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THE
COLORADO CONTINUUM OF CARE
SYSTEMS DEVELOPMENT
PROJECT

Colorado Department of Social Services

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Denver, Colorado 80203-1714

June 1989

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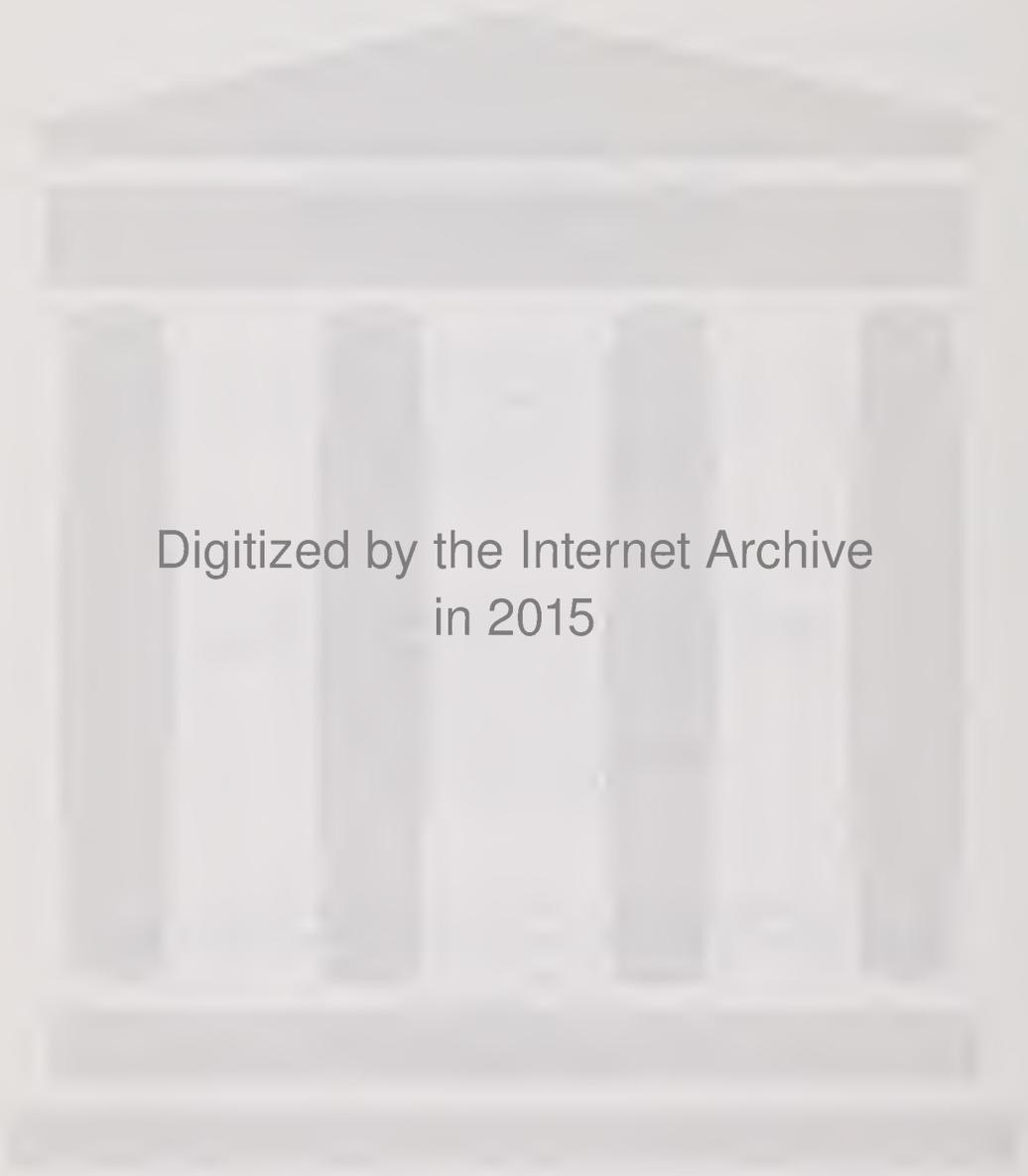
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PROJECT ABSTRACT

The Colorado Continuum of Care Project was funded by the Administration on Aging to the Colorado Department of Social Services for a two-year period from September 1986 to December 1988. The overall objective of this project was to develop and demonstrate models for system change in aging and long term care programs in Colorado through a continuum of care framework. System design and demonstration occurred at two levels: in four local communities (Weld, El Paso, and Denver Counties, and Region XI on the Western Slope) and within the State Unit on Aging. The project provided support and direction at the Colorado Department of Social Services to the State's long term goal of developing a statewide coordinated and locally flexible community-based care delivery system.

The major outcomes of this effort included the development of two case management models which became fully operational programs during this period in Weld and Denver counties, serving about 650 clients. The El Paso County site was responsible for training about 1,500 persons statewide and nationally regarding adult abuse and neglect and adult protection, community task forces were started, and a training manual was produced. A multi-county task force collected data and identified major issues regarding the creation of service areas for adult programs on the Western Slope. At the State level, long term care became a departmental priority, a special Division of Long Term Care System Development was established, staff were assigned responsibility for developing strategies for system change, a Legislative Long Term Health Care Task Force was established, and an internal policy group was convened to develop departmental long term care goals and policies.

The major policy findings included:

- * A continuum of services needs to be available in local communities for individuals needing long term care which balances nursing home care and community-based care and more emphasis needs to be placed on the development of alternative community-based resources and increased support for family caregivers.
- * Statewide reform needs to address the problems of accessibility of services at the local level through the development of single entry points where the elderly can receive information, access to services, and care management. These units should serve both public and privately funded clients.
- * Case management should be considered as a core service in the design of these single access units.
- * A uniform screening and assessment process for long term care services needs to be in place statewide.
- * Adult protection is a key service in any system of long term care.
- * Local communities need to assume "ownership" of long term care problems, but need assistance from the state, county departments of social services, and the Area Agencies on Aging (AAAs) in designing solutions.
- * To facilitate the implementation of the lessons learned, informal and formal mechanisms are needed to help transfer information from local demonstration sites to public policy makers at the state level.

EXECUTIVE SUMMARY

The Colorado Continuum of Care Project was funded by the Administration on Aging for a two-year period from September 1986 to December 1988. The overall objective of this project was to develop and demonstrate models for system change in aging and long term care programs in Colorado through a continuum of care framework. System design and demonstration occurred at two levels: in four local communities (Weld, El Paso, and Denver Counties, and Region XI, which includes four counties on the Western Slope of Colorado) and within the State Unit on Aging. The project provided support and direction at the Colorado Department of Social Services to the State's long term goal of developing a statewide coordinated and locally flexible community-based care delivery system. The major products and outcomes of this project are described below:

El Paso County

The purpose of this demonstration, a coordinated effort of the County Department of Social Services and the Area Agency on Aging, was to provide training and community awareness on adult protection. As a result, El Paso County developed a coordinated system for the referral and handling of adult protection cases. The major products at this site included:

- * Training curriculum on adult protection
- * A training manual and video
- * The development of an Adult Protection Task Force
- * Establishment of formal linkages between the County Department of Social Services and the AAA
- * The development and implementation of training for agency staff, legal, police, and health care professionals (training sessions for 1,500 individuals)
- * Statewide training in 30 counties on how to identify adult abuse issues and establish community task forces on adult protection. A number of counties developed local efforts to address adult protection.

Region XI (Mesa, Garfield, Rio Blanco, Moffat Counties)

The purpose of this demonstration was to study the feasibility of developing an integrated social services district for aging and adult programs in four counties on the Western Slope. The project was conducted through the Area Agency on Aging. Products included data collection, program and fiscal analyses of programs operated in the four counties, a planning model, the formation of a task force of social services staff and county commissioners, and recommendations for implementing a regional approach.

Weld County

The main objective at this site was to design and implement a single access case management program at an Area Agency on Aging (AAA), using a community planning model which included 25 agencies. This program became fully operational and, as of December 1988, was serving 45 non-Medicaid clients and the Home and Community Based Services (HCBS) program contract was being transferred to the AAA. Major products available for replication include:

- * A community level planning model
- * A uniform intake form
- * Computerized application procedures for handling referrals and client tracking
- * Model interagency agreements
- * Screening and client functioning assessment tools
- * Procedures for case handling, care planning and case management
- * Training programs for case management staff

Denver County/Adult Care Management, Inc. (ACMI)

The purpose of this demonstration was to support the development of a free-standing, non-profit case management agency in Denver, which would be available to private and public clients. The major project activities included:

- * The development of a coordinated referral process
- * Screening and assessment procedures
- * Procedures for combining private and public clients in a single agency
- * Computerized fiscal management and case handling

This company grew during the time of the project from 20 clients in 1987 to over 600 individuals by December 1988. At the time the project ended ACMI was managing the Home and Community Based Services program (Medicaid-waiver) for Denver County, had contracts with several other organizations, and served as a national Living-at-Home case management demonstration site.

State/Aging and Adult Services

Internally, the focus of State level activities was on overall project management, provision of technical assistance to the sites, information dissemination, and participation in tasks relative to long term care development. In addition, a computer consultant provided assistance to the State and local sites and both hardware and software were purchased for two sites and the State. Major accomplishments in long term care development during this period included:

- * Development of system-wide long term care goals and objectives
- * The purchase of forecasting data for Colorado from Savant, Inc., and the use of data in training and forecasting service utilization by geographic regions

- * Conducted long term care training and technical assistance for Area Agencies on Aging, county staff, and other community agencies
- * Development of new assessment process for the Home Care Allowance program and conducted statewide training at 13 sites
- * Provided staff assistance for the long term care legislative subcommittees
- * Participated in the development of long term care legislation ('88, '89)
- * Received two Administration on Aging grants (Alzheimer's, Quality Assurance for In-Home Services) to support additional activities
- * Presented project findings at numerous local meetings and at the National Home and Community Based Services Conference

In summary, this project facilitated the development of two case management models which became fully operational programs during this period, serving about 650 clients. Approximately 1,500 individuals were trained nationally, statewide, and in over 30 counties and, regarding adult abuse and neglect and adult protection, community task forces were started, and a training manual was produced. A multi-county task force collected data and identified major issues regarding regionalization for adult services. At the State level, long term care became a departmental priority, a special Division of Long Term Care System Development was established, staff were assigned responsibility for developing strategies for system change, a legislative Long Term Health Care Task Force was established and an internal policy group was convened to develop departmental long term care goals and policies.

The following section summarized the major policy implications of the work conducted:

- * A continuum of services needs to be available in local communities for individuals needing long term care which balances nursing home care and community-

based care. Historically, nursing homes are a more highly developed resource in Colorado. At this time more emphasis needs to be placed on the development of alternative community-based resources such as congregate facilities with services, personal care boarding homes, alternative care facilities, adult foster care homes, and a full range of supportive services. In addition, increased support for family caregivers needs to be addressed in public policies.

- * Statewide reform needs to address the problems of accessibility of services at the local level through the development of single entry points in specific geographic areas where the elderly can receive information, access to services, and care management. These units should serve both public and privately funded clients.
- * Case management should be considered as a core service in the design of these single access units. This service should be available to those in need and should be provided by qualified, well-trained personnel.
- * A uniform screening and assessment process for long term care services needs to be in place statewide. A single assessment instrument for access into all public programs, including nursing homes, should be developed and implemented statewide as soon as possible.
- * Adult protection is a key service in any system of long term care. Staff of all community programs including social services, the legal system, police, and fire departments, and health care professionals should have training in case identification and referral procedures.
- * Local communities need to assume "ownership" of long term care problems, but need assistance from the state, county departments of social services, and AAA's in designing solutions.
- * To facilitate the implementation of the lessons learned, informal and formal mechanisms are needed to help transfer information from local

demonstration sites to public policy makers at the state level. Public education forums, replication of activities at other sites, and the formation of special task forces or community groups were established during the course of the project. An internal policy group in the Colorado Department of Social Services, a Legislative Task Force on Long Term Health Care, and a community advisory committee were set up. In addition, a special unit on long term care system development was established within the Department which provided credibility and support for the efforts undertaken at the demonstration sites.

POLICY IMPLICATIONS PAPER

The overall purpose of this project was to develop and implement certain key components of a new long term care delivery system for older adults in Colorado. At the state level major changes were needed in reorganizing the entire system, including both nursing home and community care. Early in the project, it was concluded that the widespread reform needed could best be achieved incrementally. Additionally, the fact that Colorado has a county-administered social service system and that the work of area agencies on aging had traditionally not been coordinated with county activities, necessitated a slow approach to change at both the state and local levels.

During the two-year period that the project was in operation, the information collected and lessons learned at the local sites provided impetus for change at the state level and a basis for long term care planning efforts.

The following section summarized the major policy implications of the work conducted:

- * A continuum of services needs to be available in local communities for individuals needing long term care which balances nursing home care and community-based care. Historically, nursing homes are a more highly developed resource in Colorado as in other states. At this time more emphasis needs to be placed on the development of alternative community-based resources such as congregate facilities with services, personal care boarding homes, alternative care facilities, adult foster care homes, and a full range of supportive home services. In addition, increased support for family caregivers needs to be addressed in public policies.
- * Statewide reform needs to address the problems of accessibility of services at the local level through the development of single entry point service areas where the elderly can receive information, access to services and care management. These units should serve both public and privately funded clients.
- * Case management should be considered as a core service in the design of these single access units. This service should be available to those in need and be provided by qualified, well-trained personnel.

- * A uniform screening and assessment process for long term care services needs to be in place statewide. A single assessment instrument for access into all public programs, including nursing homes should be developed and implemented statewide as soon as possible.

- * Adult protection is a key service in any system of long term care. Staff of all community programs including social services, the legal system, police, fire departments, and health care professionals should have training in case identification and referral procedures.

- * Local communities need to assume "ownership" of long term care problems, but need assistance from the state, county departments of social services, and AAA's in designing solutions.

- * To facilitate the implementation of the lessons learned, informal and formal mechanisms are needed to help the transfer of information from local demonstration sites to public policy makers at the state level. Public education forums, replication of activities at other sites, and the formation of special task forces or community groups were established during the course of the project. An internal policy group in the Colorado Department of Social Services, a Legislative Task Force on Long Term Health Care, and a community advisory committee were set up. In addition, a special unit on long term care system development was established within the Department which provided credibility and support for the efforts undertaken at the demonstration sites.

DISSEMINATION AND UTILIZATION PAPER

The dissemination of information about this project and the products developed as a result of the activities at the sites were an important aspect of this effort. A number of vehicles were utilized in disseminating this information such as workshops, training sessions, formal presentations, and the development of materials for distribution. Each site was responsible for extensive local dissemination; the state staff also conducted training and made presentations to a variety of agencies and organizations.

The major products included:

- * A training manual on Adult Protection entitled Elder Abuse: Identification, Referral, and Intervention at the Community Level.
- * A video to be used in training caseworkers on Adult Protection
- * Materials on case management prepared by the Weld County AAA. The materials can be used by planners in case management programs and for developing training programs for case managers.

Presentations were made to the following groups over the project period:

- * The Long Term Health Care Legislative Task Force
- * The Continuum of Long Term Health Care Subcommittee of the Legislative Task Force
- * The AAA Association; presentations were made to individual AAA's on many occasions
- * Senior citizen groups in local communities
- * Adult Supervisors of County Departments of Social Services
- * The National Conference of Home and Community Based Services
- * Staff of the Colorado Department of Social Services in the Information Resources Management Section

- * The Administration on Aging Regional office, local foundations, churches, schools, and colleges
- * Special Task Forces
- * The Colorado Gerontological Society meeting of the American Society on Aging, San Diego, California
- * Directors of County Departments of Social Services in Colorado

INTRODUCTION

Colorado has a population of approximately 3.3 million persons; thirteen percent are age 60 and over, and about four percent are age 75+. As with most states, a rapid growth in the population age 85 and over is anticipated in the future; from 1988 to the year 2000, a growth of 58 percent is estimated. Tables 1, 2, and 3 illustrate the percent and distribution of individuals by age and impairment levels in Colorado.

For FY 1987-1988, Colorado spent approximately 170 million dollars on long term care. Over three fourths (79%) of the total budget was allocated for nursing home care, while the remainder (21%) was spent on community-based care. Figure 1 illustrates this distribution by funding sources. Figure 2 depicts projected public expenditures for long term care, 1986 through 2010.

Colorado has been struggling over the past ten years to appropriately address the changing needs of its older population. Inadequate resources, conflicting priorities, and a decentralized service delivery system have historically impeded the implementation of major system changes. The infusion of federal dollars for this project served as an enabler for developing increased acceptance of the need for change at local and state levels, and for the actual implementation of system changes within local units. It also accelerated awareness and consensus-building among policy makers at the state level.

For the five years prior to this project, Colorado had a number of significant accomplishments in long term care which created a firm base for change in aging, adult, and long term care programs. In 1980-1982, Colorado was awarded a Long Term Care Systems Development grant from the Administration on Aging to develop a State Plan for Long Term Care. In the period from 1981 to 1983, the Colorado Department of Social Services developed and established the Home and Community-Based Services (HCBS) Medicaid waiver program. A single Level of Care Screen was initiated for admission into Medicaid programs for both nursing homes and the HCBS program. In 1984, an Alternative Care Facilities pilot program was developed to expand resources for Medicaid clients by creating Medicaid certified facilities which provided a lower level of care than nursing homes - this became a permanent program in 1987. Other significant events which occurred between 1984 and 1988 included: passage of the Older Coloradan's Act; licensing of board and care facilities; a case mix reimbursement study, a governor's conference on aging,

TABLE 1

STATE: COLORADO

PROJECTED NUMBER OF PERSONS WITH LIMITATION IN ACTIVITY DUE TO
CHRONIC CONDITIONS AND PERCENT CHANGE BY AGE AND SEX, 1980-2000

TOTAL	NUMBER OF PERSONS (000)'s)			PERCENT CHANGE		
	1980	1990	2000	1980-1990	1990-2000	1980-2000
All ages	402	524	695	30.36	32.47	72.69
Under 65	287	371	507	29.40	36.48	76.61
Under 15	29	36	42	26.28	15.97	46.44
15-44	139	184	209	32.89	13.69	51.08
45-64	120	151	256	26.11	69.13	113.29
Age 65 & over	115	153	188	32.75	22.74	62.93
65-74	62	80	89	28.26	11.99	43.64
75 & over	53	73	98	38.03	34.48	85.62
MALES	1980	1990	2000	1980-1990	1990-2000	1980-2000
All ages	204	267	359	31.24	34.28	76.24
Under 65	154	204	282	31.78	38.51	82.52
Under 15	16	21	24	26.69	16.07	47.06
15-44	77	105	120	35.75	14.87	55.94
45-64	61	78	138	28.14	76.08	125.63
Age 65 & over	49	64	77	29.57	20.80	56.51
65-74	29	38	43	28.51	13.40	45.73
75 & over	20	26	34	31.14	31.59	72.57
FEMALES	1980	1990	2000	1980-1990	1990-2000	1980-2000
All ages	199	257	336	29.45	30.59	69.05
Under 65	133	168	225	26.62	34.03	69.72
Under 15	12	15	18	25.71	15.84	45.62
15-44	61	79	89	29.31	12.13	44.99
45-64	59	73	118	24.01	61.68	100.51
Age 65 & over	66	89	111	35.13	24.12	67.72
65-74	33	42	47	28.04	10.71	41.76
75 & over	33	47	64	42.14	36.06	93.40

TABLE 2

IMPAIRMENT LEVEL AND PERCENT DISTRIBUTION OF INDIVIDUALS 65+ IN COLORADO FOR 1980, 1990 and 2000

<u>Impairment Level (Percent)</u>	<u>1980</u>	<u>1990</u>	<u>2000</u>
Little (%)	175,336 (71)	237,458 (73)	290,323 (73)
Moderate (%)	49,251 (20)	61,612 (18.5)	73,290 (18.5)
Severe (%)	21,777 (9)	27,871 (8.5)	33,299 (8.5)
Totals	<u>246,364</u> (100)	<u>326,941</u> (100)	<u>396,912</u> (100)

Source: Savant Focus Program, 1988

NOTE: Percent growth in population 65+ from 1980-1990 estimated to be 33% and from 1990-2000 to be 22%. U.S. Forecasts are 24.7% for 1980-1990 and 10.2% for 1990-2000.

TABLE 3

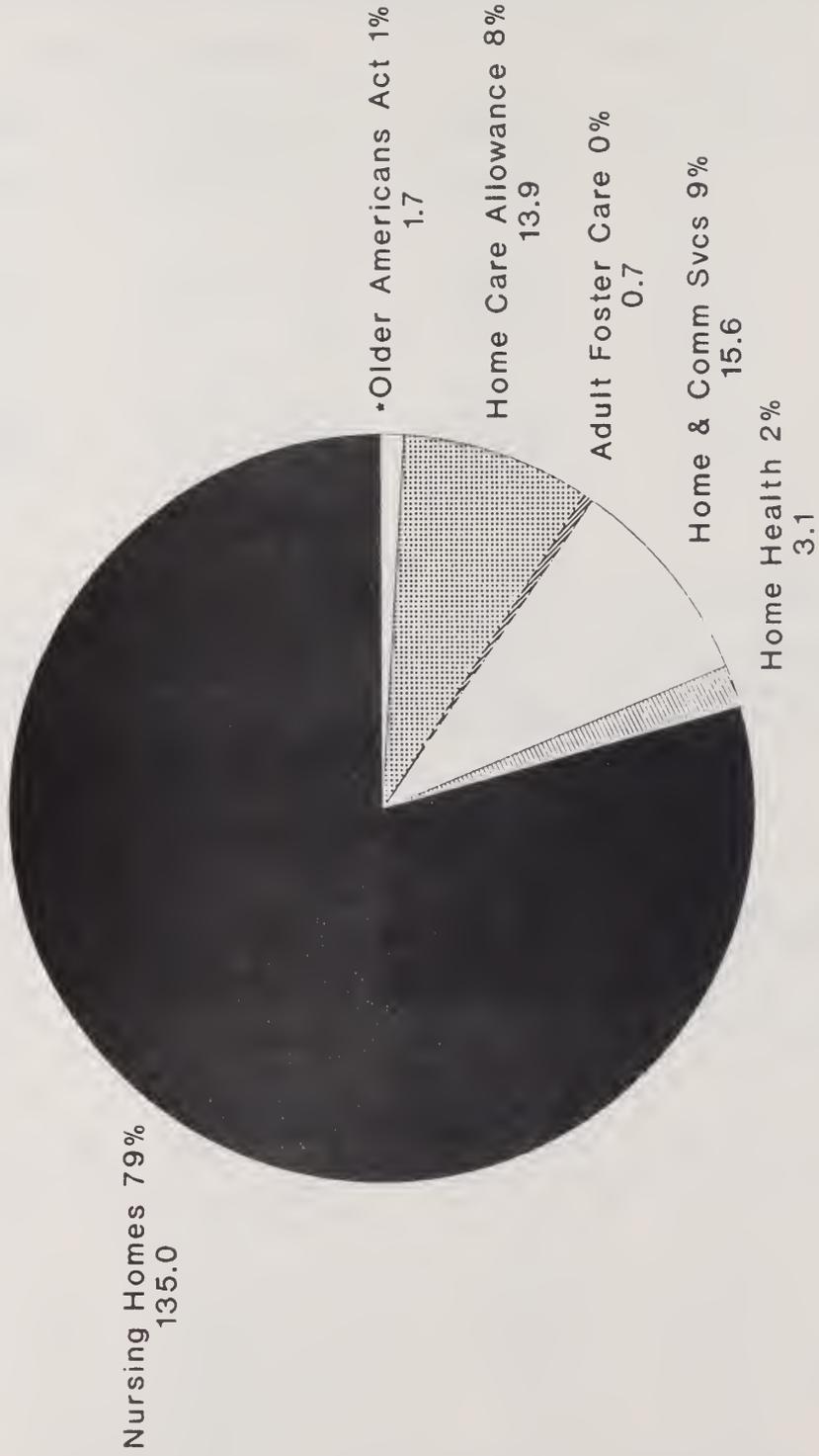
IMPAIRMENT LEVEL AND PERCENT DISTRIBUTION OF INDIVIDUALS 60+ IN COLORADO FOR 1990

<u>Impairment Level (Percent)</u>	<u>1990</u>
Little (%)	343,597 (75.5)
Moderate (%)	74,574 (16.5)
Severe (%)	35,398 (8.0)
Totals	<u>453,569</u> (100)

Source: Savant Focus Program, 1988.

FIGURE 1

Colorado Long Term Care Expenditures Fiscal Year 1987-88

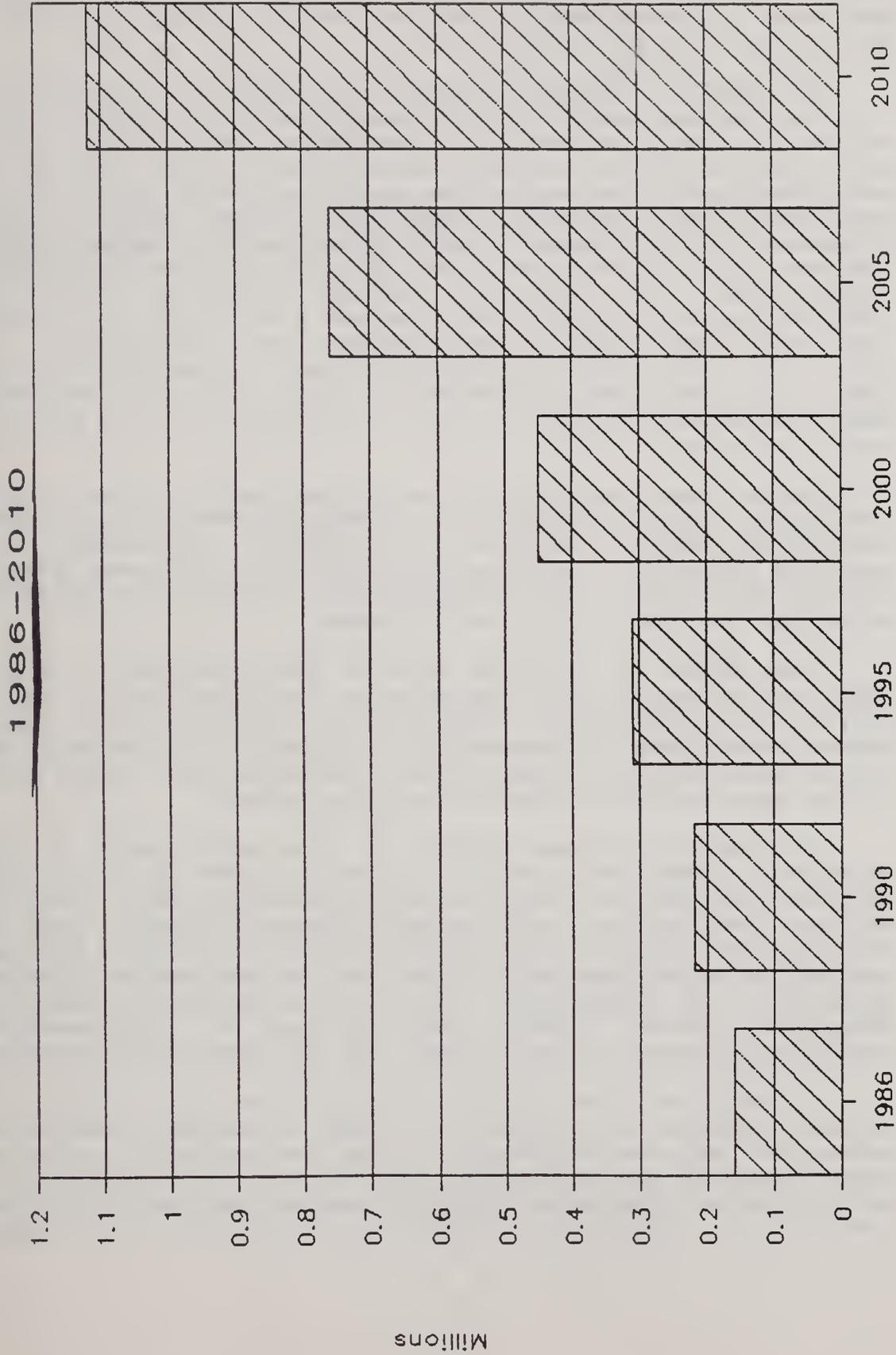


in millions of dollars

*Includes In-Home Svcs, LTC Ombudsman and Home Delivered Meals

FIGURE 2

PROJECTED PUBLIC EXPENDITURES FOR
LONG-TERM CARE IN COLORADO
1986-2010



SOURCE: State Auditor's Office analysis based on State Demographer and Department of Social Services Data.

development of a private-duty nursing program for technology dependent infants and children, and two additional projects funded by the Administration on Aging for training on Alzheimer's Disease and the development of a quality assurance system for in-home services.

