

HB

374

HOUSE BILL 374

"An Act relating to equalizing the costs of full-time residential or nursing care."

It is generally acknowledged that older persons would rather live in their communities than be separated from familiar patterns and people. The advantages of keeping people in their own communities are numerous. Most people prefer it. It enhances morale and provides security. Persons receive more individualized care, and the family and friends of the elderly in turn tend to become more involved when older persons reside close by. It is often apparent that many older people perceive institutionalization, even in a Pioneer Home, as a "punishment" for getting sick and feeble. They fear the isolation and loneliness, not to mention the boredom, that comes from being displaced to a new setting. The thought of "dying alone" becomes a frightening preoccupation. Persons should not have to leave their communities, even to enter a Pioneer Home, unless it is their personal preference or they have become too ill for the treatment capacities of their community facilities.

Alaskans have been generous with their financial resources in supporting the Pioneer Home program, but that program presently revolves around facilities in four communities in the State. Fiscal reality tells us that we cannot construct and operate Pioneer Home programs in every community or even in every geographical region of the State. The cost per client is simply too prohibitive.

Considerable State resources have also been committed to the five nursing homes and the long-term care units of seven general hospitals throughout the State. All of the twelve facilities presently available have adequate bed-space to accommodate additional nursing home patients. In addition, these twelve facilities are built to Medicare/Medicaid standards and can draw upon the resources of those programs should the patient be eligible. It would be folly to duplicate these beds, or indeed to jeopardize the financial status of the seven general hospitals which depend on their long-term care units to a large degree to assure fiscal solvency.

The approach proposed by House Bill 374 appears much more rational. This proposal suggests that we respond to the needs of Senior Alaskans by dedicating resources to a

broader based pioneer program -- one that responds to the preference of the pioneer to remain in his own community, either in a residential setting or a nursing home, if a Pioneer Home is not accessible.

The Department is interested in maximizing the residential care component suggested in House Bill 374. Recent surveys demonstrate that a significant number of current nursing home placements in Alaska are institutionalized for social rather than medical reasons. Not only is such placement a terribly expensive over-reaction to the problems of these individuals, but it does not represent a satisfactory solution either for the person or for those concerned with his welfare. Non-medical residential care can provide such individuals with a protected atmosphere in a community setting as an alternative to 24-hour nursing/medical care. The Department feels that this kind of living arrangement will help maximize the person's ability to function as independently as possible while at the same time providing necessary guidance and assistance sufficient for independent living. House Bill 374 would offer an important source of revenue to provide such residential care for those individuals qualifying for the Pioneer Home program.

The Department of Health and Social Services is most enthusiastic about the thrust of House Bill 374 and looks forward to working with the sponsor and other legislators to enact this community-oriented approach to caring for pioneer Alaskans. The attached sheet illustrates some of our initial thoughts concerning House Bill 374. The Department of Health and Social Services will be happy to work with the Department of Administration to develop cost projections along the lines of the methodology suggested in the attachment. We will also be pleased to assist in suggesting at least some initial parameters for the program to keep fiscal projections reasonable.

Approved by:

Helen D. Beirne  
Helen D. Beirne, Commissioner  
Department of Health and  
Social Services

3-20-79  
Date

Attachment

HOUSE BILL 374

I. Amendments:

1. Set limits on amount allowed for residential care (rather than "amount charged," establish limit of daily or monthly rate of \$\_\_\_\_\_).
2. Set criteria for eligibility in addition to (1) thru (3) of 47.25.108, to add "at risk of institutionalization" (in residential or nursing home setting). Would reduce eligibles - approximately 10% "at risk"?

II. Cost Offsets:

1. Could draw Medicare/Medicaid reimbursement for nursing care in certified nursing homes to offset Pioneer Home expenditures for nursing home care for Medicaid eligibles.
2. If limits set on amount allowed for residential care, could offset daily rate in Pioneer Home for same residential care.
3. Increased occupancy levels in LTC units of 7 general hospitals would contribute to financial viability of those community hospitals.
4. Will contribute significantly to establishment of residential alternative care settings for all individuals by providing a mechanism for funding those with Pioneer status.

III. Determining Cost-Impact:

1. Establish potential eligibles
  - a. Population over 65 by community
  - b. Exclude communities with Pioneer Homes
2. Determine likely Pioneer Home eligibles from #1;
3. Determine population "at risk of institutionalization" from #2;
4. Multiply percent likely to enter residential care times daily rate limit;
5. Multiply percent likely to enter nursing care times daily rate in communities with LTC facilities (draw from surrounding areas);
6. Subtract potential Medicaid offsets;
7. Subtract decrease in daily rates for residential care vs. Pioneer Home rates for residential care.

IV. Recommendation:

That HB 374 be referred to the Special Committee on Services to the Elderly proposed by SB 179 and funded by SB 177.

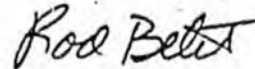
OR

Request research analyst from Legislative Affairs to work with the Department of Health and Social Services and Department of Administration in the interim to develop program and fiscal implications.

NURSING HOME RATES AS OF FEBRUARY 23, 1979

	Current I.C.F. Rate	Current S.N.F. Rate	Certified Capacity			Current Occupancy			% Occupancy
			I.C.F.	S.N.F.	TOTAL	I.C.F.	S.N.F.	TOTAL	
Seage House (Anchorage)	55.00		101		101	41		41	41%
Seage North (Fairbanks)	84.50	93.00	101*		101	61	29	90	89%
Sordova Hospital L.T.C.	72.72	80.80	6*		6	4	2	6	100%
Hope Park and Ocean Park ICF/MR	124.36		31		31	31		31	100%
Stichikan Hospital L.T.C.	65.00		48*		48	43		43	90%
Stokoyia (Anchorage)	103.00	125.00	116	100	216	111	42	153	71%
Stron Sound L.T.C. (Nome)	228.00		6		6	4		4	67%
Stetersburg (L.T.C)	51.30	57.00	12*		12	9	2	11	92%
South Peninsula (Homer)	108.00		4		4	1		1	25%
St. Ann's (Juneau)	75.00	82.50	45*		45	18	1	19	42%
Stalley Hospital L.T.C. (Palmer)	104.85		6		6	3		3	50%
Strangell Hospital L.T.C.	70.00	77.00	14*		14	13		13	93%
Steslevan (Seward)	42.30		64		64	54		54	84%
TOTALS			542	100	654	393	76	469	72%

All beds certified for both SNF and ICF.

  
 Rod Betit, Director  
 Division of Public Assistance

Date  
 Feb 23, 1979

Name	Address	Organization	Bill No.
<del>St. An</del> Pat Denny Howie M. Kull Sister Patrick Mary Louis La Beaume	419 6 <sup>th</sup> St. Juneau 326 - 4 <sup>th</sup> St 520 Harris Street " " "	St. Ann's Nursing Home American Relief Party Senior Citizen Programs " " "	374   374 * 374

# STATE OF ALASKA

## DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

POUCH C - JUNEAU 99811

JAY S. HAMMOND, GOVERNOR

March 22, 1979

Honorable Thelma Buchholdt  
Chairman, House Health, Education &  
Social Services Committee  
Alaska State Legislature  
Pouch V  
Juneau, Alaska 99811

Re: H B 374

Dear Representative Buchholdt:

Attached is some information you requested concerning the number of residents at the Pioneers' Homes and the cost per resident.

At this time we are still in the process of trying to determine the fiscal impact that this bill will have if passed. A number of areas are still unknown as to population of eligible applicants, the effect of Medicaid and Medicare, the net result of cost per care at effected facilities and potential impact on the existing program. We are working with the Department of Health and Social Services to answer these questions.

If you need more information or a clarification of the information presented, please let us know.

Respectfully,



W. R. Hudson  
Commissioner

WRH/mjc  
Attachments

FEBRUARY, 1979

	<u>SITKA</u>	<u>FAIRBANKS</u>	<u>PALMER</u>	<u>ANCHORAGE</u>	<u>TOTAL</u>
Available Beds					
Residence	100	65	42	133	340
Nursing	30	54	54	20	178
Vacancies					
Residence	34	11	2	9	56
Nursing	5	4	0	20	29
Waiting List					
Residence	2	17	70	97	186
Nursing	6	5	10	0	21

The current rate per month charged at the Pioneers' Homes is \$225.00 for resident care and \$275.00 to skilled nursing care.

PIONEERS' HOMES  
AVERAGE COST PER RESIDENT  
FY 1978

	Average No. Residents FY 78	Cost Per Year	Cost Per Month	Cost Per Day
<u>Average Cost All Homes</u>				
Resident Care	287	\$ 17,819	\$ 1,485	\$ 49.01
Nursing Care	151	26,893	2,241	73.68
Average for Both	438	\$ 21,494	\$ 1,791	\$ 58.89
<u>Sitka</u>				
Resident Care	71	\$ 14,827	\$ 1,236	\$ 40.62
Nursing Care	48	27,174	2,264	74.45
Average for Both	119	\$ 19,807	\$ 1,651	\$ 54.26
<u>Fairbanks</u>				
Resident Care	55	\$ 17,433	\$ 1,453	\$ 47.76
Nursing Care	50	28,273	2,356	77.46
Average for Both	105	\$ 22,595	\$ 1,883	\$ 61.90
<u>Palmer</u>				
Resident Care	38	\$ 17,401	\$ 1,450	\$ 47.67
Nursing Care	53	25,231	2,102	69.12
Average for Both	91	\$ 21,961	\$ 1,830	\$ 60.16
<u>Anchorage*</u>				
Resident Care	123	\$ 21,613	\$ 1,801	\$ 59.21
Nursing Care	-0-			
Average for Both	123	\$ 21,613	\$ 1,801	\$ 59.21

\* Anchorage was only open for nine months in FY 78. These numbers have been prorated to reflect a twelve month period.

# STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 - JUNEAU 99811

March 12, 1979

The Honorable Russ Meekins  
Chairman, House Finance Committee  
Alaska State Legislature  
Pouch V  
Juneau, Alaska 99811

Dear Mr. Meekins:

As per your request we submit a proposal for the Division of Public Assistance to start a Pilot Project Residential Care Program for thirteen (13) nursing home patients in the Anchorage area, and a Pilot Home Care Alternatives Project to prevent other individuals at high risk from entering nursing homes. The idea of the Residential Care Pilot Program is to identify persons currently in nursing homes who might wish to live in boarding care in the community if given supportive services to do so, to provide an alternative program to accomplish this goal, and to evaluate costs and savings potential from such a program at the end of a one-year period. (See attached project narrative.) The idea of the Home Care Alternatives Project is to identify persons currently in their own homes who, without intervention and service support would be in immediate risk of institutionalization or nursing home placement. (See attached project narrative.)

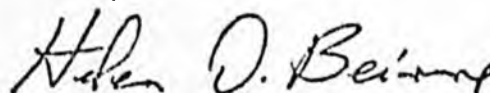
This amendment would transfer funds between Budget Request Units within the Division.

A summary of this amendment is as follows:

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>GENERAL FUNDS</u>
Medicaid-Nursing Homes	(373.4)	(186.7)	(186.7)
General Relief-Residential Care	81.6		81.6
General Relief-Home Care	84.8		84.8
Old Age Assistance	20.3		20.3
TOTAL SAVINGS	<u>(186.7)</u>	<u>(186.7)</u>	<u>-0-</u>

Thank you for your consideration of this request.

Sincerely,



Helen D. Beirne

## RESIDENTIAL CARE PROJECT NARRATIVE

It is generally acknowledged that older persons would rather live in their communities than in nursing homes. The questions have been: Can they adequately care for themselves in that environment, is their quality of life really improved, and does such an arrangement cost more or less than nursing home care?

Historically, there have been few options for the older person in Alaska who is no longer able to live independently. And persons of lower income who become unable to care for themselves currently have no recourse except either boarding homes, which generally do not provide personal care and services, or medical facilities, which are staffed and equipped for the treatment of illnesses rather than for social care. Often, for one reason or another, a nursing home or institution represents an expensive, unwanted, or even unnecessary over-reaction to the person's problems. People have had to go into nursing homes because there was no alternative. This does not represent a satisfactory solution either for the person or for those concerned with his welfare.

In response to this situation, the Alaska Department of Health and Social Services has developed an alternative residential care project. The project is designed to meet the needs of a specific group of people who are considered to have functional deficiencies in one or more of the following areas: economic, social, emotional or physical adjustment. The project will provide these adults who request the service with a protected atmosphere in a community setting as an alternative to 24-hour institutional or nursing/medical care. It is felt that this kind of living arrangement will help maximize the person's ability to function as independently as possible while at the same time providing necessary guidance and assistance to persons in those functional area that are insufficient for them to maintain independent living.

The aim of this pilot project is to develop a more humane as well as cost effective quality program with the primary focus being on social restoration rather than on medical/health care. It is a program specifically tailored to meet the needs of persons whose abilities to perform the essential activities of daily living are so impaired as to require a level of care beyond that available in an independent or room and board living situation, but whose disabilities are not such as to require 24-hour medical care. The desired result is a more satisfying and productive life for the individual. There is also a potential cost saving in that studies show a substantial number of such persons are now cared for in public or private institutions or nursing homes.

Funding for the project will consist of current state dollars already being spent on the identified pilot project population. Present state match monies already allocated through the State's Medicaid Program will be transferred to the General Relief fund and budgeted to the residential care project from the general fund.

