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Evaluating long-term care inititiatives in Ohio

Robert Applebaum
Miami University, commons@lib.muohio.edu

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Scripps Gerontology Center

Upham Hall
Miami University
Oxford, Ohio 45056
(513) 529-2914

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Robert Applebaum, Ph.D.
Shahla Mehdizadeh, Ph.D.
Jane Karnes Straker, Ph.D.
Christiane Pepe, M.G.S.

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With the Assistance of:

Gregg Warshaw
Elizabeth Gothelf
Irene Moore
Office of Geriatric Medicine
University of Cincinnati

Richard Fortinsky
Karen Bowman
Robert Binstock
Division of General Internal
Medicine & Health Care Research
Case Western Reserve

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PREFACE

This report represents the collaborative efforts of three universities involved in long-term care research: the Scripps Gerontology Center, Miami University; the Office of Geriatric Medicine, University of Cincinnati; and the Division of General Internal Medicine and Health Care Research, Case Western Reserve University. The report was prepared by researchers at each of the three universities. Chapter 1 was prepared by Robert Applebaum and Jane Karnes Straker of Miami University. Chapter 2 was prepared by Robert Applebaum and Shahla Mehdizadeh of Miami University. Chapter 3 was prepared by Christiane Pepe and Shahla Mehdizadeh of Miami University. Chapter 4 was prepared by Jane Karnes Straker of Miami University, Karen Bowman, Richard Fortinsky, and Robert Binstock of Case Western Reserve, and Gregg Warshaw, Elizabeth Gothelf, and Irene Moore of the University of Cincinnati. Chapter 5 was prepared by Shahla Mehdizadeh, Jane Karnes Straker, and Robert Applebaum of Miami University. Chapter 6 was prepared by Robert Applebaum and Jane Karnes Straker of Miami University.

This final report was requested by the state legislature as it considered long-term care policy reform in Ohio. Funding for the research was provided by the Ohio Legislature to Miami University.

EXECUTIVE SUMMARY

Evaluating Long-Term Care Initiatives in Ohio: Final Report

Scripps Gerontology Center, Miami University

The administrative and legislative branches of Ohio's government have become acutely aware of the fiscal challenges facing the state as it attempts to serve those needing long-term care. An expanding long-term care Medicaid budget, allocated primarily to nursing facility care, the continued increase in the number of older persons with disabilities, and concerns about the lack of long-term care options have been identified as major challenges for the state.

In response, Ohio has enacted legislation to address concerns about the long-term care system. Key legislative actions include two categories of initiatives: 1) a change in the process of admissions to nursing facilities, called pre-admission review, and 2) an increase in the type and number of long-term care settings available to older Ohioans, termed Community Care Choices. (Community Care Choices includes PASSPORT, OSS, and Assisted Living.)

Although both sets of actions have been praised for modifying and expanding the available long-term care options, some important questions have been identified as these efforts are implemented. To address these questions, the Scripps Gerontology Center at Miami University, in conjunction with the Office of Geriatric Medicine at the University of Cincinnati, and the Division of General Internal Medicine and Health Care Research at Case Western Reserve was asked by the Ohio Legislature to design and implement an evaluation of these areas. The evaluation addressed two key questions: 1) Is the pre-admission review process effective in directing older Ohioans to the appropriate long-term care setting? and 2) What effect does the

Community Care Choices program have in its overall objective of diverting individuals from nursing facility care to other long-term care settings?

Pre-Admission Review

In an effort to ensure that disabled individuals had access to information about long-term care services and that the services were appropriate, the state implemented a pre-admission review for Medicaid long-term care. The evaluation of pre-admission review activities produced these findings:

1) The volume of pre-admission reviews was considerable; more than 99,000 reviews were completed between January 1, 1994 and December 31, 1994. Slightly more than half (54%) of pre-admission reviews pertained to Medicaid requests; the remainder were mental health and MR/DD reviews required by the federal government.

2) Almost half of the pre-admission reviews (47%) were conducted on applicants in a hospital; the remainder were divided between those in the community (31%) and those in a nursing facility (23%). Nearly half (42%) of the Medicaid reviews came from those already living in nursing homes.

3) We expected that persons exempt from an in-person assessment (those who were clearly determined to need a nursing-facility level of care) would be more disabled than the others. This was the case; for example, about 60 percent of the sample undergoing desk review had four or more impairments in the activities of daily living, compared with 34 percent for the in-person group.

4) Pre-admission reviews were completed in timely fashion. Ninety-seven percent of the desk reviews from hospitals were completed within the one-day deadline, and 92 percent of the desk reviews from nursing facilities were completed within the five-day limit. Eighty-eight percent of the in-person assessments of community applicants were completed within five days.

5) Professionals, such as hospital discharge planners and nursing facility employees, reported that pre-admission review was done in a timely manner. However, they often felt that the desk review for discharges from the hospital or referrals to a nursing facility was a duplication of their work.

6) The desk review component of pre-admission review cost about $30 per review. The in-person review was estimated to cost $213 for the level-of-care assessment and just over $300 for a comprehensive assessment (used for those who could receive community-based long-term care).

7) On average, less than 1 percent of the pre-admission reviews resulted in denial of the level-of-care request for Medicaid reimbursement.

8) The majority of long-term care applicants reported feeling positive about the pre-admission review process. Most, however, did not understand the reason for the review process, and many were dissatisfied with the quality of long-term care choices offered.

9) The majority of caregivers knew about the pre-admission review process, and in general reported high satisfaction with the approach used.

10) A review of the appropriateness of the long-term care placement by clinical professionals found that in the great majority of cases (94% those record reviewed and 98% those seen in-person), individuals were in the proper setting.

Diversion

The second purpose of the evaluation was to assess the possible diversionary effects of Community Care Choices and pre-admission review on the use of nursing homes. Findings on this subject include the following:

1) The number of nursing facility residents did not appear to be changed in the initial 12-month period of study. The short time frame, however, as well as limitations in the Medicaid information system and delays in implementation of Community Care Choices, seriously limited the ability of the evaluation to address this question.

2) The targeting efforts of the long-term care programs in Ohio have improved over the past 12 months. Individuals admitted to nursing facilities in 1994 tend to be more disabled than those admitted in 1993.

3) The characteristics of long-term care recipients and the nature of long-term care are changing. More men, more nonwhites, more married individuals, and persons with higher levels of disability are among those who are entering nursing facilities. A comparison of those who are now being admitted with the population already in place suggests two categories of long-term care recipients: sub-acute and long-term stay.

4) Nursing facilities now provide a considerable amount of short stay care. Twenty-nine percent of those admitted during the initial quarter were no longer residents at the end of that quarter. More than half (52%) were no longer residents after 6 months.

Issues for Further Consideration

The pre-admission review program has enjoyed a number of successes in its initial year of operation. Experience has shown that the pre-admission review process serving large numbers of older Ohioans can be completed quickly and efficiently with positive results. Yet, this initial investigation into the questions surrounding the pre-admission review gives rise to a number of important issues. One such issue is whether pre-admission review resources can be targeted more effectively to provide more and/or different alternative long-term care settings for those who can take advantage of them. To accomplish such a goal a series of care options must be available. However, respondents consistently identified restricted intake into PASSPORT as a barrier, and also discussed the need for alternative long-term care settings such as Assisted Living.

Patterns of long-term care use need to be understood. Implicit in the cost-effectiveness of pre-admission review is an assumption that costs can be saved by diverting an individual from a long-term stay in a nursing facility. Evidently, however, nursing facilities are serving a group of people who are different from the long-term residents, and who may need only short-term care at less than a hospital level. Continued examination of admission and discharge patterns would provide valuable information regarding current and future trends affecting the long-term care industry in Ohio.

CHAPTER 1

BACKGROUND

The administrative and legislative branches of Ohio's government have become acutely aware of the fiscal challenges faced by the state as it attempts to care for those who require long-term care. Several factors, including an ever-expanding Medicaid budget, the continued increase in the number of older persons with disabilities, and concerns about the lack of long-term care options, have been identified as major challenges.

In response to these concerns, Ohio enacted legislation that includes two categories of initiatives: 1) a procedural change in the nursing facility admissions process and 2) an expansion in the type and number of long-term care settings available to older Ohioans.

Although both sets of actions have been praised for modifying and expanding the long-term care options available to older people, some important questions involving evaluation have been raised in connection with these efforts. To address these questions, the Ohio Legislature asked the Scripps Gerontology Center at Miami University to design and implement an evaluation. This evaluation report provides information for state policy makers who face the challenges associated with long-term care.

Two key research questions have been identified for study: 1) Is the newly implemented pre-admission review process effective in directing older Ohioans to the appropriate long-term care setting? and 2) What are the effects of the Community Care Choices program in its overall objective of diverting individuals from nursing facilities to other long-term care settings?

LONG-TERM CARE IN OHIO

Reform of acute health care has been prominent in discussions of national domestic policy. Long-term care, however, with public expenditures of over $50 billion, is a major concern for state policy makers. From the perspective of the states, the growth of Medicaid, largely unanticipated when the program was enacted in 1965, has been a constant concern since the 1970s. Steady increases in nursing home expenditures have made long-term care an item on the problem list of most states. Between 1982 and 1993, for example, national Medicaid expenditures on nursing homes increased from $14 to $36 billion (Burwell 1994; Taueber 1990).

As these numbers indicate, long-term care has become a major component of state policy and budgeting. In this chapter we describe long-term care in Ohio, focusing on the characteristics of those with a disability requiring long-term care, the cost of long-term care, and the characteristics of long-term care recipients in various settings.

WHO RECEIVES LONG-TERM CARE IN OHIO?

Ohio is one of the nine states with more than 50,000 persons age 65 or older living in nursing facilities (84,081 over 65 and 93,769 persons of all ages; Taueber 1990). Nursing facility beds in Ohio increased approximately 31 percent (22,290) between 1980 and 1990, a considerably greater increase than in comparable midwestern states (12.4%) or in the United States on average (24.2%).

Using 1990 census data, we estimate that about 250,000 older people in Ohio suffer a disability that requires long-term assistance (Mehdizadeh 1993). About half of these people (122,000) are classified as severely impaired; they need assistance with the basic activities of

daily living such as bathing, transferring from bed to a chair, and dressing. Many of these people also are cognitively impaired. The remaining group is classified as moderately impaired; they require assistance with instrumental activities of daily living such as shopping, preparing meals, and traveling to medical appointments. It is projected that by 2010, the group of severely disabled older people will have increased by about 40 percent (Mehdizadeh et al. 1990).

The growth in the size of the older population in Ohio and in the nation is unprecedented in U.S. history. This demographic trend, combined with other societal changes such as a lower fertility rate, a higher proportion of women in the workforce, and greater mobility across states, makes informal caregiving difficult for many families. As family structures change, long-term care becomes an increasing challenge for the citizens of Ohio. Yet despite changes in the family, more than half of the older Ohioans who need long-term care receive such care exclusively from the informal system of family, friends, and neighbors. About 18 percent of disabled individuals receive combined care from home health agencies, from Ohio's PASSPORT home care program, and from informal caregivers. Just over 30 percent (30.6%) of disabled individuals receive care in a nursing facility (Mehdizadeh and Atchley 1992).

HOW MUCH DOES LONG-TERM CARE COST?

Despite the significant role of the informal system in providing long-term care for older Ohioans, the public sector has become heavily involved in financing long-term care. Ohio's cost patterns for long-term care mirror those for the nation; Medicaid expenditures on nursing facilities rose from $651 million in 1985 to $1.7 billion in 1992. This figure represents about 43 percent of the state's total Medicaid expenditures. Nationally, about 30 percent of Medicaid

expenditures were allocated to nursing facility care. Over half (54%) of all long-term care expenses in Ohio are paid by the Medicaid program. Private out-of-pocket spending (27%) is the next largest source of funds. Private long-term care insurance (4%) and the federal Medicare program (5%) round out the list of major payers (Mehdizadeh and Atchley 1992).

As in many states, most long-term care expenditures in Ohio have gone to nursing facility care. In 1990 Ohio spent about 7 percent of its long-term care funds on noninstitutional care. Although the proportions for total long-term care allocation have changed only minimally, Ohio has substantially increased the Medicaid funds allocated to community-based long-term care. For example, spending for the PASSPORT home- and community-based waiver program increased from $5 million in 1987 to $59 million in 1993. Spending on all Ohio home care waivers almost doubled in 1994 alone, rising from $46 to $88 million. Home health care expenditures under Medicaid, which supports both acute and long-term care, also increased, rising from $21 to $25 million in the last year. The recent legislative changes in long-term care should result in steady increases in the resources allocated to community-based services. Because of the projected growth in the size of the disabled older population, exploration of noninstitutional settings will increase.

WHAT ARE THE CHARACTERISTICS OF THOSE RECEIVING LONG-TERM CARE IN VARIOUS SETTINGS?

As described previously, long-term care in Ohio is provided in several different settings, both institutional and community-based. Yet little is known about the kinds of people who actually are served, and how these populations compare across different long-term care settings.

In the following section we describe the participants in various long-term care programs in Ohio as of June 1993. (A more detailed description appears in Chapter 5.)

Nursing Facility Residents

Each quarter, Medicaid-certified facilities provide information about their residents to the Ohio Department of Human Services via the Minimum Data Set Plus (MDS+). Demographic, functional, cognitive, and diagnostic information is provided for each resident in a Medicaid-certified bed on the last day of the quarter. This data set includes newly admitted persons as well as long-time residents.

Data for 80,672 nursing facility residents for the quarter ending June 30, 1993 show that Medicaid is the primary payment source for nearly one-third (30.8%) of these residents, and provided some payment during the quarter for another one-third (33.9%). Because the MDS+ collects payment information over the course of the quarter, we cannot estimate precisely how many residents depended on Medicaid on any given day. For example, many residents enter nursing facilities from hospitals, using Medicare funding typically for 20 days of skilled nursing care. After Medicare is exhausted, Medicaid funding might pay for the rest of the resident's stay for that quarter. The State of Ohio, through Medicaid, had at least some stake in the long-term care of about two-thirds of the residents in Medicaid-certified facilities as of June 30, 1993.

Who are these residents? On average, a nursing facility resident is about 80 years old, is very likely to be female, and is more likely to be Caucasian than nonwhite. Only a small percentage are married; most were married at one time, but now are widowed. About one-quarter lived alone before moving to the nursing facility; more than half lived with another

person or persons. Medicaid and non-Medicaid residents are similar on demographic characteristics.

Nursing facility residents suffer severe functional impairment, as evidenced by data on the activities of daily living (ADL) such as eating, dressing, and bathing. About two-thirds of the residents require hands-on assistance with all ADLs except eating. Nearly three-quarters are impaired on four of six ADLs. More than half are incontinent in bowel, bladder, or both. More than half also suffer cognitive problems such that they have moderate or severe difficulties in making daily decisions. More than 10 percent exhibit abusive or wandering behaviors.

PASSPORT Clients

PASSPORT is Ohio's community-based long-term care Medicaid waiver program for citizens age 60 years and older. Functional requirements for PASSPORT are the same as those for Medicaid eligibility for long-term care services in a nursing facility. PASSPORT is designed to serve clients at a lower cost than a nursing facility placement: the cost of services is capped at 60 percent of the cost for a nursing facility.

In an effort to provide descriptive information about PASSPORT clients, we examined the initial assessments for clients who were enrolled in PASSPORT as of June 1993. For some clients, the initial assessment was recent; for others, it may have been made much earlier. Demographic, diagnostic, and social support information for 4,552 clients was available in the PASSPORT Management Information System. To gather information about functional ability and cognitive functioning, we supplemented this data source by sampling 500 of these clients for additional data collection.

PASSPORT enrollees are predominantly female, the majority are not married, and more than two-thirds are white. Their average age is 75. More than 75 percent live in their own homes or apartments; fewer than 20 percent live with relatives or friends.

PASSPORT clients show a fairly high level of functional impairment. On average, they could not independently perform three of the six ADLs examined. More than one-third (37.4%) have four or more impairments. Instrumental activities of daily living are important for persons living in the community and managing their own households: PASSPORT clients have more difficulty in this area, with almost all (96.8%) showing impairment in four or more of the activities examined.

Cognitive functioning is important for independent living, particularly for health and safety. More than one-quarter of those enrolled in PASSPORT show at least some degree of cognitive impairment, although only a small proportion (3.8%) wander or pose a threat to safety.

Optional State Supplement (OSS) Clients

The Optional State Supplement (OSS) program in Ohio provides a monetary supplement for persons in group living quarters such as board and care homes, group homes, and rest homes.

Before pre-admission review was implemented, little information about the characteristics of OSS recipients had been collected systematically. Beginning in November 1993, all current OSS enrollees were assessed using the comprehensive assessment and referral evaluation (ODA 1028). The information presented here is based on the results of these assessments for the

population of clients who were enrolled in OSS as of June 1993. Assessments were conducted and data were entered by PAA staff members.

OSS clients reflect the eligibility criteria for this program. Almost half are less than 60 years old; the average age is 61, about 20 years younger than other long-term care clients. Only slightly more than half are female, and almost none are married. More than half have never been married. All are living in group homes or other group settings, as required by OSS eligibility criteria.

In physical functioning on activities of daily living, OSS clients show a fairly low level of impairment. Nearly 60 percent (58.6%) are independent in bathing, generally the activity in which long-term care recipients are most likely to be impaired.

Many of these OSS clients, however, are quite impaired in instrumental activities of daily living (IADLs). About 90 percent need hands-on assistance with laundry (92.9%) and meal preparation (89.6%). Ninety percent have impairments in four or more of these activities. Impairments in IADL functioning are often a result of cognitive difficulties; one-quarter (25.1%) of OSS recipients have at least one cognitive impairment.

SUMMARY

As of June 1993, Ohio's long-term care programs were serving an array of functionally and cognitively impaired individuals. Although each long-term care setting serves a group of clients that differs from the others in some ways, the overriding characteristic of all groups is a need for assistance in many areas of life. Some settings contain a higher proportion of

severely impaired individuals; others contain more moderately impaired clients who need different kinds of assistance.

ORGANIZATION OF THE REPORT

In the remaining chapters of this report we address the two research questions. In Chapter 2 we present the study design and data collection activities used in the evaluation.

Chapter 3 examines the pre-admission review process. We describe the process and offer data on the volume and characteristics of those reviewed, timeliness, and costs.

Chapter 4 examines the pre-admission review from the perspective of long-term care consumer applicants and their families. We also provide information on appropriateness of care from the viewpoint of clinical experts.

Chapter 5 examines long-term care use patterns and diversion from nursing facilities to other long-term care settings.

Chapter 6 summarizes the information from the preceding chapters that is relevant for policy, and offers policy recommendations.

CHAPTER 2

STUDY DESIGN AND DATA COLLECTION

Our presentation of the study design is organized around the two key research questions; pre-admission review and long-term care use patterns and diversion. For each area we present the background and the key evaluation research questions, the methodological approach used in the evaluation, and the data sources and data-collection strategies employed.

Is the Pre-Admission Review Process Effective?

Before the legislative change in procedure, Medicaid applicants received a brief paper review in order to be admitted into a nursing facility. Under the new procedure, long-term care applicants who require Medicaid to finance their care receive a level-of-care review through either a record review or an in-person assessment before an admission is approved for Medicaid reimbursement. This process is designed to establish whether an applicant is eligible for Medicaid long-term care, to determine the level of care needed by the applicant, to review information about alternative sources of care, and to offer the applicant service options that adequately meet his or her long-term care needs. On January 1, 1995, the pre-admission review was expanded to cover all applicants to Medicaid-certified nursing facilities regardless of payment status. Long-term care applicants originate from the community, from hospitals, and from nursing facilities. To determine whether these clients are served effectively by the pre-admission review process, we address the following questions in Chapters 3 and 4:

What does the pre-admission review process look like?

Are the key referral sources (hospitals, nursing facilities, community agencies) satisfied with the procedures for administering the pre-admission review process?

What is the volume of reviews, and what are the characteristics of those reviewed?

Are long-term care applicants satisfied with the pre-admission review process and the outcomes of that process?

Are informal caregivers satisfied with the pre-admission review process and the outcomes of that review?

Are the care settings chosen by older consumers as a result of the review process appropriate from the viewpoint of other health and social service professionals?

Is the pre-admission review completed in timely fashion?

How much does pre-admission review cost?

What Are the Long-Term Care Use Patterns and Diversionary Effects of Community Care Choices?

In addition to pre-admission review, the state has proposed several other initiatives to increase long-term care alternatives. Program elements of the state initiative, termed Community Care Choices, are as follows: an expansion of PASSPORT, Ohio's home care program for the chronically impaired, from 5,500 to 15,900 clients; the development of Assisted Living, a new type of care, designed to serve about 1,300 Medicaid recipients in fiscal year 1995, but not yet implemented; and the expansion of the Optional State Supplement Program (OSS) for individuals living in adult care facilities including group homes and rest homes (an increase of about 2,000 clients during the 1994-1995 biennium).

Now that additional resources are being allocated to long-term care settings other than nursing facilities, a question for evaluation arises: What is the effect of the Community Care Choices program on diverting individuals from nursing facilities to other long-term care settings?

To address this area, we discuss the following questions in Chapter 5:

How have the characteristics of nursing facility residents changed over time?

How effective is each of the care approaches in targeting care to those individuals whom the programs are designed to serve?

What is the effect of Community Care Choices on the use of nursing facilities as measured by utilization patterns and length of stay?

How have the characteristics of PASSPORT and OSS clients changed over time?

STUDY DESIGN

To address these key research areas, the study relies on an array of methodological approaches and data-collecting procedures. Table 2-1 provides an overview of the primary data-collecting approaches for each of the major evaluation questions.

Is the Pre-Admission Review Process Effective?

Data collection for the pre-admission review component includes a variety of research activities. We gathered new research information directly from the following sources: 1) a sample of long-term care consumer applicants (or proxies) who participated in the pre-admission review process; 2) a sample of family members or friends who were the informal primary caregivers for individuals undergoing pre-admission review; 3) a sample of those professionals involved in long-term care pre-admission assessment, including PASSPORT Administrative Agency (PAA) employees; and those who refer long-term care applicants to pre-admission review, such as nursing facility social workers and administrators, and hospital discharge planners; and 4) a sample of long-term care applicants whose records were reviewed to assess the appropriateness of the pre-admission review decision.

