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RURAL EDUCATION ATTENDANCE AREAS EXPENDITURES
SCHOOL OPERATING FUND

FY-78 Audited

Accumulated

REAA	Regular Instr.	Vocational Education	Special Education	Corresp.	Support Services Pupil	Support Services Instr.	General Admin.	Operation & Maintenance	Pupil Trans.	Boarding Home	Other Non-Prog.	Fund Balance (GF)	FY-77 Fund Bal. GF
Adak	995,500	107,334	21,264	---	32,051	43,901	439,270	365,314	80,209		44,337	313,258	171,308
Alaska Central	638,303	122,655	66,596	---	147	16,872	287,245	376,722	163,667		39,135	608,714*	280,287
Alaska Gateway	755,368	59,058	108,175	64,119	1,033	55,119	364,843	397,765	163,454	482	51,659	170,162	108,390
Aleutian Chain	552,521	30,580	121,688	16,700	11,423	91,838	439,877	280,890	---	---	38,497	206,142	44,503
Annette Is.	442,272	83,789	81,409	---	61,458	8,674	179,010	248,867	4,446	---	33,327	219,452	110,870
Bering Strait	727,943	146,126	124,868	11,031		57,106	642,168	961,767	21,080	308,694	152,814	399,519	43,284
Chatham	278,818	53,451	46,409	---	2,625	---	196,678	189,528	---	---	6,836	280,956	210,011
Chugach	124,736		25,529	---	1,498	---	61,561	63,096	---		6,971	176,909	115,537
Copper River	1,165,105	144,489	112,797	168,825	99,029	4,679	456,658	636,231	298,548	9,404	5,800	101,661	134,226
Delta/Greely	1,133,964	167,441	138,853	106,215	77,299	108,151	299,448	604,126	273,097		61,500	388,389	192,411
Iditarod	627,712	133,687	79,042	37,871	15,420	152,314	264,493	481,135		25,065	173,272	245,734	255,965
Kuspuk	867,694	48,845	81,833	65,292	---	27,791	420,597	620,886	16,658	5,058	86,088	340,245	141,990
Lower Kuskokwim	2,168,713	309,409	468,586		665,297	441,424	1,023,721	2,038,109	52,954		202,233	887,798	394,790
Lower Yukon	1,310,978	195,584	225,058	148	653	44,184	414,521	1,446,129	4,520	116,744	420,766	1,136,441	418,859
Northwest Arc.	2,724,554	407,493	399,192	22,243	78,511	263,440	1,154,759	2,744,593	9,480	100,453	464,590	19,794	627,355
Pribilof	321,174	59,373	94,973	---	---	---	166,140	103,406			62,265	549,207	297,091
Southeast Is.	959,029	48,221	115,069	190,333	23,872	49,684	188,243	384,945	18,071		---	206,823	202,874
Southwest	1,004,328	196,959	174,208	75,163	---	30,111	485,215	1,046,261			362,324	462,167	185,862
Lake & Pen.	855,320	104,586	82,960	10,571	30,760	94,171	417,671	865,074	17,187		112,952	474,854	251,945
Yukon Flats	640,064	101,608	75,920	46,339	20,142	654	283,834	532,123		2,421	164,013	85,372	48,511
Yukon-Koyukuk	1,211,738	243,804	170,469	210,494	77,194	64,198	581,200	1,405,649		124,554	97,443	197,968	75,019
TOTALS	19,505,834	2,764,492	2,814,898	1,025,344	1,198,412	1,554,311	8,767,152	15,792,616	1,123,371	692,875	2,586,832	7,479,565	4,311,028

