

Florida Statewide Quality Assurance Program

**Waiver Support Coordinator Caseload:
Impact on Performance Evaluation**

July 1, 2004 – June 30, 2005

Florida DD HCBS Waiver

Prepared by the Delmarva Foundation

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and

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Execute Summary

Waiver Support Coordinators (WSCs) coordinate services and supports for people served through the Developmental Disabilities and the Family and Supported Living Home and Community Based Services waivers (DD HCBS and FSL). In order to coordinate services and ensure individuals are able to voice their preferences and work to achieve desired goals, it is imperative the WSC knows and understands the communication style and natural support systems of the individual. The purpose of this study is to explore the potential impact of the WSC's caseload size on the WSC's capacity to provide optimal support coordination to the individuals served. The working hypothesis is that larger caseloads will negatively impact the WSC's performance evaluation.

Data for this study were taken from the Waiver Support Coordinator Consultation (WiSCC) and Medicaid Claims Data for WSCs who rendered services through the DD HCBS Waiver to individuals with disabilities, during the 12 month period ending June 30, 2005. The WiSCC has two primary components. The first component includes a consultation with the Waiver Support Coordinator entities (solo or treating WSC within an agency), evaluating them on 11 elements. Six are performance expectations that are outcome or results oriented, measuring the degree to which the WSC knows the individual and ensures the individual's desired outcomes and goals are achieved. Five are the Minimum Service Requirements (MSR) that are compliance oriented, measuring key requirements such as background screening and documentation of training specific to each service. The second component of the WiSCC is the face-to-face interviews with randomly selected consumers from the caseload of the solo WSC or from each treating provider (WSC) within the agency. This includes the completion of Personal Outcome Measures (POM) interviews, based on the 25 POMs developed by The Council on Quality and Leadership. There were 671 WSCs and 1,305 individuals available for analysis.

We use regression analysis and crosstabulation (chi-square) to explore the impact of caseload size on WSC performance based on the 11 WiSCC elements and also on the outcomes and supports present for individuals receiving services, as measured by the POM interview process. Results from the regression inform us that working either as a full time (30 to 36 consumers) or part time (fewer than 30 consumers) WSC does not impact overall performance in terms of the six outcome oriented elements, such as having organizational systems in place that help the WSC know the people being served, having systems that ensure a person-centered approach to services is used, and using organization practices that generate positive results for individuals.

At the element level, results are somewhat counterintuitive. Findings indicate WSCs with a full time caseload are more likely to have an effective method for learning about the people who are receiving their supports and services than WSCs with fewer than 30 consumers to serve. In addition, full time WSCs were more likely to have documentation verifying Level II Background Screening and documentation they had received required training. These are preliminary results and shown only at the bivariate level, indicating no other variables that could impact the results have been factored into the analysis.

Based on this study, the current maximum caseload of 36 individuals per WSC in Florida appears to be appropriate. However, there remains a widespread perception that large caseloads hinder the WSC's ability to complete necessary paper work accurately or in a timely manner. This could be due to various factors not explored in this study, such as individuals falling in and out of Medicaid eligibility, time spent by each WSC per individual, family influences, and the varying demands of people with different levels and types of disabilities. Therefore, we make the following recommendations:

Recommendation 1: The current full time caseload as recommended by the state in the DD HCBS program should remain as is.

Recommendation 2: APD should explore caseload turnover and Medicaid eligibility complications as a possible explanation of a perceived problem in terms of caseload size, and revise procedures WSCs must follow to ensure a smoother transition of individuals "on and off" the waiver. This should include a review of the current handbook expectations and revisions if appropriate. This will, in turn, help to alleviate issues for service providers who need service authorization that requires correct paper work from the WSCs.

Recommendation 3: APD should ensure WSCs are adequately trained on all procedures pertaining to adding and losing consumers in order to facilitate a more effective and efficient process.

Recommendation 4: Focus groups with service providers, family members and individuals with disabilities were successfully used to explore barriers in the DD HCBS service delivery system. Conducting focus groups with WSCs across the state may help to explore the many variables pertaining to caseloads at a more in-depth level.

Introduction

As of August 2006, over 31,000 individuals with disabilities in Florida received services through the Developmental Disabilities or the Family and Supported Living Home and Community Based Services (DD HCBS and FSL) Waivers. Individuals may qualify for any number of 32 different services such as Non-Residential Support Services, In Home Supports, Adult Day Training or Respite Care. As an integral component of this system, every individual works with a Waiver Support Coordinator (WSC) who acts as a “case manager”. However, the Support Coordinator goes beyond the “medical model” typical of case managers. Case managers generally coordinate services and activities necessary for medical care. The WSC uses a more holistic approach, pulling all people together who impact an individual’s life. According to the Developmental Disabilities Waiver Services Coverage and Limitations Handbook (June 2005):

Support coordination is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a recipient, or assisting the recipient or family to access supports and services on their own. These services may be provided through waiver and Medicaid State Plan services, as well as needed medical, social, educational, other appropriate services, and community resources regardless of the funding source through which access is gained. The waiver support coordinator is responsible for assessing a recipient’s needs, preferences and future goals (outcomes)... and assists the recipient...by linking the recipient with natural and generic supports and services available through family, friends and community resources.....When (these are) unavailable the waiver support coordinator assists the recipient in locating services available through local, state or federal sources, including Medicaid, the DD Waiver and the Developmental Disabilities Program, as authorized.

