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Older Adults' Access to Medicaid's Home-and Community-Based Services

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Abstract

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MA, University of Michigan, 2008

BS, University of Michigan, 2005

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
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Abstract

As the U.S. population ages, the need for public policies regarding long-term care increases, as the need is unequal to demand. The purpose of this qualitative study was to explore and describe the role of senior service providers (SSPs) who have dealt with health policies from being responsible for the decision-making processes of implementing federal and state guidelines in Michigan on access and wait-listing of older adults for home and community-based services (HCBS). The theoretical foundation for this study was the social construction and policy design theory. The central research question sought perceptions of SSPs as to their ability to impact the social construction for their targeted population. Data were collected via open-ended surveys that were distributed to SSPs in Michigan (n = 10). Codes and themes emerged from the manually analyzed data. Findings included the importance of getting medical help for older adults needing HCBC. Additionally, participants indicated enrollment policies should be equally applied across HCBS providers to decrease waitlists and increase access, and extended waitlist periods may not provide the services required or preferred, a problem likely to worsen as more baby boomers reach retirement age. Improving HCBS policy implementation may result in positive social change for this expanding population, baby boomers, and the remaining members of the generation that precedes them, a cohort of people that will likely double in 12 years.

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Dedication

To my wife of 56 years, Delores Roberts Horton (1937-2016), for the years she took care of me, especially when I started on my educational journey, our children, our grandchildren, our great-grandchildren and infinite generations to come....

Acknowledgments

My deepest gratitude goes to my dearest friend, Virginia Hutchins, who has stood by me through this entire journey with her limitations, she managed to communicate with me using her own uniquely personal style. She is a woman of courage and determination who contributed to my understanding when I could not hear a word she may have spoken. With pleasure, I acknowledge her, especially for believing in my lifelong dream of having a PhD before I die. Being denied education as the son of a sharecropper and grandson of a slave, Virginia understood my quest for knowledge was needed to make me feel like a whole person connected to the world with meaning and purpose.

Many other people inspired me, but Denise Allen introduced me to Walden University and encouraged me to go for my dream, and the many who doubted my ability to obtain my educational goal. Those that inspired and challenged me can join the celebration.

Most importantly, I would like to acknowledge my Chair, Dr. Anne J. Hacker, who believed in me before she met me. My topic was an inspiration to her, and she trusted that I could improve my scholarly abilities and make this dissertation a contribution in support of older adults in need of access to home and community-based services. Thanks to the other members of my committee, Dr. Gema G. Hernandez and Dr. Tanya Settles for an outstanding job of putting up with me as they help guide me through this phase of my journey. P.S., Cat Heck, Doctoral Specialist, from student success and Angie Drennan from Form and Style, you both are remarkable individuals, thanks so very much.

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Chapter 1: Introduction to the Study

The topic for this study was the limited access through Medicaid to Home- and Community-Based Services (HCBS) for older adults. Wait-listing older adults for HCBS has received increasing attention in the press and from practitioners and researchers (Dube, 2010; Mabie, 2014; Ng Harrington, & Kitchener, 2010; Reaves, 2015; Sexton, 2016; Wysocki et al., 2012). The older adults who desire care in their homes and from their local communities may be on waitlist status for years, and many have died before they gained access to services (Sexton, 2016). Older adults in nursing homes or being placed on waitlists instead of receiving HCBS services presents a social problem that, according to Shirk (2006), is a "dangerous precedent." This problem threatens the current Medicaid coverage if states opt to limit enrollment rather than provide care benefits (p. 21).

There is a need for the perspectives of senior service providers who are program monitors responsible for preparing the area plan while confronting the decision-making processes of implementing federal and state policy in Michigan on access and wait-listing of older adults for HCBS. In this chapter, after presenting the background of the study, I detail the problem statement and purpose. Following that is the research question and the theoretical foundation and nature of this qualitative, exploratory study. Finally, I include the definitions, assumptions, scope and delimitations, and significance of the study.

Background of the Study

Many baby boomers, those born between 1946 and 1964, have hit retirement age and beyond, which will increase the need for healthcare as they become older adults. The most former members of this generation are over 70 and the youngest are over 50 (Blancato & Ponder, 2015). By 2030, the aging population is predicted to double, with fewer younger Americans to replace them in the workforce and provide revenue mostly through payroll tax deductions for the care of older adults (Blancato & Ponder, 2015). But the most promising trend involves rebalancing the direction of federal program dollars such as those in Medicaid funding (Blancato & Ponder, 2015). Only 5% of older adults are in nursing homes and other similar institutions with trends going toward community care, which will enhance their life quality. Still, such programs and solutions and the problems of ageism persist (Administration for Community Living, 2016).

Further, many important issues regarding older adults remain unsolved or not sufficiently studied. The increasing need for long-term services for the older adults may lead to challenges in providing and financing Medicaid (Reaves & Musmeci, 2015). There are also several key issues regarding the long-term care (LTC) needs (Calmus, 2013) such as safe environments, caregiving, affordable housing, elder abuse, and finances for retirement (Kleyman, 2017).

Despite issues with LTC and older adults, there has been progress in LTC for older adults ranging from HCBS to nursing facilities (Ng & Harrington, 2010). In expenditures and participation between 1999 and 2008, the waivers, personal care services, and home health care have increased. However, there are inconsistent expenditures and involvement in different states (Ng & Harrington, 2010). Additionally, from 2002 through 2010, in contrast to nursing facilities, demand for HCBS has increased yet so have unmet needs. Statistically, with goals to expand HCBS to 60% of all LTC participants, the expenditures for such care in 2002 were only 30% (Ng & Harrington, 2013). Further, Chapin, Hickey, Rachlin, and Higgins (2008) looked at the way the Medicaid waiver program worked for older adults with low incomes from 1999 to 2004 in a state in the Midwest and found that the percentage of assisted living older adults who had the Medicaid waiver services did not increase, but their room and board costs did by 114%. Furthermore, places in urban areas did not accept older adults with Medicaid as often as medium or smaller facilities did. Due to these challenges, the people who use HCBS tend to be of low income, among the oldest adults, Black, single, and Medicaid recipients (Sonnega, Robinson, & Levy, 2017). People who had HCBS were also more likely to use less traditional services for seniors like tax preparation advisement and exercise classes (Sonnega et al., 2017).

Most scholarly studies regarding nursing home service providers are related to residents in institutions and home healthcare but not those on HCBS waiting lists. For instance, Medicaid.gov (2017) reported that in 2014, HCBS comprised 53% of their budget for LTC (80.6 billion vs. $71.2 billion for other HCBS); however, the site mostly reported on care for younger adults, including those with mental illnesses and developmental or intellectual disabilities. Substantive articles on waiting lists have raised concerns on how potential Medicaid cuts could have negative impacts on home care (Baker, 2017; Claude Pepper Center, 2017). However, there is a lack of studies from on the issue of a waiting list for community-based Medicaid services for older adults. Evidence from backlogged waiting lists found in Internet articles suggests that many states are not complying with the Americans with Disabilities Act and the Olmstead decision. For example, Sexton (2016) reported that nearly 6,000 Floridians die each year while on HCBS waiting lists. Consequently, a failure to implement waivers and adhere to the Americans with Disabilities Act and the Olmstead decision increases inequities and patient's ill-health status (Shirk, 2006). Thus, there is a need to explore the perspectives of administrators and service providers tasked with implementing federal and state policy in Michigan regarding access and wait-listing for HCBS.

Problem Statement

As the U.S. population ages, the need for public policy related to LTC, medical services increase. But many older adults who need LTC have been put on wait lists not only for nursing home care but also for HCBS, the focus of this study. The Area Agency on Aging (AAA, 2014) in southeastern Michigan compared outcomes for older adults and adults with a disability who remained on the waitlist for HCBS and those who received HCBS within 2 years. Two years later, of the 1,471 placed on the wait list, 62% (441) had died without receiving HCBS care (Mabie, 2014). Being able to access services makes a difference in quality of life for all, but especially for older adults.

Those who are waitlisted for long periods of time may not get the services they prefer. For example, Mabie (2014) compared waitlist stay outcomes without needed services to those who move off the list and with provisions of necessary services. Of the initial group, 71% (193) remaining on the waitlist were five times more frequently placed in nursing homes or placed on waitlists inappropriately to wait for services (Mabie, 2014). Evidence from backlogged waiting lists also suggests that many states are not complying with the Americans with Disabilities Act and the Olmstead decision, and over

5,000 older adults in Florida die every year as they wait for HCBS (Saxton, 2016). The problem is likely to grow worse when the population of older adults increases substantially as more baby boomers reach retirement age.

Additionally, the health care needs of retiring baby boomers will have an impact on the Medicaid HCBS programs. The current pace of moving older adults from the waitlist to community living may create American with Disability Act lawsuits (*Boyd v* Herrmann-Steckel, 2010) and the 1999 Olmstead decision, which prohibited the unjustified segregation of individuals. Low-income older adults most often seek government assistance and may need monitoring while they wait for community placement because of their declining health. Inappropriate healthcare environments regularly poorly meet the older adult's needs. Thus, public administrators must implement federal guidelines associated with HCBS and be more compliant in applying the intent of laws (O'Keeffe et al., 2010) to overcome dangers to health status to wait-listed older Americans.

Senior service providers at the state level play an important role in public policy. Although the federal government dominates quality assurance in nursing homes regarding spending, quality measures, and regulations required by law (Weiner et al., 2002), state public administrators operate with much independent regulation flexibility for HCBS. Administrators within the Department of Health and Human Services delegate HCBS to local agencies such as AAA (Department of Health and Human Services on Aging, 2015). The administrative directors and senior service providers who operate within federal guidelines select the beneficiaries for HCBS and waitlist participants.

With a lack of centralized coordination and different delivery systems, several government subdivisions with the various funding sources, plus the rapid demand for HCBS, the role of public administrators and the process of access for older adults and their health status while on HCBS waitlists are uncertain. Statistics from the Americans with Disabilities Act Participatory Action Research Consortium (2017) from 2016 showed a relatively low waiting list compared to other states with 3,311 on the Michigan list compared to Texas with the most extensive waiting list of 232,068 and neighboring Ohio with 64,546 (Americans with Disabilities Act Participatory Action Research Consortium, 2017). However, according to Medicaid.org (2018), the Michigan site reported that there was no waiting list for the state. On the other hand, an online document tells potential HCBS clients that their wait time will be between 6 and 12 months before services begin (American Elder Care Research Organization, 2018). But a survey of 50 respondents conducted by the College of Human Medicine at Michigan State University (2018) in January and February of 2018 reported high satisfaction levels with the Valley AAA.

Though scholarly studies can be found on the role of Medicaid and medical needs for older adults, including HCBS, there is a gap in the literature on the length of time seniors spend on waitlisted for such services and the harmful effects of not receiving timely support for aging in place. There is a need to explore the perspectives of senior service providers tasked with implementing federal and state health policy in Michigan regarding access and wait-listing for HCBS.

Purpose of the Study

The purpose of this qualitative study was to explore and describe the role of senior service professionals confronted with the decision-making processes of implementing federal and state policy in Michigan on access and wait-listing of older adults for HCBS. Waiting list numbers are likely to increase rapidly as baby boomers begin to enter the LTC health system (Brandon, 2014). In this study, I used open-ended questions to allow senior service providers in Michigan who are responsible for access and wait-listing older adults for HCBS to explore and describe their perspectives regarding service provision under the existing policy. To help triangulate the data to increase understanding, I kept a journal of my impressions of the survey process and the data analysis stages.

Research Question

The central question this study was the following: What are the perceptions of senior service providers as to their ability to impact the social construction of their targeted population while implementing federal and state policy in Michigan regarding access and wait-listing for HCBS?

Theoretical Foundation

The theoretical foundation of this exploratory, qualitative study was SCPD theory. Social construction theory is the way people believe about the world, and much of what becomes a reality is social inventions; therefore, reality is set by people and constructed by society (Cheung, 1997). In the theory, social construction takes a role in making policies and putting them forth (Schneider & Ingraham, 1993; Schneider & Sidney, 2009). The theory combines power in target groups with social construction to shed light on policy development and how to understand them better (Pierce et al., 2014). Researchers have used the SCPD theory with increasing frequency in many different cases, especially in public policy, both internationally and domestically (Pierce et al., 2014). Scholars' focus on understanding what causes events fits the feed-forward proposition of SCPD (Pierce et al., 2014). Some target populations are categorized as dependents, advantaged, deviant, and contenders.

Based on the theory, people assume or rationalize what supports policies, which is the social constructions of targeted groups (Schneider & Sidney, 2009). This social construction involves language and the ways messages are viewed by target groups, which influence their perspectives on whether their needs should be of reasonable concern to the public. For example, the U.S. welfare policy often blames poor people for their poverty, not the society that creates it in the first place. Because poor people often internalize all this lack of power and self-blame, they tend not to get together to find public policy solutions (Schneider & Sidney, 2009). Related to home care is a disability, and this lack of power and self-blame is not a medical or individual issue but a socially constructed concept involving how people experience their disabilities concerning their surroundings (Jones, 1996).

Social construction theory was the best framework for my study because it integrated with public policy. More specifically, it helped elucidate how social services like Medicaid's distribution in the United States and how people must often wait a long time to get HCBS. Based on the reality people receive, the social constructions of society and public policy managers addressing the social needs of a population do not necessarily have the power to direct their future or to fight back when the results are inadequate (Schneider & Sidney, 2009). A more detailed analysis of how SCPD theory relates to points of view of senior service providers and their ability to impact the social construction of their targeted population as they implement federal and state policy in Michigan is provided in Chapter 2.

Nature of the Study

The nature of this study was qualitative research. Qualitative studies are suitable for improving the understanding of how something happens (Patton, 2001). Compared to quantitative studies that are analyzed statistically, qualitative research provides in-depth descriptions of people's perspectives, particularly because unexpected responses might emerge, which further enhances the data (Yin, 2016). Additionally, as part of this study, analycentric policy analysis refers to decision support tools, which provides an understanding of policies and different techniques such as policy-analytic methods using simple tools such as questionnaires (Jordan & Turnpenny, 2015).

Open-ended surveys were administered to Michigan senior service providers to gather their perspectives of wait times for HCBS for older adult regarding perspectives on public policy. The administrators' and senior service providers' input on the implementation of policies as they related to seeking HCBS and wait-listing older adults provided rich information in understanding the likely impact of such policies. The approach aided in understanding how senior service organizations have implemented HCBS and wait-listed older adults in their counties.

Upon completion of the open-ended survey, I read through the data several times using a continuous iterative process to find repetitive words and phrases for coding. I then used the question worktable to list and code the data. Coding consists of using short phrases that capture the essence of data based on the language (Saldaña, 2016) of the respondents, which derived from the open-ended questions. Starting with the preliminary coding framework based on the theory and questions in the protocol, I got a rough idea of themes regarding the perspective of agency administrators and service providers in Michigan from various agencies that serve older adults. In other cycles (the second or third time going more carefully through the data), I used an iterative process to filter, manage, and emphasize certain parts of the data derive categories and themes and perceive concepts to generate results (Saldaña, 2016). Additionally, journaling was used (Balsan & Holsblat, 2017). In Chapter 3, the Methods section further details the data collection and analysis stages of the study.

Definitions

Home- and community-based services (HCBS): HCBS is a Medicaid program that involves home-based community living, including assisted living, and individuals receive Medicaid if the description is person-centered as opposed to institutional care (Zimmerman et al., 2014).

Medicaid: Medicaid is a U.S. program under which individuals of low income can receive healthcare, including parents, pregnant women, children, individuals with disabilities, and older adults of low socioeconomic status (Theis et al., 2017).

Older adult: Petry (2002) classified people 55 and above as older adults. Avers et al. (2011) argued that the phrase *elderly* is subject to not being specific and is too general to be accurate and is an ageist term that diminishes older people; thus, the *older adult* reflects accuracy and freedom from value judgment.

Assumptions

Assumptions are researcher-accepted truths that have no foundation on substantial evidence (Marshall & Roman, 2016). The primary assumption of the study was that the participants had a role in dealing with waitlisted older adults for HCBS Medicaid programs. They were assumed to have reality-based perspectives on how the programs operate and the effects on older adults. It was also assumed that the staffs' involvement in Medicaid policies allowed them to respond to the open-ended survey questions with honesty and enough detail to provide rich data from which themes emerged through data analysis.

Scope and Delimitations

The scope of a study is its parameters (Simon & Goes, 2013). Delimitations are characteristics within the researcher's control that define boundaries of the study, such as research questions, theoretical framework, and variables (Simon, 2011). Although Medicaid is a federal program, the Department of Health and Human Services delegates the administration of local programs to the state and local agencies on aging (Department of Health and Human Services on Aging, 2015). It is local senior service providers who choose HCBS beneficiaries and put others on the waiting list. There is uncertainty not only about older adults' access to the programs but also the status of their health as they wait for services and if that contributes to high death rates. In Florida, for example, annually almost 6,000 people die as they wait for HCBS (Sexton, 2016). The populations included in this qualitative study were directors and senior service providers who were most familiar with public policy for older adults in HCBS and who have perspectives on knowledge about the high numbers of older adults they serve. Excluded from the study were the older adults who would have personal lived experiences being on waitlists, which would be more phenomenological and not related to public policy, the focus of the study.

There is a gap in the scholarly literature on waitlists for HCBS. However, there are many studies on the rapidly increasing older population as well as HCBS itself and its benefits compared to entering institutions like nursing homes (Blancato & Ponder, 2015); Zimmerman et al., 2014). The theoretical framework of the study was the SCPD theory, which is a practical theory to understand more clearly the development of public policies (Pierce et al., 2014). The findings of the study should help fill the literature gap on waitlists for HCBS. Additionally, the results can increase knowledge for policymakers and senior service professionals who enact these policies on the societal harms to older adults who are not receiving necessary medical services to improve their life quality.

