national institute for advanced studies

ALTERNATIVES TO INSTITUTIONALIZATION: AN EVALUATION OF STATE PRACTICES

Contract No. HCFA-500-77-0029

TECHNICAL ASSISTANCE MANUAL

November 1978

600 E Street, N.W., • Suite 100 • Washington, D.C. 20004

Prepared for:

Department of Health, Education and Welfare
Health Care Financing Administration
330 C Street, S.W.
Washington, D.C. 20001

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ACKNOWLEDGEMENTS

The National Institute for Advanced Studies (NIAS) is pleased to present this Final Report of the study, "Alternatives to Institutionalization: An Evaluation of State Practices." We believe that the work summarized in this report represents a significant contribution to the agency's goal of assisting states with the development of alternatives to premature institutionalization.

This study has truly been a cooperative effort, which has benefited significantly from the thoughtful assistance of Larry Knape and Mel Merchant of the Health Care Financing Administration and the Medicaid personnel in all the states visited.

Principal among the staff responsible for this report were James S. Fosdick, Director of the Division of Health and Project Manager for this project; Edna Kane, Associate Project Manager, Frank Clark and Melvena Sherard.

Michael L. Davis, Chairman
Board of Directors

INTRODUCTION

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Increasingly, emphasis has been placed on providing services in a manner that helps to avoid unnecessary or inappropriate institutionalization. Demonstration programs of alternatives have been developed by various states and legislation on a variety of different home-based services has been introduced in the Congress. For a State Medical Assistance Program, alternatives can be an attractive response to skyrocketing costs of institutional care.

It must, nonetheless, be recognized that home-based service delivery or "alternatives" (to institutionalization), are in some cases, newly approved Medicaid benefits, and in other cases, can be interpreted as qualifying under old benefit categories. This fact establishes two obstacles to implementation of alternatives by a state agency: financing the program and the "nuts and bolts" of program development and operation. In the first instance, state Medicaid agencies are faced with tight budgets for both the state share of Medicaid administratives costs, and the state share of Medical Assistance Payments (MAP). Payments for home-based care usually must be offset by reductions in other types of payments rather than merely representing an additional cost element. Studies of the cost-effectiveness of home health care and other alternatives indicate that this concommitant cost reduction most often is long-term rather than short-term, thus, financing remains an obstacle to program development.

The nuts and bolts of program development are likewise an obstacle to a Medicaid Director already beset by fraud and abuse regulations, quality control, and third party liability in addition to ongoing eligibility determination and claims processing problems. The primary purpose of this "Guide" is to assist state Medicaid personnel in this development process. A word or two about how this manual has been developed is probably in order.

The initial objectives of the Health Care Financing Administration in contracting for the development of this Guide were to:

- encourage states to develop Medicaid-supported alternative care programs,
- facilitate the development of health and social services which prevent inappropriate institutionalization, and
- reduce the inappropriate institutionalization of the elderly and functionally disabled.

In support of these objectives, the National Institute for Advanced Studies first conducted a review of relevant literature and grant file information of demonstration grantees (predominantly Section 1115 grant and waiver demonstrations). The next step in the project was development of a model which contained the various steps in the process of developing an alternative service or a package of alternative services. The contractor then visited five states and through conversations with Medicaid Directors and program personnel developed a compendium of information on state approaches to needs assessment, program planning, program development, program operations, and program evaluation (the five process model steps). The contractor is deeply indebted to personnel in California, New York, Oklahoma, Oregon and Virginia for their valuable contributions to this Guide. The information from the literature review, grant files, and site visits has been distilled into this Guide. It should be noted that of necessity this guide presents relatively general approaches and procedures. (However, a detailed section on cost benefit analysis has been included to aid program developers in assessing the financial feasibility of a program.)

Some states will include benefits to the medically needy while others will serve only the categorically eligible. Optional services will also vary from state to state as will the organizational context (location) of the Medicaid agency itself. What the

Guide attempts, then, is to provide state personnel with suggestions on optional approaches to the different steps in the process of program development. State personnel can then be selective in consulting those sections of the Guide which are relevant to their program development activities. It is also incumbent upon the reader/program developer to follow the Guide's suggestions within the context of the organizational and service characteristics of the state's Medicaid program.

We have attempted to provide a realistic view here of alternatives development, with suggestions oriented to specific aspects of program development. In attempting to be realistic we do not wish to overemphasize the problems associated with alternatives development. This Guide does not resolve the financial plight of state Medicaid programs. Imagination and cooperation with other agencies can result in pooling of resources such as Titles III and VII of the Older Americans Act and Title XX of the Social Security Act to augment Medicaid funds. The authors' experience in state government suggests that ultimately state Medicaid personnel are genuinely concerned with the welfare of the Medicaid eligible individual. Quality of life improvements that result from staving off institutionalization have appeal for program personnel. If reasonable effort is exerted to control costs and keep alternatives costs within previous expenditure [levels with the promise of actual cost reductions in the future] governors, budget offices and legislatures will more likely be supportive of alternatives development.

Medicaid laws and regulations define that Medicaid programs must serve the poor, the elderly and the functionally disabled. Medicaid staff can derive considerable satisfaction from the knowledge that their efforts, in many cases substantial efforts, have resulted in an elderly individual's being able to remain at home in familiar and

comfortable surroundings. This, then, is the challenge: to develop needed services to maintain the independence of individuals for as long as medically and socially possible within the constraints of budgetary limitations and obstacles to program development. It is hoped that this Guide can be of some assistance in this worthwhile endeavor.

NEEDS ASSESSMENT

NEEDS ASSESSMENT

A needs assessment is usually designed to answer one basic question: What services are needed by this population? In order to answer this basic question, strategies should be developed which outline a means of: (1) defining the characteristics of the potential client population; (2) determining which services are most needed (demanded); (3) determining to what extent the services already available address the needs presented; and (4) determining the extent to which available services are coordinated and accessible to clients.

Analyses such as the above will help to identify the current needs of the client population, i.e., significant gaps between the services the clients need and the services the clients receive.

1. HOW IS THE POTENTIAL SERVICE POPULATION DEFINED?

- Most often program planners are acquainted with a very broad service population (e.g. the functionally disabled). It is usually too ambitious to attempt to design a program which addresses such a broad service population. Therefore, information should be collected initially on this broad group which will allow for the identification of the segment of this population which is most needy.

  For example, in California the Department of Health has developed a needs assessment methodology which is based upon the identification of "cluster groups" which share similar needs. A total of 12 clusters were identified after studying developmentally disabled individuals in state hospitals who would be eligible for community alternative programs if they existed. Each of the clusters were defined according to individual

functioning in the areas of: 1) self sufficiency, 2) motor coordination, 3) communication, and 4) self control. The 12 clusters represented a continuum; the first cluster was composed of the most disabled individuals and the last cluster composed of the least disabled individuals. These clusters are used as the basis for identifying group service needs and subsequently, program development. Other methods of obtaining information on a service population include:

- Conduct A Consumer Survey -

  This type of survey is one which attempts to gauge the attitudes of consumers through the use of a questionnaire or other data collection instruments which can be either administered in person or via telephone. These instruments should be designed to be brief and to collect specific information. They may include open-ended response items (responses recorded in the respondents own words), closed-ended response items (items which the respondent answers by selecting one of the responses provided), or both. Following are examples of both types of response items.

  1. (Open-Ended Response Item)
     What type of services would you like to see offered by the new program?

     _____

     _____

     _____

     _____

  2. (Closed-Ended Response Item)
     Which of the following services would you like the new program to offer?

(INTERVIEWER: READ LIST).

___ Home Health Service
___ Homemaker Services
___ Legal Services
___ Transportation Services
___ Nutrition Services

Closed-ended items lend themselves to quantitative analyses, while those using all open-ended items lend themselves to qualitative analyses. For most cases, some combination of the two types is best.

A specific example of the type of community survey which can be conducted is that which was done for Oklahoma's community-based after care program for former mental patients. This survey, however, was conducted during the first year of the program, rather than prior to implementation, and allowed for an on-going assessment of client needs. The survey involved the analysis of former mental hospital patients, utilization of community resources, role problems affecting re-integration into the community, ties to social groups outside the family, recreation patterns and daily routines, feelings of stigma and special problems affecting patient adjustment and re-integration into the community.

