COST-EFFECTIVENESS OF COMMUNITY BASED LONG TERM CARE FOR THE ELDERLY POPULATION: A DESCRIPTIVE STUDY OF CURRENT FINDINGS OF UTAH'S ALTERNATIVES PROGRAM

by

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ABSTRACT

This study addressed the question of whether alternative care modes are cost effective options for the elderly who would otherwise seek nursing home care.

Descriptive and comparative information about the primarily elderly populations of the Utah state funded community based Alternatives in Long Term Care (TAP) Program and the federal/state funded Medicaid program for intermediate care facility (ICF) level of nursing home care were examined.

Results suggest that nursing personnel should be sensitive to political influences and decision making regarding cost effectiveness of alternative programs.

CONTENTS

LIST OF TABLES

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CHAPTER ONE

INTRODUCTION AND REVIEW OF LITERATURE

Problem Statement

Nursing home costs for the elderly are such an increasingly heavy public burden that the pursuit of ways to meet the long term care needs of this group and to reduce the rate of increase of the costs has become intense. Public criticism of nursing homes (Brody, 1977; Health Care Financing Administration, 1981; Kane & Kane, 1980) has encouraged the development of alternative care modes as a substitute for nursing home care. Alternative modes of care, however, also incur expense. While numerous governmental reports have estimated that a substantial proportion of the residents of nursing homes do not need that level of care (Congressional Budget Office, 1977; Department of Health, Education, and Welfare, 1976; United States General Accounting Office, 1979a, 1979b), it is an open question whether cost effective alternatives can be provided to the elderly who would otherwise require

nursing home care. This study addresses that question by generating descriptive and comparative information from the following research questions:

1. What are the demographic characteristics of community based clients and nursing home residents?

2. What types of services from all sources do the community based clients receive?

3. What are the comparative public costs of services provided in a community setting and a nursing home?

Review of Literature

Long-term care of the chronically disabled elderly has become a problem of increasing societal concern. This concern stems from two factors: a) the escalating costs of institutional care for this group (Health Care Financing Administration, 1981; United States General Accounting Office, 1979a, 1979b), and b) rapid increases in the size of the "old-old" (over 75 years) population in the United States (Health Care Financing Administration, 1981; White House Conference on Aging, 1980). In 1979, for example, more than nine billion dollars of public funds were spent for institutional care of the chronically ill, the majority of whom were 65 years of age and older (Fox & Clauser, 1980; White House Conference on Aging, 1980). Available data

indicate that functional impairment increases with age (United States Department of Health and Human Services, 1981; United States Accounting Office, 1977). This trend is substantiated by the fact that 35% of current residents of long term care facilities are 85 years of age and older (United States Department of Health, Education and Welfare, 1977). Significantly, this latter group constitutes the most rapidly growing population in the United States today and is expected to more than triple by the year 2003 (Health Care Financing Administration, 1981; White House Conference on Aging, 1980). This unprecedented demographic change is anticipated to generate increasing health care expenditures in the United States in the foreseeable future.

A United States General Accounting Office report (1977) estimated that 20% to 40% of the currently institutionalized elderly population could be more appropriately cared for through coordinated community based care options. However, due to severe restrictions in eligibility criteria for reimbursement of community based care by Medicare, Medicaid, Block Grants to States for Social Services, (Titles XVIII, XIX, and XX of the Social Security Act, respectively) and other third party payers, not enough of the services are presently

available to meet this demand (United States General Accounting Office, 1977). This situation forces many elderly and their families to choose between nonprofessional family care at home and nursing home care.

Although it is popularly believed that public financing of long term care is a relatively recent phenomenon, there has always been a significant public role in supporting care of the chronically disabled through alms houses, boarding homes, retirement hotels and rest homes (Doherty, Segal & Hicks, 1978). Prior to 1935, however, government support was largely a state and local matter.

Federal involvement in the care of the frail and dependent elderly dates largely from the passage of the Social Security Act in 1935, prompted partially by widespread dissatisfaction with state and municipal alms facilities housing indigent, disabled, and elderly people. The Social Security Act and subsequent amendments established a complex network of programs targeted by age, income and condition and largely organized along functional lines such as income support, social services and medical care. These patterns of funding and organization are found at every level of federal, state and local public responsibility. The

Congress, government officials at all levels, consumers, and health care providers generally have agreed that the present programs often fail to promote the following desired objectives (Health Care Financing Administration, 1981; United States General Accounting Office, 1979a, 1979b; White House Conference on Aging, 1980):

1. The maximum feasible independence of the individual in making decisions and in performing everyday activities.

2. The provision of services in the least restrictive environment, preferably at home or in other community settings.

3. The provision of appropriate, cost effective, accessible, and humane care to all individuals who need it.

4. The encouragement and support of the care provided by family and friends.

Since the range of services which provide assistance to the chronically disabled is broad, it is difficult to isolate how much is actually spent on long term care from all public and private sources. Existing data do not substantiate the widely held belief that spending for nursing home care is substantially larger than spending for noninstitutional care (Health Care

Fincancing Administration, 1981). However, some evidence can be cited in support of the tenet. Total federal expenditures for nursing home care were over ten times the expenditures for home health in 1978 (Health Care Financing Administration, 1981). Nevertheless, the conclusion commonly drawn from such an example cannot be substantiated for total public and private spending. Indirect use of public dollars provided through the Social Security program for long term care services in institutional or community settings cannot be accurately calculated due to the complexity of the system. Some services financed under health care programs are actually basic living services. For example, money spent on nursing home care pays for food and housing as well as nursing (Kane & Kane, 1980; LaVor & Callender, 1976). Finally, the extent to which the patterns of expenditure are appropriate is difficult to judge without more detailed analysis of population needs and service effectiveness.

Where expenditures can be definitely related to long term care, it is clear that costs are high and rapidly increasing. Accurate information on the relative costs of long term care is important to policy makers responsible for providing an adequate level of care at a reasonable cost to the public. Specifically,

policy makers are interested in knowing whether community based care or nursing home care should consume a greater portion of the public dollar. Most cost effectiveness studies evaluating long term care modes have methodological weaknesses. The hypothesis for most of the studies stated alternative care could serve as a less expensive substitute for institutionalization for certain elderly persons. Confirmation of the hypothesis has been difficult because: a) experimental groups were usually not imminently at risk of institutionalization and, consequently, the two populations were not comparable, b) secondary and tertiary costs were often omitted from cost comparisons, c) service components varied among the programs, d) administrative structures differed, e) social, economic, and demographic characteristics were often not considered, f) study samples were often too small to generalize to the population as a whole, g) studies often lasted for only a short time, which did not support the development of a stable delivery system, and finally, h) the costs of increased utilization from untapped demand were often not considered in the studies (Doherty & Hicks, 1977; La Vor & Callender, 1976; Seidl, Austin & Green, 1977).

Several approaches have been used to study the cost of alternative services. Most of the early reports

testing cost effectiveness of community based services compared to nursing home or regular hospital services suggested considerable cost savings could be achieved by substituting alternatives for institutionalization (Bricker, Janeski, Rich, Duque, Starita, La Rocco, Flannery & Werlin, 1976; Chapell & Penning, 1977; Colt, Anderson, Scott & Zimmerman, 1977; Hammond, 1977; Kistin & Morris, 1972). However, many of the studies lacked methodological sophistication with estimates of financial savings based upon the judgment of health care professionals that alternative care could have been substituted for nursing home care or hospitalization for a select percentage of the population (Brickner et al., 1976). Seidl et al. (1977, p. 7) classified the select clients as "who but fors," meaning those individuals who would be in nursing homes if it were not for the availability of alternative care services. The early studies examined the relative costs of community based care versus nursing home care by inappropriately comparing combined monthly unit costs for community services (e.g., an hour of housekeeping, an hour of home health, one home-delivered meal, etc.) with the monthly costs of nursing home care which represented an entire package of services, including room and board (La Vor & Callender, 1976). Hammond (1977) summarized

representative studies in the literature on cost effectiveness of home health care as an alternative to hospitalization or nursing home care concluding that community based care was less expensive than nursing home care for third party payers. The costs were roughly equivalent for persons receiving the same level of care whether services were rendered in the institution or the client's home.

A second approach determined a break-even point beyond which home care became more expensive than institutionalization, based upon the client's level of impairment (Health Care Financing Administration, 1981; Untied States General Accounting Office, 1977). The studies considered the costs of home care services provided by public resources and the value of the services provided by family and friends, citing the financial feasibility of rendering home care services diminishing as the impairment level of the client increased. The General Accounting Office study (1977) indicated that there was a level of impairment, or break-even point, where the cost of home services, including the value of services provided by family and friends, equalled the cost of institutional care. Beyond that impairment level, the cost of home care was significantly greater than the cost of care rendered at

an institution. This break-even point fell in the greatly impaired level, which was defined as those persons who were mildly or moderately impaired in three of the following five areas of functioning: a) social, b) economic, c) mental, d) physical, e) activities of daily living -- and severely or completely impaired in a fourth area. Ninety percent of the elderly participants fell below the break-even point, indicating that the majority could have received community care at a lower cost than nursing home care.

Other studies used an economic framework to determine the impact of alternative programs on total systemwide costs, considering the additional demand for new services, program costs, and community living costs (Doherty et al., 1978; Kane & Kane, 1980; La Vor & Callender, 1976). If alternative services could be substituted for nursing home care, and the availability of such services would increase the demand, savings realized from reduced nursing home expenditures might be obscured (Weissert, 1977). Doherty et al. (1978), as well as La Vor and Callender (1976), identified the need to evaluate how the impact of aggregate demand for care will affect expenditures when alternative services are available. An alternative services program may generate a demand from two groups: a) persons already

institutionalized or at high risk for institutionalization, and b) persons in the community needing alternative services, but not imminently at risk for institutionalization. Thus, alternative programs would serve as an additional service, rather than a substitute for nursing home care, increasing the client caseload and aggregate public expenditures (Brody, 1973).

Recent reports from some of the major federally funded demonstration projects [ACCESS in Monroe County, New York (Eggert, Bowloyow & Nichols, 1980); Georgia's Alternative Health Services Project (Georgia Department of Medical Assistance, 1982)]; the Minnesota Cost Containment Study (Anderson, Patten & Greenberg, 1980); the New Mexico Long Term Health Care Study (State Health Planning and Development Bureau, 1981); and New York State's Nursing Home Without Walls Program (New York State Senate Health Committee, 1981)] suggested that community based services targetted to meet most at risk of institutionalization may be cost effective. However, many of the projects were ongoing and the preliminary findings were not entirely consistent with critical review in the literature.

As more carefully controlled studies were performed, findings emerged indicating that alternatives

may, in fact, product positive health outcomes, but at increased cost (Kane & Kane, 1980). Employing an experimental design, the evaluation of demonstration projects authorized under Section 222 of the Medicare law found homemaker services significantly more costly. Although the experimental group lived longer, a higher rate of hospitalization resulted over the control group (Weissert, Wan, Livieratos & Pellegrino, 1980). Weissert et al. (1980) noted that "effective screening of patients to limit those served to patients at risk of institutionalization would improve cost saving projects" (p. 230). Preliminary findings from two other major demonstrations [Wisconsin Community Care Organization (Applebaum, Seidl & Austin, 1980) and the Illinois Community Care Program (Taber, Anderson & Rogers, 1980)] indicated that differences in costs of community based care and nursing home care were nonsignificant. Both studies pointed to "poor data" as being a problem area in determining if regular home delivered services "really" delayed institutionalization.

Final reports issued by two major projects (Connecticut's Triage and Washington's Community Based Care Program) indicated that alternative services were more costly. Washington's Community Based Care Program

reported that total costs were slightly greater in an experimental community receiving expanded Medicaid coverage of community based services than in a comparison community utilizing services from existing programs (Solem, Garrick, Nelson, Cadwallader & Roecher, 1979). More members of the experimental than control group used long term care services. The additional use of services in the community increased total public expenditures (including client management, supplemental security income, and food stamps); 11 percent in one experimental site and four percent in the other. Whether the small differences would increase or decrease over time was unclear, since, the actual experimental phase of the project ran only for 15 months.

The Triage project also reported substantial cost increases among clients in the experimental group (Shealy, Quinn & Hicks, 1979). The program included case management and comprehensive coverage of health and social services for the elderly. The experimental group witnessed an increase of eight percent in per capita expenditures for services in 1977 and a 32 percent increase in 1978. When case management costs were included, per capita expenditures increased 20 percent in 1977 and 46 percent in 1978. One explanation for the

increases was that, unlike other demonstrations, Triage project services were not targetted for persons likely to be institutionalized. Clients were enrolled on a first come, first served basis. Also, the Triage experimental group was more impaired than the control group, which explained some of the increased utilization. Nevertheless, the available evidence suggested that a Triage-type program could substantially increase public expenditures for long term care.

Achieving cost savings through community based long term care depends on substituting community care for some institutionalized care. If alternatives supplement rather than substitute for institutional services, the additional services will add to the cost (Weissert et al., 1978). As Doherty et al. (1978) documented, total cost for health care services could only be limited by supply, since demand could be infinite. The diversion of substantial numbers of people who definitely would otherwise have entered a nursing home could be difficult. The existing evidence indicated that most nursing home residents who might be well served by alternatives had insufficient support in the community enabling the use of alternatives and avoidance of nursing homes (Dunlop, 1980). Since the early 1970s, federal and state administrators have believed a large

proportion of nursing home residents were inappropriately placed and alternative services could have sustained them in the family home (Congressional Budget Office, 1977; Department of Health, Education and Welfare, 1976; United States General Accounting Office, 1977; 1979a; 1979b). Implicit in the argument was the belief that nursing homes could return 40 percent of the residents to the community, saving public dollars (United States General Accounting Office, 1977).

Conceptual Framework

The conceptual framework regarding cost effectiveness of community based care for the elderly as compared with nursing home care consists of two dimensions: a) long term care for the elderly as a continuum containing both community based and nursing home care operating within a political environment and b) decision making within a political system. Each of these concepts is grounded in the basic principles of general behavior systems theory. Relevant concepts have been selected from various authors to illustrate this point (Abbey, 1978; Boulding, 1978; Finch, 1969; Hazzard, 1971; Katz & Kahn, 1978; McKay, 1969; Miller, 1955).

In the 1950s, the biologist Ludwig von Bertalanffy

proposed the general systems theory which recognized the interrelationships that tie a system together (Boulding, 1978; Katz & Kahn, 1978). Miller (1955) simplistically described a system as being "all of a thing" (p. 515). The systems approach requires that the system be planned and designed as an entity in order to satisfy the needs of the user. A system is a set of elements, or services, organized to perform a set of designated functions in order to achieve desired results. An element, or service, is a set of resources organized to perform some highly interrelated subset of the desired system functions. The resources that comprise an element include personnel, material, facilities, and information. The system is embedded in a set of environments: physical, mental, social, political, economic, and technological. These environments comprise a supersystem with which there are strong, highly complex interrelationships. The environments are a source of information and constraints concerning the use of the system. An optimal system is an arrangement which is expected to best satisfy recognized human needs and/or desires according to some specified criterion. To be useful, a system must satisfy a need (Abbey, 1978; Finch, 1969; Hazzard, 1971; McKay, 1969; Miller, 1955).

Boulding (1978) proposed a hierarchy of systems or

system of systems advancing from the most fundamental closed system, with little or no interaction with the environment, to the most complex open one, with considerable interchange with the environment. Boulding's hierarchy of systems is schematically illustrated through the use of a cone shaped model with the most fundamental closed system being at the closed bottom tip of the cone and the most complex open system being at the open mouth of the cone. A closed system may be thought of as a self-contained structure that will react with a predictable outcome (Abbey, 1978). Human systems are generally described as open systems with some being more open and complex than others (Abbey, 1978; Hazzard, 1971; McKay, 1969; Miller, 1955). An open system maintains itself through a constant exchange and interchange with the environment, producing a continuous inflow and outflow of information controlled by a semipermeable boundary. The exchange and interchange result in some alteration of the system (Miller, 1955). Katz and Kahn (1978) delineated the following common characteristics of an open system:

1. Input: Importation of energy from the external environment.

2. Throughput: Transformation of input.

3. Output: Exportation of a product made from

input by throughput.

4. Cycles of events: Circular character of activities, rather than one-way causality.

5. Negative entrophy: Process of developing higher organization and complexity.

6. Negative feedback: Return of a small amount of the output of the system to the input so as to correct and guide further output and to maintain a homeostatic balance or steady state; a method of self-regulation.

7. Dynamic homeostasis or steady state: Dynamic disequilibrium whereby the composition of the system remains constant, but there is a continuous exchange and flow of component material.

8. Differentiation: Greater specialization of function.

9. Equifinality: Sameness of the end result although starting from various points.

Callahan (1981) schematically illustrated the long term care system, inclusive of both community based and nursing home care, as the throughput of an open system with the client's personal demographic and functional characteristics being the input, and maximum functional independence, humane care in the least restrictive environment, prolonged longevity and prevention of avoidable medical/social problems being the desired

output or outcomes. Callahan (1981) suggested financial resources of a society, and political and societal attitudes toward the use of the resources are part of the environment within which a long term care system must function. He declared that "proposals to reduce costs of long-term care may or may not improve outcomes but are a necessary system response to environmental pressures" (Callahan, 1981, p. 221). This implies that decision making concerning allocative processes is an integrative exchange across system boundaries which may or may not promote the maintenance of equilibrium to achieve the desired outcomes of the long term care system.

Long Term Care as a Continuum

Long term care is a system of many components providing a comprehensive coordinated continuum of care based on the needs of the individual, financed privately and publicly through a unified system of entitlements. Long term care services are best conceptualized through "the creation of a continuum of services for meeting long-term health, personal, social and housing needs" (Rhodes & Hamilton, 1977, p. 2) of the target population. In the past, this continuum was considered in terms of two extremes only -- the private home or the institution. A more realistic continuum or array of

services consists of protection, prevention and intervention services; semi-independent services; and institutional services. "The different options along the continuum are designed to provide an elderly person with a choice of methods for meeting his or her needs in the least restrictive manner and in a way that ensures self-sufficiency and dignity" (Rhodes & Hamilton, 1977, p. 2).

A continuum of care must address a range of services to meet the physical, social, emotional, functional and environmental aspects of an individual's needs. A long term care continuum of service leads from the most restrictive, institutional environment where the least number of persons require care to the least restrictive community environment where more persons need services. Boulding's (1978) conical model of a hierarchy of systems, or services, moving from the most restrictive closed system to the least restrictive open system was adapted by the state of New Mexico in the 1981 Long Term Health Care Study to schematically depict the long term care system as a continuum of services operating within a political environment and dependent upon political involvement for change. The model was modified to correspond with the existing long term care system in the state of Utah by the investigator as part

of a functional State of Utah Long Term Care Unit. Figure 1 presents this hierarchical system of services. The integration of both health and social services into a single service system within a political environment is perhaps the most problematic area in developing any program. Eisele and Hoke (1979) expressed concern that long term care in this country has developed in the direction of an institutionally based medical services model, rather than an integrated social and medical services framework. Unfortunately, Medicare and Medicaid reimbursement mechanisms favor institutional settings of the preferred care modality for the chronically impaired or functionally dependent elderly (Health Care Financing Administration, 1981). Home health care and other noninstitutional services are technically reimbursible, but, due to the complexity of regulatory limitations and fragmentation of the delivery, such services are often discouraged (Georgia Department of Medical Assitance, 1982). The issue of long term care is now viewed as a continuum of services with a shift to the social services end of the spectrum (Eisele & Hoke, 1979).

The focus in long term care should not only be on the five percent of the elderly population who currently reside in institutions, but also on the 38 percent of

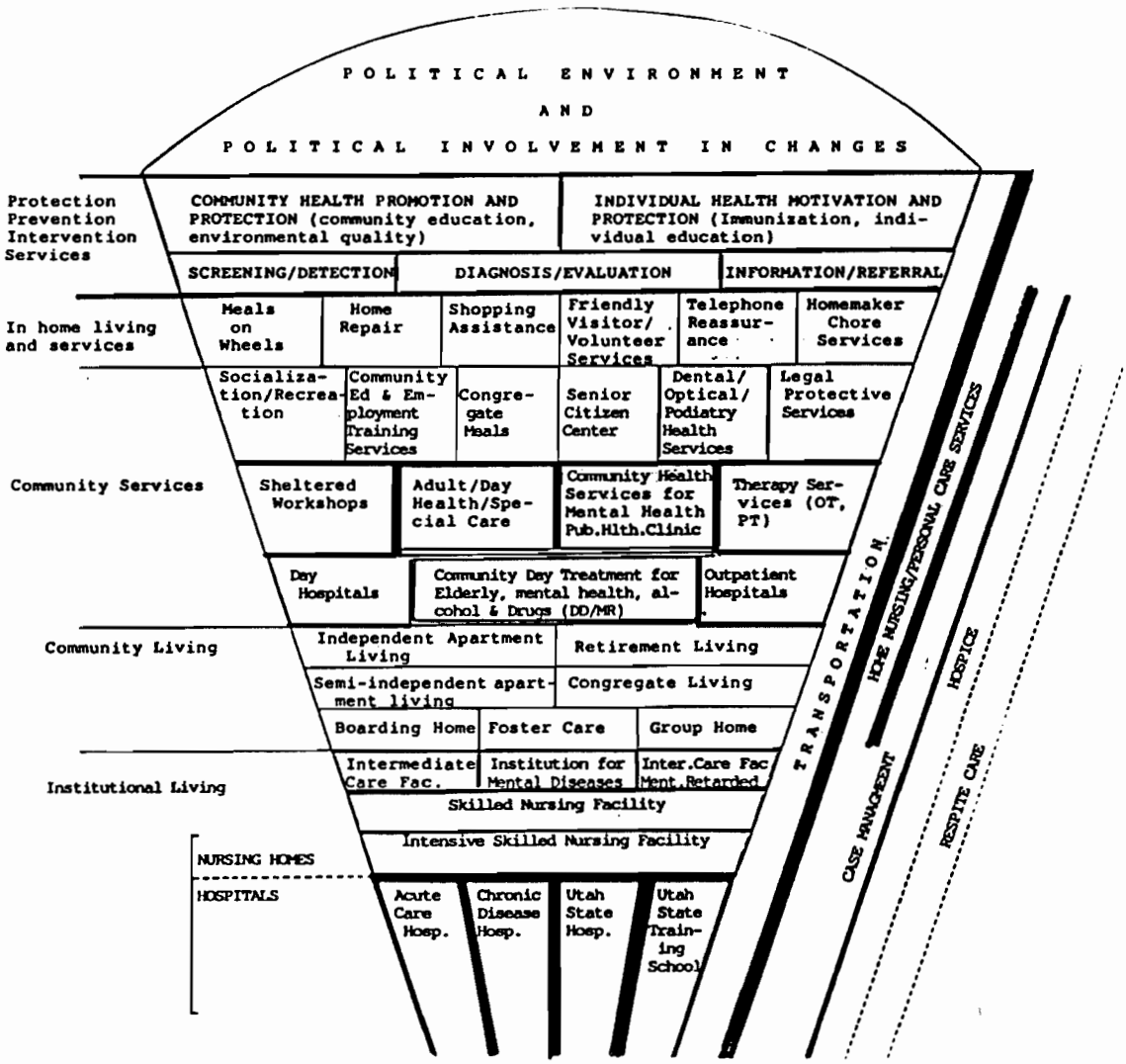

Figure 1. Long term care continuum of facilities and services. Adapted from model depicted in State of New Mexico's Long-Term Health Care Study (State Health Planning and Development Bureau, 1981, p. 28).

elderly persons who reside in the community and have major medical and social limitations (White House Conference on Aging, 1980) Any consideration of the long term care system should begin with the perception that there are many individuals who cannot be cured by medical intervention in a matter of days, weeks, months, or at all, and that the system will cause problems if not responsive to the needs of individuals over a long period of time. Institutional care is often used inappropriately in these cases because Medicaid will pay full cost of institutional care, in some circumstances, but rarely pays for social services in a noninstitutional setting (Health Care Financing Administration, 1981).

