

# **LEVEL OF CARE INTEGRITY**

## **PEER REVIEW STUDY**

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## **Executive Summary**

**Background and Purpose:** This paper presents the results of an analysis of the consistency and accuracy of assessments conducted to determine Nursing Facility Clinical Eligibility (NFCE) for specified individuals and determines whether the assessment instruments used to collect and record data during the assessment process are sufficient to permit appropriate levels of care determination. NFCE level of care assessments are conducted by Pennsylvania's fifty-two Area Agencies on Aging (AAAs). With the continued growth in the PDA Waiver program and other home and community-based services, there was a need to determine whether a statistically significant difference existed in the level of care determinations among the fifty-two AAAs.

**Issues:** Are level of care determinations consistent and correct, or are consumers being determined NFCE that do not meet the criteria? Do the assessment tools sufficiently support collection of data to make an appropriate level of care determination?

**Methodology:** Statistical analysis was conducted on expert review comparisons of existing and new face-to-face assessments. The analysis included three populations with differing data collection procedures.

**Population 1:** Ten assessments were randomly selected from each of the 5 randomly selected AAAs for a total of fifty assessments. Four clinical consultants and two expert reviewers each reviewed 25 existing assessments for a total of 150 duplicated outcomes. The reviewers recorded their outcomes for comparison to the original determinations.

Descriptive statistics showed wide variability both among the participating reviewers and between their determinations and the original assessment determinations. In addition, the reviewers noted numerous assessments for which an outcome could not be determined due to lack of documentation in the assessments.

**Population 2:** Two expert reviewers examined and recorded their determinations on 108 existing assessments. These determinations were compared to the original reviewer determinations. Assessments were randomly selected from 7 AAAs.

Descriptive statistics and hypothesis testing for consistency of results show statistically significant variances in the level of care outcomes between the expert reviewers and the original assessments. Again, the reviewers noted numerous assessments for which an outcome could not be determined due to lack of documentation in the assessments.

Hypothesis testing for consistency of results between the two expert reviewers also evidenced statistically significant differences between their levels of care determinations.

**Population 3:** Assessment teams were comprised of an experienced trained assessor, a registered nurse, and an assessment supervisor. The teams performed

new face-to-face assessments of 94 consumers selected randomly from seven randomly selected AAAs. The assessment team outcomes were reviewed by the two expert reviewers to determine the consistency and accuracy of the outcomes.

Before conducting the assessments, in a telephone conference call to organize the study, members of the assessment teams and the expert reviewers discussed the definition and criteria for NFCE. In addition, the two expert reviewers met separately to discuss the NFCE definition / criteria in order to ensure its standard application.

Comparisons of the Population 3 assessment team determinations to the determinations of the expert reviewers showed no statistical differences in the outcomes. The outcomes of both expert reviewers were consistent with the outcomes of the assessment team, as well as, consistent with each other. As defined within the study structure, this signifies that these results were consistent and accurate. In addition, review of the documentation for every face-to-face assessment determined that reviewers had included sufficient information to support the assessment outcome.

**Conclusions:**

While this review and analysis demonstrated inconsistencies and inaccuracies in assessment outcomes among AAAs using current methods, it did not signal the causes. It

is likely, however that some portion of the variance can be attributed to differences in the interpretation of criteria for clinical eligibility among assessors.

This review also demonstrated that measures exist to correct the variance among AAA determinations. Clear and concise definitions and criteria, applied by trained and experienced staff, result in assessment outcomes that are accurate and consistent. Moreover, Population 3 evidenced that when properly used, the assessment form is sufficiently comprehensive and supports the data collection necessary to determine an appropriate level of care determination.

**Recommendations:**

1. The Pennsylvania Department of Aging (PDA) and the Department of Public Welfare (DPW) should finalize and publish a comprehensive, clearly stated and enforceable definition and criteria for Nursing Facility Clinical Eligibility.
2. PDA and DPW should train physicians and medical professionals who prepare MA-51's and prescriptions for NFCE to ensure they are fully knowledgeable of the NFCE criteria and consistently apply it.
3. PDA should intensively retrain all personnel in the Aging Network to assure they are fully knowledgeable of the NFCE criteria and consistently apply it.