Long-Term Care Evaluation:
Research Questions and Data Sources

Research Questions	Description of Data Source	Sample Size
Is the pre-admission review process effective?		
What does the pre-admission review process look like? Are the key referral sources (hospitals, nursing facilities, community agencies) satisfied with the procedures for administering the pre-admission review process?	Two rounds of site visits to five regions of the state. Interviews with PASSPORT Administrative Agency staff, referral sources, and providers (Scripps Gerontology Center)	114 in-person interviews.
What is the volume of reviews, and what are the characteristics of those reviewed?	Pre-admission review database (Ohio Department of Aging) Sample of pre-admission review applicants (Scripps Gerontology Center) In-person assessment database (PASSPORT MIS)	Includes 99,039 records. Includes a sample of 2,705 individuals who have received pre-admission review. Includes 30,621 assessments.
Are long-term care applicants satisfied with the pre-admission review process and the outcomes of that process?	In-person consumer survey completed on a sample of those receiving a pre-admission review (Scripps Gerontology Center)	A sample of 1,000 individuals completing pre-admission review.
Are informal caregivers satisfied with the pre-admission review process and the outcomes of that review?	Telephone survey with primary informal caregivers of individuals receiving a pre-admission review (Case Western Reserve University)	A sample of 500 caregivers.
Are the care settings chosen by older consumers as a result of the review process appropriate from the viewpoint of other health and social service professionals?	Clinical record review on a sample of individuals receiving a pre-admission review (University of Cincinnati) In-person clinical review on a subsample of individuals receiving a pre-admission review (University of Cincinnati)	600 records reviewed. 100 in-person clinical reviews.
Is the pre-admission review completed in timely fashion?	Pre-admission review database (Ohio Department of Aging) Community to NF in-person assessment sample (Scripps Gerontology Center) In-person interviews with PASSPORT agency staff, referral sources, and providers (Scripps Gerontology Center)	Includes 99,039 records of individuals receiving pre-admission review. 114 in-person interviews conducted in five regions of the state.
How much does the pre-admission review cost?	PASSPORT monthly financial reports (Ohio Department of Aging) Time study completed by five PASSPORT Administrative Agencies, weekly PAA activity reports, manual PAR activity reports (Ohio Department of Aging)	Not applicable. 330 employees. Five sites.
What are the diversionary effects of community care choices?		
How have the characteristics of nursing facility residents changed over time?	Minimum Data Set Plus (MDS+) 1993, 1994 (Ohio Department of Human Services)	Includes nursing facility residents, June 1993 through September 1994.
How effective is each of the care approaches in targeting care to those individuals whom the programs are designed to serve?	Minimum Data Set Plus (MDS+) (Ohio Department of Human Services) In-person assessment database (PASSPORT MIS) Clinical record review and in-person assessment (University of Cincinnati)	Includes nursing facility residents, June 1993 through September 1994. Includes enrollees, June 1993 (4,552), January to December 1994 (6,946). 600 records reviewed. 100 in-person clinical reviews.
What is the effect of Community Care Choices on the individual consumer, consumer and family satisfaction with the care setting, and the care received?	Consumer satisfaction survey (Scripps Gerontology Center) Informal caregiver survey (Case Western Reserve University)	750/1,000 respondents now completed. 478/500 caregiver interviews now completed.
What is the effect of Community Care Choices on the use of nursing facilities as measured by rates of admission, occupancy, and length of stay?	Minimum Data Set Plus (MDS+), June 1993 through September 1994	About 81,000 quarterly.

In addition, data from the Ohio Department of Aging provide information on the volume of pre-admission reviews completed, as well as on the characteristics of those receiving an in-person assessment.

The sampling strategy for this element of the evaluation is hierarchical. As described in Figure 2-1, the pre-admission review (PAR) population, which includes all 99,039 persons receiving a pre-admission review, is at the top of the hierarchy. We drew a random sample of persons age 60 and over to select long-term care applicants to receive an in-person interview. This interview examines the pre-admission review process and the applicants' current long-term care services. We drew a sample of caregivers for these applicants to gain information about the caregivers' perspective on pre-admission review and services. Finally, we selected a sample of long-term care applicants who also would receive a clinical review. In this review, experts examined applicants' assessment records to determine the appropriateness of their long-term care placement. From those selected for a clinical review, we drew a subsample to receive an in-person clinical evaluation. A detailed explanation of each sample and data source follows.

Pre-Admission Review (PAR) Population

These data became available through the Ohio Department of Aging after being assembled from each of the PAAs. The data source includes the location of individuals at the time of referral, their requested long-term care setting, and their payment status. Data are recorded by the PASSPORT agencies and are transferred twice a month to Scripps through the Ohio Department of Aging. Information about pre-admission review volume is based on total entries in the PAR database.

Figure 2-1
Sampling Plan for Pre-Admission Review Evaluation

Pre-Admission Review Population
- Limited client information from Pre-Admission Review (PAR) database (i.e. client activity, payment source)
- N=99,039 from January 1, 1994 to December 31, 1994
- N=53,811

In-Person Assessment Population
- Demographic and functional information from ODHS Form 3697 or ODA Form 1028, initial in-person assessment
- N=30,621

Applicant Sample
- This stratified random sample includes individuals selected from those receiving a Medicaid LOC, chosen from the PAR database.
- N=2,705

Consumer Survey Sample
- Satisfaction with review and satisfaction with services (in-person interviews 90 days after review)
- 2,705 individuals sampled proportionally by PAA to receive an in-person consumer interview
- N=1,000

Caregiver Survey Sample
- Random sample of clients' caregivers selected for consumer survey sample
- N=500

Clinical Review Sample
- Record review and some telephone interviews with knowledgeable provider/caregiver
- N=600

In-Person Assessment
- 30 placed in nursing homes
- 70 receiving community-based service
- N=100

Long-Term Care Professional Sample Survey
- PAA, CDHS, community agency, nursing facility, and hospital professionals
- Two rounds of visits to five areas of the state
- N=114

In-Person Assessment Database

This database contains a more detailed collection of information gathered by an in-person assessment of the pre-admission review clients referred from community settings. In addition, PAAs perform in-person assessments of clients from other referral settings (hospitals and nursing facilities) on request, when a review of a client's records leaves doubt about his or her condition or appears to present an adverse (denial of services) decision. This database also includes in-person assessments that were delayed in anticipation of improvement in the applicant's condition. The in-person assessment file contains about 30,870 of the 99,039 individuals in the PAR database discussed above. The in-person assessment database provides more information because the in-person assessment is more intensive.

Scripps Sample of Pre-Admission Review Applicants

Data collection for individuals who requested long-term care began in December 1993 and continued through January 31, 1995. The data for all individuals over age 60 who received a pre-admission review were stratified according to the type of service requested by each applicant (community or facility-based) and by the region of the state. Applicants from all PAAs are represented proportionally on the basis of the volume of applicants. To ensure that all types of applicants were represented in the sample, we stratified the applicants by referral setting and their requested outcome. The size of the randomly sampled group was chosen so that the population parameters could be estimated with a 95 percent confidence interval. The long-term care applicant sample size is 2,705.

To allow for subgroup comparisons and descriptions, we oversampled clients referred from the community, persons who were sent from the hospital to a nursing facility without an

in-person assessment (assessment exempt or delayed), and persons referred to the Optional State Supplement program (OSS). Applicants converting from private pay and already in nursing facilities were undersampled. We chose this design for three reasons: 1) to include in the sample a higher proportion of applicants from the community, a group that was expected to benefit from pre-admission review; 2) to include a higher proportion of those requiring an in-person assessment; and 3) to retain an adequate number of desk-reviewed applicants in order to evaluate the appropriateness of placement.

Although the sampling strategy and design remained constant during the study, we varied the number of applicants sampled each month in response to fluctuations in the number of pre-admission review applicants. Table 2-2 shows the distribution of our sample and its relationship to the pre-admission review population. Throughout this study, we use the pre-admission review applicants sample whenever the information on subgroups is compared. When the sample is used to estimate population parameters, however, we weight the applicants to reflect their representation in the population. Weighting assigns some observations more or less importance than others to compensate for over- or undersampling.

To standardize the consumer information collected by different interviewers working in different regions of the state, we developed structured interview schedules. The interviews are designed to examine consumers' satisfaction with the review process and with the long-term care services they are receiving. In cases where the client was unable to take part in an interview, we interviewed a responsible caregiver or guardian as a proxy. We interview clients approximately 90 days after the pre-admission review in order to allow them to become accustomed to the services they are receiving. Of this sample, 720 interviews have been

Table 2-2

Sample Distribution and Response Rates for Consumer Satisfaction Survey

Client Activity	Percentage in PAR	Percentage of Sample	Number in PAR Applicant Sample	Response Rate (Percentage)
PASSPORT	13.1	46.6	1,259	63
OSS	3.6	3.2	87	69
Community to NF	11.5	16.3	442	43
Community Care	7.2	2.0	54	63
No LTC Need	0.6	0.9	25	55
Community to Hospital to NF	15.3	14.4	388	34
NF to Hospital to NF	2.0	1.0	28	16
NF to Hospital to Different NF	0.9	0.9	24	40
NF to Different NF	5.3	1.2	31	44
NF Change of Payor	40.5	13.5	367	34
Total			2,705	

completed to date. Because of the differential response rates across client activity categories the consumer sample will not be directly proportional to the PAR population.

Caregiver Sample

As part of the pre-admission review process, long-term care applicants are asked to name an authorized representative, an individual who has been providing primary caregiving assistance, or someone who would be expected to provide assistance when necessary. We selected a sample of long-term care applicants to gather additional information from their caregivers. Structured telephone interviews with caregivers examine an array of subjects including type of assistance provided by caregivers, satisfaction with the long-term care setting and formal services, and the caregiver's own stress and burden. Research interviews were conducted and descriptive data analysis was performed by a research team at Case Western Reserve University. To date, 353 interviews have been completed and analyzed.

Clinical Review Sample

Six hundred of the 2,705 long-term care applicants chosen for the pre-admission review description also received a clinical evaluation. Applicants selected for review are chosen proportionally to represent the characteristics of the long-term care applicant sample. In this portion of the study, clinical experts from the University of Cincinnati Office of Geriatric Medicine assess the appropriateness of the long-term care setting on the basis of a review of client records. Appropriateness is evaluated holistically: clients' needs for protection of health and safety are considered, as are their individual preferences. Quantitative information from this review process includes a review of the applicant's level of care data from records and (in some cases) a telephone interview with the older client, a knowledgeable provider, or a caregiver.

A sample of 100 of those who are evaluated clinically on the basis of their assessment records will also receive an in-person assessment. The same information is collected for each person; only the method of collection varies. (To date, 66 in-person reviews have been completed.) We perform both the record-based and the in-person clinical evaluations as soon as possible after the pre-admission review process to minimize the effect of changes in clients' functioning.

Integration of Sample of Applicants for Long-Term Care

As shown in Figure 2-1, this sampling design and data-collection process will result in a data set that includes pre-admission review information, data on consumers' satisfaction, data on primary caregivers, clinical evaluations, and interviews with long-term care professionals.

Sample of Long-Term Care Professionals

We selected the above-mentioned samples to provide information to describe long-term consumer applicants, to examine their opinions about long-term care and pre-admission review, and to determine whether older Ohioans' long-term care needs are being met appropriately. Older persons and their families, however, are not the only groups affected by Ohio's new initiatives in long-term care. The challenges faced in implementing new long-term care policies are also important.

To assess the pre-admission review process, we interviewed a sample of long-term care professionals such as administrators and social workers from nursing facilities, hospital discharge planners, home health providers, employees from key social service agencies, and PAA employees. Five selected urban and rural regions of the state provided a variety of service settings for conducting qualitative interviews regarding this process. The study sites were

Cleveland, Cincinnati, Columbus, Rio Grande, and Toledo. Two rounds of interviews with 114 professionals in these five locations provided important information for clarifying issues of program implementation.

Because these interviews were conducted by a small number of researchers, we used a more qualitative approach based on a semistructured interview with open-ended questions. For example, interviews with professionals in hospitals focused both on their description of review activities and on their assessment of effectiveness. This approach is also appropriate because we sought suggestions for improving the current pre-admission review process.

What Are the Long-Term Care Use Patterns and Diversionary Effects of Community-Care Choices?

The expansion of community-based long-term care services has raised a question about the possible effects on nursing home utilization: Will the resulting changes divert long-term care applicants from nursing facilities to other community care choices? Again, our evaluation relies on multiple sources of data.

Changes in Populations in Long-Term Care Settings

One approach to examining diversion is to learn how the characteristics of long-term care recipients have changed over time. If pre-admission review is effective in directing clients to long-term care settings other than nursing facilities, we would expect the population of nursing facility residents to become increasingly impaired. That is, nursing facilities might serve more of those applicants for whom Community Care Choices would not be appropriate because of their greater health and safety needs. We anticipate that such changes in disability level would

occur as well for the population receiving community-based care. The Nursing Facility Minimum Data Set Plus (MDS+) and the PASSPORT in-person assessment database provide the information we need to examine these questions.

The Nursing Facility Minimum Data Set Plus (MDS+). Since December 31, 1992 and quarterly thereafter, all Medicaid-certified nursing facilities have assessed residents in Medicaid-certified beds with the State of Ohio Minimum Data Set Plus (MDS+). Data are collected for each of these residents who is physically present in the facility on the last day of each quarter. In addition, the facilities assess residents who are temporarily absent but are paying for a bed to be held (for example, those who are out for hospital stays, visits with friends or relatives, or participation in therapeutic programs).

This information includes data on demographic characteristics and on physical and mental functioning. The Ohio Department of Human Services makes quarterly compilations of the data from all facilities. The database includes about 81,000 nursing home residents each quarter.

PASSPORT in-person assessment database. The Ohio Department of Aging assembles data from the PAAs on each of the PASSPORT and OSS enrollees. This information system includes data on the 6,946 individuals who have been enrolled in PASSPORT and on 1,728 OSS enrollees. (These figures reflect only enrollees for whom data are available.) The database includes information on demographic characteristics, physical and mental functioning, and social supports.

Medicaid Utilization Rates of Nursing Homes

To assess diversion the evaluation also examined nursing home utilization under the Medicaid program. Two aspects of utilization were examined in this area of the analysis. First, efforts were made to use the Medicaid claims file to track Medicaid nursing home admissions and discharges in the period prior to and after implementation of the expanded community care choices. A detailed examination of occupancy rate changes could provide data to assess diversion. Because of the large volume of adjustments that occur within this data set (about 40 percent per month), this data set could not be used.

We also examined the nursing facility utilization patterns and trends using the MDS+ database. Several aspects of utilization were analyzed: 1) we compared the Medicaid nursing facility (and PASSPORT) utilization rates for 1993 and 1994. The utilization rate is the number of quarterly Medicaid nursing facility residents of a given age range for one thousand persons of that age range in the estimated population; 2) we analyzed attrition rate, and the length of stay for each quarter by mapping daily nursing facility admissions for three consecutive quarters (January 1, 1994 to September 30, 1994) and establishing estimated number of admissions, discharges and deaths; and 3) we matched applicants from the pre-admission review database with the MDS+ database to examine length of stay, and attrition rate by source of referral. The possibility of diverting applicants based on setting at the time of nursing facility application is also discussed.

Data sources for this aspect of the analysis include the PAR database, the MDS+, and Ohio Population Projections developed by the Ohio Data Users Center.

SUMMARY

In this chapter we presented the major research design and data collection strategies employed in the study. We rely on a range of primary and secondary data sources to address the major questions of the study. The remaining chapters present the results of these data collection efforts and their implications for policymakers.

CHAPTER 3

PRE-ADMISSION REVIEW POLICY AND PROCESS

The development of pre-admission review legislation was an effort to respond to three factors: increasing costs of nursing facility care, concerns that some individuals entered nursing facilities inappropriately, and a need to coordinate eligibility for community and institutional long-term care services in Ohio. The concept of pre-admission review for nursing facility placement, however, is not unique to Ohio. In a national evaluation completed in 1986, Interstudy identified 31 pre-admission review programs operating in 29 states. At that time, states cited cost control and support for families' long-term care decisions as primary policy goals of the pre-admission review (Iverson 1986). Expansion of pre-admission programs has continued; 36 states now use some type of review.

Several states in addition to Ohio (Connecticut, Florida, Minnesota, and Virginia) have evaluated their pre-admission programs. These evaluations focused on a variety of questions related to pre-admission review, and resulted in findings that are difficult to compare across studies (Doan and Lombardo 1992; Harkins and Bowling 1982; Moscovice, Davidson, and McCoffrey 1987; Yeatts, Capitman, and Steinhardt 1987). For example, results from Florida and Connecticut suggest that effective targeting of the pre-admission screen is critical in diversion and cost-effectiveness (Doan and Lombardo 1992; Yeatts et al. 1987). Minnesota (Moscovice et al. 1987) and other states (Iverson 1987) found that pre-admission review resulted in increased use of Medicaid-funded community services, while the use of services funded from other sources (such as Medicare and Title XX) actually declined.

PRE-ADMISSION REVIEW IN OHIO

Before the recent legislation was passed, Ohio used a record review process to ensure that individuals using Medicaid funds for long-term care had a legitimate need for care at the nursing facility level. This process, administered at the state level by the Ohio Department of Human Services (ODHS), reviewed applicants to nursing facilities after placement on the basis of information recorded by the facility; applicants did not receive an in-person assessment as part of the review process. Because of concerns that some individuals and families were not aware of the range of long-term care options and that some individuals might be able to live in other environments, new legislation was enacted in June 1993 to alter the long-term care review process.

The legislation was based on two major principles. First, before making a decision about the location and type of long-term care to be received, an individual consumer and his or her family should have access to a review of information about potentially appropriate long-term services. Second, individuals who require public support for long-term care via the Medicaid program should meet a certain threshold of disability; this should be determined before they receive publicly funded long-term care. Such a review is intended to gather adequate information as a basis for determining eligibility for nursing facility care, and to create the opportunity to discuss community alternatives with applicants and their caregivers.

THE MEDICAID PRE-ADMISSION REVIEW PROCESS

To implement this initiative, PASSPORT agencies were assigned responsibility for coordinating access and determining eligibility for services to individuals who requested care in

all Medicaid-reimbursed long-term care settings. PASSPORT Administrative Agencies (PAAs) make final determinations as to whether the degree of disability warrants public support for long-term care services. This determination, termed level of care (LOC), applies to all individuals requesting Medicaid reimbursement in nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), and the PASSPORT and Optional State Supplement programs.

The Medicaid pre-admission review process requires the PASSPORT agencies to make in-person assessments of individuals living in the community who request community or institutional long-term care supported by Medicaid. PASSPORT agencies also evaluate the need for in-person assessments for applicants from hospitals and nursing facilities before placement into or transfer between Medicaid-certified facilities. On the basis of an initial paper review of the applicant's needs for care, termed a desk review, the PASSPORT agencies determine whether the in-person assessment is required, and, if it is required, whether it can be delayed until after placement in the nursing facility.

The state's PASSPORT agencies are also responsible for portions of the pre-admission screening and annual resident review process (PASARR) mandated by the federal OBRA 1987 Nursing Home Reform Act. PASSPORT agency staff members screen all applicants for Medicaid-certified nursing facilities and the PASSPORT program, for indications of serious mental illness or developmental disabilities. The screen is initially a paper review, followed by an in-person assessment for those identified with possible mental health or mental retardation conditions. When they identify potential problems, PASSPORT agency staff members work with the Ohio Departments of Mental Health (ODMH) and Mental Retardation/Developmental

Disabilities (ODMR/DD) to determine whether the applicant needs specialized services and whether that individual has a legitimate need for care at the nursing-facility level.

Along with these procedural changes, the LOC criteria for nursing facility placement were modified in December 1993. Skilled and intermediate levels of care required for nursing facility and PASSPORT admission, and the protective level of care required for OSS enrollment, were defined more specifically by new administrative rules.

These elements together define the pre-admission review processes for individuals seeking Medicaid-reimbursed long-term care services in Ohio. Processes for nursing facility applicants are illustrated in Figure 3-1. PASSPORT and Optional State Supplement (OSS) application procedures are illustrated in Figure 3-2. These descriptions are based on our interviews with 114 long-term care professionals including PASSPORT agency staff members, hospital and nursing home staff members, and community referral sources and care providers.

THE NURSING FACILITY APPLICATION PROCESS

Community Medicaid Applicants

As noted above, the review procedures for applicants for Medicaid-reimbursed nursing facility care vary with the client's setting at the time of request. Community referrals, defined as persons in their own homes and apartments or in other community settings such as non-Medicaid-certified nursing facilities, psychiatric hospitals, group homes, prisons, and hospital emergency rooms, are required to undergo an in-person assessment before placement in a nursing facility. Before making an in-person assessment, the intake screening unit, staffed by social workers and nurses, takes initial information about the client's situation over the phone.

