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IG originate in the Host Simulator Computer and the IG outputs video signals to the Image Presentation (display system).

The CT-5 IG system will provide various support and maintenance functions when not in training use. These functions include system calibration, system test, daily readiness tests and diagnosis, data base loading, and utility tasks associated with the management of software.

The IG system should be capable of providing visual scenes appropriate to the requirements of those training objectives which require the pilot to make decisions dependent on the recognition and interpretation of visual cues. The system can simulate the view as would be seen by the pilot in either daylight, dusk, or night under variable weather conditions. Various terrain features including hills, valleys, trees, buildings, and other objects can be provided.

The IG consists of all hardware and software necessary to generate a visual scene which is presented by the Image Presentation System to the pilot in the cab.

The IG includes, but is not restricted to, the following items:

a. General Purpose Computational System
b. Special Purpose Computer
c. Image Processing Hardware
d. Data Base Storage/Retrieval System
e. Maintenance and Control Station
f. Diagnostics
g. System Software

Data bases for the IG are designed on a separate, standalone Data Base Development Facility and then transmitted to the IG at 50K baud minimum.

The visual system has provisions for providing various weather and special effects, which enhance operational effectiveness under a variety of conditions. These effects can be provided as outlined in the following sections.

Scene Illumination

Three basic levels of scene illumination can be provided under control of the host:

a) Day
b) Dusk
c) Night

The setting of the ambient scene illumination affects the apparent brightness of polygons in the scene. The various levels are programmable during IG system initialization.

Horizon Glow

In dusk or night conditions, a horizon glow band is simulated as a general tapering of horizon brightness into the overhead sky color/brightness. This feature is effective in silhouetting three-dimentional terrain and cultural features against the horizon under good visibility conditions.

Ground Fog and Haze

The ambient visibility parameter is controllable from zero to 20 nautical miles. Ground fog can be specified to provide for a gradual transition in effective visibility between ambient visibility and the (RVR) visibility inside the ground fog. The effective visibility at a given time is based on the eye height relative to a simulated ground fog layer top. The effective visibility changes with eye height to simulate the composite effect of attenuation due to portions of the view rays that pass through the ambient visibility layer above the ground fog layer and the portions within the layer. When the eyepoint is inside the fog layer, the RVR visibility will be applied to all scene elements.

Patchy Fog

Generally, under conditions of low visibility the IG is capable of simulating patchy ground fog by pseudo-randomly varying

the visibility thus producing an effect similar to flying through pockets of dense fog.

Clouds

The capability of simulating overcast conditions, transitions into clouds including pseudo-random scud, reduced or zero visibility inside clouds, and display of a cloud model extending to the horizon as the eyepoint moves above the cloud tops can be provided.

Crash Detection

The visual system allows determination of aircraft collision with selected objects in the simulated environment. General collision detection is accomplished by determining if selected points associated with own ship lie inside various modeled collision volumes. The points typically would include important hull or flying surfaces and the collision volumes could include above-surface obstructions near landing area such as trees, buildings, parked vehicles or aircraft. Collisions will be detected and reported to the host within 0.5 seconds of occurrence, and the host may then initiate crash-indicative responses in the visual scene.

SECTION H

This section presents a proposal for the specification of curriculum and instructional content for an Alaskan aviation training system. Initial findings and preliminary results are discussed in reference to the ongoing development of the training program. The activities for the proposed follow-on contract are described and the deliverables specified.

General Findings

The information collected from the interviews showed that although some training requirements and the training objectives to meet those requirements were applicable to Alaskan aviation in general, the majority were specific to different geographical areas in the state and also to different types and configurations of aircraft (single engine ski, helicopter, multi-engine, float, etc.) It was also recognized that the primary emphasis of an Alaskan training system should be the development of decision-making skills on the part of the pilot rather than manipulative flying skills. For example, the training emphasis should be on when to make a 180° turn to escape adverse weather or leave a mountain pass, and include specific operational procedures to be performed on the basis of such a decision.

Preliminary Indicated Results

The study identified several factors that had to be considered in the design of an Alaskan aviation training system:

1. The primary objective of the training system should be acceptable and applicable to airmen conducting flight operations in a uniquely stressful environment due to weather, geographic, and other operational conditions.

2. The training system should be tailored to specific geographical areas of the State and to different types and configurations of aircraft.

3. Components of the training system should be accessible to pilots in the community in which they are located. This would avoid, as much as possible, pilots spending time away from their primary job to attend training in a distant geographic location.

4. The requirement for training system components for localized on-job-site training could be met by using transportable training devices and interactive audio-visual and print media. These programs should contain instructional components tailored to geographic areas and aircraft types. Instructional programs would be designed to teach specific decision-making skills and the operational procedures to be performed on the basis of such decisions. Evaluation of student performance must be made by qualified, certified airmen with extensive experience in the given geographical area using structured evaluation methods.

5. The training system should be capable of allowing the airmen to first learn the necessary discriminations and decision-making capabilities, and then apply these skills in an operational environment.
   Non-transportable training devices could be required for operational training.

6. Area training centers should be established for specific geographic regions. These training centers could be co-located with existing Community College facilities. The training system would thus permit the learning of needed decision-making skills and operational procedures through transportable media, and evaluation of student performance by designated airmen for localized job-site training. Support and administration for this training would be provided by the area training center.

7. Area training centers would be used to provide additional training, practice, and evaluation through training devices located at the regional facility. Evaluation of student performance at the area training centers would

again be made by qualified, certified airmen with extensive experience in the given geographical region using structured evaluation methods.

8. A centralized administrative facility would be required for the administration, standardization, and evaluation of area training centers and job-site training activities. This facility would probably be located in Anchorage.

PROPOSED FOLLOW-ON CONTRACT

AATC proposes to begin work on a continuation contract depending on fund availability. AATC will conduct an in-depth analysis of the Alaskan aviation training objectives, and will develop curriculum and instructional content specifications. This effort will be based upon the data obtained from the initial study discussed above. Two specific activities are proposed: analysis of training objectives and development of curriculum and instructional content specifications.

Analysis of Alaskan Aviation Training Objectives

The study for the Alaskan Aviation Safety Foundation resulted in the identification of training requirements for various geographical areas, different types of aircraft, and diverse types of operational conditions. In addition, training requirements were defined that are applicable to all Alaskan aircraft operations. These training requirements were synthesized into training objectives that included operational conditions and standards of performance.

In order to define an Alaskan aviation training system, each training objective must be translated into effective instructional components that will enable a student to meet the operational task performance standards specified in the training objective. AATC will conduct an in-depth analysis of each operational task specified in the training objectives.

Each operational task must be analyzed in terms of the specific behavior that must be learned. AATC will define the following components for operational tasks:

1. The task-related knowledge that must be learned. This knowledge includes the operational procedures, rules and concepts that must be learned.

2. The operational cues that must be perceived.

3 The decisions that must be derived from cue perception and based upon appropriate applications of learned knowledge, procedures, rules, and concepts.

4. The action that is required based upon a specific decision. These instructional components will be defined for the different operational conditions under which a task could be performed, such as different aircraft types and configurations.

Development of Curriculum and Instructional Content Specifications

An important step in the formulation of a training system is the sequencing of instructional components into instructional segments. These segments must be sequenced into curricula that are learning and cost-effective for each type of student population. AATC will accomplish the following activities:

1. Define training tracks based on geographical area and aircraft type and configuration.

2. Sequence instructional components into instructional segments.

3. Specify performance assessment methodology for instructional segments.

4. Specify specific learning activities for instructional segments.

5. Specify instructional strategies for instructional segments.

6. Generate instructional segment content specifications.

7. Sequence instructional segments into curricula for each training track.

The output of these steps will be instructional content specifications for each instructional segment, and the sequencing of instructional segments into curricula for each training track.

DELIVERABLES

The following items will be deliverable as a portion of the proposed contract as defined above.

Preliminary Specifications

AATC will deliver a description of the Alaskan Aviation Training System curriculum. AATC will provide the following document:

Curricula and Instructional Content Specifications

Curricula will be developed for each training track. The instructional segments will be specified and sequenced for each curriculum. An instructional content specification will be provided for each instruction segment.

Sample Training System Components

AATC will deliver a completely portable and self-contained component of the Alaskan aviation training system. This component will consist of the following items:

1. An audiovisual (sound/slide) program that is applicable to all Alaskan aircraft operators. A typical program would be:

   Subject: Navigation-Pilotage and Dead Reckoning Techniques

   Content:

   a. Approximately 160 slides with audio narration. The program will contain an instructional component of approximately 120 slides and an interactive evaluation component of approximately 40 slides.

   b. Carousels and binders for the program.

   c. Student programmed text materials for the program. These materials will include evaluation components.

   d. Instructor test evaluation guide for the program.

   e. Presentation device for audiovisual programs. This device will be a programmed learning device, using rear-screen projection with self-contained audio components. A student response feature will be included to permit correct/incorrect answer feedback to questions inserted anywhere in the program.

These deliverables will provide the basis upon which an Alaskan aviation training system can be produced.

Development Of Specified System Components and Operational Metholodogy

The development of specifications for training system components and operational methodology can be initiated at any-time after the initial specification determination activity is essentially complete. As a practical matter, however, the availability of funds probably will be the pacing factor.

Guidance of the Alaskan Aviation Safety Foundation and the Alaskan Air Carriers Association will be sought throughout the intervening time period as well as during the actual implementation. AATC will be pleased to discuss these concepts and to attempt to clarify any uncertainties at the convenience of the customer.

