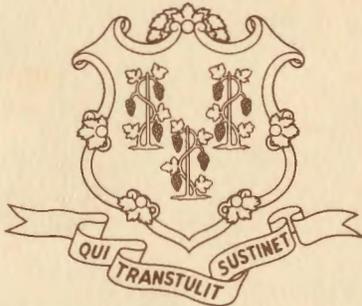


Elderly Home Care In Connecticut

Connecticut
General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

January 1982

CONNECTICUT GENERAL ASSEMBLY

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 as the Legislative Program Review Committee to evaluate the efficiency and effectiveness of selected state programs and to recommend improvements where indicated. In 1975 the General Assembly expanded the Committee's function to include investigations and changed its name to the Legislative Program Review and Investigations Committee. During the 1977 session, the Committee's mandate was again expanded by the Executive Reorganization Act to include "Sunset" performance reviews of nearly 100 agencies, boards, and commissions, commencing on January 1, 1979.

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Leslee L. Meltzer, Program Analyst
Toby Moore, Ph.D., Program Analyst
Gary J. Reardon, Program Analyst
Lillian B. Crovo, Administrative Assistant
Mary Lou Gilchrist, Administrative Assistant

Staff on this Project

Anne E. McAloon, Leslee L. Meltzer

Legislative Office Building, 18 Trinity St., Hartford, CT 06115 (203)566-8480

THE STATE'S HOME CARE FOR
THE ELDERLY PROGRAM:
A PROGRAM REVIEW

LEGISLATIVE PROGRAM REVIEW AND
INVESTIGATIONS COMMITTEE

JANUARY 1982

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LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The State's Home Care for the Elderly Program:
A Program Review

SUMMARY

Medical and technological changes in the twentieth century have resulted in more people living longer lives. In Connecticut, the number of elderly residents (60 and over) has increased by one-quarter in the last ten years. In 1980, 521,534 of the state's 3.1 million residents were 60 years of age or older. At the same time, changes in the make-up of families have resulted in more elderly people living alone or with relatives who are out of the home working for at least part of the day.

Home care services provided by private and governmental organizations have developed as one means of meeting the needs of people who require assistance with their medical and social needs from someone outside their families. Since a variety of services are available in the homes of individuals of all ages during periods of recovery from an acute illness as well as on a long-term basis, home care can represent an alternative to institutionalization.

Early in 1981, the Appropriations Committee of the General Assembly asked the Legislative Program Review and Investigations Committee to look at the state's home care for the elderly program, operated by Connecticut Community Care, Inc. (CCCI). The Appropriations Committee was particularly interested in whether the average cost per client for CAM services was justified or whether changes in the program might be possible to reduce per client expenditures. As part of the program review, LPR&IC examined the types of services provided through the program, the cost of providing those services, the number of clients receiving services, the amount of services needed, statewide demand for the program and alternative methods of providing home care services to elderly people in danger of inappropriate institutionalization.

A major component of the state home care program examined by LPR&IC was the process known as coordination, assessment, and monitoring (CAM), which is used to ensure that a person receives the appropriate level and amount of home care services. Assessment involves an initial evaluation of a client to determine whether any unmet needs impede the person's ability to remain in the community and avoid institutionalization. Coordination

involves contacting providers to arrange specified services and ensuring the availability of funds to pay for services. Monitoring functions include verifying that a client has received the quantity and quality of services contracted for.

The Legislative Program Review and Investigations Committee was unable to reach a consensus on the future structure of the state's home care program for the elderly because the members were divided on the issue of what type of agency should perform CAM. The committee finally resolved that the problem was a central policy issue that could only be settled by the full General Assembly. If the separation of CAM is determined to be unnecessary, some committee members believe a model containing a reduced administrative structure should be utilized to disburse payments for direct purchased services. If it is determined that CAM should continue to be performed by a separate agency, then the existing organization can remain in place, but changes suggested by the committee should be implemented.

Both models formulated by LPR&IC members attempt to balance monetary constraints and program resource needs. It was the intention of the committee that any savings in administrative and CAM costs achieved by the models be added to the money already set aside to pay for the purchase of direct services.

Model C represents a program where CCCI, under contract to the Department on Aging, acts as a fiscal intermediary to disburse program funds. Licensed home health care agencies continue to perform assessments and coordinate and monitor the service needs of clients in the same manner they currently do. Under Model E, CCCI would continue to be an independent CAM agency, but modifications in the areas of client eligibility, staffing patterns and program expenditures would be made. Outlined below are summaries of the major features of each of the models.

Suggested Changes--Model C

Organizational Structure - The Department on Aging (SDA) continues to serve as the state agency accountable for the operation of the program. CCCI, under contract to SDA, acts as fiscal intermediary for the program and is responsible for the approval of services for clients and the disbursement of payments to direct providers.

Reimbursable Services - Most likely, only three services--homemaker, home health aide and companion--will be eligible for reimbursement in order to make the limited program funds available to as many needy elderly as possible.

Geographic Area - All 169 towns will be covered.

Eligibility Criteria - Reduce the maximum allowable income to 60 percent of the state's median income or 150 percent of the federal OMB poverty level. Also, take into consideration the liquid assets of an applicant.

Fees - Establish a sliding fee schedule.

Staffing - Reduce the number of CCCI employees with a majority handling administrative and fiscal tasks.

Suggested Changes--Model E

Geographic Area - Towns should be included in the program on the basis of the need of their residents. All 169 towns should be ranked using a formula that takes into consideration income, minority residents, the number of elderly, the town setting, and the availability of other agencies that can perform CAM functions. Initially serve at least 50 towns and, if possible, as many as are currently served. Expand to other towns as funding permits.

Eligibility Criteria - Reduce the maximum allowable income to 60 percent of the state's median income or 150 percent of the federal OMB poverty level. Also, take into consideration the liquid assets of an applicant.

Fees - Establish a sliding fee schedule for receipt of CAM and purchased services.

"Safeguarding Only" Clients - Consider reducing the scope of activities for these types of clients in recognition of the fact that some coordination and monitoring functions are performed by the sources paying for the purchased home care services.

Assessment Tool - Condense and refine. Also, make greater use of client evaluations performed by groups that refer clients to CCCI.

Greater Independence for Clients - Allow clients and their families to take more responsibility for their plans of care. Develop mechanisms for verifying that services have been provided, problems have developed or a change in circumstances has occurred.

Staffing Needs - Lower the minimum educational standards for some professional positions and use more clerical personnel for coordination and monitoring functions. Utilize contracts with home health care agencies to have their nurses perform assessments during periods when there is a long waiting list for that portion of the CAM service. Employ full-time management staff at CCCI.

Regulations - Eliminate the 80 case load restriction in the CAM regulations.

Program Evaluation Criteria - Establish criteria for the future evaluation of program performance.

Place a Cap on CAM Expenditures - Limit expenditures for CAM costs (including general and administrative expenses) to a maximum of 30 percent of the total CCCI budget.

CHAPTER I

INTRODUCTION

Medical and technological changes in the twentieth century have resulted in more people living longer lives. In Connecticut, the total population counted during the 1970 and 1980 censuses remained about the same. The number of elderly residents (60 and over), however, increased by one-quarter. Citizens in this category now comprise nearly 17 percent of the state's population; 28 percent of these people are 75 and over.¹

Changes have also been occurring in the make-up of families. They are often smaller in size and have more members in the work force. Likewise, there are fewer extended families residing together. As a result, more elderly are living alone or with relatives who are out of the home working for at least a portion of the day. In order to remain in the community and out of an institution, increasing numbers of older people require assistance with their medical and social needs from individuals and groups outside their family.

Home care provided by private and governmental organizations is one means of meeting some of this demand. These agencies, which may be voluntary, private nonprofit, proprietary or government supported, offer a variety of medical and social services for individuals of all ages. In addition to obtaining nursing assistance during recovery from an acute illness, home care is used by people who are unable to perform daily living functions for themselves. Some agencies provide a wide range of services while others provide only one or two.

Focus of Review

In early 1981, the Appropriations Committee of the Connecticut General Assembly asked the Legislative Program Review

¹ In 1970, there were 3,031,709 people in Connecticut, 414,991 of whom were 60 and over. In 1980, the population totaled 3,107,576; 521,534 people were 60 and over.

Data obtained from Connecticut Office of Policy and Management, Comprehensive Planning Division, Connecticut Census Data Center News, Vol. I No. 2 (Fall, 1981), p.4.

and Investigations Committee (LPR&IC) to review the state's home care for the elderly program. Begun as a pilot project in 1976 with a budget of about \$800,000, the program was budgeted at \$2.7 million for FY 1981-82. A major component of the program was the provision of coordination, assessment and monitoring (CAM) services² to elderly clients in danger of inappropriate institutionalization. Funding was also available for the purchase of direct home care services for those clients unable to pay for such care themselves and ineligible for an alternative funding source.

Based on data available in February 1981, it appeared that the average cost per client for CAM services was close to \$800.³ One of the primary concerns of the Appropriations Committee was whether this cost was justifiable or whether changes in the program might be possible to reduce per client expenditures.

During the review conducted by the Legislative Program Review and Investigations Committee, the types of services provided through the state's home care program for the elderly, the cost of providing those services, the number of clients receiving services and the amount of services they needed were all examined. The committee also considered potential statewide demand for the program and alternative methods of providing home care services to elderly people at risk of inappropriate institutionalization. As part of this latter analysis, the committee looked at other programs currently in operation in Connecticut as well as efforts in other states.

Chapter II of this report provides a detailed description of the state's home care for the elderly program as it has evolved during the past six years. Brief outlines of several other programs in Connecticut that arrange for the provision of home care services are also included. Chapter III discusses the Legislative Program Review and Investigations Committee's findings and presents two home care program models considered by the committee during its deliberations. An overview

² CAM is a process used to ensure a person receives the appropriate level and amount of home care services. For a detailed description of the process, see Chapter II, p. 7.

³ The average cost per client is actually lower than \$800, but there is some disagreement about what the specific number is. Chapter III provides a detailed discussion of the cost issue. (See pp.26-29,)

of the major public funding sources for health and home care services is provided in Appendix III.

Methodology

Data for this program review were obtained from multiple sources. In addition to a six-hour public hearing conducted by the Legislative Program Review and Investigations Committee in May 1981, interviews were held with representatives of private and governmental agencies involved in the funding or provision of home care services, and budgetary materials from the state program were examined.

Questionnaires were sent to the following groups: the staff members of Connecticut Community Care, Inc. (CCCI) who work directly with elderly clients; the directors of the 98 home health care agencies that were licensed as of March 1981; and hospital discharge planners at 33 short-term, acute care hospitals in the state. Eighty-one percent of the 27 CCCI staff who received questionnaires responded, 68 percent of the home health care agencies returned their surveys and 64 percent of the hospital discharge planners responded. (See Appendices IV-VI.)

At various stages of the review process, representatives of both proprietary and nonprofit home health care agencies, the board of CCCI, and Blue Cross/Blue Shield met with members of the LPR&IC and its staff. Information about other states with programs providing reimbursement for home care services for the elderly was obtained through telephone conversations with program staff in those states.

An additional source of information was visits to the homes of elderly people in potential need of home care services. LPR&IC staff accompanied CCCI employees from different regional offices on assessment and reassessment visits. Several licensed home health care agencies also allowed committee staff to accompany nurses on home visits to elderly clients.

CHAPTER II

BACKGROUND AND HISTORY

In the mid-1970's, the state of Connecticut began a pilot program aimed at improving the ability of the elderly to obtain home care services. The current Promotion of Independent Living for the Elderly (PILE) program, which is operated by Connecticut Community Care, Inc., evolved from that earlier effort. An overview of the changes that led to the existing program and a detailed description of how it operates today are presented in this chapter. Brief descriptions of other programs in the state that arrange home care services are also included at the end of the chapter.

Home Care

Home care has been defined as "the array of services provided, either singly or combined, in order to sustain the elderly in their own homes at an optimum level of health, activity and independence."⁴ This definition includes both home delivered services, including meals-on-wheels, chore services and home-maker-home health aides, and those services available outside the home, such as day care and services offered at health clinics and group eating sites.

Home care services encompass health related services as well as those services peripherally related to health which are needed by a person in order for them to remain at home. Health related services include those offered by physicians, speech therapists, physical therapists, and home health aides. Home-maker, companion, chore, counseling, transportation and other services are considered supportive services and are not directly health related.

By providing assistance with nutrition, home maintenance and personal care, home care can preserve the elderly person's life in the community.⁵ For an individual who has no one able or willing to assist him or her with daily living needs, the

⁴ State of Connecticut, Department on Aging, A Report on Home Care, January 1973, p. vii.

⁵ Home care services are available for people of all age groups who may need such assistance on a short or long term basis. The focus of this review, however, is home care for the elderly.

availability of home care services can mean the difference between remaining in a home setting and being institutionalized in a long term care facility.

Home care services are generally provided by private organizations known as homemaker and home health agencies, which may be nonprofit or proprietary operations. Certain services like chores or meals are also available from single purpose agencies. Home health care agencies have existed in Connecticut for many years. Since January 1, 1979, such organizations have been required to be licensed in order to operate (C.G.S. Section 19-576). As part of the licensure requirements, an agency, in addition to providing professional nursing services, must provide at least one of the following services: homemaker-home health aide services; physical, speech or occupational therapy; or medical social services. Homemaker-home health aide agencies, which provide supportive services under the supervision of a registered nurse, are also required to be licensed.

Home care is thought to produce savings in both human and financial terms. Many individuals would be happier and healthier retaining their independence in a familiar environment. Home care is not an economical alternative to institutionalization for everyone, however, since for some people nursing home care is the most appropriate and cost effective.

Recently, home care has gained greater recognition as a viable alternative to institutional care. According to a report of the Connecticut General Assembly, elements of both the public and private sectors have recognized the need for the provision of home care services and have begun to respond to that need. The home care industry has been growing steadily and is expected to continue growing to meet increased demand. Nevertheless, problems with quality, availability and accessibility of services still exist.⁶

There have been attempts by various states to integrate and coordinate the wide array of services needed by elderly persons to avoid inappropriate or unnecessary nursing home placement, but the approaches are many and varied. The federal government's role has historically been limited to providing direct reimbursement for home health and other in-home services through Medicare, Medicaid and Title XX of the Social Security Act. Lately, certain reimbursement limitations have been eliminated so additional services are covered. For example, the

⁶ State of Connecticut, Report of the Subcommittee on Home Health Care of the Joint Committee on Public Health and Safety, Home Health Care in Connecticut, Issue Paper #1, October, 1976, p. 1.

1980 federal Omnibus Reconciliation Act expanded Medicare coverage to include reimbursement for an unlimited number of home health visits, a provision previously limited to 100 visits.

One process gaining increasing attention as a way to ensure that appropriate home care services are recommended for and provided to an elderly person is known as CAM--coordination, assessment and monitoring. The assessment component involves the initial evaluation of a client to determine his or her current physical and mental well-being and whether there are any unmet needs that impede his or her ability to remain in the community and avoid institutionalization. As a result of this assessment, a plan of care is developed, specifying which services the client requires in order to meet those needs.

The coordination function involves contacting providers to arrange specified services and ensuring the availability of some type of funding to pay for the services. Monitoring functions are carried out on an on-going basis and include verifying that the client has received the quantity and quality of services contracted for. Another component of monitoring is to ensure that the level of services prescribed for a client continues to be appropriate. If changes in the plan of care are necessary, then modifications in the levels and types of services are made as required. On a regular basis, a reassessment of the client is performed. At that time, the plan of care is reevaluated.

CAM may be performed either by an agency established solely for that purpose or by the staff of an agency which also provides direct services to clients. In either case, it is generally a nurse who performs the assessment and reassessment, although he or she may be assisted by a social worker. Coordination and monitoring activities may be handled by a variety of personnel, including nurses, social workers and case aides or clerks.

