

CONSUMER DIRECTION IN OHIO:

FINDINGS FROM TWO DEMONSTRATION PROJECTS

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EXECUTIVE SUMMARY

Over the last 30 years, both nationally and in Ohio there has been an increase in publicly funded home care services provided to older adults. At the same time, advocates and older adults with physical and intellectual disabilities have expressed the need to have more choice and control over their in-home services. The results of the rigorously tested Cash & Counseling demonstrations during the late 1990s have helped to bolster support for consumer- or self-directed services. More self-directed programs have been created as federal agencies such as the Centers for Medicare and Medicaid Services and the Administration on Aging have become more willing to provide funding to support these programs.

In the last decade, Ohio has implemented and evaluated two consumer-directed programs focused primarily on older adult clients. In the first, the planning and service area site (PSA 6) received a grant from the Robert Wood Johnson Foundation to implement one such program within the state's Medicaid Waiver Program (PASSPORT). The Council on Aging of Southwestern Ohio, implemented a consumer-directed program within two of its Elderly Services Programs; locally funded levy programs serving clients unable to qualify for PASSPORT.

At both sites, those who enrolled in the consumer-directed program had very high levels of satisfaction. The high levels of satisfaction were significantly different from their own satisfaction levels before enrolling in the consumer-directed option. Their satisfaction levels also increased to the levels of those who continued receiving traditional services. Informal caregivers were also affected by the program. There was a decline in the number of unpaid care hours provided. At the same time, there was an increase in caregiver satisfaction with the services; the majority of caregivers stated that the consumer-directed program gave them respite or more free time to focus on other things besides caregiving.

Similar to the national Cash & Counseling demonstrations, Ohio's consumer-directed services cost significantly less per hour of service than agency services since the services were directly contracted by clients with workers avoiding additional administrative costs. The lower service cost, however, did not translate to savings for either of Ohio's consumer-directed programs as participants spent a larger proportion of their allotted budgets than traditional clients.

Findings from these two programs were very positive and similar to the earlier findings from the National Cash & Counseling Demonstration and Evaluation. Ohio has expanded the consumer-directed option in the PASSPORT program to two additional sites, while the Council on Aging has continued to provide the consumer-directed option within the two original demonstration counties.

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BACKGROUND

Strategies for meeting the needs of individuals who need long-term care services have changed in the U.S. over the past 30 years. In response to ever expanding public long-term care budgets and individuals' growing preferences for in-home care, states have developed alternatives to nursing home care such as Medicaid home- and community-based waiver services (Lanspery, 2002; Stone, 2000). As there has been a policy shift toward long-term care services provided in the home and away from institutions, there has also been a growing call from older adults with disabilities to have more choice and control over their in-home services.

The idea of consumer empowerment took root in the independent living movement of the early 1970s, when younger persons with disabilities advocated for more autonomy and flexibility in their services. The philosophy behind the movement asserted that individuals with disabilities knew best how their needs should be met. Individuals with disabilities successfully argued that the medical model, in which decision-making ultimately resided with health care professionals, was not appropriate for in-home supportive services (Benjamin & Fennell, 2007). The movement to give consumers control over their own services has become known as consumer- or self-direction. The national terminology is more likely to be self-direction, however, the programs evaluated in Ohio called themselves (and still do) consumer-directed.

OLDER ADULTS AND CONSUMER DIRECTION

Empowering older recipients of publicly funded long-term services has been slow compared with other populations such as persons with intellectual disabilities, although significant momentum has built over the last

decade (Stone, 2006). A telephone survey of 40 state administrators found that approximately 75% of states had consumer-directed services for older adults (Infeld, 2004). A recent study also found that nearly 48% of Area Agencies on Aging provide some form of consumer-directed services (Kunkel, Linscott, & Straker, 2008).

Attitudes and beliefs that challenged the appropriateness of consumer direction for older adults were responsible for the early roadblocks to program expansion. Nationally and in Ohio, some stakeholders questioned the appropriateness of consumer-directed programs for older adults, focusing specifically on concerns over clients' level of motivation, safety, family involvement, and over-utilization of services (Benjamin & Fennell, 2007; Stone, 2006).