In order to coordinate services and ensure individuals are able to voice their preferences and work to achieve desired goals, it is imperative the WSC knows and understands the communication style and natural support systems of the individual. WSCs must not only develop a relationship of trust and understanding with individuals but also develop a relationship with other providers, family members and friends on whom the individual depends. While Delmarva was researching various barriers to services across the state, conducting group and individual interviews with service providers and Area Quality Leaders, the perceived negative impact to these relationships due to large caseloads among WSCs was often discussed. However, no empirical evidence exists to support these assumptions.

The Delmarva Foundation, through a contract with the Agency for Health Care Administration (AHCA) and in conjunction with the Agency for Persons with Disabilities (APD) since September 2001, has provided a quality assurance program for persons served through the DD HCBS Waiver, called the Florida Statewide Quality Assurance Program (FSQAP). As part of this program, Delmarva’s Quality Improvement Consultants (QIC) conduct a Waiver Support Coordination Consultation (WiSCC)

annually with each WSC to determine the extent to which they have organizational systems in place that help individuals achieve desired outcomes and goals.¹ The WSCs' performance evaluation is based on how well they know individuals on their caseload and if they positively impact their lives. The purpose of this study is to explore the potential impact of caseload size on the WSC's capacity to provide optimal support coordination to the individuals served. The working hypothesis is that larger caseloads will negatively impact the WSC's performance evaluation.

Background

Until the 1970's most people who needed assistance in carrying out daily activities of living were cared for in institutional settings. During the 1970s the prevailing theory was that most of the people who were institutionalized could receive better care in community-based settings. However, the creation of a non-institutionalized service delivery setting complicated established systems within communities. Different services were rendered by different providers, with various funding sources, and a wide array of eligibility criteria. Case management evolved as a means to assist individuals in evaluating and selecting appropriate services and controlling cost and utilization when possible.²

Each state adopted its own definition/title for the "case manager" and developed a description of the case manager's services appropriate to the state's needs. A 2000 Health Care Financing Administration study notes that organization, provision and caseload size for case management services to HCBS recipients vary widely across the country:³

- In Indiana, individuals are free to hire a private/contracted case manager or one from the Area Agency on Aging (AAA). Case managers assist in planning services that address health and safety, assess the effectiveness and quality of services, and lead a team to develop a plan of care. The average caseload for private case managers is about 20 individuals, whereas the average for case managers working for the AAA is between 80 and 100.
- Case managers in Kansas provide "targeted case management" to help recipients find and use both paid and natural supports designed to foster independence and integration. The average caseload is about 25 individuals.
- In Louisiana, where a majority of HCBS recipients receive case management services through private agencies, the average caseload size is 35 people.

¹ Go to http://www.dfmc-florida.org/provider_resources.htm for a description of the WiSCC tool and procedures.

² Minnesota's Case Management System for Persons with Developmental Disabilities, Minnesota Department of Administration Management Analysis Division, February 1991.

³ Lakin, K. Charlie and Hewill, Amy. Medicaid Home and Community-Based Services for Persons with Developmental Disabilities in Six States: Observations from Site Visits Between February and August, 2000. Health Care Financing Administration. The Lewin Group.

- The New Jersey case management system has three levels. Primary case managers are provided to people who are relatively more vulnerable because of potential isolation or a need for special attention. Program case managers work with people who are enrolled in structured programs with regular oversight by a range of people. Resource case management is intended for people who may not need ongoing traditional case management. Caseloads range from 40 to 55, 90 to 100, and 250 individuals respectively.
- The Designated Agency, a non-profit agency, administers case management services throughout Vermont. Case managers assist individuals and families in gaining access to needed services irrespective of their funding source. Vermont has the lowest consumer-to-service coordinator ratios in the United States, about 12:1.
- Case managers in Wyoming are Individually Selected Service Coordinators (ISC) and are usually employees of the same organizations that provide services to HCBS recipients. Caseloads are generally 20 to 25 individuals.

While there is not a direct comparison that can be made between Support Coordinators in Florida and other “case managers”, previous research may shed some light on possible impacts of caseload size WSCs may experience. Little work has explored the effect of caseload size on case managers, but some previous research suggests that large caseloads can negatively impact their performance and/or well being. In a study of mental health case managers in Oregon, greater job dissatisfaction was associated with specialized training, larger caseload size and greater intention to leave the position.⁴ In a Connecticut study, some case managers claimed that caseload size prohibited sufficient devotion of time to respond to crises, forge service linkages and follow-up on referrals.⁵ Research on mental health case managers in an Australian community suggests higher caseloads are significantly associated with lower personal efficacy and increased personal distress.⁶ Caseloads in the Australia study ranged from 5 to 79 people. The maximum allowable caseload for WSCs in the Florida DD HCBS program is 36 and a caseload of between 30 and 36 is considered to be full-time.

Data and Methods

Data for this study were taken from the Waiver Support Coordinator Consultation (WiSCC) and Medicaid Claims Data for WSCs who rendered services through the DD HCBS Waiver to individuals with disabilities, during the 12 month period ending June 30, 2005. Waiver Support Coordinators operate in a solo capacity or within an agency.

⁴ Hromco, Joseph G., Lyons, John S. and Nikkel, Robert E. Mental Health Case Management: Characteristics, Job Function, and Occupational Stress. Community Mental Health Journal. 1995. 31 (2): 111-125.

⁵ Beasley, Joan B. and duPree Kathryn. A Systematic Evaluation and Implementation Strategy to Promote Effective Community Services Systems for Individuals with Coexisting Developmental Disabilities and Mental Illness: National Service Trends and the “Connecticut Blueprint”. www.nasddd.org/pdf/beasley-duPree.pdf.

⁶ King, Robert, Le Bas, James, and Spooner, Darren. The Impact of Caseload on the Personal Efficacy of Mental Health Case Managers. Psychiatric Services. March 2000. 51: 364-368.

