Cost Containment Study: Home Care

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HOME CARE

— The Second in a Series of Studies Relating to the Containment of Costs in Minnesota's Medicaid and General Assistance Medical Care Programs

"Up to $175,000 of the appropriation made in Laws, 1977, Chapter 455, Section 19, Subdivision 2, to the state planning agency for human services board grants may be **used to support the development of a human services data base, including, but not limited to, an examination of existing home care programs, their current funding sources and an estimate of additional services needed . . .**"

— 1978 Laws of Minnesota, Chapter 793, Sec. 6, Subd. 1

HOME CARE

EXECUTIVE SUMMARY

INTRODUCTION

Concern with long-term care issues has grown in recent years, due largely to the realization that a rapidly increasing elderly and disabled population with a longer life expectancy is resulting in an expansion of a segment of the population with high health and support service needs. With escalating costs of institutional care, particularly within the Medicaid program, and concern over inappropriate placement of individuals into institutional settings, there has been increasing emphasis on placing individuals in appropriate, less intensive and less costly levels of long-term care.

In Minnesota, of the over $400 million spent in the Medicaid program, 65 percent supports nursing home care. Less than 0.4 percent is spent on non-institutional long-term care. Although long-term care encompasses an increasing variety of forms, public resources disproportionately support the institutional types.

Long-term care encompasses a spectrum of services and settings which allows individuals a choice of the type of care which most appropriately fits their needs. This report deals with what is considered the least restrictive setting of the long-term care system — home care.

Home care consists of long-term care services provided in the client's home. It includes services needed by individuals if they are to remain in their own homes including: chore, homemaking, home-delivered meals, transportation, home health aide, attendant/personal care, home nursing, respite care and family subsidies.

In Minnesota the primary goals of home care have been the prevention of inappropriate or premature institutionalization, the removal of individuals currently in nursing homes who need not be there, the reduction of the cost of long-term care services, and the provision of an option preferred by many persons. However, these goals may not apply to all individuals. There will always be a need for institutionalization in certain cases. An expanded home care system will not close down nursing homes; it may not even remove a large number of people from them. It does attempt to prevent the elderly and disabled from entering institutions or to delay their admission for months or years. When an individual's impairment level eventually requires an intensive package of home care services, institutionalization may be appropriate. It is also not clear whether home care will be less expensive. Costs will depend on client impairment levels, quality of care, types of care provided, available family support and service utilization. Cost savings may be a long-run phenomenon whereby a number of years are needed before the effect of this preventive approach will be seen.

As a result of the concern over the costs of long-term care and the perceived advantages of home care the 1978 Minnesota Legislature mandated an examination of state home care programs, their current funding sources and an estimate of additional services needed. This report is a response to that mandate.

Section One: An Examination of the Minnesota Home Care System

This section examines all of the programs in Minnesota that fund or provide home care services. Each program is examined in terms of the overall program, administration, funding sources, eligibility criteria, home care services offered, current home care expenditures, and number of clients served.

At least $26.7 million is currently spent annually for home care services in Minnesota through public programs. Of this amount, 15 percent represents state expenditures, 43 percent is federal and 32 percent is local and other non-federal funds. In addition, an undetermined amount of private funds, both from agencies and individuals, is spent for home care services.

In Minnesota there are more than 16 sources of funding for home care services which are administered by six federal agencies, three state agencies, over 300 local agencies and uncounted private sector providers. Each program has different eligibility criteria, services and restrictions.

The public programs funding home care services are listed by administrative agency.

Department of Public Welfare

Medicaid (Title XIX)
General Assistance Medical Care (GAMC)

Department of Public Welfare (Continued)

Catastrophic Health Expense Protection Program
Title XX of the Social Security Act
Title III of the Older Americans Act
Title VII of the Older Americans Act
Mental Retardation Family Subsidy Program
Title IV-B of the Social Security Act
Cost of Care

Department of Health

Community Health Services

Department of Economic Security

Community Action Program
Vocational Rehabilitation

Social Security Administration

Medicare (Title XVIII)

Veterans Administration

Veterans Administration Home Health Care

ACTION

Senior Companion

Housing and Urban Development

Community Development Block Grants

Section Two: An Examination of the Need for Home Care in Minnesota

This section defines the three target population groups for this report — the elderly, the physically disabled and the developmentally disabled — in terms of their numbers and their need for home care services. This section also estimates the number of these individuals who are potentially in need of home care in order to prevent institutionalization and those who could be removed from institutional placement.

Estimation of need for home care is a difficult task because need depends on several factors about which very little information has been collected. The following numbers are ranges of estimates determined by applying needs estimates from the literature and from other states to Minnesota population statistics.

The following table summarizes the current number of people potentially in need of home care services in Minnesota. These figures indicate the number of people who potentially need formal services from either public or private sources. They do not indicate potential demand for these services nor the number of individuals currently served by home care programs.

THE NON-INSTITUTIONALIZED POPULATION

Elderly	
Chore	38,000
Transportation	30,600
Homemaking	13,005
Personal Care	7,680
Physically Disabled	
Chore	62,816
Transportation	102,696
Homemaking	62,816
Personal Care	50,195
Developmentally Disabled	
Chore	1,817-10,250
Transportation	1,817-10,250
Homemaking	1,817-10,250
Personal Care	1,817-10,250
TOTAL	
Chore	102,633-111,066
Transportation	135,113-143,546
Homemaking	77,638-86,071
Personal Care	59,692-68,125

The need for home health aide services, home nursing and home-delivered meals is not estimated since it depends primarily on an individual's condition rather than functional limitations. This information is not available. There are an estimated 325,000 families caring for impaired elderly, physically disabled and developmentally disabled individuals. Although not all these families will require formal respite care services, they are the potential population in need.

THE INSTITUTIONALIZED POPULATION

Good Potential for Restoration to Independent Living

Elderly	639
Nonelderly	320
TOTAL	**959**

Moderate Potential for Restoration to Independent Living

Elderly	1,489
Nonelderly	857
TOTAL	**2,346**

Section Three: An Analysis of Minnesota's Supply of Home Care Services

This section assesses the adequacy of Minnesota's supply of home care services. Determining the adequacy, however, entails more than identifying which services are and are not available. The adequacy of the supply of services depends upon many factors including the size of the population needing each service (i.e., the client impairment levels and the consequent levels of needed services), the demand for each service, the availability of current programs and services, the eligibility criteria of the various programs and the program restrictions. This section examines these factors and determines how they influence the adequacy of service supply.

The following are prioritized lists of the services which should be expanded in the state. The first list consists of the services which need to be expanded statewide. The second list consists of those services which need expansion in certain areas of the state but may not be needed in others.

Services in Need of Statewide Expansion

1) Attendant/Personal Care
2) Homemaking Services
3) Respite Care
4) Family Subsidies

Services in Need of Expansion in Certain Areas of the State

1) Chore Services
2) Transportation Services
3) Home-Delivered Meals

In addition to the problem of the supply of home care services, the following is a list of other issues of concern regarding Minnesota's home care system.

1) Funding mechanisms make institutionalization a less expensive option for counties. Under current Department of Public Welfare programs, counties pay only four percent of institutional care costs under Title XIX (Medicaid), but from 60-100 percent of home care costs under Title XX.
2) The long-term care system is fragmented making it difficult for individuals to get a package of needed care. The individual with multiple needs seeking assistance may be confronted with an assortment of agencies, each with one or more of the needed services, with an array of eligibility regulations, varying rules on how services are provided, and overlapping jurisdictions. Arranging all needed services may be even more difficult for persons with mental confusion, physical frailty or mobility limitations. Once services are arranged, the agencies may operate independently of each other.
3) There are few viable long-term care options for individuals other than institutionalization. Because of the difficulties in finding and obtaining a needed package of services, and because of current funding mechanisms, institutional placement is often the most viable long-term care option.
4) There is a lack of information about the availability of home care services. This lack of information on the part of individuals, physicians and agencies can result in unnecessary institutionalization.
5) Eligibility criteria frequently are limited to certain population groups, leaving out other needy individuals. Current programs emphasize low-income individuals, making it difficult for middle-income persons to obtain care. Some programs are limited to the elderly, resulting in the exclusion of younger disabled individuals.
6) There is very little regulation or quality assurance of home care agencies, particularly those which do not receive public reimbursement. There are few training requirements for home care workers.

Section Four: Legislative Recommendations

1) The legislature should appropriate a minimum of $5,000,000 in state funds for home care to be distributed to county boards.
2) A pre-admission screening program for Medicaid should be put into effect to prevent inappropriate nursing home placement, possibly on a demonstration basis.

3) Homemaker services should be included under the Title XIX Attendant Care Program.
4) The legislature should make the following modifications in the Mental Retardation Family Subsidy Program:
   - make this a permanent rather than a pilot program,
   - include developmentally disabled individuals,
   - remove the 50-family limit,
   - award subsidies on a per-child basis rather than per-family basis,
   - waive the $250 maximum subsidy limit in selected cases, and
   - appropriate additional funds for the program.

   In addition, a similar pilot project should be conducted which would include physically disabled, developmentally disabled individuals, and elderly individuals.
5) The Minnesota Departments of Health and Public Welfare should be directed to examine methods of regulation and quality assurance for home care services.

TABLE OF CONTENTS

INTRODUCTION

In recent years long-term care* costs and their rapid escalation have been of major concern to policymakers across the nation. In 1975, approximately $12 billion was spent on long-term care in the United States. Public expenditures totaled $5.7 billion, while the private sector spent an estimated $5.9 to $7.7 billion. In Minnesota, of the over $400 million spent annually in the Medicaid program, which is the principal public funding source for long-term care, over 65 percent is paid to providers of nursing home care (compared to 38 percent nationally). However, less than 0.04 percent is paid for noninstitutional long-term care.

Long-term care expenditures are expected to continue increasing for several reasons. The elderly population, the group with the greatest health and social service needs, is growing more rapidly than any other segment of the population. Between 1970 and 1977 the national population aged 65 and over increased at a rate of 18 percent, compared with five percent for the rest of the population. The proportion of the total United States population over age 65 rose from 9.8 percent in 1970 to 10.9 percent in 1977, and by the year 2000 will be 12.2 percent, with one in eight Americans over 65 years of age. Furthermore, the oldest portion of the elderly population is growing even faster than the younger elderly. In Minnesota from 1970 to 2000, the age 60 to 64 group is expected to increase by 12 percent, the age 65 to 74 group by 16 percent, and the over age 75 group by 37 percent. With increased age, service needs tend to increase as does the risk of institutionalization.

The disabled population, like the elderly, is also believed to be increasing in size largely due to medical advances which enable more people to survive serious injury, congenital problems and diseases. These persons, however, may have serious lifetime impairments that limit their ability to live without assistance.

Along with the increased size of the population needing some type of long-term care is an increase in the life expectancy of this population. Not only are there more elderly and disabled persons, but they are living longer. The average person who reaches age 65 can expect to live another 15 years. This increase in population and potential utilization of long-term care services, combined with continued inflation, is expected to further drive up the costs of long-term care.

Another concern with the current long-term care system relates to the assertion that many people are inappropriately placed in institutions. Although it is difficult to determine what is an appropriate level of care or an appropriate placement for a variety of reasons, numerous studies have attempted to estimate the extent of this problem. The Quality Assurance Review (QAR) of the Minnesota Department of Health annually assesses the placement of all Medicaid recipients in long-term care institutions. In fiscal year 1977 the QAR determined that 14 percent of the patients assessed had a moderate or good potential for moving to a lower level of institutional care or independent living. Other national research has estimated that the percent of patients inappropriately placed in long-term care facilities could be as high as 40 percent. However, this figure indicates that the individuals could be discharged or moved to a more or less intense level of care.

ALTERNATIVES TO INSTITUTIONAL LONG-TERM CARE

As a result of this concern over the increasing costs of institutional long-term care, particularly within the Medicaid program, and the inappropriate placement of individuals into institutional care, both policymakers and advocacy groups for the elderly and disabled became interested in examining alternatives to institutional long-term care.

Long-term care encompasses a spectrum of services and settings. This spectrum or continuum of care, which ranges from skilled nursing care in an institutional setting (which is considered the most intense and restrictive level of care) to home care, includes:

home care → board and lodging → congregate housing → adult day care → adult foster care → boarding care → nursing home care → intermediate care → skilled nursing care.

*Although long-term care is commonly used only to refer to institutional care, in this report it is used in a broader sense to mean health and social services provided to the chronically ill and disabled on an ongoing basis. Chronic illness is a condition which is or is expected to be ongoing in nature or which recurs frequently.

The focus of this report is on one component — home care. Home care consists of long-term care services provided in the client's home and includes services needed by individuals in order for them to remain independent. Home care is viewed as one possible way to provide an appropriate, less intensive and less costly level of long-term care. In addition, it is often the preferred type of care for an elderly or disabled individual in need of assistance. In Minnesota the primary emphasis of home care has been on the goals of preventing inappropriate or premature institutionalization, removing individuals currently in nursing homes who need not be there, reducing the cost of long-term care services, and providing an option preferred by many persons.

Home care has frequently been purported to be more cost-effective than nursing home care, i.e., it attains the same outcome at less cost. However, such claims may be misleading, since costs of various long-term care alternatives depend upon several factors, all of which must be considered when making valid cost comparisons. These factors include the type and severity of client impairments; the type, amount and cost of needed services; the type of costs included in comparing settings; the type of agency or facility providing the services and the quality of care. Because so many variables affect costs, it cannot be said unequivocally that home care will consistently be less costly than nursing home care.

Expanded home care services may, however, save money by preventing or delaying the entrance of people into institutions. In this case cost savings from home care may be a long-run, rather than an immediate phenomenon. If home care were more widely available, it might be used as preventive care, i.e., more people might use it before their condition deteriorated to the point of requiring institutionalization. Cost savings would then be apparent in the long-run when institutionalization would be delayed and individuals who would otherwise have been institutionalized remain in their homes. However, in the short run, the fact that home care may cost less than nursing home care may be offset by the fact that home care services may be used by more people. (See Appendix B for a more detailed discussion of the cost issue.)

It has also been claimed that home care may be a more appropriate type of long-term care. However, it may not be the most appropriate in all cases. There will always be a need for institutions for severely impaired individuals. A home care system will not close down nursing homes; it may not even remove a large number of individuals from them. It does attempt to prevent the elderly and disabled from entering institutions or delay their admission for months or years. When an individual's impairment level eventually requires an intensive package of home care services, institutionalization may be appropriate.

Home care also attempts to provide an option that is preferred by many individuals. Several surveys have indicated that individuals prefer to remain in their own homes as long as possible. The intensity of this preference to retain maximum independence may be evidenced by the fact that individuals often choose to remain at home even in the absence of needed assistance.

The gerontological literature reports the possible negative effects of institutionalization, such as feelings of isolation, abandonment and depersonalization. Although it cannot be stated with certainty that institutionalization is the cause of these reactions, it does seem certain that institutionalization is regarded with fear and apprehension by most impaired individuals. Given the strong preference to remain at home, many believe that home care may promote quicker recovery or improvement in ill individuals than other forms of long-term care.

LEGISLATIVE MANDATE

Given the interest generated in home care services by concern over institutional care costs and inappropriate placements, the 1978 Legislature mandated an examination of the state's home care programs, their current funding sources and an estimate of additional services needed (1978 Laws of Minn., Chapter 793). This report is the response to that legislative mandate.

THE STUDY

This study has been jointly prepared by the Minnesota State Planning Agency and the Minnesota Department of Public Welfare and consists of the following four sections.

Section One: An Examination of the Minnesota Home Care System

This section examines all of the programs that fund or provide home care services in Minnesota.

Section Two: An Examination of the Need for Home Care in Minnesota

This section defines the three target population groups for this report — the elderly, the physically disabled and the developmentally disabled — in terms of their numbers and their potential need for home care services.

Section Three: An Analysis of Minnesota's Home Care System

This section determines the adequacy of the provision of home care services and identifies the problems with the overall home care system in Minnesota.

Section Four: Conclusions and Recommendations

This section summarizes the findings of the report and recommends legislative action to improve the home care service system in Minnesota.

During the course of this study, advice from home care consumers, providers and advocates for the elderly and disabled was solicited by means of an 18-member advisory committee appointed by the Commissioner of Public Welfare. Representatives from federal, state and county agencies involved in the provision of home care services also served on the advisory committee. This committee met monthly, reviewed all work completed for this project and assisted in the development of the legislative recommendations. (See Appendix G for a list of the individuals who participated in this advisory committee.)

DEFINITIONS

The term "home care services" can refer to a variety of services which do not always have common definitions. For the purposes of this report home care services include: chore, homemaking, home-delivered meals, transportation, home health aide, attendant/personal care, home nursing, respite care and family subsidies. These services are defined as follows:

1) **chore services** provide home repair, home maintenance and heavy cleaning;
2) **homemaking services** provide laundry, dishwashing, dusting, light cleaning, meal preparation, home management (e.g., paying bills), and grocery shopping;
3) **home-delivered meals** provide nutritious meals delivered to the individual's home;
4) **transportation services** provide transportation for emergencies, medical and therapy appointments, food stamps, grocery shopping, recreation and other activities;
5) **home health aide** care provides assistance with medication, ambulation or transfers, toileting, and general health care under a nurse's supervision;
6) **attendant/personal care** provides assistance with ordinary activities of daily living and personal care, such as bathing, dressing, grooming, toileting, ambulation and transfers;
7) **home nursing services** provide skilled nursing care by a public health nurse, a registered nurse or a licensed practical nurse in the home;
8) **respite care** provides relief for families who are caring for disabled or elderly individuals in their homes by allowing for time off from their responsibilities; and
9) **family subsidies** provide financial assistance to those families who decide to care for disabled or elderly family members in their home rather than placing them in institutions.

SECTION ONE

AN EXAMINATION OF THE MINNESOTA HOME CARE SYSTEM

INTRODUCTION

Before the need for additional home care services can be assessed, the entire home care system in the state must be examined. This examination attempts to determine the amount of home care services delivered in the state, current expenditures and the number and type of clients being served. All the programs in the state involved in the funding or provision of home care are identified and the following information is presented for each program: a description of the overall program, program administration, funding sources, services offered and eligibility criteria.

TITLE XX OF THE SOCIAL SECURITY ACT (Social Services)

General Program Description

When the Title XX Social Services program went into effect on October 1, 1975, it became the largest single source of federal social services funding. The program was meant to consolidate and replace the social services provisions in Titles IV-A and VI. It was particularly significant, however, because it provided the states with maximum flexibility in determining needs, defining services and planning for the delivery of services. A federal funding ceiling of $2.5 billion was imposed at the time of enactment. However, a temporary increase of $400 million will be in effect during fiscal year 1979. (Two hundred million dollars of this increase is earmarked for child day care services. The use of the remaining $200 million may be determined by the states.) This money is allocated to the states based on population and the amount of state matching money. Approximately $46 million is allocated to Minnesota for federal fiscal year 1979. The law stipulates a 75 percent federal/25 percent state match for most services and a 50/50 match for program administration. However, rather than providing a 75 percent matching rate for services, the federal Title XX allocation funded approximately 37 percent of Minnesota's total services expenditures in fiscal year 1977.

Eligibility

Title XX is directed at individuals who are recipients of Aid to Families with Dependent Children (AFDC), Supplementary Security Income (SSI) or Minnesota Supplemental Aid (MSA). However, individuals with incomes under 115 percent of the state median income are also eligible. Federal regulations stipulate that individuals with an income between 80 and 115 percent of the state median income are required to pay a fee for the services provided. The state has the option of lowering the 80 percent level, and in Minnesota it is set at 60 percent of the state median income. The following is a summary of Title XX eligibility.

Eligible	Fees Required
Recipients of AFDC, SSI, MSA	No
0-60 percent of state median income	No
60-115 percent of state median income	Yes
Not Eligible	
Over 115 percent of state median income	Not Applicable

Services

Title XX established five goals for services provided under the program. They are: 1) self-support, 2) self-sufficiency, 3) the prevention of neglect, abuse or exploitation of children or adults, and the preservation of families, 4) the prevention of inappropriate institutional care through community-based programs, and 5) the provision of institutional care where appropriate. At least one service must be directed at each of the five goals. Twenty-five services are available through the Title XX program in Minnesota.

Program Administration

There are three levels of administration in Title XX: the federal Department of Health, Education and Welfare, the Minnesota Department of Public Welfare and the county welfare departments. Each level has separate, although not mutually exclusive, responsibilities. The Department of Health, Education and Welfare has responsibility for providing funding to the states at a level of $2.5 billion, setting broad guidelines through regulation, providing technical assistance and ultimately approving states' social services plans.

The Department of Public Welfare has a limited role in the administration of Title XX. The state approves the counties' social services plans, compiles the state plan and sets further guidelines for counties, specifically designating the services which are mandatory, priority or optional for county provision. The state's role in funding is limited to paying for program administration and approximately 5 percent of service expenditures.

The county welfare agencies have primary responsibility for the Title XX program in Minnesota. The county determines eligibility, decides which services should be provided, purchases the services to be provided to the client or provides those services directly, collects fees, provides additional funding over and above the federal allotment, and compiles the county social services plan.

Home Care Services

Title XX includes the following home care services:

1) chore services (a priority service for SSI/MSA recipients, optional for all other eligible individuals),
2) homemaking services (a priority service),
3) home-delivered meals (a priority service for SSI/MSA recipients, optional for all other eligible individuals), and
4) transportation services (a priority service for SSI/MSA recipients, optional for all other eligible individuals).

In Appendix C, data are presented to describe the services provided in Minnesota. The charts in Appendix C indicate, by county, total social services expenditures, federal Title XX allotment, amount and percent of local effort, total home care expenditures, home care as a percent of total social services expenditures, expenditures and number of clients for each home care service, and the amount of money from each funding source. The following table is a statewide summary of that data.

Title XX Program Data
Fiscal Year 1977

Total Social Service Expenditures	$104,895,600
Federal Title XX Allotment	39,000,000
Local Effort	65,895,600
Percent Increase of Local Effort over Federal Title XX Allotment (county range: 69 percent to 1256.5 percent)	169%
Total Annual Home Care Expenditures	$11,006,141
Chore	3,111,565
Home-delivered Meals	195,428
Homemaking	6,495,323
Transportation	1,203,825
Home Care as a Percent of Total Social Services Expenditures (county range: 3.1 percent to 40.4 percent)	10.5%
Share of Home Care Expenditures	
Federal	53.1%
State	5.1%
County	41.6%
Other	.2%

Number of Counties/Geographic Service Areas Providing or Purchasing:

	Number	Percentage
All Four Services	35	40%
Three Services	42	48%
Two Services	9	11%
One Service	0	0%
No Service	1	1%

Unduplicated Clients Served Annually:

	Total	Aged	Blind & Disabled	Others
Chore	6,515	1,244	916	4,355
Meals	2,163	250	237	1,676
Homemaking	7,372	915	841	5,616
Transportation	7,925	546	974	6,405

Source: FY'77 Title XX State Plan and Social Service Reporting Requirement (SSRR).

Home Care Program Restrictions

The Title XX program restricts the provision of home care to those in need in the following ways.

1) The eligibility criteria limit Title XX services to public assistance recipients or low-income individuals who are not necessarily the home care needy.
2) There is no assurance that the services will be provided in all geographic areas in the state. Counties have the option of not providing home care services.
3) Federal funding is limited resulting in considerable competition between the various social services for funds. The funding ceiling of Title XX has not been increased since the enactment of the law which in effect means a lower funding level due to the erosion caused by inflation. In fiscal year 1977 the federal government funded only 37 percent of Minnesota's social service programs rather than the 75 percent as indicated by matching rates.

TITLE XIX OF THE SOCIAL SECURITY ACT (Medicaid)

General Program Description

In 1965, Title XIX became part of the Social Security Act. It replaced medical coverage previously provided under the Old Age Assistance, Aid to the Blind, Aid to the Disabled, Aid to Families with Dependent Children (AFDC) programs and many state medical assistance programs. Title XIX created a single program for medical assistance with nationwide standards for eligibility and services provided. However, states retained a great deal of flexibility in determining which groups of individuals would be served and which services would be provided. Federal regulations only require states to provide eight mandatory services to cash assistance (AFDC) recipients. States have the option of providing additional services or serving additional groups of individuals (within limits of federal regulations). Minnesota has an extensive program providing all allowable services to all possible eligible individuals. The federal government provides reimbursement to the states on the basis of the AFDC matching rate which in Minnesota is approximately 55 percent. This matching rate varies from state to state.

Eligibility

There are two general categories of individuals eligible to receive Medicaid: the categorically needy and the medically needy. The categorically needy are those individuals who receive or are eligible for payments through the AFDC or the Minnesota Supplemental Aid (MSA) programs. The medically needy are those individuals who, though not eligible for cash assistance under AFDC or MSA, have sufficiently high medical bills to qualify for medical assistance. In order to receive Medicaid under the medically needy category, individuals must meet all eligibility requirements of the AFDC or MSA program except income eligibility. In other words, they must be one of the following: over 64, blind, disabled, under 21, or a caretaker of a dependent child as defined by AFDC.

The medically needy group must "spend-down" to become eligible for the Medicaid program. This requires individuals to incur medical expenses in the amount by which their income exceeds the AFDC standard of need. These expenses remain the responsibility of the individual. Once the "spend-down" amount has been incurred, Medicaid will pay the remainder of the medical bill and all medical expenses incurred during the period of eligibility.

The basis of eligibility, whether due to a categorical or medical need, is important because it affects the types of medical services which states must make available to Medicaid recipients.

Service Categories

Federal regulations divide medical services into two categories: mandatory and optional. The mandatory services must be provided by the state to the categorically needy. They are as follows:

1) inpatient hospital services,
2) outpatient hospital services,
3) laboratory and X-ray services,
4) skilled nursing facility services for individuals over 21 years of age,
5) early and periodic screening, diagnosis and treatment (EPSDT) for individuals under 21 years of age,
6) family planning services and supplies,
7) physician services, and
8) home health care.

A state may also choose to extend these services to the medically needy and has the option of providing additional or "optional" services to either or both the categorically needy and the medically needy. Minnesota provides both mandatory and optional services to all eligible individuals under Medicaid.

Program Administration

There are three levels of administration in the Medicaid program: the federal Department of Health, Education and Welfare, the Minnesota Department of Public Welfare and the county welfare departments. The federal government's role lies mainly with the provision of funding. Minnesota receives reimbursement from the federal government at a level of 55.26 percent on an open-ended basis.* The federal government also provides nationwide standards for eligibility and provision of service.

As mentioned earlier, states have discretion to pattern the program to their needs. The state determines which categories of individuals, beyond AFDC recipients, will be provided services and which services, beyond those eight mandated, will be provided. In Minnesota, the state government also provides 40.26 percent of the funding for Medicaid expenditures and is responsible for making payments to the providers.

The county welfare departments have limited responsibility under the Medicaid program. Their funding role in Minnesota is limited to 4.48 percent of expenditures, however, their primary responsibility lies in determining individual eligibility for the program and submitting this information to the state welfare department.

Home Care Services

Under Medicaid regulations all states must provide home health services including home nursing and home health aide services. Attendant care services are optional. In Minnesota three categories of home care services are provided: home health aide services, private duty nursing services (including attendant care) and medical transportation. These services amount to 1.2 percent of the total program expenditures.

*There is no ceiling on Medicaid funding at the federal or state level.

Home health care under Medicaid is generally defined as health care prescribed by a physician and provided to individuals in their own home on a part-time or intermittent basis by a certified home health agency. A certified home health agency is a public or private nonprofit agency which has been certified for the Title XVIII (Medicare) program through the Minnesota Department of Health.

Transportation services are limited to medically-related transportation only. In addition, this service is only allowed when other modes of transportation will not suffice and the service is medically necessary.

Attendant or personal care services are services provided in the recipient's home by a qualified attendant. Services must be prescribed by a physician and under the direction of a registered nurse. Attendants can be reimbursed for health-related or medically-related support services and live-in assistance. At this time the program will not pay for any social services provided by the attendant. Relatives of the recipient cannot be paid for providing these services.

In Appendix C data are presented which detail the provision of home care services through the Medicaid program by county. The following is a statewide summary of that data.

Medicaid Program Data
Fiscal Year 1977

Total Annual Medicaid Expenditures	$367,624,575
Total Annual Home Care Expenditures	4,253,399
Home Health Care	1,725,974
Private Duty Nursing	227,425
(Attendant Care Services)	(169,000)
Medical Transportation	2,300,000
Home Care Expenditures as a Percentage of Total Annual Medicaid Expenditures	1.2%
Home Care Clients Served	
Home Health Care	6,700
Private Duty Nursing	243
(Attendant Care Services)	(67)
Medical Transportation (est.)	8,000

Share of Home Care Expenditures	Percentage	Expenditure
Federal	55.26%	$2,350,428
State	40.26%	1,712,418
County	4.48%	190,552

Source: Medicaid Management Information System (MMIS).

Home Care Program Restrictions

1) There is an emphasis on home **health** care only. Medicaid does not pay for services such as homemaker, chore, meals or non-medically-related transportation.
2) The eligible population is limited to low-income individuals or cash assistance recipients.
3) Home health services are mandatory for cash assistance recipients only.
4) Attendant (personal) care, although provided in Minnesota, is an optional service.
5) A physician must prescribe the services.
6) The services generally emphasize acute rather than chronic care. (Services must be provided on a part-time, intermittent basis.)
7) Services must be provided by or under the supervision of a registered nurse.

GENERAL ASSISTANCE MEDICAL CARE (GAMC)

General Program Description

General Assistance Medical Care was implemented statewide on January 1, 1976. Prior to that time, medical services for persons who were not eligible for Medicaid were provided by counties through the General Relief/Medical Care program. Eligibility and coverage varied from county to county. When the GAMC program was established, the local General Relief/Medical Care programs were combined into a statewide program patterned after Medicaid's service coverage and eligibility, but based upon a client's ineligibility for Medicaid. The GAMC program expanded the former General Relief/Medical Care program in many counties, not only in standardizing eligibility criteria but also in making a greater range of services available.

General Assistance Medical Care payments in 1977 totaled $22,680,000. Between April and June of 1977, the average number of persons served per month under GAMC was 8,282. In comparison, the Medicaid program served an average of 114,024 recipients during the same time period.

Eligibility

An individual's eligibility for GAMC is based upon:

1) a medical need which the client has but cannot afford, and
2) ineligibility for Medicaid.

Therefore, if a client cannot receive Medicaid because s/he is not over 64, under 21, disabled, or a single caretaker of a dependent child under AFDC standards, GAMC is the program through which the client would be served. Excess income is subject to a "spend-down" under GAMC as it is under Medicaid.

Services

The state has chosen to provide the same service coverage as under Medicaid.

Program Administration

General Assistance Medical Care is administered at the state level by the Minnesota Department of Public Welfare and at the local level by the county welfare departments. GAMC costs are funded at a rate of 90 percent by the state and 10 percent by the county. There is no federal reimbursement because GAMC is a state/county program.

Home Care Services

The same service and provider requirements under Medicaid are applicable to GAMC. For this reason, the program restrictions on home care are also essentially the same for both programs.

GAMC Program Data
Fiscal Year 1977

Total Annual GAMC Expenditures	$22,680,000
Total Annual GAMC Home Care Expenditures (est.)	157,000
Home Health Care	14,000
Nursing Care	19,000
Medical Transportation	124,000
Home Care as Percentage of Total GAMC Expenditures	.69%

Source: Medicaid Management Information System, MMIS 00239.

THE OLDER AMERICANS ACT – SOCIAL AND NUTRITION SERVICES

General Program Description

The 1965 Older Americans Act (OAA) was created to assist in the development of new and improved programs to meet the needs of older persons. Until October, 1978, the Act contained separate titles for social services (Title III), senior centers (Title V), nutrition services (Title VII), and other aging-related programs. The 1978 amendments to the Act consolidated Titles III, V, and VII into a new, expanded Title III with separate appropriations for social services, congregate dining and home-delivered meals. Regulations on the amendments will not be issued until Spring of 1979. This report, therefore, describes current program operations with amended portions noted.

Under the old Title III, grants are available to develop and expand comprehensive and coordinated services for older persons. Funds are awarded annually to local public and private nonprofit agencies, usually for up to three years, on a federal/nonfederal matching basis with decreasing federal support each year. The match ratio changes from 90 percent federal/10 percent nonfederal in the first project year to 75/25 and 50/50 in the second and third years, respectively. After the third year, provider agencies are expected to secure ongoing funding to continue service provision.

Title VII is designed to promote better health through improved nutrition and to reduce isolation among the elderly primarily through congregate dining, but also through home-delivered meals and supporting social services. Grants are available at a constant 90 percent federal/10 percent nonfederal match, and there is no time limit on Title VII funding. Since 1975 the Minnesota Legislature has provided funds to supplement the federal Title VII program.

The 1978 OAA amendments remove the three-year time limit on projects and provide a constant match for all services, social and nutrition. The match in fiscal years 1979 and 1980 will be 90 percent federal/10 percent nonfederal, changing to 85 percent federal/15 percent nonfederal in fiscal year 1981, with the difference in the nonfederal share to be provided by the states. It appears that states will have discretion to impose their own time limits and matching rates on projects within the state. Under the amendments, all social services will be provided from one appropriation which means that the old Title III services will compete with the old Title VII social services and senior center construction, renovation and staffing.

Eligibility

Currently, Title III eligibility extends to all older persons (as defined by local projects). Although priority is given to low-income, minority, disabled and isolated persons, no means test is permitted. Title VII eligibility currently includes persons aged 60 and over and their spouses with priority given to the same groups as in Title III. The amendments appear to retain the same eligibility categories, but state that preference is to be given to persons with "the greatest economic or social needs."

Services

Currently under Title III, 23 categories of services are defined by the Minnesota Board on Aging including social, health, recreational, educational, legal and nutrition services. Four services – transportation, home care services, legal and counseling services, and residential renovation and repair – are "national priority services." This means that some or all of them must be provided in each state and at least 33 percent of a state's funds must be allocated for them.

Title VII's focus is currently on congregate dining although home-delivered meals and supporting services also are provided. These services are: outreach, transportation and escort to and from sites, information and referral, counseling, nutrition education, shopping assistance and recreation. Up to 20 percent of a state's funds may be expended on these services and up to 10 percent of meals provided may be home-delivered.

Under the amended Title III, at least 50 percent of the social service appropriation in each state must go to three categories of services: access services (transportation, outreach, and information and referral), home care services (homemaker, home health aide, visiting, telephone reassurance, and chore), and legal services, with some funds spent in each category.

Program Administration

Older Americans Act programs are conducted

by a "network on aging" consisting of the federal Administration on Aging (AOA), the Minnesota Board on Aging in the Department of Public Welfare, and nine substate area agencies on aging which deal with local organizations. Both Titles III and VII provide considerable state and substate flexibility in determining services to be provided and program operations which best meet local needs.

The AOA's role in Titles III and VII includes policy development, state plan approval, distribution of federal funds according to a statutory formula, and technical assistance to states. The Minnesota Board on Aging's role differs for Titles III and VII. For Title III the Board distributes the state's federal allocation to the area agencies; develops a state plan, policies and procedures; monitors and evaluates area agency activities; and provides technical assistance to them. Major program responsibility rests with the area agencies whose role includes area planning, grants administration and service monitoring. The area agencies make grants to public or private, nonprofit agencies to provide services. Except in unusual circumstances, neither the state nor the area agencies may provide services directly.

Administrative responsibility for Title VII currently is with the Minnesota Board on Aging which develops and implements policies, negotiates and awards grants to substate projects, monitors and assesses program operations and provides technical assistance to projects. The state is divided into 18 project areas each with a single grant recipient. These 18 projects have 247 congregate sites. The local projects have overall responsibility for program operations within guidelines set by the state.

Under the new Title III the area agencies will assume greater administrative responsibility for nutrition programs in addition to their role in social services. This joint administrative effort has already begun in Minnesota and will be phased in over the next few years.

Home Care

Under Title VII, the Minnesota Board on Aging limits home-delivered meals to 10 percent of the meals served in the state. Congregate dining is encouraged whenever possible. Each project determines whether to provide home-delivered meals and under what conditions; these policies vary considerably among projects. Projects also have discretion regarding whether to provide any of the social services allowed under Title VII.

Currently, several home care services are provided under Title III including: transportation, homemaker, home health aide, chore and home-delivered meals. As mentioned, home care services are one of three national priority services for which one-third of a state's expenditures must be spent.