Current federal programs finance a variety of long term care services at local levels, primarily under Titles XVIII (Medicare), XIX (Medicaid), and XX (Block Grants to States for Social Services) of the Social Security Act; and Title III of the Older Americans Act (social and nutrition services and senior centers). Medicaid, Social Services Block Grants, and Older Americans Act Programs are state administered, while Medicare is federally administered. Income maintenance is provided mainly through the Supplemental Security Income (SSI) program and Old Age, Survivors and

Disability Insurance, both federally administered. Building oriented programs are operated by the Department of Housing and Urban Development, often under state and local administration. Although all the programs contribute to long term care, the system has evolved primarily within the locus of medical service because of federal funding support (Health Care Financing Administration, 1981).

State and local experiences indicate that the viability and effectiveness of projects designed to prevent avoidable nursing home admissions hinge upon the establishment of adequate public funding for a comprehensive array of community long term care services. However, the fragmentation and gaps in current federal sources of funding for long term care seriously impede efforts to initiate and maintain these projects. Financing and authority for long term care are splintered among the Health Care Administration, which houses Medicare and Medicaid; the Office of Human Development Services, which encompasses the Block Grants to States for Social Services and the Administration on Aging; the Social Security Administration, which administers the Supplemental Security Income (SSI) program; and the Public Health Service, which administers the National Center for Health Services

Research (United States General Accounting Office, 1979b).

Because each federal office channels funds to the state and local levels, the patchwork long term care system is preserved at each level of government. Staff who attempt to develop comprehensive long term care projects, whether demonstration or permanent programs, must spend an enormous amount of time piecing together and coordinating several federal funding sources with varying and often conflicting program criteria. For example, the Georgia Alternative Health Services Project (1982) encountered a number of difficulties in coordinating the Medicaid, Social Services Block Grant, Social Security, SSI, Food Stamp, and Older Americans Act programs. The difficulties arose as a result of divergent federal laws and regulations regarding a) client eligibility, b) federal state cost-sharing arrangements, c) allowable program costs, and d) reimbursement methods and reporting requirements for service providers.

Projects that rely solely on existing federal financing sources are constrained by restrictive eligibility policies and benefit structures from serving the entire population at risk of institutionalization or from providing the comprehensive range of services

needed to prevent avoidable nursing home admissions (United States General Accounting Office, 1979b). Because most projects use Medicaid and Social Services Block Grant funds to provide home services, a predominantly welfare population is served. By excluding the nonwelfare, or Medicare, population, these projects miss the opportunity to prevent avoidable admissions of private pay and Medicare patients who can later convert to Medicaid (Health Care Financing Administration, 1981).

Even if a particular service provided in a home is cost effective, the issue of who pays becomes relevant. If government provided benefits replace services that are currently provided informally by family and friends, the total bill may increase even if the services are being provided more efficiently. Services provided by families, although not costless, are usually less expensive than those purchased in a formal market. Thus, the substitution (if it occurs) will increase the total proportion of gross national product devoted to long term care even if the total volume of services rendered remains constant, and, accordingly, will increase the size of the government budget for long term care. Even if the formal service were proven to be much more cost effective than an equivalent volume of

services provided by family and friends, these potential financing shifts might make the change undesirable.

Others have argued that formal benefits can supplement family efforts keeping a client who would eventually be institutionalized in the community longer before institutionalization becomes inevitable (United States General Accounting Office, 1979b). Most families institutionalize relatives reluctantly as a last resort and only after considerable personal sacrifice, and various alternative solutions have been attempted (United States General Accounting Office, 1977, 1979b). Available evidence on the extent of substitution is limited. As Dunlop (1980) documented:

> Although common sense suggests that some families would retain their dependent elderly at home longer if certain formal support services were made available to them, there appears to be no hard, unbiased evidence to support this notion. Carefully executed studies to date provide only mixed, partial, and largely indirect findings with respect to the impact of home-based care provisions on rates of institutionalization for the dependent aged population (p. 515).

Decision Making within a Political System

Decision theory has contributed to systems theory by providing a framework for identifying criteria to be used in analyzing choices between and within human environments. The external environment of any open system produces specific demands and constraints that

exert influences upon the internal decisions and actions of elements within the system. The external environment contains both friendly and hostile elements. Decision making must be viewed as a process because it must reflect both antecedent behavior and/or events as well as anticipated consequences. Decisions are not isolated events and must be viewed as they affect the integrated whole system.

Any open long term care system must deal with the external political environment because ultimate decisions concerning public programming and funding are made in this arena. Political systems are complex organizations built upon personal, as well as collective, attitudes, values, and beliefs. Decision making in the public sector can be considered the pursuit of rational or "correct" values, ends or preferences (Simon, 1957). However, it is difficult to view the political process as rational. Simon (1960), generally accepted as the "father" of administrative decision making theory, proposed that every decision making process has three major phases: a) the intelligence activity, b) the design activity, and c) the choice activity. In this problem solving approach, the intelligence activity refers to the process of identifying problems or potential problems. The design

activity is the creation of alternative solutions for the identified problem. During the choice activity, a solution or course of action, is selected from those created in the design phase. The simplest way to view decision making is to visualize a decision as an act of choice by which a decision maker selects a position or action from two or more alternatives. Simon (1957) concluded that in the complex economic and political organizations of today, individuals cannot possibly process, or even obtain, all the information relating to the decisions that must be made. Instead of seeking the most advantageous decisions, persons merely try to set goals that represent reasonable achievements of action or minimally acceptable targets, a course called "satisficing" behavior. Simon (1957) rejected as unrealistic the classical economic theory subscribing to the belief that the decision maker, known as the "economic man," is omniscient and, therefore, capable of making decisions that maximize outputs. He proposed that the decision maker is an "administrative man" who "satisfices" by looking for a course of action that is satisfactory or "good enough."

Any decision making process must consider the beliefs, biases, and value preferences inherent in the decision maker. The past political decisions to spend

most public long term care funding on institutional services and to oppose community based benefits may rest on five implicit beliefs: a) Resources are always scarce, therefore, public money should be concentrated to support the most frail or disabled elderly persons. b) These individuals can best be cared for in institutions. c) Institutional care costs less per person than home care for those dependent enough to be eligible for the former. d) Institutional care is often feared or despised; underfunding community based care, therefore, encourages families to serve their disabled member. e) Public benefits from community based care would be so attractive that use would be very difficult to control (Department of Health, Education and Welfare, 1976; Dunlop, 1980; Health Care Financing Administration, 1981; Kane & Kane, 1980; United States General Accounting Office, 1977; 1979a; 1979b; Volk, Hutchins & Doremus, 1980). These five explanations are labeled "beliefs" because little evidence is available to support or defy them. Consequently, each belief has been subjected to vigorous contention from time to time.

Advocates of improved commmunity based care benefits for the elderly decry the inhumanity and expense of care offered by some nursing homes. Opponents of improved home care benefits, mindful of

Medicare's unexpectedly high costs, find a large new public benefit inconceivable in the present political and economic circumstances. Careful study has documented that the decisions about how to fund long term care have been haphazard (La Vor & Callender, 1976). However, the ongoing emphasis on institutional long term care should not be regarded as accidental.

Trustworthy evidence about the comparative costs and effects of alternative and institutional long term care has been difficult to compile for three principal reasons: First, outcomes of long term care in either setting have seldom been clearly, realistically, or appropriately delineated. Second, even if this were done, outcomes are still hard to measure. Third, even if outcomes could be measured well, random clinical trials of the costs and effects of home or institutional care have been difficult to conduct, on both practical and ethical grounds.

Without reliable data, few legislatures would be willing to support visable improvements in community based care benefits. When a proposal has clear political support, accurate information is not usually required. In the face of clear political opposition, the information is not likely to help. Long term care policy may be an area in which fear of costs and

skepticism about the efficacy of public programs are nearly balanced by dismays over the state of current programs. In this setting, improved knowledge may affect public decisions. In a time of rapidly increasing costs and scarce resources, an understanding of who pays how much for what services and for whom is essential. Kline (1968) described decision theory as a way of evaluating the worth of benefits received (effectiveness) for the resources used (cost) through a process known as cost effectiveness analysis.

The primary purpose of cost effective analysis is to assist a decision maker in identifying a preferred choice among possible alternatives (Doherty & Hicks, 1979). Forces that operate in the environment produce demands on the political system, supporting allocation of resources toward desired or valued objectives. The myriad of essential services needed by chronically impaired elderly individuals involves, by necessity, the allocation of scarce public resources by the decision making process (Volk et al., 1980).

Volk et al. (1980) emphasized that public decision makers work in a political environment imbued with political and societal values concerning the delivery of long term care. The following values of welfare and justice were suggested as prevalent in American society:

1. All persons should have access to basic health and social services.

2. Each individual must take personal responsibility for maintaining good health.

3. The role of the family in providing long term care is of primary importance.

4. The least restrictive long term care environment (community based) is preferred to the most restrictive (institutionalization).

5. No single mode for providing long term care will be satisfactory to everyone.

6. The government should provide only those goods and services that the individual cannot provide.

7. Health and social resources are scarce resources and require different decisions on allocations. Unlimited spending for any one commodity cannot be tolerated.

8. Fiscal restraint and responsibility must guide public policy.

9. Free enterprise is essential to our democratic and economic order.

10. Government intervention is needed to ensure a fair and efficient allocation of resources.

11. Government is obligated to ensure reasonable access to long term care services for all.

Because of the rapidly increasing public expenditure for long term care, major political problem areas arise at all governmental levels. There will be (Callahan, 1981; Volk et al., 1980);

1. Increased pressure to make better decisions about how to allocate limited resources with increased scrutiny of the funding decisions and policies from legislatures, other agencies, the general public and providers.

2. Increased competition for scarce funds.

3. Increased pressure to justify, document, and account for, dollars spent to the legislature and the general public.

4. Increased pressure to be more efficient and to improve internal management.

5. Increased pressure to show a more direct relationship between cost of services and benefits received by the consumers.

6. A need to reduce dependence on federal money and attract more varied sources of income.

7. Increased need to raise public and professional understanding and awareness of the real costs of providing services.

Up to this point, the approach of this investigation has been to identify those possible

options in long term care which would provide maximum benefits for the least cost in the public domain. The possible impact of any alternative, or option, on societal systems other than the long term care system has not been addressed. In the ideal case, the decision maker would always choose the option that satisfied the need or requirement of the specific systems and had no negative effect on any other system. The ideal rarely exists because changes in one societal system always generate changes in others because they are open systems. The best approach a decision maker can make is to maximize the effectiveness of a change in one system and minimize its negative effects on as many as possible of the other societal systems (Simon, 1957). Political systems must address decisions that crosscut many societal systems. In the realm of finite public resources, a gain for one component of the long term care system most probably would mean a loss for another component of the same system or other societal systems affected by the same political process.

Conceptual Definitions

Long term care refers to a system of services required by individuals who have functional limitations as a result of, or in conjunction with, chronic illness

or conditions. Long term care services are fundamentally crosscutting, involving both medical care and social services, and are provided in a variety of settings. Long term care is not synonymous with nursing home care. A person in need of long term care is one who, because of physical and/or mental conditions, is unable to cope with the tasks of daily living without assistance for extended periods of time. Much of this care comes not from formal services, but from informal support of family and friends. The independent variables compared in this study are community based care and nursing home care. They both are subsets of long term care.

The term community based care is used interchangeably with alternatives in long term care and is an array of medical and social services required by individuals with functional limitations as a result of, or in conjunction with, chronic illness or conditions. These services are brought into a home or semi-independent living arrangement singly or in combination in order to maximize the independence of the individual requiring such services.

For the purposes of this study, nursing home care refers to care provided in an intermediate care facility (ICF) "that fully meets the requirements for a State

license to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental or physical conditions require services that are above the level of room and board and can be made available only through institutional facilities"(Office of the Federal Register, 1980, p. 578). In addition to room and board, licensed intermediate care facilities in Utah provide

> technical nursing care (care which requires selected nursing procedures in those circumstances where a professional degree of evaluative judgment is not required). . .[through] personal care services such as help in walking, getting in and out of bed, assistance to patients as required in bathing, toileting, irrigation of functioning and regulated colostomies and catheters, enemas, and other standardized procedures which are commonly carried out, such as determining temperature, pulse rate, rate of respiration, and blood pressure, supervision and administration of routine medication and treatments . . .[and] an organized program of occupational and recreational therapy designed to meet the physical, social and emotional needs of the individual (Utah State Department of Health, 1966, p. 19).

Intermediate nursing home care was chosen as the comparison variable depicting nursing home care for this investigation because it is generally accepted that this population is most affected by inappropriate institutional placement and could possibly be better served in the community setting (United States General Accounting Office, 1977).

Cost effectiveness is defined as the extent to

which alternative services (community based care and nursing home care) accomplish the common objective of improving, maintaining, or retarding the rate of deterioration in the health of an elderly client while incurring the least cost. Cost comparisons can include public costs, private costs, and the imputed costs of informal care. This study focuses on public costs.

A continuum of long term care for the elderly is progression of a vast array of medical and social services ranging from institutional care to prevention as conceptualized in Figure 1. The essential nature of chronic illness and the problems of advancing age require this comprehensive approach and continuity of care calling for choice in options of care, movement within the system to meet changing needs, and the closest possible integration of the varied elements in the system of care.

The term elderly, as utilized in this investigtion, referred to any individual 60 years of age or older.

Subjects of the community based sample are referred to as clients and subjects of the nursing home study sample are identified as residents because these terms are used most commonly among cooperating agencies and both are intended to include individuals called "patients" by some agencies. The terms are not designed

to characterize or evaluate types of care which are being or should be provided.

Assumptions and Limitations

Assumptions underlying the construct of this study are as follows. First, it was assumed that long term care is best addressed through a continuum of services (Rhodes & Hamilton, 1977). Second, all individuals should have access to options to basic health care and related social services (Volk et al., 1980). The third assumption was that the elderly individuals prefer to stay in their own homes or community environments, if possible (United States General Accounting Office, 1979b). Fourth, it was assumed that the government has an obligation to ensure reasonable access to long term care services (Volk et al., 1980). Fifth, the assumption was made that the relative growth of governmental financial participation in long term care is likely to slow in light of changing political climates and rising heatlh care costs, calling for more fiscal responsibility and accountability in public supported programs (Callahan, 1981; Volk et al., 1980). The sixth assumption was that the community based clients would be in an intermediate care nursing facility if that service were not provided (Seidl et al., 1977). One-to-one cost comparisons can be made

only if clients of a community based program would otherwise be in nursing homes without the proper intervention. Treatment modes were presumed to result in the same outcome, but at different costs.

Limitations are inherent in the use of retrospective analysis of records, resulting from the application of certain criteria to already existing programs that were not designed to be research studies. The reliability of the sources of data as well as the recorder are always in question. Also, the dependency of a retrospective study on data already available is a weaker test of association than cross-sectional or prospective studies (Diers, 1979). Another major difficulty in comparing community based care with institutional care is that the cost data for the two are not exactly parallel. Intermediate care nursing home costs, generally expressed in per diem terms, include room, board, personal care, and technical nursing care; while community based costs, expressed in per visit, per hour, or per service terms, reflect only the social and health related technical services provided by the provider. Another limitation is grounded in the "self-fulfilling prophecy" construct. The wave of political support for the success of community based programs has polarized the system raising false issues as to cost

effectiveness. Diers (1979) cautioned that retrospective studies may draw unwarranted conclusions because the outcome is already known.

Rationale and Significance of the Study

The study was prompted by a number of concerns the investigator had regarding care for elderly persons who have long term illnesses or incapacities. The number of older persons needing long term care is increasing as is the cost of such care to both public and private purchasers (Health Care Financing Administration, 1981; United States General Accounting Office, 1979a; 1979b; White House Conference on Aging, 1980). Most available public financial support of long term care has gone to nursing homes, rather than other types of long term care such as community based care (Health Care Financing Administration, 1981). Related problems were the reported lack of functioning systems of health, social and supportive services other than nursing homes and the poor quality of some nursing homes and other long term care programs as well (Brody, 1977; Health Care Financing Administration, 1981; Kane & Kane, 1980).

There is growing support inside and outside of local, state, and federal governmental units for expanding the availability of publicly financed

community based care. Decisions to do so will be based on many considerations, including the political clout and expertise of the advocates, related developments in the funding and provision of health and social services, and information regarding the costs and effectiveness of community based care. The purpose of this study was to provide a source of information based on a descriptive comparison of existing users of community based care and nursing care services.

CHAPTER TWO

DESIGN OF THE STUDY

Design

The investigator used a retrospective, cross-sectional design to study the demographic characteristics, types of services used, and public service costs of elderly persons receiving long term care services in community based and nursing home settings. This was an ex post facto descriptive study utilizing client records and published data sources.

Setting of the Study

Records of clients in private homes and semi-independent living arrangements receiving services through Utah's Alternatives in Long Term Care Program (TAP) and published data of Medicaid reimbursed residents of licensed intermediate nursing care facilities (ICFs) within the State of Utah served as the source for the sample. Statewide records of TAP clients were filed at the Utah State Department of Social Services, Division of Aging Office in Salt Lake City. Published Medicaid statistics for the State of Utah were available

through the Utah State Department of Health, Division of Health Care Financing in Salt Lake City (State of Utah, Department of Health, 1980; 1982).

Population

The population consisted of persons 21 years of age and older who used publicly sponsored programs for long term care services between the dates of July 1, 1979 and June 30, 1980.

Sample

The study described and compared 714 clients of Utah statewide, state funded, community based programs (TAP) primarily for persons 60 years of age and older who were at risk of nursing home placement with 4005 Utah statewide Medicaid reimbursed ICF residents who were 21 years of age and older for state fiscal year 1980 which included the time period July 1, 1979 through June 30, 1980.

Permission was granted by the director of the state administrative division responsible for the community based program (TAP) for the use of data from client records for this research (See Appendix A). Authorization for the use of recorded data for reporting and research was granted by a signed release form from each community based client (See Appendix B, Section E).

Before clients were admitted to the community based program (TAP), they were required to receive an interdisciplinary team assessment of physical, mental, social and financial needs (Appendix C). Following a thorough explanation by the assessment team leader, the release of information form (Appendix B) was signed at the time of the initial client assessment by the client and/or his significant other in cases where the client was unable to comprehend its significance. Clients were informed that their confidentiality would be protected, but that state agencies were required to submit public reports documenting program development for administrative, legislative and other interested public groups and were charged by the Utah State Legislature to support research and program development. Information requested included demographic factors such as age, sex, marital status, place of residence, and income as well as cost factors related to type and length of service and source of reimbursement.

The following precautions were used to protect the confidentiality of the data and the anonymity of the community based (TAP) subjects. The client's name was not recorded on data collection forms and no personally identifying information appeared on the data sheets.

No individual case files of the ICF residents were

reviewed. Aggregate data were derived from published reports of the Utah State Medicaid Program. This entailed examining reports of the Assistance Payments Administration (APA) Division of the Office of Field Services, Utah Department of Social Services, for eligibility data describing demographic characteristics of ICF residents and reports of the Division of Health Care Financing Administration (HCFA) of the Utah Department of Health for the services rendered and the public costs involved (State of Utah Department of Health, 1980; 1982).

Operational Definitions of Variables

For the purposes of this study, long term care services were considered to include services provided through public funding to both community based clients and residents of intermediate nursing care facilities. Community based clients included all those persons 21 years of age and older who were accepted for admission to and/or received services from, the Utah State Division of Aging's The Alternatives in Long Term Care Program (TAP) anytime during the time period July 1, 1979 through June 30, 1980. Each client met the following TAP eligibility requirements: a) resident of the state of Utah, b) 18 years of age or older, c) at

high risk (within 0 to 90 days) of nursing home admission as determined and documented by a private physician, d) not in a medical crisis, and e) consented to pay program fees according to an authorized sliding fee schedule if monthly income exceeded 67% of Utah's median income (See Appendix C for fee schedule). Community based services included any publicly reimbursed benefit rendered to any TAP client during this same time frame.

Residents of intermediate nursing care facilities (ICFs) for this study included all those persons 21 years of age and older who received Medicaid reimbursement for nursing home care in a Medicaid licensed ICF within the State of Utah, exclusive of all mentally retarded clients, during the time period July 1, 1979 through June 30, 1980. Because Medicaid statistics were recorded according to the age brackets under 6, 6 to 20, 21 to 64 and 65 and older it was not possible to accurately assess the number of residents who were 60 years of age and older. Each ICF resident met the following selected Medicaid eligibility requirements for reimbursement for ICF care: a) categorically eligible, b) in need of ICF level of care as determined jointly by the resident's private physician and the Medicaid Review Team housed in the

Utah State Department of Health's Office of Health Care Financing Administration (HCFA); c-1) poverty level, monthly income of $277 or less and savings of $1500 or less for single individual or monthly income of $382 or less and savings of $2250 or less for a married couple, or c-2) "spend-down" medically needy income level which did not exceed 133 1/3 percent of Utah's Aid to Families With Dependent Children monthly payment, and d) consented to contribute the above mentioned income toward the nursing home care expenses except for a $25 monthly personal allowance. Nursing home services included any service incorporated in the daily Medicaid reimbursement rate for ICF care during this same time period, exclusive of those services delivered to the mentally retarded population.