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The pilot project's three basic components are living arrangements; older persons who have difficulty in everyday living because of the frailties of age or due to physical, visual or mental impairments; and program supplementation. In considering the living arrangement component, all personal and community resources available to the prospective client will be evaluated. All boarding homes in Anchorage have been contacted and prospective client profiles discussed with house managers. Four homes have expressed an interest in being utilized as a placement service, and have indicated that additional staff and personal care services will be incorporated into their existing programs to help accommodate these particular persons' needs. All residential care facilities shall be in compliance with regulations licensing adult care facilities currently being promulgated by the Department of Health and Social Services. (Authority: AS 47.35.020; AS 47.35.070)

With regard to the older person component, there are currently, approximately one hundred (100) nursing home patients who have been identified throughout the State of Alaska by the Department of Health and Social Services whose level of care needs appear residential rather than skilled or intermediate nursing. All twelve (12) nursing home facilities in the State have client representatives in this population. Since there are few or no alternative residential care facilities in the eleven (11) geographically distributed communities who have nursing homes, a state-wide residential care project is felt to be unrealistic at this point in time. However, a pilot project in Anchorage, which has two nursing homes representing close to thirty percent (30%) of the identified population whose level of care needs appear residential, does seem feasible. Thirteen (13) provisionally identified nursing home patients have been profiled for a possible pilot project regarding alternate residential placements in the Anchorage area. Client profiles suggest that the needs of the persons considered for this project are largely social, with observation and supervision required in their activities of daily living. Medications are being taken by several of these persons, which will need to be monitored, and considerable social support and encouragement is required.

The third component of the project is program supplementation. Arrangements will be made for physician/nurse visits, medication monitoring, and supportive services as needed in the homes. The monitoring of medications may be done through use of the Anchorage community nursing program for this small pilot project, or contracting with the Nursing Registry Program in Anchorage. The Division of Social Services is now recruiting to fill a new position in Anchorage in adult services, and this position will be utilized to provide client monitoring, assessment, case-planning, and supportive services in the homes and with client placements.

The three main components described, those of homes, individuals and program supplementation, come together through the Residential Placement Agency. This project will be co-located in the divisions of Public

Assistance and Social Services, and is responsible for: assessing and certifying clients; assessing and certifying homes; and assuring the appropriateness of placement; the continuing need for the provision of care; and service management activities of case-planning, case-monitoring, and follow-up. A distinctive feature of the Residential Care pilot project is that it offers a test of an approach to use positive incentives to stimulate improved living conditions for a very vulnerable group of persons. Participation in the project is voluntary, and all persons are "grandfathered" under the new State Medicaid regulations, if no alternative living arrangements are available or until discharged from nursing home so as to insure continued funding of care for these persons after the one-year demonstration project is completed.

Projected rates are approximately \$900 per month per person for providing residential care services. Current rates being paid by Medicaid and the State for these same persons in the two Anchorage nursing homes are \$2,010 and \$3,090 per month. It is anticipated that the pilot project involving thirteen (13) persons might result in a net savings of up to \$84,000, and that a future statewide program for 100 persons could conceivably save close to \$1 million. It is expected that if the project is successful, State supplementals might be continued in expanding the program throughout the State.

Savings earned as a result of the Department's residential care program are planned to be utilized in a related pilot program to allow for supportive services to be provided to prevent the inappropriate or premature institutionalization of certain high risk individuals (see attached narrative for the Home Care Alternatives Project). Such services availability will be limited by the extent of the earned savings from the residential care project.

SUMMARY OF COSTS:::NURSING HOMES--RESIDENTIAL CARE

	Patients	Gross Billings	(3rd Party Receipts)	Total	Funding	
					Federal	GF
Nursing Homes	108	2988462	(194400) <sup>a</sup>	2794062	1397031	1397031
(Residential Care) 108		1166400 <sup>c</sup>	(488592) <sup>b</sup>	677808		677808
COST SAVINGS in MEDICAID + Additional OAA Expense <sup>d</sup>				2116254 168480	1397031	719223 168480
NET SAVINGS				2284734	1397031	887703
Nursing Homes	13	396755 <sup>e</sup>	(23400) <sup>a</sup>	373355	186678	186677
(Residential Care) 13		140400 <sup>c</sup>	(58812) <sup>b</sup>	81588		81588
COST SAVINGS IN MEDICAID + Additional OAA Expense <sup>d</sup>				291767 20280	186678	105089 20280
NET SAVINGS				312047	186678	125369

- NOTES:
- An average of \$150 per month is used for each patient.
  - Most patients, if they were not in a nursing home, would be eligible for SSI and State Supplemental payments up to \$377 per month. Very few patients would be eligible for the Longevity Bonus. For this summary, the amount of \$377 has been used.
  - Estimated costs of residential care:
 

Boarding costs - \$750 per month
Medical/social - \$150 per month
<u>TOTAL</u> \$900 per month
  - Average OAA payments - \$130 per month
  - Careage House: 7 patients @ \$24455 annually  
Nakoyia: 6 patients @ \$37595 annually

FY80 BUDGET ATTENDMENT  
COST ANALYSIS SUMMARY  
by BUDGET COMPONENT

AGENCY	CATEGORY	
DIVISION	PROGRAM	
	SUB PROGRAM	Medicaid
	ELEMENT	Nursing Homes
	SUB ELEMENT	

CODE	EXPENDITURE BY OBJECT	FY80 GOV. BUDGET	FY80 CHANGES	FY80 GOV. BUDGET
100	PERSONAL SERVICES			
200	TRAVEL			
300	CONTRACTUAL SERVICES			
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON STRUCTURAL IMPROVEMENTS			
700	GRANTS, CLAIMS, SHARED REVENUE	17541.6	(373.4)	17168.2
800	MISCELLANEOUS			
INTER AGENCY TRANSFERS (INCLUDED ABOVE)				
	<b>TOTAL</b>	<b>17541.6</b>	<b>(373.4)</b>	<b>17168.2</b>
NEW CODE				
	FEDERAL RECEIPTS	8770.8	(135.7)	8584.1
	REQUIRED GENERAL FUND MATCHING	1825.4	(185.7)	1638.7
	OTHER GENERAL FUND			
	INTER AGENCY TRANSFERS			
	OTHER: Revenue Sharing	6945.4		6945.4
	<b>TOTAL</b>	<b>17541.6</b>	<b>(373.4)</b>	<b>17168.2</b>
	PERMANENT FULL TIME POSITIONS			
	PERMANENT PART TIME POSITIONS			
	TEMPORARY (FULL TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS			

(CURRENT FY)  
↓

	FY _____	FY _____	FY _____	FY _____	FY _____	FY _____
EXPENDITURES - TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G. F. MATCH						
OTHER G. F.						
OTHER (SPECIFY)						

AGENCY	CATEGORY	
DIVISION	PROGRAM	
	SUB PROGRAM	General Relief Med
	ELEMENT	/Residential Care
	SUB ELEMENT	

CODE	EXPENDITURE BY OBJECT	FY 80 GOV BUDGET PRESENT AUTHORIZATION	REVISION INCREASE, (DECREASE)	AMENDED FY80 AUTHORIZATION
100	PERSONAL SERVICES			
200	TRAVEL			
300	CONTRACTUAL SERVICES			
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON STRUCTURAL IMPROVEMENTS	-0-	81.6	81.6
700	GRANTS, CLAIMS, SHARED REVENUE			
800	MISCELLANEOUS			
	INTER-AGENCY TRANSFERS (INCLUDED ABOVE)			
	<b>TOTAL</b>	<b>-0-</b>	<b>81.6</b>	<b>81.6</b>
NEW CODE	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	-0-	81.6	81.6
	INTER-AGENCY TRANSFERS			
	OTHER:			
	<b>TOTAL</b>	<b>-0-</b>	<b>81.6</b>	<b>81.6</b>
	PERMANENT FULL-TIME POSITIONS			
	PERMANENT PART-TIME POSITIONS			
	TEMPORARY (FULL-TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS			

(CURRENT FY)

	FY ____	FY ____	FY ____	FY ____	FY ____	FY ____
EXPENDITURES - TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G.F. MATCH						
OTHER G. F.						
OTHER (SPECIFY)						

FY 80 BUDGET AMENDMENT  
COST ANALYSIS SUMMARY  
by BUDGET COMPONENT

AGENCY	CATEGORY	
	PROGRAM	
DIVISION	SUB PROGRAM	General Relief -
	ELEMENT	Home Care
	SUB ELEMENT	

CODE	EXPENDITURE BY OBJECT	PRESENT AUTHORIZATION	REVISION INCREASE (DECREASE)	AMENDED AUTHORIZATION
100	PERSONAL SERVICES			
200	TRAVEL			
300	CONTRACTUAL SERVICES			
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON-STRUCTURAL IMPROVEMENTS	-0-	84.8	84.8
700	GRANTS, CLAIMS, SHARED REVENUE			
800	MISCELLANEOUS			
	INTER-AGENCY TRANSFERS (INCLUDED ABOVE)			
	<b>TOTAL</b>	<b>-0-</b>	<b>84.8</b>	<b>84.8</b>
NEW CODE	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	-0-	84.8	84.8
	INTER-AGENCY TRANSFERS			
	OTHER:			
	<b>TOTAL</b>	<b>-0-</b>	<b>84.8</b>	<b>84.8</b>
	PERMANENT FULL-TIME POSITIONS			
	PERMANENT PART-TIME POSITIONS			
	TEMPORARY (FULL-TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS			

(CURRENT FY)

	FY ____	FY ____	FY ____	FY ____	FY ____	FY ____
EXPENDITURES - TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G.F. MATCH						
OTHER G. F.						
OTHER (SPECIFY)						

AGENCY	CATEGORY	
	PROGRAM	
DIVISION	SUB PROGRAM	Old Age Assistance
	ELEMENT	
	SUB ELEMENT	

CODE	EXPENDITURE BY OBJECT	FY 80 GOV. BUDGET PRESENT AUTHORIZATION	REVISION INCREASE, (DECREASE)	AMENDED AUTHORIZATION FY80
100	PERSONAL SERVICES			
200	TRAVEL			
300	CONTRACTUAL SERVICES			
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON STRUCTURAL IMPROVEMENTS			
700	GRANTS, CLAIMS, SHARED REVENUE	3406.1	20.3	3426.4
800	MISCELLANEOUS			
	INTER AGENCY TRANSFERS (INCLUDED ABOVE)			
	<b>TOTAL</b>	<b>3406.1</b>	<b>20.3</b>	<b>3426.4</b>
NEW CODE				
	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	3406.1	20.3	3426.4
	INTER AGENCY TRANSFERS			
	OTHER			
	<b>TOTAL</b>	<b>3406.1</b>	<b>20.3</b>	<b>3426.4</b>
	PERMANENT FULL-TIME POSITIONS			
	PERMANENT PART-TIME POSITIONS			
	TEMPORARY (FULL-TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS			

(CURRENT FY)

	FY ____	FY ____	FY ____	FY ____	FY ____	FY ____
EXPENDITURES - TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G.F. MATCH						
OTHER G. F.						
OTHER (SPECIFY)						

# RESIDENTIAL CARE

Approved By \_\_\_\_\_

	# OF PATIENTS ASSESSED AS NEEDING RESIDENTIAL CARE	CURRENT YEARLY RATE PER PATIENT	TOTAL GROSS BILLINGS	LESS 3RD PARTY RECEIPTS	TOTAL NET COST
1	ISLAND VIEW MANOR (KETCH)	11	23725	19800	241175
2					
3	NORTON SOUND (NOME)	3	83403	5400	244309
4					
5	PETERSBURG L.T.C.	5	18725	9000	84625
6					
7	WRANGELL L.T.C.	1	25550	1800	23750
8					
9	CAREAGE NORTH (FBX)	13	30843	23400	377557
10					
11	CORDOVA L.T.C.	2	26543	3600	49486
12					
13	WESLEYAN N.H. (SEWARD)	22	15440	39600	300080
14					
15	S. PENINSULA L.T.C. (HOMER)	0	39420	-	-
16					
17	VALLEY HOSP. L.T.C. (PALMER)	3	34306	5400	97518
18					
19	ST. ANNS (JUNEAU)	4	27375	7200	102300
20					
21	CAREAGE HOUSE (ANCH)	23	24455	41400	521065
22					
23	NAKOYIA (ANCH)	21	37595	37800	751695
24					
25	<b>TOTAL</b>	<b>108</b>	<b>2938462</b>	<b>194400</b>	<b>2794062</b>
26					
27	<b>FUNDING</b>				
28	FEDERAL FUNDS				1,397,031
29	GENERAL FUNDS				1,397,031
30					2,794,062
31					
32					
33	① CAREAGE HOUSE RATE ADJUSTED FROM \$55 PER DAY TO \$67 PER DAY. ALL OTHERS AT CURRENT RATE				
34					
35					
36	② AN AVERAGE OF \$150 PER MONTH IS USED FOR EACH PATIENT				
37					
38	③ THIS DOES NOT INCLUDE COST SETTLING FOR CURRENT YEAR				
39					
40					

Form HSS Buff - Form GSSS Green

	Current I.C.F. Rate	Current S.N.F. Rate	Certified Capacity			Current Occupancy			Medicine
			I.C.F.	S.N.F.	TOTAL	I.C.F.	S.N.F.	TOTAL	% Occup
Careage House (Anchorage)	55.00		101		101	41		41	41%
Careage North (Fairbanks)	84.50	93.00	101*		101	61	29	90	89%
Cordova Hospital L.T.C.	72.72	80.80	6*		6	4	2	6	100%
Hope Park and Ocean Park ICF/MR	124.36		31		31	31		31	100%
Ketchikan Hospital L.T.C.	65.00		48*		43	43		43	90%
Nakoyia (Anchorage)	103.00	125.00	116	100	216	111	42	153	71%
Norton Sound L.T.C. (Nome)	228.00		6		6	4		4	67%
Petersburg (L.T.C)	51.30	57.00	12*		12	9	2	11	92%
South Peninsula (Homer)	108.00		4		4	1		1	25%
St. Ann's (Juneau)	75.00	82.50	45*		45	18	1	19	42%
Valley Hospital L.T.C. (Palmer)	104.85		6		6	3		3	50%
Wrangell Hospital L.T.C.	70.00	77.00	14*		14	13		13	93%
Weslevan (Seward)	42.30		64		64	54		54	84%
TOTALS			542	100	654	393	76	469	72%

\* All beds certified for both SNF and ICF.

