

Brossoie, N., & Roberto, K.A. (2011, March). Virginia's Nursing Home Diversion Modernization Grant Community Living Program I: Outcome Evaluation. Final report submitted to the Virginia Department for the Aging, Richmond, VA.

Executive Summary

Introduction

In 2009-2010, the Commonwealth of Virginia participated in a pilot project of the Administration on Aging. The Nursing Home Diversion Modernization Program, now known as the Community Living Program (CLP), was designed to assist individuals at risk of both nursing home placement and spending down to Medicaid eligibility, with continuing to live in their communities. The program included consumer-directed (CD) services and utilized the assistance of a fiscal intermediary to support participants and other persons involved with their care. The goal of the CLP outcome evaluation was to measure the success of the pilot program (CLP1) with regard to participant access, cost of implementation, and quality of services provided.

Methodology

Data for this evaluation was collected from four sources: Peer Place (a computer database in which the AAAs store information about participant characteristics and service enrollments), Public Partnerships, LLC (PPL; service enrollments and billings), Service Coordinators (SC; CLP1 staff who assisted participants in securing services and who had access to participant characteristics and recruitment information not documented elsewhere), and participants and their proxies (participant satisfaction survey). Participant-level data was connected to individual participants through the use of the Peer Place identification number, which permitted analyses at the participant level. For the purposes of this report, the dates of CLP1 are defined as Oct 1, 2009 – Sept 30, 2010, which coincide with the fiscal intermediary computer program going “live” at the AAAs and records maintained by VDA. Targeted enrollment of 55 participants was based on the number of “slots” each agency could successfully manage and fund should the program be eliminated from AAA services and funding cease.

Findings

Participant Characteristics. A total of 62 participants were enrolled in CLP1 exceeding the program enrollment goal by 7 participants. Typical CLP1 participants were between the ages of 80-89 and predominantly White, non-Hispanic, married women living with their spouses.

Seventy-two percent (72.0%) of participants experienced one to five ADL limitations with the largest number of participants (35.0%) experiencing five ADL limitations. The majority of participants reported annual household incomes above \$20,000 and liquid asset levels above \$30,000. CLP1 participants experienced a range of disabilities. Slightly more participants had a primary disability of dementia (46.0%) than physical disability (44.6%), although many experienced both. Five percent (5.4%) of the participants had a primary diagnosis of TBI, and 3.6% had an unspecified primary disability. Few significant differences in characteristics emerged among participants. Participant caregivers were generally spouses (52.0%) or adult children (40.0%). Sixty-four percent (64.0%) of caregivers reported that their caregiving duties were 24 hours a day, seven days a week. The majority of caregivers had been providing care for 1-4 years; virtually all caregivers reported being “on-call” at any given time.

Recruitment. Approximately six individuals were recruited for every person enrolled. Thirty-one percent (31.0%) of CLP1 participants were recruited from AAA participant rolls, 29.0% were referred to the program by family members or friends and 40.0% were referred from a variety of home and community-based services, government agencies, healthcare providers, and churches. Based on recruitment strategy the ratio of participants enrolled and recruited ranged from 1:1.6 to 1:8.9 across the AAAs.

Enrollment/ Unenrollment. The monthly enrollment census ranged from 10 participants in the first month to 39 participants during the last month. Nearly one third (32.8%) of all participants had been enrolled 91-180 days, and 44.9% were enrolled for 181 or more days. At the close of the pilot program, 77.0% of participants were active enrollees. Among the 24.0% of participants who unenrolled, 57.1% died and 40.0% no longer met eligibility requirements (i.e., transitioning into long-term care or no longer meeting income requirements).