4. PDA should reinforce / enhance the role of the Registered Nurse and contract medical personnel in the determination of Nursing Facility Clinical Eligibility. Because the determination of level of care is primarily a medical determination, the decisions of these personnel should have significant weight in the final decision.
5. PDA should establish a standard format for the recording of the assessment decision narrative. A standard format should assure that assessors record their findings consistent with the eligibility criteria and that they appropriately document, substantiate, and summarize their conclusions. The form would assure that assessors consider the criteria in a logical and straightforward manner and should result in more consistent and correct determinations.
6. PDA should require that the decision narrative be completed for assessments for all level of care assessments, including NFI. The preparation of the decision narrative is critical and documentation should be sufficient to support any determination.
7. At least annually, PDA should conduct a review and analysis such as this one. This will improve consistency among assessment results, ensure proper documentation, and compliance with established criteria.
8. PDA should hire a Geriatric Registered Nurse Practitioner to conduct regular and periodic compliance monitoring, establish a continuous quality improvement process for level of care determinations, and provide on-going consultation and training to AAA assessors, care managers, and medical personnel.

## **LEVEL OF CARE INTEGRITY PEER REVIEW STUDY**

### **Background:**

State regulations and policies require Area Agencies on Aging (AAAs) to conduct level of care assessments to determine Nursing Facility Clinical Eligibility (NFCE) for consumers seeking placement in nursing care and other residential facilities, or for enrollment in government-funded services. In Pennsylvania these NFCE level of care assessments are locally conducted by Pennsylvania's fifty-two Area Agencies on Aging (AAAs). With the continued growth in the PDA Waiver program and other home and community-based services, there was a need to determine whether a statistically significant difference existed in the level of care determinations among the fifty-two AAAs.

### **Issues:**

The major question addressed by this study is whether the NFCE assessments apply the appropriate criteria and result in correct and consistent determinations. In addition, the studies sought to determine whether the assessment instruments used to collect the data are sufficiently comprehensive and pose the questions necessary to support a level of care determination.

### **Methodology:**

There does not exist an absolute standard or computational algorithm through which an assessment can be measured to determine correct outcomes. NFCE is determined by

comparing consumer data to an established definition and criteria. This determination is, by its nature, subject to human interpretation and application. To address these issues, we decided to conduct an analysis of the findings from existing assessments and from comparisons to new face-to-face assessments. The analysis would consist of two populations with differing data collection procedures. The analytic technique for both populations would be the same.

### Population 1:

In the first population, five (5) AAAs were randomly selected from a sample composed of three (3) strata, defined by the range of the number of assessments conducted annually by the AAAs. This was to ensure representation from AAAs of all sizes and to preclude introducing bias by having any one AAA or strata over-represented in the study. From each of these AAAs, ten (10) consumers were randomly selected and the most recent, comprehensive level of care assessment was extracted for each consumer. These assessments formed the base sample against which reviews would be compared.

The assessment results, NFCE or Nursing Facility Ineligible (NFI ), were tabulated by individual consumer. Assessments were ‘sanitized’ by removing all references to the level of care so that only the assessment question responses, text entries, and the decision narrative summation remained. These sanitized assessments were reviewed by PDA personnel whose NFCE/NFI determinations were compared to the determinations on record. Assessment documentation, assessor notes, and decision narratives were reviewed for this purpose. This cross comparison established a measure of the

consistency of the results. Reviewers included the Division Chief and four (4) clinical consultants from the PDA Clinical Consultation and Quality Assurance Division, all experienced assessor, care managers or care management supervisors, and the Director of Bureau of Home and Community Based Services, a registered nurse.

The two expert reviewers and the clinical consultants were each randomly assigned 25 assessments to be reviewed. Assignments assured that each ‘sanitized’ assessment was separately reviewed by three experienced assessors that would determine the level of care, based on the data recorded by the original assessor. Three outcomes could result from these reviews: NFCE, NFI, or NEI (Not Enough Information). An NEI outcome tracked instances where the reviewers were unable to make a determination based upon the data recorded by the original assessor.