*Rod Betit*      Feb 23, 19

Rod Betit, Director      Date  
Division of Public Assistance

## HOME CARE ALTERNATIVES PROJECT

### NARRATIVE

The Department of Health and Social Services has determined that the comprehensive, coordinated care necessary to assist individuals in avoiding inappropriate institutionalization is not always readily accessible in Alaska. Often this is largely due to the funding mechanisms available. Existing funding sources are willing to reimburse expensive, highly skilled medical/nursing care. They are less willing to reimburse less expensive, less technical, but often more satisfying preventive and supportive care. This bias toward institutional care is apparent even when institutional admittance is purely for social reasons rather than medical reasons. (Social reasons include such things as: 1) a person being alone and unable to care for themselves; 2) the vacation of the family or friend, thus requiring nursing home admission; 3) personal choice; 4) the family of the person not being able to provide care to the person; 5) the family not willing to provide the necessary care. Medical reasons include such things as: 1) a terminal illness case requiring constant medical attention; 2) 24-hour nursing care requirements; 3) rehabilitation therapy, etc.)

Some 200 persons were admitted to nursing homes or long-term care units of general hospitals in Alaska in 1978. Approximately 100 of the current 469 nursing home residents have been identified as institutionalized for social rather than medical reasons. The Department feels that the high number of placements for social reasons are inappropriate and/or premature.

The state of Alaska has demonstrated a willingness to meet the needs of Senior Alaskans requiring services. The question is whether to provide those services in an institution (nursing home) or in the individual's community or home.

There is no doubt that nursing homes must be considered as a component in the total service continuum designed to meet the needs of senior Alaskans. But continual increases in Medicaid expenditures and the negative psychological impact of premature and/or inappropriate nursing home placements suggest that alternatives should be developed and tested.

Most of those admitted to nursing homes are recipients of Medicaid assistance which covers their costs of care while institutionalized. Even those few who might pay their own way upon entering a nursing home will likely require Medicaid assistance eventually as personal resources are rapidly exhausted by exorbitant daily nursing home rates. Daily nursing home rates in Alaska run from a low of \$42.75 to a high of \$228.00. Medicaid assistance costs are shared on a ratio of 50% federal dollars to 50% state dollars. Thus inappropriate or premature placements are very expensive to both the state and federal government.

In order to reduce the inappropriate and/or premature nursing home admissions and to more appropriately utilize state dollars being spent on the care of senior Alaskans, the following pilot project is proposed.

The Department requests that 84.8 general fund monies be diverted from the state share of the Medicaid-Nursing Home FY 80 budget. These monies will be utilized to fund a pilot project to demonstrate that the coordinated intake process and delivery system can provide community-based services to senior Alaskans to prevent inappropriate and/or premature admissions to nursing homes for social reasons. The objectives of the proposed pilot project are:

Objectives:

1. Through community-based supportive services, reduce the number of inappropriate and/or premature admissions of senior Alaskans to nursing homes (for social reasons), to the satisfaction of those being served. (Community-based services include such things as homemaker services, home-delivered or senior center meals, transportation, home health services, companion programs, respite care, etc.)
2. Limit the number of those individuals served by the funding available as a result of the diversion of Medicaid monies stemming from the Residential Care Project (see attached).
3. Prevent an increase in state nursing home expenditures for those senior Alaskans served during the project. (State expenditures refers to state funds required to match federal dollars under the Medicaid program.)

The 84.8 of diverted State Medicaid-Nursing Home monies will be used to purchase services needed to assist senior Alaskans in high risk of social nursing home admission if intervention does not take place.

An existing employee within the Department's Division of Social Services will have primary responsibility for developing a coordinated intake process and service delivery system to offset the premature and/or inappropriate institutionalization of senior Alaskans participating in the project. The Project Director will implement the Home Care Alternatives Project along the lines of the general Standards, Procedures and Guidelines enumerated in Attachment 1.

Predicted Outcomes of the Home Care Alternatives Project:

Should this pilot project be approved, the following positive outcomes will result:

1. There will be an impact on the number of senior Alaskans institutionalized, in that the number of premature and/or inappropriate nursing home placements will be reduced.
2. There will be a greater effort to place individuals in settings where their needs can best be served.
3. There will be better and proper utilization of existing services.

4. There will be a heightened awareness of those services to be phased down or out.
5. There will be reduction in the duplication of services or in the payment for unneeded or dependence-creating services.
6. The freedom of senior Alaskans will be increased as a result of the options offered the participants in the project. As independence is increased, the individual's dignity and sense of self-worth will be heightened, thus improving the quality of life for senior Alaskans.

ATTACHMENT 1

STANDARDS, PROCEDURES AND GUIDELINES

HOME CARE ALTERNATIVES PROGRAM

- I. Criteria for Admission to Home Care Alternatives Project:
- a. Resident of the State of Alaska.
  - b. Sixty (60) years of age or older or handicapped or disabled.
  - c. Client must be in high risk of social nursing home admissions if intervention does not take place (0-90 days). Client determined to be medical crisis candidates will not be accepted.
  - d. Private physicians must be contacted to determine:
    1. high-risk category, and
    2. appropriateness of Home Care Alternatives Project in relationship to the client.
  - e. Initial assessment must be completed on each candidate by an Assessment Team. The Assessment Team will be composed of a Social Worker and a Registered Nurse.
  - f. If the Assessment Team determines that the client is an appropriate admission to the Home Care Alternatives Project, then the Assessment Team must develop a complete individual case plan for the client. Individual assessments and care plans must be submitted to the Project Director immediately after completion.
  - g. All informal support systems presently in place must be retained (family, friends, church, etc.). The Home Care Alternatives Project should not replace informal support systems already in place.
  - h. Alternative services for the family, friends, etc., may be supplied if indicated by the assessment (i.e., respite care).
  - i. When deemed necessary by the Assessment Team, services may begin immediately. Services to be reimbursed by the Home Care Alternatives Project must be authorized by the Project Director on the basis of the care plan submitted. The Project Director may authorize a care plan by telephone.
  - j. Follow-up visits must be made within 10 working days after services begin and at least every 30 days from the first follow-up visit. Follow-up visits will include: monitoring of services; appropriateness of services; quality of services; changes in client's condition.

k. Persons who are currently patients in nursing homes may be considered for the Home Care Alternatives Project if the following conditions are met:

1. The client is inappropriately placed at the time of referral to the Assessment Team, and
2. The physician approves of alternative placement.

## II. Donations/Fees:

- a. Client donations and fees will be accepted and considered Project income. A sliding fee schedule will be devised according to the ability to pay. Fees will be payable to the Project fund to be established within the General Relief BRU.
- b. Services Provided with Older Americans Act Funding and Title XX Funding: Services available under Titles III and VII of the Older Americans Act and under Title XX will not be reimbursed by the Home Care Alternatives Project. Such services will be reported by cost of unit service to enable collection of accurate cost data for the project. In the event services normally available under Title III or VII or under Title XX are not available due to over-subscription or lack of resources, similar services may be acquired from other sources and reimbursed by the project. Alternative project clients will be placed in appropriate Title III and VII or Title XX programs when slots become available.

## III. Staff Responsibilities:

- a. Assessment Team Functions (Social Worker and Registered Nurse):
  1. Initial Assessment
  2. Case Plan Development
  3. Arrangement and coordination of services
  4. Follow-up visits
    - A. First follow-up visit within 10 working days after services have begun.
    - B. Follow-up visits every 30 days.
  5. Reassessment within 90 days of initial assessment and every 90 days thereafter, unless case plan calls for more frequent assessments.

6. Requests for reimbursement filed monthly with Project Director.
- b. Project Director Functions:
1. Provide funds to reimburse services provided in support of program activities in accordance with approved case plan.
  2. Maintain individual assessment and case plans in a separate file.
  3. Review care plans and authorize services as necessary.
  4. Monitor clients and services on a random basis each quarter.
  5. Provide technical assistance as requested.

#### IV. Case Plan Management:

Case management is a process to coordinate services for the elderly. With respect to the Home Care Alternatives Project, case management will provide access to the entire services system and insure the coordinated delivery of multiple services to individual clients at high risk of institutionalization. Basic to case management is an initial broad-based assessment of the client's needs. In addition, the case management process involves insuring that a service plan is written which considers all available services solutions, assures that the client is re-examined at regular intervals. Thus the goals of the case management process are: 1) To facilitate access to a complete continuum of care ranging from home care to institutional care; 2) To facilitate choice of the most appropriate service alternatives for the client's unique conditions and concerns; 3) To ensure the coordinated delivery of services to each clients; and 4) to ensure periodic review of the appropriateness of the service being provided.



## Social Services

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

The Alternatives Program For the Elderly

Louise P. Lintz, Model Projects Director

DATE: July 1, 1978 - June 30, 1979

P O M E Summary & Program Goals

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### BACKGROUND STATEMENT

With the prospect of a thirty-five million dollar expenditure for nursing home care for the fiscal year 1977/78, the Utah State Legislature, in March of 1977, mandated to the Utah State Department of Social Services the responsibility to study Alternative to Nursing Home Care for the Elderly. This responsibility was then charged to the Utah State Division of Aging. A seventy member task force was organized to carry out this mandated study.

In addressing the legislative concerns and as a part of the overall study, the task force conducted a survey of nursing home patients to determine why people entered nursing homes. Of the 168 persons studied in the survey, it was learned that not all admissions were made because of medical needs. Forty of the 168 persons surveyed, or 24%, were admitted to nursing homes for social reasons instead of medical reasons. (Social reasons were defined as and included such things as: 1) a person being alone; 2) the vacation of the family or friend, thus requiring nursing home admission; 3) personal choice; 4) the family of the person not being able to provide care to the person; and 5) the family not willing to provide the necessary care. Medical reasons were defined as and included such things as 1) a broken bone; 2) a terminal illness case; 3) nursing care requirements; 4) rehabilitation

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tion therapy, etc.)

Note: For purposes of this memo, it is important to note that of the forty admits for social reasons, twenty-six were on Title XIX, Medicaid Assistance (a medical program for certain low-income qualifying individuals which pays all medical costs). This study also showed that the comprehensive, coordinated care necessary for avoiding inappropriate institutionalization of the elderly is not readily available. The ease with which a person can be permanently institutionalized contrasts with the difficult negotiation through the complex, fragmented, and uncoordinated system necessary to maintain a person at home. This disparity parallels that between abundant institutional beddage, and sparse social and life-support services in communities; between the willingness of third party payers to reimburse expensive, highly skilled, crisis-oriented medical care, and their reluctance to reimburse less expensive, less technical, preventive and supportive care; between the clear single assessment process to obtain institutional care, and the obscure, multi-agency, multi-assessment process to obtain non-institutional care; and between the concentration on highly skilled medical services and the lack of attention accorded preventive and supportive services such as transportation and nutrition, that are vital to maintenance of good health and independence.

#### PROBLEM

According to the admission study for the elderly in nursing homes in Utah, there is an average of forty admissions per month to nursing homes for those reasons defined above as social reasons. The task force concluded that these admissions to nursing homes were inappropriate and/or premature. Study results indicate that the reason for these inappropriate and/or premature placements was the result of a lack of available services to deal with the identified needs in the home of the person, or a lack of knowledge of or about the available services in the community. Twenty-five of the forty persons admitted to nursing homes for social reasons were recipients of Medicaid assistance to pay for their nursing home care. (It is important to note

that, according to the Utah Health Care Association, 96% of all long-term care patients will eventually require Medicaid assistance as their own resources are exhausted.) Medicaid assistance costs are shared on a ratio of 69% paid by the Federal Government with 31% State money required as matching funds in order to receive the 69% Federal dollar amount. The cost to the State alone for the 26 new persons (average) per month receiving Medicaid assistance of \$535,000 per year (31% of total), not to mention the other 69% of the cost paid by the Federal Government. These inappropriate and/or premature placements are very expensive to the State and to the Federal Government.

In order to reduce the inappropriate and/or premature nursing home admissions and to more appropriately utilize the State dollars being spent on care of the elderly, the following objectives are made.

#### OBJECTIVES

- 1) Through community-based in-home services, reduce the number of inappropriate and/or premature admissions of elderly persons to nursing homes (for social reasons) by twelve persons per month, to the satisfaction of those being served. (The number of twelve persons per month was selected for the first year because of the limitation of funding. In-home/community based services include such things as homemaker services, home-delivered meals, transportation, home repair, home-health and nursing services, companion programs, etc.)
- 2) Prevent any increase in State expenditures for these elderly patients during the first year, and, within the second year, cut the State expenditure by 25%. (By State expenditure, we are referring to the State money that would be required to match the Federal dollars under Medicaid--the 31%. The 69% Federal money would be eliminated entirely.)

#### METHODS

- 1) A pre-admittance screening team will be established by the Project Director to explore alternative care with each individual being considered for social

admission to a nursing home:

- 2) An individual case plan will be developed showing the exact service requirements, providers, and cost, in order to maintain each individual in his/her own home.
- 3) Purchase of service agreements/vouchers will be prepared to cover the cost for the individual if existing resources are not adequate to cover the need.
- 4) All case management files will be retained in the Utah Division of Aging, and the Project Director will insure that monthly progress notes are recorded and that monthly reports on the total project are available to the Division, Department of Social Services, and the State Board of Aging.
- 5) Based on the project results, recommendations will be made to the Utah State Legislature for their further action.

EVALUATION - Recommendations for Program Measurement

The following steps will be accomplished in order to evaluate the project effectiveness:

- 1) Documentation of 144 individuals ( per year ) who would have been admitted to nursing homes for social reasons and who, because of the project, have been maintained in their own homes receiving community-based, in-home services.
- 2) No increase in the projected State fund expenditure (see objective number two).
- 3) Administration of a service satisfaction questionnaire on the quality of care and satisfaction to the older persons receiving services under the project.
- 4) Evaluation of the quality and completeness of service rendered, on the service provider, by the project director on a random basis to determine quality of care and whether or not service is adequate. (For example, if the service rendered was homemaker service--is the home kept clean, is there clean linen on the bed, is the client/patient receiving proper skin care, is there any sign of decubitus ulcers, etc.?)

