Right Place, Right Time, Right Care:

An Evaluation of Ohio's Nursing Home Diversion and Transition Initiative

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EXECUTIVE SUMMARY

Background

As a state with a large and growing aging population Ohio faces unprecedented challenges in developing a system of long-term services and supports that both meets the needs of its citizens and is affordable to the state. Today, Ohio has more than two million individuals over the age of 60, ranking seventh highest in the nation. By 2020 the older population is projected to increase by 25% and to more than double by 2040. As in many states, Medicaid supports a high proportion of nursing home residents. With Medicaid accounting for one-quarter of Ohio's state general revenue expenditures, the large number of older people and high nursing home utilization rates represent a difficult combination for policy makers. As a response to these challenges the General Assembly included the Ohio Diversion and Transition Initiative as part of the 2010/2011 budget, asking the Ohio Department of Aging (ODA) to create a diversion and transition program that would target 2300 individuals for diversion from long-stay nursing home placement and transition from nursing homes.

Diversion and Transition Strategies

The new program was specifically designed to achieve two distinct goals: to prevent unnecessary long-term nursing facility placement (diversion), and to provide community-based alternatives for long-stay nursing home residents who preferred and were able to live in a community setting (transition). The specific intervention strategies are classified into two categories: identification of consumers who would be good candidates for the program, and diversion and transition services. Identification strategies are innovations to better find community-dwelling consumers at risk of nursing home placement, and nursing home residents with the potential to return to the community. Service-related strategies are interventions that more effectively assist high-risk nursing home consumers in staying or returning home. The demonstration was implemented by Ohio's 13 PASSPORT Administrative Agencies (PAAs); each organization chose the interventions that were most appropriate for their respective region. An evaluation of the intervention included both an analysis of consumer outcomes and a process review of program implementation and promising practices.

Results of Diversion and Transition

- During the 15-month period, 3799 at-risk Ohioans were identified to participate in the intervention (2244 diversions and 1555 transitions).

- The total number of diversion and transition interventions conducted by each region was generally proportional to the number of waiver consumers they typically serve. However, Cleveland, which accounts for 18% of waiver enrollment state-wide, recorded 34% of the total diversions and transitions.

- To assess the effectiveness of the program, the evaluation followed consumers six months after they entered the program. Four in five diversion consumers and three-quarters of those who transitioned from nursing homes (74%) who were still alive at the time of their six-month follow-up were residing in the community.

- There were nine possible triggers that assessors used to determine whether an individual was at high risk of long nursing home placement, and thus a good candidate for the diversion program. The possible triggers included such areas as: health deterioration, caregiver interest in considering nursing facility placement, individual was seriously considering entering a nursing home, and problems with housing in the community. On average, just under two reasons (1.7) for needing the diversion intervention were recorded; health deterioration was the most common (73.4%).

- All of the transition consumer group members had been nursing home residents (most for at least three months) prior to the program. The most common reasons for consumers being identified for the transitions program were a request to return to the community from the individuals themselves (93%) or their caregiver (65%). (A consumer could have multiple reasons.)

- Thirty-five percent of diversion consumers were already enrolled in the PASSPORT or Assisted Living Waiver Program.

- For waiver consumers, the most widely used diversion intervention was increasing the type and intensity of care plan services, reported in about two-thirds (65.3%) of cases. More than 30% of waiver consumers were short-stay nursing home residents receiving targeted attention to help them avoid an unnecessary long stay. For non-waiver diversion consumers, the most common intervention strategy was a referral to PASSPORT or the Assisted Living Waiver Program, reported for three-quarters (73.2%) of individuals

- On average, transition consumers received between one and two interventions (1.6), with the most common intervention by far being a referral to PASSPORT or

the Assisted Living Waiver Program (86%). About one-third of consumers received caregiver education.

Promising Practices

A review of program implementation found five promising practices that should be examined as PAAs and ODA explore state-wide expansion of the diversion and transition initiative including:

- PAA modifications to their organizational structure and culture to support diversion and transition activities,
- Partnerships and even co-location of PAA staff in hospitals,
- Working with nursing homes to identify and transition residents,
- Improved collaborations with the ombudsman program, and
- More extensive outreach and educational efforts with family members.

Overall Evaluation Recommendations

The findings presented in this report indicate that the Ohio Diversion and Transition Initiative produced positive outcomes. With 3800 diversions and transitions completed; results for the surviving sample showed that four in five of those diverted and three-quarters of those transitioned from Ohio nursing homes remained in the community after six months. The process analysis provided examples of how the PAAs had changed practice in order to achieve these outcomes. The following recommendations, based on the evaluation, can provide guidance as the program moves to statewide implementation.

(1) Clarify diversion and transition definitions and continue to track outcomes. There still appear to be considerable differences in diversion and transition rates across the regions. We recommend that ODA work with the PAAs to refine the definitions based on the substantial operational experience that they have now gained in implementation of the initiative.

(2) Targeting consumers for transition requires continued refinement of targeting criteria to better identify which short stay residents are most vulnerable to an unnecessary and undesirable long stay. Specifically, we recommend that the implementation activities associated with the use of the new MDS Section Q question about consumer interest in getting out of the nursing home be monitored carefully over the next six months.

(3) We are aware that the initial HOME Choice program required a six month stay prior to referral and this was reported as a barrier by PAA staff. Given the enhanced federal match received by the state on this initiative and the additional resources available for transition, we recommend that ODA work with the PAAs to explore why this intervention is not more widely used and to correct any barriers to the program.

(4) Because of the growing importance of the blending of long-term and acute care needs, the role of PAAs in bridging the gap will need to continue, and to be dramatically expanded.

(5) The diversion and transition program represents a shift in practice for the PAAs and for ODA. It will now be important for the aging network to refine the business model and expected outcomes to match the expanded scope and mission of the PAAs.

BACKGROUND

As a state with a large and growing aging population Ohio faces unprecedented challenges in developing a system of long-term services and supports that both meets the needs of its citizens and is affordable to the state. Today, Ohio has more than two million individuals over the age of 60, ranking seventh highest in the nation. By 2020 the older population is projected to increase by 25% and to more than double by 2040. Coupled with the large numbers of older people, Ohio ranks among the top ten in nursing home bed capacity and utilization (Houser, Fox-Grage, & Gibson, 2009). As in many states, Medicaid supports a high proportion of nursing home residents (63%); in 2009, Ohio's Medicaid program spent more than $3.3 billion on nursing home care (Mehdizadeh & Applebaum, 2011). With Medicaid accounting for one-quarter of Ohio's state general revenue expenditures, the large number of older people and high nursing home utilization rates represent a difficult combination for policy makers. Ohio has been working to reform the long-term services and supports system for the last two decades and has made substantial progress. In 1993, one in ten older people receiving Medicaid funded long-term care did so in the community. By 2009, four in ten older Ohioans receiving Medicaid long-term services resided in the community. Despite this progress, Ohio still ranks 40th in the ratio of Medicaid institutional to community-based services spending for people of all ages; for those 60 and older, Ohio ranks 33rd (Eiken et al., 2010).

As Ohio, and the nation overall, addresses these long-term care challenges, nursing home diversion and transition programs have received increased attention. The Money Follows the Person program, begun in 2003 by the Centers for Medicare and Medicaid Services (CMS), is the largest-scale national initiative designed to help Medicaid beneficiaries who had lived in an institution for at least six months (now three months) transition back to the community. By 2008,

30 states, including Ohio, were participating. As suggested by its name, the program called for states to ensure that Medicaid funding was linked to the individual rather than the provider. In a parallel effort, hospital-based diversion programs were also being developed to help individuals avoid long-term placement in nursing homes. Changes to Medicare funding for hospitals had amplified the number of older people leaving the hospital for a short-term stay in a nursing home. While many such placements were appropriate, some were unnecessary and some short-term placements resulted in inappropriate long stays in nursing facilities.

The impetus for both diversion and transition activities in Ohio actually came from both the PAAs and state policy makers. A strong emphasis on diversion and transition strategies came from the PAAs themselves and was very much driven by efforts to provide better services to program participants. PAAs across the state reported consistent challenges in trying to coordinate services for individuals who required assistance across the acute and long-term care networks. Oftentimes PASSPORT participants had health challenges that required them to use both hospital and nursing home care even as they remained enrolled in PASSPORT. Communication problems among home care agencies, hospitals and nursing homes resulted in a system that did not effectively meet consumer needs. In response to this system failure, PAAs across the state had begun to explore partnerships with hospitals and health systems. A second motivation for the diversion and transition initiative came from the Ohio General Assembly and the Ohio Departments of Aging and Job and Family Services, as they addressed Medicaid funding constraints, both current and future. Ohio's higher-than-average nursing home utilization rate made emphasis on transition an important policy interest. The convergence of these two sets of motivations resulted in the diversion and transitions initiative activities currently under way. As a response the General Assembly, in its 2010/2011 budget, directed the Ohio Department of Aging

to implement a nursing home diversion and transition initiative. This report is an evaluation of that program.

The Ohio Diversion and Transition Initiative called for the Ohio Department of Aging (ODA) to create a diversion and transition program that would target 2300 individuals. The initiative was to be implemented by the 13 PAAs (12 Area Agencies on Aging and one not-for-profit organization) with the objective of assisting individuals and their families with their long-term care options and decisions. These 13 regional organizations have the responsibility to operate both the PASSPORT and Assisted Living Waiver Program for Ohio. At the state level the Ohio Department of Aging is responsible for operational management and the Ohio Department of Job and Family Services has fiduciary responsibility. ODA formed a workgroup comprised of in-home care specialists from the PAAs and state staff. The workgroup met regularly over the course of five months, developing a range of diversion and transition approaches. Each PAA chose to implement the interventions that were most appropriate for their respective region.

