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Expanding Eligibility for the Family Caregiver Support Program in SFY 2012

Updated Findings

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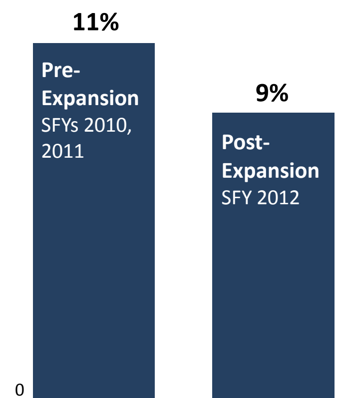
WASHINGTON STATE'S FAMILY CAREGIVER SUPPORT PROGRAM (FCSP) serves Washingtonians who provide uncompensated care for a parent, spouse, or another adult with medical issues, mobility limitations, or decreased cognitive functioning. In a 2007 statewide survey, the Washington State Department of Health found that many family caregivers feel time-constrained and have high levels of stress.[1] Designed to mitigate these burdens, FCSP services include information and outreach, screening and assessment, respite care, support groups, and resources to assist with mobility limitations and other needs. One goal of providing FCSP services is to delay or make unnecessary the placement of care receivers in long-term care facilities.[2]

The 2011 Legislature increased the state funding for FCSP in State Fiscal Year (SFY) 2012 by $3.45 million dollars. The expansion allowed FCSP to broaden its reach to family caregivers with a wider range of caregiver burdens, as identified by an evidence-based screening tool, the Tailored Caregiver Assessment and Referral System (TCARE®).[3] A legislatively mandated evaluation of the expansion, completed by the Washington State Institute for Public Policy (WSIPP) in November 2012, demonstrated promising findings. Using data from the short follow-up period available at that time, WSIPP found that the expansion was associated with delayed use of Medicaid long-term care services (LTC).[4] This report revisits the question of how the FCSP expansion affected the use of Medicaid LTC, now that care receivers' outcomes have been observed for a longer period of time.

Key Findings

- Due to the FCSP expansion, caregivers screened in SFY 2012 were more likely to receive a full assessment and a broader range of support services than those screened in prior years.
- Care receivers whose caregivers were screened post-expansion were about twenty percent less likely to enroll in Medicaid LTC services in the 12 months following screening compared to prior years (9 vs. 11 percent), despite the fact that more post-expansion care receivers were already enrolled in Medicaid medical coverage at the time of screening.
- Care receivers whose caregivers were screened post-expansion were slower to transition to Medicaid LTC, controlling for differences in baseline characteristics; the FCSP expansion is likely a contributing factor to this positive outcome.

Use of Medicaid LTC Services
In 12 Months After First TCARE Screen



Family Caregiver Support Program Changes

Pre- versus Post-Expansion Differences

In SFY 2010, FCSP began using an evidence-based screening tool, the Tailored Caregiver Assessment and Referral System (TCARE®), to assess the caregiving situations of family caregivers in Washington State and to help determine what levels and types of services are needed.[3] The TCARE® screening tool identifies and categorizes caregivers' levels of burden (High, Medium, Low) in five domains: 1) relationship burden; 2) objective burden; 3) stress burden; 4) depression; and 5) caregiver identity discrepancy. Caregivers who complete the screening are eligible for the standard level of FCSP services. Those whose screening results indicate a higher level of caregiver burdens become eligible to additionally receive a full TCARE® assessment from a Family Caregiver Specialist, followed by consultation, the development of a care plan, and a higher tier of FCSP services.