Many early detractors assumed that older adults would not want to or even be able to manage their own services, instead they believed that the daily operations of services were best suited to professional agency workers. During the 1980s and 90s, policymakers were also concerned that older adults with cognitive impairments would be unable to direct their own services (Stone, 2006). Since consumer-directed services rely on the consumer to train their workers, they argued that without regulations in place to ensure that workers were well-trained and monitored by an agency – either a case manager or agency worker – participants would be at greater risk of harm and abuse through injury, inadequate care, or fraud.

Another more pragmatic fear dealt with employing and paying family members. If family members were to relinquish their unpaid roles, to become publicly-paid caregivers, long-term care expenses could increase sharply as an estimated 80% of long-term care is provided by unpaid family members (U.S. General Accounting Office,

1977). Finally, there were concerns of a more services to recipients the services become more desirable increasing the number of people utilizing the services (Stone, 2006). Again, policy-makers feared an increase in program costs.

CASH & COUNSELING'S POSITIVE RESULTS LEAD TO EXPANSION

In practice, all consumer-directed programs are not the same. These programs range in flexibility, from the Cash & Counseling model, where individuals have the ability to use their own budgets to hire workers and purchase additional goods and services, to the consumer-directed model currently found in Ohio and elsewhere, where individuals have the ability to hire, manage, and fire their workers, but are restricted from using their budgets for additional goods and services not covered under Medicaid. These are typically things such as repairs to assistive devices, vehicle modifications, and handyman services, among others. Another important feature of Cash & Counseling is the ability to carry unspent dollars from one month to the next in order to save for larger purchases such as microwaves or car adaptations that will help the participant remain independent.

The Cash & Counseling demonstrations in Arkansas, New Jersey, and Florida addressed many of the questions concerning the appropriateness of consumer direction for older adults. From 1999 to 2003, these states implemented and rigorously evaluated the Cash & Counseling option in the states' Medicaid programs. Participants, either children, adults with disabilities, or seniors, in the Cash & Counseling programs were given the opportunity to hire and manage their own workers and to purchase goods and services.

Overall, the Cash & Counseling options did not increase enrollment in the state programs and did not place participants at greater risk than those participants receiving

care from agency workers (Carlson, Foster, Dale, & Brown, 2007). At the same time, consumers and caregivers were highly satisfied with services. Furthermore, Cash & Counseling participants reported better quality of life than their traditional case-managed counterparts.

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The demonstration results in the three states were so promising that the Robert Wood Johnson Foundation and the Centers for Medicare and Medicaid Services (CMS) expanded Cash & Counseling to 11 more states in 2004 - Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. Illinois also received funding from the Retirement Research Foundation to implement cash & counseling.

The promising findings from the Cash & Counseling Demonstration also positioned consumer direction to be included in the Deficit Reduction Act of 2005. In order to lower expenses over the next 10 years, The Deficit Reduction Act of 2005 mandated changes to Medicaid. Among the changes, states are allowed to develop cash and counseling programs within their Medicaid state plans without the current approval and renewal process (1915c waivers) from CMS.

The Act also increases spending to allow 60,000 Medicaid clients across the country to use the cash and counseling program (Kaiser, 2006).

Consumer-directed services are also being implemented within non-Medicaid programs through the Nursing Home Diversion Modernization Grant program. Through the Older American's Act statute, states can provide more flexible options to help individuals remain independent and in their own homes. To date, the Administration on Aging (AoA) has awarded 28 states funding to provide older adults and veterans consumer-directed services (Coffey, 2008).

OHIO'S OLDER ADULTS AND CONSUMER DIRECTION

Ohio provides a unique opportunity to study consumer direction in that two different demonstration projects were implemented in a similar time frame with different funding sources in different areas of the state.

Planning and Service Area 6 (PSA 6) - Choices Program

Implementation of the Choices program began in 1997 after Ohio was chosen as 1 of the 13 states to receive grant funding from the Robert Wood Johnson Foundation's *Independent Choices: Enhancing Consumer Direction for People with Disabilities* program to develop and evaluate consumer direction. The Ohio demonstration project focused on older adults receiving home care services through the state's 2176 Medicaid home- and community-based waiver program, PASSPORT. Planning and Service Area 6¹ was chosen as the site to implement the Choices program. PSA 6 is in central Ohio and serves an eight county area that includes

¹ Planning and Service Area 6 is also known as The Central Ohio Area Agency on Aging.

the Columbus metropolitan area. The PASSPORT program at this planning site served approximately 2,000 adults during the evaluation phase.