The new Title III defines several categories of services, one of which is "services to assist an older person to continue living independently in a home environment." This category includes pre-institutional evaluation and screening, home health services, homemaker services, shopping services, escort services, reader services, letter-writing services and other similar services. Transportation services are also available under Title III. Home care services (defined as homemaker, home health aide, visiting, telephone reassurance, and chore/maintenance) are one of the three categories of services which **must** be provided in each state and for which at least 50 percent of funds must be spent.

The new Act also provides separate appropriations for home-delivered and congregate meals. The amount available for home-delivered meals is expected to be significantly larger than that currently available.

Home Care Program Restrictions

Until regulations are issued, there will be uncertainty regarding program restrictions under the amended Act. Current program restrictions include the following.

1) Eligibility is limited to older persons, and services are targeted but not restricted to low-income, minority and disabled individuals.
2) Title III funds have been limited to three-year projects with increasing local participation in funding. Under the amended Act, these limitations will no longer be federally mandated, but may continue at state discretion.
3) Home-delivered meals have been limited to 10 percent of meals served in the state since the program is focused on congregate dining. Under the new Act, however, congregate and home-delivered meals have separate authorizations, and funding will be

significantly expanded for home-delivered meals.

4) Not all geographic areas are served with all services. Also, within projects, restrictions on home-delivered meals vary according to local discretion. Currently under Title VII, projects may choose not to provide home-delivered meals.
5) Although Title III includes home care services in the national priority category, they compete with other limited Title III dollars. Under the amended Act, home care services will compete with an expanded pool of services, including senior center construction and staffing, plus the old Title VII social services. Home care services, however, are assured at least some portion of the 50 percent that must be expended on the new priority services.
6) Although funds are set aside for home care services, these services may not be provided if there are no provider applications.
7) Title III funds are intended only for new or expanded service programs. This prohibits existing organizations from seeking money to maintain current service levels.

The data presented below indicate expenditures and clients served for home care services for Titles III and VII in Minnesota.

Title III
(1-1-78 to 12-31-78)

Total Direct Services Expenditures	$3,744,864
Federal	2,609,959
Non-federal (includes public and private)	1,134,905
Total Home Care Expenditures	1,477,956
Homemaker	290,129
Home Health Aide	90,471
Chore	149,458
Home-Delivered Meals	64,898
Transportation	883,000
Home Care as Percentage of Total Expenditures	40%
Clients Served (10-1-77 to 9-30-78)	
Homemaker	596
Home Health Aide	368
Other Home Care (category includes home-delivered meals and chore)	1,594
Transportation	12,402

Source: Program Performance Report for Title III, Area Agency and Social Services Information and area agency plans.

Title VII
(4-1-77 to 3-31-77)

Total Expenditures	$6,675,474
Federal	4,448,642
Title VII	4,183,882
USDA	264,760
Non-federal	2,226,832
State	743,296
Project Match	475,578
Project Income	1,007,958
Home-Delivered Meals	
Expenditures	$343,242
Meals Served	100,919
Average No. of Meals Served Per Day	566

Source: Minnesota Title VII Quarterly Statistical Report Summaries.

TITLE XVIII OF THE SOCIAL SECURITY ACT (Medicare)

General Program Description

Title XVIII of the Social Security Act (Medicare) was enacted in 1965 to provide payment for the health care of certain elderly and disabled individuals. Since Medicare is a part of the Social Security program, any individual receiving Social Security old age or disability cash benefits (OADI) is automatically eligible for benefits under this program.

There are two forms of coverage in the Medicare program: Part A (Hospital Insurance) and Part B (Medical Insurance). All beneficiaries of OADI are covered by Part A. This part consists of hospital insurance benefits which include inpatient hospital services and certain post-hospital care provided in a skilled nursing facility or the individual's home. These benefits are financed through special Social Security payroll taxes.

Part B is a voluntary, supplementary medical insurance program financed by beneficiary premiums of $8.20 per month and federal contributions which amount to approximately 70 percent of total Part B expenditures. Individuals can receive Part B coverage regardless of whether they are receiving coverage under Part A.

Program Administration

Medicare is a federally financed and administered program and provides uniform eligibility and services throughout the country. It is administered at the federal level by the Health Care Financing Administration (HCFA) under the Department of Health, Education and Welfare (DHEW). The role of HCFA involves setting regulations and guidelines for the program.

Eligibility determination is handled by the Social Security Administration's district and branch offices. Minnesota residents are served by 20 such offices. Caseworkers from those offices travel to contact stations in outlying areas to reach those individuals who find it difficult to travel to the main offices. Personal visits are made to those individuals who are homebound. Determinations of eligibility for reasons of disability are typically made by the Minnesota Division of Vocational Rehabilitation.

Claims are generally handled by fiscal intermediaries for Part A and carriers for Part B. DHEW contracts with the intermediaries and carriers to manage the claims reimbursement system. They are reimbursed by DHEW for administrative costs and any federal contributions toward the service payment. In Minnesota the Blue Cross and Blue Shield of Minnesota insurance company is the only intermediary for Part A. Blue Cross and Blue Shield of Minnesota and Travelers Insurance Company are both Part B carriers. There are also provisions for direct reimbursement from HCFA.

The Medicare intermediary/carrier determines the amount of payment for a claim based on reasonable charges. This is determined by intermediary/carrier reviews of actual charges made by providers in their geographic area during the previous year. Even though reasonable charges differ from state to state, this level of reimbursement is considered full payment under Part A. Under Part B, reimbursement is made at 80 percent of reasonable charges after the beneficiary has paid an overall annual $60 deductible. The beneficiary is responsible for paying the provider the deductible amount plus the 20 percent co-insurance amount.

Home Care Services

Home care services under Medicare are limited to home health care. These services are generally defined as:

1) part-time or intermittent nursing care provided by or under the supervision of a registered nurse,
2) physical, occupation or speech therapy,
3) medical social services, supplies and equipment, or
4) part-time or intermittent services of a home health aide under the supervision of a registered nurse.

Eligibility for these services and the extent to which they are available are dependent upon the part of Medicare under which the individual is covered. In order for the beneficiary to receive home health care under Part A, six conditions must be met.

1) The beneficiary must have been hospitalized for at least three consecutive days or cared for in a skilled nursing facility.
2) Home health care services must be for further treatment of the condition for which the individual was hospitalized or admitted to the skilled nursing facility.
3) The care needed must be part-time nursing care, physical therapy or speech therapy.
4) The individual must be confined to the home.
5) The doctor must certify the need for home health care and set up a home health plan within 14 days of discharge from the hospital or skilled nursing facility.
6) The home health agency providing the services must be certified to participate in the Medicare program.

Part A will pay 100 percent of the reasonable charge for services, but limits the number of visits to 100 per benefit period. A benefit period is defined as the twelve month period directly following the discharge from the hospital or skilled nursing facility. In addition, the physician must recertify the need for the home health services every two months.

Part B home health coverage does not include as many restrictions on eligibility. The patient, however, must have paid an overall annual $60 deductible plus a 20 percent co-insurance on all services received and is limited to 100 visits per calendar year rather than per benefit period. Part B benefits can be used when Part A coverage has been exhausted.

The following matrix details the differences in the requirements for Part A and Part B.

HOME CARE ELIGIBILITY REQUIREMENTS

Requirement	Part A	Part B
Three-day prior hospitalization	Yes	No
Condition-related treatment	Yes	No
Part-time, intermittent care	Yes	Yes
Homebound requirement	Yes	Yes
Physician determination of need	Yes	Yes
Home health plan by physician	Yes	Yes
Home health agency certified by Medicare	Yes	Yes
Visits	100/benefit period	100/calendar year
Reimbursement	100 percent of reasonable charges	80 percent of reasonable charges after payment of $60 overall annual deductible

Home Care Program Restrictions

1) Medicare tends to be a short-term acute care alternative to hospitalization. It is possible that many individuals with chronic illness or health maintenance needs could be excluded from coverage.
2) Medicare does not allow proprietary agencies to be reimbursed unless they meet state licensure requirements. Minnesota does not have these requirements.
3) Medicare limits the number of home care visits which can be used (100 per benefit period under Part A and 100 per calendar year under Part B). However, few beneficiaries exhaust these benefits.
4) Medicare requires patients to be hospitalized for three days in order to be eligible under Part A. (However, 97 percent of beneficiaries under Part A are also covered under Part B.)
5) Medicare requires patients to be homebound.
6) Medicare requires physician authorization for services.
7) Medicare does not reimburse non-health related services, e.g., homemaking or chore services.
8) Under Part A, services provided must be directly related to the condition for which the individual was hospitalized.
9) There is a strong emphasis on part-time, intermittent care.

PUBLIC HEALTH NURSING

General Program Description

Public health nursing consists of 78 agencies serving 87 counties in the state. These agencies cover 100 percent of the state's population. These agencies provide health-related services which can appropriately be received in a home or community setting. These services are provided to individuals with an evidenced need on a sliding fee scale basis.

Program Administration

Public health nursing agencies are relatively independent organizations accountable mainly to the county board of health. Public health nursing agencies may be certified for Medicare/Medicaid reimbursement by the Minnesota Department of Health. All but six agencies are so certified. Funding comes from many sources including local funds, Medicaid and Medicare reimbursement, contracts to provide services for the county welfare departments and other agencies, Veterans Administration reimbursement, fees and insurance. The predominant source of state funding is Community Health Services.

In 1976 the Minnesota Legislature passed the Community Health Services (CHS) Act which gave state funding and guidance to public health nursing agencies. The legislation provided that the state could be divided into Community Health Services areas which would be determined locally within general guidelines, including a requirement that each area have a population of at least 30,000. The emphasis was on joint local planning, with eight district offices and the Minnesota Department of Health overseeing the total operation.

Home Care Services

Home care through the public health nursing agencies focuses on the ill and disabled of all ages. The services offered are home nursing, physical therapy, nutrition, occupational therapy, speech therapy, homemaker services, medical social work and home health aide (under nursing supervision). The objective is the prevention of unnecessary institutionalization. The following is a table indicating the number and percentage of counties offering some type of home care services through their public health nursing agencies.

	Number of Counties	Percent of Counties
Home Nursing	80	92
Home Health Aide	79	91
Homemaker	74	85

Currently, all counties except Roseau provide some type of home care services through their public health nursing agencies.

In calendar year 1978, $6,351,473 was allocated for home care services out of $27,682,166 total program expenditures under the Community Health Services program. The local areas contributed a total of $5,243,974 for home care, the state contributed $1,107,499. As indicated previously, however, other money is also contributed to the provision of home care through the public health nursing agencies including local funding, Medicare, Medicaid, fees and insurance. The total home care expenditure of the public health nursing agencies is unknown.

COMMUNITY ACTION PROGRAM (CAP)

General Program Description

The Community Action Program was initially conceived during Lyndon Johnson's War on Poverty in 1966 and designed to promote economic and community development in areas with high unemployment, dependency and physical deterioration. Local governments were given responsibility for establishing community action agencies for the purposes of:

1) directing resources at the poor through local communities,
2) providing for a local coalition against poverty,
3) mobilizing resources against poverty, and
4) being an advocate for the poor.

Because community needs and resources differ widely, the Community Action Program was designed to provide as much flexibility in planning and providing for services as possible. The community action agencies provide direct services within six broad service categories: 1) head start, 2) manpower, 3) energy and housing, 4) senior citizens, 5) community food and nutrition, and 6) winterization.

Federal funding is available to cover costs of developing and administering the program. Matching rates depend on the service category but generally range from 50 percent to 80 percent federal funding. State appropriations can be used as match and in Minnesota $4.5 million was appropriated for the biennium by the legislature in 1978 for this purpose. Federal and state money is distributed directly to the community action agencies.

Program Administration

There are three levels of administration under the CAP. At the federal level, the Community Services Administration in the Department of Health, Education and Welfare is responsible for the program. At the state level, the program is administered by the State Economic Opportunity Office. In Minnesota, this is the Department of Economic Security. At the local level, the program is administered by the community action agency. In Minnesota there are 33 such agencies covering all but six counties.

The community action agencies have central responsibility for carrying out the purposes of the program at the local level. They determine objectives, select program content, operate the programs and provide direct services.

Home Care Services

Some community action agencies provide direct home care services. However, they are limited to: meal services, transportation services and chore services. In most cases these services are limited to low-income elderly in the agency's service area. The following table* gives the expenditure levels for the home care services offered by the community action agencies in Minnesota.

*More detailed data, by agency, is provided in Appendix C. These expenditures do not include any funding received through the Older Americans Act.

SERVICES

Sources of Funding	Meals	Transportation	Chore	Total
Federal	$ 29,872	$ 28,000	–	$ 57,872
Non-federal (unspecified)	38,572	73,358	$46,667	158,577
State	987	114,385	–	115,372
Local	67,522	225,077	5,000	297,599
Income (Fees)	37,456	–	–	37,456
Private Industry	500	–	–	500
Other	24,242	–	–	24,242
	$199,151	**$440,820**	**$51,667**	**$691,138**

Source: CAP service plans.

Home Care Program Restrictions

1) Limited types of home care services are available.
2) Services are targeted toward low-income individuals.
3) Home care services are targeted toward the elderly.
4) Not all geographic areas are served by the home care program.

VETERANS ADMINISTRATION HOME CARE

As an example of the types of home care services available through the Veterans Administration, the following report examines the programs of the Minneapolis Veterans Administration Hospital.

General Program Description

The Minneapolis Veterans Administration (VA) Hospital has a hospital-based home care program (HBHC) budgeted annually at $226,000. The program is available to patients after discharge from the hospital with all home care services provided by the hospital staff. Because of this, the services tend to be directed at acute care rehabilitation, although care is also provided to the chronically ill and terminally ill if those patients tend to require repeated hospitalization. The goal of the program is to reduce acute care re-admissions and the number of days in acute care hospitalization.

The home care staff consists of a team of five different professional staff including physicians, nurses, social workers, dieticians and occupational therapists. The team members needed by a patient typically visit two times per week and emphasize teaching the family members to properly meet the needs of the patient. However, the team also provides patient care.

Eligibility

Honorably discharged veterans are eligible for HBHC if they:

1) live within 30 minutes or 30 miles of the VA hospital,
2) need the services of at least three of the five health professionals on the team,
3) are homebound (cannot reach the hospital), and
4) have a friend or relative to assist with 24-hour care.

Home care is provided at no charge to the patient for as long as it is deemed necessary by the team.

Services

The services available to the patient include:

1) medical care provided by a physician, including 24-hour phone coverage,
2) part-time nursing care emphasizing teaching and assisting the family with the provision of care,
3) rehabilitative therapy,
4) counseling and arrangements for other social services by a social worker,
5) dietetic services emphasizing teaching and assisting with the provision of special diets,
6) the provision of medication, supplies and medical equipment, and
7) transportation to the VA hospital.

The following services are not provided:

1) full-time nursing care,
2) housekeeping, and
3) home-delivered meals.

Before an individual can receive care an eligibility assessment is performed. The individual must be referred to the program by the hospital staff, after which the team members visit the individual to determine the eligibility for and appropriateness of the HBHC program. If an individual lives outside the 30-mile radius from the VA hospital, services can be obtained through a certified home health agency and reimbursed through the VA.

Home Care Program Restrictions

1) The program is limited to veterans.
2) There is an emphasis on acute care treatment.
3) Services are limited to home health care.
4) Service eligibility is dependent upon the occurrence of hospitalization.
5) The program is limited to persons living near the VA hospital.
6) Patients must require service from at least three of the five team members.
7) Patients must have a source of informal assistance.

PRIVATE PROVIDERS

General Program Description

The private provision of home care services encompasses care provided both by agencies and by individuals, who may either be employed or part of the informal system of family, friends and neighbors. There is little specific information on private sector provision of services, particularly in the informal system, although studies indicate that the great majority of home care is provided by family members. Definitions of services vary greatly making it difficult to know exactly what is provided. Private providers of home care services are unevenly distributed throughout the state with about 66 percent operating in the Twin Cities area. The metropolitan area, Duluth and Rochester combined have approximately 72 percent of the state's private home care agencies. Most of the outstate agencies provide home-delivered meals (66 percent) or provide chore and housekeeping services (32 percent).*

Within the Twin Cities area there are numerous private home care agencies. Over 40 private agencies provide either home nursing, home health aide or homemaking services in Hennepin and Ramsey counties. In Hennepin county alone there are over 30 private agencies providing chore services and over 25 home-delivered meals programs.

Private agencies are a diverse group, differing along several dimensions including proprietary and non-profit, affiliation, purpose and services. Home care services are provided by agencies affiliated with or under the auspices of a variety of organizations including hospitals, churches, nursing homes, social service, health and employment agencies. Home care may be the primary type of service offered by an agency or it may be only a part of a wider range of services offered. An agency may specialize in health services, domestic services or a combination. Within each of these categories an agency may offer a range of home care services or only one. Some agencies which provide home care services are organized primarily to provide employment opportunities rather than home care services. These agencies may act as employment brokers between individuals seeking assistance and service workers, or they may provide home service employment as part of another program, e.g., providing chore services as part of a chemical dependency treatment program or a youth employment program.

While most agencies offer services for as long as the client needs and/or can pay for them, there are several private agencies which provide services only on an emergency or temporary basis until longer-term arrangements can be made. These agencies, often affiliated with churches, tend to use volunteers extensively to provide their services.

Although most private agencies that provide home care services are nonprofit, over 50 proprietary agencies operate in this state with 55 percent in Hennepin and Ramsey counties. In the Twin Cities area, proprietary agencies offer a range of services, while in the outstate areas they tend to provide only homemaking and chore services.

Eligibility

Little is known about the populations served by private providers, especially the proprietary agencies. Since the basis of eligibility for proprietary agencies is the ability to pay for services, their clientele are generally not low-income. Some of the nonprofit agencies appear to provide services to individuals who are just above the maximum income levels set by public programs. Other nonprofit agencies, such as the relatively new home health agencies, cater almost exclusively to a Medicare-eligible population.

*Data presented in this section from Home Care Agency Questionnaire. (See Appendix D.)

Financing

In addition to the public funds, such as Social Security Act Titles XVIII, XIX, XX and Older Americans Act Titles III and VII, going to private agencies for the provision of home care services, other sources of revenue include fees; client donations; contributions from businesses, churches and members; grants (including United Way funds); and private insurance.

Coverage of home health services has, until recently, been rare in private insurance policies, but in the last year and one-half has become standard and widely available in group medical policies. The home health benefits vary among insurance policies regarding the number of covered visits, deductibles and co-insurance, and requirements for prior hospitalization. The covered services, however, tend to be limited to home nursing and home health aide services.

Regulation

Private home care agencies are largely unregulated in Minnesota except when they provide services under public programs, such as Medicare, Medicaid and Title XX. Minnesota requires neither licensing nor certification of home care providers with the exception of the federally-mandated Medicare certification for home health agencies conducted by the Minnesota Department of Health. (This also is used for Medicaid providers.) As of July, 1978, there were 78 Medicare-certified home health agencies in Minnesota which served 80 counties. Six of these are hospital-based, five are nonprofit corporations and one is a health maintenance organization. The rest are public health nursing agencies.

In Minnesota only public or private nonprofit agencies may be certified. Federal regulations permit proprietary home health agencies to be certified to participate in Medicare and Medicaid if they are licensed by the state. Minnesota has no home health licensure, so the thirteen proprietary home health agencies in the state are precluded from participation in and reimbursement from these programs. Twenty-one states license home health agencies.

Regulation of personal care attendants under Medicaid consists of supervision by a registered nurse of a plan of care prescribed by a physician. The regulations do not specify how attendants are to be selected or trained or what the supervision should entail.

Thirteen states have passed certificate of need legislation for home health agencies. Such legislation attempts to relate the distribution and capacity of health services to the need for services and attempts to control quantity and cost by controlling entry into the field.

Federal law requires that by 1981 all states have a certificate of need (CON) law which contains specific provisions. While Minnesota already has a CON law, it must be modified to bring it into compliance with the federal requirements. Although federal law does not require inclusion of home health agencies in CON, these agencies may be included in such legislation. Minnesota legislation currently does not include home health agencies.

Counties set standards for social services in accordance with Department of Public Welfare rules for homemaker and chore services provided under Title XX, but counties vary in the amount of training and supervision given to their home care staff. The Department of Public Welfare standards do not apply, however, to non-publicly funded home care services.

Voluntary accreditation is available from a national organization, the National Council for Homemaker-Home Health Aide Service, Inc., which has developed basic standards for homemaker-home health aide agencies and awards accreditation to agencies which meet the standards. Two Minnesota agencies have this accreditation.

Individual Providers

Self-employed providers of attendant, homemaker, housekeeper and chore services are another segment of the private sector serving elderly and disabled persons. Individual providers are used for the Medicaid attendant care program and in counties for Title XX and county-funded home care services. In May, 1978 the United States Civil Service Commission ruled that these home care providers under individual contract are considered county employees. Counties are now responsible for the employer's share of Social Security taxes and unemployment compensation for these workers, which the counties say will increase the cost of providing home care services.

Individual providers are also hired directly by service consumers on a private pay basis. However, there have been no estimates of the extent of these arrangements or the number of persons served.

INFORMAL ASSISTANCE*

The focus on organized home care programs and services diverts attention from what is probably the major source of assistance for disabled and elderly individuals — informal assistance. Informal assistance is help from family members, friends and neighbors. For older persons this assistance is most likely to be from adult children and spouses; for disabled children, from parents; for disabled adults, from parents, spouses, or children.

While estimates of the extent of informal assistance vary, several national studies indicate that between 64 percent and 90 percent of persons receiving home care get most of their care from informal sources.[1] The studies are not clear on whether informal assistance is the only source of help or whether it is supplemented by other sources. It does seem clear, however, that most home care is provided in this way.

The caregivers and the person needing assistance may reside in the same or in separate households. In Minnesota over 70 percent of those over age 65 live with relatives: 49 percent with their spouses, 13 percent with their children, and 8 percent with other relatives.[2] If it can be assumed that persons living with impaired individuals provide some assistance, then almost three-fourths of the state's elderly would receive such assistance. Little is known about the extent of assistance from relatives or persons who live in separate households. Some evidence indicates that over 85 percent of elderly live within one hour of at least one of their children which may suggest the potential for informal assistance if not the actual receipt of such help.[3]

Informal assistance encompasses a range of types including personal care, household assistance, transportation, meal preparation and shopping. Some evidence indicates that family and friends are most likely to provide help with tasks requiring less skill, such as household tasks rather than personal care, or personal care rather than medically-related care, although they also are the major providers of these more highly-skilled tasks. Little is known, however, about the quality or adequacy of care provided informally.

One study of nonelderly, disabled persons indicated that assistance from family and friends, while the major source of help for all types of home care, was higher for less skilled tasks.[4]

Percent of Cases in Which Family was Major Source of Assistance	Tasks
91%	grocery shopping
88%	meal preparation
84%	housecleaning
78%	personal care

Another study found that about 80 percent of the elderly population who received home care had all or part of the care provided by a relative living in the household. Approximately 84 percent of the persons receiving personal care had assistance from related household members; 39 percent received care provided by other sources. (These percentages add up to more than 100 since some persons received care from both sources.) Of medically-related care, approximately 18 percent was provided by registered nurses, 73 percent by related household members and 18 percent by other persons.[5]

A study of persons discharged from rehabilitation hospitals in Massachusetts indicated that in 64 percent of cases families were the major source of assistance with daily living activities. They also provided most of the chore and household assistance (80 percent).[6]

Despite the extent to which families and other sources provide home care, several trends indicate that this provision may be reduced in the future.

1) The increasing participation of women, who provide most of the care given to elderly and disabled persons, in the labor force reduces their availability to care for impaired family members at home.
2) The trend to smaller families means there will be fewer children to care for elderly parents.
3) The increasing life expectancy means that it will be increasingly common to have families with two or more elderly generations. An 85 year old person who needs assistance, for example, may have children in their sixties who also need care and are thus unable to care for the parent.

While not much is known about the conditions under which families assist their impaired members, there is some evidence that family and other informal sources may not be viable in several types of cases. Factors which may affect the ability or willingness of family and friends to help include the following.

*Notes for this section are in Appendix F.

1) Not all older or disabled persons have family or friends to care for them: 20 percent of the elderly have no surviving children; 30 percent have no grandchildren; 20 percent have no living brothers or sisters.[7] As people age, they lose friends through death, institutionalization and for other reasons.
2) Families may require two incomes and thus not have someone available at home to care for the impaired person. Even if someone is available, a low-income family may not have the resources necessary to support an additional member, particularly one with special needs.
3) Even if an older or disabled person has relatives, family relations may not be ideal. Family members may not get along. The older or disabled person may resist becoming dependent on other family members.
4) Caring for a disabled relative may cause stress within families and may result in abuse or neglect of the dependent person. This may particularly occur if the impaired person lives with a family and if the family is rarely or never relieved of its caretaking responsibilities. Stresses may be increased if money and energy go disproportionately to the impaired person.
5) The duration of care may affect the willingness or ability to provide care. One study indicated that in 70 percent of cases families were willing to take the disabled person home and provide all care after the first discharge from a rehabilitation hospital. Where there were successive hospitalizations and no supplemental help to the family, however, the percentage of willing families dropped to 38 percent.[8]
6) The type or intensity of care required may affect willingness. One study found that while 80 percent of families felt that convalescent care at home was most desirable, about one-third could not provide it under any circumstances.[9] The family may be willing to help but if some skill is required, they may feel inadequate and defer to professional care.

Several types of services and financial incentives have been proposed or tried to encourage or help families to care for their impaired members. These services include: respite care, adult day care, and family education and counseling. The financial incentives include: payment to families for provision of specific services, monthly family subsidies for care, tax credits and tax deductions for expenses, and low cost loans for home renovation to remove barriers to the disabled or to add space to allow the frail person to live with the family.

Current public programs vary with regard to allowing payments to relatives. Such payments are prohibited under Medicare, Medicaid and General Assistance Medical Care. Under Title XX relatives or other individuals may be reimbursed if county policies allow this, however, counties may restrict payments to families only when the county is unable to otherwise deliver the service (i.e., if there are no other providers available, if the client lives in a remote area, or if the case is difficult).

Minnesota has a state-funded pilot family subsidy program for 50 families with mentally retarded children who are cared for at home rather than in institutions. This program provides monthly payments, up to $250 per family, to pay for a planned program of home care and training. Elsewhere in the country, Title XX is used to make subsidy payments to close relatives to care for elderly and disabled persons at home.

Some fear that if public support to families to care for their impaired members is increased, family responsibility will be undermined and that care formerly provided "free" by families will be paid for with public funds, resulting in greatly increased public costs.

Several providers of home care services indicate that this is not the case. In their experience families do not relinquish their responsibilities even when services are available. In most cases when the older person has some family available, the family wants to help out. One social service agency which deals primarily with elderly persons, as part of its case planning routinely asks if family members are available and willing to help and what they are able to do. The agency's services are considered residual to the informal assistance, but families are assured of help when and if it is needed.

This evidence, however, is discounted by others who fear that if payments to families become widespread and more acceptable over time, family responsibility will erode.

The basic issue regarding family assistance is how to balance family and public responsibilities in caring for impaired individuals. Where such

care becomes an economic liability or cause of stress in families, it may be necessary to reduce the burden by assisting and encouraging families through public programs. However, this assistance should be supplemental and not supplant family responsibility.

OTHER PROGRAMS

Title IV-B of the Social Security Act

Title IV-B funds child welfare social services. In Minnesota this money is typically included under Title XX but retains its target population of children, particularly those at risk of removal from the family. Title IV-B is a non-means tested program providing funding for the following home care services:

Services	Expenditures	Clients
Chore	$ 15,126	64
Homemaking	40,228	30
Home-delivered meals	1,799	17
Transportation	50,819	200
	$107,972	

The program is administered by the Department of Public Welfare.

Source: Social Service Reporting Requirement (SSRR), fiscal year 1977.

Catastrophic Health Expense Protection Program

The Catastrophic Health Expense Protection Program (CHEPP) is a state-funded program administered by the Department of Public Welfare which covers expenses for specified health services for eligible individuals. There are two parts to the CHEPP program which differ in their requirements and coverage.

CHEPP-1, which began in July, 1977, covers expenses for 14 categories of health services including home health services (up to 180 visits per year). CHEPP-2 covers nursing home expenses. Eligibility for CHEPP-1 extends to persons who incur expenses for any of the covered services which exceed 40 percent of household income up to $15,000 plus a percentage of income over $15,000, or $2,500, whichever is greater. CHEPP-1 patients are responsible for a 10 percent co-payment on covered services, with the state paying for the remaining 90 percent.

In the first 14 months that CHEPP-1 has operated, 149 cases were opened (covering 345 individuals). None of the CHEPP patients used home health services.

Senior Companion Program

The Senior Companion Program, which is administered and funded through ACTION, recruits low-income senior citizens to provide visitation to isolated persons over age 60 who live in their own homes or institutions. During their visits volunteers perform some personal assistance, such as grooming, as well as provide transportation and escort for clients. The clients tend to live alone and have chronic conditions or disabilities. Currently there are 77 senior companions in Minnesota, each serving approximately five clients during a 20 hour week. The clients are provided by 19 agencies who contract with the Senior Companion Program. There is a waiting list of agencies wanting senior companions.

Volunteers receive $1.60 per hour plus a transportation allowance. The program, which operates in 14 Minnesota counties, had an annual budget in 1977 of $395,000, of which $250,000 was from the state and $145,000 was federal.

Vocational Rehabilitation

The Minnesota Division of Vocational Rehabilitation (DVR) provides services to physically, mentally and emotionally handicapped persons to assist them in preparing for and getting employment. Services are available to disabled persons of employable age regardless of income who are expected to benefit from vocational rehabilitation services.

A wide range of services is available which are tailored to individual need. Counseling and guidance, medical and vocational evaluation, job placement assistance and short-term training are provided by DVR without cost to the client. Individuals are expected to participate in the payment of any medical treatment and long-term training costs. Some individuals are provided with limited amounts of home care services – attendant care and transportation – while they are in the vocational rehabilitation program.

The Division of Vocational Rehabilitation is part of the Minnesota Department of Economic

Security and has 30 field offices throughout the state. The basic vocational rehabilitation program has 80 percent federal and 20 percent state funding. Minnesota DVR expenditures in fiscal year 1977 totaled over $20 million. During that year 5,231 persons completed rehabilitation and became employed.

Community Development Block Grants

The 1974 Housing and Community Development Act provides federal funds to assist local governments with community development activities. The Community Development Block Grant (CDBG) program is part of the Act which consolidated several categorical programs, including Model Cities and Urban Renewal, into one program designed to rebuild and preserve urban areas. CDBG funds support a variety of programs including physical development, water and sewer projects, housing rehabilitation, human services, environmental protection, and political organization, although the focus is on physical development rather than human services.

Funds flow directly from the federal government to local governments. Cities with populations over 50,000 and certain counties with populations over 200,000 are entitled to direct CDBG grants, with other CDBG funds available on a discretionary basis to eligible applicants. Funds are allocated according to a formula whose factors include population, poverty status and overcrowded housing.

In Minnesota in fiscal year 1978, 22 localities received CDBG direct entitlement funds totaling $45,435,000, with an additional $13,705,000 of discretionary funds available to Minnesota communities. Data on the extent of these funds spent on human services or home care services are unavailable. One Minneapolis agency received CDBG funds of $368,000 in fiscal year 1978 for services to the elderly which included homemaker, chore, home-delivered meals and transportation.

Under guidelines issued in 1978 the federal Department of Housing and Urban Development requires cities to designate "Neighborhood Strategy Areas" to ensure that more of the funds are spent in the poorest areas rather than on city-wide programs. This change poses problems for some CDBG-funded agencies who are without other funding sources and who will have to restrict their services to smaller geographic areas.

The Mental Retardation Family Subsidy Program

In 1975, the Minnesota Legislature created the Mental Retardation-Family Subsidy Program, a three year experimental program which granted a public subsidy to 50 families to care for their mentally retarded child(ren) in the natural or adoptive home. Minnesota was the first state to provide direct cash assistance to families for this purpose.

The stated purpose of the legislation was to:

> "determine the effectiveness of the family unit in providing alternative living arrangements and providing or arranging for the training and development opportunities provided in a state hospital or licensed community residential facility . . ." (M.S. 252.27, Subd. 4)

Eligibility requirements include children under the age of 18 years who would be eligible for placement in a state institution or licensed community residential facility. There is no income eligibility requirement for families. Currently, the program is operating at the full 50 families, with a waiting list of 25 families. Another 90 applications have been received.

There is a maximum grant of $250 per month per family which includes the costs for: (1) diagnostic assessments, medical expenses, medication; (2) special diets and special clothing; (3) special equipment; (4) parental relief and child care costs; (5) educational and training programs supplementary school programs, including visiting nurses, therapists and behavior management specialists; (6) adaptive housing; and (7) related transportation costs.

Fifty-two mentally retarded children under the age of 18 were served in 1977-1978. Children ranged from borderline to severe mental retardation. Twenty-five of the children were multiply handicapped and eight children were diagnosed as autistic. Eighty-six and a half percent of the children had never been placed outside of their own home. The families were from 24 counties in Minnesota, with about 50 percent residing in the metropolitan area.

The annual appropriation for the Mental Retardation Family Subsidy Program is $150,000. However, because of the 50 family limit on the program, only $106,183 was used in fiscal year 1978.

The program is administered by the Department of Public Welfare.

Long-Term Care Demonstration Project

In 1979 the Department of Public Welfare in combination with the University of Minnesota's Center for Health Services Research will begin work on a long-term care demonstration project which will entail one year of planning and up to five years of demonstration. This project will be funded by the Health Care Financing Administration in the Department of Health, Education and Welfare.

The purpose of the project is to demonstrate innovative long-term care alternatives in two or three areas of the state in order to find effective mechanisms to control costs and improve the quality of long-term care services. The project will attempt to demonstrate the effectiveness of case management, central long-term care agencies, coordination among agencies and the use of a continuum of long-term care.

Cost of Care

Respite care is included as part of "temporary care" funded through the Cost of Care program under Rule 30. Children who are mentally retarded or epileptic may receive up to 90 days of temporary care in any 12 month period. Temporary care is defined as placement in a licensed facility for purposes of diagnostic services or boarding for a child requiring 24-hour care and treatment. Only out-of-home respite care is allowed. Cost of Care reimbursement is available to children who are ineligible for payment of all or part of their boarding care costs through other resources such as Medicaid, Title XX, AFDC and GAMC.

The program is funded primarily by the counties, with the state reimbursing a varying percentage of county costs. Parents are responsible for reimbursing the county according to a sliding fee scale.

There are no statewide data on the number of persons using this respite care nor on expenditures for this care.

SUMMARY

In Minnesota, there are more than 16 sources of funding for home care services which are administered by six federal agencies, three state agencies, over 300 local agencies and uncounted private sector providers. Each program has different eligibility criteria, services and restrictions.

The following is a table which summarizes the major provisions of each program.