The 2011 Legislature increased the state funding for the FCSP in SFY 2012 by $3.45 million dollars. Washington's Aging and Long-Term Support Administration used most of this funding to lower eligibility thresholds for the higher tier of services, and to provide that tier of services to a greater number of family caregivers. Prior to the expansion (up through the end of SFY 2011), caregivers were eligible if they scored "High" in at least four out of five burden domains on the TCARE® screen. Starting in SFY 2012, caregivers were eligible if they scored "High" in at least one domain or "Medium" in at least three domains. [5] For additional background on the Family Caregiver Support Program and its expansion, please refer to WSIPP's November 2012 report[4] or the website of Washington's Aging and Long-Term Support Administration.[6]

Table 1 (adjacent page) presents the number and characteristics of caregivers who first received a TCARE® screen in the two pre-FCSP-expansion years (SFY 2010, SFY 2011) and in the first post-expansion year (SFY 2012), as well as the number and characteristics of caregivers in both periods who screened into the higher tier of FCSP services. The caregivers who met eligibility criteria to receive the higher level of services including first assessments were a subset of those screened. In the post-expansion year, not only were caregivers screened at a higher rate (nearly the same number in SFY 2012 than in the previous two fiscal years combined) but a greater proportion of them were screened into the higher tier of services (71 percent vs. 61 percent).

Public awareness of the expansion was expected to yield a post-expansion screening population with somewhat lower needs than the pre-expansion screening population; that is indeed reflected in the data. Of caregiver-receiver dyads screened in SFY 2012, caregivers reported fewer burdens and receivers were less likely to have dementia. Care receivers were also more likely to be enrolled in Medicaid medical coverage.[7] The analyses in this report use statistical models to control for these and other compositional differences between caregivers screened in the two time periods.

The eligibility changes instituted under the expansion also resulted in different characteristics for caregiver-receiver dyads who screened into the higher tier of FCSP services before and after the expansion. Consistent with the lowered eligibility thresholds, caregivers who screened into the higher tier of services in SFY 2012 reported lower levels of burden on the TCARE® screening, cared for their care receivers for fewer hours per week, and had been caring for care receivers for a shorter period of time. Care receivers were also slightly younger, less likely to be the spouse of the caregiver, less likely to have a dementia diagnosis, and more likely to be enrolled in Medicaid medical coverage.

Despite these differences, it is important to note that caregivers served in both time periods had high levels of burdens and needs. The average number of caregiving hours per week was lower for those screened into the highest service tier after the expansion (52 versus 43), but post-expansion caregivers still provided care at a level of hours equivalent to a full-time job. A recent analysis of 2007 statewide survey data found that "high-intensity caregivers"— those who provide more than 20 hours per week of care for a period of one year or longer—were five times more likely than non-caregivers to have severely poor mental health and also had significantly worse physical health

compared to non-caregivers, controlling for age, gender, and income. Although those findings derive from survey data with a different wording of the hours of caregiving question, a parallel measure constructed from the TCARE® assessment data shows that nearly three-quarters (73 percent) of caregivers screened into the higher tier of FCSP services in the pre-expansion period could be considered "high-intensity" caregivers, as well as the majority of caregivers (61 percent) screened into the higher tier of FCSP services in the post-expansion period.[8]

TABLE 1.

Number and Characteristics of Caregiver-Receiver Dyads

	Caregivers Receiving First TCARE® Screen			Caregivers Screened into Higher Tier of FCSP Services		
EXPANSION PRE vs. POST ▸	**PRE**	**POST**	*Diff.*	**PRE**	**POST**	*Diff.*
STATE FISCAL YEAR ▸	**2010, 2011**	**2012**		**2010, 2011**	**2012**	
Number of caregiver-receiver dyads	3,347	3,266		2,039	2,321	
Characteristics of caregiver-receiver dyads						
Total number of "High" burdens	2.7	2.4	*	3.2	2.8	*
High burden scores on individual items:						
Relationship burden	39%	33%	*	47%	38%	*
Objective burden	58%	46%	*	72%	55%	*
Stress burden	51%	44%	*	62%	53%	*
Depression	51%	43%	*	61%	51%	*
Identity discrepancy	72%	70%		82%	79%	
Caregiver is caring for:						
Spouse	52%	45%	*	57%	48%	*
Parent	37%	41%	*	34%	40%	*
Child	2%	2%		2%	3%	
Other	9%	11%		7%	9%	
Caregiver age	65.8	63.1	*	66.5	63.8	*
Care receiver age	77.9	77.0	*	78.5	77.7	*
Care receiver is male	48%	47%		50%	49%	
Caregiver would definitely consider placing receiver out-of-home	7%	7%		6%	7%	
Care receiver has diagnosed dementia	39%	35%	*	42%	38%	*
Care receiver enrolled in Medicaid medical coverage at screen	10%	14%	*	7%	11%	*
Hours of caregiving per week	*Not available*			52	43	*
Caregiver has been providing care:						
Less than 6 months	*Not available*			10%	13%	*
6 to 12 months	*Not available*			9%	12%	*
13 to 24 months	*Not available*			13%	15%	
24 months to 5 years	*Not available*			30%	29%	
Over 5 years	*Not available*			39%	31%	*
"High-Intensity" caregiver *More than 20 hours per week for more than 1 year*	*Not available*			73%	61%	*