After programmatic delays connected to waiver approval, enrollment in the program began February 1st, 2002. All participants were eligible for PASSPORT, having incomes low enough to qualify for Medicaid and impairments severe enough to make them eligible for a nursing home level of care designation.

Council on Aging of Southwestern Ohio - Elderly Services Program

The Council on Aging of Southwestern Ohio², implemented a consumer-directed (CDC) care model at two of its five county levy-funded Elderly Services programs (ESP): Hamilton County and Butler County.

Hamilton County, which includes portions of the Cincinnati metropolitan area, had over 5,500 clients receiving case-managed services, while Butler County had 3,200 participants. Enrollment began in August, 2001. All enrollees did not qualify for PASSPORT services either because they were not impaired enough to meet nursing home level of care or they did not qualify financially for Medicaid.

It should be emphasized that all clients participating in the consumer-directed demonstration projects at both sites were recruited from the population who were already receiving traditional case-managed services. Those enrolling into either program for the first time were not given the option to choose consumer direction.

There were some notable implementation differences between the consumer-directed and the traditional case-managed

² The Council on Aging of Southwestern Ohio is also an Area Agency on Aging.

services. In the consumer-directed options, case managers provided extensive training to those choosing to enroll. Case managers were required to provide 2-3 trainings that focused on the philosophy and basics of consumer direction, hiring and managing workers, and working with the fiscal intermediaries or payroll, among others. These training sessions varied in length, some sessions taking as little as one half hour, while others went as long as two hours. Training had not been a part of the enrollment process in traditional case-managed services. So, with the consumer-directed option, case managers' roles changed from preparing the budget with input from clients, to coaching and training individuals to develop and manage a personalized care plan. Furthermore, case managers in the consumer-directed program needed to continually be aware of how their own professional standards could negatively impact the clients' choice for independence (Kunkel & Nelson, 2006).

Training had not been a part of the enrollment process in traditional case-managed services. So, with the consumer-directed option, case managers' roles changed from preparing the budget with input from clients, to coaching and training individuals to develop and manage a personalized care plan.

Participants in the programs were given the option to hire who they wanted such as family members and friends, whereas in traditional case-managed programs workers were assigned to them. Finally, participants in the consumer-directed program potentially had more of their budget at their disposal as they were directly contracting with the workers instead of going through a third party or agency to find a worker. In other words, similarly impaired clients in the two programs would receive the same monthly budget, but the money would go farther in the consumer-

directed option. If that sum were \$1,100 per-month, the PASSPORT client, whose services cost roughly \$22.00 per-service hour, would receive about 50 hours of care per month; whereas the consumer-directed client, whose services cost roughly \$13.00 per hour, would receive close to 85 hours of care – approximately 30% more hours.

PSA 6 and The Council on Aging of Southwestern Ohio separately contracted with the Scripps Gerontology Center at Miami University to compare their clientele receiving consumer-directed services with those who chose to remain in the traditional case-managed home-care programs. The Scripps Gerontology Center and the demonstration sites sought to identify and compare consumer-directed and traditional case-managed clients on the following:

1. Client characteristics;
2. Client satisfaction levels;
3. Impact on informal caregivers; and
4. Cost of services.

METHODS

From 2001 to 2004, 169 PSA 6 clients enrolled in the PASSPORT Choices demonstration, while 165 participants enrolled in ESP's Consumer-Directed Care option. Multiple methods were used to gather information from clients and family members. Client information such as age, gender, activities of daily living (ADL) and instrumental activities of daily living (IADL) impairment levels, cost of current traditional services, satisfaction levels, and informal support was gathered from existing client administrative data and a three-page survey administered to clients by case managers during initial client training. Using a pre-test/post-test design, clients who chose consumer direction were compared at entry into the program and after six months to examine potential changes in service

satisfaction levels, informal caregiver supports, and service costs. Using a survey that included questions identical to those asked at baseline (entry), Scripps researchers conducted follow-up telephone interviews at six months. The response rates for both sites' follow-up interviews were 58%.

Approximately 400 enrollees at both sites who remained under traditional case-managed services were randomly selected for comparison with the consumer-directed groups. Similar to the consumer-directed groups, socio-demographic information such as age, gender, race, medical conditions, and service cost, as well as activity of daily living characteristics were gathered from existing client administrative data. Information about informal support and satisfaction levels was also gathered either through phone calls (PSA 6) or through mailed surveys (ESP). Response rates for these interviews and surveys were modest: 43% for PSA 6, 58% for ESP.