Program	State Administration	Home Care Services	Home Care Funding	State Share of Funding	
Title XX (Social Services)	Department of Public Welfare	Homemaking Chore Transportation Meals	$ 6,495,323 3,111,565 1,203,825 195,428		
			$11,006,141	$ 570,000	(5.2%)
Title XIX (Medicaid)	Department of Public Welfare	Home Nursing/ Attendant Care Home Health Aide Medical Transp.	$ 227,425/ 169,000 1,725,974 2,300,000		
			$ 4,253,399	$1,712,418	(40.26%)
General Assistance Medical Care	Department of Public Welfare	Home Nursing/ Attendant Care Home Health Aide Medical Transp.	$ 19,000 14,000 124,000		
			$ 157,000	$ 141,300	(90%)
Title III Older Americans Act	Department of Public Welfare (Minnesota Board on Aging)	Transportation Homemaking Chore Home Health Aide Home-Del. Meals	$ 883,000 290,129 149,458 90,471 64,898		
			$ 1,477,956	—0—	
Title VII Older Americans Act	Department of Public Welfare (Minnesota Board on Aging)	Home-Del. Meals Transportation	$ 343,242 unknown		
			$ 343,242	$ 38,316	(11%)
Title XVIII (Medicare)	Social Security Administration District Office	Home Nursing Home Health Aide	$ 1,257,980 527,540		
			$ 1,785,520	—0—	
Community Health Services	Department of Health	Home Nursing Home Health Aide			
			$ 6,351,473	$1,107,499	(17.4%)
Community Action Program	Department of Economic Security	Transportation Home-Del. Meals Chore	$ 440,820 199,151 51,667		
			$ 691,638	$ 115,372	(16.7%)
Veterans Administration	Veterans Administration	Home Health Aide Home Nursing Transportation	unknown	—0—	
Title IV-B (Child Welfare)	Department of Public Welfare	Chore Homemaking Home-Del. Meals Transportation	$ 15,126 40,288 1,799 50,819		
			$ 107,972	—0—	

Program	State Administration	Home Care Services	Home Care Funding	State Share of Funding	
Catastrophic Health Expense Protection Program	Department of Public Welfare	Home Health Aide Home Nursing	—0—	—0—	
Senior Companion	ACTION	Transportation	$ 395,000	$ 250,000	(63%)
Vocational Rehabilitation	Department of Economic Security — Div. of Voc. Rehab.	Attendant Care Transportation	unknown		
Community Development Block Grants	—	unknown	unknown	—0—	
Mental Retardation Family Subsidy	Department of Public Welfare	Family Subsidy	$ 150,000	$ 150,000	(100%)
Cost of Care	Department of Public Welfare	Respite Care	unknown	unknown	
Private Providers	—	ALL	not applicable	—0—	
Informal Assistance	—	ALL	not applicable	—0—	
			$26,719,341	**$4,084,905**	**(15.3%)**

SECTION TWO

AN EXAMINATION OF THE NEED FOR HOME CARE IN MINNESOTA

INTRODUCTION

The previous section in this report describes Minnesota's home care system. To assess the adequacy of that system in meeting the need for home care services, however, the characteristics and size of the population groups in need must be determined. This section describes the groups within the population with the greatest potential need for home care services due to their limitations in performing daily living tasks — the elderly, the physically disabled and the developmentally disabled. Descriptions of these target groups include their special characteristics, estimates of their current and projected sizes and an estimate of the number of persons potentially in need of home care services.

The Need for Home Care

The need for home care services is difficult to assess for several reasons. First, need depends upon many variables including a person's condition, impairment, abilities, and the availability of housing, financial and social supports. Also, need may be defined in several ways:

1) having a particular condition, e.g., multiple sclerosis, arthritis or other chronic condition;
2) having a condition and requiring assistance as a result of it;
3) having a condition and needing assistance but not receiving any; and
4) having a condition, needing assistance, and receiving it, but inadequately.

Further complicating the definition of need are problems with distinguishing between the need and the demand for home care services. Persons may be considered in need of home care according to the definitions above but may not request services. For example, they may be unaware of services or reluctant to request assistance. Each of the above ways of defining need is used in this section to determine the number of individuals most in need of home care services.

The Purpose of Home Care

Despite the difficulties described previously, the potential population in need of home care may be defined as follows:

1) persons currently residing in institutions who would be able and willing to live in the community with appropriate supports (examples are physically disabled and chronically ill persons in nursing homes and mentally retarded persons in residential facilities), and
2) persons currently residing in their homes who require assistance with personal and household tasks due to declining functional ability and who, without home care, would either have to enter an institution or continue living at home despite possible risk to their safety and health.

Thus, home care services can serve two purposes: the prevention of premature institutionalization and the discharge of individuals inappropriately placed in nursing homes. Accordingly, estimates of need are divided into two parts, one devoted to each of these purposes.

THE PREVENTION OF PREMATURE INSTITUTIONALIZATION*

Many individuals may be at risk of institutionalization due to their functional disabilities but may not actually require nursing home placement. The purpose of home care in these cases would be to delay or prevent institutionalization as long as possible. This part defines the three target population groups, estimates the size of these groups and the number of individuals potentially in need of the various home care services.

*Technical notes for this section are found in Appendix E.

The Elderly

The term "elderly" is generally used to characterize an individual whose age is over some limit. While the age limit varies with programs and policies, it most commonly begins between the ages of 55 and 65. There are some problems, however, with defining elderly by an arbitrary age limit. Some 55-year-olds may be much more impaired than some 75-year-olds due in part to heredity, health status, lifestyle and employment status. For purposes of this report, the elderly are defined as individuals over age 65.

In determining the need for home care services, the elderly in need are typically those who have one or more functional disabilities (such as the inability to climb stairs or dress themselves) or chronic conditions (such as arthritis). These functional disabilities and chronic conditions may present themselves at any time in life; however, they tend to increase in numbers and severity as an individual ages. As this occurs, many individuals find themselves in need of long-term care services. This has policy implications for all levels of government considering the increase in the elderly population, their past use of long-term care services and the anticipated increases in their population and future service use.

The following table indicates that the number of Minnesota elderly is increasing. In 1970, the number of individuals over age 65 was 407,257. By 2000, this number is expected to reach 506,384.

Age	1970 Number	1980 Number	2000 Number
65-69	130,155	148,293	145,376
70-74	110,251	120,006	132,783
75-79	83,443	87,965	106,665
80-84	51,330	60,838	73,974
85+	32,078	38,995	47,586
Total	**407,257**	**455,897**	**506,384**

Source: *Minnesota Population Projections, 1970-2000,* Minnesota State Demographer, 1975.

Between the years 1970 and 2000 segments of the elderly population are expected to increase by the following percentages:

Age	Percentage Increase
65-69	11.7
70-74	20.4
75-79	27.8
80-84	44.1
85+	48.0

An overall increase in the state's elderly population of 24 percent is expected, compared to an increase in the overall population of 22 percent.

The important fact is that the largest proportional increases are taking place in the over 80 age groups — the groups that are the most susceptible to chronic illness and loss of functional abilities. It is the individuals in these groups who will most likely need long-term care services. This is demonstrated in the following table.

PERCENTAGE DISTRIBUTION OF ELDERLY BY LEVEL OF INDEPENDENT LIVING AND AGE GROUP UNITED STATES, 1972

Level of Independent Living	Age Groups: Over 64 Years (Percent)	65-74 Years (Percent)	Over 74 Years (Percent)
No Limitation	70.8	77.4	59.5
Some Limitation	29.2	22.6	40.5
Limited but Independent	12.4	11.1	14.7
Needs Help in Mobility	11.5	8.5	16.7
Needs Help in Personal Care	5.3	3.0	9.1

Source: S.Z. Nagi as presented in "The Need for Personal Care," Brandeis, page 31.[1]

As is shown in the above table, most elderly individuals do not need long-term care services. However, as age and functional disabilities increase and living arrangements change toward single person households, a portion of the elderly will need supportive home care services to maintain themselves in their homes.

It has been estimated that approximately 30 percent of the elderly population have some limitation in their activities of daily living (22.6 percent of the individuals aged 65 to 74 and 40.5 percent of those over 75).[2] This group can be further divided between those who are "limited but independent" (those who may need intermittent help with their limitations but are generally independent) and those who are functionally disabled (those who have problems performing certain activities of daily living and are potentially in need of supportive services or institutionalization). The "limited but independent" group makes up approximately 12.6 percent of the over 65 population, with the functionally disabled group making up from 11.8 to 16.8 percent of the over 65 population.[3]

Level of Impairment	Percent Over Age 64	Population
Some Limitation	29.2	133,152
Limited but Independent	12.4	56,544
Functionally Disabled	11.5-16.8	52,440-76,608

Elderly individuals who are considered functionally disabled, and also many who are limited but independent, have problems with activities of daily living that may require assistance. The following table lists those activities and the percentage and number of the over age 65 population in Minnesota with difficulties in performing those activities.

PERCENTAGE AND NUMBER OF MINNESOTA ELDERLY HAVING PROBLEMS WITH ACTIVITIES OF DAILY LIVING

Activity	Over Age 65	
	Percent	Number
Climbing stairs	30.1	137,225
Working around the house	17.4	79,344
Getting outside the house	13.3	60,634
Getting around the house	11.1	50,605
Bathing	10.5	47,869
Dressing	7.5	34,192
Eating without help	0.8	3,648

Source: *The Status and Needs of Minnesota's Older People,* 1971, page 56. Percentages are applied to 1980 population figures.

Each of the two impairment levels has different limitations which may result in a service need. The following table indicates the types of limitations most likely to be experienced by the impairment groups including the number of individuals within the group with that particular impairment.

Impairment Level	Limitations	Number of Individuals w/Limitations	Possible Services Needed
Limited but Independent (56,544 individuals over 65)	Climbing stairs	56,544	
	Working around the house	27,000	Occasional chore services
Functionally Disabled (52,440-76,608 individuals over age 65)	Climbing stairs	52,440-76,608	
	Working around the house	52,440-76,608	Chore services
	Getting around the house	(50,605)	Homemaking services
	Getting outside the house	(60,634)	Transportation services
	Bathing/Dressing	(47,869)	Personal attendant care
	Eating without help	(3,648)	Occasional home health and/or home nursing care

Using this information the following are estimates of the numbers of individuals potentially in need of assistance with the specified home care tasks.[4]

Service	Population Potentially in Need
Chore	100,000 (79,000 regular, 21,000 occasional)
Transportation	60,000
Homemaking	51,000
Personal/Attendant Care	48,000 (34,000 regular, 14,000 occasional)

The need for services such as home-delivered meals, home health aide and home nursing care is impossible to estimate due to their relationship to an individual's physical condition rather than limitation in functional ability.

Respite care services would be needed at some time by many families who are caring for impaired elderly individuals. Since 70 percent of all elderly live with someone, an assumption is made that these individuals would be the potential population in need of respite care. According to this estimate of living arrangements, 36,700-53,600 families of functionally disabled elderly individuals may need this service.[5]

These numbers, however, do not indicate the number of individuals in need of publicly provided home care services. Many individuals receive a substantial portion of the needed assistance through informal sources. The following table shows the percentage and number of elderly who are likely to receive assistance from these informal sources.[6]

Service*	Population Needing Service	Estimated Percent With Need Met By Family	Estimated Number With Need Met By Family
Chore	100,000	62	62,000
Transportation	60,000	49	29,400
Homemaking	51,000	74.5	37,995
Personal Care	48,000	84	40,320

*No information is available on the extent in informal assistance for respite care.

This results in an estimated elderly population needing services through formal (either public or private) sources as follows:

Chore	38,000
Transportation	30,600
Homemaking	13,005
Personal Care	7,680

The Physically and Developmentally Disabled

Disability may be defined in various ways. It is sometimes defined by diagnosis or type of condition, but this approach has limited usefulness for planning purposes since the severity of the disability may vary greatly within any category. For example, not all persons with the same disease are equally impaired or in need of assistance. A better way to define disability for purposes of planning for service need is by the degree of limitation in performing daily living tasks.

Although estimates of the prevalence of disabilities vary, observers agree that the size of the disabled population is growing. The prevalence and types of disability have changed in recent years due to medical advances which have enabled more people to survive serious injury, congenital problems or diseases than was previously possible. These persons, however, may have serious lifetime impairments that limit their self-care abilities.

The home care needs of disabled individuals, while similar to the needs of the elderly, are unique in many respects. Care of the disabled tends to be for a much longer period of time. In addition, the conditions and the resulting service needs of the disabled tend to be more stable over time than those of the elderly whose conditions tend to fluctuate or decline. Disabled individuals, more than the elderly, may require 24-hour assistance, not necessarily consisting of 24 hours of service, but of having someone always available to help with dressing, eating and toileting. Finally, severely disabled persons in need of home care, unlike some elderly, cannot live at home without care. While an older impaired individual may be able to remain at home without assistance, albeit in a less than safe and healthy condition, severely disabled individuals do not have this choice. Without assistance at home, they must receive care in an institution.

For purposes of this report, two types of disability are considered — physical disability and developmental disability. These groups were selected because they comprise the major types of disabilities which result in a need for home care services. Physical disability may be generally defined as a limitation of ability due to a physical disease or injury which is permanent or long-lasting. Developmental disability is a disability attributable to certain conditions — mental retardation, cerebral palsy, epilepsy or autism — which originate in childhood. There is overlap between the developmentally and physically disabled populations since individuals may have more than one type of disability and since developmentally disabled individuals frequently have one or more physical disabilities as well. Estimates of the extent of this overlap vary considerably.

Following are estimates of the size of the developmentally disabled and physically disabled populations. Insofar as possible, separate estimates of the size of these two groups have been made. In order to estimate the number of disabled individuals in the state, results of studies done in Minnesota have been used. When these studies are inadequate, findings from national studies have been applied to the Minnesota population.*

The Developmentally Disabled

The 1970 Developmental Disabilities Act defines a developmental disability as any disability which:

1) is attributable to mental retardation, cerebral palsy, epilepsy, or autism, or another neurological condition closely related to mental retardation,
2) originates before age 18,
3) is expected to continue indefinitely, and
4) constitutes a substantial handicap to the individual's ability to function normally in society.

These conditions are grouped together in this definition based on the similarity of services required, functional characteristics, age at the onset of the condition and the severity and chronic

*The data on the extent and nature of disabilities are limited and comparing the findings of different studies is difficult due to the varying definitions of disability and its severity. Little has been done on estimating the extent of disability in Minnesota and most of the national data are not recent.

nature of the condition. As reported in the fiscal year 1978 Minnesota Developmental Disabilities State Plan published by the Minnesota State Planning Agency, the literature on disability indicates that between one and three percent of the national population are mentally retarded. Of this group, 89 percent are mildly retarded, 6 percent are moderately retarded, 3.5 percent are severely retarded and 1.5 percent are profoundly retarded.[7]

Estimates of the number of individuals with cerebral palsy range from 0.3 percent to 0.4 percent of the total population, while the prevalence of epilepsy is estimated at from 0.6 percent to 2 percent and autism at approximately 0.04 percent.[8]

The following percentages and numbers of the developmentally disabled population in Minnesota are taken from the state plan.[9]

Disability	Percent of General Population	Number
Mental Retardation	1.276	52,020
Epilepsy and MR	0.265	10,804
Cerebral Palsy and MR	0.257	10,477
Condition implying MR	0.095	3,873
Cerebral Palsy alone	0.093	3,791
Epilepsy alone	0.064	2,609
Autism alone	0.006	245
Total	**2.06**	**83,819**

Source: *Fiscal Year 1978 Minnesota Developmental Disabilities State Plan,* page II-14.

According to the plan, two percent of the general population have a developmental disability, with approximately 92 percent of these persons being mentally retarded.

It has been estimated that there are approximately 84,000 developmentally disabled individuals in Minnesota. Since the institutionalized and elderly developmentally disabled are dealt with in other parts of this section, they are subtracted from this total estimate. Therefore, it is estimated that there are approximately 68,654 noninstitutionalized, developmentally disabled individuals under age 65 in Minnesota.[10]

The following tables indicate the diagnosis and age breakdowns of these individuals.[11]

Age	Percent of Non-Elderly, Non-Institutionalized Developmentally Disabled Population	Number
0-4	9	6,179
5-19	28	19,223
20-59	58	39,819
60-65	5	3,432
Total	**100**	**68,654**

Diagnosis	Percent	Number
Mental Retardation	92.1	63,230
(Mild)	(89.0)	(56,275)
(Moderate)	(6.0)	(3,794)
(Severe)	(3.5)	(2,213)
(Profound)	(1.5)	(948)
Cerebral Palsy	4.5	3,089
Epilepsy	3.1	2,128
Autism	0.3	206
Total	**100.0**	**68,654**

The developmentally disabled population is divided into three groups according to probable ability to live independently and service needs. These groups are as follows:

1) the severely and profoundly mentally retarded and the autistic,
2) the mildly mentally retarded and epileptic, and
3) the moderately mentally retarded and those with cerebral palsy.

Due to the severe nature of their conditions, it is assumed that all of the severely and profoundly retarded and the autistic who are living out of institutions are living with others and are unlikely to be able to live outside a family setting even with home care services.

It is also assumed that the mildly mentally retarded and epileptic generally do not need assistance with activities of daily living and can live independently without services.

Thus, the moderately mentally retarded and those with cerebral palsy seem to be the most likely target for home care services since they are likely to need assistance with daily living tasks yet are not so severely impaired as to preclude the ability to live independently if assistance is available. Although some of the moderately retarded/ cerebral palsy group may not need home care

assistance, and individuals in the other groups may, there is insufficient information to determine these needs. It is assumed that these differences will balance each other.

The three groups are estimated to contain the following numbers of individuals:

Severely MR	2,213
Profoundly MR	948
Autistic	206
	3,367
Moderately MR	3,794
Cerebral palsy	3,089
	6,883
Mildly MR	56,275
Epilepsy	2,128
	58,403

The three developmentally disabled groups may be classified by living arrangement as follows.[12]

	Severe/ Profound/ Autistic	Moderate/ CP	Mild/ Epilepsy
Living with family	3,367	5,066	42,989
Living alone	0	1,817	15,414
Total	**3,367**	**6,883**	**58,403**

These living arrangements were translated into service needs as follows. For the severe/profound/autistic group a range of estimates of service needs was made. While all of these individuals are believed to be living with families and these families are most likely providing needed assistance with activities of daily living, it is not known whether these informal sources provide all needed assistance. Also, families may be providing all needed assistance but this assistance may represent a significant burden. At a minimum, all 3,367 individuals will need respite care or family subsidies. However, some portion of the 3,367 may also need personal care, homemaker, chore or transportation services.

The 58,403 mildly mentally retarded/epileptic individuals are assumed to generally not need home care services. While some individuals in this group may require assistance, no estimates can be made with available data.

The 6,883 moderately mentally retarded/ cerebral palsy group constitutes the major home care service target population. Of the 5,066 living within a family setting, it is assumed that most needs are met by informal sources. Since data are unavailable to indicate the extent of this assistance, a range of estimates of service needs must be done. The 5,066 living in families are the potential target population for respite care and family subsidies. Homemaker, chore, personal care and transportation will likely be needed by most of the 1,817 living alone and possibly by some portion of the 5,066 living with families.

The size of the populations potentially needing each home care service is as follows.

Respite Care	
severe/profound/autistic – all	3,367
moderate MR living with families	5,066
	8,433
Family Subsidy	
severe/profound/autistic – all	3,367
moderate MR living with families	5,066
	8,433
Personal, Homemaker, Chore, Transportation	
severe/profound/autistic	0-3,367
moderate MR living alone	1,817
moderate MR with family	0-5,066
mild MR/epilepsy – all	0
	1,817-10,250

This group of 1,817 to 10,250 will also require home-delivered meals, home health aide and home nursing occasionally, although it is impossible to determine the frequency of this need.

The Physically Disabled

For purposes of this report, physical disability is defined as a permanent or long-lasting limitation of ability due to a physical disease or injury. Persons who are physically disabled have impairments which result in functional limitations or activity restrictions. Physical disability or functional limitations are classified by degree of severity. The degrees of functional limitation are commonly defined as follows:

- minor loss – manual or body movement limitations other than walking or inability to use one or both hands,
- moderate loss – limitations in walking **or** severe manual limitations,

severe loss — limitations in both walking **and** manual activities,

functionally dependent — confined to home or needing assistance in transportation, to go outside the home, or in self-care activities regardless of the extent of physical limitation.

How many individuals are physically disabled? Six national studies done between 1966 and 1975 indicate that between 10.6 and 17.2 percent of working age adults have some disability.[13] Other studies indicate that between 3.0 and 3.7 percent of all children have some disability (as measured by their inability to perform their major activities of playing or attending school).[14]

A 1976 Minnesota Division of Vocational Rehabilitation study which sought to assess the extent of **all** types of disability shows that 1 in 7 (14.5 percent) noninstitutionalized Minnesotans of all ages perceive themselves to be disabled. This population is classified as follows:

Category	Percent of Disabled Population
Physical Disability	59.8
Hearing	12.6
Blindness and Vision	5.1
Developmental	3.1
Mental	2.4
Speech	1.4
Chemical Dependency	1.1
Other	14.5
Total	**100.0**

Source: Abstract of "The Assessment of Disability in Minnesota — A Household Survey," Minnesota Department of Economic Security, Division of Vocational Rehabilitation, August 31, 1978, p. 2.

The Division of Vocational Rehabilitation Survey estimates that more than half of the disabled reside in the seven-county metropolitan area, with concentrations in Hennepin and Ramsey counties where 42 percent of the state's disabled live. Two regions, Region 11 (metropolitan) and Region 10 (southeastern) contain almost 65 percent of the state's disabled population.[15]

General rates, while useful in providing an idea of the overall extent of disability, do not indicate the need for home care. Preferable measures are more specific measures of functional and mobility limitations. Functional limitation measures indicate an inability to perform activities such as climbing, reaching, lifting and so on. Limitation in these general activities may affect a person's ability to perform self-care and household activities. Mobility limitations refer to being confined to the home or bed or needing assistance with transportation or with going outside the home. Several national surveys have assessed these activities, and in the absence of surveys specific to Minnesota, these national rates were examined and applied to the state.

The following table summarizes findings from three national surveys on the degree of functional limitation in working age adults.

PERCENTAGE DISTRIBUTION OF WORKING AGE ADULTS BY DEGREE OF FUNCTIONAL LIMITATION UNITED STATES 1966, 1972 AND 1975

Degree of Functional Limitation	Source: Social Security Survey — 1966	Social Security Survey — 1972	Urban Institute Estimates — 1975
No Functional Limitation	87.4	88.8	85.3
Some Functional Limitation	12.6	11.2	14.7
Minor Loss	4.9	3.8	4.6
Moderate Loss	3.4	2.6	5.5
Severe Loss	1.5	2.8	1.5
Functionally Dependent	2.8	2.0	3.1
Totals	**100.0**	**100.0**	**100.0**

Source: "The Need for Personal Care," Brandeis, p. 21.[16]

The above table shows that between 2.0 and 3.1 percent of the working age population are estimated to be functionally dependent. Between 4.3 percent and 4.8 percent of the working age population experience severe loss of function or are functionally dependent.

Other national surveys have sought to assess mobility limitations. These results are presented in the following table.

	Percent of Working Age Population Needing Help With Mobility
1966 Social Security (age 18-64)	1.8
1972 Social Security (age 20-64)	2.4
1972 Ohio State (age 18-64)	1.8
1972 Health Interview Survey (age 17-64)	0.7

Source: "The Need for Personal Care," Brandeis, page 36.[17]

Information in the previous tables indicates that only a small proportion of the working age

population is considered functionally- or mobility-limited.

The Minnesota Division of Vocational Rehabilitation estimates that there are 468,830 non-institutionalized individuals in Minnesota who consider themselves physically disabled.[18] This disabled population represents 11.5 percent of the total state population and is categorized as follows:

	Percent of Physically Disabled	Percent of State Population
Physical Disability	75.3	8.7
Blindness and Vision	6.4	0.7
Other (excluding developmental, mental, speech, hearing, chemical dependency)	18.3	2.1
Total	**100.0**	**11.5**

Source: Abstract of the "Assessment of Disability in Minnesota – A Household Survey," 1978, Minnesota Department of Economic Security, Division of Vocational Rehabilitation, page 2.

Since there are approximately 137,000 physically disabled persons over age 65, it can be estimated that there are approximately 331,830 non-elderly, physically disabled persons in the state.

In order to determine these individuals' need for home care, an estimation of the extent of disability is necessary. For this purpose, results of several national surveys of disability among working age adults (aged 20-64) have been combined into a functional limitations index. The national rates for these categories have been applied to Minnesota's working age population and are presented in the following table.

	Percent of Working Age Population by Degree of Functional Limitation	Estimated Number
Some Functional Limitation	11.2-14.7	254,820-334,450
Minor Loss	3.8- 4.7	86,457-111,484
Moderate Loss	2.6- 5.5	59,155-125,135
Severe Loss	1.5- 2.8	34,128- 63,705
Functionally Dependent	2.0- 3.1	45,504- 70,530

Source: "Need for Personal Care," Brandeis, page 21.[19]

In addition it has been estimated that between 3.0 and 3.7 percent of all children under age 19 have some disability, with 0.2 to 0.4 percent having a severe disability.[20] In Minnesota these rates for persons under age 19 are:

	Estimated Number
Some disability	40,371-49,791
Severe disability	2,691- 5,383

However, as was shown previously with the elderly and the developmentally disabled populations, not all individuals in a disability group will need assistance with daily living tasks or home care services. The following table indicates the percentage and number of the working age disabled adults in Minnesota (286,830) who need no help with services, receive informal assistance and need formal assistance.[21]

Service	Percent	Number
Personal Care		
Needs No Help	71.2	204,223
Receives Informal Assistance	11.3	32,412
Needs Formal Assistance	17.5	50,195
Home-Delivered Meals		
Needs No Help	41.5	119,034
Receives Informal Assistance	34.9	100,104
Needs Formal Assistance	18.0	51,629
Homemaking		
Needs No Help	36.7	105,267
Receives Informal Assistance	41.4	118,748
Needs Formal Assistance	21.9	62,816
Transportation		
Needs No Help	48.0	137,693
Receives Informal Assistance	16.2	46,471
Needs Formal Assistance	35.8	102,696
Chore Services		
Needs No Help	36.7	105,267
Receives Informal Assistance	41.4	118,748
Needs Formal Assistance	21.9	62,816

As is the case with the elderly and the developmentally disabled populations, estimates of the need for the health-related services are impossible to calculate due to a lack of information regarding the health status of the disabled individuals. The potential population in need of respite care would be all families caring for disabled individuals in the home. There are an estimated 275,700 physically disabled individuals living in a family setting (45,000 children and 230,700 working age adults).[22] Not all of these families would need respite care and a portion of those who need it may receive it through informal assistance by friends, neighbors or other relatives. However, the extent of need and informal assistance is unknown.

In summary, the following numbers represent the physically disabled population in need of formal, public or private services.

Personal Care	50,195
Home-delivered meals or assistance with meal preparation	51,629
Homemaking	62,816
Transportation	102,696
Chore services	62,816

THE DISCHARGE OF INAPPROPRIATELY INSTITUTIONALIZED INDIVIDUALS

There are two categories of individuals who could be considered inappropriately placed in nursing homes in Minnesota: those who could maintain independent lives without any home care assistance and those whose physical and mental conditions are such that independent living is possible with an array of home care services. This part estimates the number of individuals who fit into each of these categories.

Estimates of the number of individuals who could potentially be discharged from institutions in Minnesota have been obtained by using information from the Minnesota Department of Health's Quality Assurance Review (QAR) data.[23] The QAR reviews the care received by Medicaid patients in skilled nursing facilities, intermediate care facilities and intermediate care facilities for the mentally retarded. Each patient is reviewed for the appropriateness of their level of care and placement. It is then determined whether there is a moderate or good potential for restoration to independent living or for placement in a lower level of institutional care.

This review is difficult because individuals may be institutionalized for reasons other than physical or mental conditions. Home care may not be the crucial element which could return individuals to their homes. Once individuals are institutionalized, they may be unable to return to their home regardless of their condition. They may have no home to return to, they may have no financial resources, they may have become psychologically dependent on the care received in the institution, or they may have family pressures to remain in the nursing home. These factors should be considered when estimating the number of individuals who could feasibly be removed from institutional placement. However, this is very difficult unless it is performed on a case-by-case basis. Because of this, the estimates in this report will necessarily exclude those factors. the QAR considers only the physical and mental condition of the patient in determining the potential for restoration to independent living, not the possible availability of community support services, family assistance or the desires of the patient.

The following part estimates the number of individuals in Minnesota's nursing homes who have a moderate or good potential for restoration to independent living. Those with a good potential are judged to be capable of discharge to their home regardless of the support services available. Those with a moderate potential are seen as capable of maintaining independent living if some services which address their particular needs are available to them. In other words, those with a good potential for restoration to independent living are those who are inappropriately placed in Minnesota's nursing homes at this time and could live at home without any support services. Those with a moderate potential are the population in nursing homes who need home care services if they are to be restored to independent living. The following estimates of these two groups include all individuals in skilled nursing facilities, intermediate care facilities, intermediate care facilities for the mentally retarded, nursing homes, boarding care homes and supervised living facilities, both Medicaid and non-Medicaid recipients.[24]

THE NUMBER AND PERCENTAGE OF NURSING HOME POPULATION WITH A GOOD POTENTIAL FOR RESTORATION TO INDEPENDENT LIVING

	Total Number in Institutions	Total Number with Good Potential	Percentage
Elderly	34,355	639	1.9
Nonelderly	10,107	320	3.2
Total	**44,462**	**959**	**2.2**

THE NUMBER AND PERCENTAGE OF THE NURSING HOME POPULATION WITH A MODERATE POTENTIAL FOR RESTORATION TO INDEPENDENT LIVING

	Total Number in Institutions	Total Number with Moderate Potential	Percentage
Elderly	34,355	1,489	4.3
Nonelderly	10,107	857	8.5
Total	**44,462**	**2,346**	**5.3**

SUMMARY OF ESTIMATES*

The following table summarizes the number of people in Minnesota in need of formal home care services provided publicly or privately in Minnesota in order to remain in their home. It also provides the number of institutionalized individuals with a good and moderate potential for restoration to independent living.

*The need for home health aide services, home nursing care and home-delivered meals is not estimated since it depends primarily on an individual's condition rather than on their functional limitations. This information is not available. There is an estimated 325,000 families caring for impaired elderly, physically disabled and developmentally disabled individuals. Although not all these families will require formal respite care services, they are the potential population in need.

These summary estimates indicate the number of individuals in the state who have sufficient impairments to require certain types of assistance. In addition, these estimates denote the number of individuals who are probably not receiving informal assistance with these tasks. Thus, they are the group which is in need of formal, publicly or privately provided home care services. The population estimates are duplicative across the services; in other words, if individuals need both homemaking and transportation services they are counted under both service categories. Also, all individuals in a service category will not need the same amount or intensity of services. The following sections further specify these estimates according to service packages and units of service needed by the group.

The Non-Institutionalized Population

Elderly	
Chore	38,000
Transportation	30,600
Homemaking	13,005
Personal Care	7,680
Physically Disabled	
Chore	62,816
Transportation	102,696
Homemaking	62,816
Personal Care	50,195
Developmentally Disabled	
Chore	1,817- 10,250
Transportation	1,817- 10,250
Homemaking	1,817- 10,250
Personal Care	1,817- 10,250
Total	
Chore	**102-633-111,066**
Transportation	**135,113-143,546**
Homemaking	**77,638- 86,071**
Personal Care	**59,692- 68,125**

The Institutionalized Population

Good Potential for Restoration to Independent Living

Elderly	639
Nonelderly	320
Total	**959**

Moderate Potential for Restoration to Independent Living

Elderly	1,489
Nonelderly	857
Total	**2,346**

SECTION THREE

AN ANALYSIS OF MINNESOTA'S HOME CARE SYSTEM

The problems with Minnesota's home care system which have become apparent during the course of this study are presented in this section. These problems and deficiencies are those which have a major impact on the delivery of services to impaired individuals in the state. They have been identified through the private and public home care agency survey (which is presented in Appendix D), information provided by members of the advisory committee, interviews with consumers and providers of home care services, analyses of Minnesota's home care programs and the literature on home care services. Following is a list of the major problems identified by this study.

1) There is an insufficient supply of home care services, given the needs identified in this study, resulting from insufficient funding and various program restrictions. The extent of this problem, however, varies across the state.

2) Funding mechanisms make institutionalization a less expensive option for counties. Counties pay only 4.5 percent of institutional care costs under Title XIX (Medicaid), but from 60 to 100 percent of home care costs under Title XX (Social Services).

3) The home care system is fragmented, making it difficult for individuals to arrange needed home care services. The individual with multiple needs who is seeking assistance may be confronted with an assortment of agencies, each with (a) one or more of the needed services, (b) an array of program eligibility requirements, (c) varying rules on providing the services and (d) overlapping jurisdictions. Arranging all needed services may be even more difficult for persons with mental confusion, physical frailty or mobility limitations.

4) There are few long-term care options for individuals other than institutionalization. Because of the difficulties in finding and obtaining a needed package of services and because of current funding mechanisms, institutional placement is often the most viable long-term care option.

5) There is a lack of information about the current availability of home care services. This lack of information on the part of individuals, physicians and agencies can result in unnecessary institutionalization.

6) The lack of quality assurance, regulation and training of home care providers is a concern expressed by many members of the home care advisory committee. Particularly in the case of private agencies which receive no public reimbursement, there are no assurances that the home care staff are adequately trained to assess individuals' needs or provide the specialized care needed. Since home care services are provided in a client's home often without direct supervision by agency personnel, clients often feel a need for assurance that the individuals providing the services are well trained, responsible and adequately supervised.

Although all of these problems with Minnesota's home care system should be dealt with, the problem which should be addressed first by the Legislature is the insufficient supply of home care services since an increased supply may alleviate many of the other problems. The availability of more home care services should increase individuals' options and awareness of the system. Increased funding for more home care services may help alleviate some of the problems with funding mechanisms which provide incentives for nursing home care. In addition, the supply of services directly relates to the client in need. Without these services, the individuals may require institutional placement.

Determining the adequacy of the service supply entails more than identifying which services are and are not available. The adequacy of the supply of services depends upon many factors including the size of the population needing each service (i.e., the client impairment level and the consequent level of needed services), the demand for each service, the availability of current programs and services, the eligibility criteria of the various programs and the program restrictions. This next section examines these factors and determines how they influence the adequacy of service supply.

FACTORS WHICH DETERMINE THE ADEQUACY OF SERVICE SUPPLY

The Size of the Population Needing Each Service

As discussed earlier in this report, the degree of impairment determines the level of services needed, with more severely disabled individuals needing a more extensive and intensive level of

services. These severely disabled individuals not only need skilled services, but also tend to need a wider range of services. For example, an individual who needs home nursing care is also likely to need assistance with homemaking, chore services, preparing meals and transportation. These severely disabled individuals, however, are a relatively small group. Additionally, a lower level of service such as respite care or chore may be needed not only by the most severely disabled individuals, but also by a larger number of less disabled individuals who may not need skilled services.

In other words, there is a continuum of services which ranges from skilled services such as home nursing to less skilled services such as chore. This continuum also relates to the number and type of clients needing each service. Although fewer individuals need services at the skilled end of the spectrum, they are the most severely disabled and may also need many of the less skilled services. A larger number of less disabled individuals will need services at the less skilled end of the spectrum and will probably need only those services. This is important since it means that there will be a higher demand for the less skilled services. The following diagram portrays this continuum of services. The services are arranged from most skilled to least skilled, from least demand to most demand, and from those needed by the more severely impaired to the less severely impaired individuals.

home nursing → attendant/personal care → home health aide → home-delivered meals → homemaker → transportation → chore

(Family subsidies and respite care do not fit into this continuum due to their relationship to living arrangement rather than impairment level. It should be noted that respite care in particular would be needed at some time by most families who care for impaired members.)

The Availability of Current Programs and Services

Each of the home care services examined in this report, with the exception of respite care and family subsidies, is provided by at least three public programs as well as by private providers and informal sources. (Family subsidies and respite care are each available through only one public program.) Although most services are provided through several programs, the availability of both programs and services within programs is uneven throughout the state. Two factors which have an impact on the availability of services are the geographic distribution of services and client access to services.

Some home care services are not available in all areas of the state. For example, in three counties in Minnesota there are no public programs nor private providers which offer chore services to their residents. Furthermore, within a county or region, service availability may vary, with some areas better served than others. For example, a county may have only one or two providers of a particular service which are located in or near the large population centers of the county. Particularly in larger counties it may be difficult for clients to get to these population centers, and equally difficult for the home care staff to get to the home of the client. If a county's home care staff must travel great distances between clients' homes, more staff will be needed by a larger county to provide the same amount of service than by a smaller county. In addition, the costs of providing the services may be increased due to the distances traveled.

When examining the geographic distribution of services within a county or region, the size of the program should also be considered. A county may provide homemaker services, for example, but have only one half-time homemaker on the staff. This program may not meet the need for homemaker services in that area.

Geographic distribution also affects client access to the service. Particularly since home care has a physically or mentally impaired target population, clients have difficulty arranging services. Additionally, without sufficient outreach, the people most in need of the services, i.e., the homebound, will be least aware of the availability of services.

Eligibility Criteria of the Programs

Many public programs serve only limited target populations, most commonly the elderly or low-income individuals. (See chart on page 40.) Private providers tend to serve persons who can afford their full fee, although a few private agencies serve middle-income individuals according to a sliding fee schedule. Thus, some individuals who have income above the limits for the public programs (which range from $2,868 to $10,766 for a single individual) but insufficient income to afford private care will be unable to obtain needed home care services. These individuals may

enter nursing homes, spend the money they have within the first few months, and then become eligible for Medicaid, resulting in the public sector paying for their care.

Income eligibility for services may also cause work disincentives, particularly for younger disabled persons. If, through rehabilitation and personal care assistance from an attendant, a disabled individual becomes capable of working and obtains employment, the individual's earnings may exceed the Medicaid standards. Although attendant care is available on a fee basis from some private providers, the cost of this service is prohibitive for most disabled individuals. This in turn makes it impossible for the individual to receive the attendant care needed in order to continue working.