Limitations

Limitations are method or design characteristics that can influence how researchers interpret their findings, including practice applications, generalizability constraints, or utility of results (Price & Murnan, 2004). Home and Community-Based Services is a Medicaid waiver program that is not the same nationwide. Each state presents its HCBS plan to the federal government and the Department of Health and Human Services; therefore, findings for this study only apply to the Michigan HCBS program, and the participants are engaged in enacting federal policies on a state and local level. The small size of the survey group prohibited generalizing the result to all senior service staff in aging programs. Finally, the recommendations are only applicable to Michigan. Although I am an older adult myself, I used bracketing to avoid bias in the open-ended survey process as I received them and opened the individual responses.

Significance of the Study

This research addresses a gap in the knowledge of the role of senior service providers in access for the older adult and their medical condition while they wait for Medicaid HCBS. The uniqueness of this research is the focus on understudied issues of the older adults and their access to HCBS (Dube, 2010) and their health status during their wait. Articles, though mostly found on the Internet, can be found relating to patients' deaths while waiting for HCBS (Mabie, 2014). Nearly two decades ago, researchers urged additional research on the inclusion of health status of waitlisted older adults as an added benefit when studying policy trends (LeBlanc et al., 2000). Today, there is a need for research regarding the trends of older adults dying while waiting for HCBS (Sexton, 2016).

This study might have a significant impact on policy and practice by improving policy-maker awareness of the HCBS waitlist and not as a name or number. The results can also advance knowledge in the discipline of public policy because of the lack of research on the adverse health effects of having to wait for long periods for necessary medical care, having hindered political and human service action on the problem. Once the issue surfaces, past practices would diminish. Thus, improving HCBS might result in positive social change for a growing segment of the population, baby boomers, and the remaining members of the generation that precedes them, as this population will likely double in 12 years (Blancato & Ponder, 2015).

Summary

In Chapter 1, I presented the problem involving public policies for older adults with wait-listed status for HCBS. There is a gap in the scholarly literature of wait-listing and the harmful effects of not being able to get needed medical care at home or in community-based places such as assisted living housing. The purpose of this qualitative study was to explore the role of senior service providers confronted with the decision-making processes of implementing federal and state policy in Michigan on access and wait-listing of older adults for HCBS as well as their perspectives on the barriers in accessing such services and how the staff help waitlisted older adults get their needs met.

Chapter 2 includes the literature regarding Medicaid, HCBS, and wait-listing issues for older adults as well as summaries of available public documents to inform the open-ended survey questions. Although there are many articles in government and other general audience publications, there is a gap in the scholarly literature on waitlists. Also presented are further details on the theoretical framework as well as similar studies done for public policy and aging services area of public policy. Chapter 3 outlines the chronology of conducting qualitative research including population, sample, participant recruitment, data collection, data analysis, and protection of participant recruitment.

Chapter 4 present the results of the study, and Chapter 5 concludes the study with an interpretation of data, limitations, implications, recommendations, and conclusions.

Chapter 2: Literature Review

As the baby boomer generation ages, the need for medical services and LTC and policies to guide these services is increasing. Yet the demands are currently higher than the supply. Nursing homes and HCBS have waitlists for many older adults needing LTC. Evidence from backlogged waiting lists suggests degrees of state noncompliance with the Americans with Disabilities Act and the Olmstead decision, resulting in many deaths of older adults as they wait for services (Sexton, 2016). Low-income older adults usually need assistance from the government and health monitoring as they wait for community placements. Older adults can overcome health status dangers when AAA professionals carry out the HCBS federal guidelines according to the intent of the law (O'Keeffe et al., 2010).

Although research has been done on Medicaid's role in meeting the needs of older adults, little research has been done on the perspectives of senior service program providers responsible for preparing the area plan and who are engaged in working with waitlisted older adults. The purpose of this qualitative study was to explore and describe the perspectives of senior service providers responsible for implementing federal and state policy in Michigan on access and wait-listing of older adults for HCBS. The literature review contains several categories—general categories like the theoretical framework and summary and conclusions and topic-related categories including the history of Medicaid for older adults, background of HCBS, public policy for HCBS, agency roles in carrying out public policy (e.g., Office for the Aging), outcomes for HCBS versus nursing homes, and studies on related topics.

Literature Search Strategy

To find literature relevant to the problem, purpose, and research questions for the study, I conducted database searches in Walden University library to find peer-reviewed articles that were published recently. After looking for peer-reviewed literature from between 2014 and 2018, I expanded the years in the search to uncover more relevant articles. In completing this academic search, I used EBSCO Host, Academic Search Premier, ProQuest, and PubMed. Because there is a lack of research on HCBS regarding older adults, I also did a Google search for government and other reputable websites that had information and links to substantive articles on HCBS and baby boomers, for example. I also searched for available books and e-books from the college library.

Some of the academic journals accessed in the completion of this literature review were the *Journals of Cultural Diversity,* the *International Journal of Organizational Innovation,* the *International Journal for Equity in Health,* the *Journal of Mixed Methods Research,* the *journal of Family Psychology, Children & Youth Services Review,* the *Journal International Business Studies,* and the *Bulletin of the Association for Business Communication.* Different search keywords and phrases included the following: *aging in place, death rates in nursing homes, home and community-based care, Medicaid for older adults for aging offices for the aging, retiring Baby Boomers, waitlisting for nursing homes,* among other topics including *social construction* and *policy design theory.*

I then bookmarked relevant articles to be sent to e-mail and developed a reference list as I went along. After categorizing the topics, I scanned the material for pertinent information I could use in the literature review. I pasted relevant parts of the articles by snip tool onto a Word file to connect the information to the heading and find an internal narrative within the various studies and have the information in view. I also snipped essential parts of government and local web sites because they were the primary source of information on HCBS either with physical bookmarks in the case of works found in print or via the browser for those found online.

Through tables provided in a PowerPoint presentation on developing a literature review from Walden, I was able to fill in the essential information from the peer-reviewed articles. Most articles were written in the last several years to fit into the Walden suggestion to make them not more than 5 years (2014-2018). However, I did not overlook important works I came across despite the search setting for 2014 and up only because they were older. If they were relevant, I used them.

Theoretical Framework

Over the last several decades, many researchers have set theories and models for public policy that have laid the groundwork for the theoretical framework for the study, the SCPD theory. SCPD theory, which is considered one theory developed by Schneider and Ingram, has been used increasingly in research (Pierce et al., 2014). Mainly researchers use the theory to understand changes in target population positioning. In a seminal work using the theory, Kingdon (1984) posited that three streams operate both separately and conjointly with each other: the problem, policies, and solutions to the problem, and politics. Kingdon saw streams of policy developed and focused on social networks that come about from one of the streams. Some of the people who act on the policy are media, politicians, and academics who combine the streams with setting agenda and finding open windows for action (Koliba et al., 2010). The foundations of Kingdon's model are coordinated acts that occur just before public policies are selected and designed (Koliba et al., 2010). Combining of multiple streams and policy stages/streams as related to decision-making stages of policymaking and policy formation can aid in understanding both subtle and complex traits of the process of making policy (Howlett et al., 2015). Kingdon's work laid out the explanation for agenda change as a set of factors and how changing public mood is a slow process with randomness that is hard to predict (Baumgartner, 2016).

In the context of policy centered on particular groups, the policy can make inequality worse (Liang, 2015). For example, racial minorities mostly live in communities of considerable environmental risk, but few studies address how broad institutional and political contexts relating to people of color influence the implementation of policies about the environment at the state level (Liang, 2015). But discrimination can negatively impact the politics and attitude of these groups and, in turn, how the public perceives these groups. People's reality is their perceptions and social inventions. People define reality and construct it as a group (Cheung, 1997).

Further, social construction theory leads to a bigger conversation on designing policy (Simon, 2017). Public administration has a vital role in developing the benefits to which people at the margins of society are entitled (Liang, 2015). But concerns exist about how policymakers see target populations shape the foundations of public policy and the costs and benefits extended through the policies as well as how the objectives of the policies are carried out (Simon, 2017). To illustrate that point, felons addicted to drugs face prison time for crimes that probably stemmed from their addictions in contrast to the palliative care and counseling that middle-class adolescents get when faced with similar charges (Simon, 2017). Thus, the words that surround certain target groups (i.e., criminal, addict) translate into public policy, which maintains how society views the groups and how inequitable policies and practices will go on almost indefinitely (Simon, 2017).

Social construction involving target groups presented in the late 1980s and early 1990s as a theory (Ingram et al., 2007; Ingram & Schneider, 1988; Schneider & Ingram, 1990, 1991, 1993). Target populations are seen either as negative or positive, and the benefits the groups received not only mirrored these social constructions, but the distribution is maintained according to this framework (Ingram et al., 2007). For example, the long wait times for HCBS has a myriad of negative impacts on the target population, including early deaths for those wanting to age in place in their communities. Social construction theory explains the discrepancy of oppressive policies in the context of democracy, addressing how Americans learned they were equal in the eyes of the law, where advantages for citizens are distributed unequally (Ingram et al., 2007). Even more prominent is unequal treatment by policymakers, and the social constructions and power balance bring change to the balance of power and institutions of these target groups (Ingram et al., 2007), which would include inequality in health care, the topic of this study.

As the framework for the study, social construction theory was the best fit. Many researchers on policy analysis do not use policy analysis theory to back up their evaluations, which affects their influence on policy (Embrett & Randall, 2014). However, public policy researchers founded this theory, and it might explain how adults, even those who did not experience poverty and deprivation, become marginalized as they age. The theory framed this study that involved surveying senior service providers who carry out public policies on HCBS daily for an older target population; what the latter receive is grounded in society's social constructions. Public policy managers directed to address the social needs of a community that does not have the power to direct their future or to fight back when the results are inadequate (Schneider & Sidney, 2009).

Literature Review

Current literature found on HCBS and related topics has a focus on younger adults, particularly those with disabilities. Literature searches were done on Medicaid in general and those more specifically focused on older adults. There is a gap in the literature on the roles of senior service providers professionals, such as those who direct Offices for the Aging in helping older adults' access HCBS. There is also a lack of literature on waitlists for these same individuals and the consequences of not being able to get timely help for their medical conditions. The literature review covered Medicaid and public policy for HCBS. A review of several publicly available documents informed the open-ended survey questions, how agencies carry out public policy for the program, how nursing homes contrast with being able to age in place, and studies on similar topics involving public policy and health care. The goal of the study was to address the gap in how senior service provider professionals view their role in HCBS.

Medicaid

Medicaid is a program founded over 50 years ago to address gaps in income. At present, 10,000 older U.S. citizens become new Medicaid recipients every day (Burke et al., 2016). People who will reach age 65 or higher, when Medicare starts and when Medicaid can be accessed if necessary, will be at a 120% higher number in the 40 years between 2010 and 2050 (Burke et al., 2016). Furthermore, the number of older adults age 85 or higher will likely triple. Due to increasing income gaps, many older adults will live in poverty (Burke et al., 2016). Additionally, some of the obstacles in Medicaid include income limits, restrictive tests for users, and extensive paperwork on state levels (Burke et al., 2016). More than 6 million older Americans receive Medicaid benefits (Mann et al., 2016), but some who had qualified in the past might suddenly lose their Medicaid benefits when the need increases because of the choice system of expensive long-term supports and services in the Medicaid program. Further, proposed federal caps and block grants on a per capita basis may transform Medicaid from a program to which everyone who qualifies is entitled to one that will have unrealistic costs that cannot match needs and end up affecting the quality of care (Mann et al., 2016).

Additionally, although the Affordable Care Act was legislated to improve access to services, at the state level, many geographical regions have not expanded Medicaid. Ninety-two percent of older individuals are experiencing a chronic illness or physical or mental condition, and 77% have more than one of these challenges (Akinyemiju et al., 2016). It is more likely that people who live in poverty will have medical issues than those of higher incomes. States that expanded Medicaid had more people with incomes over $50,000 and more health insurance coverage compared to states that did not extend the federal program (Akinyemiju et al., 2016). Those who were not insured had a higher chance of being obese, and they had more comorbidities (Akinyemiju et al., 2016). Therefore, those who did not live in Medicaid expanded states were more likely to have no health insurance coverage and suffer from chronic illnesses and other medical conditions (Akinyemiju et al., 2016). Moreover, unless health management or prevention programs are developed in states that have not expanded Medicaid, health disparities will rise significantly (Akinyemiju et al., 2016). Private nursing home care can cost up to $90,000 a year, while home-based care, still out of the reach of most people, would cost $20,000 annually (MetLife Mature Market Institute, 2012). Although long-term services and supports might come through Medicaid, not all states would give low-income people the services they need (Cubanski & Buccoti, 2015).

Despite criticisms of Medicaid, the authors of the government Medicaid site have called the program sustainable and people-friendly. They listed partnerships and programs and claimed to be achieving a system that is:

- person-driven, where people with chronic conditions and disabilities can choose where they live and with whom, their service providers, their jobs, and who will support them in community life;
- inclusive, in that Medicaid encourages and supports individuals to choose where they live and access many services and supports;

- effective and accountable, where services are of good quality and improve lives. Medicaid also shares responsibility and accountability with private and public partners and includes planning and personal responsibility for LTC needs and increasing awareness and use of private funding sources;
- sustainable and efficient, where efficiency and economy are achieved through managing and coordinating service packages appropriate for the individual and financed by the applicable party;
- coordinated and transparent, where services are organized from different funding streams to coordinate support~~s~~ seamlessly and to use right information technology (IT) to be open with payers, health providers, and customers, and
- culturally competent, where Medicaid considers linguistic and cultural requirements. (Medicaid.gov, n.d.)

Also listed are some programs related to HCBS, including Money Follows the Person Rebalancing Demonstration Grant, in which most states participate, which allows people who have been in institutions to be reintroduced to their communities. Another program is the Community Initiative in which people directly asked if they would like to return to their community and if so, the facility staff refers them to local contact agencies designated by the state. These older adults plan to reenter the community if they are eligible for Medicaid HCBS options (Medicaid.gov, n.d.).

Regarding programs in Michigan, MI Choice used to be known as the HCBS for the Elderly and Disabled program. It is a Medicaid waiver program for older and disabled adults who need the same kind of care provided in a nursing home. It is delivered at home or in the community like an assisted living home for the aged or even adult foster care in a private home (Paying for Senior Care, 2019a). The participants can either control their care or ask for help managing their care from the state. They can also appoint a representative, and family members can become paid caregivers, though husbands or wives are not able to be paid for these services. Other benefits include home modification assistance like for bathroom safety and walk-in bathtubs (Paying for Senior Care, 2019a).

Another state Medicaid HCBS program is Home Help under the auspices of the Michigan Department of Health and Human Services (MDHHS) for disabled and older Michigan adults who need more significant help with their instrumental and daily living. Some of the services helped with bathing and toileting, laundry, and essential shopping as well as personal care. The program helps older adults be independent of delaying living in a nursing home. The program cannot be by offered to those living in assisted care, nursing homes, or foster care houses (Paying for Senior Care, 2019b). The consumer direction part of the program is known as self-direction or participant direction. Caregivers, who can be friends and family members, can be paid and work with a county case manager to judge the right amount of care the older adult needs. The rates are different in each county but would be “much less” than the national price of $21.75 an hour (Paying for Senior Care, 2019b).

A third Michigan program is the Michigan Health Link. Those who can take advantage of this program must be eligible both for Medicare and Medicaid. To distinguish-it from Home Help, Michigan Health Link gives help with personal care in assisted living places as well as adult foster care houses (Paying for Senior Care, 2019b).

Medicaid Utilization

Those who can avail themselves of the free services that come with Medicaid use them in different ways. While often thought that being able to visit a medical office freely would cut down on emergency department use that is not necessarily the case (Petersen et al., 1998; Tang et al., 2010; Widmer et al., 2014). The use of the emergency department had risen by almost 40% in the ten years measured by Tang et al. (2010). Between 1997 and 2007, many of those who received Medicaid benefits did not always use the emergency department strictly for emergencies. Many used the emergency department for ambulatory care for conditions such as high blood pressure. Insurances cover those emergency department visits, or the patients lack coverage entirely (Tang et al., 2010). Some may prefer the emergency department over other ambulatory care settings like their primary providers (Tang et al., 2010).

Widmer et al. (2014) conducted a study on whether adults on Medicaid used the emergency department when they were able to use office-based visits. The researchers used the Medical Expenditure Panel Survey, which contains information on U.S. citizens who are not in institutions. Widmer et al. looked at a sample of 1,497 individuals who had Medicaid coverage throughout 2009. The researchers looked at the following variables: usual care sources, beneficiary demographics, type of insurance, and whether they had chronic conditions, that connected to the number of times they visited the emergency department. Widmer et al. adjusted their multivariate analysis for health conditions and the high probability of using the emergency department. The correlating factors were with more visits to the emergency department (at least one visit) were (a) history of myocardial infarction and high blood pressure, (b) Latino ethnicity, and (c) age. Widmer et al. found that having a primary care provider (PCP) had little effect on the reduction of emergency department visits. However, they found that visits to their provider were associated with more emergency department visits, along with the findings on age, ethnicity, and chronic conditions (Widmer et al., 2014).

