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UTILIZATION OF LONG TERM HEALTH CARE: A HOSPITAL CHANNELING PROGRAM

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UTILIZATION OF LONG TERM HEALTH CARE:

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by

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ABSTRACT

UTILIZATION OF LONG TERM HEALTH CARE:

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As the number of people needing long term care expands and the programs to meet those needs diversify, one of the most critical questions will be the appropriate utilization of services available. As such, "channeling" has surfaced as an important consideration in a multiplicity of government pilot programs. Channeling is defined as a mechanism for appropriately linking elderly clients to needed services on the continuum of home health to institutional care. The purpose of this study was to assess the outcome of a channeling project implemented in a large, private, acute, general hospital in central Arkansas.

The research targeted two groups of hospitalized patients. The two groups selected for comparison were a 100% sample of persons who met the following criteria: 65 years of age or older, in need of long term care, and referred by the physician between May 15 - August 15, 1982, for discharge planning. A standardized assessment instrument was used by the department social workers for discharge planning with the experimental group (N = 51). The assessment instrument was the same tool being used in other areas of the state by the Office on Aging. The social work staff continued to

complete the traditional, open-ended assessment and discharge planning activities with the control group ($N = 62$). The two groups were then compared.

It was hypothesized that: 1. the use of a standardized instrument would result in increased accuracy and consistency of assessment and thus an increase in the appropriate utilization of long term care services, 2. the assessment instrument would increase patient/family involvement in the decision-making process, and 3. standardized assessments would decrease the number of premature nursing home placements initiated by physicians.

Variables examined included: demographics of the groups, levels of impairment, number of diagnoses and prescription medications, number of interviews and amount of time spent by the social worker, outcomes relative to initial physician's orders, post-discharge satisfaction with the decision-making process, and a comparison of outcomes (home health, extended care, or nursing home.)

The primary conclusion was that the outcomes between the experimental and control groups were comparable; there were no significant differences. The department was prepared to implement a formalized channeling program in the hospital, but the findings did not merit such a change. It is important to note that the experimental group reported significantly less satisfaction with the decision-making process, suggesting that the relationship between the social worker and the patient and the patient's perception of

involvement was negatively affected by the use of such a standardized instrument. The study supported the effectiveness of professional social workers in assessing need for post-hospital long term care of the elderly and linking the client to those services.

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I dedicate this dissertation to my 93-year old grandmother, Wylma Maude Roebuck, who continues to maintain her own home and without whose love and care I might never have survived childhood; and to my "Jewish mother", Rose Dobrof, without whose help I would never have embarked on doctoral study or survived the trials and tribulations of either doctoral education or life in New York City.

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MEETING THE LONG TERM CARE NEEDS OF THE ELDERLY: INSTITUTIONALIZATION OR HOME HEALTH CARE?

For many of the nation's elderly, long term care has become a way of life. Illnesses and trauma that would have once been fatal are now being survived. Survival is frequently accompanied by extremely limited capabilities for independent functioning which result in the need for long term care. Meeting the long term care needs of the elderly in the most responsive and efficient manner has become a national dilemma and has spurred controversy between proponents of institutional long term care and home health care.

Utilizing recent practice and research literature, it is the purpose of this paper to (1) present the rationale for the examination of institutionalization and home health care in meeting the needs of the elderly, (2) document the need for both home health care and institutional care as alternatives for provision of care, (3) identify variables which impede the appropriate utilization of both institutional care and home health care, (4) identify selected areas for future study and research needed to facilitate the development and appropriate utilization of long term care, both institutional and home-based, (5) design and analyze a program focused on decision making and channeling of elderly hospitalized clients in need of long term care, and (6) prepare a procedure for systematic assessment of program results.

RATIONALE FOR STUDY

Between 1977 and 2035, the total population in the United States is projected to grow by about 40%; the elderly population is projected to more than double in size with over 45% of the elderly being over 75 years of age by the year 2000.[1] By 1985, the institutionalized elderly population is expected to exceed 2.6 million, more than doubling the current institutionalized elderly population.[2] There is general agreement that long term care is an increasingly urgent policy issue, that there has been rapid growth in the numbers of the chronically ill and frail elderly, and that these problems will intensify as the population of chronically ill and frail elderly expands.[3] Approximately 1,300,000 Americans, including five percent of those 65 years or older, reside in 18,900 nursing homes. Additionally, some twenty percent of the elderly will spend some time in a nursing home prior to death.[4] By contrast, the number of home health care agencies approved for participation in the Medicare program from 1970 to 1975 remained stable at about 2,200.[5] The impaired elderly living currently at home may be institutionalized as they grow older and experience increased levels of impairment.[6] An estimated 25% of those over age 75 will become institutionalized at some time if the current system of care provision remains unchanged.[7] Chronic illnesses limit the activities of about 60% of those over the age of 75 years and prevent one person in five from carrying out basic activities of daily living.[8]

According to Robert A. Derzon, Administrator, Health Care Financing Administration of the Department of Health and Human Services, "Long term care will be government's health financing dilemma of the '80's."[9] To substantiate Derzon's claim, one need only examine some of the major findings of the 1981 report prepared by the Health Care Financing Administration. Services for impaired elderly that involve a monetary transaction are increasingly becoming a government responsibility. For example, although total expenditures on nursing home services rose 280% between 1970 and 1979, public expenditures increased 343%. In 1979, Federal, State, and local expenditures totaled $10.1 billion and represented 56.7% of the $17.8 billion total nursing home bill.

The report further states that Medicare and Medicaid account for about 90% of all Federal Long Term Care expenses. Approximately half of all nursing home residents are supported totally or partially by Medicaid. Specifically, Medicaid paid $8.8 billion. Furthermore, Medicare is the largest purchaser of home health services among Federal programs ($520 million in 1978). As the population inevitably ages, the pressures for public involvement can only intensify.[10]

A coherent policy on goals and methods in long term care has yet to be shaped. Elderly go without the care they need and others are in facilities inappropriate to their needs. Many believe institutionalization could have been postponed or prevented for thousands of current residents if viable home health care and supportive services existed.[11]

Public policy continues to favor institutional care over home health care particularly in the area of funding. Expenditures for home health care in 1978 came to no more than 1% of both Medicare and Medicaid budgets[12] while institutional long term care absorbed 25% of Medicare and Medicaid budgets.

Given the current and projected demographic data, the cost of providing long term care, and the current state of public policy in the area of meeting the long term care needs of the frail elderly, an examination of both home health care and institutional long term care appears in order.

WHY HOME HEALTH CARE?

Although home health care services in the United States have been established sporadically since the Boston Dispensary started the first home care program in 1876, until recently this segment of the health care delivery system was largely ignored.[13] With the rising cost of health care, the criticisms of institutional long term care, and the increased longevity resulting in increasing numbers of frail elderly, home health care has emerged as a possible solution to meeting the long term care needs of the aged.

A survey of the literature reveals that home health care is frequently proposed as an alternative to or postponement of long term institutional care. "It is generally accepted that although 5 percent of the aged currently reside in institutions, a percentage of those might not if adequate provision existed in the community."[14] However, there seems to be a wide divergence in opinions about the percentage of

those elderly who are actually inappropriately placed. For example: a Connecticut long term care PSRO official estimated that the majority, 85 to 95 percent, of residents in skilled care nursing facilities were inappropriately placed in the State of Connecticut;[15] Karnes, in 1976, stated that as many as 40 percent of the institutionalized elderly do not need the type of services, particularly acute and skilled medical care, that long term care institutions provide;[16] Oktay and Sheppard asserted that assessments indicated that no more than 15 to 25 percent of institutional residents could be maintained at home;[17] and the Plass study of one long term skilled nursing facility in New York State indicated that only 2 percent of the residents could have been discharged home even if more extensive home health care services had been available.[18] While it is conceivable that some statistical differences could be attributed to regional differences, an examination of those studies and articles reveals little or no explication of the criteria used in assessing whether a resident of an institution could, in fact, be maintained in the community. In addition, statements regarding postponement of institutionalization appear to be subjective assessments rather than based on actual studies, and, once again, criteria for the assessment remain unstated. Still, preventing or postponing institutionalization of the elderly whenever possible, regardless of the exact percentages, remains a legitimate argument for home health care, especially when considered with the 1976 Shanas and Maddox study which

found that 90 percent of elderly respondents with children preferred home health care to institutionalization, as did 70 percent of those children.[19] With the diversity of statistical findings and estimations, it remains difficult to assess the extent of the need for home health care in preventing or postponing long term institutionalization.

Another justification for long term care being offered in the home is that it provides service to a wider range of elderly clients.[20] The 1976 Plass study which tracked 100 percent of the geriatric patients admitted over one year to a New York State hospital revealed that 13 percent of the hospital admissions were transferred to another hospital, and 70 percent of the geriatric hospital patients returned home. The patients who returned home, approximately 500, presented a profile that generated concern for their continuing health care needs. Of those 500 patients, 175 presented a need for home health care; however, the existing home care agency was able to provide appropriate services to only about half those patients with defined needs.[21] In addition, Shanas and Maddox estimate from their study that two to three times as many older persons who are either bedfast or homebound due to physical impairment live at home rather than in institutions.[22] There is general agreement in the literature that the homebound physically impaired elderly represent a largely unserved or underserved population and that this gap in services increases the utilization of both the long term care facility and the acute care hospital.

Another rationale for meeting the needs of the elderly through provision of home health care is economic. If hospitals, nursing homes, and other institutions provided the only solution for the elderly who need some health care, the financial drain to society would be enormous.[23] The operating costs of both acute care and long term care facilities has increased as the character of health care has progressed from custodial to curative and restorative. The costs of personnel and of providing them with the complex physical plant and equipment to do their work has grown higher and higher.[24] The cost argument again centers around the either home health care or institutionalization position and is based on the difference in cost of a long term care facility or nursing home (approximately $45 per day) and that of maintaining a patient through home care services (approximately $12-$14 per visit).[25] While cost effectiveness can be argued from this position, how cost effective depends on determining the extent of avoiding or delaying institutionalization. Oktay states that home care is cost effective primarily for cases in which the disability is not severe. In addition, she states expansion of home health care services to the large number of persons in need of long term care who are not in institutions and who are now receiving no services would undoubtedly increase expenses rather than conserve them.[26] Therefore, an overall cost efficiency argument for home health care seems ill advised at this point. Seidle, et al, conclude that operational experience with home care

will show how varying considerations affect cost, as will carefully designed research with randomized designs to assure an equal baseline between home health care and institutional nursing home care. Such study is basic to the unraveling of cost considerations.[27] Currently the cost effective position can only be advocated when the disability is less severe and in those instances in which unnecessary institutionalization is, in fact, avoided or delayed.

In summary, the development and/or expansion of home health care services to meet the long term care needs of the elderly is justifiable from a number of perspectives: (1) it can prevent or delay institutionalization for some elderly, (2) home care has been found to be the stated preference of the majority of elderly, (3) it is a way of expanding services to the elderly and of providing health care to a currently unserved or underserved population, and (4) at least for some, it is a cost-effective method of delivering health care.

WHY INSTITUTIONAL LONG TERM CARE?

The need for the maintenance of long term care facilities in meeting the health care needs of the elderly, especially those who are severly impaired can, perhaps, best be justified through a portrait of the current population of the nation's long term care facilities.

> The average age of residents in long term care facilities is 82 years, and 70 percent are over 75 years of age. Studies reveal that residents generally have four chronic or crippling disabilities. Cardiovascular disease ranks first, experienced by 65 percent of the population,

> followed by organic brain syndrome, fractures, and arthritis. Fifty-five percent or more of long term care residents are mentally impaired. Less than half the patients can walk. About 55 percent require assistance in bathing, 47 percent need help in dressing, 33 percent are incontinent, and 11 percent require assistance in eating.
>
> The average institutional resident in long term care facilities takes 4.4 different drugs per day, some taken 2 to 3 times daily; 70 percent take five or more drugs per day; and almost 50 percent take seven drugs per day.[28]

A third of the residents of long term care facilities have no close relatives. Those who do have families have generally been institutionalized only as a last resort. For the most part, families have exhausted all other alternatives, endured severe personal, social and economic stress in the process, and made the final decision to place in a nursing home with the utmost reluctance.[29] Population changes such as new and alternate family structures, an increasing divorce rate, a decline in birthrate, the increase in single parent families, and an increasing number of women in the work force all suggest a reduction of family available to provide continual personal care for the elderly.[30]

It also seems fair to project that as people live longer, they will encounter more severe and more numerous disabilities. One need only look again at the projected demographic picture presented in the "Rationale for Study" to realize that even if institutionalization remains the necessary alternative for only 5 to 6 percent of the elderly, the weight in sheer numbers will require not only maintenance but expansion of the capacity of the long term care institutions.

There is also a cost effective justification for institutional long term care. More severely disabled clients will require more extensive services, and the more extensive the services, the more likely it is that an institution can provide it at less cost than a home care program. One of the structural benefits of an institution is its ability to provide centrally a range of services that, if provided in a decentralized fashion in the community, might cost more.[31] Again, it seems that, as with home health services, the best indicator of costs for a specific person will be that person's level of disability and subsequent service needs. If the need is for 24-hour-a-day skilled care, it may not be either practical nor cost-effective to provide that care in the home.

In summary, the justification for the maintenance and even expansion of institutional long term care to meet the health needs of the elderly can also be presented from a number of perspectives: (1) the severity and number of diagnoses frequently found among a percentage of the elderly, (2) the extent and level of care needed to manage multiple diagnoses, (3) the hardship placed on families (when there are families) in attempting to meet demanding skilled care needs, (4) the numbers presented by demographic projections of elderly likely to need institutional care, and (5) for those in need of on-going skilled care, institutionalization is, in all probability, cost effective.

INSTITUTIONAL CARE AND HOME HEALTH: WHY NOT?

As previously stated the percentage of elderly experiencing chronic disease and combinations of chronic diseases is increasing. Even with acute illness, the period of recuperation for the elderly is frequently longer, increasing the need for both home health care and institutional based long term care.[32] From data obtained in the Plass study, one can conclude that home health care cannot ameliorate all problems of the elderly and that home care cannot totally replace the long term care facility.[33] Neither is it rational to expect institutional long term care to meet the health care needs of the majority of elderly currently living in their own homes or with family. While there will always be highly disabled patients who require full-time institutionalization in long term care facilities, persons capable of remaining in their own homes should have the right to choose.[34] In order for a choice to be made, there must of necessity be available sufficient institutional long term care and sufficient home health care.

IMPEDIMENTS TO LONG TERM HOME HEALTH CARE

While there are a number of factors which influence the appropriate utilization of home health care in meeting the long term care needs of the elderly, it seems appropriate for this discussion to limit the presentation to the major impediments or barriers to appropriate utilization of such services. Since for all practical purposes, long term home health care remains in the developmental process, it is

first logical to look at those factors which have slowed the development of home health care as a part of the health care delivery system.

Of primary importance is the issue of funding. Despite the high costs of in-patient care, the number of home health agencies have continued to decline because Medicare reimbursement policies inhibit the use of such services.[35] As a consequence, home health agencies are not yet available in sufficient numbers and they face financial problems. Home health services are not fully reimbursable as services in their own right.[36] Public funding policies have continued to support acute, short-term care and treatment within institutions.[37] The insufficient level of federal funding for home health services and the eligibility requirements regarding income and medical status for reimbursement (particularly for Medicare) are severe hindrances to the development of home-based health care services.[38] Reimbursement of home care services is largely limited to skilled nursing services or services that require the supervision of a physician.[39]

Looking at the limited reimbursement pattern in home health care leads to yet another obstacle in utilization of home care services: What are home health care services? A pamphlet published by the American Hospital Association--The Hospital and the Home Care Program--lists the following items as being basic to any home health care program:

1. Medical care and supervision
2. Nursing care and supervision
3. Social work services
4. Physical therapy
5. Occupational therapy
6. Speech therapy
7. Inhalation therapy
8. Medical technician services
9. Appliance, equipment and sterile supply services
10. Availability of hospital in-patient services
11. Nutritional guidance
12. Laboratory and radiology services
13. Pharmaceutical services
14. Transportation for patient and equipment
15. Homemaker-home health aide services

Home health care programs sponsored by the Veterans Administration hospitals have followed the American Hospital Association model.[40] However, the typical Visiting Nurse Association sponsored program and Public Health Department program tend to place emphasis on nursing care and retain consultants to offer more comprehensive services.[41] The typical proprietary home health care program usually offers only nursing and home health aide services. In short, there is no clear definition of home health care, frequently leaving the elderly and their families unaware of what services can or could be provided. Whether funding shapes program or program shapes funding may be a cyclical question.

However, the V.A., in the absence of the funding dilemma experienced by the remainder of the public, voluntary, and private sector, has tended to define home health care in its most comprehensive fashion. The separation frequently found in the literature between home health (usually referring to skilled care) services and home social services seems an arbitrary separation and by no means accepted throughout the literature.

A third problem interfering with the development and utilization of home health care is that of fragmentation. Nowhere is fragmentation more evident than in the delivery of home health services. Programs which provide medical or supportive services for the elderly in their homes include Medicare (Title XVIII of the Social Security Act), Medicaid (Title XIX), the new Social Services Program (Title XX), the Public Health Service Act Amendments (home health grants), State and community grant program for the elderly (Title III of the Older American Act), nutrition programs for the elderly (Title VII), the Senior Companion Program and Retired Senior Volunteer Program both under Title II of the Domestic Volunteer Service Act, and various programs under the Community Services Act.[42] As a result, programs are administered by a variety of different agencies leaving the elderly in need of a range of home health services traveling from agency to agency.

IMPEDIMENTS TO LONG TERM INSTITUTIONAL CARE

The combination of cost of long term institutional care and the current funding pattern for institutional care erect a barrier to appropriate utilization of long term care facilities. Although funding is a problem in home health care, the problems in funding of long term care facilities are of a different order. In 1974, the average nursing home cost was in excess of $600 per month, while the average income for a retired person was under $200 per month.[43] Medicare is of little help, paying only for short-term skilled care (referred to as extended care) following acute care hospitalization. It is Medicaid, requiring a means test, which is extensively used. Many are too proud to seek "welfare", while others refuse to participate because of their reluctance to virtually deplete their assets in order to become eligible for Medicaid.[44] On the other side, since there is at least payment available for institutional care, elderly who might otherwise be maintained at home utilize institutional long term care.

A second barrier to the appropriate utilization of long term care facilities is their public image. Abuses of patients have been well publicized and evidence of substandard care has been repeatedly documented.[45] Elderly who might benefit from institutional long term care refuse, out of fear of poor care and abuse, loss of liberty and human dignity. To many Americans, nursing homes or long term care facilities have become synonymous with death and protracted suffering before death.[46]

Tied to the problem of substandard care is the difficulty in regulating long term care facilities. Regulation has been a continuing problem, and inspection sanctions have rarely been pursued vigorously. Substandard facilities have been allowed to remain open on the theory that patients in them would have no place to go if they were closed.[47] Historically, proprietary institutions have presented the greatest challenge to regulation,[48] and 90% of the nation's long term care facilities are proprietary.[49]

DECISION MAKING IN UTILIZATION OF LONG TERM CARE

In addition to the previously discussed impediments and barriers, the decision-making process involved in the selection of services presents a series of obstacles to appropriate utilization of long term health care services. Elderly persons are often faced with making decisions, or having decisions made for them, regarding long term health care needs under conditions of stress. The need for long term health care services frequently arises during times of diminished capacities and limited time frames, leaving the elderly person with a sense of little or no choice. Frequently, long term care, whether institutional or home-based, is presented by medical professionals and/or families as a mandate, rather than a choice in which the elderly recipient participates. Not only do others decide that elderly individuals are in need of long term health care, but the decisions of what services are to be utilized, in what setting and provided by whom may be made with little or no participation by the aged client.

When an individual perceives that outcomes are outside his/her control, a phenomenon called "learned helplessness" occurs. It is characterized by (1) depression, (2) discontinuation of efforts to control outcomes, and (3) inability to differentiate when one's action has influenced an outcome.[50] In 1962, Ferrari documented that mortality was significantly greater among those elderly who perceived that they had no choice in the plan to enter a nursing home in contrast to those who perceived that seeking admission to a nursing home was their personal choice.[51] In addition, Janis and Mann state that a decision making process in which there is a thorough search and exploration of options by the individual, leads to greater satisfaction with a decision independently of whether its implementation leads to satisfactory or unsatisfactory consequences.[52]

In planning services for the elderly, there is a tendency to rely upon professionals' perception of service need.[53] It may then be feasible to assume that attitudes of health care professionals impact on the decision making process in utilization of long term health care services. References to medical neglect and disinterest in the aged by physicians and other professional groups are sprinkled throughout the professional literature. In 1968, Spence, et al, found that medical students perceived old people as more emotionally ill, disagreeable, inactive, economically burdensome, dependent, dull, socially undesirable, dissatisfied, socially withdrawn, and disruptive of family harmony

than youths or other adults.[54] If one generalizes the findings of the Spence study to practicing physicians or to a percentage of practicing physicians, it is rational to conclude that physicians would not generally want to spend the time necessary in involving the aged in decision making around long term health care needs, nor would physicians be inclined to view that process as a priority for other health care professionals such as social workers. Since the health care system in the United States tends to be physician dominated, the attitudes and actions of physicians are particularly significant to clients and other health care professionals alike.

Nowhere are the problems within decision making around long term health care for the elderly more evident or traumatic than with the hospitalized elderly patient. Many older people have adverse reactions to hospitalization. Separated from familiar surroundings and in heightened states of anxiety around physical well-being, the elderly may become more easily confused and disoriented, or even delusional.[55] If the decisions about long term health care occur during hospitalization when the elderly may be at their most disoriented, the risk of inappropriate planning, such as premature or unnecessary nursing home placement is heightened.

Hospitalization is by definition a time of stress; mental, emotional, and physical capabilities are diminished by acute illnesses or exacerbation of chronic illness, or a combination of the two. With the increased emphasis on

shortening acute care hospital stays, there is little time for exploration of options or a thorough assessment of personal, family and community resources available to meet the long term care needs. The actual discharge of a hospitalized individual usually occurs within 24 to 48 hours after the physician's decision to discharge.[56] It is not atypical for the decision to discharge and the physician's decision to recommend or order post discharge long term health care to come concommitantly, giving the elderly person, their family, and the hospital social worker (if there is a social worker involved) from 4 to 48 hours to make appropriate arrangements. Still another frequent and observable phenomenon is the physician writes an order for nursing home placement or specific home health services, taking the decision completely out of the hands of the elderly person. Given the previously discussed increased disorientation that accompanies hospitalization, coupled with the physician's decision being based on assessment of the individual during hospitalization, there is accelerated need for careful assessment and planning with little time to accomplish the task. Unfortunately, many patients, families, and social workers simply follow the doctor's order.

More than any other adult group in society, the elderly find themselves dependent on professionals and family in making decisions which have dramatic impact on their life. Given the circumstances under which the elderly must make consequential life decisions, or find decisions being made

for them, one can conclude that the decision making process itself is frequently a barrier to appropriate utilization of long term health care services.

TRENDS AND INDICATIONS FOR FUTURE STUDY

The review of the literature revealed that practice focused literature and descriptive studies far outweighed the number of evaluative studies. Evaluative studies are difficult to implement in service to the aged, a field in which data are so soft and criteria for evaluation so amorphous. The impact of research on policy remains limited. Most decisions about expanded programs continue to be made on the basis of societal preference and influence expressed in a political arena, not on the basis of conclusions from rational analysis.[57] While there is substantial literature in the area of long term care in meeting the needs of the elderly, estimates and projections appear throughout. Increasingly, issues related to long term health care and the aged, and recommended programs to meet those needs, appear in testimony before both House and Senate Committees and Sub-committees. However, even in testimony before legislative committees, there are contradictory statements and opinions, and frequently there is little explication as to how and by whom facts and figures were gathered.

There has been a marked growth in the professional literature about home health care in the past decade. In addition, home health care is commanding increasing attention in legislative committee hearings. Both would tend to

indicate a trend toward the development and expansion of home health care in meeting the long term care needs of the elderly. There has also been an increase in the number of home health care programs sponsored by government over the past decade. There is a trend in most recent national policy toward the position that the health care needs of the elderly should be met first in the home with institutionalization offered when care in the home is not feasible.[58]

Studies which have tended to argue from either side, home health care versus institutional care, especially in reference to the current institutional population, have come up with widely divergent findings. Since criteria for findings remains largely unstated, it would seem that there is need for development of uniform criteria, including medical and social factors, to assess the ability of current nursing home residents and hospitalized aged to be maintained in the home. Statements regarding postponement of institutionalization are even less well documented. However, it would seem possible to arrive at an assessment in that arena by utilizing the same uniform criteria and applying it to the medical and social records of residents at the time of admission to a long term care facility or prior to discharge from a hospital. Only then can the extent of the need for long term home health care be determined in preventing or postponing institutionalization.