Therefore, especially in geographic and service areas with few private providers, there are home care service gaps for certain groups of people, particularly the nonelderly disabled and persons with incomes above public program eligibility limits.

Home Care Program Restrictions

Even if individuals reside in an area where needed home care services are available and even if they are eligible, they may not receive the service in sufficient amounts or they may not receive it at all due to other program restrictions. (The chart on page 40 indicates, by program, some of these restrictions which result in further service gaps.) Generally, the restrictions are in terms of the allowable amount, type or duration of services. For example, Medicare restricts the number of home health care visits to 100 per year regardless of existing need; Medicaid limits transportation services to medically-related trips only; Vocational Rehabilitation limits services to the period of time an individual is in training or rehabilitation. These program restrictions act to fit the client to the program's requirements rather than to fit the program to the client's needs.

DISCUSSION OF THE ADEQUACY OF THE SERVICE SUPPLY

This part discusses each of the target services described in this report and assesses whether these services are in adequate supply in the state given the needs determined in this study. To determine the adequacy of supply, many factors are examined including the relative size of the population needing each service, the critical nature of the service for the continued well-being of the individual in need, the geographic coverage of the current programs across the state and within counties and regions, the number of providers in a geographic area, the number of programs serving a particular area, the program restrictions, the availability of the services to the target population groups and the likelihood of informal assistance to provide the services. The remainder of this part discusses each of the services individually and finally prioritizes the services according to those which most need expansion.

This analysis of the adequacy of home care service supply is based on the program examination in Section One; the results of the agency survey; interviews with providers, advocates, consumers and others involved with home care services; and the needs estimates presented in Section Two.

Home Nursing and Home Health Aide Services

Home nursing and home health aide services are funded by seven public programs, county funds and private providers. Over $10 million from public sources alone is spent annually in the state. Currently, the primary providers of these services are the public health nursing agencies. In many counties in the state these agencies are also the only eligible providers of services through Medicaid, Medicare and the Veterans Administration programs. Although services through these programs are available in every county in the state there are some problems with access to the agencies which can provide these services, particularly if the public health nursing agency is located in only one area of the county. In this case, individuals in other areas of the county may find it difficult to obtain the services. However, regardless of the possible problems with access to the public health nursing agency in a county, the provision of home health aide and home nursing services is better than for any of the other home care services discussed in this report. This does not mean, however, that all of the needs for home nursing and home health aide services are currently being met.

Family Subsidies

Family subsidies are currently provided through only one program and are limited to 50 families

	Programs Providing or Funding Home Care in Minnesota	Funding	Clients Served
HOME NURSING SERVICES	Title XIX	$ 58,425	174
	General Assistance Medical Care	19,000	unknown
	Title XVIII	1,257,480	3,224
	Veterans Administration	unknown	unknown
	Community Health Services	6,351,473	unknown
	Local Funding	unknown	unknown
	Private Providers	unknown	unknown
HOME HEALTH SERVICES	Title XIX	$1,725,974	6,700
	General Assistance Medical Care	19,000	unknown
	Title III	90,471	368
	Community Health Services	included in nursing	unknown
	Title XVIII	527,540	1,352
	Veterans Administration	unknown	unknown
	Vocational Rehabilitation	unknown	unknown
	Local Funding	unknown	unknown
	Private Providers	unknown	unknown
	Informal Assistance	—	—
ATTENDANT/ PERSONAL CARE SERVICES	Title XIX	$ 169,000	67
	General Assistance Medical Care	included in nursing	included in nursing
	Vocational Rehabilitation	unknown	unknown
	Private Providers	unknown	unknown
	Informal Assistance	—	—
HOMEMAKING SERVICES	Title XX	$6,445,323	6,372
	Title IV-B	40,228	30
	Title III	290,129	596
	Community Development Block Grants	unknown	unknown
	Private Providers	unknown	unknown
	Informal Assistance	—	—
	Local Funding	unknown	unknown
CHORE SERVICES	Title XX	$3,111,565	6,515
	Title IV-B	15,126	64
	Title III	149,458	unknown
	Community Action	51,667	unknown
	Community Development Block Grants	unknown	unknown
	Private Providers	unknown	unknown
	Local Funding	unknown	unknown
	Informal Assistance	—	—
HOME-DELIVERED MEALS	Title VII	$ 343,242	unknown
	Title XX	195,428	2,163
	Title IV-B	1,799	17
	Community Action	199,151	unknown
	Title III	64,898	unknown
	Community Development Block Grants	unknown	unknown
	Private Providers	unknown	unknown
	Informal Assistance	—	—
	Local Funding	unknown	unknown

	Programs Providing or Funding Home Care in Minnesota	Funding	Clients Served
TRANSPORTATION SERVICES	Title XX	$1,203,825	7,425
	Title XIX	2,300,000	8,000
	General Assistance Medical Care	124,000	unknown
	Title III	883,000	12,402
	Title VII	unknown	unknown
	Community Action	440,820	unknown
	Title IV-B	50,819	200
	Veterans Administration	unknown	unknown
	Senior Companion	unknown	unknown
	Vocational Rehabilitation	unknown	unknown
	Local Funding	unknown	unknown
	Private Providers	unknown	unknown
	Informal Assistance	—	—
RESPITE CARE SERVICES	Cost of Care	unknown	unknown
	Private Providers	unknown	unknown
	Informal Assistance	—	—
FAMILY SUBSIDIES	Mental Retardation Family Subsidy	$ 150,000	50 families

Local Funding which is provided as match to specified programs is included under the total funding for that program.

Program	Home Care Services Offered	Target Population	Maximum Income Limit*	Program Restriction
TITLE XX (SOCIAL SERVICES)	Homemaker Chore Transportation Home-Delivered Meals	Low Income Cash Assistance Recipients Some use of sliding fee	115% of median income $ 5,606 without fees $10,766 with fees	– geographic differences – county option of lowering income limit – funding limitation
TITLE XIX (MEDICAID)	Home Health Aide Home Nursing Attendant/ Personal Care Med. Transportation	Low Income Cash Assistance Recipients Use spend-down	$2,868	– physician certification – registered nurse supervision – transportation for medical only
TITLE XVIII (MEDICARE)	Home Health Aide Home Nursing	Elderly and Disabled Social Security Beneficiaries	Not Applicable	– Medicare restrictions – 100 visits – 3 day hospitalization – homebound – physician certification
TITLE III OLDER AMERICANS ACT	Homemaker Chore Home-Delivered Meals Transportation Home Health Aide	Elderly	-0-	– geographic differences – projects may have own restrictions
TITLE VII OLDER AMERICANS ACT	Home-Delivered Meals Transportation	Elderly 60+	-0-	– projects may have own restrictions – 10% home-delivered meals limitation
MENTAL RETARDATION FAMILY SUBSIDY	Family Subsidy	Families with Mentally Retarded Child under age 18	-0-	– 50 family limit – $250/month limit
COMMUNITY HEALTH SERVICE	Home Health Aide Home Nursing	None Sliding Fee Scale	-0-	
COMMUNITY ACTION PROGRAM	Chore Home-Delivered Meals Transportation	Low Income Elderly	Poverty Level $6,200 for a non-farm family of four	– availability limited – geographic differences
VETERANS ADMINISTRATION	Home Health Aide Home Nursing Transportation	Honorably Discharged Veterans	-0-	– proximity limitation – informal assistance necessary – physician determination – need more than one service
COMMUNITY DEVELOPMENT BLOCK GRANTS	Homemaker Chore Home-Delivered Meals	Depends on Program	Not Applicable	– limited by area
TITLE IV-B (CHILD WELFARE)	Transportation Chore Homemaker Home-Delivered Meals	Children	-0-	– funding limited

*For a single individual unless specified.

Program	Home Care Services Offered	Target Population	Maximum Income Limit	Program Restriction
VOCATIONAL REHABILITATION	Attendant/ Personal Care Transportation Home Health Aide	Disabled with Employability Potential	-0-	– only available while in training or rehabilitation
GENERAL ASSISTANCE MEDICAL CARE	Home Health Aide Transportation Home Nursing Attendant/ Personal Care	Age 21-65 Low Income or GA Recipient (Not Eligible for Medicaid)	$2,868 --- Use spend down	– same as Title XIX
SENIOR COMPANION	Transportation	Low Income Isolated Elderly	Unknown	– limited availability – geographic variation
COST OF CARE	Respite Care	Disabled Children	Use sliding fee	– out of home respite only – limited to MR and epileptic children
PRIVATE PROVIDERS	All Services	None	Generally Not Applicable	

with mentally retarded children. Although the size of the population needing some type of family subsidy in order to assist them in retaining impaired family members in their homes is unknown, it is known that 325,000 families are currently caring for physically disabled, developmentally disabled and impaired elderly family members. Some of these families may need financial assistance in caring for impaired family members. There is currently a waiting list of 20 families for the Mental Retardation Family Subsidy Program, in addition to 100 applications for the program awaiting processing and numerous daily inquiries from interested families about the program. The extent of need for family subsidies for the other target population groups is unknown.

Home-Delivered Meals

Home-delivered meals are funded by five public sources in the state and are also provided by private providers and informal assistance. Over $1,100,000 in public funds are currently being spent for this service.

The geographic distribution of home-delivered meals is good. No county is without a home-delivered meals program, eight counties have only one program and most counties have three or four programs. Furthermore, home-delivered meals is the service most commonly provided by the private non-profit sector. There are currently over 42 private agencies outside Hennepin and Ramsey counties which provide home-delivered meals.

Problems do exist, however, with access to this service. Particularly in large rural counties the service is difficult to provide since the meals have to be delivered over long distances. Since many drivers for this service tend to be volunteers, the lack of these volunteers often results in waiting lists, late delivery of meals and cold meals once they are delivered. In addition, most home-delivered meals programs are limited to the elderly although a wider range of persons may need it.

Home-delivered meals is a service that may need expansion in areas of the state which have few private providers, large geographic areas, few or no programs which provide meals to non-elderly individuals and difficulty in obtaining volunteers.

Transportation

There are at least ten public sources of funding providing $5 million for transportation services to the elderly and disabled in Minnesota, plus extensive private provision of services and informal assistance.

Although transportation is a high demand service, in the sense that a large proportion of the impaired population needs assistance with

transportation, all of the target population groups are covered by the service. The main problems lie in the limitations on the use of transportation service and the unavailability of specialized vehicles or escorts which disabled or elderly people may need. Only one county is without transportation services, thirty-three counties have one public program, and the remainder have more than one. The geographic gaps tend to lie within counties in much the same manner as they do with home-delivered meals. Transportation can be a difficult service to provide in terms of scheduling and distances to cover in large rural areas. Again, as with home-delivered meals, this is not a service that needs expansion over the entire state, however, in those areas with few public programs, few private providers and larger areas to cover, more transportation services may be needed.

Chore Services

There are four public funding sources for chore services providing approximately $3.5 million annually. In addition, there is considerable private and informal provision of this service since it requires less skill to provide than some other home care services. There tend, however, to be fairly large geographic and target population gaps. Three counties currently have no chore service providers, either public or private. Sixty-four counties have only one public provider. In addition, there tend to be geographic gaps within counties. As with most home care services, there are access problems not only in getting individuals into agencies for eligibility determination but also in getting the home care staff to the individual's home. Also, chore service tends to be a high demand service with almost all disabled individuals needing help with these tasks.

The estimated population in need of chore services in Minnesota ranges from 102,633 to 111,066. Since an estimated 6,500 persons currently receive chore services through the major public programs, the supply of services does not currently meet the estimated need.

Current eligibility limitations are very restrictive since they are limited predominantly to low-income persons, elderly persons, and public assistance recipients. Disabled individuals who are above public assistance standards are virtually eliminated from eligibility. Because of the geographic gaps described, the target population limitations and the fact that chore is a service needed by most impaired individuals, there is a need for expansion to cover these gaps in service provision.

Respite Care

The Department of Public Welfare's Cost of Care program is the only public source of respite care, with services limited to mentally retarded or epileptic children. In addition, Cost of Care provides only out-of-home respite care. Although the number of families needing respite care is not known, the number of disabled and elderly persons living with their families is estimated at 325,000. While not all of these families need respite care, or would use it if it were available from public sources, this number represents the maximum possible number of target families.

Respite care is a service which is needed by a large group of elderly and disabled. Virtually every family caring for an elderly or disabled individual will need this service at one time or another. With an estimated potential need of 325,000 families, current provision of this service is not adequate. This service is in need of expansion across the entire state.

Homemaking Services

There are currently four public programs providing over $6,000,000 in funding for homemaking services. However, there are a number of restrictions on this type of care. The target population tends to be limited to public assistance recipients, low-income, and elderly persons. As with chore services, disabled individuals who are above the low-income limits are not adequately served. The geographic gaps tend to be within counties where access to the agencies and to the clients' homes is difficult.

Currently, 7,998 individuals receive homemaking services through the major programs, while the potential need for homemaking services ranges from 77,638 to 86,701. This indicates a need to expand these services in almost every area of the state. This finding is supported by the agency survey in which homemaking was mentioned most often as the service most in need of expansion.

Attendant/Personal Care

Attendant/personal care services are currently available through the public programs of Medicaid, General Assistance Medical Care, and Vocational Rehabilitation as well as through private providers. Within these programs the target populations are extremely limited and the program restrictions

are numerous. Medicaid and General Assistance Medical Care are limited to low-income individuals who have a physician's determination of need and an approved plan of care. In addition, only certain medically-related services are allowed. Vocational Rehabilitation limits its services to those individuals in training or rehabilitation. Once individuals obtain employment or complete rehabilitation, they are no longer eligible. In addition, the eligibility criteria for these services create work disincentives by making individuals ineligible for needed services once employed.

With a potential need for attendant/personal care ranging from 59,692 to 68,125 and only 67 persons currently receiving this service through Medicaid, the provision of this service is insufficient to meet the need. Even after taking into account the fact that some homemaking services include personal care as part of the homemakers' duties, the number served is still below the potential need.

This service needs to be expanded to include more individuals, particularly those above Medicaid-eligibility limits, and to include non-medically-related services.

SERVICES IN NEED OF EXPANSION

The following are prioritized lists of the services which should be expanded in the state based on this study's analysis of need and the availability of services to meet that need. The first list consists of those services which need to be expanded statewide; the second consists of those services which need expansion in some areas of the state.

Services in Need of Statewide Expansion

1) Attendant/Personal Care

Because of the high need for this service in maintaining independent living for elderly and disabled individuals, the limited number of programs offering this service, restrictive eligibility criteria, program restrictions and work disincentives in current programs, ATTENDANT/PERSONAL CARE SERVICES should be the first priority for statewide expansion. In addition, this service should be expanded to include provision of non-medically related tasks such as homemaking services (current programs limit attendant care to medically-related personal care only) and to provide eligibility to impaired individuals whose income is above current eligibility limits.

2) Homemaking Service

Again, because of the high need for this service in maintaining independent living for elderly and disabled individuals, restrictive eligibility criteria, limited funding in current programs, and indication statewide through the home care agency survey that this service is most in need of expansion, HOMEMAKING SERVICES should be the second priority for statewide expansion.

3) Respite Care

Because of the limited number of programs offering this type of care, the limited eligibility criteria, and the desire to assist families to care for their impaired members, RESPITE CARE should be the third priority for expansion statewide.

4) Family Subsidies

Because of the limited availability in the state, limited eligibility and because this service is important in maintaining family ties and in alleviating the financial burden of caring for impaired individuals in the home, FAMILY SUBSIDIES for impaired individuals living in their family's home should be the fourth priority service for statewide expansion.

Services in Need of Expansion in Selected Areas of the State

Some services, while provided in substantial numbers on an aggregate statewide basis, are not delivered adequately in all areas of the state depending on the size of current programs in the county or region and the distances that must be traveled to deliver the services. Three of the services which tend not to need expansion on a statewide basis but could use expansion in certain georgraphical areas are chore, transportation and home-delivered meals.

Chore services tend to have the largest geographic gaps across the state. Three counties have no providers for this service, either public or private. Because of this and the fact that chore services are needed by most impaired individuals if they are to remain in their own homes, CHORE SERVICES should be a priority service for expansion.

Although transportation services and home-delivered meals are fairly well distributed throughout the state, many counties have difficulty in providing these services to all the individuals in

the county who may need them due to long distances to travel, a dependence on volunteers and, for transportation, the need for special equipment which may be needed to transport disabled individuals. For these reasons TRANSPORTATION and HOME-DELIVERED MEALS should be expanded in counties that find it difficult to meet the need.

SECTION FOUR

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The already high and escalating costs of institutional long-term care have focused concern on ways to restrain these expenditures. Of particular concern to policymakers is the Medicaid program in which institutional care accounts for 65 percent of the $407.5 million program. Restraining these costs, however, will be increasingly difficult as more long-term care services are required in upcoming years. The growth of the elderly and disabled populations combined with an increasing life expectancy indicates that the need for and use of long-term care services will continue to grow. Control of costs will not be possible through reducing this need and use.

The issue, then, is not how to reduce the use of long-term care services but how to ensure that institutional care is reserved for those who really need it and to ensure that those who need a lower level of care have options other than institutionalization. Policymakers face three alternatives for dealing with the increased need for long-term care: 1) not to meet the increased need, 2) to continue the current emphasis on institutional long-term care by increasing the number of nursing home beds, and 3) to develop alternatives to institutional long-term care.

This examination has found that there is a substantial amount of publicly-funded home care provided in Minnesota. Sixteen funding sources which are administered by three state departments provide over $26 million for home care services. All of the target services – chore, homemaking, home-delivered meals, transportation, home health aide, home nursing, attendant/personal care, respite care and family subsidies – are available to some groups in some areas of the state. However, there are numerous problems with the long-term care system generally and the home care system specifically which make the current provision of services inadequate. The predominant problem is an insufficient supply of home care services. Several service gaps exist which preclude individuals in need of home care from receiving the services. All home care services are not available statewide. Programs are often limited to certain population groups such as elderly or low-income individuals. Also many of the programs have restrictions on the type and amount of services that may be provided.

Home care is not a panacea for the problem of high long-term care costs. An expanded system of home care will not close nursing homes since institutionalization will always be required for certain individuals who are greatly impaired. Nor will home care necessarily be less costly than institutional care. Home care costs depend on impairment levels, type and amount of services required, availability of family and informal assistance, and the quality of care. For individuals with extensive and intensive service needs, a nursing home may be the least costly care setting.

Expanded funding for home care should not be expected to result in immediate cost savings in the long-term care system. First, it is unlikely that many individuals who are currently in nursing homes would be able to return to the community. Second, persons currently living at home who need care but receive none would likely make use of home care if it were more readily available, thus adding on a new group of long-term care clients. Third, cost savings from home care would likely be apparent only in the long run. While for a given individual there may be significant and immediate cost savings with use of home care rather than institutional care, overall savings to the system from expanded use of home care would largely result from delaying persons from entering nursing homes and from delaying or reducing the construction of new nursing home beds.

Of the three options which Minnesota policymakers have before them to respond to the current and projected increase of long-term care needs, the first – not meeting the need – is not consistent with past Minnesota policy of providing for long-term care needs. This past concern is evident in Minnesota's decision to include reimbursement of intermediate care facilities in the Medicaid program, in the amount of money spent in Medicaid on long-term care, in previous studies of long-term care conducted in the state, and in the overall climate of concern about the needs of elderly and impaired persons.

The second option – constructing more institutional beds – conflicts with the concern over the high cost of institutional care in general and Medicaid long-term care costs in particular. Other interests, including the appropriateness and quality of care and accommodating the preference of

persons to remain at home in the community, all contribute to the undesirability of this option in responding to long-term care needs.

Given the limitations of the first two options, the third – to develop alternatives to institutional care – seems most desirable. Long-term care costs will continue to climb. Home care and other non-institutional options provide the possibility of slowing the rate of these cost increases and of providing care in a way preferred by most individuals.

In view of the information presented in this report, the following recommendations have been developed for consideration by the Minnesota Legislature.

RECOMMENDATIONS

Recommendation:

It is recommended that between $5,000,000 and $10,000,000 be appropriated annually by the state legislature to provide the following prioritized services:

1) attendant/personal care,
2) homemaking services,
3) respite care,
4) chore services,
5) home-delivered meals,
6) transportation services,
7) home health aide services, and
8) home nursing.

It is recommended that these funds be used as funds of last resort, i.e., they be used for impaired or chronically ill elderly, physically disabled, or developmentally disabled individuals who are ineligible for other public home care programs or for whom home care services are unavailable in an area. The funds may be used to expand existing home care services or to begin new home care services, including 24-hour care and weekend care. Counties or human service boards must use the funds to provide at least one of the listed services.

Target Population

Services provided through these funds should be limited to individuals with the following characteristics:

1) are impaired or chronically ill elderly, physically disabled, or developmentally disabled,
2) are at risk of institutionalization without supportive services,
3) are ineligible for existing public programs or other programs not available to them due to geographic location or program restrictions,
4) have inadequate or no family assistance with service needs, and
5) are unable to pay for privately provided services.

Financing and Administration

1) The state would provide funds to the county boards or human service boards to be distributed to the county welfare agencies and/or public health nursing agencies.
2) The county board or human service board would be responsible for determining the need for these services in their area and distributing the funds accordingly.
3) The funds would be distributed to the county boards or human service boards using the Title XX social services formula which consists of the following components:
   a) social service caseload,
   b) total population in the county,
   c) county Titlx XX expenditures, and
   e) the equalization aid formula.

   This distributional formula would be used in order to avoid the development of a new formula. This would further delay the distribution of the funds to the counties due to rulemaking procedures. Using an existing formula would be more expendient.
4) These proposed funds would be available either to provide services directly; to purchase services from a private nonprofit, proprietary or other public agency; or funds could be paid to family members to provide care or directly to individuals to purchase services.
5) To ensure that these funds would not be used to offset current home care expenditures and would be used to expand the supply of home care services, counties receiving this money would be required to maintain the fiscal year 1979 level of service expenditures from all sources of funding for each of the specified home care services.
6) Fees for services on a sliding fee basis would be collected from those individuals with an ability to pay according to their income level.

Cost Analysis

The following is an analysis of the services which may be provided given varying levels of appropriation. The matrix indicates the average number of people who can be served with $1 million increments of funding. It is felt that $5 million should be a minimum annual appropriation since, when divided among counties, a lower appropriation would not provide counties with an adequate level of funding to provide an increased number of services. This matrix can be used to determine the appropriation level needed to provide a specific number of services. It should be noted that these are based on average costs and average hours of home care services used by the impaired target populations. The $1 million funding increments may provide more or fewer services depending on the type of individuals served (whether they are more or less impaired than the average clients) and the actual cost of the service.

Service	Average Cost Per Hour	Average Hours/Week Average Hours/Year	No. Units of Service Provided Per Year*	No. Clients Served/ Year
Chore	$3.28	1.5/week 78/year	304,878 hours	3,909
Homemaking	5.94	8/week 415/year	168,350 hours	405
Home-Delivered Meals	1.36 per meal	7 days/week 365 days/year	735,394 meals	2,015
Transportation	.15 per mile	—	6,666,667 miles	—
Home Health Aide	7.37	1.5/week 78/year	135,685 hours	1,740
Home Nursing	23.31	1.8/week 94/year	42,900 hours	456
Attendant/Personal Care	4.50	5.4/week 281/year	222,222 hours	791

*Given $1,000,000 annual expenditures.

Recommendation:

A pilot pre-admission screening program for current and potential Medicaid recipients should be developed to prevent inappropriate nursing home placement.

Before the costs of institutionalization can be controlled, there must be some control over the rate of admissions to institutions. As reported in this study, 483 Medicaid-eligible individuals currently in intermediate care facilities and skilled nursing facilities have physical and mental conditions which would allow them to maintain independent lives. A pre-admission screening program may have prevented or delayed the admissions of some of these individuals to nursing homes.

The current system of reviewing individuals after they have entered the nursing home is adequate for determining changes in condition and preparing for discharge, but it is not adequate for assessing the appropriateness of admissions. As stated previously, once individuals are placed in a nursing home it is difficult, if not impossible, to discharge them. They may have sold their homes, depleted their financial resources or have few friends or family members remaining to assist them with the transition to independent living. The point at which to assess the appropriateness of placement is prior to admission in order to prevent the individual from becoming dependent upon the institution.

Currently, at least six states — Connecticut, Montana, New York, Pennsylvania, Utah and Virginia — use a pre-admission screening program for Medicaid recipients. Some of these states also require the assessment of individuals who will be eligible for Medicaid within 90 days of nursing home admission. Although only fifteen percent of individuals who enter institutions are Medicaid-eligible, the Medicaid program is currently paying all or a portion of the costs of nursing home care for 70 percent of all nursing home residents. As a result of the spend-down provision in the Medicaid program, many individuals enter nursing homes on a private pay basis but in a short time spend all their resources on the cost of nursing home care and become eligible for Medicaid.

Two of the states that have instituted pre-admission screening — New York and Virginia — have evaluated the program and found a reduced rate of Medicaid admissions into nursing homes. The evaluations indicate that in the first year of the program in Monroe County, New York, the county decreased its Medicaid admission rate to nursing homes by 28 percent. In Virginia, a statewide program decreased the Medicaid nursing home admission rate by 25 percent in one year.

Administration and Financing

1) It is proposed that this program be mandatory for all Medicaid-eligible individuals and all individuals who would be Medicaid-eligible within 90 days of entering a nursing home. In addition, the screening program would be available on a sliding fee basis to all residents of the state who may be in need of long-term care.
2) Assessment of the need for nursing home care would be the responsibility of the public health nursing agency in the individual's county and would be performed by a team comprised of a public health nurse, a physician, a social worker from the county welfare agency and possibly the individual's physician, and the individual seeking nursing home placement or a representative. The county welfare agency would administer the program and would reimburse the public health nursing agency for the cost of the assessments.
3) No individual who is eligible for Medicaid or within 90 days of Medicaid eligibility would be admitted to a nursing home without written authorization from the county welfare agency and the public health nursing agency.
4) No individual would be denied admittance to a nursing home if: (a) the individual was assessed to need long-term supportive services and (b) supportive services other than nursing home care were not available in that area.

5) The screening program should be conducted initially on a demonstration basis in two or three counties to evaluate its effectiveness and to project the impact of a statewide program.
6) The screening program would be financed primarily through federal Medicaid funds. (Federal reimbursement for pre-admission screening programs is allowed under current regulations.) Federal Medicaid funds would reimburse 55.26 percent of the costs of screening the recipients and 75 percent of the cost of administering the program. A state appropriation and county match would fund the remaining 45 percent of the cost of screening the recipients, the remaining 25 percent of the cost of administering the program, and the costs of subsidizing the non-Medicaid recipients who choose to have the screening performed. These non-Medicaid individuals would pay according to a sliding fee scale and the state would fund whatever cost remains after the fee is applied.
7) The agency roles for this program would be as follows:

   a) The state Department of Public Welfare would supervise the program, select sites for the demonstration, and establish an evaluation procedure to assess the outcome of the project.
   b) The county welfare agencies would assess an individual's eligibility for the assessment, arrange the assessment with and reimburse the public health nursing agency and collect the client fees.
   c) The public health nursing agency would perform the individual screenings and assess individuals' need for long-term care.
   d) If nursing home care was found to be inappropriate, clients would use the existing service system to arrange alternative services, if needed.

Cost Analysis

The following analysis of the cost of the program is divided into two components. The first component determines the cost of a mandatory program available only to Medicaid recipients. The second component determines the cost of a program which is mandatory for Medicaid recipients and is available to all other residents of the state who are considering nursing home placement. Due to lack of data, a cost analysis including those within 90 days of Medicaid eligibility upon entering the nursing home is impossible. However, the two components which are discussed give a minimum and maximum cost of the program if implemented on a statewide basis.*

1977 Admissions to Nursing Homes and Boarding Care Homes	23,369
1977 Medicaid Admissions to Nursing Homes (SNF and ICF)	4,162
Annual Cost of a Pre-admission Screening Program for All Admissions**	$1,335,295

	Screening Costs	Administrative Costs	Total Costs
Federal Share	$ 126,496	$37,500	$ 163,996
State Share	1,148,544	6,250	1,154,794
County Share	10,255	6,250	16,505

Annual Cost of a Pre-admission Screening Program for Medicaid Recipients Only	$ 278,910

	Screening Costs	Administrative Costs	Total Costs
Federal Share	$ 126,496	$37,500	$ 163,996
State Share	92,159	6,250	98,409
County Share	10,255	6,250	16,505

Recommendation:

The Department of Public Welfare should include homemaker services under the Medicaid attendant/personal care program.

Under current federal Medicaid program regulations, the Medicaid program can pay for certain homemaking tasks when they are provided to clients receiving services through the Medicaid attendant/personal care program. Other states, including New York and New Jersey, either are currently allowing reimbursement for these services or are in the process of changing funding sources from Title XX to Title XIX. This modification in Minnesota's attendant/personal care program is recommended for the following reasons.

1) Although the scope of the current attendant care program includes only medically-related services, the disabled recipients need assistance with other activities of daily living. This care is often not available from other sources. If it is available through the Title XX program, it frequently results in the county sending two individuals into the

*Based upon a $55 per screening payment to the public health nursing agencies and total administrative costs of $50,000 annually.

**This cost projection assumes that the state will pay for the total screening cost of all non-Medicaid admissions. It does not take into account any county share which might be required or any cost sharing on the part of the client.

recipient's home to perform tasks which could be completed by one individual. Since without this care independent living may be impossible, counties should assure that these services are available.

2) Providing these services through the Medicaid attendant/personal care program would result in the county sending only one person to complete all of the tasks needed by the disabled individual. Additionally, the state would maximize federal dollars since the federal Medicaid program would contribute over 55 percent to the costs of the providing this service. In addition, this program would make use of an unrestricted funding source rather than using the limited Title XX program, freeing those funds for provision of other Title XX services.

Administration and Financing

This program would be administered under the current Medicaid program in Minnesota.

Cost Analysis

Based on the current caseload of 67 individuals in the Medicaid attendant/personal care program, and given an average number of hours of homemaking services of 5.6 per week at $4.50 per hour (which is the current salary level for Medicaid attendants), the additional cost to the Medicaid program would be $87,797 annually. The federal government would reimburse $48,727 of this expenditure, the state government would pay an additional $35,119, and the county could pay the remaining $3,951. For each additional individual entering the program, an average of $1,310 per year would be added to the cost of the program. It should be noted that only those individuals who qualify under the Medicaid attendant/personal care program would be eligible to receive the homemaking services under this program.

Recommendation:

The legislature should make the following modifications to the Mental Retardation Family Subsidy Program:

1) that the MR-FSP be established as a permanent department program rather than a pilot,
2) that there be no maximum limit on the number of children in the program,
3) that the maximum monthly subsidy payment of $250 be waived in cases of extraordinary need, not to exceed 50 percent of the potential average institutional costs for the child,
4) that the subsidy be granted on a per child basis rather than on a per family basis, and
5) that the legislature appropriate $1,200,000 for the biennium to the Mental Retardation Family Subsidy Program.

The Mental Retardation Family Subsidy Program has been a pilot program for four years. Evaluations have indicated its effectiveness in reducing the financial burden on families with mentally retarded children. For this reason, the program should become a permanent department program.

The 50-family limit has resulted in the return of money to the general fund every year, at the expense of serving additional families within the legislative allocation. In fiscal year 1978, the 50-family ceiling prevented, at a minimum, an additional 14 families from being served. In fiscal year 1978, $43,817 (25.6%) was returned to the general fund; $20,142 (13.2%) was returned in fiscal year 1977.

The individual needs of families vary due to the uniqueness of each situation. Seventeen (34%) of the participating families have documented needs above the $250 per month maximum. In addition, 22 (44%) families are currently receiving less than the maximum monthly subsidy. However, according to law, the unused funds: (a) cannot be directed to those families requiring additional assistance in excess of the $250 limit, or (b) cannot be used to place additional families on the program.

Two families in the program each had two retarded children, but were limited to $250 for both children. Both families had eligible expenses as a result of providing for their two children in excess of the $250 limit.

Cost Analysis

The request for an appropriation of $1,200,000 is based on a documented need for a minimum of 200 children at $250 per child. There should be no legislative limit to the number of children in the program. Within this budget, it is estimated that the Department of Public Welfare should have the ability to fund more than 200 families.

Recommendation:

The legislature should establish a pilot family subsidy program modeled after the Mental

Retardation Family Subsidy Program for families who are providing or will provide care for their developmentally disabled, physically disabled or impaired elderly members within the same household.

As has been shown in the evaluation of the Mental Retardation Family Subsidy Program, family subsidies are an effective means of providing financial assistance to families with disabled members. These families are particularly burdened with extraordinary expenses due to the presence of the disabled member and in certain cases this results in institutionalization which may have been prevented if financial assistance had been made available. For these reasons, other impaired population groups should have access to family subsidies. This recommendation would make family subsidies available to the other target population groups of this study — the developmentally disabled (other than the mentally retarded), the physically disabled and the impaired elderly.

Administration and Financing

The eligibility for this family subsidy program would be based upon the presence of a severely disabled family member residing in the family's home, who is ineligible for other family subsidy programs and needs special care which is not ordinarily provided in a family setting. In addition, the family must be unable to privately purchase or provide the needed care. An assessment would be completed which would determine whether a family meets these criteria. Once a family is determined to be eligible for the program, the amount of the subsidy (not to exceed $250 per disabled member) would be based on extraordinary expenses incurred by the family due to the presence of the impaired individual in the home and the family's and/or individual's income. This subsidy program would be reserved for the most severely disabled individuals in Minnesota, i.e., those who would be unable to live independently. Without assistance by the family, the individual must need institutional placement.

Cost Analysis

An annual appropriation of $450,000 is recommended for this pilot program. These funds would provide family subsidies for at least 50 families with elderly members, 50 families with physically disabled members and 25 families with developmentally disabled members. In addition, $50,000 would be needed for program administration and evaluation.

Recommendation:

The Departments of Health and Public Welfare should be directed to examine the various types of home care regulation and make recommendations to the 1980 Minnesota legislature regarding action that should be taken.

Concern has been expressed by the home care advisory committee and various providers regarding the lack of quality assurance and regulation for home care services. These services are provided to an impaired and vulnerable population with little direct supervision. This can result in a potential for abuse and neglect if agencies do not provide quality services. Regulation of this industry is currently limited to providers of publicly funded services. This includes Medicare/Medicaid certification of home health agencies and minimal training requirements under Title XX. This, however, excludes a number of agencies and providers from any regulation.

Regulation can be used to accomplish a number of goals: the control of new agencies entering the market, quality assurance, and the expansion of additional agencies into the Medicare and Medicaid programs. Depending upon the intended goal, different types of regulation can be used.

Certificate-of-need is one type of regulation for home health agencies. It serves to limit the number of agencies in an area by requiring new agencies to prove an unmet need for their services. This is particularly useful if there is an adequate supply of services in an area and a need to prevent overexpansion or duplication. Certificate-of-need does not control quality nor does it ensure an adequate distribution of services across the state. Minnesota does not currently include home health agencies under certificate-of-need.

Certification is the procedure which non-profit home health agencies must go through in order to receive reimbursement under Title XVIII (Medicare) and Title XIX (Medicaid).

Federal regulations stipulate that proprietary agencies cannot be certified unless licensed by the state. Certification serves to maintain minimum levels of quality and training for services paid for with Medicare and Medicaid funds.

Licensure is a possible state regulation of home care agencies. It can be as lenient or as stringent as the state desires. Typically it is used to guarantee certain levels of quality by enforcing training

requirements and minimum levels of supervision, in combination with inspections of the agencies' premises. If a state has a licensure law, no agency can operate without meeting the standards. However, no matter how stringent the licensure requirements, licensure does not supplant certification requirements. Licensure allows proprietary agencies the option of becoming certified for Medicaid or Medicare reimbursement but does not automatically make them eligible for reimbursement. Minnesota does not currently have a licensure law.

All of these types of regulation have different goals and outcomes. However, the home care industry may be in need of some type of regulation, particularly if new money is appropriated to further expand services. The Departments of Health and Public Welfare should be directed to examine the various types of home care regulation and make recommendations to the 1980 Minnesota legislature regarding action that should be taken.

