Brief Report
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Ohio's Aging Network Efforts to Enhance Nursing Home Diversion and Transition

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Key Findings

In response to a legislative mandate the Ohio Department of Aging, in conjunction with the Area Agencies on Aging, developed a nursing home diversion and transition program. Between March 2010 and February 2011, 1974 individuals were identified for diversion and 1259 individuals for transition from Ohio nursing homes.

After six months, about two-thirds of individuals identified for diversion remained in the community, 17% were residing in a nursing home and 18% were deceased.

A review of nursing home residents in the transition program found that, after six months, 53% of individuals were residing in the community, 14% in assisted living, 23% remained in nursing homes and 10% were deceased.

These results are preliminary, and include follow-up data for only half of the sample. However, the finding that two-thirds of both the diversion group and the nursing home transition group are in the community after six months indicates a potentially promising practice for the area agency network.

Background

Ohioans use nursing homes at a rate higher than the national average. Because two thirds of the state's nursing home residents are supported by the Medicaid program, high utilization has important implications for the state budget. During the 2009 legislative session, the Ohio Department of Aging was asked to develop a nursing home diversion and transition program that would assist individuals to live in a home and community-based care setting. Although the state had existing home care programs in place, such as PASSPORT, Ohio Home Care, and HOME Choice, this legislative initiative was designed to identify a new approach that would result in an increase in the number of individuals being diverted from, or transitioning out of, Ohio nursing facilities. This research brief presents preliminary results of the newly implemented diversion and transition activities.

Diversion and Transition Strategies

To develop a new set of strategies for nursing home diversion and transition, the Ohio Department of Aging initiated a workgroup in August 2009 comprised of staff from Ohio's 12 Area Agencies on Aging (AAAs) who would ultimately implement the effort. The workgroup focused on two target populations: diversions and transitions. The diversion group was comprised of individuals at high risk of long-term nursing home placement who were in the community, hospital, or in a short-term nursing home stay. Some of these individuals were already enrolled in the PASSPORT or Assisted Living Waiver programs. The transition group included individuals who were longer-stay nursing home residents, but who could possibly return to live in the community. The demonstration included a range of innovations. Ohio's AAAs chose the interventions that were most appropriate for their respective region. In some instances, because the approaches were different from current practice, agencies established new administrative units to house the diversion and transition program.

Diversions

As noted, the diversion strategies were targeted to individuals who were determined to be at very high risk of entering a nursing facility. Because previous studies have shown that almost half of the participants leaving the waiver programs enter a nursing home, one of the important diversion strategies was to better identify and serve these high-risk individuals. Operational strategies, such as increasing the amount and intensity of in-home services, enhanced caregiver training and support, and a more proactive plan for waiver participants who had entered a nursing home for a short term stay, were implemented. Diversion activities for non-waiver individuals included a heavy emphasis on working with hospitals and other providers, such as home health and social service agencies, to identify high-risk consumers. Several of the area agencies actually located staff members in hospital settings to enhance this linkage.

Results of the Diversion and Transition Interventions

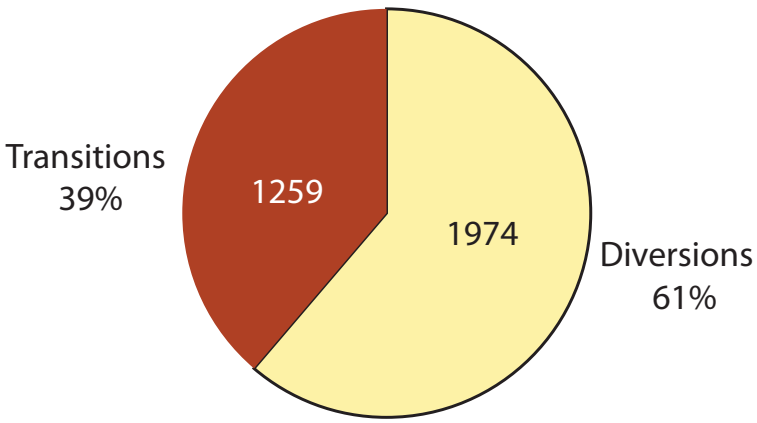
The AAAs began the diversion and transition intervention on March 1, 2010. During the one year time period through February 2011, 3233 at risk Ohioans were identified by the AAAs and agreed to participate in the diversion and transition intervention (1974 diversions and 1259 transitions) (See Figure 1). In some instances, individuals or family members chose not to receive assistance after exploring their care options, but they are still included in the overall evaluation sample. Diversion and transition consumers were followed-up six months later, to examine the impact of the intervention. Initial data on diversions and transitions was recorded by AAA staff and submitted electronically to the Scripps Gerontology Center. Follow-up data to track diversion and transition consumers came from the PASSPORT Management Information System (PIMS), the Nursing Home Minimum Data Set (MDS), and telephone interviews with consumers and family members conducted by Scripps.

