Final Report

The Live Well At Home Project

Minnesota Department of Human Services
Minnesota Board on Aging
Nursing Home Diversion Modernization Grant

Contract No. 333-08-NHDP-003 (Administration on Aging)
Grant Number: 90AM3167/01
Project Period: 9/30/2007-3/31/2010
University of Minnesota
Reporting Period: 10/1/2008-9/30/2009

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Executive Summary

The Minnesota Board on Aging (MBA) in partnership with the Area Agencies on Aging (AAAs) and Minnesota Department of Human Services (MN-DHS) was awarded a grant from the Administration on Aging to formalize a nursing home diversion program for Title III, Alzheimer's Disease Demonstration Grant, or any other non-Medical Assistance (MA) funding. The goals of this 21-month project were to: 1) Further develop flexible service options for older adults and family caregivers who are eligible for Medicaid (Medical Assistance [MA]) and other public programs as well as those who will pay privately; and 2) Develop a more consistent, effective and evidence-informed process to identify and triage individuals who are at high risk of nursing home (NH) admission and MA spend-down.

The subsequent program that was developed to meet these objectives in Minnesota, the Live Well at Home Program (LWAH), aimed to: 1) Develop triage and follow-up processes and protocols that can be replicated statewide; 2) Identify older adults who have needs associated with risk of NH admission, assisted living (AL) entry, and MA spend-down; 3) Effectively link identified older adults and/or family caregivers to flexible service options to prevent or delay NH admission, AL entry, or MA spend-down; 4) Target Title III, Alzheimer's Disease Demonstration Grant to States (ADDGS) and grant funds to identify high risk individuals and facilitate their utilization of consumer-directed services options; and 5) Collect evidence that can inform the state's system development and service re-design (Vujovich, 2008). The primary objective of the Live Well at Home (LWAH) project was: **to identify private-pay clients at-risk of NH admission, AL entry, or spend-down to MA in order to "divert" them to community-based services.**

To achieve this objective, the LWAH developed and piloted service content. Initial efforts focused on developing an efficient, evidence-based "rapid screen" to identify community-residing older adults at highest risk for NH admission or AL entry (since MA spend-down often occurs in these contexts, a specific focus of the LWAH rapid screen was to target this risk). Following the compilation of systematic reviews and meta-analyses and pilot testing in the field, a 7-item Live Well at Home Rapid Screen (LWAH-RS) was developed. The 2nd component of the LWAH aimed to provide immediate consultation on the risk factors identified during the LWAH-Rapid Screen (LWAH-RS) process in order to educate the client and begin to develop a risk management plan for clients and/or their proxies (termed "post-screen consultation"). The 3rd component included the implementation of Diversion Support Services (DSS), which is intense, ongoing, 1:1 direct support performed by a person skilled in coaching, risk management, and self-direction that helps the client develop and monitor a risk action plan in order to prevent or delay NH admission or AL entry. A parallel goal of diversion support services is to facilitate clients' use of private funds to purchase evidence-based support services on their own.

With the LWAH action plan in place, project activities turned to collecting data for a 6-month, preliminary evaluation of the LWAH for clients in three AAAs: the Arrowhead Agency on Aging (AAAA), the Central Minnesota Council on Aging (CMCOA), and the Minnesota River Area Agency on Aging (MNRAAA). Formal training protocols, ongoing data management and transfer processes, and regular team meetings between the MN-DHS team (Jane Vujovich, Pat Yahnke), the University of Minnesota technical advisement evaluation team (Joseph E. Gaugler,

Mary Boldischar), and AAA partners ensured coordinated implementation and data collection activities.

The following number of participants completed the LWAH and evaluation procedures:

- 261 clients completed the LWAH-Rapid Screen;
  - 12.4% were delivered directly to "proxies" (almost all were self-identified family caregivers) and 42.8% were delivered jointly to clients and proxies
- 217 clients completed post-screen consultation;
  - 11.3% were delivered directly to proxies and 43.7% were delivered jointly to clients and proxies
- 77 clients completed diversion support services;
  - 45.1% were delivered directly to proxies and 10.6% were delivered directly to clients and proxies
- 119 clients completed 3-month telephone evaluation interviews;
  - 37.8% were completed by proxies
- 43 clients completed 6-month telephone evaluation interviews.
  - 27.9% were completed by proxies

The following questions guided the preliminary evaluation of the LWAH:

- Who underwent the LWAH Rapid Screen process? How many of the individuals were deemed eligible for the LWAH diversion support service (i.e., non-MA eligible)? As noted, 261 participants underwent the LWAH-Rapid Screen protocol. Over 2/3 of clients and 3/4 of proxies were female, and over half of all screenings occurred at the CMCOA site. Over 80% of all screenings were completed with the older client present (about equally divided between whether the client was alone or with a proxy present). Administration of the LWAH-Rapid Screen detected a range of risk factors for NH admission, AL entry, or spend-down, particularly activity of daily living (ADL) needs (such as ambulation), caregiver stress, and living alone. Specifically close to 70% of those who completed the LWAH-Rapid Screen were classified as "high risk" (i.e., a score of 3 or above on the LWAH-Rapid Screen, or, the presence of 2 or more risk factors). Falls, caregiver stress, and ADL dependence were the most consistent factors that were reported for clients at higher risk scores. These findings suggest that the LWAH-Rapid Screen was appropriately targeting high-risk clients

  One challenge of the LWAH-Rapid Screen protocol was the inability to develop a concise, focused procedure to determine non-MA eligibility for the purposes of further targeting. Most providers were reluctant and uncomfortable in asking complicated income questions that included calculation of income and assets. These questions were revised several times with the goal of making this "income question" easier. Eventually, the questions were simplified to income only and providers were able to ask the income question during the Rapid Screen process. Another challenge for the AAAs was to achieve projected LWAH-Rapid Screen enrollment targets during 4th quarter 2008 while simultaneously addressing Medicare Part D enrollment activity. For these reasons, LWAH-Rapid Screen was conducted with a wide range of participants including those with incomes greater than 250% of federal poverty guidelines (FPG) in order to achieve

adequate testing numbers. Few if any clients had spent-down to MA at the outset of the project. Later data collection efforts found that 34% of clients' incomes were under 200% of the federal poverty guidelines, another 34% at 200-250%, and 32% at over 250%.

Approximately 95% of all screeners (N = 207) conducted the post-screen consultation assistance session. The average length of consultation sessions was approximately 40 minutes (with a median duration of 35 minutes), with some sessions as short as 5 minutes and some as long as 2 hours. Post-screen consultation was longer in instances where the same person who administered the LWAH-Rapid Screen also delivered post-screen consultation.

- Of those who were screened as eligible for LWAH Diversion Support Services how many made contact with the diversion support provider? What characteristics differentiated those who did or did not make contact with the diversion support provider? Of the 261 clients screened, 77 clients had documented diversion support service contacts. Various factors were associated with whether clients did or did not use diversion support services. Clients at the Arrowhead site appeared more likely to use diversion support services than clients at the other 2 participating AAA sites. Also, clients who received the LWAH-Rapid Screen in-person and scored in the "high" risk category (or had a higher total risk score on the LWAH-Rapid Screen) were more likely to use the service. When the LWAH-Rapid Screen was administered to proxies only, it appeared that diversion support services were more likely to occur. Clients who took more time to complete the LWAH-Rapid Screen or received post-screen consultation more positively appeared to be more likely to use diversion support services. These findings suggest that: 1) clients with the greatest need for diversion support services appeared most likely to receive diversion support services; and 2) clients who received the LWAH-Rapid Screen and post-screen consultation components in a more positive fashion also used and received diversion support services to a greater extent than those clients who had a less positive experience.

- What was the frequency and duration of contact with the LWAH diversion support service provide? As noted above, 77 clients were documented as receiving diversion support service during the 6-month evaluation period. The number of diversion support service contacts ranged from 1 to 11, and on average clients received 3.16 diversion support service contacts. These contacts occurred over a 52.26 day period, on average, with a range from 0 to 273 days.

  Additional data were collected during the diversion support service procedure. Nearly 2/3 of all diversion support service contacts took place over the telephone, with over 40% delivered to proxies alone and 30.5% to clients alone. Each diversion support service contact took, on average, 42.60 minutes with some lasting as long as 2 hours (and some as short as 15 minutes). Most contacts focused on communication with other sources of support (e.g., family meetings; 50.8%), risk factor education (57.3%), and follow-up support (59.3%). A considerable number of diversion support service contacts also focused on risk factor action plan development (46.3%) and implementation (35.4%).

There was considerable consistency in those who provided diversion support services, and clients or proxies were highly satisfied with the diversion service supports they received.