The first stage of analysis for a needs assessment should consist of preliminary analyses necessary for the completion of more complex analyses (given the design of the survey, sophisticated analytical procedures may not be necessary). In the case of open-ended response items, this stage will consist of aggregating the data collected according to the various response categories and developing classification schemes. These schemes can then be

used to assign appropriate codes to responses so that, if required, this data can be key-punched onto computer cards.

In the case of closed-ended response items, this initial stage will consist of completing editing and coding procedures necessary to present the data in a form amenable to quantitative procedures. This information can also be keypunched onto computer cards.

Once coding and tabulation are completed, the data should be summarized via data-descriptive procedures. Procedures such as frequency and percentage distribution are examples of techniques for describing the data in some summary fashion. When these tallies are completed, variable relationships can be assessed if such variables have been identified.

- Review of Secondary Sources

Secondary sources include federal, state and local government data, census data, published materials (e.g. books, journal articles, newspaper articles). These sources often contain information which documents the results of other needs assessments for the same broad service population being investigated. Reviewing these sources first can eliminate the possibility of duplication of effort. For example, all state agencies on aging and agencies requesting Title XX funding are required to conduct a needs assessment before their funding requests are approved. Similarly, State Health Planning and Development Agencies (SHPDAs) and local Health Systems Agencies (HSAs) aggregate data on their

respective service areas. Another potential source of secondary data are state and local government planning departments. In summary, the wealth of secondary data sources suggests that individualized surveys for general population data should not be necessary. Aside from providing information on the results of similar needs assessments, previous studies can also provide valuable background information on prevailing treatment philosophies and new placement theories, and can help to bring program planners "up-to-date." Through this process program planners can also note any special problems which demand immediate solutions.

- Review of Records of Other Agencies -

Interagency collaboration is essential if a new program is to be launched. All agencies which might have any association with the broad service population being investigated should be contacted in an effort to secure their cooperation in having their records reviewed. This review can be conducted by these external program planners, or, if necessitated by confidentiality restrictions, by the agency's own internal staff. Aside from helping to define the new program's service population, agency records can indicate the level of client participation in past programs, most often used services, underutilized services, problems encountered, and identify existing resources and gaps in resources.

- Use of Expert Consultants -

Instead of a review of secondary sources, or to supplement such a review, program planners might

elect to consult with known experts in the field. These experts can be identified by contacting local professional associations, universities and service agencies. Once identified, these experts can be surveyed in a manner similar to that used for the consumer survey; however, the program planners may want to address different questions to each of the consultants, depending upon their area of specialty. In any case, the consultants should be asked to prepare written responses to questions posed, or, if a "round table" discussion is to be held, provision should be made to record the proceedings. These measures insure that all information is retained in a form which will facilitate its review at a later date.

- Use Of An Advisory Group -

  Another means of using expert consultants is to invite them to serve as members of an advisory group, along with consumers, agency personnel, and other public or private officials. Such advisory groups can pool the knowledge of their members and can help to identify which segment of the broad service population being investigated is most in need of services.

2. ONCE THE PROFILE ON THE SERVICE POPULATION TO BE SERVED HAS BEEN COMPLETED, WHICH METHODS CAN BE USED TO DETERMINE THE GREATEST NEED FOR SERVICES?

- The information collected must be analyzed so that a list of problems/needs can be developed and prioritized. This prioritized listing will become the basis for the selection of those problems/needs which will be considered in selecting those services which will be offered by the

new program. The list of problems should be prioritized in terms of:

- Number of Persons Involved -

  The frequency with which a particular need occurs is a key indicator. If analysis of the collected information identifies that 300 elderly citizens are without transportation, while 50 are in need of leisure time activities, it is clear that transportation is the more pressing need.

- Intensity of Problem -

  Identified needs must also be assessed in terms of their severity; in the case of the functionally disabled, a major consideration would be those needs which endanger their ability to sustain themselves in the community and which might lead to premature institutionalization.

- Probability of Success -

  A need which occurs frequently and is seen as critical must also be assessed in terms of the likelihood of designing a program which can adequately meet the need. Program planners must be careful not to be too ambitious in selecting those needs to be addressed.

- Impact on Other Needs -

  Any prioritization of needs must take into account how a particular problem impacts other needs and whether its resolution will have a positive effect on these other needs. For example, the provision of nutrition services to the homebound elderly may improve their health status to a point where they no longer need certain health services.

- Logical Sequence of Service Delivery -

  Program planners should determine the correct sequence of service delivery so that the identified problems can be addressed in a logical order. For example, lack of transportation and nutrition services may represent two needs of an area's handicapped population. But if nutrition services are provided without the development of transportation services to enable the handicapped to obtain these services, then the new services will be underutilized. The logical sequence would have been to meet the need for transportation services first, and then provide nutrition services.

- Time Available -

  Program planners should determine the length of time that is required to adequately address the identified needs. The time required for the resolution of each need should be assessed in terms of such factors as for how long funding can be secured, how long it will take to hire and train staff, and the time it will take to fully operationalize the program.

- Resources Needed -

  Each of the needs identified through the data analysis will require a commitment of resources if the need is to be met. In developing the prioritized list, the level of resources needed to address each problem should be compared.

- Cost vs. Benefits -

  Given the general lack of resources that confronts most program planners, it is best to try and determine how one can accomplish the most

with the least amount of expenditure, while considering all other factors. The benefits to be accrued, and any "spillover" effects which would result from the implementation of the program should be weighed in light of the resources required.

- Suitability for Achieving Coordination -

  The prospects for coordinating the programs efforts with other related efforts to produce a greater impact is a final criterion to be used in prioritizing the identified needs.

3. THE ABOVE PRIORITIZATION PROCESS WILL ENABLE THE PROGRAM PLANNER TO IDENTIFY THE NEEDS TO BE ADDRESSED BY THE PROGRAM AND THE SPECIFIC TARGET POPULATION TO BE SERVED. AFTER THIS STAGE OF NEEDS ASSESSMENT, HOW IS EXISTING SERVICE AVAILABILITY TO BE EVALUATED?

- Before planning further for the program, surveys should be conducted to determine if any of the proposed services are currently being offered in the community or state, but perhaps are not being utilized for some reason. Such an evaluation at this stage would preclude the duplication of services, and could perhaps identify the reasons why these needed services are being underutilized (e.g. poor advertisement). The evaluation of service availability would involve the following:

  - Survey of Present Community Resources -

    This type of survey is really a cataloging of all the community organization resources which could be used by the programs target population. Such resources might include churches, social service agencies, activity centers and civic associations.

- Comprehensive Service Survey -

This type of survey catalogs all of the existing services which are available to the program's target population. In conducting this survey, the program planner should be attuned to the various types of services which must be included in this process: 1) preventive services, 2) outreach services, 3) training services, 4) indirect services (counseling, placement, testing, etc.), and 5) direct services (health services, transportation services, social services, etc.).

Several cost-effective methods of surveying service availability present themselves to the Medicaid program development staff-member. First, where Medicaid programs involve county personnel the stage program can mail a survey instrument to all county Medicaid program directors asking for an itemization of services available (regardless of agency) in the county. In place of, or in addition to, such a survey the state Medicaid program can seek the cooperation of another branch or another agency in securing information. For example, in preparing for the development of "the community care organization" a Medicaid initiated alternatives program in Wisconsin, the Medicaid program development staff prepared a questionnaire which was subsequently mailed by the Secretary of the State Department of Health and Social Services to all county Departments of Social Services. The data obtained permitted development staff to analyze service availability and gaps on a county-by-county basis. The data was also useful in identifying

an initial county site for program implementation.

4. HOW ARE EXISTING SERVICE COORDINATION AND ASSESSIBILITY TO BE EVALUATED?

- In cataloging existing community resources and services, program planners have an opportunity to develop strategies to avoid future duplication of these subjects and resources. Two such strategies are:

  - Information Sharing Mechanisms -

    One method of insuring that services aren't duplicated is to develop information-sharing mechanisms which maintain a continually up-dated data-bank on existing resources and services. All of the agencies and organizations involved would have to cooperate in the upkeep of this data bank.