When performed by a separate agency, CAM is the only function of the staff, although other employees in the organization may handle the disbursement of funds for services to eligible clients. The CAM functions performed by a direct provider agency may be combined with the actual provision of home care services and, therefore, will not always be as easily identifiable. For example, an initial assessment and a skilled nursing service may be performed during the same visit to a client's home.

State Department on Aging

The State Department on Aging (SDA) has statutory authority for the overall planning, development and administration of a comprehensive delivery system for elderly persons (C.G.S. Section 17-137). Among its mandated duties are: measuring the need for and evaluating services; developing educational outreach programs; supervising pilot programs; and surveying methods of administering service delivery programs. Besides developing service programs itself, SDA also encourages and advises other state agencies on the development and provision of services.

The department not only utilizes its own staff, but also those of many other organizations which together with SDA make up the "network on aging". The key elements of the network are the 5 Area Agencies on Aging (AAAs),⁷ the 13 elderly nutrition projects and the department's advisory council. Until June 30, 1980, the AAAs also administered the state's elderly home care program (known then as SAIL).

SAIL

A major program administered by the state Department on Aging is the state's home care program for the elderly. Former Commissioner Charles E. Odell stated that the program was to be a "viable, compassionate, cost-effective and socially desirable alternative for older persons who otherwise would be placed in long-term care institutions."⁸

Originally called SAIL (Strengthened Assistance for Independent Living), the program began in August 1976 as a demonstration of home care alternatives to institutionalization. The primary objectives of the program included:

- 1) deinstitutionalize inappropriately institutionalized elderly persons;

⁷ AAAs are private, nonprofit organizations whose responsibilities are to plan and develop services for the elderly within their regions. They also coordinate and pool resources from other public and private sources in order to develop services for the elderly. Area Agencies on Aging are funded by the federal government for all but 25 percent of their administrative expenses, which must be raised on the local level.

⁸ "Making Home Care A Viable Alternative to Institutional Care," statement presented to the Blue Ribbon Committee on Nursing Homes, June 16, 1976.

- 2) prevent inappropriate institutionalization of elderly persons who are within 90 days of institutionalization;
- 3) provide single entry case management to clients by performing an initial assessment, planning and coordinating service delivery, ensuring the delivery of services, and monitoring the services as often as necessary (but at least every 60 days);
- 4) develop and expand services to help maintain elderly persons in their homes;
- 5) develop an interface with state, municipal, and private service providers; and
- 6) treat the elderly person with dignity.

Organization. When SAIL began, SDA subcontracted with the five Area Agencies on Aging for the implementation of the program in their respective geographical regions of the state. Generally, each agency had a regional director, nurses, social service coordinators, administrative assistants, secretaries and claims processors assigned to staff the program. One of the area agencies employed a program evaluator and a bookkeeper.

According to an evaluation prepared by the Office of Policy and Management, this system produced project differences since not all five programs were organized and administered identically. Each of the projects served populations which differed greatly. Project staff, personnel policies and operating procedures also varied among the five agencies. For example, the southwestern regional office contracted with nursing agencies to assist with initial assessments while the other four agencies all had full-time nurses on their staffs.

The case review boards or committees functioned differently throughout the five regions with respect to the number of members and the time necessary to review cases. In four of the five projects, the AAA board/subcommittee was the governing body, while in the fifth project, a SAIL policy board was established. In addition, staff salary ranges and personnel policies were not uniformly administered throughout the five agencies.⁹

⁹ Connecticut Office of Policy and Management, SAIL Evaluation Report (March, 1979).

Service area. SAIL served 49 towns during its first year of operation. BY FY 1979-80, three years later, it was serving 1,900 clients in 83 towns. (See Table II-1.) The decision on which towns would be served in each region was made by the AAA Board of Directors for that area. SAIL was not available state-wide because the level of funding was insufficient to cover all 169 towns. During the life of the program, new towns were added gradually; sometimes a reduction in service in a town already served was necessary to extend service to a new town.

Table II-1. SAIL -- Program Statistics.

<u>Fiscal Year</u>	<u>Towns Covered</u>	<u>Clients Served</u>	<u>Expenditures</u>
FY 1976-77	49	1,014	\$.8M
FY 1977-78	69	1,497	\$1.6M
FY 1978-79	73	1,644	\$2.0M
FY 1979-80	83	1,900	\$2.4M

Eligibility criteria. The stated criteria for eligibility into the SAIL program were that a person must:

- 1) be 60 years of age or older;
- 2) reside in a served town; and
- 3) be within 90 days of inappropriate institutionalization or be inappropriately institutionalized.

The first two criteria were easily verified, but the third was susceptible to possible variations in interpretations. For example, the intent of the 90 day certification was to insure that the individuals served were those closest to institutionalization and hence the program's neediest clients. It was sometimes difficult, however, to determine exactly how many days away from institutionalization a person was.

There were no financial eligibility limitations on receiving coordination, assessment and monitoring services. Under the Title XX requirements, any elderly person (60 years of age or older) was eligible for CAM and could not be charged for those services. Eligibility for purchased services was limited on the basis of income to clients whose family incomes did not exceed 80 percent of the gross median income for the state. Due to the program's fiscal constraints and an inability to serve

all eligible individuals, priority for CAM services was given to persons who qualified for Supplemental Security Income (SSI), State Supplemental Assistance (SSA) and Medicaid, or those already inappropriately institutionalized.

There were several criteria for discharge from the SAIL program. They included: client death, client request, client institutionalization, client found to be ineligible, client moved out of a town served by the program or the cost of care exceeded the average cost of a skilled nursing facility in the project's health service area.

Available services. During FY 1979-80, SAIL arranged over 20 different services from over 110 provider agencies for program clients. All services were obtained under contract with individuals and nonprofit, voluntary and proprietary agencies. Services most often arranged were: homemaker, home health aide, home delivered meals, nursing units, companions and chore/handyman services. Other services included legal and financial counseling, transportation, day care and speech therapy.

Funding. The SAIL program was financed primarily with state general fund monies, partially reimbursed by Title XX of the Social Security Act. Some Title XX pass-through funds were also available as well as Title III money from the AAAs. These funds paid for CAM costs and the purchase of direct services. Total expenditures for CAM and purchased services increased from \$789,186 during FY 1976-77 to \$2.4 million by FY 1979-80.

Payments for purchased services were also made by Medicare, Medicaid, private insurers and, whenever possible, clients themselves. Only as a last resort, when other funding was unavailable or exhausted, were SAIL program funds utilized to pay for services for clients.

CCCI

Since July 1, 1980, Connecticut Community Care, Inc. has administered the state's single entry coordination, assessment and monitoring program for elderly persons. CCCI works under contract with SDA and is funded by state appropriations and Title XX money. SDA continues to be responsible for oversight of the program. (Approximately \$117,000 was spent for the department's administrative activities during FY 1980-81.)

A private, nonprofit agency, centrally managed and regionally administered, CCCI has an independent Board of Directors

that includes representatives from provider service agencies, private industry, and the aged themselves. Each AAA is represented on the board and also recommends a representative from each regional home care advisory committee for board membership.

Development. CCCI was established after a review of SAIL by the Department on Aging revealed that improvements were needed. Initiated in early 1979 at the request of Commissioner Marin J. Shealy, the report stressed the value and importance of the home care program, but it suggested reorganization was needed.

During the LPR&IC public hearing on the elderly home care program, Commissioner Shealy outlined the factors leading to that suggestion. Among the reasons were: the needs of the elderly required moving out of the demonstration program to an ongoing program; there was a need for an administrative structure that would allow the program to grow; the AAAs wanted to maintain their essential planning and advocacy functions; more uniformity among the five regional programs was needed, and the passage of Public Act 77-601 (C.G.S. 19-576 and 19-577) required the Department of Health Services to license CAM agencies using a statutory definition not all of the AAAs could meet.¹⁰

Although the program was renamed Promotion of Independent Living for the Elderly, the eligibility criteria for clients, the geographic service area and the provisions for payment of purchased services remained the same. The budget for FY 1980-81 was increased slightly to \$2.8 million, and more than 1,900 clients were served.

The decision to establish CCCI as the contractor for PILE was based on the belief that program administration "would be enhanced and greater flexibility could be obtained by placing the program under strong, non-state, central management."¹¹ The Department on Aging, the board chairmen and executive directors of the AAAs, the SAIL directors, representatives from the Governor's office and representatives of the Office of Policy and Management all agreed to the proposed changes.

Staff/activities. In order to prevent any disruption in client services, CCCI staff was drawn from the people employed

¹⁰ Marin J. Shealy, commissioner, Department on Aging, LPR&IC public hearing on the state's home care program for the elderly, May 18, 1981, p. 4.

¹¹ Ibid., p. 4.

by the AAAs to operate the SAIL program. These workers were familiar with both the program and the needs of the clients served under it.

CCCI utilizes the broad based skills of nurse clinicians and social service coordinators. These staff members have experience in clinical assessment techniques and knowledge of community resources. Elderly persons referred to CCCI are assessed by either one or both of these professionals.

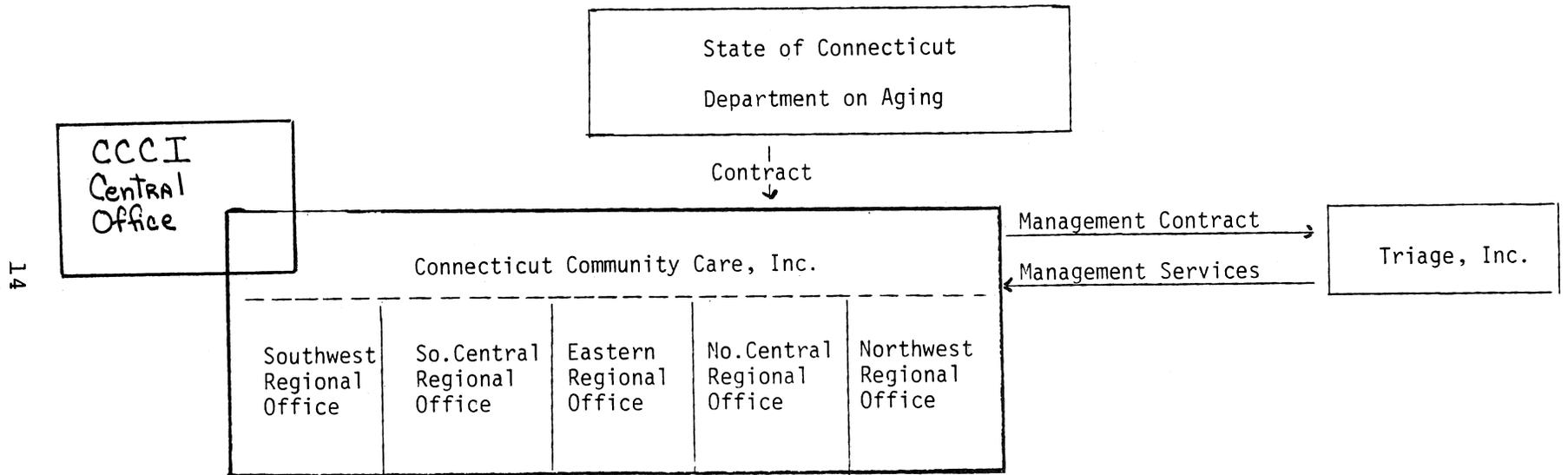
Assessments may be performed in a patient's home, in a acute care hospital, or in a skilled nursing facility, using a comprehensive standardized assessment form. Each client's health and social history is recorded, along with personal, nutritional, environmental and related information necessary to determine individual needs. To gather adequate information, the assessment team consults with family members, physicians, provider agencies and others.

Based on each client's situation, the CCCI team, the client and his or her primary supporters develop a long term plan of care to fit the client's particular needs. CCCI staff then arrange for the necessary services to be provided, utilizing existing service providers; when necessary, CCCI develops new resources. To insure that services are being delivered and continue to be appropriate to the client's needs, CCCI monitors service delivery and reassesses the client every six months to update client characteristics.

In addition to nurses and social service coordinators, each of the five regional offices also employ regional directors and other personnel such as claims processors, case aides, secretaries, bookkeepers and clerk typists, who perform a variety of duties. The central office staff consists of a bookkeeper, an accounting clerk, a clerk typist and a data entry clerk; they are co-located in Plainville with Triage, Inc. CCCI contracts with Triage for the services of management personnel. (See Figure II-1.)

Management contract between CCCI and Triage. CCCI established its contract with Triage for the provision of management services because it was felt the organization had acquired expertise in the management of a CAM agency for the aged. The services to be provided are subject to the policies and procedures established by the CCCI Board of Directors and must be in conformance with the Department on Aging's contract with CCCI.

Figure II-1. FY 1980-81 Promotion of Independent Living Program--Organization Chart.



Source: State Department on Aging.

These management services include:

- 1) supervise the management of each regional office and the central office;
- 2) establish staff levels and work schedules;
- 3) recommend and implement personnel policies and operating procedures;
- 4) supervise the employment of all CCCI employees;
- 5) provide purchasing controls;
- 6) provide staff training;
- 7) provide and supervise an accounting system;
- 8) obtain the necessary insurance coverage for each regional office;
- 9) provide public relations services and coordinate with governmental agencies having jurisdiction over the operation of CCCI;
- 10) prepare cost reports;
- 11) recommend and implement operating policies and procedures;
- 12) administer funds in accordance with state and federal regulations; and
- 13) report to CCCI on its performance.

The staff used by Triage on a part-time basis to provide these management services to CCCI are: an executive director, an associate director, three assistant directors, a data manager, a financial manager and a nurse clinician. These eight professional employees devote approximately 10 to 25 percent of their time to CCCI. The FY 1980-81 contract cost \$80,761.

Triage

In 1972, the Governor of Connecticut directed the Commission on Aging to conduct a feasibility study for a statewide plan to

provide alternatives to institutional care. The commission's Home Care Task Force prepared a report on establishing a state-wide personal care program for the elderly. This study constituted the rationale for the subsequent joint state and federal initiative known as Triage.

History of development. The Triage project was started in 1974 by the Connecticut Council on Human Services as a research and demonstration project to test a client/consumer centered model for an alternative health care delivery system. It was a response to the increasing cost of health care, the growing number of elderly in need of services, the complexity of those needs, and the growing use of institutionalization as the course of least resistance for elderly in need of medical and social services. The objective of Triage was to examine the total needs of each client and, working with multiple agencies, ensure that arrangements were made to meet those needs. In other words, staff would perform coordination, assessment and monitoring functions.

Launched with state monies and funds granted under the Older Americans Act of 1965, two Administration on Aging model project grants and continuing state appropriations carried the project through its two year developmental period. In 1976, a grant from the National Center for Health Services Research was awarded to the Department on Aging; it paid for program costs from April 1976 to March 1979. At that time, the Health Care Financing Administration (HCFA) awarded Triage a two year grant to continue in operation through March 1981. The project subsequently received several 90 day extensions, but funding was finally terminated on December 31, 1981.

Triage served the Central Connecticut Regional Planning Area, which is composed of the towns of Burlington, Plymouth, Bristol, Plainville, New Britain, Southington, and Berlin. This region was chosen because it typifies characteristics of the state; it incorporates rural, urban, and suburban areas, as well as a wide array of service providers.

Triage, Inc. When the program began, a sponsor for the project was sought from the private, nonprofit sector. During the two year developmental period, a homemaker-home health care agency, Community Health Services of Central Connecticut, accepted the role of local project sponsor. On July 1, 1975, Triage, Inc., a private, nonprofit agency, was incorporated in the town of Plainville. Triage, Inc. took over management and control of the property and affairs of the program. A consortium of providers and elderly consumer representatives served on the board

of directors, which included 18-25 members who represented hospitals, community health agencies and the elderly population of the seven town region.