One of the challenges facing ODA and the workgroup was defining diversion and transition. There were two underlying issues. First, because the PAAs are already in the business of helping people stay at home for as long as appropriate, many of their consumers could be considered diversion clients. The second issue involved individuals currently in nursing homes for either short or long-term stays; the challenge here was to decide what constitutes a diversion (preventing a long-term nursing home stay for an individual who is, for all intents and purposes, still living in the community), and what constitutions transition (helping an individual move back to the community after a long-stay in a nursing home). The workgroup eventually defined the diversion group as those individuals who were currently living in the community, hospital, or

short-term nursing home stay who were at high risk for long-term nursing home placement. This latter condition, high risk for nursing home placement, helps to distinguish the diversion individual from other consumers who may need assistance staying at home. Some of the diversion consumers were currently enrolled in either PASSPORT or the Assisted Living Waiver Program (waiver consumers), while others were not currently part of the Medicaid long-term services system (non-waiver consumers). To be classified as a transition consumer, the individual had to consider the nursing home as their permanent placement, and typically had been in the facility for three months or longer.

DIVERSION AND TRANSITION STRATEGIES

The new initiatives were specifically designed to achieve two distinct goals: to prevent unnecessary long-term nursing facility placement (diversion), and to provide community-based alternatives for long-stay nursing home residents who preferred and were able to live in a community setting (transition). The specific intervention strategies developed by the workgroup are classified into two categories; identification of consumers who would be good candidates for the initiative, and diversion and transition services (See Table 1). Identification strategies are innovations to better find community-dwelling consumers at risk of nursing home placement and nursing home residents with the potential to return to the community. Service-related strategies are interventions that more effectively assist high-risk consumers to stay or return home.

CONSUMER IDENTIFICATION STRATEGIES: DIVERSION

As noted, the diversion initiative was targeted to individuals who were current waiver participants but at very high-risk of nursing home placement, and non-waiver individuals who

were considering entering a nursing facility. Waiver participants were most often identified by their care manager based on a discussion with the individual or family member or precipitated by an incident involving a hospital or nursing home admission. Non-waiver consumers were typically identified by hospital, home health or social services agency staff and viewed as a likely nursing home admission if they did not receive some assistance. Better identification of at-risk waiver participants was accomplished in several ways: developing a classification system to recognize triggers for high-risk, and setting up an information system so that a PASSPORT agency would know as soon as one of their participants was admitted to the hospital and that the hospital staff would know when a person who is admitted was a PASSPORT enrollee. There are two components to this "information system" strategy: a collaboration between hospitals and PAAs to inform each other when a PASSPORT participant is admitted to the hospital, and an identification card that will inform physicians and other health providers that the individual is enrolled in PASSPORT.

For non-waiver individuals (not already in contact with the PAA), the identification strategies focused on working with hospitals and other providers such as home health and social service agencies to identify high-risk consumers. PAAs developed information materials and conducted training sessions to highlight the diversion services available to older people in the community. PAAs also developed caregiver outreach and education efforts to help provide better information to caregivers about the possible community options available.

Table 1
Ohio Aging Network Diversion and Transition Strategies

Category	Diversion Activity	Transition Activity
Identification Innovations to better find community-dwelling consumers at risk of nursing home placement, and nursing home residents with the potential to return to the community.	• Target hospitals with high discharge rates to nursing homes and/or that have heavy rehab caseloads (designed for non-waiver consumers). • Provide information to caregivers about home care options (for non-waiver consumers). • Identify current waiver participants who are at high risk of nursing home placement. • Give waiver recipients a Program ID card and a medical information card for use when working with hospitals and doctors.	• Use state and nursing home information systems to identify individuals who could transition from nursing homes. • Partner with LTC Ombudsman to identify nursing home residents appropriate for transition. • Use MDS data to identify nursing homes that serve a high proportion of low casemix residents. • Identify hospitals that include licensed nursing home beds.
Service Interventions that more effectively assist high nursing-home-risk consumers to stay or return home.	• Provide more intensive services to current waiver recipients: - Increase service plans. - Clinical rounds to improve care. - Caregiver training and support. - Special plan for participants in nursing home. - Target those in need of high-risk case management. • Implement models to work with hospitals to improve discharges and readmissions (both waiver and non-waiver consumers). This could involve co-locating case management in the hospital. • Implement models to work with caregivers to assist in supporting family member to remain in community (both waiver and non-waiver consumers). • Refer consumers to levy programs or non-Medicaid services, including: mental health, Centers for Independent Living (CIL), and housing (non-waiver consumers). • Link consumers to waiver programs including PASSPORT, Assisted Living waiver, Ohio Home Care (non-waiver consumers).	• Care managers assigned to nursing homes for routine visits. • Care managers follow up on individuals who might be potential transitions – either referred by ombudsman program or identified in PAR or MDS database review. • Refer potential transition consumers to appropriate program such as: PASSPORT, Assisted Living, Ohio Home Care, Centers for Independent Living (CIL) or Home Choice. • Reduce or eliminate the convalescent care exemption.

SERVICE STRATEGIES: DIVERSION

All of the PAAs developed special strategies for those at high-risk of long-term nursing home placement. Typically these at-risk individuals had extensive medical problems, had frequent hospital or emergency room use, were in a nursing home receiving rehabilitation, or there was concern that the primary caregiver was having difficulty continuing to provide care. Some PAAs established a "clinical rounds" process in which care managers had an opportunity to present the circumstances of their most at-risk enrollees to a group of peers and supervisors in an effort to identify a service approach that would help the individual remain in the community. Many PAAs developed a mechanism that allowed care managers to temporarily increase the service plan in order to stabilize an immediate care crisis.

Some service strategies were applicable for both waiver and non-waiver consumers, such as working with hospitals to improve discharges and reduce readmissions, and providing education and support to caregivers so that they were better able to assist their family members to remain in the community.

Working with hospitals was a new practice for some PAAs, while others had ongoing relationships with hospitals that had been established prior to the initiative. Collaboration with hospitals typically involved working with discharge planners; some PAAs even co-located staff within hospitals. Through the use of new hospital-based nursing home diversion models, PAAs were able to partner with hospital staff to better coordinate services for high-risk consumers leaving the hospital. Other times hospital activities simply provided an opportunity to ensure that PAA staff could follow the consumer from the hospital to the nursing facility in preparation for a future return to the community following a short-term nursing home stay.

Non-waiver diversion service strategies focused on enrolling consumers in programs that could provide the services they required to stay in the community. The most common non-waiver consumer diversion service strategy was to link consumers to PASSPORT or the Assisted Living Waiver Program. In some instances, where consumers might not have met the financial or functional requirements for waiver programs but were still at high-risk of long-term nursing home placement, staff referred them to county property tax levy funded programs or non-Medicaid services.

CONSUMER IDENTIFICATION STRATEGIES: TRANSITION

Nursing home transitions were a fairly new practice for PAAs. One approach used to identify candidates for nursing home transition was to utilize the available databases containing information on nursing home residents: the nursing home pre-admission review system (PAR), and the nursing home Minimum Data Set (MDS). The MDS includes a section that asks whether the nursing home resident would like to return to the community. Most PAAs also partnered with the Long-Term Care Ombudsman Program to identify nursing home residents who were appropriate for transition.

SERVICE STRATEGIES: TRANSITION

Similar to non-waiver diversion consumers, transition consumers were not enrolled in either PASSPORT or the Assisted Living Waiver Program at the initial referral point, and could only receive limited services from PAAs until so enrolled. Therefore, transition service strategies focused heavily on enrolling consumers in programs that would provide the services they needed to return to and sustain them in the community. In order for PAA staff to better work with transition consumers in nursing homes, many AAAs assigned staff to nursing homes for routine

visits. Care managers would follow-up with potential transition consumers who were either referred by the ombudsman, family members, or nursing homes themselves, or identified from the nursing home databases. Once the PAA was in a position to effectively work with a transition consumer, they then referred them to the appropriate service programs, such as PASSPORT or the Assisted Living Waiver Program for those 60 and older, the Ohio Home Care Waiver programs for those under age 60, and the HOME Choice program for individuals of all ages who were waiver-eligible and needed more resources for transition.

Because of the potential importance of the nursing home diversion and transition initiative on future state policy, ODA included an external evaluation as part of the demonstration. The evaluation was designed to address the following questions:

1. What strategies and approaches were employed by Ohio's PAAs to support diversion and transition efforts?
2. What were the challenges and successes during the early phases of implementation?
3. How many individuals participated in diversion and transition programs?
4. Where were these individuals living and what services were they receiving six months later?

METHODOLOGY

Two major approaches were used to address the evaluation questions. A process analysis examined the nature and implementation of diversion and transition strategies. The second method involved data tracking of diversion and transition consumer outcomes. These data were collected at two points in time: when consumers were first identified as a diversion or transition participant, and then six months later.

PROCESS ANALYSIS

The process analysis began with telephone interviews with each PASSPORT program site director. These semi-structured interviews took place in October 2010 and were typically about an hour in length. Six months had elapsed since the initial launch of the diversion and transition program, so a primary objective for the site director interviews was to take a snapshot of each agency's initial progress. A secondary objective was to ask the site directors to recommend staff for participation in a state-wide focus group.