LIMITATIONS OF THE PROPOSED MEASURES AND SPECIAL ATTENTION REQUIREMENTS

Although there are many limitations and difficulties with any attempt at

..... the following appear to be among the most significant:

- 1) In order for the above measures to be truly indicative and useful, the costs of all required services must be taken into account. It needs to be recognized at the outset that different geographical areas will require more or less money for the same service. For example, the wage scales will vary from one location to another. Travel distances may make one service more costly to deliver in one area than another. It may be useful to look at the difference between service provision in urban vs. rural areas.
- 2) Whenever client satisfaction is measured, care has to be taken in order to produce accurate measurement results. It would not be advisable to have the individual rendering the service administer the client/patient satisfaction questionnaire. This should be done by a different individual, or through a mail-in form, where the client/patient identity is not traceable. (A special telephone number could be given for individual complaints on service satisfaction during the course of the project.) The client/patient should be assured of the confidentiality of his/her response, and that service continuation will not be connected in any way to his response.
- 3) In the evaluation of the quality of care rendered by the service provider, attention should be given to make sure that this is carried out on a random basis so as not to indicate harassment. Although the main focus of this evaluation will be to assure adequate services, care should be taken to assure that there is not unnecessary service which would create more of a dependency on the part of the client/patient. Finally, the evaluation process should be as complete as is possible and reasonable so that the important considerations are not neglected.
- 4) Possibly, one of the more significant limitations of the proposed measurements is the multiple criteria problem. Although there is a major advantage in considering multiple variables, sometimes these variables or measures can be in conflict. For example, we have established measurements of client/patient

satisfaction and that of cost containment. What if the costs go up in the provision of community-based, in-home services, but at the same time client/patient satisfaction is significantly improved? Which then becomes the more important measurement--the dollar savings or the client/patient satisfaction, quality of life, independence, etc?

- 5) There is also a generalizability problem. Even if the various measurement problems can be solved, a problem still arises as to how widely one can generalize the resulting evaluation criteria to other situations and organizations.
- 6) Whenever one attempts to quantify something for measurement purposes, there arises the measurement precision problem. Quantification or measurement is often made difficult, due to the complexity and magnitude of the concept under study. Also, how consistent are such measures over time? In addition, are we sure that we are making the proper level of analysis? Have we been too broad, or indeed too narrow, in our measurements and evaluation?

For the purposes of the first year of the study, it would appear that the measurements outlined above would be adequate. However, over time, additional measurements should be instituted to take into consideration such things as the increased demands (and resultant increased cost) in home care resulting from project encouragement of the use of community-based in-home services.

#### PREDICTED POSITIVE OUTCOMES OF THE MEASURES

Several positive outcomes should develop as a result of the above measures. First of all, cost measurements will indicate whether or not project objectives have been accomplished at a higher, lower, or for the same approximate cost, thus enabling better judgments on an economic basis. Client satisfaction and preferences will also be determined as a result of the measures, thus giving the Department and Division a better idea of effective and appropriate service delivery methods. Finally, the measurements proposed should help indicate the kinds of services that need to be developed further (or reduced, as the case may be) and whether or not

in-home community-based service is a viable alternative to institutionalization.

PREDICTED POSITIVE OUTCOMES OF THE PROJECT

It was the consensus of the task force that there is no question but that services should be provided to meet the needs of those requiring such services. The choice is whether to provide these services in an institution (nursing home) or in the individual's community or home. The study, previously referred to, indicates that nursing homes should be considered as a part of the total service continuum to meet certain medical needs; however, continual increases in Medicaid expenditures and the negative psychological impact of premature and inappropriate nursing home placements demand that alternatives be further developed and tested. If this is carried out, the following positive outcomes are predicted:

There will be a tremendous impact on the institutionalization of the State's elderly. There will be a greater effort to place client/patients in settings where their needs can best be serviced. The number of inappropriate and premature nursing home placements will be reduced. There will be a better and proper utilization of existing services. The State Social Services will also have a better idea of those services that need further development or conversely to be phased down or out. It is also anticipated that there will be a reduction in the duplication of services or for the paying of unneeded and dependence-creating services.

When services are rendered at the proper level of requirement, and in a manner to allow for a choice on the part of the client/patient, there is obviously an increase in freedom. Independence, which is much too often denied the State's elderly, is increased or maintained as well as the person's dignity and feeling of self-worth. Quality of life then takes on a renewed meaning for those people who, before, were forced to accept fewer choices and options.

ALTERNATIVES PROGRAM  
STANDARDS, PROCEDURES, AND GUIDELINES

A. Criteria for Admission into the Alternatives Program:

- 1) Resident of the State of Utah
- 2) 60 years of age or older
- 3) Client must be in high risk of social nursing home admissions if intervention does not take place (0 - 90 days). Clients determined to be medical crisis candidates will not be accepted.
- 4) Private physicians must be contacted to determine:
  - a) high-risk category, and
  - b) appropriateness of Alternatives Program in relationship to the client.
- 5) Initial assessment must be completed on each candidate by the Assessment Team. The Assessment Team will be composed of an Area Agency on Aging designee and a Registered Nurse.
- 6) If the Assessment Team determines that client is an appropriate admission to the Alternative Program, then the Assessment Team must develop a complete individual case plan for the client.
- 7) All informal support systems presently in place must be retained (family, friends, church, etc.). The Alternatives Program should not replace informal support systems presently in place.
- 8) Alternative Services for the family, friends, etc., may be supplied if indicated by the assessment (e.g., Respite, Payment for care in the home of another, etc.).
- 9) Individual assessments and case plans must be submitted to the State Division of Aging immediately after completion.
- 10) When deemed necessary by the Assessment Team, services may begin immediately; however, services to be reimbursed must be authorized by the State Division of Aging within a time period of 14 calendar days from the date of initial assessment. Case plans must be received by the State Division of Aging before they will be approved. The State Division of Aging may authorize a case plan by telephone.
- 11) Completed case plans must be received by the State within 7 calendar days of the initial assessment.
- 12) Follow-up visits must be made within 10 working days after services begin and again every 30 days from the first follow-up visit, except when the Assessment Team determines that an emergency exists, a follow-up visit will be made in advance of ten working days.

13) Follow-up Visits must include:

- a) monitoring of services (e.g., service connections and coordination),
- b) appropriateness of services,
- c) quality of services, and
- d) changes in client's condition.

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

- a) The client is inappropriately placed at the time of referral to the Assessment Team, and
- b) the physician approves of alternative placement.

B. Donations/Fees:

- 1) Each client should be encouraged to donate to the program. All donations are voluntary.
  - 2) Donations and fees will be considered Project Income and will be transferred to the State Division of Aging or considered as partial payment to the contractee for services provided if they are made directly to a member of the Assessment Team. Donations made to non-alternative funded services will be treated as non-alternative Project Income.
  - 3) Sliding scale fee schedule will be used for those persons whose monthly income exceeds 74% of the state's median income (see attached fee schedule). Fees will be assessed by the Assessment Team to the client. Fees are payable to the Area Agency on Aging and will be treated as alternative Project Income.
  - 4) Fees will be assessed for the entire package of services, not for individual services.
  - 5) Exception to the above #4 will apply when the service is provided by a Title XX program. Fees assessed will then be paid to Title XX (e.g., Division of Family Services, Homemaker Program) when applicable.
  - 6) When a Title XX service is required by the case plan, a signed Title XX group eligibility form must accompany the case plan when it is submitted to the State.
  - 7) Services may be provided for those clients above the allowable sliding scale income level; however, fees assessed will be determined on an individual basis with each individual who is above the sliding scale income level. The Assessment Team will determine what fees should be assessed.
- B) Assets will not be considered for eligibility in the program.

C. Services Provided with Older Americans Act Funding:

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

D. Services Provided with Title XX Funding:

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

E. Area Agency Responsibilities:

- 1) Initial Assessment
- 2) Case Plan Development
- 3) Arrangement and Coordination of Services
- 4) Follow-Up Visit
  - a) First Follow-Up Visit within 10 working days after services have begun except when the Assessment Team determines that an emergency exists, a follow-up visit will be made in advance of ten working days.
  - b) Follow-Up Visits every 30 days
- 5) Reassessment within 90 days of initial assessment and every 90 days thereafter, unless case plan calls for more frequent assessments.
- 6) Requests for Reimbursement filed monthly.

F. State Division of Aging Responsibilities:

- 1) Provide money (cash assistance) to project in support of project activities in accordance with the State Division of Aging approved case plan services.
- 2) Individual Assessment and Case Plan will be maintained on each individual in a separate file.
- 3) Case plans will be reviewed and services authorized, if approved, within 7 days after being received in the State Division of Aging office and returned to the Area Agency on Aging with any changes made by the Project Director.

- 4) Monitoring of clients and services will be conducted on a random basis quarterly.
- 5) Technical Assistance will be available as requested.
- 6) Authorization of requests for reimbursement to the Utah State Finance Department monthly in accordance with the individual approved case plan.

ALTERNATIVES PROGRAM FEE SCHEDULE

6/30/78

FAMILY OF ONE		FAMILY OF TWO		FAMILY OF THREE	
MONTHLY GROSS INCOME	MONTHLY FEE	MONTHLY GROSS INCOME	MONTHLY FEE	MONTHLY GROSS INCOME	MONTHLY FEE
0 - 277	0	0 - 382	0	0 - 484	0
278 - 300	0	383 - 400	0	485 - 500	5
301 - 400	5	401 - 500	5	501 - 600	10
401 - 500	10	501 - 600	10	601 - 700	15
501 - 532	15	601 - 696	15	701 - 800	20
533 - 600	20	697 - 800	20	801 - 860	25
				861 - 900	30

## THE ALTERNATIVE PROGRAM

### CASE MANAGEMENT

#### DEFINITION

Case management is a process to coordinate services for the elderly. Done for and with a selected sub-set of clients, it provides access to the entire services system and insures the coordinated delivery of multiple services to individual clients. Basic to case management is an initial broad-based assessment of the client's needs. In addition, the case management process involves insuring that a service plan is written which considers all available service solutions, that the client is actually connected to service, and that the progress of the client is re-examined at regular intervals.

#### GOALS

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

## CASE MANAGEMENT COMPONENTS

### DEFINITIONS

Needs Assessment

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

Service Plan

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

Arranging for Service

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

Reassessment

is the scheduled re-examination of the client's situation and functioning to identify changes which occurred since the initial assessment to measure progress toward the goals outlined in the service plan and to assure that the services are being delivered. In so doing, the case manager determines whether the service plan needs to be updated and the pattern of service delivery changed.

Recording

All pertinent information regarding each client will be recorded in an individual case file, maintained at the State Division of Aging and guaranteeing the confidentiality of each person and file.

THE ALTERNATIVES PROGRAM  
MAJOR SERVICE GOALS

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

Enter this on the bottom of the assessment sheet.

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

Example of Goal:

- a) Complete recovery from illness or disability.
- b) Satisfactory adjustment to a major crisis.
- c) Adequate learning re: nutrition, health practices and procedures.

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

Example of Goal:

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

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

Example of Goal:

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

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

Example of Goal:

- a) Maintenance level of ADL:

- b) Prevent regression and complications.
- c) Retard disease progression.
- d) Detect early signs of deviation from normal or status quo.

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

Example of Goal:

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

326 Fourth Street - Apt. 500  
Juneau, Alaska. 99801.  
20 March 1979.

The Committee on Health, Education  
and Social Service  
House of Representatives  
State of Alaska.

May I add my ongoing support of  
House Bill No. 374 now before the  
Eleventh Legislature of the House?

For an Act entitled: "An Act relating  
to equalizing the costs of full-time  
residential or nursing care."

I approve completely this far-  
sighted and hopeful legislation  
to insure the complete care of aged  
or aging persons according to the  
amendment of Section 47-25, by  
adding new sections to qualify  
and safeguard the Act:

New Sections 47.25.103

" 47.25.104

and three provisions concerning  
eligibility.

As a recipient of Homemakers care  
I am encouraged that full care may  
be added as needed by me, any person  
fulfilling State of Alaska requirements,

Sister Trinity B.S.I.  
(Sarah Swift-Carter).

TO REPRESENTATIVE THELMA BUCHHOLDT HOUSE HESS  
REPRESENTATIVE RUSS MEEKINS, HOUSE FINANCE  
SENATOR JOHN SACKETT, SENATE FINANCE

FROM ROSE PALMQUIST, PRESIDENT, OLDER PERSONS ACTION GROUP 276-4041

HB 374, EQUALIZING COSTS OF RESIDENTIAL OR NURSING CARE, DOES NOT ADDRESS THE REAL PROBLEM WITH PIONEERS HOMES VS. OTHER INSTITUTIONAL CARE. THE BEST FIRST APPROACH IS HOME CARE, AND AFTER THAT, EVALUATION OF OTHER CARE RESOURCES. REGARDING THE PIONEERS HOMES, THE LEGISLATURE SHOULD ADDRESS THE NECESSITY FOR A SLIDING SCALE OF FINANCIAL CONTRIBUTION BY THE RESIDENTS TOWARD THE END THAT THE RESIDENTS PAY WHAT THEY CAN AFFORD BEFORE THE TAXPAYERS PICK UP THE TAB. MANY RESIDENTS OF PIONEERS HOMES AMASS ASSETS FOR THEIR HEIRS WHILE IN THE HOMES. THIS PROBLEM COULD BE CORRECTED BY A CHANGE ONE RULES WITHIN THE DIVISION OF PIONEERS BENEFITS AND WOULD NO DOUBT RESULT IN FEWER APPLICATIONS FOR ADMITTANCE INTO THE HOMES. THUS, THE PROBLEM THAT HB 374 ADDRESSES COULD BE RESOLVED WITHOUT ADDITIONAL LEGISLATION.