Older adults who use traditional Medicare but do not qualify for Medicaid face rising expenditures. The ones who are eligible for Medicaid receive a variety of medical advantages that others do not (Cubanski & Boccuti, 2015). If older adults do not meet eligibility requirements, then they might be able to obtain Medicare supplemental plans, Medigap coverage, or retiree benefits. Still, the policy premiums may run into the hundreds or thousands of extra dollars annually in additional personal costs. Cubanski and Boccuti (2015) included information from a 2010 graphic by the Kaiser Foundation on such out-of-pocket costs (with HCBS at 1%). Figure 1, with data also derived from the Kaiser Foundation, shows both out-of-pocket costs and service costs for older adults except those on Medicare Advantage plans. Older adults 85 years and older have the most expenses as many of them age into Medicaid eligibility (Cubanski & Boccuti, 2015).

Cubanski and Boccuti (2015) concluded that even though older adults are generally satisfied with Medicare and all its features, the gaps in coverage and costs and barriers are not to be taken lightly because often those who need ~~it~~ the most suffer the hardest. Therefore, enhanced financial protections and improved coverage need to be in places such as dental care and more substantial limits on out-of-pocket expenses

(Cubanski & Boccuti, 2015. Older adults face changes by being put off Medicaid at a time in their life when they are likely to face worsening health, which is another barrier to accessing HCBS at a time when the older population will consist mostly of boomers and triple by 2050 (Burke et al., 2016).

Medicare involves many out-of-pocket expenses not only for uncovered services but also for covered treatments. Willink et al. (2016) looked at people who were on Medicare, over age 65 but were still underinsured. Those who had insufficient insurance coverage and physical and cognitive disabilities were nearly two times the rate to enter Medicaid within 16 years. However, people with supplemental health insurance reduced that change by almost a third (Willink et al., 2016). The researchers advised that the traditional Medicare program should have a ceiling on out-of-pocket expenses as well as target support for those with disabilities. That way, Medicaid coverage could be postponed, and the program would see savings.

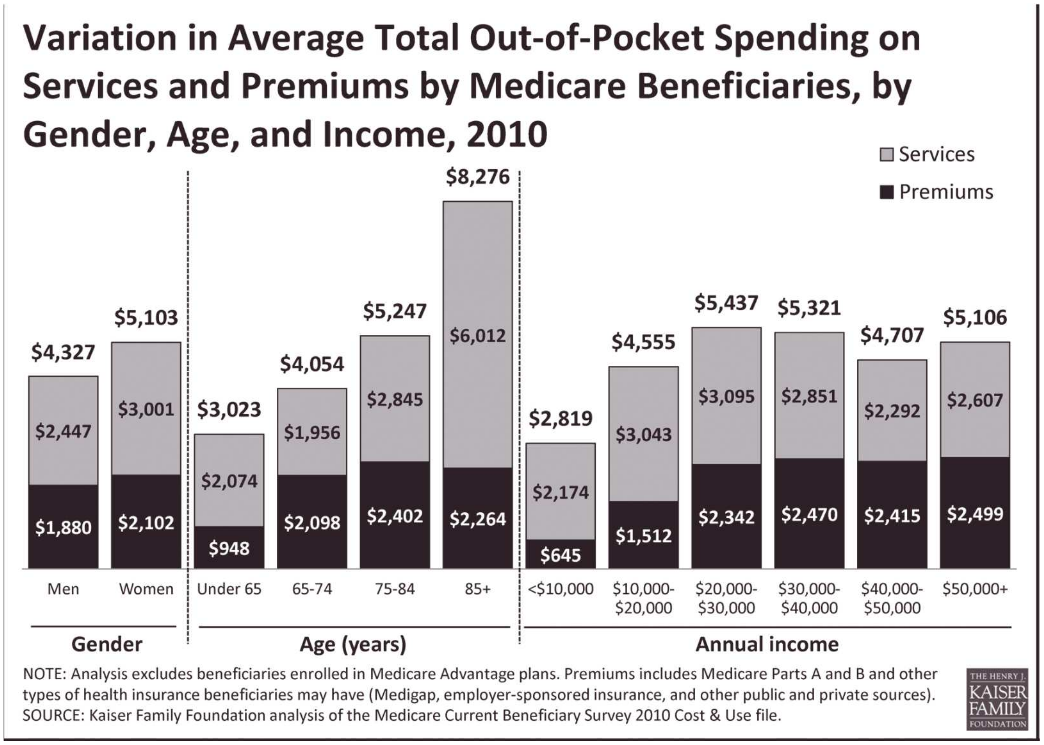

Figure 1. Average variation in money spent on services and premiums by older adults.

Aging Boomers

The oldest members of the baby boomer generation will turn 72 in 2018, and many of the parents of this newly aging generation have already died. By 2035 over 30% of household heads will be 65 or older. Their population, currently at 48 million, will grow to 79 million over the next two decades (Arieff, 2017). Older adults in the United States increased by approximately 6 million in four years (2010-2014). The main concentration of this growth is in the West and the South (Johnson & Parnell, 2016). Overall, the U.S. population will go from 321 million to 380 million, an 18% increase (Johnson & Parnell, 2016).

In 2010 when the oldest boomers turned 65, it was recognized that there would be challenges when they became health care consumers at higher rates than the previous generation (Kahana & Kahana, 2014). Because those of this generation who were disabled lived longer than they did throughout history, demands for chronic care will be higher. Responsiveness to these demands by health providers who are already overwhelmed will need to be firmly in place (Kahana & Kahana, 2014). Baby boomers have differentiating characteristics from their parents' generation. They tend to be more conscious of their health, more assertive in their demands, and more engaged in healthcare.

Doctors must recognize that they should talk to their older patients much like they talk to younger ones, in a more egalitarian way, knowing that the patients will expect to share all decision-making about their health care (Kahana & Kahana, 2014). Baby boomers generally research potential health issues before they arrive in the doctor's office; thus, doctors must recognize patient expectations, principles, and subjective assessments of their state of health. Even though baby boomers will encounter health care needs as they age, they have tended to adopt lifestyles that promote better health outcomes than did older generations. Kahana and Kahana (2014) concluded that the wellness revolution had been mostly brought into existence by baby boomers.

A few baby boomers are retiring because they have not saved adequately for their later years. This lack will be a significant obstacle for many (Mann et al., 2016). In 2013, people in the decade before qualifying for Medicare (those from 55-65) had an average savings of $14,500 in the face of needing over a quarter million dollars just for healthcare (per couple) in those years (Fidelity Investments, 2016; Rhee & Boivie, 2015). Their younger children are outpacing baby boomers, the Millennials, who are saving 10% of their income for retirement, Generation X'ers 8%, and baby boomers a mere 5% (O'Shea, 2017).

Many of the aging baby boomers of today were once the generation, unlike those who went before, who defied tradition, spearheaded political and social movements, and raised awareness of society's injustices; they are likely to have the same perspective and activism voices on ageism. Golant (2017) described the scenes of the 1960s and posited that aging baby boomers yet show the spirit of independence, including aging in place if they can. Their wishes are often against the advice of experts who believe most of their homes are not appropriate for older adults who may be experiencing a host of limitations, losses, and chronic health issues (Clarke & Gallagher, 2013; Golant, 2017).

With baby boomers retiring in the past seven years, those on Medicaid and Social Security will rise 100% in the next 12 years. In those dozen years, about one-fifth of the U.S. population will be 65 or older. It is a challenge for the government to sustain the system. There will be a significant impact on paying for LTC, retirement programs, and economic growth. On the one hand, the demands of retirees will result in more services and products, thus, creating more growth. On the other hand, it will result in a smaller labor force and lower productivity (Atkins, 2016).

Many boomers have already retired or plan to soon. Taylor, Pilkington, Feist, Dal Grande, and Hugo (2014), in an Australian study conducted in 2011, surveyed people by telephone between 50 and 65 years who were presently employed and had been for the last three years. The data weighted by age, gender, postcode, and household selection probability. They were asked their thoughts on retirement, their present job, the type of employment place, and the hours worked. The respondents were also asked about their body mass index, if they were smokers, about their life satisfaction, and their health status (Taylor et al., 2014). This researcher used univariable and multivariable analysis to compare associations between people who wanted to continue work and those who planned their retirements. Because governments have tried to stop the trend in early retirement for the boomer generation, compliance is a good thing. Taylor et al. (2014) did find that many boomers did not want to stop working or would take part-time work. The researchers suggested that workplaces make their environment flexible, welcoming, and safe as possible to encourage potential retirees to continue to work in some capacity rather than leaving the workforce altogether.

The main reasons boomers do not want to age anywhere, but their homes are that they are used to autonomy and control and will strive to stay that way. Second, they do have better opportunities than did their parents both from public and private sources, and they are aware they can use them to exercise their prerogatives. Thus, because they have more at their disposal to connect with services, caretaking, and goods, they will try to remain independent if possible (Arieff, 2017). Still, they will face many of the same challenges as their parents. One fear that many older adults express is that they live in places inaccessible by any other means than car travel, which is valid for most adults (Arieff, 2017). Compared to 1900, there will be 12 times the older adults living in the United States (National Institutes of Health, 2014). By 2035, one out of three household heads will be over 65, 9.3 million of them single adults (Arieff, 2017).

The National Institutes of Health (2014) commissioned a special census report on the phenomenon of the aging of this population explosion, acknowledging that baby boomers will shape the future of the United States. In 32 years, the numbers of adults over 65 will more than double (40 million in 2010 to 84 million in 2050). Along with this shift in demographics, a myriad of health challenges will be present for many boomers who do not follow empowered lifestyles (National Institutes of Health, 2014). Smoking and abuse of alcohol have dropped among this population, yet obesity is on the rise. Only 8% of older adults in 2008 had no chronic conditions, while 51% had two, and 41% had three or more. More than 38% of older adults had walking disabilities that inhibited their ability to run errands, go up or downstairs, or walk (National Institutes of Health, 2014). High divorce rates, as well as a solitary living, will lessen older adults' support systems. Two positive things for baby boomers are their massive participation in elections, and their job rates did not go down during the Great Recession (National Institutes of Health, 2014). Funding for the report came from the National Institute on Aging, which is part of the National Institutes of Health.

In a commentary on the future when the 45th President of the United States takes office, Hoagland (2016) surmised that the central part of the inaugural address would highlight growth in the economy along with opportunities. Yet, on that day, it would have been ten years since the first baby boomers retired, and the administration would have to consider the impacts (fiscal, economic, and financial) such growth would have on aging baby boomers. Many of today's newly retired baby boomers will live a long time. The projections are that people over 90 will be four times in 2050 what they were in 2010

(Hoagland, 2016). The disappointing economy and increasing challenges have a direct relationship to this group (Maestras et al., 2016).

Home and Community-Based Services

One of the main reasons for HCBS is to ensure the quality of life for older adults, especially those who might harm themselves by not taking care of themselves for a variety of reasons. Dong and Simon (2014) carried out community-based research on elder self-neglect and one-month readmission to hospitals, a population-based study. These older adults were among 7,219 participants in the Chicago Health and Aging Project, where social service agencies received 1,228 reports of possible self-neglect, which was the main predictor in the study. Dong and Simon intent on finding the yearly hospital readmission rate sourced from the Center for Medicare and Medicaid data on hospitalization between 1993 and 2009 using Poisson regression models. Average annual readmission rates for people who did not neglect their health was 0.2 (SD 0.7), and for those who did, it was 0.9 (SD 2.8).

In the same study, Dong and Simon (2014) adjusted for the following traits: socioeconomic and sociodemographic, cognitive function, physical function, psychosocial well-being, and medical comorbidities, which led to a 30-day readmission rate significantly higher. Further, analyzing interaction term, this relationship between 30-day readmission and self-neglect was unmoderated by cognitive impairment, psychosocial well-being, physical disability, or medical conditions. Dong and Simon concluded that for this Chicago population, the severity of the self-neglect led to a more considerable rise in 30-day hospital readmission.

Ko et al. (2014) examined the association between payment rates for personal caregivers and long-term service and support after being discharged from a hospital for those who had dual Medicare and Medicaid benefits. Their data came from the California Medicaid long-term service and support records between 2006 and 2008. Identified in their study were adults with dual benefits, discharged from a hospital that offered acute care, but they had no similar issues during the previous year. Ko et al. found that the payment rates for personal caregivers were associated moderately with HCBS use vs. nursing home use after hospital discharge. They concluded that paying higher for private caregivers could raise the utilization of HCBS, "but with a limited substitution for nursing facility care" (p. 1812).

Thomas et al. (2014) reported that 31.5% of the Medicaid budget (out of $400 billion) goes to long-term service and support for older adults and those with disabilities at the state and federal levels. Thus, reductions in spending will be the goal, however possible. A practical solution to lower costs would be to shift LTC to HCBS (Thomas et al., 2014). A simple step as supporting home-delivered meals cuts down on people going to nursing homes whose needs are lower than those with chronic mental and physical conditions (Thomas et al., 2014).

Providing meals and other services under HCBS, also known as community LTC, Hasche et al. (2013) noted that community LTC helps with personal care, the meals, and caregiver relief. However, about one-quarter of people who live at home and receive such services are (appear) to suffer from depression. Hasche et al. explored if identifying depression could have an influence on service authorization in the face of other competing demands such as cognitive impairment, number of prescriptions, and other health problems. Out of 1,508 participants, (who all spoke English and were their legal guardians), 299 who met the depression criteria agreed to phone interviews. The researchers examined if their community LTC worker noticed their depression, what kind of services were authorized if there were competing demands, and what were the sociodemographic variables.

Some of the results were that when community LTC workers saw personal care needs, the depressive symptoms were not connected. Clients were more likely to get the services if they were not White and had more physical but fewer cognitive health issues. Homemaker services ordered more frequently if the adults were older and lived in rural regions. The rendered services were also more likely if clients took more prescriptions but had less cognitive impairment issues. Yet, in contrast to authorizing homemaker and personal care services, nursing services were allowed more if there were noting of depression by the workers, and their numbers of medications were higher (Hasche et al., 2013). Hasche et al. concluded that in the presence of depressive symptoms, there are still many unmet needs among older adults receiving community LTC services. The researchers recommended having standardized depression screenings for community LTC recipients so that they may be led to the right services to improve their symptoms. Finally, Hasche et al. suggested that social workers undergo more training because they could identify depression and connect the clients to necessary resources in their community.

Public Policy on Home and Community-Based Services

Health care systems around the world are facing the same problem of a burgeoning population of aging baby boomers. Though health needs tend to be increasing, governments are inviting older adults not only to engage in social interactions with all generations but also to live at home if they can (Bruin et al., 2016). In response to the growing needs of this population, nations in the European Union were working on a project for integrating care for older adults (Bruin et al., 2016). Addressing older adult's needs, but at the same time, attention to the rising expenditures that are increasingly unsustainable in the face of a shrinking labor pool with less productivity, must also be a factor. Integrated care is one of the most obvious ways to address the changing demographic and the economy, Bruin et al. acknowledged the inconclusiveness of its effectiveness in implementation, practice, and transfer to other countries with their unique healthcare systems.

The rapid aging of the global population will become a health challenge on a worldwide scale. Peipei and Yu (2015) highlighted the tremendous burden on most countries. The apparent challenge due to the 23.1% of diseases and other health disorders and conditions occur in people over 60. Having more than one illness (multi-morbidity) is especially prevalent among the oldest age cohorts (Peipei & Yu, 2015). The aging-in-place phenomenon is most common in high-income countries to coordinate the most cost-effective care for older adults. There are also other factors to keep people out of costly institutions in the information and communications technology field, including medical diagnosis, devices to assist communication and different needs, and ways to intervene safely (Peipei & Yu, 2015). Peipei and Yu revealed that using big data on a web service platform can support care continuation as an efficient system of collaboration established as public policy. However, such use of information does have drawbacks concerning gathering data, information sharing, and guarding personal data.

In one nation in the European Union, Switzerland, the population of older adults is aging and expanding as in other countries across the globe. Leaders are trying to find solutions to financing social welfare and their system of social security. Those living at home will be increasingly likely to need unneeded hospitalizations and home care (González Ortiz et al., 2015). González Ortiz et al. highlighted the Swiss LTC system as superior in accessibility and quality, and its approach centered on people. Still, to keep people in their homes, there are several initiatives to address the needs of older adults, experimental adult day care centers, Alzheimer café, and protected apartments.

González Ortiz et al. (2015) wished to probe more deeply to see if any solutions were missing is if those that are already in place are working to full capacity. Because this peer-reviewed conference paper written as a description of future research, there were no recorded results. However, they conducted research expecting to find many needs undergirding independent living for older adults. Providing for their needs should maximize their self-management skills and independence as well as keep their social capital and boost their state of well-being. González Ortiz et al. concluded that HCBS could complement integrated care programs, so it is valid to learn from the HCBS programs that are already present and build toward a holistic system.

U.S. programs for HCBS guided by public policies and private agencies. Programs vary from state to state. As people age and their needs for healthcare increase, the traditional option is a nursing home, which can be prohibitively expensive, especially in the United States. Blackburn et al. (2016) researched spending policies for long-term service and support after a hip fracture, which carried a high risk of a nursing homestay. However, if the patient can access HCBS, the risk is lowered as well as expenses. Mann et al. explored how long-term policies led to outcomes by researching spending at the state level for HCBS if it were likely that a patient who suffered a broken hip would be in a nursing home.

In another study on HCBS and nursing home rates for working age and older adults, Miller (2011) examined rates of nursing home admissions at the state level between 2000 and 2007. They were using multivariate fixed-effect models to examine how rates of use and the state's economics, programmatic, economic, programmatic characteristics, and supply. Miller found that nursing homes decreased for older adults over 65 in two-thirds of states and Washington DC but increased among working adults ages 31 through 64 in most states. Miller concluded that efforts in public policy to expand HCBS and decrease nursing home capacity seemed necessary. However, to increase compliance with the Olmstead decision, research was recommended to help older working adults understand why their service use was rising.