In order to increase our knowledge about the impact of consumer-directed services on caregivers, we sampled caregivers of consumer-directed clients in the Elderly Services Program, (N = 45). We attempted to contact caregivers who provided the majority of informal support prior to the participants' enrollment. We asked caregivers in the 15 to 20 minute semi-structured phone interviews to respond to closed and open-ended questions related to the amount of care they provided to participants, their satisfaction with the services received by participant, and how the services impacted their lives.

RESULTS AND DISCUSSION

Fewer than 5% of the existing clients from the PASSPORT or the ESP programs enrolled in the consumer-directed option during the two years of the study. In comparison, approximately 8-10% of the older participants chose consumer direction in the Cash & Counseling Demonstration sites

(Mahoney & Simone, 2006). In both Ohio's programs older adults needed to be enrolled in the home care option prior to receiving consumer-directed services; this stipulation was similar to the New Jersey and Florida Cash & Counseling Demonstrations, so it is not entirely clear why a smaller percentage of participants in the Ohio studies chose the services.

Similar to the Cash & Counseling programs, the majority of participants at both sites hired family members. A snapshot of these workers suggests that most participants hired one individual provider, usually a family member, even though participants could hire more than one worker to perform different shifts and/or tasks.

A high percentage of consumer-directed clients chose to use an authorized representative, that is, a person to hire and train care providers and manage services for the client. In PSA 6's PASSPORT Choices program, 79% of the consumer-direction demonstration clients designated an authorized representative. In regard to authorized representatives, their use in Ohio's Medicaid waiver program was slightly higher than in the Florida demonstration sites' elderly populations (a comparable Medicaid waiver program), where 60% to 70% had a representative to manage allowances. In ESP, the use of authorized representatives was lower, at 41%. It is likely that authorized representatives were assigned more frequently in the PSA 6 program because of the clients' generally lower levels of functioning as evidenced by the nursing home level of care requirement.

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sites hired family members. A snapshot of these workers suggests that most participants hired one individual provider, usually a family member, even though participants could hire more than one worker to perform different shifts and/or tasks.

CLIENT CHARACTERISTICS

Clients choosing consumer-directed services at both sites tended to be older and Caucasian (see Table 1). Participants at the ESP site were less likely to live alone than their counterparts who stayed in the traditional program (48% compared with 68%). At PSA 6, even fewer consumer-directed clients lived alone, 23%.

At both sites, participants choosing consumer direction tended to be more impaired. Of PSA 6’s consumer-directed

clients, 50% were impaired in four or more ADLs, compared to 29% of a sample of 399 traditional clients. Even greater differences were noted for the ESP consumer-directed clients, where 20% had four or more ADLs compared to 5% of those who remained in the traditional program.

At both sites, consumer-directed participants were more likely to have cognitive impairments than their traditional case-managed counterparts. In that regard, those clients at the PSA 6 PASSPORT site who chose the consumer-directed option had a nearly 3% higher rate of dementia than those staying with traditional services, with nearly 1 in 5 participants having Alzheimer’s disease or dementia. Interestingly, the number of consumer-directed participants with Alzheimer’s/dementia at the ESP site had

**Table 1
Characteristics of Consumer-Directed and Traditional Clients**

	PSA 6: PASSPORT Program		Elderly Services Program	
	Choices PASSPORT N = 168	Traditional PASSPORT N = 399	CDC ESP N = 165	Traditional ESP N = 407
Age	78.7	77.3	82.0	80.7
Female	80.7	83.7	83.9	79.4
African American	25.7	26.7	30.1	27.3
Lived alone	23	NA	47.6	67.6 *
4 or more ADL impairments	49.6	29.1*	20.4	5.1 *
Alzheimer’s/Dementia	19.0	16	26.1	10.5*

* Significant at ≤ .05

significantly higher rates of dementia; more than double that of the traditional case-managed group (26% to 11%).

CLIENT SATISFACTION

The consumer-directed client satisfaction levels were most remarkable in PSA 6's PASSPORT site (see Table 2). Not only were these differences significant from their own baseline attitudes taken before entry into the program, their satisfaction levels increased to the levels of those who did not choose to enroll in the consumer-directed program. After six months, 100% of the 87 consumer-direction clients surveyed rated the quality of the program as good or excellent. Taken together with the findings from the Cash & Counseling sites which showed that the majority of participants were satisfied with the program overall, these findings suggest that the consumer-directed program gave a satisfactory alternative to those who might not be completely satisfied with their traditional services.