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CITY & BOROUGH SCHOOL DISTRICT EXPENDITURES

FY-78 Audited

	Regular Instruction	Vocational Education	Special Education	Corres- pondence	Support Services Pupil	Support Services Instruction	General Admin.	Operation & Managemt.	Pupil Trans.	Boarding Home	Other Non-Prog.	Fund Balance FY-78	Fund Balance FY-77
Anchorage	46,916,208	3,146,750	4,785,094		1,461,107	1,310,980	10,452,233	14,327,599	4,990,316		1,190,197	10,764,926	10,145,331
Bristol Bay	383,469	103,260	66,085		40,426	46,004	195,784	252,163	73,024		64,237	159,622	240,497
Cordova	661,774	139,049	172,278		69,840	106,805	304,220	258,733	18,918		9,238	(41,330)	1,630
Craig	228,950	58,205	54,682		1,920	42,537	118,030	80,549	23,147		28,111	219,771	131,627
Dillingham	625,192	181,427	159,924		66,371	43,007	367,520	291,264	68,954		60,649	415,858	202,611
Fairbanks	10,680,671	1,203,898	1,775,702	110,149	820,814	902,697	2,796,409	5,575,082	3,369,353	26,500		-0-	-0-
Galena	216,391	81,774	56,051		43,555	13,826	111,272	152,642	14,229		70,072	450,985	249,064
Haines	654,773	82,465	139,044		46,169	14,307	172,350	217,341	55,974		15,499	350,397	160,474
Hoonah	307,312	101,985	88,028		35,771	43,947	147,560	158,152			57,570	211,268	212,276
Hydaburg	139,804	49,880	35,164		238	---	89,783	73,694			54,420	136,082	20,521
Juneau	5,533,157	577,082	646,917	40,324	527,565	439,445	1,659,893	1,669,457	610,065		128,219	400,481	559,548
Kake	255,439	96,281	81,779		7,524	7,663	160,659	121,590	12,020		70,515	220,544	210,533
Kenai	7,324,371	834,480	907,528	201,381	561,366	619,782	1,871,133	1,902,968	1,844,294	45,896	502,165	1,401,921	801,122
Ketchikan	2,919,636	460,944	424,845	68,889	455,090	256,809	554,097	1,192,667	380,605		237,746	109,645	109,645
King Cove	211,276	64,205	41,814			15,732	146,767	88,458	253	4,004	35,848	306,429	254,505
Klawock	85,923	---	17,135		5,831	3,105	61,852	33,217			22,644	169,942	26,469
Kodiak	2,675,015	298,053	452,457	81,518	188,924	253,636	752,180	1,148,482	164,292	110,540	370,832	---	---
Mat-Su	4,808,288	682,903	384,351	263,985	416,040	378,750	1,502,961	1,978,965	1,784,714		19,641	5,400	322,399
Nenana	269,297	162,256	83,348	---	23,302	14,084	154,545	177,304	26,365		76,261	139,405	150,541
Nome	1,326,242	197,752	259,997		101,813	1,075	424,772	977,463	71,588		131,520	412,181	244,502
North Slope	2,346,384	713,764	644,011	8,538	377,875	91,538	1,962,592	3,533,431	260,828		934,603	520,173	230,703
Pelican	90,974	15,783			522	2,133	24,173	31,716			2,025	31,071	37,561
Petersburg	745,227	103,770	161,227		37,900	43,455	189,221	287,630	55,127		109,106	80,998	29,548
Sitka	2,317,255	246,168	278,437	16,802	124,353	214,455	533,082	702,865	174,838		322,665	571,041	400,213
Skagway	332,216	55,225	50,402		16,358	14,006	75,850	69,328	1,119		22,343	165,797	140,265
St. Mary's	125,549	104,591	175,364			17,447	140,508	148,758			64,867	242,427	79,186
Unalaska	315,310	73,141	72,929		3,387	40,673	108,441	112,028	65,833	6,392	40,835	83,656	65,637
Valdez	1,157,845	211,985	437,557		18,573	203,299	525,354	983,294	135,868		99,399	454,109	672,318
Wrangell	774,885	117,183	117,837		46,025	40,412	206,035	155,649	47,789		20,875	59,770	126,051
Yakutat	215,215	79,675	74,456				95,099	87,222	29,974		36,137	6,717	(26,754)
TOTALS	95,143,148	10,243,934	12,644,443	791,586	5,498,659	5,181,609	25,904,375	36,789,711	14,289,487	193,332	4,798,239	18,094,116	15,854,777