Eligibility criteria. During each year of operation, the Triage program served approximately 1,400 clients. (See Table II-2.) In order to be eligible for Triage, a person had to be:

- 1) 65 years of age or older; or 60 years of age or older, disabled and already eligible for Medicare; and
- 2) residing in the seven town region.

There were no income eligibility requirements.

Table II-2. Triage -- Clients Served.

<u>Year</u>	<u>Clients Served</u>
1976-77	1,200
1977-78	1,500
1978-79	1,329
1979-80	1,405
1980-81	1,392
1981-82	No new clients accepted

Source: State Department on Aging.

Reimbursement procedures. During the project's developmental period (1974-75), Triage paid for some of the prescribed services under the terms of the start-up grants. The majority of expenses, however, were covered by third party payment (Medicare, Medicaid or private insurance) or by the client.

Beginning in August 1975, comprehensive waivers on the use of Medicare Trust funds were awarded to the Connecticut Council on Human Services¹² by the then U.S. Department of Health, Education and Welfare. The waiver of Medicare restrictions made it possible for Triage to authorize payment for many ancillary

¹² The Council of Human Services was abolished in 1976, and the Triage grant was transferred to the Department on Aging in April of that year.

and supportive services not traditionally covered by Medicare, such as pharmaceuticals, dental care, mental health services, homemaker services, glasses, and hearing aids. Moreover, many specific Medicare requirements such as deductibles and co-insurance, as well as several restrictions on home health care, were waived.

The federal fiscal intermediary, which determined the reasonable costs of services and reimbursed the providers, was the Division of Direct Reimbursements (DDR) of HCFA. The participation of the division permitted a unified and simplified tracking of client costs. It was the responsibility of Triage to verify client eligibility and authorize payment of providers.

Project staff. Since the concept of Triage was a single entry model for delivery and reimbursement of health and social services, a multidisciplinary staff was required. Triage staff members were trained in a variety of disciplines, including nursing, social work, business administration, accounting, data processing and secretarial services.

Other Home Care Programs

In addition to the state home care for the elderly program run by the Department on Aging and the Triage program, there are other private and public programs that help arrange for the provision of home care services. Some of these programs serve people of all ages while others are limited to the elderly. There are also several publicly supported programs that provide companionship visits to elderly people.

Breakthrough to the Aging. The Breakthrough to the Aging (BTA) program provides "friendly visits" and telephone reassurance to over 2,000 elderly in the Capitol Region who have limited mobility. Administered by the Capitol Region Conference of Churches, the program receives funds from a variety of sources, including \$25,000 from the state for FY 1980-81. Volunteers are provided with training by BTA staff and direct supervision is handled by local private and governmental agencies that volunteer their time.

Essential Services. The Essential Services program provides funding to pay for homemaker, companion, chore and other services elderly and disabled adults need in order to function adequately in their own homes. The program also provides for the care of children when the parent or usual caregiver is unavailable, for example, due to emergency hospitalization.

On July 1, 1981, responsibility for the operation of the program was transferred from the Department of Income Maintenance (DIM) to the Department of Human Resources (DHR). The FY 1980-81 budget for the program was \$3.1 million; \$2.6 million from the state's General Fund has been appropriated for FY 1981-82.

The Essential Services program has been in existence for at least 20 years under various names and operated under the jurisdiction of various state agencies. Aimed at Title XIX clients, need is determined by a case worker who examines the physical conditions surrounding the individual and the recommendation of the client's physician.

Hospital discharge planning. When a patient is preparing for discharge from a hospital in Connecticut, personnel are available to assist in arranging services the patient may need during his or her recovery period. The needs of the individual are identified by a nurse or social worker and a recommended plan of care is developed. Referrals are made to agencies that provide the needed services.

In some cases, particularly with elderly and high risk patients, planning assistance is available to establish home care plans that will provide for long term assistance. The hospital workers may perform some follow-up services for these people. On occasion, they also refer eligible clients to CCCI.

Project FIND. Begun as a pilot project in October 1977 "For Individuals In Need of Deinstitutionalization", Project FIND is run by the Department of Human Resources. Until the recent changeover to the Social Services Block Grant, project staff were funded with Title XX money. Direct provider services which are purchased for clients are paid for as part of the regular Title XIX process.

The purpose of this program is to explore, develop and use alternatives to institutionalization for aged, blind or disabled persons who are recipients of financial or medical assistance through the Department of Income Maintenance. Persons as young as 18 can be served under this program.

Currently available to residents of 42 towns in the Middletown and Norwich districts, funding limitations have prevented intended expansion to the Hartford and New Haven areas. Referrals to Project FIND are made by DIM and other agencies; notices of admissions to skilled nursing facilities are also received by project staff in order to obtain information about potential clients.

The program objective of providing the most appropriate, humane and cost-effective living arrangement possible for Project FIND clients is achieved through comprehensive case management that includes performing a client assessment, planning for the client's needs, arranging needed services and conducting follow-up activities. The desired outcome is to help a client remain in the community by furnishing the supportive services that will meet his or her medical and social needs.

A client successfully assisted by this program will be able to function with the services provided for up to six months, and if progress permits and other resources exist, will move to an inactive status after three months of follow-up. Clients may be reinstated in the program; those who continue to need safeguarding services are transferred to the care of the PILE program if CCCI is able to add the clients to its case load.

Project FIND is run by a staff of nine--one supervisor, seven social workers and one clerk typist. During the period from October 1, 1977, through March 31, 1981, the project deinstitutionalized 319 people, relocated 73 people from a higher level of medical care to a lower one, and prevented the institutionalization of 227 people. Comparing the total cost of community care to the cost of institutional care, it is estimated that the case management activities of the program have saved the state nearly \$3.2 million during this time.¹³

Protective Services for the Elderly. Under Public Act 77-613, the Connecticut General Assembly established a mandatory reporting system to protect elderly citizens (60 years of age and over) from abuse. The Departments on Aging and Human Resources share responsibility for providing protective services to elderly people identified under this law.

After a report of suspected abuse, neglect, exploitation or abandonment is received, staff in the SDA Ombudsmen Office investigate the situation. (During FY 1980-81, 1,408 reports were received.) If it is determined that assistance is needed, then the case is referred to the Protective Services Unit in the appropriate DHR regional office. Staff there make arrangements for services necessary to insure the health and well-being of the elderly person.

¹³ May 15, 1981, letter from Ronald E. Manning, commissioner of human resources to the Legislative Program Review and Investigations Committee.

During FY 1980-81, 786 of the client referrals were added to the program. As of September 1981, 10 caseworkers and 6 social workers, located in the 6 DHR regional offices, were assigned to handle an active caseload of 444 clients. Approximately 16 percent of these cases are individuals who have required care for more than one year. The commissioner of human resources has been appointed conservator for 8 percent of the cases. In those instances, the protective services staff act as agents of the commissioner in all aspects of providing for the personal needs of the clients, including making periodic reports to the appropriate probate court.

Approximately \$208,000 was spent on this program during FY 1980-81. Nearly \$20,000 was spent for the purchase of home management services, and almost \$189,000 in Title XX pass-through funds paid for the cost of the 10 caseworkers.

RSVP. The Retired Senior Volunteer Programs (RSVP) are operated with funds from the federal agency ACTION, the United Way and private donations. There are 12 chapters in Connecticut which provide coverage for the whole state; nationwide, there are 714 chapters. RSVP is responsible for coordinating a wide variety of volunteer activities for senior citizens, particularly "friendly visits" to elderly people who are homebound or institutionalized. These volunteers do not carry out any activities involving physical labor. Anyone interested in performing homemaker services is referred to an agency that provides those services.

CHAPTER III

OPTIONS

Determining the proper role for the state in the provision of home care services for the elderly is not easy. In a period of growing fiscal austerity, money may not be available to offer a full range of services to all elderly Connecticut residents who may need assistance. As a result, decisions must be made about the types of services to fund and the eligibility criteria for receipt of those services.

Current Situation

The state began its home care program for the elderly in 1976 as a pilot project serving 49 towns. Since that time, it has expanded into 83 towns and the number of clients served has increased from just over 1,000 to almost 2,300. The program is aimed at state residents over the age of 60 who are in danger of inappropriate institutionalization. It tries to keep people in their own homes as long as the cost of the home care services provided remains below 75 percent of the cost of institutionalization.

On July 1, 1980, responsibility for the daily administration of the program, including the performance of coordination, assessment and monitoring functions and the disbursement of funds to direct service providers, was given to Connecticut Community Care, Inc. As a private, nonprofit agency, CCCI receives its funding from the State Department on Aging, which continues to serve as the state agency for the program.

Committee Considerations

When this study began, several legislators pointed out that, although the basis of the state's home care program for the elderly was more than six years old, CCCI with its community oriented, broadly representative board had been administering the program for less than one year. As a result, the group had not had an opportunity to fully implement all of the proposed operational changes it was considering. Noting that the board had implemented several cost saving measures on its own, there was some discussion among LPR&IC members about whether the board should be given additional time to revise its operations before the legislature recommended any changes. The committee decided, however, that at least some changes of a more comprehensive nature than what the board was then considering were needed, and those should be identified.

CAM as a separate function. A major factor in the determination of how the state's home care program for the elderly should be operated is whether CAM needs to be performed as a separate function by an agency that does not provide direct home care services. The Legislative Program Review and Investigations Committee spent many hours discussing this issue during the course of the review and strong personal feelings on both sides of the question emerged.

Advocates for the performance of CAM activities by a separate agency give several reasons for their view:

- *An arrangement of this type can provide an independent client needs assessment, thereby preventing conflict of interest recommendations. A separate CAM agency is never in the position of interpreting clients' needs based on services that are offered by the agency because it does not provide any direct services.*
- *A single entry case management mechanism can be provided for clients. Clients and their families are able to utilize one organization to gain access to a wide network of care for the elderly. This single source can provide them with information about a broad range of services.*
- *Home care services from a wide variety of providers can be coordinated more easily. A separate CAM agency has no restrictions on the types of home care services for which it makes arrangements so it can provide accessibility to a wide spectrum of services. Often able to utilize community-based, low or no cost delivery systems, these agencies can also provide a link between public and voluntary efforts to coordinate a flexible system of care.*
- *Providers of home care services can be monitored for adherence to specified standards by an external organization. A separate CAM agency objectively verifies the delivery of services to ensure that the quantity and quality of care contracted for have been provided. They also reevaluate services regularly to ensure that they remain responsive to a client's individual needs.*

- *Program consistency can be assured.* A separate CAM agency can require uniformity in the methods used to assess clients' needs, coordinate services and monitor service delivery.

Proponents of the view that the performance of CAM can be handled by licensed home health care agencies provide a number of reasons for their perspective:

- *The use of a separate CAM agency duplicates activities that are already built into the existing direct service provider system.* By state regulation, HHCAs are required to perform assessments of all their clients. In addition, the agencies develop care plans and coordinate and monitor the delivery of services to individuals served by the agency. While the scope and format of these functions may vary among agencies, performance of CAM by a separate agency means there is at least some overlap whenever a client of that agency needs a direct service.
- *Money that could be used to pay for direct services must be expended to staff a separate CAM agency.* Since limited state dollars are available for home care services for the elderly, the use of state money for separate CAM services (and the administrative costs associated with them) means less money is available to purchase direct services.
- *Use of a separate CAM agency does not guarantee a centralized entry point for clients.* Depending upon the source of client referral, the scope of services needed and the type of reimbursement system a client utilizes, it is possible that a client might, in fact, have contact with several other agencies even though a separate agency is providing CAM services. Indeed, many elderly enter the home care service network through hospital discharge planners or local agencies they contact themselves. Likewise, if an elderly person is receiving reimbursement from a third party payer, then he or she may have contact with that organization and certainly will have contact with the agency providing the direct service.

- *At this time, concern that HHCAs will over prescribe the home care services their agencies provide does not appear warranted in Connecticut. There is no documented evidence that excessive requests for reimbursement for home care services have occurred in this state, and HHCAs have been in business for many years. In addition, the limited availability of people willing to work as homemakers and home health aides places a restraint on the delivery of unneeded services because justified demand already exceeds supply in many areas.*

Cost of CAM. Another important aspect of the decision whether or not to retain a separate CAM agency is its cost of operation by function. The LPR&IC spent considerable time debating the appropriate functional categories for the allocation of CCCI costs. Three different breakdowns were developed.

Several committee members supported use of the budget categories used by CCCI itself which identify expenditures for "Services to Clients" and "General and Administrative." The other analyses show costs if: 1) CAM is considered the only service of the agency so that all expenses are attributable to CAM; or 2) the disbursement of funds for direct services is considered a separate, identifiable service so that some expenses are attributable to that function while the remaining expenses are charged to the performance of CAM. Each of these models was preferred by one or more committee members.

For comparison purposes, a breakdown of CCCI's estimated budget for FY 1981-82 was prepared for all three methods. In each case, a total budget figure of \$2,984,813 was used (see Figure III-1), and the total unduplicated CCCI client case load was assumed to be 2,200. The cost per client attributable to CAM using each method was \$348, \$618, and \$464, respectively. (See Figure III-2 for the detailed calculations.)

Recommendations

The Legislative Program Review and Investigations Committee was unable to reach a consensus on the future structure of the state's home care program for the elderly because the members were divided on the issue of what type of agency should perform CAM. The committee finally resolved that the problem was a central policy issue that could only be settled by the full General Assembly. If the separation of CAM is determined to be unnecessary, some members of the LPR&IC believe Model C, outlined on the following pages, contains a reduced administrative structure that should be utilized to disburse payments

Figure III-1. Connecticut Community Care, Inc. Consolidated Budget, FY 1981-82.

Revenue

SDA's Promotion of Independent Living Program \$2,984,813

Expenses

Services to Clients

Purchased Services	\$1,626,310
CAM Service Personnel	600,630
Regional Office Personnel - 50%	164,818
	<u>\$2,391,758</u>

General & Administrative

Regional Office Personnel - 50%	\$ 164,818
Travel	20,760
Space Occupancy	52,710
Utilities	6,775
Telephone	28,600
Supplies	4,300
Printing	15,000
Copying Costs	5,000
Postage	2,100
Insurances	9,400
Data Processing	30,000
Dues & Subscriptions	500
Central Office	157,572
Management Fee	95,520
	<u>\$ 593,055</u>

TOTAL EXPENSES

\$2,984,813

Source: Connecticut Community Care, Inc. and the State Department on Aging.

Figure III-2. CCCI Costs Per Client--Three Methods of Calculation.

CCCI'S Budget Categories

Utilizing the cost breakdown supplied by CCCI and shown in Figure III-1, the average costs per client for services are:

Total Services to Clients	<u>\$2,391,758</u>	<u>2,200</u> = \$1,087.16/client
Purchased Services	<u>\$1,626,310</u>	<u>2,200</u> = \$739.23/client*
CAM Service and Regional Office (50%) Personnel	\$ <u>765,448</u>	<u>2,200</u> = \$347.93/client
General & Administrative	\$ <u>593,055</u>	<u>2,200</u> = \$269.57/client

* It should be noted that not all CCCI clients receive funds to pay for the purchase of direct services so the actual average cost per client receiving funds would be higher than this. For example, during the month of June 1981, only 54 percent of the 1,916 clients received money for purchased services. If a similar percentage was applied to 2,200 then 1,188 clients would receive funds for the purchase of services, raising the average per client cost to \$1,368.95. (CCCI estimates the average expenditure per client for those who receive funds to pay for direct services is about \$150/month. This equals approximately \$1,800/year.)