### Population 2:

For the second population, seven (7) AAAs were randomly selected from a sample composed of three (3) strata, defined by the range of the number of assessments conducted annually by the AAAs. This ensured representation from AAAs of all sizes to preclude introducing bias by having any one AAA or strata over-represented in the study. None of the 7 AAAs was included in Population 1. From each of these AAAs, 25 consumers were randomly selected for whom assessments had been conducted during the period of January 1 to May 31, 2005 and which resulted in the provision of home and community based services. The most recent comprehensive level of care assessment was extracted and face-to-face reassessments were conducted.

Assessment teams were formed to conduct these assessments. The teams were composed of a trained assessor, a Registered Nurse, and an experienced Assessment Supervisor. These personnel were screened to ensure they were experienced and qualified. The teams were established such that no team had members from the same agency in any two positions within the same team. This ensured that no particular agency interpretation or implementation of the established criteria for nursing facility clinical eligibility was able to skew the results.

The intent was to compare the results of the face-to-face reassessments to the initial assessments to check for comparable results. Since the four-month time period allotted for the assessments could potentially skew the comparability of the original assessments to the reassessments, the study was separated into two (2) phases with a total of three (3) populations. The description of each phase, the populations, the analysis, and conclusions follow.

#### Phase I:

This phase has two components.

The first component is Population 1 as previously described. These 50 historical assessments were reviewed and their analyses are provided below. This analysis was primarily used to determine whether the determinations were consistent between the assessors.

The second component uses Population 2 as previously described. Two expert assessors reviewed the initial completed assessments and made their determinations of clinical eligibility, which each reported as NFCE, NFI, or NEI. Because this analysis measured outcomes between the historical assessment and the results of our experts, it became a measure of the accuracy of their assessments. If their determinations were found to be inconsistent with expert determinations, then the results of the historical assessments would be determined as inaccurate.

For each of the two components, descriptive statistics on the results of the reviews were presented. These statistics showed the numbers of assessments distributed by the outcomes of the reviewers. For Populations 2 and 3, these descriptive statistics were analyzed using statistical techniques to determine if there is a statistical significance among the differences in results.

### **Population 1**

This Population included 50 assessments, which were reviewed by one of two expert reviewers and two of four clinical consultants. Along with the original assessments, this resulted in four assessment outcomes that were compared for consistency (See Table 1). These assessments resulted in 39 original determinations of NFCE.

<b>Table 1: Pop 1 NFCE Assessment Review Distribution by Assessor</b>						
<b>Reviewer Determination</b>	<b>Clinical Consultant Pair 1</b>		<b>Clinical Consultant Pair 2</b>		<b>Expert Reviewer</b>	
<b>NFCE</b>	33	84.6%	30	76.9%	29	74.4%
<b>NFI</b>	5	12.8%	6	15.4%	6	15.4%
<b>NEI</b>	1	2.6%	3	7.7%	4	10.2%
<b>TOTAL</b>	39	100%	39	100%	39	100%
<b>Original NFCE Determinations n=39</b>						

As shown in Table 2, all three reviewers agreed with the original NFCE determination for 27 (69.2%) of the 39 assessments. At least two reviewers agreed with the NFCE determinations on 30 (76.9%) assessments. At least one reviewer agreed with the NFCE determination on 34 (87.2%) assessments. Expert reviewers agreed with the NFCE determination on 29 (74.4%) of the 39 assessments.

<b>Table 2: Pop 1 NFCE Grouped Assessment Reviews</b>						
<b>Reviewer Determination</b>	<b>All 3 Reviewers Determined</b>		<b>At Least 2 Reviewers Determined</b>		<b>1 Reviewer Determined</b>	
<b>NFCE</b>	27	69.2%	30	76.9%	34	74.4%
<b>NFI</b>	2	5.1%	6	15.4%	9	15.4%
<b>Original NFCE Determinations n=39</b>						

A similar outcome was noted on nursing facility clinically ineligible (NFI) determinations. There were 11 original determinations of NFI. As shown in Table 3, there was very little movement or change in the outcomes for NFI determinations.