JHEOM/

Name	Address	Organization	Bill No.
Margaret C. Caranagh	Rt. 2, Box 3003, Apt 201, Juneau	Retired Social Worker	HB 374
Howe W. Kull	Mendenhall Apts 1010, Juneau	Americanless Retired Person	HB 374
Thomas F. Landon	1270 Glacier Cir apt 105-11		HB 374
Clifford Swag	Box 1117 Juneau, Ak.	AARP	HB 374
H. H. Biggs	423 East St., Juneau, Ak	AARP	HB 374
Dee C Biggs	423 East St. Juneau, Ak	AARP	HB 374
Louis La Beaume	865 West 12 <sup>th</sup> Juneau Ak.	AARP	HB 374
Sister Barbara Huse	3100 Tongass ave. Ketchikan	Long Term Care Division of Ak State Hosp. comm. and Ketchikan Hosp. / Island View Manor	HB 374
John R. Pugh	Dept. of H + S		HB 96
Barbara Baker	424 East Street Juneau	Southeast Nutrition Program for the Elderly	HB 374
John W Houser	2321 CANARY court, Anchorage	Yakojin Health Care Ctr	HB 374
George Elye		Department of Administration	HB 374
Pat Denny	419 6 <sup>th</sup> St, Juneau Ak	Catholic Community Service	HB 374
Donna Stephen	SRA - 94T Anch. AK 99507	Careage House	HB 374
Richard R. Wilton	P.O. Box 847 Fairbanks A99901	Careage North	HB 374
Emma S. Jay	P.O. Box 80 Wrangell, Alaska 99929	Wrangell Gen. Hosp. and Long Term Care Facility	HB 374
Louise Lofay	Box 589 Petersburg, ALASKA 99833	Petersburg General Hospital and Long Term Care	HB 374

ALTERNATIVES PROGRAM  
STANDARDS, PROCEDURES, AND GUIDELINES

A. Criteria for Admission into the Alternatives Program:

- 1) Resident of the State of Utah
- 2) 60 years of age or older
- 3) Client must be in high risk of social nursing home admissions if intervention does not take place (0 - 90 days). Clients determined to be medical crisis candidates will not be accepted.
- 4) Private physicians must be contacted to determine:
  - a) high-risk category, and
  - b) appropriateness of Alternatives Program in relationship to the client.
- 5) Initial assessment must be completed on each candidate by the Assessment Team. The Assessment Team will be composed of an Area Agency on Aging designee and a Registered Nurse.
- 6) If the Assessment Team determines that client is an appropriate admission to the Alternative Program, then the Assessment Team must develop a complete individual case plan for the client.
- 7) All informal support systems presently in place must be retained (family, friends, church, etc.). The Alternatives Program should not replace informal support systems presently in place.
- 8) Alternative Services for the family, friends, etc., may be supplied if indicated by the assessment (e.g., Respite, Payment for care in the home of another, etc.).
- 9) Individual assessments and case plans must be submitted to the State Division of Aging immediately after completion.
- 10) When deemed necessary by the Assessment Team, services may begin immediately; however, services to be reimbursed must be authorized by the State Division of Aging within a time period of 14 calendar days from the date of initial assessment. Case plans must be received by the State Division of Aging before they will be approved. The State Division of Aging may authorize a case plan by telephone.
- 11) Completed case plans must be received by the State within 7 calendar days of the initial assessment.
- 12) Follow-up visits must be made within 10 working days after services begin and again every 30 days from the first follow-up visit, except when the Assessment Team determines that an emergency exists, a follow-up visit will be made in advance of ten working days.

13) Follow-up Visits must include:

- a) monitoring of services (e.g., service connections and coordination),
- b) appropriateness of services,
- c) quality of services, and
- d) changes in client's condition.

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

- a) The client is inappropriately placed at the time of referral to the Assessment Team, and
- b) the physician approves of alternative placement.

B. Donations/Fees:

- 1) Each client should be encouraged to donate to the program. All donations are voluntary.
- 2) Donations and fees will be considered Project Income and will be transferred to the State Division of Aging or considered as partial payment to the contractee for services provided if they are made directly to a member of the Assessment Team. Donations made to non-alternative funded services will be treated as non-alternative Project Income.
- 3) Sliding scale fee schedule will be used for those persons whose monthly income exceeds 74% of the state's median income (see attached fee schedule). Fees will be assessed by the Assessment Team to the client. Fees are payable to the Area Agency on Aging and will be treated as alternative Project Income.
- 4) Fees will be assessed for the entire package of services, not for individual services.
- 5) Exception to the above #4 will apply when the service is provided by a Title XX program. Fees assessed will then be paid to Title XX (e.g., Division of Family Services, Homemaker Program) when applicable.
- 6) When a Title XX service is required by the case plan, a signed Title XX group eligibility form must accompany the case plan when it is submitted to the State.
- 7) Services may be provided for those clients above the allowable sliding scale income level; however, fees assessed will be determined on an individual basis with each individual who is above the sliding scale income level. The Assessment Team will determine what fees should be assessed.
- 8) Assets will not be considered for eligibility in the program.

C. Services Provided with Older Americans Act Funding:

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

D. Services Provided with Title XX Funding

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

E. Area Agency Responsibilities:

- 1) Initial Assessment
- 2) Case Plan Development
- 3) Arrangement and Coordination of Services
- 4) Follow-Up Visit
  - a) First Follow-Up Visit within 10 working days after services have begun except when the Assessment Team determines that an emergency exists, a follow-up visit will be made in advance of ten working days.
  - b) Follow-Up Visits every 30 days
- 5) Reassessment within 90 days of initial assessment and every 90 days thereafter, unless case plan calls for more frequent assessments.
- 6) Requests for Reimbursement filed monthly.

F. State Division of Aging Responsibilities:

- 1) Provide money (cash assistance) to project in support of project activities in accordance with the State Division of Aging approved case plan services.
- 2) Individual Assessment and Case Plan will be maintained on each individual in a separate file.
- 3) Case plans will be reviewed and services authorized, if approved, within 7 days after being received in the State Division of Aging office and returned to the Area Agency on Aging with any changes made by the Project Director.

- 4) Monitoring of clients and services will be conducted on a random basis quarterly.
- 5) Technical Assistance will be available as requested.
- 6) Authorization of requests for reimbursement to the Utah State Finance Department monthly in accordance with the individual approved case plan.

ALTERNATIVES PROGRAM FEE SCHEDULE

6/30/78

FAMILY OF ONE		FAMILY OF TWO		FAMILY OF THREE	
MONTHLY GROSS INCOME	MONTHLY FEE	MONTHLY GROSS INCOME	MONTHLY FEE	MONTHLY GROSS INCOME	MONTHLY FEE
0 - 277	0	0 - 382	0	0 - 484	0
278 - 300	0	383 - 400	0	485 - 500	5
301 - 400	5	401 - 500	5	501 - 600	10
401 - 500	10	501 - 600	10	601 - 700	15
501 - 532	15	601 - 696	15	701 - 800	20
533 - 600	20	697 - 800	20	801 - 860	25
				861 - 900	30

## THE ALTERNATIVE PROGRAM

### CASE MANAGEMENT

#### DEFINITION

Case management is a process to coordinate services for the elderly. Done for and with a selected sub-set of clients, it provides access to the entire services system and insures the coordinated delivery of multiple services to individual clients. Basic to case management is an initial broad-based assessment of the client's needs. In addition, the case management process involves insuring that a service plan is written which considers all available service solutions, that the client is actually connected to service, and that the progress of the client is re-examined at regular intervals.

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Honorable Chair Persons & Committee members

also CW Sup  
3 yrs Clinical SW NP PE  
8 yrs Alex ANAAS  
+ Pol for Certin 3 Missed  
HE 5/1/1974

Subject: HB 374 Today 1:00 Room 112 Capitol Bldg

The passage of this Bill into law will enable many older persons to remain in their own homes as long as possible and help to hold families together.

For 8 years, I was Director of Alaska Homemaker-Home Health Aide Service. Our basic funding originally was from the Older American's Act, Office of Aging. In 1974-75, this agency served statewide 253 older Alaskans. By age groups there were

age	number
55-60	12
60-65	20
* 65-70	131
70-75	25
75-80	18
80-85	20
85-90	12
90-95	10
95-100	2
100-113	3
	<hr/>
	253

J. Duncan -  
H. Bigne - H455  
Elice - Adm. in ch  
S. Barbara - Kitchell  
G. H. ... - ...

With a combination of quality homemaker-home health aide service and local nursing homes re-imburserd from the pioneer fund, Senior Alaskans can remain in their own homes & own communities

as long as possible. This plan would be less traumatic  
for human beings; and, per person, less expensive  
for government.

An old aging woman said, "I was  
driven from my home and family and I did  
did <sup>soon after</sup> 98 years of age. Her grand daughter and  
grand grand daughters pleaded unsuccessfully  
for means to keep her at home - or her home  
or near so that they could visit. Often the lack  
of money or the lack of in-home care forced  
relatives to send their aging members away

→ <sup>Legislative</sup> Dave M. Kull, Chair Person M.S.W., U.S.A.  
General Chapter of American Ass'n of Retirees  
160 members in the Chapter

3-20-79

Mrs. Dave M. Kull  
Mendenhall Apts. #1010  
326 - 4th Street  
Juneau, Alaska 99801

Dr. Robt. Butler, Air. W. Ill. Gen.  
In-home care is 80% less expensive

TO:

Janice Gates, Special Assistant  
to the Commissioner  
Dept. of Health & Social Services

DATE: March 28, 1979

FILE NO:

TELEPHONE NO:

FROM:

*Harold L. Cosgrove, Jr.*  
Harold L. Cosgrove, Jr.  
Associate Coordinator  
Office on Aging

SUBJECT: Elderly Population  
(60+, 65+, 75+)  
by Region and City.

For: M.D. Plotnick, Coordinator

The following are tabular presentations of your telephone request of March 24, which was further updated in a personal briefing on the morning of March 28.

There are an estimated 19,749 elderly 60+ (July 1, 1979)  
There are an estimated 10,337 elderly 65+ (July 1, 1979)  
There are an estimated 3,200 elderly 75+ (July 1, 1979)

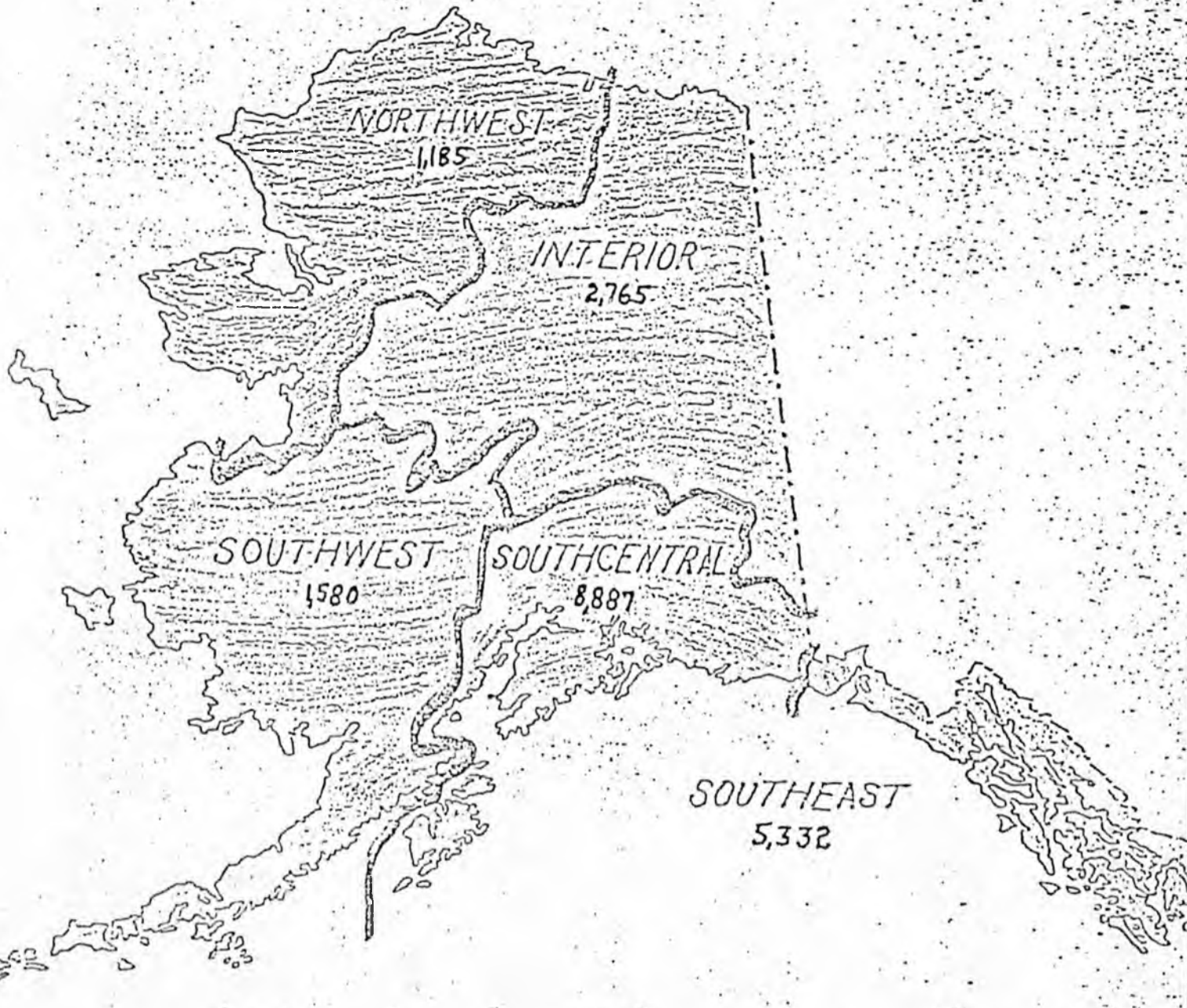
Regions	60+	65+	75+
Northwest	1,185	708	217
Interior	2,765	1,297	405
Southwest	1,580	910	290
Southcentral	8,887	4,362	1,293
Southeast	5,332	3,060	995
Total	19,749	10,337	3,200