Regarding Olmstead, Milne (2012) explained the Americans with Disabilities Act with all its titles, which, regardless of age, covers all nursing home users. Milne noted that the Americans with Disabilities Act helps to define what is reasonable for modifications and accommodations. Still, Title II (forbidding discrimination in any activities, programs, or services of state governments) is the dominant player in the LTC system. Milne added that government self-evaluation “used to identify and correct policies and practices inconsistent with Title II can be evidence of that government’s good faith effort to comply with Title II requirements” (p. 45).

Health care in the United States is in crisis as the strong possibility of cuts in entitlement programs loom, further breaking down the social safety net. Naylor et al. (2015) argued that the U.S. system is ineffective, fragmented, and replete with concerns about quality, which has important implications for adults who are impaired functionally or have disabilities. Naylor et al. outlined the three usual strategies to better long-term service and support. They include “expanding noninstitutionalized care, integrating payment and care delivery, and realigning incentives through market-based reforms” (p. 531).

Naylor et al. (2015) analyzed the three with an evaluation framework including effective transitions among many providers in different settings; ease of access; setting/provider choice; racial/ethnic disparity decreases; effectiveness in cost; life/care quality; political feasibility; ability to implement; and family/caregiver support, the latter of which can impact self-esteem, life satisfaction, and happiness (Nguyen et al., 2016). The base with which the researchers worked had limited breadth to analyze the impact across all the dimensions; however, because the system is so complex and interdependent, public policy decision makers would need to address the system in a long-term, holistic way to make needed changes. To address the long-term service and support in the United States, a multipronged strategy is called for that would need a spectrum of social and health services to meet the needs of many different people in many different places (Naylor et al., 2015).

Public policy in the United States does not only concern Alaska, Hawaii, and the "lower 48"—the United States owns territories under its jurisdiction that do not have equality in distribution of funds and services. Portela and Sommers (2015) contrasted access to care and health insurance in the United States to that of Puerto Rico, which is its most significant territory in terms of nearness and size. Over 4 million American citizens reside in the territory, but it lays outside of U.S. health public policies, including the Affordable Care Act distributions. Still, despite financial disparities, Puerto Rico has several outstanding health care plans and care access (Portela & Sommers, 2015). The Affordable Care Act did increase health distributions in the territory. However, there are restrictions on the federal level on premium tax credits and Medicaid, both of which make health challenges harder to face in Puerto Rico.

Paying for home care is an expensive proposition and it comes from both public and private sources. Janus and Ermisch (2015) examined the sources for service payment for older Americans with disabilities who get care at home. They sought to find the mix of funding relating to the resource's recipients must use, what their care needs were, and what sociodemographic characteristics they had. Janus and Ermisch used the National Long-Term Care Survey—11,725 person-years from its waves taking place in 1989, 1994, 1999, and 2004. They performed a two-part regression analysis to show care hours obtained from all payers. They also found similar results from both fixed and random effects.

Janus and Ermisch (2015) found that 63% of caregivers are paid by personal resources only. Conversely, public funding alone pays 28% of them. Nine percent are paid from a combination of the two. Those who take care of people who earn more than 75,000 dollars annually give 8.5 more hours of care than for those who earn 15,000 dollars or less. People with the highest incomes fund 97% of the care personally, which has implications for relying heavily on personal finances and economic disparities in HCBS for older adults with disabilities and their families (Janus & Ermisch, 2015).

Blackburn et al. (2016) used data from 7,778 Medicare patients between 2005 and 2010 specifically for hip fractures. They used a multilevel generalized estimating equation to find the connection between a potential nursing home admission and the state budget allocated to HCBS. Mann et al. found that states differed in their spending on HCBS, anywhere between 17.7% and 83.8% of their Medicaid budgets. Of the 38% who went to nursing homes, 25% of them died within a year. HCBS reduced nursing home admission by .017%. Therefore, those states that tend to prioritize spending on HCBS have patients with lower risks of nursing home institutionalization (Blackburn et al., 2016).

Many people are already dually certified for both Medicare and Medicaid. Rahman et al. (2015) conducted a study based on national Medicare enrollment data and health claims as well as the Minimum Data Set. They looked at a total of 890,922 Medicare fee-for-service recipients who had been discharged from a hospital to be admitted to a skilled nursing facility (July 2008 through June 2009). Rahman et al. found that patients who were dually eligible are similarly likely to have hospitalization within a month, stay long-term, and survive longer 180 days than those who are not (i.e., by 2 percent). The researchers concluded that patients who are dually eligible for both Medicare and Medicaid survive at higher rates than Medicare only patients. Spending more on HCBS could reduce stays in skilled nursing homes without a high death rate and save money for the programs (Rahman et al., 2015).

Regarding skilled nursing homes, Ronald et al. (2016) noted that because nursing home patients are so vulnerable, the quality of care is an concerning issue. Ronald et al. noted that from observation, for-profit homes offer worse care than public ones. In the past 10 years, developed nations have been privatizing facilities more and more, which begs the question of the quality of care. Ronald et al. also noted that using Bradford Hill causation guidelines in scholarly studies that there is likely a causal link between substandard care and for-profit facilities, which should be taken into consideration when public policies are being developed.

Researchers have called for changes in public health policies to reach out to an increasingly needy population to extend simple programs to raise their quality of life and thus prevent many of the physical and mental issues they face in their declining years. Anderson et al. (2012) outlined programs that could improve quality of life for those over 65. Such interventions could help to prevent falls and raise exercise levels. People even older than 85 can benefit from weight lifting and safe walking programs based in the community along with changes in the environment (Anderson et al., 2012). All of these initiative needs public policies to lend them support and in turn help the 20% of the population who will be 65 and older in 12 years.

Often public policies and health initiatives fall to local people, who develop their own programs to help older adults to prevent a host of health issues, including the important issue of mobility. A Matter of Balance is a program developed by lay people to less falling risks and the negative consequences to mobility. Ghimire et al. (2015) studied how older adults who participate in Matter of Balance might contribute to reducing Medicare costs under an umbrella effort to find value in community-based wellness and prevention programs. The researchers used a controlled retrospective cohort method between 2012 and 2013 based on 2006-2013 data from Medicare and between 2007 and 2011 based on Matter of Balance data. Ghimire et al. wanted to look at the effects of Matter of Balance on falls and the fractures resulting from them.

The researchers found that people who used the program ended up with a total savings in medical costs of $938 each in a year. For unexpected hospital admissions it was $517 each, $81 for home care, and $234 for skilled care at a nursing facility. Although the frequency of falls was not found, cost savings could add up through other areas (Ghimire et al., 2015). Therefore, Ghimire et al. (2015) posited that prevention programs like Matter of Balance can potentially decrease Medicare costs. They called for more research into delivery costs for the program to help to apprise preventive costs covered by Medicare.

Several states have developed policies and programs for older adults and younger people with disabilities to use HCBS. Alabama has a program for medical support and home care. Bronstein et al. (2016) conducted a study to measure how home medical support has impacted clinical services and Medicaid expenses. Their source of data was records on Medicaid claims between October 2010 and September 2013. Bronstein et al. used a differences-in-differences model contrasting changed in the nonintervention group to changes in expenditures and use of the intervention group.

In using community-based support, Bronstein et al. (2016) only found a slight decrease in use and no significant impact on expenditures except for those with mental disabilities and chronic illnesses. In those cases, there was a statistically significant rise in both expenditures and use, but a modest one. There were more expenses for inpatient and walk-in patients, but less use. Finally, all groups had an increase in emergency department use. Though there were no significant savings across the board, Bronstein et al. concluded that there are other benefits in the long term for HCBS.

Alabama has the Patient 1st program that gives its citizens access to basic home care. The program was founded in 1997 and it accepts all Medicaid recipients of any age who are not institutionalized. One exception is maternity care, which falls under another contractor under a 1915(b) waiver (Bronstein et al., 2016). A newer program created in 2011 is known as The Patient Care Networks of Alabama. This public policy gives primary care doctors support to provide a medical home. The networks have thorough data analysis to find providers and enrollees to reach out to them and educate them as well as to oversee capacity, effectiveness, access, and quality toward self-management and education about disease states. They have campaigns on public health and clinical pharmacists in-house for advising doctors on protocols for treating patients. In addition, they have weight loss, nutrition, vaccination care sites and campaigns. As opposed to using remote patient care management, the Alabama care networks engage with patients and pull in community resources and primary physicians. Their teams are multidisciplinary, which is based in evidence to save money and improve care (Bronstein et al., 2016).

Wingate et al. (2014) also conducted a study on an Alabama program. They used a mixed methods approach to identify community at risk profiles quantitatively, and qualitatively to find the gaps and resources in existing home visit services. They used both surveys and focus groups to gather data. Examined in the program were gaps, capacity of existing home visit programs, resources, and program quality. The programs are not only for older adults but also children and anyone else who are at risk of poor developmental, social, and health outcomes (Wingate et al., 2014).

Liew (2018) responded to the gap in emphasizing the important assessment of how type of facility, accessibility, and affordability, different aspects of LTC, were satisfying to patients. Though some older studies were focused on in- and out-patient care and others were focused on long-term and nursing home care, none have been on how satisfied patients were with looking for and utilization of care and what was most important in this search for healthcare (Liew, 2018). The system is slowly moving from pay-for-each-service to pay-for-performance.

Liew (2018) used the Health and Retirement Study, which was a joint project between the Social Security Administration and the National Institutes of Health to collect data. In the Health and Retirement Study were data on age, education, race and ethnicity, behaviors regarding health, gender, job, systems of family support, and so on. Liew used cluster analysis (distinguishing in the latter socioeconomic/ethnic groups) conjoint analysis on the Health and Retirement Study because it obtains rankings, ratings, and preferences of people. Not only does it show preferences but also a sense of what an individual would trade for another service, for example. Liew concluded that the two forms of analysis could help policy makers match their healthcare delivery to what people in different clusters prioritize, which would thus lead to more efficiency in healthcare resource allotment and customization of programs.

As people get older, an end to their life is inevitable, but decision-making toward that end can be complicated. Hornick et al. (2016) wrote on end of life care and urged medical facilities to respect advance directives and patient autonomy. Those who are in assisted living facilities are home and generally prefer to die there, in what have become their familiar surroundings. Still, staff in those facilities worry, of unnecessarily about regulatory or legal liability issues and tend to transfer residents in distress to emergency facilities, ignoring the residents' wishes. Hornick et al. described the balance among practices in assisted living, Department of Health policies, and doctors' opinions. When the patient is unable to make a decision the forces compete with advance directives. Hornick et al. recommended that combining telemedicine triage with emergency medical services to guarantee both compliance with regulations and the safety of the patient.

Publicly Available Policy Documents in Michigan

I was able to find several public policy documents directly related to HCBS in the state of Michigan. They can be found on the web site of the MDHHS. The Adult Services

Manual Table of Contents is a four-page document that provides an alphabetical list of topics with the title and the manual code number (MDHHS, 2018). Three examples are ASM 001, Adult Services Training Requirements; ASM 004, Adult Community Placement Program Overview; and ASM 005, Adult Community Placement Reasonable Accommodations and Person-Centered Planning. Each of the codes/topics goes to the actual manual. Some of the content in the manual for the first topic, Adult Services Training Requirements, states that every worker and supervisor for Adult Services must have at least eight training hours for inservice each year, starting with January 2016; and that the training must be done by the end of November (MDHHS, 2018). I asked the respondents in the qualitative Survey about the quality of their inservice training and how well it transfers to their duties and the work of the people they supervise. There is also a document, the *Adult Services Glossary*, which contains a list and explanation of important legal terms related to HCBS. One example is the term competency for Adult Protective Services defined as being about to understand in general the results of an action, a transaction, or a document. It was noted that the only entity that can determine competency is the legal system (MDHHS, 2018).

The Comprehensive Health Care Program Cost Effectiveness form is a lengthy application related to Medicaid waivers. The program history section provides a short history of the programs “authorized under the waiver” (MDHHS, 2018). The Comprehensive Health Care Program started officially in 1996 for the purposes of improving care for beneficiaries and cost control. The Medicaid Health Plans or MHPs got state contracts for providing and managing the care. Many populations were enrolled in MHPs such as pregnant women, children that qualified for both Title V and Title XIX, and foster children. People who could get both Medicaid and Medicare could enroll voluntarily (MDHHS, 2018). Some of the MHPs are the Medicaid expansion plan and the Healthy Michigan Plan. In the form are listed various services and geographic areas in which they operate as well as information about tribal services for Native peoples in the state (MDHHS, 2018).

A document from the Center for Medicaid and Child Health Insurance Program Services, specifically from the Disabled and Elderly Health Services Group is another one related to the Medicaid waiver displayed on the MDHHS web site. The cover letter indicated that an extension had been granted to the State of Michigan at the request of MDHHS. It was the thirteenth temporary extension of Michigan's Habilitation Supports Waiver that had been ready to end on September 14, 2018. The extension of 90 days let it "continue operating through December 13, 2019, at cost and utilization levels approved for the first year of the waiver program with Federal financial participation" (MDHHS, 2018). The goal was to allow the state enough time to complete the 1915(c) waivers. The lengthy 227-page document seems to indicate that the bureaucratic process for getting and keeping the waivers might be an onerous one. An appropriate question to ask the respondents is what their role is, if any, in this process and if it might interfere with the assurance of continuing HCBS programs smoothly. The documents from the MDHHS are connected to public policy and practice, and the respondents got to weigh in on public policies affect their positions as they serve older adults who are waiting for HCBS.

Public Policy Home- and Community-Based Services

Liew (2018), in response to the gap in emphasizing the important assessment of how type of facility, accessibility, and affordability and different aspects of LTC, were satisfying to patients. Though some older studies were focused on in-out-patient care and others were focused on long-term and nursing home care, none have been on how satisfied patients were with looking for and utilization of care and what was most important in this search for healthcare (Liew, 2018). The system is slowly moving from pay-for-performance. Liew used the Health Retirement Study, which was a joint project between the Social Security Administration and the National Institutes of Health to collect data. In the Health and Retirement Study were data on age, education, race and ethnicity, behaviors regarding health, gender], job, systems of family support, and so on. Liew used cluster analysis (distinguishing in the latter socioeconomic/ethnic groups) conjoint analysis on the Health and Retirement Study because it obtains rankings, ratings, and preferences of people. Not only does it show preferences but also a sense of what an individual would trade for another service, for example. Liew concluded that the two forms of analysis could help policy makers match their healthcare delivery to what people in different clusters prioritize, which would thus lead to more efficiency in healthcare resource allotment and customization of programs.

Agency Roles in Carrying Out Public Policy

As part of the problem of older adults waiting for services for their increasing needs, there is a gap in the literature on the length of time they are waitlisted for such services and the negative effects of not receiving timely support for aging in place. Often missing from the topic of HCBS is that many recipients of home-based care get their support from informal caregivers and how agencies have a role in carrying out public policy that could help both. Freedman and Spillman (2014) highlighted older adults on Medicare who cannot go about their day-to-day lives without assistance from others, which comes frequently if not most of the time from informal caregivers. Still, many older adults in these situations experience adverse effects because all their needs are not met (Freedman & Spillman, 2014). The authors reported that there are almost 10,000,000 older adults in the United States who get assistance from sources other than nursing homes. They have an average of 2.2 caregivers who donate 144 hours a month, which increases if the care recipients have severe conditions.

Because the stress level is high for these partners, children, or spouses of the older adults (6/10 are such relatives), the rising tensions will often lead to giving up on the older adults or sending them to be institutional settings (Freedman & Spillman, 2014). The role of these caregivers is usually threefold: to transition the older adults between care settings, to find ways through the health system, and to do medically based tasks. Because these functions are crucial to the recipients’ health outcomes, caregivers need more support including information, direct assistance, and training, all of which should be a goal of public policy that could come from the U.S. Department of Health and Human Services National Plan to Address Alzheimer’s Disease, the National Family Caregiving Support Program, and Aging and Disability Resource Centers, all of which fall under Administration for Community Living Initiatives (Freedman & Spillman, 2014).

In an agency in California, the In-Home Supportive Services, approximately 400,000 caregivers serve 425,000 people who need to be served (Howes, 2015). In “Homecare: The Fastest Growing Low-wage Industry,” Howes (2015) highlighted the problem of exploiting a group of people doing the important job of caring for people with high needs. The program is the largest one directed at consumers. Public authorities arranged that these caretakers (unrelated to their clients) be reclassified to employee from independent contractor, which allowed unionization under the National Labor Relations Act and subsequent collective bargaining, which is a good strategy in the beginning for workers in home care programs funded by Medicaid. The only places where such employees have had raises are in agencies that have been unionized. Howe claimed that an advantage to unionization for workers is that the state is paying them directly so that the people they serve do not have price sensitivity. Thus, when the largest portion of HCBS is directed by consumers, increasing wages in public agencies can significantly impact pay in the private sector (Howe, 2015).

Summary and Conclusions

The literature search resulted in many recent peer-reviewed articles and government sites on the role of Medicaid and other public programs and policies guiding HCBS for older adults with increasing health needs. It also covered SCPD theory, the theoretical framework of the study, which can have an impact on HCBS according to the perspectives of administrators and service providers in their roles in the social construction and policy development aspects of HCBS. I could find few peer-reviewed articles in the scholarly sphere through college databases on wait listing and its consequences on long- and short-term health outcomes for older adults, though there were several legal and government documents directly related to the topic. An online search did come up one peer-reviewed related to wait listing for veterans (Pizer & Prentice, 2011) but not older adults.