Table 3: Pop 1 NFI Assessment Review Distribution by Assessor						
Reviewer	Clinical		Clinical Consultant		Expert	
Determination	Consultant Pair 1		Pair 2		Reviewer Pair	
NFCE	1	9.1%	1	9.1%	0	0%
NFI	8	71.7%	10	90.9%	10	90.9%
NEI	2	18.2	0	0%	1	9.1%
<b>TOTAL</b>	11	100%	11	100%	11	100%
<b>Original NFI Determinations n=11</b>						

All three reviewers agreed with the original NFI designations on 7 (63.6%) of the eleven assessments. At least two reviewers agreed with the original NFI determination on 10 (90.9%) assessments. At least one reviewer agreed with all of the original NFI determinations.

Table 4: Pop 1 NFI Grouped Assessment Reviews						
Reviewer	All 3 Reviewers		At Least 2 Reviewers		1 Reviewer	
Determination	Determined		Determined		Determined	
NFCE	0	0%	0	0%	1	9.1%
NFI	7	63.6%	10	90.9%	11	100%
<b>Original NFI Determinations n=11</b>						

Notably, there were 6 (15.4%) assessments that expert reviewers determined as nursing facility ineligible (NFI) that had originally been determined as NFCE. For all six assessments, there was at least one clinical consultant that agreed with the NFI

determination. This is noteworthy since over 15% of the NFCE determinations were later determined to be NFI.

Another factor that impacted the outcome is that some assessments could not be scored because there was insufficient assessment documentation (NEI) to make a determination. We were unable to determine whether the information was never obtained or whether it was obtained but never recorded. What is known is that the assessment forms were sufficient to record the necessary information.

## Population 2

The second set of assessments included 108 assessments. At least one of two expert reviewers examined them. Sixty-two (62) of the 108 had original NFCE determinations. Of the assessments reviewed by the Care Manager expert reviewer, 34 were originally determined NFCE. The Care Manager (CM) expert reviewer agreed with twenty-two (64.7%) of the original determinations, with another 10 that the CM expert reviewer determined to be NEI due to lack of documentation.

<b>Table 5: Pop 2 NFCE Assessment Review Distribution by Assessor</b>				
<b>Reviewer Determination</b>	<b>Expert Reviewer</b>		<b>Expert Reviewer (CM)</b>	
		<b>(RN)</b>		
<b>NFCE</b>	12	36.4%	22	64.7%
<b>NFI</b>	17	51.5%	2	5.9%
<b>NEI</b>	4	12.1%	10	29.4%
<b>TOTAL</b>	33	100%	34	100%
<b>Original NFCE Determinations</b>				

The CM expert reviewer agreed with all the original NFI determinations. The RN expert reviewer noted one assessment that could not be resolved due lack of information.

<b>Table 6: Pop 2 NFI Assessment Review Distribution by Assessor</b>				
<b>Reviewer Determination</b>	<b>Expert Reviewer (RN)</b>		<b>Expert Reviewer (CM)</b>	
NFCE	0	0%	0	0%
NFI	30	96.8%	24	100%
NEI	1	3.2%	0	0%
<b>TOTAL</b>	<b>31</b>	<b>100%</b>	<b>24</b>	<b>100%</b>
<b>Original NFI Determinations</b>				

Significantly, the RN expert reviewer determined that 17 (51.5%) of the original 33 NFCE determinations were nursing facility ineligible (NFI). This is of particular interest since only 5.9 % of the NFCE determinations reviewed by the CM expert reviewer were later said to be NFI.

However, the CM reviewer did identify significantly more assessments as NEI. This does not account for the large variances in NFCE determinations between the CM expert reviewer and the RN expert reviewer.

The objective of this analysis was to determine if the outcomes of the original assessments were accurate, measured against the outcomes from the expert reviewers. The outcome tested was whether the proportion of NFCE and NFI determinations by expert reviewers would be equal to the original determinations. This was tested using a t-

test, testing for equal proportions that determines if the proportion of expert NFCE are statistically the same for the AAA staff. A separate test was done for the NFI determinations. For example, if the expert determinations show 80% of the assessments had NFCE determinations, then the AAA staff should have close to 80% of their determinations as NFCE.