For this interim report, six-month follow-up information was available for about one-half of the 3233 diversion and transition consumers (1739).

Transitions

While diversion has been a long standing goal of the area agencies, transitioning individuals from the nursing home setting represented a more significant shift. To identify nursing home residents who were transition candidates, the AAAs used two existing data bases that provide detailed information about nursing homes residents in their region. One of those was the Nursing Home Minimum Data Set (MDS), which included a question about whether the resident would like to return to the community. In fact, since October of 2010, changes in federal rules as part of the MDS now require nursing homes to directly ask residents about their desire to return to the community. The second data base used included all individuals receiving a pre-admission review prior to nursing home placement. The long-term care ombudsman and nursing homes themselves were also important partners in the process. To work with residents, area agencies sent staff into the facility to explore the feasibility of returning to the community. For those residents who chose transition, the area agency staff member developed a plan and arranged for the necessary services to facilitate the return to the community.

Figure 1
Number Identified for Diversion and Transition for 12-Month Time Period

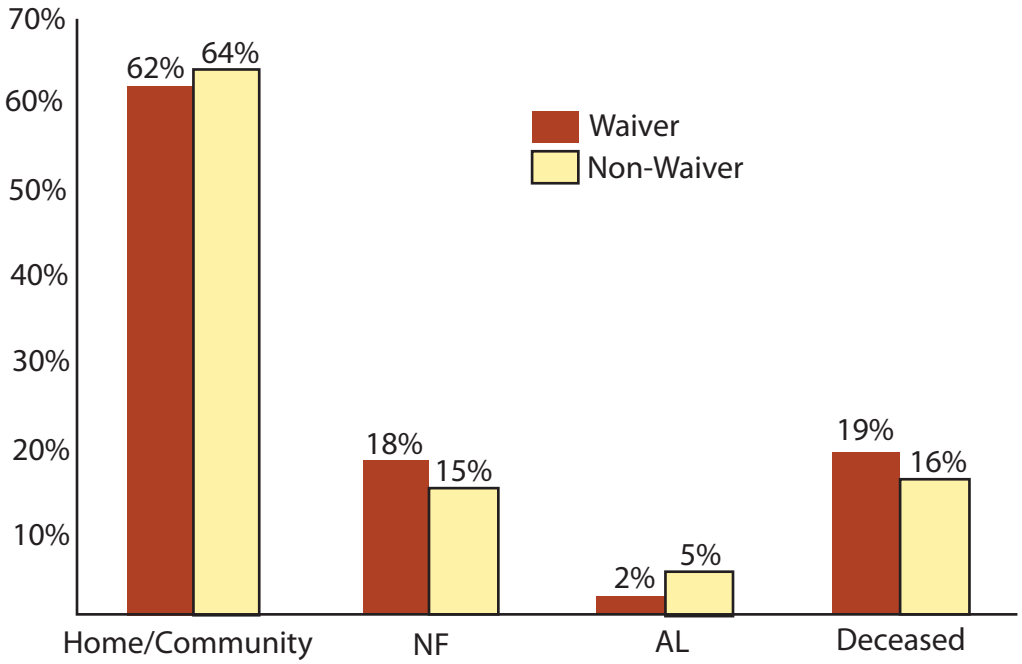


Diversion Results

The location and program status of individuals was examined six months after they had been identified as diversion consumers. Diversion consumers were differentiated by whether they were, at baseline, enrolled in the PASSPORT or Assisted Living Medicaid waiver programs (waiver participants) and those who were not enrolled in either waiver at the baseline (non-waiver consumers). This distinction was important because the interventions varied by waiver status. Follow-up data show that 63% of diversion consumers were residing in the community at the six month mark and another 3% were in assisted living (See Figure 2). Slight differences existed in the proportion at home after six months, depending on whether the individual was enrolled in waivers at the start (62%) or classified as non-waiver at the initial time of targeting for diversion (64%). Those enrolled in a waiver at the baseline were slightly less likely to be in assisted living at six months (2% vs. 5%). About 17% of diversion consumers were in a nursing home after six months, again with small differences for the waiver and non-waiver samples (18% waiver, 15% non-waiver). This is the case even though 30% of the waiver group members were classified as short-stay nursing home residents at baseline, compared to 18% for the non-waiver group. About 17% of diversion consumers were deceased at the six months follow-up (19% waivers, 16% non-waiver).