It is a more difficult task for researchers to determine the extent of the need for home health care for the

elderly living in the community. However, tracking of geriatric patients as done in the Plass study following discharge from the acute care hospital would appear to be feasible to begin to identify the unserved and underserved population returning to their homes with health care needs.

There appear to be adequate descriptive studies of the institutionalized population, no doubt, related to the captive nature of residents in long term care facilities and the relative ease with which data is retrievable. Descriptive studies of the institutionalized population will need to be continued by researchers, especially with the emergence of home health care as an alternative, to determine the nature of the institutionalized population as trends shift. One might hypothesize that as home health care expands, allowing the less severely impaired elderly to be maintained at home, the institutionalized population will be more severely impaired than is currently the case requiring more skilled care within the nation's institutions. There is evidence that home health care is more readily available in New York State than is currently true nationwide. (70% of the nation's Medicaid expenditures for home health care were in New York State, according to the 1978 U. S. Congressional budget office.) Therefore, it might be possible to begin to get a picture of the impact of home health care on the nature of the institutionalized population by doing a comparative descriptive study between the institutionalized population of New York State with a state in which home health care is less available.

While some authors have stated the issue as home health care versus institutional care, there appears to be an increasing awareness in light of demographic projections that institutionalization will continue to be a necessity for many elderly and that both home health care and long term institutional care are necessary components of the health care system. More recently, and more appropriately, the trend is to focus on how to utilize and develop home health care and institutional care in meeting the needs of the aged.

Although public policy and newly emerging programs reflect an awareness for the need of home health care, major funding sources, specifically Medicare and Medicaid, continue to support institutional care to a much greater degree than home health care. That fact is consistently stated in both professional literature and Congressional reports. A case can be made for the utilization of research findings in influencing public policy makers, either directly or by using findings as a basis for mobilizing public pressure within the political arena.

Certainly there remains a need for definition of home health care services; however, the reality may be that the differences in definition are largely reflective of the differences in care needs experienced by the elderly living in the community. Some clients may, in fact, need comprehensive home health services (including social services) while others can be maintained with limited services, either skilled or unskilled. It may be that, as is the case for

other areas of health care, levels of home health care may well emerge as desirable. Once again, needs assessments are critical in determining both the range, comprehensive to limited, and level, skilled to unskilled, of home health care needed by the elderly.

Fragmentation is a continuing and recurrent problem in the delivery of home health care. While, as with funding inequities, fragmentation is consistently referred to throughout the literature, there is little statistical documentation of the impact of fragmentation on either duplication of home health care services, or underutilization of those services. Research designed to statistically demonstrate duplication of services with the inherent cost of such service duplication demonstrated could be an effective tool toward pressing for changes in public policy. Another, but perhaps more difficult area to research, would be identifying those elderly in need of home health care that is available but so fragmented as to be inaccessible.

On the whole, institutional long term care has been a much more fully researched area than home health care. Again, this is probably reflective of the relative ease of gathering data and doing research with an institutionalized population, as opposed to a difficult to identify population within communities. Still, there remains a need for on-going research in long term care facilities particularly around quality of care issues.

While the Shanas and Maddox study found a 90 percent preference for home health care over institutional care, the degree to which preference is found may, in part, be reflective of the public perception of substandard care in long term care institutions. Long waiting lists do exist for long term care facilities perceived as offering high quality care.[59] It might, therefore, be informative to replicate in part the Shanas and Maddox study stipulating quality institutional care. There is also a need for additional comparative research around quality of care in public, voluntary, and proprietary institutions. Depending on individual research findings in the area of quality of care in long term care institutions, research could serve as public protection or to dispel the myths around long term care institutions, or both.

Studies concerning the decision making process in utilization of long term health care highlight a multiplicity of difficulties for the nation's elderly. Once again, the need for established criteria emerges to assist families, the elderly, and health care professionals in selecting appropriate services. There is clear evidence to support involvement of the aged client in the decision to enter a long term care facility. However, relocation of the physically ill from hospital to their own homes has not been studied from the perspective of personal choice.[60] While it is generally assumed that the hospitalized elderly are more likely to be referred to and consequently receive

appropriate long term health care services, current studies tend to suggest that hospitalized elderly may be at greater risk than the general elderly population.

FOOTNOTES

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[27]Frederick Seidl, et al, p. 11.

[28]Nursing Home Care in the United States: Failure in Public Policy, p. 15.

[29]Ibid, p. 14.

[30]Long Term Care: Background and Future Directions, p. 6.

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[60]Rosalie Kane, p. 10.

CHAPTER 2

CHANNELING: A PROGRAM DESIGNED TO FACILITATE THE APPROPRIATE UTILIZATION OF LONG TERM HEALTH CARE BY THE HOSPITALIZED ELDERLY

DESIGN

CHANNELING: A PROGRAM DESIGNED TO FACILITATE THE APPROPRIATE UTILIZATION OF LONG TERM HEALTH CARE BY THE HOSPITALIZED ELDERLY

DESIGN

As the number of people needing long term health care expands and the programs to meet those needs diversify, perhaps the most critical questions will concern the appropriate utilization of the services available. Although barriers to the utilization of long term care services do exist, there remains a need for both institutional long term care and home-based long term care. With the recognized importance of appropriate utilization of long term health care services, channeling has surfaced as an important consideration, if not the focus, in a multiplicity of government pilot programs and projects. At the same time, guidelines for eligibility for long term services are in a constant state of flux; and programs, particularly in the area of home health care, are increasing in both number and range of services.

The National Channeling Demonstration Program was created to develop and test methods to maximize the efficient use of existing long term care resources. In an effort separate from the national project, the Arkansas Office on Aging began a pilot channeling project in January, 1982. The Arkansas channeling project began from a federal systems development grant, a forerunner of the National Channeling Demonstration Project, which resulted in the passage of Act 380 by the

Arkansas Legislature mandating the development and implementation of a comprehensive long term care assessment system. (See Appendix I.)

ARKANSAS CHANNELING PROJECT: BACKGROUND

The Arkansas project began in selected counties in northern and southern sections of the State of Arkansas. The pilot project focused on individuals applying for state assistance (Medicaid) in financing long term health care. The goals of the State project were as follows:

1. To present an alternative model for long-term care services,
   a. To develop a coordinated system of community-based services to assist Medicaid recipients in maintaining independent living,
   b. To improve or maintain clients' functional abilities,
   c. To encourage and support family care giving and informal support networks,
2. To encourage the use of home or community care whenever it is appropriate and less expensive than institutional care,
3. To target services to Medicaid eligibles who are at risk of being institutionalized,
4. To contain or reduce total per capita public expenditures,
5. To promote analysis of system-wide implications,

6. And to develop a coordinated policy direction between various state and local service providers.[1]

The primary motivation for the passage of Act 380 and the subsequent development and implementation of a public channeling project was to contain and, preferably, to reduce state public expenditures for long term care.

In Arkansas in 1981, the State legislature made three separate appropriations of Medicaid funds totaling $302.3 million for the fiscal year beginning July 1, 1981. The Division of Social Services found these amounts short of that required for the year at the planned program level. The projected shortage of $31 million[2] has far-reaching effects on the availability of health care services for many Arkansas residents. In Arkansas, approximately 85 percent of the nursing home residents are supported by Medicaid funds.[3] Allocations indicate that 51.7 percent of all the Medicaid budget is expended on nursing home care, leaving small sections of the budget for all other services provided by Medicaid. As a result, the State legislature called for a moratorium on nursing home construction and expansion and asked for alternative considerations in a cost-effective long-term care delivery system. In particular, home or community services were promoted as alternatives to "expensive" institutional care. The legislature directed the three major agencies in the State who deliver alternative long-term care to devise a plan for a cost-effective long-term care system.

As a result of this directive, the Arkansas Office on Aging, Arkansas Social Services-Medicaid Division, and the Arkansas Department of Health proposed a long-term care channeling demonstration project which received legislative support. The project was initiated in January, 1982, for at least one year's duration. It is essentially a State sponsored project costing over 2 million dollars. There have been no changes in the spectrum of services offered, reimbursements or eligibility in the different parts of the State.

Several hypotheses were postulated by the project planners. The hypotheses that were, no doubt, of most significance to legislators were as follows:

1. Total costs in the demonstration areas will be significantly lower than originally projected for the demonstration areas.
2. Average cost per client will be significantly lower in the demonstration areas than projected originally.
3. Average cost per client will be significantly lower in the demonstration areas than in the control areas.[4]

The projected cost reductions became particularly attractive when the Medicaid expenditures for 1980-81 in the Aid to the Aged category were reviewed. (See Table I, page 31.)

The channeling demonstration project is scheduled for legislative review in the 1983 session. There is little question that particular attention will be paid to cost

TABLE I.

State of Arkansas Medicaid Expenditures*

Aid to Aged 1980-81

Provider	Dollars Spent	No. Claims
Hospital	$ 5,757,005	16,000
Outpatient	1,357,438	25,143
Clinic	12,857	203
Physician	4,114,261	43,695
Other Practitioners	322,747	7,755
Dental	109,347	2,116
Lab and X-ray	7,379	180
Drugs	12,231,253	56,119
Home Health	154,491	448
Personal Care	3,246,311	1,033
Nursing Home	80,065,038	19,138

* A comparison between the Aid to Aged Medicaid expenditures for the budget year 1975-76 and the budget year 1980-81 found a 53.3% increase per recipient for nursing home care.[5]

factors. If the project receives legislative approval during the 1983 session, it will be implemented throughout the State of Arkansas.

CHANNELING PROGRAM: ST. VINCENT INFIRMARY

In August, 1981, by mutual agreement between the State Office on Aging, Arkansas Social Services, and the Director of the Department of Social Service at St. Vincent Infirmary, a multi-service acute care general hospital in central Arkansas, the social work director at St. Vincent Infirmary designed and implemented a channeling program for the hospital utilizing the same assessment criteria as the project administered by the Office on Aging of the State of Arkansas. (See Appendix II.) Although the same assessment criteria were used, there were basic differences between the State demonstration project and the pilot channeling program at St. Vincent Infirmary:

1. St. Vincent Infirmary is not within the geographical boundaries of the State demonstration project.
2. The St. Vincent program only assessed hospitalized clients 65 years of age or older rather than all clients of a geographical area requesting or receiving Medicaid payment for long-term care services.
3. The hospital channeling program was not limited to those requesting Medicaid payment for long-term care services.

4. Professional social workers employed by the hospital administered the assessment instrument rather than non-professionals or other disciplines employed by area agencies on aging.
5. The primary objectives of the hospital channeling program were patient-centered rather than cost related.

The objectives of the hospital project were as follows:

1. To utilize uniform criteria in assessing the long term care needs of the hospitalized elderly,
2. To match services used to the identified needs of the clients,
3. To document the need for long-term care services which do not exist or are in short supply,
4. To increase client and/or family participation in the decision-making process involved in the utilization of long-term health care services, and
5. To expand the role of social work within the hospital setting in the area of post-discharge utilization of long-term health care services by strengthening the discharge planning process.

FINANCING

St. Vincent Infirmary Department of Social Service, with administrative approval, absorbed costs incurred by the development and implementation of the channeling program for the hospitalized elderly at St. Vincent. Primary costs were in the areas of additional time spent by the hospital social work staff, printing and duplication of materials such as the assessment tool, and, originally a possibility of discharge delays was projected. However, in the initial planning, it was pointed out to Administration that there were factors which offset and/or limited the actual cost of such a program to the hospital:

1. Although the utilization of a uniform assessment tool initially resulted in an increase in the amount of time spent by social workers with individual patients and families, it did not involve new or additional caseloads.
2. The program was designed and implemented within existing staffing patterns within the Department of Social Services.
3. The Joint Commission on Accreditation of Hospitals requires that the Department of Social Service perform two audits per annum and states that "particular attention shall be given to the appropriateness and effectiveness of the transfer of patients to long term care facilities and to home placement with supportive

services."[6] Documentation of outcome results of the channeling program satisfied one audit requirement under Joint Commission guidelines and completion of the follow-up patient/family questionnaire satisfied the second audit requirement. (Results, findings, and questionnaire tabulations appear in a later section of this paper.)

4. The channeling program targeted hospitalized patients 65 years of age and over, the majority of whom were Medicare recipients. Medicare guidelines stress the importance of appropriate discharge planning and allow up to 72 hours reimbursable delay of discharge for appropriate discharge plans to be implemented. A small percentage of discharge delays (less than 1%) were already occurring due to delays in the discharge planning process. It was not felt that the assessment process would impact significantly in the area of discharge delays. In the event of some delay, it was highly unlikely that a delay in excess of 72 hours would occur as the result of implementing a channeling program.
5. Since the same assessment tool was used by both the St. Vincent program and the Office on Aging administered State program and prior agreements were made for sharing of data between

> the two programs, if the State program were implemented throughout the State, St. Vincent would be prepared in advance for the program. Comparative results might also justify assessments being done by the hospital Department of Social Service rather than by an employee of the Office on Aging. An increase in hospital back-up days when the outside agency was assessing post hospital care needs was documented by the Monroe County Long-Term Care Program in Silver Spring, Maryland.[7]

ASSESSMENT INSTRUMENT

The original State channeling demonstration program had planned to use the Placement Information Base as the assessment instrument. The P.I.B. had been extensively tested for reliability, validity, and inter-rater reliability over a five year period by the State of Oregon. That instrument was in place and to be used at the time of the St. Vincent project proposal. However, as frequently occurs in politically sponsored programs, changes occurred prior to the implementation date of the State program which resulted in the P.I.B. being dropped as the assessment instrument. Subsequently, the Office on Aging and Arkansas Social Services contracted with the Arkansas Gerontology Center to develop an instrument for assessment and to evaluate the entire channeling project. It then became necessary for St. Vincent Department of Social Service, considering the possibility of

Statewide implementation of the channeling program using the new instrument, to accept the new instrument as the assessment tool for the hospital project. Although testing for reliability and validity of the new instrument was not as extensive as reliability/validity testing of the P.I.B., tests were conducted on the new instrument by the Arkansas Gerontology Center.

RELIABILITY, VALIDITY, AND INTER-RATER RELIABILITY

Thirty test-retest questionnaires were collected to determine the reliability of responses by subjects in the State demonstration project. Subjects who were initially tested as having low to moderate levels of disability were chosen to be retested within two weeks of the first interview.

A total of 20 inter-rater tests were conducted in the two State pilot regions with two separate assessments completed by different individuals on the same client. Results of the separate assessments were then compared by the Arkansas Gerontology Center which arrived at an inter-rater reliability of 85.0.

Dr. Robert Baker entered into a contract with the Arkansas Gerontology Center to perform ten physical assessments on clients immediately following an assessment by the State pilot project in order to determine validity. Dr. Baker's results were sent to the Gerontology Center independently of the project results. No significant difference was found in determining functional disability.

In addition to the efforts made by the Arkansas Gerontology Center, the Department of Social Service at St. Vincent Infirmary presented three cases in staff meeting, and each worker made an independent assessment of the case using the Gerontology Center Instrument. While there were some differences in individual worker assessments on specific questions usually in "needs limited assistance" or "needs occasional assistance" (a 1 or 2 rating), assessments in the final scoring were consistent (see Table II, page 39.)

Since the Placement Information Base (see Appendix III) had been extensively field tested for reliability and validity, the Director of Social Service took the first five (5) cases assessed with the Arkansas Gerontology Center instrument and re-assessed those cases using the P.I.B. Differences in the assessment of functional disability appeared to be related to the five level scoring on the P.I.B. and the three level scoring on the Gerontology Center Instrument. However, no impairment on the Arkansas instrument would be comparable to scale 1 on the P.I.B.: "Functions about average or better." Functional assessments in the minimum range on the Arkansas instrument were rated as either 2, "beginning to have some problems with functions", or 3, "mild but continuing problems with function". Functional assessments in the moderate range on the Arkansas instrument also fell in the moderate range on the P.I.B. Functional assessments in the severe range on the Arkansas instrument were rated severe using the P.I.B. In all five cases, using both instruments, the risk of placement was comparable.

TABLE II. PILOT TEST OF INSTRUMENT BY NINE SOCIAL WORK STAFF ON THREE CASES TO DETERMINE INTER-RATER RELIABILITY

Functional Disability Categories

	LEVEL OF FUNC-TIONAL DIS-ABILITY	Mental Health Status	Bathing	Dressing	Toileting	Continence	Eating	Mobility	Telephone	Transportation	Shopping	Meal Preparation	Housework	Home Repair	Laundry	Legal Administration	Wandering	Abusive	Delusion/Hallucinations	Health	Therapy	Medication	Vision	Hearing	Speech	Caretaker Ability	Placement Risk
CASE I	None	9				9										9	9	9	9			9			9	9	
	Minimum		1		9		8		9												8		9	9			9
	Moderate		8	9			1	9		9	9	9	9							9	1						
	Severe													9	9												
CASE II	None																9	9	9								
	Minimum																				1		9	8			
	Moderate	9																			8			1		1	
	Severe		9	9	9	9	9	9	9	9	9	9	9	9	9	9				9		9			9	8	9
CASE III	None			8	8	9	9																9	9	9		
	Minimum		9	1	1				9									8		1	9						
	Moderate							8										1	9	8							
	Severe	9						1		9	9	9	9	9	9	9	9					9				9	9

	ARKANSAS INSTRUMENT	P.I.B.
Case 1	Minimal	Not likely
Case 2	Severe	High probability
Case 3	Severe	Very high probability
Case 4	Moderate	Moderate
Case 5	Minimal	Low probability

STAFFING

The channeling program for St. Vincent Infirmary was designed and implemented within existing staffing patterns for the Department of Social Service. The Director of the Department was administratively responsible for the program. The Director, having received technical assistance from the State Office on Aging in the use of the assessment instrument, provided assistance to the staff of the Department of Social Service in administering the assessment instrument. Existing departmental supervisory channels remained intact for the hospital channeling program. One hundred percent of the St. Vincent Infirmary Social Work staff participated in the channeling program. The staff consisted of six (6) Masters of Social Work (M.S.W.), three (3) of whom were members of the Academy of Certified Social Workers (A.C.S.W.), one (1) Bachelor Social Worker (B.S.W.) and two (2) Bachelors of Art (B.A.) workers. Both B.A. workers had over five years experience in hospital social work each. All Social Work staff were licensed to practice social work in the State of Arkansas.

St. Vincent Infirmary social workers have historically been involved in the assessment of patients in need of post hospital long term health care and referral of those patients to both institutional and home care programs. However, prior to the implementation of the channeling program, no uniform assessment tool was used by social workers in the discharge planning process. The program, therefore, required procedural changes within the department which impacted on social work staff.

Hospital social workers administered the Arkansas Gerontology Center standardized assessment instrument to all patients 65 years of age or over in need of post hospital long term health care referred for social work services in selected pilot areas of the hospital. Since it was primarily the social work staff who were asked to make changes, they were involved in the planning and decision making activities preliminary to the implementation of the channeling program. Giving more time to one task necessitated giving less time to another. Social workers were allowed to set priorities and make recommendations regarding their own time management. Secretarial assistance for some routine tasks previously performed by social workers was utilized by social work staff and secretarial agreement. The Director collated the individual assessments with secretarial assistance.

Along with initial resistance to change, it was possible to predict resistance, initially, to the utilization of an instrument for assessment. Staff in-service was used to focus

on the rationale for uniform assessment and its potential positive outcomes for both client and worker. An overview of the channeling project being administered by the State of Arkansas along with the rationale of both State and Federal government was presented to social work staff in regular staff meetings.

LEGITIMATION

Although the scientific basis of a profession is partly measured by the level of technology available to assess client's problems, helping professionals frequently make judgments about the client's needs without sufficient guidance from validated measurement.[8] Utilization of a standardized, tested tool for assessment seemed a legitimate method in facilitating appropriate utilization of post discharge long term health care services. Although there is little doubt that there were instances in which professional judgment remained a key factor in service utilization, information and documentation previously omitted was available as a basis for referral to appropriate services.

It was also felt that it was a legitimate function of social work to be the key profession in a channeling program. In 1980, a study conducted by the Arkansas Office on Aging, using the OARS as a basis for assessment, found that of the elderly in Arkansas participating in long term health care, the institutionalized elderly were more impaired than the non-institutionalized elderly in mental health, social resources, activities of daily living, and economic resources.

However, as a total group, the institutionalized elderly were no more physically impaired than elderly receiving home health care, and, in fact, the percentage of institutionalized elderly in the severely impaired category was less than the percentage of homebound elderly found to be severely physically impaired.[9] It, therefore, seemed more appropriate to delegate the core responsibility for a channeling program to social work rather than to other professionals within the hospital setting whose primary focus is in the area of physical functioning. Such a program did not represent a new role for social work but rather an expansion and refinement of that traditional role of discharge planner.

INTER-ORGANIZATIONAL RELATIONSHIPS AND COMMUNICATION PATTERNS

While workload management and delegation of duties within a department was viewed by the hospital administration as the responsibility of the director of that department, it would have been strategically unwise to embark on a new program or project without obtaining administrative sanction through appropriate channels. The channeling program was presented to the Assistant Administrator for Patient Care who maintained administrative responsibility for the Department of Social Service. The Assistant Administrator for Patient Care subsequently discussed the program with the hospital administrator.

There were over three hundred physicians with staff privileges at St. Vincent Infirmary. While there are sectional physician meetings, it is frequently the case that

only a small percentage of physicians attend those meetings regularly. Since the channeling program did not focus on one designated area of the hospital but on selected pilot areas throughout the hospital, utilization of physician sectional meetings as a means of communication to physicians would necessitate attendance of a multiplicity of meetings representing a small percentage of physicians who practice at the hospital. It is also the case that the relationship between social work and medicine is frequently maintained within the relationships between line social workers and staff physicians. It was, therefore, felt that physician cooperation could best be facilitated by line workers discussing the program with their area physicians. While the dual approach of utilizing formal meetings and line social worker to staff nurse was used with nursing, communication to staff physicians primarily centered around line social workers to individual staff physicians. It is important to note that physician resistance has, at times, been increased rather than decreased through presentation at sectional meetings, a forum the physicians tend to view as their own.

The utilization of multiple avenues of communication opened both lateral and hierarchical communication channels and recognized both the formal and informal organizational structure. The hospital itself is structured in a hierarchical manner from administrator, to assistant administrators, to department managers, to supervisors, and to line workers. Side by side with the formal structure exists an informal,

though well recognized, authority system composed of staff physicians. The hospital is a matrix organization having a dual authority system, even though the formal organizational chart fails to recognize the matrix. Utilizing the most productive avenues in communicating to staff physicians, whose veto power is well established, was crucial since failure on the part of any of the subparts of the organization to recognize the matrix would be disastrous.

DECISION-MAKING PROCESS

As discussed earlier, although the decisions about implementation and management of a program within a department are viewed as the responsibility of that department manager, the decision-making process is more complex than what appears in the hospital policy and procedure manual. Middle management decisions are influenced from above and below and by the formal and informal organization. While the department managers may be the primary decision makers regarding what programs to implement and how to implement within their respective departments, unless the department managers are careful to involve others in the decision-making process, new programs and methods for implementing new programs could be undermined in a variety of ways. Lack of administrative sanction, physician resistance, lack of cooperation from nursing or interdepartmental resistance all have the potential to render decisions impotent. It was insufficient to simply inform others. Allowances were made for alteration in both design and implementation strategies through input and suggestions from within

the organization. For example, the Director of Social Service had originally planned to utilize physician sectional meetings to present the channeling program. However, a rationale against such an approach and an alternate plan for approaching staff physicians was presented by another department manager that was subsequently adopted by the Director of Social Service. The decision-making process then involved collecting information and suggestions from those in a position to assess the possible consequences of the decisions being made as well as the collection of information and suggestions from those who were affected.

Initial decision making involved decisions about obtaining administrative approval for the new program and administrative support. While fundamentally approval and financing were necessary first steps in program design, the decision-making process was, in reality, cyclic. Evaluation of current staffing patterns and demands on social workers had to be made prior to seeking administrative approval. If it had been decided that the program would necessitate the hiring of additional social work staff, the strategy for obtaining administrative approval and support would have been more formalized and included meetings with the budget director, wage and salary committee, and the director of the personnel department. Although one may contend that core decisions such as organizational approval, funding and staffing are initial stages of decision making, once again, knowledge of avenues of communication, decisions around how to publicize

the program, and other decisions which are traditionally presented as following core decisions do, in fact, influence core decisions. It may then be that in program design and implementation beyond the decision of what one wants to accomplish, the decision-making process becomes an intermingling of primary and secondary influences rather than a clearly staged process.

