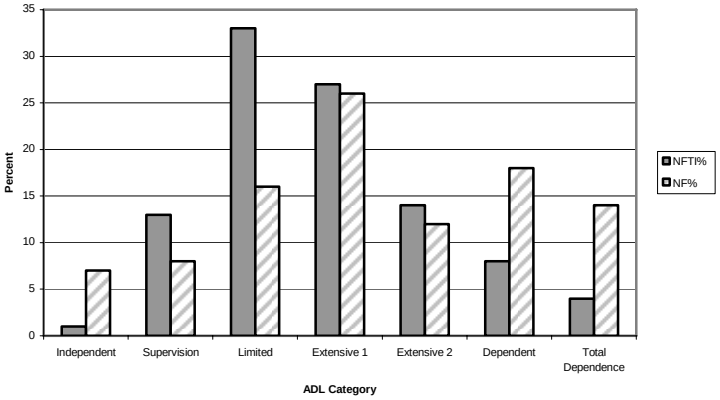
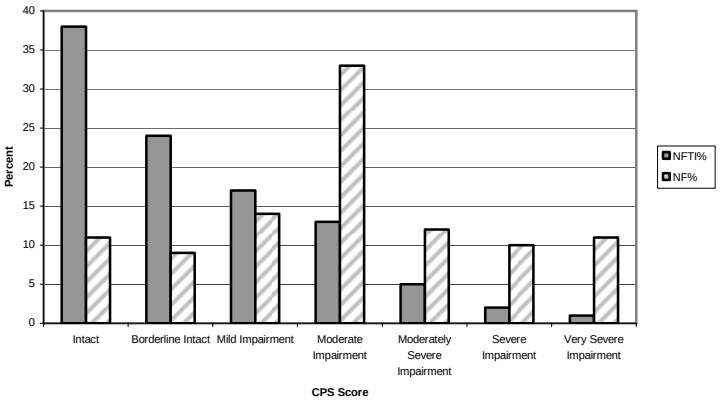


Figure 3 below shows the distribution of Cognitive Performance Scale (CPS) scores in the transition population compared to the nursing facility population.[42] Transitionees were concentrated in the lower CPS range, while Michigan nursing facility residents are distributed more or less in a normal bell curve.

Figure 3: CPS Scores, Transitions vs. NF Population
Source: Youngs et al., (2005)



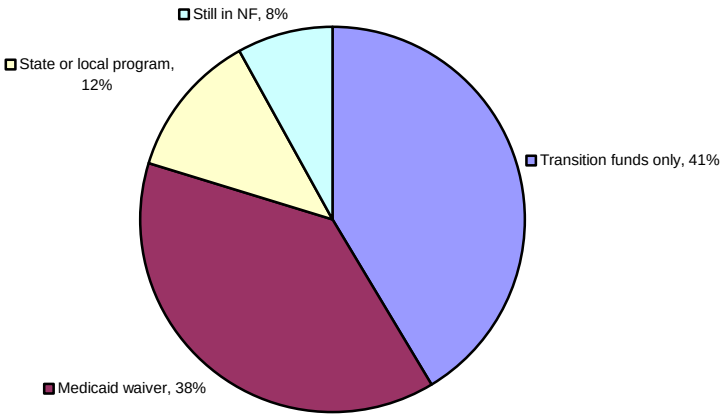
Programs and Services Used by Transitioned Consumers

Figure 4 shows the types of programs that transitioned consumers entered. Half used either Medicaid waiver services or state or local agency programs. **A startling 41 percent had no further requirements after transition services.** A small percentage were still awaiting transition at the end of the evaluation. Based on MDS data for residents in the reduced physical function A category (RUG hierarchy), the estimated percentage of future transitionees not needing services could be at least eight percent.[43]

[42] These scores were based on a modified CPS for waiver participants composed of four areas: memory, cognitive skills with respect to daily decision-making, expressive communication, and eating.
[43] Youngs, D., comments at Nursing Home Transition Summit, September 2005.