The first section in the literature review on Medicaid used information from the U.S. government program site and scholarly studies. Despite the government programs, aging increasing expenses for most people and those who were not originally on the program must go through much paperwork, loss of personal assets, and bureaucratic obstacles to get help. Part of the reason is that skilled nursing facilities can cost around $90,000 a year as opposed to $20,000 a year for HCBS (Cubanski & Buccoti, 2015). Patients often avail themselves of emergency department services for nonessential reasons when they can go to a primary care doctor, which drives costs up further (Tang et al., 2010). Widmer et al. (2014) found that most emergency department use is a result of myocardial and blood pressure issues. Those who originally got Medicaid are surprised to find that when they get to retirement age, the transition can be financially challenging (Cubanski & Boccuti, 2015).

The aging of baby boomers presents an unprecedented demographic and financial problem not encountered before. Overall, baby boomers have lower savings than the next generation after them. (Mann et al., 2016). They will have many financial challenges in the coming years as the labor market contributing to the social safety net shrinks. Further, though they demand more autonomy than their parents and grandparents wanted, they will still succumb to debilitating physical and mental conditions despite the desire of many to prolong their lives with healthful eating and exercise (Kahana & Kahana, 2014). By 2035 more than one third of households will be headed by a person 65 or older and the current population of 48 million will grow to 79 million over the next 20 years (Arieff, 2017).

I found several articles on HCBS not only in the United States but also in other countries. All nations face the aging of the baby boomers with scarcer resources than before. Literature on public policies for HCBS can also be found (e.g., Bruin et al., 2016; González Ortiz et al., 2015; Ghimire et al., 2015), but I could find little on the wait listing issue for HCBS or on the viewpoints of professionals who administrate these programs. Also, regarding methodology, all the studies on older adults accessing medical care and supports were quantitative. There is a need to fill the gap in the literature on the perspectives of senior service provider professionals in HCBS programs in an open-ended qualitative Survey, which the study helped fulfil. In Chapter 3, I present the methodology by which the research for the present study was conducted.

Chapter 3: Research Method

The goal of this qualitative study was to explore and describe the role of senior service program monitors responsible for preparing an area plan and who are confronted with the decision-making processes of implementing federal and state policy in Michigan on access and wait listing of older adults for HCBS. Waiting list numbers are likely to increase rapidly as baby boomers begin to enter the LTC health system (Brandon, 2014). In this study, I used an open-ended survey to explore and describe the perspectives of senior service provider professionals in Michigan's agencies who were responsible for access and wait-listing older adults for HCBS. In the literature review, I reviewed publicly available data to increase understanding. These demographic and statistical documents in the literature review helped inform some of the open-ended survey questions. Chapter 3 contains the research design and rationale, the role of the researcher, the methodology, issues of trustworthiness, and a summary of the chapter.

Research Design and Rationale

The following research question guided the study: What are the perceptions of senior service providers as to their ability to impact the social construction of their targeted population while implementing federal and state policy in Michigan regarding access and wait-listing for HCBS? The central concept of the study involved how senior service providers implement policy for HCBS for those who are on waiting lists. Of the three main types of research (quantitative, qualitative, and mixed methods), a qualitative method made the most sense because the aim of the study was to get the perspectives of senior service providers. Understanding the experiences and perceptions of life of life is more multifaceted than collecting facts and statistics with the goal of having a well-integrated study (Miller, 2016).

In quantitative research, which is largely statistical, researchers develop hypotheses and use instruments already developed or which they must develop themselves (Yin, 2016). The large numerical base from quantitative research can be used to better generalize results (McCusker & Gunaydin, 2015). Even though quantitative research can help to deter bias because it is objective, I wanted to collect data that would present an in-depth exploration of what these administrators consider in implementing policy on a day-to-day basis and their feelings are on what their clients face during the wait to get HCBS. Further, to keep the study straightforward and simple, mixed methods research were too complicated.

A qualitative researcher collects rich experiential data through in-depth interviews of participants as well as through document review, observations, and other forms of data collection (McCusker & Gunaydin, 2015). In qualitative research, there is the case study approach along with several perspectives including narrative inquiry, grounded theory, phenomenology, and ethnography (Edmonds & Kennedy, 2017). Case study can be combined with these other perspectives (Edmonds & Kennedy, 2017), but I chose only to conduct an exploratory study in search of senior service providers' points of view on HCBS access and wait lists.

I did consider these other perspectives but rejected them in favor of an open-ended qualitative survey for the following reasons. Narrative inquiry involves collecting anecdotes from participants on a subject. It can give the research a vocabulary for stories that have sense making and universal meaning (Lenfensky et al., 2016). It can also acknowledge those who are not ordinarily respected (Lenfensky et al., 2016). But the administrators do not fall into that category, and they detailed their perspectives rather than their personal experiences, so I discarded narrative inquiry. Additionally, grounded theory is used when the researcher is looking to develop a new theory rather than using an established one to come up with new theories based on participants shared experiences (Hoare et al., 2013). I did not use grounded theory because I already had an established theoretical framework, SPCD theory.

Another perspective, ethnography, is used for cultural descriptions. A culture generally shares ideas, beliefs, and principles (Edmonds & Kennedy, 2017). Researchers in the behavioral or social sciences as well as education might use cultural participant perspectives. However, it did not fit my study on people who would likely come from a variety of backgrounds, and instead I sought perspectives, so I rejected ethnography. Finally, phenomenology is commonly used in doctoral research for qualitative interviews. Phenomenological researchers seek people's lived experiences on a certain phenomenon. It often involves lengthy interviews solely on a given experience (Lewis, 2015) rather than perspectives on public policy, for example. Therefore, I discarded phenomenology.

A qualitative open-ended survey fit the present research the best because I sought respondent perspectives on implementing public policy regarding wait lists for HCBS. My study was in a real-life context on the phenomenon of implementing public HCBS policy based on the perspectives of senior service program monitors who help older adults who seek help from their agencies. In this study, my role as the researcher was to gather and analyze the data with the purpose of exploring policies on HCBS.

Role of the Researcher

As the researcher, with the help of a community partner, I conducted an open-ended survey to explore the perspectives of senior service program providers. Due to my hearing limitations, I selected an open-ended survey that required detailed written responses via e-mail at the suggestion of my chair. Thus, I was unable to observe body language and voice tones. After conducting research on the efficacy of qualitative open-ended surveys from several sources, I decided that such a strategy would advance my study and not only be a timesaver but also be relatively stress-free in moving the research further.

I am an older adult living with some of the same challenges older adults face who need such services, but I had no personal or professional relationship with the respondents. Before I retired and obtained my postsecondary education, I did not work in a health professional field, so I had no supervisory, power or relationship with those who worked in senior services agencies. There were no conflicts of interest or need to use incentives to get people to participate in my study.

As the researcher, I attempted to make sure that ethical protocols were observed. I made sure that the respondents knew about all the ethical boundaries at the beginning of the study. Because the open-ended surveys were not face to face, there were fewer chances for participants to experience distress. However, it was clear that even through email, they should not have answered any questions with which they might feel uncomfortable and that they could exit the study at any time without repercussions. Any concerns that might have come up were addressed on the informed consent form, especially the emphasis on voluntary participation without financial or other incentives. There was no way a respondent could be identified to ensure that no one was hurt by the study directly or indirectly.

Methodology

Participant Selection Logic

The populations for this study were those who facilitated services for older adults in need of HCBS. The sample consisted of senior service program providers responsible for preparing the area plan who are confronted with the decision-making processes of implementing federal and state policy in Michigan on access and wait listing of older adults for HCBS. The sampling strategy was purposive sampling in which area senior service provider agencies were identified through the help of a community partner at the state level who consented to distribute the survey on my behalf. Letters were sent out requesting participation of people within the area who were involved with helping older adults deal with access and wait lists for HCBS. The criteria for respondents was as follows: (a) employee in senior service provider position involved in outreach or facilitation of HCBS, (b) at least 21 years of age, (c) at least 2 years' experience in social services.

Ten to 20 respondents from a larger population of individuals involved in senior service provision would be enough to achieve saturation, particularly when they are in homogenous categories (Guest et al., 2006; Latham, 2013, 2016). If saturation had not been achieved with these respondents, then more respondents would have been recruited. If I had not recruited enough respondents, I would have increased my search to other areas in the state of Michigan. The snowball method was an option to get potential respondents to recommend other people who may be interested in participation.

When the open-ended surveys were all collected, and data saturation was reached, they were reviewed for clarity, and each were edited for clarity and categorized by hand on a detailed question work table. Because all the surveys were submitted over the Internet, there was no need for member checking to make sure the information given was valid (Denzin, 2012), and the consent form informed the respondents of their option to review what they wrote if they desired.

Instrumentation

I, as the researcher, was the main instrument for data collection. After the respondents were recruited, I set up a timeframe for the respondents to answer the open-ended survey, and 10 participants responded. Along with the survey questions was an informed consent form for respondents to accept or reject participation before they could begin answering the survey questions. There were eight open ended survey questions. I kept some notes of my impressions as the open-ended surveys came in along with a few notes throughout the data collection and analysis processes.

Procedures for Recruitment, Participation, and Data Collection

The data were collected from e-mail surveys of senior service provider professionals in Michigan who advised and worked with older adult. I was the chief collector of the data, which were derived from the open-ended surveys via e-mail after the respondents agreed to participate and continue with the survey. The data were collected once. Because I collected written data, there was no need to record face-to-face surveys.

Data Analysis Plan

Through detailed email surveys, the data collected from the senior service provider respondents were geared to the research questions. As a result, the central question was addressed: How senior service providers tasked with the care of the aging population impact SPCD (the theoretical framework) of implementing federal and state policy in Michigan on access and wait listing for HCBS? These collected survey data from the senior service providers also addressed their decision-making process, a description of their roles in the decision-making process, and finally, the impact, if any, of their roles on access and wait listing for HCBS older adults. Similarly, my informal examination of publicly available documents under the theoretical framework of SPCD, discussed in the literature review would highlight how public agencies, especially those that work with Medicare and Medicaid, are impacting wait lists and access to HCBS for the older population. When the open-ended Surveys were compiled, I used a continual iterative process (Srivastava & Hopwood, 2009) to help seek out the important codes. Srivastava and Hopwood (2009) emphasized that the process of hunting for concepts and themes in qualitative analysis involves handling the data with proficient interpretation skills, both rigorously and systematically. Lacking interpretation proficiency (gut instinct and logical data analysis) can ruin the results of a study.

I started a deductive coding process using Question Worktables, I carefully read each survey and added new codes as they arose. I then tallied the many times a code was mentioned by all participants. Each new code represented the continuous iterative coding process. Once I completed the coding for each of the ten survey responses, I began to think about categories to group the codes under looking for viable themes. Saldaña (2016) emphasized those writers who expected to code for themes are using mistaken terminology. Only after the data were coded, categorized, and undergo reflective analysis did themes emerge. A unit of data if it is relevant to the study must be coded first so that the researcher can decide what the context and meanings are to categorize them into, even before the theme stage (Saldaña, 2016). Initially, I read over the Survey responses (placing them first on a Question Work Table) several times until I understood the complete picture and then started the coding process in tables, which involved organizing the data into words and phrases that showed categorizable patterns (Cochrane, 2016). These readings of the collected data aided categorization to get a bigger picture (John-Matthews, 2016). However, I was not certain that themes would be necessary with such a small number (8) of questions.

Using the Question Work Tables, coding was done manually. The data were next categorized by units of similar meaning so they could possibly be grouped into another category in a new Worktables. I had no need to use a program like NVivo, but I read the book for accuracy and watched several YouTube videos. Based on Saldaña (2016), I used the continuing iterative coding method with the use of the Question Worktable, which included the survey questions as a heading and a brief explanation of the number of participants with similar responds. The responses were placed in one column and the tentative codes were placed in the next column. The codes and frequencies were put into a table for each survey question and counted with one tick per response and the last row included the frequency totals. The code frequencies were transferred to a final table, Code *frequency* Worksheet, (Appendix A) that represented the aggregate frequency that indicated how many times the code was mentioned by all participants per question. The final aggregate *frequency* table was included in the dissertation.

My plan was to foster an alignment among the SCPD theoretical framework and the emerging themes to demonstrate how public policy plays a role in access and wait listing for older adults who desire HCBS. I compared the senior service provider professionals' responses to find commonality among the data from which themes ultimately emerged that did extend knowledge and understanding of their role in the social construction and policy development aspects of HCBS. The desire to age with home and community support for an increasing population of older adults no matter their background or socioeconomic level might be realized with the respondents' implementation of public policies and their recommendations for the future of HCBS.

The eight survey questions that was based on the central research question and the theoretical framework of SCPD were as follows. See bracketed information on how they connect to public policy and the theoretical framework:

1. In what ways has the Medicaid Waiver changed older adults' ability to access HCBS in Michigan? [public policy and SCPD]

2. How do you believe local senior services providers are managing the applications for Medicaid waivers and extensions related to HCBS? [public policy]
3. What are the good things or “best practices” being done with training in your community? [respondent perspectives on HCBS]
4. What do you believe is the level of awareness among the community of older adults about accessing HCBS? [respondent perspectives on HCBS]
5. How would you describe your role in the decision-making processes regarding implementing the federal and state policies relevant to access and wait listing of older adults who are interested in HCBS? [respondent perspectives on HCBS]
6. What role do advocacy groups play in the funding of HCBS and what role do local senior services offices play in that process? Please list the name of the advocacy group in your answer. [public policy and SCPD]
7. What are your thoughts on the increase in for-profit assisted living options and what impact, if any, have they had on not-for-profit programming or older adults who are wait listed for HCBS? [respondent perspectives on HCBS]
8. What recommendations would you make to change public policy related to HCBS? [respondent perspectives on HCBS]

Issues of Trustworthiness

Credibility

For the study to be internally valid, I originally planned to use triangulation to add to the in-depth open-ended Survey, which comprised looking through publicly available documents on access and wait listing for HCBS to help inform the survey questions (See the section in the literature review on publicly available documents), but I did not use them in data analysis, though they did help inform the research questions. Unfortunately, the surveys were neither face to face nor emailed to me by individuals, though fortunately, I had the aid of a community partner who recruited individuals to participate. Therefore, I not only missed the opportunity to observe facial expressions, tone, and body language but also to collect data through anonymous individuals rather than people whose names I knew. Still, the in-depth survey questions to which eventually were added prompts produced good details from the respondents. Even though the surveys were sent in pdf and the data was entered into Word documents, and I was able to analyze the results.

Transferability

Morse (2015) defined external validity as the degree to which a study's results can be transferred to another setting. The detailed findings I expected to have in my study could transfer to other researchers who are studying the increasing number of older adults who desire HCBS. The methodology and findings should be detailed precisely enough to replicate the study in other formats, such as a quantitative survey for senior service provider professionals who work with older adults seeking to age in place, for instance. Presently, there is a gap in the literature on this subject, and more work needs to be done.

Dependability and Confirmability

I employed triangulation to ensure dependability and confirmability, which, again, involved journaling and publicly available documents in the literature review stage to provide me a better concept of the public policies on HCBS in Michigan and to help inform the survey questions. I also kept some notes of personal observations of my feelings in process of reading the surveys, which helped to decrease bias (Lincoln & Guba, 1991). When a study is dependable, it can be replicated with similar results to the original one (Saldaña et al., 2016) and confirmability means the results can be corroborated by others (Trochim, 2006).

Ethical Procedures

All the senior service providers who agree to participate agreed had to agree with the terms of the informed consent before they could begin the survey. Once they agreed with the informed consent, the respondents were directed to the first survey question. The consent form clearly communicated to the respondents that their information would not be shared with anyone with whom they work. I had all the open-ended Surveys sent to my official Walden University email address rather than my personal one. I ensured the data integrity by keeping them in a locked file cabinet in a private room in my home. The papers and any computer analysis will be destroyed after a period of 5 years. Only I had access to the data throughout the dissertation process.

Respondents were identified solely as P1, P2, and so on in the results of the study. Their responses would only be used for the study and they could decide at any time not to answer certain questions and they could have exited the study at any time. In fact, out of the 14 people who consented, only ten answered questions. Although all entered the survey after consent, four chose not to answer any questions. Anything connected to the study including open-ended surveys, informed consent forms, my notes, and collected documents will be kept in a locked cabinet and destroyed after a period of 5 years. None of the respondents were my coworkers, so there were no conflicts of interest or relationships of power that would inhibit honesty in the open-ended Survey.

Data from this qualitative study were derived from open-ended Survey of the role of senior service providers responsible for preparing the area plan, who are confronted with the decision-making processes of implementing federal and state policy in Michigan on access and wait listing of older adults who want to age in their own homes and communities. The use of a qualitative open-ended survey could answer the research question on how senior service providers impact the social construction and policy development of implementing federal and state policy in the state of Michigan regarding access and wait listing for HCBS and the nature of the decision-making process, their role in the decision-making process, and how they describe their roles in helping older adults who desire access to HCBS.

The analysis units involved all the above. I triangulated the data through journaling, writing on publicly available documents in the literature review stage, and open-ended Survey of the respondents. My research instrument was an 8-question survey guide that directly connected with the research question.

I tried to find study respondents by contacting Area Agencies for the Aging, introducing myself and providing study details via email invitations but got no responses. However, I believe that the Covid-19, played a major role in the lack of response. My Chair connected me to the new deputy state director, a Walden graduate, who consented to distribute the surveys to AAA professionals throughout the state of Michigan. I explained that all surveys would be open-ended survey questions that would be sent back via email, so there were no face-to-face recorded interviews. I assured the respondents that their answers would be anonymous after I received the surveys, and they would only be identified as P1, P2, et cetera. Still, I got no responses. Eventually, my chair found a Community Partner who agreed to send out consent forms/Survey, which led to a data collecting. I received ten valid responses. All completed printed-out surveys and documents related to data analysis will be kept in a locked file cabinet for a period of 5 years, after which it will be destroyed.