NOTE: All variables come from the TCARE® screen with the exception of hours of caregiving, length of time caregiver has been providing care, and "high-intensity" caregiver. These three, from TCARE® assessment data, are not available for the larger population of caregivers receiving the first TCARE® screen. Significant differences shown: *p<0.01.

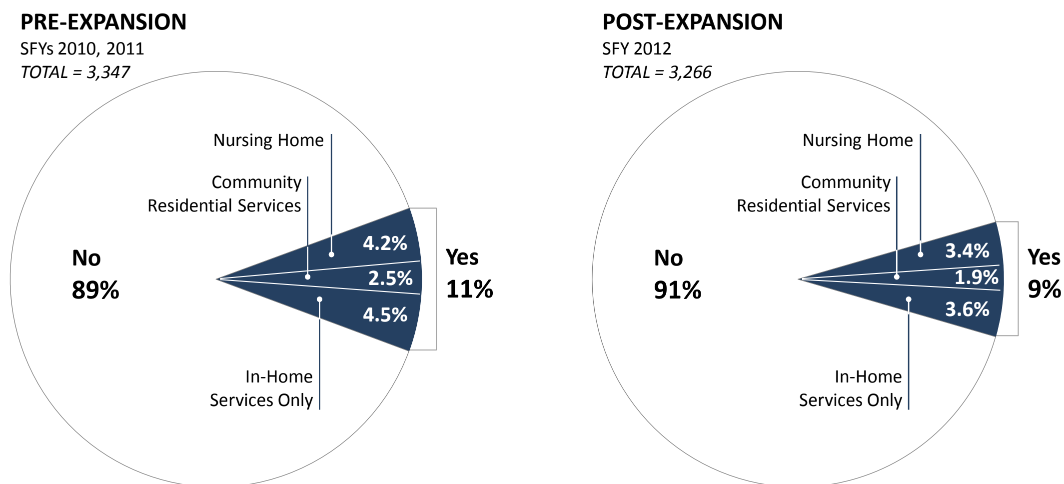
Use of Medicaid Long-Term Care in Year after TCARE® Screen

Pre- versus Post-Expansion Comparison

Because caregivers screened in SFY 2012 were more likely to receive the higher level of FCSP services, they may also have been able to continue providing care for a longer period of time, delaying the need for their care receivers to enroll in Medicaid long-term care services.

The data shows that the great majority of care receivers whose caregivers are served by FCSP (roughly 9 in 10) do not utilize Medicaid long-term care services within a one-year period. But those whose caregivers completed TCARE® screens in the post-expansion period (SFY 2012) were about 20 percent less likely to use Medicaid LTC services in the year following the screen compared to care receivers whose caregivers were screened in the pre-expansion period (SFY 2010, SFY 2011): 9 percent of care receivers of dyads screened in the post-expansion period enrolled in Medicaid LTC within 12 months, compared to 11 percent of care receivers of dyads screened in the pre-expansion period. Among those who did go on to receive Medicaid LTC in the follow-up year, the proportion in nursing home services, community residential services, and in-home services only was roughly equal for care receivers whose caregivers were screened in the two time periods.

Used Medicaid Long-Term Care services in 12 months following TCARE® screen?