CAM--The Only Service of the Agency

The cost per client if all expenses other than purchased services are charged to the performance of coordination, assessment and monitoring was determined by the committee to be:

CAM Service Personnel	\$600,630
Regional Office Personnel (50%)	164,818
General and Administrative	<u>593,055</u>
	\$1,358,503
<u>\$1,358,503</u>	<u>2,200</u> = \$617.50/client

A similar figure of \$619.80/client was derived by looking at the time spent per CAM function plus the regional and central office expenses. (See Appendix II.)

Disbursement of Funds--Identifiable Service of the Agency

No specific numbers were available to the committee on the program's costs with the expenses for distributing funding for provider services separated from those attributable to CAM. LPR&IC staff, however, developed a hypothetical breakdown.

If it is presumed that the expenditures for the central office and the management fee support the provision of two services (CAM and payments for purchases services, then perhaps half of those expenses should be charged to the payments function (i.e., \$126,546). Likewise, it seems that the equivalent of the portion of the regional office personnel attributed to general and administrative expenses would have to handle the paper work functions related to the payments task even if the agency was only distributing funding. Therefore, this expense (\$164,818) should also be added to the calculation. Finally, to obtain an approximate total cost, the full time equivalent of one nurse and one social worker (\$46,659) should also be added, since a portion of the time spent on CAM functions is related to authorizing payment for services.

The cost of \$338,023 obtained by this method must then be subtracted from all non-purchased service dollars to obtain the expenses attributable to CAM. The per client cost in this case is:

$$\begin{array}{r} \$1,358,503 \\ - 338,023 \\ \hline \$1,020,480 \end{array}$$
$$\frac{\$1,020,480}{2,200} = \boxed{\$463.85/\text{client}}$$

for direct purchased services. If it is determined that CAM should continue to be performed by a separate agency, then the existing organization can remain in place, but the changes suggested in Model E should be implemented.

The decision to recommend operational changes in the PILE program, even if it continues to be operated by CCCI, is based on an analysis of quantitative and qualitative data. Even those committee members who strongly support retention of CAM within a separate agency believe there is a need for tighter eligibility criteria and more limits on program expenses. While the home care needs of the elderly are an important concern of the legislature, the financial restraints on the entire state budget must be taken into consideration. The two models developed by the LPR&IC attempt to balance monetary constraints and program resource needs.

In order to increase the funds available for the purchase of direct services, it is the intention of the Legislative Program Review and Investigations Committee that savings in administrative and CAM costs achieved by these models be added to the money already set aside for provider services. In this way, more clients can be served for the same amount of money. The changes required to implement each of the proposed models are outlined on the following pages. The organizational structure, client eligibility criteria and staffing patterns for each are included.

Model C

If it is determined by the General Assembly that coordination, assessment and monitoring activities can be performed adequately by home health care agencies, then the PILE program will have to be restructured. The model proposed by several Legislative Program Review and Investigations Committee members will utilize CCCI as a fiscal intermediary responsible for the disbursement of state and certain federal funds for the purchase of specified home care services for qualified elderly citizens. This restructuring will allow coverage of the 169 towns in Connecticut, and all licensed home health care agencies will be eligible to participate in the program. In reviewing the experiences of service providers and reimbursement sources, the proponents of this model feel the monitoring system built into it is capable of evaluating the appropriateness of the amount and duration of services prescribed for a client.

Figure III-3. Summary of Suggested Changes--Model C.

ORGANIZATIONAL STRUCTURE: The Department on Aging (SDA) continues to serve as the state agency accountable for the operation of the program. CCCI, under contract with SDA, acts as fiscal intermediary for the program and is responsible for the approval of services for clients and the disbursement of payments to direct providers. (Home health care agencies perform assessment, coordination and monitoring activities. Latter function is also performed by other funding sources.)

REIMBURSABLE SERVICES: Most likely, only three services--homemaker, home health aide and companion--will be eligible for reimbursement in order to make the limited program funds available to as many needy elderly as possible.

GEOGRAPHIC AREA: All 169 towns will be covered.

ELIGIBILITY CRITERIA: Reduce the maximum allowable income to 60 percent of the state's median income or 150 percent of the federal OMB poverty level. Also, take into consideration the liquid assets of an applicant.

FEES: Establish a sliding fee schedule.

STAFFING: Reduce the number of CCCI employees to 13 with a majority handling administrative and fiscal tasks.

Organizational structure. Under this model, the Department on Aging will continue to serve as the state agency accountable for the operation of the program and the funds appropriated to it. CCCI will remain under contract with SDA, but the duties and organizational structure of the nonprofit agency will be reconfigured to reflect its limited role of paying for approved, direct provider services.

As discussed earlier, all licensed home health care agencies already perform CAM functions. Under this model, they will continue to serve their clients in the same ways they previously did, incorporating a uniform CAM process within the services they provide. In a few cases, it may be necessary for agencies to make revisions in the information they collect during an assessment in order for CCCI to receive the same type of information about all clients wishing to obtain reimbursement from the state's program. These changes should be limited, however, because it is anticipated that the data required by CCCI will be similar to that mandated by Medicare and Medicaid, programs which most HHCAs already participate in.

Service approval. Before service can be authorized for any elderly person, a plan of care will have to be submitted to CCCI. The agency will then determine client eligibility, verify the acceptability of the diagnosed service based on the assessment data submitted, and, if proper, authorize payment for the services reimbursable under the state's program. CCCI will monitor the provision of approved services on an ongoing basis to insure that the quality and quantity of service contracted for are being delivered.

Home health care agencies will be required to submit client-service delivery reports 14 days after services begin and every 30 days thereafter. CCCI will conduct quarterly on-site visits to HHCAs to review each agency's operation.

In order to receive payment for services rendered, a home health care agency must submit monthly bills to CCCI. Only services which have previously been authorized and contracted for will be reimbursed. CCCI will receive its funds from the State Department on Aging in quarterly allotments. If CCCI runs out of funds before the end of a quarter, it will have to temporarily discontinue accepting new clients or authorizing increases in services for existing clients. To ensure the availability of funds for services already authorized, CCCI will maintain a cumulative record of services already contracted for in future time periods.

Reimbursable services. The types of home care services eligible for reimbursement by the state program will be reduced under Model C. In order to make the limited state funds available to as many elderly as possible, it is anticipated that only three specific services will be paid for--homemaker, home health aide and companion. These services were selected because they are the ones most frequently needed by clients currently participating in the PILE program and other funding sources often place restrictions of the extent to which payment will be made for these services. As Table III-1 indicates, more than one million dollars was spent on these three services during the first three-quarters of FY 1980-81. Several other more medically-oriented services (e.g., skilled nursing visits and occupational and physical therapy) are not recommended for inclusion in the program because they are generally eligible for reimbursement by other third party payers.

Even for these three services, reimbursement from other sources or self-pay by the client and his or her family will be sought before CCCI uses its funds. The state program will continue to reserve its pool of funds for use only when another source is unavailable and only for clients who fall within specified income guidelines. In the event that during the year the demand for homemaker, home health aide, and companion services appears to be far greater than the available funds will be able to pay for, then CCCI is authorized to cut back on the scope of services it will reimburse for. Payments for companion services and then home health aide services should be suspended so that CCCI can continue to pay for homemaker services.

Client eligibility. Residents of all 169 towns who are 60 years of age or older, in danger of inappropriate institutionalization or already inappropriately institutionalized and who meet certain income and asset guidelines will be eligible to participate in the PILE program under Model C. At the present time, a person with an income below 80 percent of the state's annual median income is qualified to receive reimbursement under the program. While the maximum income limits for the federally funded portion of the program are expected to be lowered during the next year, the Legislative Program Review and Investigations Committee believes lower guidelines should be put in place now.

The committee believes that either a standard of a maximum allowable income of 60 percent of median income or 150 percent of the federal OMB poverty level would be more appropriate. (See Table III-2.) In addition, liquid assets, such as savings accounts, certificates of deposit, stocks and bonds, should be taken into consideration when determining clients'

Table III-1. Purchased Services Reimbursed By CCCI From July 1, 1980 Through March 31, 1981.

<u>Purchased Services</u>	<u>Dollar Amounts</u>	<u>Unduplicated Client Count</u>	<u>Client Months</u>	<u>Avg. Dollars/Client Served</u>
Homemaker	\$577,055.01	728	3,284	\$792.66
Companion	201,238.20	232	962	864.70
Home Health Aide	161,955.18	349	1,419	464.05
Home Help	62,909.85	85	546	740.12
Day Care	53,755.65	75	322	716.74
Transportation	10,866.15	67	896	162.18
Visiting Nurse	6,656.28	61	138	109.12
Chore	2,763.69	65	179	42.52
Nursing Assessment	2,148.31	61	61	35.22
Medical Equipment	1,359.08	14	22	97.08
Medical Supplies	616.99	9	9	68.55
Counseling	315.00	3	3	105.00
Meals	240.54	3	4	80.18
Hearing Aids	202.17	1	1	202.17
Physical Therapy	185.71	1	6	185.71
Home Mgmt./Maint.	136.00	3	3	45.33
Speech Therapy	103.48	2	2	51.74
Occupational Therapy Supplies	65.00	3	3	21.67
Audiological Evaluation	13.89	1	1	13.89
Bath Aide	9.50	1	1	9.50

TOTAL CCCI Service Dollar
Expenditures \$1,082,595.68

Source: Connecticut Community Care, Inc.

ability to pay for services themselves. In no event should the value of the residence of a person be considered an asset since the whole purpose of the program is to keep an elderly person in his or her home.

Table III - 2. Maximum Allowable Income Levels.

<u>Family Size</u>	<u>80 Percent of Annual Median Income, FY 1981-82*</u>	<u>60 Percent of Annual Median Income, FY 1981-82*</u>	<u>150 Percent of Federal OMB Poverty Level, April 1981 - March 1982</u>
1	\$10,155	\$ 7,616	\$ 6,465
2	13,279	9,959	8,535
3	16,404	12,302	10,605
4	19,528	14,646	12,675

*Obtained from: Connecticut Department of Human Resources, Connecticut Comprehensive Annual Services Final Plan FY '82 (June, 1981), p. 15.

A sliding fee schedule should also be established so that clients pay a portion of the cost of the services they need. Not only will this change spread the money among more people, but it should provide elderly clients with a greater interest in the proper delivery of services since they are contributing toward the purchase price.

Administrative costs. The cost of operating a program such as that outlined in Model C can only be estimated. As a basis for making calculations, the staffing pattern utilized by Blue Cross/Blue Shield (BC/BS) in its capacity as the fiscal intermediary for 80 licensed home health care agencies who receive Medicare reimbursements was examined.

Under the current PILE program, CCCI handles about 800 bills per month. It is estimated that under Model C, when the sole function of the organization will be claims processing, that CCCI will manage approximately 3,000 transactions per month. This figure is based on the presumption that, although income eligibility standards will be reduced, the geographic expansion of the program will result in an increased client load. While only about 1,100 clients currently receive payments for direct services, the funds available to pay for a reduced range of services are expected to nearly double under this model. As a result, it is estimated that nearly three

times as many clients can be served.

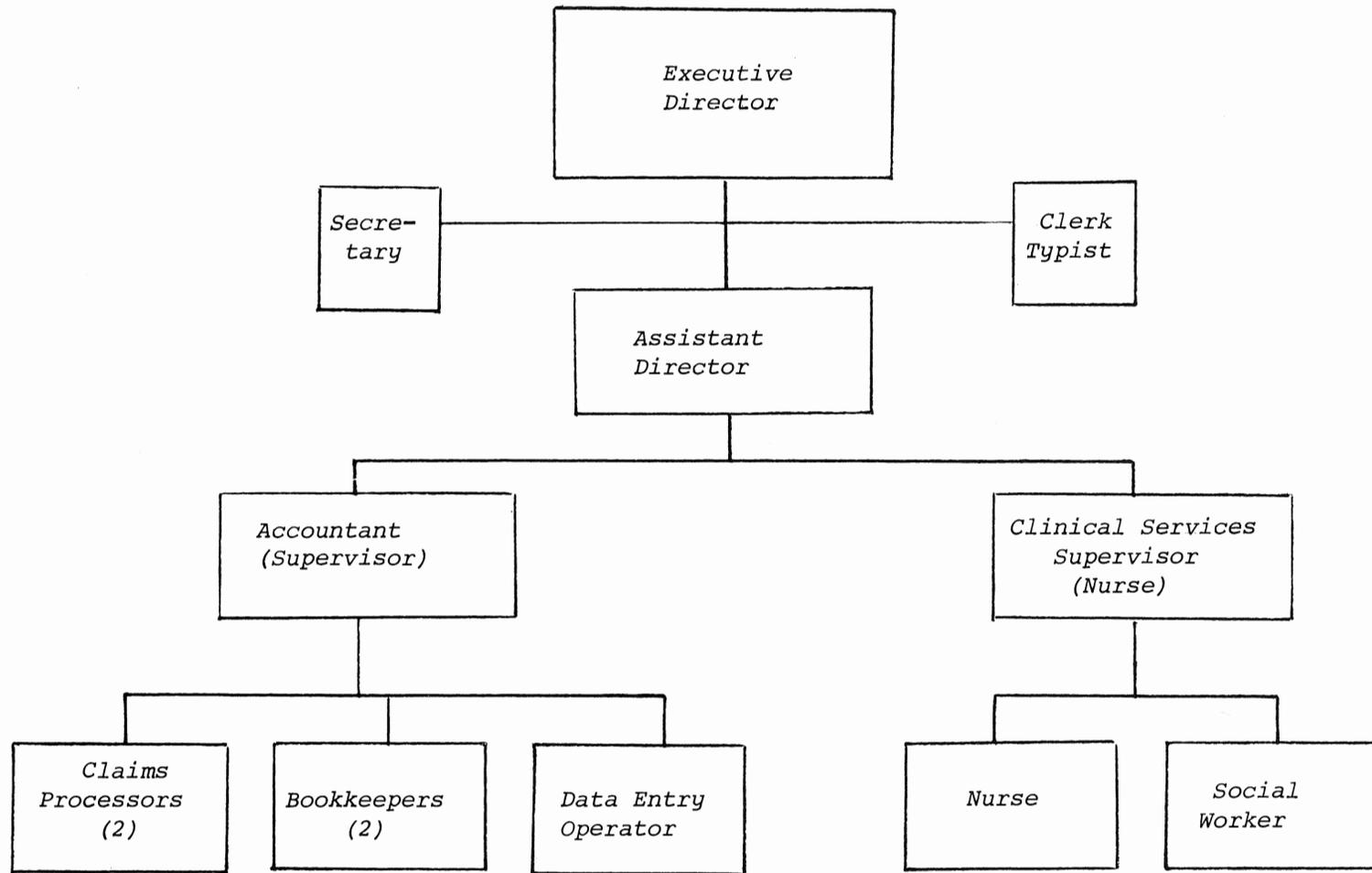
Blue Cross/Blue Shield currently assigns about 14 full-time equivalents to handle approximately 3,500 transactions per month for 80 agencies. It is estimated that about 13 employees will be needed by CCCI to process 3,000 claims from 100 home health care agencies. The specific job titles and salaries of the personnel CCCI is expected to employ are presented in Figure III-4. The total budget is \$440,100, including all office expenses and a contingency item for temporary help if the workload proves to be greater than expected or particularly heavy during one part of the fiscal year. Expenditures at this level will mean that an additional \$918,000 is available to pay for the purchase of direct services, since the FY 1981-82 budget for CCCI (Figure III-1) includes a total of almost \$1.36 million for CAM and General and Administrative Expenses.

Figure III-4. Model C -- Estimated 12 Month Budget.