APPENDIX A

Company Names and Pilots Interviewed

COMPANY NAMES AND PILOTS INTERVIEWED

Aero Tech Flight Service
    Richard Ardaiz

Air Logistics of Alaska
    Les Bays

Air North
    Tom Olson

Airpac, Inc.
    Robert Horschel

Akland Helicopters, Inc.
    Dennis Brown

Alaska Aeronautical Industries
    Bruce Walker

Alaska Air Guide
    Gary Limage
    Don Cogger

Alaska Air Service
    Frank Bauder

Alaska Bush Carriers
    David Klosterman

Alaska Central Air
    Pete Haggland

Alaska Fisherman
    Douglas Askerman

Alaska Floatplane Service
    Lynwood Marshall

Alaska Helicopters
    Bill Woolen

Alaska International Airlines
    Ralph Brumbaugh

Alaska Island Air, Inc.
    Lloyd Roundtree

Alaska North Flying Service
    Bill Aregood

Alaska Travel Air
    Dean Carrell

Alyeska Air Service
    Ken Triplett

Anchorage Air Service
    George Kitchen

Anchorage Airways
    Walt Remele
    Ron Bernard

Arctic Aviation
    John Stohner

Arctic Circle Air Service
    Doug Bulter

Armstrong Air Service
    Neil Armstrong

Audi Air
    Walt Audi
    Liz Pintchuck

Aurora Air Service
    Dennis Parrish

Avent Co.
    Tom Laughead

Baker Aviation
    Ed Kornfield
    Joe Jackson

Bellair, Inc.
    Ken Bellows

Beluga Lake Floatplane
    Jon M. Berryman

Bering Air Service
    Ken Zachery

Big Red's Flying Service
    W. K. Bohman

Bishop Brothers
    Jim Bishop

Bran Air
    Dennis Branham
    E. G. Branham
    Chris Branham

COMPANY NAME AND PILOTS INTERVIEWED

Bush Air
Fred Lane

Cape Smythe
Bud Graham

Central Airways
Dave Goocey

Channel Flying, Inc.
Ken Loken

Chisum Flying Service
David Clark Dechant

Chitna Air Service
David Erbey

Coastal Aviation
Larry Erick

Cook Inlet Aviation, Inc.
Robert Vasey

Delaire
Dennis Gander

Delta Aviation
Charlie Adams
Don Cramer

Dept. of Public Safety-Pilots
Roy Trembley
L. Samsall

Dept. of Transportation and Public Facilities
Jim Moody

Eagle Enterprises
Hugh Hartley

ERA Helicopters, Inc.
Jim Vandervoode
Dave Baumeister

Evergreen Helicopters of Alaska
Ken Conky
Steve Howard

Executive Charter Service
Tom Ratledge
Louis Green

Flight Training Devices
Terry Lagone

Flirite, Inc.
Ralph Wright

Forty Mile Air Service
Art Werbelow

Foster Aviation
Richard Foster

Frontier Flying Service
Tom Ruppert
John Hajdukovich

Galena Air Service
Norman Yaeger

Gifford Aviation
Chris Holmlund

Gordon's
George Jones

Gregerson Leasing, Inc.
Dwight Gregerson

Griechen Air Taxi, Inc.
Monte Handy

Gulf Air Taxi
Pete Peterson

Hal's Air Service, Inc.
Harold W. Dierich, Jr.

Harbor Air Service, Inc.
Keith Knighton

Harold's Air Service
Norman Sommer
Don Wainwright

Hermans Air Service
Stan Hermans

Homer Air, Inc.
Larry Thompson

Homestead Air Service
Bob Tears

COMPANY NAME AND PILOTS INTERVIEWED

Hudson Air Service
    Cliff Hudson

Iliaska Lodge
    Ted Gerken

International Air Transport
    Warren Lowry

Island Air Service
    Robert Stanford

Kachemak Air Service, c.
    Bill DeCreeft

Katmai Air Service
    Ray Peterson, Jr.

Kenai Air Alaska
    Tim Miller

Kenai Aviation
    Robert Bielefeld

Kennedy Air Service
    Gayle Ranney
    Gene Eddy

Ketchikan Air Service
    Mike Salazar

Ketchum Air Srvice
    Ketch Ketchum

King Flying Service
    Ed King

Kodiak Air Taxi
    Herbert L. Downing

Kodiak Western Alaska Airlines, Inc.
    Frank Humphreys

Kotzebue Tech Center
    Russ Lloyd

K2 Aviation
    Jim Okonek

L.A.B. Flying Service
    Layton A. Bennett

Lee Air Taxi
    Ellie Lee

Lee's Sea Air
    Lee Staheli

Livingston Copters
    Bill Zeman

Missionary Aviation & Repair Center
    Fred Chambers

Maritime Helicopters
    Don Fell

Mountain Aviation
    Steve Hamilton

Munz Northern Airlines
    Dick Galleher
    Durrell McAbee
    Rich Raburn

Northern Air Cargo
    Bob Long

Parker Associates
    Walt Parker

Peninsula Airways
    George Tibbetts, Sr.
    George Tibbetts, Jr.

Rainbow King Lodge

Reeve Aleutian Airways
    Gary Lintner

Revilla Flying Services
    Dale David Clark

Rocky Mountain Helicopters
    Gene Franks

Rust's Flying Service
    Hank Rust

Ryan Air Service
    Boyuk Ryan

COMPANY NAME AND PILOTS INTERVIEWED

Sand Point Air Service, Inc.
George Kimball

Sea Airmotive (Anchorage)
Ted Lamb

Sea Airmotive (Bethel)
Wayne Peterson

Seaplane Pilots Association
John Pratt, Jr.

Shell Lake Enterprises
Norman Helwig

Shellenbarger Aviation
David Furber

Silvertip Lodges
Gary Archer

Skagaway Air Service
Scott Logan

South Central Air, Inc.
Bruce Clements

Southeast Alaska Airlines
Paul Breed

Southeast Skyways
David Wunsch

Southwest Airways

Sunshine Copters
Bill Merkley

Talarik Lake Lodge
Kevin Vrem
Floyd Polmateer

Talkeetna Air Taxi
Lowell Thomas, Jr.
Doug Geeting

Tanana Valley Community College
Bill Nelmes

Taquan Air Service, Inc.
Jerry Scudero

Teller Air service
Jim Johnson
Bob Blodgett

Temsco Helicopters, Inc.
Ken Eichner
Earl Walker

The Flying Machine
Brad Reed

Tikchik Lodge
Robert "Bob" Curtis

Trail Lake Flying Service
Ludwig Pfleger

Trans-Alaska Helicopters
Don Wood

Troy Air
Mark Jacobsen

Tundra Copters
Craig Fielding

Tyee Airlines, Inc.
Herman Ludwigsen

Valdez Airlines
Ron Watson

Ward Air
Larry McGee

Western Yukon Air
Edward Hoelscher

Wilbur's Flight Operations
Joe Wilbur

Wood's Air Service
Warren "Buddy" Woods

Wrangell Air Service
Don Baldwin

Wright's Air Service
Al Wright

Yute Air Alaska
Tom Tucker

INDIVIDUAL PILOTS

Tom Belleau (OAS)

Herbert Downing

Lew Earhardt

Jonathan Fritz

James Gallagher

Timothy Laporte

Leonard Mach

Charles Muhs (FSS Chief, Anch.)

Bill Overway (FAA)

Ray Peterson, Sr.

Don Rogers M.D. (FAA-AME)

Richard Roles

Lloyd Samsall

R. Tony Schultz

John Swiss

Warren Thompson (FSS-Kotzebue)

Tom Wardleigh (FAA)

Dave Werner

Richard Wien

Alden Williams

APPENDIX B

Persons Attending Meetings with Lloyd's of London Underwriters

A.A.S.F. MEETING 19TH APRIL 1982

A.A.S.F.

GAYLE ANDERSON	BOARD MEMBER, AACA
REX BISHOPP	PRESIDENT AASF
RUTH BISHOPP	ALASKA HELICOPTERS, INC
JIM DODSON	SEC/TREAS AASF
CHARLES EICHHORN	PROJECT INVEST. AATC
DR. M.K. MITCHELL	PROJECT DIRECTOR AATC

UNDERWRITERS

M.E. CHARLESWORTH	M.E. CHARLESWORTH	UNDERWRITER
D.L. CHRISTIE	SCOTTISH LION INS CO	UNDERWRITER
B. COLEMAN	COLEMAN & ORS	UNDERWRITER
E. DI SILVIO	M.E. CHARLESWORTH	ASSISTANT U/W
R.A. FLEW	DOMINION	ASSISTANT U/W
A.G. HINES	A.G. HINES	UNDERWRITER
P.J. HUBERT	N.R.F.	UNDERWRITER
P.W. MARIOTT	NORWICH UNION	ASSISTANT U/W
T. MITCHELL	A.I.V.	UNDERWRITER
R.E. MORRIS	D.L. DANN SYND	UNDERWRITER
R.J. MORSE	D. WILLIS SYND	ASSISTANT U/W
A. PAGRAM	ATMOS SYND 581	UNDERWRITER
A.E. PORTER	GUARDIAN ROYAL EXCHANGE	DEPUTY UNDERWRITER
M.B. QUIN-HARKIN	M.E. CHARLESWORTH	DEPUTY UNDERWRITER
J. SARGEANT	M.V. SPRATT & ORS	UNDERWRITER
J. TUFF	SPHERE DRAKE	UNDERWRITER
D. VALE	J.A. WHITE & ORS	DEPUTY UNDERWRITER
B.J. WILKES	GENERALI	UNDERWRITER
P. WISEMAN	SYND 802	UNDERWRITER

L.A.U.A.

B. DALBY

BROKERS

M. AUSTIN	ROBT. BRADFORD
J. BRAITHWAITE	C.T. BOWRING
P. BUTLER	STEWART WRIGHTSON
G. DERRICK	CAYZER STEEL BOWATER
R. FLACK	C.T. BOWRING
C.J. SELLENS	H.R.Q.
M. WARD	REED STENHOUSE
D. BARDER	LYON DE FALBE

A.A.S.F. MEETING 20TH APRIL 1982

A.A.S.F.

GAYLE ANDERSON	BOARD MEMBER, AACA
REX BISHOPP	PRESIDENT AASF
RUTH BISHOPP	ALASKA HELICOPTERS, INC
JIM DODSON	SEC/TREAS AASF
CHARLES EICHHORN	PROJECT INVEST. AATC
BILL FISHER	BOARD MEMBER AACA
DR. M.K. MITCHELL	PROJECT DIRECTOR AATC

UNDERWRITERS

M.E. CHARLESWORTH	M.E. CHARLESWORTH	UNDERWRITER
A.R. CROW	ENGLISH & AMERICAN	DEPUTY UNDERWRITER
D. DARK	A.G. HINES SYND 577	DEPUTY UNDERWRITER
K. DOHERTY	E.R.H. HILL & ORS	DEPUTY UNDERWRITER
P. GUINERY	J.M. POLAND	UNDERWRITER
A. HERMITAGE	K.F. ALDER	DEPUTY UNDERWRITER
T. JARVIS	BRIT. RESERVE INS	UNDERWRITER
C.R. JEFFS	AVIATION & GENERAL	UNDERWRITER
P. LYON	AVIATION & GENERAL	UNDERWRITER
G. MILLER	M.G. MILLER & ORS	UNDERWRITER
R.A. PAGRAM	ATMOS SYND 581	UNDERWRITER
M.B. QUIN-HARKIN	M.E. CHARLESWORTH	DEPUTY UNDERWRITER
H.J. ROSE	M.J. LANGTON & ORS	DEPUTY UNDERWRITER
R.F. STONE	M.E. CHARLESWORTH	
M. SUGDEN	P.W. HARDY	UNDERWRITER
E.O. WALKLIN	HUGHESDON & ORS	UNDERWRITER
D. WALLACE	SPHERE DRAKE	DEPUTY UNDERWRITER
J. WESCOTT	AVIATION & GENERAL	DEPUTY UNDERWRITER
P. WISEMAN	SYND 802	UNDERWRITER

L.A.U.A.