In addition, the administrative structure of the various state units responsible for components of the long term care delivery system underwent major reorganizations in 1982, 1986, and 1988. In 1982, a single administrative unit, Aging and Adult Services, was created for programs funded by the Older American's Act, Social Services block grants, Medicaid HCBS programs, and the state-funded program for in-home services, the Home Care Allowance Program. In 1986, the reorganization consolidated the assistance payment component into the division set up in 1982, and created a new unit to address long term care planning, development, and evaluation. In 1988, this division experienced another reorganization, and those programs funded by Medicaid, along with the Long Term Care System Development division, were placed in the Medical Services unit.

While these reorganizations attempted to promote more integrated planning, they also slowed the progress of system development due to changes in leadership, philosophy, and staffing patterns. As a result, building consensus within the Department, the county departments, and the area agencies on aging, has been a difficult process.

The State of Colorado has a state-managed, county-administered social services system; this has been a major barrier to integrating programs and administrative units across county and AAA boundaries. Accessibility of services for clients through a single entity has been problematic, due to the decentralized framework of the system.

The major problems related to the development of any "system" of long term care in Colorado included the following: multiple procedures, policies and assessment tools for the various institutional and community-based programs; lack of coordination among the programs; lack of comparable program evaluation mechanisms and information systems across existing programs; case management is limited to primarily publicly supported clients (HCBS); and the lack of comprehensive quality of care and program accountability monitoring systems.

At the time the original proposal for the project was written, several local areas had begun to design coordinated models for service delivery to older persons which would be more accessible and cost-effective, and to look at better ways to address such issues as adult protection and administrative coordination. Specific efforts at the selected sites needed

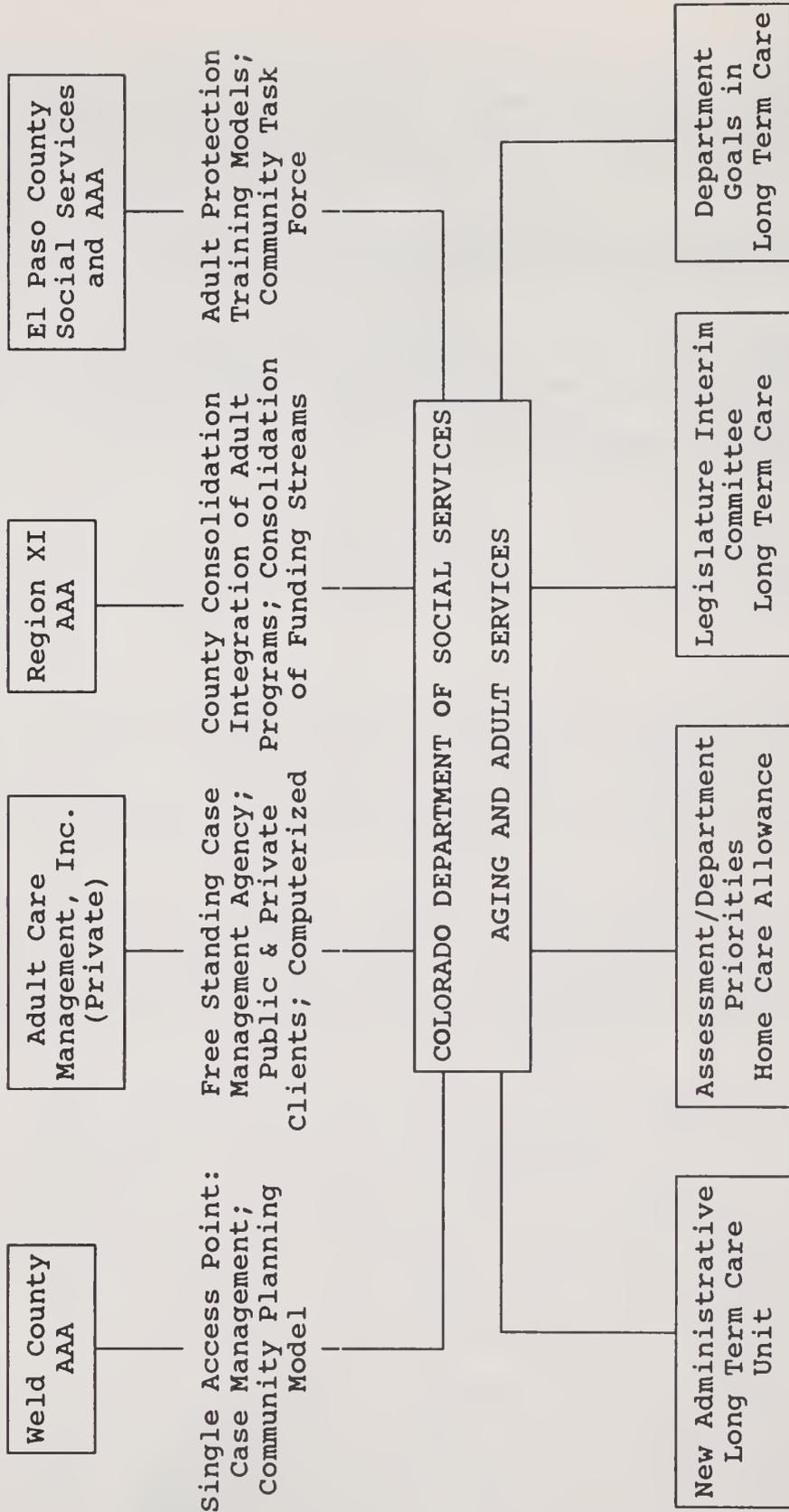
more resources and wider support from the state and local areas. At the state level, major problems existed in linking nursing home and community-based programs, as well as between the State and its local agents in long term care development. Further, no comprehensive, uniform process existed for identifying and assessing clients, and program comparisons and client tracking across public programs was not possible.

In light of these issues, this project originally sought to address the need to develop incrementally key components of a long term care system at local levels along with activities at the state level which focused on policy development (see Figure 3).

FIGURE 3

CONTINUUM OF CARE PROJECT

(January 1986 to December 1988)



METHODS

The overall objective of this project was to develop and demonstrate models for major system changes in aging and long term care programs in Colorado through a continuum of care framework. System design and demonstration occurred at two levels: in four local communities and within the state unit on aging, Aging and Adult Services (AAS), in the Colorado Department of Social Services. This unit had major responsibility for the administration of community-based and financial assistance programs for adult and aging populations. In addition, this unit served as a conduit for long term care system development statewide. Overall, this project has provided support for a major goal of the Department, to develop a statewide coordinated and locally flexible community-based system for the funding and delivery of services which is more comprehensive, accountable, and accessible than the existing system.

The goals, methodology, and results of each site will be described in detail in the body of this report. A brief description of each of the site and the activities conducted at the state level follows.

Denver County: This demonstration focused on the development of a free-standing case management agency, Adult Care Management, Inc. (ACMI), to serve public and private clients. Project funds supported certain key components of this program, including the design of a uniform assessment and case handling procedures, a coordinated referral system, a computerized system for tracking services and the fiscal management of the program.

Region XI: The purpose of this effort was to test the feasibility of developing an integrated social services district by coordinating the administration of adult programs in four rural counties of the state (Mesa, Garfield, Rio Blanco, and Moffat Counties). Products have included data collection, a planning model, and coordination of key political and human services staff through an ongoing task force.

Weld County: The main objective of this site was to design and implement a case management system for a single county, using a community-level planning model which included twenty-five local

agencies. Products of activities conducted at this site include: a community-level plan, a uniform intake form, and computer application for handling referrals and client tracking, model agreements for interagency coordination, an evaluation design, models for client assessment, case planning, and case management; and training for program staff.

El Paso County: This demonstration focused on a training program and community education model for addressing adult protection problems at the local level. Products include training modules for community leaders and agencies, community education forums, coordinated referral procedures, a training manual, and statewide training replication.

At the state level, this project was operated out of the state unit on aging, Aging and Adult Services, at the Colorado Department of Social Services. Project staff consisted of a project director, a part-time staff assistant, and a computer consultant. Activities undertaken by state staff, which related to long term care system development were integrated with the project objectives as appropriate.

Technical assistance, overall project management, and direction were provided to the sites by the state staff. Team meetings were held regularly and on-site visits were made. Training for staff was provided, particularly in the area of computer applications. A forecasting model for long term care population needs in Colorado was purchased from Savant, Inc. to support long term care planning efforts at the local level. This information was made available to the area agencies on aging and training was provided on utilization of these materials.

Project staff provided a leadership role in many of the activities undertaken within Aging and Adult Services. The main focus of these tasks was to established goals and objectives for the long term care system, design, and marketing of these concepts to the policy makers within the Department.

RESULTS

The major results of this project at the state level which related to the development of a long term care system included the following:

1. Development of system-wide goals and objectives for long term care. Prior to this project, there was little awareness of the long term care issues which needed to be addressed within the state. One of the first action steps taken was to provide information to Department staff in aging and adult programs and to obtain consensus on the specific goals and objectives which the Department needed to address in formulating public policy on long term care. Although these were modified over the project period, the initial effort served as a mechanism for achieving staff support for any change efforts.
2. The establishment of a Long Term Care System Development Division within the state unit on aging. During the second year of the project, a unit was created composed of four staff persons, to develop long term care planning policies and procedures; coordinate long term care design efforts, and to manage federal and local grants which addressed various pieces of the system reforms. This development supported the goal of making major changes in the long term care delivery system within the Department.
3. The development of a Legislative Task Force on Long Term Health Care to study, over a two-year period, the changes needed in long term care and to introduce the necessary legislation to accomplish this.
4. The development of an assessment instrument for the Home Care Allowance (HCA) Program. One of the major recommendations during the course of this project, particularly from the two case management sites, was the need to develop a single assessment process for all long term care programs. A sudden increase in the number of applications for the HCA Program occurred, resulting in overall budget problems. It should be noted that the HCA program provides a state stipend for the care and support of frail

elderly and disabled adults living in their own homes, and as such, is a key resource for a statewide, community-based delivery system. As a result, the first statewide assessment instrument for programs outside the Medicaid delivery system (HCBS) was developed for the HCA Program. Unfortunately, legal problems temporarily halted the use of this instrument after it was implemented. Its utilization was, however, the forerunner of the development of a uniform assessment instrument for all programs, which began as this project ended. Funds were initially requested from the legislature for instrument development. When this was unsuccessful, support was sought and received from a local foundation for the development phase of the assessment process. Most of the key actors within the Department supported the need for this instrument.

5. Conducted training on long term care for local agencies, organizations, the AAA's, the federal regional office, and selected state and county social services staff. In addition, project staff provided technical assistance on long term care planning and development for AAA's as they requested it. This training addressed planning skills; long term care issues from national, state, and local perspectives; and development work occurring in long term care in other states (Oregon, Nebraska, North Dakota, Utah). In addition, the National Conference on State Legislators provided training on working with state legislators.
6. During this period, we applied for, and received, additional funding to develop other components of the long term care system. Scarce resources within the Department had made it impossible to conduct much development work in this area. Additional funding from the Administration on Aging (AoA) and a local foundation was received. The AoA projects included an Alzheimer Disease training project and a quality assurance for in-home services project. A local foundation provided match for this project.
7. A major sub-goal of this project was to assist local areas, through the AAA's, in assessing their long term care service needs and preparing plans to address these issues. To assist in this activity,

we purchased from Savant, Inc., service need forecasting data on Colorado. This data was broken out by local areas and was used in training and for forecasting service needs. In addition, the data was made available to AAA's for general planning.

8. Model components of the long term care system in Colorado were developed by the sites. The Department assembled the major decision makers to establish a strategy for designing and implementing the necessary changes in the long term care system and the information developed by project participants provided an important back drop for policy-making within the Department of Social Services.

EL PASO COUNTY

BACKGROUND

The overall objective of this demonstration was to improve the capability of the courts, law enforcement personnel, and other community agencies to appropriately identify, evaluate, and refer elderly persons suspected of being abused, neglected, and exploited to county departments of social services. This effort was achieved through the coordinated activities of the Pikes Peak Area Agency on Aging (AAA) and the El Paso County Department of Social Services.

Prior to the beginning of this project, staff from the County Department and the Area Agency had been informally working together for several years to facilitate cooperation between the agencies and develop additional resources to address the problems of adult abuse and neglect. The funding for this project facilitated this effort by enabling the hiring of a staff person to implement the ideas and strategies generated by these agencies.

METHODOLOGY

This project was managed jointly by the AAA and the El Paso County Department of Social Services. A full-time trainer/coordinator was hired to develop and implement the training and to conduct the community coordination activities. This individual was housed in the County Department and received supervision from a staff person at the Department. The AAA staff provided fiscal management and overall project

supervision. A faculty member in the gerontology program at the University of Colorado in Colorado Springs provided consultation to the project in evaluation and training design, and provided training components as necessary. The following activities were conducted during the project (these activities are described in detail in the project manual entitled, Elder Abuse: Identification, Referral and Intervention at the Community Level):

- * Core community groups were identified for in-service training and participation on the advisory group for the project. These included representatives from: police, fire departments, law enforcement, mental health, nursing homes, social services, health, senior service programs, domestic violence, and hospitals.
- * A pre-test and preliminary needs assessment were administered to the core group of community participants to identify content areas which needed to be addressed in the on-going training sessions.
- * A community advisory group was formed for the project, comprised of representatives of the core agency groups. The purpose of this group was to assist in identifying the participants, the training needs, and the major issue areas which needed to be addressed in training.
- * In-service training sessions were provided for the designated core groups. The content of the training was designed by the project staff, who used existing training materials and films adapted for this training. These training sessions, served as an initial introduction to the major adult protection issues facing local communities (See manual for details).
- * A major workshop was conducted for the core group and other community participants. Approximately 120 individuals from the legal, social, and health fields attended. Ms. Mary Joy Quinn, of San Francisco, was the keynote speaker. Content areas addressed included: data and problem significance; legal aspects of adult protection; identification, referral, and intervention, prevention and treatment; a panel discussion; and role playing.

A post-test of participants was administered at the end of the conference, and results were used in modifying future training sessions.

A three-part approach to training design and information gathering was initiated, including surveys of community leaders, interviews of community leaders and with key informants, and compilation of the results. The objectives of this component of the project included:

- * Examining the major parameters of community knowledge concerning adult abuse and neglect
- * Determining guidelines used by various factions of the community in working with adult abuse issues
- * Providing an open ended forum for suggestions and comments concerning adult abuse issues to increase community cooperation

Interviews were also conducted with various community service providers in addition to the designated core groups. This process verified that the major areas of concern regarding adult abuse as identified by the advisory council and project staff were on target and consistent throughout the community. In addition to the initial and ongoing training, the following activities were also coordinated as a part of this project:

- * The coordinator of this project served on statewide groups on adult protection, such as the Adult Protection Legislative Committee, the statewide Adult Protection Task Force, and the Adult Protection Task Force in El Paso County.
- * The Adult Protection Task Force in El Paso County evolved from the Elder Abuse Awareness Advisory Council to provide a vehicle for case coordination, case planning, community education, care monitoring, and public policy making.
- * Secondary groups (staff from nutrition sites, home-delivered meals, rehabilitation, paramedics, emergency room staff, the Medicaid waiver program, senior recreation programs, and senior housing) were identified in the community during the second year

of the project and in-service training was provided to them.

- * A training manual, public service announcements, and a video were developed during the second year. These materials provide the framework for further replication activities.

- * A specific community planning model was developed to be used in state-wide training and replication activities to assist other local areas in developing adult protection task forces. This model was developed from the findings of the training and evaluations conducted during the first eighteen months of the project in El Paso County.

RESULTS

The products developed at the El Paso County site included: the formation of community groups and coordination concerning adult protection issues, in-service training sessions for community leaders, a one-day workshop, participation in training at a statewide conference, statewide training in 30 counties, production of a video, media presentations, and a training manual. Each of these activities is described briefly below.

The process of project coordination for this site began with the creation of a mutual understanding between the Pikes Peak Area Agency on Aging and the El Paso County Department of Social Services. As a result of this agreement, a long-term working relationship between the two agencies was established. This interagency coordination has enabled the quality of services for elderly persons of both agencies to be enhanced by the networking benefits provided.

Community involvement was initiated by selecting the members of the Elder Abuse Awareness Advisory Council which included key community representatives from the health, social, and legal service fields. Monthly advisory council meetings provided members with the opportunity to gain a better understanding of adult protection issues through training, policy making, and networking. Council members were surveyed and interviewed regarding community attitudes on adult protection issues. This information provided the basis for training design.

This process provided a community overview of the problem of elder abuse and as a result of training sessions and monthly meetings, elder abuse was acknowledged as a community problem. The Adult Protection Task Force has continued to address community attitudes and problems associated with elder abuse. Serving the Victim of Elder Abuse, a packet of materials adapted by the project coordinator, provided valuable information from which the task force was modeled; and it has been distributed for task force modeling purposes around the state.

The Adult Protection Task Force in El Paso County has continued to provide long-term assistance in support, case planning, community education, monitoring of special cases, and members increased the task force communication among themselves regarding elder abuse issues. An increase in requests for information and on-going referrals to the Department of Social Services Adult Protection Unit were reported as a result of the work of the task force.

On October 13, 1987, professionals from El Paso and Teller Counties attended the first seminar held in the region concerning elder abuse and neglect. Professionals from the legal, social, and health fields were notified of the conference by written correspondence, and fliers were posted throughout Colorado Springs.

Approximately 120 people attended the day-long training session designed to encourage professional development. The following morning and afternoon sessions offered were: data and problem significance; legal aspects; identification, referral, and intervention; and prevention and treatment. The remaining sessions of the conference were open to the general public and included the keynote address, a panel discussion, role playing, and a wrap-up session. Many of the conference participants had previously completed a project "post-test". The purpose of the post-test was to measure the gain in information trainees received from the training sessions and the conference. The information provided by the results indicated the areas which needed to be emphasized during future training. The majority of the "pre-test" and "post-test" questions were altered and adapted to become the widely used Discussion Questionnaire (see Manual). It should be noted that the majority of participants involved with the "post-test", (a sample of 52 individuals), were professionals in related fields. The Discussion Questionnaire was distributed around the state to over 1,500 trainees.

Adult protection caseworkers and generalists from throughout the state of Colorado received training on adult protection issues during a three-day seminar in April 1988. The Continuum of Care training portion of this conference,

entitled "Ethical Issues: Ethics and Casework Intervention," was based upon a video entitled "Difficult Choices: Ethical Issues in Casework," produced by the University Center on Aging, University of Massachusetts. Approximately 120 participants received information crucial to ethical casework decision-making and guidelines were developed for future training sessions.

Several publications and a video were developed during the grant period. The project manual, Elder Abuse: Identification, Referral and Intervention at the Community Level, was distributed to county departments of social services and area agencies on aging throughout the state. The purpose of the manual was: to provide information on elder abuse; to provide the information necessary to replicate the Continuum of Care pilot project in other areas of the state; and to assist in the establishment of adult protection task forces at local levels.

Eight hundred copies of the manual were printed. Five thousand brochures were printed for distribution county-wide and then statewide for duplication. The brochure provides at-a-glance information on elder abuse, neglect, and exploitation.

A public service announcement (PSA) was developed and distributed to encourage community awareness and acknowledgment of the problem of elder abuse. The announcement also indicated whom to contact to make a referral of a suspected elder abuse case. A video entitled "Elder Abuse: Casework Intervention" was developed to show a case example to new adult protection workers and to reacquaint veteran caseworkers with casework techniques. Statewide distribution of the video has been accompanied by video guidelines and training materials.

Local television and radio appearances provided elder abuse information to the general public in El Paso County. Many viewers and listeners reacted with predictable shock, having never heard of the problem of elder abuse. Referrals resulted from every spot, indicating the necessity of continued radio and television appearances in the future.

The purpose of telephone communication with counties statewide was to emphasize the value of the project and reinforce county efforts to replicate the project during this period. The publications and video provided professionals throughout the state with the opportunity to obtain materials designed to address the many facets of the elder abuse problem.

STATEWIDE TRAINING

During the six-month period from June to December, 1988, participants from thirty counties throughout the state of Colorado received the training on how to develop community task forces on adult protection. The purpose of the training was three-fold:

- * To enhance participant awareness of elder abuse, and the procedures for referral and intervention
- * To encourage replication of their training, as outlined in the project manual, on a community-wide level
- * To educate participants about the formation and advantages of adult protection task forces

Participants in this training included clergy, staff from police and fire departments, mental health counselors, long-term care facility staff, department of social services personnel, home health care workers, area agency on aging staff, the nursing home ombudsman, senior volunteers, hospital staff, senior service providers, county health department staff, outreach workers, legal services, and county attorneys. The evaluation process for the statewide training indicated a unanimously positive response to the training, and replication of the project was usually seen as an important and feasible community goal. Many participants asked for further assistance in establishing their county-wide adult protection task forces.

RESULTS

Two major changes occurred in referral patterns of adult protection cases since the project began. Referrals to county departments increased and these referrals were more appropriate than in the past. It can be assumed that the provision of statewide training influenced these patterns. Hopefully, as task forces continue to be implemented in local areas, community "ownership" of this problem will be accelerated, and adult protection cases will be handled more appropriately.

The project training throughout the state of Colorado was extensive during the grant period. Two areas of concern continued to surface during the training sessions, indicating that more work needs to be done in this area. First, much

more time is needed to help individual counties actually establish their adult protection task forces. This process takes a long time and cannot be done in many of the rural counties without professional staff, experienced in adult protection. Second, no training curriculum addressing competency currently exists in Colorado. Workers in various human service fields are now required to assess an individual's competency, with or without screening tools and mental status examinations. As a result, both professionals and clients can be placed in very precarious positions.

SUMMARY

The scope of work undertaken at this demonstration site was extensive, including training, public relations, and agency and program coordination concerning adult abuse and neglect. While the original focus was on activities in a single county, El Paso, the training was extended statewide and major efforts were made to replicate the development of adult protection task forces in many local communities. The response to this demonstration was very positive; the work conducted made an appreciable difference in how the system now responds to adult abuse and neglect. An increase in more appropriate referrals was documented in El Paso County and community awareness of this issue increased statewide.

REGION XI

BACKGROUND

The overall purpose of this demonstration was to study the feasibility of consolidating the funding sources and the administration of publicly supported aging and adult programs among four counties (Mesa, Moffat, Rio Blanco, Garfield) on the western slope of Colorado.

There had been a strong interest in integrating programs in this part of the state since 1983. The major impetus for this came from the Associated Governments of Northwest Colorado (AGNC) and the Area Agency on Aging which is part of the AGNC. Initially, the AAA and the county commissioners sought to streamline public programs for older persons. Concern centered around cash flow delays in funding from the state to the counties and lack of local control in budgeting and program development. Counties also felt that the State did not acknowledge the large amount of local support that was

provided for elderly programs in the area. At that time the Colorado Department of Social Services was developing a Long Term Care Plan and the Aging and Adult Services unit was formed to consolidate programs at the state level. Given these activities, community leaders on the western slope felt it was an opportune time to press for local program consolidation. Policy-level discussions were held between the Associate Director at the State Department of Social Services, county commissioners, and AGNC staff. The focus of these interactions was on possible alternative methods for financing and programming of aging programs in this region. Unfortunately, these discussions were not continued, due primarily to the lack of resources needed to complete a comprehensive feasibility study of the issues and problems surrounding the integration of aging and adult programs in the area.

In 1984, a major policy paper was developed by the Colorado Department of Social Services. The purpose of this document was to outline policy options for determining the role of the area agencies on aging and allocations for Older American Act funds statewide. The AGNC and County Councils on Aging in the area took this opportunity to support the option to block grant Older Americans Act funds, with the AAA's playing a lead role in the administration of these dollars.

In 1985, funds became available through this project to support a full-fledged study of the feasibility of consolidation in this area and to assist in making policy recommendations regarding the creation of service areas.

METHODS

Activities at this site were managed by the Director of the Area Agency on Aging in Region XI. This AAA is an administrative entity under a regional council of governments.

A local task force was formed to study this matter, including representatives of county departments of social service, county commissioners, consumer representatives, members of the Aging Advisory Council, and field staff from the Colorado Department of Social Services. The AAA chaired this group which met approximately every two months during the first year and less frequently during the second year. The purpose of this task force was to review statutory, demographic, programmatic, and economic information presented by the project staff and to make recommendations regarding any consolidation activities.

In addition to the task force, three consultants were retained to develop special reports, prepared as background materials for any decisions which needed to be made. The reports, described in more detail in the next section of this report, addressed characteristics and service needs of the elderly population, public programs, regulatory issues related to changes in any state policies and procedures, and the fiscal implications of combining programs.

In addition to the collection and analysis of relevant information, the site project director met at frequent intervals with county staff and commissioners to collect fiscal and program data and to establish working relationships with the key actors. State staff attended some of the meetings of the task force and made presentations regarding the project as appropriate.

RESULTS

Four major products were developed as a result of activities at this site: 1) an analysis of the older population in this region, their characteristics, and service needs; 2) a study of the regulatory barriers or constraints in the state social service system which would enhance or prohibit consolidation at the county level; 3) an analysis of the program areas under consideration, their services and eligibility requirements; and, 4) a financial analysis of the county management of aging and adult programs in the region.

In addition to the information obtained from the site consultants, the frequent interchange of information about the project among county directors and staff on the task force facilitated interaction among a range of county officials, educating them about long term care issues and problems and potential alternative solutions to them.

The following information describes each of the major products:

1) **A Model for Developing a Regional Service District**

This report outlines a model for integrating service programs in the Region XI population. National, state, and county demographic data is presented for the elderly population including characteristics and services utilization (nursing homes, home care allowance, HCBS, casework services, and adult protection). Estimates are presented by county for the need for long term care as well as the resources currently available for the area, based on the methodology developed in the report, Aging

America, prepared by the U.S. Senate Subcommittee on Aging. In addition, 1980 census data was used to project population changes for the elderly by age cohorts (see report in Appendix).

2) **A Statute and Regulatory Review**

This report presents the findings of two research efforts; a review of state and federal documents and interviews with staff from the Colorado Department of Social Services, county departments, and other social service agencies providing long term care. This study concluded that, from a regulatory perspective, there were no regulatory barriers to developing a social services district in Region XI. It was felt that program integrity could be maintained while allowing for increased efficiency in planning and administering service delivery. New procedures for monitoring and fiscal accountability would be need to be developed at the state level. Additionally, there was nothing in the written program regulations for Medicaid, the Home Care Allowance program, the OAA programs, and Adult Protection which would prohibit consolidating these programs under a single administrative unit. However, fiscal and programmatic reporting requirements would need changes. Funding of matching requirements and eligibility determination would also need to be clarified and negotiated among participating counties and the state agency (see report in Appendix).

3) **Aging and Adult Programs**

A chart was prepared (see Figure 4) to provide descriptive information about the programs housed in the county departments of social services, including eligibility determination for the programs and casework service activities.

4) **Financial Analyses**

Data was collected from the county staff and staff at the Colorado Department of Social Services regarding full time equivalents (FTEs) and funding allocations to the counties, and expenditures by functional areas (casework and eligibility determination). In addition to the provision of descriptive information, the major findings from these analyses included: more FTE's and dollars are

usually allocated to eligibility determination than casework services, and three of the four counties spent less money on adult programs than was allocated for this purpose from the state (see Tables 4-8).

SUMMARY

Although the activities at this site did not result in the formation of a new district for the administration of aging and adult programs, the work completed provided a framework of information concerning regionalization. A major goal of the Colorado Department of Social Services has been to examine the feasibility of combining funding sources for long term care, including the administration of programs. In addition, a recent study commissioned by the Legislature, recommended regionalization of the social service system.

To assist in this development, the following recommendations were made from work completed at this site:

- * A major obstacle to consolidating the functions of counties relative to aging and adult programs is the fact that this would require political and financial restructuring of the delivery system. Dollars allocated by the state to the counties are awarded to specific program areas, but counties have the flexibility once they receive these funds to shift them across programs. These dollars are often reallocated from aging and adult programs to children's programs, where the service demands are higher. Consolidation could conceivably mean fewer administration dollars for some of the counties and higher costs to county governments.
- * There was considerable discussion among the smaller counties in the region that if consolidation were mandated, the smaller units would end up giving dollars to the larger counties.
- * It was recommended that the state assume a more proactive role in administering social services by demanding more accountability from the counties, both programmatically and fiscally. There is relatively little accountability at the present time as far as programming is concerned.

- * Currently, counties receive more dollars and FTE's for eligibility determination than for casework services. This matter needs more investigation in order to determine where these functions should be housed if aging and adult programs were combined. In general, it was felt that counties should be required to report expenditures by program areas. However, at the very basis of this issue lies the county-administered social service system in Colorado, which not only supports, but is built upon a philosophy of local flexibility and self-determination.

- * Because counties operate autonomously in their administration of social services, there is some distrust between them and the state department, as well as a prevailing attitude of laissez-faire. These attitudes present barriers to consolidation.