APPENDIX A

STATES' ACTIVITIES AND DEMONSTRATION PROJECTS IN HOME CARE

INTRODUCTION

The increased interest in expanding long-term care options has resulted in an assortment of programs and activities providing home care services throughout the United States. For several years federal, state, regional and local governments and private organizations alike have conducted a variety of home care programs intended to expand the supply of home services and improve their delivery. An examination of what other states have done and are currently doing with regard to home care and a look at some of the most notable demonstration projects may yield insights and indicate possible directions for Minnesota in improving its long-term care system.

Information for this report was gathered by examining the literature, by writing to all the states about their recent and current activities in home care, and by visiting those demonstration projects that appeared to be the most innovative.

GENERAL TYPES OF STATES' ACTIVITIES

Many of the states contacted provide home care services through the "conventional" programs such as Titles XIX or XX with no special attempts to broaden the scope of services provided or meet client needs more comprehensively than categorical programs usually allow. Several states, however, have enacted legislation or otherwise tried to improve or expand their home care services by the following types of activities:

- mandating home care services under Title XX;
- mandating private insurance coverage of home health care;
- requiring licensure, certificate of need, or other regulation of home care agencies or services;
- requiring prior authorization or pre-admission screening under Medicaid for appropriateness of nursing home placement;
- expanding the scope of services offered under current programs, e.g., New York provides homemaker services under Medicaid;
- providing supplementary payments for home care under the SSI state supplement;
- appropriating state funds to expand existing service programs or to begin new programs; and
- setting up mechanisms for case management or service coordination, such as the Massachusetts system of Home Care Corporations.

Following are brief descriptions of states' activities in home care.

Alabama

Alabama provides homemaker services, adult day care and adult foster care through Title XX.

Alaska

No information is available.

Arizona

Home care services are available through a state supplement to SSI recipients. Some counties also provide services through Title XX and the county health department. The state is currently conducting a study to determine the need for a statewide program providing homemaker, home health, housekeeper and chore services. The report will be submitted to the legislature.

Arkansas

No information is available.

California

California has developed an In-Home Supportive Services program (IHSS) providing chore, homemaker, meals, personal care, protective supervision and rehabilitative instruction services to approximately 75,000 aged, blind and disabled individuals. The program is state supervised by the Department of Social Services and county administered. It is funded with a $91 million federal Title XX allocation and a $63 million state appropriation for a total annual program budget of $154 million. Clients are eligible for IHSS if they meet SSI eligibility criteria. If the client's income is below the SSI standard, the services are provided at no charge. If the client's income is above the SSI standard, the excess income is applied to the cost of the service. Providers for the program include: 1) public and private agencies (including

proprietary), 2) county welfare employees, and 3) individual providers (including relatives). Payments may be made directly to the client to hire an individual provider.

Colorado

Colorado has a demonstration Medicaid waiver project based on the Wisconsin CCO. (See Wisconsin.)

Connecticut

(See in-depth report.)

Delaware

No information is available.

District of Columbia

No information is available.

Florida

Florida currently has two programs directed at preventing inappropriate or unnecessary institutionalization. The first program is Community Care for the Elderly, which was passed by the legislature in 1976 as a demonstration and has retained that status. It is administered by the Department of Health and Rehabilitative Services. The demonstration has seven sites which include four programs: 1) family placement, 2) multiservice senior centers, 3) home care, and 4) adult day care.

The second project is Home Care for the Elderly. In 1978 the legislature appropriated enough money to make it a statewide program providing for up to three elderly individuals to reside in an adult, family-type situation. It is funded by a subsidy payment through SSI.

Georgia

Georgia has a three-year Medicaid waiver project entitled Alternative Health Service Project. The project began in July, 1976, and will continue through 1979. All individuals who are over age 50, eligible for Medicaid, with physical health problems and at risk of nursing home placement within a few months (or currently in a nursing home) are eligible. The project has three service alternatives which attempt to provide appropriate levels of care at lower costs. These include:

1) alternative living services,
   - adult foster care,
   - board and care,
   - congregate living,
2) home-delivered services, and
3) adult day care.

The program is administered by the Department of Human Resources and operates in two of ten health districts.

Hawaii

Hawaii provides chore, homemaker and individual/family adjustment services through Title XX.

Idaho

Idaho is in the process of developing a proposal for a neighborhood aide program. No other information is available regarding Idaho's program.

Illinois

Illinois has a model program consisting of three comprehensive alternative care centers. The state hopes to develop 11 new centers next year. The program is designed around a case management system and provides adult day care, homemaker, chore and health screening services to clients over age 60, with Title XX funding and a state appropriation.

Indiana

Indiana provides personal care assessments for the elderly, and homemaker, handyman, home health and transportation services through Title XX.

Iowa

Since 1977 Iowa has appropriated state funds to expand public health nursing and homemaker/home health aide services for the elderly. This money, $1,600,000 in FY 1978 and $2,228,000 in FY 1979, is administered by the Health Department. The University of Iowa is evaluating the current system of home care in the state.

Kansas

Kansas provides homemaker services through Title XX. They are also working on a plan to have a statewide home health service.

Kentucky

Kentucky has implemented a home care demonstration project entitled Project Independence for the Elderly. The project is directed at assisting local communities in the provision of the following services: homemaker, personal care, home management, housekeeping, home-delivered meals, congregate meals, tenant counseling, transportation, day care, community-based living, information and referral, crisis intervention, chore, friendly visitor, recreation, consumer protection, telephone reassurance, safety services, group activities, employment services, education services, assistance in securing prosthetic devices and assistance in securing or providing cosmetic care and weight control.

The Kentucky legislature has also mandated the provision of the following services statewide: homemaker, home therapy, day care, meals, transportation, foster care and home health.

Louisiana

No services are available.

Maine

A 1977 law provided for home health coverage in all health care insurance policies and contracts.

Maryland

Maryland has one home care program entitled Community Home Care Services which is a coordinated social services program serving the elderly. The following services are available: home care, case aide, protective services, health-related services, and foster care.

Maryland is also implementing a pilot domiciliary care project at three sites. This project will include three alternative living arrangements: licensed domicilary care, adult foster care and family group care and is expected to be implemented statewide by 1981.

Mississippi

Homemaker, meals, day care and recreational services are provided by the counties.

Massachusetts

Massachusetts has developed a system of 27 Home Care Corporations enabling elders to remain in their homes as long as possible. They are non-profit corporations that act as funding magnets and administrative resources for local aging programs, providing case management, information and referral, and subcontracting with vendors for other services. All corporations provide homemaker service, chore service, transportation, case management, protective services and information and referral. They are attempting to use Medicaid funds for services provided through the program. Funding sources for the program are Titles III, VII, and XX, and a state appropriation.

Michigan

Chore services and personal care are provided through Title XX. The client is the employer and chooses either agency staff or individual providers, including relatives. Eligibility is limited to SSI recipients or potential recipients.

Missouri

No information is available.

Montana

Montana provides the following home care services: home health, meals, shopping assistance, homemaking, transportation, day care and foster care. They have a pre-admission screening program for long term care placement and are looking into the possibility of turning nursing home wings into non-medical personal care homes.

Nebraska

Nebraska provides chore, homemaker, legal and meals services through the Area Agencies on Aging. Home health agencies provide home health services. The state has submitted two model project applications to the Administration on Aging. The first would be a community care model incorporting service integration, assessment and Medicaid waivers. The second would be a community continuum of care model concentrating on rural areas and a single-entry model, relying on a consortium of nursing homes and senior centers for service provision.

Nevada

Home care services are mandated statewide through Title XX.

New Hampshire

New Hampshire provides home health, nursing, homemaker, chore and day care services through Titles XIX and XX.

New Jersey

New Jersey provides home health and medical day care through Medicaid. Services under medical day care include: medical services, nursing services, counseling, shopping assistance, discharge planning, transportation, personal care, dietary services, social activities and rehabilitative services. They are in the process of transferring homemaker services from Title XX to Title XIX under attendant care services. Under this program Title XIX would be the "payment of first resort." Services for individuals not eligible for Title XIX would be provided by Title XX. If no money was available under Title XX, Title III would provide the service.

New Jersey has prior authorization for nursing home admission **and** for home health care.

New Mexico

No information is available.

New York

(See in-depth report.)

North Dakota

North Dakota has nine certified home health agencies.

Ohio

Current programs are unknown. Legislation is pending on two issues:

1) the licensure, certification and regulation of home health agencies, and
2) the application of 75 percent of the cost of an individual's institutional care to the provision of home care.

Oklahoma

No information is available.

Oregon

Oregon has implemented Project Independence. In 1975, the legislature appropriated $1 million for the biennium. This was increased to $2.7 million in 1977. The program is administered by the Department of Human Resources and is meant to provide services to individuals over age 60 who are at high risk of institutionalization. Priorities are given to individuals over age 70 who are living alone. Individuals with income under $3000 ($5000 for a couple) receive the services free. If income is above those limits, fees are charged. Welfare recipients are **not** eligible. The money is distributed to the area agencies on aging and to nonprofit incorporated councils to provide the following services: telephone reassurance, friendly visitor, screening, counseling, outreach, escort, chore, homemaker, meals, and home health.

Pennsylvania

Pennsylvania provides homemaker, chore, meals, day care, transportation, protection, legal, social/recreational, education, housing improvement, employment, foster care, domiciliary care, service management and assessment services through the area agencies on aging.

The Westmorland County Area Agency is experimenting with pre-admission assessments for the county nursing home.

Rhode Island

No information is available.

South Carolina

No information is available.

South Dakota

No information is available.

Tennessee

No services are available.

Texas

As part of its Title XX plan, Texas has a program of community care for aged, blind and disabled adults with the goal of preventing inappropriate institutionalization. Along with the usual services – chore, homemaker, day activity, meals, health assessment, protection and information and referral – alternative living plans and family care services are provided.

In family care services clients recruit one or more individuals to provide household services, companionship, protective supervision and personal care, including medically-related personal care if the provider has received training and is approved by the client's physician. The state Department of Human Resources approves payments. Local social service workers assess the ability of the provider to perform tasks based on state minimum standards.

A "Mutual Aid – Self Help" pilot project operates to organize older persons to provide home care services to each other on a volunteer basis to prevent or delay inappropriate institutionalization. This is a joint project between the state welfare department and University of Texas.

Utah

Utah has developed an Alternatives Program for the elderly which incorporates nursing home pre-admission screening and individual case planning to reduce the number of inappropriate or premature admissions of elderly into nursing homes. An individual must be over 60 and within 90 days of institutionalization to be eligible. The individual's physician and the assessment must also determine that home care is appropriate for the individual.

The program does not replace informal systems of assistance, Titles III, VII or XX. A sliding fee scale is used for individuals with incomes above 74 percent of the state median income.

Vermont

No information is available.

Virginia

The Virginia Department of Welfare provides homemaker, chore and companion services through Title XX. The Department of Health administers a nursing home pre-admission screening program for individuals who are or will be eligible for Medicaid within 90 days. Nursing home Medicaid admissions declined 25 percent since this program went into effect.

Washington

In 1976 the Washington legislature passed the Senior Citizens Services Act, a model project administered by the Department of Social and Health Services. With a biennial appropriation of $11.8 million, the program provides health screening, day care, home health aide services, volunteer services, nutrition services, homemaking services, legal services, home maintenance, chore services and death counseling for low-income elderly. Services are free to individuals with incomes below 40 percent of the state median income. Sliding fees are charged to those with higher incomes.

West Virginia

The Department of Welfare provides chore, meals and homemaker services through Title XX. Individuals eligible for SSI with income not exceeding 37 percent of the state median income are eligible. No one under 18 is eligible. Chore services are provided by neighbors, friends or relatives. Homemaker services are provided by agency employees.

A Home Health Services Act was recently passed resulting in statewide availability of home health care.

Wisconsin

(See in-depth report.)

Wyoming

Wyoming provides homemaker services through Title XX.

MODELS OF HOME CARE SERVICES

The home care projects which are examined in this report are both ongoing and temporary and differ from each other in three major ways: financing, service delivery and organization. Some of the major alternative ways of organizing each of these areas are presented here, to indicate how the more innovative home care programs differ from the more conventional ones.

Financing

In an attempt to get more flexibility into the existing categorical programs (which tend to be limited to specific services for particular categories of persons) some of the projects have obtained waivers of federal and state rules and regulations. Waivers are usually of regulations pertaining to statewideness and amount, duration and scope of services. Although waivers are usually of Medicaid regulations as in Wisconsin, Colorado, Georgia,

New York and Oregon, Connecticut's Triage project has a Medicare waiver.

Alternatively, projects may pool various categorical funds under central management. This pooling of funds may be at the state or local level and may combine funds from any number of programs, with or without waivers. Connecticut's SAIL program, for example, pools funds from Title XX, Title III, a state aging appropriation, and private agency contributions.

Some of the projects examined use or are interested in using payment methods which differ from the usual reimbursement of service providers on a fee-for-service basis, with capitation and disability payments the most common alternative methods. In a capitation system, a fixed amount is paid for each person served per period of time without regard to the amount or nature of services provided to the person. Massachusetts is interested in demonstrating this mechanism. On the other hand, disability payments are made to individuals based on the degree of disability and, in some cases, financial need. The individual is responsible for purchasing any needed services. Under its Title XX program, Milwaukee County provides disability payments to be used for home care services.

Service Delivery

Service delivery systems may be characterized by the functions performed. Major functions include:

- intake into the system,
- assessment of client need,
- advocacy with providers to arrange services,
- indirect service provision (through purchase),
- direct service provision, and
- monitoring, follow-up, and reassessment of need.

How these functions are combined vary considerably among the home care programs examined, although the existing demonstration projects all provide a more comprehensive assessment of client needs than is commonly performed. This comprehensive assessment is usually one of the most prominent features of the demonstrations. Some projects, such as Triage, have staff to perform the assessment, while others, including Monroe County, purchase assessments. Connecticut's SAIL program uses both direct and purchase methods for their assessments.

The major demonstrations follow client assessment with case planning and provision of services. Although some projects are limited to assessment, case planning and advocacy with provider agencies for clients, most of the demonstrations also provide services. Most projects try to utilize existing community services (purchasing services rather than providing them directly) and cite numerous reasons for extensive use of contracting including:

- allowing the demonstration project staff to focus on assessment, case coordination and follow-up tasks;
- reducing start-up time and costs;
- utilizing expertise in the community; and
- facilitating interest in and cooperation with the demonstration project on the part of community agencies.

Where a particular service is unavailable or inadequate, the demonstration projects may hire staff for direct provision of services.

A prevalent characteristic of the demonstration projects is that they are single-entry points to long-term care services. In a single-entry system, a client can enter the system at one point and have access to all needed services, unlike a multiple-entry system where clients may have access only to the particular services provided by the agency to which they happen to go.

The services provided and clients served by the demonstrations vary according to their funding sources, project design and sites. Some services are common to virtually all projects. These services include: case management, homemaker, chore, home-delivered meals, transportation, home health aide, home nursing, companion, counseling, friendly visiting, shopping assistance and education. Other services frequently offered are respite care (both in and out of the home); day care; physical, speech and occupational therapies; education for family members; medical and dental care; medical supplies and equipment; assistance with living arrangements; moving assistance and home repair/renovation.

Most of the demonstrations are targeted at the elderly although the Wisconsin CCO also serves younger disabled adults. While most projects limit services to low-income clients (e.g., Medicaid-eligible), at least two, the Washington State Senior Citizens Services Program and Oregon's Project Independence, serve persons above the public assistance income levels.

Service Organization

The organization of services varies considerably in terms of degree, type and location of control. The most common model seems to have basically centralized control (at the state or local level) by either a single agency or a consortium of agencies. Some degree of decentralization of authority is common in many projects, within a framework established by the central group. In Connecticut's SAIL program, for example, a comprehensive client assessment is a central feature of overall program design, but is handled differently by each of the five sites.

Following are more in-depth descriptions of innovative home care projects in three states. These projects, which include both demonstration and ongoing programs, are:

Connecticut:	SAIL Triage, Inc.
New York:	Monroe County Long-Term Care Program, Inc. The Lombardi "Nursing Home Without Walls" Program
Wisconsin:	Milwaukee County Supportive Home Care Program Wisconsin Community Care Organization

CONNECTICUT – SAIL

General Program Description

Strengthened Assistance for Independent Living (SAIL), sponsored by the Connecticut Departments of Aging and Social Services, is designed to develop alternative care for persons aged 60 and over who are within 90 days of inappropriate institutionalization or already institutionalized. Combining funds from a variety of sources, primarily state appropriations and Title XX, the program provides comprehensive client assessment and case planning, and purchases up to 20 different services. This is an ongoing program, not a demonstration.

The program began in 1975 and has expanded to five areas within the state, including 49 towns. The state Department on Aging, which is responsible for the overall administration of the program, contracts with the area agencies on aging (AAA) to administer the program in the regions. Each area program is funded based on its ability to meet needs of area elderly. Thus, there are variations in the extent of coverage, level of funding and project organization among the areas. The area agencies subcontract with provider agencies for services.

Eligibility

Any person meeting the following three requirements is eligible for assessment and case planning regardless of income:

- aged 60 or older;
- resides in one of the towns served by the program; and
- is within 90 days of institutionalization if a viable social support system is not available.

SAIL has purposely not clarified guidelines for the third eligibility factor, feeling that individual professional judgments are the most appropriate in order to avoid making arbitrary decisions regarding individuals.

Service Delivery

SAIL is designed as a single-entry point into the services system, providing comprehensive client assessments, case planning and service arrangements. The process works as follows.

1) A detailed telephone prescreening is performed.
2) If a client is found to be appropriate, a two-hour assessment of eligibility and condition is done by a nurse and/or social worker in the client's home, hospital, or nursing home.
3) A case plan is developed.
4) Services are arranged (whether financed by the program or not).
5) Services are purchased (if the client is income-eligible).
6) A reassessment is done at least once every three months.

Most of the variations among sites are in assessment and case planning approaches. While some projects have SAIL staff perform assessments, others purchase some or all components of the assessment from community agencies. (Title XX training money is used to train nurses from vendor agencies to do comprehensive assessments.) Case planning is done in a variety of ways. It may be done by the same individual or team that performed the assessment, or it may be done

by a committee of providers entirely separate from the assessors. This latter type of case planning has been controversial within the project. Those who favor it believe that a committee can bring more expertise and greater awareness of available resources and that it facilitates acceptance of SAIL by agency personnel. Those opposing this type of case planning maintain that there could be a conflict of interest if providers are involved in case planning; that it is more time-consuming; that if planning is not done with the client in the client's home, the services may be less acceptable to the client; and that there are problems with personality conflicts.

Each of the five SAIL projects offers some of the twenty services listed below:

Service	Percent of Clients Receiving Service	Percent of Total Service Dollars Spent
Case management	100.0	—
Homemaker	59.5	45.5
Home health aide	21.4	16.5
Nursing	19.1	9.3
Chore/handyman	14.0	*
Companion	13.8	11.4
Home-delivered meals	11.1	9.3
Day care	5.9	2.7
Transportation	5.9	1.0
Bath aide	2.4	***
Counseling	1.5	*
Physical therapy	1.5	1.1
Friendly visitors	1.2	***
Shopping service	0.8	***
Education	0.4	**
Meals-on-wheels	0.4	—
Medical social work	0.4	**
Services to family members	0.4	**
Speech therapy	0.4	*
Occupational therapy	0.1	*
Other	—	2.2

*less than one percent
**counted in "case management" category
***included in "other" dollars category

In addition to the services financed through the program, SAIL assists the client in arranging for other services when appropriate. The mix of services provided is influenced by restrictions placed on the use of funds from various sources. Because services are restricted to those allowable under Title XX, funding gaps have occurred. For example, SAIL is unable to finance home health aide care except in those cases where the home health aide services are less than 35 percent of the cost of the care plan. Clients needing more extensive home health aide service are referred to local visiting nurse associations.

As mentioned earlier, all persons meeting the age, geographic and "within 90 days of inappropriate institutionalization" criteria may receive assessment and case planning services regardless of income. The Title XX income scale is used to determine the cost of services to the client, with free services provided to those individuals with a gross income under $6,854 and a sliding fee scale for those with an income between $6,854 and $9,852. A client's assets are not included in determining the ability to pay. Ninety-five percent of SAIL clients have incomes below $6,854.

Except for case management, most of which is provided directly by SAIL staff, all services are purchased by SAIL. Where a particular service was nonexistent in a SAIL area, the project assisted in its development. Services are provided by both public and private (proprietary and nonprofit) agencies and by individual providers. While individual providers are believed to be cheaper and important in providing continuity of care in some cases, SAIL directors prefer not to use them, or use them only in the absence of agency staff.

Problems with the use of individual providers include:

- difficulty with their supervision (SAIL staff are responsible for doing this),
- lack of training,
- lack of job security, and
- lack of employee benefits.

SAIL pays the patient who then pays the individual providers. The project does not pay close relatives due to fears of taking over family responsibility and disrupting family dynamics.

Financing

SAIL combines funds primarily from the Department on Aging's state appropriation ($850,000) and Title XX ($750,000) which are awarded specifically for use by SAIL. These are used to pay for administration, case management and services. In addition to these monies, SAIL projects administer funds from Title III of the Older Americans Act and contributions from local agencies. Additional funding sources used, but not administered by SAIL, include any funds that can be utilized on a case-by-case basis, such as

Medicare, Medicaid, Titles VII and IX of the Older Americans Act, and contributions of clients, families, private agencies and insurance.

In the quarter ending in June, 1978, funding for SAIL was as follows:

Title XX and State Aging appropriations	58%
Medicare	10.4%
Title III	7.2%
Client/Family contributions	7.5%

These funds were used as follows:

Administration	12.8%
Case Management	10.8%
Services	76.4%

Based upon October/November, 1977 expenditure data, the cost per client per month from all sources averaged $290.24, of which $181.50 was direct service cost.

The average total cost for both services and living expenses for a SAIL client was $450.29 per month, which was 47 percent lower than the average reimbursement rate for a skilled nursing facility ($852.88) and 20 percent lower than the average rate for an intermediate care facility ($556.92).

The Future

For fiscal year 1979 the State Department on Aging has requested a state appropriation of $1,575,000 for SAIL ($1,000,000 to maintain current service levels with necessary cost increases and $575,000 to assist in the transition of eligible Triage clients to the SAIL program.)

A major problem with the initiation of the SAIL program was that staff had little idea of the potential demand for the program. Shortly after SAIL began accepting clients, intake of new clients had to be halted because the great demand for the program taxed its limited capacity. No new clients were taken for months and program credibility suffered.

During its first year, SAIL returned 25 persons to the community who had been in nursing homes.

CONNECTICUT – TRIAGE

General Program Description

Triage is a research and demonstration project begun in 1974 which is financed by Medicare trust funds with waivers. A full spectrum of care, including medical, social and other services, both in and out of institutions, is provided through a model incorporating single-entry, comprehensive assessment, case management and regular follow-up. The central purpose of the Connecticut project is to study the cost-effectiveness of service dollars spent for care appropriate to client need rather than according to restrictions of third party payors. Triage operates in seven towns in a central Connecticut planning region whose population characteristics reflect those of the state.

The specific objectives of the project, which will be evaluated by the University of Connecticut, are to:

1) increase the number and availability of home-based services for the elderly,
2) cause a greater integration of human services in the region,
3) reduce the per capita expenditures for health care of the elderly,
4) increase the effectiveness of services for the elderly, and
5) reduce the incidence and prevalence of institutionalization among the elderly.

After a two-year developmental period from 1974 to 1976, which was supported by state appropriations and federal Administration on Aging Model Project grants, Triage received waivers of Medicare regulations and a grant from the National Center for Health Services Research. The full experimental phase of the program began in April, 1976 and will end in March, 1979.

The project operated for two years without waivers. However, Medicare regulations, including those relating to the three-day prior hospital stay, the physician plan of care, coinsurance and deductibles, and allowable services, are currently waived.

As a research project, Triage emphasizes data collection rather than service delivery. Two groups of people, an experimental group (i.e., the Triage

clients) of approximately 1560 and a control group of 200-300, receive initial and periodic assessments, but only those in the experimental group receive Triage's comprehensive services. Persons in the control group arrange their own services in the traditional service system.

Eligibility

Persons eligible for Triage are those aged 65 and older regardless of income and those aged 60 and over who are disabled and eligible for Medicare.

Service Delivery

As previously mentioned, Triage is organized on a single-entry basis, which is a means of gaining access to the variety of types and levels of care through one source. The Triage procedure is outlined below.

1) The client approaches Triage.
2) A comprehensive assessment is performed in the client's home by a geriatric nurse clinician. The assessment documents the person's physical, mental and social needs, including living conditions and functioning status, and assists in planning appropriate services and gathering research data.
3) The nurse performs a modified physical examination of the client.
4) The nurse organizes the information collected and decides on an appropriate care plan. (This differs from the physician plan of care required under usual Medicare regulations.)
5) The nurse and a social caseworker arrange for services to be provided.
6) The caseworker keeps in regular touch with the client to monitor services. This follow-up is done monthly if the client is actively receiving services.

The only service provided directly by Triage staff is case management. All others are purchased. Triage subcontracts with 191 providers of service, most of them agencies. Individual providers are used only for counseling and companion services. Triage has eight nurse/caseworker teams, each of which covers a specific geographic area.

Triage is active in developing needed services which do not exist in the community. For example, in the absence of a meals-on-wheels program, Triage staff worked with local hospitals and restaurants to provide the meals and with churches to deliver them. Likewise, youth groups were approached to provide chore services which were needed but unavailable.

Financing

Since August, 1975, Medicare trust funds have been available to pay for all nurse clinician-approved services. All bills for services go to Triage for review and approval and then are forwarded to the Social Security Administration which issues payments to service providers.

Organization

The Connecticut State Department on Aging contracts with a private, nonprofit organization, Triage, Inc., to operate the program.

Triage, Inc., which was formed specifically for the program, has a board of directors consisting of 18-25 members, who are consumers or members of the boards of directors of provider agencies. The purposes of the corporation are to ensure services within the region; to coordinate the activities of other agencies providing services; to gather information and conduct studies regarding the conditions and service needs of elderly persons; and to receive funds from federal, state, municipal and private sources.

As mentioned, Triage subcontracts with numerous service providers, both nonprofit and proprietary. For those providers who are not certified to participate in the Medicare program, Triage defines the services and regulations which the providers must meet.

The Department on Aging contracts with the University of Connecticut for the research component of the project.

The Future

The Triage project is due to end in March, 1979. About half of its 1554 clients who are eligible for Title XX are expected to be absorbed by the SAIL program (see previous report) within the limits of SAIL's funding. The other half are expected to be immediately institutionalized, indicating the serious condition of many of the project's clients.

NEW YORK – MONROE COUNTY LONG-TERM CARE PROGRAM, INC.

General Program Description

The Monroe County Long-Term Care Program (MCLTCP) is a demonstration project utilizing Medicaid waivers. It is a nonprofit community organization with goals of:

1) increasing a person's choice of which services should be received,
2) giving increased support and services to patients and persons caring for the chronically ill in their own homes, and
3) reducing total costs of long-term health care services.

The primary service provided by MCLTCP is ACCESS. Through ACCESS, the process of reviewing the patients' service needs, advising the family and patient of what level of care is appropriate, arranging services and following up on the client is provided at no charge to all Monroe County residents over 18 years of age and in need of chronic health services. The emphasis of ACCESS is determining the appropriate level of care and placement. Once this level is determined, a package of services is arranged.

Service Delivery

The following is an outline of the ACCESS process.

1) The project receives a call from the client, the family, a friend or another individual to request services for the client.
2) An assessment of the client is done by a public health nurse (if the individual is at home) or by a hospital discharge planning/utilization review team (if the individual is in a hospital or a nursing home).
3) The nurse or team makes a decision regarding the appropriate level of care and placement.
4) The decision is reviewed by the client's physician and MCLTCP's case manager and is approved or disapproved.
5) Upon approval, MCLTCP's case aide contacts institutions or agencies to start services or arrange a date of entry to a nursing home.

At MCLTCP, it is felt that an issue in long-term care is not only that an individual receive an appropriate level of care but also that the person be placed in an appropriate setting. Although the emphasis of the program is directed toward home care, MCLTCP feels that at some point institutionalization may be needed. Home care thus is limited to situations where its cost is less than 75 percent of the cost of an equivalent level of nursing home care. If the cost of home care exceeds the 75 percent level, prior approval from the director of the Department of Social Services is required. The criteria for approval include the client's prognosis and whether the condition is stable.

The MCLTCP is a Medicaid demonstration project funded 75 percent by the federal government, 12.5 percent by the state and 12.5 percent by the county. The project includes a number of federal and state Medicaid waivers including:

1) allowing payment for the assessments of non-Medicaid eligible persons,
2) waiving the statewideness requirement,
3) using a different assessment form than is used by the New York State Department of Social Services,
4) giving prior approval authority to the project director rather than the state Medicaid director,
5) omitting the confidentiality requirement on patient data, and
6) allowing an expanded range of services.

Eligibility

As mentioned earlier, the ACCESS assessment can be performed on any individual over 18 years of age and in need of chronic health services. If individuals are assessed to need skilled nursing facility or intermediate care facility placement, they are eligible to have services arranged by ACCESS, regardless of their Medicaid eligibility status.

Once the services are arranged, only Medicaid-eligible persons have their services provided at no charge. Non-eligible individuals must arrange some other form of payment, such as private payment, private insurance or Medicare. Even for Medicaid-eligible individuals, however, Medicaid is the payment of last resort.

Services available through MCLTCP include all traditional Medicaid services* plus:

*New York State provides homemaker services through the Medicaid Attendant Care Program.

1) moving assistance,
2) housing and rent subsidies,
3) chore services,
4) limited home modifications,
5) respite care,
6) non-medical transportation, and
7) friendly visiting.

When the service package is approved, a service order is sent to each vendor. Follow-ups on services are conducted at least once every three months. Unless there is evidence of great deterioration, however, this does not include a complete reassessment.

One reason this program was developed was that occupancy rates were low in area hospitals and high in area nursing homes. Because of this, the nursing homes did not admit Medicaid patients. Area hospitals, due to low occupancy rates, lacked incentive to discharge Medicaid patients. There was thus a great demand for nursing home beds in the county by Medicaid individuals waiting in acute care hospitals. One purpose of the MCLTCP was to prevent this phenomenon by placing people in their homes rather than retaining them in the hospital while they awaited nursing home placement.

For the first six months of 1978, there were 28 percent fewer skilled nursing facility and 27 percent fewer intermediate care facility Medicaid admissions than in the same period in 1977.

SNF/ICF Medicaid Admissions
January-June, 1977 and 1978

	1977	1978	Percent Change
SNF	404	290	−28%
ICF	131	96	−27%
	535	386	−27.8%

Also, based on three-month cost projections for services rendered to 302 Medicaid home care clients, the cost of ACCESS services plus an estimated cost for all other Medicaid-reimbursed non-institutional services was calculated at less than 50 percent of the comparable institutional rate.

The Future

The future for MCLTCP is promising. If savings continue to be demonstrated, Monroe County will continue funding the program after the Medicaid waivers and demonstration project are completed in 1981. MCLTCP also is applying for Medicare waivers and Administration on Aging grants to further expand the program.

NEW YORK – THE LOMBARDI "NURSING HOME WITHOUT WALLS" PROGRAM

General Program Description

The Lombardi "Nursing Home Without Walls" bill, which was passed by the New York State Legislature in 1978, is intended to provide a comprehensive, statewide home care program. It's goals include reducing the need for nursing home care, reducing the backlog of patients in acute care hospitals awaiting nursing home placement and reducing nursing home placements of New York residents in other states. "Phased implementation" of the program began in September, 1978. This program is **not** a demonstration, but a permanent program being phased in gradually to cover the entire state. The first site is Erie County with five additional sites expected by the end of the first year.

The Lombardi program will use a single-entry model of service delivery. Sites for this single-entry organization will be chosen by the Health Department according to the areas having the most individuals in acute care hospitals awaiting nursing home placement. Each of the six sites expected to be operating in the first year will be assigned a maximum client capacity.

Three models of service provision will be used by the program to determine the most effective method of service delivery:

1) certified home health agencies,
2) hospital-based home care, and
3) residential-based home care, i.e., nursing homes.

A Medicaid waiver will be needed to permit reimbursement to non-certified home health departments in hospitals or residential facilities. The program will not include proprietary agencies. The providers for each site will be determined on the basis of recommendations by the Health Services Agency (HSA) and the State Hospital Review and Planning Council.

Service Delivery

Along with traditional Medicaid home health and attendant care services, New York has asked for Medicaid waivers to provide the following additional services:

1) nutrition counseling,
2) respiratory therapy,
3) respite services,
4) chore services,
5) moving service,
6) twenty-four hour phone coverage, and
7) medical social services, including mental health counseling and counseling for chronic illness and terminal illness.

New York already provides homemaker services through the attendant care program to all Medicaid-eligible individuals.

Eligibility

To be eligible for the Lombardi program a person must be eligible for Medicaid and adjudged to be a nursing home candidate. An assessment determines whether individuals are eligible for nursing home placement and what services are needed to retain those persons in their own homes. This is considered the crucial aspect of the program. The assessment is completed by a Department of Social Services caseworker and a long-term care nurse initially and every 120 days thereafter. Prior to authorizing placement in a nursing home, the county social services commissioner must notify the patient of the availability of the home care assessment. If the patient and physician agree to the desirability and appropriateness of home care, the assessment is performed. Ninety-five to ninety-eight percent of the clients are expected to be elderly.

Financing

The primary funding source for the Lombardi program is Medicaid. The budget for a client's package of services is limited to 75 percent of the average monthly cost of institutional care. Individuals may accrue paper credits if they do not use the maximum care amounts, which may be used during unusually high cost months (i.e., when the cost of care goes above the 75 percent ceiling). This credit can be carried for one year.

Under this program, Medicaid will be the payor of last resort. The program will attempt to maximize Medicare and third party payments.

Conclusion

New York is attempting to solve the problem of a lack of nursing home beds for those who need them. They feel the only other alternative, to build new nursing homes, would be costly.

Again, the Lombardi program is not a demonstration, but an example of phased implementation of a permanent program. The state is seeking waivers to make the program run more smoothly. The program, however, will be implemented regardless of the outcome of the waiver request.

WISCONSIN -- MILWAUKEE COUNTY SUPPORTIVE HOME CARE PROGRAM

General Program Description

The "supportive home care" program, provided as a Title XX social service, is designed to help adults who are limited by age and/or infirmities to continue to remain at home and prevent inappropriate institutionalization. Payments are made to clients to pay for needed services.

The service must:

- support independence and prevent institutionalization;
- assist the client with activities of daily living which do not require supervision by a health professional; and
- meet the physical, psychological or social needs of the recipient.

Eligibility

Clients served include Title XX-eligible persons over age 65 as well as younger disabled adults. The typical client receives Supplemental Security Income benefits.

Service Delivery

Caregivers are chosen by the client to provide assistance. Eligible caregivers include family members, friends or agency personnel. If the care is provided in the home of the provider, however, the county requires that the provider/client relationship be that of parent, child or spouse. All other relatives are excluded from eligibility as home care providers. They may, however, be certified under another program, Adult Family Care, if they seek to provide care in their home.

A monthly payment is sent directly to the client who then reimburses the provider. The amount of monthly payment varies from case to case, depending upon the severity of the client's disabilities and the degree of care needed. The county establishes a rate based upon a statement of care needs submitted by the client's physician. While there have been isolated problems with individuals requesting higher rates for the services provided, these have not occurred in significant numbers.

The maximum monthly payment is $354 for a client needing the highest level of care, with clients needing a lower level of care receiving a correspondingly lower amount. Currently, 445 adults are receiving this service.

Financing

The program is financed through Title XX.

WISCONSIN COMMUNITY CARE ORGANIZATION

General Program Description

The Wisconsin Community Care Organization (CCO) is a research and demonstration project designed to show that care for the elderly and disabled provided in their own homes or in a community setting can be an effective alternative to inappropriate institutional care. The CCO uses Medicaid funds with waivers for the payment of an expanded scope of services, both medical and non-medical, in non-institutional settings. Sections of the Wisconsin state plan for Medicaid dealing with statewideness, amount, duration and scope of services are waived to create a stable funding source for the project.

Through the funding and coordination of home care services, the goals of the CCO are:

1) to prevent inappropriate or premature institutionalization,
2) to provide for a better quality of life for CCO clients, and
3) to provide needed services at less cost than institutional care.

The demonstration is conducted at three sites, each of which comprises an entire county, one urban (Milwaukee), one rural (Barron), and one urban-rural (LaCrosse). Within the framework of overall goals and objectives, the specific operations of each site vary according to local needs and desires to test various approaches to organization, case management and assessment.