CCCI's Costs

Executive Director	\$ 30,000
Assistant Director	22,000
Secretary	12,000
Accountant (functional supervisor)	18,000
Claims Processor	10,000
Claims Processor	10,000
Bookkeeper	14,000
Bookkeeper	14,000
Data Entry Operator	9,000
Clerk Typist	9,000
Clinical Services Supervisor (nurse)	18,000
Nurse	16,000
Social Worker	16,000
	<u>198,000</u>
25% fringe on salaries	49,500
	<u>247,500</u>
temporary help	5,000
	<u>252,500</u>
General and Administrative (current central office costs and additional funds for data processing)	187,600
	<u><u> </u></u>
TOTAL	\$440,100

Figure III-5. Model C-- Organizational Structure.



Model E

Even if it is decided that the state's home care for the elderly program should continue to provide coordination, assessment and monitoring by a separate agency, members of the Legislative Program Review and Investigations Committee believe changes are needed in the operation of the program. Model E describes ten areas where revisions of varying scopes should be made in the existing program operated by CCCI. (See Figure III-6 for a summary of the changes.)

Geographic area. Ideally, committee members would like to see all 169 towns in the state covered by the program. Because of the added cost of a separate CAM agency and the greater diversity of services covered in Model E, sufficient funding does not appear to be available to serve the whole state. (See Figure III-7.) The LPR&IC, therefore, believes the towns to be included in the program should be chosen on the basis of the needs of their respective residents.

At the present time, 83 towns are covered by the program. Some were selected on the basis of need, but specific criteria varied from region to region when initial selections were made. All towns added to the program in the past few years have been selected using need as the primary consideration. There are an additional seven towns which were covered previously by Triage, but which will lose all service on December 31, 1981. At least 50 towns, and, if possible, as many towns as are currently served, should be eligible for the restructured home care for the elderly program.

In reevaluating need for the future, each town in the state should be ranked using a weighted formula that takes into consideration: the income levels of residents; the number of minority residents; the number of elderly 60 years of age and over and the number 75 years of age and over; the town setting (urban, suburban or rural); and the availability of other agencies (including providers of home care services) that can perform CAM functions. After the actual demand for CAM and reimbursement for purchased services has been evaluated for a period of time, additional towns may be added as funding permits. New towns should not be added, if lengthy waiting lists exist in any of the initial 50 or more towns.

Residents of towns that were previously in the program but which are not among the towns selected under the new rating system will not be eligible to participate in the program. Any person currently enrolled will be allowed to continue participating as long as he or she meets all other eligibility criteria.

Figure III-6. Summary of Suggested Changes--Model E.

GEOGRAPHIC AREA: Towns should be included in the program on the basis of the need of their residents. All 169 towns should be ranked using a formula that takes into consideration income, minority residents, the number of elderly, the town setting, and the availability of other agencies that can perform CAM functions. Initially serve at least 50 towns and, if possible, as many as are currently served.

ELIGIBILITY CRITERIA: Reduce the maximum allowable income to 60 percent of the state's median income or 150 percent of the federal OMB poverty level. Also, take into consideration the liquid assets of an applicant.

FEES: Establish a sliding fee schedule for receipt of CAM and purchased services.

"SAFEGUARDING ONLY" CLIENTS: Consider reducing the scope of activities for these types of clients in recognition of the fact that some coordination and monitoring functions are performed by the sources paying for the purchased home care services.

ASSESSMENT TOOL: Condense and refine. Also, make greater use of client evaluations performed by groups that refer clients to CCCI.

GREATER INDEPENDENCE FOR CLIENTS: Allow clients and their families to take more responsibility for their plans of care. Develop mechanisms for verifying that services have been provided, problems have developed or a change in circumstances has occurred.

STAFFING NEEDS: Lower the minimum educational standards for some professional positions and use more clerical personnel for coordination and monitoring functions. Utilize contracts with HHCA's to have their nurses perform assessments during periods when there is a long waiting list for that portion of the CAM service. Employ full-time management staff at CCCI.

REGULATION CHANGES: Eliminate the 30 case load restriction in the CAM regulations.

PROGRAM EVALUATION CRITERIA: Establish criteria for the future evaluation of program performance.

PLACE A CAP ON CAM EXPENDITURES: Limit expenditures for CAM costs (including general and administrative expenses) to a maximum of 30 percent of the total CCCI budget.

Figure III-7. Cost of Statewide Access to the PILE Program.

If the PILE program was extended to 169 towns, it is estimated by the State Department on Aging that as many as 13,000 - 15,600 state residents over the age of 60 might require CAM services. Using the current CAM costs presented earlier in this chapter, the minimum annual cost would be:

13,000 clients x \$348 = \$4,524,000
13,000 clients x \$618 = \$8,034,000
13,000 clients x \$464 = \$6,032,000

Since all of those estimates are greater than the current total budget, the LPR&IC considered the cost of serving all towns, but only accepting as many people per town as the current average per town. The results of those calculations showed a cost of:

2,200 unduplicated
83 towns currently served = 26.5 clients/town

169 towns x 26.5 clients/town = 4,478 clients

4,478 clients x \$348 = \$1,558,344
4,478 clients x \$618 = \$2,767,404
4,478 clients x \$464 = \$2,077,792

These expenditures would only leave between \$150,000 and \$1.3 million for the purchase of direct services, which is less than what is currently spent for 2,200 clients.

A number of other calculations can be made incorporating other suggested changes in this report, but the committee found all of them too expensive to enable statewide coverage under Model E.

Eligibility criteria and fees. Currently state residents who are: 60 years of age and over; in danger of inappropriate institutionalization; and meet certain income criteria, are eligible to receive reimbursement for home care services. Technically, there are no income restrictions on the receipt of CAM services, but because of the limited funding available for the program and the limit it places on the size of the staff, people above the income limits are served infrequently.

The Legislative Program Review and Investigations Committee is concerned about several aspects of these criteria. First, there is a problem identifying cases where premature institutionalization would actually occur if the state PILE program did not exist. When the program began back in 1976, a person had to be inappropriately institutionalized or within 90 days of institutionalization to qualify for the program. Ascertaining that entry into a nursing home or hospital would indeed occur within 90 days was difficult.

When reference to the specific time limit was dropped, it was still the intent of the program that an elderly person be very close to the point of entering an institution due to the dearth of home care services rather than a need for the full range of care offered by such a facility. In some cases, an elderly person will not enter such an institution if there is any way for him or her to stay home. Although it may be presumed that the elderly will have to enter an institution if they do not receive home care services, in fact many will make do with a lower quality of life rather than enter a nursing home.

One solution considered by the LPR&IC was a specific requirement that people prove they had applied to a nursing home or skilled care institution before they could be considered for participation in the state's home care for the elderly program.¹⁴ Although many committee members liked this concept because it would refocus the program back to its original intent, several problems with this criterion were identified.

Some people who have no intention of entering a nursing home might apply to one just to gain admission to the PILE program, thereby creating additional paperwork for the facility without reducing the demand for the services provided by CCCI. For other individuals who apply to a nursing home because they see it as their only alternative, the discovery that a variety of home care services can be obtained through CCCI may be too late. Psychologically they have adjusted to the

¹⁴ Referral from a hospital discharge planner or a licensed home health care agency with an assessment from either organization indicating that a person would have to enter a nursing home unless he or she could receive support from the PILE program would also have qualified a person for acceptance as a CCCI client.

idea that the rest of their lives will be spent in an institution and/or they have made arrangements to dispose of their homes without which they have nowhere to receive home care services.

Finally, the ability of people to obtain information about CCCI at the time of their application to an institution may not be consistent statewide. Because nursing homes would not have any financial incentive to work with CCCI (and some homes would have a disincentive because they have trouble filling vacancies) there would be no way to mandate that potential CCCI clients receive information about the program. A major public relations effort would have to be undertaken to ensure the workability of this change.

The Legislative Program Review and Investigations Committee did agree that the income limits for elderly citizens covered by the state's home care for the elderly program should be restructured. As previously described under Model C, the maximum allowable income should be reduced and liquid assets should be taken into consideration; additionally, a sliding fee schedule should be established. (See pp.33, 35 and Table III-2.) Consideration should also be given to placing liens on the property of individuals who receive CAM services and funds for purchased services from CCCI.

"Safeguarding Only" clients. After some discussion, the committee decided that as long as CAM was going to be available from a separate agency, then even those citizens who did not need assistance paying for provider services should be able to obtain CAM. In continuing to provide this service, however, CCCI should be more flexible in recognizing that some coordination and monitoring functions are being carried out by other funding sources. For example, fiscal intermediaries for Medicare require a service agency to establish a plan of care for a client and submit written reports at specified intervals on services provided in order for funds to be received. It would seem that monitoring efforts can probably be reduced for "safeguarding only" clients, depending on the scope of the activities carried out by the particular third party payer.

Assessment tool. The Legislative Program Review and Investigations Committee believes the existing assessment form used by CCCI can be condensed and refined without hindering the collection of information needed to develop a plan of care and monitor the condition of a client. According to the results of the questionnaire the committee sent to CCCI staff who have direct contact with program clients, it took an average of two hours to perform an assessment. While

management personnel indicate the time per assessment should decline as employees become more familiar with the tool, the committee believes a more abbreviated form will not diminish the quality of the services performed by CCCI. Home health care agencies and hospital discharge planners also assess clients, but it is the understanding of the committee that less detailed instruments are used by those organizations.

In addition to reducing the scope of its assessment form, CCCI should consider making greater use of client evaluations performed by groups that refer clients to the PILE program. Moreover, CCCI should establish a prescreening process for those clients it is readily apparent will not need a full array of services. A less comprehensive assessment form should be used to evaluate their needs. Finally, CCCI should give its staff some flexibility to use their professional judgement as to the scope of the assessment needed by a particular client. Perhaps categories of questions could be established and only some from each group would have to be completed, depending on the complexity of the case.

Greater independence for clients. Whenever possible, CCCI clients and their families should be allowed to take greater responsibility for overseeing their own plan of care. CCCI should develop a form so clients and their families can verify that services contracted for have been provided and continue to meet the clients' needs. This would reduce the follow-up activities of CCCI staff. A mechanism should be in place so clients and their families are able to contact CCCI staff if a problem develops or a change in circumstances occurs.

Staffing needs. The Legislative Program Review and Investigations Committee considered several changes in the area of personnel and staffing resources. Some of these suggestions may enable CCCI to save money while others should at least reduce the growth rate of its expenses.

The committee believes lower, minimum-educational standards can be instituted for several positions and more clerical personnel can be used for coordination and monitoring functions. At the present time, in some of the CCCI regional offices nurses or social workers perform all of the CAM functions for a client. In other offices, once the plan of care has been determined, a case aide makes the arrangements for any direct services that are needed.

A major cost reduction per client could be achieved if personnel, such as case aides, performed all coordination and monitoring functions associated with the arrangement for,

provision of and payment for direct provider services. Since the average hourly rate (including fringe benefits) for a nurse or social worker at CCCI is \$11.97 while the rate for a case aide is \$6.60 (see Appendix II for calculations), substituting the two types of personnel could result in a savings of approximately \$102 per year per client.¹⁵ Further, more of the time of the nurses and social workers would be freed up to perform assessments and reassessments.

A temporary measure CCCI should consider, during periods when its total client case load may be increasing rapidly, is to use existing home health care agency personnel to perform assessments. When CCCI assumed management of the SAIL/PILE program in 1980, HHCAs in the southwestern region of the state were used to perform assessments. A similar arrangement should be considered in the future so CCCI can avoid expanding its staff needlessly. If case loads per staff are increased (as recommended below) and more of the coordination and monitoring functions are performed by clerical workers and case aides, then additional nursing personnel may not be needed on a full-time basis. Temporary contracts with home health care agencies, which already have nurses available and experienced in performing assessments, might be more cost effective.

The final committee suggestion in this area is the employment of permanent full-time management staff by CCCI. Since its creation, the administration of CCCI has been handled by eight part-time people whose time was provided through a contract with Triage, Inc. This revision was being discussed by CCCI's board, but the termination of Triage, effective on December 31, 1981, has precipitated a change in this area sooner than originally expected.

The staffing proposal considered by LPR&IC called for two or three full-time employees with salaries of \$35,000 and \$28,000 or \$35,000, \$22,000 and \$22,000 respectively. Combined with fringe benefits of 25 percent, the total cost of this proposal would have been between \$79,000-99,000. The CCCI Board was in the process of finalizing its organizational plan when the program review committee completed its review.

¹⁵ It is estimated that on the average 3½ hours are spent on coordination activities twice a year per client. About two hours, six times a year, are spent on monitoring functions. Multiplying the difference in the two salaries (\$5.37) times 19 hours equals \$102.

Regulation changes. The Department of Health Services' regulations for CAM agencies currently state that the total number of active cases to be handled by a caseworker at any given time shall not exceed 80 (Regulations of Connecticut State Agencies, Sec. 19-13-D96(e)). Although the regulations have been interpreted to allow a caseworker to carry 89 cases before another staff worker must be hired, LPR&IC found this limit to be unnecessarily restrictive. Since no one could explain why the specific number of 80 was selected in the first place, and given other changes LPR&IC recommends that will reduce the workload per case for nurses and social workers, the committee believes the maximum load could be increased significantly or eliminated.

Home health care agency caseworkers are not restricted by this case load regulation and they carry case loads that range between 20 and 200 clients. There is a major difference between the cases handled by these workers and CCCI staff, however, in that HHCAs generally serve short term acute clients while CCCI carries chronic long term care clients who may require more services. The staff of Triage which served chronic long term clients maintained case loads of 125 people each.

In order to avoid problems with a new mandated constraint on case loads, the program review committee believes all restrictions should be eliminated from the regulations. After CCCI has had an opportunity to assess the effect of all of the Legislative Program Review and Investigations Committee's suggestions on the amount of time CCCI staff spend on CAM activities, it should be possible to determine an optimal case load per worker.

Program evaluation criteria. At the time of this study, CCCI did not have any established objectives upon which to judge its performance. While LPR&IC realizes such a requirement will not directly affect the cost of CAM services, the committee does believe there should be measurable standards against which the program can be evaluated in the future. Specified criteria should also make it easier for the CCCI board and staff to determine whether the program is meeting its goals.

Place a cap on CAM expenditures. The issue of exactly what portion of the resources allocated for the state's home care for the elderly program should be spent on coordination, assessment and monitoring functions was a major concern of the Legislative Program Review and Investigations Committee. The committee believes a major share of the dollars should be used to pay for the direct services that individuals need in order

to remain in their homes. While the committee does not want to limit funding for CAM activities so strictly that CCCI will not be able to make use of funds designated for the purchase of direct services because there is no money to pay for an assessment, the committee does feel limits are necessary.

At the start of FY 1980-81, CCCI was spending \$1.45 million or 50 percent of its total \$2,895,000 budget on CAM activities (including general and administrative expenses). Through various cost saving measures, CCCI reduced these expenses to 45 percent of its total budget. For FY 1981-82, \$1.36 million or 46 percent of the total \$2,984,813 budget is allocated for CAM costs (including general and administrative expenses).

Recognizing that there are limits on the cost efficiencies that can be achieved by CCCI and that the existing staff cannot handle an infinitely increasing case load, LPR&IC decided the limit on nonpurchased services should be a percentage of the CCCI total budget. The committee does not have enough data to state what the actual cap should be, but the consensus was that CAM costs should not exceed 30 percent of the total budget.

Only state and federal dollars specifically available to SDA and CCCI for their disbursement shall be considered part of their total budget for purposes of applying the percentage cap. Funds available from sources such as Medicare and Medicaid are disbursed and monitored by others who accrue their own administrative expenses so those dollars should not be considered part of the program's total budget. For the funds currently budgeted for FY 1981-82, a 30 percent cap would be \$895,444.