Public costs included all reported payments made to providers for community based services for TAP clients and to licensed ICFs for institutional services from purely State of Utah general funds, Titles XVIII (Medicare), XIX (Medicaid), and XX (Block Grants to States for Social Services) of the Social Security Act, and Titles III C-1 (congregate meals) and C-II (home delivered meals) of the Older Americans Act.

Cost effectiveness was measured in terms of the difference between public costs for community based

services for TAP clients and public costs for services for ICF residents during the time period July 1, 1979 through June 30, 1980.

Data Collection Procedures

The content chosen for this study was based primarily on information required for program evalution by decision making legislative bodies. Community based TAP client records were reviewed for the following information:

1. Local service district.
2. Admission date.
3. Age of client.
4. Sex of client.
5. Income level for client (or for both client and spouse, if married).
6. Place of residence.
7. Types of services rendered.
8. Funding source for each service.
9. Aggregate service costs per service district.
10. Date and reason for client termination.
11. Reason for denial of admission to program.

Published Medicaid reports on ICF care were reviewed for the following information:

1. Age of resident.
2. Sex of resident.

3. Public reimbursable daily costs for care.

4. ICF service components.

Statewide original individual case records for community basd TAP clients for the time period July 1, 1979 through June 30, 1980 were filed at the Department of Social Services, Utah Division of Aging in Salt Lake City, which is the legislatively mandated administrative office for community based programs for the Utah elderly population. Individual TAP case records were filed alphabetically and categorized according to the appropriate numerical designation for 12 Utah local aging planning and service districts, 11 of which were called Area Agencies on Aging. Three separate categories of TAP client files for each district were maintained for the time period July 1, 1979 through June 30, 1980: a) open files for clients who received TAP services during the designated time frame and were still considered to be active clients as of June 30, 1980, b) Closed files for clients who received TAP services sometime during the stated time frame but were terminated from TAP on or before June 30, 1980 primarily because they no longer wanted or required TAP pure state funded services, entered a nursing home or hospital, moved from the service delivery area, required services whose costs were above the monthly $350 regulatory

limitation for TAP clients, or were deceased, and c) Denial files for those individuals who were assessed for TAP during the designated time frame, but were not admitted to TAP primarily because they did not want or need the service, required services not available in the service delivery area, required services whose costs were more than the $350 per month regulatory limitation, decided not to accept services because the sliding scale fee was not personally acceptable, died, moved, or entered a nursing home or hospital before services could be provided.

Each individual open, closed and denial TAP file contained the original assessment form and case plan completed by an interdisciplinary team which included a registered nurse, aging specialist, and any other professional deemed necessary by the service district TAP director. The case plan for each TAP client listed units and costs for individual services funded by TAP and other state and federally funded programs such as Medicare, Medicaid, the Social Services Block Grant, and the Older Americans Act. Individual open and closed files also contained reassessment forms an case plans completed at six month intervals by the same or similarly constituted interdisciplinary team, as well as monthly followup forms which documented quality,

quantity and effectiveness of service delivery. Individual closed and denial TAP files contained forms which declared why the individuals were terminated or never admitted to TAP. Monthly reimbursement request forms from each service district listing detailed service units and costs to be paid by TAP funds were also filed at the state administrative agency. Appendix C contains copies of assessment, case plan, monthly followup, termination, denial and reimbursement request forms.

Available demographic and service data from community based client records were first transcribed into individual tally sheets by the investigator. The data were then aggregated into totals for each category specified above. Statewide totals were then derived. Appendix D contains the data collection tools.

The demographic and financial data for Medicaid-reimbursed intermediate care facility (ICF) residents were derived from published Medicaid reports for the time period July 1, 1979 through June 30, 1980. Individual and district specific data for ICF residents were not available.

CHAPTER THREE

DATA ANALYSIS

The data analyses consisted of a) a description of and comparison of selected demographic characteristics of each Utah long term care group studied -- community based clients in the Alternatives in Long Term Care Program (TAP) and Medicaid reimbursed residents of intermediate care facilities (ICFs), b) delineation of types of services and utilization by the community based sample, c) listing of service components included in per diem costs for the ICF sample, and d) comparison of the public costs of services provided for each group.

The data for the community based TAP sample were collected from individual case records and quarterly reimbursement requests (see Appendix C) and tabulated manually for frequency distributions and measures of central tendencies and variability, both within separate local planning and service areas and statewide (See Appendix D for the complete tabulations for each aging district and statewide). The data for the ICF sample were derived from published statistical reports (State of Utah Department of Health, 1980; 1982). Absolute

dollar value comparisons between public costs for community based (TAP) care and nursing home (ICF) care were examined because significance levels are probably not as useful or meaningful in considering different levels of cost.

Descriptive Analysis

TAP Program Statistics

Table 1 represents a frequency distribution of the total number of individuals served and state funds expended by TAP during state fiscal year 1980 for the time period July 1, 1979 through June 30, 1980 according to twelve aging districts. The total number of persons served are categorized as to the individuals a) denied admission to the program, b) terminated during the limited time frame, and c) still active in the program as of June 30,. 1980. The aging districts represent the following Utah planning and service areas:

1. Bear River encompasses Box Elder, Cache and Rich Counties.
2. Weber includes Morgan and Weber Counties.
3. Salt Lake denotes Salt Lake County.
4. Davis is Davis County.
5. Tooele indicates Tooele County.

Table 1

The Alternatives Program (TAP) Clients Served and Expenditures

July 1, 1979 to June 30, 1980

Aging District	Denials		Terminations		Active As of 6/30/80		Total Clients	Funds Expended
	n	percent	n	percent	n	percent		
Bear River	11	26	15	37	15	15	41	$6,940.00
Weber	36	43	24	29	23	28	83	60,880.00
Salt Lake	45	19	76	31	121	50	242	69,238.36
Davis	7	6	51	44	58	50	116	22,880.00
Tooele	0		0		3	100	3	352.04
Mountainlands	5	6	47	56	32	38	84	14,505.70
Central	4	13	17	55	10	32	31	14,757.06
5-County	6	20	9	30	15	50	30	10,280.00
Uintah	1	5	11	52	9	43	21	24,320.00
Southeastern	5	9	21	37	30	54	56	7,700.00
San Juan	0		0		1	100	1	132.72
Sr. Cit. Ex. Assn.	0		5	83	1	17	6	14,227.32
Statewide	120	17	276	39	318	44	714	246,213.20

6. Mountainlands includes Summit, Utah, and Wasatch Counties.

7. Central incorporates Juab, Millard, Piute, San Pete, Sevier and Wayne Counties.

8. Five-County includes Beaver, Garfield, Iron, Kane and Washington Counties.

9. Uintah denotes Dagget, Duchesne, and Uintah Counties.

10. Southeastern encompasses Carbon, Emery, and Grand Counties.

11. San Juan is San Juan County.

12. Senior Citizens Executive Association (Sr. Cit. Ex. Assn.) is an independent retirement organization whose service area encompasses the Wasatch Front, including Davis, Salt Lake, and Weber Counties. It is not an Area Agency on Aging.

A $250,000 appropriation for TAP was assigned for fiscal year 1980 by the Utah State Legislature and included as a line item in the total budget allocation for the Utah State Division of Aging. Table 1 shows total statewide expenditures for TAP were $246,213.20 which means that $3,786.80 was lapsed and returned to the state general fund.

TAP Client Demographic Characteristics

Age. Table 2 depicts the age distribution of total TAP clients served within single aging districts and statewide. Six hundred ninety-eight of the total sample (99%) were 60 years of age and older. The mean for the total sample was 77 years, the median 78 years, and the mode (not shown) 82 years. The range was 81 years (21 to 102), although only seven persons (1%) of the total sample were under age 60. Seven of the 12 aging districts reported no clients under 60 years of age. The lowest district means (61 years) were found in the Tooele and San Juan districts where samples consisted of two and one clients, respectively.

Sex. Table 3 represents the percentage of the total sample who were male and female according to specific aging districts and statewide. A statewide total of 486 (68%) were female. Males were the majority in the three districts with small ns -- Tooele, Uintah, and Senior Citizens Executive Association.

Marital status. Table 4 shows the marital status of individuals who were active TAP clients sometime during state fiscal year 1980. Persons assessed, but denied admission to the program, are not included because data were most often unrecorded. Marital status is categorized both within specific aging

Table 2

Age of TAP Clients in Years

Aging District	60+		18-59		Total N	Mean	Median	Range
	n	percent	n	percent				
Bear River[a]	37	100	0		37	78	77	60-91
Weber	81	98	2	2	83	77	80	21-94
Salt Lakea	241	100	0		241	78	79	60-98
Davis	115	99	1	1	116	78	79	53-102
Tooele	2	67	1	33	3	61	62	44-77
Mountainlands	84	100	0		84	78	79	62-96
Central	31	100	0		31	76	73	60-93
5-County	28	93	2	7	30	77	77	53-97
Uintah	21	100	0		21	74	72	60-88
Southeastern[a]	52	100	0		52	77	78	63-93
San Juan	1	100	0		1	61	61	61
Sr. Cit. Ex. Assn.[a]	5	83	1	17	5	71	70	52-96
Statewide	698	99	7	1	705	77	78	21-102

Note. [a]Summation of n is less than total clients served because of unrecorded data.

Table 3

Sex of TAP Clients

Aging District	Male		Female		Total N
	n	percent	n	percent	
Bear River	12	29	29	71	41
Weber	28	34	55	66	83
Salt Lake	73	30	169	70	242
Davis	40	34	76	66	116
Tooele	2	67	1	33	3
Mountainlands	22	26	62	74	84
Central	10	32	21	68	31
5-County	11	37	19	63	30
Uintah	13	62	8	38	21
Southeastern	13	23	43	77	56
San Juan	0		1	100	1
Sr.Cit.Ex.Assn.	4	67	2	33	6
Statewide	228	32	486	68	714

Table 4

Marital Status of TAP Clients

Aging District	Never Married		Married		Divorced		Widowed		Total N
	n[a]	percent	n[a]	percent	n[a]	percent	n[a]	percent	
Bear River	1	3	19	63	2	7	8	27	30
Weber	5	11	12	25	7	15	23	49	47
Salt Lake	5	3	64	32	17	9	111	56	197
Davis	8	7	40	37	7	6	54	50	109
Tooele	0		1	33	1	33	1	33	3
Mountainlands	8	10	26	33	1	1	44	56	79
Central	0		13	48	1	4	13	48	27
5-County	1	4	10	42	2	8	11	46	24
Uintah	0		4	20	2	10	14	70	20
Southeastern	5	10	19	37	7	14	20	39	51
San Juan	0		0		0		1	100	1
Sr. Cit. Ex. Assn.	2	33	2	33	0		2	33	6
Statewide	35	6	210	35	47	8	302	51	594

[a]

Note. Summation of n is less than total clients served because of unrecorded data for persons assessed but denied admission to TAP.

districts and statewide as to never married, married, divorced and widowed. Three hundred two (51%) of the total sample were widowed and 210 (35%) were married. Notable exceptions to this distribution occurred in the following two districts: a) 63% of the Bear River sample were married, and b) 100% of the San Juan sample were widowed. In the latter instance, the n was one individual.

Place of residence on admission. Table 5 depicts the place of residence of individuals at the time of admission to TAP. Persons assessed, but denied admission to the program are not included because data were unrecorded in most instances. Data within specific aging districts and statewide illustrate applicants accepted for TAP resided in their own homes, apartments, mobile homes, residential living facilities, private homes of others, boarding homes, hotels and nursing homes. Most individuals (57%) lived in their own homes. Data for the following three rural districts showed 100% of the subjects lived in their own homes: a) Tooele with an n of three, b) Central with an n of 27, and c) San Juan with an n of only one. Only two clients statewide lived in hotels, both in the Salt Lake district.

Monthly income. Table 6 represents the mean and

Table 5

Place of Residence of TAP Clients At Time of Admission

Aging District	Own Home		Apartment		Mobile Home		Res Facility		Home of Mother		Boarding Home		Hotel		Nursing Home		Total N
	n[a]	percent	n[a]	percent	n[a]	percent	n[a]	percent	n[a]	percent	n[a]	percent	n[a]	percent	n[a]	percent	
Bear River	28	94	0		1	3	0		1	3	0		0		0		30
Weber	18	38	13	28	3	6	8	17	5	11	0		0		0		47
Salt Lake	96	49	33	17	6	3	27	14	15	8	13	6	2	1	5	2	197
Davis	50	46	40	36	4	4	0		13	12	0		0		2	2	109
Tooele	3	100	0		0		0		0		0		0		0		3
Mountainlands	51	65	12	15	7	9	0		5	6	0		0		4	5	79
Central	27	100	0		0		0		0		0		0		0		27
5-County[b]	18	75	2	8	2	8	0		1	4	0		0		1	4	24
Uintah	15	75	3	15	0		0		2	10	0		0		0		20
Southeastern	28	55	15	29	5	10	0		3	6	0		0		0		51
San Juan	1	100	0		0		0		0		0		0		0		1
Sr.Cit.Ex.Assc.[b]	2	33	2	33	0		1	16	1	16	0		0		0		6
Statewide	337	57	120	20	28	5	36	6	46	8	13	2	2	0	12	2	594

Note. [a]Summation of n is less than total clients served because of unrecorded data for persons assessed, but denied admission to TAP.
[b]Summation of percentages does not equal 100 percent due to rounding to whole numbers.

Table 6

Monthly Income of TAP Clients

Aging District	Single			Couple			Total N
	n[a]	Mean	Range	n[a]	Mean	Range	
Bear River	11	$356	$203-692	19	$736	$330-1,689	30
Weber	35	388	224-540	12	752	397-1,080	47
Salt Lake	133	309	83-701	64	520	188-930	197
Davis	69	373	80-1,015	40	683	187-1,340	109
Tooele	2	401	825-477	1	787	787	3
Mountainlands	53	394	188-917	26	746	406-1,570	79
Central	14	254	149-413	13	252	100-379	27
5-County	14	275	88-505	10	593	197-1,060	24
Uintah	16	393	242-849	4	765	510-1,119	20
Southeastern	32	567	192-1,700	19	677	296-1,642	51
San Juan	1	485	485	0	0	0	1
Sr. Cit. Ex. Assn.	4	460	39-514	2	722	375-1,068	6
Statewide	384	365	80-1,700	210	621	100-1,689	584

[a] Note. Summation of n is less than total clients served because of unrecorded data for persons assessed, but denied admission to, TAP.

variability of monthly income for TAP clients within specific aging districts and statewide. Persons assessed, but denied admission to TAP are not included because data were most often unrecorded. Incomes are categorized according to marital status. Single depicts monthly incomes for individuals who were never married, divorced, or widowed. Couple infers aggregated monthly incomes for both spouses for married TAP clients, even though only one spouse may have been served by TAP. The statewide range for single monthly incomes was $1,620 ($80 to $1700) with a mean of $365. The statewide range for couple monthly incomes was $1,589 ($100 to $1,689) with mean of $621. The lowest single and couple means ($254 and $252, respectively) were found in the Central district. The lowest single monthly incomes of $80, $83 and $88 were listed in the respective Davis, Salt Lake and Five-County districts. The lowest couple monthly incomes of $100, $187, and $188 were found in the Central, Davis and Salt Lake districts, respectively.

Mean months on program. Table 7 portrays the mean length of stay on TAP in months within specific aging districts and statewide. One month was considered to include 15 or more days within a calendar month. Anything less than 15 days was not counted as a month. Records were often not detailed enough to provide a

Table 7

Mean Months on Program for TAP Clients

Aging District	Mean
Bear River	4.8
Weber	10.4
Salt Lake	6.5
Davis	5.0
Tooele	2.3
Mountainlands	9.7
Central	10.7
5-County	6.3
Uintah	8.4
Southeastern	8.1
San Juan	1.0
Sr. Cit. Ex. Assn.	10.0
Statewide	7.3

specific count per day. A major determinant of length of stay was the span of time the program was operational in each of the aging districts. The Weber district inaugurated TAP in June 1978, while Tooele and San Juan were not operationalized until March 1980 and June 1980, respectively. Except for the Uintah district which began accepting clients in February 1979, all other districts were functional by November 1978. The range for the total sample was 9.7 months (1 to 10.7) with a mean of 7.3 months. The lowest means for months on the program were found in the Tooele (2.3) and San Juan (1.0) districts. The highest means were recorded for the Central (10.7), Weber, (10.4) and Senior Citizens Executive Association districts (10.0).

Reason for termination. Table 8 categorizes the following reasons for termination from TAP within specific aging districts and statewide: a) service need fulfilled, b) client request, c) entered a nursing home, d) died, e) moved from the service area, e) entered a hospital, f) referred to a more appropriate program, and g) depletion of allocated state funding. The most common reasons for termination were service need fulfilled (26%), death (24%), entered a nursing home (22%), and client request (21%). Of the total number who were terminated, 1% moved, 1% entered a hospital,

Table 8

Reason for Termination from TAP

Aging District	Need Fulfilled		Client Request		Nursing Home		Deceased		Moved		Hospital		Referred		Lack of Funds		Total N
	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	
Bear River	8	53	1	7	3	20	2	13	0		1	7	0		0		15
Weber	5	21	5	21	9	37	3	13	0		0		2	8	0		24
Salt Lake	19	25	22	29	16	21	16	21	0		2	3	1	1	0		76
Davis	11	22	16	31	10	20	14	27	0		0		0		0		51
Tooele	0		0		0		0		0		0		0		0		0
Mountainlands	13	28	7	15	10	21	17	36	0		0		0		0		47
Central	0		0		2	12	3	17	2	12	0		0		10	59	17
5-County	5	56	1	11	1	11	2	22	0		0		0		0		9
Uintah	2	18	1	9	2	18	5	46	1	9	0		0		9		11
Southeastern	4	19	5	24	7	33	5	24	0		0		0		0		21
San Juan	0		0		0		0		0		0		0		0		0
Sr.Cit.Ex.Assn.	4	80	0		0		1	20	0		0		0		0		5
Statewide	71	26	58	21	60	22	68	24	3	1	3	1	3	1	10	4	276

and 1% were referred. Ten terminations (59%) from the Central district occurred because the allocated funding was depleted before the end of the fiscal year. Other notable exceptions to the statewide distribution were: a) four of the five terminations in the Senior Citizens Executive Association district were due to the fulfillment of the clients' needs, b) 56% and 53% of those terminated in the respective Five-County and Bear River districts occurred because the service needs were fulfilled, and c) 46% of the terminations in the Uintah district were due to death of the clients.

Reason for nonadmittance to TAP. Table 9 illustrates the rationale for not admitting applicants to TAP. The most frequent justification statewide (54%) for denied admission was the client entered a nursing home before services could be rendered. This emphasizes the high risk status of TAP clients. Other reasons included: a) client refusal of services, b) moved from service area, c) died, e) entered a hospital, and f) determined to be inappropriate for TAP because were not at risk of nursing home placement, required more services than TAP could financially provide or would be better served by another program. The Salt Lake and Weber districts listed the most number of persons denied admittance to TAP with 43 and 35, respectively. The

Table 9

Reason for Nonadmittance to TAP

Aging District	Client Refusal		Moved		Deceased		Nursing Home		Hospital		Inappropriate		Total N
	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	
Bear River	1	9	1	9	2	18	5	46	0		2	18	11
Weber[a]	11	31	0		2	6	15	43	0		7	18	35
Salt Lake[a]	9	21	0		0		27	63	0		7	16	43
Davis	0		0		2	29	4	57	1	14	0		7
Tooele	0		0		0		0		0		0		0
Mountainlands	0		0		1	20	4	80	0		0		5
Central[a]	0		0		0		2	67	0		1	33	3
5-County[b]	1	17	0		1	17	3	50	0		1	17	6
Uintah	0		0		0		1	100	0		0		1
Southeastern[a]	2	50	1	25	0		1	25	0		0		4
San Juan	0		0		0		0		0		0		0
Sr.Cit.Ex.Assn	0		0		0		0		0		0		0
Statewide[a]	24	21	2	2	8	7	62	54	1	1	18	15	115

Note. [a]Summation of n is less than total individuals denied admission to TAP because of unrecorded data.
[b]Summation of percentages does not equal 100 percent due to rouding to whole numbers.

Tooele, San Juan and Senior Citizens Executive Association had no denials. Two of the Four denials for the Southeastern district were because the clients refused TAP services. Statewide, two clients moved and one client entered the hospital before services could begin.

Delineation and Utilization of Types of Services for TAP Clients

TAP reimbursed services. Table 10 depicts the 11 most utilized services reimbursed by TAP during fiscal year 1980 for specific aging districts and statewide. Homemaker (241 clients), home health aide (125 clients), and registered nurse (86 clients) were the most frequently used services. Statewide, 53 clients (9%) received only case management services funded by TAP, although they were most often receiving services funded from other public and private sources since TAP is a case management brokering program. The statewide high frequency of the "other" category includes clients who used the following services: physical therapy, supplies, legal aid, care in the home of relative, transportation, home delivered meals, shopping assistance, night care, mileage payment for homemakers, lump sum payment for medical expenses resulting from a

Table 10

TAP Reimbursed Services by Number of Clients Served[a]

Aging District	Total Active Clients	Home-maker	Home Health Aide	Regis-tered Nurse	Case Manage-ment	Resi-dential Living	Respite Care	Senior Com-panion	Equip-ment	Friendly Visitor	Day Care	Live-In	Other
Bear River	30	19	10	1	0	0	0	0	1	0	0	0	1
Weber	47	28	1	1	2	8	0	12	1	3	3	1	8
Salt Lake	197	41	27	53	13	27	16	5	4	6	10	2	5
Davis	109	50	18	5	13	0	2	0	5	2	0	0	0
Tooele	3	0	0	0	3	0	0	0	0	0	0	0	0
Mountainlands	79	47	40	1	3	0	5	0	0	1	0	5	1
Central	27	50	7	7	4	0	0	0	0	0	0	0	0
5-County	24	14	5	4	1	0	1	0	0	1	0	0	3
Uintah	20	15	2	6	1	0	1	0	0	1	0	0	5
Southeastern	51	19	14	6	7	0	4	0	1	1	0	0	7
San Juan	1	0	1	0	0	0	0	0	1	0	0	0	0
Sr.Cit.Ex.Assn.	6	4	0	2	1	1	0	0	0	0	0	0	0
Statewide	594	241	125	86	53	36	28	17	15	14	13	9	30

Note. [a]Summation of n exceeds clients who were active during fiscal year 1980 because some clients received more than one service.

senior citizens bus accident, utility and extended auto insurance payments, and restaurant meals (See Appendix D for complete frequency tabulation). It is apparent that a wide variety of services were financed by TAP dollars. Residential living accomodations, senior companion programs, and adult day care facilities are not available statewide as reflected by their limited use in only the Weber, Salt Lake and Senior Citizens Executive Association districts.