Service delivery at each of the three sites began at different times, with LaCrosse starting in April, 1976; Barron County in July, 1977; and Milwaukee County in December, 1977.

Organization

The Wisconsin CCO, located within the office of the Lieutenant Governor, has overall responsibility for the project and is specifically involved with the establishment of and planning for local sites as well as site supervision and monitoring. The state office contracts with the boards of directors of each of the three sites to operate the program and with the University of Wisconsin to conduct program research and evaluation. A considerable amount of administrative responsibility is delegated to each site.

The organization of the local projects varies among sites. In LaCrosse, the CCO is a newly-incorporated body which has as its members almost 90 agencies and organizations. In Barron County, the project is operated through a special committee of the county board and has as its director the Director of the County Department of Social Services. In Milwaukee County, a non-profit corporation was formed, governed by a 15 member board of directors. The Lieutenant Governor appointed members to the board based on recommendations from the County Executive, the Community Action Agency and the United Way. The members represent public and private social, health and consumer agencies and individuals.

Eligibility

Eligibility varies among sites. In Milwaukee and Barron Counties, eligibility is limited to Medicaid-eligible residents of the county who are over age 65 or over age 18 and blind or disabled (as certified by the Social Security Administration) and who require services to prevent unnecessary or inappropriate institutionalization. In LaCrosse County, any person at risk of institutionalization regardless of Medicaid eligibility is eligible for CCO case management services although the individuals must pay for other services. (Approximately one-third of the LaCrosse clientele are private pay.)

Defining the target population — persons at risk

of institutionalization – has been a problem for the CCO. In Barron County, a panel of medical and social services professionals sets standards based on review of randomly-selected cases of the likelihood of imminent nursing home entry. These standards then are used in determining client eligibility. In Milwaukee and Barron Counties, scores on the Geriatric Functional Rating Scale (GFRS) are associated with the probability of entrance into a nursing home within 18 months. Even if individuals do not score within the imminent range of the GFRS, they may be accepted if the case manager believes that the chances of institutionalization are high without CCO services. To allow greater flexibility, up to 30 percent of the clients may enter the program regardless of their GFRS score.

Approximately 800 clients were served in the first two and one-half years of the program. Milwaukee had about 350 active clients in July, 1978 and expected 600 by December. In December, 1977, the overall state clientele was classified as follows:

Age 65+	68%
Disabled (Age 18-65)	31%
Blind (Age 18-65)	1%

Service Delivery

Community Care Organizations are not direct service providers, but rather are a management system. The CCOs contract with local agencies and individuals to provide assistance under CCO guidelines to clients.

The basic functions of the CCO in each site are listed below, although within this basic framework, local projects vary in the way they perform these functions:

1) receiving service referrals from nursing homes, hospitals, community agencies and individuals themselves;
2) screening applications to determine eligibility;
3) assessing client service needs;
4) arranging the delivery of services;
5) performing ongoing reassessments to re-evaluate the client's service needs;
6) developing needed services for the elderly and disabled.

Several activities are common to all three sites. Each site:

- attempts to enlist or support existing family, community or volunteer assistance when establishing a care plan for clients;
- utilizes paraprofessional staff whenever possible;
- contracts with both public and private profitmaking and nonprofit agencies; and
- tries to maximize client participation in care planning.

Within the overall program design, however, sites vary in the following ways.

Assessment Tool. While both Barron and Milwaukee use the GFRS and other tools to assess client condition and need, local staff in LaCrosse developed their own assessment form. Use of a comprehensive assessment form allows use of paraprofessionals as case managers.

Staff. Client assessments and interviews in Barron County are done by two half-time CCO interviewers. A task force of professionals from agencies which are advisory to the CCO meet with the interviewers to do case plans and make service arrangements.

In LaCrosse, the CCO purchases case management services from two hospitals and the County Department of Social Services. The CCO staff coordinator approves case plans made by these other staff.

In Milwaukee, case management is done by CCO "service plan managers." The managers screen for eligibility, do assessments and case planning, and order and monitor services. A case conference is held every 90 days at which time a case summary is presented in a meeting with participating agencies. In cases requiring specialized assessments, the CCO purchases them.

Services offered by the CCO vary by site. Milwaukee has approximately 38 providers for 16 services which include: homemaker/home health aide, transportation, homemaker, home-delivered meals, skilled nursing, medical equipment and supplies, adult day care, advocacy, chore, companionship, nutrition education, counseling, emergency and alternative housing, home repair and reconditioning, specialized assessment, court services, visiting and respite care. No individual providers are used, only agency staff.

In LaCrosse, eight providers provide 16 services.

Most client needs are for basic services which already exist in the community, so the thrust has been to assure quality services and to expand service capacities. The CCO instituted a training program for home care workers through the Western Wisconsin Technical Institute. The program trains generalist home care workers and has doubled the pool of such workers in the county.

The following list shows the service types and percentages of dollars spent on the various services in LaCrosse.

Service Type	Percentage of Total Dollars Spent
Security (companion, telephone reassurance, friendly visiting)	55.2
Home Maintenance (housekeeping, chore, home repair and reconditioning)	32.9
Transportation	4.7
Personal Care	3.4
Day Care	2.4
Support (counseling)	1.1
Health (excludes regular Medicaid services)	0.2
Nutrition	0.1
	100.0

Financing

Funds for the Wisconsin CCO come from a grant from the Department of Health, Education and Welfare, the W. K. Kellogg Foundation and Medicaid. The grant of $840,653, with 40 percent provided by the Kellogg Foundation and 60 percent from HEW, covered research costs, site start-up costs and central office staff costs during the development stages of the project. After sites were established, program service delivery costs and central office costs were shifted from the grant to Medicaid funds, which are split between HEW (60 percent) and the state (40 percent).

The CCO is the funder of last resort. If another program is funding a service, the CCO will not pay for it. Regular Medicaid funds are used first so that most of the CCO funds can be spent on services not covered by Medicaid.

The CCO only has control over Medicaid funds, but arranges services using other funds the client may be eligible for. In LaCrosse and Barron Counties there has been an increase in requests for Title XX as a result of the CCO referring individuals to local county welfare agencies.

CCOs have established maintenance of effort agreements with local counties and local agencies to ensure that the clientele of these agencies are not transferred to the CCOs. The agreements specify that the agencies will maintain their pre-CCO levels of service provision and funding for the disabled and elderly.

Cost data for CCO operations are unavailable at this time.

The CCOs operate within financial limitations established by the state CCO office and the State Department of Health and Social Services. The Milwaukee CCO's limitations are as follows.

1) Payment of funds from Medicaid is limited to $15 per client day ($450/month), taken on a total caseload basis, not on an individual client basis. This figure is based on the average cost of an intermediate care facility minus average living expenses.
2) There is a total dollar limit on funding to the CCO, which in the current year is $3,250,000.

The Future

State CCO staff are currently planning for the program's phase-out which is due to occur by April, 1979 in LaCrosse and Barron Counties. The Milwaukee site recently received an extension until December, 1979 and is trying to be extended to December, 1980. The staff feel that they need more time than originally planned, since the site began to operate later than expected.

If the CCO project proves itself to be economically and administratively viable, and if the evaluation indicates that it is cost-effective and provides better services than otherwise available, it might be continued beyond the end of the demonstration period. The Wisconsin Legislature is expected to consider possible state funding of the CCO or some variation of it.

APPENDIX B

THE COSTS OF HOME CARE

As a result of the escalating costs of long-term care there has been a search for less costly alternatives. Home care has frequently been purported to be a more cost-effective alternative than nursing home care, i.e., it attains the same outcome at less cost. However, such claims may be misleading, since costs of various long-term care alternatives depend on several factors, all of which must be considered when making valid cost comparisons.

The factors which must be considered in comparing costs of long-term care alternatives include: client characteristics, service characteristics, whether actual savings or merely redistribution of expenditures is occurring, and how expanded funding for home care might affect the supply, demand and costs of such care.

CLIENT CHARACTERISTICS

Individuals vary in the types and severity of the impairments which necessitate long-term care services. The number of services required and hours of service needed depend upon the individual's functional disability. A severely impaired person who requires constant attention requires a more extensive and intensive package of services than someone who merely has some trouble doing chores around the house. For this reason, when comparing costs of alternative long-term care settings, costs for persons of the same impairment level should be examined since the number of services needed and the frequency with which they are used increases the cost of care. Living arrangements may also affect costs. Whether individuals live alone or with someone is likely to affect the type and amount of services required and should be taken into account when analyzing the costs of home care.

While it may be true that home care is less costly for persons below a certain level of disability, nursing home care may be less expensive for persons above that disability level. Once a particular disability level is reached, the costs of the services required at home may approach or exceed what a comparable package of services would cost in a nursing home.

The chart on the following page presents the costs of several hypothetical packages of home care services and shows how these costs may approach or exceed the cost of a comparable level of institutional care — ICF-1. It should be noted that even with only four services included in this chart, the costs may exceed ICF-1 rates. The client's expenses for housing, utilities, food, transportation and other services would further increase monthly costs. (The ICF-1 level of nursing home care is used in the comparison since it's population is similar in impairment levels to home care clients.)

SERVICE CHARACTERISTICS

In order to compare costs of alternative long-term care settings, the total cost of maintaining the individual in each setting must be determined. Several types of costs must be calculated including living costs (shelter, utilities, maintenance, food, insurance) and service costs. The service costs include both the special assistance required due to the individual's impairment and the costs of other services and activities which are associated with daily living regardless of impairment, e.g., clothing, transportation and recreation.

The cost of nursing home placement includes room, board, laundry and maintenance in addition to the specialized nursing, health, therapeutic, rehabilitation services and social services that may be available. Under public reimbursement a $30.00 monthly allowance for personal spending is also included. Reimbursement of nursing homes occurs at a fixed per diem rate for each type of facility (skilled or intermediate care) regardless of which particular services an individual needs or uses.

In order to compare nursing home costs to home care costs, the full cost of maintaining individuals at home must be included. These costs include shelter, utilities, home maintenance, food, and services, including those purchased and those provided without cost by family, neighbors and friends. An individual living at home with assistance from these informal sources may require fewer purchased services resulting in a reduced cost of care.

Problems arise in how to value services provided informally including whether this volunteer/family time should be assigned a dollar value for purposes of cost comparisons. Some contend that placing a dollar value on these services

Service	Average Hourly Rate*	Hours Per Week	Weekly Cost	Monthly Cost	Possible Service Packages			
Chore	$3.88	1	$ 3.88	$ 16.68	1 hr.			
		2	7.76	33.37		2 hrs.	2 hrs.	2 hrs.
Homemaker	$5.77	1	$ 5.77	$ 24.81				
		2	11.54	49.62				
		3	17.31	74.43				
		4	23.08	99.24	4 hrs.	4 hrs.		
		5	28.85	124.05			5 hrs.	
		6	34.62	148.87				6 hrs.
Home Health Aide	$6.84	1	$ 6.84	$ 29.41				
		2	13.68	58.82	2 hrs.			
		3	20.52	88.24		3 hrs.		
		4	27.36	117.65			4 hrs.	4 hrs.
Home Nursing	$22.74 (per visit)	1	$ 22.74	$ 97.78	1 hr.			
		2	45.48	195.56		2 hrs.	2 hrs.	
		3	68.22	293.35				3 hrs.
		(days per week)						
Home-delivered Meals	$1.55 (per meal)	5	$ 7.75	$ 33.33				
		7	10.85	46.66	7 days	7 days	7 days	7 days
ICF-1	$20.77 (per diem)		$145.39	$625.00				
MONTHLY COST OF SERVICE PACKAGES:					$319	$463	$518	$640
MONTHLY DIFFERENCE BETWEEN ICF-1 AND HOME CARE:					$306	$162	$107	$+15

*Data are from the home care agency survey.

overestimates the true cost of home care since individuals currently do not pay for the services. Others maintain that such care should be valued since it represents required care which may not always be available without cost. At some point, these services might have to be purchased. Also, as discussed previously, these services are included in nursing home costs and for that reason should be included when making cost comparisons.

What value to assign this informal care is another problem. When the person providing the care foregoes employment in order to provide this care at home, the value of potential earnings may be counted as the worth of that person's time.

Within an institutional or a home setting, the cost of a service may vary among provider agencies or facilities and among geographic locations. Variables affecting cost include: the level of staff used to provide a service (e.g., home health care may be provided by a nurse or by a less costly paraprofessional), staff salaries, the distance that must be traveled to reach homes, the availability of agencies, agency size and efficiency, and the amount of regulation that must be met.

Further complicating cost comparisons is the matter of the quality of care across and within settings. Quality in long-term care is extremely hard to define and quantify, yet it affects costs. Comparing alternative levels of long-term care without regard to their quality may be misleading. Services of a higher quality may be more costly than lesser quality services. For example, agencies that provide extensive training of their staff will likely have higher costs and may provide a higher quality service than agencies which provide minimal training.

Different settings may affect client outcomes differently, although research on this point has been inconclusive. An individual who fears institutionalization, for example, may recover from

an illness or improve more quickly if allowed to remain at home in familiar surroundings. One setting may cost more per day but attain a desired outcome more rapidly than another, less costly setting and, hence, may appear less cost-effective than it really is.

COST SAVINGS OR REDISTRIBUTION?

Cost comparisons should not only specify the total costs involved in alternate settings but should indicate to whom these costs accrue. Nursing home costs, for example, are borne largely by the public sector. (Seventy percent of nursing home residents in Minnesota receive Medicaid.) This occurs because institutional care is too costly to be paid for by individuals and is required for a long period of time. (The average per diem costs of nursing home care in Minnesota in 1977 were: SNF – $25.83; ICF-1 – $20.77.)

Home care costs, on the other hand, are more equally divided among public and private payors, with a less extensive public involvement than with nursing home costs. The financing of long-term care and the level of government responsible for paying often determines the type of care which is available and used. Counties in Minnesota, for example, pay 4.5 percent of the costs of nursing homes for their Medicaid-eligible residents, but they pay 60 to 100 percent of the cost of social services needed to support continued living in the home. The purported cost savings of home care compared to nursing home care may be less of a saving than a redistribution of costs among levels of government and among the public and private sectors.

EFFECT OF EXPANDED FUNDING FOR HOME CARE

The effect of expanded funding for alternatives to nursing home care must also be anticipated. While home care may be cheaper for certain individuals, expanding the funding of home care may result in even higher long-term care costs and expenditures by stimulating demand for these services. There may be many individuals who currently need long-term care yet prefer to remain home with no services rather than become institutionalized. This group of people might use home care services if they were more readily available, and this additional demand could increase overall long-term care costs. Thus, expanded home care funding may represent add-on costs to the long-term care system rather than cost reductions in the institutional portion of the system.

It does not appear realistic to expect that more home care will result in the discharge of significant numbers of nursing home residents, particularly the elderly. Many of these persons have become dependent upon institutional care, have sold their homes and household goods, and depleted their savings, thus effectively precluding their ability to return to the community.

Expanded home care services may, however, save money by preventing or delaying the entrance of people into institutions. In this case cost savings from home care may be a long run rather than an immediate phenomenon. If home care were more widely available it might be used as a preventive type of care, i.e., more people might use it before their condition deteriorated to the point of requiring institutionalization. Cost savings would then be apparent in the long run when institutionalization would be delayed and individuals who would have otherwise been institutionalized remain in their homes. However, in the short run the fact that home care may cost less than nursing home care may be offset by the fact that home care services may be used by more people and over a longer period of time.

This report is not meant to suggest that home care is not a cost-effective way to provide long-term care nor is it meant to increase pessimism about the possibility of reducing long-term care costs. For certain persons, those with lower levels of impairment and with family assistance, home care may be less costly than nursing home care. For persons more seriously impaired or without any informal assistance, home care may not be less expensive. Many variables must be considered to assess the cost-effectiveness of home care and nursing home care and to assess the effects of expanded home care funding.

One thing is certain. The high costs of long-term care will only increase as demographic trends feed the demand for long-term care. Long-term care costs will increasingly strain the public and private pocketbooks unless something is done. Possible responses include not providing needed care, building more nursing home beds, or supporting alternative care models. Home care, while not a panacea for the cost problems in long-term care, may help slow the rapid escalation of costs, may save money in the long run, and may also be preferred by the persons who need such care.

APPENDIX C

COUNTY PROGRAM DATA

This appendix details the program data presented in Section One by county or by region. The following data are presented: the county population; the population over age 65; expenditures for the Title XX, Medicaid, Title III, Title VII and Community Action programs; and the number of clients served by each home care program.

MINNESOTA POPULATION DATA, BY COUNTY
(1980 Estimate)

County	Total Population Estimate 1980	Percent of Total State Population 1980	Population Over 65 Estimate 1980	Percent of Total State Population Over 65	Over 65 as a Percent of County Population
Aitkin	12,300	0.3	2,930	0.64	23.7
Anoka	200,300	4.9	7,695	1.7	3.8
Becker	25,600	0.63	4,073	0.89	15.9
Beltrami	30,200	0.74	3,292	0.72	10.9
Benton	23,400	0.57	2,251	0.49	9.6
Big Stone	7,600	0.19	1,434	0.31	18.8
Blue Earth	58,000	1.4	5,206	1.1	9.8
Brown	29,900	0.73	4,278	0.94	14.3
Carlton	29,300	0.72	3,814	0.84	13.0
Carver	34,400	0.84	3,376	0.74	9.8
Cass	19,400	0.48	4,608	1.0	23.8
Chippewa	14,900	0.37	2,562	0.56	17.2
Chisago	23,900	0.59	2,896	0.64	12.1
Clay	51,800	1.3	4,625	1.0	8.9
Clearwater	8,300	0.2	1,643	0.36	19.7
Cook	3,500	0.086	585	0.13	16.9
Cottonwood	14,300	0.35	2,524	0.55	17.6
Crow Wing	40,100	0.98	6,578	1.4	16.4
Dakota	181,100	4.4	10,092	2.2	5.6
Dodge	13,200	0.32	1,876	0.41	14.2
Douglas	25,900	0.64	4,393	0.96	16.9
Faribault, Martin, Watonwan	57,700	1.4	9,604	2.1	16.6
Fillmore	21,100	0.52	3,570	0.78	16.9
Freeborn	38,700	0.95	4,996	1.1	12.9
Goodhue	38,400	0.94	5,358	1.2	13.9
Grant	7,300	0.18	1,524	0.33	20.9
Hennepin	983,400	24.0	91,905	19.8	9.3
Houston	18,200	0.45	2,832	0.62	15.6
Hubbard	12,400	0.3	2,605	0.57	21.0
Isanti	21,700	0.53	2,394	0.53	11.0
Itasca	36,600	0.89	5,260	1.2	14.4
Jackson	14,200	0.35	2,311	0.51	16.3
Kanabec	11,800	0.29	1,767	0.39	15.0
Kandiyohi	32,200	0.79	4,499	0.99	14.0
Kittson	6,800	0.17	1,204	0.26	17.7
Koochiching	17,800	0.44	2,229	0.49	12.5
Lac Qui Parle	10,800	0.26	2,061	0.45	19.1
Lake	13,700	0.34	1,545	0.34	11.3
Lake of the Woods	4,200	0.1	656	0.14	15.6
LeSueur	22,900	0.56	3,511	0.77	15.3
Lincoln	7,791	0.19	1,421	0.31	18.2
Lyon	26,243	0.64	3,215	0.70	12.2
McLeod	31,400	0.77	4,282	0.94	13.6
Mahnomen	5,600	0.14	869	0.2	15.5
Marshall	13,000	0.25	1,877	0.41	14.4
Meeker	19,700	0.48	3,083	0.68	15.6
Mille Lacs	17,700	0.43	3,143	0.69	17.7
Morrison	27,300	0.67	4,104	0.9	15.0
Mower	44,100	1.1	5,941	1.3	13.5
Murray	11,896	0.29	1,858	0.40	15.6
Nicollet	26,000	0.64	2,298	0.5	8.8
Nobles	23,400	0.57	3,370	0.74	14.4
Norman	9,500	0.23	1,917	0.42	20.3
Olmsted	97,800	2.4	8,617	1.9	8.8
Otter Tail	47,000	1.2	8,243	1.8	17.5
Pennington	15,100	0.37	2,185	0.48	14.4
Pine	18,500	0.45	3,397	0.75	18.4
Pipestone	12,400	0.30	1,979	0.43	15.9
Polk	34,800	0.85	5,342	1.2	15.4
Pope	11,200	0.27	2,184	0.48	19.6
Ramsey	485,700	11.9	49,565	10.9	10.2
Red Lake	5,200	0.13	748	0.16	14.4

MINNESOTA POPULATION DATA, BY COUNTY
(1980 Estimate)

County	Total Population Estimate 1980	Percent of Total State Population 1980	Population Over 65 Estimate 1980	Percent of Total State Population Over 65	Over 65 as a Percent of County Population
Redwood	19,400	0.48	3,079	0.68	15.9
Renville	20,700	0.51	3,612	0.79	17.4
Rice	44,700	1.1	4,867	1.1	10.9
Rock	11,300	0.28	1,600	0.35	14.1
Roseau	12,100	0.30	1,748	0.38	14.4
St. Louis	217,100	5.3	29,927	6.6	13.8
Scott	39,100	0.96	3,055	0.67	7.8
Sherburne	25,500	0.63	2,904	0.64	11.4
Sibley	16,100	0.39	2,487	0.55	15.5
Stearns	106,300	2.6	10,082	2.2	9.5
Steele	29,000	0.71	3,555	0.78	12.3
Stevens	11,600	0.28	1,535	0.34	13.2
Swift	12,900	0.32	2,266	0.5	17.6
Todd	22,900	0.56	3,871	0.85	16.9
Traverse	5,900	0.14	1,064	0.23	18.0
Wabasha	18,300	0.45	3,201	0.7	17.5
Wadena	12,700	0.31	2,410	0.53	18.9
Waseca	17,300	0.42	2,376	0.52	13.8
Washington	103,700	2.5	5,819	1.3	5.6
Wilkin	9,300	0.23	1,448	0.32	15.6
Winona	46,800	1.2	6,066	1.3	13.0
Wright	51,200	1.3	5,913	1.3	11.5
Yellow Medicine	14,100	0.35	2,312	0.51	16.4
State Total	**4,122,730**	**100%**	**463,812**	**100%**	**11.3%**

Source: State Demographer.

TITLE XX PROJECTED DATA
(Fiscal Year 1978)

Counties	Total Social Service Expenditures	Federal Title XX Allotment	Local Effort	Percent Increase of Local Effort Over Title XX Allotment	Total Home Care Expenditures	Home Care as a Percent of Total Social Service Expenditures	Chore Services	Congregate and Home-Delivered Meals	Homemaking Services	Transportation Services
Aitkin	$ 425,289	$ 183,330	$ 241,959	132.0	$ 113,220	26.6	$ 44,670	X	$ 39,385	$ 29,165
Anoka	1,817,302	890,992	926,310	104.0	213,519	11.7	32,597	X	114,793	66,129
Becker	490,880	233,712	257,168	110.0	65,000	13.2	10,000	X	45,000	10,000
Beltrami	606,673	358,926	247,747	69.0	67,450	11.1	49,767	$ 4,767	3,383	9,533
Benton	311,747	108,963	202,784	186.0	38,666	12.4	7,530	X	27,268	3,868
Big Stone	166,206	60,786	105,420	173.4	16,695	10.0	9,219	X	X	7,476
Blue Earth	810,645	383,720	426,925	111.3	67,503	8.3	25,460	1,000	28,934	12,109
Brown	468,925	129,920	339,005	260.9	59,201	12.6	20,163	3,591	30,994	4,453
Carlton	761,240	308,724	452,516	146.6	154,443	20.3	12,237	352	103,115	38,739
Carver	897,545	250,878	646,667	257.8	92,720	10.3	21,686	X	30,009	41,025
Cass	750,000	275,359	474,641	172.4	152,614	20.3	123,700	5,307	18,300	5,307
Chippewa	387,285	107,248	280,037	261.1	37,240	9.6	21,030	X	14,030	2,180
Chisago	226,066	117,583	108,483	92.3	21,686	9.6	7,376	157	10,525	3,628
Clay	568,359	201,775	366,584	181.7	56,598	10.0	50,683	X	X	5,915
Clearwater	331,690	153,698	177,992	115.8	130,040	39.2	11,649	X	90,239	28,152
Cook	178,796	53,562	125,234	233.8	27,931	15.6	10,203	594	11,381	5,753
Cottonwood	147,662	77,281	70,381	91.1	11,146	7.5	unknown	X	9,398	1,748
Crow Wing	883,553	430,716	452,837	105.1	109,405	12.4	24,596	3,498	63,517	17,794
Dakota	2,552,689	653,834	1,898,855	290.4	93,822	3.7	29,761	X	53,009	11,052
Dodge	219,514	51,275	168,239	328.1	8,733	4.0	3,684	X	3,882	1,167
Douglas	400,862	130,837	270,025	206.4	57,077	14.2	25,987	X	18,703	12,387
Faribault, Martin, Watonwan	1,766,455	329,226	1,437,229	436.6	115,924	6.6	39,934	X	42,384	33,606
Fillmore	192,156	72,958	119,198	163.4	14,391	7.5	14,391	X	X	X
Freeborn	624,442	191,783	432,659	225.6	69,195	11.1	4,173	X	59,418	5,604
Goodhue	459,821	145,530	314,291	216.0	17,764	3.9	1,409	1,500	1,500	13,355
Grant	101,895	39,686	62,209	156.8	15,461	15.2	3,276	X	8,343	3,842
Hennepin	59,571,199	14,553,659	45,017,540	309.3	3,601,503	6.0	1,264,692	46,150	1,663,058	627,603
Houston	236,375	70,225	166,150	236.6	24,492	10.4	14,078	X	8,257	2,157
Hubbard	218,031	103,419	114,612	110.8	31,512	14.4	26,855	X	4,657	X
Isanti	538,784	180,506	358,278	198.5	76,706	14.2	18,119	12,222	42,562	3,803
Itasca	1,164,292	414,990	749,302	180.6	185,772	16.0	102,004	66,000	X	17,768
Jackson	363,639	88,231	275,408	312.0	52,386	14.4	8,873	4,641	24,587	14,785
Kanabec	312,279	112,895	199,384	176.7	126,103	40.4	12,145	322	112,314	1,322
Kandiyohi	471,500	200,532	270,968	135.0	60,181	12.8	28,939	7,216	14,011	10,015
Kittson	134,505	50,431	84,074	166.7	42,649	31.7	24,065	1,000	12,422	5,162
Koochiching	561,332	207,164	354,168	171.0	94,636	16.9	64,176	2,175	16,271	12,014
Lac Qui Parle	151,469	53,328	98,141	184.0	19,735	13.0	X	1,319	16,705	1,711
Lake	287,757	99,924	187,833	188.0	45,719	15.9	X	X	28,784	16,935
Lake of the Woods	96,612	31,162	65,450	210.0	34,394	35.6	7,466	X	18,739	8,189
LeSueur	426,987	133,747	293,240	219.0	56,100	13.1	43,031	X	1,514	11,555
Lincoln, Lyon, Murray	626,392	310,692	315,700	102.0	117,586	18.8	9,298	3,017	92,037	13,234
McLeod	561,192	122,790	438,402	357.0	58,360	10.4	22,988	X	29,559	5,813
Mahnomen	172,900	59,070	113,830	192.7	34,026	19.7	3,166	569	23,409	6,882
Marshall	136,175	69,534	66,641	95.8	13,228	9.7	5,086	X	4,368	3,774
Meeker	171,115	87,212	83,903	96.2	10,343	6.0	4,176	2,095	4,072	X
Mille Lacs	416,436	194,303	222,133	114.3	52,899	12.7	40,349	1,117	5,612	5,821
Morrison	434,381	183,511	250,870	136.7	86,063	19.8	19,768	X	63,467	2,828

Mower	914,361	258,487	655,874	253.7	44,360	4.9	17,058	X	27,302	X
Nicollet	317,820	94,607	223,213	235.9	21,602	6.8	1,895	1,795	17,912	X
Nobles	422,880	138,150	284,730	206.0	49,312	11.7	23,418	X	12,599	13,295
Norman	122,646	52,515	70,131	133.5	12,836	10.5	2,455	X	9,819	562
Olmsted	2,237,259	648,365	1,588,894	245.0	176,536	7.9	24,921	8,400	104,876	38,339
Otter Tail	608,741	265,407	343,334	129.4	44,935	7.4	X	X	35,318	9,617
Pennington	214,700	101,625	113,075	111.3	12,925	6.0	X	X	8,955	3,970
Pine	760,838	242,413	518,425	213.9	125,379	16.5	111,997	X	948	12,434
Pipestone	192,934	76,430	116,504	158.7	32,811	17.0	13,900	950	13,839	4,122
Polk	528,998	275,345	253,653	92.1	138,457	26.2	8,291	1,327	126,737	2,102
Pope	190,694	81,664	109,030	133.5	22,887	12.0	14,530	X	7,613	744
Ramsey	17,270,755	6,660,253	10,610,502	159.3	949,543	5.5	226,898	285,549	376,345	60,751
Red Lake	113,510	44,778	68,732	153.5	11,330	10.0	2,810	X	5,210	3,310
Redwood	311,509	116,429	195,080	167.6	46,471	14.9	19,074	1,553	16,207	9,637
Renville	281,842	92,563	189,279	204.5	43,150	15.3	15,787	4,924	15,696	6,743
Rice	413,894	158,812	255,082	160.6	20,738	5.0	7,026	2,796	4,325	6,591
Rock	92,559	40,640	51,919	127.8	16,275	17.6	3,910	1,488	7,710	3,167
Roseau	163,287	63,494	99,793	157.2	20,331	12.5	3,420	X	11,479	5,432
St. Louis	10,779,236	3,441,317	7,337,919	213.2	1,558,489	14.5	245,694	58,272	1,130,230	124,293
Scott	2,886,873	211,415	2,675,458	1265.5	196,596	6.8	65,000	X	40,000	91,596
Sherburne	420,784	111,272	309,512	278.2	31,035	7.4	2,272	X	26,800	1,963
Sibley	223,538	67,032	156,506	233.5	30,056	13.4	6,548	895	3,138	19,475
Stearns	1,001,343	399,999	601,344	150.3	193,168	19.3	21,012	3,376	152,516	16,264
Steele	320,816	126,210	194,606	154.2	21,536	6.7	3,412	X	18,124	X
Stevens	201,875	65,485	136,390	208.3	27,633	13.7	1,369	3,335	17,825	5,104
Swift	291,496	99,486	192,010	193.0	37,328	12.8	7,815	1,170	26,545	1,798
Todd	493,150	187,165	305,985	163.5	76,944	15.6	49,079	1,800	3,437	22,628
Traverse	135,535	45,561	89,974	197.7	22,974	16.9	968	734	18,304	2,968
Wabasha	193,293	88,722	104,571	117.9	22,473	11.6	389	X	12,554	9,530
Wadena	312,380	127,902	184,478	144.2	95,729	30.6	71,088	X	21,821	2,820
Waseca	157,943	79,229	78,714	99.3	6,436	4.1	2,476	X	2,992	968
Washington	2,193,072	628,725	1,564,347	248.8	129,125	5.9	6,000	X	99,031	24,094
Wilkin	240,077	51,660	188,417	364.7	33,255	13.9	X	6,843	22,677	3,735
Winona	827,041	242,880	584,161	240.5	26,022	3.1	1,828	293	17,397	6,504
Wright	1,498,018	254,945	1,243,073	487.6	125,755	8.4	44,658	2,681	59,549	18,867
Yellow Medicine	415,635	89,391	326,244	365.0	43,068	10.4	17,342	X	15,968	9,758
Total	**$131,352,381**	**$39,000,000**	**$92,352,381**	**236.8%**	**$11,119,337**	**8.5%**	**$3,368,295**	**$556,790**	**$5,505,713**	**$1,688,539**

Source: Title XX State Plan.

MEDICAID DATA
(Fiscal Year 1977)

Counties	Total Medicaid Expenditures	Total Medicaid Home Care Expenditures*	Percent of Medicaid Dollars Spent On Home Care	Home Health Care		Private Duty Nursing	
				Expenditures	Unduplicated Clients	Expenditures	Unduplicated Clients
Aitkin	$ 1,776,402	$ 13,912	0.78	$ 9,304	90	$ 4,608	DNA
Anoka	7,644,965	9,479	0.12	6,640	17	2,832	2
Becker	2,791,440	32,122	1.2	32,122	294	–	–
Beltrami	3,424,155	18,890	0.55	18,890	119	–	–
Benton	1,799,786	4,914	0.27	4,914	25	–	–
Big Stone	917,867	6,698	0.73	6,698	46	–	–
Blue Earth	3,503,690	2,018	0.06	2,018	13	–	–
Brown	2,223,043	6,162	0.28	1,202	7	4,960	1
Carlton	2,920,731	50,416	1.7	50,416	109	–	–
Carver	2,035,735	2,830	0.14	2,830	11	–	–
Cass	2,648,423	16,272	0.61	16,222	78	50	1
Chippewa	1,307,199	11,503	0.88	11,198	36	305	1
Chisago	1,832,236	13,501	0.74	13,501	39	–	–
Clay	2,424,499	39,492	1.6	27,530	70	11,962	70
Clearwater	1,333,884	73,925	5.5	70,280	247	3,645	2
Cook	362,382	–	–	–	–	–	–
Cottonwood	1,352,382	7,641	0.57	7,391	31	250	1
Crow Wing	3,504,639	26,854	0.77	26,854	105	–	–
Dakota	7,662,158	16,085	0.21	14,134	38	1,951	2
Dodge	1,160,031	8,232	0.71	8,232	26	–	–
Douglas	2,325,055	16,372	0.7	16,372	163	–	–
Faribault	2,024,627	11	0.0005	11	1	–	–
Fillmore	2,342,750	11,220	0.48	6,840	42	4,380	3
Freeborn	2,700,933	1,742	0.06	1,742	37	–	–
Goodhue	3,040,209	6,656	0.22	6,656	30	–	–
Grant	726,399	3,217	0.44	3,217	17	–	–
Hennepin	106,834,737	397,396	0.37	355,136	1,414	42,260	43
Houston	1,199,841	1,417	0.12	1,417	7	–	–
Hubbard	1,462,878	33,696	2.3	33,696	179	–	–
Isanti	1,489,062	2,542	0.17	2,542	8	–	–
Itasca	4,501,709	13,649	0.3	12,737	76	912	1
Jackson	1,245,785	8,211	0.66	8,211	30	–	–
Kanabec	1,346,042	867	0.06	867	6	–	–
Kandiyohi	2,536,423	10,016	0.39	10,016	20	–	–
Kittson	1,127,058	7,926	0.7	7,800	12	126	2
Koochiching	2,319,567	777	0.03	567	5	210	5
Lac Qui Parle	965,334	2,300	0.24	2,300	15	–	–
Lake	689,023	2,066	0.3	1,558	6	508	DNA
Lake of the Woods	426,180	20,256	4.8	–	–	20,256	1
LeSueur	2,056,514	5,629	0.27	5,629	55	–	–
Lincoln	985,090	1,607	0.16	1,607	7	–	–
Lyon	1,771,478	8,908	0.5	8,590	75	318	1
McLeod	1,807,295	3,737	0.2	3,737	37	–	–
Mahnomen	694,186	7,085	1.0	7,085	77	–	–
Marshall	1,247,540	17,741	1.4	17,741	96	–	–
Martin	1,473,750	3,995	0.27	3,995	10	–	–
Meeker	1,514,853	7,484	0.49	7,426	20	58	1
Mille Lacs	1,932,320	29,835	1.5	29,835	78	–	–
Morrison	3,586,466	25,733	0.72	23,443	78	2,290	2
Mower	3,312,641	8,804	0.27	4,111	25	4,693	5
Murray	767,443	1,335	0.17	1,335	15	–	–
Nicollet	1,291,430	4,798	0.37	4,798	41	–	–
Nobles	1,338,963	9,549	0.71	2,362	10	7,187	3
Norman	1,026,143	3,151	0.31	3,151	19	–	–
Olmsted	5,039,074	62,620	1.2	62,620	139	–	–
Otter Tail	4,731,291	9,938	0.21	9,938	58	–	–
Pennington	1,194,731	23,751	2.0	23,751	63	–	–
Pine	2,579,206	19,736	0.77	19,736	45	–	–
Pipestone	1,053,315	11,256	1.1	10,151	15	1,105	5
Polk	4,103,424	52,569	1.3	52,569	183	–	–
Pope	1,223,277	570	0.04	570	6	–	–
Ramsey	56,122,019	440,874	1.7	354,040	707	86,834	40
Red Lake	837,832	4,924	0.59	4,924	43	–	–
Redwood	1,765,416	8,996	0.51	8,996	29	–	–
Renville	2,112,062	3,390	0.16	1,692	16	1,698	41
Rice	3,216,440	16,918	0.53	16,918	41	–	–

*Does not include transportation.