Summary

Chapter 3 indicated the method I used to conduct the study. In the beginning, I explained why I chose a qualitative method over a quantitative one and then why I thought an open-ended qualitative survey was the best way to get senior service providers to give their perspectives on how they were involved with decision making and implementation of federal and state policies on access and wait listing for HCBS. I listed the procedures with which I recruited respondents, got their consent to be involved in the study, collected, and analyzed the data. I outlined the trustworthiness of the study as far as its credibility, transferability, dependability, and confirmability and how I protected the respondents ethically. After the study was approved and carried out, I provided the results in Chapter 4 and interpreted and offered implications, recommendations, and conclusions in the final chapter.

Chapter 4: Results

The purpose of this qualitative study was to explore and describe the role of senior service program providers responsible confronted with the decision-making processes of implementing federal and state policy in Michigan on access and wait listing of older adults for HCBS. The central question this study addressed was "What are the perceptions of senior service providers as to their ability to impact the social construction of their targeted population while implementing federal and state policy in Michigan regarding access and wait listing for HCBS?" This chapter is organized as follows. First, I describe the setting of the research and the demographics. Then I outline the steps taken in the data collection. Next, I describe in detail how the data were analyzed, coded, and placed in categories under the developed themes. In the next section, I describe how the evidence of trustworthiness of the study was achieved including credibility, transferability, dependability, and confirmability. The Results section is organized by themes developed from the responses to the survey questions.

Setting

A community partner in a mid-region of Michigan agreed to distribute the survey that resulted in sufficient data for analysis. Throughout the process, I maintained contact with IRB at Walden University and operated under their approval (Approval No. 05-13-19-0250346).

Demographics

All survey participants worked in senior services programs in various capacities involving HCBS and related to access and wait listing. Because they responded to the invitation I sent to the community partner, and they agreed to the informed consent at the beginning of the survey, it appeared that they were employees in a senior service provider position involved in outreach or facilitation of HCBS and that they met the screening protocol. None of the respondents were known to me directly or indirectly. No demographic information was collected as a part of this study; therefore, only the screening protocol listed in the recruitment letter provided a glimpse of the demographics of the respondents who completed the surveys. The criteria used to invite participants was as follows: (a) senior services providers in administrative or another professional position involved in outreach or facilitation of HCBS, (b) at least 21 years of age, (c) at least 2 years' experience in social services.

Data Collection

Surveys were collected from 10 participants. Though 14 people agreed to the informed consent, four did not answer any of the survey questions. Participants survey responses were sent from their work site e-mails and then sent to my Walden University e-mail, so they were anonymous. The window for collecting surveys was approximately10 days. Each survey was assigned a reference number of P1, P2, etc., and their responses were recorded verbatim on the question worktable for each participant under each survey question for manual coding and analysis. There was no deviation from what was written in Chapter 3.

Data Analysis

The data collection from the participants were based on eight interview questions aligned with the research question and SCPD theoretical framework. The central research question was based on how senior service providers tasked with the care of the aging population impact the social construction of policy development of implementing federal and state policy in Michigan on access and wait-listing for HCBS. These collected survey data from the participants also addressed their decision-making process, a description of their roles in the decision-making process, and finally, the impact, if any, of their roles on access and wait-listing for HCBS older adults. When the responses were compiled, I used a continuous iterative process to search for concepts and themes systematically (Srivastava & Hopwood, 2009).

I used Saldaña's (2016) deductive coding process to analyze the data. Saldaña emphasized that only after the data were coded, categorized, and undergo reflective analysis do themes emerge. Data units must be coded first so that the researcher can decide on the context and meaning to categorize them before the theme stage (Saldaña, 2016). First, I read over the transcripts several times, after which I placed them in question worktables to understand the full context. Based on Saldaña, I developed a coding table comprised of three columns containing the identifier for the responding participant, their response in the next column, and the tentative preliminary coding in the third column. On the second and third read through of respondent responses, I recorded the developing codes and themes that showed categorizable patterns (see Cochrane, 2016). The readings themselves of collected data can enhance categorization (John-Matthews, 2016).

I compared the responses from participants to find connections among the data from which final themes ultimately emerged that might extend knowledge and understanding of their role in the social construction and policy development aspects of HCBS. Based on the data tables, I developed a second chart with final themes and the evidence to support them. The themes that arose were as follows:

1. The Medicaid waiver has changed HCBS,
2. Local senior service providers are managing waiver applications,
3. Best practices are carried out locally,
4. There is limited level of awareness of HCBS among older adults,
5. Advocacy groups play a role in HCBS,
6. For-profit LTC facilities intersect with HCBS, and
7. HCBS can be improved and enhanced.

Discrepancies in the data included P9's and P11's response to Question 8 regarding their thoughts on the increase in for-profit options and the impact on not-for-profit programming for older adults who are wait-listed for HCBS. P9 responded that a consensus in the for-profit homes believe that if they accept the waiver, it will be more work, more inspections, and possibly clientele that are not great tenants. P11 responded that if they are reputable, sometimes self-pay is the only option care in the short-term or long-term. The qualities of these two responses were considered odd and were factored into the analysis under Theme 2 (Barriers).

Evidence of Trustworthiness

Credibility

For the study to be internally valid, I originally planned to use triangulation to add to the in-depth, open-ended survey questions, which comprised looking through public available documents on access and wait-listing for HCBS to help inform the survey questions. I wrote a section in the literature review on publicly available documents but had to make an adjustment for their use in the data analysis. However, the documents did help inform the research questions.

Additionally, the surveys were not face to face, and I had the aid of a community partner who recruited individuals to participate. Therefore, though I missed the opportunity to observe facial expressions, tone, and body language, it helped to decrease bias and added a layer of objectivity. Further, the survey questions to which eventually were added prompts produced good details from the respondents.

Transferability

Transferability, or the external validity, means the likelihood the results of a study can be transferred to another setting (Morse, 2015). The findings can be used by other researchers who are engaged in studies involving older adults who want to access HCBS. The methodology and findings are detailed sufficiently to replicate the study with other methods such as a similar though quantitative survey for senior providers who work with older adults seeking to age in place. Regarding scholarly studies, there remains a gap in the literature on HCBS, and more research needs to be carried out.

Dependability and Confirmability

A dependable study can be replicated with similar results to the original one (Saldaña et al., 2016), and confirmability means the results can be corroborated by other researchers (Trochim, 2006). I employed triangulation to ensure dependability and confirmability by reviewing publicly available documents when compiling the literature review to provide a better concept of the public policies on HCBS in Michigan and inform the survey questions. Additionally, the steps I took in my study to ensure dependability and confirmability were presented clearly, including a detailed data table with complete survey question answers from all 10 respondent; primary, secondary, and rough categories and themes; and another table that outlines the frequencies of coded phrases elaborating on how the seven themes emerged. Thus, the study can be replicated with similar results, which can be corroborated by other researchers.

Results

The central question this study was the following: What are the perceptions of senior service providers as to their ability to impact the social construction of their targeted population while implementing federal and state policy in Michigan regarding access and wait listing for HCBS? All eight survey questions aligned with the research question as did the seven themes that arose. Following are the eight questions that went into the surveys including how each response was coded and they were based on the central research question and the theoretical framework of SCPD.

Survey Question 1: In what ways has the Medicaid Waiver changed older adults' ability to access HCBS in Michigan? This question related to public policy implementation, access, and the theory of the SCPD. Table 1 displays the frequency counts for the themes from the senior service providers' open-ended responses to the question.

Table 1

Code Frequency (f) for Responses to Question 1 (N = 8)

Code	*f*	%
Access to community care	5	62.5
Services available & expanded	5	62.5
Stay in home	3	37.5
Affordable & inome limitations overcome	2	25.0
Service barriers & inconsistency	2	25.0
Caregiver respite	1	12.5
Advocate	1	12.5

The most frequently mentioned themes were access community care (62.5%), services available and expanded (62.5%), and the ability to stay in the home (37.5%). An example of a response for the themes of access community care and services available and expanded was “The MI Choice Waiver provider older adults with assistant identifying and setting up needed services and then ongoing coordination of care which can be overwhelming to manage by either the older adult or the family members.” An example of a response for the themes of access community care, stay in home, and caregiver respite was “It has allowed older adults to received care in the community and the ability to stay in their home longer. It gives caregivers a break and relieves them of providing at the care that a frail elder might need.”

Survey Question 2: How do you believe local senior services providers are managing the applications for Medicaid waivers and extensions related to HCBS? This question is related to public policy implementation. Table 2 displays the frequency counts for the themes from the senior service providers’ responses to the question.

Table 2

Code Frequency (f) for Responses to Question 2 (N = 8)

Code	*f*	%
Larger scale (more seniors, system stress & waitlists)	3	37.5
Collaboration among providers	2	25.0
MMAP volunteers	2	25.0
Another organization	2	25.0
Service barrier	1	12.5
Resource availability	1	12.5
Trusted source of information	1	12.5

The most frequently mentioned themes were larger scale (more seniors, system stress, and waitlists) (37.5%), collaboration among providers (25.0%), MMAP volunteers (25.0%), and another organization (25.0%). An example of a response for the themes of collaboration among providers, larger scale (more seniors, system stress, and waitlists), and service barrier was

> I think that most of the providers are working together, but I believe there is a gap in how we can help the aging population. There are many services that these programs can provide, and more aging adults need those services. Many of these programs have wait lists, and if we work together and not against each other, we could potentially get help for every one of these older adults.

An example of a response for the themes of MMAP volunteers and another organization was, “They usually send the application to the AAA, contact MMAP volunteers, or if they have trained staff, fill it out themselves.”

Survey Question 3: What are the good things or “best practices” being done with training in your community? This question was geared to elicit respondent perspectives on HCBS. Table 3 displays the frequency counts for the codes from the senior service providers' responses to the survey question.

Table 3

Code Frequency (f) for Responses to Question 3 (N = 7)

Code	*f*	%
Collaboration with other providers & organization	4	57.1
Community-based resources	3	42.9
Evidence-based	2	28,6
Self-management	2	28.6
Evidence-based	2	28,6
Self-management	2	28.6
Caregiver & patient education	2	28,6
Person-center care	2	28.6
Consistent training	2	28.6
Low-cost & financial relief	2	28,6
Improve the communication with community	1	14.3
Aging in place & stay at home	1	14.3

The most frequently mentioned codes were collaboration with other providers & organizations (57.1%) and community-based resources (42.9%). An example of a response for the themes of evidence-based, self-management, caregiver and patient education, and person-centered care was "Evidence-based best practices chronic disease self-management and caregiver education programs are in place, person-centered care is a standard in funded services." An example of a response for the themes of self-management, aging in place and stay at home, community-based resources, and collaboration with other providers and organizations was, "There is some work on aging in place; Pace organizations are expanding." An example of a response for the theme of evidence-based, consistent training, collaboration with other providers and organizations, and low cost and financial relief was, "There are some efforts to providing consistent training to multiple providers in the community (i.e. Covid-19 management, infection control practices, financial relief, etc.)."

Survey Question 4: What do you believe is the level of awareness among the community of older adults about accessing HCBS? Table 4 displays the frequency counts for the codes from the senior service providers' open-ended responses to Survey Question 4. This question related primarily to accessibility of services.

Table 4

Code Frequency (f) for Responses to Question 4 (N = 10)

Code	*f*	%
Limited awareness	7	70.0
Higher & improving awareness	3	30.0
Organizations that should have more awareness	2	20.0
Mixed awareness	2	20.0
Delay care until urgent	2	20.0
Unsure if qualified	2	20.0
Collaboration	1	10.0
Stereotypes of senior care	1	10.0
Benefit from in-field employment	1	10.0
Information confusing	1	10.0
Intake process too long	1	10.0
Lack transportation	1	10.0
Stability of MI Choice	1	10.0

The most frequently mentioned themes were limited awareness (70.0%), higher and improving awareness (30.0%), organizations that should have more awareness (20.0%), mixed awareness (20.0%), delay care until urgent (20.0%), and unsure if qualified (20.0%). An example of a response for the code related to higher and improving awareness, limited awareness, organizations that should have more awareness, and mixed awareness was "I think the level of awareness varies among the different programs. It always seems that the level of awareness of PACE programs and services is lower than expected. I believe the community awareness around the waiver program is higher." A response for the code of limited awareness, lack transportation, and unsure if qualified was "I think that many older adults know that there are some options but they either don't know where to look, thin they won't qualify so don't look or have limited access to travel to access." An example of a response for the themes of limited awareness, stereotypes of senior care, and delay care until urgent was "Average level of awareness. Many older adults don't want to know unless it affects them right now. Children of older adults immediately think nursing home."

Survey Question 5: How would you describe your role in the decision-making processes regarding implementing the federal and state policies relevant to access and wait listing of older adults who are interested in HCBS? Table 5 displays the frequency counts for the themes from the senior service providers' open-ended responses to Survey Question 5, which again focused the inquiry on the respondents' perspectives of HCBS implementation.

Table 5

Code Frequency (f) for Responses to Question 5 (N = 8)

Code	*f*	%
Not involved	2	25.0
Socioeconomic need priority	2	25.0
Advocacy	2	25.0
Work directly with state or policymakers	2	25.0
No waitlist	1	12.5
Services with limited gaps	1	12.5
Limited collaboration	1	12.5

Policy for funding	1	12.5
Referrals to waivers	1	12.5
Personally recommend	1	12.5
Policy hampered by politics	1	12.5
Person-cantered planning	1	12.5

The most frequently mentioned codes were socioeconomic need priority (25.0%), advocacy (25.0%), and work directly with state or policymakers (25.0%). In addition, two respondents said they were not involved in the decision-making processes (25.0%). An example of a response for the code of no waitlist and socioeconomic need priority was “My organization do not have a waiting list. However, we have agency policies that identify “greatest social and economic need” as a guide for prioritizing who is served.” An example of a response for the code of services with limited gaps and limited collaboration was “I have very small role in that I work for a PACE organization as a manager and have worked successfully with Senior Services in bridging the gap for services and making sure every older adult is getting the services they need. Other programs are not so open to working together and helping every old adult whatever the program is.” An example of a response for the themes of advocacy, work directly with state or policymakers, and person-centered planning was “Constantly work to share best practices with the state; strong advocate in person-centered planning to all needs; work steadily to streamline access for consumers.”

Survey Question 6: What role do advocacy groups play in the funding of HCBS and what role do local senior services offices play in that process? Please list the name of the advocacy group in your answer. This question focused on the respondents’ attention on issues of policy and the theory of SCPD. Table 6 displays the frequency counts for the themes from the senior service providers' open-ended responses to Question 6.

Table 6

Code Frequency (f) for Responses to Question 6 (N = 9)

Code	*f*	%
Other organizations	6	66.7
AAA	5	55.6
State or government organizations	3	33.3
Care Well	2	22.2
Connected to policymakers	2	22.2
Silver Key Coalition	1	11.1
PACE	1	11.1
Awareness	1	11.1
More training needed	1	11.1

The most frequently mentioned themes were other organizations (66.7%), AAA (55.6%), state or government organizations (33.3%), CareWell (22.2%), and connected to policymakers (22.2%). An example of a response for the themes AAA, awareness, connected to policymakers, and other organizations was "Advocacy groups assist greatly in awareness of the value of HCBS options and sharing with policymakers how policy and law impact consumers: AAAs & CILS play important roles." An example of a response for the themes of state or government organizations, AAA, and connected to policymakers was "Advocacy groups advocate and represent the needs of their constituent groups to elect officials. Locally, state aging departments, local or city senior services, legal aid, AAAs, etc." An example of a response for the themes of CareWell, more training needed, and other organizations was County Professionals in Aging

CareWell Senior Services. I think all of these are great advocates, but I believe that more training for those of us on the street would be a great option."

Survey Question 7: What are your thoughts on the increase in for-profit assisted living options and what impact, if any, have they had on not-for-profit programming or older adults who are wait listed for HCBS? Table 7 displays the frequency counts for the themes from the senior service providers' open-ended responses to Question 7, which reflected perspectives on HCBS and economic factors.

Table 7

Code Frequency (f) for Responses to Question 7 (N = 9)

Code	*f*	%
Limited or no impact	3	33.3
Room for both to coexist	2	22.2
Need more options for lower income	2	22.2
Costs out of reach	1	11.1
For-profit diverts resources	1	11.1
For-profit prefer clients not on waivers	1	11.1
Self-pay only option available	1	11.1
Conflicts with mission and spirit of Medicaid	1	11.1
Non-profit invests in more services	1	11.1

The most frequently mentioned themes were limited or no impact (33.3%), room for both to coexist (22.2%), and need more options for lower income (22.2%). An example of a response for the themes of room for both to coexist and limited or no impact was "I think there is a room for both and that neither have an impact on each other. Many individuals have money to be able to pay for an ALF while others need to use the HCBS under a non-profit." An example of a response for the themes of need more options for lower income and self-pay only option available was "If they are reputable, sometimes self-pay is the only option to obtain care in the short-term or long-term." An example of a response for the themes of limited or no impact and conflicts with mission and spirit of Medicaid was "Personally, I think for-profit residential service providers feel like a conflict in the spirit of the mission and the use of Medicaid funding. I'm personally not aware of the impact for-profit assisted living options have had on the non-profit HCBS options."

Survey Question 8: What recommendations would you make to change public policy related to HCBS? Table 8 displays the frequency counts for the related to the policy process.