Time until Use of Medicaid Long-Term Care

Controlling for Baseline Differences

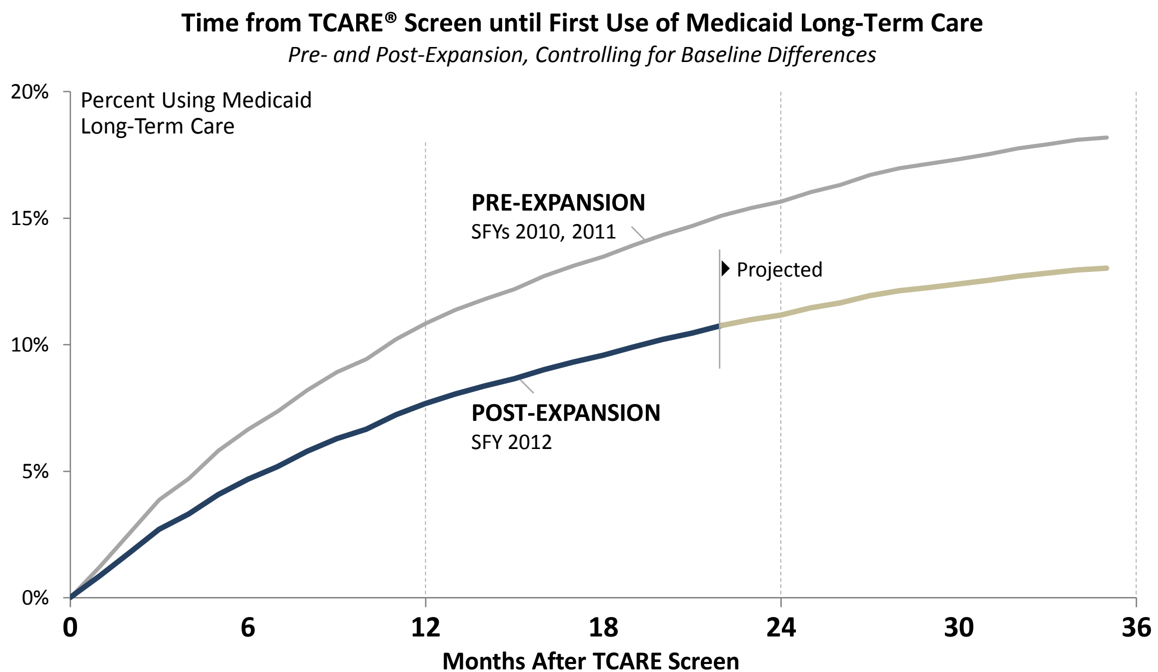
The lower overall use of Medicaid LTC for care receivers whose caregivers were screened in the post-expansion period could be due to the expansion itself—more caregivers screened in SFY 2012 received services that enabled them to keep caring for their care receivers in the home—or could be attributable to differences in characteristics of the caregiver-receiver dyads screened in the two time periods. We use statistical models to control for those compositional differences between caregivers served in the two time periods that were captured by the TCARE® screening.

Using statistical survival models, we compare the time elapsed between a caregiver's first TCARE® screening and his or her care receiver's first use of Medicaid LTC services, for pre- and post-expansion FCSP family caregivers. The many FCSP care receivers who never use Medicaid LTC are accounted for in these models, as are care receivers with varying lengths of follow-up time.

Results indicate that the expansion of FCSP was associated with a statistically significant delay in the use of Medicaid LTC services, controlling for baseline differences (differences at screening) between pre- and post-expansion caregiver-receiver dyads. The full model can be found in the technical notes. Although results suggest that the expansion successfully helped more family caregivers better

manage their caregiving and decreased the rate at which their care receivers move onto Medicaid LTC services, it remains a possibility that other differences between pre- and post-expansion caregiver-receiver dyads, that were not possible to identify and control using existing data, also influenced study findings.

The figure below shows the estimated time from TCARE® screen until first use of Medicaid long-term care services, by the time period in which the caregiver was screened, if they were to share the same set of baseline characteristics (measured at the time of the TCARE® screen).[9] As shown, care receivers whose caregivers were screened in the pre-expansion period transitioned onto Medicaid LTC services more quickly than those screened in the post-expansion period—who were more likely to be eligible for a full TCARE® assessment and a higher level of TCARE® services. The difference in the percent using Medicaid LTC was minimal in the first months after the TCARE® screen, but grew over time.