Since participants have the ability to choose their own worker, it is not surprising that there was a significant difference between traditional and consumer-directed participants on the question 'How satisfied right now are you with the ability to choose the person who takes care of you?' One hundred percent of the PSA 6 participants who chose the consumer directed program were satisfied with their ability to choose their worker, compared to 93% in traditional services. Similarly, more of these participants were significantly more satisfied with the level of input into the type of services they received than traditional PASSPORT participants. This should be expected, since consumer-directed participants have the ability to determine what services they receive, who provides them, and when they are provided. Finally, there were differences between the PSA 6 groups on satisfaction with their case manager's advice.

PSA 6 consumer-directed participants were significantly more satisfied with the advice given by case managers.

The consumer-directed client satisfaction levels were most remarkable in PSA 6's PASSPORT site (see Table 2). Not only were these differences significant from their own baseline attitudes taken before entry into the program, their satisfaction levels increased to the levels of those who did not choose to enroll in the consumer-directed program.

It is clear from these studies that the process of case management in consumer direction is different. Professionals are now responsible for coaching and educating, whereas in the traditional program, clients might feel that the case manager is not giving advice, but telling them what to do. One case manager reflected in a focus group held after a training session about consumer direction, "We are first a trainer, then an observer" (Kunkel & Nelson, 2007, p.81). In this study we see that those who choose consumer direction are satisfied with the case manager's new role.

It is notable, that, at both sites, those who chose consumer direction were more satisfied with the number of service hours received in the new program than what they received in traditional services. Still, the results suggest that for PSA 6 even the increased number of received hours of service may not be enough.

Table 2
Satisfaction Levels for PSA 6 PASSPORT Choices
and ESP CDC Participants at Baseline and After Six
Months Compared to Traditional Home Care Clients

	PSA 6: PASSPORT			Elderly Services Program		
	Baseline Choices N = 168	Six Month Choices N = 87	Traditional PASSPORT N= 207	Baseline ESP-CDC N = 165	Six Month ESP-CDC N = 84	Traditional ESP N = 157
Overall how would you rate the quality of the services received?	90.8	100.0 ^a	97.1	NA	95.0	NA
How satisfied right now are you with ...						
the ability to choose the person who takes care of me?	51.9	100.0 ^a	93.3 ^b	72.5	97.5 ^c	93.6 ^d
the opportunity to choose the types of services that I need?	77.0	100.0 ^a	93.3 ^b	82.1	98.8 ^c	95.0 ^d
the number of hours of service that I receive?	61.3	76.7 ^a	81.6	64.3	85.2 ^c	85.2
the availability of case manager advice when I am making decisions?	95.0	98.8	92.8 ^b	89.8	92.3	96.2 ^d

- a: Comparison of baseline Choices to six month Choices significant at $\leq .01$
- b: Comparison of six month Choices to traditional PASSPORT significant at $\leq .01$
- c: Comparison of Baseline ESP-CDC to six month ESP-CDC significant at $\leq .01$
- d: Comparison of six month ESP-CDC to Traditional ESP significant at $\leq .01$

It is notable, that, at both sites, those who chose consumer direction were more satisfied with the number of service hours received in the new program compared to what they received in traditional services. Still, the results suggest that for PSA 6 even the increased number of received hours of service may not be enough. The lower levels of satisfaction with hours should not be

surprising since the comparison on physical functioning, living arrangements, and cognitive functioning shows us that PSA 6 participants were more impaired than their counterparts remaining in the traditional program, suggesting that they may have a greater need for more hours of care, even (more) than the additional hours that consumer-directed program could provide.

Those who chose the consumer-directed option were significantly more satisfied with the relationship with their workers, the level of respect shown by workers, and the completion of tasks (see Table 3). Again, this should not be surprising since most workers hired by PSA 6 and ESP participants were family members. The largest difference between consumer-directed and traditional programs dealt with workers arriving on time and staying as long as they should. Of the consumer-directed clients, at PSA 6 (94%) expressed satisfaction in contrast to only 82% of the traditional clients. This difference might be a product of consumer-directed clients and workers having the flexibility to negotiate mutually agreeable schedules, especially if workers are family members. Additionally, agency workers may have to move on to their next scheduled client, even if they have not completed all the tasks asked of them.