Figure 4: Programs Used by Transitioned Consumers

Source: Youngs et al. (2005)

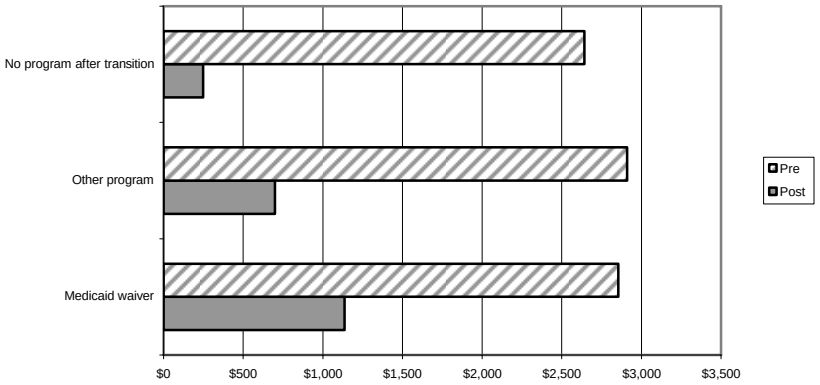


Of those transitionees who used services (which was 55 percent of those who left nursing homes during the evaluation period), three-quarters or more used personal care and homemaker services. Around half used emergency response systems and home delivered meals. About 20 percent used transition funding for home start-up costs or modifications. A similar number required specialized medical equipment or private duty nursing. About one in seven required special equipment or modifications for accessibility. Six consumers (12 percent) required tube feeding.

Cost Savings for Transitioned Consumers

The evaluation looked at costs during the six months prior to and following transition. For the group of consumers that required no services beyond help with the transition itself, costs were reduced by 90 percent. For those on the MI Choice Medicaid waiver program, costs were reduced by 60 percent. For those on other programs, costs went down 76 percent, on average. Figure 5 below illustrates the decrease in costs as an average per person, per month. Nursing facility costs were nearly $3,000 per person, per month. The cost for HCBS averaged about $1,100 for consumers utilizing the Medicaid waiver and about $700 for those using other programs. The “monthly” figure for consumers who did not use any programs after transition is a bit misleading, as the cost was incurred for the transition only and will not continue in the future, but is presented here for comparison purposes.

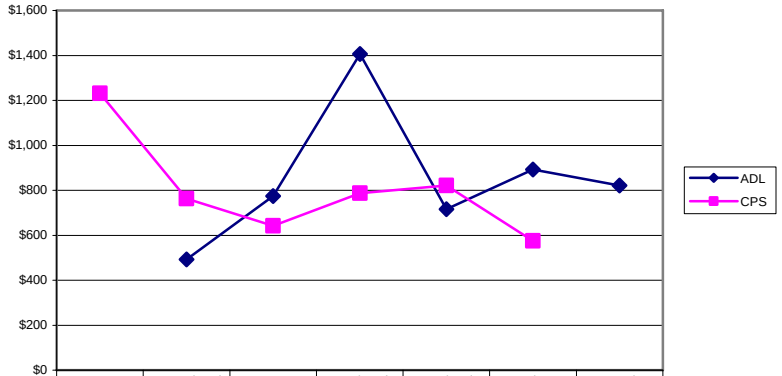
Figure 5: Costs 6 Months Pre/Post Transition, Averaged Per Person Per Month
Source: Author calculation from data in Youngs et al. (2005)



	Medicaid waiver	Other program	No program after transition
Pre	$2,854	$2,912	$2,642
Post	$1,137	$700	$249

The average cost per person per service month during this period was $917. The cost varied a bit depending on the acuity level of the consumer, but was not always more on average for those with more severe disabilities. In fact, costs were highest for those in the mid-hierarchy for ADLs and for those with the least impairment in CPS scores (the latter may have had more severe physical disabilities). Figure 6 breaks down the average costs by level in ADL and CPS groups.

Figure 5: Average Service Costs for ADL & CPS Groupings
Source: Youngs et al. (2005)



	Indep./Intact	Superv./Bord. Intact	Ltd./Mild Imp.	Ext 1/ Mod. Imp.	Ext 2/Mod. Sev. Imp.	Dep./Sev. Imp.	Tot. Dep./Very Sev. Imp.
ADL		$493	$775	$1,406	$716	$893	$821
CPS	$1,231	$763	$642	$787	$821	$575	

Consumers Diverted

There were 118 consumers enrolled in the diversion program, 90 of whom were followed after their discharge to a nursing home.[44] Of the 90, 66 were discharged to the community—56

[44] Supiano et al. (2004). Of the 28 who were not followed, three died in the hospital and 25 were discharged to a location other than a nursing facility. Some of the 25 were discharged home, but were not counted as diversions, presumably because they had not received services.

went home, eight went to assisted living and two went into adult foster care. Of the remainder, 13 died in the nursing facility or a hospital and the rest remained in the nursing facility.[45]

Transition Sustained

Michigan announced on April 1, 2005 that Nursing Facility Transition costs would be covered under its MI Choice program, a 1915c waiver program for the elderly and disabled, and that consumers wanting to transition out of nursing facilities would be a priority category for waiver slots.[46] Further, a waiver slot will be added for each person transitioned out of a nursing facility.[47] The MI Choice program will cover waiver agents for coordination and support services and transition expenses, such as housing and utility deposits, cleaning expenses and furniture, appliance and moving expenses. Up to $3,000 will be reimbursed without prior approval.