MEDICAID DATA
(Fiscal Year 1977)

Counties	Total Medicaid Expenditures	Total Medicaid Home Care Expenditures	Percent of Medicaid Dollars Spent On Home Care	Home Health Care		Private Duty Nursing	
				Expenditures	Unduplicated Clients	Expenditures	Unduplicated Clients
Rock	$ 599,275	$ 2,093	0.35	$ 2,093	10	–	–
Roseau	1,373,119	1,139	0.083	1,139	25	–	–
St. Louis	26,026,048	47,831	0.18	47,221	400	$ 610	4
Scott	2,440,509	2,456	0.1	2,456	10	–	–
Sherburne	1,333,226	13,349	1.0	68	3	13,281	1
Sibley	1,573,080	4,204	0.27	4,204	13	–	–
Stearns	6,951,635	13,952	0.2	13,952	64	–	–
Steele	1,573,768	657	0.04	657	6	–	–
Stevens	812,734	43,827	5.4	43,827	58	–	–
Swift	1,328,541	26,755	2.0	26,755	34	–	–
Todd	2,791,508	18,364	0.66	17,046	163	1,318	DNA
Traverse	756,925	370	0.049	370	7	–	–
Wabasha	1,482,351	13,107	0.88	10,145	28	2,962	1
Wadena	1,447,880	18,896	1.3	15,771	50	3,125	1
Waseca	1,378,858	–	–	–	–	–	–
Washington	5,524,385	19,154	0.35	19,154	71	–	–
Watonwan	933,399	1,145	0.12	1,145	11	–	–
Wilkin	1,061,791	281	0.026	281	6	–	–
Winona	3,307,734	12,932	0.39	12,932	86	–	–
Wright	3,074,659	6,046	0.2	6,046	13	–	–
Yellow Medicine	1,139,685	9,535	0.84	6,811	11	2,724	3
Total	**$367,624,575**	**$1,953,399**	**0.53%**	**$1,725,974**	**6,720**	**$227,425**	**243**

DNA = Data Not Available

Source: Medicaid Management Information System

TITLE III DATA
(Budget Period 1-1-78 to 12-31-78)

Region	Area Agency on Aging	Total Direct Services Expenditures	Federal Title III	Non-Federal Match	Total Home Care Expenditures	Home Care as Percent of Service Expenditures	Chore	Homemaker	Home Health Aide	Home Meals	Transportation
1	Northwest	$ 134,726	$ 59,920	$ 74,806	$ 81,000	60	$ 40,000	–	–	–	$ 41,000
2	Headwaters	133,037	89,908	43,129	41,870	31	–	$ 10,967	–	–	30,903
3	Arrowhead	420,659	300,400	120,259	188,987	45	30,281	68,000	–	$22,222	68,484
4	W. Central	273,819	186,614	87,205	93,533	34	–	55,200	–	–	38,333
5, 7E, 7W	Tri-Regional	500,594	349,304	151,290	188,184	38	–	25,000	$40,583	17,519	105,082
6E, 6W, 8	Southwestern	276,290	193,842	82,448	170,425	62	–	50,667	–	–	119,758
9	Region Nine	241,286	141,165	100,121	148,000	61	–	–	–	–	148,000
10	Southeastern	447,027	294,435	152,592	187,622	42	–	35,798	29,584	25,157	97,083
11	Metro. Council	1,317,426	994,371	323,055	378,335	29	79,177	44,497	20,304	–	234,357
	TOTAL	**$3,744,864**	**$2,609,959**	**$1,134,905**	**$1,477,956**	**40**	**$149,458**	**$290,129**	**$90,471**	**$64,898**	**$883,000**

Source: Minnesota Board on Aging.

TITLE VII DATA
(4-1-77 to 3-31-78)

			EXPENDITURES							MEALS					
			Federal		Non-Federal									Average No. Meals/Day**	
Region	Project	Total Expenditures	Title VII	USDA Value	State	Project Match	Project Income	Meals	Services	Total Meals Served	Home	Con-gregate	Percent Home	Con-gregate	Home
I	Tri-Valley	$ 460,297	$ 284,687	$ 13,401	$ 44,149	$ 38,840	$ 79,220	$ 302,293	$ 69,065	97,695	7,573	90,122	8.0	419	18
II-1	Headwaters	138,964	87,843	3,464	15,551	3,496	28,610	102,437	12,796	57,257	6,293	50,964	11.0	248	37
II-2	Red Lake Reservation	107,288	80,656	5,274	7,600	8,962	4,796	60,362	15,671	12,329	2,105*	8,060	23.0	38	30
III-1	Arrowhead	379,081	241,850	18,875	47,834	26,872	43,650	295,413	36,838	123,949	3,895*	120,054	4.0	508	12
III-2	Duluth	215,975	127,912	15,732	19,300	14,212	38,819	178,636	11,422	98,712	2,400*	96,312	3.0	451	36
IV	Lutheran Social Services	600,090	376,968	31,322	89,058	41,885	60,857	477,171	58,333	191,810	19,000	172,810	10.0	813	109
V-1	Tri-County	323,089	188,910	12,266	33,557	20,989	67,367	216,808	41,401	99,152	16,804	82,348	17.0	406	56
V-2	Chippewa Tribe	324,637	250,846	14,025	17,050	27,872	14,844	194,202	24,425	88,774	9,512*	79,262	14.0	323	42
VI-E	6E CAA	295,943	198,189	10,834	22,776	18,833	45,311	217,432	40,189	79,689	2,362*	77,327	4.0	406	15
VI-W	Prairie 5 CAA	196,065	118,325	10,176	17,567	12,026	37,971	135,312	23,397	64,435	234*	64,181	0.4	—	—
VII	Catholic Charities	644,664	435,981	29,975	51,498	48,441	78,769	421,325	83,390	175,325	10,440*	164,805	8.0	696	68
VIII	Western	313,602	194,386	14,145	37,438	23,518	44,115	217,765	33,856	81,686	1,946	79,740	2.0	420	8
IX	Minnesota Valley	389,931	211,174	21,595	40,460	23,464	93,238	301,858	55,117	131,607	473*	131,134	0.5	669	5
X-1	SEMCAC	560,615	301,298	15,642	120,228	28,969	94,478	398,924	70,241	151,129	7,650*	143,479	7.0	540	46
X-2	Olmsted	100,132	55,730	6,701	9,990	6,158	21,553	70,137	4,097	29,938	—	29,938	—	124	—
XI-1	Ramsey	540,408	321,510	12,048	66,424	35,723	104,653	428,299	39,369	201,512	5,026*	196,486	4.0	1,000	36
XI-2	Salvation Army	1,067,839	707,617	29,415	102,816	78,284	149,707	720,765	203,277	291,714	4,244	286,470	2.0	1,374	39
XI-3	Scott-Carver	122,129	82,234	5,268	8,474	9,097	17,056	76,814	18,990	35,684	962*	32,204	4.0	158	9
	TOTAL	**$6,658,620**	**$4,183,882**	**$264,760**	**$743,296**	**$475,578**	**$1,007,958**	**$4,739,139**	**$822,884**	**2,006,615**	**100,919**	**1,905,696**			

*Data cover three quarters, 4-1-77 to 12-31-77.
**Data are for May, 1978.

Source: Minnesota Board on Aging.

The following is a list of the counties included in the area agency on aging regions for purposes of Title III and Title VII of the Older Americans Act.

Region	Counties in Region
1	Kittson, Marshall, Norman, Pennington, Polk, Red Lake, Roseau
2	Beltrami, Clearwater, Hubbard, Lake of the Woods, Mahnomen
3	Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis
4	Becker, Clay, Douglas, Grant, Ottertail, Pope, Stevens, Traverse, Wilkin
5	Cass, Crow Wing, Morrison, Todd, Wadena
6E	Kandiyohi, McLeod, Meeker, Renville
6W	Big Stone, Chippewa, Lac Qui Parle, Swift, Yellow Medicine
7	Benton, Chisago, Isanti, Kanabec, Mille Lacs, Pine, Sherburne, Stearns, Wright
8	Cottonwood, Jackson, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, Rock
9	Blue Earth, Brown, Faribault, LeSueur, Martin, Nicollet, Sibley, Waseca, Watonwan
10	Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Rice, Steele, Wabasha, Winona
11	Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington

COMMUNITY ACTION PROGRAM DATA
(Fiscal Year 1977)

	Home-Delivered Meals	Transportation Services	Chore Services	Total
Anoka County CAP	$5,000 — funded by CSA.	—	—	$5,000 (CSA)
Arrowhead Economic Opportunity Agency	Service provided through Title VII funding.	$110,000 (local) — 23,000 elderly passengers in six months of 1977.	$46,667 (non-federal) — Also receives Title III. Includes services to the disabled.	$110,000 (local) 46,667 (non-federal)
Bi-County CAP	Service provided through Title VII funding.	$ 10,000 (non-federal) — Also receives Title III. Serves 250 elderly.	—	$10,000 (non-federal)
Clay-Wilkin Opportunity Center	$ 9,000 (CSA) — Serves 10,336 elderly. 24,242 (CEP) 500 (city)	$ 5,000 (non-federal) — Also receives Title III. 38,248 elderly passengers in six months (1977).	—	$ 9,000 (CSA) 24,242 (CEP) 5,000 (non-federal) 500 (city)
Duluth CAP	Service provided through Title VII funding.	—	—	—
Goodhue-Rice-Wabasha Citizens Action Council	$14,333 (non-federal) — Also receives Title VII. Serves 30-50 elderly per day.	$18,900 (non-federal) Also receives Title III. 5,000 elderly passengers projected.	—	$33,233 (non-federal)
Inter-County Community Council	—	—	—	—
Koochiching-Itasca Action Council	$ 9,372 (CSA) — Serves 800 elderly. 987 (state) 67,022 (county) 500 (private industry) 37,456 (individual contributions)	$444 (non-federal) — Also receives Title III.	—	$ 9,372 (CSA) 987 (state) 67,022 (county) 37,456 (individual contributions) 500 (private industry) 444 (non-federal)
Lakes and Pines CAC	—	—	—	—
Mahube Community Council	—	$16,000 (non-federal) — Also receives Title III. Serves 300 elderly.	—	$16,000 (non-federal)
Minneapolis CAP	—	—	—	—
Minnesota Valley Action Council	Services provided through Title VII funding.	$61,000 (state) 9,300 (local)	—	$61,000 (state) 9,300 (local)
Northwest Community Action	Services provided through Title VII funding.	Services provided through Title III funding.	—	—
Ottertail-Wadena CAC	—	—	—	—
Prairie 5 CAC	Services provided through Title VII funding.	—	—	—

	Home-Delivered Meals	Transportation Services	Chore Services	Total
Ramsey Action Programs	Services provided through Title VII funding.	–	–	–
Region 6E CAC	Services provided through Title VII funding.	–	–	–
Scott-Carver Economic Council	Services provided through Title VII funding.	–	–	–
SEMAC, Inc.	$24,239 (non-federal) – Also receives Title VII funding.	$9,017 (non-federal) – Also receives Title III funding. Serves 3,000 elderly.	–	$33,256 (non-federal)
South Central CAC	–	–	–	–
Southwestern Minnesota Opportunity Center	Services provided through Title VII funding.	$12,000 (county) 19,500 (city) – Also receives Title III funding. Serves 288 riders per month.	–	$12,000 (county) 19,500 (city)
Tri-County Action Programs	Services provided through Title VII funding.	$28,000 (federal) 48,000 (local) – Provides 9,900 rides.	–	$28,000 (federal) 48,000 (local)
Tri-Valley Opportunity Council	Services provided through Title VII funding.	$53,385 (state) 26,277 (county and DOT) – Serves 350 persons per month.	$5,000 (county) – Also receives Title III funding. Serves 200 persons.	$53,385 (state) 26,277 (county and DOT) 5,000 (county)
West Central Communities Action	$6,500 (federal) – Serves 35 elderly.	–	–	$6,500 (federal)
Western Community Action	Services provided through Title VII funding.	$13,997 (non-federal) – Also receives Title III funding. Serves 2,500 elderly.	–	$13,997 (non-federal)
Wright County Community Action	–	–	–	–

NOTE: Many CAP Agencies are funded through Title III or Title VII of the Older Americans Act. These expenditures are not shown on this chart as they are counted in the Older Americans Act Report.

Source: Community Action Association

The following is a list of counties which are included in the community action agencies' jurisdiction.

Anoka Community Action Program
- Anoka

Arrowhead Economic Opportunity Agency
- Cook
- Lake
- St. Louis

Bi-County Community Action Council
- Beltrami
- Cass

Clay-Wilkin Opportunity Council
- Clay
- Wilkin

Duluth Community Action Program
- City of Duluth

Goodhue-Rice-Wabasha Citizens Action Council
- Goodhue
- Rice
- Wabasha

Intercounty Community Council
- Clearwater
- East Polk
- Pennington
- Red Lake

Koochiching-Itasca Action Council
- Koochiching
- Itasca

Lakes and Pines Community Action Council
- Carlton
- Aitkin
- Pine
- Chisago
- Kanabec
- Mille Lacs
- Isanti

South Central Community Action Council
- Cottonwood
- Jackson
- Martin
- Watonwan

SEMCAC
- Fillmore
- Winona
- Houston
- Dodge
- Steele

Southwestern Minnesota Opportunity Council
- Murray
- Nobles
- Pipestone
- Rock

Tri-County Community Action Program
- Crow Wing
- Todd
- Morrison

Tri-County Action Programs, Inc.
- Benton
- Sherburne
- Stearns

Tri-Valley Opportunity Council, Inc.
- Norman
- W. Polk
- W. Marshall

West Central Minnesota Communities Action
- Traverse
- Grant
- Stevens
- Douglas
- Pope

Region Six East Community Action Agency
- Kandiyohi
- Meeker
- McLeod
- Renville

Mahube Community Council
- Mahnomen
- Becker
- Hubbard

Wright Community Council
- Wright

Minnesota Valley Action Council

- Blue Earth
- Brown
- Nicollet
- Le Sueur
- Waseca
- Sibley

Northwest Community Action Council

- Kittson
- Roseau
- Lake of the Woods
- East Marshall

Ottertail-Wadena Community Action Council

- Ottertail
- Wadena

Ramsey Action Program

- Ramsey

Scott-Carver Economic Council

- Scott
- Carver

Western Community Action Council

- Lincoln
- Lyon
- Redwood

Prairie Five Community Action Council

- Lac Qui Parle
- Chippewa
- Yellow Medicine
- Big Stone
- Swift

Minneapolis Community Action Agency

- City of Minneapolis

APPENDIX D

HOME CARE AGENCY QUESTIONNAIRE

This appendix consists of the tabulation of results from an agency survey completed for this project. The survey was sent to 87 county welfare departments, 78 public health nursing agencies, 109 private, nonprofit and proprietary agencies and 33 other public agencies involved in the provision of home care, e.g., the Veterans Administration, area agencies on aging and community action agencies. The following table indicates the response rates for each agency category.

Response Rates

County Welfare Departments	71% (62 responses of 87 sent)
Public Health Nursing Agencies	60% (47 responses of 78 sent)
Private Agencies	64% (70 responses of 109 sent)
Other Public Agencies	67% (22 responses of 33 sent)
Overall Response Rate	65% (201 responses of 307 sent)

In the following tabulation, many questions are compiled by service. Because of differing definitions of these services the survey sought information on specific home care tasks; these tasks were subsequently grouped into consistent service definitions. An explanation of how these tasks were combined is shown in Question #1.

It should also be noted that since different agencies provide different packages of services, the number of agencies responding to each question and to each part of a question will differ. Because of this a number appears above each agency category and within many of the tables to indicate how many agencies responded (n=X). In some cases agencies did not respond to particular parts of questions. In these cases the percentages within a category may add to less than 100 percent. If percentages add to more than 100 percent, this means that the relevant agencies responded to more than one option.

Question #1:

Which services does your agency purchase or provide?

1) Chore (home repair/maintenance, heavy cleaning);
2) Homemaking (home management, instruction in home management, meal preparation and planning, light housecleaning, laundry);
3) Home Health Aide, Personal or Attendant Care (bathing, dressing, grooming, assisting with transfers, assisting with toileting, health or medically-related assistance);
4) Home Nursing;
5) Transportation;
6) Home-Delivered Meals; or
7) Live-In Assistance.

The following percentages indicate the agencies responding that provide the services:

	n=62 County Welfare (percent)	n=47 Public Health Nursing (percent)	n=70 Private (percent)	n=19 Other Public (percent)
1. Chore	81	6	33	37
2. Homemaking	94	87	44	32
3. Home Health	74	100	34	26
4. Home Nursing	45	100	23	21
5. Transportation	77	9	27	58
6. Home-Delivered Meals	42	4	57	47
7. Live-In	47	4	19	5

Question #2:

This question requested that the agencies indicate the most prevalent characteristics of their home care clients (i.e., age, condition, income, size of household and sex) by service. Many agencies indicated more than one characteristic, resulting in percentages adding to more than 100%. The percentages indicate the agencies which provide the services to the various age groups.

	1) Age	n=61 County Welfare (percent)		n=46 Public Health Nursing (percent)		n=64 Private (percent)		n=18 Other Public (percent)	
Meals	<18	—	n=26	—	n=2	—	n=36	—	n=8
	18-25	4		—		—		—	
	26-45	4		—		8		—	
	46-60	19		50		19		—	
	61-74	81		100		83		75	
	75+	69		100		94		75	
Chore	<18	—	n=50	—	n=3	5	n=21	—	n=7
	18-25	12		—		14		—	
	26-45	22		33		19		—	
	46-60	40		33		33		14	
	61-74	100		67		71		29	
	75+	78		33		76		14	
Homemaker	<18	21	n=58	5	n=40	18	n=28	17	n=6
	18-25	36		3		18		17	
	26-45	48		13		18		17	
	46-60	43		15		36		17	
	61-74	60		40		54		17	
	75+	53		30		54		17	
Home Health Aide	<18	9	n=46	9	n=46	14	n=22	—	n=5
	18-25	22		13		23		20	
	26-45	22		22		32		20	
	46-60	28		43		36		20	
	61-74	61		76		55		20	
	75+	41		59		50		20	
Home Nursing	<18	7	n=28	46	n=46	33	n=15	—	n=4
	18-25	21		46		27		25	
	26-45	29		46		40		25	
	46-60	32		59		60		25	
	61-74	54		89		60		25	
	75+	46		80		60		25	
Transportation	<18	23	n=48	—	n=4	6	n=17	10	n=10
	18-25	29		—		6		10	
	26-45	35		—		6		20	
	46-60	35		—		12		20	
	61-74	75		50		71		70	
	75+	52		25		71		50	

The percentages indicate the agencies which provide services to persons with the following conditions.

	2) Condition	n=59 County Welfare (percent)	n=44 Public Health Nursing (percent)	n=52 Private (percent)	n=16 Other Public (percent)
Meals	Acute	36 n=25	100 n=2	50 n=30	13 n=8
	Chronic	72	100	80	25
	Physically Disabled	64	50	80	25
Chore	Acute	23 n=48	— n=3	12 n=17	— n=6
	Chronic	81	33	41	17
	Physically Disabled	83	—	35	—
Home-maker	Acute	31 n=55	11 n=38	26 n=23	20 n=5
	Chronic	45	29	65	20
	Physically Disabled	47	21	65	20
Home Health	Acute	36 n=44	64 n=44	56 n=18	25 n=4
	Chronic	50	80	67	25
	Physically Disabled	39	61	56	25
Home Nursing	Acute	41 n=27	80 n=44	100 n=12	67 n=3
	Chronic	44	82	100	67
	Physically Disabled	44	75	75	67
Trans-portation	Acute	22 n=45	— n=4	14 n=14	11 n=9
	Chronic	58	25	36	11
	Physically Disabled	56	—	36	56

The percentages indicate agencies which provide services to individuals with the following incomes.

	3) Income	n=61 County Welfare (percent)		n=37 Public Health Nursing (percent)		n=56 Private (percent)		n=18 Other Public (percent)	
Meals	<5,000	85	n=26	67	n=3	97	n=32	75	n=8
	5,000-10,000	23		100		53		25	
	10,000-15,000	8		67		19		–	
	15,000+	4		33		13		–	
Chore	<5,000	100	n=49	50	n=2	61	n=18	29	n=7
	5,000-10,000	35		50		44		–	
	10,000-15,000	10		–		17		–	
	15,000+	4		–		17		–	
Home-maker	<5,000	100	n=57	31	n=32	52	n=25	17	n=6
	5,000-10,000	32		19		36		17	
	10,000-15,000	12		6		28		17	
	15,000+	7		3		28		17	
Home Health	<5,000	58	n=45	43	n=37	74	n=19	–	n=5
	5,000-10,000	27		38		53		20	
	10,000-15,000	2		24		42		–	
	15,000+	2		24		42		–	
Home Nursing	<5,000	60	n=27	62	n=37	85	n=13	25	n=4
	5,000-10,000	26		51		62		25	
	10,000-15,000	15		24		69		–	
	15,000+	15		27		69		–	
Trans-portation	<5,000	79	n=47	33	n=3	47	n=15	60	n=10
	5,000-10,000	30		33		47		40	
	10,000-15,000	4		–		20		–	
	15,000+	–		–		–		–	

The percentages indicate agencies which provide services to individuals by their size of household.

	4) Size of Household	n=61 County Welfare (percent)	n=43 Public Health Nursing (percent)	n=63 Private (percent)	n=17 Other Public (percent)
Meals	1	81 n=26	100 n=2	100 n=36	88 n=8
	2	35	100	72	50
	3+	15	—	14	25
Chore	1	96 n=49	33 n=3	48 n=21	50 n=6
	2	63	33	43	17
	3+	24	33	19	—
Home-maker	1	56 n=57	19 n-37	50 n=28	20 n=5
	2	40	19	54	20
	3+	46	27	29	20
Home Health	1	49 n=45	51 n=43	76 n=21	— n=4
	2	36	60	71	25
	3+	16	23	38	—
Home Nursing	1	56 n=27	58 n=43	100 n=14	25 n=4
	2	44	70	100	50
	3+	26	33	71	50
Trans-portation	1	72 n=47	— n=4	53 n=17	60 n=10
	2	43	50	41	50
	3+	28	—	6	20

The following percentages indicate the agencies which service predominantly female clients or male clients.

	5) Sex	n=58 County Welfare (percent)	n=44 Public Health Nursing (percent)	n=65 Private (percent)	n=17 Other Public (percent)
Meals	F	83 n=24	100 n=2	100 n=37	75 n=8
	M	63	100	89	63
Chore	F	94 n=47	33 n=3	62 n=21	33 n=6
	M	57	—	43	33
Home-maker	F	71 n=55	42 n=38	62 n=29	20 n=5
	M	44	21	45	20
Home Health	F	60 n=43	82 n=44	64 n=22	— n=4
	M	37	59	64	25
Home Nursing	F	58 n=26	84 n=44	80 n=15	25 n=4
	M	38	57	67	50
Trans-portation	F	73 n=45	50 n=4	44 n=18	50 n=10
	M	44	25	33	40

Question #3:

When you assess an individual's needs, does your agency:

a. not assess need?
b. assess only the need for a specific service?
c. assess any needs which can be met by your agency?
d. assess all the needs of the client regardless of whether they can be met by your agency?

The following percentages indicate the type of needs assessment performed by the responding agencies. Percentages may add to more than 100% since many agencies employ more than one method.

	n=62 County Welfare (percent)	n=46 Public Health Nursing (percent)	n=67 Private (percent)	n=20 Other Public (percent)
a	–	–	10	7
b	3	–	33	13
c	10	13	25	13
d	90	91	48	67

Question #4:

If a client needs services provided by another agency, which of the following procedures is used most frequently by your agency?

a. inform the person that these other services are available and let the person follow through
b. give the person information about available services and how to contact these programs
c. call other services for the client and set up appointments, etc., for him/her
d. use written referral forms to refer client to the appropriate agency

The following percentages indicate the referral procedures performed by the responding agencies. Percentages may add to more than 100% since agencies can employ more than one method.

	n=62 County Welfare (percent)	n=46 Public Health Nursing (percent)	n=63 Private (percent)	n=19 Other Public (percent)
a	18	35	29	21
b	61	67	57	37
c	65	63	54	42
d	29	56	8	16

Question #5:

Please indicate the length of time persons typically receive each home care service provided by your agency. The following figures indicate the percentage of agencies responding to each time period for each service.

		n=60 County Welfare (percent)		n=40 Public Health Nursing (percent)		n=63 Private (percent)		n=16 Other Public (percent)	
Chore	0-1 month	6	n=49	—	n=2	29	n=21	—	n=6
	1-6 months	14		—		19		—	
	6 mos.-1 yr.	37		50		14		—	
	1-2 years	35		50		10		—	
	2+ years	33		—		24		—	
Home-maker	0-1 month	4	n=56	3	n=35	14	n=28	—	n=5
	1-6 months	25		26		21		—	
	6 mos.-1 yr.	30		20		21		—	
	1-2 years	32		9		18		—	
	2+ years	20		9		11		—	
Home Health	0-1 month	11	n=44	5	n=40	29	n=21	—	n=4
	1-6 months	34		78		48		—	
	6 mos.-1 yr.	23		23		24		—	
	1-2 years	9		5		10		—	
	2+ years	9		10		24		25	
Home Nursing	0-1 month	11	n=27	13	n=40	14	n=14	—	n=3
	1-6 months	30		78		71		—	
	6 mos.-1 yr.	15		35		21		—	
	1-2 years	19		15		7		—	
	2+ years	—		13		2		—	
Trans-portation	0-1 month	28	n=46	—	n=4	18	n=17	11	n=9
	1-6 months	22		—		12		11	
	6 mos.-1 yr.	15		25		12		11	
	1-2 years	20		—		—		22	
	2+ years	43		25		35		56	
Meals	0-1 month	12	n=25	—	n=2	17	n=36	13	n=8
	1-6 months	28		50		22		38	
	6 mos.-1 yr.	36		100		44		38	
	1-2 years	12		50		33		38	
	2+ years	12		100		25		50	

Question #6:

Describe the limits your agency places on the home care services you provide. The percentages indicate the agencies which have the following limits.

1) How often can a client receive each home care service (e.g., maximum days/week)?

Services	Days Allowed Per Week (limits)	n=59 County Welfare (percent)	n=42 Public Health Nursing (percent)	n=62 Private (percent)	n=18 Other Public (percent)
Chore	no limit	65 n=48	33 n=3	40 n=20	— n=7
	1 per week	8	—	15	—
	2 per week	4	—	—	—
	3 per week	4	—	5	—
	5 per week	21	33	—	—
Home-maker	no limit	51 n=55	14 n=37	48 n=27	17 n=6
	1 per week	13	5	7	—
	2 per week	4	—	4	—
	3 per week	5	—	4	—
	4 per week	—	3	—	—
	5 per week	16	35	7	17
Home Health	no limit	43 n=44	31 n=42	43 n=21	— n=5
	1 per week	2	—	—	—
	3 per week	2	5	5	20
	4 per week	—	2	—	—
	5 per week	11	55	19	—
Home Nursing	no limit	41 n=27	69 n=42	64 n=14	— n=4
	1 per week	4	—	7	—
	2 per week	—	—	—	25
	3 per week	4	5	—	—
	5 per week	11	26	21	—
Trans-portation	no limit	76 n=45	25 n=4	12 n=17	40 n=10
	1 per week	4	—	—	—
	2 per week	2	—	6	—
	3 per week	7	—	12	—
	5 per week	9	25	35	40
Meals	no limit	40 n=25	— n=2	23 n=35	13 n=8
	1 per week	4	—	—	—
	3 per week	4	—	3	—
	5 per week	72	100	77	50
	6 per week	4	—	6	13

2) For how long can a client receive each service? (I.e., is there a maximum number of visits or time period allowed?)

Services	Limits	n=58 County Welfare (percent)	n=42 Public Health Nursing (percent)	n=62 Private (percent)	n=18 Other Public (percent)
Chore	No limit	100 n=47	33 n=3	70 n=20	43 n=7
	(No Response)	—	67	30	57
Home-maker	No limit	91 n=55	49 n=37	63 n=27	17 n=6
	Short term	—	3	4	—
	1 month	—	—	4	—
	(No Response)	9	48	29	83
Home Health	No limit	67 n=43	81 n=42	71 n=21	20 n=5
	2-4 months	—	2	—	—
	6 months	—	2	—	—
	Medicare	—	10	5	—
	Ability to pay	—	2	—	—
	(No Response)	33	3	24	80
Home Nursing	No limit	65 n=26	86 n=42	79 n=14	25 n=4
	2-4 months	—	2	—	—
	Medicare	—	10	14	—
	Ability to pay	—	2	—	—
	(No Response)	35	—	7	75
Trans-portation	No limit	100 n=45	25 n=4	65 n=17	70 n=10
	(No Response)	—	75	35	30
Meals	No limit	100 n=24	100 n=2	100 n=35	75 n=8
	6 months	—	—	—	13
	(No Response)	—	—	—	12

3) Is there a maximum or minimum number of hours per day you are willing to provide each home care service to a client?

Services	Limits	n=56 County Welfare		n=45 Public Health Nursing		n=59 Private		n=16 Other Public	
		Maximum (percent)	Minimum (percent)	Maximum (percent)	Minimum (percent)	Maximum (percent)	Minimum (percent)	Maximum (percent)	Minimum (percent)
Chore	None	56	56 n=45	—	— n=3	26	26 n=19	—	— n=6
	½ hr. per day	—	4	—	—	—	—	—	—
	1 hr. per day	2	7	—	—	—	—	—	—
	1½ hrs. per day	—	2	—	—	—	—	—	—
	2 hrs. per day	7	4	—	—	—	26	—	—
	3 hrs. per day	9	—	—	—	—	—	17	—
	4 hrs. per day	13	—	—	—	11	5	—	—
	5 hrs. per day	—	—	33	—	—	—	—	—
	6 hrs. per day	4	—	—	—	—	—	—	—
	8 hrs. per day	9	—	—	—	11	—	—	—
Homemaker	None	43	43 n=53	10	10 n=39	23	23 n=26	—	— n=5
	½ hr. per day	—	4	—	8	—	4	—	—
	1 hr. per day	—	6	—	21	—	15	—	—
	1½ hrs. per day	—	2	—	—	—	—	—	—
	2 hrs. per day	11	2	5	5	—	23	—	—
	3 hrs. per day	6	2	13	—	8	—	—	—
	4 hrs. per day	—	—	10	—	4	12	20	—
	5 hrs. per day	9	—	3	—	4	—	—	—
	6 hrs. per day	6	—	—	—	—	—	—	—
	7 hrs. per day	2	—	—	—	—	—	—	—
	8 hrs. per day	8	—	5	—	8	—	—	—
	9½ hrs. per day	—	—	—	—	4	—	—	—
	12 hrs. per day	—	—	3	—	4	—	—	—
Home Health	None	41	41 n=41	6	6 n=45	15	15 n=20	—	— n=4
	½ hr. per day	—	5	—	11	—	5	—	—
	1 hr. per day	—	5	—	40	—	15	—	—
	2 hrs. per day	10	—	24	—	—	25	25	—
	3 hrs. per day	—	—	9	—	15	—	—	—
	4 hrs. per day	2	—	40	—	—	20	—	—
	5 hrs. per day	—	—	—	—	5	—	—	—
	8 hrs. per day	5	—	11	—	—	—	—	—
Home Nursing	None	48	48 n=25	13	13 n=45	29	29 n=14	—	— n=3
	¼ hr. per day	—	—	—	2	—	—	—	—
	½ hr. per day	—	4	—	11	—	7	—	—
	1 hr. per day	4	4	16	7	7	21	33	—
	1½ hrs. per day	—	—	4	—	—	—	—	—
	2 hrs. per day	4	—	20	—	—	7	—	—
	3 hrs. per day	—	—	7	—	7	—	—	—
	4 hrs. per day	—	—	—	—	—	36	—	—
	8 hrs. per day	—	—	4	—	—	—	—	—
	16 hrs. per day	—	—	2	—	—	—	—	—

Question #7:

Does your agency have a waiting list for home care services?

	n=57 County Welfare (percent)	n=44 Public Health Nursing (percent)	n=57 Private (percent)	n=9 Other Public (percent)
Yes	7	11	42	33
No	93	89	58	67

For which services? (in rank order)

1. Home-delivered meals (n=14)
2. Homemaking services (n=13)
3. Home Health Aide (n=5)
4. Chore Services (n=5)
5. Nursing Services (n=1)
6. Live-In (n=1)

What are the usual reasons people get off the waiting list? (in rank order)

1. Service Becomes Available (n=11)
2. Individual Receives Services Elsewhere (n=10)
3. Individual Admitted to Nursing Home (n=7)
4. Services No Longer Needed (n=5)
5. Death (n=3)

Question #8:

Does your agency charge fees for home care services?

	n=57 County Welfare (percent)	n=45 Public Health Nursing (percent)	n=62 Private (percent)	n=10 Other Public (percent)
Yes	46	100	79	70
No	54	–	21	30

If yes, do you use a sliding fee scale?

	n=26 County Welfare (percent)	n=45 Public Health Nursing (percent)	n=49 Private (percent)	n=7 Other Public (percent)
Yes	81	76	31	–
No	19	24	69	100

Question #9:

Please indicate your funding sources for each home care service. The percentages indicate the funding sources used by the responding agencies for each service. They do not indicate how much of the agencies' funding comes from these sources.