IMPACT ON CAREGIVERS

Enrollment in consumer-direction now allows the consumer to hire the previously unpaid caregiver or hire a family member or friend who they know and trust and who can assist whenever they are needed.

In PSA 6's consumer-directed program, clients at pre-enrollment and at 2-3 month and 6 month intervals, were asked how many hours of informal, unpaid care they received per day from family members or friends (see Table 4). There was a significant reduction of unpaid care hours from enrollment to six months. At pre-enrollment, 155 consumer-directed clients surveyed received an average of 8.1 hours of unpaid caregiving from family and friends, slightly more than the 7.1 hours a day received by the traditional clients. After six months,

consumer-directed clients received six hours of unpaid service a day from unpaid family/friend caregivers. A comparison of PSA 6 consumer-directed participants at six months and a snapshot of traditional clients shows that fewer informal care hours were provided for participants receiving consumer-directed services. Patterns of unpaid caregiving hours in the Elderly Services Program mirror those of PSA 6. It is clear that the level of unpaid care does decline in consumer-directed programs. These findings were similar to the Cash & Counseling demonstration where the number of hours provided by primary informal caregivers in Arkansas declined (Foster, Brown, Phillips, Carlson, 2005). It is important to note, however, that participants did not receive more hours of care than specified in their care plan after transitioning into the consumer-directed program, this suggests that they utilized more of their authorized hours of care. Before consumer direction, someone who was authorized to receive homemaking and personal care services, might have decided against it because he or she did not want a stranger in the home or because scheduled services conflicted with other activities such as medical appointments. Instead, an informal caregiver performed the services. Enrollment in consumer direction now allows the consumer to hire the previously unpaid caregiver or hire a family member or friend who they know and trust and who can assist whenever they are needed.

In order to assess the impact of consumer-directed services on caregivers, we surveyed caregivers at the ESP site. Before surveying, we attempted to assure that caregivers responding were providing the majority of unpaid care prior to participants' entry into ESP and not providing paid services currently. Of the 45 caregivers assessed in ESP, most of the informal caregivers were daughters and nearly 50% of respondents acted as authorized representative, fore-

Table 3
PSA 6 Comparison of Consumer-Directed Participants to
Traditional Participants' Satisfaction with Worker

	PSA 6 PASSPORT Choices	PSA 6 PASSPORT Traditional
	N = 87 %	N = 207 %
Are you satisfied with the relationship between you and your worker?		
Yes	100	95.2*
Do the workers who provide services to you respect your values?		
Yes	98.8	94.7*
In the past month, has your worker failed to complete assigned tasks?		
No	98.8	88.8*
In the past month, has your worker neglected you?		
No	100	98.5
In the past month, has your worker arrived late or left early?		
No	93.8	82.7*
In the past month, has your worker treated you disrespectfully or rudely?		
No	100	96.1

* Significant at $\leq .05$

Table 4
Informal Caregiving for PSA 6 Choices PASSPORT Participants

	PSA 6 Choices Baseline N=155	PSA 6 Choices 2-3 months N=141	PSA 6 Choices Six months N=122	PSA 6 Traditional PASSPORT N= 193
Number of Informal Care Hours	8.1	6.2	6.2*	7.09

* Significant at $\leq .05$ comparing Choices PASSPORT at six months to Traditional PASSPORT

going payment in order to assist the consumer with the administration of ESP services. Most were providing nearly seven hours of unpaid care per day.

All of the caregivers acting as authorized representatives and not providing services were satisfied with the services received by the care-recipient, agreeing that the quality of services was good to excellent, and that the workers were following participants' preferences when completing tasks. Nearly 90% of the caregivers acting only as authorized representatives thought that the consumer-directed services provided them with more free time and 95% thought that the paid caregiver did their job the way that the care-recipient wanted them to. The majority of authorized representatives stated that the services helped them be better caregivers and nearly eight out of ten stated that it has given them more free time. Every caregiver acting as an authorized representative stated that they would recommend the program to others.

COST OF SERVICES

Consumer-directed services cost significantly less per hour than agency services since the services were directly contracted by clients with workers and there were no administrative costs. The lower service cost, however, has not translated to

savings for either consumer-directed program. As previously mentioned, each program gave consumer-directed clients a dollar amount equivalent to the dollar amount assigned for traditional clients assessed at the same level of impairment and need. Because of lower hourly unit costs, consumer-directed participants could purchase more hours of service.