The program reimburses expenses incurred in the six months prior to transition. There are also provisions to provide some funds to cover the expenses for consumers who are unable to transition successfully, those who have expenses not reimbursable under Medicaid (such as delinquent debt), or those who do not meet level of care requirements for the MI Choice program.[48] Waiver agents and Centers for Independent Living statewide are receiving training to implement the program.

While the findings of cost savings are undoubtedly persuasive, officials are quick to credit the ongoing work the disability advocacy community has done (and continues doing) to press for change.[49] In its Money Follows the Person grant, Michigan is using funding to increase consumer awareness of and participation in long-term care reform[50]

Summary of Challenges

Despite the successes of the nursing home transition initiative, challenges remain. Many will be addressed through Michigan's ongoing efforts. For example, through the single point of entry initiative called for in the governor's executive order, augmented by its ADRC initiative, Michigan will work to improve access to its long term care system, which will help address consumer access to information and services.[51] The Office of Long-Term Care Supports and Services' work will bring the practice of person-centered planning into all aspects of the system.[52] Workforce issues are being addressed through the Quality Community Care Council, funded by the Real Choice Systems Change grant and the CPASS grant.[53]

---

[45] These figures are calculated based on the summary on page ten and Tables 24-28 in Supiano et al. (2004).
[46] Reinhart, P. (2005, April 1).
[47] Reinhart, P. & Christensen, J. (2005).
[48] Reinhart, P. (2005, April 1).
[49] Comments from Michael Daeschlein at Nursing Home Transition Summit, September 2005.
[50] Daeschlein (2005b).
[51] Granholm, J. (2005, June).
[52] Michigan Medicaid Long-Term Care Taskforce. (2005).
[53] Daeschlein (2005a). See http://www.mqccc.org/

A general lack of government funds for services remains a problem for Michigan and other states, as does a shortage of affordable, accessible housing. Housing was an area of focus in the 2001 NFTI grant after being identified as a major barrier in the demonstration program.[54] In the Detroit site for the 2001 NFTI grant, a retired executive from the state housing authority was very helpful in coordinating existing resources,[55] but access to housing remained a barrier because of the overall lack of funding.[56]

Another barrier identified in the evaluation was concerns about the finances of consumers—after paying their nursing facility expenses, consumers are left with very little to save toward transitioning to the community. Also, some consumers had medical crises resulting in a damaged credit history that had to be addressed in order to secure housing.[57]

A final barrier was the lack of up to date resident data (such as care needs and existing supports) from nursing facilities, which made it difficult to identify potential transitionees or plan for transition.

Replication Requirements

Utilize/Support Expertise and Build Evaluation In

Michigan has built evaluation into many of its programs from the start to ensure quality and performance. Mary James, a former state official instrumental in development the HCBS waiver (now at the University of Michigan), was known for her commitment to using data to inform policy.[58] In planning and carrying out its programs and evaluations, Michigan has utilized experts in a variety of ways—from tapping into the knowledge and energy of its advocacy community to consulting with academic experts at the University of Michigan and elsewhere.

David Youngs, CEO of DYNS Services Inc., who did the NFTI evaluation, was a former employee of the state of Michigan, where he learned the details of waiver data.[59] Michigan benefits from the expertise of RoAnne Chaney, a nationally recognized expert on long term care now with the Michigan Disability Rights Coalition.[60] Dr. Brant Fries, at the University of Michigan, is the co-developer of the National Resident Assessment Instrument, and continues to be involved with the state on issues of assessment and evaluation.[61]

---

[54] Eiken et al. (2002).
[55] Daeschlein, M., comments at Nursing Home Transition Summit, September 2005.
[56] Youngs et al. (2005).
[57] Ibid.
[58] See http://www.iog.umich.edu/faculty/james.html (accessed February 23, 2006).
[59] Daeschlein, M., comments at Nursing Home Transition Summit, September 2005.
[60] See http://www.copower.org/mdrc/staff.htm#rc (accessed February 23, 2006).
[61] See http://www.iog.umich.edu/faculty/fries.html or http://www.sph.umich.edu/scr/faculty/profile.cfm?uniqname=bfries (accessed February 23, 2006).