AGE BREAKOUTS BY COMMUNITY WITHIN THE 5 REGIONS

		60+	65+	75+
<u>NORTHWEST</u>	{ Barrow	174-185	84-113	29
	{ Nome	247-279	150-198	34-40
	{ Kotzebue	134-151	78-99	17
<u>INTERIOR</u>	Fairbanks	1,425-2,123	706-1,346	186-211
<u>SOUTHWEST</u>	{ Bethel	151	105	23
	{ Dillingham	84-116	41-80	6-19
<u>SOUTHCENTRAL</u>	{ Anchorage	3,936-6032	1,924-3650	538-597
	{ Cordova	152-158	84-103	17
	{ Homer	139-152	83-102	22
	{ Kenai	129-230	63-129	15
	{ Kodiak	345-467	197-310	57-65
	{ Palmer	152-162	87-109	28
	{ Seward	255-275	170-216	49-51
<u>SOUTHEAST</u>	{ Valdez	81-131	42-72	12
	{ Juneau	1,387-1,679	757-1,145	179-209
	{ Ketchikan	1,006-1,039	632-744	184-193
	{ Petersburg	312-315	201-224	57
	{ Wrangell	242-268	138-185	34-41

Attachment

# REGIONAL DISTRIBUTION <sup>of</sup> ALASKA'S 60+ POPULATION



# REGIONAL DISTRIBUTION of ALASKA'S 65+ POPULATION



# REGIONAL DISTRIBUTION of ALASKA'S 75+ POPULATION



LA 11 0857 10.45 JA01 0004 12.03.93/23/79

TO REPRESENTATIVE (THELMA BUCHHOLDT), HOUSE HESS  
REPRESENTATIVE RUSS MEEKINS, HOUSE FINANCE  
SENATOR JOHN SACKETT, SENATE FINANCE

FROM ROSE PALMQUIST, PRESIDENT, OLDER PERSONS ACTION GROUP 276-4041

HB 374, EQUALIZING COSTS OF RESIDENTIAL OR NURSING CARE, DOES NOT ADDRESS THE REAL PROBLEM WITH PIONEERS HOMES VS. OTHER INSTITUTIONAL CARE. THE BEST FIRST APPROACH IS HOME CARE, AND AFTER THAT, EVALUATION OF OTHER CARE RESOURCES. REGARDING THE PIONEERS HOMES, THE LEGISLATURE SHOULD ADDRESS THE NECESSITY FOR A SLIDING SCALE OF FINANCIAL CONTRIBUTION BY THE RESIDENTS TOWARD THE END THAT THE RESIDENTS PAY WHAT THEY CAN AFFORD BEFORE THE TAXPAYERS PICK UP THE TAB. MANY RESIDENTS OF PIONEERS HOMES AMASS ASSETS FOR THEIR HEIRS WHILE IN THE HOMES. THIS PROBLEM COULD BE CORRECTED BY A CHANGE ONE RULES WITHIN THE DIVISION OF PIONEERS BENEFITS AND WOULD NO DOUBT RESULT IN FEWER APPLICATIONS FOR ADMITTANCE INTO THE HOMES. THUS, THE PROBLEM THAT HB 374 ADDRESSES COULD BE RESOLVED WITHOUT ADDITIONAL LEGISLATION.

JHEOM/

original

THE LEGISLATURE OF THE STATE OF ALASKA  
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 374

Title An act relating to equalizing the cost of full time residential or nursing care \*

Requested by Duncan and Miller

Date 4/11/79

\* for pioneer Alaskan's.

II. FISCAL DETAIL

Agency Affected Div. of Pioneers' Benefits/Department of Administration

Program Category Affected Social Services

Budget Request Unit(s) Affected Alaskan Pioneers' Home

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES		185.1	199.9	215.9	(Cost are assumed to	
200 TRAVEL		6.0	6.5	7.0	increase at the same	
300 CONTRACTUAL		7.0	7.6	8.2	rate)	
400 COMMODITIES		3.5	3.8	4.1		
500 EQUIPMENT		2.8	3.0	3.3		
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		7,876.0	8,663.6	9,529.9		
TOTAL		8,080.4	8,884.4	9,768.4		

FUNDING (Thousands of Dollars)

GENERAL FUND		8,080.4	8,884.4	9,768.4		
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME		3	3	3		
PART TIME		8	8	8		
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Administrative costs were determined based on the assumption that the Department of Administration would have an RSA with the Department of Health & Social Services to provide the administrative support. (See Attachment A)

Cost for nursing and residential care assumes that the rates for care and the number of people served will remain constant. (See Attachment B)

IV. DATE 4/11/79

PREPARED BY George Elgee

AGENCY Office of the Commissioner/Dept.

PHONE 465-2217

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

ATTACHMENT A  
 HB 374  
 Personal Services

(1) Assumption: The costs are based upon the Department of Administration having an RSA with the Department of Health & Social Services to provide the administrative support. In order to provide this support it will require the following personnel:

Medical Surveillance Officer	(1/4)	\$ 11,820 -
Central Office Coordinator	(1/2)	13,116 -
Fiscal Compliance Auditor	( 1 )	22,656 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Administrative Assistant II	( 1 )	19,548 -
Accounting Clerk II	( 1 )	14,136 -

Total \$ 139,920

Benefits: .2383 % plus  
 \$141.32 per mon/per person 45,211

\$ 185,131

8% FY 81 \$ 199,941

8% FY 82 \$ 215,936

ATTACHMENT B  
HB 374  
Schedule of Costs for Residential & Nursing Care

The potential eligible population is estimated to be approximately 10,000 people.

National statistics indicate that 5% of this population will need nursing care and 9% will need some sort of alternative care.

Presently (as of Feb. 1979) 409 people are receiving nursing care statewide and 284 people are receiving residential care at the Pioneers' Homes.

5% of 10,000 equals 500 people. 409 people are receiving nursing care which indicates that 91 people (500-409= 91) need nursing care. 9% of 10,000 equals 900 people. 284 people are receiving residential care which indicates that 616 people (900-284 = 616) need some sort of residential care.

The rates for nursing care and residential care as provided by the Department of Health and Social Services indicates a rate of \$88 per day for nursing care and \$900 per month for residential care. The Pioneers' Home presently charge \$275.00 per month for nursing care and \$225.00 per month for residential care. This will reduce the rates for nursing care to \$79.00 per day and residential care to \$675.00 per month.

Nursing Care Costs

(As of Feb. 1979)	91 people X \$79/day X 365/days =	\$ 2,623.9
FY 80	10% inflation factor =	<u>\$ 2,886.4</u>
FY 81	10% inflation factor =	<u>\$ 3,175.0</u>
FY 82	10% inflation factor =	<u>\$ 3,492.5</u>

Residential Care Costs

*FY 80	616 people X \$675/mo. X 12 mo. =	<u>\$ 4,989.6</u>
FY 81	10% inflation factor =	<u>\$ 5,488.6</u>
FY 82	10% inflation factor =	<u>\$ 6,037.4</u>

# Municipality of Anchorage



PCUCH 6-650  
ANCHORAGE, ALASKA 99502  
(907) 264-4431

GEORGE M. SULLIVAN,  
MAYOR

March 26, 1979

OFFICE OF THE MAYOR

Thelma Buchholdt  
House of Representatives  
Pouch V  
Juneau, AK 99811

*Thelma*  
Dear Representative Buchholdt:

Under provisions of Section 504 of the Rehabilitation Act of 1973 the U.S. Congress mandated that no otherwise qualified handicapped individual in the United States shall solely by reason of his or her handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. The implementation of Section 504 is now being enforced by all Federal Departments. In June of 1978, the U.S. Department of Transportation issued guidelines for enforcement of Section 504 which are predicated on a new definition of a handicapped person. This Federal interpretation is much more liberal than the current definition used by the Municipality of Anchorage for our handicapped program. It will undoubtedly require future expansion of our present program in order for the Municipality to comply with Section 504 guidelines.

Supplemental handicapped transportation (demand responsive, curb to curb service) as set forth by the current Municipality of Anchorage specifications was started January 1, 1977 on a six month contractual trial basis with a budget of \$22,000. Completion of this trial program indicated a strong need for continuing this type of supplemental service. As a result of this demonstration project the program was funded by the Municipality of Anchorage for the remainder of 1977. In 1978, \$75,000 was budgeted for this program and the same amount likewise was budgeted for 1979. To date all funding for this program has come from the Municipality's general fund as opposed to the Senior Citizen Transportation Program which has been heavily funded by State grants.

Ridership for Transportation of the Handicapped Program in 1978 was 13,223. The present operation is sub-contracted to Far North Transportation, Inc. Each handicapped applicant with a supplemental card (issued by the Municipality of Anchorage) is entitled to the use of this service daily between the hours of 7:00 a.m. and 7:00 p.m. Transportation needed for special occasions such as plays, dinners, etc. are available by special request between the hours of 7:00 p.m. and 11:00 p.m. This is a service demand transportation program with a 24-hour advance call for demand response. There is one unit available with a lift for those patrons with wheelchair needs. During the first part of May the Municipality anticipates the delivery of two additional wheelchair lift units. At present there are approximately 350 handicapped supplemental passes issued in the Anchorage area based on the criteria above.

One of the main elements of the handicapped program has been the Municipality's definition of handicapped eligibility, which has used the following criteria:

1. Non-ambulatory disability requiring the use of wheelchairs;
2. Semi-ambulatory disability requiring the use of braces or crutches or other prosthetic devices;
3. Functional blindness.

The Federal government in effect now will require us to expand our definition. The following is an excerpt from the Federal Register, dated June 8, 1979:

Under Section 504 the handicapped person means any person who (1) has a physical or mental impairment that substantially limits one or more major life activities, (2) has a record of such an impairment, or (3) is regarded as having such an impairment. As used in this definition (1) "Physical or mental impairment" means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin and endocrine, or any mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, mental retardation, emotional illness, drug addiction, and alcoholism.

"Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a record of such an impairment" means has a history of, or has been classified, or misclassified, as having a mental or physical impairment that substantially limits one or more major life activities.

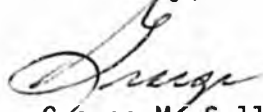
"Is regarded as having an impairment" means has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; has a physical or mental impairment that substantially limits major life activity only as a result of the attitudes of others toward such an impairment; or has none of the impairments set forth in the preceding paragraphs of definition, but is treated by a recipient as having such an impairment.

By altering our Transportation of the Handicapped Program to include all handicapped persons meeting the Section 504 definition, the Municipality of Anchorage expects to quadruple our present ridership. Utilizing Section 504 criteria, it is estimated that in the Anchorage area there is in excess of 6,000 potential handicapped riders. Considering the additional equipment on order as well as the projection of available handicapped riders using the new criteria, the Municipality would need a 1980 budget in excess of \$260,000 in order to maintain the same level of service. We plan to maximize the load

factor and reduce the cost per passenger, which hopefully would reduce the total 1980 budget to approximately \$200,000.

As a result of past discrimination of handicapped persons, and the Federal mandate of Section 504, which requires correction of these discrepancies, the Municipality plans to commit itself to comply with these new regulations and urges the State of Alaska to jointly fund our Transportation of the Handicapped Program with a grant of \$100,000. The Municipality will match this amount. This action will help distribute in an equitable manner State and local government's financial obligation to the handicapped and will enable the program to be partially funded by the State similar to the State's current funding of the Transportation of the Elderly Program. Your legislative support of this proposed joint program is requested.

Sincerely,



George M. Sullivan  
Mayor

# Municipality of Anchorage

## MEMORANDUM

DATE: January 2, 1979  
TO: Opportunities For The Handicapped Commission  
FROM: Douglas Weiford, Municipal Manager  
SUBJECT: Proposed Definitions of the term "Handicapped"

Listed below are three definitions of the term "handicapped". Please review and discuss the language of each definition and comment with regard to its suitability to the Municipality's transportation program for the handicapped.

1. "Physical Handicap" means any physical disability, infirmity, malformation, or disfigurement which is caused by bodily injury, birth defect, or illness including epilepsy, and includes any degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, or physical reliance on a guide dog for the blind, wheelchair, or other remedial appliance or device.

Source: 6 AAC 30.170(B) (current Alaska Human Rights Commission definition).

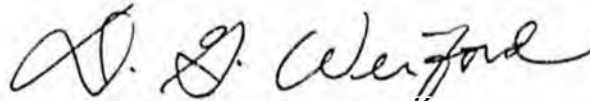
2. "Handicapped" means any person who is unable to use the mass transportation system without special facilities by reason of a physical or mental impairment or disability and has been so certified by a doctor licensed by the State of Alaska.

Source: New.

3. "Handicapped Persons" means those individuals who by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected.

Source: 49 USC 609.3 (current UMTA definition).

MUNICIPALITY OF ANCHORAGE

  
Douglas Weiford  
Municipal Manager

DW:JG:ah

Original sponsors: Duncan and Miller

1 IN THE HOUSE

BY THE HEALTH, EDUCATION AND  
SOCIAL SERVICES COMMITTEE

2 CS FOR HOUSE BILL NO. 374

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 ELEVENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to equalizing the costs of full-time  
7 residential or nursing care."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 \* Section 1. AS 47.25 is amended by adding new sections to read:

10 Sec. 47.25.103. CONTRACTUAL AGREEMENTS. (a) The commissioner of  
11 administration shall enter into contractual agreements with licensed  
12 institutions providing full-time residential or nursing care for the  
13 elderly to provide care to Alaska residents eligible under AS 47.25.108.  
14 A contractual agreement under this section shall provide for payment of  
15 the full daily (or monthly equivalent) charges by the institution for  
16 each eligible patient, less the amount charged under AS 47.25.030 for  
17 the equivalent level of care for a patient at the Alaska Pioneers' Home.  
18 The commissioner shall enter into an agreement under this section with  
19 the type of institution that is consistent with an individual's treat-  
20 ment needs.