The maximum value of the t test statistic, calculated against 64 assessments in the test population, is 2.29 or -2.29 for a two-tailed test for the RN expert reviewer that would conclude the determinations are consistent. The maximum value the t test statistic, calculated against 58 assessments in the test population, is 2.30 or -2.30 for a two-tailed test for the CM expert reviewer that would conclude the determinations are consistent.

The actual test statistics are as follows:

Expert Reviewer (RN) vs. Original Determination – 7.595 p-value = 0.000

Expert Reviewer (CM) vs. Original Determination – 3.647 p-value = 0.000

From the t tests, we conclude that the proportions of NFCE and NFI determinations were inconsistent with the original determinations. The proportions of NFCE determinations made by the experts were not consistent with the proportion of original NFCE determinations.

The descriptive and test statistics from the two expert reviewers bring into question the consistency between the expert outcomes. Accordingly, a t test was conducted to test the consistency of the results between the two expert reviewers.

Using a 95% confidence interval on the t test, the test statistic parameters show the determinations are consistent if the resulting statistic is in the range -.2838 to -.0872. The resultant test value, 0.373, is not within the bounded range of the parameters, indicating that the two expert reviewers are not consistent in their outcomes.

### Conclusions:

#### **Phase I:**

For both components of this Phase I analysis, analyzing assessments for Populations 1 and 2, there are statistically significant differences in the proportions of consumers assessed NFCE and NFI that the levels of care are not consistent from original to reviewer or within reviewer results.

It is noteworthy that for Population 2, for which the expert reviewers reviewed only the assessments, a very high inconsistency existed in the findings of the original assessments and between the expert reviewers. Therefore, the objective of the analysis for this population, to determine consistency and accuracy could not be met.

Because of this statistically significant difference, it is evident that one set of assessment outcomes is erroneous. It is highly probable that a large number of the level of care

determinations in the original assessments were incorrect. It is evident from the inconsistency between the expert reviewers, the original assessments, and the reviews by the clinical consultants that there is significant variability in the understanding and application of the definition and criteria for NFCE.

Expert Reviewer Comments: Discussions with the expert reviewers regarding the major points of disagreement where assessment reviews resulted in a different level of care outcome pointed to four (4) significant factors:

1. Assessors were determining that consumers were NFCE for medication monitoring and setup. However, the assessment responses, notes, and narratives did not evidence that the consumer required services by or under the supervision of skilled medical personnel.
2. Assessors were determining that consumers were NFCE without physician-ordered medical services or medical services required on a regular basis.
3. Assessors were determining that consumers were NFCE without a medical plan of care to provide services normally required in a nursing facility.
4. Consumers were being determined NFCE based upon deficiencies in activities of daily living (ADLs) and independent activities of daily living (IADLs), absent underlying medical conditions that required skilled medical services existed.

## **Phase II:**

This phase involved face-to-face reassessments for Population 2 and did not compare the results to the initial assessment. Instead, the two expert assessors reviewed the results of the reassessments and provided determinations that were compared to the reassessments performed by the assessment teams.

To overcome the inconsistencies noted in Phase I related to level of care determinations between the CM and the RN expert reviewers, these individuals met, reviewed, and discussed NFCE criteria to form a common understanding and application before the expert reviewers performed their assessment reviews of Population 3. Most members of the assessment teams participated in a conference call wherein the NFCE criteria were reviewed. It is likely that the assessors, who were among the best and most experienced, would be especially diligent in assessing, documenting, and reviewing assessments.

Members of the assessment team were provided a template (attachment 1) containing a format and logic model to be used in completing the assessment Decision Narrative. This Decision Narrative was used to summarize the findings of the assessors and to document the justification for the level of care decision. The template was withdrawn and assessment team members were told not to use it. Its structure showed assessors the decision logic they should follow in making their decisions and as such, its influence on the level of care determinations must be considered.