Figure 3-1

Request for Medicaid-Funded Nursing Facility Care

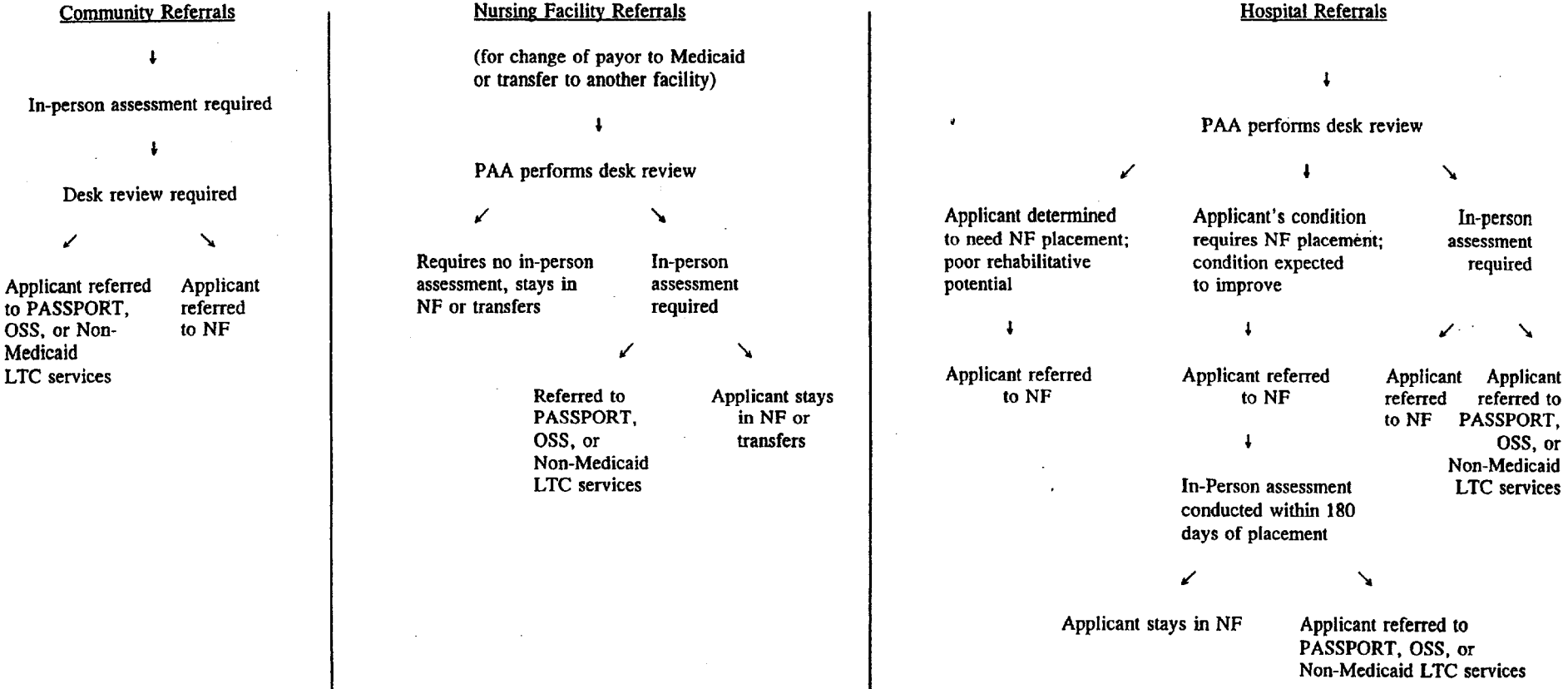
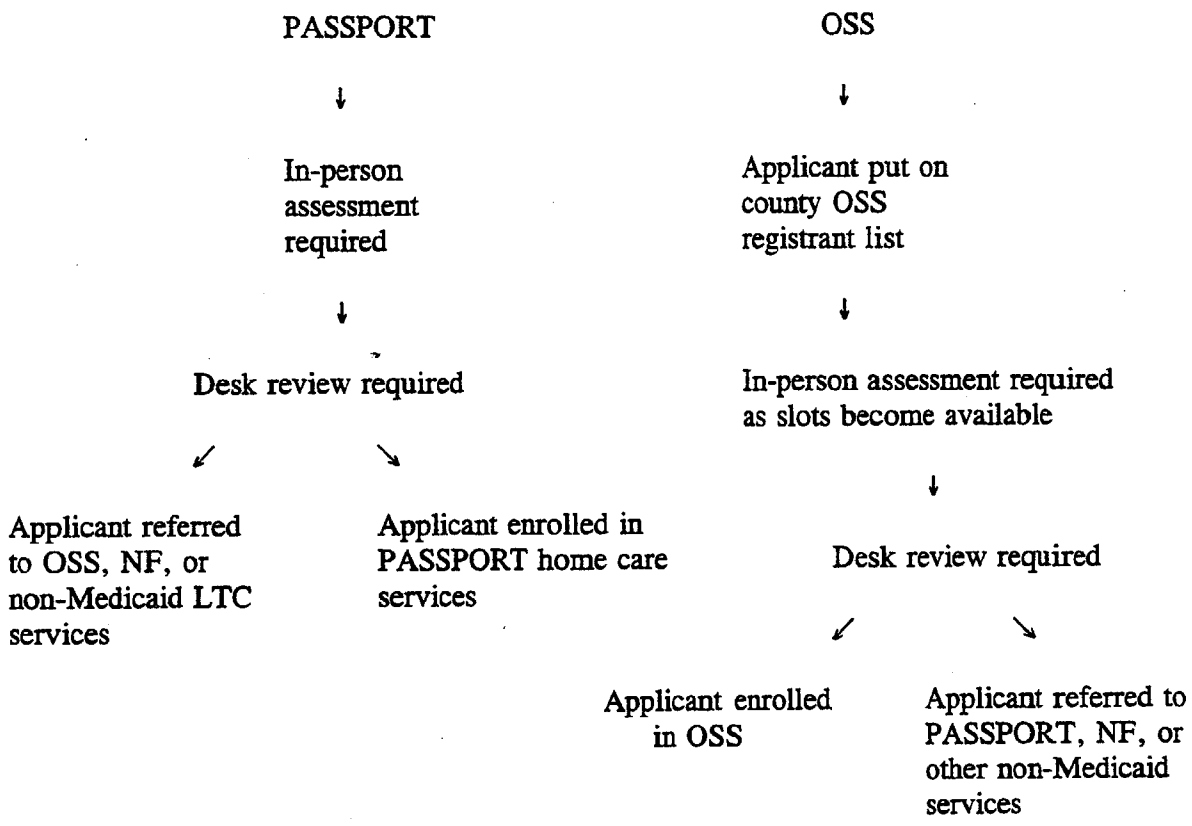


Figure 3-2

Request Procedure for
PASSPORT Home Care /OSS Group Home Reimbursement



Through this discussion of both clinical and financial eligibility, the objective of the intake screen is to develop a basic understanding of the applicant's need for care and request for service. Intake screeners may also gather required mental health/mental retardation information as appropriate for applicants to Medicaid-certified nursing facilities, regardless of their source of payment.

Depending on the client's specific request for care--nursing facility care, PASSPORT, Optional State Supplement, or a general assessment of home care needs--assessors perform either a "comprehensive assessment" (using the ODA's Form 1028) or the shorter level of care (LOC) assessment (ODHS Form 3697).

The in-person assessment is performed by a social worker and/or a nurse trained to determine level of care and presumptive financial eligibility for Medicaid. The goal of this assessment, especially for those still living in the community, is to explore the use of PASSPORT, OSS, or other community services as alternatives to a nursing facility. After the in-person assessment, separate staff members perform a desk review of the documentation to determine final program eligibility. Applicants are notified in writing about the outcome of this review. Professionals from key health and social services agencies report that the in-person assessment component for community applicants provides the consumer, family, and community professionals with valuable information about long-term care options.

Medicaid Hospital Applicants

Applicants who request Medicaid-reimbursed nursing facility placement from acute-care hospitals initially undergo a desk review by nurses or social workers at the PASSPORT agency.

Reviews for Medicaid-funded applicants are based on written information sent to the pre-admission unit by hospital social workers or discharge planners, for determination of the need for an in-person assessment and for level of care review. Also required is a physician's signature stating that the information provided is true and accurate. Hospital discharge planners have reported considerable frustration with this signature requirement and with the mental health/mental retardation screen. The level of care portion of the process, however, has caused less difficulty for this group than they anticipated.

Those Medicaid applicants who show a clear clinical need for placement in a nursing facility upon initial review are determined to be exempt from the in-person assessment. Others are identified as having potential for improvement; in those cases, the in-person assessment is delayed to within 180 days after admission. Those applicants whose level of care cannot be determined on the basis of the information submitted, or who request an assessment, must receive an in-person assessment within one calendar day of the request. In-person assessments also are performed for those who do not appear to meet the level of care criteria or who might be served better in a community setting. Applicants are notified in writing about the outcome of the review.

Medicaid Nursing Facility Applicants

Residents of nursing facilities who request transfer to another facility or whose payment status is changing from private or insurance reimbursement to Medicaid are considered a third, distinct referral group. Applicants from this group initially undergo a desk review. Nursing facilities typically submit information from a federally mandated standardized instrument, the

Minimum Data Set Plus (MDS+). The need for an in-person assessment is determined on the basis of the applicant's prognosis and potential for rehabilitation, or length of stay in the nursing facility. An applicant may be exempt from an in-person assessment, or the assessment may be delayed because of clinical circumstances. Applicants who have lived in the facility for more than 180 days are exempt from the in-person assessment.

PASSPORT/Optional State Supplement (OSS) Applicants

Applicants for both the PASSPORT and the Optional State Supplement (OSS) programs must undergo an in-person assessment regardless of referral setting. For PASSPORT applicants, intake screeners take initial information over the phone in preparation for an in-person assessment. For OSS, the applicant's request for service is maintained in a county-specific registry until a slot becomes available. The client is then assessed in person for the service; a comprehensive assessment tool is used. Desk review is performed after the in-person assessment, and the applicant is enrolled or referred to other services as appropriate.

Non-Medicaid Pre-Admission Review

Beginning January 1, 1995, non-Medicaid applicants to Medicaid-certified nursing facilities have been required to receive a pre-admission review. Non-Medicaid community applicants, like Medicaid applicants, require an in-person assessment by the PASSPORT agency to discuss long-term care options. Applicants whose stay is anticipated to be short (less than 30 days) are exempt from the process; applicants who meet the Medicaid level of care criteria are also exempt. Hospitals, nursing facilities, or PASSPORT agencies determine this initial

exemption, depending on the applicant's setting at the time of the request for nursing facility placement. Nursing facilities must notify the PASSPORT agency about these exempt individuals so that the agency can notify the new resident that an assessment is available. These facilities must request an assessment for residents whose stay extends beyond the period of exemption. They must also request an assessment for residents who, on request for a transfer to another facility or on readmission from a hospital, exhibit a significant improvement that would make them ineligible for Medicaid reimbursement.

Those non-Medicaid applicants from hospitals to nursing facilities who are not determined to be exempt by the hospital social worker or discharge planner require a pre-admission review. They must submit identifying and clinical information for use in determining need for nursing facility services. Assessment outcomes are not binding and do not prevent admission to the nursing facility; the goal is to provide applicants with information about their long-term care alternatives and about their potential eligibility for Medicaid-reimbursed services.

The Ohio Department of Aging reported 801 non-Medicaid requests for pre-admission review during January and February 1995.

Overall the pre-admission review process is intended to perform three functions: it responds to federal PASARR requirements, ensures that Medicaid applicants meet the established minimum level of care threshold of disability, and identifies and assesses in person the applicants most likely to use community-based long-term care services.

VOLUME OF PRE-ADMISSION REVIEWS

Because of the legislated changes in the pre-admission review process, it was important for the evaluation to determine the volume of reviews completed. The pre-admission review (PAR) database was designed to collect identifying information about applicants and to track them through the pre-admission process. Here we present pre-admission volume figures for all applicants to long-term care programs, regardless of payment status.

Table 3-1 displays the total volume of all pre-admission activity by the applicant's location and the source of payment for the services requested. For this 12-month period (January 1, 1994 to December 31, 1994), 99,039 requests were processed: 53,811 for Medicaid services and 45,228 for non-Medicaid services.

Hospitals were the primary location of individuals applying for long-term care services. Slightly less than one-half (46.7%) of all pre-admission applicants were being discharged from the hospital. Hospital referrals were especially dominant among those who did not require Medicaid. More than four-fifths (82.5%) of the non-Medicaid referrals, compared with only 16.7 percent of Medicaid applicants, were in hospitals. This figure can be explained by the fact that most individuals who seek nursing facility placement use Medicare or other private funds immediately after being discharged from the hospital.

The remaining applicants were divided between applicants located in the community (30.8%) and those located in nursing facilities (22.5%). Again, the distribution of applicants is related to payment status: a far higher percentage of Medicaid applicants (41.8%) than non-Medicaid applicants (17.5%) came from the community, possibly because PASSPORT applicants

Table 3-1

Volume of Pre-Admission Reviews, by Location of Applicant and Payment Status: January 1, 1994 to December 31, 1994

	Payment Status					
Location of Applicant	**Medicaid**	**Percentage**	**Non-Medicaid**	**Percentage**	**Total**	**Percentage**
Community Referral Setting	22,529	41.8	7,931	17.5	30,460	30.8
Hospital Referral Setting	8,985	16.7	37,297	82.5	46,282	46.7
Nursing Facility Referral Setting	22,297	41.5	0	0	22,297	22.5
Total	53,811	100	45,228	100	99,039	100

Source: Pre-admission review database.

are included in the community category, or because non-Medicaid applicants may be less likely to choose a nursing facility until a crisis occurs and they appear as applicants from hospitals.

A large proportion of the Medicaid referrals (41.5%) came from nursing facility residents. Most of these applicants were requesting Medicaid reimbursement for their stay after the use of Medicare benefits or the depletion of private resources. A very small percentage (2.6%) are current Medicaid-reimbursed residents of nursing facilities requesting transfer to another facility.

Table 3-2 identifies the type of service and the source of payment requested for all applicants reviewed from January 1, 1994 to December 31, 1994. Requests for nursing facility placement (80.4%) represent the great majority, followed by requests for PASSPORT (7.8%). About one-tenth of the total volume of reviews was requested for previously enrolled PASSPORT clients, reassessed for continued program eligibility. About two-thirds of the Medicaid applicants requested nursing facility care; another one-third requested review for PASSPORT services. Although these data cover a 12-month period, PASSPORT enrollment was restricted for three months because of funding limitations.

Because nursing facility placements represent such a large proportion of the pre-admission reviews, we examine these in greater detail. Table 3-3 identifies the referral setting and the source of payment requested for all applicants to nursing facilities. The table shows that the majority (56.3%) of all nursing facility applicants were hospitalized at the time of their request. Another 25 percent were living in nursing facilities and requested Medicaid payment. Only 14 percent of applicants were living in the community or other settings. Among Medicaid applicants, the majority (62.6%) already were living in a nursing facility; about 25 percent were

Table 3-2

Volume of Pre-Admission Reviews, by Service Request and Payment Status: January 1, 1994 to December 31, 1994

	Payment Status					
Service Request	**Medicaid**	**Percentage**	**Non-Medicaid**	**Percentage**	**Total**	**Percentage**
Nursing Facility	35,703	66.2	43,798	96.9	79,501	80.4
PASSPORT						
New applicants	7,808	14.5	0	0	7,808	7.8
Reassessed clients[a]	10,113	18.8	0	0	10,113	10.2
Optional State Supplement (OSS)	0	0	1,186	2.6	1,186	1.2
Other	187	0.5	244	0.5	431	0.4
Total	53,811	100	45,228	100	99,039	100

[a] PASSPORT reassessment is required every six months. Some applicants received more than one assessment.

Source: Pre-admission review database.

Table 3-3

Applicants to Ohio Nursing Homes: January 1, 1994 to December 31, 1994

Location of Applicant	Payment Status					
	Medicaid	Percentage	Non-Medicaid	Percentage	Total	Percentage
Community	4,421	12.4	6,501	14.8	10,922	13.7
Hospital						
New nursing admission	7,429	20.8	37,297	85.2	44,726	56.3
Nursing facility readmission	1,039	2.9	N/A	0	1,037	1.3
Changed nursing facility	464	1.3	N/A	0	464	0.6
Nursing Facility						
Changed nursing facility	2,527	7.1	N/A	0	2,527	3.2
Change of payor, same facility	19,770	55.5	N/A	0	19,770	24.9
Total	35,703	100	43,798	100	79,501	100

Source: Pre-admission review database.

in hospitals and requested Medicaid admission; 12 percent were in the community and requested Medicaid-reimbursed placement. Among the non-Medicaid applicants to nursing facilities, the great majority (85.2%) came from hospitals. Table 3-4 presents the volume of pre-admission review requests for each of the thirteen PASSPORT administrative agencies.

Overall these tables illustrate that referrals to long-term care services (specifically to nursing facilities) come primarily from hospitals. Most of these referrals are non-Medicaid, reflecting the fact that Medicare is the most common source of funds for hospital discharges to nursing facilities. When the payment source is Medicaid, however, applicants are most often living in nursing facilities; usually they are requesting a change of payor from Medicare or other resources to Medicaid.

CHARACTERISTICS OF THOSE RECEIVING A PRE-ADMISSION REVIEW

Although a Medicaid LOC determination requirement has been operating for some time, little is known about the characteristics of the people seeking long-term care services in Ohio. To address this issue we present demographic and functional characteristics of applicants requiring Medicaid pre-admission review. To reflect the two types of pre-admission review processes, we sampled from persons whose eligibility was determined by desk review only and from those who received an in-person assessment.

Information about the demographic characteristics, functional abilities, and living arrangements of those receiving an in-person assessment was available in data collected by the Ohio Department of Aging. We drew a sample of 1,867 pre-admission review applicants from the in-person assessment database. Because this sample is not proportional to the distribution

Table 3-4

Percentage of Total Volume of Pre-Admission Reviews for Thirteen PASSPORT Administrative Agencies

PAA	Location	Percentage
1	Cincinnati	12.5
2	Dayton	9.7
3	Lima	3.4
4	Toledo	8.9
5	Mansfield	5.0
6	Columbus	8.1
7	Rio Grande	5.6
8	Marietta	2.3
9	Cambridge	5.7
10A	Cleveland	19.2
10B	Akron	10.3
11	Youngstown	6.0
CSS	Sidney	3.1
Total		100%

of applicants reviewed in person in terms of their referral setting and outcome, we assigned weights to the applicants so that the data represent the total in-person assessments.

Data on those long-term care applicants whose eligibility was determined by only a desk review (PAR database) are more limited than on the in-person assessment group. We drew a sample of 838 applicants whose eligibility was determined only by a desk review. On the basis of a sample of desk review applicants, we recorded selected information on functional abilities, living arrangements, and demographic characteristics from records used at the PASSPORT agencies to make review decisions. Although a small percentage of applicants in this sample may later have received an in-person assessment, the data for this sample are collected only from information received at initial desk review. Information came from the Minimum Data Set Plus, for applicants already living in nursing facilities, and from transfer and continuity-of-care forms and physicians' records for applicants in hospitals. This sample does not correspond to the actual population of pre-admission review applicants in terms of age, referral setting, and outcome. Again we used weights to make the data represent the population of long-term care applicants who received only a desk review.

Findings

Findings for the sample are presented for the two major pre-admission review categories: in-person assessment and desk review. Age data were available for all applicants. Although long-term care is often regarded as a service for the elderly and although the evaluation focuses on the older long-term care applicants, long-term care needs occur in all age groups. In the first column of Table 3-5 we present data on the age distribution of all pre-admission review

Table 3-5

Demographic Characteristics of Clients Receiving a Pre-Admission Review: January 1, 1994 to December 31, 1994

Characteristic	All Pre-Admission Reviews	In-Person Assessment		Desk Review[b]
		Under 60 (Percentage)[a]	60 Years and Older (Percentage)[a]	60 Years and Older (Percentage)[a]
Age				
Less than 1	0.4	1.0		
2-18	0.2	1.2		
19-45	2.9	47.1		
46-59	4.0	50.7		
60-65	5.4		9.7	7.2
66-74	19.2		26.5	20.1
75-84	36.6		38.6	38.5
85-90	20.3		17.1	22.6
91+	10.9		8.1	11.6
Average Age	78.0	43.8	78.0	79.7
Gender				
Female	N/A[c]	46.7	77.5	68.8
Race				
White	N/A	78.5	73.9	95.8
Marital Status	N/A			
Never married		59.1	6.2	9.0
Widowed/divorced/ separated		32.2	72.7	64.9
Married		7.7	21.1	26.1
Current Living Arrangement	N/A			
Own home/apartment		24.8	72.5	2.0
Relative or friend		14.6	17.9	1.1
Congregate housing/ elderly		0.9	1.3	0.2
Group home		53.7	6.9	0.4
Nursing facility		0.5	0.1	48.3
Acute hospital		0.0	0.0	36.2[e]
Other		5.5	1.3	11.8
Population	99,039	1,642	28,979[d]	
Weighted Sample				33,572

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.
[b] The information in this column is based on a stratified random sample of applicants requesting Medicaid long-term care services.
[c] Pre-admission review database has no demographic information on applicants, except date of birth.
[d] The in-person assessment database records each assessment independently. Some PASSPORT clients have multiple assessments in this database.
[e] These applicants were referred to desk review from a hospital.

Sources: In-person assessment database; Pre-admission review database.

applicants. Ninety-two percent of the applicants are age 60 and over; 7,357 applicants under age 60, however, requested long-term care services requiring a pre-admission review. Overall the average age of pre-admission review applicants was 78; on average, non-Medicaid applicants were four years older than Medicaid applicants (80 and 76 respectively).

The demographic characteristics of Medicaid long-term care applicants are examined in the remainder of the table. Consistent with the overall figures on pre-admission review, the proportion of applicants under age 60 who received an in-person assessment is relatively small (5% of the in-person sample). As expected, the younger and the older in-person applicants differ markedly: nearly eighty percent of the over-60 in-person applicants are female, compared with less than half of the younger group. More than 70 percent of the over-60 in-person group are widowed or divorced, while almost 60 percent of the younger group have never been married. Almost three quarters (72.5%) of the over-60 group live in their own home or apartment; more than half (53.7%) of the younger applicants live in group homes.

We also compare the over-60 applicants in the in-person assessment group with those receiving only the desk review. Those who received only a desk review were older, less likely to be female, and less likely to belong to a minority group. Marital status is similar in the two groups. We found considerable differences in living arrangements between the groups at the time of the assessment: nearly half of the desk review sample, but fewer than 1 percent of the in-person group, lived in a nursing facility. These figures reflect the procedural differences in the design of the pre-admission review process.

When the impairment levels of those who received only a desk review are compared with those receiving an in-person assessment, we find that the desk review sample is more

functionally impaired (see Table 3-6). On average, the desk review applicants have a greater number of impairments in activities of daily living (3.6 to 2.8). A much higher percentage have four or more functional impairments (60.5% versus 34.2%), and a greater proportion have at least one cognitive impairment (48.6% versus 42.4%). These characteristics reflect the intention of the desk review process: to allow nursing facility admission for applicants who are served appropriately in an institutional long-term care setting, without requiring an in-person assessment.

Timeliness of Pre-Admission Review

As the pre-admission process was developed, hospitals and nursing facilities expressed concern about timeliness of access to placement in a nursing facility. Hospitals were concerned that delays would occur for individuals who needed such placement, and that additional hospital days would result. Nursing facilities were concerned about delays for individuals at home or in the hospital who awaited placement. Specific timeline requirements were developed to address this concern. Information on the date of request and the date of the decision are recorded in the pre-admission review database. This database was developed in phases as PASSPORT's responsibilities for pre-admission increased and as new referral sources were required to participate. Significant changes were made to the system in May 1994; these allowed for more complete and more specific data entry for desk review referrals. The evaluation of timeliness of review is based on analysis of the period from June 1 to December 31, 1994, for hospital and nursing facility applicants. In order to evaluate the timeliness of the in-person component of the process, we collected a sample of 264 nursing

Table 3-6

Functional Characteristics of Pre-Admission Review Applicants:
January 1, 1994 to December 31, 1994

Characteristic	In-Person Assessment 60 Years and Older (Percentage)[a]	Desk Review[b] 60 Years and Older (Percentage)[a]
Percent with Impairment in Activities of Daily Living (ADLs)		
Bathing	78.7	83.5
Dressing	54.6	76.6
Transfer	35.4	64.0
Toileting	37.6	69.9
Eating	14.4	33.5
Grooming	44.5	74.1
Number of ADL Impairments[c]		
0	15.6	18.3
1	7.2	5.5
2	22.3	7.0
3	20.7	8.7
4 or more	34.2	60.5
Average Number of ADL Impairments	2.8	3.6
Cognitive Impairment		
Confused	7.9	27.5
Disoriented on name, date, or place	35.7	40.1
Wanders	11.9	2.3
One or More Cognitive Impairments[d]	42.4	48.6
Rehabilitation Potential		
Improve	N/A[e]	25.5
Prognosis		
Fair, good	N/A	61.9
Weighted Sample	18,586	33,572

Note: The information in this table is limited to a small sample. The sample is weighted to mirror the population.