21 (b) In this section the phrase "institution providing full-time  
22 residential care" means an institution

23 (1) that provides minimum basic care and protective super-  
24 vision of residents of the institution;

25 (2) that does not routinely provide nursing or other medical  
26 services; and

27 (3) that is licensed under AS 47.35.020.

28 Sec. 47.25.108. ELIGIBILITY. A person is eligible to receive  
29 contractual services under AS 47.25.103 if

1           (1) he is eligible for admission into the Alaska Pioneers'  
2 Home under AS 47.25.010 - 47.25.110;

3           (2) he is not eligible for benefits from any source that  
4 would pay for the cost of full-time residential or nursing care;

5           (3) he resides more than 50 miles, by highway, from the  
6 Alaska Pioneers' Home, or he cannot be admitted to the Alaska Pioneers'  
7 Home because the home is full to capacity; and

8           (4) he is at risk of being institutionalized outside of his  
9 community if care is not provided under AS 47.25.103.

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Name	Address and Phone	Organization/Self	For/Against or Observing
1/ Duncan (Joyce?)			
2/ Com. Helen Bevins		H&SS	
3/ Sue Green		Administrator	
4/			
5/			
6/			
7/			
8/			
9/			
10/			
11/			
12/			
13/			

FISCAL NOTE

I. REQUEST

Bill/Resolution No. H.B. 374

Title An Act relating to providing for full-time residential care for Pioneer Alaskans

Requested by \_\_\_\_\_ Date \_\_\_\_\_

II. FISCAL DETAIL

Agency Affected Administration

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected Pioneers' Homes

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		0	0	0	(costs are assumed	
200 TRAVEL		6.5	7.2	7.9	to increase at the	
300 CONTRACTUAL		263.1	289.4	318.3	same rate.)	
400 COMMODITIES		3.8	4.1	4.5		
500 EQUIPMENT		7.0	0	0		
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		12,640.3	14,599.6	16,862.5		
<b>TOTAL</b>		<b>12,920.7</b>	<b>14,900.3</b>	<b>17,193.2</b>		

FUNDING (Thousands of Dollars)

GENERAL FUND	12,920.7	14,900.3	17,193.2		
FEDERAL FUNDS					
OTHER (Specify Fund Source)					

POSITIONS

FULL TIME	4	4	4		
PART TIME	7	7	7		
TEMPORARY					

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Administrative costs were determined based on the assumption that the Department of Administration would have an RSA with the Department of Health and Social Services to provide the administrative support (See attachment A).

IV. DATE 3/10/80

PREPARED BY George J. Michael D. Michael  
AGENCY Administration

PHONE 465-4401

Original: Legislative Finance  
cc: Budget and Management  
Prime Sponsor (First Legislator Named)

ATTACHMENT A  
H.B. 374  
Personal Services

(1) Assumption: The costs are based upon the Department of Administration having an RSA with the Department of Health and Social Services to provide the administrative support. In order to provide this support it will require the following personnel:

Medical Surveillance Officer	(1/2)	\$ 17,503
Central Office Coordinator	(1)	32,538
Fiscal Compliance Auditor	(1)	32,538
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Administrative Assistant II	(1)	24,420
Clerk Typist III	(1)	<u>16,856</u>
Subtotal		\$197,115
Benefits: 21% plus \$127 per month/person		<u>58,158</u>
Total FY 81		\$255,273
Total FY 82		\$280,800
Total FY 83		\$308,830

Inflation of 10% per year is assumed.

ATTACHMENT B

H.B. 374

Schedule of Costs for Residential & Nursing Care

The potential population of people in Alaska over 65 years of age is estimated to be approximately 12,000 people. However, not all these people would qualify under the eligibility requirements of H.B. 374, particularly the 15-year residency. The total number of people which would be eligible is approximately 10,000.

National statistics indicate that 5% of this population will need nursing care and 9% will need some sort of alternative care. Alaskan experience is somewhat higher due to inclement weather and the fact that more elderly Alaskans are not able to benefit from having a family nearby. A figure of 8% is more realistic for nursing care and 12% for residential care.

Presently 644 people are receiving nursing care from privately operated or municipal facilities and 154 are in Pioneers' Homes, for a total of 798 people presently receiving nursing care. Two hundred eighty-eight people are currently receiving residential care in Pioneers' Homes.

Eight percent of 10,000 eligible people equals 800 people. Seven hundred ninety-eight people are presently receiving nursing care, which indicates that substantially all people needing nursing care are receiving that care through some means.

Twelve percent of 10,000 people equals 1,200 people. Two hundred eighty-eight people are presently receiving residential care in the Pioneers' Homes. The number of needy persons receiving residential care in private homes is not known, but it is presumed to be negligible. Therefore, it is believed that 912 eligible people could benefit from residential care in Alaska.

The rates for nursing and residential care as provided by the Department of Health and Social Services averaged \$2,670 per month per person for nursing care and \$1,000 per month per person for residential care.

The above figures are based on present experience. It is believed that need will grow at approximately 5% per year due to the following:

1. More elderly people will be retiring in Alaska in the future due to improvements in services and benefits to the elderly.
2. H.B. 374 will make it possible to obtain care which has not been available in the past due to economic hardship.

Therefore, a 5% per year growth rate is projected.

Additional Cost of H.B. 374

Residential Care

FY 81	912 people x 105% x \$1,000 x 12 + 10% inflation = \$12,640,320
FY 82	FY 81 + 5% increased need + 10% inflation = \$14,599,569
Fy 83	FY 82 + 5% increased need + 10% inflation = \$16,862,501

POSITION PAPER  
ON  
HOUSE BILL NO. 374

"An Act relating to equalizing the costs of full time residential or nursing care."

House Bill 374 amends the statutes to allow the Commissioner of Administration to enter into contracts with private residential and nursing care providers to purchase services for certain senior Alaskans who are eligible for Pioneer Home benefits. These eligible persons must meet:

1. All eligibility requirements for admission into the Alaska Pioneer Homes, including being age 65 or over and having at least 15 years of continuous Alaska residency immediately prior to admission;
2. Are not eligible for benefits from any sources (including Medicare, Medicaid or private medical insurance) that would pay for the cost of full-time residential or nursing care; and
3. Do not reside less than 50 highway miles from a Pioneer's Home that has bed space available and could admit the individual.

The Department of Administration would pay for the fees charged by the facility less the monthly contribution of \$225-\$250 that pioneers are required to contribute if they are able to pay towards their cost of care.

#### General Overview

Most social scientists, health professionals, and seniors themselves acknowledge the advantage of keeping older persons in their communities and preferably in their own homes. Remaining in the community, even in cases of where the person is in an institution, enhances the senior's morale and provides security of familiar settings and being close to family and friends. Too often in Alaska seniors are not given the choice of remaining in their home community when they become in need of medical or social support services, because the services they need are often unavailable or unaffordable. House Bill 374 would increase the access to residential and nursing home care for certain pioneer Alaskans who were unable to receive them from the Pioneer's Home Program due to unavailable bed space in a Pioneer's Home facility within 50 highway miles from the person's home community.

#### Discussion Items

1. There are many pioneers living in communities outside of the towns where Pioneer's Homes are located. In some cases such as in Juneau and Bethel, there are facilities with available bed capacity which could provide the care that these pioneers need. Presently, the

Pioneer's Home Program is limited to the provision of care only on Pioneer Home facilities and the program is not designed to purchase care from local community resources. Relocation of seniors to a Pioneer's Home in a different community at this time in the older person's life may cause a hardship on the patient, as well as his/her family.

2. There are many pioneers, as well as other seniors, who are financially unable to pay for the purchase of care in a local facility. Costs of residential care can sometimes run from \$800-\$1,200 a month, while nursing home care costs are considerably higher at \$1,500-\$4,000 a month. Senior pensions of over \$625 a month are inadequate to purchase the care, but make the person financially ineligible for coverage by Medicaid or other public assistance programs.
3. Insurance coverage for residential or nursing home coverage is extremely limited. Most policies, if they cover nursing care services, at all limit coverage to 30 days of care. Also, the care generally must be necessary in place of more costly hospital care services. Residential care, since it generally does not include medical services, is not reimbursable by virtually all insurance and assistance programs to our knowledge (including Medicaid and Medicare).
4. The Department of Health and Social Services has experienced a few cases this fiscal year of pioneers who are eligible for Pioneer's Home admission, but are in need for specialized or intensive medical care that is unavailable at the Pioneer's Homes facility. These persons who are determined "too sick" to be appropriately placed in Pioneer's Homes are currently receiving care in private nursing facilities. Often the person's resources are inadequate to cover the nursing home bill, yet they are over income to be eligible for public assistance. The bill would have to be amended to allow coverage of these individuals.
5. House Bill 374 provides for the Department of Administration to base reimbursement rates on the fees charged. Our experience through Medicaid, General Relief-Medical, and Social Services programs has found that providers often charge amounts in excess to their actual allowable costs under the program. Also, allowing fees charged by providers to be reimbursable would provide no incentive for cost containment by the residential and nursing care facilities. We would recommend the Committee consider linking the rates paid under H.B. 374 to the state fees allowed under Medicaid for nursing homes or under the Division of Social Services for residential care.
6. The legislature is currently considering the passage of the Older Alaskan's Commission through H.B. 618 and S.B. 328. This Commission was designed to address these long range aging issues. It may be

appropriate, in light of the significant change of direction of H.B. 374, to reserve judgement until such a issue could be formally addressed by the Commission and/or Governor's Advisory Committee on Aging and Pioneer's Home Board.

- 7. In many areas of Alaska, especially in the remote ones, pioneers may still be required to leave their communities to receive care even if H.B. 374 were passed. Residential care and nursing home services are generally only available in urban areas and rural regional centers. This bill, though, may serve as an important catalyst to encourage private enterprise to develop facilities in those areas in the future by providing an important source of continuing revenue to pay for operating expenses.

Department's Position

The Department of Health and Social Services recognizes the need addressed in House Bill 374 and is supportive of the concept of increasing the availability of services to permit seniors to remain in their local communities.

Approved by:



Helen D. Beirne, Commissioner  
Department of Health and Social  
Services

3/11/80  
(TE)

NURSING HOMES

CENSUS: January 1980

	Current Rate		Certified Capacity			Current Occupancy				% Occupancy of Total Beds			
	ICF	SNF	ICF	SNF	Total	Medicaid DPA* Placements		Non-DPA Placements		Current Vacant Census	Beds	Overall	Medicaid
Seage House (Anchorage)	55.00		101**		101	37	0	0	2	39	62	39%	37%
Seage North (Fairbanks)	84.50	93.00	101		101	52	24	0	2	78	23	77%	75%
Ordova Hospital L.T.C.	<del>135.68</del>		8		8	4	0	0	1	5	3	63%	50%
etchikan Hospital L.T.C.	73.31		48		48	37	0	0	1	38	10	75%	77%
akoyia (Anchorage)	103.00	125.00	116**	100	216	39	99	0	6	144	72	67%	64%
orton Sound Hosp. L.T.C. (Nome)	100.00		6**		6	6	0	0	0	6	0	100%	100%
etersburg Hosp. L.T.C.	51.30	57.00	12		12	7	1	0	2	10	2	83%	67%
uth Peninsula Hosp. L.T.C. (Homer)	108.00		4		4	3	0	0	0	3	1	75%	75%
St. Ann's (Juneau)	<del>126.56</del>		45		45	23	4	1	3	31	14	69%	60%
alley Hospital L.T.C. (Palmer)	104.85		6		6	3	0	0	0	3	3	50%	50%
rangell Hospital L.T.C.	75.00	82.50	14		14	13	0	0	1	14	0	100%	93%
esleyan (Seward)	52.00		64		64	49	0	0	5	54	10	84%	77%
odiak Hospital L.T.C.	100.00		19**		19	8	0	0	0	8	11	58%	53%
TOTAL			544	100	644	281	128	1	23	433	211	67%	64%

ICF Certified Capacity means that all beds are certified for both SNF and ICF unless otherwise noted.

\* includes GR Medical placements  
\*\* beds are certified for ICF only

*Rod Betit* 2/20/80  
Rod Betit, Director Date  
Division of Public Assistance

Last year interest in this bill was one of several factors influencing the development of the Interim Committee on Elderly Services. As you are aware, one of the major recommendations of that interim work has been the legislation to establish the Older Alaskans Commission. Because we believe HB 374 to represent a significant change in direction for the Pioneers' Home Program, as originally designed by the Legislature, we believe that it deserves review and recommendation from the Pioneers' Home Board and Commission. Thus we first urge passage of the Older Alaskans Commission bill now in House Finance Committee.

The concept of dollars following the person eligible for entrance to a Pioneers' Home is not altogether undesirable, but it is fraught with several concerns that suggest it should be addressed in a comprehensive approach.

The program for the elderly are all creatures of the Legislature and can, of course, take new directions as desired by the Legislature. We would, however, urge an orderly approach to the new directions of services such as would be more readily available to you through the work of the Pioneers' Home Board and Commission during the next year or two.

A question must be raised regarding priorities when a bill with expensive price tags is addressed. As I read the testimony collected across the State by the Interim Committee on Services to the Elderly, high priority goes to finding a mechanism to assist the elderly and disabled who "fall through the cracks" of existing services and assistance programs, providing more home and health aide services to all elderly citizens, not just those meeting Pioneers' Home Program qualifications.