CITY & BOROUGH SCHOOL DISTRICT REVENUES

FY-78 Audited

	Other Federal	Federal 874	Total Federal	Foundation	Pupil Trans	Boarding; Home & Tuition	Other State	Total State	Appropria- tion	Rental	Interest Income	Other Income	Total Local	Total All
Anchorage	53,057	2,280,063	2,333,120	53,366,996	4,784,289	2,008,958	461,678	60,621,921	22,521,854	123,326	658,522	310,737	23,614,439	86,569,480
Bristol Bay		149,700	149,700	1,021,987	59,237	18,325	11,978	1,111,527	80,000			3,089	83,089	1,344,316
Cordova		27,924	27,924	1,266,521	17,000	52,340	55,987	1,391,918	170,765		3,492	21,569	195,826	1,615,668
Craig		99,885	99,885	558,965	23,321	22,621		604,907	13,000	5,372	185	926	19,483	724,275
Dillingham	2,000	164,341	166,341	1,601,000	61,743	44,025	5,327	1,712,095	30,000		21,294	48,892	100,186	1,978,622
Fairbanks		443,050	443,050	16,516,620	2,930,658	103,326	122,677	19,673,281	6,359,676	29,833		23,319	6,412,828	26,529,159
Galena		196,850	196,850	721,995	14,229	13,696		749,920	6,468			8,495	14,963	961,733
Haines		45,994	45,994	1,164,842	65,285	25,365	9,620	1,265,120	246,490		10,524	29,717	286,731	1,597,845
Hoonah		119,709	119,709	797,095				797,095	13,994	1,688	6,519	672	22,513	939,317
Hydaburg		40,189	40,189	413,822			11,348	425,170	---		1,648	12,245	13,893	479,252
Juneau		309,066	309,066	7,883,508	543,693	28,497	25,140	8,480,838	2,931,700	4,054		50,686	2,986,440	11,776,344
Kake		166,262	166,262	621,203	12,355	4,614		638,172	15,000		3,270	777	19,047	823,481
Kenai		357,683	357,683	11,596,365	1,800,759	32,645	6,968	13,436,737	3,520,000	7,617		58,874	3,586,491	17,380,911
Ketchikan		69,572	69,572	4,773,760	353,914	28,344		5,156,018	1,634,770			33,290	1,668,060	6,893,650
King Cove		84,865	84,865	614,541	7,697	3,766		626,004	27,146		5,105	622	32,873	743,742
Klawock		133,850	133,850	236,522				236,522	1,500		---	408	1,908	372,280
Kodiak		253,745	253,745	5,186,334	132,238	202,990	173,701	5,695,263	457,180	35,387	13,315	59,032	564,914	6,513,922
Mat-Su		42,339	42,339	7,362,022	1,746,325	64,357		9,172,704	2,536,240			95,239	2,631,799	11,846,522
Nenana		9,751	9,751	803,781	51,584	80,170		935,535	17,000		8,239	1,555	26,794	972,080
Nome		49,039	49,039	2,829,350	72,832	55,622	409,800	3,367,604	64,475	26,861	13,245	87,678	192,259	3,608,902
North Slope		1,508,098	1,508,098	4,737,769	214,013		14,402	4,966,184	5,149,100	164,639		35,245	5,348,984	11,823,266
Pelican		---	---	151,033	---	1,819	---	152,852	6,635	---	1,349	---	7,984	160,836
Petersburg		39,295	39,295	1,316,446	51,527	122,233	5,000	1,495,206	231,371	1,354	16,371	---	249,096	1,783,597
Sitka		517,106	517,106	3,434,227	145,466	3,475		3,583,168	783,288	6,477	40,356	137,689	967,810	5,068,084
Skagway		---	---	600,995	1,122	3,737	3,782	609,636	49,000		3,253		52,253	661,889
St. Mary's		140,739	140,739	723,022	---	---	48,879	771,901	---	11,350	2,247	14,088	27,685	940,325
Unalaska		42,916	42,916	634,606	55,630	9,755	---	699,991	112,500		---	1,580	114,080	856,987
Valdez		---	---	2,253,281	125,602	48,304		2,427,187	995,644		60,498	13,041	1,069,183	3,496,370
Wrangell		17,105	17,105	1,168,920	43,097	911	886	1,213,814	215,500		8,461	5,529	229,490	1,460,409
Yakutat		---	---	590,610	30,573	5,028		626,211	20,369		944	3,725	25,038	651,249
	55,057	7,309,136	7,364,193	134,948,138	13,344,259	2,984,923	1,367,181	152,644,501	48,210,665	417,958	878,477	1,058,719	50,565,819	210,574,513