### **Population 3**

This population consisted of 94 assessments from the same AAAs as Population 2. These assessments were completed using the shortened Level of Care assessment form (see attachment 2), developed for the Community Choices process. This shortened assessment form, approved for use by DPW and the GOHCR to determine consumer level of care, is a reduced question set from the more commonly used PACOAF (see attachment 3). The Level of Care assessment form was the only data collection instrument used by the assessment teams in collecting and recording the information needed to make the level of care determination.

Like the Pennsylvania Comprehensive OPTIONS Assessment Form (PACOAF), the Level of Care assessment form has a note area for every question in which the assessor can note comments to further expand or explain the responses selected from the available menus. In addition, assessors and reviewers are to document their justification for their determination within the Decision Narrative. This portion of the assessment was available for assessors to document additional information used in the decision process that did not have an assigned area in the Level of Care assessment form.

Due to logistical problems in conducting the face-to-face assessments, the number of assessments to be reviewed is not the same as those for Population 2. However, a sample set of 94 assessments is sufficiently large to produce statistically reliable results at a meaningful confidence interval.

Of the issues reported by the assessment teams in the conduct of the face-to-face assessments and their subsequent reviews by team members, there were numerous anecdotal examples of both RN's and assessment supervisors calling other members of the team to obtain more detail or clarity when making their recommendations. This behavior is indicative of the degree of importance placed on this exercise and without a doubt contributed greatly to consistency and accuracy of the results. In particular, the RN's were very active and involved in ensuring the levels of care determinations met the medical needs components of the NFCE criteria.

These assessments had 44 determinations of NFCE by the AAA staff. As shown in Table 7, the expert reviewers concurred in every assessment determined NFCE by the assessment teams.

<b>Table 7: Pop 3 NFCE Assessment Review Distribution by Assessor</b>				
<b>Assessment Determination</b>	<b>Expert Reviewer (RN)</b>		<b>Expert Reviewer (CM)</b>	
	NFCE	44	100.0%	44
NFI	0	0%	0	0%
NEI	0	0%	0	0%
<b>TOTAL</b>	44	100%	44	100%
<b>Original NFCE Determinations n=44</b>				

<b>Table 8: Pop 3 NFCE Grouped Assessment Reviews</b>				
<b>Reviewer Determination</b>	<b>Both Reviewers Determined</b>		<b>1 Reviewer Determined</b>	
	NFCE	44	100.0%	44
NFI	0	0%	0	0%
<b>Original NFCE Determinations n=44</b>				

The nursing facility clinically ineligible (NFI) had a similar outcome. There were 50 original determinations of NFI. Both reviewers determined in 47 of the 50 (94.0%) assessments an NFI determination was appropriate. One reviewer made an NFCE determination on 3 (6.0%) of the forty-four assessments.

<b>Table 9: Pop 3 NFI Assessment Review Distribution by Assessor</b>				
<b>Reviewer Determination</b>	<b>Both Reviewers Determined</b>		<b>1 Reviewer Determined</b>	
NFCE	0	0%	3	6.0%
NFI	50	100.0%	47	94.0%
NEI	0	0%	0	0%
<b>TOTAL</b>	<b>50</b>	<b>100%</b>	<b>50</b>	<b>100%</b>
<b>Original NFI Determinations n=50</b>				

<b>Table 10: Pop 1 NFI Grouped Assessment Reviews</b>				
<b>Reviewer Determination</b>	<b>At Least 2 Reviewers</b>		<b>1 Reviewer Determined</b>	
NFCE	0	0%	3	6%
NFI	47	94.0%	47	94.0%
<b>Original NFI Determinations n=50</b>				

The outcome tested was whether the proportion of NFCE and NFI determinations by expert reviewers would be equal to the original determinations. This was tested using a t-test, testing for equal proportions that determines if the proportion of expert NFCE are statistically the same for the AAA staff. A separate test was done for the NFI determinations. For example, if the expert determinations show 80% of the assessments had NFCE determinations, then the AAA staff should have close to 80% of their determinations as NFCE.

The maximum value the t test statistic could be, calculated against all 94 assessments in the test population, is 2.28 or -2.28 that would conclude the determinations are consistent.