WSCs who had rendered support coordination within the previous six months (solo) or three months (agencies), based upon Medicaid claims data, are eligible for a Delmarva evaluation (WiSCC). WSC entities are required to be evaluated annually.

There were 671 treating providers evaluated during the study period. Each of these providers had received, during the study period, only one WiSCC evaluation. The WiSCC has two primary components. The first component includes a consultation with the Waiver Support Coordinator entities (solo or treating WSC within an agency), evaluating them on eleven elements. Six are performance expectations that are outcome or results oriented, measuring the degree to which the WSC knows the individual and ensures the individual's desired outcomes and goals are achieved. Five are the Minimum Service Requirements (MSR) that are compliance oriented, measuring key requirements such as background screening and documentation of training specific to each service. The MSR elements are scored as Met or Not Met. WSCs are rated on the six outcome elements as Achieving, Implementing, Emerging or Not Emerging.⁷ The following table provides the distribution of scores by element.

Table 1: WiSCC Outcome Elements by Evaluation Level
July 2004 - June 2005

Number of WSCs = 671							
WiSCC Outcome Elements							
Evaluation Level	Knows People (1)	Knows Health (2)	Person Directed (3)	Evaluate Supports (4)	Facilitate EEE (5)	Generate Results (6)	Total
Achieving	35.8%	11.9%	12.8%	17.3%	10.0%	10.7%	16.4%
Implementing	40.4%	27.6%	43.2%	42.8%	35.9%	35.0%	37.5%
Emerging	23.4%	56.3%	42.9%	38.7%	51.0%	49.2%	43.6%
Not Emerging	0.4%	4.2%	1.0%	1.2%	3.1%	5.1%	2.5%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
WiSCC Minimum Service Requirement Elements							
	Level II Screening (7)	Training (8)	Authorized/ Cost Plan (9)	Billing Authorized (10)	Billing Documented (11)	Total	
Percent Met	94.9%	77.9%	96.7%	96.7%	88.7%	91.0%	

On average, the WSCs were most likely to score Emerging or Implementing on the outcome elements. Element 1, indicating the WSCs have an effective way to learn about the people they are serving, was most likely to be scored as Achieving. On the other hand, WSCs were most likely to score Not Emerging on Element 6 (n=34) and Element 2 (n=28). These elements measure components of the health, safety and well-being of individuals (Element 2) and the WSC's capacity to facilitate positive results for individuals (Element 6).

⁷ See Attachments 1 and 2 for a description of each outcome element and each evaluation level.

The support coordinators scored well on the MSR elements, with an average of 91 percent Met. They were least likely to score Met on Element 8 (77.9% Met), indicating they have not always attended the required training sessions. In addition, 88.7 percent of the WSCs scored Met on Element 11, meaning that 76 Support Coordinators did not have documentation required for billing purposes.

The second component of the WiSCC is the face-to-face interviews with randomly selected consumers from the caseload of the solo WSC or from each treating provider (WSC) within the provider entity. This includes the completion of Personal Outcome Measures (POM) interviews, based on the 25 POMs developed by The Council on Quality and Leadership. These measure the extent to which outcomes are met for individuals and supports are present (to enable each specific outcome to be met), that enhance the quality of life for the individuals.⁸ The total number of interviews completed as part of the WiSCC varies by the size of the agency (or provider entity) and is based on a review of two consumers per treating provider, not to exceed eight treating providers (or 16 consumer interviews) for any given agency.

Dependent Variables

The independent variable of interest in this study is the caseload size of the WSC. We test the impact of this on both the WSC's performance on the WiSCC evaluation and on the outcomes and supports present in the lives of the individuals they serve. An overall *WiSCC Outcome Score* is calculated for each Waiver Support Coordinator, based upon the scores they received on each of the six outcome elements, using the following scale:⁹

- Achieving = 3
- Implementing = 2
- Emerging = 1
- Not Emerging = 0

It is important to note the score is an average calculated from an ordinal level variable. The number attached to each level is for analytic purposes only, to determine relative differences among WSC. The dependent variable *WiSCC Score* for the 671 WSCs ranges from 0 (n=1) to 18 (n=16), with a mean of 10.1, a median of 10.0, and a normal distribution. This places the average WSC performance around the high Emerging or low Implementing level.

The *Percent Outcomes Met* and the *Percent Supports Present* are used to determine the impact of caseload size on the quality of life of individuals the WSC serves. This analysis is based upon only two individuals per WSC. While they are randomly selected,

⁸ See Attachment 3 for a list of the 25 outcomes that are measured. A more detailed description of the process and statewide results are available in the Quarterly and Annual Reports to the state http://www.dfmc-florida.org/annual_quarterly_reports/index.htm and the home page for CQL at <http://www.thecouncil.org>.

⁹ While sometimes referred to as the WiSCC Score, this always represents results based upon the six outcome elements and is technically the WiSCC Outcome Score.

results must be interpreted with caution. There were 1,305 individuals who received a POM interview as part of 671 WSCs who were evaluated during the 12 month period ending June 30, 2005. On average they had 45.2 percent of the 25 outcomes met and 48.3 percent of the 25 supports present. Each is normally distributed.

Independent Variables

Caseload Size is taken from the WiSCC data, as recorded by the Delmarva Consultant at the time the sample is selected for the POM interviews. When the WiSCC process was implemented in August 2004, the electronic application had not been developed for use on each consultant’s lap top. Therefore, data for the first several months were sent to a central office and entered from hard copy reports. There was some confusion at that time as to how to enter the “total number of individuals” element and it appears this was often entered with the number of individuals interviewed (2) or number of WSCs included in the WiSCC (1 to 4) instead of the caseload of the WSC. A list of the WSCs’ caseloads as recorded in the WiSCC data was sent to all the QICs so they could correct and/or verify the information for WSCs they had interviewed. In addition, claims data were used to identify some caseload information, using the average number of claims per WSC over the 12 month period prior to the WiSCC.