K. NELSON

BROKERS

J. BERTWHISTLE	BAIN DAWES
A. FULTON	A. GIBBS SAGE
I. LEWIS	T.R. MILLER
R. MARSH	C.E. HEATH
S. RENNIE	WILLIS FABER
G. TAYLOR	WIGHAM POLAND
M. WARD	REED STENHOUSE
T. WARD	J. PLUMMER

APPENDIX C

Milestones and Timelines for Alaskan Aviation Training Analysis

MILESTONES AND TIMELINES FOR ALASKA TRAINING ANALYSIS	CALENDAR DAYS										PHASE ONE								PAGE ONE					
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
CONDUCT MEETING OF AACA SAFETY FOUNDATION BOARD		▲																						
REVIEW LIST OF ALASKAN AIR TAXI OPERATORS	△		▲																					
IDENTIFY CRITICAL AREAS AND REGIONS TO BE STUDIED			△	▲																				
PREPARE MEDIA RELEASES DESCRIBING STUDY		△		▲																				
SCHEDULE INTERVIEWS FOR FIRST TWO WEEKS			△		▲																			
TRAIN CLERICAL STAFF			△	▲																				
TRAIN STAFF IN INTERVIEW PROCEDURES				△	▲																			
PREPARE INTERVIEW QUESTIONNAIRE				△			▲																	
PREPARE CRITIQUE OF INTERVIEW FORM				△			▲																	
CONDUCT FIRST CYCLE OF INTERVIEWS IN ANCHORAGE								△	1 INTERVIEW/DAY (14/INTERVIEWER)												▲			
CONDUCT SYNTHESIS MEETINGS FROM FIRST CYCLE INTERVIEWS									△														▲	

MILESTONES AND TIMELINES

FOR ALASKA TRAINING ANALYSIS

DAYS — PHASE ONE — PAGE TWO

	25	26	27	28	29	30 P.D.	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48
CONFER WITH ENGINEERING AND PROGRAM DEVELOPMENT IN FORT WORTH AND COMP TIME AT HOME	△ TRAVEL	—	—	—	—	—	—	—	▲ TRAVEL															
PLANNING MEETINGS FOR SECOND CYCLE INTERVIEWS										▲														
ARRANGE INTRASTATE TRANSPORTATION										▲														
CONDUCT SECOND CYCLE INTERVIEWS ANCHORAGE, FAIRBANKS, JUNEAU											△	1 INTERVIEW/DAY	—	—	—	21 INTERVIEWER	—	—	—	—	—	—	—	→
TYPE DATA FROM FIRST CYCLE	△	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	▲
SECOND CYCLE SYNTHESIS MEETING IN ANCHORAGE																▲						▲		
WRITE TRAINING OBJECTIVES																△	—	—	—	—	—	—	—	→
REVIEW RESULTS OF 1ST INTERVIEWS WITH BOARD AASE.										▲														
												F	F	F	F	F	F	F	F	F	F	F	F	F

F= DAYS INTRASTATE AIR TRAVEL MAY BE REQUIRED

P.D.= PAYMENT DUE

MILESTONES AND TIMELINES FOR ALASKA TRAINING ANALYSIS	CALENDAR DAYS											PHASE ONE								PAGE THREE				
												P.D.												
	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72
CONDUCT SECOND CYCLE OF INTERVIEWS ANCHORAGE, FAIRBANKS, JUNEAU (CONT)	—	—	—	—	—	—	—	▲																
CONDUCT SYNTHESIS MEETINGS				▲					▲															
MEET WITH ENGINEERING AND PROGRAM DEVELOPMENT PERSONNEL IN FORT WORTH										△ TRAVEL	—	—	—	—	—	—	—	△ TRAVEL						
MEET TO PREPARE FOR THIRD CYCLE OF INTERVIEWS																			▲					
MAKE INTRASTATE TRAVEL ARRANGEMENTS				△	—	—	—	—	▲											▲				
CONDUCT THIRD CYCLE OF INTERVIEWS -REMAINDER OF ALASKA BUSH-																					△	I	T	I →
MEET WITH AACA SAFETY FOUNDATION BOARD OF DIRECTORS																			▲					
WRITE TRAINING OBJECTIVES (CONT)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	→
IDENTIFY SKILLS AND KNOWLEDGES FOR T.O.																				△	—	—	—	→
DESCRIBE COND. AND STD. FOR EACH T.O.																					△	—	—	→
	F	F	F	F	F	F	F	F													F	F	F	F

F = DAYS INTRASTATE AIR TRAVEL MAY BE REQUIRED
P.D. = PAYMENT DUE

MILESTONES AND TIMELINES

FOR ALASKA TRAINING ANALYSIS

CALENDAR DAYS — PHASE ONE — PAGE FOUR

P.D. ↓ (at day 90)

Activity	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96
CONDUCT THIRD CYCLE OF INTERVIEWS -REMAINDER OF ALASKAN BUSH - (CONT)	T	I	T		T	I	T	I	T	I	T		T	I	T	I	T	I	T		T	I	T	I ▶
SYNTHESIS MEETINGS				▲								▲								▲				
MEET WITH AACA SAFETY FOUNDATION BOARD OF DIRECTORS				▲																▲				
WRITE TRAINING OBJECTIVES (CONT)	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─▶
WRITE SKILLS AND KNOWLEDGES FOR EACH TRAINING OBJECTIVE (CONT)	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─▶
WRITE CONDITIONS AND STANDARDS FOR EACH TRAINING OBJECTIVE (CONT)	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─	─▶
MEET WITH INSURANCE UNDERWRITERS				△	─	─	─	▲																
	F	F	F		F	F	F	F	F	F	F		F	F	F	F	F	F	F		F	F	F	F

F = DAYS INTRASTATE AIR TRAVEL MAY BE REQUIRED

P.D. = PAYMENT DUE

TIMELINES AND MILESTONES FOR
ALASKA TRAINING ANALYSIS

CALENDAR DAYS — PHASE ONE — PAGE FIVE

	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120 P.D.
CONDUCT THIRD CYCLE OF INTERVIEWS (CONT)	T	I	T		T	I	T	I	T	I	T		T	I	T	I	T	I	T		T	I	T	→
SYNTHESIS MEETINGS				▲								▲								▲				
MEET WITH AACA BOARD OF DIRECTORS AND SAFETY FOUNDATION												▲												
WRITE TRAINING OBJECTIVES (CONT)																								→
WRITE SKILLS AND KNOWLEDGES FOR EACH TRAINING OBJECTIVE (CONT)																								→
WRITE CONDITIONS AND STANDARDS FOR EACH TRAINING OBJECTIVE (CONT)																								→
	F	F	F		F	F	F	F	F	F	F		F	F	F	F	F	F	F		F	F	F	F

F = DAYS INTRASTATE AIR TRAVEL MAY BE REQUIRED
P.D. = PAYMENT DUE

MILESTONES AND TIMELINES FOR ALASKA TRAINING ANALYSIS	CALENDAR DAYS											PHASE ONE								PAGE SIX				
	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144
CONDUCT THIRD CYCLE INTERVIEWS - REMAINDER OF ALASKAN BUSH (CONT)	T	I	T		T	I	T	I	T	I	T		T	I	T	I	T	I	T		T	I	T	I →
SYNTHESIS MEETING				▲								▲								▲				
MEET WITH AACA SAFETY FOUNDATION BOARD OF DIRECTORS												▲												
WRITE TRAINING OBJECTIVES (CONT)																								→
WRITE SKILLS AND KNOWLEDGES FOR EACH TRAINING OBJECTIVE (CONT)																								→
WRITE CONDITIONS AND STANDARDS FOR EACH TRAINING OBJECTIVE (CONT)																								→
MEET WITH INSURANCE UNDERWRITERS														△					▲					
	F	F	F		F	F	F	F	F	F	F		F	F	F	F	F	F	F		F	F	F	F

F = DAYS INTRASTATE TRAVEL MAY BE REQUIRED

MILESTONES AND TIMELINES FOR ALASKA TRAINING ANALYSIS

CALENDAR DAYS — PHASE ONE — PAGE SEVEN

P.D. = day 150

	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168
CONDUCT THIRD CYCLE INTERVIEWS - REMAINDER OF ALASKAN BUSH (CONT)	T	I	T		T	I	T	I	T	I	T		T	I	T	I	T	I	T	▲				
SYNTHESIS MEETINGS				▲								▲								△				▲
MEET WITH AACA SAFETY FOUNDATION BOARD OF DIRECTORS												▲												
WRITE TRAINING OBJECTIVES (CONT)																								→
WRITE SKILLS AND KNOWLEDGES FOR EACH TRAINING OBJECTIVE (CONT)																								→
WRITE CONDITIONS AND STANDARDS FOR EACH TRAINING OBJECTIVE (CONT)																								→
	F	F	F		F	F	F	F	F	F	F		F	F	F	F	F	F	F					

F = DAYS INTRASTATE TRAVEL MAY BE REQUIRED

P.D. = PAYMENT DUE

MILESTONES AND TIMELINES FOR ALASKA TRAINING ANALYSIS

PHASE ONE

CALENDAR DAYS — P.D. — PAGE EIGHT

	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192
MEET WITH AACA SAFETY FOUNDATION BOARD OF DIRECTORS	▲																							
MEET WITH ENGINEERING AND PROGRAM DEVELOPMENT IN FT. WORTH AND COMP TIME		△ Travel																		▲ Travel				
PREPARE SPECIFICATIONS FOR TRAINING DEVICES (ENGINEERING)								△																→
WRITE TRAINING OBJECTIVES (CONT)							▲																	
WRITE SKILLS AND KNOWLEDGES FOR EACH TRAINING OBJECTIVE (CONT)							▲																	
WRITE CONDITIONS AND STANDARDS FOR EACH TRAINING OBJECTIVE (CONT)													▲											
MEET WITH INSURANCE UNDERWRITERS																					△			▲
PREPARE FINAL REPORT														△										→

MILESTONES AND TIMELINES FOR

ALASKA TRAINING ANALYSIS

CALENDAR DAYS — PHASE ONE — PAGE NINE

P.D. ↓ (day 210)

Task	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216
PREPARE SPECIFICATIONS FOR TRAINING DEVICES (ENGINEERING) (CONT)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	▲						
MEET WITH ENGINEERING AND PROGRAM DEVELOPMENT AS REQUIRED (CONT)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	▲						
PREPARE FINAL REPORT	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	→						
REVIEW DRAFT OF FINAL REPORT WITH AASE BOARD OF DIRECTORS				▲																				

FINAL REPORT TO BE DELIVERED 60 DAYS AFTER CONCLUSION OF STUDY.