Focus groups with PAA staff were held in December 2010, approximately nine months after the launch of the diversion and transition program. This provided sufficient time for individuals to become familiar with their PAA's diversion and transition approach and the associated interventions. Two separate focus groups were conducted: one with direct practice staff (care/care managers/assessors), and one with supervisors. The separate groups were designed to promote an open environment for staff to share their thoughts and suggestions. Focus group members were asked to discuss implementation barriers, successful interventions, and promising practices in their agencies. The most commonly mentioned promising practices became the subject of more in-depth review in the final round of data collection.

As a follow-up to the site director interviews and the focus groups, in-depth, semi-structured telephone interviews about promising practices were conducted in the middle of April 2011 with three PAAs. The sites chosen for further follow-up were not the only ones involved in a particular practice; had more resources been available, we would have completed interviews with more sites. We interviewed site directors and at least two staff members from each of the PAAs; at least one staff member from each PAA specialized in hospital-based diversion and another in nursing facility transition. The site director in-depth interviews primarily focused on

the organizational processes associated with the development and administration of the new program. The staff in-depth interviews, typically with care managers/assessors and supervisors, provided more hands-on detail about the diversion and transition processes, promising practices, and barriers.

TRACKING DIVERSION AND TRANSITION OUTCOMES

The first step of the data tracking process began when an individual was initially assessed by a PAA staff member for either nursing home diversion or transition. Two data collection forms (one for diversion and the other for transition) were created to collect baseline data. These forms were submitted electronically to the evaluator. The general purpose of these forms was to document the reasons why an individual was at risk of long-term nursing home placement and what type of interventions they received. The forms required PAA staff members to assign an identification number for each person and to enter individuals into the PASSPORT Information Management System (PIMS), which provided access to the necessary contact information to conduct follow-up telephone surveys six months after the initial intervention date.

A six-month follow-up was completed on all individuals identified as a diversion or transition consumer. Our six-month follow-up data collection required a mixed strategy. We first examined the PIMS database to see which of the diversion and transition consumers were enrolled in either the PASSPORT or Assisted Living Waiver Program. For those individuals who were currently enrolled, we could track their status in PIMS. In instances where an individual had been enrolled, but had subsequently left the waiver program as a result of nursing home placement or death, we also used PIMS to record their status at six months. We next reviewed the nursing home Minimum Data Set (MDS) to see if any of the individuals not in the PIMS

database were or had been nursing home residents. For those found in the MDS database we used that source to identify their status at six months. Finally, those not in either the PIMS database or the nursing home MDS database were mailed a letter, then later called and asked to participate in the follow-up survey. This survey could be completed either by the consumers themselves or by a close family member or friend.

Six-month follow-ups began in October 2010 and ended in May 2011, allowing us to track those who had entered the program between March 2010 and October 2010. The follow-up sample (those enrolled for at least six months) comprised two-thirds of the total diversion and transition consumers served. Individuals enrolling after November 1, 2010, were not part of the follow-up sample because the evaluation period ended before they had been enrolled for six months.

RESULTS

The PAAs began the diversion and transition initiative in March 2010; this report includes data collected through May 2011. During that 15-month period, 3799 at-risk Ohioans (2244 diversions and 1555 transitions) were identified to participate in the intervention (see Figure 1). The greater proportion of diversion consumers likely reflects the fact that nursing home diversion work is already integral to the daily practice of the PAAs; the new initiative might have required that such efforts be re-emphasized, more highly targeted, and in some cases, restructured, but the basic infrastructure was already in place. On the other hand, the set of tasks associated with transitioning a consumer out of a nursing home and back into the community was relatively new to most PAAs. The total number of diversion and transition interventions conducted by each region was generally proportional to the number of waiver consumers they

typically serve, with several exceptions (see Table 2). Cleveland, which accounts for 18% of waiver enrollment state-wide, recorded about one third (32.8%) of the diversion and transition total, Cambridge with 6% of waiver enrollees had 1% of the diversion and transition total, and Columbus with 11% of the waiver caseload had 5% of the diversion and transition total. There are numerous factors that explain differences in diversion and transition counts including the number and type of approaches adopted by the PAA, nursing home bed supply in the region, and variation in how sites defined a diversion and transition participant.

Figure 1. Number Identified for Diversion and Transition for 15-Month Time Period

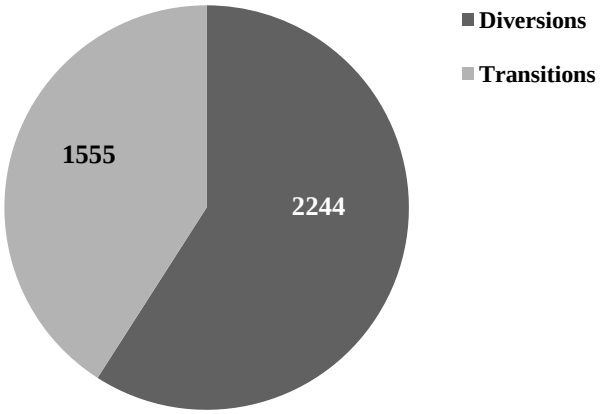


Table 2. Number of Diversions and Transitions by PAA

PAA	Location	Number PASSPORT/ Choices/AL Consumers	Percentage of Total PASSPORT/ Choices/AL Consumers	Number Diversion Consumers	Percentage Diversion Consumers	Number Transition Consumers	Percentage Transition Consumers	Total Diversion/ Transition Consumers	Percentage Total Diversion/ Transition Consumers
1	Cincinnati	3142	8.5%	249	11.1%	97	6.2%	346	9.1%
2	Dayton	3652	9.9%	138	6.1%	195	12.5%	333	8.8%
3	Lima	668	1.8%	151	6.7%	48	3.1%	199	5.2%
4	Toledo	2444	6.6%	48	2.1%	138	8.9%	186	4.9%
5	Mansfield	2170	5.9%	181	8.1%	50	3.2%	231	6.1%
6	Columbus	4006	10.9%	101	4.5%	94	6.0%	195	5.1%
7	Rio Grande	3937	10.7%	256	11.4%	9	0.6%	265	7.0%
8	Marietta	899	2.4%	57	2.5%	16	1.0%	73	1.9%
9	Cambridge	2138	5.8%	28	1.2%	11	0.7%	39	1.0%
10A	Cleveland	6688	18.2%	754	33.6%	491	31.6%	1245	32.8%
10B	Akron	4277	11.6%	227	10.1%	256	16.5%	483	12.7%
11	Youngstown	1863	5.1%	24	1.1%	108	6.9%	132	3.5%
CSS	Sidney	954	2.6%	30	1.3%	42	2.7%	72	1.9%
Total		36,838	100.0%	2244	100.0%	1555	100.0%	3799	100.0%

The number of diversion and transition interventions conducted by month for the 15-month study period is presented in Table 3. A greater proportion of diversion and transition consumers were identified in the first few months of the study period with 20% of the total recorded during the first month of the intervention. Two factors help to explain this finding. First, the PASSPORT waiting list was lifted in March 2010, so the higher numbers for March were likely related to pent-up demand. Second, at the start of the new initiative there was a definitional problem, particularly with how diversions were identified. Because PAAs had already been heavily involved in diversion-related activities, a high number of individuals referred to the PASSPORT program were counted in diversion totals in the first month. When the Ohio Department of Aging provided a clarification to the diversion and transition definitions, identification rates leveled off (at month three) and remained constant throughout the demonstration time period. The greater proportion of diversion and transition interventions in the first few months does not appear to affect the results, as those early-enrolled consumers closely resemble the remainder of the study population.

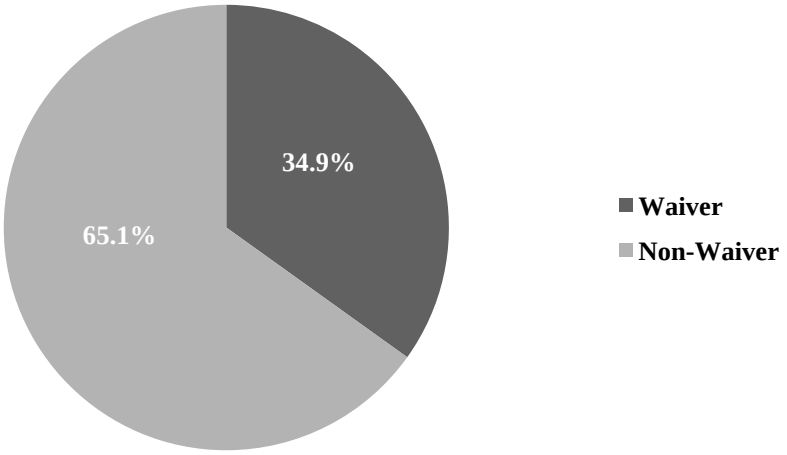
Diversion Triggers and Interventions – As described earlier, diversion consumers were divided into two groups: those enrolled in PASSPORT or Assisted Living Medicaid Waiver Program at the time of the intervention (waiver consumers), and those not enrolled in either waiver (non-waiver consumers) at the time of their intervention. This distinction was made because the specific strategies available to participants varied by their waiver status. As shown in Figure 2, about 35% of diversion consumers were already enrolled in waiver programs at baseline; nearly all of the waiver consumers (almost 99%) were enrolled in PASSPORT.