Table 8

Code Frequency (f) for Responses to Question 8 (N = 10)

Code	*f*	%
Simplified or streamline the process	4	40.0
Expand program to higher incomes	3	30.0
Waiver follow PACE model	1	10.0
More resources for prevention wellness	1	10.0
Involve waiver agents in policy & funding	1	10.0
Math nursing home funding	1	10.0
Eligibility by independent third party	1	10.0
Easier for married couples	1	10.0
Consistent enrollment policies	1	10.0
Options counseling	1	10.0
Defund nursing homes	1	10.0

The most frequently mentioned codes were simplified and streamline the process (40.0%) and expand to higher incomes (30.0%). An example of a response for the themes of waiver follow PACE model and more resources for prevention wellness was "The waiver needs to move into the same capitated, managed-care model as PACE (Program for All Inclusive Care of the Elderly) which is more cost effective and delivers better care. More funding should be directed to prevention focused wellness programs." An example of a response for the themes of involve waiver agents in policy and funding and match nursing home funding was "Involve the Waiver Agents in developing policy and funding. Give HCBS the same annual funding guarantee that the Nursing Homes have." An example of a response for the themes of simplify and streamline process, consistent enrollment policies and options counseling was "Make enrollment policies the same for all HCBS providers types to decrease the wait list and increase access to services. Fast track an objective and transparent options counseling process to increase access to needed services that are available."

Themes

The next section of this chapter is organized by themes garnered from the coded data. There were seven themes that emerged from the data.

Theme 1: The Medicaid Waiver has Changed Home- and Community-Based Services

According to the respondents, the Medicaid Waiver has indeed made HCBS more accessible for older adults for the care they deserve and need. This theme was supported by data related to Community (*f* = 9), Service Availability (*f* = 10), Financial Considerations (*f* = 5), Age in Place and Stay at Home (*f* = 8), Training, Advocacy and Awareness (*f* = 20), and Collaboration (*f* = 38).

Participants noted that "It assisted these individuals to identify and set up "needed services and then ongoing coordination of care, which can be overwhelming to managed by either the older adult or the family members," "… older adults were staying home and receiving services that helped eliminate SNF service." Another respondent described an "advocate (care manager) who can help assess [older adults'] needs and wants and connect them to needed services," while another stated "… the Waiver allows people to stay in their homes longer and gives caregivers a break and relieves them of providing all the care that a frail elderly might need."

Importantly, P9 saw the Waiver giving "those in dire situations the ability to access care when needed and private pay was not an option." P11 indicated that MI waiver "made it more accessible and affordable." Finally, P14 touted the Waiver as a "greatly expanded choice of HCBS services in the home – it's the primary vehicle for HCBS in the state.

Theme 2: Local Senior Service Providers are Managing Waiver Applications

Six out of ten respondents felt all the local senior agencies collaborated well in their mission to connect older adults with HCBS services while some though the agencies needed improvement in coordinating services. This theme is supported by the data related to Recommendations (*f* = 15), Community-based resources (*f* = 3), and Collaboration among providers (*f* = 6).

Comments from the surveys included that participants saw a "strong collaboration among all senior service providers". However, others saw a gap in how the older population can be serviced even though P2 said "most of the providers are working together." P2 also mentioned wait lists for some programs, so if they work "together and not against each other" they could "potentially get help for each older adult."

The Medicare/Medicaid Assistance Program trainings for volunteers and staff "who are trained to assist in the application process." P9 thought they were doing the best they could but "it could be done on a much larger scale." P11 believed the senior service providers are doing a good job but "as need increases, it does place stress on the system." P14 thought the senior service providers were "very helpful to the consumer; a trusted source of information." So, all in all, the senior service providers conveyed that the agencies are managing waiver applications well, though the system could always be improved.

Theme 3: Best Practices are Carried Out Locally

When asked about their best practices, the respondents gave specific information on many practices that worked in their community. This theme is supported by the data related to Age in Place and Stay at Home ($f = 8$), and Collaboration ($f = 38$) access community care ($f = 5$).

"Evidence-based" practices, specifically including chronic disease self-management and caregiver education programs that are "in place' were deemed to be important. P2 added that "person-centered care is a standard in funded services." It was noted that some work was being done on "Aging in Place" and that PACE organizations are expanding. The "Area Agency on Aging (AAA) provides training to our Service Partners every month, free of charge and often with continuing education units (CEU)." One community decided together "as a group of those who serve elders to use a common dementia training" with the goal (as is often done) of being able to "move from one employer to another with consistent training and community benefits." P12 added, "there are some efforts to providing consistent training to multiple providers in the community (i.e., COVID management, infection control practices, financial relief, etc.)," which were recently updated to conditions that did not exist four months ago.

Theme 4: Limited Level of Awareness of Home- and Community-Based Services Among Older Adults

On the level of awareness of HCBS among older adults, most respondents gave detailed answers though often contradictory. This theme is supported by the data related to Barriers (*f* = 22), Education for Caregiver and Others (*f* = 6), Training, Advocacy, and Awareness (*f* = 20), and Recommendations (*f* = 15), Limited level of awareness of HCBS among older adults (*f* = 7).

Examples from the data present a varying pattern in relation to the level of awareness in that P2 thought older adults in the community had "higher awareness than many other communities that services are available," but added that seniors would not necessarily know of "all the services." In contrast, P3 said the level of awareness was "not good," adding that if they did not work in the health field, their family "would have no idea of the benefits one could find" adding that the "community needs to be educated."

P5 thought the awareness of HCBS is "limited at best; even geriatric health facilities, senior service community-based organizations are not of local resources, state, and federal policies, or eligibility and enrollment rules." P6 though the level of awareness was "average." However, P6 also said that "many older adults did not want to know unless it affects them right now," adding that the children of older adults "immediately think ‘nursing home.’” P7 complained that the information is very confusing and the intake process is too long.” P8 conceded that the awareness is “probably not great” and that it seems as though families “don’t get to [them] until it’s an emergency” and that they “could provide benefits for so much longer” if people were aware before they were in dire straits. P9 summed up the situation succinctly: “Many older adults know there are some options, but they either don’t know where to look, think they won’t qualify so don’t look, or have limited access to travel to look.” P12 saw the awareness level as “mixed.” The most vulnerable “have several good avenues with community resources. Others, especially those with some financial means, but don’t qualify for certain service are less aware of options.” P12 believed the “community awareness around the Waiver program is higher” compared to PACE programs, for example. Finally, P14 thought awareness had “steadily increased due to the stability of the MI Choice system,” adding that “community word of mouth is enhanced greatly with stability.

Theme 5: Advocacy Groups Play a Role in Home- and Community-Based Services

In the survey question regarding the role of advocacy group in promoting HCBS, the answers given by the respondents mostly outlined certain groups, statewide and local. This theme is supported by the data related to Community (*f* = 9), Service Availability (*f* = 10), Training, Advocacy, and Awareness (*f* = 20), Collaboration (*f* = 38), and Recommendations (*f* = 15).

A few examples of advocacy groups noted by the respondents were the MI Association of Area Agencies on Aging, Leading Age, AARP, Association of Senior Centers, Senior Service Waiver, the county Advocates for Senior Issues, and PACE. P5 explained advocacy groups as, "Advocacy groups advocate and represent the needs of their constituent groups to elected officials. Locally, state aging departments, local or city senior services, legal aid, AAAs, etc." After naming a few local groups, P9 noted, "I believe that more training for those of us on the street would be a great option." P14 stated, "Advocacy groups assist greatly in awareness of the value of HCBS options and sharing with policymakers how policy and law impact consumers" and that "AAAs and CILs play important roles."

Theme 6: For-Profit Long-Term Care Facilities Intersect with Home- and Community-Based Services

When asked if an increase in for-profit LTC facilities such as assisted living facilities or nursing homes had any impact on HCBS, the answers varied from having some impact to simply existing side by side. Many of the answers addressed the dilemma of not having enough money for the former or too much to qualify for the latter. P2 noted that the prices charged by the for-profit assisted living are "beyond the reach of persons who are eligible for state/federally funded HCBS.," but P3 did not think there was any impact of one on another and that there is room for both. P5 strongly noted that for-profits do take advantage of government services not covered in their rent such as meals and transportation, which "takes away resources from lower income individuals." P7 claimed many options should be available and there are those who can afford private pay; however, "more options for people making under $60,000 should be available."

P9 hinted at a likelihood of waiver acceptance possible would be some discrimination against lower income residents should they be accepted in assisted living:

"I think the general consensus in for-profit homes is that if they accept the waiver, it will be more work, more inspections, and possibly clientele that are not great tenants." However, exact clarification of the statement "not great tenants" was not available, but only low-income clients qualify for waivers. P11 would agree to increase in for-profit assisted living options "if they were reputable, sometimes self-pay is the only option to obtain care in the short-term or long-term." P12 saw the issue as moral one: "I think, personally, for-profit residential service providers feels like a conflict in the spirit of the mission and the use of Medicaid funding," but P12 conceded, "I'm personally not aware of the impact for-profit assisted living options have had on the non-profit HCBS options."

Theme 7: Home- and Community-Based Services can be Improved and Enhanced

This theme is supported by the data related to Service Availability (*f* = 10), Barriers (*f* = 22), Financial Considerations (*f* = 5), Collaboration (*f* = 38), Policy Issues (*f* = 9), and Recommendations (*f* = 15). In addition, consideration of for-profit LTC facilities intersected with HCBS was services available and expanded (*f* = 6).

The respondents made suggestions on how access to HCBS could be improved and or enhanced. P2 felt that "more funding should be directed to prevention focused wellness programs. P3 stated that HCBS "should be available to every individual, not just those who are low-income eligible." P3 added, "There are so many older adults who are in that gap of not enough money to pay privately but not poor enough to get help."

Regarding financial considerations, P5 suggested "an increase in the asset limit so more needy people can take advantage of HCBS services—despite the cost it's more cost effective than LTC." P6 would have like the Waiver Agents to be involved in "developing policy and funding. Give HCBS the same annual funding guarantee that the nursing homes have!" P7 felt HCBS was "very confusing to people who need services. Simplify the program!" P8 claimed, "I would implement a streamlined intake process with eligibility determined by an independent third party" and P9 insisted that the process should be "changed for married couples." P11 stated that "funding should be available to individuals with modest means that currently don't qualify."

Policy considerations were made. P12 suggested the state "make enrollment policies the same for all HCBS provider types to decrease the wait list and increase access to services." Further, P12 said, "Fast track an objective and transparent options counseling process to increase access to needed services that are available." P14 wanted to "change the "default" in MI to HCBS rather than nursing homes; let money follow the person!"

The desire to age with home and community support for an increasing population of older adults no matter their background or socioeconomic level might be realized with the respondents' implementation of public policies and their recommendations for the future of HCBS.

Based on the central research question involving the perceptions of senior services providers on their ability to impact the social construction of their targeted population while implementing federal and state policy in Michigan regarding access and wait listing for HCBS, 10 respondents answered eight survey questions on this topic, many of which were connected to access issues. Themes from all the responses which were interpreted in chapter five. Chapter 5 also includes implications, limitations, recommendations, and conclusions.

Chapter 5: Discussion, Conclusion, and Recommendations

The purpose of this qualitative study was to explore and describe the role of senior service professionals confronted with the decision-making processes of implementing federal and state policy in Michigan on access to HCBS. I used open-ended questions delivered via an online survey to allow senior service providers in Michigan who are responsible for access and wait-listing older adults for HCBS to provide their perspectives regarding service provision under the existing policy. The key findings in this study involved seven themes related to access to HCBS:

1. The Medicaid waiver has changed HCBS.
2. Local senior service providers are managing waiver applications.
3. Best practices are carried out locally.
4. Limited level of awareness of HCBS among older adults.
5. Advocacy groups play a role in HCBS.
6. For-profit LTC facilities intersect with HCBS.
7. HCBS can be improved and enhanced.

Chapter 5 includes the interpretation of these themes, the limitations of the study, recommendations for practice and future research, implications for the individual, family, organization, and societal/public policy, and the conclusions drawn from this study.

Interpretation of Findings

After reviewing the literature on aging and the public policies surrounding HCBS as well as the publicly available documents on the policy in Michigan and how senior service professionals carry out public policy, my study findings extend knowledge in the field of caring for older adults in Michigan. Much can be found on the Medicaid Waiver both on government sites such as those involving Medicaid and Medicare, there is a gap in the literature on peer-reviewed articles on access and wait-listing for HCBS. Public documents indicated that there was a waiting list based on 2018 for both aged and disabled individuals of 3,021 in Michigan. This number was low compared to states like Louisiana at 36,743 and Texas at 35,224 (Kaiser Family Foundation, 2020); still, the responses of the respondents in my study indicated that HCBS was either barely known or can be misunderstood in the community. Two respondents also indicated that people who would have access to the program simply assume they make too much money to qualify when the opposite is true.

Additionally, the findings conform to the theoretical foundation of SCPD theory (Schneider & Sidney 2009). People assume or rationalize what supports policies, the social construction of targeted groups in how these groups view language and messages if their needs should be of reasonable concern to policymakers (Schneider & Sidney, 2009). In the subsections that follow, I present interpretations of the seven themes that arose during the data analysis stage of the study.

Theme 1: The Medicaid Waiver Has Changed Home- and Community-Based Services

Eighteen remarks from the 10 respondents acknowledged positive changes to HCBS since the advent of the MI Choice Waiver. The waiver helps senior service professionals identify and set up needed services and then ongoing care coordination in the face of what can be overwhelming to many families of older adults or the older adults themselves. The important element is choice, and now older adults no longer must go in nursing facilities or assisted living facilities. P3 stated that although people can generally choose to stay in their homes, access is not uniform across states, much fewer counties in Michigan.

Another change is the help of an advocate or a care manager who can assist older adults and their families in assessing what they genuinely want and need and then connect them to the appropriate services. Not only does this service allow older adults to stay in their homes longer, but it also gives caregivers a break to relieve them "of providing all the care that a frail elder might need" (P5). P9 saw the waiver program in two ways: "It has provided some access to needed supports and services. It has also created barriers to needed supports and services." P10 simply saw the MI Choice Waiver as the primary vehicle for HCBS in Michigan.

In relation to the findings of the study, Miller (2011) found that with HCBS, nursing home admission decreased for older adults over 65 in two-thirds of states and Washington, DC. Miller concluded that efforts in public policy to expand HCBS and reduce nursing home capacity are appropriate. In the face of aging baby boomers, health care for older adults is in crisis in the United States, indicating that the status quo must change (Naylor et al., 2015). One strategy that has been suggested to better long-term service and support is to expand noninstitutionalized care (Naylor, 2015), which HCBS is doing (O'Keefe et al., 2010).

Theme 2: Local Senior Service Providers are Managing Waiver Applications

After the MI Choice Waiver was made law, it was mostly up to local providers to organize service delivery. The first respondent indicated that there was strong collaboration "among all senior service providers" and praised the Medicare/Medicaid Assistance Program for training volunteers and staff throughout the county to assist families in the application process. However, most respondents saw gaps between what was being done and what could be done. P2 even implied there was a need to work together rather than against each other, so not everyone saw local provision of HCBS as a smooth process. P3 indicated that level of service depended upon state, county, and resource availability. Local providers send applications to AAAs and contact volunteers or fill out the applications if they have the trained staff.

P5 also noted that one program (PACE) took in people much more quickly than the CareWell Services Waiver Program. P7 referred to the need for a "much larger scale," and P8 acknowledged the "stress on the system" as demands increase. Finally, P10 saw local providers as a "trusted source of information." Getting help for older adults is done mostly on a local level, yet in areas with wait lists, many remain on the lists for years or die before they can get help (Sexton, 2016). Though different in Michigan for the most part, people in other areas who are waitlisted rather than served with HSBC in a timely way are seeing a dangerous precedent that threatens present Medicaid coverage (Shirk, 2016). Thus, Theme 2 confirms that most issues with HCBS are seen at the local level.

Theme 3: Best Practices are Carried Out Locally

The respondents named best practices carried out locally. One is Person-Centered Care, which is a standard in funded services. However, another respondent thought the community was poorly informed about the services offered and wondered how to fix it. P3 noted PACE organizations are expanding and P4 touted the monthly service partner training, adding the training was free or at least low cost. A common dementia training across local organizations was executed as a decision of the community partnerships as a group. The rationale was that as people are wont to go from one agency to another, the training is consistent. Local senior service partners do communicate with physicians and practice care managers regarding IHP's care management, financial relief, and infection control practices (P9). Thus, there is a variety of best practices that senior service providers carry out. Ingram et al. (2007) discussed the unequal distribution of advantages for citizens where the majority gets little to nothing while a few people get most of the resources. Though more must be done, when senior service professionals carry out best practices in their communities, as the respondents described, it would appear the balance gets realigned and most people can age in place.

Theme 4: Limited Level of Awareness of Home- and Community-Based Services Among Older Adults

Despite the local senior providers' best efforts, many respondents criticized the limited level of awareness of community services for older adults. It appeared that various people's assumptions prevented them from accessing HCBS. Based on the SCPD theory, what people get is based on societal social construction and public policy managers addressing the social needs of people who do not always have the power to direct their own future or fight back in the midst of inadequate results (Schneider and Sidney, 2009). Because the MI Choice Waiver has a relatively new influence on HCBS, people are maybe being directed by outdated assumptions, which are evidenced by the persistent lack of knowledge of the program as outlined by the respondents. For example, even though P1 thought that the community had a higher awareness than others that the services are available, P1 added that most would not be aware of “all the services available.” Still, again claiming strong collaboration among local agencies, P1 emphasized there was “no wrong door” and referrals “are easily made between agencies.” P2, on the other hand, asserted that the level of awareness was “not good” and felt many had no ideas “what is out there for them or their loved ones.” P2 emphasized the need for better community education. P3 echoed P2’s comments, saying the level of awareness was “limited at best” and some organizations were “not of local resources.”