ASSUMPTIONS

There were a number of assumptions made in the design and implementation of the hospital-based channeling program:

1. Use of a standardized tested instrument will result in increased accuracy and consistency of assessment,
2. Thorough assessment of client functioning increases the appropriate utilization of long term health care services,
3. The process of an in-depth interview between social worker and patient and/or family will increase patient/family involvement in the decision-making process,
4. Comprehensive assessments by social workers will, over time, decrease the number of premature nursing home placements initiated by physicians,
5. Use of a standardized instrument with uniform criteria decreases the frequency and degree of subjective judgment,

6. Subjective judgment negatively impacts on the appropriate utilization of long term care services,
7. Implementation of a comprehensive and consistent assessment program conducted by social workers will increase the impact of social work in discharge planning decisions, and
8. Assessment of mental functioning, social resources, economic status, activities of daily living, as well as physical functioning is necessary for appropriate utilization of long term health care services.

Less clearly defined considerations, but nonetheless, factors which would be categorized as assumptions, were as follows:

1. St. Vincent Infirmary patients are sometimes prematurely placed in nursing homes,
2. Needs for long term health care services are not being appropriately assessed or identified currently, and
3. Given the considerations of cost containment, state and federal cutbacks in hospital reimbursement, and the across-the-board denial of programs within the hospital which involve increased staffing in any department without producing significant revenue for the hospital,

any program proposal which necessitated the hiring of additional staff would not receive administrative sanction.

The latter may be considered as a fact since department managers had been informed by administration that programs would not be approved with additional staff unless critical need could be demonstrated.

IMPLEMENTATION

Since implementation of a new program was expected to produce resistance, the channeling program was implemented in stages:

1. Explanation and overview of the channeling program with the staff of the hospital social service department.
2. Assessment of current workloads and decisions related to workload management by staff social workers.
3. Social work staff training in use and administration of the client assessment tool.
4. Selection of specific areas within the hospital for pilot implementation of the channeling program.
5. Hospital wide communication regarding the channeling program.
6. Implementation of the program on pilot areas.
7. Three month assessment and evaluation of the pilot programs.

Areas within the hospital selected for the pilot program were representative of the hospital at large; for example: one general surgical unit, one general medical unit, one intensive care unit, one oncology unit, one orthopedic unit, and one diagnostic unit. Only by selecting representative areas for the pilot could results of the assessment and evaluation be generalized to the hospital at large and appropriate adjustments in design be made for hospital wide implementation.

SELECTION OF PILOT AREAS

Procedures for selection of pilot areas were as follows:

1. Elimination of areas of the hospital based on the number of patients meeting the criteria of over 65 and in need of home health care or institutional care. Areas eliminated and the rationale for elminiation were as follows:
   a. Pediatrics: age
   b. All nurseries: age
   c. Intensive Care Areas: patients are generally transferred to another area prior to discharge. A twelve-month retrospective examination of social work intervention in those areas revealed only a small number (less than 1 per month) of patients over 65 were discharged directly from Intensive Care Areas to long term care institutions or to home with in-home

health care. Generally patients were transferred to a medical or surgical area prior to discharge. Social work discharge plans tended to be made on the general medical/surgical areas. Intensive care areas include Coronary Intensive Care, Respiratory Intensive Care and Intensive Care.

d. Out-patient Dialysis: this unit consisted largely of home care patients whose initial assessment and planning had been completed previously.

e. Self-care Unit: this is primarily a diagnostic self-care area. Again, a 12-month retrospective study revealed a very rare direct transfer to home health care or institutional long-term care, the exception being newly-diagnosed cancer patients referred for temporary institutional placement in an Extended Care Facility, or out of town cancer patients needing a course of radiation therapy. If a diagnosis was confirmed on the self-care unit which necessitated prolonged hospitalization for medical treatment and/or surgery, the patient was transferred to another floor.

f. Emergency Room: utilization of social work in the Emergency Room tended to be predominantly with drug overdoses, alcoholism, suicide attempts

and other psychiatric emergencies. Less than 1 patient per month receiving only Emergency Room treatment met the criteria of over 65 with social work intervention for home health care or institutional long-term care. Patients seen in the Emergency Room meeting the above criteria tended to be admitted to the hospital for in-patient treatment with discharge planning being done while the patient was hospitalized.

2. Analysis of the computer print out from data processing showing admission patterns of patients over age 65.
3. Staff discussion of areas for pilot.
4. The areas remaining for consideration for the pilot were as follows:

    2E - gynecology
    2NW - general medical
    2W - coronary step-down
    3E - short-term surgery
    3W - short-term surgery
    3N - urology
    3NW - psychiatry
    4E - orthopedic surgery
    4W - orthopedic surgery
    4N - orthopedic surgery
    4NW - general surgery
    5E - oncology

5W - general medical

6E - oncology

6W - general medical

7E - neurosurgery

8W - short-term medical

Areas were then broken down into three categories:

Specialty

2E - gynecology

2W - coronary step down

3N - urology

3NW - psychiatry

5E - oncology

6E - oncology

Surgical

3E - short-term general

3W - short-term general

4E - orthopedic

4W - orthopedic

4N - orthopedic

4NW - general

7E - neuro

Medical

5W - general

6W - general

8W - short-term general

2NW - general

5. Factors used for selection of the pilot areas were as follows:
   a. which areas are representative of other similar areas?
   b. to which areas is the target population admitted in greater number?
   c. which areas utilize social work services?

Areas which could be compared based on comparable nature were orthopedics (4E, 4W, 4N), oncology (6E, 5E), general surgical (3E, 3W, 4NW), and general medical (5W, 6W, 8W, and 2 NW). There was no significant difference in target population admissions to the three orthopedic units or to the two oncology units. While there was not a significant difference in social work time utilization in the orthopedic areas or oncology areas, it was decided that the orthopedic unit and the oncology unit having a slightly higher social work utilization would be selected for the pilot, 4N and 6E.

Of the general surgical areas, 4NW, an area of all private and/or isolation rooms, had a lower admission rate of the target population than did 3E or 3W. While social work time utilization was higher on 4NW, that was reflective of the complexity of the cases on the area rather than numbers of cases. 3W had a slightly higher percentage of target admissions and social work utilization than did 3E and was selected for the pilot.

Of the General Medical areas, 5W had both higher admission rates for the target population and higher utilization of social work time and was, therefore, selected for the pilot.

Of the remaining specialty areas, none of the units could be considered representative of the others; 3NW, an acute care psychiatric unit, showed high social work utilization but a low percentage of the target population; 2E, gynecology, showed low target population and low social work utilization; 3N, urology, showed adequate target population and low social work utilization; 2W, coronary step-down, showed adequate social work utilization and adequate target population and was chosen for the pilot.

Final pilot areas were 6E, oncology, 5W, general medical, 4N, orthopedic surgery, 3W, general surgery, and 2W, coronary step-down.

LIMITATIONS

Although an instrument with uniform criteria was used in the assessment process, no instrument guarantees one hundred percent accuracy. Even with the instrument being administered by a trained social work staff, there was the possibility of individual differences in interpretation and individual interviewing techniques resulting in some differences in responses by clients. Given the inter-rater reliability findings, individual worker differences impacting on assessment was felt to be minimal. If there were errors in the assessment process which was designed to assess and

identify needs of clients, there would still be a possibility of some over or under utilization of long term health care services. Despite individual variations within the administration and interpretation of the instrument, it was believed that the formalized process would reduce subjective judgment in the assessment process and increase the appropriateness of long term care service utilization.

Regardless of the accuracy of the assessment, limitations to matching services to the identified needs of clients remained. Needs were identified for which no services existed or were inaccessible to the client due to geography, cost, criteria for eligibility, short supply, or a combination of factors. Regardless of needs identified, some clients and/or families elected to utilize services less than those indicated by identified needs, to utilize services not equipped to meet the needs as identified, to ignore certain identified needs, or refused to use services altogether.

Increasing client and/or family participation in the decision-making process about utilization of long term health care services was, in some instances, limited by the presenting problem itself. For example, when the patient was mentally or physically impaired to such a degree that inclusion in the decision-making process was not feasible, the objective of increased involvement of the patient was not met. In situations where there was no family or the family was estranged and unwilling to participate, the objective of increased participation by family in the decision-making process was not met.

The project was limited in the generality of its findings. The two groups selected for comparison were 65 years of age or older and hospitalized at St. Vincent Infirmary, Little Rock, Arkansas between May 15, 1982 and August 15, 1982. The findings cannot be extended to a non-hospitalized aged population. Findings cannot necessarily be generalized to other hospitalized populations unless said groups are similar in composition to the groups compared in this program.

Because of hospital policy which requires a physician order for social work intervention, both groups were limited to those aged patients hospital staff physicians either identified as in need of social work services or agreed with the social worker or nurse who presented a patient as having need of social work services. The groups compared, therefore, did not represent a 100 percent sample of the patients meeting the criteria for comparison and hospitalized at St. Vincent Infirmary.

Since hospital staff physicians were more likely to refer multi-problem patients and families for social work services, the groups were comprised of a greater number of multi-problem cases with either a higher number of needs or a greater degree of needs than was necessarily true for all aged individuals hospitalized at St. Vincent Infirmary within the same time frame.

The above sampling limitations were also applicable to the retrospective population of May 15, 1981 to August 15, 1981.

EVALUATION OF PILOT CHANNELING PROGRAM

Evaluation should be an on-going part of any program with some formal or informal process of evaluation occurring at each stage of program implementation. Following the explanation and overview of the channeling program, social work staff were given the opportunity to discuss the program and offer suggestions in design and implementation. In a sense, the discussion with staff social workers was an opportunity for staff evaluation of the program. It also gave the opportunity to alter areas where feasible and identify sources of staff resistance. Assessment of work loads involved statistical gathering of number and services being provided by each worker in the department. Evaluation of the training in the use and administration of the assessment tool was accomplished by the director of the department reviewing the three initial assessments completed by each worker. The selection of areas for pilot involved a computerized check of admissions, diagnostic categories and other relevant patient information on all areas of the hospital to insure units selected were typical of the areas they represented.

The formal evaluation of the pilot channeling program was based on a comparative analysis of pilot and non-pilot groups of patients hospitalized at St. Vincent Infirmary between May 15, 1982 and August 15, 1982. All participants in the project on both pilot and non-pilot areas were 65 years of age or older and in need of post hospital long term care in an institution (nursing home or extended care facility),

or in need of home health care services. In addition to a concurrent comparative analysis, a retrospective review of patients meeting the same criteria as the pilot program participants was conducted using the same time frame (May 15 through August 15) of the preceding year.

Fifty-one (51) patients and their families (when families were available) participated in the channeling pilot program. The pilot group was compared to sixty-two (62) patients and their families (when families were available) in non-pilot areas of St. Vincent Infirmary during the time frame of the pilot program. Retrospectively, one hundred and fifteen (115) patients were reviewed. The initial evaluation of both concurrent groups and retrospective groups focused on outcomes, i.e., numbers and percentages of patients actually going from the hospital into nursing homes, extended care facilities, or home health care. Channeling program participants on the pilot areas were compared for number and degree of functional ability impairments assessed and the formal assessment's relationship to outcomes.

Characteristics of the different groups were compared as were process considerations, such as social work contacts with patients and families, total social work time spent, and discharge delays related to social work intervention.

Decision making participation and satisfaction were evaluated by a follow-up phone call to twenty (20) patients (or families, if the patient was unable to respond) from the pilot program and twenty (20) patients or families from the

non-pilot areas. Patients were selected for follow-up contacts by stratified random sampling. Stratification was done to insure that persons using home health care services and persons using institutional long-term care were equally represented. The telephone survey was conducted using the following instrument:

Name:

Age:

Pilot/Non-Pilot:

Current Living Status:

Home? If so, home health care?

Nursing Home?

Responder:

Where did you (your family member) prefer to go for your health care upon discharge from St. Vincent Infirmary?

Did anything hinder or prevent you (your family member) from going to your place of preference? _____Yes _____No. If so, explain.

Are you satisfied with your (your family member's) post discharge health care? _____Yes _____No. If no, explain.

SD=Strongly Disagree; D=Disagree;
A=Agree; SA=Strongly Agree

1.	My hospital social worker discussed different ways in which to meet my (my family member's) health needs after discharge from St. Vincent Infirmary.	1. SD 2. D 3. A 4. SA
2.	I took part in my plans for my (my family member's) care after discharge from St. Vincent Infirmary.	1. SD 2. D 3. A 4. SA

3.	My hospital social worker included me (my family members) in making a decision regarding my health care after discharge from St. Vincent Infirmary.	1. SD 2. D 3. A 4. SA
4.	My hospital social worker took into consideration my (my family member's) needs and requests regarding my care upon discharge.	1. SD 2. D 3. A 4. SA
5.	My hospital social worker clearly outlined and explained my choices regarding care options following discharge.	1. SD 2. D 3. A 4. SA
6.	Prior to making a decision, I (my family member) carefully considered and evaluated all of my care options upon discharge from St. Vincent Infirmary.	1. SD 2. D 3. A 4. SA
7.	Considering my needs, I felt I had enough choice and freedom in making a decision regarding my (my family member's) care upon discharge.	1. SD 2. D 3. A 4. SA
8.	I was satisfied with the ways in which my (my family member's) hospital social worker assisted me in making a decision regarding my care upon discharge.	1. SD 2. D 3. A 4. SA

Do you have any suggestions for hospital social workers helping people plan for after-hospital care?

_____

_____

_____

FOOTNOTES

[1]Terry, Richard, "The Long Term Care Assessment and Referral Project", Arkansas Gerontology Center, unpublished, 1981, p. 1.

[2]Office on Long Term Care, Arkansas Social Services, unpublished reports, 1981.

[3]Ibid.

[4]Terry Richard, p. 5.

[5]Medicaid Expenditure Report, Arkansas Social Services, July, 1981.

[6]Accreditation Manual for Hospitals, 1981, (Washington: JCAH, 1981), p. 180.

[7]Lewis C. Price, et al, Second and Third Year Evaluation of the Monroe County Long Term Care Program, (Silver Spring, Maryland: Micro Systems, Inc., December, 1979).

[8]Carol Austin and Frederick Seidl, "Validating Professional Judgment in a Home Care Agency", Health and Social Work, (New York: N.A.S.W., 1981), Vol. 6, No. 1, p. 30.

[9]The Arkansas Office on Aging and Adult Services 1980 Report, (Little Rock: Arkansas Office on Aging, 1980), p. 11.

CHAPTER 3

ST. VINCENT INFIRMARY

PILOT CHANNELING PROGRAM: FINDINGS

ST. VINCENT INFIRMARY

PILOT CHANNELING PROGRAM: FINDINGS

This chapter presents an analysis and discussion of the program findings. The first section provides an examination of designated demographic variables and characteristics of the pilot and non-pilot groups. The second section presents a comparative analysis of outcomes between the pilot and non-pilot groups and designated demographic data comparisons between pilot and non-pilot groups by outcomes. The third section presents a retrospective (T_1 - T_2) study comparing outcomes and age of groups sampled by outcomes. In addition, section three presents a comparison of outcomes related to recent hospital admissions. Section four presents a comparison of outcomes between the pilot group, the non-pilot group and the retrospective group. Section five presents comparative data regarding the number of social work interviews per patient on pilot and non-pilot areas, the amount of social work time spent per patient, a comparison of the average length of hospital stay, and a brief analysis of discharge delays occurring during the three month pilot program on both pilot and non-pilot areas. Section six presents data related to physician orders for nursing home placement and the impact of those orders on outcomes. The seventh section presents information regarding patients participating in the pilot channeling program obtained from the assessment

instrument. In section seven, data is presented analyzing mental status, problem behavior, activities of daily living, diagnoses and health status, medication maintenance needs, communication impairments, and care taker perceptions of care needs. The eighth and final section of this chapter presents the findings of the follow-up survey regarding the responders' perceptions of information having been given by the social workers, the responders' perceptions of having been included in the decision-making process, and the responders' satisfaction with social work assistance during the discharge planning process. Survey results are compared between pilot and non-pilot groups by outcomes. No conclusions from findings are presented in this chapter. Conclusions from findings are presented in Chapter 4.

DEMOGRAPHIC CHARACTERISTICS OF THE PILOT AND NON-PILOT GROUPS

Designated demographic variables are presented to address group comparability since the pilot and non-pilot groups were in different areas of the hospital. Although pilot areas had been selected to minimize differences, it was conceivable that the groups differed on variables which might influence results.

Age:

Table III (page 69) displays the age distribution of the Pilot and Non-pilot groups. Within the pilot group, the actual age range was from 65 to 94 years. Within the non-pilot group, the actual age range was from 65 to 97 years. The mean age

in the pilot group was 76.5 years, and the mean age in the non-pilot group was 77.1 years. There was no statistically significant difference in the age distribution of the pilot and non-pilot groups.

TABLE III

Age Distribution of the Pilot and Non-pilot Groups

Age in Years	Pilot Group		Non-pilot Group	
	Number	Percent	Number	Percent
65-74	16	31%	21	34%
75-84	25	49%	31	50%
85 and over	10	20%	10	16%
Total	51	100%	62	100%

Sex:

A comparison of the pilot and non-pilot groups by sex distribution is presented in Table IV (page 70.) As indicated, there was a slight (9%) imbalance between the pilot and non-pilot groups which was unavoidable since a one-hundred percent sample of patients meeting the designated criteria was used in both the pilot and non-pilot groups during a specified three month time frame. However, the majority of both groups was female which is consistent with national and local statistics indicating that females outnumber males in the 65 and over age range.

TABLE IV

Comparison of Pilot and Non-pilot Groups by Sex

Sex	Pilot Group		Non-pilot Group	
	Number	Percent	Number	Percent
Female	29	57%	41	66%
Male	22	43%	21	34%
Total	51	100%	62	100%

Race:

Table V presents a comparison of the pilot and non-pilot groups by race. Only Black and White are presented in the table since no other racial group was represented in this study. A slight imbalance (7%) is shown. The majority of both groups was White which is. again, consistent with national and local statistics.

TABLE V

Comparison of Pilot and Non-pilot Groups by Race

Race	Pilot Group		Non-pilot Group	
	Number	Percent	Number	Percent
Black	17	33%	16	26%
White	34	67%	46	74%
Total	51	100%	62	100%

Marital Status:

Table VI indicates that the majority of both groups were widowed. Both groups followed the same pattern of marital status. In descending order, the marital status pattern was as follows: widowed, married, single, separated/divorced. While there were minor imbalances, the largest difference between the two groups being five percent, the groups were comparable.

TABLE VI

Marital Status of the Pilot and Non-pilot Patient Groups

Marital Status	Pilot Group		Non-pilot Group	
	Number	Percent	Number	Percent
Married	15	29%	16	26%
Single	5	10%	5	8%
Widowed	28	55%	37	60%
Separated/Divorced	3	6%	4	6%
Total	51	100%	62	100%

A COMPARISON OF OUTCOMES AND THE RELATIONSHIPS OF DEMOGRAPHIC DATA TO OUTCOMES

The disposition outcomes tracked in the channeling program at St. Vincent Infirmary were discharge to home health care, discharge to an extended care facility, and discharge to a nursing home. While the study did not originally intend to include the utilization of extended care facility beds, it became apparent as data was being collected that people in both pilot and non-pilot groups meeting the established criteria for participation in the channeling program were being discharged to extended care facilities. The extended care facility (ECF) is Medicare reimbursed and is intended as a short-term, usually no more than twenty-one days, recuperation period after hospitalization prior to returning to the community. In Arkansas, ECF beds are located in nursing homes. However, the majority of ECF patients would be expected to return to their own home, a family home, or back to the community in an alternate living situation with home health care, if needed. While ECF placement is additional institutional care, it could not be categorized as nursing home placement in the traditional sense; neither, of course, is ECF comparable to home health care. Since patients in both groups who had been included in the assessment process were discharged to extended care beds, a decision was made to include those patients in the findings rather than to delete them from the study.

Outcomes:

Table VII presents the discharge outcomes of both the pilot and non-pilot groups. This table demonstrates no significant difference in outcomes using a formalized assessment instrument (pilot areas) versus the traditional social work assessment process (non-pilot areas).

TABLE VII

Comparison of Outcomes

between Pilot and Non-Pilot Group

	Pilot		Non-Pilot	
Outcomes	Number	Percent	Number	Percent
Home Health Care	21	41%	28	45%
Extended Care Facility	10	20%	10	16%
Nursing Home	20	39%	24	39%
Total	51	100%	62	100%

Age relationships to outcomes:

Tables VIII and IX (page 75) present the relationships of age groups to outcomes in percentages. While there are differences between the pilot and non-pilot groups in actual numbers and percentages, the age distribution patterns by outcomes are consistent in the first two age groups. In the 65 to 74 years of age group, in both the pilot and non-pilot groups, the majority of patients were discharged to home health care followed by nursing home care and then extended

care. In the 75 to 84 years of age group, a larger percentage of patients were discharged to nursing home care (but not a majority) followed by home health care and then extended care. In the over 85 years of age category in the pilot group, the majority of patients discharged from the hospital went to nursing home care followed by home health care and then extended care. In the non-pilot group, the same age cohort of over 85 years of age demonstrated a different pattern of post-hospital health care utilization with the largest number going into extended care (but not a majority) followed by home health care and then nursing home care.

Interpretation of Tables VIII and IX vertically rather than horizontally demonstrates differences between pilot and non-pilot groups. For example, of the patients receiving home health care post discharge in the pilot group, the largest consumer of home health care was the 65 to 74 years of age cohort followed by the 75 to 84 years of age cohort and finally those over 85 years of age. In the non-pilot group, the largest consumer of home health care services was the 75 to 84 years of age group, followed by those 65 to 74 years of age and then the 85 years and over age cohort. However, in both the pilot and non-pilot groups, the number and percentage of people receiving post hospital nursing home care was greatest among the 75 to 84 years of age cohort. In interpreting data vertically, one must also consider that the 75 to 84 years of age group also represents the greatest

percentage of participants in the study. While the 75 to 84 years of age group represents a majority of patients receiving nursing home care in both the pilot and non-pilot groups, a majority of that age cohort did not go into nursing homes.

TABLE VIII

Age Distribution of the Pilot Group

by Outcomes in Percentages

Age in Years	Home Health Care	Extended Care Facility	Nursing Home	Total
65-74	20%	5%	6%	31%
75-84	15%	12%	22%	49%
85 and over	6%	3%	11%	20%
Total	41%	20%	39%	100%

N = 51

TABLE IX

Age Distribution of the Non-pilot Group

by Outcomes in Percentages

Age in Years	Home Health Care	Extended Care Facility	Nursing Home	Total
65-74	18%	3%	13%	34%
75-84	21%	6%	23%	50%
85 and over	6%	7%	3%	16%
Total	45%	16%	39%	100%

N = 62

Relationships of Sex Distribution to Outcomes:

Tables X and XI (page 77) present the relationships of sex to outcomes in percentages. In the pilot group of the females participating in the study, a majority received home health care following hospital discharge with an equal percentage receiving extended care and nursing home care post discharge. In the non-pilot group, the largest number of females (but not a majority) received nursing home care, followed by home health care, and then extended care. In the pilot group of the males participating in the program, a majority received nursing home care, followed by home health care, and extended care in descending order. Of the males in the non-pilot areas, a majority received home health care, followed by nursing home care, and then extended care. Interpreting the tables vertically rather than horizontally, females were the larger utilizer of both home health care and extended care in the pilot group, with males being the larger utilizer of nursing home care. In the non-pilot group, females were the larger utilizer of post hospital care in all three outcome categories. However, in both groups, females also represented the larger percentage of participants. Males were disproportionately over-represented in the nursing home category in the pilot group.

TABLE X

Sex Distribution of the Pilot Group

by Outcomes in Percentages

Sex	Home Health Care	Extended Care Facility	Nursing Home	Total
Female	29%	14%	14%	57%
Male	12%	6%	25%	43%
Total	41%	20%	39%	100%

N = 51

TABLE XI

Sex Distribution of the Non-pilot Group

by Outcomes in Percentages

Sex	Home Health Care	Extended Care Facility	Nursing Home	Total
Female	27%	10%	29%	66%
Male	18%	6%	10%	34%
Total	45%	16%	39%	100%

N = 62

Relationships of Race Distribution to Outcomes:

Tables XII and XIII (page 79) demonstrate racial distribution by outcomes in percentages. In both the pilot and non-pilot groups, blacks received post hospital care in the following descending order: home health care, nursing home care, and extended care. There was a difference in post-hospital care utilization among whites between the pilot and non-pilot areas. On the pilot areas, whites equally utilized home health care and nursing home care for their post-hospital health care needs followed by extended care. On the non-pilot areas, whites utilized post-hospital health care services in the following descending order: home health care, nursing home care, and extended care. Whites were the majority users of all three care options in both the pilot and non-pilot groups. However, whites also represented the majority of subjects in both groups. In both pilot and non-pilot groups, whites were disproportionately more likely to utilize extended care than were blacks.