Caseload Size ranged from one (n=5) to 36 (n=138) with a mean of 28 and a median of 32. Although the maximum allowable caseload for WSCs is 36, there were nine WSCs listed with caseloads over this, up to 46.¹⁰ The distribution of *Caseload Size* is not normal, nearly 33 percent of WSCs rendered support to 35 or more individuals. We therefore use a dichotomy in the analysis. Because a caseload of from 30 to 36 is considered to be full time work for a WSC, the variable is divided between a full time and part time caseload, comparing those with caseloads of 30 or more to those with fewer individuals to serve. More WSCs work with a full time caseload (59.0%) and these WSCs have a somewhat higher *WiSCC score*: 10.29 compared to 9.75 for WSCs with smaller caseloads. This is not a statistically significant difference. However, the probability this is due to chance is only p=0.052, just over the p=0.05 cut off point.

Table 2: Caseload Size and WiSCC Score
July 2004 - June 2005

Caseload Size	Number	Percent	WiSCC Score
< 30	275	41.0%	9.75
>= 30	396	59.0%	10.29
Total	671	100.0%	10.07

¹⁰ Caseload size over 36 occurs if/when a support coordinator leaves an organization and her/his caseload is temporarily spread among other WSCs. Because the QICs had verified the number of individuals per WSC, we left these in the data as recorded.

Other independent variables included in the analyses have been utilized in previous research and are discussed briefly here. As noted earlier, there are two different *provider types*: WSCs operate as solo entities or within the context of a WSC agency. There were slightly more WSCs working within an agency than in a solo capacity. The difference in their overall *WiSCC Score* is negligible, as demonstrated in Table 2.

Table 3: WiSCC Score by Provider Type
July 2004 - June 2005

Provider Type	Number	Percent	WiSCC Score
Agency	361	53.8%	10.19
Solo	310	46.2%	9.93
Total	671	100.0%	10.07

The *size of the APD Area* in which the provider renders services has been shown to impact outcomes for individuals. Because larger, more urban areas are likely to offer more activities for individuals, a greater variety of medical professionals to offer support, and more service providers with whom the WSC can establish contacts, this may impact the WSC's performance evaluation. Using Medicaid Claims we identify the number of consumers living in each Area during the study period. Areas with over 2,000 consumers on the DD HCBS waiver were categorized as Large. These include the Orlando, Miami-Dade and Suncoast (Tampa) areas. Medium size areas had from 1,000 to 1,999 consumers (e.g., Jacksonville, Pensacola, Tallahassee) and Small areas fewer than 1,000 consumers. The categories contain the following APD Areas:

- Large—7, 10, 11, 23 (N = 342 WSCs and 662 individuals)
- Medium—1, 2, 3, 4, 9, and 13 (N= 235 WSCs and 456 individuals)
- Small—8, 12, 14 and 15 (N = 94 WSCs and 187 individuals)

These are entered into the analysis using Large Areas as the reference group. When interpreting results, the Medium and Small Areas are compared to Large Areas.

The distribution of individuals in the study by Age Group, Home Type, Primary Disability and Area Size is presented in Table 4. The percent of outcomes met and supports present is also provided.¹¹

Table 4: Outcomes and Supports by Demographics
July 2004 - June 2005

Age Group	Number	Percent	Percent Outcomes Met	Percent Supports Present
<= 17	179	13.7%	55.0%	57.0%
18 - 21	85	6.5%	43.9%	46.2%
22 - 25	121	9.3%	45.8%	49.7%
26 - 44	552	42.3%	43.7%	47.2%
45 - 54	195	14.9%	44.5%	47.5%
55 - 64	83	6.4%	39.0%	41.7%
65+	23	1.8%	33.4%	34.1%
Unk	67	5.1%	46.3%	49.6%
Home Type				
Family	713	54.6%	48.5%	51.4%
Ind/Sup	249	19.1%	53.1%	56.9%
Group Home	324	24.8%	31.6%	34.8%
Other	19	1.5%	49.5%	52.0%
Primary Disability				
Intellectual Disability	1,067	81.8%	43.5%	46.9%
Cerebral Palsy	117	9.0%	50.6%	53.6%
Autism	63	4.8%	51.6%	53.0%
Other	58	4.4%	59.7%	59.0%
Area Size				
Small	187	14.3%	44.8%	48.4%
Medium	456	34.9%	46.5%	48.6%
Large	662	50.7%	44.5%	48.0%
Total	1,305	100.0%	45.2%	48.3%

Results in Table 4 reflect findings from other studies conducted by Delmarva through the FSQAP contract:

- Younger individuals have better outcomes and supports than adults;
- Individuals living in group homes have the lowest percent of outcomes and supports met among all living arrangements;

¹¹ The ABC database from the Agency for Persons with Disabilities was used to “fill in holes” on date of birth, disability, and home type. However, not all of the data elements were retrieved. Therefore, not all of the 1,305 individuals have complete data on all of the relevant variables. In addition, some are coded as unknown or other. These are removed from the data for the regression analysis, leaving a total of 1,169 individuals.

- Individuals living with an intellectual disability have the lowest percent of outcomes and supports met among all the disabilities;
- Individuals in medium size areas appear to have somewhat higher outcomes than individuals in other areas, but only by two percentage points.