In addition to tapping the knowledge of advocates, Michigan has built support for consumer participation into its Money Follows the Person grant to ensure access to information and consumer involvement in the development of the long-term care system.[62]

Conclusions

> "*Earlier in my career I worked on the deinstitutionalization for the people with developmental disabilities, and I just remember we kept drawing a line in the sand. 'Well, these people can live in the community and these people can't,' and we were always wrong about that, and we had to keep scuffing out that line and redrawing it. And eventually, we got smart enough to realize that just about everybody can live in the community, if not everybody. And I think we'll see the same progression in nursing homes as we get better at it and build the support system."* Michael Daeschlein, September 2005

This statement from Michael Daeschlein, Program Specialist at the Michigan Department of Community Health, illustrates the importance of philosophy as a foundation for programs. The belief that living in the community is not safe for people with long term care needs can prevent providers from informing consumers of their options, and can be a barrier to the development of options.

The data-driven, inclusive path that Michigan has chosen for much of its long term care can create a space for constructive dialogue between constituencies emphasizing maximum freedom for disabled consumers and constituencies concerned with the safety of those with long term care needs.

Acknowledgements

We would like to thank Michael Daeschlein and Michael Head of the Michigan Department of Community Health, David Youngs of DYNS Services, Inc. and Mary James of the Institute for Gerontology at the University of Michigan for providing information for this document.

[62] Daeschlein (2005b).

References

American Community Survey (2004). Accessed February 2, 2006 from http://factfinder.census.gov.

Auerbach, R. and Reinhard, S. (2005, September). *Minnesota's Long Term Care Consultations (LTCC) Services.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at http://www.hcbs.org/files/80/3965/MinnesotaLTCC100705WEB.pdf .

Burwell, B., Sredl, K., & Eiken, S. (2005, May). Medicaid Long Term Care Expenditures in FY 2004. Medstat. Accessed February 17, 2006 from: http://www.hcbs.org/moreInfo.php/source/150/doc/1260/Medicaid_Long_Term_Care_Expenditures_in_FY_2004

Centers for Medicare & Medicaid Services. (2005, March). *Real Choice Systems Change Grants: Compendium, 4th edition.* Accessed January 23, 2006 from: http://www.hcbs.org/files/60/2991/Compendium4thEdition.pdf.

Daeschlein, M. (2005a). *Systems Change Grant Report: 91663/5 Michigan Real Choice: 2005 Annual*. CMS Disabled and Elderly Health Programs Group. (On file with authors).

Daeschlein, M. (2005b). *Systems Change Grant Report: 92115/5 Michigan Money Follows the Person: 2005 Annual*. CMS Disabled and Elderly Health Programs Group. (On file with authors).

Davis, D., Fox-Grage, W., & Gehshan, S. (2000, January). Deinstitutionalization of Persons with Developmental Disabilities: A Technical Assistance Report for Legislators. National Conference of State Legislatures. Item 6683, accessed February 21, 2006 at: http://www.ncsl.org/programs/health/Forum/pub6683.htm

Eiken, S., Burwell, B. & Asciutto, A. (2002, July). *Michigan's Transitioning Persons from Nursing Homes to Community Living Program.* Cambridge, MA: Medstat. Available at: http://aspe.os.dhhs.gov/daltcp/reports/MItrans.pdf

Fries, B.E., Shugarman, L.R., Morris, J.N., Simon, S.E., James, M. (2002). A Screening System for Michigan's Home- and Community-Based Long-Term Care Programs. *The Gerontologist* 42(4): 462-474.

Gibson, M. J., Gregory, S.R., Houser, A.N.. Fox-Grage, W. (2004). *Across the States: Profiles of Long-Term Care: Michigan.* AARP Public Policy Institute. Accessed January 23, 2006 from: http://assets.aarp.org/rgcenter/post-import/d18202_2004_ats_mi.pdf

Gillespie, J. (2005, January). *Assessment Instruments in 12 States.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community

Living Exchange. Available at: http://www.hcbs.org/moreInfo.php/source/152/doc/844/Assessment_Instruments_in_Twelve_States

Gillespie, J. & Mollica, R. (2005, June). *Streamlining Access to Home and Community-Based Services: Lessons from Washington.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at http://www.hcbs.org/files/76/3769/Wash.pdf .