FIGURE 4

AGING AND ADULT PROGRAMS
ADMINISTERED BY THE COUNTIES, 1988

PROGRAM	ELIGIBILITY	ASSESSMENT	MONITORING OF CASE	CASE DOCUMENTATION	REDETERMINATION	FACILITY EVALUATION
Home Care Allowance	Recipients of or eligible for OAP AND/SSI-CS, AB/SSI-CS. Appl. taken by income maintenance tech.	Completion of LTC-101 to determine medical and functional needs. Home visits to verify needs and determine amount of services.	Quarterly contact to assure continuing need.	Open service case with all contacts written on ROC sheets. Summary at end of each activity period.	Social Services Agreement (SS-6) every 6 months LTC-101 - yearly financial eligibility - yearly	N/A
Adult Foster Care	Recipients of or eligible for OAP, AND/SSI-CS, AB/SSI-CS.	Completion of LTC-101 to determine medical and functional needs. Home visit to determine appropriateness for AFC.	Weekly contact by caseworker with client and facility for first month, then at least quarterly.	Open service case with all contacts written on ROC sheets. Summary at end of each activity period.	Social Services Agreement (SS-6) every 6 months LTC-101 - yearly Financial - yearly.	Yearly by county dept.
Casework Services for HCBS Clients	Any client being assessed for or receiving HCBS services.	Completed with HCBS case manager to determine needs, plans, goals.	Contact frequently varies case to case. Periodic staffings with HCBS case manager.	Open service case. Written summary at end of each activity period.	Every 6 months	N/A

AGING AND ADULT PROGRAMS

ADMINISTERED BY THE COUNTIES, 1988

FACILITY
EVALUATION

REDETERMINATION

CASE

DOCUMENTATION

MONITORING

OF CASE

ASSESSMENT

ELIGIBILITY

PROGRAM

Protective Services Without regard to income or resources. Required intake information in writing. Determine if client is known to Dept. Face-to-face contact to eval. client. Assistance from law enforcement if necessary to gain admittance. Make decision of need for protective intervention in 30 days. Varies case to case. Cases not requiring protective services are closed within 30 days of decision. Open service case with all contacts written on ROC sheets. Medical, police, legal, financial reports included At least every 6 months to determine continuing incapacity and risk or to establish reasons for closure. N/A

Home and Community Based Services Clients who meet Medicaid financial requirements, nursing home level of care criteria, and for whom HCBS is determined to be both appropriate and cost-effective Verify Medicaid eligibility. Completion of LTC-101 and referral to PRO for level of care screen. Face-to-face contact to determine service needs. May request home health assessment. Determine appropriateness for ACF. For deinstitutionalized clients monthly face-to-face contact for 6 months. All other clients can be seen quarterly. Contacts with service providers. Case file for each client to include all state prescribed forms. Written documentation of all client and collateral contacts. Written summary at end of case plan period. At least every 12 months or before end of length of stay assigned by PRO. Completed by Colo. Dept. of Health & Colo. Dept. of Social Services

Prepared for the Region XI, Continuum of Care site.

Table 4

Comparison of FY 1988 and FY 1989
for Aging/Adult Programs
FTE Availability by Function

COUNTY	<u>CASEWORK</u>			<u>ADULT PROGRAMS</u>		
	'88	'89	CHANGE	'88	'89	CHANGE
Garfield	2.8	4.7	+1.9	2.39	3.65	+1.26
Mesa	6.7	8.58	+1.98	7.97	10.10	+2.13
Moffat	0.46	0.40	-0.6	1.24	0.88	-3.6
Rio Blanco	0.47	0.01	-0.46	0.69	0.4	-0.65

*After legislative adjustments

Table 5

SSBG Dollars Allocated for Aging/Adult Programs*

by Line Item, FY 1988

COUNTY	PERSONAL	%	OPERATING	%	TRAVEL	%	SPACE	%	TOTAL ALLOCATION
Garfield	\$123,657	85.4%	\$11,013	7.6%	\$5,989	4.1%	\$4,121	2.8%	\$144,780
Mesa	334,662	89.4%	25,201	6.7%	3,948	1.0%	10,542	2.8%	374,353
Moffat	36,184	83.9%	3,607	8.4%	1,962	4.5%	1,350	3.1%	43,103
Rio Blanco	<u>26,747</u>	<u>85.0%</u>	<u>2,462</u>	<u>7.8%</u>	<u>1,339</u>	<u>4.2%</u>	<u>921</u>	<u>2.9%</u>	<u>31,469</u>
TOTAL	\$521,125	87.8%	\$42,283	7.1%	\$13,238	2.2%	\$16,934	2.8%	\$593,705

*Included 20% match from counties.

TABLE 6

FTE Allocations by Program Areas

for

Aging/Adult Services, FY 1988

COUNTY	TOTAL	PROGRAM AREA I	PROGRAM AREA II	HOMEMAKER PROGRAM
Garfield	2.16	0.38	0.78	1.00
Mesa	4.76	4.20	0.45	0
Moffat	0.36	0.5	0.21	0
Rio Blanco	<u>0.03</u>	<u>0.02</u>	<u>0.01</u>	<u>0</u>
TOTAL	7.31	4.75	1.45	1.00

Table 7

Funds Allocated to Counties*

for

Aging/Adult Programs and Dollars Expended, FY 1988

COUNTY	SSBG	%	EARNED		COUNTY CSBG	%	TOTAL		DIFFERENCE
			HCBS ('87)	%			\$'s ALLOCATED	DOLLARS EXPENDED	
Garfield	\$144,780	87.9%	\$10,000	6.1%	\$10,000	6.1%	\$164,780	\$104,560	\$+60,220
Mesa	374,353	90.3%	40,000	9.6%	0	0.0%	414,353	472,512	-57,159
Moffat	43,103	100.0%	0	0.0%	0	0.0%	43,103	22,610	+20,493
Rio Blanco	<u>31,469</u>	<u>91.3%</u>	<u>0</u>	<u>0.0%</u>	<u>3,000</u>	<u>8.7%</u>	<u>34,469</u>	<u>20,000</u>	<u>+14,469</u>
TOTAL	\$593,705	90.4%	\$50,000	7.6%	\$13,000	2.0%	\$656,705	\$619,682	\$+37,023

*Includes 20% County match

TABLE 8

Casework and Eligibility Functions: Allocations and Expenditures
for Aging/Adult Programs, FY 1988

<u>CASEWORK</u>				<u>ADULT ELIGIBILITY</u>			
FTE's Allocated	SSBG \$'s Allocated	Expenditures	Difference	FTE's Allocated	SSBG \$'s Allocated	Expenditures	Difference
2.8	\$78,109	\$54,560	\$+23,549	2.39	\$66,671	\$50,000	\$+16,671
6.17	163,234	249,146	-85,912	7.97	211,119	223,366	-12,247
0.46	11,663	9,121	+2,542	1.24	31,440	13,489	+17,955
<u>0.47</u>	<u>12,841</u>	<u>10,000</u>	<u>+2,849</u>	<u>0.69</u>	<u>18,628</u>	<u>10,000</u>	<u>+8,628</u>
9.9	\$265,847	\$322,827	-56,972	12.29	\$327,858	\$296,855	+31,003

WELD COUNTY

BACKGROUND

The purpose of this demonstration was to design and implement a single access case management program at the Weld County Area Agency on Aging, utilizing a community planning model.

Weld County is a large (4,000 square mile) rural area on the eastern plains of Colorado which includes 28 small towns and cities. It is an area rich in human services resources which includes most of the necessary components of a long term care continuum.

The Weld County AAA was selected as a site for this project, primarily because of the prior existence of a very successful 25-member agency planning committee on long term care. Additionally, the AAA served a single county, had high visibility in the community, and an excellent working relationship with the provider community. The AAA had set up a very successful rural network of senior aide coordinators who served as coordinating resources in the more remote areas of the county. Historically, there has been a good working relationship between the host agency for this AAA, the Weld County Department of Human Resources, and the County Department of Social Services, which served as the local case management agency for the medical waiver home and community-based services program. In sum, Weld County had the necessary ingredients to plan and put in place a case management program. However, at the time of start-up, the community lacked effective coordination, had services duplication, and older persons lacked easy access to appropriate services in the area.

The program goals for this site included the following:

- * To achieve coordination and integration of the service delivery system.
- * To improve older adults' accessibility to services by providing a single entry point.
- * To ensure the future financial support of the case management program by reordering existing resources, and generating new sources of funding.
- * To develop computer capability which would support casework, benefit assignment, tracking, reporting, data collection, and assist with overall evaluation.

- * To integrate this program with existing case management systems in the area.

METHODOLOGY

This project operated under the direction of the Weld County AAA Director and a part time Administrative Assistant. The AAA's Long Term Care Committee, which had been in operation since 1981, provided the vehicle by which the case management project was planned and operationalized.

This committee is comprised of 25 provider agencies in the community, including nursing homes, home health agencies, social services, hospital discharge planners, adult day care facilities, mental health staff, the long term care ombudsman, and staff from the gerontology program at the University. The committee was first organized by the Board of County Commissioners to assist in the mandate to develop the County's Home and Community Based Services program through planning, coordination, and resource development. The AAA had provided staff assistance and direction for the committee since 1984 and continued to do so for this project.

In January 1987, the AAA Director and the Administrative Assistant for the project developed a work plan which acted as a guide for the future months in planning the case management program. The action plan was developed to assure buy-in from the total community, and to provide the Weld County Long Term Care Committee with a basic framework to begin to understand the proposed case management program.

Because the case management process lent itself to being divided into several planning components, four areas were identified in which Long Term Care committee members could work. These components were identified as: resource development, client-finding and outreach, assessment, and model development. The plan established subcommittees from the Long Term Care Committee to work on the development of each of these major planning areas. The action plan was then presented to the Long Term Care Committee in February 1987, to assist the committee members in understanding how the planning process would take place in Weld County and to begin to enlist their support in the process.

The major tasks for the working committees included the following:

- * **Resource development:** The objective of this committee was to identify, plan, and implement needed services in the community. Members of the

committee researched the community in order to identify gaps in services. Guardianship programs, respite care, adult day care, and home-delivered meals were identified as areas where there were gaps in services.

- * **Assessment/screening:** To develop assessment and pre-screening tools for the case management program.
- * **Client finding/outreach:** To develop methods for identifying client populations, outreach strategies, and program marketing.
- * **Model development:** To develop a case management process, including a client pathway, program components, record keeping, and the evaluation component.

In order to assure that all of the community members had the same level of knowledge regarding long term care, the Area Agency on Aging contracted with Dr. Priscilla Kimboko, Assistant Professor, Gerontology Program, University of Northern Colorado, to provide a four-hour training session on case management. The AAA and Dr. Kimboko met to outline those areas in which the committee members would need training, and identified ways to address issues or concerns which had already been expressed. The training took place on March 17, 1987, and was attended by almost all of the Long Term Care Committee as well as two members of the AAA Advisory Board. At the end of the training session, Long Term Care Committee members were given the opportunity to sign up for the subcommittees which had previously been identified in the action plan.

The AAA reviewed the subcommittee membership to identify any gaps; it was felt that each committee should include one strong leader who was committed to the idea of case management. Prior to the first meetings of each of the subcommittees, the Administrative Assistant researched other programs and models to gather information for distribution to each of the subcommittees. It was important to find a model that fit with the overall philosophy of the county and the AAA. The material collected included assessment tools and guidelines for the construction of assessment tools, pre-screening tools, models and flow charts of other programs, and resource identification charts. A subcommittee progress report was presented by each subcommittee chairperson to the Long Term Care Committee.

Three main groups were involved and consulted in the developmental process for this project: the Long-Term Care Coordinating Committee described above, the Senior Aide Program of Weld County, and the Aging Advisory Board for the AAA. The Senior Aide Program is a non-profit group consisting of nineteen rural senior aid coordinators responsible for outreach and information and referral for the rural areas of the County. It was anticipated that these individuals could serve as referral sources for the case management services. The AAA Advisory Board was an active participant in the planning of this project. It is represented by 16 members and acts as a direct advisory group to the Board of County Commissioners on policies regarding older persons.

RESULTS

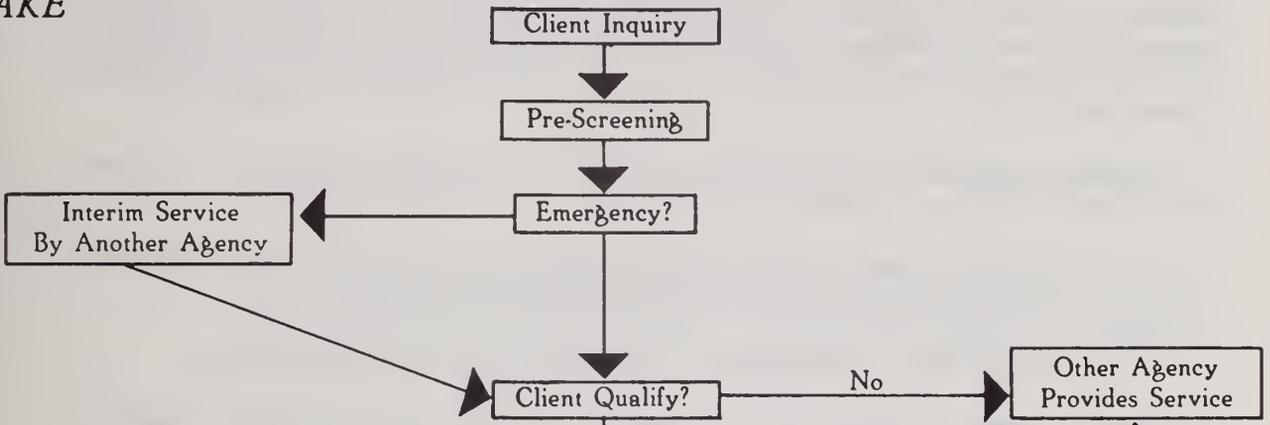
The overall goal at this site was to develop a case management program which would be available to any client regardless of sources of income. As a result, a two-step process was initiated: the implementation of a case management component for non-Medicaid clients as part of the AAA's activities and the subsequent integration of the publicly supported Medicaid waiver case management program (HCBS) into the AAA, thus serving private and public clients in a single setting.

The major results of this effort were twofold: the development of a community planning model for long term care and the design of a case management system which could be operated out of an AAA in this county. The following chart outlines the functions and operations of the developed case management model (see Figure 5).

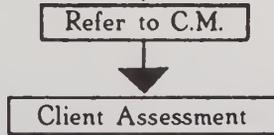
Figure 5

CARELINK FLOW CHART

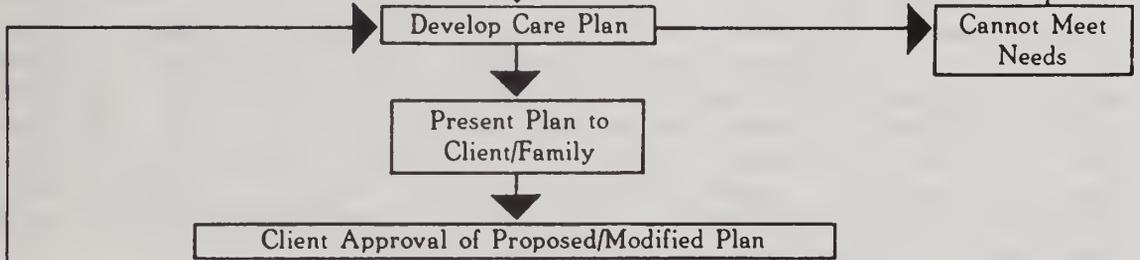
INTAKE



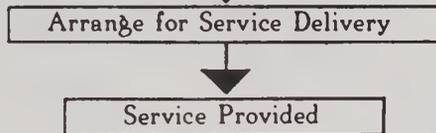
ASSESSMENT



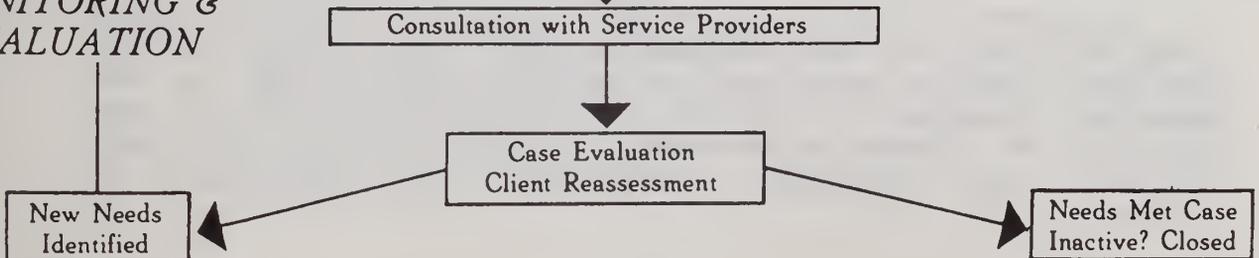
PLANNING



DELIVERY



MONITORING & EVALUATION



Target Population

The Weld County case management system was designed to serve the Weld County person age 60 years or older at risk of losing their ability to remain independent in the community (except those persons age 18 and over who were receiving Home and Community Based Services or who were eligible to receive those services through the Department of Social Services).

Individuals at high risk must have displayed one of the following characteristics:

- * Inability to provide self care without assistance due to illness or declining health.
- * Multiple, complex, and diverse service needs.
- * Lack of sufficient support for meeting care needs.

The Referral Process

To facilitate the referral process, the Weld AAA formalized written agreements with key agencies in the community who served the frail, isolated, and vulnerable elderly. These agreements spelled out the referral procedures and committed both the agency and the Weld AAA to providing quality case management services with particular emphasis on reaching out to those most in need. These agencies include Senior Companions, Meals on Wheels, Weld County Health Department, Weld County Department of Social Services, Retired Senior Volunteer Program, the Villa Alternative Care Facility, five area nursing homes, North Colorado Medical Center, Weld Information and Referral Service, three local home health care agencies, and Eldergarden Adult Day Program.

These agreements specified the obligations of the AAA and referral agency. The AAA provided ongoing training for agencies on program eligibility and the use of the pre-screening tool.

Pre-screening

In order to make a preliminary eligibility determination prior to a full intake assessment, the case manager and the referral agency completed a pre-screening tool on all potential clients. This is a short, one-page instrument designed to identify the major indicators for the more complete case management assessment (see Instrument in Appendix).

Functions of the Program

The AAA is responsible for program development, coordination, clarification, and compliance with standards of performance of the program. Overall, the program provides the following functions:

- * Pre-screening - A standardized screening process will determine program eligibility.
- * Assessment - A comprehensive assessment tool will be used to assess social/emotional and physical functioning, medications, informal support systems, financial status, and the physical environment.
- * Care Plan - A written care plan will identify the client's current problems and needs and determine the interventions necessary to meet those needs.
- * Service Brokering - Direct services for clients will be arranged or purchased according to the frequency and duration established by the care plan. Advocacy on behalf of the client will be used to ensure access to and appropriate utilization of community services.
- * Follow-up and Monitoring - Ongoing periodic contact with clients and service providers will be maintained to ensure that care plans are implemented as planned and continue to meet the needs of the clients.
- * Gap Filling - An ongoing effort will be made by the AAA, in coordination with the Long Term Care Committee, to meet the needs of the clients who have stated needs that cannot be met by existing formal or informal resources.
- * Reassessment - A standardized method of reviewing the client's social/emotional, physical, environmental status, informal supports, and financial status will be utilized at appropriate intervals.
- * Social/Emotional Support - The case manager will provide support to clients and their family members in an effort to facilitate adjustment to life changes and to become comfortable with case management intervention.

- * **Advocacy** - The case manager will provide assistance to clients and their families to gain benefits and services to which the clients are entitled.
- * **Information** - The case manager will provide information to the community concerning the case management program.

Standards of Case Management Performance

In order to provide a high quality of care to clients, the following minimum standards were developed for the Case Management Program:

- * Case management staff will consistently adhere to high professional standards in the delivery of services to clients.
- * Case management staff will receive supervision and on-going training.
- * Client's right to self-determination will be assured.
- * Clients will be informed of the cost of case management services and encouraged to make donations based on their ability to pay for services.

Comprehensive Client Assessment Policy and Procedures

Once the case manager received a client referral and information from the pre-screening tool indicated that the client could be eligible for service, a comprehensive social/emotional and physical assessment was completed within 72 working hours of initial contact. The interview with the client was usually completed in the client's home, using the developed assessment tool (see Assessment Instrument in Appendix).

In situations where the client had no previous contact with a home health care agency and/or a recent physical assessment had not been completed, the case manager contacted a home health care agency to complete the assessment. In the situation where the client was unable to complete this task, the case manager contacted a home health care agency on a rotating basis to provide a nurse who would make a home visit and complete the nursing assessment portion of the assessment tool. The home health care agencies were aware that if it was

determined that the client did need home health care service, the client retained the right to select the agency of his/her choice.

Client Care Plan Development

The care plan was completed and presented to the client (and family, when appropriate) within seven working days of the initial referral. The plan included:

- * Problems identified in the assessment process
- * All services brokered and arranged on behalf of the client
- * Frequency and duration of services
- * Cost of services, donation policies
- * Implementation date
- * Initiator of services
- * Indication that the client approved of the care plan (verbal or written)
- * The care plan should have been complete on the care plan form
- * The care plan had to be filed in the client's chart

Emergency Referrals

The Weld County Case Management System is not designed to handle crisis situations where services must be immediately put into place. Examples of this type of crisis would be instances where a client is without food, shelter, or finances or is in need of immediate medical intervention. These referrals will be made directly to appropriate service providers in the community. The Case Manager may be contacted and a comprehensive assessment will be completed once the emergency needs are met.

Service Brokerage

The service brokerage function is completed by the case manager by setting the frequency and duration of services to be delivered. The service brokerage will eliminate the need for multiple agency intake and assessment by directly arranging and/or purchasing care through agreements with service providers.

Follow-up and monitoring

Periodic follow-up and monitoring will be used to evaluate the timeliness, appropriateness, and quality of services brokered under the client care plan. Follow-up and monitoring will occur when the case manager has made contact with the client and the service providers to ensure that the services are being delivered in the manner indicated by the care plan.

Reassessment

A formal standardized reassessment will be used to review the client's social/emotional, physical, and environmental status, informal supports, and financial status. The reassessment will identify changes that may have occurred since the initial assessment and it will measure any progress that has been made towards meeting goals identified in the client care plan.

Case Record Maintenance

The case manager must establish and maintain a case record for each client. All records must include at least the following information: the pre-screening tool; the assessment tool; the care plan; the contact log displaying all contacts with the client, service providers, and pertinent others involved with the care of the client; the reassessment form; and the client participation/release of information form.

Program Evaluation

The AAA will maintain a contractual agreement with an independent, qualified person/agency (University of Northern Colorado) for the purpose of program evaluation. In addition, the Long Term Care Committee (comprised of service providers) will provide input and ongoing monitoring of this program.

Additional Results

During the two-year period of program development, the AAA simultaneously developed a number of resources for older persons in its catchment area. The identification of service gaps occurred as a result of an initial project community survey. These developments included:

- * Revision and distribution of a Senior Directory as a joint project with United Way and Weld Information and Referral Service
- * Establishment of an Alzheimer's Support Group to serve south Weld County
- * Design of a slide presentation entitled "A Time for Life," which is an overview of the services available in Weld County to Seniors and their families
- * Implementation of a Volunteer Court Appointed Visitor Program
- * Extension of home-delivered meal service to four communities in south Weld County
- * Implementation of a satellite Adult Day Care Program in Fort Lupton to cover south Weld County
- * Implementation of a volunteer respite care program
- * Assistance to Weld County Mental Health Center in receiving funding to initiate a mental health screening program at designated rural senior center sites
- * Establishment of agreements with the local Community Center Board and Schaeffer Rehabilitation Service to hire developmentally disabled workers to provide homemaker services to elderly where appropriate

IMPLICATIONS OF RESULTS

The following information describes the major areas addressed in the development of this component of the project and the issues and concerns relevant to each of these areas.

Pre-screening Phase: Difficulties were experienced in getting referral agencies to consistently complete the pre-screening tool. As a result, case managers had to spend more time in determining if clients needed case management versus information and referral. Additionally, it had initially been feared that the program would become a dumping ground for difficult-to-serve clients. However, this situation did not materialize; only a few inappropriate referrals were made, and they could be handled by the case managers.

Assessment Phase: The psycho/social and physical assessments were not completed within 72 working hours from the time of the referral, as originally promised. The case manager was not able to obtain all the needed information from clients and participating agencies within the time period set by the policy and procedure guidelines. Clients frequently had a difficult time understanding the principles of case management, and often it took several visits by the case manager before the assessment could be completed. The case manager also found that it was not possible to respond to every referral that appeared appropriate and meet the time guidelines. In response to this problem, the case manager took only two new referrals a week, and the caseload was frozen at 40 active cases. New cases could only be taken once an opening occurred. It was anticipated that, as the case manager obtained more experience in dealing with clients and the forms, the time needed to open a new case would decrease. The physical assessments were completed by the participating home health care agencies at no cost to the project. If it was determined that the client was in need of home health care services, the agency completing the assessment usually was assigned to the client. Since this was not guaranteed income, the assessment request was not always responded to in a timely manner. The case manager needed to wait until the physical assessment was received before a care plan could be fully developed. Understanding that this is a financial problem, re-evaluating both the unit cost of service and the ability to pay the home health care agencies a flat rate for every case management assessment they completed needed to be reviewed periodically.

Care Plan Phase: The plan could not be completed within 7 working days, since the assessment phase was rarely completed within three days of referral. The case manager found the care plan phase difficult and tended to avoid completing the plan, identifying problem areas and beginning services before completing all of the planning steps. Additional supervision and training needed to be available for the case manager in the development of care plans.

A care plan "how to" manual was developed through a contractual arrangement with Priscilla Kimboko, Ph.D., from the University of Northern Colorado, that will be used to train future case managers in care planning.

Follow-up and Ongoing Monitoring: Maintaining regular contact with clients, family members, and service providers did not present a major problems for the case manager. However, complete documentation was problematic, as the case manager did not always include enough information regarding the case to present a clear picture of the case.

Donation/Sliding Fee Scale: Because the case management program was initially sustained by Title III funds, clients could not be charged for the services they received. Donations, however, were encouraged, and the case manager provided clients with a donation/sliding fee scale. The scale provided the client with an idea of the amount of donation which would be appropriate, given their income. This donation system is by no means a smooth one, and plans were made to develop a billing system that would enable the client to receive a donation suggestion in the mail, based on the amount they indicated they wanted to donate every month. At end of the project, the AAA was exploring the feasibility of setting up a separate, non-profit entity to manage this program.

Case Management Forms: The Long Term Care Committee was divided into subcommittees during the pilot period, and they developed most of the case management forms. Once the forms were used by the case manager, it was determined that some were not as effective as had been hoped. The physical assessment form which was designed to be completed by a medical professional was redone when it was discovered that the form asked the client too many self-reporting questions which led to an inaccurate physical profile. A new subcommittee consisting of all

of the participating home health care agencies was formed, and a more effective physical assessment form was designed.

Pre-screening Tool: The pre-screening tool was developed to allow referral agencies and the case manager to initially determine if a client appeared to be an appropriate case management referral. Instead of completing the pre-screening tool, agencies contacted the case manager by phone and frequently provided only minimal information. This form was revised by the case management supervisor and case manager since the participating agencies stated that it took too much time to complete the old form. Each agency received copies of the new form with a letter emphasizing the importance of using the pre-screening tool. At the end of the project, staff were still having difficulty obtaining completed pre-screening tools.

The Care Plan: The care plan form was revised to allow the case manager to clearly identify the long and short term goals relating directly to the problems that were identified by the case manager and the client.

Marketing: Initially, it was found that the AAA was able to market effectively to agencies who were directly linked to the aging network. However, it did not have the time, staff, or materials needed to effectively expand the marketing approach to community organizations, businesses, and the medical community. In an effort to correct this problem, a contractual arrangement was made with a marketing firm which developed a name for the case management program (Carelink) and a brochure (see Appendix).

SUMMARY

The success of this demonstration lay in the leadership role assumed by the AAA and in the success of the Long Term Care Committee in achieving community cooperation. The participation of the members in the planning process which established the program lay the groundwork for community interaction, although it did increase the length of time it took to get the program off the ground. This site provided a wealth of information for state planning regarding changing the case management system. Information provided by the director and staff at this site to the AAA's in the state increased their knowledge about community level planning and long term care.