REVENUE
FY-78 Audited

	Other Federal	Federal 874	Total Federal	Foundation	Pupil Trans	In Lieu Of	Boarding Home	Other State	Total State	Rental	Interest	Other Local Income	Total Local
Adak		1,469,558	1,469,558	245,201	57,737	416,240	---	---	719,178	9,088	60,417	12,889	82,394
Alaska Central		355,136	355,136	1,226,448	160,372	241,488	---	1,107	1,629,415	19,402	35,815	---	55,218
Alaska Gateway		44,531	44,531	1,551,000	163,454	290,336	482	---	2,005,272	2,183	23,248	7,616	33,047
Aleutian		187,079	187,079	1,297,921	---	160,304	10,442	---	1,468,667	2,278	12,890	72,638*	87,806
Annette Island		974,909	974,909	23,125	5,645	219,472	---	1,984	250,226	---	24,209	2,500	26,709
Bering Strait		661,549	661,549	1,981,201	21,080	304,784	305,784	---	2,612,849	30,133	11,348	2,768	44,249
Chatham		278,532	278,532	410,502	---	127,968	---	---	538,470	24,073	1,670	---	25,743
Chugach		72,804	72,804	230,032	---	33,024	---	---	263,056	---	---	8,903	8,903
Copper River		343,113	343,113	1,870,637	289,715	482,976	9,404	---	2,652,732	---	19,314	21,838	41,152
Delta/Greely		900,583	900,583	1,244,417	267,219	533,200	1,760	---	2,046,596	---	36,343	1,351	37,694
Iditarod		465,099	465,099	1,239,901	---	195,392	---	61,145 ²	1,496,438	20,829	3,101	---	23,930
Kuspuk	15,880	706,247	723,127	1,363,986	31,749	233,920	4,654	33,521	1,667,830	20,255	23,864	3,951	48,070
Lower Kuskokwim	89,098	2,173,269	2,262,367	3,154,856	50,582	1,016,176	1,070,870	---	5,292,484	95,177	75,530	142,242 ⁴	312,949
Lower Yukon		1,480,442	1,480,442	2,227,933	---	615,072	---	51,500	2,894,505	148,234	68,122	46,405 ³	262,761
Northwest Arctic		2,316,087	2,316,087	3,992,413	---	1,033,376	91,811	2,711	5,120,311	169,692	50,415	22,340 ⁴	242,447
Pribilof		439,713	439,713	467,787	---	126,592	---	3,181	597,560	---	20,012	---	20,012
Southeast Island		896,690	896,690	720,310	12,332	294,464	23,793	3,253	1,054,152	---	29,415	---	29,415
Southwest		1,293,592	1,293,592	1,649,017	---	359,824	---	---	2,008,841	56,890	52,532	26,605	136,027
Lake & Peninsula		751,920	751,920	1,635,080	33,708	263,504	4,275	---	1,936,567	36,250	21,541	231	58,022
Yukon Flats		415,576	415,576	1,328,863	---	209,152	17,432	---	1,555,447	---	---	4,339 ⁵	4,339
Yukon-Koyukuk		1,259,442	1,259,442	2,184,325	---	453,392	---	51,500	2,689,217	70,505	43,400	122,574 ⁵	236,479
		17,485,871	17,591,849	30,044,955	1,093,593	7,610,656	1,540,707	209,902	40,499,813	704,959	613,187	499,190	1,817,366

- * Sale of Capital Equipment
- 2 Includes 21,000 Insurance Proceeds
- 3 Federal Payments
- 4 Includes Indirect Cost Payments
- 5 Includes AVEL Subsidy