The next respondent thought that the level was average, adding that people did not want to know unless it affected them personally and that their adult children think of nursing homes as the first resort. P5 suggested that the information was confusing and the intake process too long. P6 also indicated that people do not communicate with agencies until there exists a state of emergency, complaining that had they not waited, the services could have been provided for a much longer time. The next respondent had an interesting observation on awareness: “Many older adults know that there are some options, but they either don’t know where to look, think they won’t qualify so don’t look, or have limited access to travel to look.” In an opposite view to Schneider and Sidney (2009) regarding the most vulnerable, with HCBS, the "most vulnerable have several good avenues with our community resources" (P8). However, those with some more money who might not qualify are less aware of options. The next respondent saw a mixed level of awareness based on program. P9 suggested that the level of awareness on the waiver is higher than that of the PACE program. The last respondent had an optimistic view of the MI Choice Waiver, claiming that word of mouth is "enhanced greatly with [the] stability" of the program.

Theme 5: Advocacy Groups Play a Role in Home- and Community-Based Services

The question involving the role of the respondents in HCBS resulted in a list of different local organizations such as CareWell Services, Senior Health Partners, PACE Association of Michigan, a County Professionals in Aging organization, and so on. Three respondents gave specific information about advocacy groups. P3 stated groups advocate and represent the needs of their constituent groups to local politicians and legal aid, AAAs, local and senior services, et cetera. P7 suggested more training for "those of us on the street" would be a good advocacy option, and P10 touted advocacy groups as assisting in awareness of the value of HCBS options. They also share with policy makers how law and policy impact older adults, the consumers. Healthcare communities that lack awareness about advocacy and the extent of programming operate in a silo because of this knowledge gap (Yeager, 2018).

Theme 6: For-Profit Long-Term Care Facilities Intersect with Home- and Community-Based Services

Although for-profit facilities including nursing homes and assisted living facilities operate independently of HCBS, a few intersections exist. First, the prices charged by these facilities are “beyond the reach” of people who can receive state or federally funded HCBS (P1). P3 emphasized that for-profit assisted living options can still get public services such as meals and transportation not covered in their rent, which P3 claims takes resources away from deserving lower-income individuals. P5 felt that many options should be available and emphasized that people making under $60,000 should have more options, as they are in the middle who do not qualify for HCBS but cannot afford private facilities. Some of the respondents saw no effect on the two (assisted living vs. HCBS), but others had strong opinions. P7 implied a prejudice among assisted living facilities in that they generally ignore HCBS people as possible residents because the “general consensus is for profit homes believe that if they accept the waiver, it will be more work, more inspections, and possibly clientele that are not great tenants.” Similar research has discussed the negative or positive view of target populations and the benefits the groups received, with benefits being unevenly distributed (Ingram et al., 2007). P9 saw a “conflict in the spirit of the mission and the use of Medicaid funding” even though the respondent was not aware of the impact of for-profit assisted living options on HCBS options. These latter two perspectives conform with SCPD regarding inequality in developing discriminatory social policies.

Theme 7: Home- and Community-Based Services can be Improved and Enhanced

All respondents had suggestions on how to improve and enhance HCBS. P1 saw prevention and wellness programs as an important issue that begged funding, and P2 thought HCBS should be enjoyed by people of every economic level, especially because of the people that fall in the middle and lack access either to HCBS and private facilities. A corollary to this idea was P3's suggestion that the asset limit should be raised so middle-class people could get help aging in place, especially because HCBS is more cost effective than LTC. P4 wanted to see the same government funding levels in HCBS as in nursing homes, and P5 felt the HCBS program was too confusing and should be simplified. P6 added to this concept, stating that the intake process should be streamlined and implemented by a third party. P7 was the only respondent to mention married couples, who needed to see a change in process for HCBS. P8 stipulated that if a place is reputable, sometimes self-pay is the only option short and long-term. P9, the only person to mention a wait list, said to "make enrollment policies the same for all HCBS provider types to decrease the wait list and increase access to services." Finally, P10 wished the "default" for older adults needing care in Michigan was HCBS. From the perspective of SCPD, even though most of the population receiving HCBS are on the lower end of the socioeconomic spectrum and were traditionally marginalized, it appears that social changes are being made through the MI Choice Waiver. Should public policy makers follow the recommendations that come from the present study if they are made public, more older adults will get to age in place and start to direct their own futures or to fight back when the results are inadequate, the opposite of what Schneider and Sidney (2009) described as the job of public policy managers, fending for people who cannot fend well enough for themselves.

The purpose of this qualitative study was to explore and describe the perspectives of senior service providers who are engaged in HCBS in their community. My findings are indicated in seven themes that arose from nine Survey questions addressing one central research question involving the perceptions of senior service providers on their ability to impact the social construction of their targeted population while implementing federal and state policy in Michigan regarding access and wait listing for HCBS. All respondents addressed the open-ended questionnaire in sufficient detail. Of the 10 respondents who went ahead to answer the questions, only a few did not answer all the questions, but even they skipped only a few, which had no negative impact on the quality of the findings. Due to the gap in the scholarly literature on how senior service providers engage in HCBS in their communities, the findings extend the field of public policy with new in-depth information.

Limitations of the Study

Individuals who conduct research have limitations in their studies. Limitations can be found in how the findings are generalized, how they are applied, and in the usefulness of the results (Price & Murnan, 2004). One limitation was that though the public policies applied are from the federal government, the respondents in the study enact such policies on a local level. Even though the research concerned the Medicaid waiver, another limitation was that the research could only take place in Michigan, because it is not the same nationwide (Montgomery & Slocum, 2019) but application of the waiver and waiting lists for HCBS can vary across provider in Michigan, it is not for providers to determine eligibility for services but for the wavier application to determine.

The study is easily relatable to my position as an older adult who still live in my home. However, I have not worked in a professional or other position for senior services, so much of the information received in the surveys was new to me. My thorough reading, rereading, and organization of the answers into tables help me familiarize myself with the information to the point of being able to process it more easily over several days. Finally, due to increasing hearing and visual disabilities, I was unable to interview the respondents face to face or over Zoom as originally planned, which prevented me from being able to observe facial expressions, body language, and tone. Still, the variety of answers with common themes allowed me to gather sufficiently in-depth perspectives of senior service providers who address issues in their community on the Medicaid Waiver and HCBS.

Recommendations

Even though there were limitations in this qualitative study to explore and describe the role of senior service providers confronted with the decision-making processes of implementing federal and state policy in Michigan on access and wait listing of older adults for HCBS, the perspectives of the 10 respondents included quality material that I can address with their recommendations, the literature review, and recent material on community services for older adults. Ploeg et al. (2017) noted that adults all over the world are living longer lives, albeit with chronic conditions in many cases. Thus, they need to have optimal support to age well in their communities. Ploeg et al. further noted that teams in those communities will be working collaboratively to those ends and that such work go beyond the academic setting. They recommended both practitioners and students need to come together in the community with “well-functioning, collaborative teams (including clients and family as well as providers) as their clinical mentors” (Ploeg et al., 2017, p. 641). Two respondents in my study recommended making enrollment policies the same for all HCBS providers to decrease the wait list and increase access and that it should be fast-tracked, also to raise access. If all teams would collaborate, especially with the older adults and their families they work with, the quality of HCBS would be much improved.

Another recommendation was the need to increase awareness of all programs for HCBS. Though the perspectives on level of awareness did vary among the respondents, several implied there was the level of awareness of HCBS programs in their communities was low or tended to be raised only when it concerned them personally. One respondent stated the knowledge was limited at best and the respondent who felt awareness in their community was higher than most, people were not aware of all services. The information was confusing to people and people wait too long to have the process go easily. I would recommend more accessible and clear information be disseminated widely by the state of Michigan. The findings indicated that an inadequate amount had people had knowledge or knew enough to be able to access HCBS. Knowledge, as it is said, is power, and vulnerable older adults are made powerless if they do not have the knowledge to take control of their lives to age in place. One respondent put it the most expressively when they said older adults know that there are some options, but they “either don’t know where to look, think they won't qualify so don't look, or have limited access to travel to look." Publicity on HCBS should be put out daily on radio, television, newspapers, local online information boards, and fliers put up in places where older people gather. I believe public policies should disseminate this important information from the federal to the state level and then distribute to all communities, whether urban, suburban, or rural on all available medias.

Awareness and recommendations mentioned by one respondent was an important point that stood out to me regarding the first choice of nursing home and or assisted living facilities "default" be changed to HCBS, which I recommend if this is the practice. It appeared that the respondent was suggesting that the choice of nursing home and or assisted living was selected by the senior service providers when all applications were equal, HCBS was not selected as the first choice. However, it is not for providers to determine eligibility for services but for the waiver application to determine. One respondent in my study recommended the "default" in Michigan needs to be changed to HCBS rather than LTC facilities, but again, to qualify for HCBS the individual must meet nursing home eligibility criteria. This is the standard across all HCBS applications. HCBS is also known as a Nursing Home Diversion Program because it prevents Nursing Home admissions. Further, money needs to follow the person, but, the standard funding formula for the waivers are based on the individual impediments in the activities of daily living, no matter what option is best. Not only would care be available to more people, but the costs of the care would be lower in HCBS, a difference between $20,000 in the community and up to $90,000 a year in nursing facilities (MetLife Mature Market

Institute, 2012). A more recent MetLife (2016) table had specific information for an urban area in Michigan that revealed nursing care at $99,094 a year, assisted living at $59,173 a year, and HCBS at $28,041 a year. Thus, to be affordable, access and awareness take on a strong economic reason that HCBS should be the "default" for older people who want to remain close to home and community. Also, as an economic point, the respondents mentioned people who simply assumed they were not eligible for HCBS or made too much money for community help and not enough to go into assisted living or nursing care. I recommend the qualifications for HCBS be increased so that every aging adult in need of care have access.

My final recommendation is the same as that of one respondent, that prevention becomes a focus of care for older people and expand into HCBS. For example, the community partner who helped me disseminate the Survey was involved with senior prevention programs aside from HCBS that kept older individuals on track for good health including exercise and support programs. However, by design, prevention services are not part of the waiver program because to qualify you must demonstrate impediments in both the activities of daily living and the instrumental activities of daily living. Haider et al. (2017) found that a home-based nutritional and exercise intervention through volunteers had a positive effect on handgrip strength for older individuals who were frail or becoming frail. They found that handgrip increased the most for those who were already frail.

Therefore, prevention program expansion could become a priority for increasing access to HCBS as another measure for preventing nursing and assisted living facilities stays. It is also possible for some older adults not to need significant care at all if they were physically and nutritionally fit. However, HCBS is not designed as a prevention program. There are other programs dealing with prevention. To qualify for HCBS the individual must already have several impediments in the activity of daily living and in the instrumental activities of daily living, therefore HCBS cannot include the prevention piece.

If these recommendations are accepted as public policy and put into practice, access to HCBS will be expanded and many more adults will be served to age in place. My study can be disseminated to senior providers statewide and all 14 Area Agencies for the Aging in Michigan to raise awareness of the need to broadly publicize all aspects of HCBS to every older adult and their families. Such information may significantly reduce the issues involving access to aging within their Michigan home and community.

Implications

As mentioned in the introduction, my study might play a role in social change by calling into attention the status of HCBS, especially since the establishment of the Medicaid Waiver. My study addressed the lack of scholarly studies on the role of senior service providers in access for older adults as they wait for services that will let them age in place. Sexton (2016) for example urgently called for research regarding trends of older adults dying before they were able to access HCBS. Dube (2010) claimed these issues had not been studied enough by researchers. Although when people look up online the status of the waiting list for Michigan and find there is no waiting list for the state, as I did at the start of my research, the findings show a more complicated picture. Many people in the state are indeed on a kind of waiting list, simply because they might not have the knowledge or the means to find out about local HCBS services in the first place.

My study might have a significant impact to policy and practice because, as I stated, more senior service providers can be made aware of the fact that there is more involved in being on a wait list for HCBS than numbers and names. Also, at the beginning of the study, I argued there could be better policies developed to help ease getting the medical help older adults need, which was made clear in the surveys. My study could advance knowledge in public policy because the lack of research on the negative health effects of not having ready access to necessary medical care despite what official channels in the state report. Once the problem is brought to light, it cannot be ignored as easily as the past. Thus, improving HCBS might result in positive social change for a growing population of older adults, especially baby boomers and the smaller group of older adults that come before them. segment of the population, baby boomers and the remaining members of the generation that is projected to double between 2015 and 2027 (Blancato & Ponder, 2015).

On the individual level, the potential impact for positive social change might be notable. More information about what each city, town, or rural area needs to be disseminated, not only to older adults but also to their families, who often are involved in the decisions of how to get their spouse or parents the help they deserve. I recommended that publicity on HCBS needs to be put out every day on different media, from television to fliers put up widely. When individuals and families find out all there is to know about HCBS, after being directed to the right parties, decisions to get needed help can be fast and simple. One perspective was the need for preventive care, which can be a positive factor for healthy aging. As individuals become more aware of the need for prevention, there are strong implications that programs in the community will be expanding now and in the future. Because the baby boomer generation has a strong voice and activism, they can help get the job done for healthier living in their communities to which they will be contributing significantly.

On a policy level, revelations that HCBS lacks full accessibility can motivate policy makers to institute public policies that can increase awareness and accessibility so that every person who is qualified can get help to age in their home and community. HCBS makes sense because it can be had at a fraction of the cost of for-profit assisted living and nursing facilities. Thus, it would behoove budget-conscious local, state, and federal governments to promote HCBS through every means possible. The end goal is that HCBS should be the first choice for older adults instead of institutional LTC. Consistent enrollment policies, no matter the organization, developing strategies to increase awareness and access, changing the first choice to HCBS, and raising income limits for individuals and couples all have implications for positive social change. However, more importantly, an expansion of the HCBS program will reduce the federal budget because if the frail elderly is kept in less restrictive and expensive environment the cost of care will reduce. HCBS nationwide should include a Consumer Directed Care option so family members could be trained and hired to perform certain services for the eligible care recipient. This option already exists in other states.

Conclusions

Using an open-ended survey administered online, I was able to explore and describe the points of view of individuals involved in senior services in a variety of professional positions on access to HCBS in their communities. Regarding the SCPD theoretical framework, Pierce et.al. (2014) saw SCPD as target groups combining power with social construction not only in how policies are developed but also how to better understand them. Cheung (1997) defined SCPD as the way people, together with society, construct their own socially invented reality. As the older generations expand with the aging of the Baby Boomer generation as well as their predecessors, many of whom are living longer than did previous generations, there is a strong need to ensure home and community care to all. One popular initiative that is gaining financial support and popularity was the Aging in Place initiative. Chattopadhyay, (2020) Indicated that "aging in place" was the preferred choice by most Americans. My hope is that improved public policies will be carried out fully to ensure the reality of aging in place as a right for those who desire to do so at home and in their community with dignity and respect.

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Appendix: A Coding Aggregate Frequency Table

COMMUNITY	***f* = 9**
Access community care	5
Community-based resources	3
Improve the communication with community	1
SERVICE AVAILABILITY	***f* = 10**
Services available & expanded	6
Caregiver respite	1
Advocate/advocacy services	3
BARRIERS	***f* = 22**
Limited collaboration	1
Affordable & income limitations overcome	2
Service barriers & inconsistency	3
Stereotypes of senior care	1
Information confusing	1
Intake process too long	1
Lack transportation	1
Limited awareness	7
Large scale (more seniors, system stress & waitlists)	3
Delay care until urgent	2
FINANCIAL CONSIDERATIONS	***f* = 5**
Need low cost & financial relief	2
Need more options for lower income	2
Costs out of reach	1
EDUCATION FOR CAREGIVER AND OTHERS	***f* = 6**
Resource availability	1
Caregiver & patient education	2
Trusted source of information	1
Evidence-based	2
AGE IN PLACE & STAY AT HOME	***f* = 9**
Self-management	2
Person-centered care	2
Stay in home	4
Person-centered planning	1
TRAINING, ADVOCACY & AWARENESS	***f* = 20**
Consistent training	2
Higher & improving awareness	3
Organizations that should have more awareness	2
Mixed awareness	2
Awareness	1
More training needed	1
Unsure if qualified	2
Benefit from in-field employment	1
Not involved	2

Socioeconomic need priority	2
No waitlist	1
Service with limited gaps	1
COLLABORATION	***f* = 18**
State or government organization	3
AAA	5
Other organizations	6
CareWell	2
Silver Key coalition	1
PACE	1
Limited or no impact	3
Room for both to coexist	2
For-profit diverts resources	1
For-profit prefer clients not on waivers	1
Self-pay only option available	1
Conflicts with mission and spirit of Medicaid	1
Non-profit invests in more services	1
Collaboration among providers	6
MMAP volunteers	2
Another organization	2
POLICY ISSUES	***f* = 9**
Consistent enrollment policies	1
Defund nursing homes	1
Policy hampered by policies	1
Policy for funding	1
Work directly with state or policymakers	2
Stability of MI Choice	1
Connected to policymakers	2
RECOMMENDATIONS	***f* = 15**
Simplify & streamline process	4
Expand to higher incomes	3
Waiver referrals or follow PACE model	2
More resources for prevention wellness	1
Involve waiver agents in policy & funding	1
Match nursing home funding	1
Eligibility by independent third party	1
Easier for married couples	1
Options counseling	1