Table 3. Number of Diversions and Transitions by Month*

Month	Number Diversion Consumers	Count Diversion Consumers	% Diversion Consumers	Cum% Diversion Consumers	Number Transition Consumers	Count Transition Consumers	% Transition Consumers	Cum% Transition Consumers	Total Diversion/ Transition Consumers	Count Diversion/ Transition Consumers	% Diversion/ Transition Consumers	Cum% Diversion/ Transition Consumers
Mar.	524	524	23.7%	23.7%	240	240	16.1%	16.1%	764	764	20.6%	20.6%
Apr.	252	776	11.4%	35.1%	125	365	8.4%	24.5%	377	1141	10.2%	30.8%
May	184	960	8.3%	43.4%	115	480	7.7%	32.2%	299	1440	8.1%	38.9%
Jun.	192	1152	8.7%	52.1%	105	585	7.0%	39.3%	297	1737	8.0%	46.9%
Jul.	142	1294	6.4%	58.6%	94	679	6.3%	45.6%	236	1973	6.4%	53.3%
Aug.	144	1438	6.5%	65.1%	103	782	6.9%	52.5%	247	2220	6.7%	60.0%
Sept.	105	1543	4.8%	69.8%	75	857	5.0%	57.5%	180	2400	4.9%	64.9%
Oct.	96	1639	4.3%	74.2%	87	944	5.8%	63.4%	183	2583	4.9%	69.8%
Nov.	92	1731	4.2%	78.3%	87	1031	5.8%	69.2%	179	2762	4.8%	74.6%
Dec.	89	1820	4.0%	82.4%	68	1099	4.6%	73.8%	157	2919	4.2%	78.9%
Jan11	105	1925	4.8%	87.1%	80	1179	5.4%	79.1%	185	3104	5.0%	83.9%
Feb	87	2012	3.9%	91.0%	56	1235	3.8%	82.9%	143	3247	3.9%	87.8%
Mar.	91	2103	4.1%	95.2%	114	1349	7.7%	90.5%	205	3452	5.5%	93.3%
Apr.	67	2170	3.0%	98.2%	76	1425	5.1%	95.6%	143	3595	3.9%	97.2%
May	40	2210	1.8%	100.0%	65	1490	4.4%	100.0%	105	3700	2.8%	100.0%
Total	2210	NA	100.0%	NA	1490	NA	100.0%	NA	3700	NA	100.0%	NA

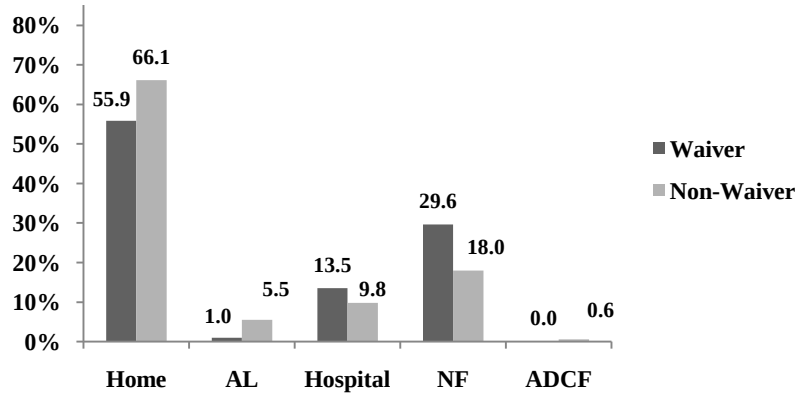
*In 99 cases the date was not recorded.

Figure 2. Diversion Consumer Waiver Status at Baseline



Overall, about two-thirds of diversion consumers were located in their own homes at baseline (see Figure 3). A relatively high proportion of waiver consumers (29.6%) were in a nursing facility or hospital (13.5%), as compared to the non-waiver group (18% nursing home, 9.8% hospital). This pattern is related to identification practices, as there were fewer opportunities for PAA staff members to work with non-waiver consumers in a hospital or nursing home setting.

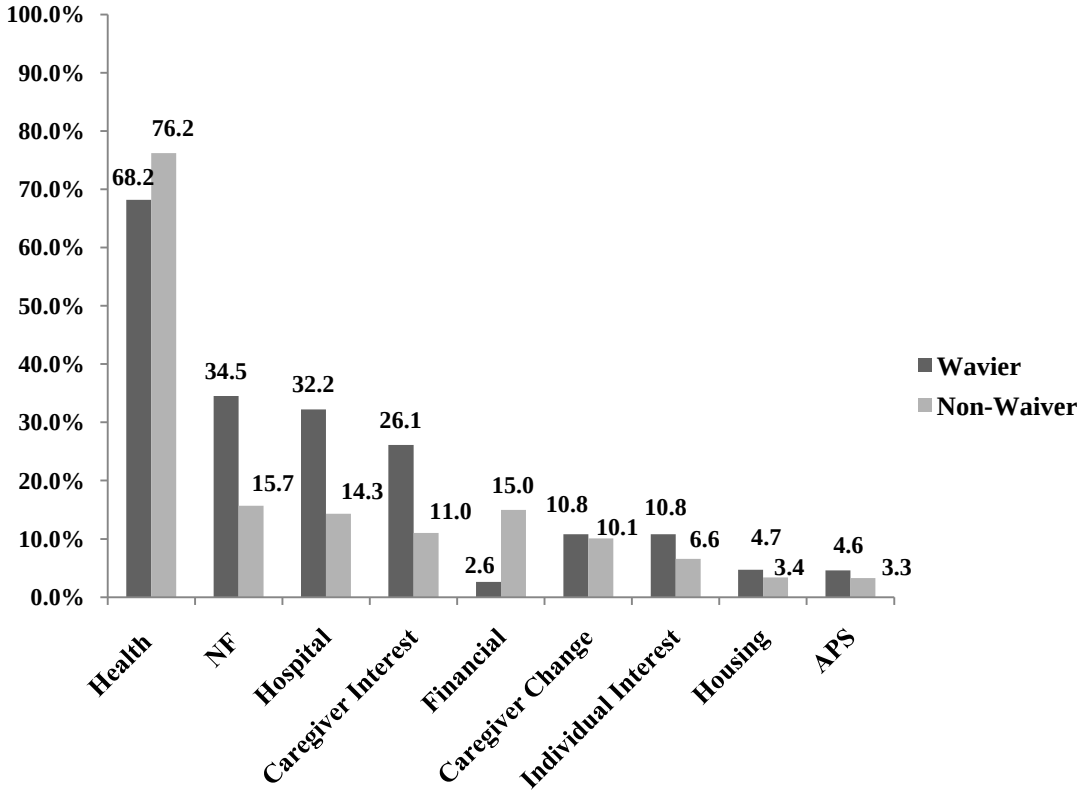
Figure 3. Location at Baseline by Waiver Status (Diversion)



Reasons that a consumer was identified for the diversion program were recorded at the time of intervention. The potential reasons recorded by program staff include a range of personal, social, and structural risks for nursing home placement. The nine possible reasons included such factors as health deterioration; caregiver interest in considering nursing facility placement options for their family member; individual was seriously considering entering a nursing home; and problems with housing in the community. On average just under two reasons (1.7) for needing the diversion intervention were recorded; health deterioration was the most common (73.4%) (see Figure 4).

Waiver and non-waiver consumers differ in some important ways. For waiver consumers, current or recent stay in a nursing facility or hospital was much more likely to be a diversion trigger than for non-waiver consumers. This pattern reflects the PAA consumer identification practices noted in the previous section. Somewhat surprisingly, a higher proportion of the caregivers of waiver consumers (25%) expressed an interest in exploring nursing home placement compared to non-waiver consumers (11%). The waiver consumer group may have been impaired for a longer period of time, placing more pressure on the caregiver. Non-waiver consumers were more likely to have financial difficulty than waiver consumers, perhaps reflecting the fact that the non-waiver consumers may be more financially fragile because they may not have qualified for Medicaid.

Figure 4. Reasons for Needing Program by Waiver Status (Diversion)



PAA staff also recorded the type of assistance planned for the consumer as a result of participation. A care manager could implement one or more of the intervention strategies. For waiver consumers, the most widely used intervention was increasing the type and intensity of care plan services, reported in about two-thirds (65.3%) of cases (see Figure 5). More than 3 in 10 (32.3%) of waiver consumers were short-stay nursing home residents receiving targeted attention. For non-waiver diversion consumers, the most common intervention strategy was a referral to PASSPORT or the Assisted Living Waiver Program, reported for three-quarters (73.2%) of individuals (see Figure 6). Other frequent non-waiver interventions included referral to Older Americans Act and other social service programs (28.3%), and providing caregiver education and training (25.8%). Quality caregiver education and training were also consistently

stressed in PAA staff interviews and focus groups as one of the most important factors for keeping consumers in the community and reducing caregiver stress. Details about promising intervention strategies are discussed in a later section.