TABLE XII

Race Distribution of the Pilot Group

by Outcomes in Percentages

Race	Home Health Care	Extended Care Facility	Nursing Home	Total
Black	16%	4%	14%	34%
White	25%	16%	25%	66%
Total	41%	20%	39%	100%

N = 51

TABLE XIII

Race Distribution of the Non-pilot Group

by Outcomes in Percentages

Race	Home Health Care	Extended Care Facility	Nursing Home	Total
Black	13%	2%	11%	26%
White	32%	15%	27%	74%
Total	45%	17%	38%	100%

N = 62

Relationships of Marital Status to Outcomes:

Tables XIV and XV (page 81) present the relationships of marital status to outcomes. On both the pilot and non-pilot areas, married individuals were slightly more likely to receive home health care post hospital discharge than nursing home care, and least likely to enter an extended care facility. On both the pilot and non-pilot areas, the majority of single individuals went to home health care post discharge followed on the pilot areas equally by extended care and nursing home care, and on the non-pilot areas followed by nursing home care with no single individuals receiving extended care. On both the pilot and non-pilot areas, widowed individuals were most likely to receive nursing home care post discharge, followed by home health care, and then extended care. Separated and divorced patients in both pilot and non-pilot groups were most likely to go to home health care, followed on the pilot areas by extended care with no one going to nursing home care, and on the non-pilot areas followed equally by nursing home care and extended care. On both pilot and non-pilot areas, widowed individuals were slightly disproportionately over-represented in the nursing home population. The majority of those individuals receiving post-hospital nursing home care were widowed. However, the majority of those widowed did not go to nursing home care even though those widowed were more likely to receive nursing home care than either of the other two options studied.

TABLE XIV

Marital Status of Pilot Group

by Outcomes in Percentages

Marital Status	Home Health Care	Extended Care Facility	Nursing Home	Total
Married	13%	4%	12%	29%
Single	6%	2%	2%	10%
Widowed	18%	12%	25%	55%
Separated/ Divorced	4%	2%	0	6%
Total	41%	20%	39%	100%

N = 51

TABLE XV

Marital Status of Non-pilot Group

by Outcomes in Percentages

Marital Status	Home Health Care	Extended Care Facility	Nursing Home	Total
Married	15%	3%	8%	26%
Single	5%	0	3%	8%
Widowed	23%	11%	26%	60%
Separated/ Divorced	3%	2%	2%	7%
Total	46%	16%	39%	101%

N = 62

RETROSPECTIVE STUDY:

COMPARISON OF OUTCOMES AND AGE BY OUTCOMES

In order to determine the impact of the channeling program over time, a decision was made to compare a one-hundred percent sample of patients meeting the same criteria for the channeling program over the same time period, May 15 to August 15 of the preceding year, 1981. Table XVI (page 83) presents a comparison of outcomes between May 15, 1981 through August 15, 1981 (T_1) and May 15, 1982 through August 15, 1982 (T_2). T_1 and T_2 combine both pilot and non-pilot areas by outcome. During both time frames, T_1 and T_2, there was no statistically significant difference in outcomes between the pilot and non-pilot areas. The total 1981 sample consisted of 115 patients, and the total 1982 sample consisted of 113 patients, or a difference of only 2 patients. During the two time frames studied, the number of patients referred for social work services who were 65 years of age or over and in need of discharge planning for post-hospital health care remained virtually the same, even though overall referrals to the Department of Social Service had increased by more than sixty percent in the 1982 time study compared to the 1981 time study.

Comparison of Outcomes T_1 - T_2:

Table XVI demonstrates a decrease in the number and percentage of patients utilizing home health care post hospitalization from T_1 to T_2, and an increase in the number

and percentage of people being discharged from the hospital into nursing home care from T_1 to T_2. The utilization of extended care facilities post hospitalization remain constant. Findings concerning the utilization of home health care and nursing home care were opposite to those projected. Organized emphasis on assessment appeared to increase rather than decrease nursing home placements post discharge from the hospital.

TABLE XVI

Comparison of Outcomes between

May 15, 1981 through August 15, 1981 (T_1)

and May 15, 1982 through August 15, 1982 (T_2)

	T_1		T_2	
Outcomes	Number	Percent	Number	Percent
Home Health Care	61	53%	49	43%
Extended Care Facility	20	17%	20	18%
Nursing Home	34	30%	44	39%
Total	115	100%	113	100%

Recidivism:

Since the T_1 - T_2 study produced findings which were contrary to those projected, the two groups were compared on the basis of recidivism. It was found that of the 113 patients in the 1982 time study, only 2 patients, or less than 2%, were also found in the 1981 time study. Of the two patients appearing in both time frames, one went to home health care in 1981 and then to extended care in 1982, and one received home health care post discharge in both time frames. Neither patient contributed to the T_2 increase in nursing home care utilization post discharge from the hospital.

T_1 - T_2 Comparison of Age:

After ruling out recidivism as a contributing variable, a decision was made to compare T_1 and T_2 groups by age categories. It seemed conceivable that if the T_2 group was, in fact, older than the T_1 group, the age variable might contribute to the increase in post hospital nursing home placements. Table XVII (page 85) presents a comparison of the 1981 patient sample with the 1982 patient sample by age. Within the T_1 group, the actual age range was from 65 to 99 years. Within the T_2 group, the actual age range was from 65 to 97 years. The mean age in the T_1 group was 77.2 years, and the mean age in the T_2 group was 76.8 years. An examination of age categories (Table XVII) showed no statistically significant difference. The age range examination and determination of mean ages for the two groups showed the T_1 group to be slightly older than the T_2 group, but not significantly so.

TABLE XVII

Comparison of Target Groups by Age

May 15, 1981 through August 15, 1981 (T_1)

and May 15, 1982 through August 15, 1982 (T_2)

	T_1-3 months, 1981		T_2-3 months, 1982	
Age in Years	Number	Percent	Number	Percent
65-74	41	36%	37	33%
75-84	48	42%	56	50%
85 and over	26	22%	20	17%
Total	115	100%	113	100%

T_1 - T_2 Comparisons of Age by Outcomes:

In order to ascertain in which age category the increase in nursing home placements had occurred, a comparison between T_1 and T_2 was done by age categories and outcomes. Tables XVIII and XIX (page 87) present T_1 age distribution by outcomes in percentages and T_2 age distribution by outcomes in percentages respectively. It was found that the increase in nursing home placements occurred in the two under 85 years of age categories: a 2% increase in the 65-74 years of age cohort, and an 8% increase in the 75-84 years of age category. The 85 years and over cohort actually demonstrated a 1% decrease in nursing home utilization post hospitalization from T_1 to T_2. Utilization of extended care facilities remained fairly consistent during both T_1 and T_2. Of the 9% decrease in home health care utilization, 2% occurred in the 65-74 years of age category, and 7% occurred in the 85 years of age and over cohort.

TABLE XVIII

Age Distribution by Outcomes

3 Months, 1981 (T_1) in Percentages

Age in Years	Home Health Care	Extended Care Facility	Nursing Home	Total
65-74	21%	6%	8%	35%
75-84	19%	9%	14%	42%
85 and over	13%	2%	8%	23%
Total	53%	17%	30%	100%

N = 115

TABLE XIX

Age Distribution by Outcomes

3 Months, 1982, (T_2) in Percentages

Age in Years	Home Health Care	Extended Care Facility	Nursing Home	Total
65-74	19%	4%	10%	33%
75-84	19%	9%	22%	47%
85 and over	6%	4%	7%	17%
Total	44%	17%	39%	100%

N = 113

Recent Hospital Admissions:

Given the T_1, T_2 findings and having eliminated recidivism and age as contributing significantly to findings, a final variable of recent hospital admissions was considered. Records of all participants in both T_1 and T_2 were reviewed for recent hospital admissions, and a statistically significant relationship to outcomes was found for both T_1 and T_2. Table XX presents recent hospital admissions related to outcomes for all groups studied, or 228 patients in pilot, non-pilot and retrospective groups. There was no statistically significant difference between T_1 and T_2 groups related to recent hospital admissions.

TABLE XX

Total Sample

T_1 and T_2 Recent Hospital Admissions

(Within 3 Months of Reported Findings)

Related to Outcomes

	Home Health Care (N=110)		Extended Care Facility (N=40)		Nursing Home (N-78)	
	Number	Percent	Number	Percent	Number	Percent
Recent Hospital Admission	46	42%	12	30%	75	96%

Total N = 228

A COMPARISON OF OUTCOMES BETWEEN
PILOT, NON-PILOT AND RETROSPECTIVE GROUPS

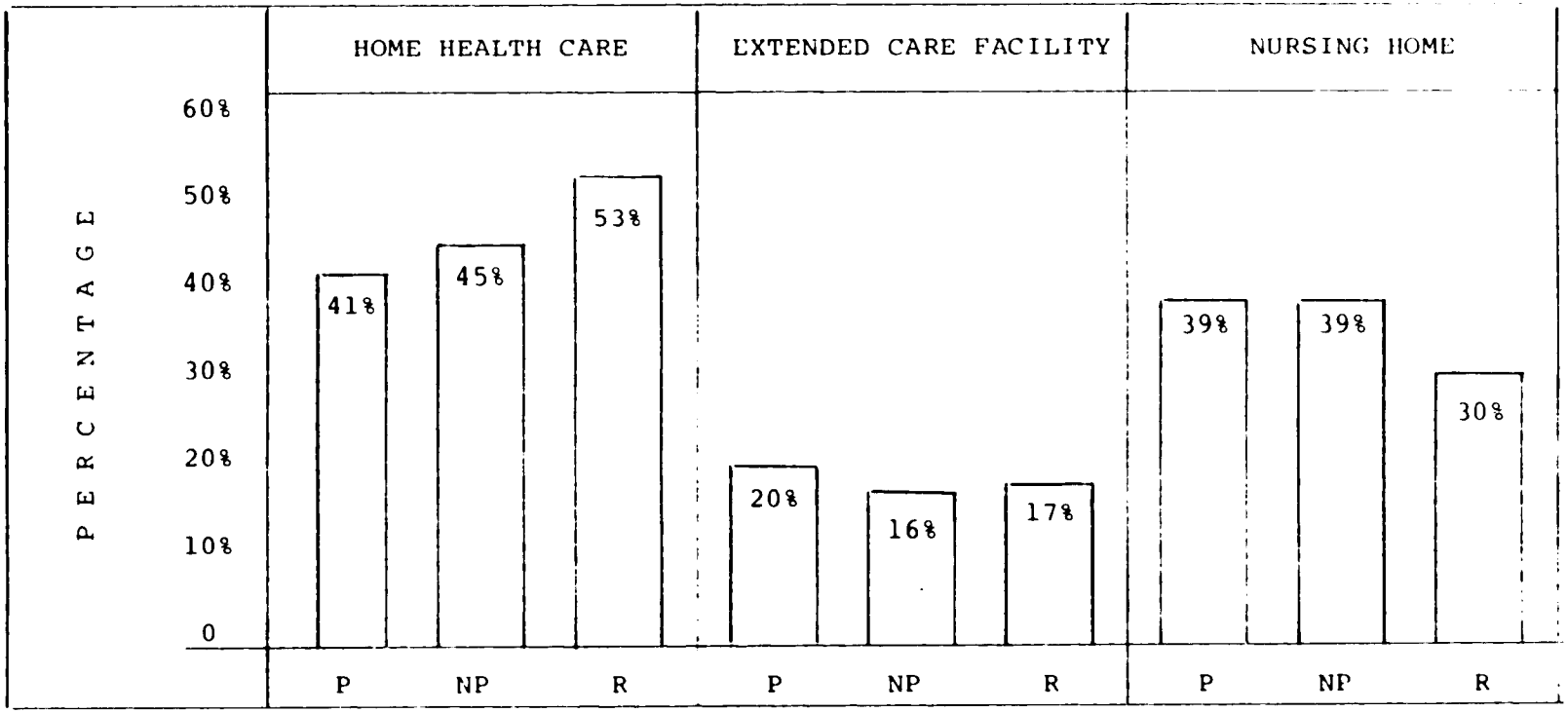
Table XXI (page 90) presents a comparison of outcomes between pilot, non-pilot and retrospective groups in percentages. Utilization of post-hospital home health care was greatest in the retrospective group (53%), followed by the non-pilot group (45%), and then the pilot group (41%).

Utilization of extended care facilities was greatest among pilot group patients (20%), followed by the retrospective group (17%), and the non-pilot group (16%). Utilization of nursing home care was equal in pilot and non-pilot groups (39%) and less in the retrospective group (30%).

TABLE XXI

Comparison of Outcomes between

Pilot, Non-Pilot and Retrospective Groups by Percentages



Key: P - Pilot
NP - Non-pilot
R - Retrospective

Number of Participants:

Pilot, N = 51
Non-pilot, N = 62
Retrospective, N = 115
Total, N = 228

PILOT, NON-PILOT COMPARISONS OF SOCIAL WORK INTERVIEWS, TIME, AND DISCHARGE DELAYS

Social Work Interviews:

Table XXII (page 92) presents the average number of social work interviews with patients and/or families during the in-patient hospital stay on the pilot and non-pilot areas. On both the pilot and non-pilot areas of the hospital, nursing home placement required the most face-to-face contacts: an average of 3.6 and 3.7 contacts respectively. In both pilot and non-pilot groups, placement in an extended care facility required the least number of face-to-face contacts, with both groups averaging 3.0. Arranging home health care on both the pilot and non-pilot areas fell between nursing home and extended care placements with an average of 3.3 and 3.5 interviews respectively. In total, there were slightly more interviews by social workers conducted on the non-pilot areas, with 3.4 interviews averaged, than the pilot areas, with 3.3 interviews averaged. The actual range of interviews on the pilot areas was from 2 to 6 interviews, and the actual range of interviews on the non-pilot areas was from 2 to 8 interviews.

TABLE XXII

Average Number of Social Work Interviews

with Patient/Family During Hospital Stay

	Average Number of Social Work Interviews		
	Pilot	Non-pilot	Average Total
Home Health Care	3.3	3.5	3.40
Extended Care Facility	3.0	3.0	3.00
Nursing Home	3.6	3.7	3.65
Total Average Number of Interviews	3.3	3.4	3.35

Social Work Time Spent:

Table XXIII presents the time spent by social workers per case on the pilot and non-pilot areas. On the pilot areas, there were 51 participants taking 229.5 hours of social work time, for an average of 4.5 hours per case. On the non-pilot areas, there were 62 participants taking 285.0 hours of social work time, for an average of 4.6 hours. The actual range of social work time spent per case on the pilot areas was from 1.5 hours to 6 hours. The actual range of social work time spent on the non-pilot areas was from 1.0 to 8.5 hours.

TABLE XXIII

Time Spent by Social Workers per Case

	Pilot	Non-Pilot
Number of Cases	51	62
Total Time in Hours	229.5	285.0
Average Time Per Case	4.5	4.6

Social Work Time Spent by Outcomes:

Table XXIV presents the average amount of social work time spent per case by outcomes. The pattern of time spent appears to correlate with the average number of social work interviews. In terms of both time spent and number of interviews, there appeared to be a greater relationship to outcomes than to the pilot and non-pilot groups themselves. For example, the findings of Tables XXII, XXIII, and XXIV tend to indicate that if the assessment resulted in planning for nursing home placement, slightly more interviews with patient/family by the social worker would occur, and slightly more social work time would be spent whether the patient was on the pilot or non-pilot areas. On both pilot and non-pilot areas, the average amount of social work time spent per case occurred in the following descending order: nursing home placement (4.7 and 4.8 hours respectively), home health care (4.5 and 4.6 hours respectively), and extended care (4.2 and 4.4 hours respectively.)

TABLE XXIV

Average Social Work Time per Case by Outcomes

Outcomes	Average Hours Pilot	Average Hours Non-Pilot	Average Total Time
Home Health Care	4.5 hrs.	4.6 hrs.	4.55 hrs.
Extended Care Facility	4.2 hrs.	4.4 hrs.	4.30 hrs.
Nursing Home	4.7 hrs.	4.8 hrs.	4.75 hrs.

Length of Stay:

Since it had been anticipated that the number of interviews and social work time spent would be greater on the pilot than the non-pilot areas, yet findings revealed time and number of interviews to be comparable with a .1 difference in both average time and average number of interviews with the non-pilot areas requiring slightly more time and interviews, a decision was made to compare pilot and non-pilot participants' average length of hospital stay. The average lengths of hospital stays were as follows:

Pilot group:	5.8 days average length of hospital stay
Non-pilot group:	6.2 days average length of hospital stay
Total hospital:	4.6 days average length of hospital stay for all patients during the same three months.

Discharge Delays:

During the 3-month pilot program, there were 11 discharge delays related to discharge planning. Six (6) of the delays occurred on the pilot areas, and five (5) occurred on the non-pilot areas. Of the total discharge delays on both pilot and non-pilot areas, six (6) resulted from a lack of bed availability in the extended care facility to which the patient was to be transferred, two (2) resulted from a patient refusing to accept nursing home placement, and three (3)

were related to the time it took families to visit nursing homes and select the facility which best met the patient/family needs. None of the discharge delays appeared to be related to the assessment and channeling process.

PHYSICIAN ORDERS FOR NURSING HOME PLACEMENTS AND THEIR IMPACT ON OUTCOMES

Physician Orders:

Physician orders for social work assistance with the pilot and non-pilot patient groups basically fell into four categories with both groups. Those categories were as follows:

1. Social worker to assist with nursing home placement.
2. Social work consult (unspecified).
3. Social worker to assist with discharge (or discharge planning).
4. Social worker to assist with home health care.

Table XXV (page 97) presents a comparison of the pattern of physician orders between the pilot and non-pilot groups. There was no statistically significant difference in the pattern of physician orders between the pilot and non-pilot groups. Findings demonstrate that the channeling program itself had no impact on the frequency with which physicians order nursing home placement.

TABLE XXV

A Comparison of Patterns of Physician Orders

on Pilot and Non-Pilot Areas

	Pilot Group		Non-Pilot Group	
Physician Orders	Number	Percent	Number	Percent
Nursing Home Placement	10	20%	12	19%
Social Work Consult	21	41%	25	40%
Assist with Discharge	16	31%	20	32%
Home Health Care	4	8%	5	8%
Total	51	100%	62	99%

Table XXV does demonstrate that physicians at St. Vincent Infirmary are more likely to write open-ended orders for social work assistance, social work consult or assist with discharge than they are to write specific orders, nursing home placement or home health care.

Impact of Orders on Outcomes:

Physician insistence on a particular form of post-hospital care, regardless of how the order was written, was found to be less common than originally believed on both pilot and non-pilot areas. In only 3 cases (2 pilot and 1 non-pilot) did the physician present nursing home as the only alternative to both patients and social workers. Two of those cases involved the same physician. Of the three cases, only one was discharged to a nursing home from the hospital; one patient went to the home of a family member with home health care provided by an outside agency; the third patient returned to her own home with home health care assistance. Of the two patients who refused nursing home care post hospitalization, one patient was later placed in a nursing home, and one patient was successfully cared for by family and the home health care agency.

In all instances (9) on both pilot and non-pilot areas, when the physician wrote an order for home health care, the patients were, in fact, discharged to home health care. The same was not true of physician-ordered nursing home placements. Of the twenty-two orders written for nursing home placements, fifteen patients (68%) were actually discharged

from the hospital into nursing home care, two patients went to an extended care facility (9%), one was transferred to another hospital (5%), and the remaining 4 patients were discharged with home health care assistance (18%). No statistically significant difference was found in final disposition on pilot and non-pilot areas.

Presentation of all alternatives for post-hospital care by social workers, and patient/family involvement in the decision-making process by social workers may have impacted on patient/family ability to pursue a plan of post-hospital care contrary to physician recommendation. Whether the social work assessment was accomplished by use of an instrument or by traditional social work interview techniques appeared to be of no consequence in enabling clients to engage in self-determination.

ASSESSMENT OF PILOT CHANNELING PROGRAM PARTICIPANTS

This section presents information gathered from the assessment instrument administered only on the pilot areas of the hospital. Data concerning the fifty-one pilot channeling program participants was compiled using the major categories of the assessment tool and organized by the final discharge disposition categories of home health care, extended care facility, and nursing home.

Mental Health Status:

Table XXVI presents a breakdown of the mental health status of the pilot program participants by outcomes. Mental health status was significantly more impaired for the nursing home group than for the other two groups. The home health care group was second to the nursing home group in mental health impairments, and the extended care facility group was the least impaired in terms of mental health status.

TABLE XXVI

Mental Health Status by Outcomes:

Pilot Channeling Participants

	Mental Health Status							
	Clear		Mild		Moderate		Severe	
Outcomes	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
Home Health Care	9	43%	5	24%	5	24%	2	9%
Extended Care Facility	6	70%	2	20%	1	10%	0	0%
Nursing Home	3	15%	3	15%	5	25%	9	45%

Table XXVII presents the average number of behavioral impairments per patient by severity and outcomes. The three categories of behavioral impairments listed by the assessment tool were as follows: 1) wandering, 2) abusive, aggressive or disruptive, and 3) delusions or hallucinations. While the home health care group was found to have a slightly higher average number of behavioral impairments than the nursing home group, the majority of behavioral impairments of the home health care group were mild. The nursing home group was slightly higher in moderate and severe behavioral impairments than the home health care group. Across the board, the extended care facility group exhibited the least number and severity of behavioral impairments.

TABLE XXVII

Average Number of Behavioral Impairments per Patient by Severity and Outcomes

	Severity of Behavioral Impairments			
Outcomes	Mild	Moderate	Severe	Total Average
Home Health Care (N=21)	1.0	0.4	0.3	0.6
Extended Care Facility (N=10)	0.4	0.2	0.0	0.2
Nursing Home (N=20)	0.6	0.5	0.4	0.5

The frequency of severe behavioral impairments in descending order by outcomes was as follows:

Patients discharged to home health care:

1. wandering
2. abusive, aggressive, or disruptive
3. delusions or hallucinations.

Patients discharged to extended care facilities demonstrated no severe behavioral impairments.

Patients discharged to nursing home care:

1. abusive, aggressive, or disruptive
2. wandering
3. delusions or hallucinations.

While all patients exhibiting problem behavior demonstrated some degree of confusion, usually moderate or severe, the reverse was not true. All confused patients, regardless of the severity of their confusion, did not demonstrate problem behavior.

Activities of Daily Living:

Table XXVIII (page 103) presents the average number of impairments in activities of daily living per patient by severity and outcomes. The activities of daily living measured by the assessment instrument were bathing, dressing, toileting, continence, eating, and mobility. All participants in the pilot channeling program exhibited some impairment in activities of daily living. The most severely impaired group in activities of daily living was the group of patients discharged to extended care facilities. However,

the majority of the extended care patients (70%) could be expected to regain adequate functioning in activities of daily living within a short period of time since extended care placement of that majority was precipitated by a hip fracture. Severity of impairments in activities of daily living was greater among patients discharged to nursing homes than those discharged to home health care, although the average number of impairments in activities of daily living was the same for the two groups (1.7).

TABLE XXVIII

Average Number of Impairments

in Activities of Daily Living

Per Patient by Severity and Outcomes

	Severity of Impairments			
Outcomes	Mild	Moderate	Severe	Total Average
Home Health Care (N=21)	2.4	1.0	1.8	1.7
Extended Care Facility (N=10)	1.4	0.4	3.0	1.6
Nursing Home (N=20)	1.3	1.1	2.8	1.7

The frequency of severe impairments in activities of daily living by outcomes and in descending order was as follows:

Home Health Care:

1. bathing
2. dressing and mobility (equal numbers)
3. toileting
4. continence
5. eating.

Extended Care Facility:

1. mobility and bathing (equal numbers)
2. dressing
3. toileting
4. eating
5. continence.

Nursing Home:

1. continence
2. toileting, mobility, and dressing (equal numbers)
3. bathing
4. eating.

Differences were found in both the type of impairments in activities of daily living and in the severity of impairments in activities of daily living among the three groups.

Health Status:

Table XXIX presents the severity of health status impairments by outcomes in percentages. All participants in the pilot channeling program, regardless of discharge outcomes, demonstrated multiple medical diagnoses. Participants discharged to home health care demonstrated an average number of diagnoses of 4.8. Participants discharged to extended care facilities demonstrated an average number of diagnoses of 4.2. Participants discharged to nursing homes demonstrated an average number of diagnoses of 4.8. Of the participants discharged to nursing homes, 70% were found to have severely impaired health status compared to 50% of the participants discharged to extended care facilities and 48% of the participants discharged to home health care.