    Or, program planners might opt to involve these same agencies and organizations in a series of training sessions which aim to improve the coordination of similar functions. This was the objective of a training project which was sponsored by Oregon's Division of Mental Health of the Department of Human Resources. This training project was designed to create a common approach to long term care placement which would be used by the providers of mental health services (state institutional staff, community program staff, psychiatrists and social workers). The training sessions focused on: 1) developing a shared approach to client assessment for placement, 2) developing a consensus on treatment priorities, 3) improving providers' assessment skills, 4) improving providers' skills in setting

treatment priorities, 5) increasing providers' familiarity with various approaches to treatment, 6) developing a shared approach to assessment of placement environments, and 7) increasing providers' familiarity with various ways of improving placement environments. Information sharing mechanisms such as data banks and staff training projects are excellent means of establishing interagency channels so as to avoid duplication of effort.

- Use of Task Forces -

Another method which can be used to prevent the duplication of services is the creation of interagency task forces which are responsible for reviewing and reporting on any potential service system "bottlenecks". These task forces could review proposals for new programs and assist staff in evaluating service availability and service coordination.

Planners for Virginia's program to provide community housing alternatives for mentally retarded adults utilized task forces. For example, the service task force of the interagency advisory council was responsible for monitoring the cost of services which were to be provided by the group homes to be established under this program. The specific purposes for the formation of this task force were: 1) to provide programmatic expertise in determining the services needed in the group homes and the cost of these services, 2) to identify funding constraints and means of utilizing funding resources, 3) to

develop a service model to be used by the group homes, and 4) to provide the interagency advisory council with data on the feasibility of proposed group home service budgets.

PROGRAM PLANNING

PROGRAM PLANNING

In planning an alternative care program, the results of the needs assessment are utilized in conceptualizing the specific features of the program. These features include: program organization, categories of service (direct or indirect), program philosophies, staff characteristics, decision-making processes and the physical location of the program.

1. WHAT FACTORS SHOULD BE CONSIDERED DURING THE CONCEPTUALIZATION OF A PROGRAM?

- Once the needs to be addressed and the target population to be served have been identified, it is then necessary to determine which aspects of these needs are to be addressed by the new program. For example, if the program is to address the lack of home health services, the various aspects of this need might be: The absence of sufficient training resources for home health aides, prohibitive licensing regulations or unresponsive health providers. In conceptualizing the specific components of the new program, the planners must decide which of the different aspects of the need will be addressed. Criteria similar to that used to select the overall need (number of persons involved, intensity, probability of success, impact on other needs, etc.) can be used to select which aspects of the overall need will be addressed.

- After the specific aspects of the need to be addressed have been determined, these aspects must be analyzed in order to identify their causes. This analysis will facilitate the subsequent selection of an intervention strategy. An intervention strategy is the approach which will be used in attempting to meet the identified need. To select the appropriate intervention strategy:

- Study past successes and failures - Review the intervention strategies which have been used by other programs in the area. If one type of intervention has met with success more often than the others, then it should be a major consideration in the final selection. Information on past programs can be obtained from local service agencies and private service organizations. Information on newer approaches and recent developments can be obtained from the social science departments of area colleges and universities and professional organizations. If a suitable intervention strategy is not discovered through these means, then a brainstorming session, attended by all those involved in the programs planning, might produce other ideas.

- After an intervention strategy has been selected, the other features of the program (e.g. staffing needs, physical location of program) should be developed.

2. HOW SHOULD THE FORMATION OF PROGRAM GOALS AND OBJECTIVES BE APPROACHED?

- In developing program objectives, planners should concentrate on establishing those which are clear, concise and measurable. Objectives tend to be stated in vague terms and are unrealistic. To avoid these mistakes, program planners should develop objectives which possess the following features:

- Action Verbs - A strong action verb is the key to a measurable objective because the verb is measurable. Examples of action verb are "to convene", "to evaluate", "to fund". Examples of verbs which are difficult to measure are "to understand", "to encourage", "to facilitate".

- Single Aim - Measurable objectives also are those which present one specific aim. Objectives should not contain a number of clauses and phrases each of which entails a different outcome. A clear, concise objective is one which states a single aim that produces a single outcome or end product.

- Specific time period - An objective should be stated in terms which plainly indicate the time period within which it will be accomplished. Whenever possible, actual dates should be included.

Many of the programs examined during this project's site visits did not have objectives which met the criteria above. For example, one program stated its objectives to be:

1. To provide in one region of the state effective comprehensive services to all elderly persons who are at risk of losing self-sufficiency, in the most appropriate, least restrictive, residential placements which will maximize self-sufficiency.

2. To gradually waive, in selected geographic areas of a state, categorical restrictions and governmental policies which constitute barriers to coordinated planning, management, and pooling of funding for a set of related programs supported by Titles XIX and XX of the Social Security Act, Titles III and VII of the Older Americans Act, state general funds, and local public and private funds.

Although each of these objectives includes a single aim, neither presents an activity that can be easily measured. Terms such as "gradually", "most appropriate", "least restrictive", and "sub-state basis" should be clearly defined.

PROGRAM DEVELOPMENT

PROGRAM DEVELOPMENT

Needs assessment and program planning have established a sound foundation for program development. Some program momentum and enthusiasm will likely have built up as development staff have talked with or surveyed other agencies and service providers. One of the critical problems, therefore, in program development is the loss of this momentum and the resulting loss of interest in the program or service itself. Three steps can be taken to prevent this losing of steam. First, consider the momentum issue as program timetables for implementation activities are established. Keep the pressure on to keep the program moving. Second, set realistic objectives with regard to achieving certain levels or degrees of implementation by certain times. So long as the schedules is not over too long a period of time, momentum can be maintained as long as scheduled dates are not missed. Third, break implementation into segments with certain achievement milestones for each segment. Successes in reaching such interim milestones achievement, prompt attention to such problems, expeditious resolution, and rescheduling if necessary can help in keeping up the program's momentum.

The program development stage will include both administrative systems implementation and the onset of service delivery with attendant client and provider problems. In the remainder of this section we shall address some of these program development issues.

1. HOW CAN THE MOST APPROPRIATE ADMINISTRATIVE PROCEDURES (INCLUDING RECORD-KEEPING SYSTEMS, PROVIDER REIMBURSEMENT PROCEDURES, AGENCY REIMBURSEMENT PROCEDURES) FOR A PARTICULAR PROGRAM BE IDENTIFIED?

- The development of administrative procedures and systems requires a thorough consideration of the range of systems available for implementation. There are many packaged systems which exist (e.g. the problem oriented record system) which can be adapted to fulfill the requirements of any service program. Program staff also have the option of developing their own systems which are specifically tailored to their program. In either case, the first step is to become acquainted with the type and quality of systems which have been implemented at other

agencies and that have been described in detail in literature dealing with service delivery. Once staff has become familiar with what is available, they should work together to determine which functions their systems must fulfill. (These functions might include tracking clients, delineating program expenditures, and monitoring referals made to other agencies). This determination must be jointly made by all staff who will be using these systems; if all staff have not yet been hired at this point, then persons who can present the viewpoint of both on-line and supervisory staff should be included.

In developing Oregon's Project Independence (which is a program designed to encourage the use of such services as home care and outreach to discourage the inappropriate institutionalization of the elderly), the Office of Elderly Affairs developed an operations manual for recordkeeping procedures, client-provider reimbursement procesures, and coordinating mechanisms to be carried out by the Area Agencies on Aging. The project made use of existing management procedures for Project Independence. Another consideration in developing or adapting such systems should be effective interface with existing Medicaid program eligibility, client recordkeeping, and claims processing systems. This will prevent a massive snarl which would result from conflicts between unrelated systems.

2. WHICH METHODS SHOULD BE USED TO EDUCATE A COMMUNITY ABOUT A NEW PROGRAM?

- Medicaid personnel are rarely familiar with advertising the availability of services and may assume that individuals will utilize the new alternatives program because the need for it is so great. They may fear that any community education effort would produce an overwhelming response and needy clients would have to be turned away. There are times, however, when relying on agency referrals alone will not produce sufficient numbers of clients to operate the program at maximum capacity. In such cases, as comprehensive an education campaign as possible, given available resources, should be launched. The key stages of this campaign are:

  - Identify Key Community Groups And Individuals- The mobilization of persons whose support would help to convince community members of the merits and legitimacy of the new program is essential. Solicit their cooperation in arranging for presentations in the community; they are likely to have access to community gatherings, church meetings and other activities of which the program staff would not normally be aware.