FIGURE 6

WELD COUNTY AREA AGENCY ON AGING
CASE MANAGEMENT MODEL

VARIABLE	DESCRIPTION	ISSUES
CASELOAD	Goal: 40 cases per case worker	- Current case load is 95-100 cases for .75 FTE. Not a high priority program for local Dept. of Social Services.
CLIENT CHARACTERISTICS	25 open cases to date primarily women 75+, widowed Income source Social Security under \$10,000 Most have some family support Loneliness great problem Ambulatory, show signs of confusion	- How to target more effectively to rural communities - How to incorporate social-ization into the care plan - "Dumping" of difficult clients into CM since it is new "kid" on the block - Reasonable priced homemaker services
CASE MANAGER QUALIFICATIONS	BA in Gerontology or related field 2 years experience in field of aging or related field Good communication skills, basic understanding of the aging process	- Additional training must be available - Skills related to case planning and goal setting - Salary
FEE SYSTEM	Private client based on ability to HCBS client, billed to Medicaid "eligible" clients only	- How to work against perception of "welfare program"

VARIABLE	DESCRIPTION	ISSUES
FUNDING STREAMS	Fees/donations Medicaid OAA, Title III United Way (future)	<ul style="list-style-type: none"> - How to structure program to carry its own weight - AAA a direct service CMA
PRE-SCREEN/ELIGIBILITY	One page pre-screening tool to assess client's probability or requiring case management	<ul style="list-style-type: none"> - Guidelines vague in some areas - Some clients probably not appropriate - Agencies not completing the screen
ASSESSMENT	Standardized form locally designed - structured interview CM completes the psychosocial section - nurse completes the physical section (CM and nurse conduct home visit separate times)	<ul style="list-style-type: none"> - Assessment lengthy - Pros and cons of 2 home visits complete the assessment - Timeliness of nursing assessment - Same assessment for private & HCBS
SERVICE PLAN	Standardized form locally developed with TA from Gerontological Dept. staff Written plan must be approved by client before implementation	<ul style="list-style-type: none"> - Additional training for case managers on goal setting and techniques of care plan writing - Contract with Gerontology plan protocols - Defines resource gaps
MARKETING	Target caregivers, employers Contract with public relations firm to develop marketing	<ul style="list-style-type: none"> - AAA is inexperienced with marketing - Overcoming welfare image - Competition with clinic, hospital

VARIABLE ----- DESCRIPTION ----- ISSUES -----

**DESIGNATION
AS CMA**

County Commissioners legal authority to both Area Agency and Department Social Services

- AAA no FTE limitation
- More service for less cost
- County saves FTE match

**IMPACT ON
SERVICE NETWORK**

25 member Long Term Care Coordinating Committee formed. All aspects of development of CM model involved participation from this committee

- CM priority build into all AAA contracts
- Home Health agencies provide free assessments on a rotating basis
- Services added: respite care, home delivered meals to south Weld, volunteer court appointed visitor program, new support groups

**INTERAGENCY
COOPERATION**

Client welfare first interest of the member agencies

- Health care providers most threatened, competitive

QUALITY ASSURANCE

Oversight by subcommittee of the LTC Task Force. Will handle grievances complaints; conduct regular monitoring of program

- Case managers supervised directly by AAA Ombudsman. Complaint investigation becomes a "conflict of interest" issue.

ACCOUNTABILITY

Weld County Board of Commissioners and State Department of Social Services

- N/A

VARIABLE

DESCRIPTION

ISSUES

MANAGEMENT INFORMATION SYSTEM

Automated, XT clone, 20 megabyte drive. Client characteristics documented on Paradox software program by AAA clerical assistant.
Billing (both private and Medicaid) handled by Fiscal Department.

- Freeing Case Manager of MIS & billing maintenance duties to maximize time with direct case direct case management activities.

INTEGRATION OF HCBS INTO AREA AGENCY

Single entry point case management service with uniform service to both Medicaid and non-Medicaid clients. Case Managers have mixed caseloads.

- 2% penalty
- No transfer of HCBS staff
- Timing of transfer of HCBS

INCENTIVES/BARRIERS TO INTEGRATION

(Incentives)
One stop service
AAA has positive image
CM enhanced by AAA coordination and resource development

- (Barriers)
- AAA involved in income eligibility program
- AAA as direct service provider
- Separation of service delivery from monitoring and oversight functions

Linda Piper
Weld County AAA, 1989

ADULT CARE MANAGEMENT, INC.

BACKGROUND

The purpose of this demonstration was to provide support for the development of a free-standing case management agency in the Denver metropolitan area. The project funding was utilized to support the development of computer expertise within Adult Care Management, Inc. (ACMI), a private, not-for-profit corporation. This agency was initially created to assure that quality services were accessible to adults over the age of eighteen who, for reasons of physical, mental, or emotional impairment, were unable to arrange for their own care. ACMI's overall mission was to improve or maintain the quality of life of persons served through professional case management. Its primary catchment area included the five-county Denver metropolitan area, which encompassed over half of Colorado's elderly population (age 60 and over, and age 75 years and older).

At the time ACMI began in August 1985, it was estimated that about 65,000 persons, age 65 years and older, lived in the City and County of Denver, and that between 10 to 15 percent of these individuals were in need of more complex care and additional services than they were receiving. Less than 3 percent of the elderly in Denver had easy access to a functional assessment or case management services. A case review of 162 clients of agencies in the area identified 53.7 percent of the clients as needing and not receiving case management, despite the fact that many of these agencies provided social work services.

Additionally, a recent study completed by the Colorado Trust found that the Denver area was rich in human services resources, but services for older persons were extremely fragmented and difficult to access. Agencies and programs for older persons were competitive for dollars and clients, and the power in the aging community was decentralized among many agencies and programs (nearly 400).

The concept for Adult Care Management, Inc. originated in January 1985, when the Manager of the Denver Department of Social Services convened a group of community leaders from the aging and mental health fields to look at the need for a non-profit, community-based case management agency. The lack of case management services for all adults, regardless of income or disability, was identified as a serious gap in the services system in the Denver metropolitan area. Professionals from a variety of human service agencies decided to form a new non-profit organization to provide such services. The option to form an independent agency rather

than to build a case management capacity into an existing agency was chosen. It was felt that this option would enhance the objectivity of case managers and encourage cooperation among the many other service providers in the community. Two main concepts were agreed upon: the need to serve all populations regardless of age, disability or income; and the need for case management to be available for those not financially eligible for public programs.

After six months of planning, Adult Care Management, Inc. was incorporated in August 1985, as a Colorado non-profit agency. A Board of Directors was convened, bylaws adopted, and 501(c)(3) tax-exempt status secured. Start-up funding was received from two local foundations which enabled the agency to hire an interim director, develop business and marketing plans, and secure insurance. At this time, ACMI also became a site for the National Living at Home demonstration program funded by the Commonwealth Fund in New York and several local foundations. This program provided funds to support a sliding fee scale for case management services for Denver residents 60 years or older. The Medical Care and Research Foundation and thirteen other Denver agencies serving the elderly population joined together in this cooperative effort. Since the beginning of the project, ACMI provided subsidized case management services for the Living at Home Program participants.

In 1986, ACMI was selected as a demonstration site for this project. The purpose of this component of the program was to test the feasibility of implementing a single access system in the Denver area and the use of computer technologies for program and client management.

Although other case management services existed in the Denver area, ACMI provided a unique agency structure characterized by the following factors: it was community-based, non-profit, free-standing, not affiliated with any agency, and privately operated. ACMI was established as a single purpose program, offering core and related case management services.

METHODS

This component of the demonstration project was developed by the Director of Adult Care Management, Inc. in conjunction with State staff. In addition, project funds provided support to enhance the computer capability of the program. Hardware, software, and a computer specialist on staff provided the basic ingredients for this aspect of the project (see Computer Technologies component).

The major goals of ACMI were to integrate multiple funding sources to support service delivery to many groups of individuals and to develop all aspects of Adult Care Management, Inc. in as coordinated a manner as possible. For this reason, the project tasks were often difficult to isolate from the total program and are included in this project summary, although financial support may not have come directly from project funds for these tasks.

To operationalize the program, the following activities were undertaken in the initial stages of development. A memorandum of participation was signed by thirteen community agencies who agreed to specific referral procedures and an intake process to be conducted by ACMI. To achieve this, a uniform screening instrument was identified by a special task force of community agencies. The Hebrew Rehabilitation Center for Aged (HRCA) Vulnerability Index was selected; its validity and reliability had been established and it could be used by non-professional staff to screen clients at the initial point of contact. Staff of the thirteen agencies were trained in the use of this instrument.

In turn, a special task force identified the Functional Assessment Inventory (FAI) (the modified Older Americans Resources and Services (OARS) instrument) developed by Eric Peiffer, M.D. at the University of Southern Florida as the assessment tool for private clients. A faculty member of the University of Colorado was trained in Florida to assist the ACMI staff in using the instrument.

As the project developed, the national office of the Living at Home Program adopted a data collection and evaluation process and this was integrated into the information collected on the FAI. Eventually the Living at Home instrument took precedence over the FAI. In turn, when the Home and Community Based Services program became part of ACMI, this group of clients were assessed by a form developed previously by the Colorado Peer Review Organization. Although a uniform assessment instrument was not in place when the Continuum Project ended, a new project was funded to continue this work. The computer-based case management program, Compass, was purchased for this site through another AoA grant. The goals of this project include the development of a uniform assessment instrument for all ACMI clients, regardless of funding sources.

In 1985, an Advisory Board for ACMI was established and fiscal management procedures were implemented. Services provided by the participatory agencies were surveyed to form the basis for developing referral procedures. In addition, the development of marketing strategies was undertaken by agency staff.

As the agency became functional in the second year, a multitude of management tasks were undertaken. Those most directly related to this project included the actual development of computerized accounting and billing systems for client and operations management.

RESULTS

During the two-year period of the project, ACMI became a fully operational free-standing case management agency in Denver. The Company grew from 20 clients in 1987 to over 600 individuals (public and private clients) by December 1988. The major functions of the program include the following:

- * Comprehensive Assessment The purpose of the comprehensive assessment is to determine the client's need for services by documenting his/her functional assets, deficits, and needs in the areas of physical health, mental health, emotional status, cognitive functioning, behavior problems, social relationships, ability to perform activities of daily living, economic status, environmental situation, and other needs identified by the client.

- * Service Plan Development The purpose of the service plan is to prepare a comprehensive, written plan with clearly defined goals and implementation responsibilities, describing services and activities which will enable the client to remain in the community.

- * Service Plan Implementation The purpose of service plan implementation activities is to assure that the client receives services as indicated in the service plan and case management supportive functions as necessary. Direct services are brokered on behalf of the client. Although direct service delivery by ACMI is not an option of first choice, if services identified in the service plan do not exist, or are not available in a cost-effective manner, or did not meet any special considerations related to the client, they are provided by ACMI.

- * Service Plan Review and Monitoring The purpose of service plan review and monitoring is to determine whether the services being received are appropriate, and of acceptable quality, and whether or not there

have been changes in the client's functioning which warrant revisions to the service plan.

- * Termination Planning The purpose of termination planning is to assure that case management is not provided when no longer needed by the client.

The following are case management supportive functions as defined by ACMI:

- * Client Advocacy Intervention with agencies or persons to assist individual clients in receiving appropriate benefits.
- * Assistance Help the client to obtain needed services or accomplish a necessary task, such as securing entitlements or funding for new housing.
- * Consultation Consult with service providers and professionals to utilize their expertise on the client's behalf.
- * Family Support Help the family or others in the client's informal support system deal with stress arising from the client's impairments and make necessary changes in the home environment or life style.
- * Networking Developing linkages between formal and informal support systems for the purpose of creating an effective continuum of care.
- * Crisis Intervention Provide short-term intervention in an emergency situation to resolve the immediate problem before a long-term service plan can be developed.
- * Assure Reimbursement Mechanisms Assure that all third-party reimbursements are utilized to the fullest.

Though case management is the major function of this Company, it was initially recognized that other services would be performed by staff, such as information and referral, and the maintenance of resource information. Ancillary planned services have been developed by ACMI as needs were identified, including resource development for individual clients or support groups, educational seminars, training sessions for human service professionals, and consultation services.

As of 1989, ACMI consisted of three major case management program areas described below:

- * Private Case Management Adults eighteen and older in the Denver metro areas are provided comprehensive care management on a fee for services basis. Individuals with multiple problems and often little or no support can remain in the community through the coordination of in-home services.

- * The Denver Living at Home Program Persons sixty and older who live in the City and County of Denver are served on a sliding-fee scale made possible through funding from The Colorado Trust, The Piton Foundation, The Anschutz Foundation, and The Commonwealth Fund, New York. Denver is one of twenty Living at Home Programs nationwide. At the time this project ended a year remained in this three-year project.

- * Home and Community Based Services Program. Adult Care Management, Inc. signed a contract in April 1988 with the Denver Department of Social Services to manage the Home and Community Based Services (HCBS) Program for Denver County. This program is for individuals eligible for Medicaid who are at the nursing home care level, but able to remain within the community with case management and home services. This public/private venture expanded ACMI's case management services to all income groups.

CLIENTS

ACMI began serving clients in April 1987. The Company was developed to provide case management services to anyone over the age of 18, regardless of income or program eligibility, who had long-term functional impairments or chronic diseases. The client group included Living at Home subsidized clients, private clients, and public clients in the Medicaid Waiver program, Home and Community Based Services (HCBS).

Individuals eligible for the Living at Home Program included persons age 60 and over who are residents of Denver County, with severe limitations, making them at risk of institutional placements. Case management services for this group have been subsidized by Living at Home funds, based on a sliding fee scale. As of November 1988, approximately 85 persons had received services under this program.

Clients served by ACMI during this period were mostly elderly, about 20 percent were physically disabled, chronically mentally ill, or developmentally disabled. With regard to income, most (84%) were HCBS Medicaid clients, 15 percent were Living at Home clients, and about 1 percent were private-pay individuals. Nearly all of ACMI clients (97%) had monthly incomes of less than \$1,236.

Table 9 depicts the number of case management clients at the end of 1988.

TABLE 9
CASE MANAGEMENT CLIENTS, 1988
 Adult Care Management, Inc.

	Clients Enrolled in 1987	Clients Active on 12/31/87	Clients Enrolled in 1988	Clients Active in 12/31/88
Private clients (under sixty & living outside Denver County)	20	5	19	9
Living at Home Clients	66	32	178	86
HCBS Clients	<u>NA</u>	<u>NA</u>	<u>383</u>	<u>571*</u>
TOTAL	86	37	580	666

*Includes 348 clients transferred with the HCBS program in April.

Adult Care Management, Inc. has received referrals from health care providers such as hospitals, home-health agencies and physicians, in addition to attorneys, banks, community service agencies, churches, and families. More than twenty professional case managers, each degreed and experienced in social work, nursing or related areas, were hired by ACMI.

The basic fees were \$350 for the comprehensive evaluation, arranging and coordination of all the services, and \$80 a month for follow-up services. The Denver Living at Home Program offered a sliding-fee scale for persons older than sixty in Denver and the HCBS Program provided case management for Medicaid recipients.

ADDITIONAL COMPONENTS

In 1987, ACMI contracted with Work/Family Elder Directions, Inc. in Watertown, Massachusetts, to provide Elder Care referral services to national corporations. With a phone call to Adult Care Management, Inc. an employee of a major corporation is able to discuss problems in relation to the care of an older relative and receive information and referral sources. Presently, ACMI is providing this service to IBM and other national corporations for Denver and certain front range communities. Since its inception in February 1988, 45 employees and/or retirees have been served by Adult Care Management, Inc. One case manager is the designated Work/Family Counselor. It is projected that the Work/Family Elder Directions Program will show steady growth in 1989 with a major expansion in 1990.

At the same time, Adult Care Management, Inc. is pursuing contracts for similar services with other local corporations. Additional programs include:

* The Quality Assurance Project

In October 1988, Adult Care Management, Inc. was selected as a demonstration site to assess the effectiveness of using the computer for the case management functions of assessment, care planning, and monitoring of services. This project, funded by the Administration on Aging, is under the lead of a case manager with the help of a task force of other case managers and staff from the Colorado Department of Social Services. Under the grant, the project manager's salary is covered and a computer and COMPASS software were purchased.

* The Benefits Eligibility Check-up Program

Through matching grants from The Commonwealth Fund and the Colorado Trust, the Benefits Eligibility Check-up Program software has been contracted for by Adult Care Management, Inc. This sophisticated software package will report to applicants which of some 35 federal, state, and local entitlement programs they might be eligible for and how to apply for them. The Colorado Trust has also provided funding for a computer for this project. The Program will be fully implemented in 1989 under the direction of a case manager and the intake coordinator.

* Money Management Resource Development Project

Adult Care Management, Inc. was awarded a program grant of \$6,200 from Work/Family Elder Directions to develop in the community the ability to assist older people with bill-paying, check writing, and record-keeping. An important objective of this component of the program is to have a system of checks and balances to protect the individual. This project began in November 1988, with completion expected mid-year 1989. The project is being directed by an ACMI case manager, though the actual money management program will be located at another community organization.

RESULTS

The major findings of this component of the project were derived from the project information collected during the two years when the program became operational. ACMI is the only free-standing case management agency serving public and private clients in Colorado. The information collected was extremely helpful for policy makers at the state level in considering the design of a new case management system statewide and for future program development. The computer applications initiated by this project provided ACMI with a stronger information base for management and program decision-making than otherwise would have been available. The major implications, products, and findings of the Adult Care Management, Inc. site included the following:

- * It was found that case management should be defined in a fluid, flexible manner and that the individual needs of clients should dictate the kind and extent of services provided. While it is generally agreed

that case management consists of a number of components, (assessment, care planning, referral, services brokering, and follow-up), not all clients will need the full range of services.

- * In addition, training for case managers needs to be available on a regular basis. Many human services professionals now providing case management have not had practical background experience in this service. The main content areas which need to be addressed in training include: skill development, clinical assessment, resource development, and working with special populations.

- * The use of a pre-screening tool by referring agencies was not successful. Initially, ACMI required that agencies use a uniform, one-page standardized screen prior to referring clients to the program. However, most agencies had their own screening or intake procedures and viewed this requirement as an increase in workload, and to some extent, as intrusive. This requirement was eventually dropped. Gradually, as ACMI became better known in the community, the appropriateness of referrals improved and the intake worker at ACMI was able to assist agencies in the process of making referrals.

- * The integration of public (HCBS Medicaid program) and private clients provided an environment which offered a continuity of care for individuals. For example, clients, depending on their eligibility status, could move from being a private pay client to Medicaid with the same case manager, in the same agency. Follow-along services by the case manager could be provided on a client-centered basis rather than one which focused on financial eligibility.

- * Frail elderly persons, most of whom were women, living alone, in the middle income range, from \$13,000 to \$24,000, were identified as needing case management services, but as unable or unwilling to pay for this service. This was a difficult group to market case management to in spite of their obvious need for this service. At the end of the project period, this problem had been isolated, but not resolved.

- * During the operation of ACMI, it was found that case managers could successfully carry integrated caseloads, combining public and private pay clients and clients with special needs such as the chronically mentally ill and the developmentally disabled. Extensive training is, however, needed for case managers serving multiple population groups.

FIGURE 7

COMPARISON OF CASE MANAGEMENT MODELS

Operated by

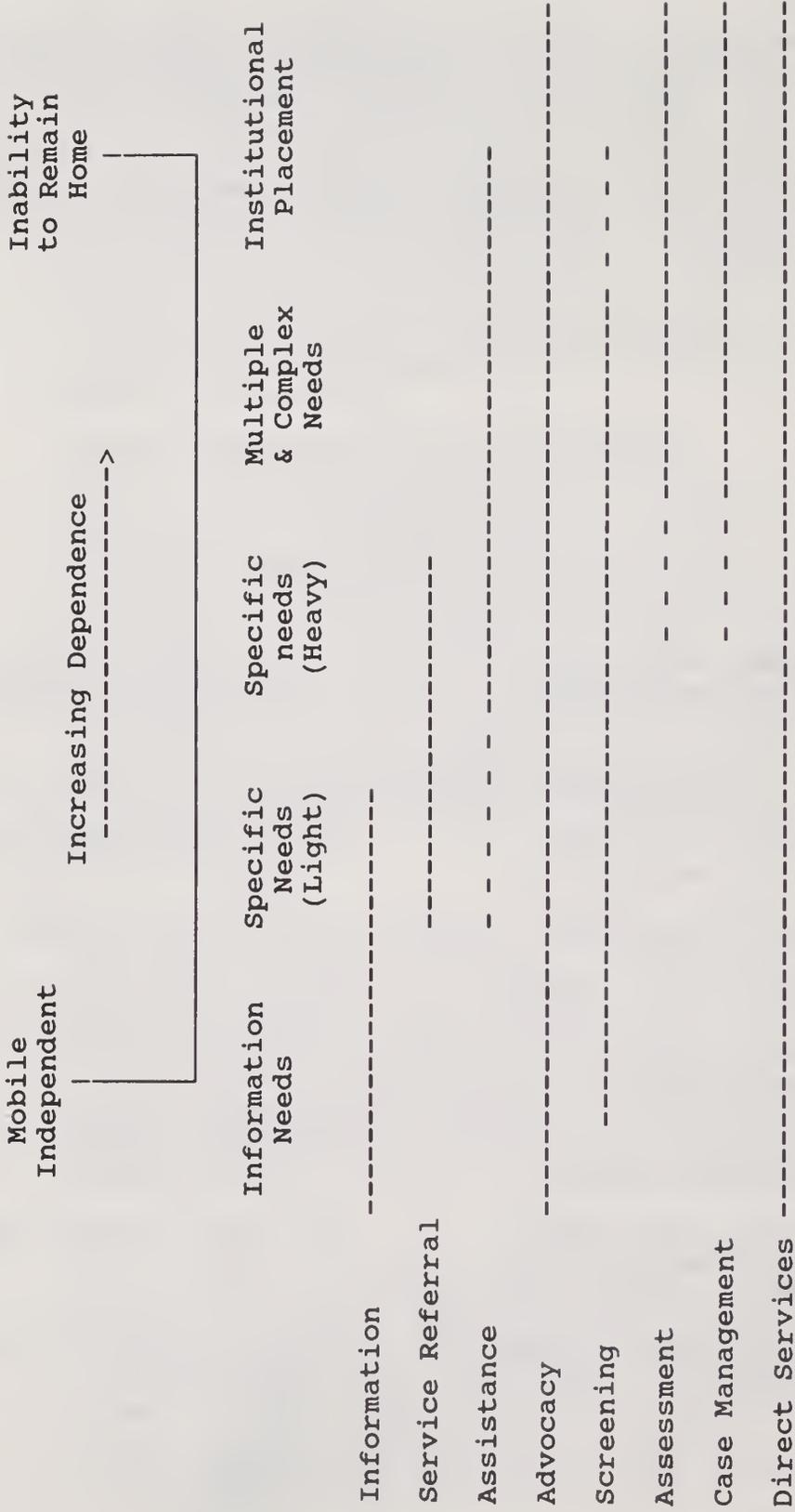
Adult Care Management, Inc.

Broker Model (<u>Living at Home Program</u>)	Service Model (<u>HCBS/Medicaid Program</u>)
Directed to quality and access	Directed to cost containment
Case management has power of persuasion and advocacy	Case manager has authority to authorize services
No control over dollars	Control over dollars
Client controls own funds	Case manager controls funds
Total client choice within own constraints	Restrictions on client choice
Case management not automatically accepted	Accepted by policy-makers - client accepts
Requires more case manager support - fewer services provided	Less case manager support needed
Unlimited agencies, community resources	Limited number of agencies (Medicaid)

Martha Hansen
Adult Care Management, Inc., 1989

FIGURE 8

POPULATION TARGETING CONTINUUM



Martha Hansen
Adult Care Management, 1989

FIGURE 9

DESCRIPTION OF MAJOR COMPONENTS AND ISSUE AREAS

ADULT CARE MANAGEMENT, INC.
November 1988

TOPIC	DESCRIPTION	ISSUES
Client Characteristics	Serve 18 and older 65+ clients Also young disabled, CMI, borderline developmentally disabled 84% - HCBS 15% - sliding scale (LAH) 1% - full pay 97% - income less than \$1,236/month	High number of clients "fell through the cracks" Low number of higher income Difficult clients Too strong an identification with HCBS - may prevent referrals
Caseloads	40/case manager - HCBS 30-35/case manager - private	Why workloads are different Integrated v. separate caseloads
Case Manager Qualifications	Majority are MSW/RN/MA or MS Fewer bachelor levels 2-4 years related experience Ladder for advancement Supervising Program management/development Senior Case Manager salary - \$19,500 to \$23,000	Specialization for special populations Special training needs for special populations Same qualifications for all programs Same case management Starting standards regardless of program

TOPIC

DESCRIPTION

ISSUES

Fee System

Fee for services for private clients
\$350 - Initial Phase
80 - monthly ongoing
60 - consultation
sliding fee scale - LAH
Fixed fee instead of hourly
Billing system automated
Separate programs billed separately

Break-even level for private clients
Ability to continue sliding scale
How long need outside Limited funding, i.e., grants, United Way

Other Funding Streams

HCBS - contract with Denver of Social Services
Living at Home Program
Work/Family Elder Direction contract
Other corporate contracts
Grants

Cross subsidization of County Dept sliding scale with other programs

Accounting Procedures

Board of Directors has ultimate financial responsibility
Acceptable accounting procedures assure proper handling of funds
Company subject to audit

Costs of internal accounting procedures
Corporation exposure

ISSUES

DESCRIPTION

TOPIC

Screening/Eligibility

Private - HCRA Vulnerability
Clients screen
HCBS - Financial
eligibility/DDSS
- program eligibility/peer
review organization
Case manager/intake
specialist

Conflict of interest -
Advocating for public
clients who then enroll
into our own system
External determination for
for public programs
Refusing service to special
populations, i.e.,
substance abusers

Assessment

Living at Home Assessment
Functional assessment instrument
(FAI) for all private
older clients
Private, younger than 60 -
separate instrument
HCBS - medical by physician
- functional is open
ended variety of
people fill out
- case managers do
separate assessment

Lack of uniform assessment
tool at the state level
Will one work for all
clients, all programs?
Which one?
Assessment by multi-
disciplinary team in a
community-based
organization
Funding source drives which
assessment tool is used

Service Plan

Formal plan - goals, objectives
services
HCBS less formal - geared to
cost containment
sign-off

Threatening to other
providers if clients are
are private
Non-threatening if HCBS Client
HCBS clients
Need to market for HCBS
also targeting full-pay
clients

TOPIC	DESCRIPTION	ISSUES
<p>Designation as Case Management Agency</p>	<p>ACMI is not the CMA Contract with the Denver Dept. of Social Services who is CMA (designated by county commissioners)</p>	<p>Quality control over program local level by County Department One step removed from State contract situation</p>
<p>Impact on Services in the Community</p>	<p>ACMI provides no direct service Refer to all services in community Case manager is provider of last choice Identify gaps in service Small grant for resource development</p>	<p>Referral system - rotation v. CM choice Complaints against agencies need for complaint procedure Advocacy for client choice Increased demand for Title III in-home services and medical transportation Significant increase in HCBS program</p>
<p>Interagency Cooperation</p>	<p>Living at Home Advisory Board has 14 agencies agencies are mainly those serving low income Screen and intake form agreed upon but not used by other agencies</p>	<p>How to measure increased integration and Referral cooperation Expanding the Advisory Board Continuing after end of LAH program dollars</p>

TOPIC

DESCRIPTION

ISSUES

Quality Assurance

Case Manager selection and training
Case management procedures and standards
Client satisfaction survey
Supervision - CM Coordinator supervised 4-5 case managers
Client grievance procedures
Computer enhanced case management demonstration

Are same standards appropriate for full pay vs. public pay vs. low-pay, subsidized, i.e., number of home visits
Need for outside evaluation
Uncontrolled growth

Accountability

To Board of Directors
To funding sources

Multiple program accountability is very difficult administratively
Reporting requirements may prevent expanding programs

Information Management

Automated for client demographics, billing, caseload/case manager time report
Integration of data to compare between programs
Management reports
Informal sharing with other agencies - client specific if related to care plan

State does not collect useful data for us
HCBS can not be tracked by county
Expense of hardware, software and programmer

TOPIC-----
DESCRIPTION-----
ISSUES-----
 ----- client:

Transfer of Information

Must meet regulatory assurances for HCBS program State and County authority do audit
 Non-client specific information provided upon request
 Communication with State goes through County

Transfer of client specific data
 Need to develop direct communications with the State

Integration of HCBS into Private Company

One entry point for public and private
 Staff and clients transferred as a unit
 Billing/record keeping is separate initially
 Integration is slow
 Clients have continuity from one program to another
 Impact on HCBS program - State dollars

Parochial attitudes of staff initially
 Fragmentation of public programs
 Impact of changes in public programs on company's future
 Control over organization with major new program staff

Incentives and Barriers to Public/Private Integration

Larger client base over which to spread fixed costs
 Client benefits - move from one program to another within same company and with same case manager
 Unable to absorb funding delays from public intermediary
 Complexities of program accountabilities

Cross-subsidization of public/private programs
 Need multiple programs for financial viability
 - administrative nightmare
 Using contract process and advance payments to make integration work

HCBS: Home and Community-Based Services - a national demonstration project, supported by foundation funds. At ACMI, LAH provided administrative dollars and subsidy for clients receiving case management.