Methodology

Regression analysis is used to determine the impact caseload size has on the *WiSCC Outcome Score* for each WSC. In regression analysis, data can be analyzed at the multivariate level. The net effect of each independent variable on the dependent variable is calculated, controlling for all other independent variables in the equation. Simply put, individual effects from each independent variable are “parceled out” or “held constant”, and the resulting effect of each factor in the equation is from “only” that factor, not intertwined with the other variables. The idea is one that “all other things being equal”, this is the impact of each independent variable on the dependent variable.

Standard Pearson’s r correlations test the strength of the association and t-tests determine the statistical significance of the association. The partial correlation gives us the correlation of each independent variable with the dependent variable, net of other influences controlled for in the equation. Values range from $r = -1$ to $r = 1$. The closer the r value is to zero, the weaker the association. For example, if a positive correlation exists, say $r=0.8$) it means that when values increase on one variable they also increase on the other variable: they “vary” together. The probability (p-value) associated with the t-test informs us how likely it is the association is due to chance. A standard probability level used to determine “statistical significance” is $p \leq .05$ (t-score of 1.96 or greater). This means there is only a five percent probability or less the results from the sample are due to sampling fluctuation or chance.

Regression analysis also tells us how much variation in the dependent variable is accounted for by the factors in the equation. The R-Squared value is the percent of variance in the dependent variable that is explained by the independent variables in the equation. This tells us how much the variation from one WSC to the other on the total *WiSCC* score depends upon the variables we were able to use in the analysis.

In addition to the strength and significance of the relationship, the B Coefficient informs us of the magnitude of the relationship (the slope). If the association between Group Home and the Percent of Outcomes Met is significant ($p \leq .05$), and the B coefficient is $-.14$, this tells us that for an individual living in a group home, compared to a family home, the percent of outcomes met will decrease, on average, by 14 percentage points, holding the other variables constant. It tells us how much the dependent variable changes in response to a unit change in the independent variable.

Using categorical analysis, crosstabulation and Chi-square significance tests, we also examined the association of the WSC caseload on each *WiSCC* element separately to explore the possibility that having a full v part time caseload might impact different components of the WSC’s organization in different ways. For example, one element measured by the *WiSCC* may be more sensitive to large caseloads than another.

The Chi-square statistic is used for categorical variables and tells us if what we found in the sample within groups is different than what we would expect to find based on sample totals. For example, if 70 percent of all WSCs scored as Achieving and Implementing on WiSCC Element 1, we would *expect* approximately 70 percent of WSCs with a full time caseload to also score Achieving or Implementing on this element. Chi-square tells us the likelihood the difference between the *observed* (actual) score and *expected* score (70%) is due to chance. As with a t-test p-value, a Chi-square p-value of 0.05 or less shows there is a statistically significant difference.

Results

The first analysis explores the impact of *caseload size* on WSC performance as measured by the overall *WiSCC Outcome Score* and controlling for the various demographic variables as described above, using two separate equations. Because this analysis reflects results from the first WiSCC for each WSC, we believe it is important to control for the Percent of Outcomes Met and the Percent of Supports Present for individuals as well. Hopefully, the WiSCC itself will help the Support Coordinator learn to generate better individual level results in these areas. However, because this is the first WiSCC, it is also important to determine how the individuals' current quality of life may impact the WSCs evaluation, although causality may be difficult to determine. In these equations we control separately for the individuals' outcomes and supports.¹² Because these two variables are highly correlated with each other ($r = 0.89$), it is not appropriate to include them in a single model as "independent" variables.

**Table 5: WiSCC Outcome Score as Dependent Variable
Controlling for Percent of Outcomes Met
July 2004 - June 2005**

Independent Variables	B	t-score	p-value	Partial Correlation
Age	-0.006	-8.670	0.386	-0.025
Agency	-0.205	-1.058	0.290	-0.031
Small Size	0.464	1.615	0.107	0.047
Medium Size	0.020	0.186	0.853	0.005
Group Home	0.126	0.505	0.614	0.015
Independent/Supported	0.290	1.090	0.276	0.032
Cerebral Palsy	0.258	0.785	0.433	0.023
Autism	0.236	0.509	0.611	0.015
Percent Outcomes Met	5.055	10.673	0.000	0.299
Caseload >= 30	0.240	1.219	0.223	0.036

R-square=11.6%

N = 1,169

¹² These are used as dependent variables in the next analysis.

Table 5 gives the results of the analysis, controlling for the Percent of Outcomes Met. The R-square value tells us that 11.6 percent of the variance in the *WiSCC Outcome Score* is explained by the variables in the equation. None of the demographic variables (age, provider type, Area size, home type or primary disability) has a significant impact on the performance score of the WSCs in terms of the six outcome elements. The Percent of Outcomes Met for individuals served by the WSC has a significant and strong positive association with the *WiSCC Score*, with a partial correlation of 30 percent. WSCs with higher performance scores are serving individuals with a relatively higher percent of outcomes met. This analysis also informs us that WSC caseload (comparing WSCs with full time caseloads with those serving fewer than 30 individuals), has no effect on the overall performance evaluation of the WSC, controlling for all the factors in the equation. For individuals with similar demographic characteristics and a similar level of outcomes met, the number of individuals served by the WSC does not appear to impact WSC performance scores on the outcome elements.

Results in Table 6 below are given using the same model as in Table 5, but controlling for the Percent of Supports Present for each individual. The information is similar to the previous analysis in that none of the demographic variables significantly impact *WiSCC* scores, holding support levels constant. The Percent of Supports Present also appears to have a strong association with the *WiSCC Score*, with an even greater partial correlation of close to 46 percent. The WSC caseload size does not appear to affect the WSC's performance level.¹³ Again, for individuals with similar demographic characteristics and a similar level of supports in their lives, the number of individuals served by the WSC does not appear to impact WSC performance scores.