Figure 5. Waiver Consumer Interventions (Diversion)

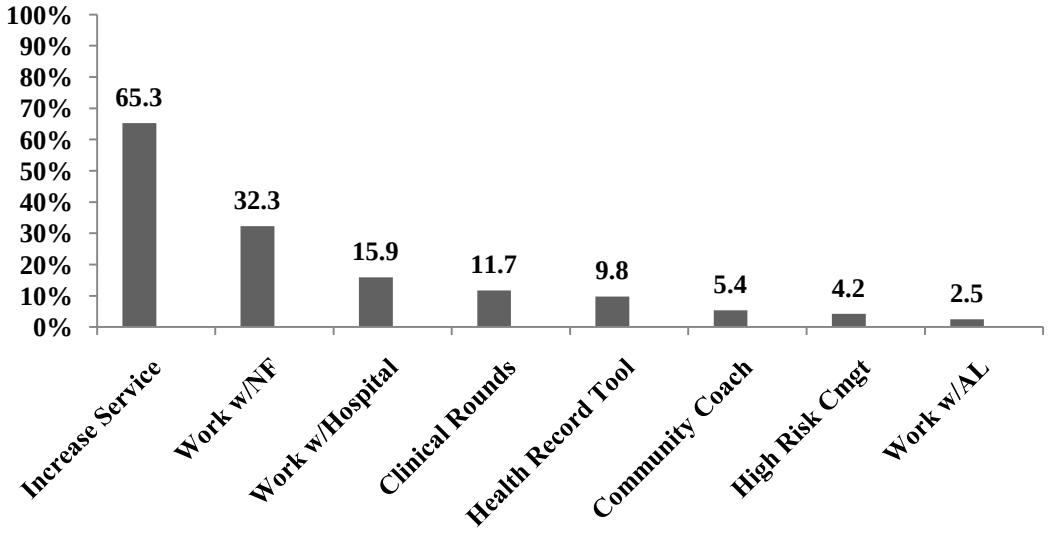
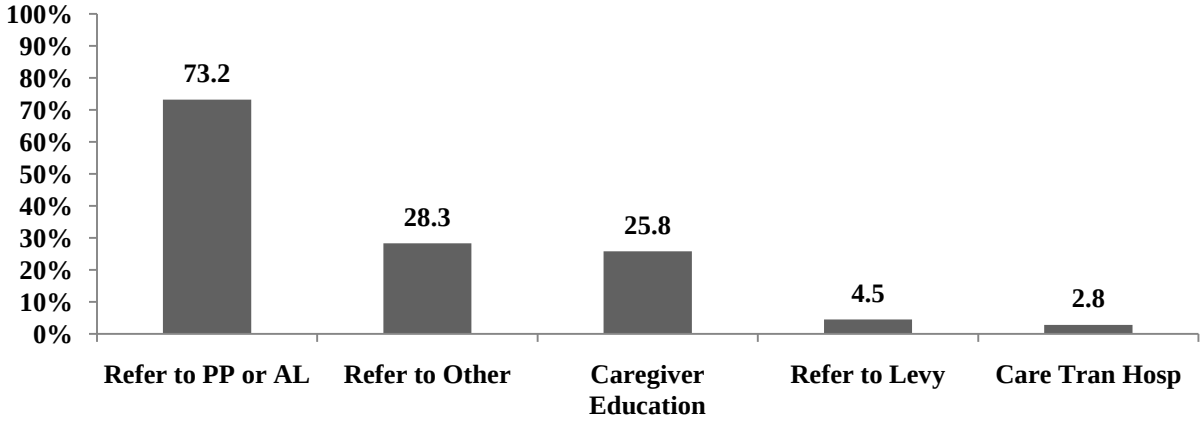
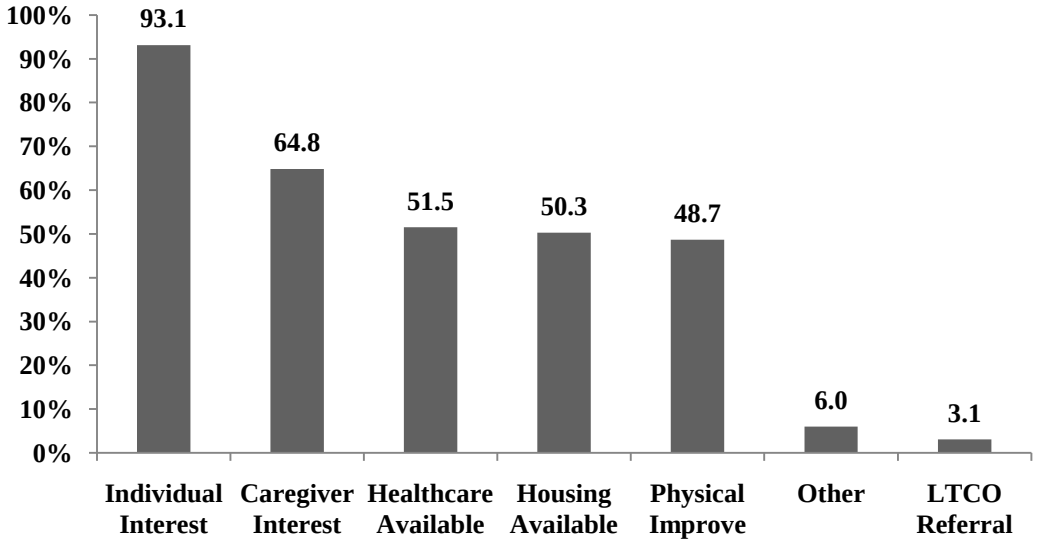


Figure 6. Non-Waiver Consumer Interventions (Diversion)



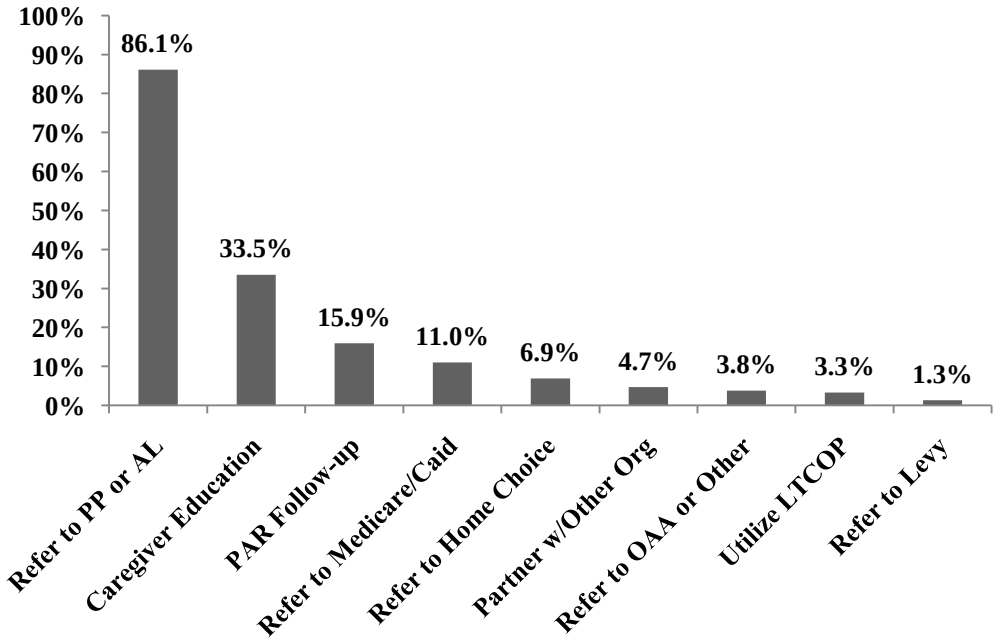
Transition Triggers and Interventions – At baseline, the transition consumer group had been nursing home residents for at least three months. The most common reasons for consumers being identified for transition was a request to return to the community from the individual (93.1%) or their caregiver (65%) (see Figure 7). Beyond individual interest in returning to the community, other reasons, recorded by about half the sample, included having the available resources like housing and in-home services and improved health conditions.

Figure 7. Reasons Return to Community (Transition)



On average, transition consumers received between one and two interventions (1.6), with the most common intervention by far being a referral to PASSPORT or the Assisted Living Waiver Program (86.1%) (see Figure 8). About one-third of consumers received caregiver education. Linkages to other health and social service programs including HOME Choice (6.9%), Medicare (11%), Older Americans Act programs (3.8%) and levy programs (1.3%) rounded out the list of proposed interventions.

Figure 8. Transitions Interventions



Outcomes at Six Months after Diversion or Transition Intervention – The most important question about the effectiveness of the program is whether it succeeded in helping people return to, and remain in the community. By this measure, the program had a strong positive impact on the lives of participants. Four in five diversion consumers and three-quarters of those who transitioned from nursing homes (73.7%) who were still alive at the time of their six-month follow-up were residing in the community (see Figures 9 and 10). The following sections provide details about specific intervention strategies and outcome locations for diversion and transition consumers.