  - Establish Community Education Task Force - In order to organize efforts, a task force composed of key community members, program staff and interested agency personnel, might be established. Specific duties and responsibilities can be assigned to each task force member. For example, one member could be responsible for working out a budget for an informational brochure, making presentations

to various advertising agencies, reviewing bids, and supervising production. Another member could arrange and schedule all public presentations and prepare the texts for these presentations.

- Utilize Media - An important component of any educational campaign is the use of area newspapers, radio and television stations in promoting the new program. The media can give the program the initial widespread coverage needed to generate an adequate pool of clients. Representatives of the media should also be notified of the significant milestones of the program's life (e.g. starting date, expanded hours, new staff) so that interest in the program can be sustained. And if a convincing argument can be made illustrating the necessity of the program and it's public and/or human interest story aspects, the media will perhaps donate the needed air time or newspaper space. In any case, good relationships between the press and program staff should be maintained at all times. Although public education is unfamiliar territory for Medicaid personnel, such outreach is critical if the programs goals of deinstitutionalization and prevention of institutionalization are to be realized.

PROGRAM OPERATIONS

PROGRAM OPERATIONS

Operating a service delivery program basically involves the performance of procedures designed to provide the services to clients in the most effective manner possible. These procedures ensure the client's successful movement through the service system, from the time of his/her entry to the time when the services are no longer needed. There are six such procedures: (1) initial client intake and screening; (2) client diagnosis/assessment; (3) service plan and development and service provision; (4) case monitoring; (5) service termination; and (6) follow-up.

1. WHAT FACTORS SHOULD BE TAKEN INTO ACCOUNT WHEN IMPLEMENTING INITIAL CLIENT INTAKE AND SCREENING PROCEDURES?

- Initial client intake and screening describes what first takes place between the client and program staff. During this interaction, the staff member must obtain vital information about the history of the client and the services which should be provided. This information will help the staff member ascertain if the potential client is actually eligible for the Medicaid-sponsored services. If not, avenues of recourse can be identified. A nursing home pre-admission screening program which is operated by the Virginia Department of Health's Medical Assistance Program is an example of one type of intake and screening mechanism which has been developed. Under this program, all applicants for admission to nursing homes are screened by the Home Health Services Utilization Review Committees of local health departments(if the applicant is not in a community hospital or nursing home at the time of application, and if the applicant is or will become Medicaid eligible within within 90 days of admission). The Utilization Review Committees are composed of (at least) a physician, a nurse, a social worker and, if possible, representatives of other agencies which might provide services to the applicant.

The social worker on the review committee is expected to provide the committee with information about each referral for screening. This information is obtained from a basic social evaluation. The local health department conducts an evaluation of nursing needs. Once these initial evaluations have been conducted, the committee meets to discuss the findings and to determine if nursing home placement is needed. The findings of the review are then forwarded to the utilization review section of the Medical Assistance Program (the form designed to present the committee's findings as well as examples of other forms, appear on the following pages). In the event that nursing home placement is inappropriate the committee must refer the applicant to the appropriate community resources.

The components of an efficient client intake and screening system minimally should include:

- The Development of Case Acceptance Criteria - These criteria establish the guidelines for program participation. The situations under which clients will be admitted to the program should be described in a concise manner so that staff are easily able to identify, based upon the background information provided, those individuals who could benefit from the program's services.

- Investigation Process - The investigation process used during intial client intake and screening should be one which allows for the verification of the information provided by the client. This process should be thorough and efficient, and completed in a timely fashion. Staff must not be tempted

EXHIBIT I

VIRGINIA

NURSING HOME SCREENING CERTIFICATE

HEALTH DISTRICT_____ HEALTH DEPARTMENT_____

Name of Patient_____ Age: ____ MF ____ MSDW
Last First Middle

Address_____

Source of Referral: Self____ Family____ Friend____ Welfare Dept.____ Other (Identify)_____

RECOMMENDATION:

Nursing Home ____

No Change ____

Other Living Arrangements

Home for Adults ____

With Relatives ____

Other (Describe) ____

COMMENTS:

_____

_____

_____

_____

_____

SERVICES REQUIRED/AVAILABLE:

1. Meals (Congregate, etc.) ____
2. Chore Services ____
3. Companion Services ____
4. Home Health ____
5. Homemaker ____
6. Day Care ____
7. Other (Define) ____

SERVICES REQUIRED/NOT AVAILABLE:

1. Meals (Congregate, etc.) ____
2. Chore Services ____
3. Companion Services ____
4. Home Health ____
5. Homemaker ____
6. Day Care ____
7. Other (Define) ____

COMMENTS:_____

_____

_____

_____

_____ _____
Date Signature

_____ _____
Man-hours, Visit Title

SOURCE: Virginia Department of Health

EXHIBIT I (Cont.)

PRIMARY DIAGNOSIS:

Hypertension ____
Diabetes ____
Heart ____
Other Cardiovascular Diseases, including CVA ____
Cancer ____
Arthritis ____
Other (Define) ____

COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____

FUNCTIONAL CAPACITY:

Completely bedridden ____
Up in chair only ____
Ambulates with help (Device) ____
Ambulates with help (Other person) ____
Independent Ambulation ____

SPECIAL DISABILITIES:

Paralysis/Paresis ____
Ambulation ____
Contractures/ Deformities ____
Impaired Vision ____
Deafness ____
Confused/Aberrant Behavior ____
Other ____

PRESENTING PROBLEMS:

Unable to Cope with Activities of Daily Living
Personal Care ____
Care of the Home ____
Food Preparation (Including Purchase) ____
Menace to Self and Others ____

COMMENTS:

_____
_____
_____
_____
_____
_____
_____

CURRENT LIVING ARRANGEMENT:

House/Apartment
Alone ____
With Spouse ____
With Child ____
With Other Relative ____
With Friend ____

Home for Adults ____
Rooming House ____
Room and Board ____
Other Institution (identify) ____

[illegible] - 1210 2/77

EXHIBIT 2

NEW YORK STATE DEPARTMENT OF HEALTH
HOME HEALTH SERVICES
HOME ASSESSMENT ABSTRACT

NAME_____ SOCIAL SECURITY #_____ (TO BE USED WITH DMS-1)

1. IS PATIENT/SPOUSE A VETERAN? YES ☐ NO ☐ 2. SPEAKS AND UNDERSTANDS ENGLISH? YES ☐ NO ☐ IF NO, WHAT?_____

3. LIVING ARRANGEMENTS:
☐ PVT HOME/APT
☐ RENTED ROOM
☐ BOARDING HOUSE

4. LIVES WITH:
☐ ALONE
☐ SPOUSE
☐ OTHER
SPECIFY_____

5. MARITAL STATUS:
☐ MARRIED ☐ SEPARATED
☐ SINGLE ☐ DIVORCED
☐ WIDOWED ☐ UNKOWN

6. SOURCE OF INCOME
☐ WELFARE ☐ VET BEN
☐ SOC. SEC. ☐ SSI
☐ PENSION ☐ OTHER
SPECIFY_____

7. PATIENT TRAITS:	YES	NO	?	
NEEDS STRONG DIRECTION AND/OR SUPPORT				IF YES, WHY?
SEEMS TO MAKE APPROPRIATE DECISIONS				IF NO, WHO DOES?
CAN RECALL MED ROUTINE/RECENT EVENTS				IF NO, DOES THIS INTERFERE?
PARTICIPATES IN PLANNING/TREATMENT PROGRAM				IF NO, WHO DOES?
SEEMS TO HANDLE CRISES WELL				IF NO, WHO DOES?
ACCEPTS DIAGNOSIS				IF NO, DOES THIS INTERFERE?
MOTIVATED TO REMAIN AT HOME				DESCRIBE

8. FAMILY TRAITS:	YES	NO	?	
IS MOTIVATED TO KEEP PATIENT HOME				IF NO, BECAUSE
IS CAPABLE OF PROVIDING CARE (PHYSICALLY AND EMOTIONALLY)				IF NO, BECAUSE
WILL KEEP PATIENT HOME IF NOT INVOLVED WITH CARE				BECAUSE
WILL GIVE CARE IF SUPPORT SERVICES GIVEN				HOW MUCH
DOES NOT WANT PATIENT IN THE HOME				BECAUSE
RESPONSIBLE FAMILY MEMBER(S) WORK				HOW LONG-HOURS
REQUIRES INSTRUCTION TO PROVIDE CARE				IN WHAT-WHO WILL GIVE