SB

118

Pete Froehlich - Asst A.G.

Gov's bill (not introduced yet) changed many times. Almost final.

No request on Sackett bill for opinion but prob would be unconstitutional because residents may go to h.s. somewhere else.

Ginger

Alaska State Legislature

Senate

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

Ms. Jana Klein
Dimond High School
2115 Crataegus Avenue
Anchorage, Alaska 99508

Dear Ms. Klein:

I thank you for your letter of January 20.

Your concerns about the student loan program are well-founded. The Senate Committee on Health, Education and Social Services, of which I am the chairman, is conducting hearings on February 5, at the University of Alaska, to consider this issue and hear from some of the people most directly affected.

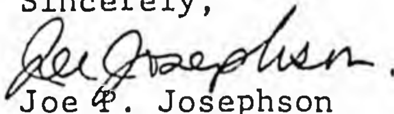
In my own family, as a matter of fact, are two students who participate in the program. Thus, I am well aware of its important benefits.

Governor Sheffield is proposing to modify the program, to set criteria or priorities that would limit its growth. The legislature will consider those proposals, as well as the public's input.

I discern that the program as it is presently constituted is very popular and has broad legislative support. Of course, the question is the anticipated budgetary impact in the years to come, in an era of expected decline in state revenues. With those constraints in mind, I shall do what I can on behalf of the student loan program, as a member of the Finance Committee and as chairman of the Health, Education and Social Services -- and as one of 60 members of the legislature.

With best wishes,

Sincerely,



Joe P. Josephson

2115 Crataegus Avenue
Anchorage, Alaska 99508

January 20, 1983

Senator Joe Josephson, Chairman
Health, Education and Social Services
Alaska State Senate
Juneau, Alaska

Dear Senator Josephson:

It is extremely disturbing to read that the Alaska Student Loan Program is out of funds for this school year and that many students will be denied their requests for financial assistance. Obviously, the program is a success, or the demand would not be as great as it is.

With the high (and rising) cost of college, there are very few students who do not need financial assistance, and the Alaska State Loan Program has proven to be a needed and welcome help to many thousands of young Alaskans.

One of the best features of the program is the provision for forgiving a portion of the loan if the student returns to Alaska for five years after completing his/her degree. Alaska needs well-educated and trained people to help deal with the State's future, and this is a good incentive for students to return to their state.

I sincerely hope there will be more adequate funding for this program next year so that many deserving students do not have to be denied their requests for financial assistance from their own state.

Sincerely,

Jana Klein
Dimond High School

RECEIVED
JAN 27 1983
Josephson.

STATE OF ALASKA
FISCAL NOTE

Revision Date , 1983

I. REQUEST
Bill/Resolution No.: SB 118
Title: An Act Re: Scholarship Loans
Sponsor: Senator Sackett
Requestor: Senate HESS

II. FISCAL DETAIL
Agency Affected: Education
Program Category Affected: Postsecondary Comm.
BRU, Program of Subprogram(s) Affected:
Student Loan Prorram

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC						
TOTAL OPERATING						
CAPITAL	N.A.	10,094.0	5,717.6	8,631.1	1,492.7	(19,873.0)
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
GENERAL FUND	N.A.	10,094.0	5,717.6	8,631.1	1,492.7	(19,873.0)
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Kerry D. Romesburg
Phone: 465-2854
Division: Commission on Postsecondary Education
Date: 3/24/83

Approved by Commissioner:
Date:
Department:

Distribution:
Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
Copy to Department (for Governor introduced bills)
Copy to Sponsor
Copy to Requestor (if different from Sponsor)

3/8/83

IV. Analysis

a. Percentage attending in-state and out-of-state

Year	In-State	Out-of-State
FY84	51.0	49.0
FY85	52.0	48.0
FY86	54.0	46.0
FY87	55.0	45.0
FY88	55.0	45.0
FY89	55.0	45.0

b. Average loan amounts

Year	In-State	Out-of-State
FY84	$4,500	$7,000
FY85	4,900	7,600
FY86	5,350	7,900
FY87	5,800	7,[illegible]50
FY88	6,350	7,[illegible]50
FY89	6,900	7,950

c. Total cost

Year	Number	Average	Volume
FY84	15,000	$5,725	$ 85,875,000
FY85	17,741	6,196	109,923,250
FY86	19,000	6,523	123,937,000
FY87	21,100	6,768	142,794,250
FY88	22,489	7,070	158,997,250
FY89	24,365	7,372	179,630,950

SB
122

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OLDER ALASKANS COMMISSION

POUCH C, M.S. 0209
JUNEAU, ALASKA 99811
PHONE: (907) 465-3250

March 10, 1983

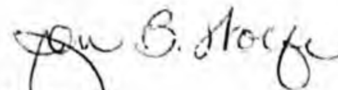
Senator Joe Josephson
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

During your recent hearing for SB 122 (Elder Abuse) testimony was given by Beth Bishop on the role of services in eliminating the root causes of elder abuse. The strain on families caring for an older member is frequently linked to abuse. Therefore, services which provide relief or assistance to families are seen as desirable. Respite care programs can be critical to this. Because you expressed interest in respite care I have taken the liberty of sending you the enclosed article.

Alaska and the other states in federal Region X are also working on a conference to be put on by the Northwest Long Term Care Gerontology Center (U. of W.) regarding respite care. If you should desire other information do not hesitate to contact the Commission.

Sincerely,



Jon B. Wolfe
Executive Director

Enclosure

cc: Eleanor Andrews
Deputy Commissioner
Department of Administration

Rebecca Burch
Special Assistant
Department of Administration

Beth Bishop, Project Director
Southeast Senior Services

RESPITE CARE: AN EMERGING FAMILY SUPPORT SERVICE

By

Judith W. Meltzer

The Center for the Study of Social Policy
236 Massachusetts Avenue, N.E.
Suite 405
Washington, D.C. 20002

June, 1982

This work was supported by the Administration on Aging, U.S. Department of Health and Human Services under a Cooperative Agreement with the National Conference on Social Welfare.

Preface

This paper is one of a series developed by staff of the Center for the Study of Social Policy under a contract with the National Conference of Social Welfare. For the past 18 months, the National Conference has been supported by the Administration on Aging, U.S. Department of Health and Human Services to disseminate information on recent long-term care developments to state and local governments, professional societies, consumer and provider groups and others involved in the development of long-term care programs and services. As part of that effort, the Center for the Study of Social Policy worked closely with several State Departments of Aging, pursuing program issues which they identified as important to them. The paper which follows, on the development of respite care services as an important family support for community-based long-term care, is in response to specific requests for information from State Aging and Human Service agencies. In preparing this paper, the Center gathered materials from many states and is particularly grateful for their cooperation and willingness to share information. It is our hope that this paper and the others in the series will provide informational assistance for the many people in every state and local community who are currently engaged with the difficult issues of planning for, financing, organizing and providing community-based long-term care services for the elderly and disabled.

Introduction

One of the most pressing social planning tasks of the decade revolves around the need to develop coherent systems of long-term care services for the elderly and disabled. The growing numbers of people in every area of the country and at all income levels who need assistance in planning for, finding and paying for needed long-term care services has elevated the issue to a major domestic priority. In searching for solutions, policy analysts have belatedly recognized the importance of the family in the care-giving system and are only now beginning to appreciate and worry about the family caregivers--the stresses placed on them and the kinds of supports and incentives they need. This understanding has been translated into a policy emphasis at the federal and state levels on "preserving informal supports," a phrase that has come to encompass both financial and service strategies which make it easier for spouses and relatives to care for the elderly and the disabled in their own homes. The decision to pursue strategies which enhance and protect informal supports is an appropriate one for several reasons. First, it reflects the strong desires of most elderly and disabled to remain in their own homes or with relatives if at all possible. Second, research evidence suggests that, contrary to mythology about abandoning the elderly, most families want to care for their relatives and make decisions about institutionalizing the elderly and the disabled very reluctantly and only in the absence of any realistic alternatives. Thirdly, from a public policy perspective, it is clear that for most individuals the costs of home care with supportive services are considerably lower than institutional care. Given the large and growing numbers of persons at risk for long-term care assistance and the enormously high costs of institutional alternatives, it is imperative that options which enable and support family caregiving be developed.

The subject of this paper is respite care, a newly-defined service area in the constellation of long term care services which is primarily directed toward the family caregiver as opposed to the person in need of long-term care services . Respite means relief and, in its most general sense, respite care encompasses a wide range of services which offer relief to the spouse or relative who has assumed the responsibilities of caring for a dependent elderly or disabled person. P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981 includes respite care as one of the home and community-based long-term care services which may be provided under a Medicaid waiver. Several states are now in the process of developing respite care services as demonstration projects or as part of state long-term care service systems and many have requested information about what is known and is being done around the country with respect to respite care. The purpose of this paper is to assess the current state of knowledge about respite care and to offer some guidance to state and local governments and community organizations interested in developing respite care services. Part I briefly reviews statistical and research evidence which supports the need for respite care services. Part II reviews the varied definitions and models for both in-home and institutonal respite care which have been developed in several states and localities. Part III provides the results of the few existing evaluations of respite care, and Part IV concludes with recommendations for program development.

Part I - The Need for Respite Care

Respite care has only recently been recognized as a useful and needed supportive service for families caring for dependent elderly and other disabled adults. Since the 1960's, respite care services have primarily been developed and financed as part of efforts to deinstitutionalize developmentally disabled and mentally retarded children. Much of the impetus for respite care grew out of research on the effects on the family of having handicapped children live at home including parental stress, anxiety and isolation and the need to free parents' time and energy to care for non-disabled family members. Respite care services for the developmentally disabled have been sporadically made available through State Mental Retardation agencies and Developmental Disabilities Councils to provide short-term relief to family caregivers both in the family's own home and in licensed institutions and foster homes. The objectives and design of respite care programs for the disabled have varied but in general they have been developed to (1) encourage non-institutional care of disabled children, (2) provide emotional and practical support to family caregivers and (3) provide a basis for organized in-home interventions including habilitation services, family education and counseling.