If this cap was placed on CAM expenses, then CCCI would either have to cut its per client CAM expenditures or increase the dollars available for direct purchased services in order to keep its current case load, let alone add more clients. For example, CCCI will have to increase its funding for purchased services from the current \$1,626,310 to \$3,169,840 in order to limit current estimated CAM costs (including general and administrative expenses) to 30 percent of the budget.

It is possible that some of this additional money could be obtained from Title III funds, of which \$2,331,171 is available statewide. Fifty percent of this money can be spent on any type of service for the elderly; the remainder of the funds are to be used for four specified activities: in-home services, legal services, community services and access (transportation).

It is anticipated that \$272,000 will be provided to the PILE program during FY 1981-82 for the home care program. Future disbursements may be affected by changes in federal Title III allocations and the specific towns in Connecticut that are served by CCCI.

APPENDICES

APPENDIX I

GLOSSARY

Area Agencies on Aging (AAAs) - private, nonprofit organizations that are responsible for planning and developing services for the elderly within their regions. Funded primarily by the federal government, they coordinate and pool resources from other public and private sources in order to develop services for the elderly. Until June 30, 1980, the AAAs operated the state home care for the elderly program.

Connecticut Community Care, Inc. (CCCI) - a private, nonprofit agency, centrally managed and regionally administered, with an independent Board of Directors. Since July 1, 1980, CCCI has operated the state's home care for the elderly program.

coordination, assessment and monitoring (CAM) - a process used to ensure that a person receives the appropriate level and amount of home care services.

Assessment involves the initial evaluation of a client to determine his or her current physical and mental well-being and whether there are any unmet needs that impede his or her ability to remain in the community and avoid institutionalization. Coordination involves contacting providers to arrange specified services and ensuring the availability of some type of funding to pay for the services. Monitoring functions are carried out on an on-going basis and include verifying that a client has received the quantity and quality of services contracted for and ensuring that the level of services prescribed for a client continues to be appropriate. On a regular basis, a reassessment of a client is performed and the plan of care is reevaluated.

DHR - Department of Human Resources.

DOHS - Department of Health Services.

home care - the array of services, either separately or jointly, that are provided in order to sustain a person in his or her own home at an optimum level of health, activity and independence. Services available outside the home, such as day care and group eating sites, as well as home delivered services are included in this definition.

home health care agencies (HHCAs) - public or private organizations that provide professional nursing services and at least one other service (among those specified in C.G.S. Section 19-576(e)) in a person's home.

LPR&IC - Legislative Program Review and Investigations Committee.

Medicaid (Title XIX) - enacted in 1965 to finance health care services for individuals receiving public assistance as well as certain other low income people. (See Appendix III for a more detailed description.)

Medicare (Title XVIII) - a nationwide health insurance plan primarily for persons 65 years and older. Put into effect on July 1, 1966, the program was designed for acute care needs and is administered through private intermediaries. (See Appendix III for a more detailed description.)

Promotion of Independent Living for the Elderly (PILE) - since July 1, 1980, the official name of the state's home care for the elderly program.

Strengthened Assistance for Independent Living (SAIL) - the original name of the state's home care for the elderly program. Started in August 1976 as a pilot program to demonstrate the role of home care as an alternative to institutionalization, the name was later changed to PILE.

SDA - Department on Aging; the state agency responsible for oversight of the SAIL/PILE program.

Title XX - a major funding source for the state's home care for the elderly program. Created by Congress in 1975 to assist states in providing public social services, the program was recently replaced with the Social Services Block Grant. (See Appendix III for a more detailed description.)

APPENDIX II

Breakdown of Average CAM Cost Per Client Based
on Time Spent Per CAM Function (FY 1981-82)

Based on information obtained from the questionnaires sent to CCCI staff who deal directly with elderly clients, the average amount of time spent on various coordination, assessment and monitoring activities was determined. Those averages were multiplied by the estimated number of times per year that they are performed. That number was then multiplied by the average of the average hourly salaries for nurses and social workers. This figure, labeled "CAM personnel and fringe" was added to various other regional and central office costs, which had been divided by the number of unduplicated clients served by CCCI, in order to obtain an average cost per client for CAM.

Average of Average Hourly Salaries for Nurses and Social Workers

Nurse Clinician (BSN)

Salary range: \$17,035 - \$22,147
 Average salary: \$19,591 Annual w/25% Fringe: \$24,489
 \$ 10.05 Hourly (37½ hours/wk.) \$ 12.56

Social Service Coordinator (MSW)

Salary range: \$15,423 - \$20,049
 Average salary: \$17,736 Annual w/25% Fringe: \$22,170
 \$ 9.10 Hourly (37¼ hours/wk.) \$ 11.38

Nurse's hourly salary w/fringe \$12.56
 Social Service Coordinator's
 hourly salary w/fringe 11.38
 \$23.94 ÷ 2 = \$11.97 hourly rate

CAM Personnel and Fringe

Assessment (avg. = 2 hrs.)	\$11.97 x 2 =	\$ 23.94
Coordination (avg. = 3½ hrs.)	\$11.97 x 3½ (twice/year) =	83.79
Monitoring (avg. = 2 hrs.)	\$11.97 x 2 (six times/year) =	143.64
Reassessment (avg. = 2 hrs.)	\$11.97 x 2 =	<u>23.94</u>
		\$275.31/client

$$\frac{\text{Regional office personnel costs}}{\text{Number of unduplicated clients}} = \frac{\$164,818}{2,200} = \$74.92/\text{client}$$

This figure includes a portion of the time of the regional office directors (each of whom carries a modified case load), medical transcriptionists (who type up case plans and case records and do initial screenings on the telephone) and case aides (who call providers to set up services once care plans have been established for clients).

$$\text{"CAM personnel \& fringe"} \quad \overline{\overline{\$350.23/\text{client}}}$$

Other Expenses

$$\frac{\text{Regional office personnel costs}}{\text{Number of unduplicated clients}} = \frac{\$164,818}{2,200} = \$74.92/\text{client}$$

This figure includes the remaining portion of the regional office directors' time and other clerical functions, such as office receptionist, filing, ordering supplies and claims processing.

$$\frac{\text{Regional office non-personnel costs}}{\text{Number of unduplicated clients}} = \frac{\$175,145}{2,200} = \$79.61/\text{client}$$

This figure includes regional office expenses for travel, rent, utilities, telephone, supplies, printing, copying costs, postage, insurances, data processing and dues and subscriptions.

$$\frac{\text{Central office and management fee}}{\text{Number of unduplicated clients}} = \frac{\$253,092}{2,200} = \$115.04/\text{client}$$

This figure includes central office expenses for rent, utilities, supplies, copying costs, insurance, etc. It also includes approximately \$95,000 for the management contract with Triage.

$$\text{"General \& Administrative"} \quad \overline{\overline{\$269.57/\text{client}}}$$

$$\text{TOTAL CAM COST} \quad \overline{\overline{\$619.80/\text{client}^*}}$$

* At the start of this review, calculations of the CAM cost were generally based on an average case load of 1,800 clients. If that figure was substituted in the above analysis, the total CAM cost per client would be \$696.36.

In such a case, the functional CAM cost remains \$275.31, but the regional office personnel cost would become \$91.57 ($\$164,818 \div 1,800$) for a "CAM personnel and fringe" cost of \$366.88. The "general and administrative" cost would be revised to \$329.48 (regional office personnel costs: $\$164,818 \div 1,800$; regional office nonpersonnel costs: $\$175,145 \div 1,800$; and central office and management fee: $\$253,092 \div 1,800$).

APPENDIX III

Funding Sources for Provider Services

There are three federal programs which provide direct reimbursement for home health and other in-home services--Title XVIII (Medicare), Title XIX (Medicaid), and Title XX (Grants to States for Services) of the Social Security Act. Each of these programs maintains differences in eligibility criteria, type and extent of service reimbursed, and the rate and method of reimbursement. A brief description of each reimbursement program is presented below. In addition, an overview of Title III of the Older Americans Act, which provides grant money to communities to help elderly residents continue living independently, is included.

Medicare (Title XVIII of the Social Security Act). Medicare Health Insurance for the Aged, was enacted in July 1965 and became effective on July 1, 1966. It is a nationwide health insurance plan for persons 65 years and older, for persons under 65 who are disabled, and for certain persons with end-stage renal disease. The program was designed to provide acute care rather than chronic care health insurance (i.e., for short term, severe symptoms rather than long term constant symptoms) and is administered through private intermediaries.

Title XVIII contains two coordinated parts, both of which reimburse for medical home health care benefits. Part A (Hospital Insurance) pays for inpatient hospitalization, skilled nursing facility (SNF) care, and the services of a home health aide. Part B (voluntary Supplemental Medical Insurance) pays for physician services, home health care, medical and other health services, outpatient hospital services, and laboratory, pathology and radiologic services. Approximately 95 percent of the people eligible for Part A participate in the voluntary Part B.

There are several requirements a Medicare beneficiary must meet in order to receive reimbursable home health services. The individual must:

- 1) be homebound;
- 2) need services prescribed by a physician and be under the care of a physician; and
- 3) need part-time or intermittent skilled nursing service and/or physical or speech therapy.

In addition, a plan of care must be established within 14 days after discharge from the hospital or SNF, under Part A. Only by meeting these requirements may the Medicare beneficiary receive covered home health services under either Parts A or B of Medicare.

Several home health care benefits that are reimbursable under Medicare were expanded by the provisions of the 1980 Omnibus Reconciliation Act (P.L. 96-499). Previously, a person's coverage was limited to 100 home health visits per illness under Part A and 100 visits per calendar year under Part B. The 1980 act expanded Medicare coverage to unlimited home health visits under both Parts A and B. The act eliminated both the required 3-day prior hospital stay before a recipient could qualify for home health visits under Part A and the \$60 deductible for home health benefits under Part B. Other changes added the need for occupational therapy as a qualifying criterion for home health benefits, and allowed proprietary home health agencies in states without licensure laws to participate in Medicare.

By law, Medicare home health care benefits are oriented toward the need for skilled care. They were not designed nor are they intended to take care of an individual who only needs help with activities of daily living.* If, however, an individual requires skilled nursing care or physical, speech or occupational therapy, other services may then be provided. The following services are reimbursable under Title XVIII:

- 1) part-time or intermittent nursing care provided by a registered nurse or under the supervision thereof;
- 2) physical, occupational or speech therapy;
- 3) medical social services (which assist in adjusting to a patient's health problem) provided under a physician's direction;
- 4) part-time or intermittent home health aide services (e.g., hygiene, bathroom assistance, medication administration);
- 5) medical supplies (other than drugs and medications) and the use of medical appliances;
and

* U.S. Department of Health & Human Services, Planning for Home Health Services: A Resources Handbook, Health Planning Methods & Technology Series (August 1980), p. 15.

- 6) hospital-affiliated home health services provided by interns/residents.

In Connecticut, Blue Cross/Blue Shield acts as the Medicare fiscal intermediary for 80 licensed home health care agencies. The Aetna Life and Casualty Company fulfills that role for 12 other agencies.

Medicaid (Title XIX of the Social Security Act). The Medicaid program was enacted in 1965 to finance health care services for individuals receiving public assistance and certain other low income people. It enables states to furnish medical assistance and rehabilitation to the aged, blind, disabled, and families with dependent children whose income and resources are insufficient to meet the high costs of needed medical care.

According to an article in State Legislature, Medicaid is much more complicated than the Medicare program since it depends on state participation. The eligibility criteria, benefit levels and rates of payment to health care providers are determined at the state level, but must be within federal guidelines. Although Medicaid is a federal program because of its source of funding, its day-to-day operation is largely a state responsibility.*

Medicaid coverage is provided by all states to all recipients of the Aid to Families with Dependent Children (AFDC) program, and to beneficiaries of Supplemental Security Income (SSI) which includes the blind, disabled, and aged. Income eligibility criteria are determined by each state and they may extend coverage to the "medically needy"--those who do not receive cash benefits because their income is too high, but who meet other criteria for AFDC or SSI. These are persons who have too much income to qualify for cash assistance, but who do not have enough money to meet their medical needs. Their medical bills must equal or exceed the portion of their income that is above the state-set Medicaid limits. States may also choose to cover other categories, including: families headed by an unemployed male; children under 21 who meet financial eligibility requirements; general assistance persons; and those eligible for AFDC or SSI who decline cash payments.

States must provide Medicaid benefits that cover hospital and skilled nursing facility care, home health, physician, laboratory, x-ray and family planning services. Optional services

* "What Next for Medicaid," State Legislatures, June 1981, p. 13.

include outpatient prescription drugs, dental services, eye glasses, intermediate care facilities, prosthetic devices, and care for those persons over 65 in tuberculosis and mental institutions.

In order to be eligible for reimbursement for home health services under the Medicaid program, a patient's need for home health services must be certified by a physician. In November 1976, new regulations clarified the Medicaid benefits and eligibility. Under these regulations, home health services which are reimbursable are as follows:

- 1) part-time or intermittent nursing care provided by a home health agency or, if no such agency exists, by a registered nurse;
- 2) home health aide services provided by a home health agency; and
- 3) medical supplies, equipment and appliances suitable for use in the home.

States may provide coverage for physical, occupational and speech therapy, medical social services and personal care services. Services must be prescribed by a physician in accordance with a plan of care and supervised by a registered nurse.

In Connecticut, in order to be eligible for reimbursement for most home health services, prior authorization must be received from the Department of Income Maintenance (DIM), the agency administering the state's Medicaid program. However, as of October 1981, the first 10 hours per week of home health aide services do not require prior authorization, but Medicaid will not reimburse for more than 20 hours per week of this service.

Grants to States for Services (Title XX of the Social Security Act).

Title XX, providing for federal/state social service programs became effective on October 1, 1975 (P.L. 93-647). The legislation was enacted by Congress to assist states in providing public social services through federal funds matched with state and local funds. The goals of the program were to enable states to make available services directed toward:

- 1) self-support;
- 2) self-sufficiency;

- 3) protection of children and adults from abuse, neglect, or exploitation, and strengthening family ties;
- 4) prevention or reduction of inappropriate institutional care by providing home care services; and
- 5) appropriate institutional placement and services.*

The Title XX grant-in-aid program gives the states broad discretion in providing a range of social services. However, the states must provide 25 percent matching funds and are required to develop an annual plan which describes what services are to be provided, to whom, and by what methods. A variety of home-based services may be provided, including homemaker, home health aide, choreworker, home management-maintenance, personal care, financial counseling, transportation, recreation, legal and others. Services vary greatly from state to state.

Individuals who are eligible to receive services under Title XX are: persons who are eligible for cash assistance (AFDC, SSI, Medicaid, Food Stamps, CAMAD and General Assistance), and other low-income persons whose annual income is within certain income guidelines. Persons eligible without regard to income are those in need of: information and referral, family planning, and protective services. At least 50 percent of a state's Title XX allotment must be used to serve those receiving cash assistance.

Fees for Title XX services must be paid by families whose incomes exceed a certain percentage of the state's gross median income level. Others pay fees depending upon certain state options. In Connecticut, most Title XX services are offered without charge to people with incomes up to the 80 percent level. The Department of Human Resources is the designated state agency responsible for developing the Comprehensive Annual Services Program Plan, supervising the plan, and administering the Title XX Social Services program.

Title III of the Older Americans Act. Title III (Grants for States and Community Programs on Aging), which became effective in 1965, authorizes federal grants to communities to establish

* Connecticut Department of Human Resources, Annual Services Plan July 1, 1980 - June 30, 1981, p. 6.

programs to help elderly people maintain an independent life style. Many of the projects funded with Title III grants contain home health service components including homemaker, home health aide, health education, counseling, home repair, transportation, companion, chore and other services deemed necessary for the general welfare of an elderly individual. Title III also provides support, such as nutrition (home delivered meals) and supportive and preventive services, that are needed to avoid institutionalization.