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.
[b] The information in this column is based on a stratified random sample of applicants requesting Medicaid long-term care services.
[c] From list above.
[d] Problem indicated on at least one of the items from list above.
[e] This information is not available on the community referrals.

Source: Scripps study sample.

facility applicants who received an in-person assessment between January and December 1994. The proportion of the total pre-admission review population requiring an in-person assessment is estimated to be 51.7 percent.

Table 3-7 presents the number of days between a request for pre-admission desk review and the final decision on level of care for desk-review-only applications from hospitals and nursing facilities. PASSPORT agencies are required to complete reviews from hospitals within one calendar day of the request because hospital discharge planning staff members often need a prompt turnaround to facilitate discharge and placement into a nursing facility. More than four-fifths (82.8%) of requests from hospitals received a response within the same day, and 92 percent within the one-calendar-day requirement. Three and one-half percent of all hospital applicants were identified as not within the one-day timeline because they required further review for mental health/mental retardation (PASARR) before discharge; thus 96.5 percent of all hospital reviews were completed within the required timeline.

Requests from nursing facilities must undergo desk review within five days. The great majority (92.2%) were completed within this deadline; just over half (51.8%) were completed on the day of the request. On average, requests from nursing facilities were reviewed within two days. Applicants from the community are required to be assessed in person within five days of the request for nursing facility placement. Timeliness of the in-person assessment is an evaluation of the time elapsed between the initial date of the telephone intake screen and the date the assessment was performed. The majority (87.8%) of these assessments were performed within five days. On average, community applicants were assessed in person in just under three days. Assessments performed six or more days after the request include both applicants who

Table 3-7

Timeliness by Referral Setting:
January 1, 1994 to December 31, 1994

Number of Days between Review Request and Outcome	Percentage/Average
Nursing Facility	
0 (same day)	51.8
1	19.6
2	5.9
3	7.3
4	4.0
5	3.6
6 or more days	7.8
Average number of days	1.8
Hospital	
0 (same day)	82.8
1	9.3
Delayed by PASARR further review	3.5
2 or more	4.4
Average number of days	.7
Community	
In-Person Assessment	
0	11.7
1	29.5
2	17.0
3	14.4
4	7.2
5	8.0
6 or more days	12.2
Average number of days	2.9
Desk Review	
0	42.0
1	11.0
2	5.7
3	5.7
4	6.1
5	4.5
6 or more days	25.0
Average number of days	3.6

Source: PAR database (June 1 to December 31, 1994), Community to NF in-person assessment sample (January 1 to December 31, 1994, Scripps).

requested a specific assessment date, and therefore are exempt from the timeliness requirement, and those out of compliance. Data to distinguish these cases were not available.

Timeliness of the desk review for community applicants, as with hospital and nursing facility applicants, is reported as the amount of time elapsed between the date the desk review unit received the in-person assessment paperwork, and the date the final level of care decision was made. Seventy-five percent of desk review requests for community applicants were completed within five days. On average, the desk review was completed in 3.6 days.

In a few sites, desk review timeliness for community applicants did not receive the same level of priority as hospital and nursing facility applicants. In many cases, community applicants had already been admitted to the nursing facility following the in-person assessment. Thus, timeliness of the desk review was less significant to the placement process.

To supplement these data on timeliness, our evaluation team also used information from interviews with health and social services professionals working in long-term care. The team especially wished to learn how hospital discharge planners and nursing facility administrative staff members viewed the pre-admission review process. Interviews with hospital and nursing facility personnel at 37 facilities reinforced the quantitative findings.

Hospital respondents reported an initial concern about the implementation of pre-admission review, but stated that they had encountered very few delays as a result of the new process. These respondents consistently reported that the process was more efficient and more timely than previous efforts. Hospital staff members stated that the (PASARR) mental health/mental retardation screen required by the federal government was much more troublesome than the state's pre-admission screening program. Although hospital respondents were generally

satisfied with the implementation of the pre-admission review by the PASSPORT agencies, they described the process itself as a duplication of their own assessment of the client's long-term care needs. They suggested that the small number of level of care denials was evidence of this duplication.

Nursing facility respondents also were consistently positive in describing the implementation of the pre-admission review process. Staff members stated that most of their referrals came from hospitals. Nursing facility staff members emphasized the changing nature of the industry: nursing facilities reported that they serve a much higher proportion of short-term residents today than in the past.

COSTS OF PRE-ADMISSION REVIEW

The costs of the pre-admission review can be found in several areas of PASSPORT program activities: components of this review are included in telephone intake screening, assessment, and desk review. Because PASSPORT cost-reporting mechanisms did not differentiate between costs associated with desk review and types of in-person assessment performed, we implemented a time study in order to develop an allocation model for the cost analysis. The time study format distinguished pre-admission activity from other PASSPORT program activity (see Appendix for time study reporting form).

The five sites chosen as part of the long-term care professional sample were asked to participate in the time study. All members of the PASSPORT staff participated at each of the sites. Each site selected a one-week period of normal program activity during September or October to record its activities. To ensure that the study captured differences in responsibilities

for program areas, we pretested this approach at all five sites. Staff members then met with the evaluators to identify and clarify problem areas, and served as resources to other staff members when the time study was implemented.

We calculated the results of the time study using a step-down allocation method. Average monthly disbursements for fiscal year 1995, plus unpaid obligations, were calculated from the PASSPORT monthly financial reports for the month of the time study at each site. The proportion of time spent on pre-admission activities was applied to the resulting budget figures. We identified costs for each category of activity, and applied the reported volume of activity to develop a per-unit cost. We used actual weekly screening and assessment figures for the period corresponding to the study in each site to determine volume of screening and assessment activity.

The cost figures reported here are a weighted average unit cost, aggregating costs and volume from the five sites. Monthly volume figures are an extrapolation of actual weekly figures for screening and assessment activity across the five sites to monthly estimates. Monthly volume of desk reviews is based on reported activity in each site during the month of the time study.

Findings

Cost estimates for pre-admission functions are divided into clinical categories of activity and are presented in Table 3-8. Reported figures include administrative and clinical costs. The cost of a telephone intake screen, which is conducted before every in-person assessment, was estimated to be $54. The difference in estimated cost between an in-person assessment for nursing-facility level of care ($213) and a comprehensive assessment for PASSPORT or other

Table 3-8

Estimated Cost of Pre-Admission Review, by Function for Five Selected PASSPORT Agencies

Pre-Admission Review Function	Estimated Monthly Volume	Average Cost
Telephone Intake Screening		
Telephone screens for nursing facility LOC, PASSPORT, OSS, delayed assessments	1,449	$54
In-Person Assessment		
Nursing facility LOC	245	$213
Comprehensive assessment for PASSPORT, OSS, community-based, and delayed	1,019	$304
Desk Review		
PASARR mental health/mental retardation screen	3,036	$11
LOC submitted by hospital for nursing facility placement	457	$32
LOC submitted by nursing facility	1,281	$30
Community LOC for nursing facility placement	241	$29
PASSPORT/OSS	877	$12

Sources: Scripps time study, PASSPORT monthly financial report, weekly PAA activity report, PAA screen report, manual PAR activity report, Ohio Department of Aging.

community care ($304) is probably due to the difference in the level of information that is gathered and the time spent with the applicant. The LOC assessment for nursing facility admission is performed with a shorter form (ODHS 3697); this is designed to determine LOC eligibility, not to assess the living environment and to develop a plan of care, as does the comprehensive assessment form.

Differences in estimated desk review cost appear to be related to the structure of the review process. The mental health and mental retardation screen (PASARR), the most common review (estimated at $11), is simply shorter and therefore less costly. A single form (ODHS 3622) is generally used for this review. Hospital-submitted reviews for level of care may be slightly more costly (estimated at $32) because of the variety of forms and sources of information that a reviewer may be required to evaluate. Reviews submitted by nursing facilities ($30) are generally entered on the MDS+ form, but reviewers may not consistently find information in the same place on the form because several computerized versions are in use. The difference in cost between community LOC ($29) and PASSPORT/OSS ($12) reviews is the most surprising finding because PASSPORT assessors perform both of these assessments in person, using standard forms, and submit them to desk review. It is possible that desk review staff members reported the time difference between these types of reviews less precisely because both reviews were provided by the PASSPORT assessment staff.

Because applicants from the various referral settings have different review requirements, costs may differ between types of review. Table 3-9 presents common pre-admission scenarios. Community applicants, for example, always require a telephone intake screen, an in-person assessment (either comprehensive or LOC, depending on their request for service), and a desk

Table 3-9

Estimated Costs Of Pre-Admission Review[a]

Request for Preadmission Review	Telephone Intake and In-Person Assessment	Desk Review		Total Costs
		PASARR Screen	Level of Care Determination	
Community Request for Medicaid Nursing Facility Placement	$267	$11	$29	$307
Hospital Request for Medicaid Nursing Facility Placement		$11	$32	$43
With delayed in-person assessment	$358	$11	$32	$401
Nursing Facility Request for Level of Care			$30	$30
With delayed in-person assessment	$358		$30	$388
Request for PASSPORT	$358	$11	$12	$381
Request for OSS	$358		$12	$370

[a] Based on results from five selected PASSPORT agencies.

Sources: Scripps time study, PASSPORT monthly financial report, weekly PAA activity report, PAA screen report, manual PAR activity report, Ohio Department of Aging.

review. Total pre-admission review costs for a PASSPORT applicant could be as high as $381 when the costs of an intake screen, a comprehensive assessment, and a PASSPORT desk review and PASARR review are added. In contrast, hospital reviews for applicants who are determined by desk review to be exempt from the in-person assessment could cost as little as $43, for the desk review and PASARR screen. Hospital reviews for applicants determined to require a delayed in-person assessment include the costs of an initial hospital desk review ($11 PASARR and $32 level of care), a telephone intake screen, and a comprehensive assessment ($358), for a total of $401.

Costs of the pre-admission review vary depending on where the applicant is living and which components of the process are required. Concerns about cost-effectiveness can be addressed only by juxtaposing costs with benefits. One source for this type of analysis is a comparison of adverse (denial of service) outcomes by setting.

An analysis of the PAR and in-person databases resulted in some information about adverse determinations. Adverse determinations for the purpose of this analysis were those that resulted in denial of Medicaid long-term care services. As shown in Table 3-10, for applicants in hospitals, fewer than one-half of one percent (0.32%) were determined not to meet the level of care criteria. Nursing facility applicants were denied level of care only 0.71 percent of the time, and community applicants 1.8 percent. Among PASSPORT applicants, 0.67 percent were denied services on the basis of level of care, but another 10.2 percent withdrew their requests.

The LOC-determining function of the pre-admission review is only one way to assess the benefit of the pre-admission process. Very few applicants from any setting are denied admission to nursing facilities. This fact might suggest that applicants are seeking nursing facility care

Table 3-10

Adverse Level of Care Determinations by Referral Setting

	Percentage[a]
Nursing Facility	.71
Hospital	.32
Community (all Applicants)	.94
Nursing Facility Applicants	1.80
PASSPORT Applicants	.67
OSS Applicants	.80

Source: PAR database.

appropriately, in view of the current criteria. This finding, however, does not anticipate changes in referral patterns in the absence of a pre-admission process. It does not identify benefits of the in-person assessment process to consumers, nor does it report the ability of Community Care Choices to prevent application to nursing facilities.

INTERVIEWS WITH PROFESSIONALS: FINDINGS AND ISSUES

The evaluation team conducted two rounds of site visits to five sites across the state during 1994 (see Appendix for site selection criteria). A total of 114 interviews were conducted with staff members at PASSPORT agencies, hospitals, nursing facilities, OSS providers, community health and social service agencies, and county departments of human services. The following issues were raised most often by these professionals.

Community Relationships

Interviews with professionals in all of these settings in the five sites produced the impression that the PASSPORT agencies have developed positive relationships in the community as the pre-admission review has been implemented. Overall, initial concerns about significant changes in the Medicaid long-term care application process have been resolved. The professionals expressed concern and uncertainty, however, about the implementation of universal pre-admission review, which began January 1, 1995.

Service Availability

The availability of alternatives to nursing facility care is crucial to the effectiveness of the pre-admission review. Professionals from all settings expressed concern that PASSPORT has a history of opening and closing its enrollment periods unpredictably and that it was closed or significantly restricted during the first months of 1994. Some respondents said they had simply given up tracking the status of the program; only half of the respondents knew whether the program was open for enrollment at the time of the interview.

Hospital staff members did not believe that PASSPORT could begin delivering services on the day of discharge from the hospital. PASSPORT administrators stated that delays in beginning service were due to a lack of available paraprofessional home care workers in some communities.

Professionals from all settings stated a need for an assisted living service and for residential services for adults with mental health needs. Many county OSS programs had waiting lists; professionals in all settings could identify nursing facility applicants or current residents who might not require institutional care if supportive residential alternatives were available.

Professionals from all settings perceived that traditional community services were not readily available, and that their caseloads included individuals who are functionally eligible for services but do not meet the Medicaid financial criteria. Respondents in counties with locally funded community service programs spoke explicitly about the advantages of service availability in their counties, and referred their clients regularly to these programs.

Hospital, nursing facility, and PASSPORT assessment staff members consistently reported that the availability of a primary informal caregiver was crucial for community-based

alternatives to nursing facility care. They also agreed that the early discussion of long-term care alternatives was most effective at influencing a family or applicant's decision making.

Nursing facility discharge planning was recommended by several respondents as an area for policy change. One nursing facility respondent suggested the elimination of the pre-admission process requirement for facilities whose discharge rates to community settings are within an established percentage of admissions. Another suggestion for the identification of potentially dischargeable nursing facility residents was to use the existing Resource Utilization Groups Scale, used to establish nursing facility reimbursement. Individuals identified as needing fewer services in the nursing facility could be assessed by the PASSPORT agency as part of the review process, regardless of their length of stay.

Program Management: Gatekeeping and Advocacy

The structure and goals of the PASSPORT program present significant management challenges. The program is designed to be available to all who meet the eligibility requirements, but is limited in its enrollment capacity. This situation creates an inherent conflict between the program's service advocacy and gatekeeping functions. For example, all sites are required to assess (and enroll) eligible applicants within specific periods of time their request. Statewide caseload is limited by budgetary constraints, and each site responds to unofficial enrollment targets. As a result, the gatekeeping and the service advocacy roles are placed in conflict at sites where demand is especially high. Community professionals describe the advantages of providing coordinated alternatives to nursing facility care, but have been frustrated in the past by inconsistent availability of services.

In response to these conflicts, state-level administrators and PASSPORT Administrative Agencies have made significant efforts to plan for consistent service availability and geographic equity. These issues will continue to challenge the program, especially as Ohio's older disabled population increases.

Conclusions

The results of the professional survey suggest that the effectiveness of the pre-admission review depends not only on the alternatives available in the service system, but also on the timeliness of the discussion of these alternatives. Applicants and their caregivers should be provided with the tools for making decisions while housing and informal care are still in place. Professionals in all settings should be prepared to present alternatives, and at the earliest opportunity should refer applicants and their caregivers to the coordinating PASSPORT agency for lower-cost alternatives. Because we know that very few applicants to nursing facilities are denied admission, the process may be more effective at creating diversion if it prevents applications to those facilities. These policy issues will be examined further in the final chapter.

SUMMARY

In this chapter we have described the pre-admission review process, its goals, and its design. Applicants from various settings experience the process differently, and may not require all of the components. The volume and the characteristics of applicants differ across settings. Applicants from hospitals made up the majority of nursing facility applicants; applicants for Medicaid reimbursement were most often residents in nursing facilities. These two groups were

more significantly impaired than community applicants, and most of the applicants were over age 60. Overall, timeliness requirements for the review are being met. Professionals are satisfied with the PASSPORT agencies' implementation of the process, but express some concerns about the availability of services and about universal pre-admission review. In Chapter 4 we present consumers' and caregivers' perspectives on the pre-admission review.

CHAPTER 4

EFFECTIVENESS OF THE PRE-ADMISSION REVIEW: APPROPRIATENESS AND SATISFACTION

One of the major questions addressed in this study is whether the pre-admission review process results in an appropriate placement for the long-term care applicant. This process should determine eligibility for long-term care services, explore alternative settings for the care that is needed, and encourage long-term care consumers to choose the setting and services that best meet their needs and preferences. Appropriateness of placement is concerned with the individual's health and safety, and with the consumer's preferences.

Two dimensions of the pre-admission review process are examined in this chapter. First we present data on the appropriateness of the long-term care setting, based on clinical assessments by a team of health and social service professionals. Then we present data from consumers and their caregivers about the pre-admission review process and the outcomes of the review.

CLINICAL APPROPRIATENESS STUDY

To address clinical appropriateness of placement, we used a two-phase strategy. In the first phase an expert clinical team from the University of Cincinnati Office of Geriatric Medicine, composed of a physician, a nurse, and a social worker, all trained specifically in geriatrics, evaluated the appropriateness of placement of a sample of long-term care applicants by examining their assessment records and making telephone calls to the client, caregiver, or provider. In the second phase we selected a subsample of the above applicants to receive an in-

person clinical visit from one of the team members in addition to providing the data we examined in the first phase. The findings reported in the following section are based on 579 completed record reviews and 66 in-person clinical visits.

The measure for appropriateness of placement was designed to capture information that would be included regularly in a professional geriatric assessment. The clinical expert team assigned numerical ratings for each area of client functioning to provide quantitative data for research. The measure includes an assessment of functional impairment, of mental, physical, and social functioning, and an evaluation of economic and environmental needs, as well as of clients' and caregivers' overall satisfaction with placement and services.

Findings

In Table 4-1 we present the findings from the in-person clinical sample and the larger record review sample. Findings from both the clinical and the record review sample showed that in the great majority of cases, clients were in an appropriate long-term care setting (98.3% and 93.6% respectively). Differences in the percentages appropriately placed are found between the record review and the in-person clinical evaluations, as well as between the clients' settings for long-term care services. Among those clients whose records were evaluated, for example, 8.6 percent of the applicants to nursing facilities were viewed as inappropriately placed, compared with 5.2 percent of those referred to the community. When an in-person clinical evaluation was made, however, 100 percent of the referrals to nursing facilities were supported, as were 97.2 percent of the referrals to the community. The clinical team reported that when a client was judged to be placed inappropriately in a nursing facility, the judgment usually

Table 4-1

Clinical Experts' Evaluation of Long-Term Care Placement

	Clinical Record Review Sample	Clinical In-Person Sample
Percentage of Placements Supported by Clinical Evaluation	93.6	98.3
Percentage with Impairment in Activities of Daily Living (ADLs)		
Bathing	92.7	90.8
Dressing	75.3	73.4
Transferring	51.1	33.3
Toileting	56.2	40.0
Eating	26.3	23.4
Grooming	79.0	67.7
Number of ADL Impairments (percent)		
0	8.3	9.1
1	4.0	13.6
2	13.8	9.1
3	17.1	28.8
4 or more	56.9	39.5
Average Number of ADL Impairments	3.7	3.2
Percentage of Clients in Long-Term Care Placement		
Community	67.2	61.0
Nursing facility	32.8	39.0
Percentage of Clients Satisfied with Placement	91.2	91.1
Percentage of Caregivers Satisfied with Placement	93.1	94.3
Sample	579	66

derived from a strong conviction on the client's part that he or she should be living in the community. Several of these individuals had been transferred to a nursing facility from the hospital for a supposedly short stay that had not ended; these clients felt trapped. Generally, individuals who were judged to be inappropriate for community services were people with limited family support. In some situations, clients agreed that they were at some risk at home; in others, the clinical assessment conflicted with the client's stated preferences.

As one would expect, the clinical team reported that their in-person evaluations were more accurate than the record reviews. It was advantageous to observe complex or at-risk clients directly in their own environments. The team also found that record reviews usually made it possible to identify those clients who could be assessed more accurately through an in-person visit.

A major concern was whether the pre-admission review process resulted in appropriate long-term care placements for applicants. Clients' needs for health care services, their safety, and their personal preferences must be balanced in making a clinical decision. The clinical experts' review team agreed with the appropriateness of the long-term care placements for clients in the great majority of the cases, in both the record review and the in-person clinical components of the research.

CONSUMERS' AND CAREGIVERS' SATISFACTION WITH THE PRE-ADMISSION REVIEW PROCESS AND THE OUTCOMES OF THAT REVIEW

The success of a social policy can be measured by the extent of satisfaction among those affected by the policy. Information about satisfaction with programs is an important source of feedback for monitoring program quality and for determining whether programs meet the clients'

needs appropriately. The satisfaction component of the pre-admission evaluation focuses on two groups of people who are affected by long-term care services and programs in Ohio: older long-term care applicants, and friends and family members who are the primary caregivers. We conducted in-person interviews with pre-admission review applicants (or with proxies, when the client was cognitively impaired) and held telephone interviews with a sample of their informal caregivers to examine satisfaction with the pre-admission review process and the outcomes of the review. In the following section we present data from 720 interviews with pre-admission review applicants and 353 interviews with caregivers.

Measures of Satisfaction

Long-Term Care Applicants

To determine what kinds of questions about the pre-admission review and long-term care services were most relevant, we conducted qualitative interviews containing open-ended questions with older long-term care applicants or their proxies. We then pretested structured interview schedules with a sample of 20 long-term care applicants and their proxies before the questionnaire was fielded statewide. The questionnaire covers satisfaction with the pre-admission review, long-term care services, the kind and extent of help received, any unmet needs for help, and some overall questions about satisfaction and health. The Appendix contains selected questions and the frequency of responses.

Caregivers

Many of the caregiver questionnaire items were designed to be comparable to those included in the client interview, including caregiver's satisfaction with client's living arrangements, satisfaction with client's assessment, and satisfaction with client's paid help. We used several other questionnaire items to create measures of the caregiver's level of involvement and well-being, including caregiver's strain, provision of tasks, use of formal services; and perceived need for services. We pretested the questionnaire with 10 of the caregivers of the long-term care applicants who participated in the pretest.