Service Coordination. Service Coordinators (SC) have a pivotal role in linking participants to CLP1 services that can help them maintain some level of independence and remain living in their homes. All 62 participants enrolled in CLP1 received Service Coordination and 93.5% of them (58 participants) purchased additional CLP1 services. The average number of SC hours used each month was 5.4 hours per participant. Analysis of the individual approaches used by the SCs

to support participants with varying needs and service requirements did not yield a common approach or formula to explain the amount of time needed for SC services. Unexpectedly, 32.8% of participants did not have any SC hours recorded during months that they received other CLP1 services

Services. A variety of service options were presented to participants to help them remain living in their homes. Services accessed and the percent of the 58 participants receiving them included Homemaker/Companion (48.3%), Personal Care (48.3%), Personal Emergency Response System (PERS) (19.0%), Adult Day Care (15.5%), Transportation (12.1%), and Meal Services (8.5%). Less traditional one-time or intermittent services included Home Modifications (17.2%), Assistive Devices (15.5%), Non-durable Medical Supplies (12.1%), Chore Services (12.1%), and Nutritional Supplements (5.2%).

Nine of the participants (15.8%) chose services outside of the home or one-time and intermittent purchases; their choices exemplified consumer-directed services and the CLP1 mission. For example, participants bought transportation services, replaced drafty window frames with energy efficient windows, and installed adaptive shower equipment. The same nine participants (15.8%) also required half the amount of total SC time (average 13.2 hours per participant) compared to all CLP1 participants (average 27.9 hours per participant).

Participant Satisfaction with CLP1. Approximately three months after enrollment, participants or their proxies (i.e., primary caregivers) were contacted to assess their satisfaction with the CLP1 program, the services provided, and their perceptions of how the program was helping them remain independent and living in their homes. Forty (40) individuals completed the survey for a response rate of 81.6%. Overwhelmingly, respondents were satisfied with the CLP program, their Service Coordinators, the services they accessed, and use of the fiscal intermediary. Similarly, respondents agreed that the CLP1 program provided them with the services they needed, and helped keep them from entering a nursing home and facing Medicaid spend down.

Participant Costs. Prior to enrollment, 65.0% of all participants paid out-of-pocket expenses averaging \$730 per month for services and support to help them remain living in their homes. After three months of receiving services, less than half of the participants were paying out-of-

pocket expenses. The average cost for CLP1 participants who continued to have out-of-pocket expenses was \$313 per month.

Program Expenditures. Each CLP1 participant was allocated \$1200 per month to purchase services to help them manage their daily life. From that monthly amount, \$80 was deducted to pay for services provided by the fiscal intermediary, PPL. Spending the remaining balance of \$1,120 was left to the discretion of the participant. The largest expenditures in CLP1 were for Personal Care services (\$101,619), Companion/Homemaker services (\$86,548), and Adult Day Care (\$27,155). Average monthly expenses for enrolled participants ranged from \$585 - \$644 across the three services. The range of daily expenditures per participant ranged from \$6.70 to \$57.14. The average daily CLP1 expenditure per participant was \$24.90, far below Virginia's current Medicaid daily reimbursement rates for a nursing home bed, which ranges from \$134 to \$169 per day in the areas in which the pilot was conducted.

Summary and Recommendations

In summary, it is clear from the evaluation data that CLP1 achieved its goal of helping people live independently in their homes. With the help of CLP1 services, 91.4% (53) of participants were deterred from enrolling in state Medicaid programs or entering long-term care facilities. Moreover, participants and their caregivers expressed great enthusiasm and thankfulness for the program as it allowed them access to services they needed. They also expressed satisfaction with CLP1 and the service options made available through the AAA and other community and individual providers.

Based on the outcomes of the evaluation of CLP1, recommendations for delivering future community living (nursing home diversion) programs include:

Access

- Define and identify sources for recruiting participants to maximize recruitment outcomes and minimize use of SC time.
- Aim to enroll individuals with caregivers who are optimally suited for consumer direction and CLP services.

- Create a realistic and manageable enrollment timetable for each AAA, using targeted enrollment criteria.

Quality

- Continue to maintain positive attitudes and professional manners with participants and their families.
- Identify strategies to facilitate conversations with spousal caregivers about the use of consumer-directed services including one-time and intermittent service options.
- Provide SCs information and training about the range of concerns and constraints shared by spousal and non-spousal caregivers.