TABLE XXIX

Severity of Health Status Impairments

by Outcomes in Percentages

	Severity of Health Status Impairments		
Outcomes	Mild	Moderate	Severe
Home Health Care (N=21)	5%	48%	48%
Extended Care Facility (N=10)	10%	40%	50%
Nursing Home (N=20)	10%	20%	70%

Medication Maintenance:

Table XXX presents the assessment of patient need for assistance with medication maintenance following discharge from the hospital. Sixty-five percent of the individuals discharged from the hospital into nursing home care demonstrated the need for regular or constant assistance with and/or monitoring of medications compared to 20% of the individuals discharged to extended care facilities and 10% of the individuals discharged to home health care.

Categories in Table XXX are as follows:

None: no medications, or self-administered with no help needed

Low: monitoring or assistance needed less than weekly by caretaker

Moderate: professional monitoring or assistance needed less than weekly

High: regular or constant professional monitoring and/or assistance needed.

TABLE XXX

Need for Assistance with Medication Maintenance

by Outcomes in Percentages

	Need for Assistance with Medication Maintenance			
Outcomes	None	Low	Moderate	High
Home Health Care (N=21)	19%	23%	48%	10%
Extended Care Facility (N=10)	20%	30%	30%	20%
Nursing Home (N=20)	0	10%	25%	65%

Individuals who were discharged to nursing home care were found to require more prescription medications (an average of 4.6 different drugs per day) compared to patients discharged to home health care requiring an average of 3.2 different prescription drugs per day and patients discharged to extended care requiring an average of 3.0 prescription drugs per day. Individuals discharged to nursing homes were four times more likely to be taking medication that required injection than either of the other two groups.

Table XXXI presents the average number of communication impairments per patient by outcome and severity. Communication impairments assessed by use of the Arkansas Office on Aging instrument were impairments to vision, hearing and speech.

TABLE XXXI

Average Number of Communication Impairments

Per Patient by Outcomes and Severity

	Average Number of Communication Impairments			
Outcomes	Mild	Moderate	Severe	Total Average
Home Health Care (N=21)	0.9	0.6	0.3	0.6
Extended Care Facility (N=10)	1.2	0.2	0.0	0.5
Nursing Home (N=20)	0.9	0.6	0.5	0.7

The frequency of severe communication impairments in descending order by outcomes was as follows:

Home Health Care:

1. vision
2. hearing
3. speech

Nursing Home:

1. vision
2. speech
3. hearing

Extended Care Facility:

No severe communication impairments.

Caretakers Perceptions of Post Hospital Care Needs:

Table XXXII (page 110) presents the caretakers' perceptions of the patient's ability to be managed in the home by outcomes in percentages. A caretaker was defined as an individual who either had been regularly assisting with patient care prior to hospitalization, was willing to assist regularly with care post hospitalization, or both. The caretaker did not necessarily live with the participant in the hospital channeling program. Most caretakers were family members (82%), and 43% of the caretakers actually lived with the program participant. A majority of caretakers (68%) had provided care prior to hospitalization.

TABLE XXXII

Ability of the Patient

to be Managed in the Home

as Reported by the Caretaker

Outcomes	Can be Managed at Home	Becoming Unmanageable	Unmanageable	No Caretaker
Home Health Care (N=21)	48%	19%	10%	24%
Extended Care Facility (N=10)	10%	40%	10%	40%
Nursing Home (N=20)	0	30%	40%	30%

Table XXXIII presents the caretakers' perceptions of care needs and the most appropriate provider of post-hospital care. These caretaker perceptions are broken down by discharge outcomes and reported in percentages. Caretakers were given information regarding care options and what could be offered prior to asking where they thought their family member or friend should receive care. Table XXXIII demonstrates that most of the time (64% - 67%), the caretaker's perception of the setting most advisable for post-hospital care of their family member or friend correlated positively with final discharge disposition.

TABLE XXXIII

Caretakers' Perceptions of Patient Care Needs

at Discharge from the Hospital

in Percentages

	Care Needs				
Outcomes	Needs No Help	In Home With Help	In Caretakers Home with Help	Extended Care Fac.	Nursing Home
Home Health Care (N=21)	0	40%	27%	0	33%
Extended Care Facility (N=10)	0	0	16%	67%	16%
Nursing Home (N=20)	7%	7%	14%	7%	64%

Although 64% of the caretakers whose family member or friend was discharged from the hospital into nursing home care had projected nursing home care as necessary, most of the caretakers were exhausted from previously caring for the patient or arrived at that conclusion reluctantly or both.

Correlation of Assessment Instrument with Outcomes:

Among the 21 pilot program participants who were discharged from the hospital to home health care, 7 (33%) were in need of nursing home placement according to the assessment instrument. Of the seven home health care recipients who scored in nursing home range, 2 demonstrated severe mental status impairments, one of whom also exhibited severe behavioral impairment, 4 were incontinent, and all seven demonstrated mobility impairments within nursing home care range according to the assessment instrument.

Of the 20 pilot program participants who were discharged from the hospital into nursing homes, all 20 (100%) were in need of nursing home placement according to the assessment instrument. Although the instrument was not designed to assess and/or predict the need for extended care facility placement, it is interesting to note that 8 of the ten pilot patients (80%) discharged to an extended care facility scored in nursing home range in the area of mobility, and two (20%) scored in nursing home range in medication maintenance. As has been previously stated, participants discharged to extended care could be expected to regain at least partial functioning, if not total functioning, over time.

FOLLOW-UP PATIENT/FAMILY SURVEY FINDINGS

Three months post discharge from the hospital, a graduate social work student in field placement at St. Vincent Infirmary conducted a follow-up telephone survey of patients (or their families, if patients were unable to respond) who had participated in both pilot and non-pilot groups (see Chapter 2, pages 63-65). The student conducting the telephone survey had not been placed at St. Vincent during the three-month pilot channeling program, and had, therefore, no previous contacts with the patients or families surveyed. The survey was conducted under the direction and supervision of the author and Dr. Giesela Spieker, Dean, University of Arkansas Graduate School of Social Work. Patients to be surveyed were selected by stratified random sampling. The sample drawn consisted of twenty participants in the pilot channeling program and twenty patients from the non-pilot group. The sample was further stratified to include equal numbers of individuals from both pilot and non-pilot groups who were discharged to either nursing home or home health care. Since placement in an extended care facility was a temporary measure and the hospital social workers did not participate in arrangements for care post extended care placement, patients who went to an extended care facility post hospitalization were omitted from the telephone survey. The survey sample then consisted of 10 pilot participants who were discharged to home health care, 10 pilot participants who were discharged to nursing home care, and 10 non-pilot

participants who were discharged to home health care along with 10 non-pilot individuals who were discharged to nursing homes. The stratified random sample included 23 females (58%) and 17 males (42%).

Living Status:

Of the twenty patients (family members) surveyed receiving home health care post discharge from the hospital, sixteen (80%) were continuing to live in their own home three months post discharge, one (5%) had been placed in a nursing home, one (5%) was living with a relative, and two (10%) were deceased. Of the twenty patients (family members) surveyed receiving nursing home care post discharge from the hospital, six (30%) were still in the nursing homes three months post discharge from the hospital, four (20%) had returned home, and ten (50%) were deceased.

Responders:

Responders to the survey in the two home health care groups were as follows: twelve (60%) patients and eight (40%) family members. When family members served as responders, patients were unable to respond due to physical and/or mental impairment or were deceased. Responders to the survey in the two nursing home groups were as follows: five (25%) patients, and fifteen (75%) family members. As with the home health care groups, when family members served as responders, patients were unable to respond due to physical and/or mental impairment or were deceased. When responders

were categorized in terms of pilot and non-pilot group responders, the results were as follows: pilot group responders consisted of twelve (60%) family members and eight (40%) patients; non-pilot group responders consisted of eleven (55%) family members and nine (45%) patients. When family members served as responders, they responded for the patient unless their patients' physical or mental impairments had prohibited participation in the discharge planning process. In the latter case, family responders responded for themselves.

Placement Preference of Responders:

In order to determine the initial placement preference of responders, responders were asked, "Where did you (your family member) prefer to go for your health care upon discharge from St. Vincent Infirmary?" Of the twenty home health care recipient responders, eighteen (90%) preferred to go home with assistance, one (5%) would have preferred to go to a rehabilitation institute, and one (5%) had no initial preference. Of the twenty nursing home care recipient responders, eleven (55%) preferred nursing home care, seven (35%) would have preferred home care, one (5%) would have preferred to remain at St. Vincent Infirmary, and one (5%) would have preferred transfer to the local Veterans Administration Hospital. Of the ten responders (25%) who would have preferred care other than that received post discharge from the hospital, nine (90%) cited health status or adequate care could not be given in their place of preference as hindering their preferred post-hospital care and one (10%)

cited hospital policy as preventing her from staying at St. Vincent Infirmary.

Satisfaction with Post-Discharge Care Received:

When responders were asked if they were satisfied with the post hospital care given, thirty-seven (93%) responded positively, and three (8%) responded negatively. Of the three negative responses, one responder cited poor care given in the nursing home as the reason for dissatisfaction and two responders stated that they felt the home health care was discontinued prematurely by the home health care agency.

Likert Scale Survey:

The remainder of the telephone survey utilized a Likert Scale format to determine responders' perceptions of having been informed of post discharge options by hospital social workers, of having been included in the post hospital care planning and decision making for post hospital care, of having their needs and requests considered by hospital social workers, of having carefully considered all care options, of having freedom of choice in decision making for post hospital care, and of satisfaction with social work assistance in the discharge planning process.

If, during the discharge planning process, the patient was unable to participate due to severe physical or mental impairment, responders were asked to respond for themselves. Otherwise, responses were from patients themselves or family members responding for patients.

Knowledge of Post-Hospital Health Care Options:

Table XXXIV (page 118) presents the responders' perceptions of having been informed by hospital social workers of options for health care following discharge from the hospital. This table compares pilot group and non-pilot group responses by outcomes in percentages. Table XXXIV also compiles responses to survey statements one (1) and five (5). Responses to statements one and five in the telephone interviews were consistent. A statistically significant difference between pilot and non-pilot groups in explanation of care options by social workers is demonstrated with no disagreement among non-pilot responders that social workers clearly outlined care options and 40% disagreement among pilot responders that social workers discussed care options for post hospital health care. Among the pilot group responders, a significant difference between recipients of home health care and nursing home care was demonstrated with only 20% of the nursing home group disagreeing that options were given by social workers compared to 60% of the home health care group.

TABLE XXXIV

Responders' Perceptions of Having Been Informed

of Post Discharge Health Care Options

by Hospital Social Workers

Pilot and Non-Pilot Group Responses

by Outcomes in Percentages

	Pilot Responses		Non-Pilot Responses	
Care Options Were Given	Home Health Care (N=20)	Nursing Home Care (N=20)	Home Health Care (N=20)	Nursing Home Care (N=20)
Strongly Disagree	0	0	0	0
Disagree	60%	20%	0	0
Agree	35%	80%	70%	80%
Strongly Agree	5%	0	30%	20%

Inclusion in Planning and Decision Making:

Table XXXV (page 120) presents the responders' perceptions of having been included in the planning and decision-making processes regarding post hospital health care. This table presents a statistically significant difference between pilot and non-pilot groups in responders' perceptions of having been included. In both the pilot and non-pilot groups, the nursing home care recipient responders felt slightly more included in the planning and decision making processes than did the home health care recipient responders. Table XXXV represents responses to statements two (2) and three (3) of the survey questionnaire. Responses to statements 2 and 3 of the survey were consistent.

TABLE XXXV

Responders' Perceptions of Having Been Included in the Planning and Decision Making Regarding Post Hospital Care: Pilot and Non-Pilot Group Responses by Outcomes in Percentages

	Pilot Responses		Non-Pilot Responses	
I was Included	Home Health Care (N=20)	Nursing Home Care (N=20)	Home Health Care (N=20)	Nursing Home Care (N=20)
Strongly Disagree	0	0	0	0
Disagree	50%	40%	0	0
Agree	50%	55%	75%	85%
Strongly Agree	0	5%	25%	15%

Consideration of Needs and Requests
by Hospital Social Workers:

Table XXXVI (page 122) presents responders' perceptions of their needs and requests for post hospital care having been taken into consideration by their hospital social worker. (Survey statement 4). There was a notable difference between pilot and non-pilot group responses, with disagreement concerning hospital social workers having taken needs and requests into consideration greater among pilot group responders than non-pilot group responders. Within the pilot group, the majority (80%) of the nursing home care recipient responders felt the hospital social workers took patient needs and requests into consideration compared to only 40% of the home health care recipient responders.

TABLE XXXVI

Responders' Perceptions of their Needs and Requests for Post Hospital Care Having Been Taken into Consideration by their Hospital Social Worker: Pilot and Non-pilot Group Responses by Outcomes in Percentages

My Needs and Requests were Considered	Pilot Responses		Non-Pilot Responses	
	Home Health Care (N=10)	Nursing Home Care (N=10)	Home Health Care (N=10)	Nursing Home Care (N=10)
Strongly Disagree	0	0	10%	0
Disagree	60%	20%	0	0
Agree	40%	70%	60%	80%
Strongly Agree	0	10%	30%	20%

Consideration of Care Options by Responders:

Table XXXVII presents the responders' perceptions of having carefully considered and evaluated all care options. This table presents a breakdown of pilot and non-pilot group responses by outcomes. Significant differences are demonstrated between pilot and non-pilot group responses, and between nursing home and home health care recipient responses within the pilot group. Table XXXVII represents compiled responses from survey statement 6. If social workers do not give options, it appears that family members and/or patients do not explore options on their own.

TABLE XXXVII

Responders' Perceptions of Having Carefully Considered and Evaluated all Care Options: Pilot and Non-Pilot Group Responses by Outcomes in Percentages

I Evaluated Options	Pilot Responses		Non-Pilot Responses	
	Home Health Care (N=10)	Nursing Home Care (N=10)	Home Health Care (N=10)	Nursing Home Care (N=10)
Strongly Disagree	0	0	0	0
Disagree	60%	20%	0	0
Agree	40%	80%	90%	90%
Strongly Agree	0	0	10%	10%

Choice and Freedom in Decision Making:

Table XXXVIII presents the responders' perceptions of choice and freedom in making decisions regarding post hospital health care. This table presents compiled responses from survey statement 7. Significant differences are demonstrated between pilot and non-pilot group responses and between nursing home and home health care recipient responses within the pilot group.

TABLE XXXVIII

Responders' Perceptions of Choice and Freedom in Making Decisions Regarding Health Care Upon Discharge from the Hospital: Pilot and Non-Pilot Group Responses by Outcomes in Percentages

	Pilot Responses		Non-Pilot Responses	
I had Choice and Freedom	Home Health Care (N=10)	Nursing Home Care (N=10)	Home Health Care (N=10)	Nursing Home Care (N=10)
Strongly Disagree	0	0	0	0
Disagree	40%	10%	0	0
Agree	60%	90%	80%	90%
Strongly Agree	0	0	20%	10%

Satisfaction with Social Work Assistance in Decision Making During Discharge Planning:

Table XXXIX (page 126) presents the responders' satisfaction with the ways in which hospital social workers assisted them in making decisions regarding care upon discharge from the hospital. This table presents compiled results from survey statement 8. One hundred percent of both pilot and non-pilot nursing home recipient responders either agreed or strongly agreed that they were satisfied with social work assistance. A significant difference between the pilot and non-pilot home health care recipient responders was found with only 40% of the pilot home health care responders agreeing that they were satisfied with social work assistance compared with 90% of the non-pilot home health care recipient responders.

TABLE XXXIX

Satisfaction with Social Work

Assistance in Decision Making

During the Discharge Planning Process:

Pilot and Non-Pilot Group Responses

by Outcomes in Percentages

	Pilot Responses		Non-Pilot Responses	
I was satisfied with social work assistance.	Home Health Care (N=10)	Nursing Home Care (N=10)	Home Health Care (N=10)	Nursing Home Care (N=10)
Strongly Disagree	0	0	10%	0
Disagree	60%	0	0	0
Agree	30%	80%	40%	70%
Strongly Agree	10%	20%	50%	30%

Response Patterns to Likert Scale Survey:

Since all Likert Scale survey statements were worded positively, responses of "strongly disagree" or "disagree" are considered negative responses, and responses of "agree" or "strongly agree" are considered positive responses. Responses to all eight Likert Scale statements found the pilot home health care responders to most often respond negatively, followed by the pilot nursing home care responders. Among all groups surveyed, there were 320 total responses to the Likert Scale. Of the total number of responses, 63 (20%) were negative responses. Of the 63 negative responses, 61 (97%) occurred among pilot group participant responders. The two (3%) negative responses occurring among non-pilot responders were both from non-pilot home health care recipients. Subjects most likely to feel uninformed, left out of the decision-making process, and least satisfied with social work assistance were participants in the pilot channeling program. Participants in the pilot channeling program who received home health care assistance were more likely to respond negatively than those participants who received nursing home care post hospitalization. Outcome differences of nursing home care or home health care were not as significant in terms of negative responses as was whether the responder was a pilot or non-pilot group responder. Pilot group responders had a negative response rate of 38% compared to non-pilot group responders with a negative response rate of 1%.

Responders who felt uninformed and left out of the decision-making process were also dissatisfied with social work assistance.

Across the board, the most positive group of responders were non-pilot recipients of post hospital nursing home care, followed by non-pilot recipients of post hospital home health care. Responders least likely to respond positively were pilot recipients of post hospital home health care, followed by pilot recipients of post hospital nursing home care. Table XL (page 129) presents the positive response rate to the Likert Scale statements of the pilot and non-pilot groups by outcomes.

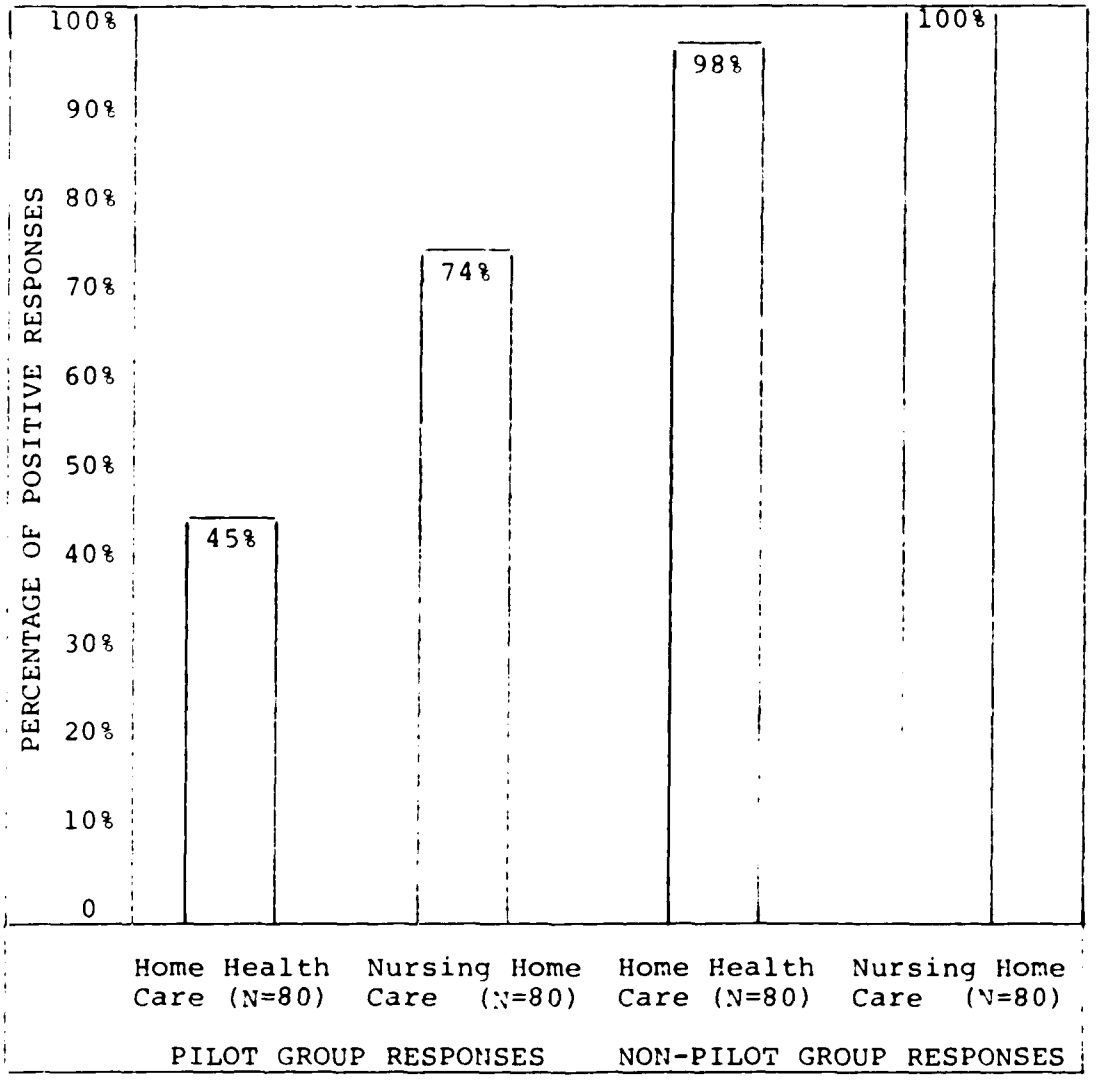
TABLE XL

Positive Response Rate

to Likert Scale Statements

of Pilot and Non-Pilot Groups

by Outcomes in Percentages



Response patterns to the telephone survey Likert Scale statements were contrary to those predicted.

Suggestions for Hospital Social Workers:

At the conclusion of the telephone survey, responders were asked if they had any suggestions for hospital social workers in helping people plan for post hospital care. Of the forty responders, only 10 (25%) offered suggestions for hospital social workers. Six of the ten suggestions were given by pilot group responders, and four suggestions were given by non-pilot group responders. Suggestions from pilot program responders were as follows:

Number of Responders	Suggestions
4	The social worker needs to spend more time with the patient and/or visit more often.
1	The social worker should consult more with the patient and listen more.
1	Discharge plans should be discussed more.

Suggestions from the non-pilot program responders were as follows:

Number of Responders	Suggestions
2	Social workers need to see the patient more often.
1	Social workers need to acquaint patients with more of their services, not just discharge planning.
1	The charge structure for social work services needs to be explained.

CHAPTER 4

THE PILOT CHANNELING PROGRAM:
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

THE PILOT CHANNELING PROGRAM:
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

THE CHANNELING PROGRAM: SUMMARY

The aged are rapidly increasing in numbers in our society. Many aged persons are healthy, alert, and basically in control of their lives. Yet, there are high risk groups within the aged population.[1] The pilot channeling program at St. Vincent Infirmary focused on one such group: the hospitalized elderly in need of long term health care after discharge from the hospital.

Assumptions made in the design and implementation of the hospital based channeling program were:

1. use of a standardized instrument would result in increased accuracy and consistancy of assessment,
2. thorough formalized assessment of client functioning would increase the appropriate utilization of long term health care services,
3. the process of an in-depth formalized assessment by social workers using an assessment instrument would increase patient/family involvement in the decision-making process,

4. comprehensive formalized assessments by social workers would decrease the number of premature nursing home placements initiated by physicians,
5. use of a standardized instrument with uniform criteria would decrease the frequency and degree of subjective judgment,
6. subjective judgment had previously impacted negatively on the appropriate utilization of long term care services,
7. implementation of a comprehensive and consistent assessment program conducted by social workers would increase the impact of social work in discharge planning decisions,
8. assessment of mental functioning, social resources, and activities of daily living, as well as physical functioning is necessary for appropriate utilization of long term health care services,
9. St. Vincent Infirmary patients were, at times, prematurely placed in nursing homes, and,
10. needs for long term health care services were not being appropriately assessed or identified prior to the implementation of the pilot channeling program.

Taking into consideration the above assumptions, the Department of Social Service at St. Vincent Infirmary implemented a pilot channeling program with the elderly hospitalized on selected units of the hospital who were in need of long term health care services. The assessment instrument adopted for use in the pilot channeling program was the instrument developed and used by the State of Arkansas pilot channeling program. In the hospital pilot channeling program, social workers utilized the uniform assessment instrument (pilot areas); in the remainder of the hospital (non-pilot areas), social workers continued to do the more traditional open-ended social work assessment interviewing. With the exception of the assessment variance, discharge planning and/or channeling was approached in the same manner on both pilot and non-pilot areas. Evaluation of the channeling program involved both process and outcome findings.

The use of the channeling assessment tool on the pilot areas of the hospital was begun by the Department of Social Service on May 15, 1982 and continued through August 15, 1982. Concurrently, social workers on non-pilot areas of the hospital continued the traditional open-ended social work assessment process that had been a part of discharge planning at St. Vincent Infirmary since the inception of the department in 1971. There was no worker within the department whose total case load fell outside of the pilot areas. Every hospital social worker engaged in both types

of assessment and channeling with the hospitalized elderly. Therefore, process and outcomes were not affected by workers' personalities or individual methods of approaching assessment and discharge planning.