The full survival analysis results indicate, as one might expect, that care receivers enrolled in Medicaid medical coverage at the time their caregivers completed a TCARE® screening are much quicker than their peers to transition onto Medicaid long-term care services – their estimated hazard of transitioning onto Medicaid LTC is more than five times that of care receivers not already enrolled in Medicaid medical.[10] It is worth noting that fewer care receivers transitioned onto Medicaid LTC services in the post-expansion period, despite the fact that more care receivers in the post-expansion period were already enrolled in Medicaid medical coverage at the time of TCARE® screening (14 vs. 10 percent).

TECHNICAL NOTES

This report evaluates the effects of the Family Caregiver Support Program expansion on care receivers' time to enrollment in Medicaid long-term care services. We compared Medicaid long-term care (LTC) utilization in the months following a TCARE® screen for those caregivers screened during the pre-expansion period (SFY 2010, 2011) with those screened during the post-expansion period (SFY 2012). To compile data for this evaluation, TCARE® screening and assessment records were linked with Medicaid enrollment and payment records as well as death records.

IDENTIFYING FIRST SCREENS

Because the FCSP expansion targeted caregivers new to the program, we identified caregiver-receiver dyads receiving their first TCARE® screens. (Only 2 percent of caregivers care for more than one receiver; these caregiver-receiver dyads were treated separately in the FCSP program and in this evaluation.) From a comprehensive file of TCARE® screens and assessments over the relevant period, we combined records from all valid screens with non-missing dates and care receiver DOBs, with similar records from initial assessments not preceded by screens (these were treated as screens for the purposes of the analysis). When caregiver-receiver dyads were associated with multiple screens, we identified the earliest screen based on the date administered.

IDENTIFYING FIRST ASSESSMENTS

Caregiver-receiver dyads who met the applicable eligibility threshold went on to get a full TCARE® assessment and a higher level of FCSP services. To identify dyads which did so, we determined whether those with a first screen during the study period (SFY 2010 through SFY 2012) received an assessment in a short window of time following their screening date. FCSP guidelines specify that an assessment should occur within 30 days of the screen. To be inclusive of exceptions to the policy and assessments with possible data entry errors, we include assessments administered up to 3 days before and up to 45 days after the screening date.

SELECTION CRITERIA FOR CAREGIVER-RECEIVER DYADS INCLUDED IN ANALYSIS

The caregiver-receiver dyads in this analysis included all those with a first TCARE® screen from FCSP during the study period (SFY 2010 through SFY 2012) who: 1) Were not being served by two other ALTSA programs, Nursing Home Diversion and the Dementia Partnerships Program; 2) Were receiving no Medicaid LTC services at the time screened; 3) Were not in public or private residential care at screening; and 4) Did not present administrative data linkage errors. Dyads in the "pre-expansion" group were those first screened in SFY 2010 and SFY 2011 (n = 3,347); dyads in the "post-expansion" group were those first screened in SFY 2012 (n = 3,266).

SURVIVAL ANALYSIS WITH STATISTICAL CONTROLS

Because the central evaluation question concerns the timing of an event—transition to Medicaid LTC services—the evaluation utilizes survival analysis, a type of regression analysis designed to examine outcomes across persons with varying lengths of follow-up time. In this evaluation, dyads first receiving TCARE® screens have more or less follow-up time depending on the date the screening was administered and the death date of the care receiver, if applicable. We used Cox regression, the standard approach for survival analysis. Survival analysis is a regression-based statistical model of longitudinal outcomes that can control for baseline characteristics. In this evaluation, we controlled for characteristics of the individual caregiver-receiver dyads identified on the TCARE® screening instrument. (Because the more extensive information gathered using the full TCARE® assessments was only available for the subset of dyads which screened into this higher level of services, it was not used among the controls for the survival analyses.)