Services	Funding Source (percent)	County Welfare (percent)		Public Health Nursing (percent)		Private (percent)		Other Public (percent)	
Home-Delivered Meals	Medicaid	—	n=26	—	n=2	3	n=37	—	n=8
	CDBG/Revenue Sharing	—		—		8		—	
	State/Local Taxes	46		50		8		13	
	Title XX	69		—		8		—	
	Title III	12		—		3		13	
	Title VII	27		—		5		25	
	United Way	12		—		22		25	
	Fees	42		100		84		50	
	Foundations	—		—		11		—	
	Other	—		—		43		25	
Chore	CDBG/Revenue Sharing	—	n=49	—	n=3	5	n=21	—	n=8
	State/Local Taxes	69		67		5		13	
	Title XX	100		67		33		—	
	Title III	14		—		5		13	
	United Way	—		—		5		—	
	Fees	37		33		43		13	
	Foundations	—		—		5		—	
	Other	2		—		10		13	
Homemaker	Medicare	—	n=57	5	n=41	—	n=29	—	n=0
	Medicaid	5		12		—		—	
	Veterans Administration	4		5		—		—	
	CDBG/Revenue Sharing	—		5		—		—	
	State/Local Taxes	58		20		3		—	
	Title XX	86		17		34		—	
	Title III	5		5		3		—	
	United Way	—		—		17		—	
	Insurance	2		—		7		—	
	Fees	23		34		55		—	
	Foundations	—		—		10		—	
	Other	2		—		7		—	
Home Nursing	Medicare	43	n=28	91	n=46	27	n=15	—	n=5
	Medicaid	69		93		13		—	
	Veterans Administration	21		85		13		20	
	CDBG/Revenue Sharing	—		11		—		—	
	State/Local Taxes	46		70		—		—	
	Title XX	29		7		—		—	
	Title III	4		4		—		—	
	United Way	—		7		7		—	
	Insurance	29		61		47		—	
	Fees	38		100		73		—	
	Foundations	—		—		7		—	
	Other	—		2		13		—	

Services	Funding Source	County Welfare (percent)		Public Health Nursing (percent)		Private (percent)		Other Public (percent)	
Home Health Aide	Medicare	43	n=46	93	n=46	31	n=16	—	n=5
	Medicaid	63		89		13		—	
	Veterans Administration	22		67		19		20	
	CDBG/Revenue Sharing	2		13		—		—	
	State/Local Taxes	41		70		6		—	
	Title XX	30		7		13		—	
	Title III	4		9		—		20	
	United Way	—		7		19		—	
	Insurance	24		43		38		—	
	Fees	28		98		88		—	
	Foundations	—		—		19		—	
	Other	—		13		19		20	
Transportation	Medicare	4	n=48	—	n=4	—	n=19	—	n=13
	Medicaid	60		—		—		—	
	Veterans Administration	4		—		—		—	
	CDBG/Revenue Sharing	4		—		5		8	
	State Local Taxes	65		50		11		21	
	Title XX	73		25		5		5	
	Title III	15		—		16		11	
	Title VII	—		—		11		5	
	United Way	—		—		16		—	
	Insurance	2		—		—		—	
	Fees	35		—		16		11	
	Other	—		25		21		5	

Question #10:

Do you see a need to expand any of your home care services?

	n=44 County Welfare (percent)	n=33 Public Health Nursing (percent)	n=42 Private (percent)	n=8 Other Public (percent)
Yes	80	73	76	63
No	20	27	24	37

Which ones? (in rank order)

County Welfare

1. Homemaker (n=18)
2. Chore (n=18)
3. Transportation (n=13)
4. Home Health Aide/Attendant Care (n=7)
5. All Services (n=3)
6. Home-Delivered Meals (n=3)
7. Respite Care (n=1)
8. Companion Services (n=1)

Public Health Nursing

1. Homemaker (n=11)
2. Home Health Aide (n=8)
3. Home Nursing (n=7)
4. Chore Services (n=1)
5. All Services (n=1)
6. Respite Care (n=1)
7. Hospice Care (n=1)
8. Transportation (n=1)

Private

1. Home-Delivered Meals (n=9)
2. Homemaker (n=8)
3. Home Nursing (n=6)
4. Home Health Aide (n=5)
5. Chore (n=4)
6. Transportation (n=3)
7. Live-In Assistance (n=1)
8. All Services (n=1)

Other Public

1. Transportation (n=2)
2. Home-Delivered Meals (n=2)
3. Homemaker (n=1)
4. Home Health Aide (n=1)
5. Chore (n=1)

Question #11:

Is your agency willing to expand?

	n=56 County Welfare (percent)	n=44 Public Health Nursing (percent)	n=52 Private (percent)	n=11 Other Public (percent)
Yes	82	98	79	82
No	18	2	21	18

What currently prohibits or discourages expansion? (in rank order)

County Welfare

1. Lack of funding (n=32)
2. Lack of staff to provide the services (n=6)
3. Attitude of county board (n=5)
4. The ruling that individual providers are county employees and must be given appropriate benefits (n=4)
5. Institutional bias of Title XIX and MSA (n=1)
6. Duplication of services possible (n=1)
7. Lack of space (n=1)
8. Lack of outreach (n=1)
9. Lack of physician referrals (n=1)
10. Lack of volunteers (n=1)
11. Lack of time (n=1)
12. Lack of community support (n=1)
13. Not enough eligible clients (n=1)
14. Paperwork (n=1)
15. Governmental attitudes (n=1)

Public Health Nursing

1. Lack of funding (n=20)
2. Lack of staff (n=11)
3. Lack of space (n=3)
4. Medicare regulations (n=2)
5. Philosophy of county board (n=2)
6. County Welfare Department not interested in giving contract for service provision (n=1)
7. Referrals lacking (n=1)
8. Administrative barriers with County Welfare Department (n=1)
9. Lack of equipment and time (n=1)

Private

1. Lack of funding (n=18)
2. Lack of staff (n=9)
3. Restrictions on licensure (n=5) (Restrictions on third-party reimbursement (n=1))
4. Lack of demand (n=3)
5. Lack of space (n=2)
6. Lack of awareness (n=1)
7. Difficulty in providing services to rural areas (n=1)
8. County hesitancy to fund private services (n=1)

Other Public

1. Lack of funding (n=5)
2. Lack of staff (n=2)
3. Lack of space (n=2)
4. Regulations (n=1)
5. Volunteer problems (n=1)

Question #12:

Does your agency plan to expand?

	n=47 County Welfare (percent)	n=36 Public Health Nursing (percent)	n=46 Private (percent)	n=6 Other Public (percent)
Yes	34	56	54	50
No	66	44	46	50

In what way?

1. Hire more staff (n=18)
   More home health aides (n=4)
   More volunteers (n=2)
   More social workers (n=1)
   More nurses (n=1)
2. Provide more services (n=4)
   Provide more homemaker services (n=13)
   Provide more chore services (n=9)
   Provide more transportation services (n=6)
   Provide more 24-hour care (n=2)
   Provide more friendly visiting (n=1)
   Provide more social/recreational services (n=1)
   Provide sheltered workshop (n=1)
   Provide more nutrition services (n=1)
3. Serve more clients (n=21)
4. Increase area served (n=4)
5. Increase coordination (n=2)
6. Increase outreach (n=2)

Question #13:

Are home care staff difficult to recruit?

	n=53 County Welfare (percent)	n=46 Public Health Nursing (percent)	n=45 Private (percent)	n=5 Other Public (percent)
Yes	70	43	60	80
No	30	57	40	20

If so, why?

1. Low salary (n=50)
2. Not fulltime/No guaranteed hours (n=20)
3. A lot of travel, particularly in rural areas (n=17)
4. Unattractive employment/Low status (n=15)
5. Need for transportation (n=7)
6. Hard work (n=5)
7. Few benefits (n=5)
8. Weekend work unattractive (n=3)
9. Lack of recruiting staff (n=3)
10. Long training (n=3)
11. Lack of individuals to do live-in work (n=2)
12. Employment rate high in area (n=1)
13. Poor vendor management (n=1)
14. Few know about the job (n=1)

Question #14:

Are home care staff difficult to maintain?

	n=51 County Welfare (percent)	n=45 Public Health Nursing (percent)	n=38 Private (percent)	n=3 Other Public (percent)
Yes	41	44	47	33
No	59	56	53	67

Question #15:

What is the approximate percent of turnover of your home care service staff in a 3-month period? (n=127)

Percent Turnover	Percent Agencies
none	43
1-5	23
5-10	15
10-15	5
15-20	6
over 20	9

Questions #16-18:

The data generated from questions #16-18, which dealt with training and supervision, were inconsistent and not useful. For this reason, these data have been omitted from the tabulation.

Question #19:

Does your agency use volunteers for home care services?

	n=54 County Welfare (percent)	n=47 Public Health Nursing (percent)	n=59 Private (percent)	n=7 Other Public (percent)
Yes	56	13	61	86
No	44	87	39	14

For which services? (in rank order)

1. Transportation (n=41)
2. Home-Delivered Meals (n=41)
3. Chore Services (n=12)
4. Visiting Companion (n=6)
5. Attendant Care (n=4)
6. Grocery Shopping (n=1)
7. Home Nursing (n=1)
8. Home Health Aide (n=1)
9. All Services (n=1)

Question #20:

What is your average cost per unit of service for each home care service you provide?

Service	n=58 County Welfare	n=47 Public Health Nursing	n=52 Private	n=16 Other Public
1. Home-Delivered Meals	n=15	n=2	n=29	n=4
Average Cost	$1.36 per meal	$1.40 per meal	$1.76 per meal	$1.70 per meal
Most frequently mentioned cost	$1.50 per meal	none	$1.25 per meal and $1.50 per meal	none
Range of costs	$.30 to $1.85 per meal	$1.30 per meal to $1.50 per meal	$.95 per meal to $3.75 per meal	$1.00 per meal to $2.31 per meal
2. Chore	n=42	n=1	n=8	n=1
Average Cost	$3.26 per hour	$4.00 per hour	$4.41 per hour	$3.83 per hour
Most frequently mentioned cost	$2.65 per hour	$4.00 per hour	none	$3.83 per hour
Range of costs	$2.00 per hour to $8.34 per hour	none	$3.94 per hour to $5.00 per hour	none
3. Homemaking	n=38	n=15	n=11	n=1
Average Cost	$5.68 per hour	$6.61 per hour	$5.01 per hour	$25 per visit
Most frequently mentioned cost	$2.65 per hour	$5.18 per hour and $6.00 per hour	$4.80 per hour	$25 per visit
Range of costs	$2.65 per hour to $15.00 per hour	$3.57 per hour to $21.00 per hour	$3.94 per hour to $7.00 per hour	none
4. Transportation	n=34	n=2	n=5	n=3
Average Cost	$0.15 per mile	$0.15 per mile	none	$0.14 per mile
Most frequently mentioned cost	$0.15 per mile	$0.15 per mile	none	none
Range of costs	$0.13 per mile to $0.35 per mile	none	$1.25 per round trip to $5.87 per hour	$0.09 per mile to $0.17 per mile

Service	n=58 County Welfare	n=47 Public Health Nursing	n=52 Private	n=16 Other Public
5. Home Health Aide	n=19	n=36	n=10	n=0
Average Cost	$5.88 per hour	$8.16 per hour	$6.49 per hour	No response
Most frequently mentioned cost	none	$6.00 per hour and $7.00 per hour	none	No response
Range of costs	$2.67 per hour to $11.84 per hour	$3.57 per hour* to $12.22 per hour	$3.94 per hour to $9.85 per hour	No response
6. Home Nursing	n=8	n=38	n=11	n=1
Average Cost	$12.06 per hour	$22.74 per visit***	$9.50 per hour	$45.50 per visit
Most frequently mentioned cost	$22.00 per hour	$22.00 per visit	none	$45.50 per visit
Range of costs	$2.67 per hour to $22.00 per hour	$10.00 per visit** to $51.00 per visit	$7.00 per hour to $20.00 per hour	none

*$14.97 per visit to $30.00 per visit
**$9.00 per hour to $36.00 per hour
***Average cost of $25.68 per hour

Question #21:

1. What major problems do you see in the home care service delivery system? Please rank each of the problems described below as very important (VI), somewhat important (SI), or not at all important (NI) in the spaces provided.

Problems	n=61 County Welfare (percent)	n=46 Public Health Nursing (percent)	n=54 Private (percent)	n=17 Other Public (percent)
Lack of adequate funding				
VI	67	67	59	53
SI	20	15	19	12
NI	8	17	20	6
Lack of adequate needs assessment				
VI	10	7	15	18
SI	36	37	30	24
NI	48	54	54	12
Lack of formal working agreements among agencies				
VI	5	11	7	6
SI	28	33	24	24
NI	61	54	74	24
Lack of informal coordination in the community among agencies				
VI	11	15	11	12
SI	25	26	39	24
NI	57	57	48	18
Lack of standards to assure quality of services provided				
VI	8	22	20	6
SI	38	15	26	24
NI	48	59	48	18
Inadequate training of staff				
VI	11	13	9	6
SI	36	17	30	24
NI	46	67	57	18
Duplication of services				
VI	15	20	17	6
SI	28	33	26	24
NI	51	48	52	24
Gaps in the social service system				
VI	16	22	19	24
SI	56	41	39	18
NI	21	35	39	12

Problems	n=61 County Welfare (percent)	n=46 Public Health Nursing (percent)	n=54 Private (percent)	n=17 Other Public (percent)
Eligibility criteria				
VI	21	20	22	24
SI	34	30	31	24
NI	38	52	41	12
The people in need don't get the service				
VI	25	24	28	24
SI	34	50	30	24
NI	34	24	39	6
Information on services not available				
VI	8	20	15	18
SI	46	43	26	24
NI	39	35	52	12

2. What do you feel should be done to improve the home care service delivery system? Please rank each of the suggestions described below as very important (VI), somewhat important (SI), or not at all important (NI) in the spaces provided.

	n=61 County Welfare (percent)	n=46 Public Health Nursing (percent)	n=54 Private (percent)	n=16 Other Public (percent)
More funding for high priority services				
VI	72	67	57	44
SI	16	17	17	19
NI	5	15	22	–
More and better needs assessment should be done				
VI	15	20	24	44
SI	44	35	30	13
NI	34	43	43	6
Duplication of services should be reduced				
VI	15	28	20	19
SI	36	26	24	25
NI	43	43	52	19
Coordination between agencies should be increased				
VI	21	39	32	50
SI	49	41	35	6
NI	23	17	30	6
Responsibility and accountability for service should be designated to a particular agency and that agency given responsibility to coordinate all services for the individual				
VI	38	28	24	44
SI	26	22	26	13
NI	30	46	44	19
Agencies should be limited in the type of services they can provide (responsibility for providing service should be given to certain agencies, so duplication or inefficiency is reduced)				
VI	38	30	20	19
SI	21	30	15	38
NI	34	35	61	19
More information about services should be available				
VI	26	50	28	38
SI	46	37	35	19
NI	20	9	33	6
Outreach should be increased so that the people in need get the service				
VI	26	54	43	50
SI	39	30	28	6
NI	28	11	26	6

	n=61 County Welfare (percent)	n=46 Public Health Nursing (percent)	n=54 Private (percent)	n=16 Other Public (percent)
The system should be made less fragmented				
VI	30	37	33	19
SI	43	35	30	25
NI	21	24	33	19
Services should be located near those that need them (decentralized)				
VI	26	35	22	38
SI	33	24	33	13
NI	34	39	41	13

APPENDIX E

AN EXAMINATION OF THE NEED FOR HOME CARE IN MINNESOTA

TECHNICAL NOTES

[1]Saad Z. Nagi, "Ohio State University Disability Survey, 1972," in his *R & D in Disability Policies and Programs: An Analysis of Organizations, Clients, and Decision-Making* (Columbus, Ohio: Mershon Center, Ohio State University, 1973), Table IV-8, p. IV-16, and S. Z. Nagi, "An Epidemiology of Disability Among Adults in the United States," (Columbus, Ohio: Mershon Center, Ohio State University, mimeo, 1975), Table 9, p. 39. As presented in: Levinson Policy Institute, "The Need for Personal Care Services by Severely Physically Disabled Citizens of Massachusetts," (Waltham, Mass.: Brandeis University, 1977), Table 11B, page 31.

[2]Levinson Policy Institute, "The Need for Personal Care," Table 11-B, page 31.

[3]*Ibid.*

[4]This chart was compiled by putting together information previously presented in this report. The impairment levels are estimates from "The Need for Personal Care," page 31. (See footnotes 1-3.) The number of individuals with the various limitations was taken from "The Status and Needs of Minnesota's Older People," a survey conducted by Mid-Continent Surveys, Inc., Minneapolis, Minnesota, December, 1971, page 56.

[5]Estimation of service needs was accomplished by combining the number of individuals in the limited but independent group and the functionally disabled group who have limitations which require assistance. The 100,000 figure for chore services was derived by adding the limited but independent group and the functionally disabled group. The estimate is slightly overestimated due to possible overlap and the fact that many of the limited but independent group will only need very intermittent help. The transportation estimate was derived by taking those functionally disabled individuals with difficulty in getting outside the house. The homemaking figure was derived by taking those individuals in the functionally disabled group with problems in getting around the house. The personal/attendant care figure was derived by taking those individuals who have difficulty in bathing and dressing. The 34,000 figure for regular assistance denotes those individuals who have problems with dressing and bathing. The 14,000 figure for occasional assistance denotes those who have problems with bathing only. The figure for respite care was derived by taking 70 percent of the 52,440 to 76,608 individuals with a functional disability. According to the *Status and Needs of Minnesota's Older People,* page 90, 70 percent of the elderly population live with someone.

[6]The estimates for the percent of need met by family were taken from "The Need for Personal Care," Levinson Policy Institute, page 421.

[7]Minnesota Governor's Planning Council on Developmental Disabilities, *Minnesota Developmental Disabilities State Plan, Fiscal Year 1978* (St. Paul: 1978), page II-11.

[8]*Ibid.,* pages II-11, II-12.

[9]The Developmental Disabilities State Plan (page II-14) includes three categories of disability which are not included in the count since this report is concerned with the disability groups most commonly considered as developmentally disabled. The three excluded groups — all other mental, all other nervous/sensory, and physical disorders (muscular) — are estimated in the state plan to include 14,921 individuals.

Estimates of the prevalence of developmental disabilities in Minnesota vary. One estimate is in the Developmental Disabilities State Plan, however the plan stresses the limitations of the data and particularly cautions against the validity of applying the data to smaller geographic units.

[10]To determine the number of developmentally disabled individuals who are under age 65 and not in institutions, the number of individuals over age 65 was subtracted from the total developmentally disabled population. The age data from the Developmental Disabilities State Plan for fiscal year 1978 was used to do this. The plan uses the following age breakdowns.

Years	Number	Percentage of the Developmentally Disabled Population
0-4	6,679	8
5-19	20,949	25
20-59	43,224	52
60-74	9,057	11
75+	3,852	5
	83,761	**100**

In order to make the age breakdowns consistent with those in this report, an "over age 65" category had to be determined. To do this age percentages from the total elderly population (age 60+) in the state were applied to the elderly developmentally disabled population. There are 12,909 developmentally disabled individuals in the state who are over age 60. Since four percent of the state population is between the ages of 60 and 64 and thirteen percent is over age 65, these percentages were applied to the developmentally disabled population resulting in figures of 3,485 for the developmentally disabled between the ages of 60 and 64 and 9,424 for the developmentally disabled over age 65.

Thus, by subtracting the over age 65 population from the total developmentally disabled population in the state, there is a total nonelderly developmentally disabled population of 74,337.

Next the under age 65, institutionalized, developmentally disabled population was subtracted. This was determined by estimating the number of Medicaid-eligible individuals in institutions who are developmentally disabled. Populations in skilled nursing facilities (SNF), intermediate care facilities (ICF) and intermediate care facilities for the mentally retarded (ICF-MR) were examined. The diagnoses of mental retardation and congenital/infant were used for the definition of developmentally disabled. The source of this data was the Minnesota Department of Health's Quality Assurance Review for fiscal year 1977.

Facility	SNF	ICF	ICF-MR
Total MA patients	11,543	12,261	5,185
Percent with Developmentally Disabled diagnoses	5%	9%	100%
Total Developmentally Disabled population	**577**	**1,103**	**5,185**

Then to determine individuals under age 65, data were applied on the age of individuals in these facilities, assuming that diagnoses were evenly distributed by age.

Facility	SNF	ICF	ICF-MR
Total Developmentally Disabled population	577	1,103	5,185
Percent under age 65	10%	13%	95%
Total nonelderly Developmentally Disabled population	**58**	**143**	**4,978**

Next the number of non-Medicaid-eligible developmentally disabled, institutionalized persons under age 65 was determined. Four hundred and forty-eight non-Medicaid-eligible individuals were found in Supervised Living Facilities (SLF). (At this point an equivalency between the SLF and the ICF-MR was assumed.) In nursing homes 8,752 non-Medicaid eligible individuals were found. (An equivalency between the nursing home and the SNF and ICF was assumed.) By assuming that the non-Medicaid-eligible population had the same diagnoses and age breakdowns as Medicaid-eligible individuals in SNFs, ICFs and ICF-MRs, the same percentages were applied to this population.

Facility	SLF	Nursing Home
Total non-MA population	448	8,752
Percent with Developmentally Disabled diagnoses	100%	7%
Total Developmentally Disabled population	**448**	**613**

(The seven percent figure for nursing homes was derived by averaging the developmental disability prevalence rates for ICFs and SNFs for Medicaid patients.)

Next the number of individuals under age 65 was identified by multiplying the appropriate age factors, assuming that the age breakdowns were consistent between Medicaid-eligible and non-Medicaid-eligible patients by facility.

Facility	SLF	Nursing Home
Total Developmentally Disabled population	448	613
Percent under age 65	96%	12%
Total non-elderly, non-Medicaid-eligible, Developmentally Disabled population	**430**	**74**

(The twelve percent figure for nursing homes was derived by averaging the age percentage under 65 of ICFs and SNFs.)

This results in a total non-Medicaid-eligible, institutionalized, under age 65, developmentally disabled population of 504.

By subtracting the elderly; the non-Medicaid-eligible, institutionalized, nonelderly; and the Medicaid-eligible, institutionalized, nonelderly, developmentally disabled population from the total developmentally disabled population, there remains a nonelderly, noninstitutionalized, developmentally disabled population of 68,654.

[11]Diagnostic and severity breakdowns are from data in the Minnesota Developmental Disabilities State Plan for fiscal year 1978, pp. II-11, II-12. Age breakdowns are taken from data presented in the plan (modified as explained in footnote 10 to determine the age 65+ population).

Age	Number	Percent of Total Developmentally Disabled Population	Percent of Nonelderly Developmentally Disabled Population
0-4	6,679	8	9
5-19	20,949	25	28
20-59	43,224	52	58
60-74	9,057	11	–
60-64	(3,485)	(4)	5
65-74	(5,572)	(7)	–
75+	3,852	5	–
	83,761	**101**	**100**

[12]This 75 percent figure was obtained from the Minnesota Individual Information System (Minnesota Department of Public Welfare, 12/15/78, page 7). Developmentally disabled persons living in four categories – independent living, live with parents/family, minimally supervised apartment and supervised apartment – were counted as the noninstitutional group. The percentages of all developmentally disabled persons in these categories were converted to percentages of noninstitutionalized developmentally disabled persons in these categories.

Current Residential Placement	Percent of Total Developmentally Disabled Population	Percent of Noninstitutionalized Developmentally Disabled Population
Independent living	7.0	17.5
Living with parents/ family	30.1	74.9
Minimally supervised apartment	1.2	3.1
Supervised apartment living	1.8	4.5
	40.1	**100.0**

Of the 51,422 developmentally disabled individuals who are living with family or parents, the severe/profound/autistic group was subtracted on the assumption that these people are all living in a family setting. This leaves 48,055 lesser-disabled persons living with parents or family.

The severe/profound/autistic group was subtracted from the 68,654 noninstitutionalized developmentally disabled population. Of the remaining 65,286 individuals, 10.5 percent were in the moderate/cerebral palsy group and 87.5 percent were in the mild/epilepsy group. These percentages were then applied to the 48,055 persons living with parents or family. (It was assumed that both of these groups were equally likely to be living in a family situation.)

[13]The findings from the six studies cited below are presented in Levinson Policy Institute, "The Need for Personal Care," Table 1, page 10.

1) Social Security Survey, 1966
Kathryn H. Allan, and Mildred E. Cinsky, "General Characteristics of the Disabled Population," *Social Security Survey of the Disabled, 1966,* Report No. 19, DHEW Publication No. (SSA) 72-11713, (Washington, D.C.: U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, July, 1972), Table E, page 9; Table 1, page 24.

2) U.S. Census, 1970
U.S. Bureau of the Census, *Persons With Disability,* 1970 Census of Population, PC(2)-6C, (Washington, D.C.: U.S. Department of Commerce, Social and Economics Administration, Bureau of the Census, January, 1973), Table 160, pages 1-499.

3) Social Security Survey, 1972
Kathryn H. Allan, "First Findings of the 1972 Survey of the Disabled: General Characteristics," *Social Security Bulletin,* 39 (October, 1976), page 18.

4) Ohio State Survey, 1972
Saad Z. Nagi, *R & D in Disability Policies,* Table IV-4, page IV-7; Table IV-7, page IV-14.

5) Health Interview Survey, 1974
National Center for Health Statistics, *Health Characteristics of Persons with Chronic Activity Limitation, United States, 1974,* Vital and Health Statistics, Series 10, No. 112; DHEW Publication No. (HRA) 77-1539, (Washington,

D.C.: U.S. Department of Health, Education and Welfare, October, 1976), Table 1, page 11.

6) Urban Institute Estimates, 1975
Urban Institute Comprehensive Needs Study (Washington, D.C.: 1975), Table 4-4, page 72.

Although definitions of disability and severity of disability vary among these six studies, researchers at Brandeis fit their findings into the following classifications to make them comparable. The classifications and their definitions are as follows.

Partial disability: The person is able to work or carry on his or her major activity but has some health-related problem that may interfere with that major activity.

Substantial disability: The person has a health-related condition that limits the amount or kind of major activity she or he is able to perform.

Severe disability: The person is unable to work or carry on his or her major activity at all.

The data in these six studies represent the United States' noninstitutionalized civilian population. The working age population is defined slightly differently among studies, beginning at age 17, 18 or 20 and ending at age 64.

[14]The findings from the three studies below are presented in Levinson Policy Institute, "The Need for Personal Care," Table 3, page 15.

1) Health Interview Survey, 1972
National Center for Health Statistics, *Limitation of Activity and Mobility Due to Chronic Conditions, United States, 1972,* Vital and Health Statistics, Series 10 No. 96; DHEW Publication No. (HRA) 75-1523, (Washington, D.C.: U.S. Department of Health, Education, and Welfare, November, 1972), Table 1, page 15.

2) Ohio State University Survey, 1972
Saad Z. Nagi and Paul C. Luken, "Childhood Disability: A Social Epidemology," (Columbus, Ohio: Ohio State University, 1975), page 13.

3) Health Interview Survey, 1974
National Center for Health Statistics, *Health Characteristics of Persons with Chronic Activity Limitation, United States, 1974.*

[15]Unpublished data from *The Assessment of Disability in Minnesota — A Household Survey,* Minnesota Department of Economic Security, Division of Vocational Rehabilitation, 1978.

[16]Levinson Policy Institute, "The Need for Personal Care," page 21. Complete citations for these studies are found in footnote 13.

[17]Levinson Policy Institute, "The Need for Personal Care," page 36. Complete citation for these studies is found in footnotes 13 and 14.

[18]To estimate the size of the physically disabled population (as physical disability is defined in this report), all disability categories other than "physical disability," "blindness and vision," and "other" were excluded. Percentages of disability types from unpublished data in "The Assessment of Disability in Minnesota — A Household Survey," (Minnesota Department of Economic Security, Division of Vocational Rehabilitation, 1978) were applied to 1980 Minnesota population statistics.

[19]Levinson Policy Institute, "The Need for Personal Care," page 21.

[20]*Ibid.*

[21]The number of working age disabled adults was derived by subtracting the approximately 45,000 disabled children from the total disabled population (nonelderly, noninstitutionalized) of 331,830. The information regarding the percentage of individuals needing no help with certain tasks, receiving informal assistance and needing formal assistance was obtained from "The Need for Personal Care," page 43. The "receiving informal assistance" category is equivalent to "having needs met within the home support system." The "needing formal assistance" group is equivalent to a combination of "having need met outside the home support system" and "unmet need." The "uncertain" category was factored out of the percentages.

[22]To determine the number of individuals living in a family setting, the following procedure was used. The "Need for Personal Care" (page 58) indicated that 79.6 percent of all noninstitutionalized disabled live in a family setting. (The institutionalized categories were factored out of the percentages.) This percentage, however, included the elderly population. This population was factored out by first determining the number of disabled elderly who live in a family setting.

Since there are approximately 133,000 disabled elderly in the state with 73.3 percent of them living in a family setting (according to "Status and Needs," page 9), that 97,489 was subtracted from the total disabled population living in a family setting. (468,830 [total disabled] X .796 = 373,189; 373,189 – 97,489 = 275,700 nonelderly disabled living in a family setting.) Of this 275,000, approximately 45,000 are children and 230,700 are working-age adults.

[23]Minnesota Department of Health, *Quality Assurance and Review Program: Summary Report, 1976,* (Minneapolis, 1977).

[24]The following discussion explains the methodology used to obtain the estimates of the population with a good and moderate potential for restoration to independent living. The data are from the QAR for fiscal year 1977.

Medicaid Elderly Estimates

There are 28,989 Medicaid patients in SNFs, ICFs and ICF-MRs. (SNF = 11,543, ICF = 12,261 and ICF-MR = 5,185.) To obtain the number of elderly in each facility the percentages of elderly in each facility were applied to these numbers.

SNF:	11,543	X	.90	=	10,389
ICF:	12,261	X	.86	=	10,544
ICF-MR:	5,185	X	.04	=	207

This results in a total Medicaid elderly population of 21,140.

To obtain the number of elderly with a moderate or good potential for restoration to independent living, the number of total patients with this classification was first obtained.

Facility	Number with moderate or good potential for restoration to independent living
SNF	420
ICF	988
ICF-MR	698

These numbers were then applied to the percentages of elderly in each group.

SNF:	420	X	.84	=	353
ICF:	988	X	.77	=	761
ICF-MR:	698	X	.02	=	14

This gives a total Medicaid elderly population with a moderate or good potential for restoration to independent living of 1,128.

In order to separate the number of Medicaid elderly with a good potential for restoration to independent living from those with a moderate potential, the percentages of persons with these potentials in each facility were applied. These percentages are derived by using the good and moderate potential percentages for the total population rather than just for the elderly group. It had to be assumed that the percentage of individuals in each facility with these potentials is constant across all age groups.

	Good potential	Moderate potential
SNF:	353 X .16 = 56	353 X .84 = 297
ICF:	761 X .23 = 175	761 X .77 = 586
ICF-MR:	14 X .27 = 4	14 X .73 = 10

This results in a total Medicaid elderly population with a good potential for restoration to independent living of 235 and a moderate potential of 893.

Medicaid Nonelderly Estimates

The number of nonelderly Medicaid patients with a good and moderate potential for independent living was obtained in the same way as for the elderly. First, the total number of Medicaid patients under age 65 was determined.

Facility	Total patients		Percent under age 65		Number under age 65
SNF	11,543	X	.10	=	1,154
ICF	12,261	X	.14	=	1,717
ICF-MR	5,185	X	.96	=	4,978

This results in a total Medicaid population under age 65 of 7,849. Second, those with moderate or good potential for restoration to independent living were determined.

Facility	Total patients with moderate or good potential		Percent under age 65		Number under age 65
SNF	420	X	.16	=	67
ICF	988	X	.23	=	227
ICF-MR	698	X	.98	=	684

This results in a total Medicaid population under age 65 with a moderate or good potential for

restoration to independent living of 978. Third, to separate those with good potential from those with moderate potential, age percentages were applied to arrive at that group.

Facility	Under age 65 patients with moderate or good potential		Percent with good potential		Number under age 65 with good potential
SNF	67	X	.16	=	11
ICF	227	X	.23	=	52
ICF-MR	684	X	.27	=	185

Facility	Under age 65 patients with moderate or good potential		Percent with moderate potential		Number under age 65 with moderate potential
SNF	67	X	.84	=	56
ICF	227	X	.77	=	175
ICF-MR	684	X	.73	=	499

This results in a total Medicaid population under age 65 with a good potential for restoration to independent living of 248 and with a moderate potential for restoration to independent living of 730.

Non-Medicaid Estimates

The number of non-Medicaid individuals in institutions was obtained through information from the Minnesota Department of Health's Licensing Division. For the reporting period of October 1, 1976 to September 30, 1977, there were 44,463 individuals in nursing homes, boarding care homes and supervised living facilities in Minnesota.

Nursing Homes	=	32,548
Boarding Care Homes	=	6,252
Supervised Living Facilities	=	5,662

For the same period there were 28,989 Medicaid-eligible individuals in corresponding institutions.

SNF and ICF	=	23,804
ICF-MR	=	5,185

By subtracting the Medicaid patients from the total population, the number of non-Medicaid-eligible patients was obtained (15,473).

To obtain the number of non-Medicaid elderly and nonelderly individuals in institutions in Minnesota, the number of individuals in the various facilities was obtained. The QAR data for Medicaid-eligible patients was used to determine this. In order to use the QAR data it had to be assumed that the following facilities have corresponding populations:

Nursing Homes Boarding Care Homes	=	Skilled Nursing Facilities Intermediate Care Facilities

AND

Supervised Living Facilities	=	Intermediate Care Facilities for the Mentally Retarded

The QAR data was then used to further define the population. By assuming that the age breakdowns for non-Medicaid patients are the same as the breakdowns for Medicaid patients in these institutions, QAR percentages of elderly and nonelderly can be applied to the non-Medicaid institutionalized population. First, it was determined how many non-Medicaid patients are in the various facilities.

Facility	Total population	Medicaid population	Non-Medicaid population
Nursing Home Boarding Care SNF ICF	38,800	23,804	14,996
SLF/ICF-MR	5,662	5,185	477

Second, the percentages of elderly and nonelderly in these types of facilities were applied.

Nursing Homes, Boarding Care, SNF and ICF

Total non-Medicaid population		Percent elderly		Elderly non-Medicaid population
14,996	X	.88	=	13,196

Total non-Medicaid population		Percent nonelderly		Nonelderly non-Medicaid population
14,996	X	.12	=	1,800

Supervised Living Facilities, ICF-MR

Total non-Medicaid population		Percent elderly		Elderly non-Medicaid population
477	X	.04	=	19

Total non-Medicaid population		Percent nonelderly		Nonelderly non-Medicaid population
477	X	.96	=	458

Third, again by assuming the same distribution of age, disability and potential for restoration to independent living as was assumed in the Medicaid population, the QAR data can be used to apply percentages of good or moderate potential for restoration to independent living.

Nursing Homes, Boarding Care, SNF, ICF

Good Potential for Restoration to Independent Living (Non-Medicaid)

Elderly	13,196	X	.015	= 396
Nonelderly	1,800	X	.015	= 27

Moderate Potential for Restoration to Independent Living (Non-Medicaid)

Elderly	13,196	X	.045	= 594
Nonelderly	1,800	X	.045	= 81

Supervised Living Facilities and ICF-MR

Good Potential for Restoration to Independent Living (Non-Medicaid)

Elderly	19	X	.04	= 8
Nonelderly	458	X	.04	= 18

Moderate Potential for Restoration to Independent Living (Non-Medicaid)

Elderly	19	X	.10	- 2
Nonelderly	458	X	.10	= 46

This results in a non-Medicaid-eligible, institutionalized population with a good potential for independent living of 404 for the elderly and 45 for the nonelderly or a total of 449 and with a moderate potential of 596 for the elderly and 127 for the nonelderly for a total of 723.

APPENDIX F

INFORMAL ASSISTANCE NOTES

1. These studies include:

   - National Center for Health Statistics, "Home Care for Persons 55 Years and Over: U.S. July 1966 to June 1968," *Vital and Health Statistics,* Series 10, No. 73, July 1972.

   - Gerald M. Eggert, Carl V. Granger, Robert Morris, and Sylvia Pendleton, "Community-based Maintenance Care for the Long Term Patient" (Levinson Policy Institute, Brandeis University: Waltham, Massachusetts, June 1966).

   - Denise Humm-Delgado and Robert Morris, "Family Policy and the Disabled: Examples of Family Payments for Long Term Disability" (Levinson Policy Institute, Brandeis University: Waltham, Massachusetts, Sept. 1976).

   - Alan Sager and Gerben DeJong, "The Need for Personal Care Services by Severely Physically Disabled Citizens of Massachusetts" (Levinson Policy Institute, Brandeis University: Waltham, Massachusetts, April 15, 1977).

2. Mid-Continent Surveys, Inc., "The Status and Needs of Minnesota's Older People" (Minneapolis, Minnesota, December 1971), p. 90-1.

3. Matilda Riley and Anne Foner, *Aging and Society, Vol. 1, An Inventory of Research Findings* (New York: Russell Sage, 1968), pp. 541-44.

4. Data are from a survey done for the Massachusetts Rehabilitation Commission presented in Sager and DeJong, "The Need for Personal Care," Table 38, p. 78.

5. National Center for Health Statistics, "Home Care," Table F, p. 10.

6. Eggert et al., "Community-based Maintenance Care," pp. 25 and 29.

7. Riley and Foner, *Aging and Society,* cited in Robert Morris, "Family Responsibility: Implications of Recent Demographic and Service Trends for a National Helping System" (Levinson Policy Institute, Brandeis University: Waltham, Massachusetts, Nov. 1977), p. 6.

8. Eggert et al., "Community-based Maintenance Care," p. 5.

9. Theodore J. Litman, "Health Care and the Family: A Three-generational Analysis," *Medical Care,* 9:67-81, 1971.

APPENDIX G

HOME CARE ADVISORY COMMITTEE

In order to have ongoing input into the home care project by individuals in Minnesota most interested in the topic of home care, the Commissioner of the Minnesota Department of Public Welfare appointed an 18 member advisory committee comprised of consumers, providers, advocates and agency personnel. The following is a list of the members of this advisory committee and the organizations they represent:

Katherine Sehlin	Minnesota Board on Aging
May Berry	Metropolitan Senior Federation
Wayne and Leah LaBar	Consumers of home care services
Sandy Anderson	United Handicapped Federation
Clint Schultz	Consumer of home care services and former long-term care resident
Judy Silverman	Jewish Family and Children's Service
Mavis Young	Hennepin County Welfare Department
Tom Tjepkema	St. Louis County Social Services Department
Steve Moon	State Council for the Handicapped
Fran Decker	Minnesota Department of Health
Rich Nelson	Minnesota Board on Aging
LaRhae Knatterud	Metropolitan Council – Aging Division
Glen Samuelson	Social Security Administration
Mary Stuber	Minnesota Housing Finance Agency
Steve Watson	Community Action Association
Jim Franczyk	State Planning Agency
Jay Greenberg	Center for Health Services Research
Wendy Lerner	Nursing Services, Inc.