8 A T REPORT
 ANNUAL EDUCATIONAL ATTENDANCE AREAS
 FOOD SERVICE, PUPIL ACTIVITY AND SPECIAL REVENUE FUNDS

REAA	FOOD SERVICES FUND						PUPIL ACTIVITY FUND			SPECIAL REVENUE FUNDS			
	Food Srv. Sales	Federal Reim.	School Dist. Subsidy	Salaries & Benefits	Food & Milk	Other Exp.	Generated Revenue	Sch. Dist. Subsidy	Total Exp.	State Grants	Federal Grants	Local Funds	Total Grant Expenditures
Adak	\$ 39,222	\$ 2,202	\$ 7,867	\$ 22,232	\$ 27,059	\$ -0-	\$ 25,805	\$ 36,470	\$ 59,497	\$ 24,812	\$ 36,164	\$ -0-	\$ 60,976
AK Central	11,349	-0-	2,272	8,593	4,233	795	35,502	36,863	75,758	31,936	30,189	3,000	65,125
AK Gateway	-0-	696	9,321	-0-	10,017	-0-	23,435	36,243	53,753	1,419	178,777	-0-	180,196
Aleutian	NO FOOD SERVICE PROGRAM						NONE REPORTED			35,441	234,561	29,074	299,075
Annette	10,156	12,356	30,429	42,100	7,982	2,859	42,479	2,595	42,452	4,512	109,725	5,675	119,912
Bering Strait	3,055	126,126	13,492	80,967	58,633	3,073	-0-	33,101	33,101	-0-	609,814	25,530	635,344
Chatham	281	11,623	-0-	1,357	9,659	888	23,120	6,836	26,898	2,889	113,399	-0-	116,288
Chugach	-0-	-0-	3,595	2,904	691	-0-	-0-	3,376	3,376	-0-	16,242	-0-	16,242
Copper River	NO FOOD SERVICE PROGRAM						60,778	-0-	60,778	33,185	132,734	-0-	165,919
Delta Greely	37,607	10,220	30,120	43,721	24,197	10,029	32,458	23,964	60,646	24,739	87,471	5,927	118,137
Iditarod	-0-	-0-	25,229	9,700	15,529	-0-	-0-	51,400	51,400	15,985	365,926	40,878	422,789
Kuspuk	4,426	22,934	56,800	35,623	48,537	-0-	9,965	-0-	9,809	-0-	163,395	6,091	169,486
Lake & Pen.	9,925	21,520	98,553	79,371	49,718	909	4,005	-0-	1,287	72,280	201,643	-0-	273,923
Lower Kusk.	33,482	-0-	406,838	233,457	133,641	73,222	-0-	63,675	63,675	89,012	1,554,691	-0-	1,643,703
Lower Yukon	-0-	157,664	129,538	129,591	145,387	12,224	29,563	-0-	32,529	166,330*	772,616	3,897	942,843
Northwest	41,146	122,835	364,296	296,295	225,951	6,031	N/A	98,632	98,632	70,832	1,048,820	-0-	1,119,652
Pribilof	NO FOOD SERVICE PROGRAM						5,563	-0-	4,291	19,212	79,514	6,086	104,812
Southeast	NO FOOD SERVICE PROGRAM						13,320	-0-	12,528	4,807	60,181	-0-	64,983
Southwest	-0-	15,554	102,847	62,136	56,265	-0-	-0-	2,904	26,301	-0-	434,781	-0-	434,781
Yukon Flats	7,022	24,029	47,334	49,056	24,674	4,655	11,822	8,729	20,551	67,974*	295,142	25,945	389,061
Yukon-Koyukuk	9,865	47,201	95,938	40,955	62,985	49,064	-0-	695	695	133,726*	462,068	810	596,604
TOTALS	\$207,536	\$574,960	\$1,424,469	\$1,138,058	\$905,158	\$163,749	\$317,815	\$405,483	\$737,957	\$799,091	\$6,987,853	\$152,913	\$7,939,857