9. HOME	YES	NO	?	
NEIGHBORHOOD SECURE/SAFE				
HOUSING ADEQUATE IN TERMS OF: SPACE				
CONVENIENT TOILET FACILITIES				
HEATING ADEQUATE AND SAFE				
COOKING FACILITIES AND REFRIGERATOR				
TELEPHONE ACCESSIBLE AND USABLE				
IS PATIENT MOBILE IN HOUSE				
ANY DISCERNIBLE HAZARDS (PLEASE CIRCLE)				SMOKES CARELESSLY, LEAKY GAS, POOR WIRING, UNSAFE FLOORS, STEPS, OTHERS, SPECIFY
CAN CLIMB STAIRS				
EXCESS USE OF ALCOHOL/DRUGS BY PATIENT/CARETAKER				EXPLAIN
IS PATIENT'S SAFETY THREATENED IF ALONE				EXPLAIN

10. ADDITIONAL ASSESSMENT FACTORS:

11. RECOVERY POTENTIAL ANTICIPATED	YES	NO	?	1-3 MO	4-6 MO	6 MOS	COMMENTS
FULL RECOVERY							
RECOVERY WITH PATIENT MANAGEN RESIDUAL							
LIMITED RECOVERY MANAGED BY OTHERS							
RAPID DETERIORATION							

DMS-7x - 1/12/73

SOURCE: New York State Department of Health

EXHIBIT 2 (Cont'd)

FOR THE PATIENT TO REMAIN AT HOME - SERVICES REQUIRED

	YES	NO	WHO WILL PROVIDE: FAMILY	AGENCY	AGENCY FREQUENCY
12. BATHING					
DRESSING					
TOILETING					
SPOON FEEDING					
EXERCISES/ACTIVITY/WALKING					
13. SHOPPING (FOOD/SUPPLIES)					
MEAL PREPARATION					
LIGHT HOUSEKEEPING					
PERSONAL LAUNDRY/HOUSEHOLD LINENS					
14. RAMPS OUTSIDE/INSIDE					
GRAB BARS-HALLWAYS/BATHROOM					
COMMODE/SPECIAL BED/WHEELCHAIR					
CANE/WALKER/CRUTCHES					
SELF HELP DEVICE, SPECIFY					
ASEPTIC DRESSING/CATH. EQUIP.					
BED PROTECTOR/DIAPERS					
OTHER					
ANCILLARY SERVICES(LAB, O_2, INH, R_X, ETC.)					
15. TELEPHONE REASSURANCE					
DIVERSION/FRIENDLY VISITOR					
MEDICAL SOCIAL SERVICE/COUNSELING					
LEGAL/PROTECTIVE SERVICES					
PERSONAL/FINANCIAL ERRANDS					
TRANSPORTATION ATTENDANT					

TRANSPORTATION ARRANGEMENTS IF YES, CIRCLE, CAR, CAB, BUS, AMBULETTE, MEDICAR, AMBULANCE OTHER_____

16. DMS PREDICTOR SCORE_____ OVERRIDE NECESSARY YES NO

17. CAN PATIENT BE CARED FOR UNDER HOME CARE? YES ☐ NO ☐ - AS A PRACTICAL MATTER

IF NO, GIVE SPECIFIC REASON WHY NOT _____

18. INSTITUTIONAL CARE REQUIRED NOW? YES ☐ NO ☐ IF YES, GIVE SPECIFIC REASON WHY_____

19. LEVEL OF INSTITUTIONAL CARE DETERMINED BY YOUR PROFESSIONAL JUDGMENT: SNF ☐ HRF ☐ DCF ☐

20. CAN THE PATIENT BE CONSIDERED AT A LATER TIME FOR HOME CARE? YES ☐ NO ☐ WHEN_____

21. SUMMARY OF SERVICES/CHARGES-ASSESSORS TO COMPLETE SERVICES/PROVIDERS-UNITS NEEDED

Services	Provided by	Units Wk	Units Mo	Est. Dur.	Unit Cost	Paid by MC	Paid by MA	Paid by Self	Funds Avail.
Health Care MD									
Nursing									
Home H. Aide									
PT									
OT									
Speech									
Inhal. R_x									
Med. Soc. Work									
Transportation									
Equip/Supplies									
Other									
Sub Total									

Services	Provided by	Units Wk	Units Mo	Est. Dur.	Unit Cost	Paid by MC	Paid by MA	Paid by Self	Fur Avg
Personal Care									
Personal Care Worker									
Homemaker/ Chore									
Meal Service									
Other									
Sub Total									
TOTAL									

Assessment Completed by_____ Dat
signature, R.N.

Case Manager_____ Dat
signature

EXHIBIT 3

NEW YORK STATE DEPARTMENT OF HEALTH
LONG TERM CARE PLACEMENT FORM
MEDICAL ASSESSMENT ABSTRACT
PREDICTOR SCORE

CURRENT PAT. LOCATION
☐ HOSP. ☐ OCF
☐ SNF ☐ HOME CARE
☐ HRF ☐ OTHER
SPECIFY

REASON FOR PREPARING FORM
☐ DISCHARGE/TRANSFER TO
☐ ADMISSION FROM
☐ REVIEW FOR PERIOD FROM ____ TO
☐ MEDICAID REVIEW ☐ DEATH
☐ OTHER, SPECIFY

PATIENT NAME LAST FIRST M.I. | STREET CITY STATE ZIP | SEX ☐ MALE ☐ FEMALE

PATIENT NUMBERS
S.S. NO.
MEDICARE NO.
MEDICAID NO.
SOC. SERVICE DIST.
MEDICAL RECORD NO.
ROOM NO.

PATIENT DATES
DATE OF BIRTH AGE
DATE LATEST HOSP. STAY –
FROM
TO
DATE THIS ADMISSION
RESPONSIBLE PHYSICIAN

PROVIDER INFO
NAME
ADDRESS
MEDICAID NO.
MEDICARE NO.
DOES PATIENT HAVE PRIVATE INSURANCE?
☐ NO ☐ YES

MEDICAL COVERAGE: PATIENT'S CONDITION AND TREATMENT REQUIRING SKILLED SUPERVISION (ALL ITEMS MUST BE COMPLETED)

1. A. DIAGNOSES OCCASIONING CURRENT USE OF SERVICES:
PRIMARY
OTHER
OTHER
OTHER
B. NATURE OF SURGERY DATE
C. IF PATIENT HAD CVA/MI SPECIFY DATE
D. ALLERGIES OR SENSITIVITIES, SPECIFY

2. LIST SIGNIFICANT MEDS/INJECTIONS.
(FOR PARENTERAL MEDS ALSO CHECK ITEM 3 A)

MED	DOSE	FREQUENCY	ROUTE

1. A. NURSING CARE & THERAPY (SPECIFY DETAILS IN 5. BELOW OR ATTACHMENT)

	FREQUENCY			SELF CARE		CAN BE TRAINED	
	ROUTINE	PART SHIFT	INTERMITTENT	YES	NO	YES	NO
PARENTERAL MEDS							
INHALATION TREATMENT							
OXYGEN							
SUCTIONING							
ASEPTIC DRESSING							
LESION IRRIGATION							
CATH/TUBE IRRIGATION							
OSTOMY CARE							
PARENTERAL FLUIDS							
TUBE FEEDINGS							
BOWEL/BLADDER REHAB							
BEDSORE TREATMENT							
OTHER (DESCRIBE)							

3. INCONTINENT
URINE: OFTEN* ☐ SELDOM** ☐ NEVER ☐ FOLEY ☐
STOOL: OFTEN* ☐ SELDOM** ☐ NEVER ☐

4. DOES PATIENT NEED SPECIAL DIET? NO ☐ YES ☐
IF YES, DESCRIBE

*MORE THAN ONCE A WEEK **ONCE A WEEK OR LESS

3. D. Is the patient's condition unstable so that an R.N. must detect/evaluate need for modifications of treatment/care on a daily basis?
NO ☐ YES ☐
If yes, describe instability and specific need for nursing supervision, vital signs ranges, lab values, symptoms, etc.

E. Is there high probability that complications would arise in caring for the patient without skilled nursing supervision of the treatment program on a daily basis?
NO ☐ YES ☐
If yes, describe (a) patient's condition requiring skilled nursing supervision (b) the aggregate of services to be planned and managed in the treatment program. Indicate services needed and potential dangers of complicating clinical factors.