The potential application of the concept of respite care to the elderly and the adult disabled is an emerging development reflective of a growing interest and understanding of the importance of family caregivers and informal supports.[1] An analysis of data on health and social factors relevant to long-term care policy by Butler and Newacheck shows that most elderly and disabled are institutionalized not because of a change in health status but because of a change in marital status and living arrangements, such as the death of a spouse or the inability of a child to continue to care for them.[2] Somewhere

between 60 and 85 percent of all disabled and impaired persons are helped in signficant ways by families,[3] a fact which is only now beginning to be appreciated by policymakers and planners. It is the elderly with few or limited family relationships who are the most vulnerable for institutionalization when they become ill.[4] Family caregiving is desirable, extensive but also precarious and fragile and too little attention has been paid to the stresses placed on the caregivers and meeting their needs.

The caregivers whom respite care services can help are primarily spouses, (mostly wives with disabled or elderly husbands) and children, (mostly daughters and daughter-in-laws), who care for their elderly parents or in-laws. According to 1979 census data, 75 percent of men aged 65 and over, 78 percent of men aged 65 to 74 and 67 percent of men aged 75 and over live with a spouse. Thirty-seven percent of women aged 65 and over, 47 percent aged 65-74 and 21 percent aged 75 and over live with a spouse. About 10 percent of men over 75 and 27 percent of women over 75 live with relatives other than their spouse. Recent research has focused on the needs of wives who care for elderly disabled men[5] and daughters who care for their parents.[6] Fengler and Goodrich in a study of women who cared for their disabled husbands highlighted their social isolation, loneliness and role overload.[7] Elaine Brody, in a study of three generations of families in Philadelphia, found that the amount of help given increased sharply as the age of the caregivers and their mothers increased.[8] Caregivers between ages 40 and 50 averaged three hours of help weekly; between 50 and 59, 15.6 hours weekly and those over 60 provided 22.7 hours of weekly help to their elderly mothers. Brody has called these caregivers "women in the middle" and described them as middle-aged women who experience the stresses of multiple roles and expectations as workers, spouses, filial caregivers, parents and even grandparents. Brody's research calls attention to the role and value conflicts faced by these women who want

to help their parents but are confronted with competing demands, pressures and desires to engage in out-of-home work. She found that the amount of help provided to relatives did not correlate strongly with the work/non-work status of the caregiver. Brody's research raises the important policy issues of how to prevent the stress of caregiving from becoming too great a responsibility and even a burden, although one which is usually willingly assumed by spouses and other family caregivers. Respite care, if available and accessible to the caregiver, is one of a constellation of family support services that many believe can help to alleviate such stress. The need for respite care services is in many ways an intuitive response to a perceived problem. There have been very few formal evaluations of respite care services for disabled children and almost none for the elderly and adult disabled. If family caregiving is to be encouraged, as most policy analysts, legislators and the public would urge, then ways must be found to support the family caregivers. Respite care, in a variety of forms, emerges as an important option. The remainder of the paper explores this further by describing existing and planned respite care programs and examining issues in the further development of respite care services.

Part II - Recent Developments in Respite Care

Available information on state respite care programs is at best fragmentary, reflecting both the emerging nature of respite care as a recognized long-term care service and the lack of any clear state financing and program development strategies. The description and discussion in this paper of state respite care programs and plans are not comprehensive but are representative of what is going on around the country, both in urban and rural states. The charts which follow provide information on state respite care programs in Connecticut, Delaware, Florida, Kansas, Kentucky, Louisiana, Maine, Missouri, Montana, New York, Oregon, Pennsylvania and Vermont. Some other states which have developed respite programs as part of demonstration efforts (i.e., California, South Carolina, Utah) or who are currently planning programs under Section 2176 Medicaid waivers have not been included.

The charts array information on state programs according to the following categories:

- Definition of respite care
- Eligibility
- Eligible Providers
- Financing
- State Administration
- Additional comments

Some general observations on each of the categories are provided below.

Definition of Respite Care

There is no uniform definition or model for respite care programs. In almost every state surveyed, respite care was defined differently although there were similar elements in many of the definitions. Respite care is most generally used to refer to temporary or short term relief of caregiving

responsibilities by someone caring for a dependent individual, usually a family member (a spouse or child) living with them. Respite care is used to refer to either in-home or out-of-home care, or both. In-home respite care can include sitter-type services or can be temporary use of homemaker chore and/or home health services. Out-of-home care includes both adult day care services, temporary stays in respite group homes or foster care homes or temporary stays in nursing homes, rehabilitation centers, hospitals or other health related facilities. For example, Connecticut law defines respite care as short-term temporary care of eligible persons on a planned or an emergency basis in the home of the eligible person or in a respite care center, whereas in Montana respite care only refers to temporary out-of-home care in licensed foster homes or private non-profit agencies. Many states further define respite care by specifying a maximum allowable use of care, either in number of hours or days of allowable care. For example, Florida's Home Care for the Elderly program limits respite care to 240 hours of respite service per year while Louisiana's limit is 1440 hours per year. The essence of the definition of respite care lies in its purpose which is almost uniformly to relieve caregivers from the constant stress and demands on their time. An additional purpose most clearly articulated in those states utilizing or hoping to use Medicaid funds to finance respite care, is the goal of reducing institutional care by providing incentives, services and supports for community-based living arrangements.

Eligibility

Eligibility for respite care services varies across states even more than the definitions. Several of the states surveyed limit eligibility to the mentally retarded/developmentally disabled population (i.e., Kentucky, Montana); others include the elderly, the developmentally disabled and the

mentaly ill (i.e., Connecticut, Vermont) and still others provide respite care only to the elderly at risk of institutionalization (i.e., Florida, Minnesota, Missouri, New York). Several states have included an assessment of functional limitations and of the need for community long-term care services as a part of the eligibility determination process. Often this is part of a preadmission screening process for nursing home admission. In Minnesota, for example, respite care services are authorized by county nursing home preadmisson screening teams which assess client needs and arrange for services as an alternative to institutional placement.

There is also variation on the imposition of an income test for receipt of publically financed respite care services. In general, the early programs financed with MR/DD funds and directed primarily at families with mentally retarded/developmentally disabled children had no income tests, although in some places, sliding fee scales were locally imposed. More recently created programs focused on the elderly and adult disabled populations are more likely to include an income limit. Kansas, for example, imposes the Medicaid income eligibility test of having an income of less than $310 per month. Kentucky and Missouri similarly tie eligibility to Medicaid standards but include provisions for a Medicaid spend-down.

Eligible Providers

Eligible respite care providers are as diverse as the programs themselves and depending on the nature of the specific program design include a wide range of formal health and social service providers as well as informal providers who are not the primary caregivers. Delaware, for example, purchases services from a variety of public and private non-profit providers and does not license respite care or home health providers. Few states license respite care providers directly although a statewide respite coalition in Ohio has supported a bill in the Ohio legislature which would license

respite providers and set standards for eligibility and the amount and method of payment. The question of eligible providers is related to the definition of respite care and the overlap between what is considered respite and what is day care, home health care and in some cases temporary nursing home care. In the New York Respite Care Demonstration project, respite may be provided by any service or combination of services supplied by individuals, social services districts, a public agency or a private not-for-profit corporation, a licensed residential health facility (SNF or ICF) or home health agency. There is no such thing as a single respite care provider and a variety of resources can be seen as potential respite services.

Financing

Inadequate, fragmented and inconsistent funding of respite care services appears to be the dominant pattern, similar to many other newly developing community long term care services. Until very recently, the funding sources available for respite care were extremely minimal. They include state and local appropriations, Title XX, Older Americans Act and Developmental Disability funds. Several states with Medicaid Section 1115 and federal long-term care experiments also included limited provision for respite care in their demonstration programs (i.e., Utah, South Carolina, California). The lack of permanent financing has been cited as a particular problem by several states examining the potential of respite care services. Recently, however, with the enactment of Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), many states have already or are in the process of requesting waivers of the Medicaid program which will enable them to expand their provision of in-home and community-based long term care services in order to prevent institutionalization. Respite care is one of the services included in the waiver and several of the states in our survey have made such

requests to the Health Care Financing Administration (i.e., Florida, Kansas, Kentucky, Montana, Minnesota, Missouri, Oregon and Vermont). One of the explicit hypotheses of the waiver experiments is that the provision of community long term care services, including respite care, can help reduce the costs of institutional long term care. Current research on respite care programs does not provide any evidence to either support or refute such a hypothesis.

State Administration

State administrative responsibility for respite care programs appears to be closely tied to the source of financing (i.e., Medicaid, Developmental Disabilities) and in turn to the population served (i.e., Elderly, Developmentally Disabled). In states where several funding streams exist (i.e., Delaware, Vermont) distinct programs are separately financed and administered, with little coordination or connection between seemingly related activities. One interesting feature of the administrative patterns of the states in our survey which are utilizing Medicaid funds for respite care is the linkage between preadmission screening for nursing homes, case management and respite care as part of a constellation of family support services. The coordination of respite care services with other family and in-home supports seems particularly appropriate and desirable and one which should be carefully assessed over the next several years.

For those states interested in developing a respite care program, our survey of what states are currently doing provides fruitful ideas but little in the way of evaluative data which can be used to structure a program. There is widespread agreement and interest in developing respite care services but very little research and practice knowledge to guide program development.

Because of this lack of data and information, two state legislatures, Connecticut and New York, enacted Respite Care Demonstration Projects last year. The New York demonstration was designed to encourage the initiation and expansion of respite and to evaluate the effectiveness of respite in deterring institutionalization. It is also hoped that it will provide information on the demand for respite, the most appropriate kinds of respite care services for different levels of disability and the costs of respite services. Five projects were funded out of 42 applications received by the State Department of Social Services. Four of the projects were to be focused on coordination, information and referral and systems development, and one on the efficacy of a slidiing scale fee schedule for those not Medicaid eligible but unable to meet the full costs of respite care. The need for this kind of information is obvious, as evaluative data is in short supply. The following section of the paper briefly reports on the few existing evaluations of respite care, a report of a small research program in California and a study of institutional respite care in six facilities in New York State.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Connecticut	Short-term temporary care of eligible persons by trained respite care providers. Can be on a planned or emergency basis in the home of the eligible person or in a respite care center. Includes in-home care and out of home care on an hourly basis not to exceed 24 hours or on a daily or weekly basis. Limit of 30 covered days of respite care in any calendar year. (Public Act No. 81-40)	Persons with severe chronic disability which is: 1. Attributable to a mental or physical impairment or combination, 2. Likely to continue indefinitely, 3. Results in functional limitations in two or more areas of major life activity, and 4. Reflects the need for a plan of care and interdisciplinary long-term care.	Not specified.	State appropriations for Respite Care Demonstration Project.	Department of Health Services, Community Nursing and Home Health Division.	Demonstration project established by state in May 1981. A limited amount of respite care is also purchased with Development Disabilities funds or provided by Department of Mental Retardation funded agencies for the developmentally disabled.
Delaware	Provision of short-term care (several hours to several days) to provide relief to families caring for dependent individuals. (Definition adopted by community-based services task force of Delaware Long-Term Care System Development project.)	Not specified. Under consideration as part of long-term care systems development grant. Existing services provide respite primarily to handicapped and developmentally disabled although a few programs serve all age groups.	Public and private non-profit health and social service agencies.	Developmental Disabilities, Medicaid/Medicare (Home Health Services); Title III of the Older Americans Act through R.S.V.P.	Purchase of service arrangements through state agencies; no single administrative structure.	