Findings

Description of Applicants

The findings reported here are based on 720 face-to-face interviews with older long-term care applicants or their proxies, lasting approximately 45 minutes each.

Those contacted for participation in the consumer satisfaction interview are taken from a stratified random sample of pre-admission review applicants. The use of such a sample ensured that clients who requested long-term care services while living in the community, when being discharged from the hospital, and when changing nursing facilities or converting to Medicaid while living in a nursing facility were allowed to speak about their satisfaction with pre-admission review and the long-term care services they receive. As described in Chapter 2, we oversampled applicants with the greatest opportunity to take advantage of Community Care Choices. The sample includes a small number of clients who did not qualify for Medicaid long-term care services, although the great majority of participants in the consumer satisfaction survey

receive such services. Fifty percent of the long-term care applicant sample participated in the study. Approximately 16 percent of those whom we reached refused to participate, 15 percent could not be reached, 10 percent were deceased, and 9 percent were cognitively impaired and lacked a caregiver to serve as a proxy. We conducted interviews with proxies in about one-third of the cases. This approach seems appropriate because multivariate analyses showed that the results were not affected significantly by whether the client or the proxy responded to the survey. If clients refused the clinical evaluation, we did not contact them for participation in the consumer satisfaction interview.

Most participants in the satisfaction interviews are white (78.5%), female (76.8%), and not married (79.1%) (see Table 4-2). Their distribution across settings reflects our stratified sampling plan: about half live in the community in their own homes or with relatives or friends, about one-third live in nursing facilities, and the remainder live in other types of group settings such as board and care facilities or congregate housing. As shown in Table 4-3, participants show a high degree of impairment: nearly half (44.2%) have four or more impairments in activities of daily living, and more than 90 percent (93.1%) have four or more impairments in instrumental activities of daily living.

Applicants' Satisfaction with the Pre-Admission Review

Clients' satisfaction with the pre-admission review process provides valuable information about the implementation of the process. As mentioned earlier, only a portion of Medicaid pre-admission review applicants receive an in-person assessment. The assessment satisfaction portion of the interview was limited to those who had received such an assessment.

Table 4-2

Demographic Characteristics of Long-Term Care Applicants Responding to Satisfaction Survey

Characteristic	Percentage[a]
Gender	
Female	76.8
Race	
White	78.5
Marital Status	
Never married	7.1
Widowed/divorced/separated	72.0
Married	20.9
Current Living Arrangement	
Own home/apartment	36.9
Relative or friend	12.8
Congregate housing for elderly	10.8
Group setting	4.8
Nursing facility	32.5
Years of Education	
0 - 11	64.5
12	25.9
13 or more	9.6
Average Years of Education	9.4
Respondent Interviewed[b]	
Client	65.7
Proxy	34.3
Sample	720

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.

[b] Proxies were used when clients were cognitively impaired or otherwise unable to be interviewed.

Table 4-3

Functional Characteristics of Long-Term Care Applicants Responding to Satisfaction Survey

Characteristic	Percentage[a]
Percentage with Impairment in Activities of Daily Living (ADLs)[b]	
Bathing	85.4
Dressing	59.1
Transferring	41.3
Toileting	40.1
Eating	14.3
Grooming	71.8
Number of ADL Impairments	
0	9.7
1	13.7
2	16.5
3	15.8
4 or more	44.2
Average Number of ADL Impairments[c]	3.5
Percentage with Impairment in Instrumental Activities of Daily Living (IADLs)[b]	
Phoning	37.4
Transportation	90.4
Shopping	93.6
Meal preparation	86.2
Housecleaning or laundry	97.0
Heavy chores	97.0
Legal and financial	77.5
Medication administration	64.5
Number of IADL Impairments	
0	0.4
1	0.7
2	1.8
3	4.0
4 or more	93.1
Average Number of IADL Impairments[c]	5.6
Sample	720

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.

[b] Impairment includes all who received formal and/or informal help in the previous week to perform the task.

[c] From list above.

Applicants were given a choice of four responses from most negative to most positive for each question. As shown in Table 4-4, quality of choices offered was the area of the pre-admission review that least often received the most positive response. This was also the only area that showed significant differences between long-term care applicants living in different settings: nursing facility residents evaluated the quality of choices significantly less positively than community or group dwelling residents.

Another area of potential concern is the relatively small number of pre-admission review participants who completely understood the reasons for the assessment: more clients need to fully understand the importance of the LOC determination, the available choices of service, and the meaning of the pre-admission review for eligibility for long-term care services.

A third area that received relatively low evaluations is the extent to which assessors listened to applicants' opinions. Among community and nursing facility residents, fewer than 40 percent of consumers felt that their opinions were considered important. A higher percentage of group dwelling residents expressed satisfaction in this area, but the average scores on this item do not differ significantly across groups.

We computed an overall score for satisfaction with the assessment for each client by summing responses to the first nine items shown in Table 4-4. This approach shows good reliability (Cronbach's alpha=.85). Respondents were divided into quartiles ranging from most satisfied to least satisfied. The last item on Table 4-4 illustrates that average satisfaction with the assessment process varied significantly according to the client's living arrangement at the time of the interview. Nursing facility residents were least often satisfied with their in-person assessment. This finding may partly reflect the lack of long-term care choices available to some

Table 4-4

Percentage of Consumers Giving Most Positive Response Regarding Assessment, by Service Setting

Interview Item	Most Positive Response (Percentage)[a] Comm. (1)	Group (2)	NF (3)
"...understand why you had to have an assessment?"	40.6	29.5	37.5
"Assessors arranged for (all, most, some, none) of the help I needed."	60.2	74.1	62.3
"...extent assessment met your expectations..."	53.4	53.4	46.3
"...quality of choices offered?"	37.1	41.4	31.1[1,2]
"...quantity of choices offered?"	43.0	50.0	46.7
"Assessors listened to my opinions..."	39.9	50.0	38.2
"I got what I wanted from the assessment."	42.4	43.1	40.0
"Would you recommend...an assessment?"	96.6	96.6	94.0
"Overall assessor performance..."	52.3	50.0	45.6
Percentage in Most Satisfied Quartile[b]	26.1	31.1	16.4[1,2]
Sample	245	61	73

[a] Percentages are adjusted to include only those clients who had an in-person assessment and who remembered the process. Clients who were only desk reviewed could not respond to questions.

[b] Responses on all items were summed. Consumers were assigned to quartiles from least to most satisfied on the basis of the sum of their responses to all help items.

[1,2] Superscripts correspond to groups and show that means for each group differ from those of the groups indicated at $\leq .05$.

applicants. That is, the sample of pre-admission review participants may include a number of persons who entered nursing facilities because no other alternatives were available (as reflected by their low satisfaction with the quality of choices offered) and consequently were less satisfied with the assessment because it offered them no alternative care settings. This finding also may reflect frustration associated with high levels of impairment and with the inability to remain in a community setting.

To test these assumptions, we performed a multivariate analysis. High levels of impairment were associated with greater rather than less satisfaction with the assessment when place of residence was held constant. Also, perceptions regarding the extent of choice in daily life were related positively to satisfaction with the assessment process. Nursing facility residence and the extent to which clients wanted additional help had a negative effect on satisfaction with the assessment. Race, gender, overall life satisfaction, self-rated health, and extent of impairment in instrumental activities of daily living were not significant factors. As suggested previously, nursing facility residence shows a relationship to perceptions about the quality of long-term care choices, which may color the participant's overall perceptions about the assessment.

In summary, most pre-admission review participants show satisfaction with most aspects of the pre-admission assessment process. However, 88.2 percent of the clients gave at least one negative response to the assessment questions. Nursing facility residents are less often satisfied than residents in other care settings when they recall how they felt about the in-person assessment portion of the pre-admission review. The weakest parts of the assessment are

satisfaction with the quality of choices offered and the extent to which long-term care applicants understand the reasons for the pre-admission review.

Applicants' Satisfaction with Review Outcomes

Services. One of the most important questions addressed by this study concerns clients' satisfaction with the paid service they receive as a result of the pre-admission review. As shown in Table 4-5, around half of the clients were very satisfied with the aspects of service that were examined in this interview. More than half felt very positively that they could rely on the help they received, and also were very positive about not making any changes. Nursing facility residents showed significantly lower satisfaction than community and group dwelling residents on four items, and lower scores than community residents on two items. Nursing facility residents were significantly less likely than community or group dwelling residents to express high satisfaction about the extent to which they would change their help. Smaller proportions of consumers felt that their helpers did things exactly the way they wanted, and were very sure about how to make changes in the help they received. Again, on these two items, nursing facility residents were the least likely to give positive responses. In addition, nursing facility residents showed significantly lower satisfaction than both community and group dwelling residents on ratings of overall performance of their helpers, and on the extent to which they would like to change aspects of their help. They were significantly less positive than community residents on the extent to which they felt their helpers had helped them cope.

These findings suggest that service providers in all settings must work to provide long-term care service recipients with opportunities to express their personal preferences about how

Table 4-5

Percentage of Consumers Giving Most Positive Response Regarding Paid Help, by Service Setting

Interview Item	Most Positive Response (Percentage)[a] Comm. (1)	Group (2)	NF (3)
"...can rely on getting help you need?"	56.3	47.7	48.7
"If you could change things about the help you get...?"	59.2	60.7	43.4[1,2]
"My helpers do things exactly the way I want."	33.5	33.6	20.1[1,2]
"Have your helpers helped you to cope more effectively?"	44.8	39.6	36.7[1]
"...sure you can get your care changed if you need to?"	36.2	34.6	31.5[1]
"Overall, how would you rate the performance of people who help you?"	49.0	49.5	35.0[1,2]
Percentage in Most Satisfied Quartile[b]	13.1	12.2	7.1[1,2]
Sample	358	112	235

[a] Percentages are adjusted to include only those clients who responded to each question. Clients without help could not respond to questions.

[b] Responses on all items were summed. Consumers were assigned to quartiles from least to most satisfied on the basis of the sum of their responses to all help items.

[1,2] Superscripts correspond to groups and show that means for each group differ from those of the groups indicated at $\leq .05$.

they want things done. Also, older people must be helped to understand how to contact the agencies or the managers who are responsible for providing care, and must feel free to do so. Anecdotal reports from several interviewers suggest that a few clients in this study were reluctant to criticize any of their helpers because they were afraid of losing services.

We computed a score for overall satisfaction with services for each client by summing responses to the first six items shown in Table 4-5. This approach shows good reliability (Cronbach's alpha=.80). Respondents were divided into quartiles according to their score on this scale, from most satisfied to least satisfied. Comparisons of clients' average satisfaction with services vary significantly across service settings: those in nursing facilities show a significantly lower average score than clients in other settings and account for a lower percentage of residents in the most satisfied group. This finding reflects their lower average satisfaction with services on 5 out of the 6 service aspects we examined.

To determine what factors had the greatest influence on service satisfaction, we performed a multivariate analysis. Five out of 10 factors showed a significant relationship to satisfaction with services. In order of importance, these were 1) the extent to which the client wanted additional help with activities of daily living, 2) overall life satisfaction, 3) residence in a nursing facility, 4) perceived amount of choice in everyday life, and 5) level of ADL impairment. These findings support Ohio's interest in expanding Community Care Choices. Feeling a need for additional help and nursing facility residence were related negatively to satisfaction with services even when all other factors were held constant. All other factors showed a positive relationship, including level of impairment. As impairment level increases, satisfaction with help increases as well. This could be the case because the most seriously

impaired depend more heavily on services and thus are less willing to criticize, or it could reflect appropriate targeting of programs and services: those most in need are also receiving services in a way most satisfying to them. Perceived amount of choice also plays an important role: it may be that those who feel they have control and choice in their lives are better able to adjust to dependency, or perhaps are better able to manage their relationships with their service providers to improve their own satisfaction with service.

On the whole, long-term care consumers expressed high levels of satisfaction with the reliability of services and overall performance of their helpers. Areas for improvement include educating clients regarding changes in their services and in making helpers more responsive to client preferences. Persons living in the community or in group settings other than nursing facilities often were significantly more satisfied with various aspects of the pre-admission review and services than were nursing facility residents. Only 11.4 percent reported on one or more aspects of their service in the most negative way. At the same time, they were also less likely to give an "excellent" evaluation to their service providers than to their assessor.

Environment. Clients' perceptions about their environment are also important in determining overall appropriateness of a placement. We asked consumers about three aspects of the environment that had seemed most salient to respondents during our initial qualitative interviews: 1) safety, 2) privacy, and 3) choice. Table 4-6 displays the percentages of respondents giving the most positive evaluation of their environment across the three different long-term care settings. Safety was viewed positively by most residents: more than three-quarters of the residents in every environment stated that they had no concerns about safety. Privacy was not a concern for community and group dwelling residents: more than half strongly

Table 4-6

Percentage of Consumers Giving Most Positive Responses Regarding the Environment, by Service Setting

Selected Items	Community (Percentage)[b] (1)	Group Setting[a] (Percentage)[b] (2)	Nursing Facility (Percentage)[b] (3)
"...Have enough privacy here?"***	58.2	59.6	20.3[1,2]
"...how much choice ...over what you do?"*	43.1	43.1	27.0[1,2]
"...ever worry about safety here?" ("no" response)	78.1	80.7	78.9
Sample	352	109	227

[a] Group settings include board and care, rest homes, and congregate housing.
[b] Percentages based on those clients for whom information was available on both variables.
[1,2] Superscripts correspond to groups and show that means for each group differ from those of the groups indicated $\leq .05$.
* $p \leq .05$
*** $p \leq .001$

agreed that they had enough privacy. Choice was a slightly less satisfactory aspect. Nursing facility residents showed significantly lower evaluations of privacy and choice than did the other resident groups. The salience of client choice in relation to overall satisfaction with services and with the in-person assessment indicates the importance of understanding and considering long-term care applicants' needs for control and choice in determining appropriate and satisfying placements.

Description of Caregivers

The findings in the following section are based on 353 interviews conducted by telephone with informal caregivers of pre-admission review applicants. These interviews are expected to be typical of family members and friends who provide support to an older person in need of long-term care. The characteristics of caregivers who participated in telephone interviews are shown in Table 4-7. Sixty-four percent of caregivers completed interviews; 24 percent were not found, 7 percent of the clients were deceased and no caregiver interview was attempted. Other reasons for noncompletion were that the caregiver was too ill (1%), that the caregiver refused (3%), and "other," for special circumstances not falling into any other category (1%).

As is typical in long-term care, most caregivers for pre-admission review applicants were female (72.6%), white (77.1%), and married (68.8%). African-Americans made up 21 percent of the sample. Caregivers ranged in age from 23 to 91 years, with an average of 56 years. About one-half reported that their total household income was less than $20,000, and about 20 percent had children under age 18 living with them in addition to their caregiving responsibilities.

Table 4-7

Demographic Characteristics of Caregivers Responding to Caregiver Satisfaction Survey

Characteristic	Percentage[a]
Age	
Under 40	15.4
40-59	45.4
60-79	34.3
80 and over	4.9
Average Age	55.6
Gender	
Female	72.6
Race	
White	77.1
Marital Status	
Married	68.8
Years of Education	
0 - 11	27.6
High school diploma	39.0
Some college	25.2
College degree	8.2
Income	
Less than $10,000	18.8
$10,000 - 19,999	31.4
$20,000 - 29,999	19.4
$30,000 - 49,999	17.8
$50,000+	12.6
Current Living Arrangement	
Client lives with caregiver	31.6
Client lives in nursing facility	41.5
Relationship to Client	
Spouse	15.3
Child/in-law	61.8
Sibling	6.5
Grandchild	4.2
Other	12.2
Sample	353

[a] Percentages are adjusted to reflect only those caregivers for whom information was available on each variable.

Although almost all primary caregivers (96%) were relatives of the client, they came from three generations: 22 percent were of the client's generation, either spouses (15.3%) or siblings (6.5%); well over half (61.8%) were children or children-in-law, with daughters (42%) named more often than sons (15%). Four percent were grandchildren. The remainder (12.2%) were friends or other kinds of relatives.

About 42 percent (41.5%) of the caregivers were providing help to clients living in nursing facilities. The remaining 58 percent were caregivers assisting clients who lived in community settings. Of the caregivers assisting community-dwelling clients, 54 percent were living in the same household as the client; the remainder lived in separate households.

Caregivers were asked several questions about their involvement in helping clients. The first item asked respondents to identify the type of caregiver they perceived themselves to be--that is, their self-identified role as caregiver (Table 4-8). About two-thirds of both community and nursing facility caregivers identified themselves as the main informal caregiver (45.6% and 44.9% respectively) or the only caregiver (26.0% and 21.1%). Whether clients were living in the community or in nursing facilities, most of the caregivers reported that they were centrally involved assisting clients.

Informal Caregivers' Satisfaction with the Pre-Admission Review

Most caregivers (84%) were aware that the client had been assessed. Caregivers who knew that an assessment had been made and whose relative had received an in-person assessment were asked to rate their understanding of why the assessment had been made and to state whether they had been present during the assessment. As shown in Table 4-9, nearly all of these

Table 4-8

Roles of Caregivers Responding to Caregiver Satisfaction Survey

	Clients in Community (Percentage)[a]	Clients in Nursing Facility (Percentage)[a]
Percentage Helping with Activities of Daily Living (ADLs)		
Bathing	49.3	23.3
Dressing	56.1	26.0
Transferring	44.9	30.1
Toileting	38.1	26.7
Eating	31.7	26.0
Grooming	56.1	48.1
Percentage Helping with Instrumental Activities of Daily Living (IADLs)		
Phoning	34.3	13.7
Transportation	77.6	52.1
Shopping	86.8	81.5
Business matters	75.6	79.5
Medical matters	60.0	19.2
Self-Identified Role		
Supplemental caregiver	10.8	9.5
Share caregiving equally	17.7	24.5
Main caregiver	45.6	44.9
Only caregiver	26.0	21.1
Sample	206	147

[a] Percentages are adjusted to reflect only those caregivers for whom information was available on each variable.

Table 4-9

Percentage of Caregivers Giving Most Positive Response Regarding Client's Assessment

Interview Item	Most Positive Response (Percentage)
"...understand why client had to have an assessment?"	64.6
"Assessors arranged for (all, most, some, none) of the help client needed."	65.7
"...extent assessment met your expectations..."	66.8
"...quality of choices offered?"	43.3
"...quantity of choices offered?"	45.2
"Assessors listened to client's opinions..."	34.3
"Client got what they wanted from the assessment."	27.6
"Would you recommend...an assessment?"	98.9
"Overall assessor performance..."	58.7
Sample	263[a]

[a] Responses to all items after the first include only those caregivers who were present for the client's assessment.

caregivers (89.7%) said they understood completely (64.6%) or almost completely why the assessment had been made; more than three-fourths (79.4%) reported that they had been present at the assessment. Caregivers who were present during the assessment were asked a series of questions about their satisfaction with the overall assessment process. More than half (58.7%) rated the assessor's overall performance as excellent. Two-thirds (65.7%) felt that the assessors arranged for all the help needed by the client and met all their expectations about the assessment (66.8%). The quality of choices was rated excellent by 43.3 percent of the caregivers and good by 45 percent. Almost half (45.2%) of the caregivers felt that clients had been offered all the choices they wanted.

Almost all of the caregivers agreed (58.7%) or strongly agreed (34.3%) that the assessors had given clients plenty of input during the assessment. Slightly more than one-quarter (27.6%) strongly agreed that clients had received what they wanted from the assessment process. Finally, the caregivers were extremely willing to recommend PASSPORT: virtually all (98.9%) reported that they would recommend to a friend that they call and undergo an assessment.

In general, the caregivers gave very positive evaluations of the assessment process. They understood the reasons for the pre-admission review assessment more often than the group of applicants themselves and they felt more often that the assessor's performance was excellent. Caregivers were least likely to provide the most positive response regarding the extent to which assessors gave clients' input and met their expectations about the assessment. Possibly the assessors direct their explanations and questions to caregivers when they are present, thus reducing the extent to which client input is considered. It is also possible that the caregivers initiated the pre-admission review process because they needed help, and thus learned about the

process and provided their own input as they underwent it on behalf of the client. Their deeper involvement in the system may have led to greater understanding and appreciation for the pre-admission decision process. In general, informal caregivers strongly support the pre-admission review process and assessment.

Informal Caregivers' Satisfaction with Review Outcomes

Services. The 328 caregivers who said their clients received paid help, either in the community or in nursing homes, were asked a series of questions evaluating all of the persons who were considered to be clients' paid helpers. Of the nine items analyzed in this section, significant statistical differences between answers of caregivers for community-dwelling and nursing facility clients were found on four: caregivers' desire to change clients' help, caregivers' perceptions that paid helpers do things as clients want, and caregivers' perceptions that paid helpers help clients cope more effectively with their problems (see Table 4-10).

Caregivers were asked how sure they felt that clients could have a change in care if necessary. More than half (53.0%) felt very sure. When asked whether they would change things about clients' paid help, about 61 percent (60.6%) of nursing facility caregivers, but only about 40 percent (38.9%) of community caregivers, said they would do so.

Caregivers were asked whether they agreed or disagreed that paid helpers did things exactly as clients wanted. About one-quarter (26.0%) of community but fewer than one-fifth (17.8%) of nursing facility caregivers said they strongly agreed with this statement.

Both groups of caregivers felt that some improvements in clients' paid help were possible. Most community caregivers reported little room for improvement in how paid helpers

Table 4-10

Percentage of Caregivers Giving Most Positive Response Regarding Client's Paid Help

Interview Item	Most Positive Response (Percentage)[a]	
	Community	Nursing Facility
"...can rely on getting help you need?"	69.8	62.1
"If you could change things about the help you get...?"***	60.6	38.9
"My helpers do things exactly the way I want."***	26.0	17.8
"Have your helpers helped you to cope more effectively?"***	63.1	42.3
"...sure you can get your care changed if you need to?"***	64.6	35.4
"Overall, how would you rate the performance of people who help you?"	47.5	41.0
"[Client] gets all help he/she needs?"	68.7	57.9
Sample	326[b]	

[a] Percentages are adjusted to include only those caregivers who responded to each question. Caregivers for clients without help could not respond to questions.

[b] Responses include only caregivers of clients with paid help. Some did not answer all questions.