Objectives of the pilot channeling program were as follows:

1. to utilize uniform criteria in assessing the long term care needs of the hospitalized elderly,
2. to match services used to the identified needs of the clients,
3. to document the need for long term care services which did not exist or were in short supply,
4. to increase client and/or family participation in the decision-making process involved in the utilization of long term health care, and
5. to expand the role of social work within the hospital setting in the area of post discharge utilization of long term health care services by strengthening the discharge planning process.

CONCLUSIONS FROM FINDINGS

Demographics:

The pilot and non-pilot patient groups were found to be demographically comparable regarding age, sex, race, and

marital status with under ten percentage points difference between pilot and non-pilot groups in any subcategory of the four demographic variables tabulated. It can, therefore, be concluded that the variables of age, sex, race and marital status did not impact significantly on process or outcome comparisons between the pilot and non-pilot groups.

Outcomes:

It was found that there was no statistically significant difference in outcomes between the pilot and non-pilot patient groups. On the pilot areas, using a standardized assessment instrument, of the fifty-one (51) participants, 21, or 41%, were discharged into home health care, 10, or 20%, were discharged to an extended care facility, and 20, or 39%, were discharged from the hospital to a nursing home. On the non-pilot areas, using traditional open-ended social work assessments, of the sixty-two (62) participants, 28, or 45%, were discharged to home health care, 10, or 16%, were discharged to extended care facilities, and 24, or 39%, were discharged from the hospital to nursing homes. It can, therefore, be concluded that the channeling program using a formalized assessment instrument had no significant impact on outcomes.

Relationships of Demographic Data to Outcomes
Combining Pilot and Non-pilot Participants:

Findings demonstrated that the majority of participants in both pilot and non-pilot groups who were from 65 to 74

years of age and in need of long term health care services were discharged from the hospital with home health care assistance. Nursing home care was the second most utilized option by this age cohort, and extended care facilities were the least utilized care option. The 75 to 84 years of age group demonstrated little difference in the utilization of home health care or nursing home care for their long term health care needs, and there was no majority care option found. The order of utilization of post hospital care options among the 75 to 84 years of age group was nursing home, followed closely by home health care, and then extended care. Participants over age 85 years also demonstrated a pattern of utilization of nursing home care, followed closely by home health care, and then extended care with no majority care option found for meeting post hospital long term health care needs. From this study of 113 hospitalized elderly, it may be concluded that the majority of hospitalized individuals in need of long term health care post hospitalization between 65 and 74 years of age will meet their care needs through utilization of home health care services. Individuals 75 years of age and older will meet their long term health care needs post hospitalization through utilization, in descending order, of nursing home care, home health care, and extended care with little difference in the percentage using nursing home care and home health care and with no majority care option.

Combining both pilot and non-pilot groups, the composition by sex was 62% female and 38% male. While no majority care option was demonstrated by males or females, a difference in the order of post hospital long term health care was found. In descending order, females were discharged from the hospital to home health care, followed by nursing home care, and then extended care. Males were discharged to nursing home care, followed by home health care, and then extended care. From this study of 113 hospitalized individuals, it can be concluded that although more females 65 and older in number utilize nursing home care, males 65 and older are slightly more likely to utilize nursing home care in proportion to their numbers than are females.

The composition of pilot and non-pilot groups combined by race was 29% black and 71% white. No majority care option was utilized for post hospital long term health care by either blacks or whites. The pattern of utilization of post hospital health care services was the same for both racial groups: home health care, followed by nursing home care, and then extended care facilities. Findings did demonstrate in proportion to their numbers that whites were two times more likely to utilize extended care facilities post discharge from the hospital than were blacks. It can be concluded from this study that post hospital utilization patterns for home health care, nursing home care, and extended care facilities are basically the same for blacks and whites 65 years of age and older. However, whites are

more likely to receive extended care facility placement post hospitalization in proportion to their numbers than are blacks.

The pattern of outcomes of the combined pilot and non-pilot groups by marital status were found to differ. The majority of unmarried individuals who were not widowed, whether single, separated, or divorced, utilized home health care to meet their long term health care needs, followed by nursing home and extended care facilities. Married individuals demonstrated the same utilization pattern as those who were single, separated, or divorced with the majority of married individuals being discharged with home health care services. Those who were widowed utilized post hospital long term care in the following order: nursing home, home health care and extended care. From this study of 113 participants, it can be concluded that widowed individuals 65 years of age and older are at greater risk of nursing home placement than are married individuals or other categories of unmarried persons.

Retrospective Study:

The T_1 - T_2 comparison of outcomes demonstrated a 9% increase in post hospital nursing home utilization rather than the projected decrease. A significant number of recidivists was not found from T_1 to T_2, and those who were recidivists did not enter nursing homes during either T_1 or T_2. No significant age difference was found between T_1 and T_2 groups. From the T_1 - T_2 study, it could be concluded

that channeling increases rather than decreases the utilization of nursing home care for those 65 years of age and older. However, such a conclusion should be approached with caution for several reasons:

1. Since the nursing home utilization increase during T_2 was demonstrated equally by pilot and non-pilot groups, unless there was a "halo effect" from pilot to non-pilot groups, the assessment process of the pilot channeling program did not necessarily contribute to the increase in post hospital utilization of nursing homes;
2. Whether a "halo effect" existed, a case can be made that discharge planning as traditionally practiced by hospital social workers is, in fact, a form of channeling. Therefore, a less formalized form of channeling was taking place at St. Vincent Infirmary during both T_1 and T_2. If a broader definition of channeling is employed, rather than the governmental approach which emphasizes the use of an assessment instrument, the increase in nursing home utilization cannot be attributed to channeling, and
3. The variable of the state of the economy during T_1 and T_2 was not considered and may be contributory.

According to the Administrator at St. Vincent Infirmary, overall utilization of hospital days was down during 1982 from 1981, elective procedures were less, people were entering the hospital with poorer health status, and patients were more likely to demonstrate multiple problems during 1982. He further stated that staff physicians report a 1982 decline in office visits. The Administrator's findings are consistent with other hospitals in the state, and there appears to be a general consensus among hospital administrators that the changing picture is related to the worsening economy. Since patients who entered the hospital during 1982 were "sicker" than those entering in 1981, the difference in health status of hospitalized individuals could well contribute to the increase in nursing home utilization demonstrated during T_2. A more valid T_1 - T_2 conclusion might then become as follows: an organized channeling program using a formalized assessment instrument does not decrease the utilization of nursing homes post hospitalization compared with traditional discharge planning for individuals 65 years of age and older in need of long term health care.

A T_1 - T_2 comparison of outcomes and recent hospital admissions demonstrated no statistically significant difference in recent hospital admissions between T_1 and T_2 patients. However, among all patients (n=228) in both T_1 and T_2 groups, a significant relationship was found between outcomes and recent hospital admissions (within 3 months prior to the admissions being studied). Of the patients discharged from

the hospital entering nursing homes, 96% demonstrated recent hospital admissions. From this study of 228 individuals, it can be concluded that individuals 65 years of age and older in need of long term health care having recent hospital admissions are at greater risk of nursing home placement than those having no recent hospitalizations.

Number of Interviews with Participants by Social Workers:

No statistically significant difference in the number of interviews conducted by social workers with patients and families was found between pilot and non-pilot areas, with findings of 3.3 and 3.4 average interviews per case respectively. However, on both pilot and non-pilot areas, findings demonstrated slightly more interviews being conducted with patients and/or families in need of nursing home placement, followed by those needing home health care assistance, and then those patients who would be going to extended care facilities. From this study of 113 individuals 65 years of age and older in need of long term health care, it can be concluded that slightly more social work interviews are conducted with individuals needing nursing home placement, followed by those needing home health care, and then those in need of extended care facility placement.

Time Spent by Social Workers:

No statistically significant difference in the time spent by social workers was demonstrated between pilot and non-pilot areas with findings of an average of 4.5 and 4.6

hours respectively. However, it was demonstrated on both pilot and non-pilot areas that nursing home placement required slightly more social work time, followed by home health care assistance, and then extended care facility placement. It may then be concluded that with hospitalized elderly in need of long term health care, slightly more social work time is spent with those needing nursing home placement, followed by those needing assistance with arranging home health care, and then those needing extended care facility placement.

It was also noted that the minimal difference in time spent between the pilot and non-pilot areas with an average difference of .1 hour more being spent with non-pilot patients appeared to correlate positively with the slightly longer (.4 days) average length of stay of the non-pilot patients. While sufficient data was not gathered to reach a definitive conclusion, it seems fair to speculate that the longer the length of stay, the more time is likely to be spent by social workers. Findings also indicate that elderly patients in need of long term health care have a longer average length of hospital stay than the average length of stay of all hospitalized patients.

Discharge Delays:

During the three month channeling program, there were eleven discharge delays. Six of the delays occurred on the pilot areas, and five of the delays occurred on the non-pilot

areas. None of the discharge delays appeared to be related to the assessment and channeling process. From this study, a conclusion may be drawn that with the hospitalized elderly in need of long term care, neither formalized channeling nor traditional social work discharge planning contribute to discharge delays.

Physician Orders:

No significant difference in physicians writing orders for nursing home placements was found on the pilot and non-pilot areas. Findings did indicate that physicians at St. Vincent Infirmary were more likely to write open-ended orders for social work (social work consult or assist with discharge) rather than orders for a specific plan to be implemented by social workers. Over 70% of the physicians wrote open-ended social work orders with "social work consult" being written more frequently than "assist with discharge." It may then be concluded from this study that most physicians at St. Vincent Infirmary write open-ended orders for social work and, therefore, do not impose a particular plan of care on elderly patients in need of long term care.

When physician orders were written specifying a plan of post hospital care, that order was 2½ times more likely to be for nursing home placement than for home health care. In all instances when doctors wrote orders for home health care, patients were discharged to home health care. In only 68% of the cases in which an order was written for nursing home placement were the patients placed in nursing homes post

hospitalization. However, a review of the pilot assessments completed on patients whose physician had written the order for nursing home placement revealed that all those pilot patients scored in either "high probability" or "very high probability" of nursing home placement. In most instances when the social worker and patient/family worked out an alternate plan of care, the physicians were agreeable to the alternate plan. Of the patients whose physician had written an order for nursing home placement who chose another option, 18% elected to return home with home health care, and 9% went to extended care facilities. It can be concluded from this study that when physicians at St. Vincent Infirmary write specific orders for post hospital health care, they are more likely to specifically request nursing home placement. When orders are written for nursing home placement, assessments performed by social workers indicate that the physician orders are appropriate to the care needs of the individuals. It can also be concluded that elderly patients and families do not uniformly follow physician orders for nursing home placement.

Assessment of Pilot Channeling Program Participants:

This section presents conclusions from information gathered from the assessment instrument administered only on the pilot areas of the hospital. Data concerning the fifty-one pilot channeling program participants was compiled using the major categories of the assessment instrument and organized by final outcomes.

Pilot program participants who entered nursing homes post hospitalization were found to be significantly more impaired in the category of mental status than were those who entered extended care facilities or received home health care post hospitalization. Behavioral impairments were found not to be significantly different between nursing home care recipients and home health care recipients; however, extended care recipients exhibited significantly fewer behavioral impairments than did the other two groups. All pilot patients exhibiting problem behavior were found to be moderately or severely confused. The reverse was not true: moderately or severely confused individuals did not necessarily exhibit problem behavior. It can then be concluded from this study that elderly who are impaired in the area of mental status are more likely to enter nursing homes than elderly whose mental status is clear. It can also be concluded that hospitalized elderly exhibiting problem behavior are, generally, moderately to severely confused, but that moderate to severe confusion does not necessarily lead to problem behavior among the hospitalized elderly in need of long term care.

The severity of impairments in activities of daily living was found to be greater among patients discharged to nursing homes than those discharged to home health care, although the average number of impairments in activities of daily living was the same for the two groups. The most severely impaired group in activities of daily living was those patients who were discharged to extended care facilities. However,

extended care recipients were usually elderly recovering from fractures who could expect at least a partial return in functioning in activities of daily living within a relatively short period of time. It can be concluded that impairments in activities of daily living are common in all three outcome groups with an average of around 5 impairments noted in all three groups; that at discharge from the hospital, elderly entering extended care facilities are the most severely impaired in ADL, but recovery potential is greater than for the other groups; and that nursing home care recipients are more severely impaired than are home health care recipients in activities of daily living. It can also be concluded from the specific impairments found among the three groups that nursing home care recipients are most likely to be incontinent, extended care recipients are most likely to exhibit impairments in mobility and bathing, and home health care recipients are most likely to require assistance in bathing.

All participants in the pilot channeling program, regardless of discharge outcomes, demonstrated multiple medical diagnoses. However, patients who were discharged from the hospital into nursing homes had diagnoses that were more debilitating than did the other two groups. It can, therefore, be concluded that multiple medical diagnoses are characteristic of hospitalized elderly in need of long term health care, but that recipients of nursing home care are more severely impaired by their health care status than are home health care or extended care recipients.

There was a statistically significant difference demonstrated by elderly who were discharged to nursing home care in the need for regular or constant professional monitoring of medication and/or assistance needed with medication maintenance. The nursing home care group was found to require more prescription medications per day than the other two groups and were four times more likely to be taking medication that required injection than either of the other two groups. It can, therefore, be concluded from this study that elderly patients discharged from the hospital into nursing homes require more assistance with medication maintenance and are more likely to require injections than are the other two groups.

Patients discharged from the hospital into nursing homes were found to have slightly more in number and more severe impairments in communication than were home health care recipients. Extended care recipients exhibited no severe communication impairments. From this study of 51 participants, it can be concluded that elderly discharged from the hospital into nursing homes tend to be slightly more impaired in vision, hearing, and speech than those discharged from the hospital into home health care.

It was found that informed caretakers perceptions of where care could best be provided following hospitalization correlated positively with final outcomes in over 60% of the cases studied. Caretakers' perceptions of the ability of the patient to be managed at home also correlated positively

with final outcomes in the majority of the cases studied. In addition, it was found that patients who were institutionalized post hospitalization, whether in nursing homes or extended care facilities, were more likely to have no caretaker available than were those patients who were discharged to home health care. Conclusions can then be reached from this study that most caretakers can and will accurately predict where post hospital care should be provided for their respective hospitalized elderly, and whether their patient can, in fact, be managed in the home. This study did not attempt to ascertain the impact of caretakers' perceptions themselves on final outcomes, but simply to establish the correlation between caretakers' perceptions and final discharge outcomes. It can also be concluded from this study that elderly individuals institutionalized post hospitalization are more likely to have no caretaker available than are those elderly discharged from the hospital into home health care.

According to the combined categorical findings of the assessment instrument, all (100%) of the patients receiving post hospital nursing home care were in need of nursing home care. It can, therefore, be concluded from this study that no pilot patients were inappropriately placed in nursing homes. One-third of the patients discharged into home health care scored in nursing home range. While it can be concluded from this study that at least two-thirds of the patients receiving home health care were appropriately placed, it cannot

necessarily be concluded that one-third of that group was inappropriately placed. Patients scoring within nursing home range and receiving home health care were generally found to have unusual personal and/or family strengths, to be adamantly opposed to nursing home placement, or both. These findings would suggest that if individuals possess unusual personal and/or family strength, are adamantly opposed to nursing home care, or both, utilization of post-hospital home health care may be appropriate. All pilot patients placed in extended care facilities scored within nursing home range. Since Medicare guidelines for admission to extended care facilities are stringent, placements were, no doubt, appropriate. From this study, it may then be concluded that users of extended care facility beds will in some categories assess as being in need of nursing home care at the time of discharge from the hospital.

The follow-up telephone survey conducted with both pilot and non-pilot groups by a graduate student in field placement at St. Vincent Infirmary found that three months post hospitalization the majority (85%) of elderly patients discharged to home health care were continuing to live in their own homes or the homes of relatives. In addition, 5% had been placed in a nursing home, and 10% were deceased. It can, therefore, be concluded that discharge to home health care was appropriate in meeting the needs of that group. Of the patients surveyed receiving post hospital nursing home care, 30% were still in nursing homes 3 months post discharge,

20% had returned home, and 50% were deceased. A conclusion cannot be reached from the telephone survey living status findings regarding the appropriateness of nursing home placement for that patient group.

The telephone survey found that 75% of the participants polled received the post hospital care option which they preferred, and that 90% of those receiving a form of post-hospital care not preferred cited their health status as requiring a different form of care. From the survey, it can be concluded that post hospital care received was care preferred by recipients, recognized as needed by recipients, or both. In addition, the survey found that 93% of those polled were satisfied with the care they received following hospitalization. It may, then, be concluded that the care received following hospitalization was satisfactory to recipients of care.

Survey findings regarding the discharge planning and channeling processes themselves were varied. Responders most likely to feel uninformed, left out of the decision-making process, and least satisfied with social work assistance were participants in the pilot channeling program. Outcome differences in nursing home care or home health care were not as significant in terms of negative process responses as was whether the responder was a pilot or non-pilot group participant. Since hospital records of all participants indicate that information was given by social workers regarding post hospital care options available to patients and families

and that traditional social work practice of consulting with patient/family was followed with both pilot and non-pilot groups, it can only be concluded that implementation of a formalized channeling program using a standardized assessment instrument impacted negatively on participants' perceptions of involvement in the process and on satisfaction with social work assistance.

CONCLUSIONS REGARDING CHANNELING PROGRAM ASSUMPTIONS AND OBJECTIVES

Conclusions relating to program assumptions can be drawn from the findings of this study.

1. Assumption: The use of a standardized instrument would result in increased accuracy and consistency of assessment.
   Finding: Accuracy and consistency of assessments were found to be comparable between pilot and non-pilot groups based on consistency of outcomes between pilot and non-pilot groups.
   Conclusion: The use of a standardized instrument is no more accurate or consistent than traditional social work assessments.
2. Assumption: Thorough formalized assessment of client functioning would increase the appropriate utilization of long term health care services.

Finding: No statistically significant difference was found between pilot and non-pilot groups in the utilization of long term health care services. Appropriate service utilization was demonstrated on pilot areas. Outcomes were comparable on pilot and non-pilot areas.
Conclusion: Formalized assessments do not increase appropriate utilization of long term care services compared to traditional professional social work practice.

3. Assumption: The process of an in-depth formalized assessment by a social worker using an assessment instrument would increase patient/family involvement in the decision-making process.
Finding: Pilot program participants felt less involved in the decision-making process than did non-pilot participants.
Conclusion: A formalized assessment instrument decreases the patient/family perception of involvement in the decision-making process compared to traditional social work practice.

4. Assumption: Comprehensive formalized assessments by social workers would

decrease the number of premature nursing home placements being initiated by physicians.

Finding: No evidence of premature nursing home placements being initiated by physicians was demonstrated in this study.

Conclusion: No conclusion can be reached on the impact of formalized social work assessments on premature physician-initiated nursing home placements from this study.

5. Assumption: Use of a standardized instrument with uniform criteria would decrease the frequency and degree of subjective judgment.

   Finding: Outcome comparability between pilot and non-pilot groups and hospital records of both groups did not indicate that subjective judgment was used in traditional social work assessments.

   Conclusion: No conclusion can be reached from this study on the impact of standardized assessments on subjective judgment.

6. Assumption: Subjective judgment had previously impacted negatively on the appropriate utilization of long term care services.

Finding: $T_1 - T_2$ studies did not support that subjective judgment had been used previously or impacted negatively on appropriate utilization of long term care services.

Conclusion: Subjective judgment did not previously impact negatively on the appropriate utilization of long term care services.

7. Assumption: Implementation of a comprehensive and consistent assessment program conducted by social workers would increase the impact of social work in discharge planning decisions.

   Finding: No difference was found between pilot and non-pilot areas in physicians' writing open-ended orders for social work.

   Conclusion: The kind of social work assessment process practiced does not affect the impact of social work on discharge planning decisions.

8. Assumption: Assessment of mental functioning, social resources, and activities of daily living, as well as physical functioning is necessary for appropriate utilization of long term health care services.

Finding: Assessment of the above factors was demonstrated formally or informally on both pilot and non-pilot areas and found to impact on appropriate utilization of long term health care services.

Conclusion: Assessment of mental functioning, social resources, and activities of daily living, as well as physical functioning is necessary for appropriate utilization of long term health care services.

9. Assumption: St. Vincent Infirmary patients were previously inappropriately placed in nursing homes.

Finding: T_1 - T_2 studies did not support the assumption of previous inappropriate placements. Inappropriate placements were not in evidence during the 1981 time study.

Conclusion: Although this study does not support the assumption of previous inappropriate nursing home placements, the time and number limitations of the T_1 - T_2 studies prohibit a definitive conclusion being reached.

10. Assumption: Needs for long term health care services were not being appropriately assessed or identified prior to the implementation of the pilot channeling program.

    Finding: Neither the T_1 - T_2 studies nor the concurrent non-pilot study support that the pilot channeling program resulted in more appropriate assessment and identification of needs for long term health care services. T_1 - T_2 studies do not support a previous lack of assessment of needs for long term health care services.

    Conclusion: Needs for long term health care services have been assessed and identified appropriately prior to the implementation of the pilot channeling program.

Conclusions regarding objectives of the pilot channeling program are as follows:

1. Objective: To utilize uniform criteria in assessing the long term care needs of the hospitalized elderly.

   Conclusion: Uniform criteria were used in assessing the care needs of the hospitalized elderly. The objective was met.

2. Objective: To match services used to the identified needs of the clients.
   Conclusion: Services were matched to the identified needs of the clients. The objective was met.
3. Objective: To document the need for long term care services which did not exist or were in short supply.
   Conclusion: Documentation of discharge delays resulting from the shortage of extended care facility (Medicare) beds was forwarded to the State Utilization Review Office. The objective of documenting the need for long term care services which did not exist or were in short supply was partially met.
4. Objective: To increase client/family participation in the decision-making process involved in the utilization of long term health care.
   Conclusion: Perception of involvement in the decision-making process was decreased. The objective was not met.
5. Objective: To expand the role of social work by strengthening the discharge planning process.
   Conclusion: The role of social work was not affected. The objective was not met.

With the exception of the first objective, when objectives were met or partially met by the pilot channeling program, those objectives were also met in the non-pilot areas.

Conclusions Regarding Hospital Social Work Practice:

Based on the findings and conclusions presented in Chapters 3 and 4, additional conclusions can be drawn concerning hospital social work practice.

1. Professional hospital social workers accurately assess post hospital care needs with or without a standardized assessment tool.
2. The relationship between hospital social workers and their clients may be negatively affected by the use of a standardized assessment instrument.
3. Professional hospital social workers are effective practitioners in assessing needs for post hospital long term care services and in assisting in linking clients with those services through the use of traditional social work practice.
4. When professional social workers are employed by hospitals and participate as discharge planners, use of a standardized assessment instrument adds

cost, has potential negative impact on relationships, and does not increase accuracy in either assessments or utilization of post hospital health care services.

THE IMPACT OF FINDINGS AND CONCLUSIONS ON PROGRAM PLANNING

Outcome and process findings demonstrated no significant difference between pilot and non-pilot areas of the hospital. However, the survey of participants hospitalized on pilot and non-pilot areas revealed a negative impact of the formalized channeling program in terms of perceptions of involvement, perceptions of having been given complete information regarding care options, and satisfaction with social work assistance. The pilot channeling program was found to consume more clerical time and involved an increase in time spent on paperwork for social workers but did not increase patient care time. Although the Department of Social Service was prepared to implement a formalized channeling program throughout the hospital, findings and conclusions drawn from the findings did not support hospital-wide implementation of a formalized channeling program. While valuable data was obtained from the channeling pilot program, it was determined such data can be obtained through random sampling or pilot programs and does not justify hospital-wide program implementation. Utilization of the department's secretary for routine tasks previously performed by social workers was found to be of assistance to social workers in

releasing them for more patient care time. It was decided to continue to use the secretary for those tasks which she had assumed during the pilot channeling program. As a result of the findings and conclusions drawn from the pilot channeling program, the Department of Social Service at St. Vincent Infirmary returned with renewed vigor to the traditional social work processes of assessment and assisting the elderly in need of post hospital long term health care.

It seems fitting to close this section with an excerpt from the quarterly report of the State of Arkansas pilot channeling program from the months of June, July, and August 1982. "Of the 210 clients who requested nursing home service, 205, or 98%, were assessed at three different levels of nursing home care. Only 5 clients (2%) were diverted from their request of nursing home care to alternative care. Twelve clients (2%) of those requesting alternative services were assessed at nursing home care levels. This reinforces the theory that even the client, by his own request, has self-assessed his condition fairly accurately."[2]

RECOMMENDATIONS

Even though this study contains evaluative components as well as descriptive and practice-focused components, it seems appropriate to again note an observation from the review of the literature in Chapter 1: the number of evaluative studies with the elderly remains limited, and the need for such studies continues. The need for utilization

of evaluative research findings in public policy decision making is crucial. Findings and implications from findings contained within this paper could provide useful information to policymakers involved in decision making regarding appropriate utilization of long term health care services by the nation's elderly. Today's governmental channeling programs, whether federal, state or local, emphasize the use of standardized assessment instruments for all recipients of public funds to determine needs. No allowance has been made for programs already in place which may, in fact, already be assessing and channeling effectively. One such program, as demonstrated by this study, is the use of professional social workers by hospitals to assist hospitalized elderly in assessing their needs and then assisting in linking those elderly to the appropriate services. The current channeling model which creates additional assessment teams and demands utilization of assessment instruments is costly and a duplication of services being provided by professional hospital social workers.