* Includes Boarding Home

FY 1978 AUDIT REPORT
 CITY AND BOROUGH SCHOOL DISTRICTS
 FOOD SERVICE, PUPIL ACTIVITY AND SPECIAL REVENUE FUNDS

District	FOOD SERVICES FUND						PUPIL ACTIVITY FUND			SPECIAL REVENUE FUNDS			
	Food Srv. Sales	Federal Reim.	School Dist. Subsidy	Salaries & Benefits	Food & Milk	Other Exp.	Generated Revenue	School Dist. Subsidy	Total Exp.	State Grants	Federal Grants	Local Funds	Total Grant Expenditures
Anchorage	\$2,350,962	\$ 895,684	\$ 125,841	\$1,753,214	\$1,040,189	\$ 579,084	\$1,147,577	\$ -0-	\$1,115,205	\$1,829,184	\$2,741,228	\$ 27,768	\$ 4,598,180
Bristol Bay	13,465	5,902	29,364	32,036	15,244	1,451	27,139	21,148	50,860	-0-	70,639	5,438	76,077
Cordova	17,428	9,250	8,784	26,684	7,746	1,032	34,227	36,510	70,122	-0-	180,951	454	181,405
Craig	5,031	5,792	16,347	13,251	12,348	1,571	-0-	11,764	11,764	2,637	77,542	-0-	80,179
Dillingham			NO FOOD SERVICE PROGRAM				77,282	25,000	101,662	129,899*	240,441	7,246	377,586
Fairbanks	70,748	34,906	-0-	11,681	93,427	546	407,784	149,434	647,317	256,201**	503,060	12,861	772,122
Galena	7,351	5,790	29,271	27,904	10,411	4,097	10,867	28,673	26,757	-0-	48,929	30,717	79,646
Haines			NO FOOD SERVICE PROGRAM				23,930	11,000	36,632	34,881	64,553	1,161	100,595
Hoonah	6,364	33,632	29,999	33,387	33,549	3,109	23,172	18,500	38,464	6,180	275,833	8,129	290,142
Hydaburg	-0-	12,849	14,711	16,398	9,812	1,350	6,969	11,191	8,444	1,163	67,952	-0-	69,115
Juneau			NO FOOD SERVICE PROGRAM				183,232	62,959	232,888	250,446**	384,585	-0-	635,031
Kake	1,936	16,297	8,152	8,519	13,273	4,593	32,648	15,532	44,252	10,127	111,885	9,431	131,443
Kenai	323,511	126,363	165,188	308,913	256,548	49,601	334,749	342,665	650,377	63,654**	329,035	-0-	392,689
Ketchikan	88,874	85,613	40,868	91,529	117,032	6,794	188,886	38,600	225,429	13,512	274,197	2,733	290,442
King Cove	841	1,562	5,318	1,952	4,706	1,063	5,652	11,563	16,411	2,018	54,651	18,967	75,636
Klawock			NO FOOD SERVICE PROGRAM				-0-	-0-	-0-	1,150	39,732	267	40,849
Kodiak	65,690	64,106	15,034	76,886	58,250	9,694	90,764	90,709	181,431	295,397*	357,431	733	650,561
Mat-Su	246,690	95,168	91,111	71,017	210,307	51,645	236,711	17,000	240,877	98,120**	320,026	10,197	428,343
Nenana	4,120	1,328	1,018	1,766	4,424	276	18,789	433	28,134	45,123**	9,904	1,099	56,126
Nome	17,258	28,471	29,299	25,340	48,844	844	47,564	23,000	67,476	76,391	807,368	31,974	915,733
North Slope	11,514	83,918	555,278	366,636	278,640	5,434	60,150	315,382	281,488	177,627	838,207	600	1,016,434
Pelican			NO FOOD SERVICE PROGRAM				-0-	-0-	-0-	-0-	8,000	2,543	10,543
Petersburg	8,308	5,237	13,437	9,773	16,033	1,176	17,151	28,321	45,931	23,746	58,129	36,254	118,129
Sitka	92,841	21,050	18,508	62,617	67,144	2,638	85,419	41,679	127,098	52,285	243,122	-0-	295,407
Skagway			NO FOOD SERVICE PROGRAM				7,386	21,972	27,728	1,515	17,936	-0-	19,451
St. Mary's	-0-	13,230	32,492	29,408	15,672	642	-0-	-0-	-0-	-0-	149,867	1,231	151,098
Unalakleet	3,366	3,090	12,600	5,267	11,721	2,067	19,719	9,097	28,816	-0-	31,811	3,625	35,436
Valdese			NO FOOD SERVICE PROGRAM				46,817	55,486	98,842	-0-	45,701	7,202	52,803
Wrangell			NO FOOD SERVICE PROGRAM				69,179	19,875	93,341	5,699	115,637	5,960	127,296
Yakutat	10,462	5,263	17,367	21,650	9,155	2,303	4,299	19,123	23,422	5,330	31,833	-0-	37,163
TOTALS	\$3,346,760	\$1,554,551	\$1,259,987	\$3,095,828	\$2,334,460	\$ 731,010	\$3,208,062	\$1,426,618	\$4,521,168	\$3,382,285	\$8,496,785	\$ 226,590	\$12,105,660
Anchorage On-Base	131,505	58,669	2,742	116,317	79,753	46,846	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Fairbanks On-Base	12,002	4,454	-0-	-0-	16,220	236	48,232	40,084	100,104	-0-	-0-	-0-	-0-

* Includes Boarding Home
 ** Includes RSVP

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.