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Florida	One of family preservation services provided under Home Care for the Elderly (HCE) project to encourage provision of care for elderly in family type living arrangements within private homes. Purpose is to provide opportunity for caregiver to have a rest away from the stresses and demands placed on them. Caregivers are eligible for 240 hours of respite care services per year. This can be increased to 360 hours when recommended by the case manager.	Persons 60 and older who meet Title XIX criteria for institutional care.	Community Care for the Elderly (CCE) authorized program service agencies. No specific licensing for respite agencies. Usual provider is a licensed home health agency. The CCE case manager authorizes respite care in the service plan. It is arranged for by the HCE adult services counselor.	State appropriation; Title XIX demonstration funds.	Department of Health and Rehabilitation Services through either local AAA's or district offices of HRS.	Florida has submitted a request to HCFA for a Section 2176 Title XIX waiver to provide respite care for the aging, disabled, and mentally retarded populations.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Kansas	Temporary short-term services provided in person's home or in an institutional setting. (A more precise definition of services and duration is being developed by the state.)	Medicaid eligibility (income of less than $310 per month, and in need of nursing home care services not available in the community). Respite care will be provided as one of a range of community services to prevent institutionalization.	Local health and social service providers.	Medicaid; cost of community based services (including respite care) must be 10% less than nursing home care in area.	State Social & Rehabilitation Services. SRS local caseworker and nurse from Home Health Agency (or contract R.N.) will assess client needs. This pre-admission team will develop a plan of care if the evaluation shows that the client could be prevented from nursing home entry if community care is provided and if such care is 10% less costly than nursing home care. The team submits plan to state SRS for approval. Services are then arranged through local case manager.	Kansas has submitted a request to HCFA for a section 2176 Medicaid waiver to finance this program. Expected implementation date is July, 1982.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Kentucky	Services provided to an individual on a short-term basis because the person who usually provides care is absent or needs respite. Limited to up to ten days per year.	Eligible person must be aged, disabled or mentally retarded and have care needs at the ICF/SNF level. They must have resided with the caretaker seeking respite for at least two months. Local home health agency must assess need and determine that no relative is available to provide respite without cost. Financial eligibility up to Medicaid spend down level.	Medicaid providers of homemaker/home health services. Family/client is responsible for locating respite care providers.	Title XIX (Reimbursement cannot exceed ICF daily rate).	State Division of Medical Assistance; Local Home Health Agencies (hospital based, local health departments, other) must do an assessment of eligibility and need for respite care and obtain pre-authorization from the Division of Medical Assistance.	Kentucky has submitted a waiver request to HCFA under Section 2176 to finance the described program.
Louisiana	Temporary in or out of home care provided for up to 30 days (720 hours) in a six-month period to a developmentally disabled or handicapped person.	Persons of all ages with a developmental disability or handicap. Persons whose handicap results primarily from old age are excluded, however 41% of those receiving in-home respite in FY 1981 were over 65.	In-home by a skilled caretaker associated with a respite placement agency. Out-of-home by a certified facility (i.e., community respite center residential treatment facilities, pediatric hospitals, nursing homes, ICF's, day care centers, etc.).	100% state funds. (Prior to 1979-1980, Title XX funds were used.)	State Department of Health and Human Services.	Primarily focussed on MR and DD populations.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Maine	(Respite care is not now covered under any entitlement program or other sources of funding. Possible use of Title XX funds in the future.)					
Minnesota	Respite care services are provided through the Alternative Care Program when required as an alternative to nursing home placement. Respite can be provided for an individual who is unable to care for him/herself and needs short term care due to caregiver absence or need for relief. Services can be in an individual's home or in a facility approved by the state, including a hospital, nursing home, foster care home or community residential facility. Respite care service can include room and board as a reimbursable item in per diem rate.	Persons aged 65 or older. (Those who are Medicaid eligible are supported by Medicaid funds; all others are supported by state grants to counties.)	Not specified.	Medicaid; state appropriation ($1.8 million FY '81) (As of 1981-82, state provides grants to counties which have adopted voluntary nursing home pre-admission screening program. 25 of 87 counties now participate and more are expected to after July 1.)	State Department of Public Welfare (Pre-admission Screening and Alternative Care Program) administers grants to counties with operational PAS programs. When a client applies to nursing home a team of M.D., public health nurse and social worker perform screen and determine service needs. Counties set up their own procedures for respite care.	Minnesota has submitted a waiver request to HCFA under Section 2176. Prior to the enactment of State Alternative Care Program, about six counties used county funds to provide respite care.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Missouri	Includes two-day stay in nursing facilities; extended stay not to exceed six weeks if primary caregiver is hospitalized and needs to be away from constant care; also in-home respite on a daily basis for client who is homebound or in case of emergency.	Medicaid eligible persons over 60, in need of ICF level care. Medicaid spend down allowed.	Not specified.	Medicaid, Older Americans Act, Title XX.	The Division on Aging, Department of Social Services. Respite is part of community service package to be provided under channeling demonstration in Kansas City and pre-screening case management program being instituted in two counties. Initial assessment will be by M.D.'s followed by pre-admission screen by DSS social workers when person applies to nursing home or through hospital discharge. Social worker (state employee) or private agency worker in channelling site will arrange for service.	Missouri has submitted a request to HCFA for a Section 2176 Medicaid waiver to finance respite care and other needed community services.
Montana	Out-of-home care for no more than six months during any one twelve-month period.	Families with children who are developmentally disabled and between the ages of 0 and 6 without regard to income. Physician's evaluation of severity, cause and age of onset of disability required.	Care is purchased from licensed foster homes or private non-profit agencies who have contracts with the State Developmental Disabilities Division. Purchase is authorized by county social worker or developmental disabilities specialist	State appropriation; Title XX	Developmental Disabilities Division, Department of Social and Rehabilitation Services.	Montana has submitted a request to HCFA for a Section 2176 Title XIX waiver to provide respite care for the mentally retarded population.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
New York (Nursing Home Without Walls)	Assessing the need for, arranging for and providing the temporary institutional and home care services needed to allow family members who ordinarily care for the patient relief from these duties when such services are included in a plan of care as approved by a physician.	Persons assessed to be in need of ICF or SNF care for whom home care can be provided at average annual expense of no more than 75% of cost of institutional care. No age restrictions. Private pay patients eligible at either Medicare or Medicaid rate.	Certified home health agency, hospital or residential health care facility (SNF or ICF).	Medicaid (Section 1115 Waiver).	State Departments of Health and Social Services.	Demonstration program operating in 13 urban and rural localities in the state.
New York (Respite Care Demonstration, Project Chapter 767 of Law of 1981	Provision of infrequent and temporary substitute care or supervision of frail or disabled to provide relief from the stresses or responsibilities of providing constant care. Respite shall be limited to periods of 24 consecutive hours or longer, but may not exceed six weeks in any calendar year for any individual.	Caregivers of frail or disabled adults. Priority to those frail or disabled adults 60 years or older. Caregivers are defined as the family member or other natural person who normally provides daily care or supervision. Caregiver may, but need not reside in the same household as frail or disabled adult.	Respite may be provided by any service or combination of services supplied by individuals, social services districts, a public agency or a private not-for-profit corporation or any licensed residential health facility (SNF or ICF) or home health agency.	State appropriation of $430,000 for demonstration. ($60,000 for state administration and $370,000 to fund 5 demonstrations. Direct service costs to be secured if possible from Medicaid, Medicare, third party payers and clients.)	Department of Social Services.	Demonstration project to encourage the initiation and expansion of respite, evaluate the effectiveness of respite in deterring institutionalization, evaluate demand for respite and ascertain the most appropriate service for various levels of disability and disfunction and for the cost of the services and their coordination. Five projects will be funded. Four projects are for coordination, information and referral and systems development. One is an improved fiscal access project which will provide respite on a sliding fee scale for those not eligible for Medicaid, but unable to pay full costs.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Oregon	(Not currently provided by State or as part of FIG/Waiver Long-Term Care Demonstration Project. Request has been submitted to HCFA for a Title XIX Medicaid waiver under Section 2176 to provide respite care for the mentally retarded.)					
Pennsylvania	(During 1979, Title IX funds from the Older Americans Act were used to train and employ older workers to serve as respite workers for the State Domiciliary Care home providers. Due to budget cuts, this program was discontinued.)					
Vermont	Respite care services are short-term interventions provided to persons who are unable to care for themselves in the absence of those who normally provide such care. Services may be provided in an individual's home or a facility approved by the state for respite. The extent and schedule of care is determined by family or other caretaker need. May include a number of hours per week (limited respite) or for longer periods to enable a family to vacation.	Elderly; Developmentally Disabled State-funded Program for the MR/DD population available without regard to income. (Medicaid waiver request for MR/mentally ill population will add Medicaid income requirements and need for ICF level of care, but ineligible families will still be eligible for state funded program.)	1. Home health agencies. 2. Agencies serving the developmentally disabled.	1. State general fund appropriation ($700,000 FY 1981) for home care services to purchase "limited respite care." 2. State general fund appropriation for family support services, including respite care, for MR clients. 3. ACTION provides stipends for senior companions to provide elderly respite care.	1. Department of Health. 2. Department of Mental Health/Division of Community Mental Retardation Programs. 3. Through local AAAs.	Vermont has applied to HCFA for a Section 2176 Title XIX waiver to provide respite care to the MR/mentally ill population.

Part III - Existing Research Regarding Respite Care

The basic premise behind state and local interest in developing respite care services is that it is an important social support to family caregiving and that the presence of such social supports plays a critical role in influencing who goes into a long-term care institution and who remains in the community. Respite care services, whether in-home assistance or temporary institutional care which enables a break in the daily routine of caregiving is believed to relieve the physical and psychological pressures associated with caring for the chronically ill elderly and disabled. As mentioned earlier, the basic intellectual impetus for respite care has been drawn from research on families caring for retarded and developmentally disabled children. The parallels to the elderly and adult disabled population have only recently begun to be explored.