- Based on reports from providers who administered the rapid screen, diversion support service providers, and clients/caregivers themselves: what were the perceived strengths of the LWAH? What were the barriers to utilization? The Rapid Screen was delivered quickly and easily by providers. Most providers determined this could be integrated into their practice. Older adults and proxies were receptive to the Rapid Screen content as well as the language used in the screen and during the post-screen consultation. The most apparent barrier and concern was that while the LWAH-Rapid Screen was delivered successfully, many clients did not receive diversion service follow-up. One explanation was that the workload of diversion support services providers and partner AAAs did not allow for successful follow-up or completion of diversion support services. Another is a potential lack of understanding of the LWAH process and the importance of proactive follow-up with clients to ensure that diversion support services are provided. The latter point was also apparent during the research coordinator's data management efforts, as the lack of clarity in the data entry process as well as the LWAH program as a whole led to the need for frequent contact between the research coordinator and AAA partners to ensure completion of all data elements. Other key issues were the selection and wording of certain measures in the evaluation protocol and the reliance on telephone survey methodology.

  The research coordinator also emphasized the positive feedback she received from multiple clients who had praise for the LWAH program and provider staff alike. One particular proxy who was the client's caregiver shared with the research coordinator that the services provided were very much needed and reduced her stress, and allowed the client to live independently.

- What services did clients and caregivers utilize 3- and 6-months following the rapid screening procedure? What factors differentiated the amount and type of service utilization? At both 3- and 6-months the most frequently used services included physician visits, in-home help, and dental services. Approximately 30% of clients across the 6-month evaluation period also utilized medical specialist services. A small number of clients (n = 5) utilized nursing home services during the 3- and 6-month evaluation intervals for rehabilitation services. The range of time spent in the nursing home was from 4 to 60 days.

  A few indices were consistently linked to service use across the 3- and 6-month LWAH evaluation interval. Clients who were married utilized more adult day services. Proxies, typically family caregivers, who were married or were spouses of clients were also more likely to have clients use adult day services.

- At 3- and 6-months post-screening, how many clients and caregivers entered nursing homes (NHs) or assisted living facilities (ALs) or underwent spend-down to MA? Prior to the 3-month evaluation, 4 clients entered a NH and 4 entered an AL. Between the 3-

and 6-month evaluation intervals 1 client entered a NH and 1 client entered an AL. A total of 3 clients reported spending down to MA in the 6 months following administration of the LWAH-Rapid Screen. As these results suggest, few if any clients experienced the adverse outcomes that the LWAH was targeted to prevent. There are several caveats to this finding however, ranging from the short follow-up period (health service outcomes such as NH admission or AL entry should be modeled over longer time periods, such as 3 years; see Gaugler et al., 2007) as well as the lack of a comparison group to determine if such trends are similar among community-residing older persons who did not receive the multi-component LWAH service.

- How helpful was the rapid screen score in not only identifying those at potential risk of NH admission or AL entry, but also in determining appropriate service approach? This is a key evaluation objective, but could not be definitively addressed due to the preliminary design of the LWAH and limited evaluation time-frame. Most clients were considered at "high" risk on the LWAH-Rapid Screen, but the lack of NH admission or AL entry events during the 6-month evaluation period precluded an analysis of sensitivity and specificity. The clients who participated in LWAH-Rapid Screen clearly scored positive on several potential risk factors for NH admission or AL entry, but whether risk scores adequately predict future NH admission or AL entry in prospective fashion could not be determined.

  Similarly, refinement of the diversion support service component has continued during the preliminary LWAH evaluation. A primary focus of this refinement was the transition from a traditional case management/coaching paradigm to a targeted risk management and private pay/consumer-directed service model. This work continues. As noted above, many diversion support service contacts included risk factor education and risk factor action planning and implementation. Future refinements of the diversion support service should enhance: 1) how each risk factor is specifically addressed and are incorporated into the actual diversion support service intervention; 2) whether clients utilize existing evidence-based, community interventions designed to alleviate these risk factors; and 3) assessment/administration of the LWAH-Rapid Screen to determine if risk is reduced, or whether the risk factor is adequately managed to delay long-term NH admission, AL entry, or MA spend-down.

These preliminary findings are promising and suggest the success of the LWAH in implementing a feasible, efficient risk management process for community-residing older adults and their family caregivers. In order to extend these findings to generate more high quality evidence for later evaluation and replication, it is recommended that future efforts: 1) incorporate a control/comparison group; 2) increase ethnic or racial diversity among future LWAH participants; 3) determine if or how clients privately purchase services; 4) instill a culture or evaluation that facilitates complete, longitudinal data; 5) determine sensitivity and specificity of the LWAH-Rapid Screen; 6) refine survey evaluation items and processes; and 7) finalize and refine the components of the LWAH to allow for replication and implementation.