Cost

- Allocate a minimum base rate of reimbursement from participant funds to cover SC costs.
- Monitor the time SCs spend on supporting persons using employee-hire services and initiate strategies to offset related support costs to the program.

Roberto, K.A., Blieszner, R., & Savla, T. (2009, September). Caring for a Spouse with Mild Cognitive Impairment: Daily Challenges, Marital Relations, and Physiological Indicators of Health. Final report submitted to the Virginia Center on Aging.

Project Abstract

Mild cognitive impairment (MCI) is a term used for early decline in memory and in the abilities to carry out a series of steps in sequence and make appropriate decisions. It is an ambiguous condition because often the person with MCI appears to be healthy and able to function normally in many ways, yet begins to show some signs of memory loss, confusion, and apathy. Physicians usually cannot predict whether or when the MCI might worsen.

The changes associated with MCI are likely to affect spouse care partners as well as those with this condition. Thus, this research examined the effects of having a spouse with MCI on older care partners' physical health, psychological well being, and marital relationship. A unique feature is the daily diary approach used to gather the data. Thirty care partners responded to telephone interviews on each of seven consecutive days. They also provided saliva samples five times throughout the day on four of the interview days. Lab tests of the saliva revealed the amount of cortisol and alpha-amylase, hormones indicating stress, at different times of the day and across the days. Sustained high cortisol levels can be detrimental to health. Thus, we had evidence about the effects of caring for a loved one with MCI both from answers to interview questions and from indicators of physiological responses to stress.

We found that problem behaviors of persons with MCI had a significant impact on the care partners' positive or negative outlook and on their marital interactions. The results also showed that on days when care partners experienced more stressors in situations other than problems with the person with MCI, they reported more physical health symptoms. In contrast, on days when care partners reported memory-related problems in their spouses, they had higher levels of salivary cortisol and alpha-amylase. These atypical, stress-related hormone reactions may put the care partners at greater risk for their own physical health problems than they would otherwise be. Health workers and other professionals could use these findings to encourage care partners to get needed help and find ways of coping with stress.

Roberto, K.A., & Brossoie, N. (2008, October). ADRC Advisory Council Survey. Final report submitted to Virginia Department for the Aging, Richmond, VA.

Executive Summary

Introduction

“No Wrong Door” is the Commonwealth of Virginia’s approach to one-stop access for adult health and human services. The vision of the No Wrong Door System (NWD) is to have Aging and Disability Centers (ADRC) in every community where individuals can turn for information on the full range of long-term support options and entry to public long-term support programs and benefits. The first goal of the Virginia “No Wrong Door”/Aging and Disability Center (NWD/ADRC) evaluation plan states, “Older adults, adults with disabilities, and family caregivers will know where to turn for long-term support information, assistance, and services.” To assess progress toward meeting this goal, the Center for Gerontology (Center) at Virginia Polytechnic Institute and State University (Virginia Tech) conducted surveys of advisory council members at selected NWD/ADRC sites. This is a report of findings on the second assessment conducted in August, 2008 of five NWD/ADRC sites.

Methodology

In July 2008, each of the 10 NWD/ADRC site facilitators were contacted and asked to report the number of times their NWD/ADRC advisory council had met during the last 12 months. Sites that met three or more times in the past year received an invitation to participate in the assessment. Five sites met the criteria and participated: (1) Bay Aging (Bay); (2) Senior Connections, Capital Agency on Aging (Capital); (3) Peninsula Agency on Aging (Peninsula); (4) Rappahannock-Rapidan Community Service Board/Agency on Aging (R&R); and (5) Senior Services of Southeastern Virginia (Southeast). Advisory council members at each site were sent a brief survey instrument comprised of 15-items (11 structured items with force-choice response set; 4 open-ended questions), which addressed their current knowledge, perceptions, and satisfaction with the NWD/ADRC initiative at the local and state levels as well as their beliefs about the future implementation and success of the program. Advisory council members received a packet by postal mail that included a letter explaining the purpose of the assessment, a copy of the survey instrument, and a self-addressed stamped envelope to return the completed survey. Participants who did not return the survey by the designated date were contacted by telephone and offered the option of completing the survey over the phone or receiving a duplicate survey to complete. The final response rate was 74.5%, with 59 of the 79 council members completing and returning their surveys.