Table 6: *WiSCC Outcome Score as Dependent Variable*
Controlling for Percent of Supports Present
July 2004 - June 2005

Independent Variables	B	t-score	p-value	Partial Correlation
Age	-0.003	-0.442	0.659	-0.013
Agency	-0.062	-0.341	0.733	-0.010
Small Size	0.441	1.647	0.100	0.048
Medium Size	0.081	0.820	0.412	0.024
Group Home	0.365	1.585	0.113	0.047
Independent/Supported	0.182	0.735	0.462	0.022
Cerebral Palsy	0.197	0.645	0.519	0.019
Autism	0.278	0.645	0.519	0.019
Percent Supports Present	6.515	17.543	0.000	0.458
Caseload >= 30	0.145	0.789	0.430	0.023

Rsq=23.3%

N = 1,169

¹³ This model was also tested without the outcomes or supports entered as an independent variable, and caseload size did not exhibit a significant effect.

We are also interested in the possible impact of the caseload size on the Percent of Outcomes Met and Supports Present for individuals on the WSC's caseload. This analysis is based on approximately two individuals per WSC and results should be viewed with caution. However, results suggest that at current caseloads, there is no difference between full and part time WSCs in the degree to which they impact outcomes or supports for individuals (Tables 7 and 8).

Table 7 shows the results of the regression analysis using the Percent of Outcomes Met as the dependent variable. As has been demonstrated in past research, children tend to have higher levels of outcomes present and individuals living independently or in supported living have more outcomes met than individuals in family homes. Individuals living in group homes have lower levels of outcomes met than those in family homes.

**Table 7: Percent Outcomes Met as Dependent Variable
Controlling for WiSCC Score
July 2004 - June 2005**

Independent Variables	B	t-score	p-value	Partial Correlation
Age	-0.001	-2.832	0.005	-0.083
Agency	-0.014	-1.231	0.218	-0.036
Small Size	0.010	0.559	0.573	0.017
Medium Size	0.004	0.568	0.570	0.017
Group Home	-0.140	-9.869	0.000	-0.279
Independent/Supported	0.053	3.399	0.001	0.099
Cerebral Palsy	0.035	1.817	0.069	0.053
Autism	0.054	1.963	0.051	0.058
WiSCC Score	0.018	10.673	0.000	0.299
Caseload >= 30	0.006	0.543	0.587	0.016

R-square=23.3%

N = 1,169

Caseload size reflects a p-value of 0.587, well above the 0.05 standard for testing statistical significance, and therefore does not appear to impact the outcomes in people's lives. However, the *WiSCC Score* does seem to be associated with the Percent of Outcomes Met, with a partial correlation of 30 percent. As demonstrated in the previous tables, this analysis suggests there is a positive association between the Percent of Outcomes Met and the WSC's performance on the six outcome oriented elements of the WiSCC. However, we can not be sure of causality, and this will be discussed in the next section.

Results in Table 8 show the same regression model, using the Percent of Supports Present as the dependent variable. Again, the results indicate the difference between having a full

or part time caseload does not appear to impact the Percent of Supports Present. WSC evaluation scores do seem to be positively associated with the Percent of Supports Present in the lives of the individuals they serve. This is a relatively strong relationship with a partial correlation of close to 46 percent.¹⁴

**Table 8: Percent Supports Present as Dependent Variable
Controlling for WiSCC Score
July 2004 - June 2005**

Independent Variables	B	t-score	p-value	Partial Correlation
Age	-0.001	-2.525	0.012	-0.074
Agency	-0.027	-2.153	0.032	-0.063
Small Size	0.001	0.032	0.975	0.001
Medium Size	-0.007	-1.068	0.286	-0.031
Group Home	-0.134	-8.496	0.000	-0.242
Independent/Supported	0.047	2.685	0.007	0.079
Cerebral Palsy	0.028	1.295	0.195	0.038
Autism	0.025	0.822	0.411	0.024
WiSCC Score	0.032	17.543	0.000	0.458
Caseload >= 30	0.014	1.085	0.278	0.032

Rsq=30.8%
N = 1,169

Categorical analysis was used to test the one-to-one (bivariate) association of caseload size with each WiSCC outcome element. Results are presented in the following table.

**Table 9: WSCs Scoring Achieving/Implementing by Element
July 2004 - June 2005**

N = 671		Percent of WSCs at Achieving/Implementing					
		WiSCC Element					
Caseload Size	WSCs	Knows People (1)	Knows Health (2)	Person Directed (3)	Evaluate Supports (4)	Facilitate EEE (5)	Generate Results (6)
< 30	275	72.0%	37.8%	52.4%	57.8%	44.4%	42.5%
>=30	396	79.0%	40.7%	58.6%	61.6%	47.0%	48.0%
Chi-square							
p-value		0.035	0.459	0.110	0.323	0.505	0.165

Data in Table 9 compare the percent of WSCs with a full time caseload to WSCs serving fewer than 30 individuals, across elements for WSCs who scored the element as Achieving or Implementing. Therefore, percents in the table represent the percent of

¹⁴ This model was also tested without the WiSCC score as an independent variable and the caseload size did not exhibit a significant effect on outcomes or supports.