F. Circle the minimum number of days/week of complex skilled nursing supervision:

REQUIRES	RECEIVES
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7

OMS—1 (1/77)

SOURCE: New York State Department of Health

EXHIBIT 3 (Con't.)

PATIENT NAME	LAST	FIRST	M.I.	PATIENT S.S. NO.	MEDICAL RECORD NO.	ROOM NO.

4. FUNCTION STATUS	SELF CARE	SOME HELP	TOTAL HELP	CAN NOT	REHAB* Poten.
WALKS WITH OR W/O AIDS					
TRANSFERRING					
WHEELING					
EATING/FEEDING					
TOILETING					
BATHING					
DRESSING					

5. MENTAL STATUS	NEVER	SOME-TIMES	ALWAYS		REHAB* Poten.
ALERT					
IMPAIRED JUDGMENT					
AGITATED (NIGHTTIME)					
HALLUCINATES					
SEVERE DEPRESSION**					
ASSAULTIVE					
ABUSIVE					
RESTRAINT ORDER					
REGRESSIVE BEHAVIOR					
WANDERS					
OTHER (SPECIFY)					

6. IMPAIRMENTS	NONE	PARTIAL	TOTAL		REHAB* Poten.
SIGHT					
HEARING					
SPEECH					
COMMUNICATIONS					
OTHER (CONTRACTURES, ETC.)					
SPECIFY					

7. SHORT TERM REHAB. THERAPY PLAN
(TO BE COMPLETED BY THERAPIST)

A. DESCRIBE CONDITION (NOT DX) NEEDING INTERVENTION	SHORT TERM PLAN OF TREATMENT AND EVALUATION & PROGRESS IN LAST 2 WEEKS	ACHIEVEMENT DATE

B. CIRCLE MINIMUM NUMBER OF DAYS/WEEK OF SKILLED THERAPY FROM EACH OF THE FOLLOWING:

REQUIRES		RECEIVES
0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	SPEECH	0 1 2 3 4 5 6 7

8. DO THE WRITTEN ORDERS OF THE ATTENDING PHYSICIAN AND PLAN OF CARE DOCUMENT THAT THE ABOVE NURSING AND THERAPY ARE NECESSARY? NO ☐ YES ☐

9. A. SHOULD THE PATIENT BE CONSIDERED FOR ANOTHER LEVEL OF CARE: NO ☐ YES ☐ IF YES: WHEN? _____ WHAT LEVEL? _____

B. AS A PRACTICAL MATTER, COULD PATIENT BE CARED FOR AS AN OUTPATIENT? NO ☐ YES ☐

C. AS A PRACTICAL MATTER, COULD PATIENT BE CARED FOR UNDER HOME CARE? NO ☐ YES ☐

IF YES TO ANY OF ABOVE, ATTACH A DISCHARGE PLAN.

10. SHOULD THE PATIENT/RESIDENT BE MEDICALLY QUALIFIED FOR SNF CARE? COVERED ☐ QUESTIONABLE ☐ NON-COVERED*** ☐

11. ADDITIONAL COMMENTS ON PATIENT CARE PLAN/REHAB. POTENTIAL _____

12. I CERTIFY, TO THE BEST OF MY INFORMATION AND BELIEF, THAT THE INFORMATION ON THIS FORM IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

_____ (SIGNATURE OF DESIGNATED RN AND TITLE) _____ DATE ASSESS. COMPLETED

TO BE COMPLETED BY U.R. AGENT OR REPRESENTATIVE UPON CONTINUED STAY REVIEW

13. ADDITIONAL INFORMATION BY U.R. REPRESENTATIVE

_____

_____

14. NEXT SCHEDULED REVIEW DATE _____

15. U.R. REPRESENTATIVE PLACEMENT _____

SIGNATURE _____ DATE _____

16. U.R. PHYSICIAN: PLACEMENT _____

SIGNATURE _____ DATE _____

*CHECK THE BOX CORRESPONDING TO APPROPRIATE CRITERION IF THERE IS A LIKELIHOOD THAT THE PATIENT WILL RESPOND UNDER A COORDINATED PLAN OF RESTORATIVE TREATMENT. (INDICATE PLAN IN ITEM 3, E OR 11).

**IF PATIENT HAS SEVERE DEPRESSION, PSYCHIATRIC CONSULTATION SHOULD BE OBTAINED.

*** IF CHECKED "NON-COVERED", SNF PLACEMENT CANNOT BE APPROVED BY MEDICAID.

A. ITEMS 1, 2, 3, 4, 5, 6 SHOULD BE COMPLETED BY NURSE
B. ITEM 7 SHOULD BE COMPLETED BY THERAPIST.
C. ITEMS 8, 9, 10, 11, 12 TO BE COMPLETED IN CONSULTATION WITH THE HEALTH TEAM.

DMS—1 (1/77)

EXHIBIT 4

GERIATRIC FUNCTIONAL RATING SCALE

NAME_____ Date of Birth_____

ADDRESS_____ Tel. No._____

Sex: M F Marital Status: Si M W D S Rel: H P C O

Relative or Friend:

Name_____

Address_____ Tel. No._____

1/ PHYSICAL CONDITION		SCORE		SCORE		SCORE
A) Eyesight	Good Reading TV Reads Needlework	0	Distinguishes Faces	-3	Sees Light only	-10
B) Hearing	Good	0	Loud Voice	-1	Deaf	-5
C) Mobility	Fully Mobile - Dresses Carries Parcels Rides Bus	0	Uses Cane or should use one Dependent on railings	-1	Requires Cane & other support - Wheelchair	-15
D) Pulmo-Cardio-Vascular Function	No Restrictions	0	1 Flight of Stairs 1 City Block	-1	Partially or Totally Restricted	-10
E) Diet	No Restrictions	0			Yes	-1

2/ MENTAL CONDITION		SCORE		SCORE		SCORE
A) Disorientation	None	0	Time	-1	Person &/or Place	-15
B) Delusions	None	0	Mild - Severe Suspiciousness	-1	Overt	-10
C) Memory Loss	None	0	Senile	-1	Malignant	-20
D) Energy & Drive	Normal	0			Hyperactive or Hyperactive	-5
E) Judgment	Intact	0			Impaired	-5
F) Hallucination	None	0			Auditory &/or Visual	-10

SOURCE: Grauer, H. and F. Birnbum, "A Geriatric Functional Rating Scale to Determine the Need for Institutional Care," Journal of the American Geriatric Society, 1975.

EXHIBIT 4 (Con't.)

3/ FUNCTIONAL ABILITIES	SCORE
A) Reads and writes letters	- 2
B) Able to use telephone	- 3
C) Able to bank and shop	- 5
D) Able to prepare simple meals and bake	- 7
E) Washes, dresses and toilets self without assistance	- 5
F) Uses public transportation	- 7
G) Able or would be able to take own medication and follow diet	-10

4/ SUPPORT FROM THE COMMUNITY	SCORE
A) Family compatibility	- 3
B) If living alone, can get support and help from a reliable relative, friend, neighbor, janitor	-10
C) Able to shop at reliable grocer's (willing to deliver when necessary)	- 5
D) Available supportive and recreational facilities - -Clubs geared to aged	- 1
-Church, synagogue	- 1
-Library	- 1
-Park, shopping center, restaurant, movies	- 1
E) Geographic availability of - Public health nurses	- 1
- Meals-on-Wheels service	- 1
- Homemaker services	- 1
- Friendly visitor	- 1
- Hospital with emergency and clinic facilities	- 1
- Public transportation	- 1

5/ LIVING QUARTERS	SCORE
Elevator service or living on ground floor or basement	- 1

6/ RELATIVES AND FRIENDS	SCORE
A) Not married but lives with compatible and helpful relative or friend	- 3
B) Lives with incompatible relative, friend or spouse	0
C) Lives with sole and incompatible spouse	-10

7/ FINANCIAL SITUATION	SCORE
A) Totally independent	- 5
B) Dependent on helpful relative	- 3
C) Dependent mainly on Old Age Pension &/or other comm. resources	0

Total Plus Score _____

Total Minus Score _____

Final Score _____

to assume or make personal judgements about the information presented by the client.