At the baseline, 36% of all individuals in the diversion group were enrolled in either the PASSPORT or Assisted Living Waiver programs. By the six month time period, seven in ten (71%) of those diversion consumers remaining in the community were enrolled in PASSPORT or the Assisted Living Waiver, indicating the importance of these programs to the diversion efforts. Nearly all (95%) percent of those waiver enrolled were PASSPORT participants.

Figure 2
Six Month Follow-up Location (Diversion)

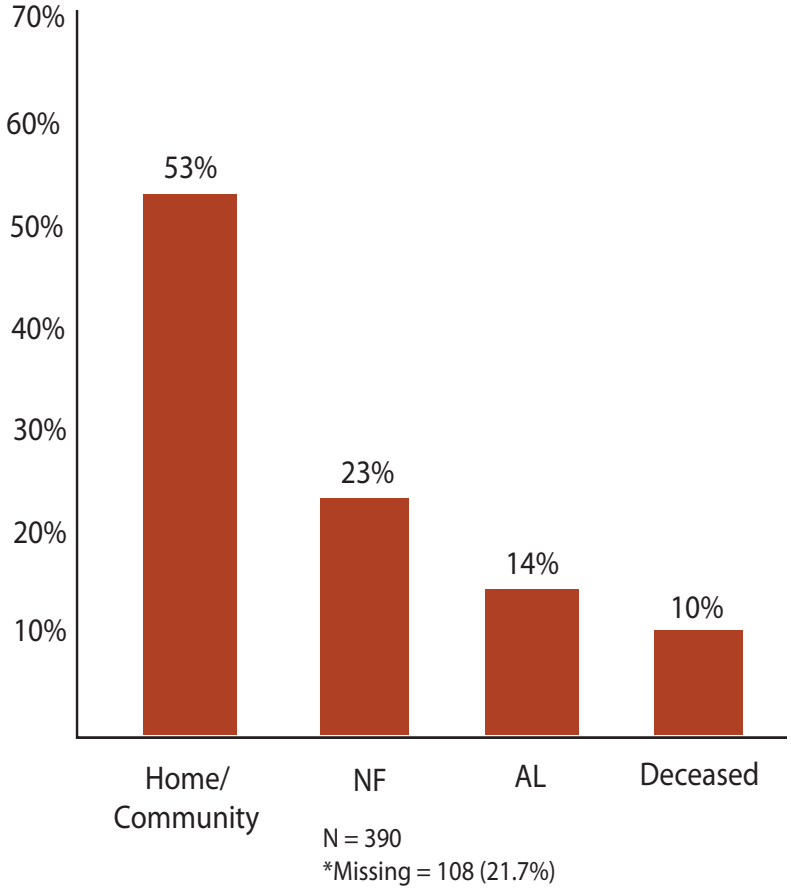


(Waiver N = 376, Non-Waivers N = 496)
*Missing = 20.7%

Transition Results

At baseline, all of the transition consumer group had been long-term nursing home residents (3 months or longer). In select instances, individuals had been residents for five years or more. After six months, more than two-thirds of transition consumers were living in a home setting or an assisted living facility (53% and 14% respectively) (See Figure 3). About one-quarter (23%) were residing in a nursing home at the six month mark. Finally, 10% of consumers were deceased by the time of the six month follow-up. The majority (82%) of transition consumers living in the community were enrolled in the PASSPORT or Assisted Living Waiver programs.

Figure 3
Six Month Follow-up Location (Transitions)



Conclusion and Next Steps

Preliminary results indicate that about two-thirds of diversion and transition consumers were residing in the community after six months. Since 100% of the transition group had been long-term nursing home residents, this finding suggests that transition efforts could represent a significant change for the home care delivery system operated by the network of aging agencies. However, these results are preliminary. They include follow-up data for the earlier one-half of diversion and transition consumers; results could change with the full sample. In the following months, the Scripps team will continue to track diversion and transition consumers being identified by the AAAs and complete the six month follow-up. Follow-up will continue through May 2011 in preparation for the final report to be released by the end of June. The final project report will include detailed information about the strategies implemented by the AAAs, based on interviews and focus group with area agency staff from around the state. This component will include a review of promising practices for diversion and transition developed by the AAAs as well as barriers to success.

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