LAH: Living at Home Project

Martha Hansen
Adult Care Management, 1988

COMPUTER TECHNOLOGIES

BACKGROUND

A sub-objective of this project was to provide hardware, software, and technical assistance by a computer consultant to the two case management sites. Prior to the project, neither site had developed computer capability for data management, fiscal accountability, or client tracking. Initially the consultant provided training for project staff on the software, assisted in equipment selection, and was available to provide assistance on-site throughout the project.

Adult Care Management, Inc. in Denver and the Weld County Area Agency on Aging were the two sites involved in this aspect of the project. Each site received an NCR PC-6 with 20 megabyte storage, modems, monitors, and Epson LQ-1000 printers. The software purchased for the sites included Wordperfect, Paradox, and Lotus 1-2-3.

DENVER/ADULT CASE MANAGEMENT, INC.

The primary goal of the Denver site, Adult Care Management, Inc., was to provide a single access point for the frail and disabled to the long term care system through the development of a community-based agency. Supporting goals included the development of uniform assessment services to help direct clients and access services and the development of a coordinated referral system both internally and within the community.

The need for a computer-based system to support this new agency was extensive. Financial systems as well as client, resource, and other management systems and case management data systems needed to be established. Because of the complexity and extent of the technical needs, Adult Care Management, Inc. hired a computer specialist with an extensive accounting background as a member of the agency start-up team.

By the end of this project, the agency was established, serving a case load of approximately 280 private clients and 570 HCBS clients with a staff of 32. The computer systems were critical to this development, and the continuing presence on staff of a computer expert facilitated growth and expansion, because it allowed the computer systems to be flexible. For example, the agency was able to successfully accommodate the addition of the HCBS cases which almost tripled the caseload. Consequently, the number of staff

increased from seven staff members on April 14th, to twenty on April 15th. Without sophisticated computer support in place, the organization would not have been able to keep up with such radical growth.

The technical accomplishments of the Denver site have been prodigious. Adult Care Management, Inc. has a general ledger system in place with the ability to produce balance sheets and profit and loss statements. Client billing, accounts receivable, payroll, budgeting, cash flow analysis (including client and salary projections, unemployment insurance and workman's compensation payments) and a variety of miscellaneous financial reporting systems have also been established. Client and resource databases have been developed as well as a system to analyze case manager time. In addition, the county HCBS data system was installed at the agency with the transfer of responsibility for the HCBS case load.

The number of different client groups served at this site caused a variety of problems. In developing an assessment instrument, agency staff learned the ins and outs of this issue, and worked on a new assessment tool using Compass software, which, in the future, will be tested across all client populations. In addition, the internal need to cross-train staff was facilitated by having a single intake coordinator and by moving to a single computerized intake form.

WELD COUNTY AREA AGENCY ON AGING

The Weld County AAA is located in a county agency and, as part of this system, had no need to establish a separate agency with supporting financial systems. The focus at this site was on monitoring and evaluation and the establishment of a case management system using a uniform assessment tool.

During the course of the project, outside expertise on monitoring and evaluation were acquired through a contract with the University of Northern Colorado. After the assessment instrument was developed, a staff member with technical expertise was borrowed from other duties to establish the computer database.

The supporting technical goals of developing a computerized assessment instrument and a case management database were met. Although the case management computer program was established late enough in the project period to generate a great deal of data, the case management database contained 114 data items on 24 clients at the end of the

project. The capacity to manipulate the case management data and to produce reports continues to be enhanced.

The computer capacity has also been used to develop databases to support several of the other AAA functions. For example, nineteen items of data are collected on about 2000 individual clients at senior nutrition sites to provide true unduplicated counts of client participation and report meal participation by site. About 500 volunteers are tracked in another database used primarily to monitor insurance needs for about 20 sites and provide data about insurance carriers, lists for coordinators, and information for volunteer recognition. The Weld County site initially used Paradox software to collect information on mini-bus operation, a system that has since been transferred to the county-supported database system, dBase. The spreadsheet program is used to track volunteers' hours and miles for 19 sites.

Although the program at the Weld County site lacked full time in-house technical support, significant use was made of the computer tools provided and non-technical staff generated their own computer applications.

The lack of technical support and a technically skilled staff member assigned to this project caused some major problems. The Director had to use the spare time of a staff member with other responsibilities who never became proficient with the software. Staff became dependent on him and when he left the project, the non-technical staff had to learn to use the system by trial and error. When it was time to monitor the case load, staff were unable to generate the information they wanted for the monitoring, much less in the desired form, but were able to pull out basic information in a default multi-page format which was then manually supplied with names. Although non-technical staff are becoming more proficient on their own, additional training and support will be needed. Although the Paradox software was chosen because of its ease of use by non-technical personnel, actions accomplished by trial and error can be flawed by the user's subsequent inability to reproduce the steps that generated the desired result. It is also very time-consuming for a novice to derive the procedures in the first place. For example, after the technical person had left the organization, it took staff a half day to locate the scoring system that the technical person had set up to calculate an assessment score for a case.

Additional technical difficulties include the lack of county support for the database software, Paradox, because dBase was the standard, and problems with the county network. Staff were unable to screen print the assessment/evaluation scores to place them in the paper files, because the screen print capability is disabled on the network. The network also

substantially slowed processing. A move to new quarters for the agency solved the network problems, because the project machine was no longer attached to the network after the move.

EVALUATION OF THE TECHNICAL TOOLS USED BY THE SITES

The computer specialist at Adult Care Management, Inc. described the hardware purchased by the project as slow, consistent, and reliable. He did express concern, however, over the amount of disk space available (20 mb hard drive), as they ran out of space and needed a larger drive. Weld County was happy with the machine but also describes it as slow, and even slower on the network.

All the software has been used by both sites. The word processing package, Word Perfect, was used extensively. The project director at Weld County had not used word processing software before and now drafts all of her correspondence and reports on Word Perfect. Weld County central data processing is planning to switch standards from DisplayWrite 3 to Word Perfect, and now provides support for Word Perfect. In addition to the usual word processing applications, Adult Care Management, Inc.'s technical expert set up a database billing system to interface with Word Perfect so that notes could be added to bills before printing.

Lotus 1-2-3 was supported as the standard spreadsheet software at Weld County and described as "the best" by the Denver expert who has worked with competing packages. Although both sites used 1-2-3, lack of project technical staff at the Weld County site meant relying on staff from other units to develop complex spreadsheet systems and development of new applications is consequently slow. Much of the complex financial reporting and analysis at the Denver site utilized 1-2-3 and interfaces were built into some systems to transfer data from database systems to 1-2-3 for calculation and reporting.

The database software, Paradox, was initially used with some resistance. The Weld County staff member who developed the case management computer system was a dBase user and would have preferred to use familiar software. The Denver expert would have purchased Data Flex. However, enthusiasm has grown over the course of the project. After the departure of the Weld County technical person, the staff have been "learning to love" Paradox. Non-technical staff are learning to use it on their own, despite the lack of technical support. ("Once you get familiar with the basic menu structure, you can accomplish things by trial and error.") The director of the project believes it has great potential. The computer staff

person at ACMI is now secretary/treasurer of the Denver area Paradox Users' Group and has used Paradox in conjunction with the other software packages to develop a sophisticated computer system with growth capability built in to support a wide range of functions. The ability for Adult Care Management, Inc. to absorb sudden growth has already been demonstrated.

The overall response at both sites has been positive. "Everything we did has been useful, either to build on or to change direction. We've learned a lot and are now ready to go on."

RECOMMENDATIONS

The primary recommendation of the site director at Weld County for other organizations planning a similar start-up project was, "budget more". Her comments can be summarized as "Don't be naive about how much it takes to do a project like this. We didn't budget enough funds to cover what needed to be done ... not for training and support or even for staff time. We underestimated the time required for planning and coordination of a program like this, and included no time at all to cover the technical aspects of development" (\$2,500 the second year for EDP setup and maintenance).

In the future, the staff at Weld County will need to learn more about developing and fine tuning reports on their current databases. The case management system is intentionally very comprehensive ("may be overkill") in order to sort out what information will prove most useful. After using the database for some time, they plan to simplify data collection, eliminating unnecessary information. The director of the Weld County program also has plans to develop other applications on Paradox. The Legal Aid Program, which opens 450 cases/year, would benefit greatly from computer support.

The Denver site director supported their decision to have a technical computer expert on staff. In addition to the actual development of the computer systems, having a computer expert on staff allows programs to be dynamic, making the automated system work for you rather than being controlled by the system. The technical expertise was invaluable in such areas as purchasing new equipment, maintenance, and reviewing of software and other software contracts. The manager could not maintain the ability to do every function as an organization grew.

The technical expert at Adult Care Management, Inc. also cautioned about the magnitude of the undertaking. He

recommended that any new venture try to get the state and state money behind them. "We couldn't have afforded to do what we did without outside help."

Future concerns of the Denver site include issues around developing connections between a variety of software systems with similar functions. Three areas of immediate focus include the integration of three systems of resource files, work on the referral/intake screen, and development of the COMPASS assessment. They would also like to use the case manager time analysis system more fully to determine why case loads differ. In the future, changes will also be made to allow the billing system to feed directly into the general ledger system. To date, the system has not been large enough to require direct posting so the current system posts lump sum amounts.

In conclusion, the infusion of computer capability into the management and delivery of services, especially case management services, has greatly enhanced the productivity and creativity of development. The support provided by this technology was especially helpful during the start-up phases of these projects. The dependency of the staff on computerized management will be ongoing, and will be incorporated into the operating budgets of these projects, although financial support, especially for computer staff, will always be problematic.

Appendix I

REGION XI AREA AGENCY ON AGING

**A MODEL FOR DEVELOPING
A REGIONAL SERVICE DISTRICT
TO PROVIDE A CONTINUUM OF
LONG-TERM CARE SERVICES
FOR THE AGING**

FINAL REPORT OF STATUTE/REGULATORY REVIEW

*A MODEL FOR DEVELOPING
A REGIONAL SERVICE DISTRICT
TO PROVIDE A CONTINUUM OF
LONG-TERM CARE SERVICES
FOR THE AGING*

A component of the
Colorado Continuum of care
Systems Development project
(Funded in part by a federal grant)

Prepared under contract with the Region XI
Area agency on Aging

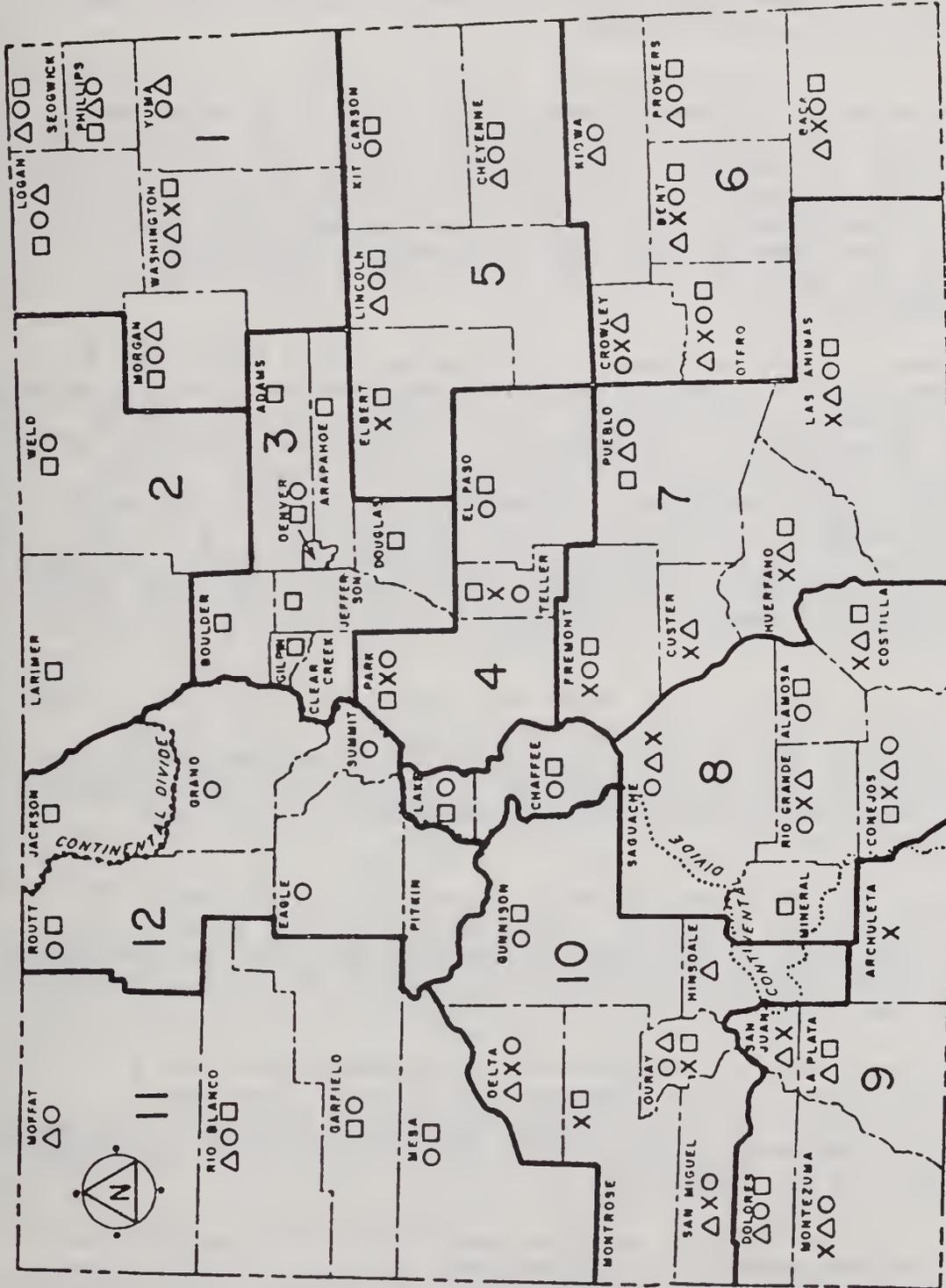
Rifle, Colorado

By

Harold A. Morse

Rifle, Colorado

COLORADO REGIONS



LEGEND

- Δ POPULATION DECLINE
- \circ DECREASE IN RELATIVE MEDIAN INCOME
- \square DEFICIT COUNTY
- \times DECLINING WEALTH PER CAPITA

INTRODUCTION

The aging population in this country, and in Colorado as well, will double in the next 65 years. The number age 85 and over will increase by five times. All of these persons have already been born and are with us today.

Because of the increasing numbers of older persons in Colorado and the associated increasing need and cost of long-term care, and in its goal of helping older citizens remain in independent living as long as possible, the Aging and Adult Services Division of the State Department of Social Services applied for a federal grant for a demonstration project to develop a system for providing a continuum of care and services for the aging. This project was initiated in June 1986 and has now been extended through September 1988.

One component of this project is development of a model for a Regional Service District for coordinating services for the aging on a regional basis in Garfield, Mesa, Moffat and Rio Blanco counties. Development of this model is under the direction of an Advisory Task Force composed of county commissioners, county directors of social services, representatives of the regional councils on aging, the Colorado Commission on Aging, and the Field Representative from the State Department of Social Services. The Region XI Area Agency on Aging has contracted with the state to assist in development of this model, with Mr. Dave Norman as Project Director.

Participation in the project does not commit the counties to the creation of the Regional Service District, but if the State Division of Adult and Aging Services is insistent on developing such districts in rural areas of the state, participation will allow the counties in Region XI to have a say in how such districts would operate.

The principal decision-making body regarding the prospects for the Regional Service District is the Advisory Task Force. The Planning Conference of this Task Force will provide the structure and the process for developing the decisions and recommendations regarding the District.

This report provides an overview of the growing need for a coordinated system of care and service for the aging and background on the efforts and plans for such a system in Colorado, with special reference to Region XI and the individual counties of the region in the Appendix.

The report also identifies certain tasks that would need to be performed in development of the Regional Service District model, and it provides suggestions for accomplishing some of the tasks.

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STATE OF CALIFORNIA DEPARTMENT OF LONG-TERM CARE SERVICES FOR THE AGING

BY SOURCE OF FUNDS

<-----INDEPENDENT LIVING-----DEPENDENT FOR CARE----->

	INDEPENDENT LIVING	DEPENDENT FOR CARE
COORDINATION AND MANAGEMENT	SUPPORTIVE COMMUNITY SERVICES	HOME & COMMUNITY BASED CARE
OLDER AMERICANS ACT:	OLDER AMERICANS ACT:	SOCIAL SERVICES BLOCK GRANT:
REGIONAL SERVICE AGENCY--	SENIOR SERVICE CENTERS	PROTECTIVE SERVICES
ADVISORY BOARD	ACCESS POINT	ALTERNATE CARE FACILITY (8 HOMES)
ADMINISTRATION	INFO & REFERRAL	ADULT FOSTER CARE (PRIVATE HOMES)
STAFFING/SITE	CLIENT ADVOCACY	TERMINAL HOSPICE CARE
EMPOWERING/FUNDING	SOCIAL AND EDUCATION PROGRAMS	ALTERNATE CARE FACILITY (8 HOMES)
AUTHORIZATION/ALLOCATION		ADULT FOSTER CARE (PRIVATE HOMES)
CONTRACT MANAGEMENT		TERMINAL HOSPICE CARE
PAYING/ACCOUNTING	CONGREGATE MEALS	ALTERNATE CARE FACILITY (8 HOMES)
PROJECT MONITORING	HOME DELIVERED MEALS	ADULT FOSTER CARE (PRIVATE HOMES)
PROBLEM RESOLUTION	TRANSPORTATION NON-MED	TERMINAL HOSPICE CARE
PLANNING AND EVAL	LEGAL SERVICES	ALTERNATE CARE FACILITY (8 HOMES)
RESOURCE DIRECTORY	OMBUDESMANSHIP	ADULT FOSTER CARE (PRIVATE HOMES)
CASE TRACKING SYSTEM	HEALTH CLINICS	TERMINAL HOSPICE CARE
CASE ASSESSMENT SYSTEM	EMPLOYMENT SERVICES	ALTERNATE CARE FACILITY (8 HOMES)
COUNTY/STATE INTERFACE		ADULT FOSTER CARE (PRIVATE HOMES)
COMMUNITY ORGANIZATION--	OTHER STATE PROGRAMS:	ALTERNATE CARE FACILITY (8 HOMES)
RESOURCE INVENTORY	LOCAL PROGRAMS:	ADULT FOSTER CARE (PRIVATE HOMES)
NEEDS ASSESSMENT	PRIVATE AGENCIES:	ALTERNATE CARE FACILITY (8 HOMES)
RESOURCE DEVELOPMENT		ADULT FOSTER CARE (PRIVATE HOMES)
COORDINATION AND NETWORKING		ADULT FOSTER CARE (PRIVATE HOMES)
OUTREACH AND PUBLIC INFORMATION		ADULT FOSTER CARE (PRIVATE HOMES)
SOCIAL SERVICES BLOCK GRANT:		ADULT FOSTER CARE (PRIVATE HOMES)
CASELOAD MANAGEMENT--		ADULT FOSTER CARE (PRIVATE HOMES)
INTAKE & REFERRAL		ADULT FOSTER CARE (PRIVATE HOMES)
CASE ASSESSMENT		ADULT FOSTER CARE (PRIVATE HOMES)
CRISIS INTERVENTION		ADULT FOSTER CARE (PRIVATE HOMES)
FINANCIAL ELIGIBILITY		ADULT FOSTER CARE (PRIVATE HOMES)
FEE SCHEDULE FOR SERVICE		ADULT FOSTER CARE (PRIVATE HOMES)
SERVICE ELIGIBILITY		ADULT FOSTER CARE (PRIVATE HOMES)
CASE ASSIGNMENT		ADULT FOSTER CARE (PRIVATE HOMES)
CASE MANAGEMENT		ADULT FOSTER CARE (PRIVATE HOMES)
CASE PLANNING		ADULT FOSTER CARE (PRIVATE HOMES)
PLAN IMPLEMENTATION		ADULT FOSTER CARE (PRIVATE HOMES)
MONITORING & FOLLOW-UP		ADULT FOSTER CARE (PRIVATE HOMES)
PROGRESS ASSESSMENT		ADULT FOSTER CARE (PRIVATE HOMES)
CASE CONFERENCING		ADULT FOSTER CARE (PRIVATE HOMES)
REPLANNING/TERMINATION		ADULT FOSTER CARE (PRIVATE HOMES)
(MAY BE CONTRACTED)		ADULT FOSTER CARE (PRIVATE HOMES)

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PROGRAMS ADMINISTERED BY THE AGING AND ADULT SERVICES DIVISION
OF THE COLORADO STATE DEPARTMENT OF SOCIAL SERVICES

*** **

ISSUES IN CASELOAD MANAGEMENT AND IN CASE MANAGEMENT

*** **

GROWTH OF THE AGING POPULATION IN AMERICA

(The following discussion is based largely on the 1985-86 edition of AGING AMERICA, PROJECTIONS AND TRENDS, prepared by the US Senate Special Committee on Aging, in conjunction with the American Association of Retired Persons, the Federal Council on Aging, and the US Administration on Aging.)

In 1900, only one person out of 25 in our nation's population was over 65 years of age. Now that ratio is more like three out of 25. At present, the aging population is growing twice as fast as the rest of the population. This trend is seen nationally, state by state, locally in our own towns and counties, and world-wide as well.

In 1900, only four percent of the nation's population was over 65. At present, 12 percent have reached that age. By the year 2050, that percentage will have grown to over 20 percent. Likewise, in 1900, less than one percent of the population was over 85 years of age, but by the year 2050, that proportion will reach 5 percent.

In the year 2050, there will be more than 67 million persons over 65 years of age in this country. That is more than the total population of most nations in the world. The year 2050 seems a long way off, but all of the people who will be over 65 in 2050 have already been born and are with us today.

This increasing aging population reflects the increasing life expectancy of both men and women, largely through better medical care and improved living conditions.

To the extent that the older person represents a burden to the rest of the population for sustenance and care, the burden of the increasingly large aging population will fall on a smaller proportion of younger persons.

Unless we begin planning and building today, those demands for financial aid, medical care and social support will exceed our capacity and our willingness to respond.

SOCIAL CHARACTERISTICS OF THE AGING POPULATION

At age 65, there are about 80 men per 100 women. At age 85 and over, this ration falls below 40 men per 100 women, largely reflecting the greater life expectancy for women.

In the 65-75 year age group, only nine percent of the men are widowed, compared with 39 percent of the women. For those over 75 years of age, only 24 percent of the men are widowed while 67 percent of the women no longer have a spouse. Older men are much more likely to remarry than are older women, as noted by the fact that at age 75 and over, 67 percent of the men, compared with 23 percent of the women, are living with a spouse. While a smaller proportion of the older women may be living with a spouse, a higher proportion of them live with off-spring or relatives, so that about 40 percent of either sex over 65 are living alone.

ECONOMIC STATUS OF THE AGING POPULATION

Income of persons over 65 is less than half that of persons in their prime earning years. While older persons are not disproportionately below the poverty line, a far greater proportion are hovering just above that level. At age 65-75, ten percent fall below the poverty line, compared with 18 percent for those over 85. At each age level, women are more likely to be in poverty than men. Seven percent of the men age 64-75 are in poverty, compared with 13 percent of the women. At 85 and over, 15 percent of the men and 20 percent of the women are in poverty.

In recent years, earnings have accounted for a decreasing share of the income of the elderly--due in part to changing employment practices as reflected in increasingly early retirement which is not always entirely voluntary. In 1950, nearly half of the men over 65 were working, in 1985 this proportion was estimated to be less than 20 percent. While earnings have decreased, the share from assets, pensions and social insurance programs has increased.

Before age 60, eighty percent of the men and 50 percent of the women are working. At age 65, twenty-five percent of the men and 14 percent of the women are working; at age 70 and over, eleven percent of the men and four percent of the women are still working.

HEALTH STATUS OF THE AGING POPULATION

Two-thirds of the aging population living in their own homes describe themselves to be in good health. About 20 percent have some degree of limitations in daily living activities, but only about five percent have severe limitations. As might be expected, the proportion with severe limitations increases with age, especially among women.

Only about 5 percent of the elderly population are in nursing homes or other institutional settings. At every age women are more likely than men to be in nursing homes, so that at age 85 and over, 25 percent of the women are in nursing homes, compared with only 14 percent of the men.

Nearly half of the aging population suffer from arthritis; 40 % from high blood pressure; 30 % from hearing loss; 25 % from heart conditions; 17 % from orthopedic problems; 15 % from sinus conditions; 10 % from non-correctable vision problems; 9 % from diabetes; 8 % from varicose veins; and 7 % from arteriosclerosis.

Heart disease and its manifestations is the leading cause of sickness and death among the elderly, followed by cancer. In the last 50 years the death rate from heart disease has been cut in half by medical advances, while the death rate from cancer continues to grow. When cancer is conquered, some other ailment or condition, maybe accidents and falls, will take over as the leading cause of death. In the 65-75 age group, the death rate is 3 % per year, compared with 6 % at age 75-85, and 15 % for those over age 85.

CARETAKERS OF THE AGING

Nearly a quarter of those over 65 years of age are in need of supportive care because of medical or mental impairment. Five percent are in nursing homes, while 20 percent are cared for in the community. In most cases the caretaker is a spouse, offspring or other relative. Thirty-seven percent of the impaired men are cared for by the wife, while only 10 percent of the women are cared for by the husband. Forty-seven percent of the men requiring care are cared for by relatives, including offspring, while 69 percent of the women are cared for by relatives. Sixteen percent of the men and 21 percent of the women are cared for through formal community programs or in nursing homes.

Because of the increasing older population and because of the greater increases in the older age groups, the number of persons needing care will grow greatly in the foreseeable future. As more and more younger women enter the labor market, more and more of the impaired aging will be dependent on formal community care. Since 1975 the percent of women in the labor force has risen from 46 percent to 55 percent in 1986. For women with children, the rise has been from 47 percent to 63 percent. For divorced women the employment rate was 82 percent in 1986. These women are consumers of community support, rather than providers of care. The days when the extended family saved one daughter for their old age is past, and the availability of free family help is rapidly diminishing.

There is the story of the caring lady who had seen her mother through the terminal stage of cancer; then an elderly woman at the church who had no relatives through her final days; then her father who had survived a severely impairing stroke; and now a maternal aunt who was alone in the world. The lady's only daughter, out of concern and wonderment, asked who would take care of her when her time would come. Without hesitation, the lady replied, "If you don't, I will haunt you to your grave."

But the daughter lives 2,000 miles away; she has an engrossing career; and she has responsibilities on the other side of the house. Time will tell, but the prospect that the daughter can be nearby when that time comes and will be able to devote the necessary time and attention grows progressively dimmer--not for the lack of love and concern, but because we all live in a fragmented society, based on scattered individualistic nuclear families, where the formal requirements of our jobs and our lives overshadow and overwhelm our personal lives and desires. The chances are that someone other than the daughter will be there when the time comes. Likewise, the mother may not be able to be there when her daughter has need of her love and support.

At present, the principal caretakers of the elderly are still the wives, daughters, neices, sisters and cousins, with an occasional husband or son who can find a way to help. Perhaps the greatest challenge before us will be to help and support these caring people so they can bear up under the burdens they have assumed.

THE NEED FOR A CONTINUUM OF CARE FOR THE AGING POPULATION

Five percent of persons age 65-75 living in the community need help in such matters as managing their money, meal preparation, housekeeping, shopping, using the phone or taking medication. At age 85 and over this proportion rises to ten percent. With help in such matters, these people could remain in their own homes.

At age 65-75 another 12 percent of those in the community have dependencies in daily activities, such as needing help in eating, bathing, dressing, use of the toilet, etc. At 85 and over, this proportion is close to 50 percent. At age 65-75, only two percent are severely disabled. This rises to five percent at age 75-85 and to 10 percent for those over 85 years of age. These persons would need daily care and attention if they are to remain in the community.

In all, about 25 percent of the aging population have some degree of dependency: 20 percent still live in their own homes while 5 percent are in nursing homes or other formal settings. It is likely that at least a fourth of the older population will need nursing home care sometime in their lives. Cognitive impairments such as Alzheimer's disease account for about 20 percent of the nursing home population.

It takes a lifetime to grow old, but growing old is better than any of the alternatives, including being forever young. An infant's needs can be counted on the fingers of one hand, and his capacities on the other. But as we age our needs expand and our capacities increase. The most characteristic thing about older people is the great diversity in their health, their awareness, their sociabilities, their experiences, their power, their wealth and the rate at which they are receding to the homogeneity and dependency of senility.

We can not live alone, anymore than we could live in a vacuum. We must have family and friends and community and social institutions if we are to survive as individuals. Some of us live in strong, supportive families with deep roots in our community and its institutions. Others live in fragile or transitory situations. Occasionally there is the person who has outlasted his family, his friends and his resources, the last leaf on the tree, so to speak.

We don't awaken one day to find ourselves in need of help. We lose a relative or a friend here, we drop an association there, strength and coordination diminish, memory shortens, awareness and concerns narrow, scars accumulate, sadness and regrets grow, trust and hope subside, and, finally, the only evidence of our existence is that we haven't seen our name in the obituaries lately.