Under Title III, states are required to provide specific priority services. At least half of the Title III funds must be used in the following four areas:

- 1) transportation (access);
- 2) in-home services;
- 3) community services; and
- 4) legal services.

The remaining 50 percent may be spent on any other services that the Area Agencies on Aging (AAAs) choose. Federal regulations also require individual recipients to determine what they are able to contribute toward the cost of services rendered.

In Connecticut, the State Department on Aging disburses Title III funds to the five AAAs, which in turn use the money for grants to service providers to implement area social service plans. During FY 1980-81, the Department on Aging awarded \$3,526,351 to the AAAs.

APPENDIX IV

LPR&IC Questionnaire--Licensed Home Health Care Agencies

(N=67)

Please answer every question on both sides of each page.

1. What towns does your agency serve? _____

2. How many individual clients were served by your agency from July 1, 1980 to March 31, 1981?

See Attachment A

3. Please indicate the percentage of your clients that fall into the following categories:

See Attachment A

_____ % under 60 years of age _____ % 60 + years of age

4. Do you perform an assessment of new clients who are referred to your agency?

65 always 2 sometimes ___ never (Skip to Ques. 10.)

5. Do you perform the same type of assessment for all clients?

39 yes 28 no

5a. If no, please indicate the reason(s) for different assessments.

mch/well child = 9

different levels = 17

psychological = 1

6. Which, if any, of the following items are included in your agency's assessment of elderly clients? (Please answer each item and specify whether it is included in all assessments, some assessments or is not included.)

	<u>All</u>	<u>Some</u>	<u>Not Included</u>
a. personal information.....	1 = 63	2 = 3	3
b. medical history.....	1 = 64	2 = 2	3
c. nutrition assessment.....	1 = 62	2 = 4	3
d. mental health status.....	1 = 61	2 = 5	3
e. observed behavior patterns.....	1 = 63	2 = 3	3
f. physical examination.....	1 = 47	2 = 14	3 = 5
g. social contacts.....	1 = 57	2 = 8	3 = 1
h. family relationships.....	1 = 61	2 = 5	3
i. family provision of services.....	1 = 59	2 = 7	3
j. environmental assessment.....	1 = 61	2 = 5	3
k. living expenditures.....	1 = 26	2 = 36	3 = 5
l. income/financial support.....	1 = 33	2 = 29	3 = 5
m. other (please specify) _____	1 = 9	2 = 1	3

7. Please estimate the average amount of time spent per elderly client on the performance of the assessment functions you identified above. Also, please indicate the type(s) of personnel who perform this activity.

See Attachment A

average amount of time spent per client _____ hours

type of personnel _____

8. Please estimate the average per client cost to your agency of performing the initial assessment you identified above. (This cost should include appropriate salary, transportation, space occupancy, office and other general costs.)

\$ See Attachment A

9. Do clients contribute toward the cost of the initial assessment?

4 always 43 sometimes 14 never

9a. If yes, on what basis are client contributions determined?

3 voluntary
39 sliding fee scale (e.g. ability to pay)
4 flat rate
11 other (please specify) _____

10. Which, if any, of the following coordination activities does your agency perform for elderly clients? (Please answer each item and specify whether it is performed for all clients, some clients or it is not performed.)

	<u>All</u>	<u>Some</u>	<u>Not Performed</u>
a. a problem list is constructed for each client...	1=53	2=11	3=2
b. a long term plan of care is developed to meet each client's needs.....	1=57	2=10	3=0
c. service providers are selected.....	1=49	2=12	3=4
d. the kind and amount of services to be provided are arranged.....	1=57	2=9	3=1
e. a re-evaluation date for service continuation is established.....	1=59	2=7	3=1
f. other (please specify) <u>goals set=2</u>	1=9	2=0	3=0

11. For an elderly client, please estimate the average amount of time spend per month on the performance of the coordination functions you identified above. Also, please indicate the type(s) of personnel who perform this activity.

See Attachment A

average amount of time spent per client _____ hours

type(s) of personnel _____

12. Which, if any, of the following monitoring activities does your agency perform for elderly clients? (Please answer each item and specify whether it is performed for all clients, some clients or it is not performed.)

	<u>All</u>	<u>Some</u>	<u>Not Performed</u>
a. contact is maintained by telephone with clients and/or primary supporters to insure the quantity and quality of service delivery.....	1=45	2=18	3=1
b. providers are required to submit periodic written reports which detail the clients' status and the service provided.....	1=52	2=10	3=3
c. other (please specify) _____	1=8	2=1	3=0

13. For an elderly client, please indicate the average amount of time spent per month on the performance of the monitoring functions you identified above. Also please indicate the type(s) of personnel who perform this activity. *See Attachment A*

average amount of time spent per client _____ hours

type(s) of personnel _____

14. Which, if any, of the following reassessment activities does your agency perform for elderly clients? (Please answer each item and specify whether it is performed for all clients, some clients or it is not performed.)

	<u>All</u>	<u>Some</u>	<u>Not Performed</u>
a. clients are visited in their homes to update characteristics noted on the original assessment in order to determine changes in need.....	1 = 64	2 = 3	3
b. if appropriate, the existing plan of care is modified.....	1 = 63	2 = 3	3
c. other (please specify) _____	1	2	3

15. Please estimate the average amount of time spent per elderly client on the performance of the reassessment activities you identified above. Also, please indicate the type(s) of personnel who perform this activity. *See Attachment A*

average amount of time spent per client _____ hours

type(s) of personnel _____

16. Do you currently have a waiting list of elderly clients in need of home care?

7 yes 60 no

16a. If yes, approximately what is the average amount of time elderly clients must wait to receive services?

1 week ; 3-6 weeks ; 2-5 days ; 1-2 weeks ; varies ; few days - 2 weeks ; 3 days - 1 week

17. Is your home health care agency: (please specify)
9 proprietary 58 not-for-profit

18. Please indicate which, if any, of the following sources of funding your agency receives. (Please check all that apply.)

- a. 65 client fees
- b. 52 town contributions
- c. 30 private agencies (e.g. United Way, Community Councils)
- d. 31 endowments
- e. 62 medicare
- f. 65 medicaid
- g. 10 Title III
- h. 28 Title XX
- i. 45 other (please specify) private insurance/Blue Cross = 27; veterans admin. = 4; donations + funds = 11; state grants = 5; misc. = 6

19. Approximately what percentage of your elderly clients utilize each type of service listed below? (Please answer each item.) Also, please indicate for each service whether your agency provides it, makes arrangements for a client to receive the service or does neither.

% Elderly Clients Utilizing Service (See Attachment A)

	Provides	Arranges	Neither
a. <u> </u> skilled nursing visits.....	1 = <u>67</u>	2 = <u>0</u>	3 = <u>0</u>
b. <u> </u> speech therapy.....	1 = <u>39</u>	2 = <u>20</u>	3 = <u>4</u>
c. <u> </u> physical therapy.....	1 = <u>48</u>	2 = <u>15</u>	3 = <u>2</u>
d. <u> </u> occupational therapy.....	1 = <u>28</u>	2 = <u>22</u>	3 = <u>12</u>
e. <u> </u> home delivered meals.....	1 = <u>4</u>	2 = <u>45</u>	3 = <u>13</u>
f. <u> </u> home health aide.....	1 = <u>58</u>	2 = <u>7</u>	3 = <u>0</u>
g. <u> </u> homemaker.....	1 = <u>28</u>	2 = <u>29</u>	3 = <u>7</u>
h. <u> </u> counseling.....	1 = <u>30</u>	2 = <u>23</u>	3 = <u>9</u>
i. <u> </u> transportation.....	1 = <u>6</u>	2 = <u>44</u>	3 = <u>10</u>
j. <u> </u> chore services.....	1 = <u>8</u>	2 = <u>28</u>	3 = <u>24</u>
k. <u> </u> companion services.....	1 = <u>13</u>	2 = <u>30</u>	3 = <u>18</u>
l. <u> </u> legal services.....	1 = <u>0</u>	2 = <u>26</u>	3 = <u>32</u>
m. <u> </u> financial counseling.....	1 = <u>17</u>	2 = <u>19</u>	3 = <u>21</u>
n. <u> </u> day care.....	1 = <u>2</u>	2 = <u>19</u>	3 = <u>33</u>
o. <u> </u> make referrals to other service providers.....	1 = <u>44</u>	2 = <u>16</u>	3 = <u>3</u>
p. <u> </u> other (please specify).....	1 = <u>11</u>	2 = <u>1</u>	3 = <u>0</u>

20. Please indicate your agency's salary range for each staff category listed below.

<u>Personnel Category</u>	<u>Salary Range for Position</u>
agency director	_____
nurse (RN)	_____
nurse (LPN)	_____
social services coordinator (MSW)	_____
social services coordinator (BSW)	_____
claims processor	_____
secretary	_____

See
Attachment
A

21. Connecticut Community Care, Inc. (CCCI) is a private nonprofit organization under contract with the State Department on Aging to provide the coordination, assessment and monitoring (CAM) service element of the state supported elderly home care program. Have you ever heard of the CCCI organization?

61 yes 5 no (Skip to end.) *no response = 1*

21a. If yes, under what, if any, circumstances does your agency come into contact with CCCI? (Please check as many responses as are appropriate.)

- a. 25 CCCI refers clients to your agency
- b. 33 your agency refers clients to CCCI
- c. 6 an agency employee serves on the Board of CCCI
- d. 19 an agency employee meets to discuss/exchange information with CCCI staff
- e. 20 have no contact with CCCI
- f. 10 other (please specify) _____

22. In your opinion, is there duplication between your agency and CCCI? See Attachment A _____yes _____no

22a. If yes, please indicate the extent and type of duplication.

See Attachment A

23. If CCCI were to terminate, could your agency provide coordination, assesemnt and monitoring services to former CCCI clients in your area?

_____yes _____no

23a. If no, why not? See Attachment A

Thank you for completing this questionnaire.

Attachment A -- Additional Responses to the LPR&IC
Questionnaire Sent to Licensed Home Health Care Agencies

Ques. #2 Individual Clients Served from 7/1/80 to 3/31/81 (N=58)

0-99 = 5 agencies	600-699 = 0	1200-1499 = 3
100-199 = 15	700-799 = 2	1500-1599 = 3
200-299 = 5	800-899 = 2	1600-1975 = 0
300-399 = 3	900-999 = 2	1976-2250 = 3
400-499 = 5	1000-1099 = 2	2251-3199 = 0
500-599 = 5	1100-1199 = 0	3200-4999 = 3

Ques. #3 Percentage of Clients 60+ Years of Age (N=63)

0-24% = 0 agencies	41-50% = 5	71-80% = 21
25-30% = 3	51-60% = 9	81-90% = 11
31-40% = 3	61-70% = 12	91-100% = 0

Ques. #7 Estimated Average Amount of Time Spent Per Elderly Client for Assessment Functions (N=64)

Less than 1 hour = 2 agencies	3-3.9 hours = 1
1-1.9 hours = 39	4-4.9 hours = 4
2-2.9 hours = 17	5-5.9 hours = 1

Types of Personnel Who Perform Assessment (N=62)

Nurse = 53 agencies
Multiple or team = 8
Social worker = 1

Ques. #8 Estimated Average Per Client Cost of Performing Initial Assessment (N=54)

Less than \$10 = 0 agencies	\$41-50 = 3
\$10-19 = 2	\$51-60 = 3
\$20-25 = 17	\$61-70 = 1
\$26-30 = 12	\$71-110 = 2
\$31-35 = 8	\$111-140 = 2
\$36-40 = 4	

Ques. #11 Estimated Average Amount of Time Spent Per Elderly Client for Coordination Functions (N=49)

Less than 1 hour = 7 agencies	4-4.9 hours = 3
1-1.9 hours = 11	5-5.9 hours = 3
2-2.9 hours = 11	6-6.9 hours = 3
3-3.9 hours = 8	8 or more hours = 3

Ques. #11 Types of Personnel Who Perform Coordination (N=61)

Nurse = 41 agencies
Multiple or team = 19
Other = 1

Ques. #13 Estimated Average Amount of Time Spent Per Elderly Client for Monitoring Functions (N=43)

Less than 1 hour = 6 agencies	4-4.9 hours = 8
1-1.9 hours = 14	5-5.9 hours = 3
2-2.9 hours = 9	10 hours = 1
3-3.9 hours = 3	

Types of Personnel Who Perform Monitoring (N=55)

Nurse = 40 agencies
Multiple or team = 14
Social worker = 1

Ques. #15 Estimated Average Amount of Time Spent Per Elderly Client for Reassessment Activities (N=49)

Less than 1 hour = 6 agencies	4-4.9 hours = 4
1-1.9 hours = 18	5-5.9 hours = 2
2-2.9 hours = 13	6-6.9 hours = 1
3-3.9 hours = 3	8-10 hours = 2

Types of Personnel Who Perform Reassessment (N=52)

Nurse = 31 agencies
Multiple or team = 20
Social worker = 1

Ques. #19 Approximately what percentage of your elderly clients utilize each type of service listed below?

a. skilled nursing visits (N = 49)		
0-20% = 4	60 - 85% = 9	100% = 18
21 - 59% = 6	90 - 99% = 12	
b. speech therapy (N = 37)		
≤1% = 17	6 - 20% = 3	61 - 70% = 1
2 - 5% = 16	21 - 60% = 0	71 - 100% = 0
c. physical therapy (N = 42)		
0 - 5% = 8	16 - 20% = 4	51 - 65% = 0
6 - 10% = 7	21 - 35% = 11	66 - 80% = 3
11 - 15% = 5	36 - 50% = 4	81 - 100% = 0

d. occupational therapy (N = 26)
0 - 5% = 17 11 - 30% = 3 61 - 70% = 1
6 - 10% = 5 31 - 60% = 0 71 - 100% = 0

e. home delivered meals (N = 23)
0 - 5% = 12 16 - 30% = 4 46 - 70% = 1
6 - 15% = 5 31 - 45% = 1 71 - 100% = 0

f. home health aide (N = 45)
0 - 10% = 1 31 - 40% = 5 61 - 70% = 2
11 - 20% = 2 41 - 50% = 8 71 - 80% = 10
21 - 30% = 5 51 - 60% = 2 81 - 90% = 6
91 - 100 = 4

g. homemaker (N = 29)
0 - 5% = 8 11 - 20% = 5 31 - 50% = 5
6 - 10 = 5 21 - 30% = 3 51 - 70% = 0
71 - 100% = 3

h. counseling (N = 30)
0 - 5% = 14 16 - 30% = 2 61 - 95% = 0
6 - 15% = 5 31 - 60% = 6 96 - 100% = 3

i. transportation (N = 23)
0 - 5% = 7 11 - 15% = 1 46 - 55% = 1
6 - 10% = 6 16 - 25% = 7 56 - 90% = 0
26 - 45% = 0 91 - 100% = 1

j. chore services (N = 20)
0 - 5% = 13 16 - 25% = 3 86 - 90% = 1
6 - 15% = 3 26 - 85% = 0 91 - 100% = 0

k. companion services (N = 24)
0 - 5% = 20 21 - 85% = 0 91 - 100% = 0
6 - 20% = 3 86 - 90% = 1

l. legal services (N = 10)
0 - 5% = 9 6 - 20% = 0 21 - 30% = 1
31 - 100% = 0

m. financial counseling (N = 17)
0 - 5% = 9 16 - 25% = 3 46 - 55% = 1
6 - 15% = 4 26 - 45% = 0 56 - 100% = 0

n. day care (N = 12)
0 - 5% = 11 16 - 25% = 1
6 - 15% = 0 26 - 100% = 0

o. make referrals to other providers (N = 29)
0 - 5% = 8 26 - 35% = 2 71 - 80% = 4
6 - 15% = 6 36 - 50% = 1 81 - 99% = 0
16 - 25% = 6 51 - 70% = 0 100% = 2

Ques. #20 Agency Salary Ranges

Agency Director (N=53)

\$13-20,000/year = 22 agencies
16-26,000/year = 17
18-30,000/year = 8
22-35,000/year = 4
27-42,000/year = 2

Nurse (RN) (N=56)

\$ 8-16,000/year = 28 agencies
11-22,000/year = 23
5.22-8.59/hour = 5

Nurse (LPN) (N=17)

\$ 7-16,000/year = 12 agencies
4.40-7.50/hour = 5
Not applicable = 24

Secretary (N=50)

\$6-8,000/year = 7 agencies
7-14,000/year = 27
10-17,000/year = 4
3.50-5.00/hour = 8
4.80-6.00/hour = 4
Not applicable = 2

Social Services Coordinator (MSW) (N=15)

\$ 8-20.00/visit = 3 agencies
21-35.00/visit = 4
8-10,000/year = 2
12-19,000/year = 4
15-24,000/year = 2
not applicable = 32

Social Services Coord. (BSW) (N=4)

\$7-18,000/year = 4 agencies
Not applicable = 38

Claims Processor (N=15)

\$7-13,000/year = 7 agencies
9-16,000/year = 8
Not applicable = 25

Ques. #22 "In your opinion, is there duplication between your agency and CCCI?"