In Marin County, California, a small program that began as a peer support group for older women caring for their disabled husbands at home, evolved, at the suggestion of the wives, into a respite care project which included case coordination, adult day care, home care and extended respite care.[9] In the Wives' Respite Project that developed, the term respite care was used generically to refer to any services that provided intervals of rest and relief for the principal caregiver. Funded with $40,000 for a two-year period, the program provided home care, overnight/weekend respite at a community residential facility and community/professional education. Home care was provided by one full-time nurse who divided her time between 10-15 persons requesting service averaging about four hours per week per couple. It is interesting to note that the participants preferred the dependability of one respite care worker to whom they could relate over time rather different workers each time they requested hep. The in-home respite care worker performed the following functions: companionship, supervision, health,

teaching, household tasks, shopping, meal preparation, emotional support and personal care. The overnight respite program used a small facility which was licensed as a six-bed adult group residential facility and linked to an adult day care center program, thus minimizing adjustment by the husbands and wives to strange people surroundings. The wives used the weekend care to go away or simply to stay at home without the pressure and responsibility of daily personal care chores for their disabled spouse. The conclusion drawn by the researchers involved with this project was that, for a relatively small investment, the project provided an enormously important resource for the involved families.

The only larger scale evaluation of a respite care program that our literature search and state survey revealed was an eighteen month project in New York state which was financed with foundation funds to demonstrate and assess the impact of providing institutional respite care as a support service for families caring for the frail elderly.[10] The project supported the development of respite care programs at six long term care facilities in New York state and examined the hypotheses that (1) respite care fills an unmet need for long-term care for the elderly in New York state; (2) respite care relieves the pressures that families feel in the care of frail elderly; (3) respite care is seen as a positive experience by the participants; and (4) providers are willing and able to provide institutional respite care services.

The facilities participating in the demonstration were licensed New York state health related facilities providing ongoing SNF and ICF care. Each facility agreed to reserve several beds for respite care patients. During the life of the project, the average age of the respite care patient was 81.6 (similar to the average nursing home resident) and the average length of stay was 18 days. Seventy-two percent of the caregivers used the respite service

for vacation and relief purposes. The sources of the payment for the respite care service were Medicaid (20 percent), Medicare (3 percent), Patient (66 percent) and caregiver (10 percent). The vast majority of the respite patients required SNF level of care and the evaluators concluded that institutional respite as a relief program has the greatest impact on SNF placements.

The findings of the evaluation report regarding regulatory, financial and other policies are summarized here because they represent a systematic assessment of some key issues that need to be considered when developing respite care programs. With respect to <u>regulatory policies</u>, the evaluation found that in a highly regulated environment like New York state, institutional respite care services could be developed with a moderate amount of regulatory conflict and that modification of some regulations could provide strong incentives to providers to offer respite. Specifically, they recommend that institutional respite care services not be established as a distinct program, thereby requiring a full and separate Certificate of Need review. Instead, they should be informally established as part of existing SNF and ICF facilities. In addition, since New York state, as is the case with many other states, requires detailed patient assessments and utilization reviews for persons entering a nursing home, provision should be made to waive these requirements for respite care clients. With respect to <u>financial policies</u>, the study found that the additional costs associated with providing respite were not a major barrier to facility participation. The projected annual cost of participating in the program was $18,000-$25,000 per year per facility or $5,000-$12,000 per bed attributable to the costs associated with vacant beds produced by short-term stays and additional personnel costs of short-term entry and discharge. The vacant bed costs arose because respite occupancy was lower (60-80 percent) than SNF-ICF occupacy (98-99.5 percent). The financial

pressures and system characteristics which propel facilities to maintain high occupancy rates is the major factor inhibiting the further development of respite in health facilities. The evaluation recommends trying to develop a Title XIX reimbursement methodology for respite which would clearly identify those costs unique to admission and treatment of a person for a short time as well as exploring the possibilities of other third party insurance for respite care and the development of a sliding fee scale for those above Medicaid eligibility. It is interesting to note, however, that the project found a strong demand for respite care among private paying patients willing and able to pay the prevailing rates which ranged from $30 to $90 per day.

Finally, four other findings were significant. First, the study found an unexpectedly helpful positive role played by nursing respite providers as a referral agency, informing and educating families of other support systems for home care. Second, the temporary admission to a nursing facility afforded a positive opportunity for reviewing and changing drug regimens for many patients. Third, there was a positive correlation between a higher level of need and a higher demand for respite. The most important time for respite services appears to be when the older person requires the most care. Fourth, and perhaps related to the above finding, was an unexpectedly high rate of institutionalization (12 percent) of the respite care population within one month of use of respite services. This compares with a rate of about .4 percent per month for a comparable 75+ population. This is an important finding with two possible explanations, each with significant policy implications. Either of two things may be occurring. The use of institutional respite services may represent one last attempt by a family to keep their relative out of an institution, suggesting that without the respite service the institutionalization rate for this population may in fact have

been higher. The other explanation is that a positive experience with institutional respite may break down family barriers to institutional placement, making it easier to permanently institutionalize the client. Clearly this issue requires greater study in the near future, particularly if policymakers are looking to respite care as a service which helps prevent institutionalization.

Part IV - The Future of Respite Care Services

As the analysis in this paper has shown, there is considerable state and local interest and activity regarding the development and implementation of respite care services but not a lot of evaluative knowledge about the extent of need, the costs of providing respite care. the best ways of organizing, financing and providing access to care, and the impact of offering respite care as a support for family caregiving. It is a service area which suggests an intuitively correct approach to assisting those who take on the responsibilities of caring for the elderly and the disabled and, as such, is an important component of state efforts to promote and assist family caregiving. In concluding, three issues which have not yet been directly addressed must be emphasized. First, respite care should not be viewed as a separate service program but should be considered as part of a system of family support functions linked to case management systems or other local coordinating mechanisms. Case managers can assume a critical role in assessing needs for care, providing access to respite care providers and matching the individual needs of the client with the personality, skills and services of a particular provider. Second, consideration should be given to extending eligibility for respite care services beyond state Medicaid eligibility levels, perhaps with sliding fee scales adjusted for income. Existing evidence suggests that families are willing to pay for the service and those who can should be required to do so. Financial support for those who cannot may offer a desirable positive incentive for family caregiving. Thirdly, attention must be paid to the issue of training respite care workers so that they are sensitive to the needs and demands of the families they serve. Care should be taken to avoid over professionalizing and bureaucratizing what is essentially an informal support, while at the same time devoting necessary resources to the training of respite caregivers.

The recent interest by the Federal government, states and localities in assisting those who take on the responsibilities of caring for elderly and disabled relatives and friends is encouraging. The challenge of meeting the long-term care needs of current and future generations of elderly and disabled will require new creativity in the financing and provision of respite care and other community and family support services.

FOOTNOTES

1. For a full discussion of the research on informal supports in long-term care, see Steinitz, Lucy, "Informal Supports in Long-Term Care: Implications and Policy Options, "Center for the Study of Social Policy, February, 1981.

2. Butler, Lewis and Newacheck, Paul, "Health and Social Factors Relevant to Long-Term Care Policy," in Policy Options in Long Term Care by Meltzer, Farrow and Richman, eds. (University of Chicago Press, 1981).

3. Callahan, James J., Diamond, Lawrence, Giele, Janet Z. and Morris, Robert, "Responsibility of Families for their Disabled Elders," University Health Policy Consortium, July, 1979.

4. Shanas, Ethel, "The Family as a Social Support System in Old Age," The Gerontologist, Volume 19, No. 2, 1979.

5. Fengler, Alfred P. and Goodrich, Nancy, "Wives of Elderly Disabled Men: The Hidden Patients," The Gerontologist, Vol, 19, No. 2, 1979.

6. Brody, E., "Women's Changing Roles and Care of the Aging Family," Aging Agenda for the 80's, National Journal Issues Book, 1981.

7. Fengler & Goodrich, Ibid.

8. Brody, E., "Women in the Middle and Family Help to Older People," Gerontologist, Volume 21, No. 5, 1981.

9. Fengler & Goodrich, Ibid.

10. Respite Care for the Frail Elderly: Final Report, February, 1982, Foundation for Long Term Care, Albany, New York.

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: SB 122 Date on Bill: 2/11/83
Title: "An Act relating to protection of the elderly"
Sponsor: Senator Josephson and Fischer
Requestor:

1. Estimated fiscal impacts on:

a. Expenditures:

(Thousands of Dollars)

			FY 83	FY 84	FY 85	FY 86		
Capital								
Operating								
Total			-0-	-0-	-0-			

b. Revenues:

Revenue								

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

4. Disclaimer:
This statement has not been reviewed by the OMB in the Office of the Governor.

Prepared By: Jon B. Wolfe, Executive Director Phone: 465-3250
Division: Older Alaskans Commission Date: 2/24/83

Approved by Commissioner: [signature] Date: 3/1/83
Department: Admin.

5. Distribution:
Original to Legislative Finance
Copy to OMB
Copy to Sponsor
Copy to Requestor

2/8/83

Statement of Support for SB 122 - Mandatory Reporting of Elderly Abuse.

Thank you for allowing my statements to be read as part of this hearing. I am unable to travel to Juneau today. I would have appreciated the opportunity to speak myself by teleconference, but do understand the problems in scheduling this hearing as a statewide teleconference.

I am very pleased that Senator Josephson and Representative Clocksin have introduced SB 122 and HB 192, a companion bill. I strongly support the mandatory reporting of suspected or known elderly abuse by health care professionals. Ten years of active duty hospital nursing and four years of emloyment in community service programs for the elderly have, in my opinion, given me some insight into elderly abuse.

The older people of this country are like other dependent populations in society. They as individuals understand and live by the old moral - "don't bite the hand of the one who feeds you". It has been recognized nationwide that child abuse was the issue of the 60's, spouse abuse of the 70's and now elderly abuse of the 80's. If SB 122 passes, Alaska joins other states in recognizing the need to report Elderly Abuse.

I was a member of the Anchorage Elderly Abuse Task Force, which began to discuss and study this growing problem well over a year ago. Although a study of the incidence of Elderly Abuse was done in Anchorage by Community Mental Health Annex, until mandatory reporting of Elderly Abuse cases is a law, we have no total picture of the problem.

Mandatory reporting will insure that health care professionals will report Mrs. X cuts and bruises and broken bones, even when Mrs. X is the mother of a neighbor. This support and legal backup will enable the reporter to make a moral decision and follow through on it without fear.