*** $p \leq .001$

did things for clients. Nursing facility caregivers, however, were more likely to feel that things were not being done exactly according to clients' wishes. More community than nursing facility caregivers felt that paid helpers had helped clients a great deal in coping more effectively with their problems (63.1% and 42.3% respectively). Yet one-third or more of each group reported that helpers helped only somewhat, so both groups may have believed that paid helpers could do more.

On questions about the extent to which paid helpers met caregivers' expectations and the amount of paid help clients received, caregivers expressed the need for some improvement. Approximately 30 percent of both groups reported that most of their expectations were met; more than one-third of both groups reported that clients received almost all the help they needed.

Environment. We used two items to assess caregivers' satisfaction with clients' living arrangements. Caregivers were asked whether they agreed or disagreed that clients had enough privacy and were safe. As shown in Table 4-11, significantly more community caregivers (59.8%) than nursing facility caregivers (29.2%) agreed that clients had enough privacy.

The second item asked caregivers whether they ever worried about clients' safety where they lived. The majority of both groups of caregivers said they did not worry about this issue. If caregivers answered "yes" to the safety question, they were asked three questions about the types of things that concerned them. A simple tally revealed that 13 caregivers worried about the neighborhood and crime, 47 about clients' having accidents or becoming ill, and 14 about clients' places of residence being safe.

Overall, caregivers appear to understand and to be satisfied with the pre-admission review, and few of their needs for service are unmet. Most are comfortable with at least the

Table 4-11

Percentage of Caregivers Giving Most Positive Responses Regarding the Environment, by Service Setting

Selected Items	Community (Percentage)[a]	Nursing Facility (Percentage)[a]
"...Have enough privacy here?"***	59.8	29.2
"...ever worry about safety here?" ("no" response)	84.1	87.8
Sample	207	147

[a] Percentages based on those clients for whom information was available on both variables.
*** $p \leq .001$

privacy and the safety in the setting where their older family member or friend receives long-term care.

Caregivers' Strain

We obtained caregivers' self-reported health status for community and nursing facility caregivers. We found statistically significant differences between the two types of caregivers on the self-reported health measure. A greater proportion of nursing facility caregivers (32.6%) than of caregivers of community clients (18.7%) said they were very healthy. In the community sample, more than one-fourth (26.8%) reported that they were sick or very sick. These caregivers may be considered at risk and in need of formal assistance or increased amounts of formal help.

The next measure of strain is related specifically to the caregiving situation: caregivers were asked how they felt helping clients had affected them. A series of 12 items followed, prefaced by the statement "Tell me yes or no, since you have been helping..." Table 4-12 displays the types of strain reported.

More than half of both groups of caregivers reported strain on seven of the 12 items: change in personal plans, emotional adjustments, client's change from former self, client's behavior upsetting, family adjustments, disturbed sleep, and having other demands on their time. One-third or more of both groups stated that they were experiencing strain on all of the items.

Statistically significant differences exist between community and nursing facility caregivers for four of the 12 items. Greater proportions of nursing facility caregivers than of community caregivers reported that emotional adjustments had been made (82.6% versus 63.0%), that it was upsetting to find that clients had changed so much from their former selves

Table 4-12

Percentage of Caregivers Reporting Strain, by Care Recipient's Residence

Interview Item	Percentage Reporting Strain	
	Community	Nursing Facility
Personal Strain		
"...change personal plans"	70.2	68.1
"...emotional adjustments"***	63.0	82.6
"...client changed from former self."**	62.1	74.8
"...client's behavior upsetting."	58.5	68.1
"Make family adjustments."	55.8	50.3
"Disturbed sleep"	52.5	51.7
"Having other demands on time"*	52.8	68.1
"Feeling confined"**	45.5	31.7
"Feeling overwhelmed"	43.7	45.8
"Physical strain"	43.3	40.7
"Inconvenienced"	42.5	39.3
"Made work adjustments."	37.6	35.8
Employment Adjustments		
"Reduced number of hours worked."	23.4	26.4
"Worked different schedule."	23.4	22.9
"...Been unable to take job."	14.4	13.2
"Given up/quit job."	11.0	11.1

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

(74.8% versus 62.1%), and that other demands had been made on their time (68.1% versus 52.8%). More community than nursing facility caregivers reported that they felt confined by having to help out (45.5% versus 31.7%).

Overall, equal or greater numbers of nursing facility caregivers reported strain. This finding is consistent with the previously cited finding that both groups of caregivers perceived themselves as centrally involved in providing help and reported doing many tasks for clients. These data do not support the notion that placing elderly care recipients in nursing facilities decreases strain for caregivers.

Table 4-12 also includes items asking caregivers how helping clients affected their employment situation. Slightly more than one-third of each group had made work adjustments because of caregiving. About one-fourth of each group reported that they had reduced the number of hours they worked or worked a different schedule or shift because of caregiving responsibilities. Few caregivers stated that they had been unable to take a job or had been forced to give up or quit a job because of caregiving duties. More of these caregivers, then, have been faced with accommodating work and caregiving obligations than with leaving or not entering the workforce.

Services to Caregivers

Caregivers also were asked about any paid help or services that they received for themselves, which helped them care for clients. It was suggested that help could include respite service, support groups, counseling, education groups, information and referral services, or paid assistance to help maintain the household or to care for other family members. We found no

differences between community and nursing facility caregivers on receipt of help; the overwhelming majority (90.4%) of caregivers were not receiving services.

Caregivers were asked whether they needed any kind of paid help that they were not receiving currently. A greater proportion of community caregivers than of nursing facility caregivers reported that they needed such help (19.4% versus 7.5%). Although the majority (81%) of caregivers for community-dwelling clients said they did not need help, some (19.4%) stated the need for formal assistance to help them in some way with their caregiving obligations. One caregiver simply stated that he or she needed "more hours in a day."

Caregiver and Client Pairs

The previous section examined data for consumers as a group, and for caregivers as a group. Another important aspect of interviewing these groups is the opportunity to examine congruence between caregivers and their clients. While caregivers as a group, and consumers as a group, are reporting about many assessments and many helpers, caregiver and client pairs are providing opinions about the same assessment process, and/or the same helpers.

In order to examine the extent to which pairs of clients and caregivers agree regarding the assessment and paid helpers, paired samples t-tests were performed. These tests provide information about the extent to which pairs of clients and caregivers show discrepant opinions on each question.

Questions examining satisfaction with the assessment show that there are significant differences for client and caregiver pairs on three of the items: 1) the extent to which the client "got what I/he/she wanted from the assessment", 2) the quality of choices offered at the

assessment, and 3) the extent to which clients/caregivers understood the reason for the assessment.

Clients were significantly less likely than their caretakers to understand the reason for the assessment. On average, they also evaluated the quality of the choices offered at the assessment lower than their caretakers. Caretakers were less likely than their care recipients to think that the client got what they wanted from the assessment. Thus, even within consumer/caregiver dyads we see divergent opinions about the same assessment experience. This finding strengthens the need for assessors to provide independent client input since clients and their caregivers do not always share a vision about "how things should be".

When evaluating satisfaction with services, only one item showed significant discrepancies between client and caregiver pairs. Caregivers evaluated the extent to which clients could rely on their help significantly higher than the clients themselves. Perhaps caregivers know the extent to which they would be willing to fill in for paid help, while clients are not as sure that anyone would help them if something happened to their paid helpers.

SUMMARY

In answer to the research questions about pre-admission review applicants' and informal caregivers' satisfaction with the pre-admission review process and the outcomes of that review, most people in both groups are satisfied with the review and its outcomes on most aspects that we examined. Further attention must be given to helping older persons understand the reasons for the pre-admission review, to ensuring that various high-quality long-term care services are available, and to considering caregivers as an integral part of the long-term care service network

in Ohio. Distinctions between long-term care settings are important because many significant differences exist between community and nursing facility settings. In general, clients were more satisfied with the in-person assessment than the services that resulted from it. Our evidence also suggests that caregivers are deeply involved in giving older persons all types of help, but that they receive very few formal services themselves. Finally, a review of the consumers' long-term placements by a clinical team of experts suggested that the great majority of the placements were appropriate. Overall the pre-admission review process results in appropriate, satisfactory long-term care services as evaluated by clinical experts, consumers, and their caregivers.

CHAPTER 5

LONG-TERM CARE UTILIZATION PATTERNS AND DIVERSION

Since the mid-1970s, the long-term care system has been criticized for emphasizing institutional care over community-based services. In response to this criticism, Congress enacted Section 2176 of the 1981 Omnibus Reconciliation Act, which allowed states to receive a waiver of the traditional Medicaid requirements in order to provide noninstitutional long-term care. Nationally the Medicaid waiver program has increased from $3.8 million in 1982 to $1.7 billion in 1991 to $2.8 billion in 1993 (Burwell 1994; Miller 1992). By 1993, Ohio's waiver programs had grown to $88 million; the PASSPORT waiver accounted for about two-thirds of this amount. As noted in Chapter 1, Ohio has enacted legislation to continue the expansion of PASSPORT and to develop a new long-term care option called Assisted Living, and has expanded the Optional State Supplement program (OSS) for persons living in group settings.

Although these changes have been praised for increasing the long-term care options available to disabled Ohioans, financing questions have arisen. Does the expansion of Community Care Choices divert people from nursing facilities to other care settings? Because of the constant increases in Medicaid expenditures for long-term care and because of the changing demographics of the state, state policy makers face the critical problem of developing a cost-effective strategy. In this chapter we examine how Community Care Choices affect utilization of nursing facilities.

IMPLEMENTATION OF COMMUNITY CARE CHOICES

Although Ohio has substantially increased the funds allocated to noninstitutional care, the effects of the Community Care Choices initiative are limited for the period covered by this study. At passage, this initiative was intended to include the adoption of pre-admission review and three additional components: 1) an expansion of PASSPORT, 2) the development of Assisted Living, and 3) an expansion of OSS. Pre-admission review began in October 1993, giving the evaluators about one year of data for this report. During this period the PASSPORT program was expanded, although it restricted intake from January to March 1994 because of budgetary constraints. The OSS program, which serves a population at less than a nursing facility level of care (as shown later in this chapter), expanded by about 1,000 persons statewide over this period. The Assisted Living initiative has not yet been implemented. Because of these factors and the short time period for the study, our ability to detect effects of nursing facility diversion is limited.

METHODOLOGY

As explained in Chapter 2, we used multiple approaches and data sources to study diversion. To understand more about long-term care use patterns across settings we examined nursing facility residents, PASSPORT clients, and Optional State Supplement clients over time to observe any changes in the characteristics of these long-term care populations. The Minimum Data Set Plus (MDS+), the pre-admission review database, and the in-person assessment database provided information that allowed us to examine possible changes. We also examined nursing facility utilization patterns and trends using the MDS+ database. We then combined

these data with population data for Ohio to examine nursing home utilization rates for the older population.

Changes in Characteristics of Nursing Facility Residents over Time

Examining the characteristics of Medicaid recipients in long-term care can provide some insights about diversion. If pre-admission review and Community Care Choices succeeded in diverting long-term care applicants who did not meet the requirements for a nursing facility level of care, and in diverting applicants for nursing facilities who could be served equally well in the community, we would expect that new admissions might become more severely disabled over time. Because persons who have undergone pre-admission review make up a greater proportion of nursing facility residents over time, those residents' functional capabilities might change.

To examine these assumptions we used data from the MDS+ database. As mentioned in Chapter 2, the MDS+ is a tool for assessing every person who occupies a Medicaid-certified bed in a nursing facility at the end of each calendar quarter. Because the MDS+ focuses on residents' outcomes and functioning, it is appropriate for measuring functional change in the population of those facilities.

Table 5-1 presents information on the demographic characteristics of all nursing facility residents in Medicaid-certified beds in June 1993 and September 1994—that is, before and after the implementation of pre-admission review and the accompanying standardization and clarification of LOC criteria. Characteristics of residents newly admitted during the third quarter (July-September) of 1994 are also presented.

Table 5-1

Comparison of the Demographic Characteristics of Residents of Nursing Facilities: June 1993 and September 1994, and the Newly Admitted in Third Quarter 1994

	June 1993		September 1994		Newly Admitted Third Quarter 1994	
	Non-Medicaid[a] (Percentage)[c]	Medicaid[b] (Percentage)	Non-Medicaid[a] (Percentage)	Medicaid[b] (Percentage)	Non-Medicaid[a] (Percentage)	Medicaid[b] (Percentage)
Age						
45 or less	1.8	4.6	1.6	4.3	2.2	9.6
46-59	2.8	5.7	2.7	5.7	3.1	13.7
60-65	2.6	4.5	2.4	4.5	3.1	9.1
66-74	12.4	12.7	11.8	12.5	15.6	14.7
75-84	33.5	30.0	32.8	29.5	37.2	27.4
85-90	24.2	21.3	24.5	21.5	22.8	15.0
91+	22.7	21.2	24.2	22.0	16.0	10.5
Average Age	81.5	78.7	81.8	79.0	79.6	71.6
Gender						
Female	73.8	75.1	73.4	74.7	66.2	65.6
Race						
White	90.4	86.4	90.2	85.7	90.3	77.9
Marital Status						
Never married	12.3	16.5	13.1	16.4	9.2	17.0
Widowed/ divorced/ separated	71.6	70.7	70.6	70.6	65.1	65.0
Married	16.1	12.8	16.3	13.0	25.7	18.0
Previous Living Arrangement						
Lived alone						
No	57.9	60.7	56.3	59.1	55.5	58.8
Yes	26.2	22.1	27.8	22.9	31.8	23.5
In another facility	15.9	17.2	15.9	18.0	12.7	17.7
Payment Source	69.3	30.7	66.4	33.6	84.4	15.6
Population	55,922	24,750	54,532	27,600	7,939	1,469

[a] Residents whose payment source for stay in nursing facility for part or all of the quarter ending in June 1993 or September 1994 was Medicare, CHAMPUS, VA, self-pay/private insurance, or other.

[b] Residents whose entire payment source for the quarter ending in June 1993 or September 1994 was Medicaid.

[c] Percentages are adjusted to reflect only those clients for whom information was available on each variable.

Source: MDS+ database for June 1993 and September 1994.

Because pre-admission review was not geared to age, marital status, or other demographic characteristics, we would expect little change in these variables over time. In addition, because of the large number of residents in Medicaid-certified nursing facilities (about 80,000), we did not anticipate major changes in the resident population over a one-year period. The results confirm these expectations: They show no significant change in the nursing facility population between June 1993 and September 1994.

To examine nursing facility use more carefully, we also focused on residents who were newly admitted to nursing facilities. By examining individuals admitted during the most recent quarter, we expected potential changes in long-term care use patterns to be more easily identifiable. In fact, an examination of new admissions during the third quarter of 1994 (see Table 5-1) shows demographic differences suggesting that this group differs in important ways from existing nursing facility populations. These clients are younger, more likely to be male, less likely to be white (Medicaid admissions only), and more likely to be married. They are also less likely to use Medicaid as a payment source than the population of nursing facility residents as a whole.

Table 5-2 provides a comparison of the functional characteristics of nursing facility residents in June 1993 and September 1994, before and after implementation of pre-admission review. The non-Medicaid residents show slightly higher levels of disability than the Medicaid group. We cannot determine from the available data whether this difference means that many of the non-Medicaid group initially were admitted from the hospital with higher levels of acuteness, or whether individuals with more resources enter nursing facilities later in their

Table 5-2

Comparison of the Functional Characteristics of Residents of Nursing Facilities: June 1993 and September 1994, and the Newly Admitted in Third Quarter 1994

	June 1993		September 1994		Newly Admitted Third Quarter 1994	
	Non-Medicaid (Percentage)[a]	Medicaid (Percentage)	Non-Medicaid (Percentage)	Medicaid (Percentage)	Non-Medicaid (Percentage)	Medicaid (Percentage)
Percentage Needing Assistance in Activities of Daily Living (ADLs)[b]						
Bathing	93.2	92.0	93.9	93.6	94.6	88.5
Dressing	82.3	79.2	83.7	82.0	86.2	77.6
Transferring	67.0	64.3	69.0	66.5	74.4	60.3
Toileting	73.7	69.7	75.4	73.0	79.6	67.8
Eating	38.6	38.6	37.6	39.5	32.3	27.7
Grooming	81.9	80.7	82.9	82.7	83.1	76.3
Number of ADL Impairments						
0	5.8	7.1	5.2	5.6	4.1	9.3
1	7.6	8.5	7.2	8.0	5.6	7.7
2	4.5	5.5	4.8	5.1	4.2	6.4
3	7.6	7.9	7.5	8.1	6.6	9.6
4 or more	74.5	71.0	75.3	73.2	79.4	67.0
Average Number of ADL Impairments[c]	4.4	4.3	4.4	4.4	4.5	4.0
Incontinence	43.5	45.9	58.1	59.2	46.0	44.7
Cognitive Impairment						
Lacks cognitive skills for daily decision making[d]	58.7	59.3	60.8	61.7	47.4	49.1
Disoriented on name, date, or place	12.5	13.4	16.8	17.9	16.9	17.7
Wanders, is verbally or physically abusive	11.0	11.4	10.9	12.1	11.0	12.0
Population	55,922	24,750	54,532	27,600	7,939	1,469

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.
[b] "Needs assistance" includes limited assistance, extensive assistance, total dependence, and "activity did not occur."
[c] From the list above.
[d] "Moderately" or "severely" impaired in cognitive skills.

Source: MDS+ database for June 1993 and September 1994.

illnesses. The data for new admissions in the third quarter show that a higher percentage of non-Medicaid residents (86.0% versus 77.0%) suffered three or more ADL impairments.

To study these trends more carefully, we examined the characteristics of new admissions for the first three quarters of 1994. Although these data are far less demonstrative than the comparisons with the entire nursing facility population, they show that changes are occurring in the nursing home population (see Table 5-3). For example, the average age of those admitted using Medicaid declined by about one year between the first and the third quarters (72.8 to 71.6). The proportion of female residents using Medicaid fell from 67 percent to 65.6 percent during the same period. Racial changes were also noted: 81 percent of the first-quarter residents were reported as white, compared with 77.9 percent in the third quarter. Interestingly, we found no major changes in these residents' functional ability.

One reason for the differences between new admissions and the existing nursing facility population may be the changing face of long-term care. Increasingly, nursing facilities are providing subacute care because hospitals have reduced the average length of stay for older people; the result is a higher level of acuteness for those who are discharged. We would expect these factors to contribute to a slow but steady increase in the functional impairment levels of nursing facility residents. The fact that the increases are slightly larger for Medicaid than for non-Medicaid residents may be an indicator of diversion. Only a longer period of time, however, will allow us to observe these trends accurately.

Table 5-3

Comparison of Demographic Characteristics of New[a] Admissions to Nursing Facilities:
January 1, 1994 to September 30, 1994

	First Quarter 1994		Second Quarter 1994		Third Quarter 1994	
	Non-Medicaid (Percentage)[d]	Medicaid (Percentage)[d]	Non-Medicaid[b] (Percentage)[d]	Medicaid[c] (Percentage)[d]	Non-Medicaid (Percentage)[d]	Medicaid (Percentage)[d]
Age						
45 or less	1.6	7.6	1.8	9.3	2.2	9.6
46-59	2.7	12.3	3.2	11.6	3.1	13.7
60-65	2.7	8.6	3.2	8.9	3.1	9.1
66-74	15.7	15.0	16.0	15.8	15.6	14.7
75-84	37.7	30.4	38.3	30.6	37.2	27.4
85-90	23.3	13.9	22.1	14.0	22.8	15.0
91 +	16.3	12.2	15.4	9.8	16.0	10.5
Average Age	80.1	72.8	79.7	71.7	79.6	71.6
Gender						
Female	66.8	67.0	65.8	66.0	66.2	65.6
Race						
White	91.0	81.0	90.4	78.3	90.3	77.9
Marital Status						
Never married	9.1	17.6	9.2	19.2	9.2	17.0
Widowed/divorced/separated	66.2	65.1	64.7	63.2	65.1	65.0
Married	24.7	17.3	26.1	17.6	25.7	18.0
Payment Source	83.9	16.1	84.4	15.6	84.4	15.6
Population	8,304	1,589	8,033	1,490	7,939	1,469

[a] Residents who have been in the nursing facilities 90 days or less.
[b] Residents whose payment source for stay in nursing facility for the entire quarter ending in June 1994 was Medicare, CHAMPUS, VA, self-pay/private insurance, or other.
[c] Residents whose entire payment source for the second quarter ending in June 1993 or June 1994 was Medicaid.
[d] Percentages are adjusted to reflect only those clients for whom information was available on each variable.

Source: MDS+ database.

Changes in Characteristics of PASSPORT Clients over Time

Given the goals of pre-admission review, we would also expect changes in the composition of the PASSPORT population. If pre-admission review is effective in ensuring that those who receive long-term care services meet the more specific level of care criteria, we would expect the population of long-term care applicants enrolled in PASSPORT to be more disabled than enrollees in previous periods. Through the in-person assessment portion of pre-admission review, applicants to nursing facilities also may become more aware of Community Care Choices; as a result, more severely disabled individuals may enroll in PASSPORT.

To determine whether the pre-admission review resulted in changes in the population served by Ohio's PASSPORT program, we drew information from the in-person assessment database for all clients who were assessed and referred to PASSPORT during the third quarter of 1994 as well as all clients already enrolled in PASSPORT and reassessed for program eligibility. We chose this quarter because it was the most recent in which pre-admission review, PASSPORT, and MDS+ data were available. We offer one warning, however: the measures changed as the criteria changed. In June 1993, for example, functional abilities were recorded with five possible levels of disability that could be recorded; the 1994 data include only three possible responses. We modified the data to reflect these alterations, but some changes in functional ability may be the result of changes in measurement.

As shown in Table 5-4, the overall demographic profile of the PASSPORT enrollees changed. The average age increased by 2.5 years and the proportion of men enrolling in the program rose slightly from 18 percent to 20 percent for all PASSPORT clients, and to 22 percent for new enrollees.

Table 5-4

Comparison of PASSPORT Clients' Demographic Characteristics at Initial Assessment (June 1993) and Most Recent Assessment (Third Quarter 1994)

	Pre-June 1993 (Percentage)[a]	Third Quarter 1994 (Percentage)[a]	Recent Enrollees Third Quarter 1994 (Percentage)[a]
Age			
60-65	9.6	9.4	11.7
66-74	27.9	27.5	27.3
75-84	39.4	39.5	38.0
85-90	15.6	16.3	16.5
91+	7.5	7.3	6.5
Average Age	75.2	77.7	77.3
Gender			
Female	82.4	80.3	78.3
Race			
White	70.3	73.3	73.1
Marital Status			
Never married	5.0	4.9	4.9
Widowed/divorced/separated	74.4	73.7	75.0
Married	20.6	21.4	20.1
Current Living Arrangement			
Own home/apartment	77.1	79.4	68.6
Relative or friend	18.0	18.0	20.7
Congregate housing/elderly	4.9	1.4	0.8
Group home	0.1	0.4	5.6
Nursing facility	0.0	0.0	0.0
Other	0.0	0.8	4.3
Population	4,552	9,293[b]	1,944

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.