- Interviews with Family Members - An assessment of the client's home situation is an important part of the information to be secured. A home visit often can uncover facts and situations not described elsewhere. Also, the outcome of such visits may be the determining factor in borderline cases of appropriateness of placement in community programs (for alternative programs, and not Title XIX eligibility).

2. WHAT FACTORS SHOULD BE CONSIDERED WHEN IMPLEMENTING CLIENT DIAGNOSIS/ASSESSMENT PROCEDURES?

- If it is decided, based upon an evaluation of all the information obtained on the client, that he/she is eligible for services, then the staff member can proceed with more detailed assessment of the problems of the client and the extent of assistance needed. This assessment/diagnosis process will culminate in the development of a service plan which specifies strategies for meeting the needs of the client. A service plan might define time limits for the accomplishment of certain tasks. The specific components of this stage of program operations are:

  - Establish and Develop Treatment Goals and Objectives -
    The service plan must outline the goals and objectives to be met during the treatment of the client. It is important that these goals and objectives are not developed in a vacuum, but take into consideration the client's total situation (e.g., job demands, financial restrictions, educational limits).

It is important that these goals and objectives be the culmination of negotiating sessions between the client, his/her family, and program staff. Service goals and objectives must not be imposed upon the client; the only hope of realistically accomplishing these tasks is to involve the client in development of goals and objectives so that the implications of the efforts required are totally understood by the client. If the client is not involved in this process, he/she may become uncooperative and defeat the aim of treatment.

In most cases, only certain of the client's total needs will be met by the Medicaid alternatives program. Again, imaginative and effective coordination with other agencies and programs can result in meeting the client's needs.

- Case Review by Multi-Disciplinary Team - A multi-disciplinary team of professionals who will be involved in the service delivery process may be convened to review the service plan to insure that it proposes the best manner of treatment for the client. This team can identify hidden constraints and other problems not discerned by program staff. It can recommend alternative services which may prove more effective. The multi-disciplinary team should be responsible for insuring that the plan allows for coordination with any other service programs.

3. WHAT FACTORS SHOULD BE TAKEN INTO CONSIDERATION WHEN IMPLEMENTING INDIVIDUAL CLIENT SERVICE PLANS?

- The treatment, or service delivery, process is the key element of program operations. This is when the service plan is implemented. During the course of implementation, the progress of the client is monitored and problems are identified, along with proposed solutions. The specific components of this stage of program operations are:

  - Adhere to Standards for Minimum Frequency of Contact/Client Monitoring -

    To avoid the clients "getting lost in the system", the staff person assigned to his/her case must periodically assess the progress being made towards the accomplishment of the goals and objectives specified in the service plan. It should not be left up to staff to determine how often to monitor client progress. Standards for minimum frequency of contact should have been previously developed, based upon the recommendations of the multi-disciplinary team that approved the clients service plan. When monitoring the client's progress, staff should discuss with the client how the client perceives their progress and ask the client for their analysis of any problems which have occured. In the event of significant improvement or the accomplishment of the goals and objectives in the service plan, if further treatment is needed, a new plan should be developed and presented to the multi-disciplinary team for approval.

- Develop Follow-up Procedures for Referrals - An integral part of the service delivery process will be the recognition of other services by the client which are not offered by the particular program. In this case, it is the staff person's responsibility to identify and obtain these services for the client through the use of existing referral mechanisms. Once referral services are obtained, the program staff should work with the other programs' staff to assure that conflicting treatment strategies or service goals and objectives are not allowed to impede the client's progress. It is essential that program staff follow-up on any referrals made for the client to document that these services are being received and to assess their impact on the client.

- Coordination with Referral Agencies and Agencies Sharing Clients - Coordinative mechanisms (such as interagency agreements) should be developed between those agencies which will be sharing or referring clients. These mechanisms will safeguard against situations when agencies are not aware of each other's activities with respect to an individual client, which may inadvertently hinder the resolution of the client's problems.

4. HOW SHOULD TERMINATION OF SERVICES TO A CLIENT BE DETERMINED?

- Assuming that the client's needs are eventually resolved, it is reasonable to expect the client to arrive at the point where he/she no longer needs the services that have been provided. Termination of

services should only occur after consultation and counseling have taken place between the client, members of his/her family, and all service providers. Specifically, program staff should:

- Employ Criteria for Determining the Timing and Procedures for Termination -
  During the review of the client's service plan, the multi-disciplinary team should suggest criteria for determining the termination of services. The most obvious criterion is to the accomplishment of specified goals and objectives. Discussions with the client and members of his/her family will help indicate the client's ability to handle termination of service.

- Make Efforts to Prepare Clients for Termination -
  Once the possibility of service termination has been discussed, program staff must make every effort to prepare the clients by gradually removing supports upon which he/she may have become dependent and observing client reaction to their removal. Program staff should recognize that in most cases there will be a resistance to service termination because the client has become comfortable with the present situation. It is the program staff's job to insure that a client no longer in need of services is made to recognize and accept this fact.

5. HOW SHOULD FOLLOW-UP PROCEDURES BE IMPLEMENTED?

- In the event of service termination, the client should be periodically contacted to determine how well he/she is managing without the services. The program should

have standards which specify minimum frequency of follow-up contacts, although for most programs follow-up procedures cannot be a priority because of lack of funds to sustain this activity. Depending on the resources that are available, either direct or indirect monitoring procedures should be implemented. Direct procedures include monthly telephone contacts and home visits. Indirect procedures include asking neighbors/family to notify the program staff in case of any sudden change in the status of the terminated client. This follow-up is essential if prevention of institutionalization is to be maintained. The same presenting conditions which made the client a nursing home candidate in the first place can return and must be responded to.

PROGRAM EVALUATION

PROGRAM EVALUATION

Program staff and administrators need means of gauging how effective their program is in terms of meeting its specified goals and objectives. This can be accomplished by first identifying an evaluation model to be used in assessing the impact of the program. The next step is the collection of data which provide documentation on the program's efficiency, comprehensiveness, effectiveness, etc. (This information should include details about costs, client service utilization per month, average length of client visits, etc.) Following the collection of data, it should be analyzed according to an analysis plan (ideally, the analysis plan should be prepared before data collection begins). Information resulting from the program evaluation will provide indicators as to what changes are needed.

1. WHAT TYPE OF INFORMATION SHOULD BE INCLUDED IN AN EVALUATION WORK PLAN?

   - Initially, the program evaluator should attempt to clarify priorities and intentions by stating evaluation objectives and evaluation requirements which clearly delineate:

     - Purpose Of The Evaluation - This section should include a narrative of 1) who the intended audience for the evaluation is, 2) which program components are to be evaluated and why, 3) a description of these program components and their status, 4) the time period during which the evaluation is to be conducted, and 5) a summary of the methodology to be used.

2. WHICH EVALUATION MODELS CAN BE USED TO EVALUATE ALTERNATIVE CARE PROGRAMS?

   - Program planners should recognize that there are various types of evaluations which require different levels of sophistication, research skills, and resources to execute. These types of evaluations include:

- Monitoring - This type of evaluation involves the assessment of managerial and operationsl efficiency through periodic site visits and other management review techniques.

  For example, the Virginia Housing Development Authority has appointed a staff member to monitor the activities of the group homes developed under the auspices of the program to provide community housing alternatives for the mentally ill. Monitoring activities include site visits to assess the upkeep of the facility and the adequacy of the services provided. Identified problems are taken to the inter-agency advisory council, which in turn recommends solutions.

- Reporting Systems - The use of reporting systems provides routine but useful information on services provided by the program, populations served, and the costs of providing these services.

- Program Impact Evaluation - This type of evaluation assesses the overall effectiveness of a program in meeting its objectives. It depends on the definition and measurement of indicators of effectiveness, and comparison or "control" groups are sometimes used, composed of members of the same target population who did not receive the program's services.

California's On Lok Senior Health Services Day Health Program has been evaluated through the use of control groups of elderly persons who were not participating in the day care program. Another impact evaluation of the On Lok program utilized personal observations of clients by program staff, interviews with staff and information from supporting documents, informal meetings and related materials in assessing the impact of the program on clients.

For example, group homes for the mentally retarded which are offered by Virginia's Roanoke Valley Mental Health and Mental Retardation Services Boards utilize a treatment strategy known as normalization. This principle embraces the theory that the mentally retarded should be taught to function independently in a normal environment. The group homes are evaluated using the Program Analysis of Service Systems (PASS) format which quantitatively depicts the group home's level of performance. Factors assessed include: how well the home blends into the surrounding community, the history of the home, its appearance and its surroundings. The group home's treatment program is also assessed in terms of the residents' appearance, their behavior and the staff's performance in carrying out treatment plans.