I encourage the passage of this bill as a positive step in assuring that all residents of Alaska can live in comfort that "victimization" is not our way of life in Alaska. Who, more than our Pioneers and Elders, deserve this comfort?

Norma Lundy
Anchorage

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: SB 122 Date on Bill: 2-11-83
Title: An Act relating to protection for the elderly
Sponsor: Josephson
Requestor:

1. Estimated fiscal impacts on:

a. Expenditures:

(Thousands of Dollars)

			FY 83	FY 84	FY 85	FY 86		
Capital								
Operating								
Total			-0-	-0-	-0-	-0-		

b. Revenues:

Revenue								

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

No Fiscal Impact

4. Disclaimer:
This statement has not been reviewed by the OMB in the Office of the Governor. It therefore does not represent the final estimate of fiscal impact.

Prepared By: Francis C. Allan Phone: 269-5691
Division: Alaska State Troopers Date: 2-16-83

Approved by Commissioner: [illegible signature] Date: 2/25/83
Department: Public Safety

5. Distribution:
Original to Legislative Finance
Copy to OMB
Copy to Sponsor
Copy to Requestor

2/15/83

To: Representative Walt Furnace

From: Steven C. Levi, Staff

RE: SB 122

Date: February 23, 1983

SB 122 is a bill for the protection of the elderly. Staff feels the bill deals with a subject of merit but wishes to express concern as to four sections of the bill.

1) Staff notes that in AS 47.24.010 (a)(9) the clergy is listed as a responsible party who must, within 24 hours, report an abuse to an elderly citizen. Staff notes that this may infringe on the separation of Church and State. [Page 2, Line 8]

Staff notes that in dealing with the elderly Sec. 47.24.010 (f), a person is required to report a suspected incidence of violence and such person "is immune from prosecution." Yet, this seems to imply that if a persons <u>commits</u> the act and then, in good faith, reports it, there is no case for criminal prosecution. [Page 3, Lines 4-8.]

Staff notes, AS 47.24.030 (a) that if the Department of Health and Social Services deems that protective services are needed and it cannot receive consent from the elderly person, the Department may petition to court for the "appointment of a guardian or temporary guardian for the elderly person for the purpose of obtaining consent." Staff wonders if this would lead to court cases where the elderly person felt that his or her rights were being violated by having a guardian forced upon them. [Page 4, Lines 1-6.]

Staff notes, AS 47.24.075, that "neither the physician-patient nor the husband-wife privilege is a ground for excluding evidence regarding an elderly person's harm, or its cause, in a judicial proceeding." Staff expresses concern that such a policy may be unreasonable or unusual.

Staff suggests discussions with Rose Palmquist and Sam Pestinger.

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF PUBLIC SAFETY

COUNCIL ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT

POUCH N
ROOM 312, GOLDSTEIN BUILDING
JUNEAU, ALASKA 99811
PHONE:

April 12, 1983

Number of victims 55 years of age and older reported through Alaska Council on Domestic Violence and Sexual Assault state forms:

	Domestic Violence
1982	
July	4
August	5
September	4
October	5
November	3
December	3
1983	
January	1
February	3
Total	28

Karen VanDusseldorp
Research Analyst

12-L16LH

FACT SHEET ON ELDER ABUSE — Based on Aging Committee Report, April, 198?

Incidence of Elder Abuse

4 % of older Americans are victims of some sort of abuse each year — this is equal to one million older persons per year

The "typical" abused older person is a 75 year old woman who relys on others for her care and is repeatedly abused by the caregiver

The "typical" abuser is a caregiver who is experiencing a great deal of stress, often from marital or financial problems, and may resort to alcohol or drugs to relieve his stress.

21% of the abusers are the sons of the older person
17% " " " " " daughters " " "
the 3rd most likely abuser is the spouse (husband more often than wife)

Older persons do not report abuse because they are ashamed, frightened of retaliation, or do not want to cause family troubles

More than 70% of reported cases are reported by third parties

Case histories were presented from all States in the following categories: physical & sexual abuse, negligence, financial exploitation, psychological abuse, violation of personal rights & self neglect

1/3 of the cases were incidences of physical abuse
1/4 " " " " " " financial exploitation

STRESS is believed to be a major factor leading to the abuse of older persons by caregivers — one study found that the elderly person was a significant source of stress in 63% of the cases

Other factors leading to abuse may be: retaliation, violence as a way of life, lack of financial resources & community/supports, resentment of dependency, increased life expectancy, and over-crowded living environment

State Responses to Questionnaire

63% of the States said the greatest hinderance to their ability to help the abused elderly was lack of appropriate statutory authority — the second most frequest hinderance was lack of skilled staff, community resources, and funding (MRO's BILL IS AIMED AT RESOLVING THESE PROBLEMS

On a national average, only 6.6% of state funds for protective services are spent on services for abused elderly (Ohio spends less than 1%)

Only 16 states require mandatory reporting of elder abuse:
Ala., Ark., Conn., Fla., Kent., Minn., Missouri, Neb., New Hamp., N. Carol., Okla., S. Carol., Tenn., Utah, Vermont & Virginia

An additional 10 states have legislation pending (including Ohio)

- When asked if states would favor passage of H.R. 769, 74% answered YES, the remaining 26% answered UNDECIDED

FINDINGS OF A.C.M.H.C. - 1981 - Alaska

In the study conducted by A.C.M.H.C. of 75 cases documented, 34 cases (43.3%) of physical abuse were found. A breakdown of the abuse sustained follows:

lack of personal care	17.3% *
bruises and welts	13.3%
lack of food	10.7%
medicines withheld	8.0%
freezing	6.7%
malnutrition	6.7%
direct beatings	5.3%
abrasions and lacerations	2.6%
bone fractures	2.6%
sexual assault	1.3%
imprisonment	1.3%

Psychological abuse was sustained by 53 elders (70%)

fear	46.7% *
verbal assault	28.7%
threat	18.7%

Material abuse occurred in 43 cases (57.3%)

misuse of money or property	45.3% *
theft of money or property	26.7%

* categories are not mutually exclusive

There was violation of rights in 18 cases (24%)

forced social isolation	16.0% *
forced from home	6.7%
forced into nursing home	5.3%

STATISTICS ON VICTIM

Age of abused elder at the time of the abuse

60 - 70	41.3%
70 - 80	41.3%
80 - 90	13.3%
90 +	4.0%

Sex of Victim

Female	76.0%
Male	22.7%
Couple	1.3%

Race or Ethnic Group

White	69.3%
Native	18.7%
Black	9.3%
Hispanic	1.3%
Unknown	1.3%

STAISTICS ON VICTIM (continued)

Economic Status of Victim

Low	54.7%
Middle	29.3%
High	12.0%
Unknown	4.0%

Degree of Physical or Mental Impairment

Physically or mentally disabled to a great degree	38.7%
Need some assistance with Activities of Daily Living (ADL's)	21.3%
Physically self-sufficient	40.0%

Resides at the same address as victim

Alone	17.3%
Family member(s)	41.3%
Husband/wife	14.7%
Girl/boyfriend	8.0%
Boarding home	4.0%
Nursing home	4.0%
Housekeeper	5.3%
Friend(s)	4.0%
Unknown	1.3%

STATISTICS ON ABUSER

Relationship to victim

Daughter	22.7%
Son	21.3%
Husband	10.7%
Grandaughter	1.3%
Grandson	1.3%
Girlfriend	4.0%
Boyfriend	1.3%
Son-in-law	1.3%
Daughter-in-law	9.3%
Hired caretaker/housekeeper	6.7%
Entire family	5.3%
Boarding home	4.0%
Friend	10.7%

Age of abuser

20's	6.7%
30's	22.7%
40's	36.0%
50's	12.0%
60's	14.7%
70's	2.7%
80's	1.3%
Unknown	4.0%

Ethnic Group of Abuser

White	65.3%
Native	20.0%
Black	8.0%
Hispanic	1/3%
Unknown	5.3%

Economic Status of Abuser

Low	44.0%
Middle	22.7%
High	16.0%
Unknown	17.3%

Does the Abuser Live With the Victim?

Yes	69.0%
No	22.7%
Unknown	1.3%

OTHER INFORMATION

Is alcohol a factor in this situation?

Yes	49.3%
No	41.3%
Unknown	9.3%

Has this mistreatment happened before?

No	2.7%
Once	9.3%
2 - 3 times	8.0%
4 or more	74.7%
Unknown	5.3%

How did you know about it?

Self report	49.3%
Private M.D.	5.3%
Hospital	22.7%
Police	0
Public Social Service Agency	5.3%
Private Social Service Agency	6.7%
Public Health	2.7%
Neighbor	1.3%
Professionals Observation	6.7%

Did the victim seek help?

Yes	53.3%
No	43.7%
Unknown	4.0%

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

Elder Abuse in Anchorage, Alaska

A Survey of Service Providers

Teri B. Spires B.S.
Charles R. Mundorff M.S.

October, 1981

Project of Anchorage Community Mental Health Center
Annex Geriatric Unit
1020 East 4th Avenue 99501 (907) 276-5400

ELDER ABUSE IN ANCHORAGE, ALASKA

ELDER ABUSE IN ANCHORAGE, ALASKA

Teri Spires, B.S. and Charles Mundorff, M.S.

Anchorage Community Mental Health Center, Anchorage, Alaska

This study was done in response to the phenomenon of elder abuse in the State of Alaska. This particular study, focused in the Anchorage area, was designed to assist in establishing perameters to the problem. Thirty agencies, 16 physicians, and four medical clinics were contacted. Seventy-five cases of elder abuse were documented. There were 34 cases of physical abuse, 53 cases of psychological abuse, 43 cases of material abuse and 18 cases of violation of rights.

Introduction

Abuse of the elderly by their spouse, family or caretaker is a problem often observed by service providers in the Anchorage area. Elder abuse in the past has not been addressed as a specific issue in Anchorage until the last year. Previous to this study, no research had been done in Alaska, but nationally a few studies have been conducted. These studies provide a good data base that exposes the incidence of elder abuse and the need for concern in our society. Unfortunately, elder abuse has not been addressed in Alaskan domestic violence programs. Consequently, the Region X Office on Aging targeted Anchorage as a pilot city for study and community planning in elder abuse.

In November 1980 a meeting of representatives from Alaska, Idaho, Washington and Oregon was called by Chisato Kawabori (Ph.D.), Director of Region X Aging Network, and Willard Mollerstrom (Ph.D.), Region X Director of N.I.M.H. Charles Mundorff of Anchorage Community Mental Health Center (A.C.M.H.C.) attended this meeting in Seattle. At this meeting, A.C.M.H.C. was considered a focal point for the problem of elder abuse in the State of Alaska.