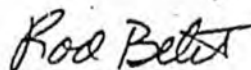
OR

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.
St. An Pat Denny Howe W. Kull	419 6 th St. Juneau 326-4th St	St. Ann's Nursing Home	374
Sister Patrick Mary Louis La Beaume	520 Harris Street " " "	American Red Cross Senior Citizen Programs " " "	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.)

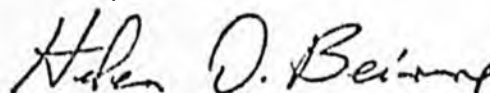
This amendment would transfer funds between Budget Request Units within the Division.

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) ^a	2794062	1397031	1397031
(Residential Care) 108		1166400 ^c	(488592) ^b	677808		677808
COST SAVINGS in MEDICAID + Additional OAA Expense ^d				2116254 168480	1397031	719223 168480
NET SAVINGS				2284734	1397031	887703
Nursing Homes	13	396755 ^e	(23400) ^a	373355	186678	186677
(Residential Care) 13		140400 ^c	(58812) ^b	81588		81588
COST SAVINGS IN MEDICAID + Additional OAA Expense ^d				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)				
	TOTAL	17541.6	(373.4)	17168.2
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
	TOTAL	17541.6	(373.4)	17168.2
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 ReliefMed
	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)			
	TOTAL	-0-	81.6	81.6
NEW CODE	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	-0-	81.6	81.6
	INTER-AGENCY TRANSFERS			
	OTHER:			
	TOTAL	-0-	81.6	81.6
	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)			
	TOTAL	-0-	84.8	84.8
NEW CODE	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	-0-	84.8	84.8
	INTER-AGENCY TRANSFERS			
	OTHER:			
	TOTAL	-0-	84.8	84.8
	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)			
	TOTAL	3406.1	20.3	3426.4
NEW CODE				
	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	3406.1	20.3	3426.4
	INTER AGENCY TRANSFERS			
	OTHER			
	TOTAL	3406.1	20.3	3426.4
	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	26975	19800	241175
2	NORTON SOUND (NOME)	3	83403	250209	5400	244809
3	PETERSBURG L.T.C.	5	18725	93625	9000	84625
4	WRANGELL L.T.C.	1	25550	25550	1800	23750
5	CAREAGE NORTH (FBX)	13	30843	400959	23400	377559
6	CORDOVA L.T.C.	2	26543	53086	3600	49486
7	WESLEYAN N.H. (SEWARD)	22	15440	339680	39600	300080
8	S. PENINSULA L.T.C. (HOMER)	0	39420	-	-	-
9	VALLEY HOSP. L.T.C. (PALMER)	3	34306	102918	5400	97518
10	ST. ANNS (JUNEAU)	4	27375	109500	7200	102300
11	CAREAGE HOUSE (ANCH)	23	24455	562465	41400	521065
12	NAKOYIA (ANCH)	21	37595	789495	37800	751695
13	TOTAL	108		2,938,462	194,400	2,794,062
14	FUNDING					
15	FEDERAL FUNDS					1,397,031
16	GENERAL FUNDS					1,397,031
17						2,794,062
18	① CAREAGE HOUSE RATE ADJUSTED FROM \$55 PER DAY TO \$67 PER DAY. ALL OTHERS AT CURRENT RATE					
19	② AN AVERAGE OF \$150 PER MONTH IS USED FOR EACH PATIENT					
20	③ THIS DOES NOT INCLUDE COST SETTLING FOR CURRENT YEAR					

Form HSS Buff - Form GSS 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
Division of Public Assistance

Date

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

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

Page Two

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	AARP	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 th 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	Alaska Health Care Ctr	HB 374
George Elye		Department of Administration	HB 374
Pat Denny	419 6 th 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.

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- 1) Each client should be encouraged to donate to the program. All donations are voluntary.
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6/30/78

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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.

Honorable Chair Persons & Committee members

also CW Sup
3 yrs Clinical SW NP PE
8 yrs Alex ANAAS
+ Pol for Certin 3 Missed
HE 5/1/1994

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'n
S. Barbara - Kitchell
G. H. ... - ...