- Cost Analysis - This is a means of determining the costs of providing services through the program. Comparative analysis can be made of costs by services or groups of services.

For example, in order to compare the outcomes of an alternatives program with those of the regular Title XIX program, a cost-benefit analysis can be developed. In this instance, the outcome variable "change in the amount of public expenditure for nursing home care" appears to be the most accessible and meaningful measure of benefit of the alternatives program and the Title XIX program, both of which are designed to provide services to sustain life and health status among the indigent, disabled, and elderly. Another potential outcome variable might be "change in the amount of public expenditure for hospital in-patient care."

The amount of institutionalization can be determined by computing the number of days of institutionalization for persons in the alternatives experimental group and dividing this number by the number of persons at risk in the sample. The same can be done for a Title XIX control group. This will provide the program administrator with a specific assessment of the average number of days of institutionalization per person at risk in the alternatives program as compared with Title XIX.

By dividing the total number of Medicaid financed days of institutionalization by the number of persons at risk, one can arrive at an average number of days of institutionalized care per elderly person at risk in the state.

$$\frac{\#\text{Medicaid financed days of institutionalization in the State}}{\#\text{of persons at risk in the state}}$$

= #days of Medicaid financed institutionalized care per person at risk.*

With this information, it will be possible to estimate the change in average number of days of institutionalization of the alternatives group and also for the Title XIX control group.

D = days

Act_e = Actual days of institutionalization in the alternatives group

Act_c = Actual days of instititutionalization in the Title XIX group

C = Cost of average day in nursing home

AC_e = Average cost per person enrolled in the alternatives group

AC_c = Average cost per person participating in Title XIX group

ΔD_e = Change in number of days of institionalization per person enrolled in the alternatives group

ΔD_c = Change in number of days institutionalization per person participating in Title XIX group

The equations for determining the change in number of days of institutionalization for the alternatives and Title XIX groups are as follows:

ΔD_e = Average # days inst./person at risk $-Act_e$

ΔD_c = Average # days inst./person at risk $-Act_c$

*It should be noted that other benchmarks could serve as well, provided the data were avaiable. For example, the actual experience of the Title XIX and alternatives groups prior to the two programs would serve as an excellent benchmark.

Then, the cost-benefit ratios can be established.

$$\frac{D_e \times C}{AC_e} \qquad \frac{D_c \times C}{AC_c}$$

In this ratio, the change in average number of days of institutionalized care for persons in the alternatives group is multiplied by the average cost of a nursing home bed/day. This figure is divided by the average cost per person enrolled in the alternatives group. A similar procedure is carried out for the Title XIX groups.

Whereas the numerator in this equation reflects the amount of saving of public funds that would have been expended for institutional care, i.e., the benefits of the programs, the denominator provides an estimation of the average costs per person in each program. These benefit-cost ratios supply Medicaid alternative program evaluator with a numerical indicator of the benefits of the alternatives and the Title XIX programs in terms of the reduction of public expenditures per persons at risk compared to the costs per person for each of the programs. In short, these measures offer a quantitative estimation of the relative efficiency of each program, i.e., how great are the returns for each dollar spent. If it can be assumed that both the alternatives and the Title XIX programs are operating effectively and efficiently, then the differences in the benefits-cost ratios would have to be attributed to some significant differences in the services being delivered.

It is important to stress, however, the benefit-cost ratios present only one aspect of an overall evaluation of the impact of a program, namely, the cost side. For example, if the cost-benefit ratios for the alternatives program and the Title XIX program were identical, it would be simplistic to assume that the programs are equivalent in their outcomes. The impact of the programs in terms of the physical/functional well-being of the clients and their level of satisfaction with the services they are receiving are equally important elements of any evaluation.

Other issues can be raised by examining the implications of the benefit-cost ratios. By looking at the numerator alone, it is possible to identify the absolute change in the number of days of institutionalization achieved by each program. If the benefit-cost ratio for the alternatives program is lower than that of the Title XIX program, but the absolute number of days of institutionalization are fewer and the clients are more satisfied, then trade-offs between cost and client well-being will be more clearly specified, and important policy questions would surface.

The administrative costs built into the alternatives and Title XIX structures should also be described. A determination of the cost of case management might be attempted by calculating staff time/client multiplied by salary unit. Among the specific matters

that might be treated are a comparison of structure and processes of the alternatives with those of the Title XIX program in terms of the following data items:

1. the number and type of personnel utilized to determine client eligibility;
2. the criteria used to assess eligibility;
3. how and by whom disallowances are determined;
4. how and by whom appeals are handled;
5. the amount of time devoted to case management;
6. time delays between client referral and delivery of services;
7. difficulties in finding avaiable services;
8. sources of client referrals, e.g., community, nursing homes, hospitals;
9. descriptions of the responsibilities associated with various positions;
10. the backgrounds of the personnel recruited to fill positions;
11. the problems associated with staff recruitment, morale, and retention.

Assessment could also be made of the trends in the alternatives and Title XIX groups in terms of: (1) proportion of recipients living in institutions; (2) proportion of newly institutionalized recipients during the course of the demonstration; (3) proportion deinstitutionalized; and (4) mortality rates; (5) number or proportion of those determined to need care which could be provided on an involuntary basis.

A major concern of such an evaluation design is identification of a control group. In many ways this depends on the location of the alternatives project. We can consider three possibilities:

1. To choose a similar area, that is the identical county approach, and do the evaluation on a sample of Medicaid recipients similar the alternatives program participants;

2. One could sample non-participating Medicaid recipients in the same location using the same instruments as the alternatives participants;

3. By far the least desirable would be to match alternatives participants with a random sample of the state Medicaid rolls.

- In conducting an evaluation, the program's staff are often resentful of what they see as an implied threat to their jobs and questioning of their competency. To overcome these problems, the evaluators should meet with the program's staff and: 1) acknowledge that data collection may temporarily interfere with other program activities, but that it is a necessary means of determining how well the program is meeting clients needs, 2) stress that the purpose of the evaluation is not to criticize staff efforts, but to help them improve service delivery, 3) explain to staff the importance of their cooperation to the success of the evaluation, and 4) identify ways in which clients receiving services can be motivated by staff to cooperate with the evaluation efforts.

3. WHAT FACTORS CAUSE EVALUATION RESULTS TO BE DISREGARDED?

- Program evaluators should recognize that the results of evaluations generally have not been applied to

program or policy decisions for following five basic reasons:

- Organizational Inertia - This refers to the fact that organizations tend to resist change. Since evaluation usually implies change, organizations tend to discount the findings.
- Disregard For The Audience- The evaluators did not take into account the evaluations intended audience resulting in misdirected finances (i.e. policy recommendations to lower level staff procedural recommendations).
- Methodological Weaknesses - Policy makers will not utilize the results of studies with inherent methodological weaknesses, but instead will rely on their own experiences or opinions.
- Inappropriate Focus - In some instances, a study may bear little or no relationship to critical program and policy issues, and therefore its results are not deemed significant.
- Poor dissemination - Results of evaluations are often not utilized because important decision makers are not shown or briefed on the results of these studies and findings are often not presented in a manner to maximize their usefulness.

4. IN WHAT WAYS CAN PROGRAM STAFF ENSURE THE UTILIZATION OF THE RESULTS OF THE EVALUATION?

- Aside from developing and evaluation work plan which includes a sound methodology, other strategies which can be used to facilitate the successful application of the evaluations findings include:

1. Presenting these findings in a manner that encourages user review and utilization;
2. sharing the findings by communicating results to elected officials and policy makers;
3. disseminating results to individual and groups who request such information;
4. conducting workshops and seminars in conjunction with other agencies and institutions; and
5. publish results in professional journals.

SUMMARY

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This guide has presented a process for the development of alternatives to institutionalization. This process is one which can be adapted to the needs of state Medicaid agencies as well as other state organizations. It provides a base of information which will help to identify important considerations in the development of alternative care programs, and thus equips the administrator with the knowledge needed to implement sound program development strategies. It must be emphasized, however, that the approaches that have been presented are suggestions which should be considered in light of the organizational and service characteristics of a state's Medicaid program.