Figure 9. Diversion Six-Month Status

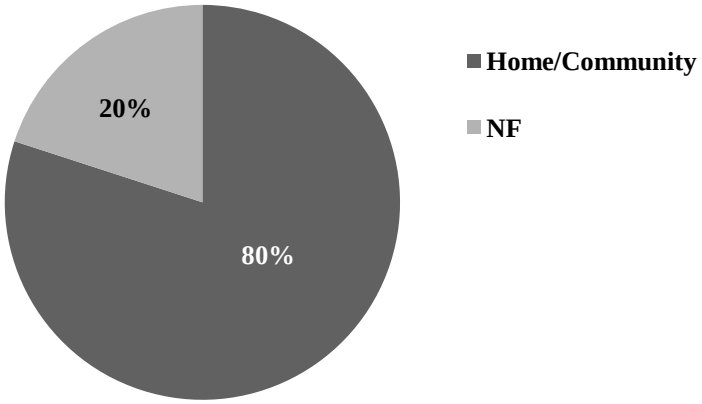
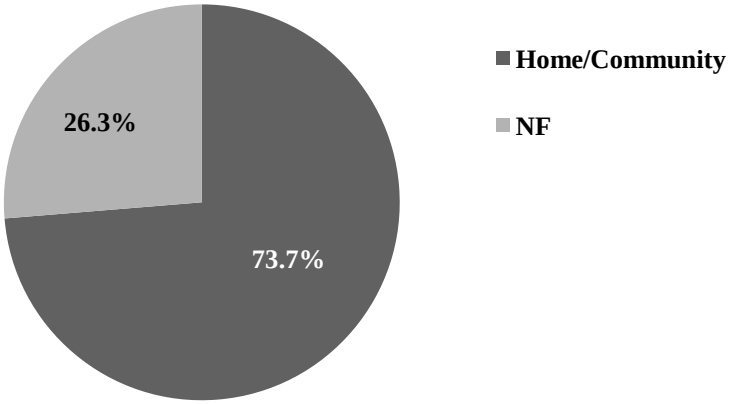


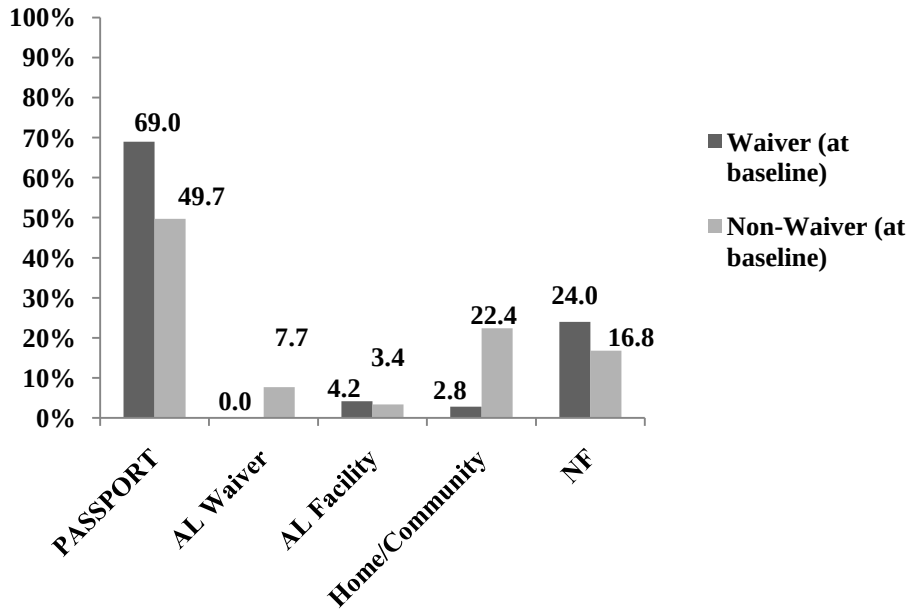
Figure 10. Transition Six-Month Status



Diversion Outcomes – While 80% of diversion consumers were in the community after six months, there were some differences between the waiver and non-waiver diversion consumers (see Figure 11). For those consumers who were still alive at the end of the six-month period and whose location was known, initial waiver consumers were more likely to be enrolled in a current waiver program (69%); almost six in ten (57.4%) of initial non-waiver consumers were also

enrolled in a waiver program at follow-up. Twenty-four percent of initial waiver diversion consumers were in a nursing facility at the six month follow up, compared to the baseline proportion of about 30%. Seventeen percent of initial non-waiver consumers were in nursing homes at the six month follow-up, nearly equal to the baseline proportion of 18%. Initial non-waiver diversion consumers were much more likely to have remained in the community without waiver services compared to baseline waiver consumers (22.4% and 2.8%, respectively). About 12% of the entire follow-up diversion consumer population had died within the six-month time period.

Figure 11. Follow-up Location by Baseline Waiver Status (Diversion Known Sample)

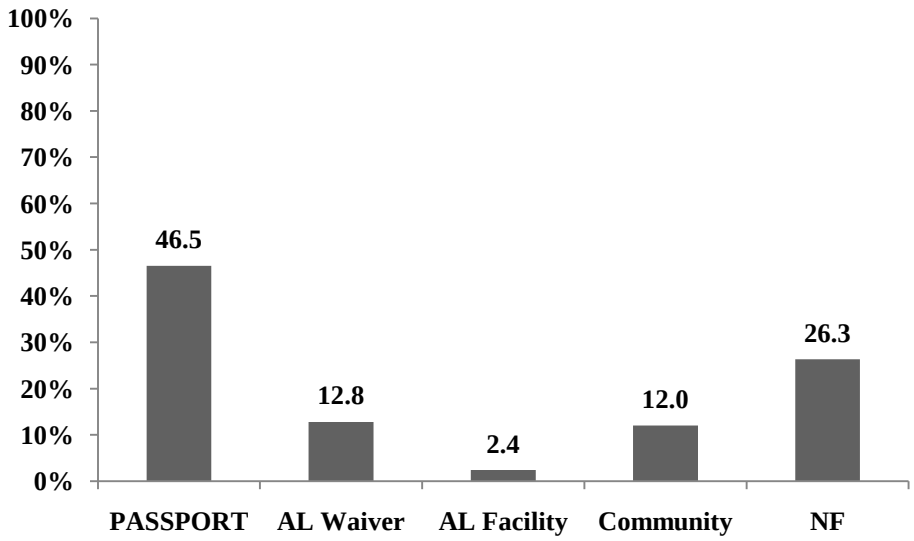


It is important to note that for about 16% of diversion consumers, follow-up status is un-known after six months. The lack of information about these participants is mostly due to the difficulties associated with tracking a highly mobile at-risk older population (see Appendix Table 1). The waiver diversion participants were typically in the PIMS database and were much easier

to track. We were able to search the MDS nursing home database for this time period, and the unknown individuals were not found in Ohio nursing homes.

Transition Outcomes – As noted, three-quarters (73.7%) of the transition consumers who were still alive at the six-month follow-up were living in the community, either at home or in an assisted living facility. Six in ten of the transition consumers (59.3%) were enrolled in either PASSPORT (46.5%) or the Assisted Living Waiver Program (12.8%), as shown in Figure 12. More than one in ten (12%) were living in the community without reliance on one of the waiver programs. Roughly 7% of all transition consumers died within the six-month time period, but place of death could not always be ascertained.

Figure 12. Follow-up Location (Transition Known Sample)



We were unable to identify outcome status at six months for 20% of transition consumers (see Appendix Table 2). The transition consumer group had been long-stay nursing home residents, and for many individuals there was no community address or phone number. We were able to search the nursing home Minimum Data Set (MDS), and these missing individuals were not in Ohio nursing homes during this time period.

IMPLEMENTATION LESSONS

To supplement the outcomes results, this study also includes a process evaluation. The goal of this component of the evaluation is to learn more from PAA staff about challenges to implementation and about the diversion and transition interventions that are most promising. As noted earlier, information for this part of the evaluation come from three sources: (1) interviews with PASSPORT site directors across the state; (2) two focus groups, one with care managers and outreach staff members of the PAAs, and one with case management supervisory staff; and (3) targeted interviews with three PAAs (site directors, supervisory staff, care managers and outreach staff who were part of the diversion and transition teams) for more in-depth examples of implementation activities. These interviews and focus groups shed light on two major topics: implementation barriers/challenges and promising practices.

BARRIERS AND CHALLENGES

While interest in the diversion and transition initiative has been high for both the aging network and state policy makers, there are barriers to program implementation. We classify barriers into internal and external categories.

Internal Barriers – Not surprisingly, one of the challenges faced by PAAs was limited resources. To some extent, the diversion and transition efforts represented a new way of doing business for the PAAs. Under normal operating procedures, the majority of administrative resources were allocated to the case management tasks necessary to coordinate services for current enrollees, with some portion of administrative funds allocated to screening and outreach. Under the new initiative, PAAs identified special diversion and transition teams, often deploying or co-locating these staff members in hospitals or nursing homes across their regions. Because administrative funding has been traditionally linked to arranging and monitoring the in-home services provided through PASSPORT, the PAAs had to now balance their existing case management responsibilities with these new diversion and transition activities. Program administrators and case management staff noted this constraint, suggesting that the diversion and transition activities were limited as a result.

Linked to the resource constraints was a concern that the state regulatory structure did not recognize the expanded focus of the PAAs. For example, the caseloads for individual care managers have been contractually mandated; some PAA respondents reported that shifting staff to the diversion and transition program was impacted by this requirement. Additionally, some case management clinical practices are mandated, such as a prescribed follow-up schedule, and there was a concern that such requirements did not allow PAAs to best match case management resources with consumer need. Finally, respondents talked about the barriers that resulted from current program funding constraints. One example involved the need to modify a home so that the person could actually leave the nursing facility. However, the care manager was unable to authorize the home modification until the person was enrolled in PASSPORT, but this could not

happen until the person actually left the nursing home. This catch-22 often delayed transitions back to the community.

An additional challenge faced by the PAAs is the long-standing orientation, philosophy, and training of outreach and case management staff. Case-managed in-home services had originally developed as a non-medical alternative that relied heavily on the social services model for providing assistance with the tasks of daily living such as bathing, dressing, and meal preparation. There was a strong emphasis on trying to develop this social model as distinct from the acute care-dominated health system. Because this more social model has been a hallmark of home and community-based services for the last three decades, including an acute care and institutional linkage, it represents a considerable change for the aging network.