Medicaid and Medicare reimbursed services. Table 11 shows 26 documentations statewide of home health services funded by Medicaid and Medicare, nine of which were reported from the Mountainlands district. One-third of the aging districts reported none. Eighteen of the 26 reported service utilizations were Medicaid reimbursed registered nurse and home health aide services. The seven service utilizations funded by Medicare included registered nurse, home health aide, and physical therapy services.

Title XX reimbursed services. Table 12 illustrates the two Title XX Block Grant services used by TAP clients in specific aging districts and statewide; 196 clients received homemaker/chore services and two required protective services. Summation of the total number of TAP clients receiving homemaker services

Table 11

Medicaid and Medicare Reimbursed Services by Number of TAP Clients Served

Aging District	Total Active Clients	Medicaid RN	Medicaid Health Aide	Medicare RN	Medicare Health Aide	Medicare Physical Therapy
Bear River	30	1	1	1	0	0
Weber	47	0	0	0	0	0
Salt Lake	97	3	0	2	0	0
Davis	109	1	3	0	1	0
Tooele	3	0	0	0	0	0
Mountainlands	79	2	7	0	0	1
Central	27	0	0	0	0	1
5-County	24	0	0	1	0	0
Uintah	20	0	0	0	0	0
Southeastern	51	0	0	1	0	0
San Juan	1	0	0	0	0	0
Sr.Cit.Ex. Assn.	6	0	0	0	0	0
Statewide	594	7	11	5	1	2

Table 12

Title XX Reimbursed Services by Number of TAP Clients Served

Aging District	Total Active Clients	Homemaker/ Chore	Protective Services
Bear River	30	5	1
Weber	47	20	1
Salt Lake	197	89	0
Davis	109	45	0
Tooele	3	2	0
Mountainlands	79	8	0
Central	27	7	0
5-County	24	3	0
Uintah	20	3	0
Southeastern	51	14	0
San Juan	1	0	0
Sr.Cit.Ex.Assn.	6	0	0
Statewide	594	196	2

funded by both TAP (n = 241) and Title XX (n = 196) shows that approximately 73% of the 594 TAP clients who were active during fiscal year 1980 utilized this service. Due to limitations in number of hours approved for reimbursement under Title XX regulations, the same individual could conceivably have received homemaker services funded by both TAP and Title XX. This was documented in less than 20 cases statewide.

Older Americans Act reimbursed services. Table 13 depicts home delivered meals (n = 99) as the most frequently used Older Americans Act service by TAP clients in specific aging districts and statewide. Twenty-eight of the total statewide sample used transportation. Less often used services included telephone reassurance and legal services. The Mountainlands, Uintah, San Juan and Senior Citizens Executive Association districts reported no utilization of Older Americans Act services.

Services funded by other sources. Services used by TAP clients, but funded through public and private sources other than Medicaid, Medicare, Title XX and Older Americans Act, included mental health counseling, health screening services, hospice care, and speech therapy. These services are not included in a table because less than ten individuals statewide were

Table 13

Older Americans Act Reimbursed Services

by Number of TAP Clients Served

Aging District	Total Active Clients	Home Delivered Meals	Transportation	Telephone Reassurance	Legal Services
Bear River	30	23	0	0	0
Weber	47	13	5	1	1
Salt Lake	197	27	20	0	0
Davis	109	11	0	0	0
Tooele	3	2	0	0	0
Mountainlands	79	0	0	0	0
Central	27	4	0	0	0
5-County	24	4	3	0	0
Uintah	20	0	0	0	0
Southeastern	51	15	0	0	0
San Juan	1	0	0	0	0
Sr.Cit.Ex.Assn.	6	0	0	0	0
Statewide	594	99	28	1	1

involved in any one service (See Appendix D for complete tabulation). Most of these services were provided in the more populous Wasatch Front districts of Weber, Salt Lake and Davis.

Public Per Diem TAP Costs

Table 14 differentiates district and statewide total per diem costs for TAP clients into TAP expenses and costs from other federal/state sources, such as Medicaid, Medicare, Title XX Block Grants to States, and Older Americans Act. The TAP per diem costs were derived from the total TAP expenditures and the mean number of months on the program during fiscal year 1980 for individuals by specific district and statewide. The statewide TAP mean per diem cost was $1.89 with a range from $.60 in the Southeastern district to $7.80 in the Senior Citizens Executive Association district. Data for other federal/state per diem costs were derived from data published in March 1979 by Management Resource Associates because this was the only available source due to unrecorded cost data for this category. The Davis district reported the lowest per diem ($.23) and the Weber district the highest per diem ($1.63) from other federal/state sources. The statewide total mean per diem cost from all sources for TAP clients was $2.58

Table 14

Mean and Variability of Public Per Diem Costs for TAP Clients

Aging District	TAP per diem costs			Other federal/state per diem costs[a]			Total per diem costs		
	$\bar{X}$	x	x^2	$\bar{X}$	x	x^2	$\bar{X}$	x	x^2
Bear River	$1.51	-1.18	1.39	$.63	-.025	.00063	$2.14	-1.21	1.46
Weber	4.04	1.35	1.82	1.63	.975	.95063	5.67	2.32	5.38
Salt Lake	1.74	- .95	.90	.48	-.175	.03063	2.22	-1.13	1.28
Davis	1.37	-1.32	1.74	.23	-.425	.18063	1.60	-1.75	3.06
Tooele	1.65	-1.04	1.08	.63	-.025	.00063	2.28	-1.07	1.14
Mountainlands	.62	-2.07	4.28	.63	-.025	.00063	1.25	-2.10	4.41
Central	1.66	-1.03	1.06	.63	-.025	.00063	2.29	-1.06	1.12
5-County	2.19	- .50	.25	.63	-.025	.00063	2.82	- .53	.28
Uintah	4.78	2.09	4.37	.63	-.025	.00063	5.41	2.06	4.24
Southeastern	.60	-2.09	4.37	.63	-.025	.00063	1.23	-2.12	4.49
San Juan	4.34	1.65	2.72	.48	-.025	.00063	4.97	1.62	2.62
Sr. Cit. Ex. Assn.	7.80	5.09	25.91	.48	-.175	.03063	8.28	4.97	24.70
Statewide	1.89			.69			2.58		
Standard Deviation		2.11			.33			2.22	

Note. [a]Data derived from March 1979 Management Resource Associates Evaluation Report (pp. 10-11).

with a low of $1.23 for the Southeastern district and a high of $8.28 for the Senior Citizens Executive Association.

The standard deviation for total per diem costs was $2.22. Variabilies for TAP and other federal/state per diem costs were standard deviations of $2.11 and $.33, respectively. All districts were within one standard deviation of the mean in all three categories, with the exceptions of Weber, Davis and Senior Citizens Executive Association. Weber was within one standard deviation for TAP per diem costs, but was three standard deviations above the mean in other federal/state per diem costs and two standard deviations above the mean in total per diem costs. Davis was within one standard deviation of the mean in TAP and total per diem costs, but was two standard deviations below the mean for other federal/state per diem costs. The Senior Citizens Executive Association was within one standard deviation of the mean for other federal/state per diem costs, but was three standard deviations above the mean for TAP and total per diem costs.

Comparison of TAP Clients with Medicaid Reimbursed ICF Residents

Age. Table 15 illustrates that 89% of the total

Table 15

Comparison of Mean Age of TAP Clients

with Medicaid Reimbursed ICF Residents

Age in Years	TAP Clients		Medicaid ICF Residents	
	na	percent	n	percent
21-64	76	11	998	25
65+	629	89	3007	75

Note. Summation of n is less than 714 total TAP clients served because of unrecorded data.

TAP clients served whose ages were recorded (n = 705) and 89% of the Medicaid reimbursed ICF (n = 4005) were 65 years of age and older. Ages for nine TAP clients were unrecorded. Elderly has been defined by the Older Americans Act as individuals 60 years of age and older and the term is in common usage throughout the public aging network and in gerontological literature. Table 2 depicts 99% of the total TAP clients (n = 698) as being 60 years of age and older. Medicaid data listing ICF residents 60 years of age and older were not available, prompting the comparison of TAP clients and ICF residents in the two categories of 21 to 64 years of age and 65 years of age and older.

Sex. Table 16 shows that approximately two-thirds of both TAP clients (68%) and Medicaid reimbursed ICF residents (66%) were female.

Mean per diem costs. Table 17 compares the mean per diem costs for TAP clients and Medicaid reimbursed ICF residents differentiated as to funding source. State of Utah general funds allocated for TAP paid 73% ($1.89) of the total mean per diem costs ($2.58) for TAP clients. Federal/state funds allocated for Medicaid paid 78% ($21.84) of the total mean per diem costs ($27.96) for Medicaid ICF residents. The cost differential from all sources was $25.38 more per diem

Table 16

Comparison of Sex Characteristic of TAP Clients with Medicaid Reimbursed ICF Residents

Sex	TAP Clients		Medicaid ICF Residents	
	n	percent	n	percent
Male	228	32	1,372	34
Female	486	68	2,633	66

Table 17

Comparison of Mean Per Diem Costs Paid for TAP Clients with Medicaid Reimbursed ICF Residents

Program	Mean per diem paid by state		Mean per diem paid by other public & private sources		Total per diem costs
	$	Percent	$	Percent	$
TAP	$1.89	73	$.69	27	$2.58
ICF	21.84[a]	78	6.12	22	27.96

Note. [a] State Medicaid budget incorporates 32% state general funds ($6.99) matched by 68% federal Medicaid dollars ($14.85).

for ICF residents than for TAP clients. The $21.84 state reimbursed per diem for Medicaid ICF residents must be divided into the $6.99 per diem (32%) from pure state funding for Medicaid recipients matched by the $14.58 per diem (68%) from the federal Medicaid budget. Considering pure State of Utah dollars, the TAP per diem costs of $1.89 can be compared with the $6.99 state Medicaid match for ICF residents showing a pure state per diem funding differential of $5.10 more for ICF care.

Services Included in Medicaid ICF Per Diem Reimbursement

In addition to room and board, ICF Medicaid reimbursed residents in the State of Utah received the following services included in the $27.96 per diem rate as defined by the Utah State Department of Health (1966, p. 19): a) personal care services, such as assistance with ambulation, transferring, oral hygiene, bathing, toileting, dressing and feeding, b) technical nursing services, such as the application of simple dressings; the performance of routine bowel and bladder, catheter, and colostomy care; vital sign monitoring of body temperature, pulse and respiratory rates, and blood pressure; and supervision and administration of routine medications and treatments, and c) occupational and recreational therapy.

CHAPTER FOUR

DISCUSSION OF FINDINGS

Case records of individuals served by the community based The Alternatives in Long Term Care Program (TAP) and published Medicaid statistical reports on intermediate care facility (ICF) residents were reviewed to describe and compare demographic, service, and cost components in an effort to consider the cost effectiveness of alternative care. Descriptive analysis was performed to provide answers to three research questions. The results, in general, indicated that the composite TAP client was a 77 year old widow residing in her own home on a monthly income of $365 who received TAP reimbursed homemaker, home health aide, and registered nurse services and Older Americans Act funded home delivered meals for a total per diem cost of $2.58. She was terminated from the program after 7.3 months because she no longer needed or wanted the service. If she was not admitted to TAP, it was because she needed the level of care provided in a nursing home, which emphasized the high risk status of the TAP client. The

composite Medicaid reimbursed ICF resident was a female over the age of 65 whose total per diem cost was $27.96 for room, board, and technical nursing services. The per diem cost differential was $25.38 more for the ICF care than for the community based care. This compared favorably with recent findings from federally funded long term care demonstration projects in New York (Eggert et al., 1980; New York State Senate Health Committee, 1981), Minnesota (Anderson et al., 1980), Georgia (Georgia Department of Medical Assistance, 1982), and New Mexico (State Health Planning and Development Bureau, 1981). However, the investigation had the following major methodological weaknesses cited in earlier studies: a) It compared combined monthly nursing home costs for the entire package of food, housing and nursing service (Kane & Kane, 1980; La Vor & Callender, 1976). b) There was no guarantee that the community based and nursing home sample groups were comparable although an analysis of the reasons reported for nonadmittance and termination from TAP showed that a combined total of 122 individuals (31%) entered a nursing home and 76 (19%) died. Eligibility for TAP required persons to be at high risk of nursing home placement as determined by their private physicians who classified them as the "who but fors" who would be in

nursing homes without the availability of alternative service options described by Brickner et al. (1976) and Seidl et al. (1977, p. 7). The substantially increased public expenditures for community based care for clients of Connecticut's Triage project were attributed by Shealy et al. (1979) to the fact that the experimental group was not targeted to the population at risk of institutionalization. c) Data on both the community based and nursing home samples were reported and collected for administrative, rather than research, purposes and were not meant to reflect the comparability and cost effectiveness of different modes of long term care. Diers (1979) cautioned against drawing unwarranted conclusions from retrospective studies.

Dunlop (1980) and Weissert (1977) expressed concern about whether alternative care options really saved public dollars by controlling the rising nursing home census or obscured savings by widening the service net of number of persons served. However, interest in expanding or revising the current long term care system has been increasing due to demands stemming from growth in the size of the frail elderly population in need of long term care and the need to reduce high public expenditures for institutional care (Fox & Clauser, 1980; Health Care Financing Administration, 1981;

United Staes Department of Health and Human Services, 1981; United States Department of Health, Education and Welfare, 1977; United States General Accounting Office, 1977; 1979a, 1979b; White House Conference on Aging, 1980).

The framework for comparing the sample groups in this study considered long term care for the elderly population as a continuum containing both community based care and nursing home care greatly influenced by political funding decisions. Callahan (1981) suggested that the long term care system functions within a political environment and must respond to attitudinal and financial pressures from that environment. Due to the increased public financial burden of the current long term care system, cost effectivenes has arisen as a major criterion upon which to measure the success of alternatives to the institutional bias of public long term care programming. The Health Care Financing Administration (1981) reported that both Medicaid and Medicare favor the medical or institutional mode of care. The community based TAP sample in this study reported only 26 instances of utilization of Medicaid and medicare services for the 594 statewide individuals who were actively served by the program in fiscal year 1980. The Georgia demonstration noted that community

health care services funded by these entitlements were technically reimbursable, but often discouraged due to eligibility restrictions which favored reimbursement for institutional care (Georgia Department of Medical Assistance, 1982).

This evokes questions concerning the infrequent utilization reported for TAP clients of all entitlements, including not only Medicaid and Medicare, but also the Older Americans Act and the Title XX Block Grant to States for Social Services. The mean per diem for other public expenditures for TAP clients statewide was only $.69 as compared with TAP per diem costs of $1.89. It is entirely possible that many TAP case managers failed to document services funded by other public sources, although the case plan format provided the mechanism for such documentation. The Weber district was three standard deviations above the mean for other federal/state per diem costs, inferring that this district may have been more responsive to full service/cost reporting. Other possible explanations include a) TAP primarily served those individuals not eligible for other entitlements; although Medicaid and Title XX had income eligibility requirements below the mean for the TAP sample, Medicare and the Older Americans Act eligibilities were primarily related to

age (65 and 60, respectively), which the TAP sample met 89% and 99% of the time, respectively. b) The entitlements were not adapted to community based care (Health Care Financing, 1981). c) TAP case managers had the same difficulty coordinating the wide range of services from different funding sources as reported by Georgia's Alternative Health Services Project (Georgia Department of Medical Assistance, 1982).

Callahan (1981) described the demographics of the target population as the input into the long term care system which is utilized by both community based care and institutional care as the throughput to achieve the desired outcomes of quality of life, maximal independence, prolonged longevity, and avoidance of preventable medical/social problems. Demographically, 89% of the TAP clients and 75% of the ICF Medicaid reimbursed residents were 65 years of age and older. Approximately two-thirds of each group were female. However, the mean monthly income levels for the TAP sample of $365 for unmarried individuals and $621 for married couples were considerably above the Medicaid income eligibility requirements of $277 for single individuals and $382 for married couples. Data were not available on the mean monthly income levels, marital status, place of residence at time of admission, and

reasons for nonadmission to and discharge from the nursing home facility for the Medicaid ICF sample.

The $25.38 per diem cost differential between Medicaid reimbursed ICF care and community based TAP appeared to support the long-held belief by public administrators reported by the Congressional Budget Office (1977) that in-home services are cost effective alternatives for the elderly who would otherwise seek nursing home care. However, even disregarding the methodological weaknesses of the study, many factors must be considered when comparing long term care per diem costs. State administrators often show an inclination to transfer as many costs as possible to federal funding sources, perhaps surmising that a fair share of federal tax levies for entitlements should return to each state because if one state does not draw to its maximal limit, other states will extract more (Volk et al., 1980). Sparsely populated Utah has a low per capital income, probably attributable to its high percentage of children; the 1980 census shows Utah to have the youngest population in the nation. Federal Medicaid regulations allow low per capital income states to receive a $.68 federal match for every $.32 spent by the state on eligible Medicaid recipients. Therefore, to analyze the impact on pure state of Utah general

funding, the $21.84 mean per diem paid by Utah must be defined in terms of the 32% ($6.99) state Medicaid dollars matched by the 68% ($14.85) federal Medicaid funding. Even when this calculation was made, Medicaid ICF pure state mean per diem costs were 370% ($5.10) higher than TAP pure state mean per diem expenditures. The $6.12 of other public and private mean per diem costs for the Medicaid ICF sample included third party payments and all personal income of the residents, except for a $25 per month personal allowance. Since approximately all resident income went to offset Medicaid costs for care, many state administrators and legislators looked upon this as a payment for the room and board components of ICF care, rationalizing that the $6.99 mean per diem paid by the state Medicaid allocation was comparable to the $1.89 mean per diem state TAP reimbursement because both paid for technical and personal care services. Obviously, none of the above rationalization was scientifically sound. The concerns about full and fair cost reporting expressed by Doherty et al. (1978), Dunlop (198), Kane and Kane (1980), and La Vor and Callender (1976) are magnified in this approach. There was no reliable way to evaluate the public cost effectiveness of restrospective aggregated per diem costs for either mode of long term care. The best that

could be accomplished was to state that both total and pure state reported per diem costs were higher for ICF care than for community based TAP. No allowance was made for basic living services such as food and housing provided for the ICF Medicaid sample.

Because the data from the TAP sample are presented both within aging districts and statewide, some discussion of variability is warranted. The total mean per diem costs for services ranged from a low of $1.23 for the rural Southeastern district to a high of $8.23 for the urban Senior Citizens Executive Association, which was three standard deviations above the statewide mean of $2.58. On the surface, it appeared as though the urban district was not as cost effective as the rural district, far exceeding the $6.99 mean per diem state match of ICF care. Because of extraneous variables not statistically shown, such as the impairment level of the clients, the availability and accessibility of services, the competency level of case managers, and the accepted community specific costs for care, the United States Accounting Office (1977) cautioned against making such assumptions. Conceivably, a district could "cream off the top" of eligible clients, accepting only those who required little or no service, other than case management, or whose services

were paid by other public and private sources. The Southeastern district reported a $.63 mean per diem for other public costs, while the Senior Citizens Executive Association data showed only $.48. No conclusions can be drawn concerning costs for care between rural and urban districts. The Southeastern district with its low total mean per diem cost of $1.23 was not comparable to the other rural districts of Uintah and San Juan who reported higher mean per diem costs of $5.41 and $4.97, respectively. All three districts were within one standard deviation of the statewide mean because of the skewing of the sample by the $8.28 mean per diem cost reported by the Senior Citizens Executive Association. Likewise, the urban districts of Weber and Senior Citizens Executive Association reported total per diem costs of $5.67 and $8.28, respectively, which were a respective two and three standard deviations above the mean, while the Davis and Salt Lake districts reported lower mean per diem costs of $1.60 and $2.22 respectively, again within one standard deviation of the statewide mean.

Mean monthly incomes reported for TAP clients varied considerably from the lowest for both single individuals and married couples in the rural Central district of $254 and $252, respectively, to the highest

for single individuals of $567 in the rural Southeastern district and for couples of $787 in the rural Tooele district. Interestingly, the most populous urban district of Salt Lake reported mean incomes for both singles ($309) and couples ($520) below the statewide means of $365 for single individuals and $621 for married couples.

The stated impetus of the community based TAP was to prevent inappropriate social admissions to nursing homes; however, the medically oriented home health aide and nursing services (n = 237) were the second and third highest utilized services for TAP clients, following the socially based homemaker/chore service (n = 437) used by the greater share of the sample. The paucity of available medically oriented home health care in some rural areas may be reflected in the less frequent reported utilization of such services in the rural districts of Tooele, Central, Five County, Uintah and San Juan districts. Homemaker/chore services were highly utilized statewide, lending credence to Eisele and Hoke's (1979) contention that the long term care continuum of services is shifting to the social service arena. However, TAP was administered through the Utah State Department of Social Services, Division of Aging,

and was admittedly targeted to individuals with social, rather than medical, needs.

CHAPTER FIVE

SUMMARY AND IMPLICATIONS FOR NURSING

With the recent growth in the elderly population, the rapid escalation of health care costs, and decreasing public financial resources, increasing attention has been focused on the challenge of providing long term care at the most appropriate professional or nonprofessional level. The problems in the current delivery system cover a broad range from existing federal and state policies to attitudes and biases of providers and consumers. There is a growing impetus to restructure existing resources into a cost effective and efficient long term care system, which allows for both institutional care and less intensive community based care. This approach has received considerable attention from state level administrators and legislators, questioning whether alternative care modes were cost effective options for the elderly who would otherwise seek nursing home care.

This study addressed that question by generating descriptive and comparative information about the

primarily elderly populations of the Utah State funded community based The Alternatives in Long Term Care Program (TAP) administered by the Utah State Department of Social Services, Division of Aging, and the federal/state funded Medicaid program for intermediate care facility (ICF) level of nursing home care administered by the Utah State Department of Health, Division of Health Care Financing, for state fiscal year 1980, which included the time period July 1, 1979 to June 30, 1980.

Research questions concerning demographic characteristics, service components, and comparative public costs for community based and ICF nursing home care were addressed by a retrospective cross-sectional analysis of 714 case files for the community based sample and published reports for the 4,005 ICF sample. The focus of the study was on the community based TAP sample because individual case records within aging districts and statewide were available for review.

The investigation showed that the majority of persons requiring long term care services from both institutional and community based public programs were females 65 years of age and older. This compares favorably with the general consensus held by most gerontologists (Congressional Budget Office, 1977;

Health Care Financing Administration, 1981; United States General Accounting Office, 1979a, 1979b; White House Conference on Aging, 1980). The mean per diem costs for Medicaid reimbursed ICF residents were $25.38 higher than for the community based TAP sample. Service components for the TAP sample followed a predictable mixture of social and medical services such as homemaker/chore, home health aide, registered nurse, home delivered meals, transportation, residential living facilities, respite care, senior companion, equipment, friendly visitor, social day care and live-in companions. In addition to room and board, the ICF Medicaid sample received technical nursing and personal care services, as well as occupational and recreational therapy. The greater share of the TAP sample were widowed, lived in their own homes on mean monthly incomes of $365 and were terminated from the program after 7.3 months because services were no longer wanted or needed. The majority of applicants who were assessed, but denied admission to TAP, entered nursing homes because that was determined to be the most appropriate level of care.