WSCs in each caseload group who scored either Achieving or Implementing on the element. Thus, for Element 1 (WSC has effective way of learning about the people served), 79 percent of WSCs with a full time caseload (30 or more) compared to 72 percent with a caseload of fewer than 30 individuals scored well. The chi-square p-value of 0.035 tells us this is significantly different than expected. Therefore, without controlling for any other factors, this one-to-one relationship indicates that having an effective method for learning about the people who are receiving their supports and services may be enhanced when the WSC has a full time caseload.

On every other WiSCC element (2 – 6), WSCs with a full time caseload were more likely to score as Achieving or Implementing than other WSCs. The largest difference among these five remaining elements is seen on Element 3 (the support plan is developed with the person and reflects that person’s preferences and choices). However, the p-values inform us the associations on these five elements are not statistically significant.

The outcome elements, as measured above, are not the only component of the WiSCC process and not the only important component of a WSC’s responsibilities. Five Minimum Service Requirement (MSR) elements are compliance oriented, measuring key requirements such as background screening and documentation of training specific to each service. The same analysis as described above for the six outcome elements was used to determine the possible impact of caseload size on the ability of WSCs to complete the more process oriented tasks of support coordination.

Table 10: WSCs Scoring Met on Minimum Service Requirements

July 2004 - June 2005

N = 671		Percent of WSCs Scored as Met				
		<i>WiSCC Element</i>				
Caseload Size	WSCs	Level II Screening (7)	Training (8)	Authorized in Cost Plan (9)	Billing Authorized (10)	Billing Documented (11)
< 30	275	92.0%	71.3%	96.0%	95.6%	87.6%
>=30	396	97.0%	82.6%	97.2%	97.5%	89.4%
Chi-square p-value		0.004	0.459	0.110	0.323	0.505

Results in Table 10 inform us that WSCs with a full time caseload appear to be more likely to have documentation on Level II Background Screening and Training, than other WSCs. While full time WSCs also scored somewhat better on the other process elements, these relationships were not statistically significant.

Discussion and Recommendations

In this study we have explored the relationship between a WSC’s caseload size and the possible impact that has on the support coordinator’s ability to effectively serve

individuals on the Florida DD HCBS Waiver program. We use the definition of a full caseload as described in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook (June 2005) to test this relationship, comparing WSCs with caseloads of 30 or more (full time) to those serving fewer individuals. The maximum caseload of 36 in Florida seems to be comparable to caseloads in six other states, as noted in the review of the literature in this study.¹⁵

However, unlike some previous research that demonstrated a negative impact of large caseloads on job satisfaction and personal efficacy, as well as generating increased personal stress on case managers, in this study we found no caseload effect on WSCs. Having a full caseload versus having fewer than 30 individuals did not appear to impact either WSC performance levels or the outcomes and supports in individuals' lives. This finding could be due to the maximum caseload size of 36. In at least one other study, maximum caseloads ranged up to 80 individuals. Perhaps at these higher limits performance levels fall and stress levels increase, but these effects are not apparent at the high end of lower caseload levels (30 to 36). This would help explain a lack of any impact from caseload size in the current study and indicates the Florida maximum caseload level appears to be appropriate.

There are, however, some interesting results worth further exploration. For every WiSCC outcome element, WSCs with full time caseloads were more likely to score either Achieving or Implementing on the elements than WSCs with fewer than 30 individuals. However, this relationship was found to be statistically significant for only Element 1 (Knows people) at the bivariate level (Chi sq $p=.035$), indicating WSCs with a full time caseload are more likely to have an effective method for learning about the people who are receiving their supports and services.¹⁶ In addition, full time WSCs were more likely to score each MSR element as Met. This was statistically significant on the elements measuring Level II Background Screening and documentation of training. Therefore, WSCs with higher caseloads had systems in place to better meet these requirements. These are preliminary results and shown only at the bivariate level, indicating no other variables that could impact the results have been factored into the analysis.

The reason for these somewhat counter-intuitive findings is not clear but there are at least a couple of plausible explanations. It is possible that WSCs working in a full time capacity are more focused on the "job at hand" or simply more dedicated to support coordination as a career rather than as a part time position (the impact generated from the WSC). In this case, WSCs with larger caseloads would be more likely to have organizational systems in place that are helping individuals learn about all the people they serve as well as helping them with other required aspects of the job such as training and background screening checks.

Alternatively, the larger caseloads themselves may dictate the need for more organized, efficient systems that can effectively meet all the consumer's needs/goals in a timely manner (the impact generated from the caseload). A busy schedule necessitates

¹⁵ Specifically the report from HCFA citing caseloads in six different states.

¹⁶ Because this is a bivariate result, no other factors have been considered, or controlled for, in the analysis.

organization in most of life's circumstances. In addition, a well organized and effective WSC may attract consumers who want the benefit of being served by a dedicated support coordinator, driving up caseload size. Any of these may be plausible explanations.

Whatever the explanation, these ideas are supported by the findings that WiSCC scores are positively associated with the level of outcomes and supports among individuals on the WSC's caseload—better WSC performance goes hand in hand with higher outcomes and supports for individuals. It is not likely the outcomes and supports of individuals drive the WSC's systems and performance level. However, it may be possible that when outcome/supports are high due to natural supports it is easier for the WSC to have systems in place to work with them. If outcomes/supports are generally low, this may create more difficult scenarios that test the WSC's organizational systems and could more easily show places where they might break down. However, in combination, it appears that full time support coordinators may have better organizational systems in place that are effectively reaching out to all the individuals they serve in a manner which helps the support coordinators know and understand individuals, and the individuals are in turn receiving better supports that generate higher outcomes.

Recommendation 1: The current full time caseload as recommended by the state in the DD HCBS program should remain as is.