While PAAs had to overcome some internal staff resistance, the bigger challenge involves a shift in care manager responsibilities and the necessary training required under this new model of care. An assessor or care manager working with or in some instances co-located in a hospital or nursing home requires different orientation, training, and supervision than the traditional care manager. One example of where enhanced training could have had an impact involved referrals to the HOME Choice program. While the HOME Choice program has additional resources to assist with nursing home transition, PAA staff used the program in a relatively small proportion of cases (7%). PAA respondents reported that the HOME Choice requirement of a six-month nursing home stay, which was changed during the course of the study to three months, was one reason they did not use the program. PAA respondents also reported that while HOME Choice could provide resources for housing, including security deposits and first month rent, the bigger problem was just locating housing. While these reasons may explain lower use it was also the case that PAA staff did not appear to be aware of an enhanced match

received by the state for enrolling individuals in HOME Choice and thus did not report any incentive to use that program resource.

External Barriers – As aforementioned, new working relationships with hospitals and nursing homes were an important component of the program. While there were numerous instances of cooperation with both types of organizations, some level of resistance was almost universal across the state. Attempts to set up programs with hospitals to facilitate diversions directly to the community, thus avoiding nursing home placement entirely, faced several barriers. First, it was common for hospitals to say that the type of diversionary discharge planning proposed was something that the hospital already did, so there was little need to have the PAA involved in such an effort. Respondents also reported resistance from hospitals because of a concern about speed of discharge and consumer safety. Establishing a plan of services to help someone return home is often more complex and time consuming than simply placing an individual in a nursing facility. This means that a decision to refer individuals with acute and chronic care needs to the community requires more planning and effort on the part of the hospital staff member. Some respondents reported that hospital staff did not have a very good idea of the in-home services available in the community, thus adding to the concern of hospital discharge planners that individuals and families could not manage services safely at home. PAA staff reported that a considerable amount of education about the role of the aging network, across all levels of the hospital, both to direct care staff such as discharge planners and to hospital administrative staff, was needed to address this challenge.

Nursing home staff also presented some barriers to transition interventions. While there were numerous reports of PAAs developing solid partnerships with nursing home administrators and social work admission coordinators, there were also consistent reports of resistance. PAA

respondents discussed instances of nursing home staff restricting access, warning their personnel that PAA assessors or care managers were in the building, and suggesting limited cooperation. In some instances, nursing home staff members were verbally confrontational to PAA assessors or care managers who were attempting to work with residents who had expressed an interest in transitioning back to the community. Addressing these challenges required the allocation of staff resources to meet with nursing homes in the region to look for common ground.

> *"Ohio has a powerful nursing home lobby, and facilities are concerned this program will reduce occupancy levels." (PASSPORT Supervisor)*

> *"Several of the discharge planners and social workers thought we were there to take their jobs. We had to reassure them that is not what we are trying to do at all." (PASSPORT Care Manager/Assessor)*

> *"It doesn't seem to bother them [nursing facility staff] so much when we are working with consumers already in our program. It's the other group of folks that aren't connected with us yet and looking to go home…." (PASSPORT Supervisor)*

Two service areas, mental health and housing, were commonly identified as substantial barriers to successful diversion and transition. In many instances, residents who have had a nursing home stay of six months or more no longer had available housing in the community, and housing for low-income older people with severe disability is in very limited supply.

Respondents noted that the HOME Choice Program does have some resources available for housing transitions, such as funds for a security deposit or first month's rent, but, in the absence of affordable and accessible housing, these resources are of limited value. Individuals

with a criminal record were also identified as very difficult to place since the public housing option was not available.

> *"Finding adequate housing for someone without family to take them in is by far the biggest challenge to nursing home transition." (Transitions Care Manager)*

Two specific concerns related to mental health were also frequently mentioned as a barrier to both diversion and transition. First, respondents were concerned about the lack of available mental health services for individuals with severe mental illness who were using long-term services and supports. The previously mentioned housing problems were magnified for individuals with severe mental illness and long-term service needs. The increase in those under age 60 with severe mental illness who are using nursing facilities was an indicator of a system-level problem. PAA respondents frequently cited examples of nursing home residents who needed support for mental health problems, rather than physical impairments, to transition from the nursing facility to the community.

> "*Housing is a big barrier on its own, combine that with severe mental health problems and you have a very difficult, if not impossible transition job on your hands." (Transitions Care Manager)*

The challenge of serving individuals under age 60 with physical disabilities was also discussed. Limited availability of the Ohio Home Care Waiver Program resulted in PAA staff reporting that they did not have viable alternatives to recommend to younger diversion and transition consumers. Respondents indicated that the capacity of the HOME Choice Program and

the Ohio Home Care Waiver Program could not meet the demand being presented by the growing under-60 population.

PROMISING PRACTICES

In response to the considerable challenges faced by the diversion and transition initiative, a number of promising practices were developed by the aging network. The practices were identified based on our statewide interviews and quantitative data on the volume of diversions and transitions. An additional round of interviews with sites involved in promising practice activities provided information to more fully describe successful strategies. The list of promising practices will expand as sites gain more experience with the new program. Five practices are described in this report: (1) modifications in organizational structure and culture to support diversion and transition activities, (2) co-location of PAA staff in hospitals, (3) working with nursing homes to identify and transition residents, (4) improved collaborations with the ombudsman program, and (5) outreach and educational efforts with family members and friends.

Modifications in Organizational Structure and Culture – Because the initiative was different from standard case management practice, a number of the PAAs actually created a new organizational structure focusing on diversion and transition. The rationale for developing a new unit was that the diversion and transitions program was appreciably different than the assessment and case management functions that have been the core of the existing waiver. In addition to the structural changes implemented, the PAAs also developed and implemented new policies and procedures regarding diversion and transition to help staff learn and understand their new role. This was viewed as an important step in keeping everyone "on the same page." It was also viewed as an important measure that helped embed the diversion and transition initiative's

philosophies and principles throughout their organization. PASSPORT directors and supervisors also reported the need to re-purpose staff and create new positions. In some cases the initiative supported changes in the organization that were already in process, and in other instances the initiative motivated the changes.

> *"This has required a definite mindset change." (PASSPORT Director)*

> *"Our staff is really good at doing PASSPORT assessments in the community, but we really had to push them more in the nursing facilities….they realized getting people back to the community after being gone for so long is a whole new ballgame." (PASSPORT Supervisor)*

> *"It's all about changing our mindset. It frustrates me because it's so easy to get wrapped up in 'this is how we do things'." (PASSPORT Supervisor)*

Co-Location in Hospital Settings – One of the significant changes being implemented by the aging network involved working with hospitals. While two of the PAAs had an established presence in hospitals in their region, even those organizations talked about their expanded collaborations and the barriers they had to overcome to be successful.

> *"We have been in our hospitals for years. Once we proved our value to them and they realized we could actually reduce some of their workload, we were no longer seen as a threat." (PASSPORT Director)*

> *"It was the realization that you can't have a strong acute care hospital and divorce it from health and human services in the community. Hospitals save lives, and community services sustain them." (PASSPORT Director)*

Many of the PAAs reported that the strategy of developing partnerships and collaborations with hospitals holds the most promise for the future success of their transition program. When asked what they felt was the best approach to establish or maintain a collaboration with hospitals, the consistent response was having dedicated staff present.

> *"It's important the facilities see the same people so relationships can be developed and they know who to call." (Care Manager/Assessor)*

> *"We have found that having full-time staff members at the hospital works best. It takes time to build relationships…need consistency." (PASSPORT Supervisor)*

When there is dedicated staff either assigned or co-located at specific hospitals, they are able to identify individuals at the best point in their trajectory for the possible intervention. For example, in some instances an individual and his or her family are well-prepared to return home immediately after a hospitalization, while in other cases a short-term stay in a nursing facility is needed. However, if PAA staff report that if they can follow that consumer from the hospital to the nursing facility, continuing to work with the individual and family members, the transition home is much easier to accomplish. PAA assessors or care managers can continually educate and remind consumers and their families about their options.

> *"I recently did an assessment on a man who was being discharged from a hospital to a nursing facility. He had just received a colostomy and had no idea how to take care of it. I followed him through to the nursing facility and was able to enroll him in PASSPORT…he is now living in the community with the help of some skilled nursing and home delivered meals through the PASSPORT program." (Transitions Care Manager)*

Approaches to Working with Nursing Homes – A number of the PAAs reported having an active presence in the nursing home and the extent to which the diversion/transition program represents a culture change.

> *"Five years ago, it was almost like we were bothering the nursing home if we walked through the door, and even when a PASSPORT person was admitted we were hesitant."(PASSPORT Supervisor)*

One PAA has developed a policy in which they visit any PASSPORT participant within five days of his or her admission to a facility. Because of the large number of nursing facilities in each region, PAAs are unable to co-locate staff as they do in hospitals, but quite often they do assign individuals to be the key contact for a specific nursing home.

To identify potential transition consumers, a number of PAAs are now using data from the new MDS Q section that asks the consumer about their desire to return to the community. While still a relatively new practice, early reports suggest it could be a fruitful mechanism to identify potential transition consumers. The challenge identified by respondents was that a high volume of individuals are self identifying under this new approach, and the resources are not available to follow up with all requests. Several respondents described efforts underway to better target individuals identified by the MDS.