With a combination of quality homemaker-home health aide service and local nursing homes re-imburshed 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 ^{soon after} 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

→ ^{Legislative} 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)

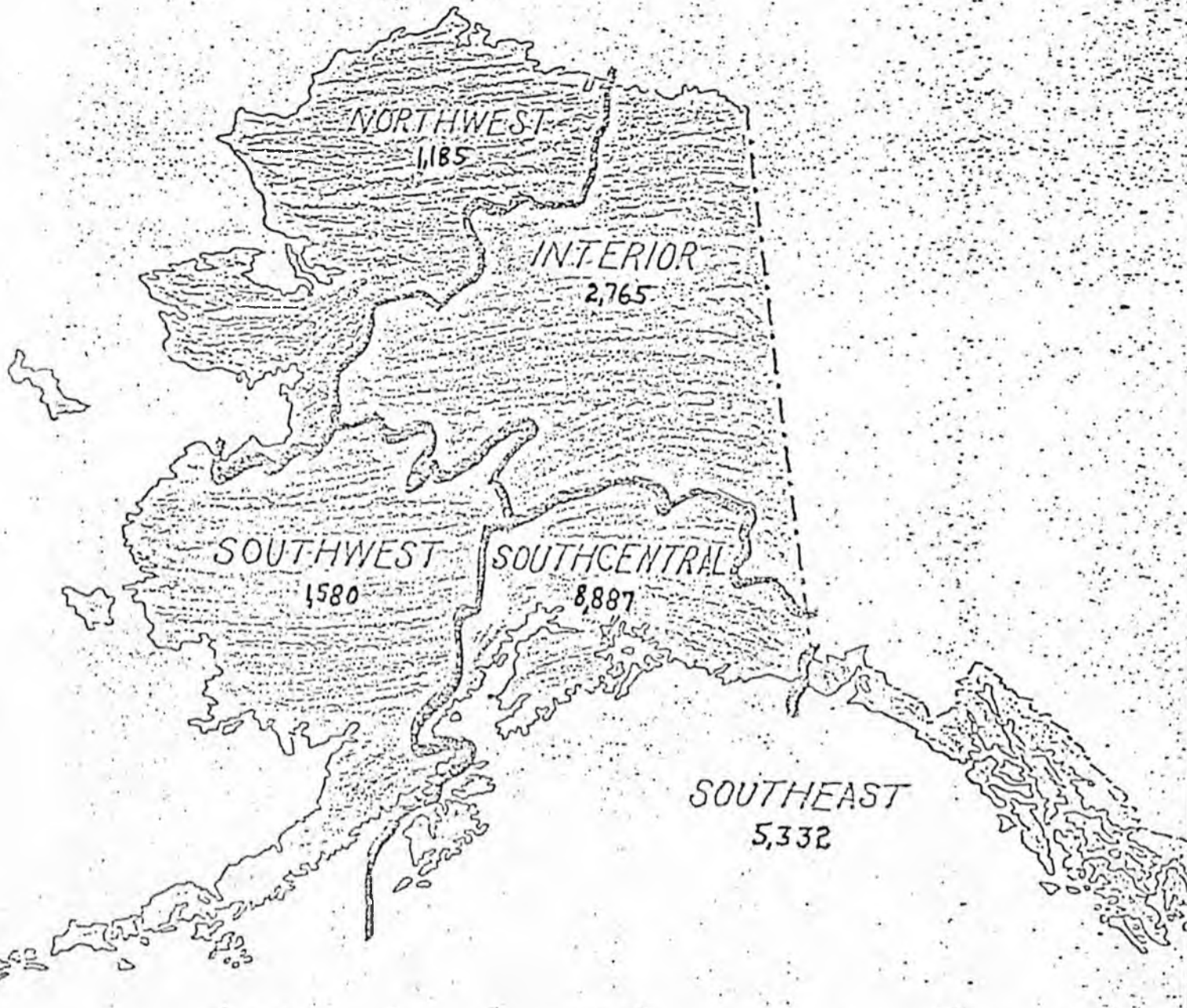
Regions	60+	65+	75+
Northwest	1,185	708	217
Interior	2,765	1,297	405
Southwest	1,580	910	290
Southcentral	8,887	4,362	1,293
Southeast	5,332	3,060	995
Total	19,749	10,337	3,200

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 ^{of} 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>