Findings

The majority of respondents (94.6%) reported having an understanding of the overall vision and goal of the NWD/ADRC initiative and felt confident about its success in implementation. Additionally, 80% of respondents agreed that they received sufficient information and support about the project to fulfill their advisory council role. Concerns about the future of the NWD/ADRC project suggested that some advisory council members doubted the feasibility of implementing the program. Although 70% were optimistic about implementing the NWD initiative in their area, only 43.6% of respondents believed that the efforts of the NWD/ADRC project would be successful at the State level. More than half (55.4%) of the respondents were undecided about the State’s ability to work with providers to integrate tools with existing and

planned computer systems. Moreover, only 32.2% of respondents believed that State agencies would be able to successfully work together to implement the project. Despite doubts about implementation, the majority of respondents (80.4%) believed that the initiative will improve consumer access to services and coordination of services.

Conclusions

Overall, respondents from the five advisory councils understood the purpose and importance of the NWD/ADRC initiative. Councils focused on developing an implementation plan, recruiting local supporters, and identifying potential challenges. More than half of the respondents were more confident in the success of their local program than the implementation of the state-wide program. There was a general consensus that unless State agencies collaborated in the initiative's development and the State committed financial and technical resources needed for successful implementation, the NWD/ADRC initiative would fail. Member concerns and comments were relatively consistent across councils and did not vary across geographic locations. Despite holding some reservations about the initiative's success, many council members believed that the time had come for implementation and indicated they were ready to support a change.

Roberto, K.A., Brossoie, N., & McPherson, M. (2007, July). New River Valley Agency on Aging 2007 Needs Assessment. Final report submitted to New River Valley Agency on Aging, Pulaski, VA

Executive Summary

Introduction

In May 2007, the New River Valley Agency on Aging (NRV AoA) contracted with the Center for Gerontology at Virginia Polytechnic Institute and State University (Virginia Tech) to design and implement the assessment reported in this document. The goal of the assessment was to identify the current and future needs of older adults served by the NRV AoA.

Methodology

Data was collected through the use of self-administered surveys completed by 346 non-institutionalized residents 50 years of age and older residing in Montgomery County, Pulaski County, Giles County, Floyd County, and Radford City. Data collection sites included community gatherings (e.g., AARP, Rotary, RSVP, AoA nutrition sites) across all jurisdictions. Information was also gathered through the use of telephone surveys with residents currently on the waiting list for homemaker and respite services offered through the NRV AoA. The data were analyzed by examining responses to each of the survey items, exploring relationships between personal characteristics of the respondents (e.g., age, health status, and living arrangements) and survey items, and comparing responses across service areas.

Findings

Overall, 20-30% of study respondents reported having some problems with managing activities of daily living currently, with difficulty with housekeeping reported as a need by 42% of the respondents. Help with home repairs/modifications and finding services and workers to provide help were the two most frequently reported needs identified by the respondents. Almost one-half of respondents indicated that they would be at least somewhat likely to use services if they need help and assistance in the future. Thirty to forty percent of respondents expressed interest in attending educational programs; programs providing tips for healthy living and long-term care planning were of interest to the greatest percentage of respondents. No consistent pattern of differences in the participants' responses according to their sex, age, health, or living arrangements was found.

Recommendations

When developing and enhancing services and programs for older adults, based on the study findings, the NRV AoA should:

- Examine how prominently health status factors into service eligibility criteria.

- Expand existing services (*homemaker, home delivered meals, respite, transportation, phone support*) and add services (*help with home repairs and modifications*) that have current and future likelihood of high demand.
- Clarify agency goals for *transportation services* to help guide programming adjustments in this area.
- Target members of the baby boom generation for education classes, particularly future planning and health optimization programs.
- Take a preventative approach to mental health programming.
- Explore educational outreach and normalization of incontinence to address the degree of problems with this issue reported by individuals aged 50-64 years.
- Train home visitors to recognize and effectively address complexity in family structures across service jurisdictions.