Given the discharge delays related to the lack of availability of extended care facility beds in the Central Arkansas area, it seems appropriate to recommend additional study of hospital discharge delays related to extended care facility beds with a focus on expansion in the numbers of such beds if additional study so indicates. Findings from this study regarding the disproportionate utilization of extended care facility beds by blacks indicate additional study in extended care facility bed utilization by minorities.

Findings from this study indicate that the hospitalized elderly are being appropriately channeled into nursing home care, extended care, and home health care with the assistance of professional social workers. Maintenance of all three care options is recommended to afford long term health care in an unrestricted home environment and institutional long term health care for those whose care needs require institutional placement beyond hospitalization.

Obtaining home health care in rural areas of the State was decidedly more difficult than obtaining home health care in the metropolitan area. Expansion of home health care in rural areas of the State appears to be indicated. No shortage in the availability of home health care was found in the metropolitan area.

This study indicates that use of a formalized assessment tool with the hospitalized elderly decreases their satisfaction with social work assistance, decreases their perceptions of involvement in the discharge-planning process, and increases their perception of being uninformed of care options. When the above factors are a consideration, use of an instrument is not recommended. Use of an instrument does limit the time spent in discussion of the client's situation with the client.

The preceding process findings, coupled with the pilot/non-pilot outcome findings leads to the final recommendation. When professional hospital social workers are available to assist the elderly in assessing their needs and to assist

them in linking with agencies appropriate to meet their needs, implementation of a formalized channeling program using an assessment instrument is not recommended.

"Effective communication is widely recognized as the key to understanding another human being and is a basic objective of social work practice. A large part of most social workers' time is spent in dialogue...that will provide the basis for further discussion."[3] It may well be that the use of the assessment tool interferred with dialogue and discussion, thereby damaging the worker/client relationship. The open-ended traditional social work assessment allows enough flexibility to engage in informal conversation which aids in the establishment of rapport yet requires no more time than the instrument used in this study and produces comparable results. It may then be that traditional social work practice with the elderly in need of post-hospital long term health care services offers effective channeling in a perceptibly caring way.

FOOTNOTES

[1]Susan O. Mercer, Helplessness and Hopelessness in the Institutionalized Aged: A Field Experiment on the Impact of Increased Control and Choice, (University of Utah, unpublished doctoral dissertation, June, 1978).

[2]"Quarterly Report on the Pilot Channeling Program", (Arkansas Gerontology Center, September, 1982), p. 31.

[3]Christine M. Schroeder, "Communicating with Hard-to-Reach Patients", Health and Social Work, (New York: N.A.S.W., 1980), p. 35.

EPILOGUE

EPILOGUE

I see you, old woman. I see the YOU, not the old. In your eyes I read the story of the years, of the pain, the sweet delights, the tender pain. I see you, Woman, know your femininity, your graceful movements, your healing tenderness.

. . . If I see you, if I can feel your pain, if I can know your joy, you are not alone. You are not a small "i" far away like a stringless kite.

. . . Look at me, Woman, as I look at you. See. . . we know each other; we are part of the same rainbow. Your colors flow into mine; mine fade into yours. We are the same combination of sun and rain and reflection of life.

There are those who look at you and say, "She is childish." But I view you and I say "She is child-like." To be childish is to be petulant, temperamental, unwilling to endure frustration or punishment or misery of any kind. But the slashes which make parentheses around your mouth show pain long endured and seldom vocalized. Your eyes bear imprints of tears shed and sorrow felt. . . . There are traces of laughter, and in your age and your tiring body there still resides the child who can awake to wonder and to the miracle of a light which is just beginning to trace gold lines on the wall of a room.

. . . Old Woman, I do see the you that was and the you that is. . . . I see you in the nursery rhyme. You still remember it, "There was an old woman who lived in a shoe. ."

It wasn't exactly a shoe you lived in, but it seemed crowded like one when the children were young. . . . But now you are an old woman. And the shoe is empty. . . . No sound in the house. Just an old woman and an empty shoe.

You still have so many children you don't know what to do. Mainly because each child has the solution to your old age. And no solution fits you, any more than someone else's shoe can match your foot. Each child wants to uproot you, place you in a new shoe, in one which has not softened to your shape with the passing years.

. . . You will not wither in total loneliness. . . solitary, away. My hands and those of people around me will reach for you in the dungeon of your alienation, will lift you, carefully, into the slanted sunlight of our lives.

Our fires will bring you warmth; our companionship will give you sustenance. We will widen our circles. . . We will open doors and invite you into the room-brightness of our lives.

I see you, old woman. But even as I look, your face turns into my own. We stand at opposite ends of the same long corridor, reflecting the image of one another.[1]

FOOTNOTE

[1]B. K. Smith, Aging in America, (Boston, 1973), p. 192.

APPENDICES

APPENDIX I

ACT 380

ACT 380 OF 1981

"AN ACT TO DIRECT ALL STATE AGENCIES WHICH ADMINISTER FUNDS FOR LONG TERM CARE SERVICES TO DEVELOP A COORDINATED AND ACCESSIBLE NETWORK OF LONG TERM CARE AND RELATED COMMUNITY-BASED SERVICES, AND FOR OTHER PURPOSES."

WHEREAS, the State of Arkansas holds the long term care needs of its citizens as a primary concern, and recognizes the development of a coordinated and accessible network of long term care and related community-based services as essential in assuring referral to appropriate services and/or in preventing premature institutionalization; and

WHEREAS, several different agencies and departments within State government currently administer funds related to long term care (primarily the Arkansas Department of Health, the Division of Social Services and the Office on Aging and Adult Services),

NOW THEREFORE,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Definitions. For the purposes of this Act the following words and phrases shall have the meanings respectively ascribed to them unless the context clearly indicates otherwise:

(1) "Committee" means that Joint Interim Committee specifically appointed by the Legislative Council to whom the State agencies in the Long Term Care Network will report the progress of this effort.

(2) "State Agencies" means the Arkansas Department of Health, the Division of Social Services, the Office on Aging and Adult Services and any other State Agency which administers funds for long term care and related community-based services.

(3) "Long term care and related community-based services" means preventive, diagnostic, therapeutic, rehabilitative and maintenance services available in the home and a variety of protected environments, including institutions, provided to persons, regardless of age, whose capabilities have been impaired by physical, mental or emotional disability.

SECTION 2. The State Agencies which administer funds for long term care shall work together to achieve a coordinated and accessible network of long term care and related community-based services, utilizing an orderly and effective inter-agency referral system. The State Agencies shall develop procedures and guidelines to assure that coordination between State Agencies in the long term care network will take place. Non-State agencies will be encouraged to participate in the long term care network. Any non-State agency which receives State funds related to long term care services will be required to abide by the policies and procedures of the long term care network.

SECTION 3. The State Agencies will work out formalized agreements among themselves that will set forth all the elements of this plan.

SECTION 4. The State Agencies will carry out a public information campaign to inform the citizens of Arkansas about this network of services.

SECTION 5. State Agencies will establish a demonstration project in a limited number of counties in order to develop a comprehensive long term care assessment system. This project will develop the role of Assessment Agencies for the long term care network. These Assessment Agencies will not be engaged in the provision of services, but will perform an assessment function to measure the client's total needs in order to refer the client to the appropriate level of care available.

SECTION 6. The State Agencies will collect and report management and caseload information to the appropriate Legislative Committee on a quarterly basis. Each agency will identify to the Committee all Agency funds and personnel involved in the delivery of long term care and related community-based services.

SECTION 7. The State Agencies will develop a plan for training home health aide providers.

SECTION 8. The Department of Health, the Division of Social Services, the Office on Aging and Adult Services and any other State Agency which administers funds and appropriations for long term care and related community-based services shall have the authority to transfer such funds and appropriations between themselves in such amounts as they deem necessary to carry out the intent of this Act. Such transfers are to be

made, upon the request of such State Agency, but only after having sought and received the advice of the Committee, by the Chief Fiscal Officer of the State.

SECTION 9. All laws and parts of laws in conflict herewith are hereby repealed to extent of such conflict.

SECTION 10. The provisions of this Act shall be severable, and, if any phrase, clause, sentence, paragraph or section of this Act is held invalid, the same shall not effect the remaining portions of this Act.

SECTION 11. Emergency Clause. It is hereby found and determined by the General Assembly that the development of a coordinated network of long term care and community-based services is essential to the health and welfare of the people of this State, and that immediate steps toward implementation of the provisions of this Act are necessary to establish this coordinated network without undue delay. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public health and welfare shall be in full force and effect from and after its passage and approval.

APPENDIX II

ASSESSMENT INSTRUMENT

Now, I'd like to ask a few questions to test your memory. These are the kinds of questions that some people know the answer to and some people don't.

What is today's date?.	CORRECT	01
	NOT CORRECT	00
_____	NOT ANSWERED	99
What is the month now?	CORRECT	01
	NOT CORRECT	00
_____	NOT ANSWERED	99
What is the year?.	CORRECT	01
	NOT CORRECT	00
_____	NOT ANSWERED	99
How old are you?	CORRECT	01
	NOT CORRECT	00
_____	NOT ANSWERED	99
In what month were you born?	CORRECT	01
	NOT CORRECT	00
_____	NOT ANSWERED	99
(Check from first page)		
In what year were you born?.	CORRECT	01
	NOT CORRECT	00
_____	NOT ANSWERED	99
(Check from first page)		
What is the name of this place?.	CORRECT	01
PROBE: Does this place have a name?	NOT CORRECT	00
_____	NOT ANSWERED	99
(Home, Name of Institution, Room, etc., are typical of correct responses)		
Where is this place located?	CORRECT	01
	NOT CORRECT	00
_____	NOT ANSWERED	99
(Address, City, Town, Street, Name of Institution are typical of correct responses)		

What is the name of the President of the U.S.?. . . . . CORRECT 01
NOT CORRECT 00
NOT ANSWERED 99

_____
(Reagan is correct)

Who was the President before this one? . . CORRECT 01
NOT CORRECT 00
NOT ANSWERED 99

_____
(Carter is correct)

Incorrect Responses:

TOTAL CORRECT____

1-3 Low disorientation
4-6 Moderate/High
7+ Severe

Interviewers Rating (Optional) of mental disorientation

_____ Low
_____ Moderate
_____ High

PATIENT NAME_____

ACTIVITIES OF DAILY LIVING

Scale

This scale is designed to measure the client's current state of functioning, not the interviewer's estimation of what is needed.

00 - Functions about average or better, managing independently.
01 - Beginning to have some problems with the function; may need occasional help.
02 - Mild but continuing problems with the function; needs limited but regular assistance in order to carry on.
03 - Moderate problems with the function; needs regular assistance.
04 - Several problems with the function; needs continuous assistance, care and supervision.

Scoring = Functional rating x care rating (i.e., 02 x 02 = 04)

Score results - (0-4 = low; 5-8 = moderate; 9-12 = high)

Please rate the statement that most appropriately reflects your present condition. Interviewer should probe briefly for nature of problem.

BATHING

Do you have any problems in taking a bath?

Functional Rating	
00	None at all.
01	Need occasional help due to some minor physical problems.
02	Need limited assistance due to continuing physical problems.
03	Need regular assistance and occasional supervision due to nature of physical or mental problems.
04	Need continuous assistance, care and supervision in order to bathe.

Care Rating	Level of Care Provided
	How often do you get help with bathing now?
00	Helper available now whenever necessary.
01	Helper available now some of the time.
02	Helper available on occasions or seldom.
03	No help available.

SCORE _____

Relationship of person providing help_____

DRESSING

Functional Rating	Do you get help with dressing now?
00	None at all.
01	Need occasional help due to some minor physical problems.
02	Need limited assistance due to continuing physical problems.
03	Need regular assistance and occasional supervision due to nature of physical or mental problems.
04	Need continuous assistance, care and supervision in order to dress.

Level of Care Provided

Care Rating	How often do you get help with dressing now?
00	Helper available now whenever necessary.
01	Helper available now some of the time.
02	Helper available on occasion or seldom.
03	No help available.

SCORE: _____

Relationship of person providing help _____

USING TOILET

Functional Rating	Do you get help with using toilet now?
00	None at all.
01	Need occasional help due to some minor physical problems.
02	Need limited assistance due to continuing physical problems.
03	Need regular assistance and occasional supervision due to nature of physical or mental problems.
04	Need continuous assistance, care and supervision in order to go to the toilet.

Level of Care Provided

Care Rating	Do you get help with using the toilet now?
00	If yes, how often is helper available?
01	At all times necessary.
02	Some of the time.
03	Occasionally or very little.

SCORE: _____

Relationship of person providing help _____

EATING

Functional Rating	How well are you able to eat your meals?
00	Need no help/Independent.
01	Need occasional help when eating.
02	Need limited assistance when eating.
03	Need regular assistance and occasional supervision when eating.
04	Need continuous assistance, care and supervision when eating.

Level of Care Provided

Care Rating	How often do you get help with eating?
00	Help available whenever necessary.
01	Help available some of the time.
02	Help available on occasions or seldom.
03	Help not available.

SCORE: _____

Relationship of person providing help _____

MOBILITY

Functional Rating	How capable are you of moving about without a cane or walker?
00	Do not need walking aids/independent.
01	Need occasional help.
02	Need limited assistance due to continuing problems.
03	Need regular assistance and occasional supervision when trying to get around.
04	Need continuous assistance, care and supervision - no mobility.

Level of Care Provided

Care Rating	How often do you get help when you wish to get around?
00	Help available whenever necessary.
01	Some of the time.
02	On occasions or seldom.
03	No help available.

SCORE: _____

Relationship of person providing help _____

CONTINENCE

Functional Rating	Do you have any control problems when either urinating or defecating?
00	Needs no help at all (completely independent).
01	Need occasional help due to periodic bladder/ bowel accidents.
02	Need limited assistance due to continuing bladder/bowel control problems.
03	Need regular assistance and occasional supervision due to incontinence problems.
04	Need continuous assistance, care and supervision in order to perform bladder/bowel functions.

Level of Care Provided

Care Rating	Are you presently receiving help with catheter or ostomy care?
00	Helper available now whenever necessary.
01	Helper available now some of the time.
02	Helper available on occasions or seldom.
03	No help available.

SCORE: _____

Relationship of person providing help _____

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Scoring Categories on Need:
0 - 1 = Low
2 - 4 = Moderate
5 - 6 = High
9 = Severe

TELEPHONE

Functional Rating	How well can you use the telephone?
00	Without any help.
01	Some assistance required.
02	Regular assistance and some supervision required.
03	Unable to use phone.

Care Rating	How often is a helper available?
00	At all times necessary.
01	Occasionally/Often.
02	Some of the time/Seldom.
03	No person available to help.

SCORE: _____

Relationship of person providing help _____

TRANSPORTATION

Functional Rating	How well can you get to places out of walking distance?
00	Can get around without help.
01	Can get around but assistance is required at times.
02	Regular assistance required.
03	Is not able to get around; need someone else to do it.

Care Rating	How often is a helper available?
00	At all times necessary.
01	Occasionally/often.
02	Some of the time.
03	No one available.

SCORE: _____

Relationship of person providing help _____

SHOPPING

Functional Rating	How well can you do your own shopping?
00	Can do shopping without help.
01	Can do shopping but usually need some help.
02	Regular assistance required in shopping.
03	Cannot do shopping independently at all.

Care Rating	How often is a helper available to assist you?
00	At all times necessary.
01	Occasionally/Often.
02	Some of the time.
03	No one available.

SCORE: _____

Relationship of person providing help _____

MEAL PREPARATION

Functional Rating	How well are you able to prepare your own meals?
00	Can prepare meals without any assistance.
01	Some assistance required.
02	Regular assistance required.
03	Unable to prepare meals.

Care Rating	How often is a helper available to assist you?
00	At all times necessary.
01	Occasionally/Often.
02	Some of the time/Seldom.
03	No person available to help.

SCORE: _____

Relationship of person providing help _____

What do you normally eat for breakfast? _____

What do you normally eat for lunch? _____

What do you normally eat for dinner? _____

HOUSEWORK

Functional Rating	How well can you do your own housework?
00	Can do own housework/Independent.
01	Some assistance required.
02	Regular assistance required.
03	Unable to do any housework/Dependent.

Care Rating	How often is a helper available to assist you?
00	At all times necessary.
01	Occasionally/Often.
02	Some of the time/Seldom.
03	No one available.

SCORE: _____

Relationship of person providing help _____

YARD/HOME REPAIR

Functional Rating	How well can you do your yard work and home repair?
00	Can do work independently.
01	Some assistance required.
02	Regular assistance required.
03	Unable to do any yard work or home repairs.

Care Rating	How often is someone available to assist you?
00	At all times necessary.
01	Occasionally/Often.
02	Some of the time/Seldom.
03	No one available.

SCORE: _____

Relationship of person providing help _____

LAUNDRY

Functional Rating	How well can you do your laundry independent of help?
00	Can do laundry without any assistance.
01	Some assistance required.
02	Regular assistance required.
03	Unable to do laundry without total help and supervision.

Care Rating	How often do you have help in doing laundry?
00	At all times necessary.
01	Occasionally/Often.
02	Some of the time/Seldom.
03	No one available.

SCORE: _____

Relationship of person providing help _____

LEGAL/ADMINISTRATIVE

Functional Rating	How well can you manage your money and other personal business?
00	Without any assistance.
01	Some assistance required.
02	Regular assistance required.
03	Unable to manage independently.

Care Rating	How often do you have someone help you manage your personal business?
00	At all times necessary.
01	Occasionally/Often
02	Some of the time/Seldom.
03	No one available.

SCORE: _____

Relationship of person providing help _____

TOTAL SCORE: _____

PROBLEM BEHAVIOR INDEX

Does client exhibit following behavior? (To be answered by informant or social worker in absence of an informant.)

	Absent	Mildly	Moderately	Severely	NA	Don't Know
__ Wandering	0	1	2	3	99	00
__ Abusive/ Aggressive/ Disruptive	0	1	2	3	99	00
__ Delusions/ Hallucinations	0	1	2	3	99	00

Relationship of informant to client _____

Medication Administration Rating

No medications or self-administered with no help needed	00)	
Monitoring needed less than weekly by caretaker	01)	= Low
Professional monitoring needed less than weekly	02	= Moderate
Regular professional (R.N. or L.P.N.) monitoring needed	03)	
Constant professional monitoring needed	04)	= High

HEALTH HISTORY INDEX

Do you have, or have you ever had, any of the following?

	Yes	No	NA	Comments
Arthritis	01	02	99	
Heart Trouble	01	02	99	
High Blood Pressure	01	02	99	
Emphysema or Chronic Bronchitis	01	02	99	
Asthma	01	02	99	
Cancer or Leukemia	01	02	99	
Cataracts	01	02	99	
Glaucoma	01	02	99	
Stroke	01	02	99	
Ulcers (of digestive system)	01	02	99	
Diabetes	01	02	99	
Kidney Disease	01	02	99	
Other Urinary Tract Disorders	01	02	99	
Liver Disease	01	02	99	
Circulation Trouble in Arms or Legs	01	02	99	
Arteriosclerosis	01	02	99	
Other: _____	01	02	99	

For review team nurse: To aid CAT team in appropriate care decisions.

Based on past and present history of health illness, at what risk is the client of being placed in a nursing home?

Not likely. 00
Low probability 01
Moderate risk 02
High risk 03

SPECIAL NURSING/THERAPY

Are you currently receiving:

	Yes	No	NA
Decubitus care	01	00	99
Eye care	01	00	99
Oxygen RX type	01	00	99
Dressing(s) Site(s)	01	00	99
Other Special Nursing - Specify	01	00	99
How many?			
Therapies	01	00	99
Inhalation	01	00	99
Occupational	01	00	99
Physical	01	00	99
Speech	01	00	99
Reality/Remotivation	01	00	99

For the interviewer:

To help the CAT team in making a decision on the appropriate level of care, please rate the at-risk level of the client below:

Based on the special nursing/therapy services required by the client, do you feel the patient is:

1. At no risk of placement	00
2. At moderate risk	01
3. At high risk	02
4. Very high risk of placement	03

COMMUNICATION INDEX

SIGHT

SCORE	Good	Minimal Loss	Moderate Loss	Severe Loss	Complete Loss
_____	00	01	02	03	04

Notes - Specify compensation, if any: _____

_____

_____

HEARING

SCORE	Good	Minimal Loss	Moderate Loss	Severe Loss	Complete Loss
_____	00	01	02	03	04

Notes - Specify compensation, if any: _____

_____

_____

SPEECH

SCORE	Good	Minimal Loss	Moderate Loss	Severe Loss	Complete Loss
_____	00	01	02	03	04

Notes - Specify compensation, if any: _____

_____

_____

CARETAKER ABILITY INDEX

How to answer if Aide in home:

(The following questions are for the caretaker, if there is one.)

Have any of the following aspects of caring for the client become a problem?

Personal care

No. 00
Yes, but manageable 01
Yes, but becoming unmanageable.02
Unmanageable. 03
NA. . . . . .99 ___

Household chores

No. 00
Yes, but manageable 01
Yes, but becoming unmanageable.02
Unmanageable. 03
NA. . . . . .99 ___

Transportation/shopping

No. 00
Yes, but manageable 01
Yes, but becoming unmanageable.02
Unmanageable. 03
NA. . . . . .99 ___

Managing finances and other personal business

No. 00
Yes, but manageable 01
Yes, but becoming unmanageable.02
Unmanageable. 03
NA. . . . . .99 ___

Supervision

No. 00
Yes, but manageable 01
Yes, but becoming unmanageable.02
Unmanageable. 03
NA. . . . . .99 ___

Caretaker Ability Index, Cont'd.

Is the client becoming difficult to get along with?

No. 00
Yes, but manageable 01
Yes, but becoming unmanageable.02
Unmanageable. 03
NA. . . . . .99 ___

Is your sleep disturbed by care demands?

No. 00
Yes, but manageable 01
Yes, but becoming unmanageable.02
Unmanageable. 03
NA. . . . . .99 ___

Has the rest of the household been adversely affected by the client's care needs?

No. 00
Yes, but manageable 01
Yes, but becoming unmanageable.02
Unmanageable. 03
NA. . . . . .99 ___

TOTAL SCORE _____

Score: 0 - 12 = Manageable
13 - 19 = Becoming unmanageable
20 - 24 = Unmanageable

CARETAKER PLACEMENT PERCEPTION

What do you believe the client's living arrangements should be?

In home, needs no help. 00
In own home with help 01
In caretaker's home with help .02
Supervised/sheltered living . .03
Nursing home. 04
NA. . . . . .99 ___

PHYSICAL, MENTAL AND SOCIAL INDICES

THAT DETERMINE LONG TERM CARE DECISIONS

		Level of Functioning			Keys
		1	2	3	Level of Functioning
M S Q	MENTAL HEALTH STATUS	... ...	/// ///	ooo ooo	
Activities of Daily Living	BATHING	... ...	... ...	... ...	Level 1 = Beginning to have some problems with functions.
	DRESSING	... ...	... ...	... ...	
	TOILETING	... ...	/// ///	### ###	
	CONTINENCE	... ...	### ###	ooo ooo	Level 2 = Mild to moderate problems with functions.
	EATING	... ...	/// ///	### ###	
	MOBILITY	... ...	/// ///	### ###	
Instrumental Activities of Daily Living	TELEPHONE	... ...	... ...	... ...	Level 3 = Severe problems with functions.
	TRANSPORTATION	... ...	... ...	... ...	
	SHOPPING	... ...	... ...	... ...	
	MEAL PREPARATION	... ...	... ...	... ...	Shading
	HOUSEWORK	... ...	... ...	... ...	(Probability that nursing home placement is necessary.)
	YARD/HOME REPAIR	... ...	... ...	... ...	
	LAUNDRY	... ...	... ...	... ...	... ... Not likely
	LEGAL ADMINISTRA.	... ...	... ...	/// ///	
Problem Behavior	WANDERING	... ...	/// ///	/// ///	/// /// Moderate chance
	ABUSIVE/AGRESSIVE/ DISRUPTIVE	... ...	/// ///	### ###	
	DELUSIONS/ HALLUCINATIONS	... ...	### ###	ooo ooo	### ### High proba-bility
Health Care Services	HEALTH HISTORY	... ...	... ...	... ...	
	SPECIAL NURSING HISTORY	... ...	/// ///	### ###	ooo ooo Very high proba-bility
	MEDICATION MAINTENANCE	... ...	/// ///	### ###	

Physical, Mental and Social Indices, Cont'd.