Nearly all 61 of the respondents who answered question #21 also answered this question (yes = 48; no = 9). In retrospect, this question should have applied only to agencies which serve one or more towns in the CCCI service area. Separating out only those agencies, the total responses equal 38; all nine proprietary agencies that responded to the questionnaire fall into this category.

(N = 35) Yes = 29 agencies No = 6 No Response = 2
(4 of these modified
their response to read
"some")

The following comments are a sample from the "CCCI-area" respondents' answers to question #22a re the extent and type of duplication.

- "State licensure and medicare regulations, as well as our own professional ethics, dictate that we provide coordination, assessment and monitoring services for all of our home health care patients. We refer clients to CCCI for payment of covered services, not for CAM activities."
- "Assessment is major duplication although there is also coordination monitoring duplication. All 3 [CAM] functions must occur to provide high quality care. Eliminating any one of the functions increases the fragmentation of care. In addition, the process of assessing, coordinating and monitoring are usually interwoven and therefore difficult to isolate."
- "All three facets (coordinating, assessing and monitoring) are required performance from our staff as part of the overall case management."
- "As a Home Health Agency we provide coordination, monitoring and assessing services to all our elderly clients. We utilize CCCI primarily to provide funds for needed supportive services. Unfortunately, from that point on the client is frequently monitored by both agencies with duplication occurring in the supervision of the client, record keeping, data collection, and this results in confusion on the part of the client, family and the health professional."
- "Only area that specifically is not duplication is the monitoring of patient's receiving other services once VNA discharges patient. But this function is usually done by the agencies that we refer to."
- "Our agency does assessment, monitoring, coordination, implementation (providing service) + evaluation on an ongoing basis with all of our clients."
- "We have yet to find anything the CCCI can help us with that we have not already provided or arranged for."

- "Duplication in use of assessment forms only."
- "...on the surface, it could be said there is 'duplication' [but].... Licensure has created some confusion on the assessment issue...[and] over who is the Primary Care Provider....I believe the concept of the CAM is good; there is much that CCCI does that we do not."
- "Although we provide essentially the same services to our clients as CCCI, we service a different population in terms of financial resources."
- "In all areas except social services."
- "As a licensed home health care agency, we are required in planning for total needs of patients to perform all CAM functions."

Ques. #23 "If CCCI were to terminate, could your agency provide CAM services to former CCCI clients in your area?"

Nearly all 61 of the respondents to question #21 also answered this question (yes = 46; no = 8). Again, it seems more appropriate to examine the responses of the respondents who serve one or more towns also serviced by CCCI. Thirty-five of the responses to this question were from such agencies.

(N = 35)

Yes = 28 agencies*

No = 7

* Six indicated they could pick up the CCCI clients if they received more funding or added services they don't currently provide.

Responses to Ques. #23a, "If no, why not?", included:

- "Patients are unable to pay for their service through our agency, and we do not coordinate."
- "This agency is not able to provide long term custodial type of care. CCCI has the social worker to deal with these clients. Our services do not encompass care needed over an extended period of time."
- "Lack of available personnel, lack of resources (financial), time."
- "We do not have staffing or funds to maintain long term cases at home."
- "We do not employ social worker nor are there any such qualified people in any of our towns. CAM's safeguarding is invaluable as well as their carrying chronic maintenance clients."
- "This agency provides an on going assessment, coordination and monitoring related to the services delivered. We cannot begin to address eligibility, funding mechanisms available, transportation, nutrition, psychosocial needs, legal counsel, day care and the array of other needs of the elderly which are not provided by the agency. The CAM agency role removes inter-agency competition and allows for coordinated appropriate individualized delivery of services in an objective role. If the agency was to act in a CAM role, it would be necessary to hire additional staff adding to costs."

APPENDIX V

LPR&IC Questionnaire--Hospital Discharge Planners

Please answer every question on both sides of each page. (N = 21)

1. What criteria determine whether your department performs an assessment of a hospital patient prior to discharge?

MULTIPLE RESPONSES	{	<u># of Responses</u>	<u># of Responses</u>
		Illness/Diagnosis - 15	Physician's Referral - 10
		Age - 11	Nurse's Referral - 9
		Home Environment - 9	Health Team Referral - 7
		Other responses included: family requests, community agency referrals, high risk patients, repeat admissions.	

2. Which, if any, of the following items are included in your department's assessment of elderly clients? (Please answer each item and specify whether it is included in all assessments, some assessments or is not included.)

	<u>All</u>	<u>Some</u>	<u>Not Included</u>
a. personal information.....	1=18	2= 3	3
b. medical history.....	1=20	2= 1	3
c. nutrition assessment.....	1= 9	2=11	3
d. mental health status.....	1=14	2= 7	3
e. observed behavior patterns.....	1=16	2= 5	3
f. physical examination.....	1=14	2= 2	3=4
g. social contacts.....	1=10	2=11	3
h. family relationships.....	1=16	2= 5	3
i. family provision of services.....	1=15	2= 5	3
j. environmental assessment.....	1=12	2= 5	3=4
k. living expenditures.....	1= 6	2=13	3=2
l. income/financial support.....	1= 8	2=11	3=1
m. other (please specify) _____	4	3	

level of nursing care needed, past community supports,
rehabilitation potential.

3. Please estimate the average amount of time spent per elderly client on the performance of the assessment functions you identified above. Also, please indicate the type(s) of personnel who perform this activity.

<u>average amount of time spent per client</u>	<u>type(s) of personnel</u>
less than 1 hour - 10 responses	Nurses - 18 responses
1 - 1.9 hours - 4	Social Worker - 8
2 - 2.9 hours - 1	Home Care Coord. - 4
Over 3 hours - 3	Discharge Planner - 3
Unable to answer - 3	Others - 9

4. Which, if any, of the following coordination activities does your department perform for elderly clients? (Please answer each item and specify whether it is performed for all clients, some clients or it is not performed.)

	<u>All</u>	<u>Some</u>	<u>Not Performed</u>
a. a problem list is constructed for each client..	1=10	2= 7	3= 4
b. a long term plan of care is developed to meet each client's needs.....	1= 9	2=11	3= 1
c. service providers are selected.....	1=17	2= 4	3
d. the kind and amount of services to be provided are arranged.....	1=17	2= 4	3
e. a re-evaluation date for service continuation is established.....	1= 3	2= 4	3=14
f. other (please specify) _____	1	2	3

5. For an elderly client, please estimate the average amount of time spent per month on the performance of the coordination functions you identified above. Also, please indicate the type(s) of personnel who perform this activity.

<u>average amount of time spent per client</u>	<u>type(s) of personnel</u>
less than 1 hour - 6 responses	Nurses - 14
1 - 1.9 hours - 3	Social Workers - 7
2 - 2.9 hours - 4	Others - 10
Over 3 hours - 3	
Unable to answer - 5	

6. Which, if any, of the following monitoring activities does your department perform for elderly clients? (Please answer each item and specify whether it is performed for all clients, some clients or it is not performed.)

	<u>All</u>	<u>Some</u>	<u>Not Performed</u>
a. contact is maintained by telephone with clients and/or primary supporters to insure the quantity and quality of service delivery.....	1=5	2=7	3=9
b. providers are required to submit periodic written reports which detail the client's status and the service provided.....	1=4	2=11	3=5
c. other (please specify) _____	1=1	2= 2	3

providers requested, not required, to submit reports; periodic case conferences are held.

7. For an elderly client, please indicate the average amount of time spent per month on the performance of the monitoring functions you identified above. Also please indicate the type(s) of personnel who perform this activity.

<u>average amount of time spent per client</u>	<u>type(s) of personnel</u>
less than 1 hour - 11 responses	Nurses - 13
1 - 1.9 hours - 1	Social Workers - 4
2 - 2.9 hours - 3	Others 5
Over 3 hours - 1	
unable to answer - 5	

8. Please indicate for each service listed below whether your department makes arrangements for a client to receive the service, refers a client to an agency which provides the service or does neither.

	<u>Arranges</u>	<u>Refers</u>	<u>Neither</u>
a. skilled nursing visits.....	1=10	2= 9	3
b. speech therapy.....	1= 7	2=13	3
c. physical therapy.....	1= 7	2=13	3
d. occupational therapy.....	1= 6	2=14	3
e. home delivered meals.....	1=11	2= 9	3
f. home health aide.....	1= 8	2=12	3
g. homemaker.....	1=10	2=10	3
h. counseling.....	1= 9	2=11	3
i. transportation.....	1=13	2=8	3
j. chore services.....	1= 3	2=17	3
k. companion services.....	1= 4	2=16	3=1
l. legal services.....	1= 2	2=17	3=2
m. financial counseling.....	1= 9	2=12	3
n. day care.....	1= 1	2=15	3=4
o. other (please specify) _____ medical/surgical supplies, lab services, nursing home placement, volunteer agencies.	1= 9	2= 2	3

9. Connecticut Community Care, Inc. (CCCI) is a private nonprofit organization under contract with the State Department on Aging to provide the coordination, assessment and monitoring (CAM) service element of the state supported elderly home care program. Have you ever heard of the CCCI organization?

20 yes 1 no (Skip to end.)

10. If yes, under what, if any, circumstances does your department come into contact with CCCI? (Please check as many responses as are appropriate.)

- 14 a. your department refers clients to CCCI
- 4 b. a department employee serves on the Board of CCCI
- 4 c. a department employee meets to discuss/exchange information with CCCI staff
- 3 d. have no contact with CCCI
- 5 e. other (please specify) _____ serves on committee with CCCI staff, _____ maintains communications with CCCI when CCCI clients are hospitalized.

11. In your opinion, is there duplication between your agency and CCCI?

6 yes 12 no

12. If yes, please indicate the extent and type of duplication. (Please give specific examples.)

Thank you for completing this questionnaire.

APPENDIX VI

LPR&IC Questionnaire - CCCI Staff

Please answer every question on each page.

(N=22)

1. How long have you been working with Connecticut's elderly home care program (either with SAIL or CCCI, etc.)? Average = 29 months

Social Services Coordinator - 15

Nurse Coordinator - 6

2. What is your job title? Case Coordinator - 1

3. On the average, what is your client caseload per month? Average=75 clients

4. A list of coordination, assessment, monitoring and reassessment activities follows. For a typical client, please estimate approximately how many hours you spend per month on the performance of the following functions.

less than 1 hr.	1-1 $\frac{3}{4}$	2	2 $\frac{1}{2}$ -3	3+	
0	0	8	11	2	a) perform an initial assessment (using form CS-11)
10	4	1	0	1	b) construct a problem list
7	2	0	3	2	c) develop a plan of care
13	2	0	0	0	d) select service providers
9	5	2	0	0	e) arrange the kind and amount of services to be delivered
5	6	4	1	0	f) maintain contact by telephone with clients and/or primary supporters to insure the quantity and quality of service delivery
14	2	1	0	0	g) verify written reports submitted by service providers detailing the services delivered and client status
0	18	2	0	1	h) visit clients in their homes to update characteristics noted on the original assessment
7	5	3	1	0	i) if appropriate, modify the existing plan of care to meet new or changed needs

5. Under what, if any, circumstances do you come in contact with licensed home health care agencies? (Please check as many responses as are appropriate.)

<u>0</u>	a. have no contact with home health care agencies
<u>22</u>	b. home health care agencies refer clients to CCCI
<u>19</u>	c. you refer clients to home health care agencies
<u>22</u>	d. you meet to discuss/exchange information with home health care agency staff
<u>10</u>	e. other (please specify) <u>Professional advisory boards, joint visits, consultation, service training, case conferences.</u>

6. Please explain why you think there is or is not duplication between the services provided by CCCI and licensed home health care agencies. (Please include specific examples.)

See Attachment 1

7. Approximately what percentage of your time per week is spent on the following activities? (The total should equal 100%.)

<u>28</u>	%	client visits (assessments, reassessments, and any other visits)
<u>28</u>	%	paperwork (in the office)
<u>8</u>	%	travel (to visits, meetings, etc.)
<u>28</u>	%	telephone conversations (with clients, providers, etc.)
<u>5</u>	%	attending meetings
<u>4</u>	%	other (please specify) <u>Conferences with family, advisory meetings,</u>
		<u>court appearances, training, office duties.</u>

Total = 100%

Thank you for completing this questionnaire.

Attachment 1

Sample Questionnaire Responses from CCCI Staff

Listed below are sample responses to one of the questions included on the LPR&IC questionnaire sent to CCCI staff who deal directly with elderly clients. The question read: "Please explain why you think there is or is not duplication between the services provided by CCCI and licensed home health care agencies. (Please include specific examples.)" Twenty-seven questionnaires were distributed; all 22 of the respondents indicated they did not believe there was duplication.

Sample Responses

- "CCCI is the only agency currently existing that uses a holistic approach, assessing and following a client physically, emotionally, socially and financially."
- "CCCI is a 'single entry' agency that coordinates a whole range of client needs so that the client is not faced with trying to work with a number of agencies."
- "CCCI offers a continuum of care."
- "Our jobs go beyond other agencies, to work specifically with the elderly, through thorough assessments and long-term involvement."
- "This is a social service agency where medical needs of the individual are incidental to the total care plan of the individual."
- "Our assessment is of the total needs of a person, not just a primary rehabilitative medical need."
- "VNAs do not utilize the team approach, which includes a comprehensive physical/psychological assessment."
- "CCCI utilizes multiple providers to construct the best possible care plan for the client."
- "There is no other agency that identifies all unmet needs of the elderly."
- "CCCI keeps clients open on the basis of need and not on financial status."
- "There is no duplication of services between CCCI and home health care agencies since the latter provides direct services to clients and CCCI does not. CCCI executes a CAM function."

- "CCCI is 'client centered' in the delivery of CAM services."
- "There is not a duplication of services for several reasons including the much broader scope of CCCI's assessment, the long-term monitoring of clients, and CCCI's ability to follow clients throughout the continuum of care (hospitals, nursing homes, at home)."
- "There is no duplication [because:] a) There is no other CAM agency which initially assesses and continues to assess and monitor the entire situation.... b) CAM agencies coordinate many funding sources, especially the family's contribution, and often find that in order to give proper care many agencies are needed.... c) The hospital discharge planners close their cases when the patient leaves the hospital, and their assessment is based on the patient's condition while in the hospital."