Roberto, K.A., Duke, J. O., Brossoie, N., & Teaster, P. B. (2007, May). The need for public guardians in the commonwealth of Virginia. Final report submitted to Virginia Department for the Aging, Richmond, VA.

Executive Summary

Introduction

In 2005, a study to assess the future need for public guardians in the Commonwealth of Virginia was funded by the Virginia General Assembly and responsibility assigned to the Virginia Department for the Aging (VDA). VDA contracted with the Center for Gerontology at Virginia Polytechnic Institute and State University (Virginia Tech) to design and implement the study of public guardianship reported in this document.

Methodology

Multiple methods were used to gather data necessary to estimate the current need for public guardians and to predict future needs for such services throughout the Commonwealth. Extant data were used in analyses designed to predict/forecast future guardianship needs. The primary agencies surveyed to establish estimates of current and future (i.e., 2010) need for guardianship included all of the existing Public Guardianship and Conservator Programs (PGCPs), Community Services Board (CSB) directors, Adult Protective Services (APS) supervisors, and directors of social services for state hospitals (SH) and training centers (TC).

Findings

Based on U.S. Census population estimates and projections and data on unmet need provided by the 114 agency representatives responding to the survey, there is an estimated need for 1,441 more public guardianship slots than are available through the Public Guardianship and Conservatorship Program. Projections are made on the assumption that the current public guardianship service level will remain stable and that the unmet need for public guardians will continue to escalate. In 2010, the unmet need will be 1,707; by 2020 it will rise to 1,939; and by 2030 the unmet need will increase to 2,170 incapacitated persons.

Individuals served through public guardianships and conservatorships range from 18 to 100 years of age. Almost one-third of those with guardianships only are over the age of 60 while more than two-thirds of those with guardianship/conservatorships are older adults. Females over the age of 60 comprised more than half of the population currently being served. Individuals living with a combination of physical, cognitive, and mental problems made up 53% of the guardianship population.

Respondents reported that over 1100 residents of the Commonwealth were on a waiting list for public guardianship/conservatorship services with 62% of individuals on the waiting aging being 60 years of age and older. Persons typically remained on waiting lists six months or more. The most common reasons for the wait were problems finding a suitable guardian and court costs inherent in the legal process. Respondents noted that the cost of the petitioning process makes

guardianship unavailable to many vulnerable adults who most need it, and that there is a chronic and unremitting lack of suitable persons available to serve as guardian when a person in need is also indigent. Occasionally, individuals are appointed who are not qualified and not able to perform the functions generally expected of someone who assumes the guardian role. When this happens it is not usually in the best interest of either the person appointed or the person who needs a guardian.

Conclusions

An immediate as well as future need for additional guardianship/conservatorship services exists in Commonwealth. As documented in previous studies in Virginia, the need for guardianship, the cost of the petitioning process, and a lack of suitable persons available to serve as guardian emerged as chronic problematic issues in providing guardianship services to vulnerable adults in need of such services

Recommendations

Pursuant to the terms of the contract with the Virginia Department for the Aging, the following recommendations are made based on our interpretation of the findings of the (a) projected needs analyses and (b) surveys completed by the respondents from the participating agencies.

- Fund individual programs to meet needs of the 1,441 individuals who are currently in need of guardianship/conservatorship services.
- Enhance funding steadily so that the individual programs can serve the projected increase in clients.
- Increase funding so that the public guardianship programs have statewide coverage.
- Create mechanisms in jurisdictions so that court costs for indigent clients can be waived or substantially reduced.
- Identify ways to cover the cost of the petitioning process for families who are willing to assume guardianship of indigent family members and are appropriate.
- Encourage agencies to keep a referral or waiting list as a means of starting to more systematically documenting the need for public guardianships/conservatorship services.