However, evidence from other research (Barriers Analysis) has suggested that many problems encountered by service providers have been perceived as a result of a WSC caseload that is too large, regardless of the findings in this study. It is therefore possible that issues faced by support coordinators that impact other service providers, who were interviewed for the Barriers Analysis study, may be due to the constant change in eligibility among Medicaid recipients and the increased work load and paper work surrounding this, rather than actual caseloads in any given month. Caseload turnover could create a set of problems not addressed in this study. The increased paper work alone may increase the number of errors on Support Plans and/or Cost Plans, which impacts other service providers.

Recommendation 2: APD should explore caseload turnover and Medicaid eligibility complications as a possible explanation of a perceived problem in terms of caseload size, and revise procedures WSCs must follow to ensure a smoother transition of individuals "on and off" the waiver. This should include a review of the current handbook expectations and revisions if appropriate. This will, in turn, help to alleviate issues for service providers who need service authorization that requires correct paper work from the WSCs.

Recommendation 3: APD should ensure WSCs are adequately trained on all procedures pertaining to adding and losing consumers in order to facilitate a more effective and efficient process.

A variable we were not able to test in this analysis is the actual time spent working as a support coordinator, whatever the caseload. For example, a very dedicated full time

WSC could spend more hours per individual than a less dedicated WSC with a part time caseload, or vice versa. We can not assume that each WSC spends the same amount of time per individual or that each individual would require the same amount of time in order to obtain supports and achieve outcomes important to them. In addition, some individuals may require more paper work than others. Some require more supports than others. A simple “number of individuals” used to measure the impact of the caseload is not a very robust indicator of all the different variables connected to any one WSC’s circumstances.

Recommendation 3: Focus groups with service providers, family members and individuals with disabilities were successfully used to explore barriers in the DD HCBS service delivery system. Conducting focus groups with WSCs across the state may help to explore the many variables pertaining to caseloads at a more in-depth level.

One additional finding in this study points to the importance of supports and the WSC’s focus on ensuring individuals have the supports they need to achieve desired outcomes in their lives. In reviewing the results in Tables 7 and 8 we find the *WiSCC Outcome Score* does impact the *Percent of Outcomes Met* and the *Percent of Supports Present*. The association appears to be somewhat stronger in terms of supports. The partial correlation of the WiSCC score with outcomes is 30 percent while the correlation with supports is closer to 46 percent. This may be an indication that WSCs can and in fact do have a great impact on supports that in turn generate outcomes for individuals. The findings support the WiSCC process which places a focus on the capacity of the WSCs’ organizational systems to develop and implement supports for individuals—an area in which the state can have a positive impact on the lives of individuals with developmental disabilities.

Attachment 1

WiSCC Outcome Element Evaluation Levels

The following offers an overall description of the WiSCC evaluation levels. However, the levels are also defined more specifically, relevant to each of the six outcome elements, in the WiSCC tool. The complete tool can be reviewed at http://www.dfmc-florida.org/docs/AA-WiSCC_Tool7-22-04.pdf.

Achieving

Implementing components are present and results are observable for the individual being served.

Implementing

Clear strategies to effect change are in place but the results have not yet been achieved; Education, Exposure and Experience (EEE) are taking place and are being integrated into service delivery; WSCs demonstrate advocacy, empowerment, action, responsiveness, and flexibility in their efforts to support individuals to achieve results.

Emerging

WSCs know the people they serve, have methodologies in place to continue to learn more about them and can define existing barriers. However, little to no appropriate or effective action is being taken on their behalf. any implementation that may exist is either inconsistent, without rationale, or without direction. No EEE are taking place.

Not Present

WSCs do not know the preferences, likes or dislikes of the individuals they serve, nor whom the supports or important people are in their lives. The WSCs may have no method in place to learn about the individuals or gather pertinent information regarding their life.

Attachment 2

WiSCC Outcome and Minimum Service Requirement Elements

Outcome Elements

1. Waiver Support Coordinators (WSC) have an effective method for learning about the people who are receiving their supports and services.
2. The WSCs are aware of the health, safety and well-being of the people they serve and advocate and coordinate in concert with them to support and address identified needs or issues.
3. The support plan is developed with the person and is reflective of the communicated choices and preferences that matter most to the individual.
4. The WSCs have evaluated the effectiveness of all supports for each person they serve and have implemented strategies to address any barriers that have been identified.
5. The WSC have facilitated educational opportunities, practical experiences, and exposure to ideas (EEE) to increase opportunities for choice and promote self-determination.
6. The WSCs have facilitated the accomplishment of positive results that reflect communicated choices and preferences that matter most to the person.

Minimum Service Requirement Elements

7. Level 2 background screenings, and five-year re-screenings, are completed for all direct service employees.
8. The WSC has attended required training.
9. WSC services and all other service providers are authorized by an approved cost plan and service authorization (or purchasing plan for individuals on CDC Plus).
10. The provider bills for the service at the authorized rate.
11. The provider maintains documentation required for billing.

Attachment 3

Personal Outcome Measures

Identity

- People choose personal goals.
- People choose where and with whom they live.
- People choose where they work.
- People have intimate relationships.
- People are satisfied with services.
- People are satisfied with their personal life situations.

Autonomy

- People choose their daily routine.
- People have time, space and opportunity for privacy.
- People decide when to share personal information.
- People use their environments.

Affiliation

- People live in integrated environments.
- People participate in the life of the community.
- People perform different social roles.
- People have friends.
- People are respected.

Attainment

- People choose services.
- People realize personal goals.

Safeguards

- People are connected to natural support networks.
- People are safe.

Rights

- People exercise rights.
- People are treated fairly.

Health and Wellness

- People have the best possible health.
- People are free from abuse and neglect.
- People experience continuity and security.