		Level of Functioning		
		1	2	3
Communi-cation	VISION	... ...	... ...	/// ///
	HEARING	... ...	... ...	... ...
	SPEECH	... ...	... ...	... ...
Caretaker Ability	ABILITY OF CARETAKER	... ...	### ###	ooo ooo
	PLACEMENT PERCEPTION	... ...	/// ///	### ###

Explanation of Keys

1. "Key to Levels of Functioning" refers to the three levels on each row scale. The key gives the general meaning of each level. For accurate results, you should refer to the exact wording of each scale.

2. "Keys to Shading" refers to the probability that nursing home placement is necessary. The key gives only a general idea of what each degree of shading means. For accurate results, you should refer to the following discussion.

   A. "Not likely" means that, with little or no help, the person can function in a normal home environment, if all scales come out in the "not likely" shading.

   B. "Moderate probability" means that the person needs part-time or full-time medical help in order to stay at home, if the person's "worst" scale or scales comes out in the "Moderate probability" shading, unless unusual help from family, friends or from community services is available.

   C. "High probability" means that, if the person's "worst" row scale or scales comes out in the "high probability" shading, the person should be recommended to a nursing home unless a substitute home (foster home, home for the aged) alternative is available, or if unusual help from family, friends, or community is available (as indicated by level 1 on scale 30.)

   D. "Very high probability" means that, if the person's "worst" rating on the scale or scales comes out in the "very high probability" shading, the person should be strongly recommended to a nursing home (intermediate care facility or skilled nursing facility, depending on need for round the clock registered nurse attention), a community hospital, or a specialty hospital or institution, unless very unusual and reliable help from family, friends or community is available.

APPENDIX III

PLACEMENT INFORMATION BASE

PLACEMENT INFORMATION BASE: BACKGROUND

The Placement Information Base (P.I.B.) is the functional assessment instrument used in the FIG/Waiver Project and later as a part of Oregon's Preadmission Screening Process. Its purpose is to provide a minimum standard data base of key, highly relevant information to assist agencies and providers in their efforts to provide the most appropriate services to clients in the most appropriate setting. The data base also provides a powerful tool for analysis and comparison of programs.

By matching functional problems to the probability of the need for nursing home placement, the P.I.B. aids the decision-makers in finalizing a description of the client's functional level as it relates to the type of placement needed and/or services required to maintain the client at his/her appropriate level of care. It is used in conjunction with other medical, fiscal, and social data to determine proper placement. The 25 items cluster into seven areas of functioning: communication, mobility, household and food management, social and emotional, finances, health, and self-care.

The tool was extensively field tested before adoption by the FIG/Waiver Project, the Office of Elderly Affairs, and the Adult and Family Services Division. Interrater reliability for the scales was established at 90.6. In other words, different raters rate the same client very similarly, disagreeing by more than one scale level on only ten percent of the scales.

Each of the 25 scales has five levels, giving the rater a sufficient range of choice to describe the level of functioning of the client. The five levels are consistent over all 25 scales, with 1 representing totally independent or unimpaired functioning and 5 representing totally dependent or impaired functioning.

The five levels are:

Level 1: Functions about average or better; managing independently.

Level 2: Beginning to have some problems with functions; may need occasional help.

Level 3: Mild but continuing problems within the function; needs limited regular assistance in order to carry on.

Level 4: Moderate problems with the function; needs frequent assistance.

Level 5: Severe problems with the function; needs continuous assistance, care, and supervision.

The scales are administered in an open-ended interview setting between a trained interviewer and a client. After training and practice sessions, interview time averages twenty minutes.

The P.I.B. is designed to allow placement personnel or agencies to improve their performance or to be monitored and audited by funding agencies. The P.I.B. facilities improved placements because some items are more predictive of clients being at risk of institutionalization than are other items. For example, a level 5 for continence may mean very high risk of nursing home placement, whereas a level 5 for vision may not mean very high risk of nursing home placement. Moreover, the P.I.B. has been designed to allow data collection and interpretation by non-specialist personnel.

Equally important, accumulated P.I.B. data can be used for local and state planning based on direct evidence regarding over-utilization of nursing home care and extent of need for expanded alternative care meeting particular requirements. For example, based on a P.I.B. sample of nearly 1,000 recent intermediate care nursing home placements in the Jackson region of AFS, 60% have "managing medications" as the only "high risk" indicator. An appreciable portion of these persons could probably receive the care they need in other settings, at lesser cost, through a combination of conventional in-home services, plus well-organized medication review, dispensing, education and monitoring.

PURPOSE OF P.I.B.

The basic instrument is to be used to provide a data base for matching the functional profiles of elderly individuals with the service capability profiles of various institutional and alternative resources. The purpose is to provide a minimum standard data base of key, highly relevant information to assist existing agencies and providers in deciding whether:

1. a given elderly person has special needs for medical, personal and social support in relation to current levels of functioning;
2. an in-home package of services could be worked out to meet the pattern of need, and
3. it would be cost-effective; and if this cannot be done, identifying the most appropriate, cost-effective type of out-of-home placement.

Since the instrument is to be used in existing agencies with existing staffing levels, it is fast and easy to use, rather than long and comprehensive. It does not require specialist training to complete.

The instrument should be an aid to decision making concerning proper placements of clients. It should standardize this decision-making process, but not replace the decision-maker. For example, natural support systems are an important concern in making placements. The instrument shows various levels of this function. The instructions suggest where placements could be made when considering this with other functions, but without specifying the almost infinite variety of different types of natural support systems in existence. The decision-makers will continue judging natural support systems on the basis of their experience and education, though this process will be assisted and standardized by the instrument.

The scales on the instrument are relevant to placement selection along the entire long-term care continuum. That is, the instrument can describe both very independent people and very dependent people. The scales are worded so that present agency and provider staff can rapidly and reliably gather the information. The instrument includes more detail than what is needed to assess whether an individual is simply at risk of institutional care, but less detail than what is needed when professional staff develop a plan of treatment within a medical facility.

The P.I.B. will not always provide all the information that an in-house service or a supervised living situation (like a nursing home, home for the aged, or foster care home) might require after the person is placed. It will, however, help you avoid some mistakes--the purpose of the P.I.B. is to help get the person to the right kind of place.

THE PLACEMENT INFORMATION BASE (P.I.B.)

Oregon Department of Human Resources FIG/Waiver Project

PLACEMENT INFORMATION BASE (P.I.B.) 6/15/79

Person Code: Observer Code: Date:

INSTRUCTIONS: For each scale, choose and write in the answer space that one level which, from your observation and knowledge of the person and/or conversation with him or her, best describes how the person is usually functioning these days. When you are not sure which of several levels to choose, because the wordings of two or more levels seem to fit the person's usual function about equally well, or because the person regularly varies among levels, select the higher numbered level.

Cluster One: Communication

1. ( ) SELF-IDENTIFICATION

   a. Individual states name, address, phone number, time and place accurately and appropriately and communicates information fluently and with detail appropriate to the situation.
   b. States name, address, phone number accurately and appropriately, but without adjustment to the situation, or uses I.D. for these purposes.
   c. Identifies self only sometimes or only partly.
   d. Hardly ever identifies self, even with I.D., or does so inaccurately at least some of the time.
   e. Does not state name/address/phone number information accurately and appropriately, does not use I.D. for these purposes.

2. ( ) VISION (with glasses, if used; if the person is confused, make the best estimate you can)

   a. Normal or minimal loss, without glasses, or with old prescription. Sees adequately in most situations; can see newsprint, public notices, television, medication labels.
   b. Normal or minimal loss, with glasses prescribed within the last year.
   c. Moderate loss, can read large print, see simple pictures, can see obstacles, but not details, usually can count fingers at arm's length.
   d. Severe loss, cannot find way around without feeling or using cane, cannot locate objects without hearing or touching them; can tell light from dark.
   e. Total blindness; no vision at all; cannot tell light from dark.

3. ( ) HEARING (with hearing aid, if used; if the person is confused, make the best estimate you can)

   a. Normal or minimal loss, without hearing aid or with old prescription. Hears adequately in most situations, can carry on an unrestricted conversation or otherwise responds appropriately to being addressed without speaker raising voice or altering normal pace and style of diction in groups as well as one-to-one; TV or radio; addressed from behind, etc.
   b. Normal or minimal loss, with hearing aid prescribed or with correction rechecked within the last three years.
   c. Moderate loss, hears adequately only in special situations, i.e., one-to-one, with firm, clear diction, raised volume of radio, etc.
   d. Severe loss, hears with difficulty even in special situations, i.e., conversation restricted, many misunderstandings, or frequently fails to respond, etc.
   e. Total deafness, no hearing at all useful for communication.

Cluster Two: Mobility

4. ( ) TRAVEL (by those means which are available and accessible)

   a. Uses private and public transportation properly and appropriately, on own. Can drive safely.
   b. Uses public transportation properly and appropriately, with a little help. Cannot or should not drive.
   c. Uses public transportation for both short and long trips with a moderate amount of help.
   d. Manages short trips with moderate assistance, but totally dependent on others for long or unusual trips.
   e. Totally dependent on help from others when any travel is necessary.

5. ( ) MOBILITY, WITHOUT AIDS. (the extent to which the individual gets around alone, without aids: walker, cane, wheelchair)

   a. Has no difficulty and takes regular outside walks for exercise.
   b. Walks or gets around without difficulty both inside and outside.
   c. Walks or gets around easily inside, can get to various rooms alone, but needs some help outside.
   d. Gets around in own room, but needs assistance beyond that.
   e. Does not get around, even in room, without continuous assistance by another person.

6. ( ) MOBILITY WITH AIDS (the extent to which the individual gets around alone, using whatever aids (walker, cane, wheelchair) he/she has)

a. Walks or gets around without difficulty both inside and outside.
b. Walks or gets around easily inside, can get to various rooms alone, but needs some help.
c. Gets around in own room, but needs assistance beyond that.
d. Gets around in room, but uses wheelchair and needs help to transfer; may or may not need assistance to go further.
e. Does not get around, even in room, without continuous assistance by another person.

Cluster Three: Household and Food Management

7. ( ) HOUSEKEEPING

a. Takes complete care of his/her living space and that of others in living situation.
b. Takes care of his/her own living space, both light and heavy work.
c. Consistently manages own light housekeeping, but not heavy work.
d. Does light housekeeping, but inconsistently or inadequately.
e. Does not take care of own living space.

8. ( ) PERSONAL SHOPPING (gets such items as newspapers, toilet articles, snack foods, within physical limitations and any other restrictions)

a. Does personal shopping regularly and properly without assistance or reminding.
b. Does personal shopping without help, but must be reminded from time to time.
c. Does personal shopping without help, but must always be reminded.
d. Needs assistance from another person to get some items.
e. Another person gets all items.

9. ( ) SHOPPING FOR AND PREPARING FOOD

a. Does food shopping and preparation of meals.
b. Shops with help; usually prepares meals.
c. Does not shop, but usually prepares meals.
d. Does not shop; prepares meals about half the time.
e. Does not shop or prepare meals, or needs special diet, does not prepare it.

10. ( ) NUTRITIONAL HABITS

a. Eats three meals a day; daily, eats at least two servings of each of (1) fruits, (2) vegetables, (3) whole grain products, (4) fish, poultry, or meat, and (5) dairy products.
b. Eats three meals a day; daily, eats at least one serving of each of (1) fruits, (2) vegetables, (3) whole grain products, (4) fish, poultry or meat, and (5) dairy products.
c. Eats three meals a day, but usually omits at least one of (1) fruits, (2) vegetables, (3) whole grain products, (4) fish, poultry or meat, each day, and (5) dairy products.
d. Eats two meals a day, but does eat at least one serving of (1) fruits, (2) vegetables, (3) whole grain products, (4) fish, poultry or meat, and (5) dairy products.
e. Eats sporadically, primarily carbohydrates and soft foods; or doesn't remember to eat, so needs reminding and/or supervision, or doesn't stop eating without reminding or supervision.

11. ( ) EATING (with special equipment if regularly used)

a. Feeds self, chews and swallows solid foods without difficulty.
b. Feeds self, chews and swallows solid foods which have been cut or pureed.
c. Needs assistance with feeding, but chews and swallows solid foods (which may have to be cut or pureed).
d. Needs assistance with feeding and has difficulty with chewing or swallowing, even with food cut or pureed. May need to be fed by tube.
e. Must be fed intravenously.

Cluster Four: Social and Emotional

12. ( ) SOCIAL ACTIVITIES

a. Involved regularly in activities with (1) family, (2) neighbors, (3) church/fraternal/occupational/social/political organization(s). Extensive and satisfying social relationships.
b. Involved regularly in activities with at least one of these three kinds of groups.
c. Will participate in activities with at least one of these three kinds of groups is reminded and/or assisted to do so; only some of the relationships may be satisfying.

d. Will go to or be present at activities of at least one of these three kinds of groups if reminded and/or assisted to, but needs prompting and encouragement to actually participate; or is responsive when visited by one of only a limited number of people.
e. Not willing to go to activities of any of these kinds of groups, nor to be involved if present at them. Is not responsive to visitors, no social relationships.

13. ( ) PERSONAL INDEPENDENCE

a. Accepts change: actively adapts, makes plans, handles crises well, is confident.
b. Accepting, but needs some help in adapting and making plans and decisions.
c. Actively resistive, refuses to make decisions; consistently negative or hostile.
d. Neutral or passive. Requires regular assurance and/or guidance.
e. Withdrawn, afraid, or insecure; needs near constant support.

14. ( ) EMOTIONAL CONTROL

a. Personal problems, disturbances, emotional states do not particularly restrict the individual's type of living arrangement and companions.
b. Personal problems, disturbances, emotional states restrict individual's type of living arrangement and companions, but things work out o.k. in present set up.
c. Personal problems, disturbances, emotional states restrict the type of living arrangement and companions, and things are not working out o.k. in present set up.
d. Person is dangerous or violently abusive to self or others, but is controllable with medications.
e. Person is dangerous or violently abusive to self or others, not controllable with medications, requires physical restraints.

15. ( ) TELEPHONE

a. Makes and takes calls appropriately, fluently with normal frequency.
b. Makes and takes calls appropriately, but infrequently.
c. Makes few calls, but takes calls and handles most of them appropriately.
d. Makes few or no calls, but takes some calls and handles at least some appropriately.
e. Neither makes nor takes calls appropriately.

16. ( ) ORIENTATION FOR LIVING ALONE (Oriented means: explains details of care, if any; reasons for it; how long it will be needed. Responsible means actually does the tasks he or she is supposed to do as part of the care.)

a. Fully oriented and responsible for care of self, if needed.
b. Fully oriented but needs to be checked up on once or twice a day.
c. Fully oriented but needs help with activities of daily living.
d. Is sometimes confused, needs reminders and/or help for activities of daily living, but does not physically wander off.
e. Is sometimes or frequently confused, needs reminders and/or help for activities of daily living, and physically wanders off regularly.

17. ( ) NATURAL SUPPORT (friends/family/neighbors/volunteers)

a. One or more persons available to give care indefinitely.
b. One or more persons available to give care regularly for several months.
c. One or more persons available to give care from time to time for several months.
d. Several persons available to help out, one at a time or in rotation, from time to time, but there is no one to take overall responsibility for helping on a regular basis.
e. No person available to help except perhaps under extreme circumstances.

18. ( ) PERSONAL ACTIVITIES

a. Spends most of the time each day in a variety of personal activities, including reading, hobbies, crafts, occupations (not including passive entertainment.)
b. Spends most of the time each day in a limited set of personal activities (other than passive entertainment.)
c. Spends mornings, afternoons, or evenings each day in personal activities (other than passive entertainment.)
d. Spends 1 to 2 hours a day in personal activities (other than passive entertainment.)
e. Spends less than an hour a day in personal activities (other than passive entertainment.)

Cluster Five: Finances

19. ( ) MONEY MANAGEMENT

a. Writes checks, pays bills without any help. Keeps expenses within income.
b. Writes checks, pays bills without any help, but needs some advice or help each month to balance checkbook or perform similar tasks.
c. Manages day to day buying, but needs help with writing checks and/or paying bills.
d. Can handle purchasing of some personal items, but cannot handle all day to day buying.
e. Completely unable to handle money.

Cluster Six: Health

20. ( ) HEALTH CONDITION

a. Excellent or good physical health; no significant illnesses or disabilities; only routine health care such as annual checkups.
b. Mild health problems needing short-term attention or corrective measures (wounds requiring dressing changes, bed sores, etc.)
c. Has one or more moderate medical problems which may be painful or which require medical attention periodically (gets dizzy on movement, etc.)
d. Highly impaired, confined to bed, requires full time medical assistance or nursing care to maintain certain vital bodily functions. (For example, turning for pressure relief and repositioning because of stroke, paralysis, weakness, or other reason.)
e. Unconscious, unable to respond, needs total care for all bodily functions.

21. ( ) MANAGING MEDICATIONS (Consider the person's currently prescribed oral, topical, and injectable medications. Select the one category which fits best.)

a. Needs no medications, or if needs them, manages medications alone. Knows what to take, takes them at correct times, keeps them properly.
b. Medications must be laid out for him/her each week, but no problems taking correct ones at correct times.
c. Must be given daily reminders, but follows them.
d. Does not manage own medications, needs to have some medication administered to him/her by someone else regularly but less than daily.
e. Does not manage own medications, needs to have some medication administered to him/her by someone else regularly, and daily or more frequently.

Cluster Seven: Self-Care

22. ( ) GROOMING AND DRESSING

a. Grooms and dresses self without any help. Combs hair, does nails, manages buttons, ties shoes, etc.
b. Grooms and dresses self without any help, but must be reminded to do so on some days.
c. Grooms and dresses self without any help, but must always be reminded to.
d. Needs help from another person to do some parts of grooming, or some parts of dressing, such as managing buttons or tying shoes; may or may not need reminding.
e. Needs help from another person to do all of grooming, or all of dressing or both, and may or may not need reminding.

23. ( ) BATHING OR SHOWERING

a. Bathes or showers self regularly, without reminders and without help for any task including turning the water on and off.
b. Bathes or showers self without any help, but must be reminded at least some of the time.
c. Bathes or showers self, but must have help for turning the water on and off.
d. Bathes or showers self, but must have help for more than turning the water on and off.
e. Does not do any part of bathing or showering, requires another person to do everything.

24. ( ) USING TOILET

a. Gets to and from toilet, adjusts clothes, cleans self, etc. without help.
b. Needs help getting to toilet, but needs no other help.
c. Gets to toilet, but needs some help once there.
d. Gets to toilet, but needs total help.
e. Does not use toilet. Neither gets there, nor handles function without at least some help.

25. ( ) CONTINENCE (To what extent are the individual's natural excretory functions under personal control, day and night, whether naturally or with ostomy, catheter, etc.; aid means having another person give an enema, insert a suppository, clean an appliance, etc.)

a. No accidents, or infrequent accidents; no problems, needs no help or aid.

b. Accidents once or twice a week, or needs help or aid once or twice a week.
c. Accidents three to five times a week, or needs help or aid three to five times a week.
d. Needs assistance regularly (daily or more frequently) with specific parts of activity.
e. Needs moderate to great assistance. Someone must be present every time to assist with all, or nearly all, parts of the activity.

RELATIONSHIP BETWEEN LEVELS OF

FUNCTIONING (Across) AND PROBABILITY THAT

NURSING HOME PLACEMENT IS NECESSARY (Shading)

Key to Levels of Functioning:

Level 1: Functions about average or better.

Level 2: Beginning to have some problems with function.

Level 3: Mild but continuing problems with function.

Level 4: Moderate problems with function.

Level 5: Severe problems with function.

Key to Shading: (Probability that nursing home placement is necessary.)


Not likely


Low probability


Moderate probability


High probability


Very high probability

	Personal and Social Functions Relevant to Long Term Care Placement Decisions	Levels of Functioning 1	2	3	4	5
Communication	1. Can identify self (or use I.D.)			... ...	... ...	... ...
	2. Vision (with glasses, if used)			... ...	... ...	... ...
	3. Hearing (with hearing aid, if used)			... ...	... ...	... ...

		1	2	3	4	5
Mobility	4. Travel (by public or private means)			... ...	... ...	... ...
	5. Mobility (without walker, cane, wheelchair)			... ...	... ...	/// ///
	6. Mobility, with aids (walker, cane, wheelchair; does not respond if aids not needed)		... ...	... ...	... ...	### ### ### ###
Food Management	7. Housekeeping (vacuums, dusts, dishes, chores)			... ...	... ...	... ...
	8. Personal shopping (newspapers, toilet articles, snack foods)		... ...	... ...	... ...	... ...
	9. Shopping for and preparing food		... ...	... ...	... ...	... ...
	10. Nutritional habits (food selection balance, amount)		... ...	... ...	... ...	... ...
	11. Eating (with special equipment if regularly used)		... ...	... ...	ooo ooo ooo	ooo ooo ooo
Social & Emotional	12. Social activities (family, neighbors, church/fraternal/occupational, social/political groups)			... ...	... ...	... ...
	13. Personal independence (acceptance of changes, handling crises and decisions positively)			... ...	... ...	/// /// /// ///
	14. Emotional control (personal problems, disturbances, emotional states do not restrict living arrangements and relationships with others; not dangerous to self or others)			/// /// /// /// /// /// /// ///	### ### ### ### ### ### ### ###	ooo ooo ooo ooo ooo ooo ooo ooo
	15. Use of telephone (making and taking calls.)				... ...	... ...

		1	2	3	4	5
Social & Emotional	16. Orientation for living alone (can explain details of self-care needed reasons, duration; and is responsible for following regime without reminding)		... ...	... ...	... ...	### ### ### ### ### ###
	17. Natural support (regular availability of reliable help from family, friends, neighbors or volunteers)			... ...	... ...	... ...
	18. Personal activities (spends substantial part of each day on reading, hobbies, crafts, occupations, etc., not including passive entertainment)				... ...	... ...
Finances	19. Money management (writing checks, paying bills, keeping expenses within income)		... ...	... ...	... ...	... ...
Health	20. Health condition (general physical status, absence of significant illness or disability)		/// /// /// ///	/// /// /// ///	### ### ### ###	ooo ooo ooo ooo
	21. Managing medications (knows what to take, takes at correct times, keeps medications properly, needs no help or reminding. Does not respond if medication not needed)		... ...	... ...	/// /// /// /// /// /// ///	ooo ooo ooo ooo ooo ooo ooo
Self-Care	22. Grooming and dressing (clothes, buttons, shoes, hair and nails)		... ...	... ...	... ...	... ...
	23. Bathing or showering (can do without help from others)		... ...	... ...	... ...	... ...
	24. Using toilet (can do without help from others)		... ...	... ...	### ###	### ###
	25. Continence (no accidents, whether naturally or with ostomy, catheter, etc., if present; no need for help from others for enema, suppository, etc.)		... ...	### ### ### ### ### ###	### ### ### ### ### ###	ooo ooo ooo ooo ooo ooo

Explanation of Keys

1. "Key to Levels of Functioning" refers to the five levels on each P.I.B. scale. The key gives the general meaning of each level. For accurate results, you should refer to the exact wording of each P.I.B. scale.

2. "Key to Shading" refers to the probability that nursing home placement is necessary. The key gives only a general idea of what each degree of shading means. For accurate results, you should refer to the following discussion.

   A. "Not likely" means that, with little or no help, the person can function in a normal home environment, if all P.I.B. scales come out in the "not likely" shading.

   B. "Low probability" means that the person needs some non-medical help from family, friends, or from community services in order to stay at home, if the person's "worst" P.I.B. scale or scales come out in the "low probability" shading.

   C. "Moderate probability" means that the person needs part-time or full-time medical help in order to stay at home, if the person's "worst" P.I.B. scale or scales come out in the "moderate probability" shading, unless unusual help from family, friends, or community services is available.

   D. "High probability" means that, if the person's "worst" P.I.B. scale or scales comes out in the "high probability" shading, the person needs to be in a nursing home unless a substitute home (foster home, home for aged) alternative is available, or if unusual help from family, friends, or community is available (as indicated by levels 1 or 2 on scale #17) or if the individual has strong desire and capacity for living alone (levels 1, 2, or 3 on scale #16) as well as strong personal independence (levels 1 or 2 on scale #13).

   E. "Very high probability" means that, if the person's "worst" P.I.B. scale or scales come out in the "very high probability" shading, the person must be in a nursing home (intermediate care facility or skilled

nursing facility, depending on need for round the clock registered nurse attention), a community hospital or a specialty hospital or institution, unless very unusual and reliable help from family, friends, or community is available.

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