The actual test statistics are as follows:

Expert Reviewer (RN) vs. AAA Staff – 0.002 p-value = 0.999

Expert Reviewer (CM) vs. AAA Staff – -0.617 p-value = 0.539

The conclusion from the t tests is that the proportions of NFCE and NFI determinations were consistent with the original determinations. The analysis was done with a 5% probability of concluding there is an inconsistency when there actually is consistency.

The correlation between the expert reviewers was 0.938, with a maximum of 1.0. This indicates a very high correlation, or relationship, between the two expert determinations.

The analysis does not explain why the results are consistent this time, just that there are consistencies. A factor that has an effect on the outcomes is that all of the assessments could be scored and a determination made.

### **Findings:**

There are no statistically significant differences between the level of care determinations made by the assessment teams and the expert reviewers. In fact, there was 100% correlation between the assessment results from the assessment teams and the RN expert reviewer.

Given that the expert reviewers had conferred after Phase 1 regarding the application of the draft NFCE definition and criteria, and that this draft definition had been provided to the members of the assessment team, ensuring that all individuals involved in the process had a clearly stated definition and criteria, results are consistent. This would indicate that, given a definition and criteria for NFCE (although draft), designed to be clear and readily understood, the Aging Network could consistently determine accurate outcomes.

While the Decision Narrative format and logic model was withdrawn, a review of the decision narratives submitted with the face-to-face assessments clearly showed the influence of this format in the structure of the narratives, the details provided and the clarity of the rationale used in making the determinations. There were no assessments for which the expert reviewers were unable to review due to NEI.

The Level of Care assessment form, a subset of the questions asked in the PACOAF, proved to be sufficient in form and content to enable the assessors to record the information needed to make an informed and appropriate level of care determination. There were no instances of the expert reviewers being unable to make a level of care determination due to not having enough information.

The assessment teams, composed of trained and experienced assessors, RN's, and assessment supervisors, worked together as teams to produce complete, well-documented and well-supported levels of care determinations.

**Recommendations:**

1. The Pennsylvania Department of Aging (PDA) and the Department of Public Welfare (DPW) should finalize and publish a comprehensive, clearly stated and enforceable definition and criteria for Nursing Facility Clinical Eligibility.
2. PDA and DPW should train physicians and medical professionals who prepare MA-51's and prescriptions for NFCE to ensure they are fully knowledgeable of the NFCE criteria and consistently apply it.
3. PDA should intensively retrain all personnel in the Aging Network to assure they are fully knowledgeable of the NFCE criteria and consistently apply it.
4. PDA should reinforce or enhance the role of the Registered Nurse and contract medical personnel in the determination of Nursing Facility Clinical Eligibility. Because the determination of level of care is primarily a medical determination, the decisions of these personnel should have significant weight in the final decision.
5. PDA should establish a standard format for the recording of the assessment decision narrative. A standard format should assure that assessors record their findings consistent with the eligibility criteria and that they appropriately document, substantiate, and summarize their conclusions. The form would assure that assessors consider the criteria in a logical and straightforward manner and should result in more consistent and correct determinations.

6. PDA should require that the decision narrative be completed for assessments for all level of care assessments, including NFI. The preparation of the decision narrative is critical and documentation should be sufficient to support any determination.
7. At least annually, PDA should conduct a review and analysis such as this one. This will improve consistency among assessment results, ensure proper documentation, and compliance with established criteria.
8. PDA should hire a Geriatric Registered Nurse Practitioner to conduct compliance monitoring, establish a continuous quality improvement process for level of care determinations, and provide on-going consultation and training to AAA assessors, care managers, and medical personnel.

**Summary:**

This review and analysis shows that there have been inconsistencies and inaccuracies in assessment outcomes. While the causes are undetermined, this review demonstrates that the Aging Network is capable of producing accurate and consistent assessment outcomes if provided clear, concise definitions and criteria by which to make these determinations. Trained and experienced staff under the direction of medical professionals is essential.

The Level of Care assessment form, and by extension the PACOAF, of which the Level of Care assessment form is a subset, enables assessors and reviewers to collect the appropriate data and record comments to justify level of care decisions.