This study has stimulated concern for the need for more randomized quasiexperimental research designs to assure an equal baseline between community based care

and nursing home care for the elderly population. Such study is basic to resolve critical cost considerations because of the meager knowledge base for all cost components. There is a question as to whether cost should be the primary, much less only, determinant of program preference. Research on long term care services should focus on methods to provide services most efficiently and effectively in different health care settings and approaches to make them more responsive to the desires and demands not only of the target population, but of the general public, as well.

Because this study was designed for practitioners whose primary interest in cost effectiveness in long term care lies in the application of a pragmatic approach, cost savings issues may be oversimplified. This study has generated questions for exploration of both community based and institutional long term care programs for the elderly as to cost effectiveness in terms of how the target population is defined, how potential clients/residents are identified, case management structure, efficacy of service, direct and indirect costs, who bears the cost and longitudinal data (Seidl et al., 1977). A one year data anlysis is clearly too brief a time dimension to generate useful information about effectiveness of long term care

programming. As with considerable research in the economics of gerontological care, a major criticism of this study is its retrospection. Replication should focus on a prospective design which examines a significant time period.

The basic implication for nursing lies in the fact that nursing personnel are the primary care providers for long term care clients both in community based and institutional settings. The term "cost effectiveness" is being used with increasing frequency when discussing long term care. Data collected under this context will influence important decisions regarding future programming and the flow of public financial support. Because these decisions will affect not only the clients and their families, but also nurses as the primary caregivers, nurses need to be knowledgeable and sensitive to their implications (Prescott, 1977). Nurses more and more are moving into leadership roles which influence major policy decisions for the elderly. Long term care is not only a health and social system, but also a political one. Nursing involvement in long term care demands understanding and participation in political decision-making processes. Another major implication for nursing concerns the setting of long term care. Previous funding mechanisms for these services had an

institutional bias since they were based on the medical mode. The integrated social/medical model demanded by the community based care will call for particular adjustments in current education and training practices for nurses specializing in gerontological and/or geriatric care. Eisele and Hoke (1979) suggested that long term care is now viewed as a continuum of services with a shift to the social services end of the spectrum. This is a promising direction for consideration by professional practitioners, analysts, and policy makers concerned about the growing problem of health care and the elderly.

APPENDIX A

STATE ADMINISTRATIVE AUTHORIZATION

FOR STUDY

Social Services

Scott M. Matheson, Governor, State of Utah
Andrew Gallegos, Executive Director

June 10, 1982

University of Utah Graduate School
College of Nursing
Thesis Supervisory Committee
Margaret Dimond, Ph.D., Chairperson
25 South Medical Drive
Salt Lake City, Utah 84112

Dear Dr. Dimond:

Carolyn Rice has my permission to review any and all client and fiscal records pertaining to The Alternatives Program for the period of July 1, 1979 through June 30, 1980 and to record and publish information contained in these documents as long as individual client confidentiality will be maintained. I understand that this information will be used in her thesis to be submitted to the faculty of the University of Utah in partial fulfillment of the requirements for the degree of Master of Science.

The Division of Aging is charged by the State Legislature to research and develop programs for the aged citizens of Utah. I consider evaluative research such as this to be of vital importance to this charge.

Each client in The Alternatives Program signs an authorization form giving permission for information contained in his/her records to be used in research. In return for this, we guarantee client confidentiality. Carolyn Rice has been an employee of the Division of Aging for two years and has had primary responsibility for this program and, thus, thoroughly understands and respects the client's rights of privacy and confidentiality.

Respectfully,

Louise Lintz, M.S.W.
Director

APPENDIX B

CLIENT AUTHORIZATION FOR THE ALTERNATIVES PROGRAM

Social Services

Scott M. Matheson, Governor, State of Utah
Anthony W. Mitchell, Ph.D., Executive Director

Authorization

I, _____, hereby give my consent to release to the Utah State Division of Aging or its authorized representative:

A. Any and all information concerning my physical condition, treatment rendered, medical and hospital records, or any other material or information related to my medical history.

B. Any and all social information related to me.

C. Authorization is further granted to the State Division of Aging to allow them to release to other agencies or persons as deemed necessary by them in order to coordinate services for me in the Alternatives Program.

D. I understand that the above information is necessary and will only be used by the Utah State Division of Aging or its authorized representatives as it pertains to the Alternatives Program.

E. I further understand that the data gathered as a result of the Alternatives program will be used in reporting and research. Individual confidentiality will be maintained.

I also understand by signing this form that:

A. I may be considered for this program, whereas refusal to either sign or submit needed information can be a cause for denial to this program.

B. If I feel I have been denied program services, or if information is wrongfully used, I am entitled to a fair hearing.

C. I have a right to inspect my own records, and can contest their validity, add data or request deletion of parts.

D. I have the right to appeal any decision to the District Court.

Dated this _____ day of _____,

19____.

Signature_____

Witness_____

Division of Aging
F. Leon PoVey, M.S.W.
Director

150 West North Temple, Suite 326
P.O. Box 2500
Salt Lake City, Utah 84110
(801) 533-6422

An Equal Opportunity Employer

DOA 1046 11/79

APPENDIX C

CLIENT RECORDS FOR THE ALTERNATIVES PROGRAM

Referral Application for the Alternatives Program

_____

Date referred_____

Referred by_____

Relationship_____

Phone #_____

_____

Name_____

Address_____

Phone #_____ SS#_____

Date of Birth_____ Age _____

Religion_____

Living arrangement of client_____

Physician_____Phone#_____

Person to call in case of emergency_____

_____ Phone#----------

Relationship_____

Problems

Is this an emergency situation?_____

Who is helping client now?_____

How?_____

Illness or operation?_____

Medications_____

Allergies_____

Smoke?_____ Drink?_____

Describe any recent traumatic event (loss of spouse, child, etc.)

_____

_____

Transportation?_____

Physical function?_____ Eyes?_____ Speech?_____

Hearing?_____

Mental function?_____ Confused?_____ Depressed _____

Presently in nursing home ? Yes_____ No_____

a) if yes, specific facility_____

b) if no, specify reason not in nursing home:

Prefers home care?_____

Nursing home not available?_____

Refuses to go to nursing home?_____

Awaiting placement?_____

Other?_____

Financial Information

Medicaid #_____ Medicare Yes_____ No _____

Veteran's pension Yes_____ No _____

Specify other insurance_____

Monthly income_____ For couple?____ Singly?_____

The Alternatives Program
Client Assessment Form

Social Services

Scott M. Matheson, Governor, State of Utah
Andrew Gallegos, Executive Director

Authorization

I, _____, hereby give my consent to release to the Utah State Division of Aging or its authorized representative:

A. Any and all information concerning my physical condition, treatment rendered, medical and hospital records, or any other material or information related to my medical history.

B. Any and all social information related to me.

C. Authorization is further granted to the State Division of Aging to allow them to release to other agencies or persons as deemed necessary by them in order to coordinate services for me in the Alternatives Program.

D. I understand that the above information is necessary and will only be used by the Utah State Division of Aging or its authorized representatives as it pertains to the Alternatives Program.

E. I further understand that the data gathered as a result of the Alternatives program will be used in reporting and research. Individual confidentiality will be maintained.

I also understand by signing this form that:

A. I may be considered for this program, whereas refusal to either sign or submit needed information can be a cause for denial to this program.

B. If I feel I have been denied program services, or if information is wrongfully used, I am entitled to a fair hearing.

C. I have a right to inspect my own records, and can contest their validity, add data or request deletion of parts.

D. I have the right to appeal any decision to the District Court.

Dated this _____ day of _____,

19____.

Signature_____

Witness_____

Division of Aging
F. Leon PoVey, M.S.W.
Director

150 West North Temple, Suite 326
P.O. Box 2500
Salt Lake City, Utah 84110
(801) 533-6422

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Social Services

Scott M. Matheson, Governor, State of Utah
Andrew Gallegos, Executive Director

The Alternatives Program

Assessment_____ Reassessment Number _____

Date_____

Name_____

District_____

City_____ County_____ Zip Code _____

Phone_____

Referred by_____

Date of Birth_____ Age_____ Sex_____

Place of Residence:

_____ Own Home
_____ Apartment
_____ Mobile Home
_____ Home of Another; Relationship_____
_____ Other: Specify _____

_____ Boarding House
_____ Hotel
_____ Nursing Home

Marital status:

_____ Never Married
_____ Married
_____ Divorced
_____ Widowed

Race:

_____ Caucasian
_____ Black
_____ American Indian
_____ Spanish
_____ Oriental
_____ Other: specify_____

In case of emergency, notify:

Name_____

Relationship_____

Home Phone:_____Business Phone_____

Physician_____ Phone_____

Division of Aging
F. Leon PoVey, M.S.W.
Director

150 West North Temple, Suite 326, P.O. Box 2500
Salt Lake City, Utah 84110
(801) 533-6422

Skill Level Categories

Homebound status:

_____ 1. Independent
_____ 2. Chauffeurable
_____ 3. Chauffeurable with help
_____ 4. Homebound

Mental status:

_____ 1. Sound judgment
_____ 2. Guidance
_____ 3. Supervision
_____ 4. Restricted

Mobility status:

_____ 1. Independent
_____ 2. Ambulation
_____ 3. Transfer support
_____ 4. Immobile

Personal care:

_____ 1. Independent
_____ 2. Hygiene care
_____ 3. Health care
_____ 4. Total care

Functional status:_____

What illnesses have you had in the last year?_____

_____

Have you been hospitalized or in a nursing home in the last 12 months?

_____ hospitalization

_____ Nursing home, specify:_____

Who is assisting the client at the present time? (Check all that apply).

_____ No one
_____ Relative
_____ Church
_____ Nonrelative or friend
_____ Agency

Type of assistance received:_____

Name, phone, and address of person/agency who is assisting:

Name_____ Phone_____

Address_____

List all medications (prescription or over-the-counter drugs). Include dosage, frequency of use, and prescribing physician:

Rx#	Pharmacy	Date	Medication	Dosage	Frequency of Use	Prescribing Physician

Total cost of monthly medications (including over-the-counter drugs):

What conditions are being medicated?_____

Are all medications actually taken as prescribed?_____

Total medical cost per month excluding medication (M.D., P.T., etc.):_____

Financial Information

Total monthly gross income_____

Is total monthly income for husband, wife, or both?_____

Source(s) of income: 1._____ 2. _____
3._____

Total Amount in Savings:_____

Monthly fee $_____ Monthly donation $ _____

Do you use food stamps? Yes _____ No _____

Do you have Medicare? Part A _____ Part B _____ No_____

Do you have a medical card? Yes _____ No _____

Do you have supplemental insurance? Yes _____ No_____

Names of persons conducting assessment:

Name_____ Name_____

Agency_____ Agency_____

Phone_____ Phone_____

Case plan:

Physicians comments:

Nurses comments:

Other's comments, specify_____

Interviewer's comments:

The Alternative Program Guide to Determine Skill Level Categories

SKILL LEVEL CATEGORIES
FUNCTIONAL STATUS

(To determine the personal limitations and abilities of an individual for the purpose of providing the or necessary level of skilled assistance needed to maintain or restore that individual to optimum good health and independence).

HOMEBOUND STATUS: (Client's ability to go outside home environment).

1 Independent (Able to drive, does not need assistance from mechanical device or an individual.

2 Chaufferable (Does not drive; is able to get into vehicle without mechanical or personal assistance.

3 Chaufferable with help (Dependent on mechanical device or personal assistance getting into vehicle).

4 Homebound (Is bedfast; or requires skilled assistance of two people, or one person and mechanical device).

MENTAL STATUS (Physical and psychological ability to make sound judgment).

1 Sound Judgment (Unimpaired; understands personal limitations and abilities).

2 Guidance (Occasionally confused; or mild physical impairment which may affect sound judgment, but will respond to guidance or instruction).

3 Supervision (Cannot be left alone. Must have constant supervision or restraints for safety sake. Example: senile dementia, mental retardation, physical impairment such as stroke or blindness.)

MOBILITY STATUS (Ability to ambulate and transfer.)

1 Independent (Ambulates alone; does not need mechanical device or personal support).

2 Ambulation Support (Uses mechanical device -- cane, walker, crutches, etc. -- but not dependent on person).

3 Transfer Support (Needs wheelchair; or personal assistance to ambulate).

4 Immobile (Bedfast; or needs two people for ambulation, or mechanical device and one person).

PERSONAL CARE (Ability to tend to personal needs -- hygiene, meal preparation, sanitation, safety).

1 Independent (Can bathe & dress alone, prepare nutritious meal, continence, keep sanitary environment, maintain safety).

2 Hygiene care (Needs assistance to bathe & dress properly, prepare better meals, help with cleaning, etc.).

3 Health care (Unable to do personal care which may affect health--hygiene, special diet, wound care, safety, etc.).

4 Total care (Totally dependent on another for personal care, meal preparation, incontinence, sanitation, mobility, etc.).

The SKILL LEVEL code is used for the following reasons:

1. To summarize the client's level of dependence and the amount of skilled assistance needed to support him/her.

a. With the code numbers in the given order, one can easily see how much help the client needs in each category. Example -- Code is 3244. The first number (3) would always indicate Homebound Status, level 3. The second number always refers to Mental Status, level 2. The third number (4)

would refer to Mobility Status, level 4. And, the last number (4) refers to Personal Care, level 4.

b. With the skill levels in ordered sequence, one can make an overall assessment of the client's total level of dependence. Example--A client whose code is 2222 would not require as much assistance as one whose code is 4344 (2344 or 1344 is not feasible).

c. The levels in the individual categories are comparable in the amount of skilled assistance needed. Example -- Level 1 needs no assistance in either category. Level 2 may need occasional assistance, but can probably manage. To further illustrate level 2, we will look at Mr. J. He cannot drive but could take a taxi or bus. He might have difficulty knowing just how to get where he is going but could seek direction or give information needed to assist him. He has ambulation support (cane, walker, crutches) but likes to be independent. Hopefully, he has family or other assistance to help with bringing in groceries, etc. His clothes may be mismatched or a bit rumpled, but he has washed at the lavatory and dressed himself. At level 3 is Mrs. G. She has had a stroke which has left her left arm paralysed and her left leg weaker than the right. She gets about the house if someone is there to help her from one object to another, and will use a cane if help is at her side. She would obviously need help with personal care, meals, etc. At level 4 is Mr. B. He is 92 years old, nearly blind, and suffers with severe arthritis. His spirits are usually light and he enjoys good company and is able to communicate well. However, he cannot get in and out of his chair alone, and his eyesight restricts his ability to work around the stove.

2. For ease in recognizing a change in client condition.

From the initial assessment to each succeeding reevaluation, one could recognize a change in the client's situation without reading the complete log.

3. For recording statistical data which is usually difficult to measure and summarize.

With the Skill level code being recorded and updated with each reevaluation, one could readily

see the number of clients who are at any particular level of each category. Example -- A chart may be read as follows: Total number of clients is 80.

Category	Level 1	Level 2	Level 3	Level 4	Total
Homebound status	00	7	28	45	80
Mental status	12	19	27	22	80
Mobility status	02	4	33	41	80

The Alternatives Program

Case Plan Form

Name_____ District_____ Category_____ Reassessment Date _____

Case# _____ Reassessment _____ Prior Approval _____ Amended _____

Reimbursable

Approved Services	Case Management			
Approved Number of Units	1/5			
Cost per Unit	$30/$10			
Total Cost	$80			
Approved Services		Client Donation	Client Fee Assessed	Total TAP Funds
Approved Number of Units				
Cost Per Unit				
Total Cost				

Existing Resources

Approved Services					
Approved Number of Units					
Cost per Unit					
Total Cost					
Approved Services				Title XX Fee Assessed	Total Existing Resources
Approved Number of Units					
Cost Per Unit					
Total Cost					

COMMENTS:

DOA 136
8/79

Approval of Services as required by Case Plan _____
Date

The Alternatives Program

Monthly Followup Form

Name_____ Client ID_____

Initial Assessment (mo/yr)_____

Followup: 1 2 3 4 5 6

Reassessment (mo/yr) _____

Case Plan Services

I. Monitoring of Services

	Receiving yes	Receiving no	Appropriate yes	Appropriate no	Quality of Care (Acceptability) yes	Quality of Care (Acceptability) no
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

II. Services Discontinued

	State Coord. Approval Yes	State Coord. Approval No	Yes	No
1.				
2.				
3.				
4.				

Services added

1.

2.

3.

4.

III. Disposition of Case

Yes	No

A. Continuing
B. Terminated _____(mo/yr)
   1. Client request
   2. Client deceased
   3. Service need fulfilled
   4. Client entered nursing home or hospital

COMMENT:

_____

_____

_____

_____

_____

DOA 137 1/79

Signature of Person conducting followup _____

date _____

The Alternative Program Yearly Client/Service Tracking Form

Client Service Tracking

Client Name_____ Initial Assessment Date ____/____/____

Reassessment Date ____/____/____

Year 198____	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
Assessment (month)												
Monthly followupe ( ) Quarterly reviews (X)												
Fee or Donation ($ collected)												
Quarterly totals	A= QR=	FU = $ =		A= QR=	FU= $ =		A= QR=	FU= $ =		A= QR=	FU= $ =	

1. Service and provider_____

   Number of Monthly Units Approved_____

	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
Units:												
$												
Quarterly Totals												

2. Service and provider_____

   Number of Monthly Units Approved_____

	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
Units:												
$												
Quarterly Totals												

3. Service and provider_____

   Number of Monthly Units Approved_____

	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
Units:												
$												
Quarterly Totals												

A = assessment; FU = monthly followups; QR = quarterly review

The Alternatives Program Service Reimbursement Form

District _____

Utah Department of Social Services
Aging Service Reimbursement Request Form

Page ___ of ___

Subgrantee _____ For the period _____ through _____

Address _____

PRIMARY RECIPIENT	Category	Initial Service Entry Date	Service Closing Date	Service Activity	Title XX Fees Collected	Alternative Fees Collected	Donations Collected	Units of Service Rendered	Rate of Reimbursement	Requested Reimbursement
				Page subtotal	$	$	$	PAGE SUBTOTAL		$
				GRAND TOTAL	$	$	$	GRAND TOTAL		$

Previous budget balance $_____
Less current month's request $_____
CURRENT BUDGET BALANCE $_____

I certify that the services listed on this statement were rendered in behalf of the above named persons; that this claim constitutes the full and complete charge for said services described above; that I will make no further claim for payment of these services; that these services have been provided without discrimination based upon race, color, creed, sex, or national origin; that this statement is subject to federal and state audit.

_____ / ___ / ___
Signature Title Mo Day Year

FOR STATE USE ONLY
Date reviewed _____ by _____
Date approved _____ by _____
Date report received by ODAS Finance _____

DOA 135
8/79

The Alternatives Program Legislative Report Form

Reporting Period:

From ___/____/____ To ____/____/_____
day mo yr day mo yr

1. Total clients served (including those receiving assessments only)_____

   A. Total clients active during reporting period: _____

   B. Total clients assessed by not admitted to program _____

2. Total TAP expenditures: $ _____

3. Total Other State/Federal Expenditures (existing resources): $ _____

4. Total project income: $_____

5. Total number of clients served per service:

Homemaker	_____
Home health aide	_____
Chore	_____
Shopping assistance	_____
RN services	_____
Physical therapy	_____
Respite care	_____
Home delivered meals	_____
Friendly visitor	_____
Senior companion	_____
Residential living	_____
Live-in	_____
Adult foster care	_____
Transportation	_____
Equipment	_____
Supplies	_____
Mental health counseling	_____

Others: (specify)_____

_____

_____

6. Total number of active client days during reporting period _____ days.

7. Age of youngest client served:_____

   Age of oldest client served: _____

8. Average age of client at time of yearly assessment: _____.

The Alternatives Program
Case Termination Form

Client Name_____

Address_____

City_____County_____ Zip_____

Age at Time of Initial Assessment_____

Termination Effective Date (Mo/Day/Yr)_____

Consecutive days on program:

from _____/_____/_____ to _____/_____/_____
month day year month day year

Reason for closure (Check appropriate number):

1. _____ Client/family request. Specify reason:_____
_____

2. _____ Client deceased. Specify date_____

3. _____ Client entered nursing home.
specify facility_____
date of admission_____

4. _____ Client entered hospital.*
specify facility_____
date of admission_____
anticipated discharge date_____

5. _____ Moved, specify location:
_____
city county state

6. _____ Service need fulfilled:

7. _____ Case management and service(s) to be provided by another agency.

Specify agency_____
Specify service(s)_____

*status pending

8. _____ Other, specify_____

Signature of Person Authorizing Termination:

_____Date_____

Title_____

Signature of Client/Family/Agency:

_____Date_____

The Alternatives Program Nonadmission Determination Form

Client_____

Address:_____

City_____County_____Zip_____

Date of Assessment (Mo./Day/Yr.)_____

Place of Assessment_____

Reason for Nonadmission to TAP (Check appropriate number):

1. _____ Client/family request, specify reason_____
   _____

2. _____ Client deceased, specify date_____

3. _____ Client entered nursing home, specify facility _____Date of admission_____

4. _____ Client entered hospital, specify facility _____ Date of admission_____

5. _____ Moved. Specify county and state_____

6. _____ Client remained in nursing home.

7. _____ Client over-incomed.

8. _____ Client not at 90-day risk of nursing home admission.

9. _____ Service(s) not available.*

   Specify needed service(s)_____
   Specify date of 90-day reevaluation of service availability_____

10. _____ TAP or nursing home services not needed.

11. _____ Case management and service(s) to be provided by another agency.
    Specify agency:_____
    Specify service(s):_____

12. _____ Other. Specify_____

Recommendations for Further Action:

_____

_____

_____

Signature of person determining nonadmission status:

_____date_____

Title_____ Licensure no. _____

*Status pending.

Spin-off program

The Alternatives Program Standards, Procedures and Guidelines

A. Criteria for Admission to the Alternatives Program:

1) Resident of the State of Utah
2) 18 years of age or older
3) Client must be in high risk of nursing home admission if intervention does not take place (0-90 days). Clients determined to be medical crisis candidates will not be accepted.
4) Private physicians must be contacted to determine:

    a) high risk category
    b) appropriateness of The Alternatives Program in relationship to the client

5) Initial assessment must be completed on each candidate by the Assessment Team. The Assessment Team will be composed of an Area Agency on Aging designee and a Registered Nurse.