Two reasons may have contributed to the increase in the cost of consumer-directed services. First, PSA 6 and ESP consumer-directed clients were more impaired on average than traditional participants. In our study, clients self-selected into the program, so those who were more disabled may have realized that consumer-direction could offer them not only choice and flexibility, but more hours of needed services. Another contributing factor to higher costs could have been that consumer directed clients used more of their allotted services. For instance, in both programs, individuals who received traditional services did not use all of their authorized hours. Some clients in traditional programs who were allocated homemaking and personal care hours chose not to utilize them because of an unwillingness to allow a stranger in the home or an inability to reschedule services if needed. Individuals in each consumer-directed program used nearly 100% of their authorized hours.

The findings from the two demonstration sites in Ohio were similar to those from the National Cash & Counseling Demonstration. Higher costs were found in the three Cash & Counseling states across all programs and age groups, except for the sample of older adults in Florida where most (due to implementation problems) did not receive Cash & Counseling services during the evaluation period. Similar reasons were suggested for the increase in cost, underutilization of services by those not choosing Cash & Counseling, and more services required for care of the Cash & Counseling group. In Arkansas, participants' expenditures on other Medicaid long-term care such as home health and nursing home usage were reduced. Compared with institutionalization costs, the Cash & Counseling recipients had 18% fewer expenditures than traditional clients (Mahoney & Simone, 2006).

IMPLICATIONS

At both the PSA 6 and ESP sites, clients gave the consumer-directed program higher marks in most categories than those given for traditional services.

Findings from these two demonstration sites bode well for consumer-directed service delivery to older adults in an area that many say matters most: client satisfaction. At both the PSA 6 and ESP sites, clients gave the consumer-directed program higher marks in most categories than those given for traditional services. This is a significant outcome as most aspects of traditional services for both PASSPORT and the Elderly Services Program have consistently earned satisfaction levels above 90% over the years. But with consumer direction, satisfaction rates on specific indicators often were in the high 90s, in addition to the 100% client satisfaction level regarding the overall quality of the

PASSPORT consumer-directed program.

The satisfaction level of the caregivers in these demonstrations rivals that of the clients themselves. Caregivers at the ESP site were unanimous in recommending the program to others. The caregivers surveyed observed that the services provided through consumer direction gave them more free time and helped them be better caregivers.

Regarding funding, while the consumer-directed clients spent more, it is very likely because their impairment level warranted more services, and not because the services themselves were more expensive than those for traditional clients. Even in studies like the Cash & Counseling evaluation, where randomized sampling eliminated the differences in socio-demographic and physical functioning characteristics, the results indicated that costs increased for those who chose consumer-directed services. Our findings in Ohio along with those from the Cash & Counseling sites suggest that there is more service utilization because the flexibility of consumer direction allows participants to utilize their authorized services to the fullest extent possible.

Finally, the 5% participation rate (and the large number of authorized representatives) in consumer direction remains a curiosity only partially explained by the popularity of traditional aging services in Ohio. But, it is likely that the participation rate will increase through word-of-mouth and other means as long as positive experiences with consumer direction continue. As more programs come on-line within Medicaid and non-Medicaid programs, the greater the chance that participants will have more choice and flexibility over their services in the future.

FUTURE STEPS

Since the conclusion of the two evaluations, each site has continued to maintain their consumer-directed programs. More recently, PASSPORT Choices, the consumer directed Medicaid waiver option was expanded to two additional, rural PSA sites in the state. Evaluation of these additional sites is expected to show differences between the PSA 6 site in this study which included the Columbus metropolitan area. The site administrator for one of the rural sites notes the benefits of the consumer-directed program:

“It is anticipated that the isolation of where the consumers reside and the lack of agency providers and workforce shortage of agency care workers in those areas may have an even greater impact on the viability of consumer-direction in

rural Ohio” (Personal Correspondence with Suzanne Shelpman, 2008).

The Deficit Reduction Act which allows states to provide consumer-directed services without a waiver is likely to increase the number of self-directed services and the number of states offering them. What remains unknown is the potential of AoA’s priority in Nursing Home Diversion consumer-directed programming for non-Medicaid individuals who are at imminent risk of nursing home placement and Medicaid spend-down. Recently, Ohio became 1 of 28 states to receive funding through the Nursing Home Diversion program to provide consumer-directed services to older individuals receiving Title III funding.

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