We are all aware of our destiny, no matter how dimly we may see it. We know somehow we must make provisions for that time. We don't want ourselves or others to have to walk that road alone.

THE ELEMENTS OF A CONTINUUM OF SERVICES FOR THE AGING

The increasing number of older persons and the increasing life expectancy of the older population and an increasing concern for the quality of life for the aging has brought forth a realization of the need for provision of a continuum of services for the elderly. Such a continuum might include:

- Mass screenings, case finding and information or referral at the community level for those elderly still in their own homes.
- The next level of service would include community based health care, homemaker and chore services, transportation, delivered or congregate meals, as well as employment services and social participation opportunities.
- Special support should be given to those relatives and neighbors who are providing care, either in the older person's home or in their own home. Without respite care these burdens can become overwhelming.
- At some point it might be necessary to institute supportive or protective social services to avoid abuse or exploitation of the elderly individual.
- As impairments increase and capacities diminish, plans need to be made for long-term care. With proper case management and adequate supportive services, the older person may be enabled to remain in his own home, which may be cheaper than nursing home care and may be more appealing to the older person.
- Adult foster homes or supervised boarding homes can offer a level of care between in-home care and nursing home care.
- Two levels of care nursing home care have been developed: the intermediate care facility providing basic nursing and maintenance services, and the skilled nursing facility where 24 hour care is required.
- Hospitals play a role in the continuum of care for those who are critically or terminally ill.
- The hospice provides an environment in which the terminally ill can spend their final days in peace and dignity.
- The mortuary and the cemetery complete the range of services that must be provided to meet the needs of the aging.

Recognizing the need for a continuum of care does not address the issue as to who can or should pay for the services. In general, the practice has been to expect the individual to pay for the services he needs. Sometimes the fees are on a sliding scale, based on the person's ability to pay. When the person's resources have been exhausted, the likely recourse is public assistance through the county departments of social services.

TOWARD DEVELOPMENT OF A SYSTEM OF SERVICES FOR THE AGING

The Social Security Act of 1935, in response to the severe economic depression at the time, provided Old Age and Survivor's Insurance, including death benefits, at age 65 for workers in certain industries, based on payroll taxes paid by both the worker and the employer. Provisions were also made to provide Old Age Assistance to those who had inadequate income or resources to meet their needs. Later these provisions were extended to include the disabled, and the eligibility age was reduced to 62, but with actuarially reduced benefits.

In 1962, the Social Service Amendments to the Social Security Act was passed, which allowed and encouraged the State Departments of Social Services to provide supportive and protective services for the aging. These services are available to all persons in the community, with a sliding fee scale based on ability to pay.

In 1965, Medicare benefits were extended to Social Security Beneficiaries and Medicaid was provided for persons receiving Old Age Assistance through the state grants-in-aid.

In 1965, the federal Older Americans Act was passed, with the goal of providing services for older persons to enable them to maintain a dignified life style and to help them maintain their independence in living. These services included development and enhancement of community services for the aging, supportive services in the home such as homemaker and chore services, transportation, home delivered meals, legal assistance, employment services, congregate meals and community centers for senior outreach and opportunities for social participation.

A recent survey by the State Legislative Council Staff identified eight federally mandated programs for the aging, including those programs of the Older Americans Act as well as weatherization of home, food commodities, job training, etc. In addition, the survey identified 28 services available to the aging under state statutes, including the federal income maintenance and social service programs, food stamps, energy assistance, tax exemptions and deferrals, veterans' care, as well as life-time fishing licenses and state park passes.

Since 1981, the Aging and Adult Services Division of the Colorado Department of Social Services has been designated as the single state agency to administer the Older Americans Act and the grant-in-aid programs and social service programs for the aging under the the Social Security Act as well as certain state programs.

The stated mission of the Aging and Adult Services Division is "to design, implement and administer a continuum of care and services for the aging, the vulnerable and/or disabled adult and home-bound child population of the State to foster and maintain their maximum level of independence", with an emphasis on quality of care, accountability, and cost-effectiveness.

THE COLORADO CONTINUUM OF CARE SYSTEM DEVELOPMENT PROJECT

In furtherance of its goal of developing an integrated system for providing a continuum of care for the aging in Colorado, The Aging and Adult Services Division of the State Department of Social Services applied for a federal grant to conduct a demonstration project in June 1986. This grant has now been extended through September 1988.

One of the components of this project is the development of a Regional Services District for the coordination of community based Long-Term Care for the aging in the State's Region XI Planning District, which includes Garfield, Mesa, Moffat and Rio Blanco counties.

Other components of the project include:

- In Weld County, development of a unified and automated intake and referral tracking system to assure that there is follow-up and resolution of requests for service.
- In El Paso County, development of a community awareness and capability for identification and referral for service of older persons suspected of being abused, neglected or exploited.
- In Denver County, development of an independent community-based case management agency for the development of a community-wide screening, assessment, referral and tracking system for the administration of services for the aging.
- On the state level, development of cooperative techniques to achieve program and systems changes in care of the aging. This would include: uniform definitions and standards, legal authorization, contracting authority and procedures, assessment and monitoring techniques, and an integrated data base.

The Region XI project combines the elements of the other three components plus securing the cooperation and support of the public and private agencies in the region. The effect of the Region XI component will be development of a coordinated system of services for the aging at a regional level, funded at the state level through block grants in part by diverting funds from the counties for the many different programs they now administer.

The expectation and question is whether specialized and coordinated services at the regional level would be more effective and less expensive than through the individual counties as at present, where the number of cases in most counties is relatively few and where there is little opportunity to specialize staff or to develop and coordinate services and resources.

The project in Region XI is but an instance in the State's plan for developing integrated services for the aging. The purpose of the project in Region XI is to develop and test a regional model for implementation in various rural regions of the state.

ROLE OF THE REGION XI AREA AGENCY ON AGING

The State Aging and Adult Services Division has established Regional Area Agencies on Aging throughout the state to administer the programs of the Older Americans Act. In Region XI the Associated Governments of Northwest Colorado, representing Garfield, Mesa, Moffat and Rio Blanco counties and headquartered in Rifle, is the contracting agency with the State Division. The Region XI Area Agency on Aging, under the directorship of Mr. Dave Norman, operates as a division of the Associated Governments.

The State Aging and Adult Services Division has contracted with the Region XI Area Agency on Aging to develop and conduct the demonstration model for regional planning and administration of services for the aging, with the guidance of an advisory task force composed of the County Commissioners, the County Directors of Social Services, representatives of the Regional Councils on Aging, the Colorado Council on Aging and the Field Representatives of the Colorado State Department of Social Services.

Participation in the project does not commit the counties of the region to creation of a Regional Service District, but if the state is insistent on developing Regional Service Districts, participation now allows the counties of the region to have a say in how such a district might function. In view of future trends and prospects, the time to begin thinking and planning is now. While the Region XI Area Agency on Aging is involved in the planning and administration of the demonstration project, it does not necessarily follow that it would then take on the functions of the Regional Service District. Creation and administration of the District would follow from recommendations from the region and negotiations with the State Aging and Adult Services Division.

So far, Mr. Norman, the Project Director:

- has met individually and in groups with members of the Advisory Task Force and the appropriate state agencies.
- He has gathered demographic and operating statistics concerning the problems of the aging in the region.
- He has arranged for a study of legislative issues that might hamper development of a Regional Service District.
- He has developed a draft of a feasibility study for district coordination.
- And, he has developed a plan for conducting a Planning Conference of the Advisory Task Force for the development of specific recommendations and strategies for the implementation a Regional Services District.

If the Planning Conference decides to proceed with development of the Regional Service District project, it is hoped that the Demonstration model can be in place by July 1988.

PLANNING TASKS FOR DEVELOPMENT OF A REGIONAL SERVICE DISTRICT

Issues that must be addressed by the Advisory Task Force include:

- The decision whether to recommend that the counties in Region XI should participate in the Regional Service District project.
- If so, develop and enact a temporary regional compact among the counties, including Garfield, Mesa, Moffat and Rio Blanco.
- Community organization and outreach including:
 - ..Assessment of service needs in the region
 - ..Identification of existing or potential resources and service providers
 - ..Outreach and public information
- Determining regional priorities/and the elements from the continuum of care to be provided by the District.
- Determine risks, liabilities and needed protections.
- Clarification of county and state enabling legislation.
- Determine the structure and functions of the District.
- Development of the by-laws and incorporation of the District.

Regarding elements, functions and structure of the District:

- Determining the site and staffing for the District.
- Development of funding, budgeting and allocation systems.
- Development of the payment and accounting system.
- Development of the contract management system.
- Development of the program and contract monitoring system.
- Development and maintenance of a regional resource directory.
- Development of a client file and case tracking system.
- Development of a client needs and progress assessment system.
- Development of the Caseload Management System including:
 - ..Intake and referral procedures
 - ..Client needs assessment procedures
 - ..Crisis intervention procedures
 - ..Service eligibility standards
 - ..Financial eligibility standards
 - ..Fee for service schedule
 - ..Case assignment or service contracting

(For individual case management see next page)

- individual case management activities (vs caseload management):
- ..Development of individual-specific case plans
 - ..Referral or implement of specific elements of the plan
 - ..Monitoring activities and reports of service providers
 - ..Follow up and assessment of the progress of case plans
 - ..Determining need for replanning or case closure
 - ..Accountability reporting to the caseload management system

This is a long list of things to do, but they represent the elements that must be considered, the decisions that must be made and the actions that must be taken to develop and implement the Regional Service District. In fact, many other problems and concerns will need to be identified and resolved before the plan can be put in operation.

It is not necessary to solve these problems from scratch. The components of the State Continuum of Care Project in the other counties will be developing methods and procedures that should be applicable to the Regional Service District. In fact, specific provisions should be made to secure the guidance and benefits that will be derived from those projects.

Many systems, such as budgeting, allocation and accounting, are fairly standard and could be adapted to the needs of the District. In some instances it will be necessary to use the methods, procedures, forms and standards of the relevant state or county agency. Among the staffs of these agencies there are experienced and knowledgeable individuals who could provide references and solutions to many of the problems.

The Region XI Area Agency on Aging provides an operating model of an organization which is now engaged in outreach, coordination, resource development, provider contracting, program monitoring, accountability and fiscal reporting on a regional level.

A STRUCTURE AND PROCESS FOR THE PLANNING CONFERENCE

The principal decision-making body regarding the prospects for the Regional Service District in Region XI is the Advisory Task Force. The Planning Conference of this Task Force will provide the structure and the process for developing the Task Force's decisions and recommendations. This conference is scheduled for one day. The morning will involve sharing information and ideas about the desirability, feasibility and operational implications of the proposed demonstration model. The afternoon will be devoted to the organization and assignment of tasks to sub-committees or work groups for consideration of specific issues and the development of plans and recommendations for development and operation of the Regional Service District model. The final session of the conference should determine if there is a consensus to proceed with the Demonstration Project. If so, these work groups would continue their efforts in support of developing the model for Region XI. The following page contains a suggested organizational structure for the planning session, with suggested areas of concern for each work group.

TASK FORCE WORK GROUP ASSIGNMENTS

The Steering Committee, Chairman: _____
(To serve as Task Force Chairman also)

County Representatives:

1. Feasibility and desirability recommendations:
2. Legal implications, cooperation compact and by laws:
3. Site and staffing:
4. Funding, fiscal control and program monitoring:
5. Coordination and reconciliation of work group reports:
- 6.

Needs and Resources Committee, Chairman: _____

County Representatives:

1. Inventory of regional resources:
2. Identification of needs and gaps in service:
3. Program elements and priorities:
4. Maintenance of the resource inventory:
5. Community outreach and resource development:
- 6.

Caseload Management Committee, Chairman: _____

County Representatives:

1. Eligibility and fee standards:
2. Case assessment, follow-up and progress reporting procedures:
3. Intake and crisis intervention procedures:
4. Case file and case tracking system:
5. Interface with District, County and State tracking systems:
- 6.

Case Management Committee, Chairman: _____

County Representatives:

1. Case planning and service coordination:
2. Contracting with service providers:
3. Monitoring of provider services and reports:
4. Progress reporting, replanning and termination:
5. Accountability reporting to the caseload management system:
- 6.

CONTINUUM OF CARE DEMONSTRATION PROJECT
LONG-TERM CARE SERVICES PROVIDED, 1986

	REGION XI	%	GARFIELD	%	MESA	%	MOFFAT	%	RIO BLANCO	%
TOTAL POPULATION-1986:	129572	>>>>	25543	>>>>	86304	>>>>	11934	>>>>	5791	>>>>>
POPULATION AGE 60 +	18667	14.41	3069	12.02	13674	15.84	1250	10.47	674	11.64
MALES	8258	44.24	1378	44.90	6017	44.00	563	45.00	301	44.70
FEMALES	10409	55.76	1691	55.10	7657	56.00	688	55.00	373	55.30
POVERTY LEVEL	2326	12.46	348	11.34	1803	13.19	92	7.36	83	12.31
MINORITY	571	3.06	52	1.69	479	3.50	39	3.04	2	.30
RURAL	5445	29.17	1305	42.52	3293	24.08	290	23.20	557	82.64
NURSING HOME UTILIZATION:										
NURSING HOME BEDS	889	>>>>	117*	>>>>	687	>>>>	60	>>>>	25	>>>>>
VACANT NH BEDS	55	6.19	2*	1.71	53	7.71	0	.00	0	.00
NURSING HOME PATIENTS	834	>>>>	115*	>>>>	634	>>>>	60	>>>>	25	>>>>>
% 60 + IN NURSING HOMES		4.47		3.75		4.64		4.80		3.71
COUNTY RESIDENTS	742	88.98	92	80.00	590	93.00	48	80.00	13	50.00
PUBLIC PATIENTS	526	63.07	92	71.30	379	59.78	45	75.00	20	80.00
PRIVATE PATIENTS	308	36.93	33	28.70	255	40.22	15	25.00	5	20.00
NUMBER OF FEMALES	598	71.76	89	76.52	437	69.00	50	83.33	23	92.00
NURSING HOME ADMITS	312	37.41	50	43.48	221	34.86	20	33.33	21	84.00
LONG-TERM COMMUNITY CARE ALTERNATIVES:		% OF POP 60 +		% OF POP 60 +		% OF POP 60 +		% OF POP 60 +		% OF POP 60 +
HOME CARE ALLOWANCE	284	1.52	20	.65	254	1.86	10	.80	0	.00
ADULT FOSTER CARE	31	.17	0	.00	31	.23	0	.00	0	.00
ALTERNATIVE FACILITY	21	.11	6	.20	15	.11	0	.00	0	.00
HOME/COMMUNITY BASED CARE	76	.41	18	.59	54	.39	2	.16	2	.30
HCRS ADMITS	50	.27	11	.36	36	.26	0	.00	3	.45
TOTAL IN ALTERNATIVE CARE	412	2.21	44	1.43	354	2.59	12	.96	2	.30
ESTIMATED NEEDING CARE **	2629	14.08	425	13.95	1952	14.28	167	13.36	84	12.46
PERCENT NEEDING, IN CARE		15.67		10.35		18.14		7.19		2.38
NEEDING, NOT IN CARE	2217		381		1598		155		82	
COUNTY DSS PROGRAMS:										
CASEWORK SERVICES (I)	347	1.86	30	.98	304	2.22	12	.96	1	.15
ADULT PROTECTION (III)	25	.13	16	.52	4	.03	5	.40	0	.00
OLDER AMERICANS ACT:										
TRANSPORTATION SERV	493	2.64								
TRIPS	33139									
CONGRE/HOME MEAL SERV	3750	20.09								
MEALS	135014									
NUTRITIONAL SERVICES	373	2.00								
MEALS	36541									
HOMEMAKER/CHORE SERV	139	.74								
VISITS	7419									
SENIOR EMPLOYMENT-RSVP	7	.00								

* DOES NOT INCLUDE THE 100 BED STATE VETERAN'S NURSING HOME IN RIFLE, CURRENTLY WITH 20 PATIENTS AND DOES NOT INCLUDE A NEW 40 BED FACILITY IN CARRONDALE, WHICH IS NOT YET IN OPERATION

** LONG-TERM CARE NEEDS ESTIMATED FROM TABLE 5-1
AGING IN AMERICA, 1985-86 EDITION

ESTIMATED 1987 POPULATION FOR REGION XI, BY AGE AND SEX

11AG/POP		TOTAL POP.	TOTAL 65 +	PERCENT 65 +	TOTAL 60 +	60-64	65-74	75-84	85 +	65 + 1990 EST.	% CHANGE FROM 1987
51:GARFIELD	TOTAL	27036	2269	8.39	3126	857	1377	659	233	2402	5.86
	MALE	13761	998	7.25	1405	407	637	270	90	1057	5.94
	FEMALE	13275	1271	9.58	1721	450	739	389	143	1345	5.80
14:HEXA	TOTAL	84917	10273	12.10	13694	3416	5986	3208	1084	10977	6.80
	MALE	42034	4355	10.36	5985	1629	2676	1299	381	4654	6.88
	FEMALE	42883	5923	13.81	7709	1787	3310	1909	704	6323	6.75
23:MOFFAT	TOTAL	14611	852	5.83	1356	504	503	252	96	961	12.79
	MALE	7554	355	4.70	607	252	228	96	31	401	12.78
	FEMALE	7057	497	7.04	749	252	275	156	65	560	12.80
21:RIO BLANCO	TOTAL	6852	451	6.58	685	234	289	115	47	481	6.65
	MALE	3549	191	5.37	306	115	128	47	16	204	6.86
	FEMALE	3303	260	7.88	379	119	161	68	32	277	6.50
41:REGION XI 1987 EST.	TOTAL	133416	13850	10.38	18861	5011	8155	4234	1461	14821	7.01
	MALE	66898	5899	8.82	8303	2404	3669	1713	517	6316	7.06
	FEMALE	66518	7951	11.95	10558	2607	4486	2521	944	8505	6.97
50:TOTAL STATE 1980 CENSUS	TOTAL	2889964	247325	8.56	349924	102599	148666	74296	24363		
	MALE	1434293	100574	7.01	149498	48924	65555	27695	7324		
	FEMALE	1455671	146751	10.08	200426	53675	83111	46601	17039		

SOURCE: COLORADO DIVISION OF LOCAL GOVERNMENTS, 7/31/86
 AGE/SEX DISTRIBUTIONS BASED ON 1980 CENSUS
 SUB-GROUPS MAY NOT EQUAL TOTALS BECAUSE OF ROUNDING

CONTINUUM OF CARE DEMONSTRATION PROJECT
ESTIMATED SOURCES FOR LONG-TERM CARE IN REGION XI

REGION XI	TOTAL	TOTAL	60-64	65-74	75-84	85 +
TOTAL	13850	18861	5011	3155	4234	1461
TOTAL MALES	5899	8303	2404	3669	1713	517
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	4148	6167	2019	2862	1028	259
LIVING WITH OTHERS	446	590	144	257	137	52
LIVING ALONE	1065	1289	223	485	436	144
IN NURSING HOME, ETC	240	257	17	65	112	63
NEED COMMUNITY CARE	938	986	48	422	331	185
CARE PROVIDER:						
SPOUSE	336	-	-	190	109	37
OFF-SPRING	228	-	-	89	76	63
OTHER RELATIVE	221	-	-	89	83	50
NON-RELATIVE	153	-	-	55	63	35
PERCENT BY NON-RELATIVE	16.30	-	-	13.00	19.00	19.00
TOTAL FEMALES	7951	10558	2607	4486	2521	944
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	3096	4843	1747	2198	756	142
LIVING WITH OTHERS	1460	1851	391	673	504	283
LIVING ALONE	2931	3382	451	1527	1074	330
IN NURSING HOME, ETC	463	482	18	88	187	189
NEED COMMUNITY CARE	1591	1643	52	585	642	364
CARE PROVIDER:						
SPOUSE	164	-	-	105	51	7
OFF-SPRING	536	-	-	170	225	142
OTHER RELATIVE	542	-	-	193	218	131
NON-RELATIVE	348	-	-	117	148	84
PERCENT BY NON-RELATIVE	21.90	-	-	20.00	23.00	23.00
TOTAL MALES AND FEMALES	13850	18861	5011	1377	4234	1461
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	7244	11010	3766	5060	1784	400
LIVING WITH OTHERS	1906	2441	535	930	641	335
LIVING ALONE	3996	4671	675	2012	1510	474
IN NURSING HOME, ECT	703	739	35	153	299	252
NEED COMMUNITY CARE	2529	2629	100	1007	973	549
CARE PROVIDER:						
SPOUSE	500	-	-	295	161	44
OFF-SPRING	764	-	-	258	301	205
OTHER RELATIVE	764	-	-	282	301	181
NON-RELATIVE	501	-	-	172	211	119
PERCENT BY NON-RELATIVE	19.82	-	-	17.07	21.64	21.65

SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-4 & 6-1
AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING

1:REG/NEED

CONTINUUM OF CARE DEMONSTRATION PROJECT
ESTIMATED NEEDS FOR LONG-TERM CARE IN REGION XI

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REGION XI	TOTAL 65 +	TOTAL 60 +	60-64	65-74	75-84	85 +
TOTAL	13850	18861	5011	8155	4234	1461
TOTAL MALES	5899	8303	2404	3669	1713	517
MALES IN COMMUNITY	5659	8046	2387	3604	1601	454
SUPPORTIVE NEEDS ONLY	310	310	--	151	114	45
MILDLY DISABLED	298	298	--	123	104	71
MODERATELY DISABLED	136	136	--	61	40	35
SEVERELY DISABLED	194	194	--	86	74	34
NEED COMMUNITY CARE	938	986	48	422	331	185
NEED NURSING HOME CARE	240	257	17	65	112	63
TOTAL WITH DEPENDENCIES	1179	1243	64	487	443	249
PERCENT WITH DEPENDENCIES	19.98	14.97	2.68	13.26	25.89	48.07
TOTAL FEMALES	7951	10558	2607	4486	2521	944
FEMALES IN COMMUNITY	7488	10076	2589	4399	2334	755
SUPPORTIVE NEEDS ONLY	487	487	--	211	198	78
MILDLY DISABLED	585	585	--	207	240	137
MODERATELY DISABLED	244	244	--	84	100	60
SEVERELY DISABLED	275	275	--	84	103	89
NEED COMMUNITY CARE	1591	1643	52	585	642	364
NEED NURSING HOME CARE	464	482	18	88	187	189
TOTAL WITH DEPENDENCIES	2054	2124	70	673	829	553
PERCENT WITH DEPENDENCIES	25.84	20.12	2.68	15.00	32.87	58.56
MALES AND FEMALES:	13850	18861	5011	8155	4234	1461
NEED COMMUNITY CARE	2529	2629	100	1007	973	549
NEED NURSING HOME CARE	704	739	35	153	299	252
TOTAL WITH DEPENDENCIES	3233	3367	134	1159	1272	801
PERCENT WITH DEPENDENCIES	23.34	17.85	2.68	14.22	30.05	54.85

SUPPORTIVE NEEDS: HOUSEWORK, COOKING, PHONING, MEDICATION, SHOPPING, BUDGETING
DISABLED: NEEDS HELP WITH EATING, BATHING, DRESSING, TOILET, ETC.

SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-1 & 6-1
AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING

FESA	TOTAL	TOTAL-----				
	65 +	60 +	60-64	65-74	75-84	85 +
TOTAL	10278	13694	3416	5986	3208	1034
TOTAL MALES	4355	5985	1629	2676	1299	381
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	3057	4426	1368	2087	779	191
LIVING WITH OTHERS	329	427	98	187	104	38
LIVING ALONE	929	1081	152	390	398	141
IN NURSING HOME, ETC	40	43	11	11	18	11
NEED COMMUNITY CARE	695	727	32	308	251	136
CARE PROVIDER:						
SPOUSE	249	-	-	139	83	27
OFF-SPRING	169	-	-	65	58	46
OTHER RELATIVE	164	-	-	65	63	37
NON-RELATIVE	114	-	-	40	48	26
PERCENT BY NON-RELATIVE	16.34	-	-	13.00	19.00	19.00
TOTAL FEMALES	5923	7709	1787	3310	1909	704
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	2300	3497	1197	1622	573	106
LIVING WITH OTHERS	1090	1358	268	497	382	211
LIVING ALONE	2461	2780	319	1178	926	358
IN NURSING HOME, ETC	72	75	3	14	29	29
NEED COMMUNITY CARE	1189	1224	35	432	486	271
CARE PROVIDER:						
SPOUSE	122	-	-	78	39	5
OFF-SPRING	401	-	-	125	170	106
OTHER RELATIVE	405	-	-	143	165	98
NON-RELATIVE	261	-	-	86	112	62
PERCENT BY NON-RELATIVE	21.91	-	-	20.00	23.00	23.00
TOTAL MALES AND FEMALES	10278	13694	3416	1377	3208	1085
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	5357	7923	2566	3709	1352	296
LIVING WITH OTHERS	1419	1785	366	684	486	249
LIVING ALONE	3391	3861	471	1568	1323	500
IN NURSING HOME, ECT	112	126	14	25	47	40
NEED COMMUNITY CARE	1884	1951	67	740	737	407
CARE PROVIDER:						
SPOUSE	371	-	-	216	122	33
OFF-SPRING	570	-	-	190	228	152
OTHER RELATIVE	570	-	-	207	228	134
NON-RELATIVE	374	-	-	126	159	88
PERCENT BY NON-RELATIVE	19.86	-	-	17.09	21.64	21.66

SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-4 & 6-1
 AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING

ESTIMATED NEEDS FOR LONG-TERM CARE IN WINTER HAVEN

MESA	TOTAL	TOTAL-----				
	65 +	60 +	60-64	65-74	75-84	85 +
TOTAL	10278	13694	3416	5986	3208	1084
TOTAL MALES	4355	5985	1629	2676	1299	381
MALES IN COMMUNITY	4176	5795	1618	2628	1214	334
SUPPORTIVE NEEDS ONLY	230	230	--	110	86	33
MILDLY DISABLED	221	221	--	89	79	52
MODERATELY DISABLED	101	101	--	45	30	26
SEVERELY DISABLED	144	144	--	63	56	25
NEED COMMUNITY CARE	695	727	32	308	251	136
NEED NURSING HOME CARE	179	190	11	47	85	47
TOTAL WITH DEPENDENCIES	874	918	44	355	336	183
PERCENT WITH DEPENDENCIES	20.07	15.34	2.68	13.26	25.89	48.07
TOTAL FEMALES	5923	7709	1787	3310	1909	704
FEMALES IN COMMUNITY	5576	7350	1774	3245	1767	563
SUPPORTIVE NEEDS ONLY	364	364	--	156	150	58
MILDLY DISABLED	437	437	--	153	182	102
MODERATELY DISABLED	182	182	--	62	76	44
SEVERELY DISABLED	206	206	--	62	78	66
NEED COMMUNITY CARE	1189	1224	35	432	486	271
NEED NURSING HOME CARE	347	359	12	65	141	141
TOTAL WITH DEPENDENCIES	1536	1584	48	497	627	412
PERCENT WITH DEPENDENCIES	25.93	20.55	2.68	15.00	32.87	58.56
MALES AND FEMALES:	10278	13694	3416	5986	3208	1084
NEED COMMUNITY CARE	1884	1952	68	739	737	408
NEED NURSING HOME CARE	526	550	24	112	226	187
TOTAL WITH DEPENDENCIES	2410	2502	92	851	964	595
PERCENT WITH DEPENDENCIES	23.45	18.27	2.68	14.22	30.04	54.88

SUPPORTIVE NEEDS: HOUSEWORK, COOKING, PHONING, MEDICATION, SHOPPING, BUDGETING
 DISABLED: NEEDS HELP WITH EATING, BATHING, DRESSING, TOILET, ETC.

SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-1 & 6-1
 AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING

MOFFAT	TOTAL 65 +	TOTAL 60 +	60-64	65-74	75-84	85 +
TOTAL	852	1356	504	503	252	96
TOTAL MALES	355	607	252	228	96	31
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	251	463	212	178	58	16
LIVING WITH OTHERS	27	42	15	16	8	3
LIVING ALONE	37	52	14	23	13	1
IN NURSING HOME, ETC	40	43	11	11	18	11
NEED COMMUNITY CARE	56	61	5	26	19	11
CARE PROVIDER:						
SPOUSE	20	-	-	12	6	2
OFF-SPRING	14	-	-	5	4	4
OTHER RELATIVE	13	-	-	5	5	3
NON-RELATIVE	9	-	-	3	4	2
PERCENT BY NON-RELATIVE	16.21	-	-	13.00	19.00	19.00
TOTAL FEMALES	497	749	252	275	156	65
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	191	360	169	135	47	10
LIVING WITH OTHERS	92	130	38	41	31	20
LIVING ALONE	141	183	42	85	49	7
IN NURSING HOME, ETC	72	75	3	14	29	29
NEED COMMUNITY CARE	101	106	5	36	40	25
CARE PROVIDER:						
SPOUSE	10	-	-	6	3	1
OFF-SPRING	34	-	-	10	14	10
OTHER RELATIVE	34	-	-	12	14	9
NON-RELATIVE	22	-	-	7	9	6
PERCENT BY NON-RELATIVE	21.93	-	-	20.00	23.00	23.00
TOTAL MALES AND FEMALES	852	1356	504	1377	252	96
LIVING ARRANGEMENT:						
LIVING WITH SPOUSE	442	823	381	313	104	25
LIVING WITH OTHERS	119	172	53	57	39	23
LIVING ALONE	178	235	57	108	62	8
IN NURSING HOME, ECT	112	126	14	25	47	40
NEED COMMUNITY CARE	157	167	10	62	59	36
CARE PROVIDER:						
SPOUSE	30	-	-	18	9	3
OFF-SPRING	48	-	-	16	18	13
OTHER RELATIVE	48	-	-	17	18	12
NON-RELATIVE	31	-	-	11	13	6
PERCENT BY NON-RELATIVE	19.89	-	-	17.06	21.71	21.78

SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-4 & 6-1
AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING

CONTINUUM OF CARE DEMONSTRATION PROJECT
ESTIMATED NEEDS FOR LONG-TERM CARE IN MOFFAT COUNTY

MOFFAT	TOTAL 65 +	TOTAL 60 +	60-64	65-74	75-84	85 +
TOTAL	852	1356	504	503	252	96
TOTAL MALES	355	607	252	228	96	31
MALES IN COMMUNITY	341	591	250	224	90	27
SUPPORTIVE NEEDS ONLY	18	18	--	9	6	3
MILDLY DISABLED	18	18	--	3	6	4
MODERATELY DISABLED	8	8	--	4	2	2
SEVERELY DISABLED	12	12	--	5	4	2
NEED COMMUNITY CARE	56	61	5	26	19	11
NEED NURSING HOME CARE	14	16	2	4	6	4
TOTAL WITH DEPENDENCIES	70	77	7	30	25	15
PERCENT WITH DEPENDENCIES	19.72	12.65	2.68	13.26	25.89	48.07
TOTAL FEMALES	497	749	252	275	156	65
FEMALES IN COMMUNITY	467	717	250	270	144	52
SUPPORTIVE NEEDS ONLY	31	31	--	13	12	5
MILDLY DISABLED	37	37	--	13	15	10
MODERATELY DISABLED	15	15	--	5	6	4
SEVERELY DISABLED	18	18	--	5	6	6
NEED COMMUNITY CARE	101	106	5	36	40	25
NEED NURSING HOME CARE	30	32	2	5	12	13
TOTAL WITH DEPENDENCIES	131	138	7	41	51	38
PERCENT WITH DEPENDENCIES	26.35	18.38	2.68	15.00	32.87	58.56
MALES AND FEMALES:	852	1356	504	503	252	96
NEED COMMUNITY CARE	157	167	10	62	58	36
NEED NURSING HOME CARE	44	48	4	9	18	17
TOTAL WITH DEPENDENCIES	201	214	14	72	76	53
PERCENT WITH DEPENDENCIES	23.58	15.81	2.68	14.21	30.20	55.19
SUPPORTIVE NEEDS: HOUSEWORK, COOKING, PHONING, MEDICATION, SHOPPING, BUDGETING						
DISABLED: NEEDS HELP WITH EATING, BATHING, DRESSING, TOILET, ETC.						
SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-1 & 6-1						
AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING						

1 GAR/NEED

CONTINUUM OF CARE DEMONSTRATION PROJECT
ESTIMATED NEED FOR LONG-TERM CARE IN GARFIELD COUNTY

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GARFIELD	TOTAL 65 +	TOTAL 60 +	60-64	65-74	75-84	85 +
TOTAL	2269	3126	857	1377	659	233
TOTAL MALES	998	1405	407	637	270	90
MALES IN COMMUNITY	958	1362	404	626	253	79
SUPPORTIVE NEEDS ONLY	52	52	--	26	18	8
MILDLY DISABLED	50	50	--	21	16	12
MODERATELY DISABLED	23	23	--	11	6	6
SEVERELY DISABLED	33	33	--	15	12	6
NEED COMMUNITY CARE	158	168	8	74	52	32
NEED NURSING HOME CARE	40	43	3	11	18	11
TOTAL WITH DEPENDENCIES	198	211	11	95	70	43
PERCENT WITH DEPENDENCIES	19.82	15.01	2.68	13.38	25.89	48.07
TOTAL FEMALES	1271	1721	450	739	389	143
FEMALES IN COMMUNITY	1199	1646	447	725	360	114
SUPPORTIVE NEEDS ONLY	77	77	--	35	31	12
MILDLY DISABLED	92	92	--	34	37	21
MODERATELY DISABLED	38	38	--	14	15	9
SEVERELY DISABLED	43	43	--	14	16	13
NEED COMMUNITY CARE	250	259	9	96	99	55
NEED NURSING HOME CARE	72	75	3	14	29	29
TOTAL WITH DEPENDENCIES	322	335	12	111	128	84
PERCENT WITH DEPENDENCIES	25.33	19.44	2.68	15.00	32.87	58.56
MALES AND FEMALES:	2269	3126	857	1377	659	233
NEED COMMUNITY CARE	408	427	17	170	151	87
NEED NURSING HOME CARE	112	118	6	26	46	40
TOTAL WITH DEPENDENCIES	520	545	23	196	198	127
PERCENT WITH DEPENDENCIES	22.90	17.45	2.68	14.25	30.01	54.46

SUPPORTIVE NEEDS: HOUSEWORK, COOKING, PHONING, MEDICATION, SHOPPING, BUDGETING
DISABLED: NEEDS HELP WITH EATING, BATHING, DRESSING, TOILET, ETC.

SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-1 & 6-1
AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING

11RIG/NEED

CONTINUUM OF CARE DEMONSTRATION PROJECT
ESTIMATED NEEDS FOR LONG-TERM CARE IN RIG GRAND COUNTY

	TOTAL	TOTAL-----					
RIG BLANCO	65 +	60 +	60-64	65-74	75-84	85 +	
71	TOTAL	451	685	234	289	115	47
81	-----						
91	TOTAL MALES	191	306	115	128	47	16
101	-----						
111	MALES IN COMMUNITY	183	298	114	125	44	14
121	-----						
131	SUPPORTIVE NEEDS ONLY	10	10	--	5	3	1
141	MILDLY DISABLED	9	9	--	4	3	2
151	MODERATELY DISABLED	4	4	--	2	1	1
161	SEVERELY DISABLED	6	6	--	3	2	1
171	-----						
181	NEED COMMUNITY CARE	30	32	2	15	9	6
191	-----						
201	NEED NURSING HOME CARE	7	8	1	2	3	2
211	-----						
221	TOTAL WITH DEPENDENCIES	37	40	3	17	12	8
231	-----						
241	PERCENT WITH DEPENDENCIES	19.56	13.02	2.68	13.26	25.89	48.07
251	-----						
261	-----						
271	-----						
281	TOTAL FEMALES	260	379	119	161	68	32
291	-----						
301	FEMALES IN COMMUNITY	246	364	118	158	63	25
311	-----						
321	SUPPORTIVE NEEDS ONLY	16	16	--	8	5	3
331	MILDLY DISABLED	18	18	--	7	6	5
341	MODERATELY DISABLED	8	8	--	3	3	2
351	SEVERELY DISABLED	9	9	--	3	3	3
361	-----						
371	NEED COMMUNITY CARE	50	53	2	21	17	12
381	-----						
391	NEED NURSING HOME CARE	14	15	1	3	5	6
401	-----						
411	TOTAL WITH DEPENDENCIES	65	68	3	24	22	18
421	-----						
431	PERCENT WITH DEPENDENCIES	24.92	17.95	2.68	15.00	32.87	58.56
441	-----						
451	-----						
461	-----						
471	MALES AND FEMALES:	451	685	234	289	115	47
481	-----						
491	-----						
501	NEED COMMUNITY CARE	80	84	5	36	26	18
511	NEED NURSING HOME CARE	22	23	2	5	8	8
521	-----						
531	TOTAL WITH DEPENDENCIES	102	108	6	41	34	26
541	-----						
551	PERCENT WITH DEPENDENCIES	22.65	15.75	2.68	14.23	30.00	55.07
561	-----						

71 SUPPORTIVE NEEDS: HOUSEWORK, COOKING, PHONING, MEDICATION, SHOPPING, BUDGETING
581 DISABLED: NEEDS HELP WITH EATING, BATHING, DRESSING, TOILET, ETC.

601 SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-1 & 6-1
611 AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING

11:R/D/CARE

CONTINUUM OF CARE DEMONSTRATION PROJECT
ESTIMATED SOURCES FOR LONG-TERM CARE IN RIO BLANCO COUNTY

	RIO BLANCO	TOTAL 65 +	TOTAL 60 +	60-64	65-74	75-84	85 +
71	TOTAL	451	685	234	289	115	47
91	TOTAL MALES	191	306	115	128	47	16
111	LIVING ARRANGEMENT:						
121	LIVING WITH SPOUSE	136	233	97	100	28	8
131	LIVING WITH OTHERS	14	21	7	9	4	2
141	LIVING ALONE	1	1	1	8	-3	-5
151	IN NURSING HOME, ETC	40	43	11	11	18	11
171	NEED COMMUNITY CARE	30	32	2	15	9	6
181	CARE PROVIDER:						
191	SPOUSE	11	-	-	7	3	1
201	OFF-SPRING	7	-	-	3	2	2
211	OTHER RELATIVE	7	-	-	3	2	2
221	NON-RELATIVE	5	-	-	2	2	1
241	PERCENT BY NON-RELATIVE	16.00	-	-	13.00	19.00	19.00
261	TOTAL FEMALES	260	379	119	161	68	32
281	LIVING ARRANGEMENT:						
291	LIVING WITH SPOUSE	104	184	80	79	20	5
301	LIVING WITH OTHERS	47	65	18	24	14	10
311	LIVING ALONE	38	56	18	44	5	-11
321	IN NURSING HOME, ETC	72	75	3	14	29	29
341	NEED COMMUNITY CARE	50	53	3	21	17	12
351	CARE PROVIDER:						
361	SPOUSE	5	-	-	4	1	0
371	OFF-SPRING	17	-	-	6	6	5
381	OTHER RELATIVE	17	-	-	7	6	4
391	NON-RELATIVE	11	-	-	4	4	3
411	PERCENT BY NON-RELATIVE	21.74	-	-	20.00	23.00	23.00
431	TOTAL MALES AND FEMALES	451	685	234	1377	115	48
451	LIVING ARRANGEMENT:						
461	LIVING WITH SPOUSE	240	416	176	179	49	13
471	LIVING WITH OTHERS	62	86	25	33	17	11
481	LIVING ALONE	38	57	19	52	2	-16
491	IN NURSING HOME, ECT	112	126	14	25	47	40
511	NEED COMMUNITY CARE	80	85	5	36	26	18
521	CARE PROVIDER:						
531	SPOUSE	16	-	-	11	4	1
541	OFF-SPRING	24	-	-	9	8	7
551	OTHER RELATIVE	24	-	-	10	8	6
561	NON-RELATIVE	16	-	-	6	6	4
581	PERCENT BY NON-RELATIVE	19.59	-	-	17.08	21.62	21.67

SOURCE: LONG-TERM CARE NEEDS ESTIMATED FROM TABLES 5-4 & 6-1
AGING AMERICA, 1985-86 EDITION, US SENATE SUB-COMMITTEE ON AGING

ISSUES IN CASELOAD MANAGEMENT AND IN INDIVIDUAL CASE MANAGEMENT

The State Continuum of Care Systems Development Project emphasizes the systems approach to the administration of the Long-Term Care Program. By "Systems Approach" is meant the consideration of the Long-Term Care Program as a complex entity comprised of a continuum of resources and techniques designed to meet the dependency needs of the aging and disabled in Colorado, along with the management information system necessary to provide the basis for over-all strategic planning, caseload management control, individual case management control, quality assurance and fiscal accountability.

Strategic planning involves the choice of objectives and the development of plans to achieve those objectives. The State's Continuum of Care Systems Development Project is an example of over-all strategic planning.

Caseload management control provides assurance that the needed resources are secured and used to effectively and efficiently accomplish the goals of the Long-Term Care Program, with "effective" meaning the achievement of the desired objective and "efficient" meaning accomplishing these objectives with maximum benefit and minimum cost.

Individual case management control assures that the specific tasks relevant to the specific needs of specific individuals are carried out effectively and efficiently.

Quality control provides assurance that the program is in fact accomplishing its goals of providing effective elemental services in an efficient manner on a case-by-case basis.

Fiscal control provides assurance to the funding sources and to the public that the program is being administered effectively and efficiently. It also provides the basis for planning and budgeting and for appropriations requests.

Program administrative control is achieved by providing standards and procedures and the necessary feed-back information to assure that the program objectives are being met and as a basis for taking corrective action.

If program administration is seen as macro control, caseload management becomes micro control where the concern is to assure that the standards and procedures are appropriately applied to assure an appropriate outcome for the individual client.

Individual case management might be seen as sub-micro control where the concern is to utilize available resources to meet the specific needs of specific individuals and to monitor the activities of those providing these substantive services. At this level the therapeutic paradigm applies, including assessment or diagnosis, treatment implementation, follow-up and disposition.

Design of the over-all management information system must provide the information needed at each level of operation: from the activities of the individual homemaker in regard to a specific client, to the scheduling and monitoring of the whole complex of services making up the individual case plan, to the assessment of the effectiveness of the services and their continuing need, to the assurance of the availability of needed resources, to assurance that applicable standards and procedures are applied, to assurance that the program is being administered so as to achieve its objectives effectively and efficiently, and so as to provide the basis for further development and improvement.

Modern information handling techniques such as computers and software programs can be designed to provide the necessary information at each level of operation. Ideally, such a system would begin at the individual case level with forms for assessment, case planning, scheduling, monitoring, follow-up and disposition on a case-by-case basis. This information could be abstracted as counts and measurements for use at the caseload management level and at the program administration level.

At present there are no generally accepted or acceptable evaluative reporting techniques and there is no agreement as to what should go into the data base at the various administrative levels. For sure, the state does not need the details of each visit the homemaker might make in helping an individual client. The state might not even need a description of the specific needs and circumstances of the individual client if appropriate measurement or descriptive scales can be developed.

One assessment proposal consists of dozens of pages and hundreds of data elements, even before consideration of the case plan, recording of service activities, reassessment or disposition. Another proposal consists of one page with twelve questions. It would seem there must be a middle ground.

Doctors and dentists often use one page checklists to record complaints and diagnoses, to indicate the specific services provided and to determine the charges for treatment. They then supplement the checklist with a summary of the diagnosis, treatment and follow-up plans. Optical scanning could be used for entry of data from such checklists into the data base. Data base systems now allow the appending of a note to the client's record.

Many large counties have data processing centers which could handle the records at the local level and provide the extracts needed at the state level. Inexpensive personal computers and powerful software programs are available to handle the needs of smaller counties. In this way the smaller counties could extract the necessary information and forward it to the state by modem or through telephone networks or exchange of diskettes. There is no particular need for the state to specify which hardware or software would be required. The only requirement should be that both the local program and the state program be able to send and receive the necessary information.

NETWORTH

STATEMENT OF INCOME, EXPENSES AND NET WORTH

WAGES, SALARIES AND TIPS

RECEIVED FROM: AMOUNT

TOTAL:

OTHER INCOME SOURCES AMOUNT

RECEIVED FROM: AMOUNT

Social Security

Old Age Pension

SSI payments

AND payments

Retirement pension

TOTAL:

INTEREST RECEIVED

RECEIVED FROM: AMOUNT

DIVIDENDS RECEIVED

RECEIVED FROM: AMOUNT

TOTAL:

RENTAL INCOME

RECEIVED FROM: AMOUNT

TOTAL:

LIVING EXPENSES

AMOUNT

House payment

Rent payment

Public Service

Telephone

Water, trash, sewer

Car payment

Life insurance

Medical insurance

Other

TOTAL:

ASSETS

TYPE OF ASSET

VALUE

Home

Car

Recreation vehicle

Boat

Rental properties

Other real estate

Banking and saving accounts

IRA and CD accounts

Stocks and bonds

Cash value of insurances

TOTAL:

The hope and expectation would be that data recorded for individual cases at the local level could be extracted as descriptive and evaluative reports for use at the management and administrative level without further input or interpretation on the part of the local level.

The mechanical and software solutions are cheap. The two uncertain elements are the design of the information itself and the documents to be used for evaluating and reporting purposes, especially with regard to how they might interface with the state's present services reporting system and its financial eligibility documents. It is clear that at some point a purely arbitrary decision will have to be made with regard to these matters, but this should not be a matter of expedience. Rather it should be based on the state-of-the-art in these matters, with due respect for their utility and simplicity of execution.

The following page illustrates the manner in which a request for services might be developed into a case plan with a measurement of functional capacities and a description of physical and mental limitations and living circumstances. The plan provides for an agreement as to the services to be provided and the need for a subsequent review and revision of the plan.

The Services Report form represents a contract or plan between the service provider, such as a homemaker, and the case manager responsible for the plan for the case. It specifies the services to be provided, and the schedule for providing these services, a record of services provided and a billing for services rendered.

A simple income and expense worksheet with a statement of networth could be developed for determining financial eligibility.

This is not to say that these forms would necessarily meet all information needs of the Long-Term Care Program, but they do get the basic job done, which is to identify and justify the need, schedule provision of the planned services, record the activities provided and substantiate the request for payment. The essential point is that it does not require 25 pages of detail to arrive at a plan nor another 25 pages to record the actions taken.

*** **

Note:

The discussion of information systems is based on the book, Planning and Control Systems, a Framework of Analysis, Robert N. Anthony, Graduate School of Business Administration, Harvard University, Boston, 1965.

The Service Request Form and the Service Report Form are adapted from forms used by Texas Department of Human Services.

REQUEST

CONTINUUM OF CARE DEMONSTRATION PROJECT, REGION XI
CLIENT SERVICE REQUEST

HH NO: _____

CLIENT NAME: _____ ADDRESS: _____ CITY: _____ ZIP: _____ PHONE: _____

SERVICES REQUESTED: _____ SOURCE OF REFERRAL: _____ PUB AST. WORKER: _____ HOME COUNTY: _____

A. NEEDS HELP WITH:

- 00 MEAL PREP 01 HOUSEKEEPING 02 SHOPPING 03 MONEY 04 TELEPHONE 05 LAUNDRY 06 DEEP CLEANING
- 10 EATING 11 TRANSFER/WALKING 12 TOILET 13 DRESSING 14 BATHING 15 EXERCISE 16 MEDICATION
- 20 HAIR/SKIN CARE 21 CARE OF NAILS/FEET 22 NON-MED TRANS 23 ESCORT 24 PROTECTIVE SUP 25 CASE MANAGEMENT

COMMENTS:

B. MEDICATION: _____ FREQUENCY: _____ PURPOSE: _____

C. MEDICAL DIAGNOSIS:

D. DOCTOR / CLINIC: _____

LAST EXAM DATE: _____ NEXT EXAM DATE: _____

- E. PHYSICAL AND/OR MENTAL LIMITATIONS:
- 40 GENERAL WEAKNESS 41 DIZZINESS 42 BLAINDOTS 43 FALLS
 - 44 TROUBLE STANDING 45 USES CANE/CRUTCH 46 USES WALKER 47 USES WHEELCHAIR 48 CHAIRFAST 49 BEDFAST
 - 50 RUNS AWAY 51 TIME/PLACE ORIENTATION 52 SUSPICIOUS 53 DEPRESSIVE 54 COMBATIVE 55 IMPASSIVE
 - 60 VISION 61 HEARING 62 SPEECH 63 SLEEPING 64 EATING 65 NAUSEA 66 INCONTINENT: Urinary Bowel
 - 70 DEFTERITY 71 MOTION 72 NUMBNESS 73 PARALYSIS 74 CONTRACTURES 75 SPASTICITY 76 MISSING LIMBS

COMMENTS:

F. LIVING SITUATION: 80 WITH SPOUSE 81 LIVES ALONE 82 WITH RELATIVES 83 FRIEND/NEIGHBOR 84 NH 85 OTHER

G. PRIMARY CARETAKER: _____

H. ABILITY OF FAMILY/COMMUNITY TO MEET CLIENT'S NEEDS: _____

I. SERVICES CURRENTLY RECEIVED (Show provider): _____

J. PLAN: 90 INFO/REF 91 HOME CARE ALLD 92 HOME HEALTH CARE 93 HCRC 94 AFC 95 HCF 96 OTHER

K. OTHER SERVICES AND REFERRALS:

L. PLANNER'S SIGNATURE: _____ PLAN DATE: _____ PLAN REVISION DATE: _____ SUP INIT: _____ INIT DATE: _____

M. SIGNATURE OF CLIENT (or agent): _____ DATE: _____

RECORD

CONTINUUM OF CARE DEMONSTRATION PROJECT, REGION XI
RECORD OF SERVICES PROVIDED

HM NO: _____

CLIENT NAME: _____ ADDRESS: _____ CITY: _____ ZIP: _____ PHONE: _____

Provider Agency: _____ Agency Supervisor: _____ PHONE: _____

A. SERVICES TO BE PROVIDED AND NAME OF SERVICE PROVIDER: _____ PHONE: _____

- 00 MEAL PREP 01 HOUSEKEEPING 02 SHOPPING 03 MONEY 04 TELEPHONE 05 LAUNDRY 06 DEEP CLEANING
- 10 EATING 11 TRANSFER/WALKING 12 TOILET 13 DRESSING 14 BATHING 15 EXERCISE 16 MEDICATION
- 20 HAIR/SKIN CARE 21 CARE OF NAILS/FEET 22 NON-MED TRANS 23 ESCORT 24 PROTECTIVE SUP 25 CASE MANAGEMENT

COMMENTS: _____

B. SERVICE: _____ FREQUENCY: _____ INSTRUCTIONS: _____

C. SCHEDULE OF AUTHORIZED WORK HOURS (SCHEDULE TIME TO NEAREST 15 MINUTES): D. RATE PER HOUR: \$ _____

DAY OF WEEK	TIME IN	TIME OUT	TOTAL	DAY OF WEEK	TIME IN	TIME OUT	TOTAL
SUNDAY	_____	_____	_____	THURSDAY	_____	_____	_____
MONDAY	_____	_____	_____	FRIDAY	_____	_____	_____
TUESDAY	_____	_____	_____	SATURDAY	_____	_____	_____
WEDNESDAY	_____	_____	_____	TOTAL AUTHORIZED HOURS PER WEEK: _____			

E. PLAN AGREEMENT. PLANNER: _____ Supervisor: _____ Provider: _____ Date: _____

F. RECORD OF HOURS WORKED, MONTH: _____, YEAR: _____, (REPORT TIME TO NEAREST 15 MINUTES):

DAY	TIME IN	TIME OUT	TOTAL	DAY	TIME IN	TIME OUT	TOTAL	DAY	TIME IN	TIME OUT	TOTAL
1	_____	_____	_____	12	_____	_____	_____	23	_____	_____	_____
2	_____	_____	_____	13	_____	_____	_____	24	_____	_____	_____
3	_____	_____	_____	14	_____	_____	_____	25	_____	_____	_____
4	_____	_____	_____	15	_____	_____	_____	26	_____	_____	_____
5	_____	_____	_____	16	_____	_____	_____	27	_____	_____	_____
6	_____	_____	_____	17	_____	_____	_____	28	_____	_____	_____
7	_____	_____	_____	18	_____	_____	_____	29	_____	_____	_____
8	_____	_____	_____	19	_____	_____	_____	30	_____	_____	_____
9	_____	_____	_____	20	_____	_____	_____	31	_____	_____	_____
10	_____	_____	_____	21	_____	_____	_____	TOTAL HOURS WORKED DURING THE MONTH: _____			
11	_____	_____	_____	22	_____	_____	_____	AMOUNT EARNED: \$ _____			

This is to certify that I worked the number of hours recorded above and have completed the assigned tasks: _____ Provider's signature: _____ Date signed: _____

This is to certify that above provider has worked the hours recorded, and has completed the assigned tasks: _____ Supervisor's signature: _____ Date signed: _____

CONTINUUM OF CARE DEMONSTRATION PROJECT, REGION XI

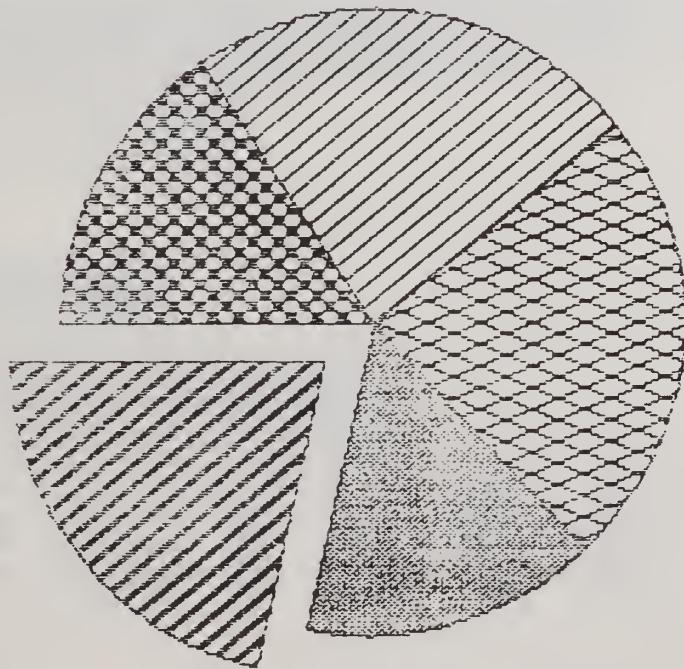
MODEL FOR INTEGRATED CONTINUUM OF LONG-TERM CARE SERVICES FOR THE AGING

BY SOURCE OF FUNDS

-----INDEPENDENT LIVING-----		-----DEPENDENT FOR CARE-----		
COORDINATION AND MANAGEMENT	SUPPORTIVE COMMUNITY SERVICES	HOME & COMMUNITY BASED CARE	ALTERNATIVE COMMUNITY CARE	NURSING HOME CARE AND INSTITUTIONAL CARE
OLDER AMERICANS ACT:	OLDER AMERICANS ACT:	SOCIAL SERVICES BLOCK GRANT:	OLD AGE ASSISTANCE:	MEDICAL ASSISTANCE:
REGIONAL SERVICE AGENCY-- ADVISORY BOARD ADMINISTRATION STAFFING/SITE BUDGETING/FUNDING AUTHORIZATION/ALLOCATION CONTRACT MANAGEMENT PAYING/ACCOUNTING PROJECT MONITORING PROBLEM RESOLUTION PLANNING AND EVAL RESOURCE DIRECTORY CASE TRACKING SYSTEM CASE ASSESSMENT SYSTEM COUNTY/STATE INTERFACE	SENIOR SERVICE CENTERS ACCESS POINT INFO & REFERRAL CLIENT ADVOCACY SOCIAL AND EDUCATION PROGRAMS CONGREGATE MEALS HOME DELIVERED MEALS TRANSPORTATION NON-MED LEGAL SERVICES OMBUDSMANSHIP HEALTH CLINICS EMPLOYMENT SERVICES	PROTECTIVE SERVICES NON-WAIVERED OLD AGE ASSISTANCE: HOME HEALTH CARE CHORE SERVICE 2176 WAIVERED OLD AGE ASSISTANCE: HOME HEALTH CARE MEDICAL ASSISTANCE: PERSONAL CARE HOMEMAKER SERVICE ADULT DAY CARE RESPIRE CARE CHORE SERVICE	ALTERNATE CARE FACILITY (8 HOMES ADULT FOSTER CARE (PRIVATE HOMES) TERMINAL HOSPICE CARE	INTERMEDIATE CARE FACILITY SKILLED NURSING CARE FACILITY ACUTE SHORT-TERM HOSPITALIZATION ACUTE LONG-TERM HOSPITALIZATION ACUTE TERMINAL HOSPITALIZATION STATE AGENCIES: STATE HOSPITAL VETERAN'S HOMES ETC.
COMMUNITY ORGANIZATION-- RESOURCE INVENTORY NEEDS ASSESSMENT RESOURCE DEVELOPMENT COORDINATION -AND NETWORKING OUTREACH AND PUBLIC INFORMATION	OTHER STATE PROGRAMS: LOCAL PROGRAMS: PRIVATE AGENCIES:			
SOCIAL SERVICES BLOCK GRANT:				
CASELOAD MANAGEMENT-- INTAKE & REFERRAL CASE ASSESSMENT CRISIS INTERVENTION FINANCIAL ELIGIBILITY FEE SCHEDULE FOR SERVICE SERVICE ELIGIBILITY CASE ASSIGNMENT CASE MANAGEMENT CASE PLANNING PLAN IMPLEMENTATION MONITORING & FOLLOW-UP PROGRESS ASSESSMENT CASE CONFERENCING REPLANNING/TERMINATION (MAY BE CONTRACTED)				