6) If the Assessment Team determines that that the client is an appropriate admission to the Alternaties Program, then the Assessment Team must develop a complete individual case plan for the client.

7) All informal support systems presently in place must be retained (family, friends, church, etc.). These support systems must be reported as part of the case plan. The Alternatives Program should not replace informal support systems presently in place.

8) Alternative services for the family, friends, etc. may be supplied if indicated by the assessment (e.g., Respite, Payment for Care in the Home of Another, etc.).

9) Service Authorizations will be developed by the designated AAA case manager on each individual client.

10) Disposition of assessment completed from referrals under the Prior Authorization project must be reported to the referring agency (e.g.,

Assistance Payments with Medical Utilization and Review). These must be reported within five working days of referral (See Prior Authorization Attachment).

11) Individual assessments, case plans and service authorizations must be submitted to the State every 15 days for computer programming.

12) Followup contacts must be made within ten working days after services begin and again every 30 days from the first followup contact. When the Assessment Team determines that an emergency exists, a followup contact will be made in advance of ten working days.

13) Followup contacts include:

a) monitoring of services (e.g., service connections and coordination).

b) appropriateness of services (e.g. service connections and coordination).

c) quality of services.

d) changes in client's condition.

These may be reported by client self-reporting, family or service provider reporting.

14) Persons who are currently patients in nursing homes may be considered for the Alternatives Program if the following conditions are met:

a) The client is inappropriately placed at the time of referral to the Assessment Team.

b) The physician approves of alternative placement.

c) Referred by Medical Utilization and Review Team.

d) Referred by Assistance Payments Administration.

B. Donations/Fees:

1) Each client should be encouraged to donate to the program. All donations are voluntary.

2) Donations and fees will be considered Project Income and must be expended for Alternative clients during the contract year in which they are collected. Donations made to nonalternative funded services will be treated as nonalternative Project Income.

3) Sliding scale fee schedule will be used for those persons whose monthly income exceeds 67% of the State's median income (see attached fee schedule). Fees will be assessed by the Assessment Team to the client. Fees are payable to the Area Agency on Aging and will be treated as alternative Project Income.

4) Fees will be assessed for the entire package of services, not for individual services.

5) Exception to the above #4 will apply when the service is provided by a Title XX program. Fees assessed will then be paid to Title XX (e.g., Field Service, Homemaker Program) when applicable.

6) Persons receiving services funded by Titles IIIb and IIIc should be informed about suggested donations. They should be encouraged to donate, but services cannot be denied if they do not donate.

7) Services may be provided for those clients above the allowable sliding scale income level; however, fees assessed will be determined on an individual basis with each individual who is above the sliding scale income level. The Assessment Team will determine what fees should be assessed.

8) Assets will not be considered for eligibility in the program.

9) Fees may be waived if medical expenses indicate a fee assessed would cause undue hardship on the client.

C. Services Provided with Older Americans Act Funding:

Services available under Titles IIIb and IIIc will not be reimbursed by the Alternatives Program. These services must be reported by cost of unit service so that accurate cost data can be developed. In the event services normally available under Titles IIIb or IIIc are not available due to oversubscription of existing programs, then similar services will be acquired from other sources and reimbursed by the State. Alternative clients will be placed in appropriate Title III programs when slots become available.

D. Services Provided with Title XX Funding:

Services available under Title XX will not be reimbursed by the Alternatives Program. These services must be reported by cost of unit so that accurate cost data can be developed. In the event services normally available under Title XX are not available due to oversubscription of existing programs, then similar services will be acquired from other sources and reimbursed by the State. The Alternative clients will be placed in appropriate Title XX programs when slots become available. When a Title XX service is required by the case plan, a signed Title XX group eligibility form must accompany the case plan when it is submitted to the state.

E. Area Agency Responsibilities:

1) Initial Assessment

2) Case Plan Development

3) Arrangement and Coordination of Services

4) Followup contact

a) First followup contact within ten working days after services have begun. When the Assessment Team determines that an emergency exists, a followup contact will be made in advance of ten working days.

b) Followup contact every 30 days.

5) Reassessment within 180 days of initial assessment and every 180 days thereafter, unless case plan calls for more frequent assessments.

6) Individual assessment and case plans will be maintained on each individual in a separate file. Client confidentiality must be maintained.

7) Requests for reimbursement filed monthly.

F. State Division of Aging Responsibility:

1) Provide money (cash assistance) to project in support of project activities in accordance with the State Division of Aging approved case plan services.

2) Individual assessment and case plans will be maintained on each individual in a separate file.

3) Program evaluation will be ongoing with a written yearly report to each Area Agency.

4) Monitoring of clients and services will be conducted on a random basis.

5) Technical Assistance will be available as requested.

6) Authorization of requests for reimbursement to the Utah State Finance Department monthly in accordance with the individual approved case plan.

Title XIX Prior Authorization Program for I.C.F. Medicaid Recipients in Long Term Care Facilities

PROBLEM: A review of the Title XIX (Medicaid) client presently receiving or actively seeking health care assistance in the intermediate care category was made. This review shows there is, at present, a large gap in the array of programs or services available to assist them with their illness or disabilities. A review of people who are seeking assistance in maintaining their health and independent living in their own home, indicates they also could benefit from a more comprehensive range of health care services.

PURPOSE: The intent of this effort is to implement a stronger, more direct management of health care services to Title XIX (Medicaid) clients in long

term care facilities, or in The Alternatives Program.

OBJECTIVE: The objectives of this program are:

1. Strengthen the management and delivery of appropriate health care to Title XIX recipients in either a long term care facility or The Alternatives Program.

2. Provide an array of health care services for Title XIX clients which offer adequate alternatives to choose from.

3. Operate a Prior Authorization Program which offers the client a detailed assessment of his/her illness or disability; a determination of the health care assistance needed; and an understanding of the services and programs available to meet those needs.

PROGRAM DESCRIPTION: the Title XIX Prior Authorization Program is best understood by looking at the following:

a. People in the community who are seeking health services under the Title XIX (Medicaid) program.

b. People presently receiving intermediate care in a long term care facility who have applied for and are qualified to receive Title XIX Medicaid benefits.

c. People who have been in a long term care facility for some time and are receiving Title XIX Medicaid benefits, and whose health has improved to a point that The Alternative Program may have appropriate services to meet their needs.

I. Clients in the Community who Apply for Medical Assistance from Title XIX (Medicaid) in a Long Term Care Facility (Chart A).

There are a number of clients who seek Title XIX (Medicaid) assistance through their doctor, Senior Citizens groups, religious leaders, or other associations and are referred to Assistants Payments Administration (APA). When Assistance Payments Adminsitration receives such an application, they will contact the local area agency representatives of the

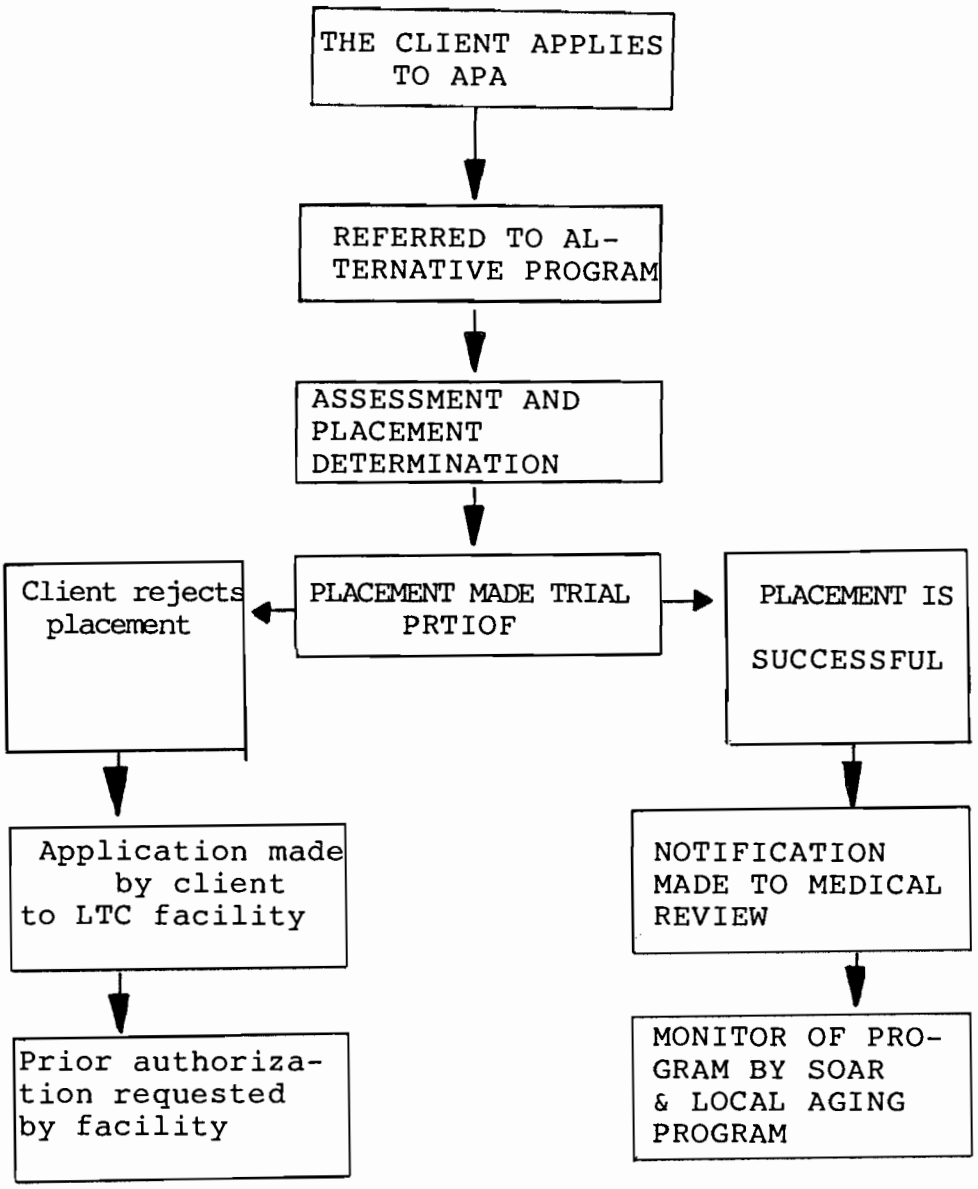

Chart A. Process chart for clients in the community who apply for medical assistance to Title XIX (Medicaid).

Alternatives Program.

The Assessment Team from this agency consists of an Aging Specialist, an RN, either from Public Health or the local Home Health Agency, or where appropriate, an RN employed by the nursing home may be used. The findings and recommendations of the Assessment Team will be discussed with and reviewed by the physician. Should there be a differing opinion between the assessment team and the physician, the physician will have the final determination authority.

The Assessment Team will discuss these recommendations with the client and his/her family or guardian. These recommendations could be the utilization of the Home Health Program, Meals-on-Wheels, Homemaker Services, a combination of the above, or related services available in the community.

During this assessment period, Title XIX eligibility determination will continue through the APA process. This determination is completely independent from the placement assessment, and neither program will have an impact on the other in terms of client eligibility for Title XIX benefits.

Process Distribution

The following is a step-by-step description of the process the client may go through.

1. The client makes application to the Assistance Payments Administration (APA) for benefits under Title XIX (Medicaid) program.

2. APA informs The Atlernative Program (TAP) that a client has applied for Title XIX benefits. The TAP Team contacts the client and conducts a medical and functional assessment. In the event the team members do not agree, the physician will make the final determination. The team coordinator then discusses the recommendation with the immediate family.

3. The client or guardian after considering all alternatives either accepts placement in the community or makes application to a LTC facility.

4. If the client enters the community based program, he/she will, after a trial period, decide if he/she wishes to continue with the placement or make

application to a LTC facility.

5. If the client enters a community placement, notification is given to the Medicaid Review Team of OHCF. Their Supplemental On-Site Admission Review Team (SOAR) will review, on a timely basis, the continued medical needs of selected clients. This will be done by performing on-site visits to these clients.

The area Aging Representative will, likewise, perform a review of the functional needs of the patient to ensure the service he/she is receiving is appropriate.

6. If it is determined the client should enter a Title XIX certified ICF facility, it will be necessary for that facility to follow a specific prior authorization procedure in order to receive Title XIX (Medicaid) payment for that client. It should be emphasized that no Title XIX payment will be made to any LTC facility which has not received prior authorization on the following types of clients:

a) new clients admitted to LTC facilities after the effective date of this program who are seeking ICF category of care.

b) Private pay clients in nursing homes who have been determined eligible for Title XIX benefits and are to start receiving those benefits in the ICF cateogry.

This prior authorization will not apply to Title XIX skilled patients already in LTC facilities whose care needs to be lowered to the intermediate category. Likewise, prior authorization will not apply to clients who are readmitted to a LTC facility in the ICF cateogry after a temporary absence.

Prior Authorization Procedure to Receive Payment:

Prior authorization is received by the facility by filling out a Form 10 on the patient and submitting it to the Medical Review Section of OHCF within five (5) days from the client's first day of admission to the facility and/or Title XIX eligibility determination. The appropriate staff will review the information on the Form 10 and within five (5) working days, notify the facility of the approval or denial of the placement of the client's placement in the facility. The facility

will follow existing reimbursement policies and procedures to receive Title XIX payment for care delivered to the client.

II. Private Paying Client Residing in a LTC Facility and has Recently Qualified for Title XIX (Medicaid) (Chart B)

1. Client is a resident in the facility and has made an application and has been approved for Title XIX (Medicaid) benefits for LTC.

2. Within five (5) days the LTC facility requests prior authorization as outlined in #1 above.

3. The Medical Review Section of OCHF reviews the client and determines:

a) assessment of client indicates a community placement in the Alternatives Program would be appropriate.

b) refers client for assessment to The Alternatives Program (TAP).

c) assessment of client indicates placement in LTC facility is appropriate.

d) no community services are available; therefore, Medical Review gives approval for payment of title XIX funds to the LTC facility.

4. Community placement is made, medical monitoring is done by SOAR team and functional monitoring is done by TAP on client in the community placement.

5. Community placement is not appropriate, therefore, approval is given for patient to receive ICF category care in the LTC facility.

III. Client has been a Title XIX Patient of Nursing Home for Some Time (Chart C)

1. Inquiry is made by the client, family, guardian or doctor of The Alternatives Program and/or the Medical Review Team.

2. the Alternatives Program's local agency Review Team performs an evaluation on the patient and

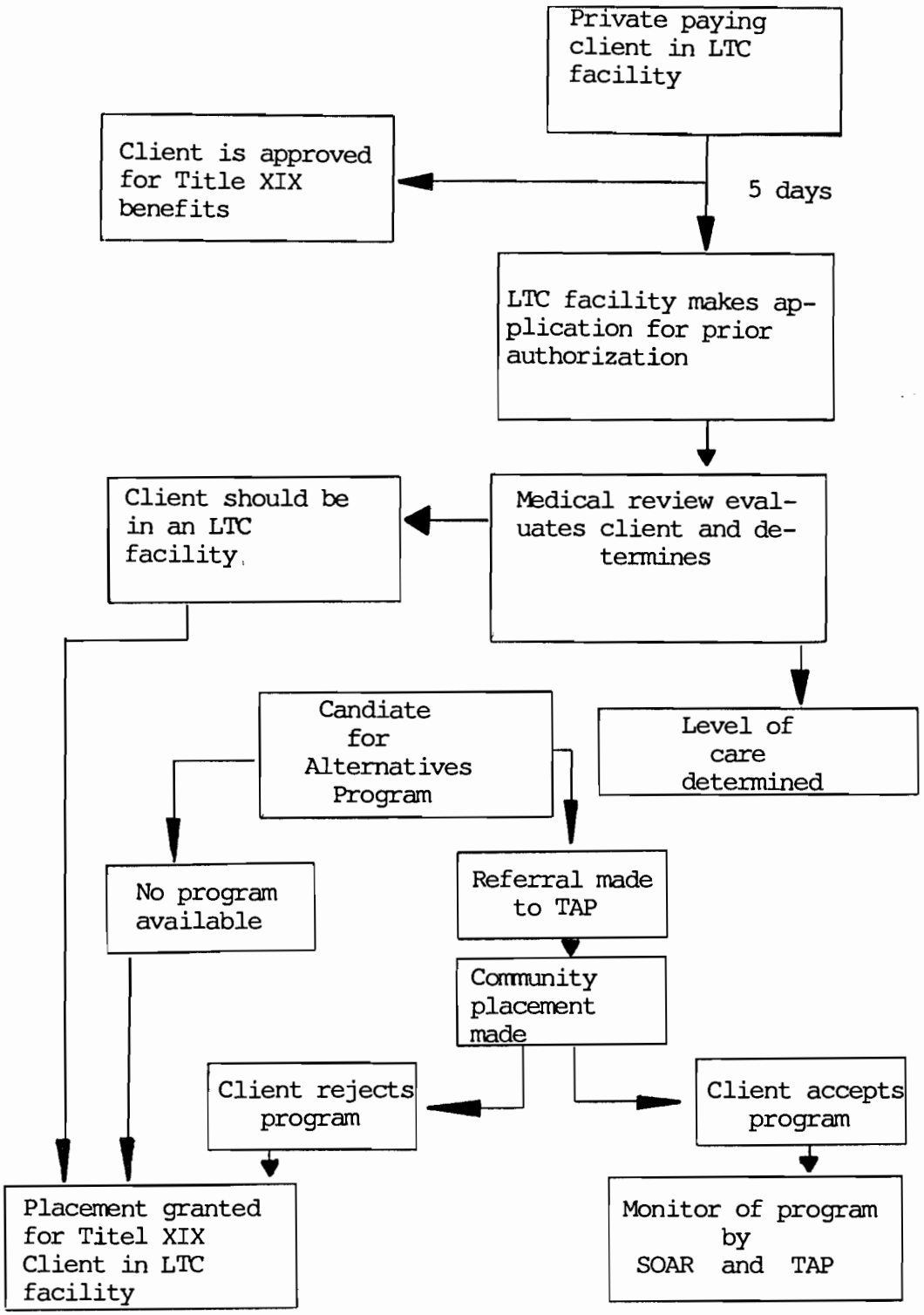

Chart B. Clients in the nursing home who have recently qualified for Title XIX (Medicaid).

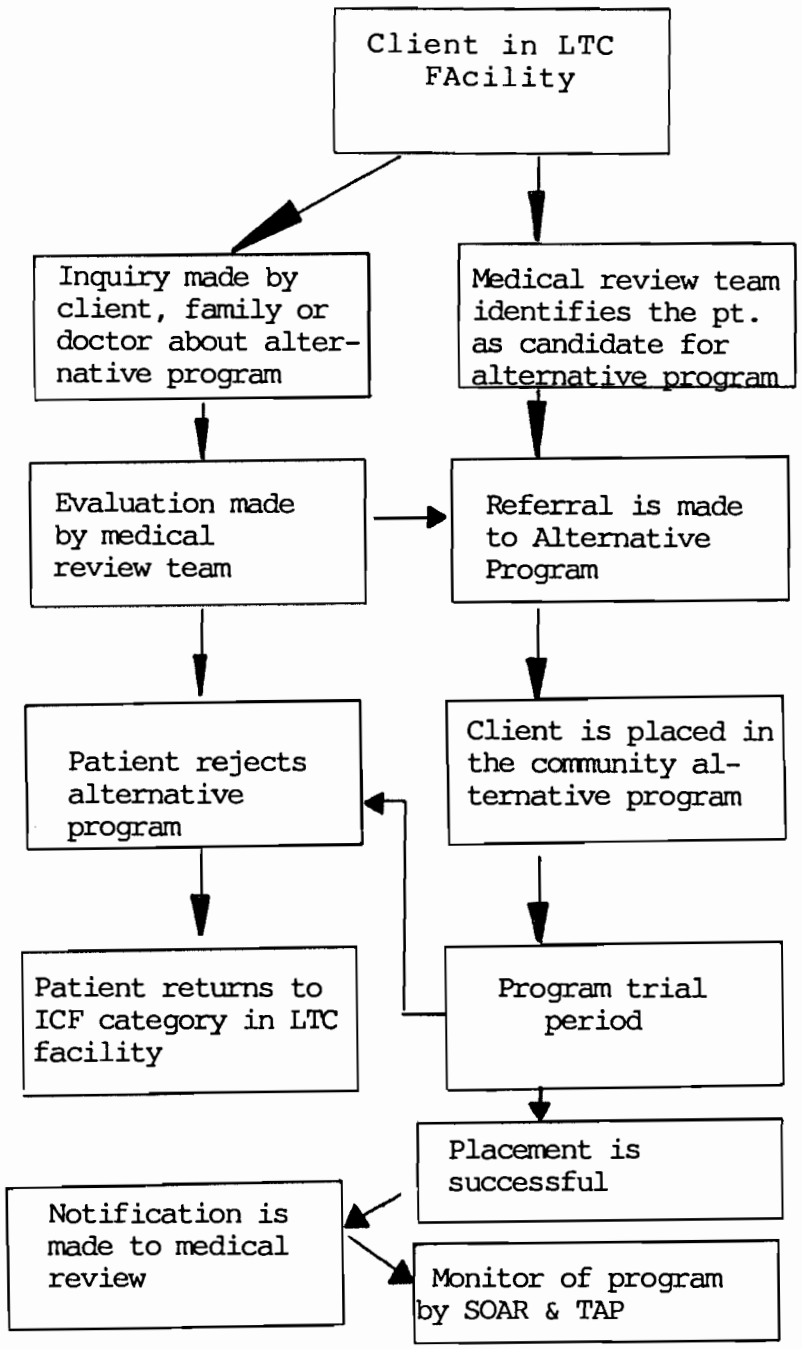

Chart C. Title clients who have been in a LTC facility for some time but could benefit from community placement.

recommends or discourages a community placement.

3. The Medical Review Team from OHCF determines the patient is a candidate for community placement in The Alternatives Program and makes the referral to TAP.