If there is sufficient need to address the need of clients for whom HB 374 was designed prior to the establishment of the Commission and a comprehensive review, then we would recommend a less costly and more efficient approach through HB 781. The approach would be more efficient because the administrative framework and expertise exist in Health and Social Services and the Catastrophic Illness statute to which HB 781 applies is a logical vehicle. Further, the benefits would address a broader base of clients, not just pioneers.

Thus, the Department of Administration would urge (1) passage of HB 618 and the establishment of the Commission for planning and recommending the future direction of elderly services, (2) involvement of the Pioneer Home Board with the Commission in that review and planning, and (3) if an interim measure is needed, the passage of HB 781 to cover both pioneer and other elderly clients.

*from Sue Green*

THE LEGISLATURE OF THE STATE OF ALASKA  
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. H.B. 374  
 Title An Act providing for full-time residential care for Pioneer Alaskans  
 Requested by Representative Buchholdt Date 3/18/80

II. FISCAL DETAIL

Agency Affected Administration  
 Program Category Affected Social Services  
 Budget Request Unit(s) Affected Pioneers' Homes

EXPENDITURES (Thousands of Dollars)

	FY80	FY81	FY82	FY 83	FY 84	FY85
100 PERSONAL SERVICES					(costs are assumed to	
200 TRAVEL					increase at the same	
300 CONTRACTUAL		2,983.0	2,857.5	3,285.7	rate)	
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
<b>TOTAL</b>		2,983.0	2,857.5	3,285.7		

FUNDING (Thousands of Dollars)

	FY80	FY81	FY82	FY 83	FY 84	FY85
GENERAL FUND		2,983.0	2,857.5	3,285.7		
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

	FY80	FY81	FY82	FY 83	FY 84	FY85
FULL TIME		4	4	4		
PART TIME		3	3	3		
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This fiscal note is based on initiation of a pilot project which would serve Southeastern Alaska only and provide for residential care only. In a recent review of need for skilled nursing care, it became apparent that substantially all of the elderly people in Alaska who need nursing care are receiving that care through some means, although there were a few cases where the person had some sort of difficulty financially in paying for necessary services. These cases generally fell into the category of having too much income to qualify for state or federal assistance, but not enough income to fully cover cost of services where special or intensive care is necessary.

(continued)

IV. DATE 3/17/80 PREPARED BY George I. Michael  
 AGENCY Administration  
 PHONE 465-4401

Original: Legislative Finance  
 cc: Budget and Management  
 Prime Sponsor (First Legislator Named) Representative Duncan  
 Office of the Governor, Keith Specking

33-001 (Rev. 10/78)

## Rationale for Determining Costs for Residential Care

The population of people in Southeastern Alaska over 65 years of age is estimated to be approximately 2,207 people. However, not all these people would qualify under the eligibility requirements of H.B. 374, particularly the 15-year residency. The total number of people which would be eligible in Southeastern Alaska is approximately 265.

These figures were arrived at by analyzing the statistics of an existing program for the elderly, the Alaska Longevity Bonus Program. February 1980 recipients of the Longevity Bonus were 2,006 in Southeastern Alaska, and 5,736 for the balance of the state. This gives a baseline of data which indicates that 26% of the state's total population over 65 have resided in Southeastern Alaska continuously for at least 25 years, the minimum for eligibility for the Alaska Longevity Bonus. This is twice the average of the population of all ages, which is 5,400 in Southeastern to 362,000 for all the rest of the state, according to most current statistics of the Department of Labor.

The minimum length of continuous residence in Alaska to be eligible for benefits under H.B. 374 is only 15 years. Therefore, it is assumed that the percentage of eligible population would be approximately 10% higher than the Longevity Bonus statistics, or 36% of the people 65 years of age and older residing in the state because of the lesser residency requirements. This is considered to be a conservative figure, since not all people over 65 and eligible have applied for and receive the Longevity Bonus.

National statistics indicate that 9% of the population 65 and older will need residential or alternative care. Alaskan experience is higher due to more inclement weather and the fact that more elderly Alaskans are not able to benefit from having a family nearby to assist them. A figure of 12% is more realistic.

Ten percent added to 2,006 (Longevity Bonus recipients) equals 2,207 people. Twelve percent of 2,207 elderly people equals 265 people. Sixty-seven residents are presently being cared for in the Sitka Pioneers' Home and a nominal amount in other facilities. Beginning approximately January 1, 1982, fifteen to twenty residents will be cared for at the Ketchikan Pioneers' Home.

Rates for residential care average \$1,000 per month per person, according to the Department of Health and Social Services.

The above figures are based on present experience. It is believed that need will grow at approximately 5% per year due to the following:

1. More elderly people will be retiring in Alaska in the future due to improvements in services and benefits to the elderly.
2. H.B. 374 will make it possible to obtain care which has not been available in the past due to economic hardship.

Therefore, a 5% per year growth rate is projected.

### Cost of Residential Care

FY 81	265 people less 67 people (cared for at Sitka Pioneers' Home) x 105% x \$1,000 x 12 months + 10% inflation = \$2,744,280
FY 82	FY 81 less 10 people (20 people cared for at Ketchikan Pioneers' Home for 6 mo.) + 5% increased need x \$1,000 x 12 mo. + 10% inflation = \$2,605,680
FY 83	FY 82 + 5% increased need + 10% inflation = \$3,009,560

Personal Services Costs

	<u>No. of Positions</u>	
Medical Surveillance Officer (R19)	1/2	\$ 16,467
Program Coordinator (R21)	1	37,890
Fiscal Compliance Auditor (R18)	1/2	15,315
Social Worker (Juneau) (R16)	1	26,538
Social Worker (Ketchikan) (R16)	1/2	13,269
Administrative Assistant II (R14)	1	23,070
Clerk Typist III (R8)	1	<u>16,020</u>
Subtotal Salaries		\$148,569
Benefits: 21% of salaries plus \$127/mo. per person		<u>\$ 39,581</u>
Total FY 81 Salaries & Benefits		\$188,150
Total FY 82 Salaries & Benefits		\$203,876
Total FY 83 Salaries & Benefits		\$223,416

Salaries are computed in accordance with the State's new salary schedules (C.S.S.B. 182) for the period July 1, 1980, through December 31, 1981. Inflation of 10% per year is assumed for salaries after December 31, 1981.

Other Program Costs

FY 81 Costs

Travel:	\$ 29,872
This would fund travel for one full-time social worker in Juneau and one half-time social worker in Ketchikan. These workers would travel to all cities and villages with a population of at least twenty-five persons where assistance is needed in relation to this program. Travel is also needed for the program coordinator. Travel between Juneau and the larger cities would be needed at the outset of the program and thereafter once a year (Yakutat, Sitka, Petersburg, Wrangell, Ketchikan) in monitoring the program.	
Contractual Services:	\$ 11,000
Office and program operating expense, such as telephones, postage, copying, printing, etc., for the staff of two full-time and five part-time personnel. Only a small allowance is included for office space under the assumption that most personnel would be operating in already existing state office space.	
Commodities:	\$ 2,700
Office supplies for office and field staff.	
Equipment:	\$ 7,000
Initial outfitting of new positions with office furnishings and equipment.	

If H.B. 374 is approved and the Department of Administration is funded for this pilot project, it is proposed to RSA these funds to the Department of Health and Social Services, for the staff to be their staff, and for them to operate the program. This program fits precisely into the type of social services programs operated by that department.

Ten percent inflation is included in "other" program costs for years beyond FY 81.

Honorable Chair Person & Committee members

9 yrs CW Sup. 15 PIS  
3 yrs Circuit SW 15 PIS  
8 yrs Dir AHAAS  
Bel for in 3 month  
7 P. 1/2 day

Subject: HB 374 Today 1:00 Room 112 Capital Building

The passage of this Bill into law will enable many older persons to remain in their own homes as long as possible and help to hold families together.

For 8 years, I was Director of Alaska Homemaker-Home Health Aide Service. Our basic funding originally was from the Older American's Act, Office of Aging. In 1974-75, this agency served statewide 253 older Alaskans. By age groups there were

Age	Number
55-60	12
60-65	20
* 65-70	131
70-75	25
75-80	18
80-85	20
85-90	12
90-95	10
95-100	2
100-113	3
	<hr/> 253

D. Muncie -  
H. P. B. - #455  
E. - Admin  
S. - Ketchikan  
T. - Anch.

With a combination of quality homemaker-home health aide service and local nursing homes re-imburse from the pioneer fund, Senior Alaskans can remain in their own homes & own communities

Mrs. Dove M. Kull  
Mendenhall Apts. #1010  
325 - 4th Street  
Juneau, Alaska 99601

3-22-79

Mr. Bill Patton Kin. McKinlay

Em-home care as set by home care agency

Let's remember in the chapter

chapter of American born of history

How will they <sup>regarding</sup> down the U.S.M.

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the money is kept here at home - no

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in my own my home and family and

as long as possible. This plan would be less burdensome  
for human beings; and, per person, less expensive  
for government.

FISCAL NOTE

I. REQUEST

Resolution No. House Bill 374  
 e "An Act providing for full-time residential care for Pioneer Alaskans."  
 Requested by Representative Jim Duncan Date March 25, 1980

II. FISCAL DETAIL

Agency Affected Administration  
 Program Category Affected Social Services  
 BRU, Program, or Subprogram(s) Affected Pioneers' Homes  
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		674.8	1,323.9	1,518.1	1,738.1	1,987.4
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
<b>TOTAL</b>		674.8	1,323.9	1,518.1	1,738.1	1,987.4

FUNDING (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
GENERAL FUND		674.8	1,323.9	1,518.1	1,738.1	1,987.4
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
FULL TIME		2	2	2	2	2
PART TIME		1	1	1	1	1
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This fiscal note is based on initiation of a demonstration project which would serve Southeastern Alaska only and provide for residential and nursing care of those who are eligible to enter Pioneer's Homes under AS 47.25.010-110, are not eligible for benefits from any source that would pay for the cost at full-time residential and nursing care, who reside more than 50 miles from the Alaska Pioneer's Home, and do not wish to enter the Pioneers' Home.

The number of elderly Alaskans who would benefit from this bill is unknown at the present time. The Department of Health and Social Services has some indication that some need exists, but cannot quantify that need.

Original: Legislative Finance  
 cc: Budget and Management  
 Prime Sponsor (First Legislator Named)

Prepared by: George Michael Date: March 25, 1980  
 Division/Office: Pioneers' Home PH: 465-4401  
 Department of Administration

## Residential Care

This demonstration project would verify the scope of need, and develop residential care capability in the private sector where virtually none now exists in Southeastern Alaska.

This fiscal note is based on the assumption that only seven (7) slots would be developed during FY 81, that twice that number of slots would be available and utilized during FY 82, and that the number of slots would increase by five (5) per year after FY 82.

Rates for residential care average \$1,000 per month per person in FY 80. One thousand dollars, less \$225 per month payable by the recipient under AS 47.25.030 would result in a net cost to the State of \$775 per month per person.

Inflation at the rate of 10% per year is included throughout this fiscal note.

### Cost of Residential Care

FY 81	7 slots X \$775 X 12 mo. + 10% inflation	=	\$ 71,610
FY 82	14 slots X \$853 X 12 mo. + 10% inflation	=	157,634
FY 83	19 slots X \$938 X 12 mo. + 10% inflation	=	235,250
FY 84	24 slots X \$1,032 X 12 mo. + 10% inflation	=	326,938
FY 85	29 slots X \$1,135 X 12 mo. + 10% inflation	=	434,478

## Nursing Care

Based on statistics of the Department of Health and Social Services, a total of 23 vacant nursing beds are available in Southeastern Alaska at the present time. It is assumed that one-half of these beds would be filled in FY 81, and all 23 would be filled by FY 82.

The average cost for nursing care in FY 80 is \$3,422 per month per person. Three thousand four hundred twenty-two dollars, less \$275 per month payable by the recipient under AS 47.25.030 would result in a net cost to the State of \$3,147 per month per person for FY 81. It should be noted that overall cost of care in the Pioneers' Homes is \$2,110 per month per person for FY 81.

### Cost of Nursing Care

FY 81	12 beds X \$3,147 X 12 + 10% inflation	=	\$ 498,485
FY 82	23 beds X \$3,462 X 12 + 10% inflation	=	1,051,063
FY 83	23 beds X \$3,808 X 12 + 10% inflation	=	1,156,109
FY 84	23 beds X \$4,189 X 12 + 10% inflation	=	1,271,780
FY 85	23 beds X \$4,610 X 12 + 10% inflation	=	1,399,596

## Administrative Costs

At the outset, a Program Coordinator would be required to develop the program, contact prospective providers of residential and nursing care to encourage development of capacity in existing and/or new facilities, and guide those providers by setting standards, providing information relative to licensing, determining standard operating procedures, etc. When the program is up and running, the Program Coordinator will have the responsibility for successful continuation of the program.

A Social Worker is needed on a half-time basis to advise and assist the eligible elderly persons in obtaining benefits and with personal problems.

A Clerk Typist is needed for clerical support of the Program Coordinator and Social Worker.

		<u>FY 81 Cost</u>
Personal Services		\$ 74,413
Salaries - Program Coordinator (R-18)	\$29,580	
Social Worker III (R-16) (1/2)	12,792	
Clerk Typist III (R-8)	15,324	
Subtotal	<u>\$57,696</u>	
Benefits	16,717	
Total Salaries and Benefits	<u>\$74,413</u>	
Travel		14,000
For Program Coordinator and Social Worker		
Contractual Services		10,500
Office and program operating expenses		
Commodities		1,500
Office supplies for office and field staff		
Equipment		4,800
Outfitting of new positions with office furnishings and equipment		<u>          </u>
Total Administrative Cost		\$104,713

If House Bill 374 is approved and the Department of Administration is funded for this pilot project, it is proposed to RSA these funds to the Department of Health and Social Services to operate the program.