[b] The in-person database includes applicants who were assessed and found eligible for the PASSPORT Program. Not all of those found eligible enroll. As a result, the PASSPORT population shown here is about 10 percent higher than the actual PASSPORT caseload.

Source: PASSPORT MIS database.

As displayed in Table 5-5, the PASSPORT population in 1994 consistently showed more impairment than clients served in 1993. The proportion of enrollees with severe disability (three or more ADL impairments) increased by about three percentage points (60.1% to 63.3%) between 1994 and 1993. The proportion with no disabilities in activities of daily living declined from 10.8 percent in 1993 to about 1 percent in 1994. Impairment in each of the major activities of daily living increased consistently. For example, the proportion of those impaired in bathing rose from 85 percent to 97 percent; the percentage impaired in dressing increased from 59 percent to 70 percent. Impairment in instrumental activities of daily living remained about the same. Only two activities of daily living, grooming and eating, do not fit this trend. A clarification of the criterion for impairment in grooming, issued in March 1994, may have reduced the likelihood of meeting that criterion, while a change in answer categories between the earlier and the later measure may have affected findings for eating.

Changes in Characteristics of OSS Clients over Time

The demographic characteristics of Optional State Supplement (OSS) recipients at three periods are presented in Table 5-6. Data are presented for the period preceding implementation of pre-admission review, for OSS applicants as they were assessed up to the end of September, and for new enrollees admitted during the third quarter of 1994. Changes in gender and race composition as well as a drop in age show that the OSS population is also changing. This conclusion is reaffirmed by review of the functional characteristics of the OSS population across the periods (Table 5-7). OSS enrollees are decreasingly impaired in ADLs and increasingly impaired in IADLs. The characteristics of OSS recipients reflect their distinctive disabilities,

Table 5-5

Comparison of PASSPORT Clients' Functional Characteristics at Initial Assessment (June 1993) and Most Recent Assessment (Third Quarter 1994)

	Pre-June 1993 (Percentage)[a]	Third Quarter 1994 (Percentage)[a]	Recent Enrollees Third Quarter 1994 (Percentage)[a]
Percentage with Impairment/Needing Hands-On Assistance, Activities of Daily Living (ADLs)[b]			
Bathing	85.0	96.8	96.4
Dressing	58.6	69.9	67.8
Transferring	31.8	35.8	37.5
Toileting	27.3	34.0	33.0
Eating	25.9	11.2	9.3
Grooming	77.0	73.8	71.0
Number of ADL Impairments			
0	10.8	1.2	1.2
1	10.2	3.4	3.2
2	18.9	32.1	33.9
3	22.7	28.8	27.8
4 or more	37.4	34.5	33.9
Average Number of ADL Impairments[c]	3.0	3.2	3.1
Percentage with Impairment in Instrumental Activities of Daily Living (IADLs)			
Phoning	27.5	31.8	32.7
Transportation	94.4	84.8	86.4
Shopping	97.2	97.9	97.3
Meal preparation	84.9	86.8	86.3
Housecleaning or laundry	97.8	97.8	98.1
Heavy chores	97.0	99.6	99.6
Legal and financial	78.3	75.5	77.7
Medication administration	52.8	40.9	39.4
Number of IADL Impairments			
0	0.4	0.0	0.0
1	0.0	0.5	0.0
2	0.6	3.0	0.7
3	2.2	10.0	3.1
4 or more	96.8	86.5	96.2
Average Number of IADL Impairments[c]	6.3	6.2	6.2
Sample	498	N.A.	N.A.
Population	N.A.	9,293	1,944

Note: ADL and IADL information for June 1993 was not available in PASSPORT MIS. This information was entered by Scripps from a sample of client records.

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.
[b] Impairment includes all who could not perform by themselves or could perform with mechanical aid only.
[c] From list above.

Source: PASSPORT MIS database.

Table 5-6

Comparison of OSS Clients' Demographic Characteristics at Initial Assessment: June 1993 and Third Quarter 1994

	Pre-June 1993 (Percentage)[a]	Third Quarter (Percentage)[a]	Recent OSS Clients Third Quarter 1994 (Percentage)[a]
Age			
Under 19	0.2	0.8	1.2
19-45	22.2	26.1	30.2
46-59	23.6	21.3	25.9
60-65	11.5	10.2	7.5
66-74	17.0	17.6	15.6
75-84	15.0	14.1	9.7
85-90	5.6	5.8	5.9
91+	4.9	4.1	4.0
Average Age	60.8	59.2	56.3
Gender			
Female	59.0	56.8	53.1
Race			
White	86.4	83.3	81.7
Marital Status			
Never married	53.9	53.3	50.7
Widowed/divorced/separated	43.2	43.3	45.3
Married	2.9	3.4	4.0
Current Living Arrangement			
Own home/apartment	0.0	1.8	4.3
Relative or friend	0.0	1.0	0.5
Congregate housing/elderly	0.0	0.3	1.1
Group home	97.0	93.9	88.9
Nursing facility	0.0	0.0	0.3
Other	3.0	3.0	4.9
Population	633	2,121[b]	375

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.

[b] The in-person database includes applicants who were assessed and found eligible for the OSS Program. Not all of those found eligible may enroll. As a result, the OSS population shown here is higher than the actual OSS caseload.

Source: In-person assessment database.

Table 5-7

Comparison of OSS Clients' Functional Characteristics at Initial Assessment: June 1993 and Third Quarter 1994

	Needs Hands-On Assistance (Percentage)[a] Pre-June 1993	Needs Hands-On Assistance (Percentage)[a] Third Quarter 1994	Recent OSS Clients: Needs Hands-On Assistance (Percentage)[a] Third Quarter 1994
Activities of Daily Living (ADLs)			
Bathing	14.6	14.2	10.5
Dressing	3.9	4.3	4.0
Transferring	1.1	1.2	0.8
Toileting	2.1	1.9	1.6
Eating	0.6	0.9	1.1
Grooming	13.8	9.5	4.9
Number of ADL Impairments			
0	80.0	80.6	85.3
1	9.3	11.4	9.3
2	7.5	5.3	3.5
3	1.9	1.7	1.6
4 or more	1.3	1.0	0.3
Average Number of ADL Impairments[b]	0.4	0.3	0.2
Instrumental Activities of Daily Living (IADLs)			
Phoning	27.4	26.2	19.7
Transportation	75.3	71.2	66.9
Shopping	55.0	61.8	59.8
Meal preparation	89.6	89.3	86.5
Housecleaning or laundry	74.1	88.4	88.4
Heavy chores	74.5	91.9	88.9
Legal and financial	18.8	76.3	77.5
Medication administration	85.5	11.6	3.3
Number of IADL Impairments			
0	0.0	0.0	0.0
1	0.6	0.2	0.0
2	2.9	1.6	0.6
3	5.7	6.0	6.4
4 or more	90.8	92.2	92.9
Average Number of IADL Impairments[b]	5.5	5.5	5.3
Population	633	2,121	375

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.
[b] From list above.

Source: In-person assessment database.

the criteria for meeting a protective level of care, and their needs for long-term care. Members of this population are younger than nursing facility residents and PASSPORT clients, and have very little dependency in activities of daily living, but require supervision and assistance with instrumental activities of daily living. Nearly all of these individuals require assistance with four or more instrumental activities, and thus need care in a supervised group setting.

Effectiveness of Each Approach in Targeting Care to Appropriate Individuals

As mentioned in Chapter 2, one of the research questions we raised in examining the effectiveness of pre-admission review is whether the process results in appropriate placements. In Chapter 4 we approached appropriateness from the viewpoint of the client--his or her health and safety needs and satisfaction with the services and the assessment process. In this section we take a programmatic perspective and examine whether the pre-admission review has resulted in populations appropriate for each long-term care program.

To answer this question, it is important to understand the goals of each program. As discussed in Chapter 1, OSS provides a supplement for some aged, blind, or disabled persons who need a protective level of institutional care and live in an approved setting such as a group home or adult foster home.

PASSPORT is intended to provide an in-home alternative for low-income persons who need placement in a nursing facility. On average the in-home service package should cost no more than 60 percent of nursing facility care.

Nursing facilities are institutional long-term care settings certified for Medicaid reimbursement. They provide residents with room, board, and 24-hour nursing care. Because

each long-term care setting or program has different goals, corresponding differences in new enrollees would be expected. All of the programs, however, are designed to serve individuals with disabilities who require long-term care.

Some demographic differences between settings should exist because of eligibility criteria. For example, the PASSPORT program serves only persons age 60 and over; other waiver programs provide home care for younger persons with disabilities. Medicaid care in a nursing facility is available regardless of age; OSS is available to age 18 and over, as long as other disability and income criteria are met.

Tables 5-8 and 5-9 present the characteristics of the clients enrolled in the three long-term care settings during the third quarter of 1994.

Overall the new enrollees in long-term care services in the third quarter of 1994 are over 70; the majority are unlikely to have a spouse; most are likely to be female; and they are more likely to be white than nonwhite (see Table 5-8). As shown, however, these programs display demographic differences that reflect differences in program goals. OSS, which is available to applicants age 18 and over, has clients with a much lower average age (56) than the other two programs, a smaller proportion of women, and a greater percentage of clients who have never married. The OSS program is much more likely to attract mentally ill and developmentally disabled clients; the demographic characteristics reflect such a population. Although the majority of residents are widowed, non-Medicaid residents of nursing facilities are the most likely of any of the long-term care consumers to be married (25.7%).

Table 5-9 displays the functional characteristics of newly enrolled participants in long-term care. The newly admitted non-Medicaid residents of nursing facilities are more disabled

Table 5-8

Comparison of Demographic Characteristics of Recent Admissions to Nursing Facilities and Enrollees in PASSPORT and OSS Programs: September 1994

	Admissions to Nursing Facilities Third Quarter 1994		Enrollees Third Quarter 1994	
	Non-Medicaid[a] (Percentage)[c]	Medicaid[b] (Percentage)[c]	PASSPORT (Percentage)[c]	OSS (Percentage)[c]
Age				
45 or less	2.2	9.6		31.4
46-59	3.1	13.7		25.9
60-65	3.1	9.1	11.7	7.5
66-74	15.6	14.7	27.3	15.6
75-84	37.2	27.4	38.0	9.7
85-90	22.8	15.0	16.5	5.9
91+	16.0	10.5	6.5	4.0
Average Age	79.6	71.6	77.3	56.3
Gender				
Female	66.2	65.6	78.3	53.1
Race				
White	90.3	77.9	73.1	81.7
Marital Status				
Never married	9.2	17.0	4.9	50.7
Widowed/ divorced/ separated	65.1	65.0	75.0	45.3
Married	25.7	18.0	20.1	4.0
Payment Source	84.4	15.6	100.0	100.0
Population	7,939	1,469	1,944	375

[a] Residents whose payment source for stay in nursing facility for part or all of the quarter ending in June 1994 was Medicare, CHAMPUS, VA, self-pay/private insurance, or other.

[b] Residents whose entire payment source for the quarter ending in September 1994 was Medicaid.

[c] Percentages are adjusted to reflect only those clients for whom information was available on each variable.

Source: MDS+ database for June 1993 and June 1994.

Table 5-9

Comparison of Functional Characteristics of Recent Admissions to Nursing Facilities and Enrollees in PASSPORT and OSS Programs: September 1994

	Admissions to Nursing Facilities Third Quarter 1994		Enrollees Third Quarter 1994	
	Non-Medicaid (Percentage)[a]	Medicaid (Percentage)[a]	PASSPORT (Percentage)[a]	OSS (Percentage)[a]
Percentage Needing Assistance in Activities[b] of Daily Living (ADLs)				
Bathing	94.6	88.5	96.4	10.5
Dressing	86.2	77.6	67.8	4.0
Transferring	74.4	60.3	37.5	0.8
Toileting	79.6	67.8	33.0	1.6
Eating	32.3	27.7	9.3	1.1
Grooming	83.1	76.3	71.0	4.9
Number of ADL Impairments				
0	4.2	9.3	1.2	85.3
1	5.6	7.7	3.2	9.3
2	4.2	6.4	33.9	3.5
3	6.6	9.6	27.8	1.6
4 or more	79.4	67.0	33.9	0.3
Average Number of ADL Impairments[c]	4.5	4.0	3.1	0.2
Population	7,939	1,469	1,944	375

[a] Percentages are adjusted to reflect only those clients for whom information was available on each variable.
[b] "Needs assistance" includes limited assistance, extensive assistance, total dependence, and "activity did not occur."
[c] From the list above.

Sources: MDS+ database for June 1994; in-person assessment database.

than the Medicaid residents. As mentioned previously, non-Medicaid residents are likely to be admitted from the hospital on Medicare; they are likely to be more severely impaired because Medicare residents may require higher levels of skilled nursing services. New PASSPORT enrollees are less impaired in activities of daily living than new Medicaid residents of nursing facilities: 61.7 percent of the former group have three or more ADL impairments, compared with 76.6 percent of the latter group. A smaller proportion of PASSPORT enrollees (1.2%) than of Medicaid nursing facility residents (9.3%) qualified with no ADL impairments. As mentioned above, new OSS enrollees suffer less functional impairment. All groups of new enrollees show levels of impairment that would be expected among persons needing long-term care.

These data suggest that the targeting efforts of the long-term care programs have been intensified, and that the nursing facility and PASSPORT clients have become increasingly more disabled.

Patterns and Trends in Use of Nursing Homes

Earlier in this chapter we suggested that the characteristics of nursing home residents are changing. Such transitions have important implications for both the pre-admission screening and the diversionary efforts now underway in Ohio. In this section we explore these utilization patterns in greater detail.

Using the PAR and MDS+ databases, we developed estimates for the proportion of nursing home enrollees that remain in the nursing facility setting over time. As suggested by our examination of the volume of pre-admission reviews in Chapter 3, there is appreciable

movement in and out of nursing facilities. Table 5-10 shows that among those who entered nursing facilities sometime during the first quarter of 1994, 71.4 percent remained there at the close of the quarter. By the end of the second quarter, 48 percent of those residents remained in nursing facilities. Attrition appears to decrease in the third quarter, when the proportion fell to 40.5 percent. Data from the second and third quarters, although they cover only a limited period, suggest that these first-quarter trends are accurate.

In an effort to assess whether the length of stay was related to the referral setting of the pre-admission review, we examined the relationship between these two areas. Table 5-11 presents data on length of stay in nursing facilities by referral setting: nursing facility, hospital, and the community.

To examine long-term care applicants' pattern of nursing facility utilization by referral setting, we followed the individuals from the pre-admission review database over time, using the MDS+ database. Hospital referrals had the lowest retention rate: 67.7 percent of the applicants remained in the nursing facility at the end of the first quarter. The median length of stay for these applicants was 33 days. Applicants from nursing facilities had the second lowest retention rate: almost 72 percent remained in the facility at the end of the first quarter.

The community referrals had the highest retention rate, with 81.7 percent still in nursing facilities at the end of the first quarter. The median length of stay during the quarter for community referrals was 42 days; for nursing facility referrals, 43 days. This retention pattern continued in the next two quarters: the hospital referrals had the lowest retention rate, followed respectively by nursing facility applicants and community referrals. By the end of the third quarter, only one-third of the hospital referrals remained in a nursing facility, in contrast to

Table 5-10

Retention Rate of New Admissions to Nursing Facilities: January 1, 1994 to September 30, 1994

Time of Admission	Residing in a Nursing Facility		
	At End of First Quarter (Percentage)	At End of Second Quarter (Percentage)	At End of Third Quarter Percentage)
First Quarter	71.4	48.0	40.5
Second Quarter		68.0	43.4
Third Quarter			66.4

Source: MDS+ database.

Table 5-11

Retention Rate by Referral Settings: January 1, 1994 to September 30, 1994

Persons Admitted to a Nursing Facility during First Quarter 1994							
	Admitted Applicants	Remained in Facility at End of First Quarter		Remained in Facility at End of Second Quarter		Remained in Facility at End of Third Quarter	
Referral Setting	Number	Percentage	Median Length of Stay (Days)[b]	Percentage	Median Length of Stay (Days)[b]	Percentage	Median Length of Stay (Days)[b]
Community	931	81.7	42	65.6	136	58.4	229
Hospital	3,355	67.7	33	40.1	132	33.2	224
Nursing Facility[a]	619	71.9	43	57.7	134	53.3	224

[a] Nursing facility referrals are limited to those who changed their facility during the quarter, or those who changed their payment source during the quarter when they were admitted. This table does not include the nursing facility residents who were admitted previously and who changed payment source.

[b] The median is calculated for those still in the facility at the end of the quarter.

slightly more than half (53.3%) of the nursing facility referrals and almost 60 percent (58.4%) of the community referrals. As the residents stayed longer, however, the median lengths of stay for the three referral settings became more similar. Although the referral setting is an early determining factor in how long one stays in a nursing facility, after two quarters residents from all of the settings stayed for similar lengths of time. Concentrating pre-admission review on community referrals appears to be justified because these residents, once admitted, stay longest.

Medicaid Nursing Home Utilization Rates

A second component of this analysis involves a comparison of utilization rates for long-term care in the population over age 65. These data provide another indicator of diversionary trends.

To find the Medicaid nursing facility utilization rate we developed a ratio using the MDS+ census in conjunction with age-based population projections developed by the Ohio Data Users Center. As shown in Table 5-12, the Medicaid nursing facility utilization rates for all of the older population increased slightly. Nursing home use for persons age 65-74 increased by about 15 percent, from slightly less than 8 persons per thousand to just over 9 per thousand. In contrast, nursing home use by the oldest group (85 and over) declined by about 4 percent, from 168 to 162 per thousand. PASSPORT use increased in 1994 but involved only a small proportion of older Ohioans: even among those over 85, only 10 residents per thousand used PASSPORT.

These data suggest that utilization patterns for chronically disabled older people may be changing, although the time frame for analysis is too short to permit definitive conclusions. The

Table 5-12

Medicaid Nursing Facility and PASSPORT Utilization Rates: 1993 and 1994 (per Thousand)

	1993					1994				
		Nursing Facility		PASSPORT			Nursing Facility		PASSPORT	
Age	Total Population	Population[a]	Utilization Rate	Population	Utilization Rate	Total Population	Population	Utilization Rate	Population	Utilization Rate
65-74	833,340	6,545	7.86	1,387	1.66	835,120	7,559	9.05	1,910	2.29
75-84	464,900	13,676	29.47	1,786	3.84	472,900	15,222	32.18	2,534	5.36
85 +	143,700	24,212	168.14	1,048	7.29	145,600	23,608	161.70	1,518	10.42
Overall	1,441,940	44,433	30.81	4,221	2.93	1,453,620	46,389	31.91	5,962	4.10

[a] *Medicaid nursing facility population includes all residents who had Medicaid as their payment source.*

Sources: MDS+ database, in-person assessment database, PASSPORT MIS June 1993, and Ohio's population projections by Ohio Data Users Center.

data also suggest that nursing facilities are being used more heavily by members of younger age groups. This phenomenon appears to be related to the pattern of subacute care discussed earlier. If this trend continues, it will have implications for pre-admission screening.

SUMMARY

In this chapter we used a variety of data sources and approaches to examine whether pre-admission review has affected the diversion of long-term care applicants from nursing facilities to Community Care Choices. Because the time frame for this analysis was limited, we would expect it to reveal only minor changes in nursing facility utilization rates, length of stay, and clients' characteristics, given the size of the entire long-term care population in comparison with the numbers of persons available for diversion in one year. Our analyses, however, indicate some changes in long-term care that may have important implications for pre-admission review, and for how we think about long-term care.

For example, clients newly admitted to nursing facilities differ from the existing nursing facility populations in ways that are consistent with subacute admissions. Also, Medicaid utilization rates for nursing facilities show increasing proportions of the "young-old" and declining proportions of the "old-old" (85 and over). It is possible that those with true long-term care needs (chronic conditions requiring long periods of service) are being diverted to other care settings, while those who require shorter stays are going to nursing facilities from hospitals at an increasing rate. The dual nature of our findings suggests 1) that the opportunity to recoup the costs of pre-admission review is limited when a short, rehabilitative stay in a nursing facility is intended, and 2) that care in a nursing facility is no longer synonymous with long-term care.

Instead, for some populations it entails short-term, subacute care. The implications of these findings for policy will be discussed next, in the final chapter.

CHAPTER 6

SUMMARY OF POLICY AND RESEARCH ISSUES

With more than 1.4 million people age 65 and over, Ohio has one of the largest older populations in the nation. This group will continue to grow; in particular, the population over age 85 (142,000) is projected to increase more than 50 percent by 2010. Ohio spends a considerable amount on long-term care: Medicaid expenditures on this item increased to $1.7 billion in 1992. This figure represents 43 percent of the total expenditures for the Medicaid program. Nationally about 30 percent of total Medicaid is allocated to nursing home care. Ohio's per capita supply of nursing home beds is above the national average with the number of beds in the state increasing by 31 percent during the 1980s, compared with 12.4 percent for the midwest and 24 percent for the nation.

Although less than 10 percent of state expenditures are allocated to noninstitutional long-term care, Ohio has substantially increased the funds designated for community-based long-term care. The PASSPORT program grew from $5 million in 1987 to $59 million in 1993. Spending on all Ohio home care waivers almost doubled in 1993 alone, from $46 to $88 million.

Ohio, like a number of other states with a growing disabled population and many funding priorities, faces difficult challenges as it approaches the twenty-first century. Because of continued increases in the size of the population that is likely to require long-term care, the state cannot simply continue business as usual. If Ohio attempted to maintain the current ratios of nursing facility beds to population, an estimated 32,000 additional beds would be needed by 2010. Current budgetary pressures suggest that such an option is not fiscally possible. Thus,

even though the policy required to address these problems is not clear, it is obvious that the current approach cannot merely be expanded to meet the increases in population.

The pre-admission review and Community Care Choices were designed in response to these challenges. This report is the first evaluation of the policy changes. Although the period for the evaluation is not long enough to provide conclusive evidence about the initiatives, it furnishes systematic data that previously were not available to policy makers in Ohio.