4. Client is placed in the Alternatives Program for a test period.

5. If placement in the community is successful, montioring of the patient (SOAR and TAP) begins.

6. When placement is inappropriate, the patient is returned to the ICF category of the LTC facility.

The Alternatives Program Fees

Monthly Gross Income	Fee
Family of 1	
0-277	0
278-300	0
301-400	5
401-500	10
501-532 (67%)	15
Family of 2	
0-382	0
383-400	0
401-500	5
501-600	10
601-696 (67%)	15
Family of 3	
0-484	0
485-500	5
501-600	10
601-700	15
701-800	20
801-860 (67%)	25

Monthly Gross Income		Fee
Family of 4		
0-588		0
589-600		5
601-700		10
701-800		15
801-900		20
901-1000		25
1001-1024	(67%)	30
Family of 5		
0-721		5
722-800		5
801-900		10
901-1000		15
1001-1100		20
1101-1187	(67%)	25
Family of 6		
0-842		0
843-900		5
901-1000		10
1001-1100		15
1101-1200		20
1201-1300		25
1301-1351	(67%)	25
Family of 7		
0-897		0
898-1000		5
1001-1100		10
1101-1200		15
1201-1300		20
1301-1382	(67%)	25
Family of 8		
0-952		0
953-100		5
1101-1100		10
1101-1200		15
1201-1300		25
1301-1412	(67%)	25

Monthly Gross Income		Fee
Family of 9		
0-1007		0
1008-1100		5
1101-1200		10
1201-1300		15
1301-1400		20
1401-1433	(67%)	25
Family of 10		
0-1062		0
1063-1100		5
1101-1200		10
1201-1300		15
1301-1400		20
1401-1474	(67%)	25
Family of 11		
0-1117		0
1118-1200		5
1201-1300		10
1301-1400		15
1401-1505	(67%)	
Family of 12		
0-1172		0
1173-1200		5
1201-1300		15
1301-1400		15
1401-1500		20
1501-1535	(67%)	25

The Alternatives Program
Case Management

Definition

Case managment is a process to coordinate services

for the elderly, done for and with a selected subset of clients. It provides access to the entire services system and ensures the coordinated delivery of multiple services to individual clients. Basic to case management is an initial broad-based assessment of the client's needs. In addition, the case management process involves ensuring that a service plan is written which considers all available service solutions, that the client is actually connected to service and that the progress of the client is reexamined at regular intervals.

Goals

The goals of the case management process are 1) to facilitate access to a complete continuum of care ranging from home care to institutional care, 2) to facilitate choice of the most appropriate services alternatives for the client's unique conditions and concerns, 3) to ensure the coordinated delivery of services to each client, and 4) to ensure periodic review of the appropriateness of the service being provided.

Case Management Components

Definitions

Needs assessment is the collection of information about a person's situation and functioning which allows major identification of the client's problems in the major functional areas.

Service plan is an agreement between the client and worker regarding client problems identified, goals to be achieved, and services to be pursued in support of goal achievement.

Arranging for service is contacting service providers and negotiating with them for the delivery of needed services to the client in the manner prescribed in the service plan.

Reassessment is the scheduled reexamination of the client's situation and functioning to identify changes which occurred since the initial assessment to measure progress toward the goals outlined in the service plan and to assure that the services are being delivered. In so doing, the case manager determines whether the

service plan needs to be updated and the pattern of service delivery changed.

Recording is all pertinent information regarding each client being recorded in an individual case file, maintained at the State Division of Aging and guaranteeing the confidentiality of each person and file.

The Alternatives Program

Service Goals

Upon completion of the assessment, determine which of the following categories or goals are most applicable to the major purpose of the Alternatives Program.

Enter this on the bottom of the assessment sheet.

Goal Category I: Refers primarily to those clients with episodes of illness or conditions in which the major purpose of the Alternatives Program is elimination of the problem or problems (short-term care). Full independence anticipated.

Example of Goal:

a) complete recovery from illness or disability
b) satisfactory adjustment to a major crisis
c) Adequate learning regarding nutrition, health practices and procedures.

Goal Category II: Refers to clients with problems that are expected to continue but ultimate objective is to assist the client or family to provide the necessary care without The Alternatives Program.

Example of Goal:

a) Client or family or family substitute competent in total client care
b) Client of family competent to seek help as indicated.

Goal Category III: Refers to clients with conditions or problems in which rehabilitation or improvement can be anticipated.

Example of Goal:

a) rehabilitation to optimum level of function and activity -- physical, social and emotional
b) reduced pain and disability
c) disease brought into control
d) client referred to and accepted by another agency which is meeting client's needs for rehabilitation.

Goal Category IV Refers to clients who need alternatives assistance in maintenance care.

Example of Goal:

a) maintenance level of ADL
b) prevent regression and complications
c) retard disease progression
d) detect early signs of deviation from normal or status quo.

Goal Category V: Refers to clients in terminal stages of illness.

Example of Goal:

a) prevent premature institutionalization
b) achieve satisfactory level of comfort and dignity at home during terminal stages
c) delay hospitalization or nursing home placement until family unable to meet needs.

APPENDIX D

DATA COLLECTION TOOLS

Data Collection Tool

I. Community-Based Clients:

A. Client Characteristics:

A.1 District _____

A.2 Date of Admission _____
mo. day year

A.3 Age in Years _____

A.4 Sex: Male _____ Female _____

A.5 Marital Status:

Never Married _____ Divorced _____
Married _____ _____

A.6 Place of Residence:

Own Home _____
Apartment _____
Mobile Home _____
Residential Facility _____
Home of Another _____
Boarding Home _____
Hotel _____
Nursing Home _____
Other (define) _____

A.7 Monthly Income: Single _____ Couple _____

A.8 Date of Termination _____
mo. day year

A.9 Reason for Termination:

Need Fulfilled _____
Client Request _____
Nursing Home _____
Deceased _____
Moved _____
Hospital _____
Other (Define) _____

A.10. Reason for Denial for Admittance to Program:

Client Refused _____
Moved _____
Hospital _____
Deceased _____
Nursing Home _____
Inappropriate _____
Other (define)_____

B. Service Categories:

B.1 TAP Reimbursable Services:

Homemaker _____
Home Health Aide _____
Home Delivered Meals _____
RN Services _____
Physical Therapy _____
Residential Living _____
Adult Foster Care _____
Live-in _____
Day Care _____
Respite Care _____
Care in home of relative _____
Senior Companion _____
Friendly Visitor _____
Telephone Reassurance _____
Shopping Assistance _____
Transportation _____
Supplies _____
Equipment _____
Legal Aide _____
Mental Health Counsel _____

Other (define)_____

_____

B.2 Other Public Funded Services:

Medicaid:

Home Health Aide _____
RN _____
Physical Therapy _____
Equipment _____
Other (define) _____

Medicare:

Home Health Aide _____
RN _____
Physical Therapy _____
Equipment _____
Other (define) _____

Title XX Block Grant for Social Services:

Homemaker/Chore _____
Day Care _____
Transportation _____
Foster Care _____
Care in Home of Relative _____
Other (define) _____

Older Americans Act:

Congregate Meals _____
Transportation _____
Home Delivered Meals _____
Other (define) _____

Other by Source:

_____

_____

_____

II. ICF Clients (Derived, exclusive of MR)

A. Client Characteristics

A.1 Age
A.2 Sex

B. List services reimbursable by Medicaid under daily reimbursement rate.

C. List daily Medicaid costs per resident for ICF care.

First Operational 6-78 (Weber)
Last Operational 6-80 (San Juan

TAP Data

District: Statewide

1. Open Cases (Number Clients in Each Category):

1.1 Total: 318
1.2 Age for 318 clients: Total: 24,348

Range:	44-98	Mean:	77	18-20:	0
Median:	76	Mode:	None	21-64:	42
60-64:	39	65+:	276		

1.3 Sex: Male: 108 Female: 210
1.4 Marital Status:

Never Married:	15	Divorced:	23
Married:	120	Widowed:	159

1.5 Place of Residence:

Own Home:	163
Apartment	69
Mobile Home	15
Residential Facility	27
Home of Another	25
Boarding Home	8
Hotel	1
Nursing Home	10

1.6 Monthly Income:

Single	198
Total	72,618
Mean	364
Median	354
Range	80-413
Couple	120
Total	73,097
Mean	609
Median	643
Range	100-1689

1.7 Months on Program:

Total	2304
Mean	7.3

1.8 TAP Reimbursable Services:

Homemaker	125
Home Health Aide	51
Home Delivered Meals	1
RN Services	39
Physical therapy	2
Residential Living	27
Adult Foster Care	0
Live-In	4
Day Care	5
Respite Care	10
Care in Home of Relative	1
Senior Companion	11
Friendly Visitor	7
Telephone Reassurance	0
Shopping Assistance	1
Transportation	2
Supplies	1
Equipment	7
Legal Aide	2
Mental Health Counsel	0

Other (define) 1 nite care, 1 bus accident payment 4 homemaker mileage, 27 case management only.

1.9 Medicaid Reimbursable Services:

Home Health Aide	5
RN Services	4
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	1
RN Services	3
Physical Therapy	0
Other (define)	0

1.10 Title XX Reimbursable Services

Homemaker/Chore	130
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	57
Transportation	18
Other (define)	0

1.13 Other Reimbursable Services by Source:

Mental Health Counseling	8
Health Screening	4

2. Closed Cases (Number Clients in Each Category

2.1 Total: 276

2.2 Age for 273 clients: Total: 21,405

Range:	53-97	Mean:	78	18-20:	0
Median:	79	Mode:	None	21-64:	21
60-64:	19	65+:	252		

2.3 Sex: Male: 86 Female: 190

2.4 Marital Status:

Never Married:	20	Divorced:	23
Married:	90	Widowed:	116

2.5 Place of Residence:

Own Home:	174
Apartment	51
Mobile Home	13
Residential Facility	9
Home of Another	21
Boarding Home	1
Hotel	1
Nursing Home	2
Other (define)	0

2.6 Monthly Income:

Single	186
Total	68094
Mean	366
Median	401
Range	83-1700
Couple	90
Total	57258
Mean	636
Median	587
Range	118-1570

2.7 Months on Program:

Total	2014
Mean	7.3

2.8 TAP Reimbursable Services:

Homemaker	116
Home Health Aide	74
Home Delivered Meals	0
RN Services	47
Physical therapy	3
Residential Living	9
Adult Foster Care	0
Live-In	5
Day Care	8
Respite Care	18
Care in Home of Relative	1
Senior Companion	6
Friendly Visitor	7
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	3
Equipment	8
Legal Aide	1
Mental Health Counsel	0

Other (define) 1 nite care, 2 utility payment, 2 extended auto ins., 1 restaurant meals, 3 homemaker mileage, 26 case management only.

2.9 Medicaid Reimbursable Services:

Home Health Aide	6
RN Services	3
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	2
Physical Therapy	2
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	66
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0

Other (define) 2 protective services

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	42
Transportation	10

Other (define) 1 legal services, 1 telephone reassurance.

2.13 Other Reimbursable Services by Source:

Mental Health Counseling	2
Health Screening	1
Hospice	1
Speech Therapy	1

2.14 Reason for Termination

Need Fulfilled	71
Client Request	58
Nursing Home	60
Deceased	68
Moved	3
Hospital	3
Other (define)	3 referral, 10 lack of funding.

3. Denials (Number Persons in Each Category):

3.1	Total	120
3.2	Age of 114 potential clients	
	Total	8825
	6 unrecorded	
	range	21-102
	mean	77
	median	82
	mode	none
	18-20	0
	21-64	13
	60-64	11
	65+	101
3.3	Sex	
	Male	34
	Female	86

3.4 Reason for Denial

Client Refusal	24
Moved	2
Hospital	1
Deceased	8
Nursing Home	62
Inappropriate	18
Other (define)	5 unrecorded

1st client 11-78

TAP Data

District: Bear River

1. Open Cases (Number Clients in Each Category):

1.1 Total: 15
Age for 15 clients: Total: 1,204

Range:	60-91	Mean:	80	18-20:	0
Median:	84	Mode:	None	21-64:	1
60-64:	1	65+:	14		

1.3 Sex: Male: 9 Female: 9

1.4 Marital Status:

Never Married:	0	Divorced:	1
Married:	11	Widowed:	3

1.5 Place of Residence:

Own Home:	14
Apartment	0
Mobile Home	0
Residential Facility	0
Home of Another	1
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	4
Total	1479
Mean	370
Median	351
Range	305-473
Couple	11
Total	8465
Mean	770
Median	790
Range	350-1689

1.7 Months on Program:

Total	87
Mean	5.8

1.8 TAP Reimbursable Services:

Homemaker	7
Home Health Aide	5
Home Delivered Meals	0
RN Services	0
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assitance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other (define)	0

1.9 Medicaid Reimbursable Services:

Home Health Aide	1
RN Services	1
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	1
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services

Homemaker/Chore	2
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	11
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:

0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 15

2.2 Age for 15 clients: Total: 1,111

Range:	66-87	Mean:	74	18-20:	0
Median:	72	Mode:	70	21-64:	0
60-64:	0	65+:	15		

2.3 Sex: Male: 4 Female: 11

2.4 Marital Status:

Never Married:	1	Divorced:	1
Married:	8	Widowed:	5

2.5 Place of Residence:

Own Home:	14
Apartment	0
Mobile Home	1
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	7
Total	12434
Mean	348
Median	360
Range	203-692
Couple	8
Total	15523
Mean	690
Median	715
Range	330-1400

2.7 Months on Program:

Total	57
Mean	3.8

2.8 TAP Reimbursable Services:

Homemaker	6
Home Health Aide	5
Home Delivered Meals	0
RN Services	1
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	1
Equipment	1
Legal Aide	0
Mental Health Counsel	0
Other (define)	0

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	3
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define) 1 protective services	

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	12
Transportation	0
Other (define)	0

2.13 Other Reimbursable Services by Source:

0

2.14 Reason for Termination

Need Fulfilled	8
Client Request	1
Nursing Home	3
Deceased	2
Moved	0
Hospital	1
Other (define)	0

3. Denials (Number Persons in Each Category):

3.1	Total	11
3.2	Age of 7 potential clients	
	Total	571
	4 unrecorded	
	range	74-91
	mean	81
	median	80
	mode	none
	18-20	0
	21-64	0
	60-64	0
	65+	7
3.3	Sex	
	Male	2
	Female	9
3.4	Reason for Denial	
	Client Refusal	1
	Moved	1
	Hospital	0
	Deceased	1
	Nursing Home	5
	Inappropriate	2
	Other (Define)	0

1st client 6-78

TAP Data

District: Weber

1. Open Cases (Number Clients in Each Category):

1.1 Total: 23
Age for 23 clients: Total: 1,780

Range:	62-94	Mean:	77	18-20:	0
Median:	75	Mode:	75	21-64:	3
60-64:	3	65+:	20		

1.3 Sex: Male: 8 Female: 15

1.4 Marital Status:

Never Married:	2	Divorced:	2
Married:	5	Widowed:	14

1.5 Place of Residence:

Own Home:	9
Apartment	7
Mobile Home	2
Residential Facility	3
Home of Another	2
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	18
Total	7102
Mean	395
Median	392
Range	224-540
Couple	5
Total	13724
Mean	745
Median	664
Range	397-1080

1.7 Months on Program:

Total	289
Mean	12.6

1.8 TAP Reimbursable Services:

Homemaker	16
Home Health Aide	1
Home Delivered Meals	0
RN Services	1
Physical Therapy	2
Residential Living	0
Adult Foster Care	0
Live-In	1
Day Care	1
Respite Care	0
Care in Home of Relative	0
Senior Companion	6
Friendly Visitor	2
Telephone Reassurance	0
Shopping Assitance	0
Transportation	0
Supplies	1
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other (night care)	1

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services

Homemaker/Chore	12
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	9
Transportation	3
Other (define)	0

1.13 Other Reimbursable Services by Source:

Mental Health Counseling	1

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 24

2.2 Age for 24 clients: Total: 1,899

Range:	64-92	Mean:	79	18-20:	0
Median:	80	Mode:	None	21-64:	2
60-64:	2	65+:	22		

2.3 Sex: Male: 10 Female: 14

2.4 Marital Status:

Never Married:	3	Divorced:	5
Married:	7	Widowed:	9

2.5 Place of Residence:

Own Home:	9
Apartment	6
Mobile Home	1
Residential Facility	5
Home of Another	3
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	17
Total	6491
Mean	382
Median	367
Range	241-519
Couple	7
Total	5295
Mean	756
Median	671
Range	402-897

2.7 Months on Program:

Total	198
Mean	8.3

2.8 TAP Reimbursable Services:

Homemaker	12
Home Health Aide	0
Home Delivered Meals	0
RN Services	0
Physical therapy	1
Residential Living	5
Adult Foster Care	0
Live-In	0
Day Care	2
Respite Care	0
Care in Home of Relative	0
Senior Companion	6
Friendly Visitor	1
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	1
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other (define)	0

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	8
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0

Other (define) 1 protective services

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	4
Transportation	2

Other (define) 1 telephone reassurance
1 legal services.

2.13 Other Reimbursable Services by Source:

0

2.14 Reason for Termination

Need Fulfilled	5
Client Request	5
Nursing Home	9
Deceased	3
Moved	0
Hospital	0
Other (referrals)	2

3. Denials (Number Persons in Each Category):

3.1	Total	36
3.2	Age of 35 potential clients	
	Total	2749
	range	21-92
	mean	76
	median	80
	mode	none
	18-20	0
	21-64	6
	60-64	4
	65+	30
3.3	Sex	
	Male	10
	Female	26
3.4	Reason for Denial	
	Client Refusal	11
	Moved	0
	Hospital	0
	Deceased	2
	Nursing Home	15
	Inappropriate	7
	Other (unrecorded)	1

lst client 8-78

TAP Data

District: Salt Lake

1. Open Cases (Number Clients in Each Category):

1.1 Total: 121
Age for 121 clients: Total: 9,428

Range: 60-98 Mean: 79 18-20: 0
Median: 78 Mode: 80 21-64: 12
60-64: 12 65+: 109

1.3 Sex: Male: 37 Female: 84
1.4 Marital Status:

Never Married: 3 Divorced: 9
Married: 41 Widowed: 68

1.5 Place of Residence:

Own Home:	50
Apartment	21
Mobile Home	4
Residential Facility	24
Home of Another	9
Boarding Home	8
Hotel	1
Nursing Home	4

1.6 Monthly Income:

Single	80
Total	25120
Mean	314
Median	302
Range	83-680
Couple	41
Total	22028
Mean	537
Median	502
Range	207-930

1.7 Months on Program:

Total	777
Mean	6.4

1.8 TAP Reimbursable Services:

Homemaker	24
Home Health Aide	12
Home Delivered Meals	0
RN Services	23
Physical Therapy	0
Residential Living	24
Adult Foster Care	0
Live-In	1
Day Care	4
Respite Care	7
Care in Home of Relative	0
Senior Companion	5
Friendly Visitor	4
Telephone Reassurance	0
Shopping Assitance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	1
Mental Health Counsel	0

Other 1 case management only

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	2
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services

Homemaker/Chore	63
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	14
Transportation	15
Other (define)	0

1.13 Other Reimbursable Services by Source:

Mental Health Counseling	5

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 76

2.2 Age for 75 clients: Total: 5,932
1 unrecorded

Range:	60-97	Mean:	79	18-20:	0
Median:	82	Mode:	None	21-64:	6
60-64:	6	65+:	69		

2.3 Sex: Male: 24 Female: 52

2.4 Marital Status:

Never Married:	2	Divorced:	8
Married:	23	Widowed:	43

2.5 Place of Residence:

Own Home:	46
Apartment	12
Mobile Home	2
Residential Facility	3
Home of Another	6
Boarding Home	5
Hotel	1
Nursing Home	1
Other (define)	0

2.6 Monthly Income:

Single	53
Total	16021
Mean	302
Median	296
Range	83-701
Couple	23
Total	11243
Mean	489
Median	494
Range	188-893

2.7 Months on Program:

Total	508
Mean	6.7

2.8 TAP Reimbursable Services:

Homemaker	17
Home Health Aide	15
Home Delivered Meals	0
RN Services	30
Physical therapy	2
Residential Living	3
Adult Foster Care	0
Live-In	1
Day Care	6
Respite Care	9
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	2
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	1
Equipment	4
Legal Aide	1
Mental Health Counsel	0

Other 2 case management only

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	1
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	2
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	26
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define) 1 protective services	

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	13
Transportation	0
Other (define)	

2.13 Other Reimbursable Services by Source:

Mental Health Counseling	2
Hospice	1
Speech Therapy pd by rehab	1
Health Screening	1

2.14 Reason for Termination

Need Fulfilled	19
Client Request	22
Nursing Home	16
Deceased	16
Moved	0
Hospital	0
Other (referrals)	1

3. Denials (Number Persons in Each Category):

3.1	Total	45
3.2	Age of 45 potential clients	
	Total	3440
	range	60-94
	mean	76
	median	77
	mode	79
	18-20	0
	21-64	6
	60-64	6
	65+	39
3.3	Sex	
	Male	12
	Female	33
3.4	Reason for Denial	
	Client Refusal	9
	Moved	0
	Hospital	0
	Deceased	0
	Nursing Home	27
	Inappropriate	7
	Other (unrecorded)	2

1st client 7-78

TAP Data

District: Davis

1. Open Cases (Number Clients in Each Category):

1.1 Total: 58
Age for 58 clients: Total: 4,476

Range:	53-98	Mean:	77	18-20:	0
Median:	78	Mode:	None	21-64:	9
60-64:	8	65+:	34		

1.3 Sex: Male: 24 Female: 34

1.4 Marital Status:

Never Married:	4	Divorced:	4
Married:	23	Widowed:	27

1.5 Place of Residence:

Own Home:	21
Apartment	23
Mobile Home	3
Residential Facility	0
Home of Another	9
Boarding Home	0
Hotel	0
Nursing Home	2

1.6 Monthly Income:

Single	35
Total	12880
Mean	368
Median	283
Range	80-967
Couple	23
Total	15070
Mean	755
Median	677
Range	241-1159

1.7 Months on Program:

Total	280

Mean 4.8

1.8 TAP Reimbursable Services:

Homemaker	20
Home Health Aide	9
Home Delivered Meals	0
RN Services	1
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	1
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	5
Legal Aide	0
Mental Health Counsel	0

Other 7 case management only

1.9 Medicaid Reimbursable Services:

Home Health Aide	2
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	1
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	31
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	8
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:

Mental Health Counseling	2

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 51

2.2 Age for 51 clients: Total: 4,026

Range:	61-95	Mean:	79	18-20:	0
Median:	81	Mode:	81	21-64:	4
60-64:	4	65+:	47		

2.3 Sex: Male: 12 Female: 39

2.4 Marital Status:

Never Married:	4	Divorced:	3
Married:	17	Widowed:	27

2.5 Place of Residence:

Own Home:	29
Apartment	17
Mobile Home	1
Residential Facility	0
Home of Another	4
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	34
Total	12886
Mean	379
Median	301
Range	122-1015
Couple	17
Total	12259
Mean	721
Median	691
Range	187-1340

2.7 Months on Program:

Total	263
Mean	5.2

2.8 TAP Reimbursable Services:

Homemaker	30
Home Health Aide	9
Home Delivered Meals	0
RN Services	4
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	2
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	1
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0