Granholm, J. (2004, April 1). *Executive Order 2004-1: Medicaid Long-Term Care Task Force, Department Of Community Health.* Lansing, MI: Office of the Governor. Accessed February 1, 2006 from: http://www.michigan.gov/gov/0,1607,7-168-21975-90019--,00.html.

Granholm, J. (2005, June 9). *Executive Order 2005 – 14: Department of Community Health: Office of Long-Term Care Supports and Services; Michigan Long-Term Care Supports and Services Advisory Commission.* Lansing, MI: Office of the Governor. Accessed February 2, 2006 from: http://www.michigan.gov/gov/0,1607,7-168-21975-119823--,00.html.

Harrington, C., Carrillo, H., Mercado-Scott, C. (2005, August). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 Through 2004.* Department of Social and Behavioral Sciences, University of California San Francisco, CA. Accessed September 21, 2005 from: http://www.pascenter.org/documents/OSCAR2005.pdf

Michigan Department of Community Health. (2000, June). *Michigan's Long Term Care Work Group Report and Recommendations: Long Term Care Innovations: Challenges and Solutions.* Accessed January 24, 2006 from: http://www.michigan.gov/documents/ltcrpt_6955_7.pdf.

Michigan Disability Rights Coalition (2001). *Planning Tools for Assisting Individuals to Transition from Nursing Homes to Community Living.* Accessed February 21, 2006 at: http://www.macil.net/issues/NHtransplan.php

Michigan Medicaid Long-Term Care Taskforce. (2005, May). *Modernizing Michigan Medicaid Long-Term Care: Toward an Integrated System of Services and Supports.* Accessed February 1, 2006 from: http://www.ihcs.msu.edu/LTC/Reports/Final_LTC_Task_Force_Report.doc.

Reinhard, S. & Farnham, J. (2006, February). *Indiana's Efforts to Help Hoosiers Prevent Unwanted Nursing Home Residence.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/84/4181/INUnwantedNHResidenceWEB.pdf

Reinhard, S. & Farnham, J. (2006, January). *Meeting Summary: Sustaining Nursing Home Transition.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/83/4144/NHTSummitNJSept05WEB.pdf

Reinhard, S. & Gillespie, J. (2005, October). *Nursing Facility Transition Toolbox.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Accessed January 11, 2006 at: http://www.hcbs.org/files/80/3964/NFTToolbox10-12-05WEB.pdf

Reinhard, S. & Petlick, N.H. (2005, December). *Sustaining New Jersey's Evolving Community Choice Counseling Program*. New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Accessed March 13, 2006 at: http://www.hcbs.org/files/83/4109/NJCCCdec20WEB.pdf

Reinhart, P. (2005, April 1). MI Choice Program Nursing Facility Transition Services and Waiting List Policy. *Bulletin*, MSA 05-21. Lansing, MI: Department of Community Health, Medical Services Administration. Accessed February 7, 2006 from: http://www.michigan.gov/documents/MSA_05-21_120931_7.pdf.

Reinhart, P. & Christensen, J. (2005, November 17). Letter L05-38to MI Choice Program Agents regarding MI Choice Program Transition Costs, from Director, Medical Services Administration and Interim Director, Office of Long Term Care Supports and Services. Lansing, MI: Department of Community Health, Medical Services Administration. (on file with authors)

Statistical Abstract of the United States. (2006). Accessed February 2, 2006 from: http://www.census.gov/prod/www/statistical-abstract.html.

Supiano, K., Carroll, A. & Blomquist, A. (2004, September). *Nursing Facility Diversion: Mobilizing Residents, Families and Resources to Facilitate Return to Community Living (The Report of the Turner Geriatric Clinic-Social Work and Community Programs Nursing Facilities Transition Grant).* Ann Arbor, Michigan: The Geriatrics Center.

Youngs, D. (2005). *Systems Change Grant Report: 91667/5 Michigan Nursing Facility Transition – 2005 Annual.* CMS Disabled and Elderly Health Programs Group. (On file with authors).

Youngs, D., Clifford, C. & Perry, S. (2005). *Michigan Nursing Facility Transition Initiative Project Evaluation Report: Transition Component.* Michigan Department of Community Health, Division of Community Living.