SUMMARY OF FINDINGS

Pre-Admission Review

In an effort to ensure that disabled individuals had access to information about long-term care services and that the services were appropriate, the state implemented a pre-admission review for Medicaid long-term care. The evaluation of pre-admission review activities produced the following major findings:

1) The volume of pre-admission reviews was considerable; 99,039 reviews were conducted during 1994. More than half (54.3%) of these reviews pertained to Medicaid requests; 44.2 percent were mental health/mental retardation reviews required by the federal government; the remainder were reviews for OSS.

2) Slightly fewer than half (46.7%) of the pre-admission reviews were conducted on applicants in a hospital. The remainder were divided between those in the community (30.8%) and those in a nursing facility (22.5%). Payment status influenced the nature

of the review process: more than four-fifths (82.5%) of the non-Medicaid reviews, but only 16.7 percent of the Medicaid reviews, pertained to hospital referrals. Almost half (41.5%) of the Medicaid reviews came from those already living in nursing homes.

3) We presented data comparing individuals who received a pre-admission review in person with those who received only a record or desk review. We expected that persons exempted from an in-person assessment (those receiving the desk reviews, who were clearly determined to need a nursing-facility level of care) would be more disabled. This was the case: for example, more than half (60.5%) of the desk review sample had four or more impairments in activities of daily living, compared with about one-third (34.2%) of the in-person assessment group.

4) Pre-admission reviews were completed in timely fashion: 96.5 percent of the desk reviews from hospitals within the one-day deadline, and 92.2 percent of the desk reviews from nursing facilities within the five-day deadline. Almost 90 percent (87.9%) of in-person assessments were completed within five days.

5) The desk review component of pre-admission review cost about $30 per review. The in-person review was estimated to cost $213 for the level of care assessment, and just over $300 for a comprehensive assessment. The latter was used for those who could receive community-based long-term care.

6) Fewer than 1 percent of the pre-admission reviews resulted in denial of the level of care request for Medicaid reimbursement.

7) Professionals such as hospital discharge planners and nursing facility employees reported that the pre-admission review was conducted in a professional and timely manner. Often, however, they felt that the review for hospital or nursing facility referral was a duplication of their work.

8) Some professionals thought incentives for maintaining appropriate discharge levels from nursing facilities would be helpful. Targeting the least disabled nursing facility residents for in-person assessments also might help to ensure that those most able to live in the community receive information to help them do so.

9) Of those consumers who responded, the majority reported feeling positive about the pre-admission review process. Most consumers, however, did not fully understand the reason for this process. Many were dissatisfied with the quality of long-term care choices offered. Consumers were less satisfied with their long-term care services than with pre-admission review.

10) The majority of caregivers knew about the pre-admission review process, and in general reported high satisfaction with the approach used. They were also satisfied with most

aspects of long-term care services. Many, however, reported illness and strain themselves.

11) In review of the appropriateness of the long-term placement, clinical professionals reported that individuals were in the proper setting in the great majority of cases (94% of those receiving a record review and 98% of those examined in-person).

We conclude that the PASSPORT administrative agencies have responded well to the use of pre-admission review. Despite the very high volume, these agencies completed the overwhelming majority of the reviews in the required time. Long-term care professionals consistently reported that the review process is efficiently performed.

Diversion

Another purpose of this evaluation was to assess the possible diversionary effects of community care choices and pre-admission review on the use of nursing facilities. Findings in this area include the following:

1) The number of Medicaid nursing facility residents did not appear to change greatly in the initial 12-month period of study. Yet the short time frame, limitations in the Medicaid information system, and delays in implementing Community Care Choices seriously limited the evaluators' ability to address this question in this report.

2) Targeting by the long-term care programs in Ohio has improved over the past 12 months. Individuals admitted to nursing facilities in 1994 continued to be more disabled than those admitted in 1993. PASSPORT enrollees were significantly more disabled in 1994: 68 percent were impaired in three or more activities of daily living, compared with 60 percent in 1993.

3) We observed changes in the characteristics of long-term care recipients and in the nature of long-term care. Nursing facilities now provide a considerable amount of short-stay, rehabilitative care. Twenty-nine percent of those admitted during their initial quarter were no longer residents at the end of that quarter. More than half (52.0%) were no longer residents at the end of six months. More men, more nonwhites, more married individuals, and more persons with greater levels of disability make up the population of those who enter nursing facilities. A comparison of present admissions with the population already in nursing facilities, information on length of stay, and utilization rates all suggest that institutional care is becoming less long-term.

IMPLICATIONS OF FINDINGS

As highlighted in the findings above, the pre-admission review program has enjoyed a number of successes in its initial year of operation. Older people, their caregivers, and professionals involved in implementation were generally satisfied with the overall process. Through standardization and enforcement of the criteria for a nursing-facility level of care, decisions about long-term care placements were made appropriately in almost all cases. Links

have been established between Community Care Choices for persons with Medicaid eligibility, the acute care system, and nursing facilities. Experience now has shown that a procedure serving large numbers of older Ohioans can be performed quickly and efficiently, with positive results. Even so, this initial investigation of the issues surrounding the pre-admission review generates a number of important questions; some of these lie outside the pre-admission review legislation currently in effect.

For example, the pre-admission process itself raises questions. As noted, even a timely and satisfactory process is not without costs; a desk review costs the state about $30. The in-person assessment, which costs between $200 and $300, is conducted on more than half (51.7%) of the Medicaid level of care reviews (approximately 28,460 assessments), although many of these assessments serve to gather information for planning PASSPORT care as well as determining level of care. Older long-term care applicants, families, and professionals felt that the in-person assessment process was performed well and had an important function, but they were less sure about the value of a desk-review level of care determination. Professionals outside the PASSPORT agencies believed that the desk review duplicated their work. Fewer than one percent of these reviews resulted in denial; this finding suggests that discharge planners and nursing facility employees do not recommend Medicaid nursing facility services unless they are justified. Yet because it is not clear how many individuals did not apply because of the pre-admission review, this denial rate should be interpreted carefully.

In its favor, pre-admission review implements objective criteria for determining the appropriateness of nursing facility placement, providing standardization across the state. The high volume of reviews, the low rate of adverse decisions, and the characteristics of the

individuals receiving only a desk review indicate that the state should carefully examine the current approach. One question to be considered is whether pre-admission review resources might be used more appropriately to provide more and/or different alternative long-term care settings for those who can take advantage of them. This point was discussed by many of the long-term care professionals whom we interviewed.

In addition, professionals consistently cited the restricted intake into PASSPORT as a barrier. They also discussed the need for alternative long-term care settings. Assisted living was mentioned frequently as an option that could combine access to 24-hour supervision with consumers' desire for choice and independence.

This study also highlights the need for more fully detailed information to clarify patterns of usage for long-term care. Implicit in the cost-effectiveness of pre-admission review is the assumption that costs can be saved by diverting a client from a long-term stay in a nursing facility. Some evidence, however, suggests that nursing facilities are serving a group of people who are different from the long-term residents, and who may need only short-term care at less than a hospital level. Many professionals stated that in fact this was the situation. This point was suggested throughout the chapter on long-term care utilization patterns and diversion, and was highlighted in the findings in this chapter. This indicates that longitudinal data on long-term care utilization would provide valuable information about current and future trends affecting the long-term care industry in Ohio. Information that would assist in targeting pre-admission resources to those with long-term care needs would also be beneficial.

Considerable long-term care challenges confront Ohio and many other states. State policy makers face difficult decisions as they prepare for a future that includes a growing

disabled population and limited fiscal resources. To address these issues, information about long-term care needs and utilization by Ohio's citizens is critical. This report is an initial step in the state's effort to meet this challenge.

REFERENCES

Burwell, Brian. 1994. "Medicaid Long Term Care Expenditures in FY 1993." Memo, SysteMetrics: Cambridge, MA.

Chang, B.L. 1978. "Perceived Situational Control of Daily Activities: A New Tool." Research in Nursing and Health 1(4):181-88.

Doan, R.M. and R. Lombardo. 1992. "Targeting Resources for Community-Based Long Term Care: A Case Study of Dade County, Florida—1989-92, Final Report." Unpublished report. Washington, DC: Gerontological Society of America.

Harkins, E.B. and C.A. Bowling. 1982. Executive Summary, study of the Virginia Nursing Home Pre-Admission Screening Program, Executive Summary. City?

Iverson, L.H. 1986. "A Description and Analysis of State Pre-Admission Screening Programs." Excelsior, MN: InterStudy.

Iverson, L.H. 1987. "Pre-Admission Screening: Impact on Long-Term Care." Pride Institute Journal 6(1):7-11.

Mehdizadeh, Shahla A. 1993. Revised Estimates of Disabled Older Population, 1990. Oxford, OH: Scripps Gerontology Center, Miami University.

Mehdizadeh, Shahla A. and Robert C. Atchley. 1992. The Economics of Long-Term Care. Oxford, OH: Scripps Gerontology Center, Miami University.

Mehdizadeh, Shahla A., Suzanne R. Kunkel, Robert C. Atchley, and Robert A. Applebaum. 1990. Projected Need for Long-Term Care in Ohio's Older Population, 1990-2010. Oxford, OH: Scripps Gerontology Center, Miami University.

Miller, Nancy A. 1992. "Medicaid 2176 Home and Community-Based Care Waivers: The First Ten Years." Health Affairs. Washington, DC: Health Care Financing Administration.

Moscovice, I., G. Davidson, and D. McCaffrey. 1987. "Evaluation of the Minnesota Pre-Admission Screening and Alternative Care Grants Program." Unpublished report, Division of Health Services Research and Policy, School of Public Health, University of Minnesota.

Reid, D.W., G. Haas, and D. Hawkings. 1977. "Locus of Desired Control and Positive Self-concept of the Elderly." Journal of Gerontology 32:441-50.

Taueber, Cynthia. 1990. Nursing Home Population: 1990 (CPH-L-137). Washington, DC: Economics and Statistics Administration, Bureau of the Census.

Yeatts, D.E., J.A. Capitman, and B.J. Steinhardt. 1987. "Evaluation of Connecticut's Medicaid Community Care Waiver Program." The Gerontologist 27(5):652-59.

Appendix
Table of Contents

Note: A volume of complete instruments, cover letters, etc. is available from the Scripps Gerontology Center, Miami University, Oxford, OH 45056

I want to ask you some questions now about the people who are paid to help you. As I ask you the questions below, please think about your opinions in regard to the people who are paid to help you. If none of your helpers are paid, either by you or someone else, answer according to your opinions about your non-paid help. IF PROXY IS ALSO THE ONLY HELPER, SKIP TO QUESTION 13 ON PAGE 10. IF CLIENT RECEIVES NO INFORMAL OR FORMAL HELP, SKIP TO QUESTION 13 ON PAGE 10.

7. How sure do you feel that you can rely on getting the help you need?
Would you say:

Very Sure	Somewhat Sure	Somewhat Unsure	Very Unsure	
4 (363)	3 (247)	2 (54)	1 (22)	HLPTH

8. If you could change things about the help you get, would you:

Change Nothing	Change A few Things	Change A lot of Things	Change Everything	
4 (372)	3 (260)	2 (31)	1 (21)	HLPCHAN

9. How much do you agree with the following statement: My helpers do things exactly the way I want.

Strongly Agree	Agree	Disagree	Strongly Disagree	
4 (200)	3 (388)	2 (68)	1 (27)	HL

10. Have your helpers helped you to cope more effectively with your problems?
Would you say:

They've helped a great deal	Yes, they help somewhat	No, they don't help	No, they seem to make things worse	
4 (284)	3 (325)	2 (57)	1 (10)	HLPCOP

11. How sure do you feel that you can get your care/help changed if you need to?

Very Sure	Somewhat Sure	Somewhat Unsure	Very Unsure	
4 (232)	3 (258)	2 (137)	1 (37)	NEEDCHN

12. Overall, how would you rate the performance of the people who help you?

Excellent	Good	Fair	Poor	
4 (303)	3 (308)	2 (58)	1 (12)	PERF

13. How much do you agree with the following statement: I have enough privac here.

Strongly Agree	Agree	Disagree	Strongly Disagree
4 (323)	3 (307)	2 (45)	1 (28)

14. Do you ever worry about being safe here? Yes 1 (150) No 0 (553)

If YES, ask "Do you worry about.."

a. the neighborhood and crime? Yes 1 (71) No 0 (79)

b. having an accident or becoming ill? Yes 1 (134) No 0 (16)

c. whether your house/the building is unsafe? Yes 1 (54) No 0 (96)

15. How satisfied are you with your life in general right now?

Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
4 (127)	3 (318)	2 (147)	1 (90)

16. Day to day, how much choice do you have about what you do and when you do it? Would you say you have--

A Great Deal of Choice	Some Choice	Not Very Much Choice	No Choice
4 (265)	3 (274)	2 (101)	1 (55)

17. How would you describe your health?

Poor	Fair	Good	Very Good	Excellent
1 (232)	2 (205)	3 (212)	4 (41)	5 (13)

18. Is there anything else you would like us to know about the care you need, the care you are getting, the place you live, or your health?

(IF CLIENT WAS DESK REVIEWED, SKIP TO QUESTION 32.)

19. A few months ago you went through an assessment which determined the amount and kind of care that you needed. A nurse or social worker visited you and asked you a number of things about what you were able to do for yourself, how you were feeling, how your memory was, and what kinds of help your friends or family were giving you. Do you remember that visit?

Yes	No	
1 (386)	0 (204)	VIS

(IF NO, SKIP TO QUESTION 32, PAGE 13.)

20. Do you understand why you had to have an assessment?

Yes, Completely	Yes, Fairly Well	No, Not Very	No Not at All Well	
4 (146)	3 (152)	2 (57)	1 (31)	YASSW

21. Would you say the assessors arranged for...

All the help you needed	Some of the help you needed	A little of the help you needed	None of the help you needed	
4 (236)	3 (107)	2 (20)	1 (12)	ASS

22. To what extent did the assessment meet your expectations?

Almost all my expectations were met	Most of my expectations were met	Only a few of my expectations were met	None of my expectations were met	
4 (193)	3 (142)	2 (21)	1 (12)	EXPE

23. How would you rate the quality of the choices you were offered?

Excellent	Good	Fair	Poor	
4 (132)	3 (184)	2 (24)	1 (18)	QCH

24. How would you describe the number of choices you were offered?

I had all the choices I wanted	I had almost all the choices I wanted	I wanted a few more choices	I wanted a lot more choices	
4 (159)	3 (149)	2 (28)	1 (19)	NCHOIC

25. To what extent do you agree with the following statements?

The assessors listened to my opinions.

Strongly Agree	Agree	Disagree	Strongly Disagree	
4 (152)	3 (197)	2 (18)	1 (3)	OPINIC

26. I got what I wanted from the assessment process.

Strongly Agree	Agree	Disagree	Strongly Disagree	
4 (154)	3 (180)	2 (24)	1 (9)	ASSPRC

27. If a friend needed some help, would you recommend to them that they call PASSPORT and go through an assessment?

Yes	No	
1 (356)	0 (14)	RECOPPI

28. Overall, how would you rate the performance of the people who talked with you?

Excellent	Good	Fair	Poor	
4 (187)	3 (157)	2 (22)	1 (4)	ASSPEI

29. If they assessed you again today, would you say your:

Situation is the same	3 (56)	REASSNC
Situation is slightly different	2 (129)	
Situation is very different	1 (188)	

30. Do you feel like the choices you made then are still the right ones today?

Mostly yes	1 (357)	RTCHOI
Mostly no	0 (13)	

Scripps Gerontology Center
Oxford, Ohio 45056
513 529-2914

MIAMI UNIVERSITY

PASSPORT/PREADMISSION REVIEW TIME STUDY INSTRUCTIONS

THIS TIME STUDY IS PART OF THE SCRIPPS GERONTOLOGY CENTER'S EVALUATION AND WILL BE USED TO REPORT TO THE LEGISLATURE ABOUT THE COST OF THE PREADMISSION REVIEW PROCESS.

ALL PASSPORT STAFF WILL PARTICIPATE IN THE TIME STUDY FOR ONE WEEK. ALL PASSPORT STAFF HOURS FOR THE WEEK SHOULD BE REPORTED ON THE FORM.

THIS TIME STUDY FORMAT INCLUDES MORE SPECIFIC INFORMATION THAN THE TIME STUDIES YOU GENERALLY COMPLETE. STAFF WHOSE RESPONSIBILITIES FALL INTO MORE THAN ONE CATEGORY SHOULD REPORT TIME IN THE APPROPRIATE CATEGORIES. IF YOU HAVE MEETINGS/ADMINISTRATIVE TIME THAT FITS INTO MORE THAN ONE CATEGORY (SCREENING/ASSESSMENT/CASE MANAGEMENT), ALLOCATE THIS AT THE PERCENTAGE YOU ARE SCHEDULED TO WORK IN EACH CATEGORY. THE STUDY REQUIRES THAT TIME BE RECORDED TO THE CLOSEST QUARTER HOUR; PLEASE BE AS DETAILED AS POSSIBLE WHEN FILLING OUT THE FORM.

THE FOLLOWING PAGE INCLUDES GUIDELINES FOR EACH CATEGORY ON THE FORM. IF YOU HAVE QUESTIONS, PLEASE CONTACT YOUR SUPERVISOR OR CHRISTI PEPE AT (513) 529-2914. THANKS FOR YOUR COOPERATION.

SCREENING/SCHEDULING

Screeners will need to identify how much time is spent each day in support of each of the Screening/Scheduling categories. The I&A General category is for time spent working on behalf of clients whose request is for general information. If the request is for PASSPORT, NF LOC, or OSS, time should be reported in these categories. You may, for example, take several phone calls, gather PAS/ID information, and complete a screen on behalf of a client seeking NF placement. In this case, you will have to distinguish the time you spent on the PAS/ID from the rest of the process, and report in the both the PAS/ID and LOC for NF Placement categories. Because the Screening function covers so many possibilities, you may have to think about the purpose of the activity you are performing, and apply this to the appropriate category.

ASSESSMENT

Assessors will need to identify time spent preparing for, performing, and following-up on assessments in the Assessment categories. Time spent gathering PAS/ID information must be reported separately from type of assessment. Whenever an activity is performed that directly supports one of the identified assessment types, report time in the appropriate assessment category.

DESK REVIEW/PREADMISSION

Preadmission Unit staff will need to keep track of time spent on each type of review, taking care to report PAS/ID time as separate from LOC Review activity. Follow-up phone calls and paperwork in support of a review should be reported as part of the review or PAS/ID as appropriate.

CASE MANAGEMENT

All Case Management hours should be reported in the Total Case Management category, but there is no need to break down by category.

MANAGEMENT/SUPERVISION

Managers and Supervisors should identify the amount of time spent in each of the PASSPORT clinical areas, including Desk Review. Be specific whenever possible; use the general category when there is no potential for distinction.

SUPPORTIVE SERVICES

This category is intended for use by PASSPORT staff whose responsibilities are not specific to a clinical area (e.g. administrative secretary or Data Entry staff), or whose responsibilities cannot be easily categorized by type of clinical activity (e.g. Case Aide, Records Assistant). Report only hours spent working in the PASSPORT program.

TOTAL SCRIPPS EVALUATION ACTIVITY

Report time spent on activities specific to the evaluation (copying, responding to faxes, completing time study form) that would not otherwise be part of PASSPORT activities.

VACATION/SICK LEAVE/OTHER LEAVE

If you have taken paid time off for any reason, report this time here.

TOTAL HOURS

Total hours should be the sum of all of the previous categories, and should reflect the total hours worked each day.

PASSPORT/PREADMISSION REVIEW TIME STUDY

NAME _____ **WEEK FROM:** _____

JOB TITLE: _____ **PAA:** _____

WEEKLY SCHEDULED HOURS: _____

Complete form with hours worked (to closest quarter hour segment) in each activity each day.

SCREENING/SCHEDULING	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TOTAL
I&A General						
PAS/ID						
LOC for NF Placement						
PASSPORT Comprehensive & Reassessments						
OSS						
Delayed						
Statistics/Reporting						
Meetings/Administration/Training						
TOTAL SCREENING						

ASSESSMENT:	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TOTAL
PAS/ID & Further Review						
LOC for NF Placement						
PASSPORT						
OSS						
CBA						
Delayed						
ARR						
Meetings/Administration/Training						
TOTAL ASSESSMENT						

DESK REVIEW/PREADMISSION	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TOTAL
PAS/ID						
Hospital Review LOC						
NF Review						
Community LOC for NF Placement						
OSS						
PASSPORT						
Meetings/Administration/Training						
TO[illegible] DE[illegible] REV[illegible] REA[illegible] SS						

PASSPORT/PREADMISSION REVIEW TIME STUDY, Page 2

CASE MANAGEMENT:	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TOTAL
Log all CM hrs; no further breakdown						
TOTAL CASE MANAGEMENT						
MANAGEMENT/SUPERVISION	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**TOTAL**
Screening						
Assessment						
Desk Review						
Case Management						
General						
TOTAL MANAGEMENT/SUPERVISION						
SUPPORTIVE SERVICES–Clerical/MIS	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**TOTAL**
PAS/ID						
PASSPORT						
OSS						
LOC						
CBA						
Other						
TOTAL SUPPORTIVE SERVICES						
TOTAL SCRIPPS EVALUATION ACTIVITY						
VACATION/SICK LEAVE/OTHER LEAVE						
TOTAL HOURS (all categories)						

Employee Signature

Date submitted

UPAR Site Selection Criteria

	Stage of Operation	% of Ohio's 65+ Population	% of June 1993 PASSPORT Caseload	Rural Factor*	Additional Community Diversion Alternatives	65+ Medicaid Certified Nursing Facility Bed Ratio	Geographic Location
PAA 1	Phase 1	12	15.4	1.82	Local Levy	.0543	SW
PAA 2	Phase 2	7.5	6.4	.550		.0465	SW
CSS	Phase 1	3	4.6	3.98		.0557	W
PAA 3	Phase 2	3	2.6	3.85		.0620	NE
PAA 4	Phase 2	8	5.6	5.41		.0544	NW
PAA 5	Phase 2	5	4.2	4.87		.0586	CEN.
PAA 6	Phase 1	10	11.2	4.39	Local Levy	.0546	CEN.
PAA 7	Phase 2	4	7.4	7.26		.0629	S
PAA 8	Phase 2	2	4	6.21		.0553	SE
PAA 9	Phase 2	5	6.4	5.82		.0549	E
PAA 10A	Phase 2	21	16	1.55		.0394	NE
PAA 10B	Phase 1	11	10	1.45		.0464	NE
PAA 11	Phase 2	8	6.4	1.50		.0518	NE

*% of over 60 population living in rural area.