Other 6 case management only

2.9 Medicaid Reimbursable Services:

Home Health Aide	1
RN Services	1
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	14
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	3
Transportation	0
Other (define)	

2.13 Other Reimbursable Services by Source:
0

2.14 Reason for Termination

Need Fulfilled	11
Client Request	16
Nursing Home	10
Deceased	14
Moved	0
Hospital	0
Other (referrals)	0

3. Denials (Number Persons in Each Category):

3.1	Total	7
3.2	Age of 7 potential clients	
	Total	588
	range	69-102
	mean	84
	median	82
	mode	None
	18-20	0
	21-64	0
	60-64	0
	65+	7
3.3	Sex	
	Male	4
	Female	3

3.4 Reason for Denial

Client Refusal	0
Moved	0
Hospital	1
Deceased	2
Nursing Home	4
Inappropriate	0
Other	0

1st client 3-80

TAP Data

District: Tooele

1. Open Cases (Number Clients in Each Category):

1.1 Total: 3
Age for 3 clients: Total: 183

Range: 44-77 Mean: 61 18-20: 0
Median: 62 Mode: None 21-64: 2
60-64: 1 65+: 1

1.3 Sex: Male: 2 Female: 1
1.4 Marital Status:

Never Married: 0 Divorced: 1
Married: 1 Widowed: 1

1.5 Place of Residence:

Own Home:	3
Apartment	0
Mobile Home	0
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	3
Total	802
Mean	401
Median	402
Range	355-477
Couple	1
Total	787
Mean	787
Median	787
Range	787

1.7 Months on Program:

Total	7
Mean	4.8

1.8 TAP Reimbursable Services:

Homemaker	0
Home Health Aide	0
Home Delivered Meals	1
RN Services	0
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other	0

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	2
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	2
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:

0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 0

2.2 Age for 0 clients: Total: 0

Range: 0 Mean: 0 18-20: 0

Median: 0 Mode: 0 21-64: 0

60-64: 0 65+: 0

2.3 Sex: Male: 0 Female: 0

2.4 Marital Status:

Never Married: 0 Divorced: 0

Married: 0 Widowed: 0

2.5 Place of Residence:

Own Home:	0
Apartment	0
Mobile Home	0
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	00
Total	00
Mean	00
Median	00
Range	00
Couple	00
Total	00
Mean	00
Median	00
Range	00

2.7 Months on Program:

Total	0
Mean	0

2.8 TAP Reimbursable Services:

Homemaker	0
Home Health Aide	0
Home Delivered Meals	0
RN Services	0
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other	0

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	0
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	

2.13 Other Reimbursable Services by Source:
0

2.14 Reason for Termination

Need Fulfilled	0
Client Request	0
Nursing Home	0
Deceased	0
Moved	0
Hospital	0
Other (referrals)	0

3. Denials (Number Persons in Each Category):

3.1	Total	0
3.2	Age of 0 potential clients	
	Total	0
	range	0
	mean	0
	median	0
	mode	None
	18-20	0
	21-64	0
	60-64	0
	65+	0
3.3	Sex	
	Male	0
	Female	0

3.4 Reason for Denial

Client Refusal	0
Moved	0
Hospital	0
Deceased	0
Nursing Home	0
Inappropriate	0
Other	0

1st client 7-78

TAP Data

District: Mountainlands

1. Open Cases (Number Clients in Each Category):

1.1 Total: 32
Age for 32 clients: Total: 2,407

Range:	62-88	Mean:	75	18-20:	0
Median:	75	Mode:	85	21-64:	4
60-64:	4	65+:	28		

1.3 Sex: Male: 8 Female: 24

1.4 Marital Status:

Never Married:	3	Divorced:	0
Married:	12	Widowed:	17

1.5 Place of Residence:

Own Home:	21
Apartment	5
Mobile Home	2
Residential Facility	0
Home of Another	1
Boarding Home	0
Hotel	0
Nursing Home	3

1.6 Monthly Income:

Single	20
Total	7640
Mean	382
Median	326
Range	188-917
Couple	12
Total	8876
Mean	740
Median	708
Range	406-1285

1.7 Months on Program:

Total	341
Mean	10.7

1.8 TAP Reimbursable Services:

Homemaker	25
Home Health Aide	9
Home Delivered Meals	0
RN Services	0
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	2
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0

Other-3 case management only

1.9 Medicaid Reimbursable Services:

Home Health Aide	2
RN Services	1
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	4
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:
0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 47

2.2 Age for 47 clients: Total: 3,738

Range:	62-96	Mean:	80	18-20:	0
Median:	80	Mode:	None	21-64:	3
60-64:	3	65+:	44		

2.3 Sex: Male: 14 Female: 33

2.4 Marital Status:

Never Married:	5	Divorced:	1
Married:	14	Widowed:	27

2.5 Place of Residence:

Own Home:	30
Apartment	7
Mobile Home	5
Residential Facility	0
Home of Another	4
Boarding Home	0
Hotel	0
Nursing Home	1
Other (define)	0

2.6 Monthly Income:

Single	33
Total	13239
Mean	401
Median	335
Range	188-871
Couple	14
Total	10510
Mean	751
Median	742
Range	412-1570

2.7 Months on Program:

Total	426
Mean	9.1

2.8 TAP Reimbursable Services:

Homemaker	22
Home Health Aide	31
Home Delivered Meals	0
RN Services	1
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	3
Day Care	0
Respite Care	5
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	1
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other 8 case management only	

2.9 Medicaid Reimbursable Services:

Home Health Aide	5
RN Services	1
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	1
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	4
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	

2.13 Other Reimbursable Services by Source:
0

2.14 Reason for Termination

Need Fulfilled	13
Client Request	7
Nursing Home	10
Deceased	17
Moved	0
Hospital	0
Other (referrals)	0

3. Denials (Number Persons in Each Category):

3.1	Total	5
3.2	Age of 5 potential clients	
	Total	374
	range	62-82
	mean	75
	median	77
	mode	None
	18-20	0
	21-64	1
	60-64	1
	65+	4
3.3	Sex	
	Male	0
	Female	5

3.4 Reason for Denial

Client Refusal	0
Moved	0
Hospital	0
Deceased	0
Nursing Home	4
Inappropriate	0
Other	0

1st client 8-78

TAP Data

District: Central

1. Open Cases (Number Clients in Each Category):

1.1 Total: 10
Age for 10 clients: Total: 694

Range:	60-81	Mean:	69	18-20:	0
Median:	71	Mode:	None	21-64:	2
60-64:	2	65+:	8		

1.3 Sex: Male: 4 Female: 6

1.4 Marital Status:

Never Married:	0	Divorced:	1
Married:	7	Widowed:	2

1.5 Place of Residence:

Own Home:	10
Apartment	0
Mobile Home	0
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	3
Total	834
Mean	278
Median	273
Range	149-413
Couple	7
Total	11613
Mean	230
Median	266
Range	100-303

1.7 Months on Program:

Total	113
Mean	11.3

1.8 TAP Reimbursable Services:

Homemaker	4
Home Health Aide	1
Home Delivered Meals	0
RN Services	2
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0

Other-3 case management only

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	4
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:
0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 17

2.2 Age for 17 clients: Total: 1,352

Range:	60-92	Mean:	80	18-20:	0
Median:	82	Mode:	83	21-64:	1
60-64:	1	65+:	16		

2.3 Sex: Male: 4 Female: 13

2.4 Marital Status:

Never Married:	0	Divorced:	0
Married:	6	Widowed:	11

2.5 Place of Residence:

Own Home:	17
Apartment	0
Mobile Home	0
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	11
Total	2715
Mean	247
Median	264
Range	88-392
Couple	6
Total	11659
Mean	277
Median	301
Range	118-379

2.7 Months on Program:

Total	177
Mean	10.4

2.8 TAP Reimbursable Services:

Homemaker	6
Home Health Aide	6
Home Delivered Meals	0
RN Services	5
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other 1 case management only	

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	1
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	3
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	4
Transportation	0
Other (define)	

2.13 Other Reimbursable Services by Source:
0

2.14 Reason for Termination

Need Fulfilled	0
Client Request	0
Nursing Home	2
Deceased	3
Moved	2
Hospital	0
Other -lack of funding	10

3. Denials (Number Persons in Each Category):

3.1	Total	4
3.2	Age of 4 potential clients	
	Total	302
	range	67-93
	mean	76
	median	71
	mode	None
	18-20	0
	21-64	0
	60-64	0
	65+	4
3.3	Sex	
	Male	2
	Female	2

3.4 Reason for Denial

Client Refusal	0
Moved	0
Hospital	0
Deceased	0
Nursing Home	2
Inappropriate	1
Other (unrecorded)	1

1st client 9-78

TAP Data

District: Five County

1. Open Cases (Number Clients in Each Category):

1.1 Total: 15
Age for 15 clients: Total: 11,114

Range:	63-94	Mean:	74	18-20:	0
Median:	74	Mode:	None	21-64:	2
60-64:	2	65+:	13		

1.3 Sex: Male: 5 Female: 10

1.4 Marital Status:

Never Married:	0	Divorced:	1
Married:	7	Widowed:	7

1.5 Place of Residence:

Own Home:	11
Apartment	2
Mobile Home	0
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	8
Total	22351
Mean	294
Median	345
Range	125-464
Couple	7
Total	14186
Mean	598
Median	566
Range	200-1060

1.7 Months on Program:

Total	92
Mean	6.2

1.8 TAP Reimbursable Services:

Homemaker	8
Home Health Aide	4
Home Delivered Meals	0
RN Services	3
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	1
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other-1 case management only	

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	1
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	3
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	2
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:
0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 9

2.2 Age for 9 clients: Total: 712
Range: 53-97 Mean: 79 18-20: 0
Median: 84 Mode: None 21-64: 2
60-64: 0 65+: 7

2.3 Sex: Male: 4 Female: 5

2.4 Marital Status:

Never Married:	1	Divorced:	1
Married:	3	Widowed:	4

2.5 Place of Residence:

Own Home:	7
Apartment	0
Mobile Home	1
Residential Facility	0
Home of Another	1
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	6
Total	11498
Mean	250
Median	336
Range	88-505
Couple	3
Total	11744
Mean	581
Median	601
Range	197-982

2.7 Months on Program:

Total	59
Mean	6.6

2.8 TAP Reimbursable Services:

Homemaker	6
Home Health Aide	1
Home Delivered Meals	0
RN Services	1
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	1
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	1
Equipment	2
Legal Aide	0
Mental Health Counsel	0
Other 1 restaurant meals, 2 homemaker mileage	

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	0
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	2
Transportation	0
Other (define)	

2.13 Other Reimbursable Services by Source:

0

2.14 Reason for Termination

Need Fulfilled	5
Client Request	1
Nursing Home	1
Deceased	2
Moved	0
Hospital	0
Other	0

3. Denials (Number Persons in Each Category):

3.1	Total	6
3.2	Age of 6 potential clients	
	Total	488
	range	67-87
	mean	81
	median	84
	mode	None
	18-20	0
	21-64	0
	60-64	0
	65+	6
3.3	Sex	
	Male	2
	Female	4

3.4 Reason for Denial

Client Refusal	1
Moved	0
Hospital	0
Deceased	1
Nursing Home	3
Inappropriate	1
Other (unrecorded)	1

1st client 2-79

TAP Data

District: Uintah

1. Open Cases (Number Clients in Each Category):

1.1 Total: 9
Age for 9 clients: Total: 649

Range:	60-88	Mean:	72	18-20:	0
Median:	72	Mode:	None	21-64:	2
60-64:	2	65+:	7		

1.3 Sex: Male: 7 Female: 20

1.4 Marital Status:

Never Married:	0	Divorced:	1
Married:	2	Widowed:	6

1.5 Place of Residence:

Own Home:	7
Apartment	1
Mobile Home	0
Residential Facility	0
Home of Another	1
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	7
Total	12675
Mean	382
Median	308
Range	265-646
Couple	2
Total	1410
Mean	705
Median	705
Range	5470-870

1.7 Months on Program:

Total	92
Mean	10.2

1.8 TAP Reimbursable Services:

Homemaker	8
Home Health Aide	0
Home Delivered Meals	0
RN Services	4
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	1
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	2
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other-2 homemaker mileage	

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	1
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:
0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 11

2.2 Age for 11 clients: Total: 830

Range:	62-88	Mean:	75	18-20:	0
Median:	76	Mode:	None	21-64:	1
60-64:	1	65+:	10		

2.3 Sex: Male: 5 Female: 6

2.4 Marital Status:

Never Married:	0	Divorced:	1
Married:	2	Widowed:	8

2.5 Place of Residence:

Own Home:	8
Apartment	2
Mobile Home	0
Residential Facility	0
Home of Another	1
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	9
Total	3611
Mean	401
Median	407
Range	242-849
Couple	2
Total	1650
Mean	825
Median	601
Range	510-1119

2.7 Months on Program:

Total	75
Mean	6.8

2.8 TAP Reimbursable Services:

Homemaker	8
Home Health Aide	2
Home Delivered Meals	0
RN Services	2
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	1
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other 1 case mangement only, 2 extended auto insurance	

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	2
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	3
Other (define)	0

2.13 Other Reimbursable Services by Source:
0

2.14 Reason for Termination

Need Fulfilled	2
Client Request	1
Nursing Home	2
Deceased	5
Moved	1
Hospital	0
Other	0

3. Denials (Number Persons in Each Category):

3.1	Total	1
3.2	Age of 1 potential clients	
	Total	66
	range	66
	mean	66
	median	66
	mode	66
	18-20	0
	21-64	0
	60-64	0
	65+	1
3.3	Sex	
	Male	1
	Female	0

3.4 Reason for Denial

Client Refusal	0
Moved	0
Hospital	0
Deceased	0
Nursing Home	1
Inappropriate	0
Other (unrecorded)	0

1st client 10-78

TAP Data

District: Southeastern

1. Open Cases (Number Clients in Each Category):

1.1 Total: 30
Age for 30 clients: Total: 2,300

Range:	63-87	Mean:	77	18-20:	0
Median:	78	Mode:	None	21-64:	3
60-64:	3	65+:	27		

1.3 Sex: Male: 6 Female: 24

1.4 Marital Status:

Never Married:	2	Divorced:	4
Married:	11	Widowed:	13

1.5 Place of Residence:

Own Home:	16
Apartment	9
Mobile Home	3
Residential Facility	0
Home of Another	2
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	19
Total	110345
Mean	544
Median	526
Range	192-1700
Couple	11
Total	6938
Mean	631
Median	500
Range	296-1104

1.7 Months on Program:

Total	215
Mean	7.2

1.8 TAP Reimbursable Services:

Homemaker	13
Home Health Aide	9
Home Delivered Meals	0
RN Services	5
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	2
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	1
Transportation	0
Supplies	0
Equipment	1
Legal Aide	1
Mental Health Counsel	0
Other-1 bus accident payment, 2 homemaker mileage, 2 case management only	

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	1
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	8
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	11
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:
0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 21

2.2 Age for 19 clients: Total: 1,431

Range:	64-93	Mean:	75	18-20:	0
Median:	76	Mode:	79	21-64:	2
60-64:	2	65+:	17		

2.3 Sex: Male: 6 Female: 15

2.4 Marital Status:

Never Married:	3	Divorced:	3
Married:	8	Widowed:	7

2.5 Place of Residence:

Own Home:	12
Apartment	6
Mobile Home	2
Residential Facility	0
Home of Another	1
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	13
Total	7810
Mean	601
Median	671
Range	232-1497
Couple	8
Total	5932
Mean	742
Median	685
Range	312-1642

2.7 Months on Program:

Total	200
Mean	9.5

2.8 TAP Reimbursable Services:

Homemaker	6
Home Health Aide	5
Home Delivered Meals	0
RN Services	1
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	2
Care in Home of Relative	1
Senior Companion	0
Friendly Visitor	1
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other 5 case mangement only, 1 homemaker mileage	

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	6
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	4
Transportation	0
Other (define)	0

2.13 Other Reimbursable Services by Source:
0

2.14 Reason for Termination

Need Fulfilled	4
Client Request	5
Nursing Home	7
Deceased	5
Moved	0
Hospital	0
Other	0

3. Denials (Number Persons in Each Category):

3.1	Total	5
3.2	Age of 5 potential clients 2 unrecorded	
	Total	248
	range	79-89
	mean	82
	median	80
	mode	None
	18-20	0
	21-64	0
	60-64	0
	65+	3

3.3	Sex	
	Male	1
	Female	4
3.4	Reason for Denial	
	Client Refusal	2
	Moved	1
	Hospital	0
	Deceased	0
	Nursing Home	1
	Inappropriate	0
	Other (unrecorded)	1

lst client 6-80

TAP Data

District: San Juan

1. Open Cases (Number Clients in Each Category):

1.1 Total: 1
Age for 1 clients: Total: 61

Range: 61 Mean: 61 18-20: 0
Median: 61 Mode: 61 21-64: 1
60-64: 1 65+: 0

1.3 Sex: Male: Female: 1

1.4 Marital Status:

Never Married: 0 Divorced: 0
Married: 0 Widowed: 1

1.5 Place of Residence:

Own Home:	1
Apartment	0
Mobile Home	0
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	0
Total	485
Mean	485
Median	485
Range	485
Couple	0
Total	0
Mean	0
Median	0
Range	0

1.7 Months on Program:

Total	1
Mean	1.0

1.8 TAP Reimbursable Services:

Homemaker	0
Home Health Aide	1
Home Delivered Meals	0
RN Services	0
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	1
Legal Aide	0
Mental Health Counsel	0
Other	0

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	0
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:
0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 0

2.2 Age for 0 clients: Total: 0

Range:	0	Mean:	0	18-20:	0
Median:	0	Mode:	0	21-64:	0
60-64:	0	65+:	0		

2.3 Sex: Male: 0 Female: 0

2.4 Marital Status:

Never Married:	0	Divorced:	0
Married:	0	Widowed:	0

2.5 Place of Residence:

Own Home:	0
Apartment	0
Mobile Home	0
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	0
Total	0
Mean	0
Median	0
Range	0
Couple	0
Total	0
Mean	0
Median	0
Range	0

2.7 Months on Program:

Total	0
Mean	0

2.8 TAP Reimbursable Services:

Homemaker	0
Home Health Aide	0
Home Delivered Meals	0
RN Services	0
Physical therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	0
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	0

2.13 Other Reimbursable Services by Source:
0

2.14 Reason for Termination

Need Fulfilled	0
Client Request	0
Nursing Home	0
Deceased	0
Moved	0
Hospital	0
Other	0

3. Denials (Number Persons in Each Category):

3.1	Total	0
3.2	Age of 0 potential clients	
	Total	0
	range	0
	mean	0
	median	0
	mode	None
	18-20	0
	21-64	0
	60-64	0
	65+	0

3.3	Sex	
	Male	0
	Female	0

3.4 Reason for Denial

Client Refusal	0
Moved	0
Hospital	0
Deceased	0
Nursing Home	0
Inappropriate	0
Other (unrecorded)	0

lst client 7-78

TAP Data

District: Senior Citizens Executive Association

1. Open Cases (Number Clients in Each Category):

1.1 Total: 1
Age for 1 clients: Total: 52

Range:	52	Mean:	52	18-20:	0
Median:	52	Mode:	52	21-64:	1
60-64:	0	65+:	0		

1.3 Sex: Male: 1 Female: 0

1.4 Marital Status:

Never Married:	1	Divorced:	0
Married:	0	Widowed:	0

1.5 Place of Residence:

Own Home:	0
Apartment	1
Mobile Home	0
Residential Facility	0
Home of Another	0
Boarding Home	0
Hotel	0
Nursing Home	0

1.6 Monthly Income:

Single	1
Total	452
Mean	452
Median	452
Range	452
Couple	0
Total	0
Mean	0
Median	0
Range	0

1.7 Months on Program:

Total	9
Mean	9.0

1.8 TAP Reimbursable Services:

Homemaker	1
Home Health Aide	0
Home Delivered Meals	0
RN Services	0
Physical Therapy	0
Residential Living	0
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0
Other	0

1.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

1.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Other (define)	0

1.11 Title XX Reimbursable Services:

Homemaker/Chore	0
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

1.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	0

1.13 Other Reimbursable Services by Source:
0

2. Closed Cases (Number Clients in Each Category):

2.1 Total: 5

2.2 Age for 5 clients: Total: 374

Range:	66-96	Mean:	75	18-20:	0
Median:	71	Mode:	None	21-64:	0
60-64:	0	65+:	5		

2.3 Sex: Male: 3 Female: 2

2.4 Marital Status:

Never Married:	1	Divorced:	0
Married:	2	Widowed:	2

2.5 Place of Residence:

Own Home:	2
Apartment	1
Mobile Home	0
Residential Facility	1
Home of Another	1
Boarding Home	0
Hotel	0
Nursing Home	0
Other (define)	0

2.6 Monthly Income:

Single	3
Total	1389
Mean	463
Median	485
Range	390-415
Couple	2
Total	1143
Mean	721
Median	721
Range	375-1068

2.7 Months on Program:

Total	51
Mean	10.2

2.8 TAP Reimbursable Services:

Homemaker	3
Home Health Aide	0
Home Delivered Meals	0
RN Services	2
Physical Therapy	0
Residential Living	1
Adult Foster Care	0
Live-In	0
Day Care	0
Respite Care	0
Care in Home of Relative	0
Senior Companion	0
Friendly Visitor	0
Telephone Reassurance	0
Shopping Assistance	0
Transportation	0
Supplies	0
Equipment	0
Legal Aide	0
Mental Health Counsel	0

Other 1 case management only

2.9 Medicaid Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.10 Medicare Reimbursable Services:

Home Health Aide	0
RN Services	0
Physical Therapy	0
Equipment	0
Other (define)	0

2.11 Title XX Reimbursable Services

Homemaker/Chore	0
Day Care	0
Transportation	0
Foster Care	0
Care in Home of Relatives	0
Other (define)	0

2.12 Older Americans Act Reimbursable Services

Congregate Meals	0
Home Delivered Meals	0
Transportation	0
Other (define)	0

2.13 Other Reimbursable Services by Source:
0

2.14 Reason for Termination

Need Fulfilled	4
Client Request	0
Nursing Home	0
Deceased	1
Moved	0
Hospital	0
Other	0

3. Denials (Number Persons in Each Category):

3.1	Total	0
3.2	Age of 0 potential clients	
	Total	0
	range	0
	mean	0
	median	0
	mode	None
	18-20	0
	21-64	0
	60-64	0
	65+	0

3.3 Sex

Male	0
Female	0

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3.4 Reason for Denial

Client Refusal	0
Moved	0
Hospital	0
Deceased	0
Nursing Home	0
Inappropriate	0
Other (unrecorded)	0

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