It is clear that there are a number of nursing home residents who want to and can transition back to the community. To a person, every one of our focus group respondents had an example of a successful transition. In a number of instances, the consumers they discussed had been residents for two, three, four or even five years. They had gone into a facility as part of a

health crisis, but once placed they were never able to make the transition back to the community even when their conditions improved.

> *"I helped a man who was living in a nursing home for a couple of years move into his own place in the community through the HOME Choice program. We had some resistance from the nursing facility, but now he is out and rides his bicycle back to the nursing home to visit his girlfriend." (Transitions Care Manager)*

> *"I was contacted by a nursing home about a resident who they thought had dementia and could no longer care for herself, but preferred to stay at home. The woman and her family were unaware that she was eligible for PASSPORT and un-informed on how to maneuver through the medical system. I helped her get to see a doctor. (She had not seen a doctor in over 20 years.) It turned out that she didn't have dementia but only a UTI, which was causing her confusion. I enrolled her in PASSPORT, and she only needed night time care for a little while before she and her family were able to manage on their own." (Transitions Care Manager)*

Collaboration with the Ombudsman Program – The Older Americans Act established the Long-Term Care Ombudsman Program to provide a mechanism for nursing home residents to have an opportunity to talk with a neutral party in the event of a question or complaint. As part of creating an opportunity for ongoing dialogue with residents, the ombudsman program has a regular presence in Ohio nursing homes. Half of the ombudsman programs are located with the area agencies and half are free standing programs. Additionally, the ombudsman program has been working with HOME Choice as a referral source. PAAs discussed new or enhanced relationships with the Ombudsman program as a cornerstone of their nursing home transition

program. The Ombudsman program was identified as an excellent source of referrals for the initiative.

> *"They [Ombudsman] know and see us as a resource in helping folks transition back into the community." (PASSPORT Supervisor)*

> *"Our Ombudsmen referred me to a man who was living in a nursing home for several years. He had never married and had very little family. I enrolled him in PASSPORT, which enabled him to move back to the community. He died not too long after that…his goal was to not die in a nursing home." (Care Manager/Assessor)*

The Ombudsman staff and volunteers were identified as helpful in assisting PAA staff with entry into the facility. *"Ombudsmen are great to work with; we get cases from them for transition. They help us get into the facilities." (PASSPORT Director)*

Organizations where the Ombudsman is in the area agency reported closer partnerships and working relationships than organizations where the Ombudsman program is an external entity. In general, the transition activities were credited with providing the opportunity to have a renewed focus/attention on the importance of the relationship between PASSPORT and the Ombudsman program.

Caregiver Outreach and Educational Efforts – The diversion and transition program includes an emphasis on targeting caregivers. Nearly every "successful" transition story shared during the group interviews involved the activation of caregivers in some way. The range of caregiver involvement included, but was not limited to: initiating transition efforts, participating in the

needs assessment and/or transition care plan process, providing care, and housing and support for the consumer so they could return to the community.

> *"Nursing homes are not providing education to consumers and their family to go home….places think, 'we'll work on educating the day they're going home'…can't do that to get them home safely and get their needs met." (Care Manager/Assessor)*

> *"I was contacted by a PASSPORT consumer's family because they were overwhelmed and wanted to send them to a nursing facility. So I worked with the family and was able to increase the consumer's service plan, which provided them with some much needed respite." (PASSPORT Care Manager)*

The tasks associated with caregiver/natural support involvement, training and education are implicit within this initiative. As one care manager put it, *"This is just what we do."*

RECOMMENDATIONS FOR OHIO'S AGING NETWORK

The findings presented in this report indicate that the Ohio Diversion and Transition Initiative demonstrated positive outcomes. More than 3800 diversions and transitions have been completed across the state in a 16-month time period. Results of the survivor sample showed that four in five of those diverted and three-quarters of those transitioned from Ohio nursing homes were in the community after six months. The process analysis provided examples of how the PAAs had changed practice in order to achieve these outcomes. Despite these positive outcomes, several recommended changes will promote improved success.

(1) Clarify Diversion and Transition Definitions and Continue to Track Outcomes

While the clarified definitions of diversion and transition issued by ODA early on in the implementation of the initiative helped to minimize differences across the sites, the problem is not completely solved. There still appear to be considerable differences in diversion and transition rates across the regions. Some of these are certainly the result of practice differences across the sites, but some are also the result of definitional differences. The diversion category continues to present the biggest challenge because many of the activities undertaken by the PAAs have diversion as a central goal. While generally more straightforward, the transition definition also requires refinement. The biggest challenge with this category involves differentiating a long-term and short stay. We recommend that ODA work with the PAAs to refine the definitions based on the substantial operational experience that they have now gained in implementation of the initiative.

(2) Targeting Consumers for Transition

The nursing home transition program faces two problems in its efforts to target consumers. First, because nursing home use now includes a high proportion of short-stay residents, some of whom would return home without help from the aging network, it is important that PAAs target their resources to those individuals who need the most assistance. Refined targeting criteria to identify which short-stay residents are most vulnerable to becoming long stay will be important. A second area involves identification strategies using the new MDS Section Q assessment question. Under the previous version of the MDS, nursing home staff, with limited input from residents, made a judgment about whether the person wanted to return to the community. It is not surprising that this approach resulted in an under-reporting of consumer interest in transition. Under MDS Section Q, nursing homes are mandated to ask residents directly if

they wish to explore the possibility of a return to the community. While an important step forward in resident's rights and autonomy, the potential volume seen by the PAAs appears to be exceeding the available resources. Either an increase in transition resources or a better mechanism to target residents who wish to, and are likely to be able to, transition is necessary. We recommend that the implementation activities associated with the use of the MDS Section Q be monitored carefully over the next six months.

(3) Improved Linkages to HOME Choice

While HOME Choice has the potential to be an important resource for transitioning individuals from nursing homes, it was used in a small number of instances (7%). We are aware that the initial HOME Choice program required a six month stay prior to referral and this was reported as a barrier by PAA staff. However, even after the requirement was changed to three months the use of this intervention was low. Given the enhanced federal match received by the state on this initiative and the additional resources available for transition, we recommend that ODA work with the PAAs to explore why this intervention is not more widely used and any barriers corrected.

(4) The Social Versus Medical Role of Home Care

Home care programs developed partly in response to a clear recognition that individuals who experience severe disability primarily need assistance with the tasks of daily living such as dressing, bathing, and meal preparation. The high touch, rather than high tech, aspect of home care has been an important underlying philosophy of the services delivered. Because there was a belief that nursing homes had become very medical in their orientation, home care programs maintained a social services orientation. Since the first home care demonstration started in 1971 (called the Personal Care Organization), the world of long-term services and supports has

changed dramatically. Today half of the participants in the PASSPORT program will remain enrolled until their death. That means that in addition to the personal care assistance that has been the hallmark of home care, there is now also an important health component as well. Quite simply, the days of the PAA as solely a social service agency are over. It is critical for ODA and the PAAs to recognize this change and make the organizational and staffing changes necessary for this shifting world. Several of the PAAs in Ohio have begun to respond to these challenges by now employing in-house medical directors, through their extensive collaborations with hospitals, and through partnerships with health networks. These practices will need continued exploration as we anticipate that the interface with the acute care system will expand in scope.

(5) Re-allocation of Resources Under a New Model of Care

As described throughout the evaluation report, the diversion and transition initiative represents a shift in practice for the PAAs and for ODA. It will now be important for the aging network to refine the business model to match the expanded scope and mission of the PAAs. This means that the tension between resources allocated for managing current waiver enrollees compared with staff resources needed for the diversion and transition strategies of today and tomorrow will need to be addressed. While ODA and the PAAs have extensive experience in operating the PASSPORT program, operational protocol may have to be changed. We recommend that ODA and the PAAs use a workgroup, similar to the one used for this demonstration, to assess possible options for addressing this challenge. Some isolated changes have been described in this report, but we believe that the complexity of the challenge requires a comprehensive solution.

CONCLUSION

Results from this evaluation are promising. The process evaluation findings, which highlight the range of strategies developed and the promising practices tested, did identify a series of barriers faced by the PAAs. Despite these challenges, the evaluation finds that the aging network is experiencing a transformation that has the potential to have an important effect on the lives of older Ohioans and their families. It will be critical for the PAAs and the Department of Aging to continue to track the outcomes of the intervention as the network moves to wide-scale implementation.

APPENDIX

Appendix Tables

Table 1. Diversion Follow-ups by Waiver Status at Intervention

	Waiver		Non-Waiver		Total	
6-Month Status	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
PASSPORT	346	57.0	324	31.2	670	40.9
AL Waiver	0	0.0	50	4.8	50	3.1
AL Facility	21	3.5	22	2.1	43	2.6
Community	15	2.5	146	14.1	161	9.8
NF	120	20.0	109	10.5	229	14.0
Deceased	92	15.3	105	10.1	197	12.0
Don't Know	6	1.0	283	27.2	289	17.6
Total	600	100.0	1039	100.0	1639	100.0

Table 2. Transition Follow-ups

6-Month Status	Number	Percent
PASSPORT	307	32.5
AL Waiver	84	8.9
AL Facility	16	1.7
Community	79	8.4
NF	174	18.4
Deceased	75	8.0
Don't Know	209	22.1
Total	944	100.0%

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