SURVIVAL ANALYSIS RESULTS: *Predicting Hazard of Transitioning to Medicaid LTC*

Characteristic of Caregiver-Receiver Dyad at TCARE® Screening	Parameter Estimate	Standard Error	Chi-Square	p-value	Hazard Ratio
Screened post-expansion (SFY 2012)	-0.3630	0.0718	25.5509	<.0001	0.6960
Caregiver's total number of "high" burdens	0.1163	0.0196	35.1806	<.0001	1.1230
Caregiver is spouse of receiver	0.0863	0.0756	1.3033	0.2536	1.0900
Care receiver age	0.0088	0.0026	11.8401	0.0006	1.0090
Care receiver is male	-0.2914	0.0746	15.2397	<.0001	0.7470
Caregiver would definitely consider placing receiver out-of-home	0.5845	0.1063	30.2453	<.0001	1.7940
Care receiver enrolled in Medicaid medical coverage at screen	1.7035	0.0809	443.9300	<.0001	5.4930
Care receiver has diagnosed dementia	0.1528	0.0726	4.4302	0.0353	1.1650
TOTAL = 6,613					

NOTES

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[1] Washington State Department of Health 2007 Behavioral Risk Factor Surveillance System (BRFSS).

[2] According to Washington State law, (RCW 74.41.020) it is intended that FCSP program shall, "Encourage family and other nonpaid individuals to provide care for adults with functional disabilities at home, and thus offer a viable alternative to placement in a long-term care facility."

[3] Montgomery, R. & Kwak, J. (2008). Tailored Caregiver Assessment and Referral (TCARE): An evidence-based model to target services for caregivers. *American Journal of Nursing,* 108, 54-57; and Montgomery, R. et al. (2011). Effects of TCARE® intervention on caregiver burden and depressive symptoms: Preliminary findings from a randomized controlled study. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 66, 640-647.

[4] Miller, M. (2012). *Did expanding eligibility for the Family Caregiver Support Program pay for itself by reducing the use of Medicaid-paid long-term care?* (Document No. 12-11-3901). Olympia, WA: Washington State Institute for Public Policy. Note: Minor differences in sample definitions between WSIPP's 2012 report and the current report yield differences in sample characteristics.

[5] Some area agencies on aging (AAAs) lowered the eligibility criteria for a TCARE® assessment and consultation to three high burdens prior to the SFY 2012 expansion.

[6] Washington State Department of Social and Health Services, Aging and Long-Term Support Administration, Caregiver Assessment and Planning (http://www.altsa.dshs.wa.gov/Professional/TCARE/).

[7] Enrollment in Medicaid coverage is distinguished from receipt of Medicaid-paid long-term services and supports. Only the subset of persons enrolled in Medicaid coverage who apply and are determined functionally eligible receive Medicaid-paid long-term services and supports.

[8] To gauge weekly hours of caregiving, the Washington State Department of Health's 2007 Behavioral Risk Factor Surveillance System (BRFSS) survey asks caregivers, "In an average week, how many hours do you provide for [care receiver] because of his/her long-term illness or disability?" In FCSP, the weekly hours of caregiving is the sum of responses to four separate questions in the TCARE® assessment: "During the past week, about how many hours total did you help the care receiver with the following activities: (a) Eating, bathing, dressing, or helping with toilet functions? (b) Meal preparations, laundry, or light housework? (c) Providing transportation to appointments and/or shopping? (d) Legal matters, banking, or money matters?" In the analysis of "high-intensity" caregivers in the 2007 BRFSS conducted by Mary LeMier, Washington State Department of Health, "high-intensity" caregivers are defined as those providing more than 20 hours per week of care for a period of one year or longer. In available TCARE® assessment data, "high-intensity caregivers" are defined as those providing more than 20 hours per week of care for a period of longer than one year.

[9] In particular, the plotted numbers reflect the estimated time to Medicaid LTC for pre- and post-expansion caregivers who both have baseline characteristics reflecting the overall average from both groups.

[10] Hazard is the instantaneous risk that an individual who has not yet experienced the event in question will do so. For additional detail, see Singer, J. & J. Willett. (2003). *Applied Longitudinal Data Analysis: Modeling Change and Event Occurrence.* New York: Oxford Press.

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Copies of this paper may be obtained at www.dshs.wa.gov/rda/ or by calling DSHS' Research and Data Analysis Division at 360.902.0701.

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