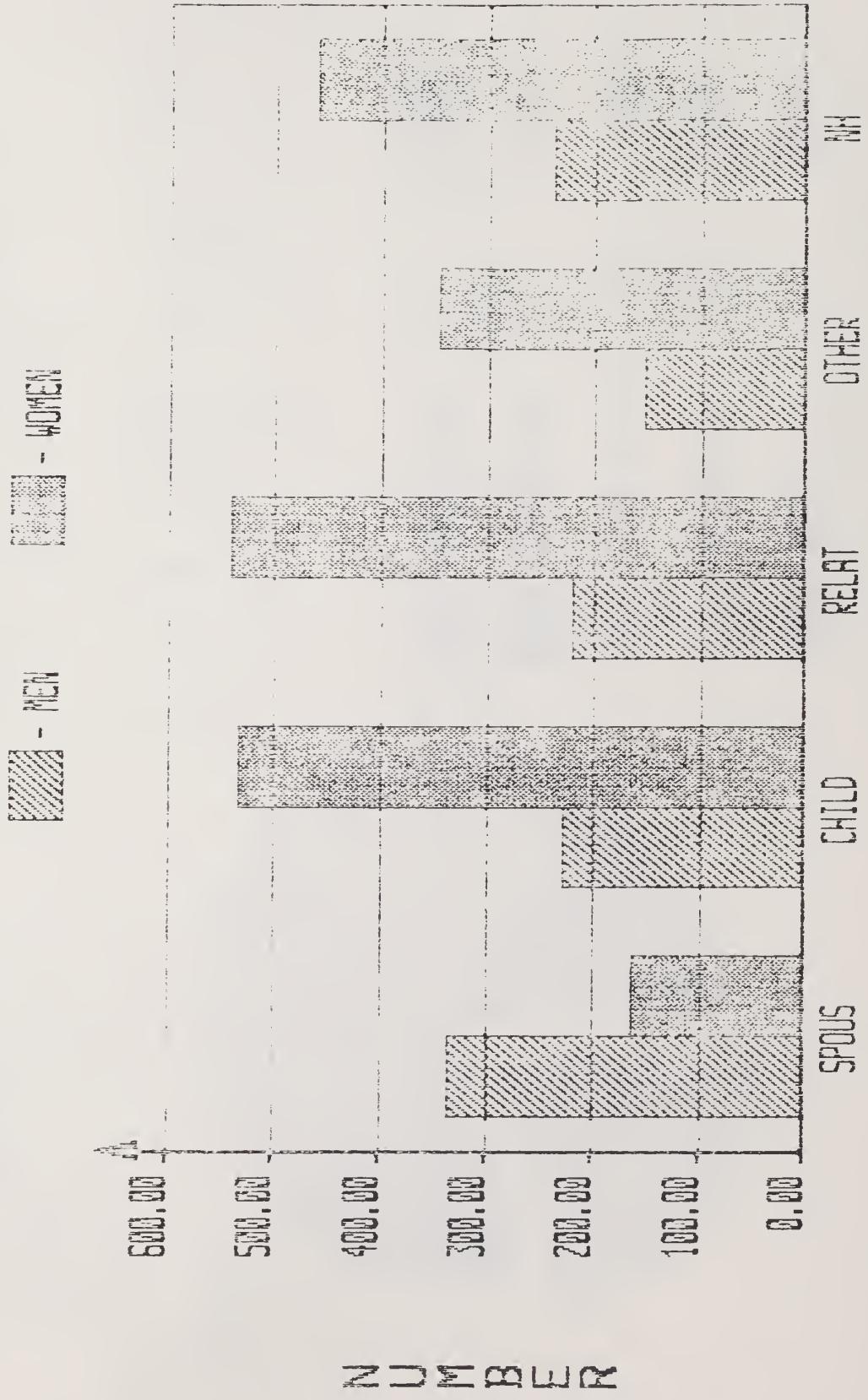
CARE PROVIDER FOR THOSE NEEDING CARE, AGE 65+

- SPOUSE	500.00 (15.5%)
- OFF-SPRING	764.00 (23.6%)
- OTHER RELATIVE	764.00 (23.6%)
- NON-RELATIVE	501.00 (15.5%)
- NURSING HOME	703.00 (21.8%)



TOTAL: 3232.00 (100%)

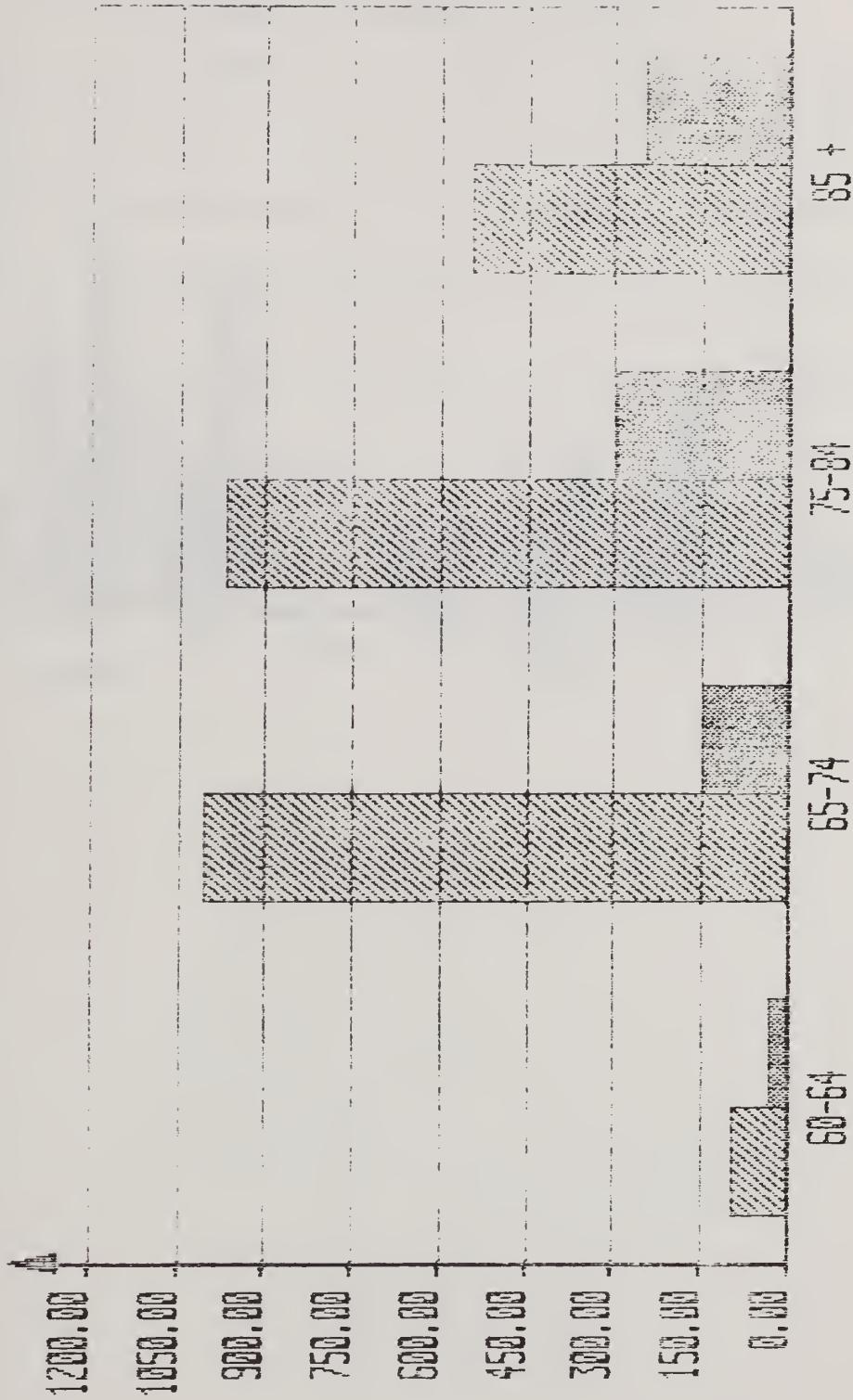
CARE PROVIDER FOR THOSE AGE 65 + NEEDING CARE



RELATIONSHIP OF CARETAKER

NEED OF COMMUNITY CARE VS NURSING HOME CARE

 - COMM CARE
 - NH CARE

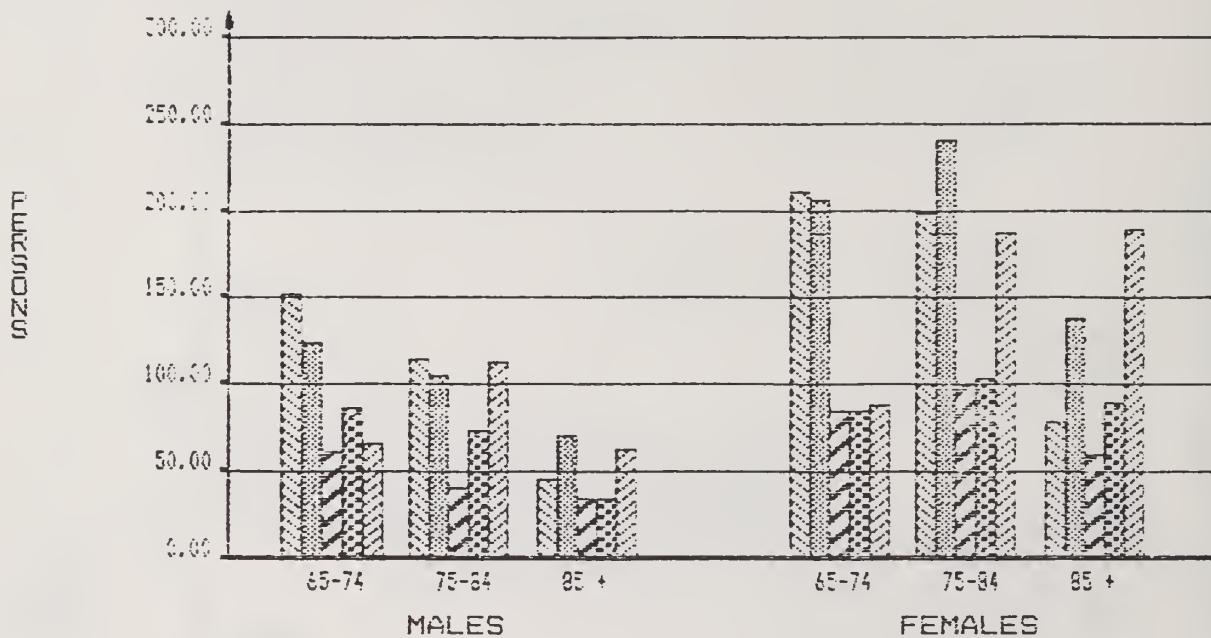


PERSONS

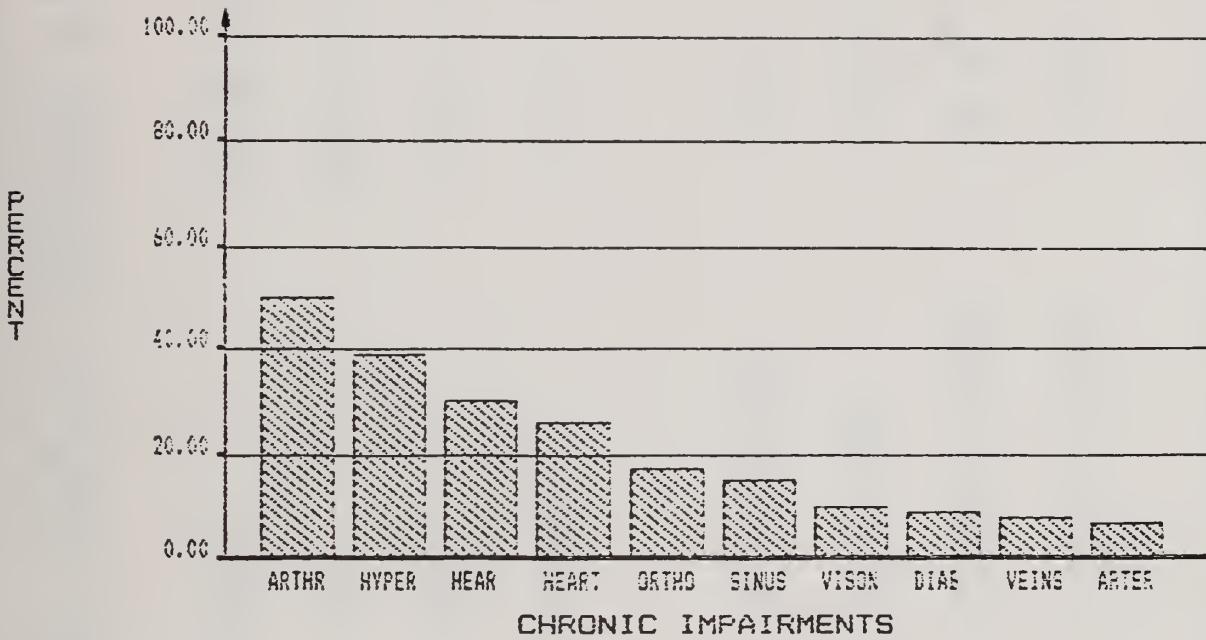
AGE

ESTIMATED DEGREE OF DISABILITY

: SUPP ONLY
 : MILD DIS
 : MOD DIS
 : SEVERE DIS
 : NEEDS NH

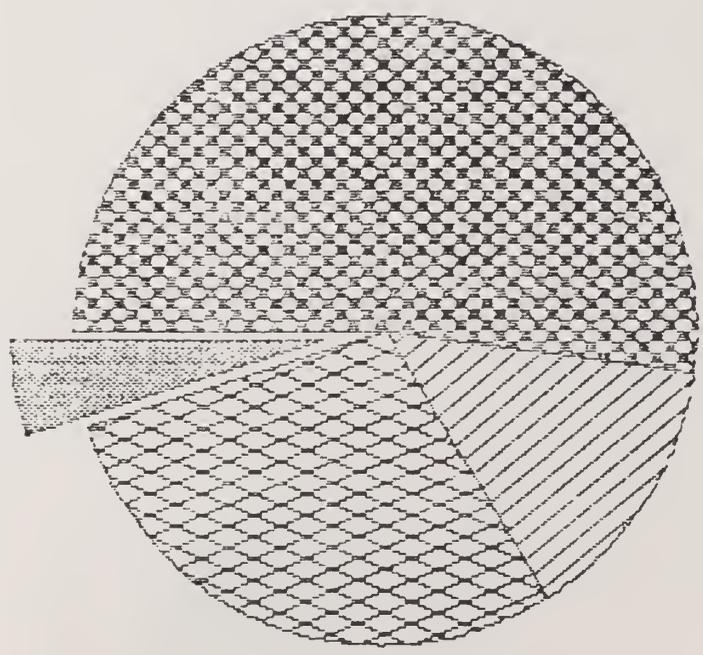


IMPAIRMENTS OF THOSE AGE 65 AND OVER



LIVING ARRANGEMENT OF THOSE AGE 65 AND OVER

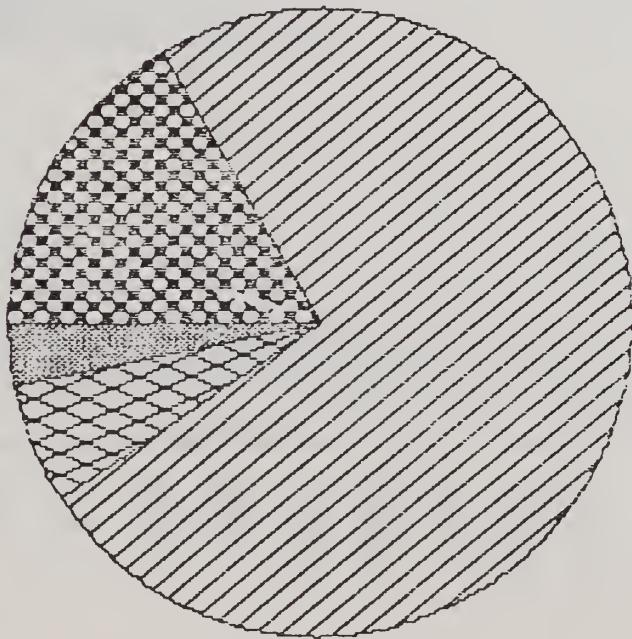
	- LIVING WITH SPOUSE	7244.00 (52.3%)
	- LIVING WITH OTHERS	1906.00 (13.8%)
	- LIVING ALONE	3996.00 (28.5%)
	- IN NURSING HOMES	703.00 (5.1%)



TOTAL: 13849.00 (100%)

PERSONS AGE 65 AND OVER, BY COUNTY, REGION XI

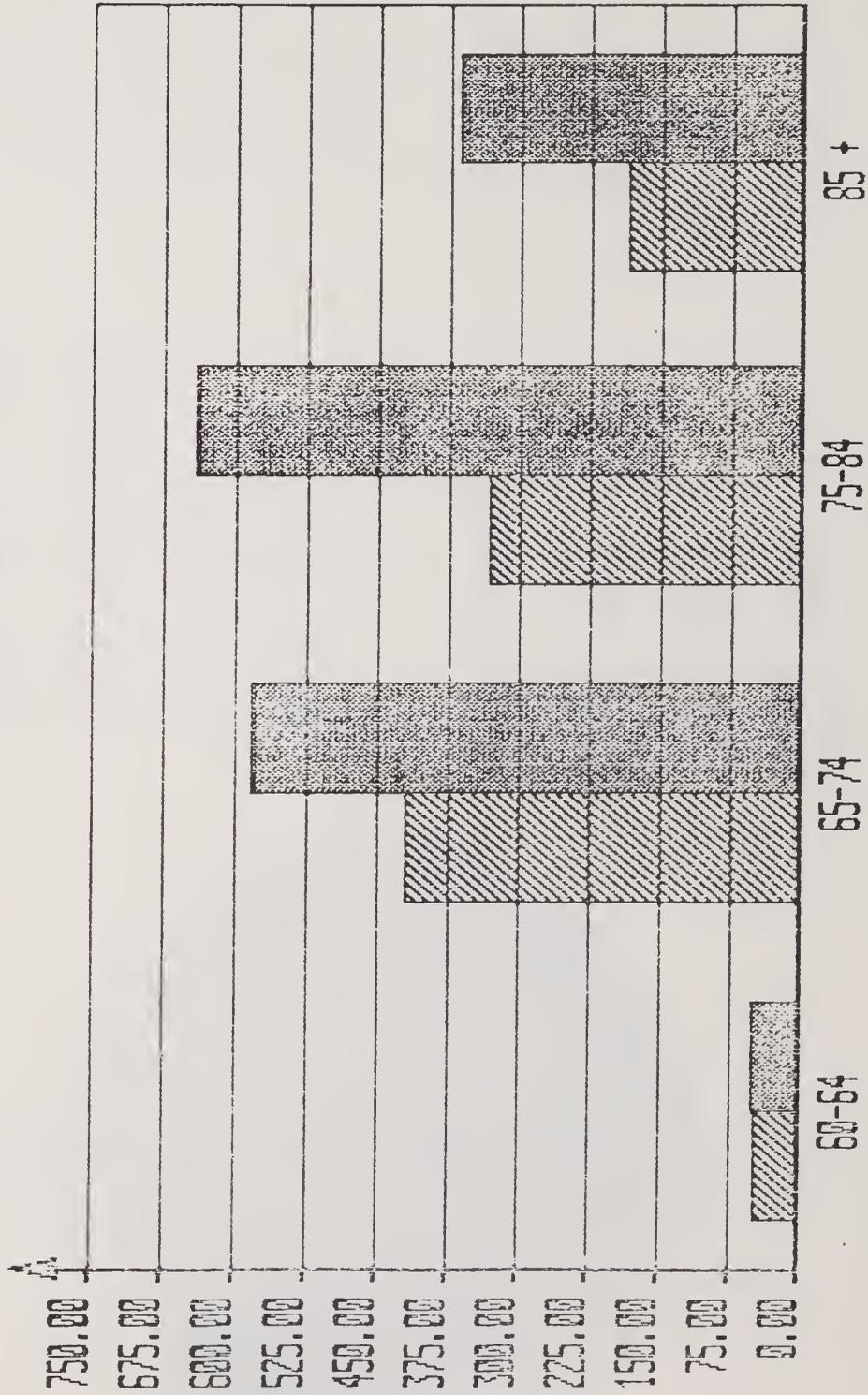
	- GARFIELD	2269.00 (16.4%)
	- MESA	10278.00 (74.2%)
	- MOFFAT	852.00 (6.2%)
	- RIO BLANCO	451.00 (3.3%)



TOTAL: 13850.00 (100%)

NEED COMMUNITY CARE, BY AGE AND SEX

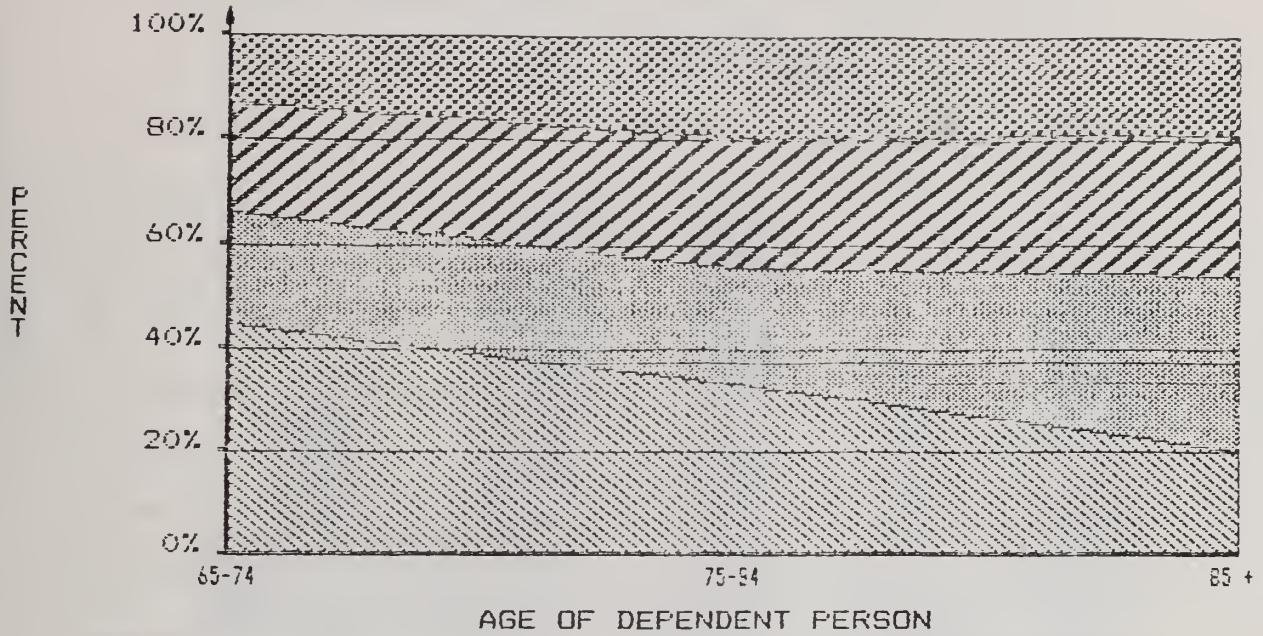
- MALES
 - FEMALES



NEEDING CARE

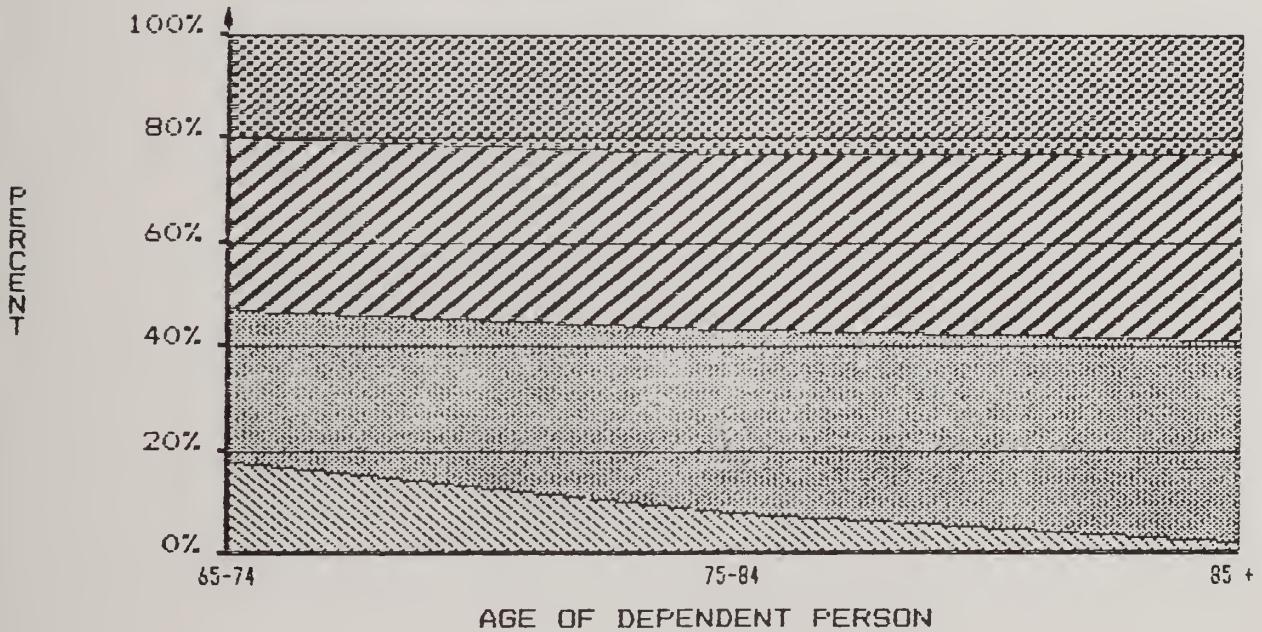
CARETAKER FOR MEN NEEDING COMMUNITY CARE

: SPOUSE
 : OFF-SPRING
 : OTHER REL
 : NON-REL

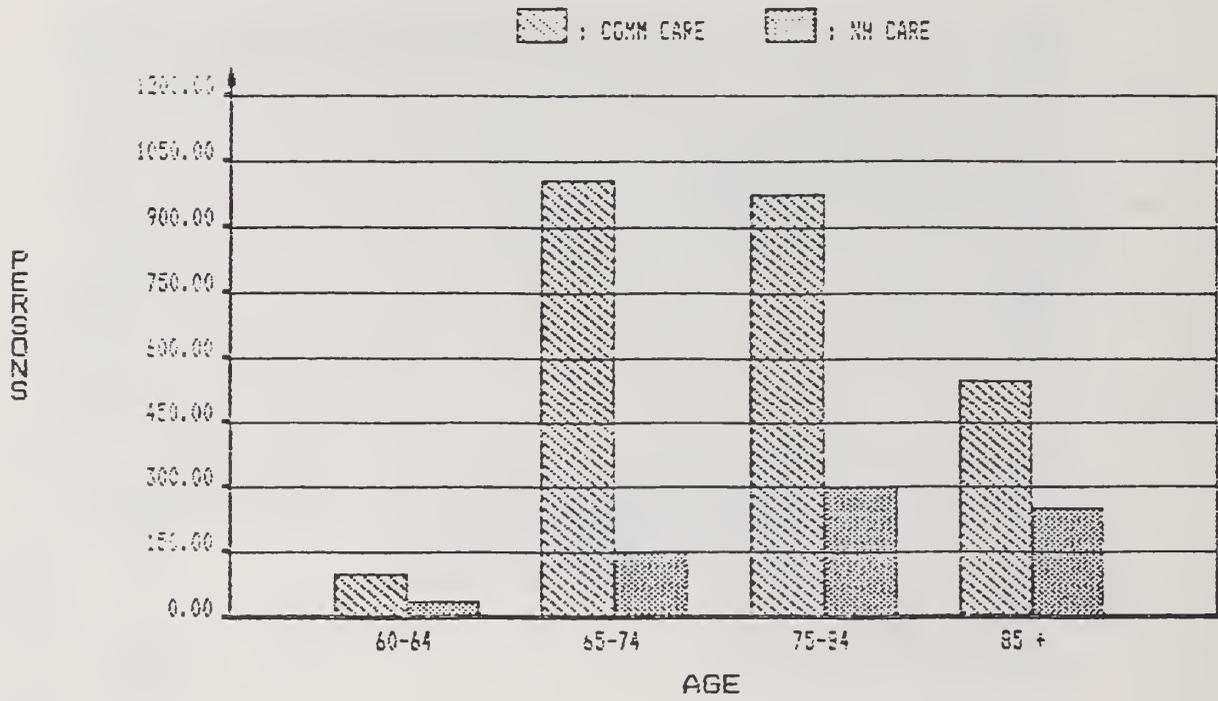


CARETAKER FOR WOMEN NEEDING COMMUNITY CARE

: SPOUSE
 : OFF-SPRING
 : OTHER REL
 : NON-REL

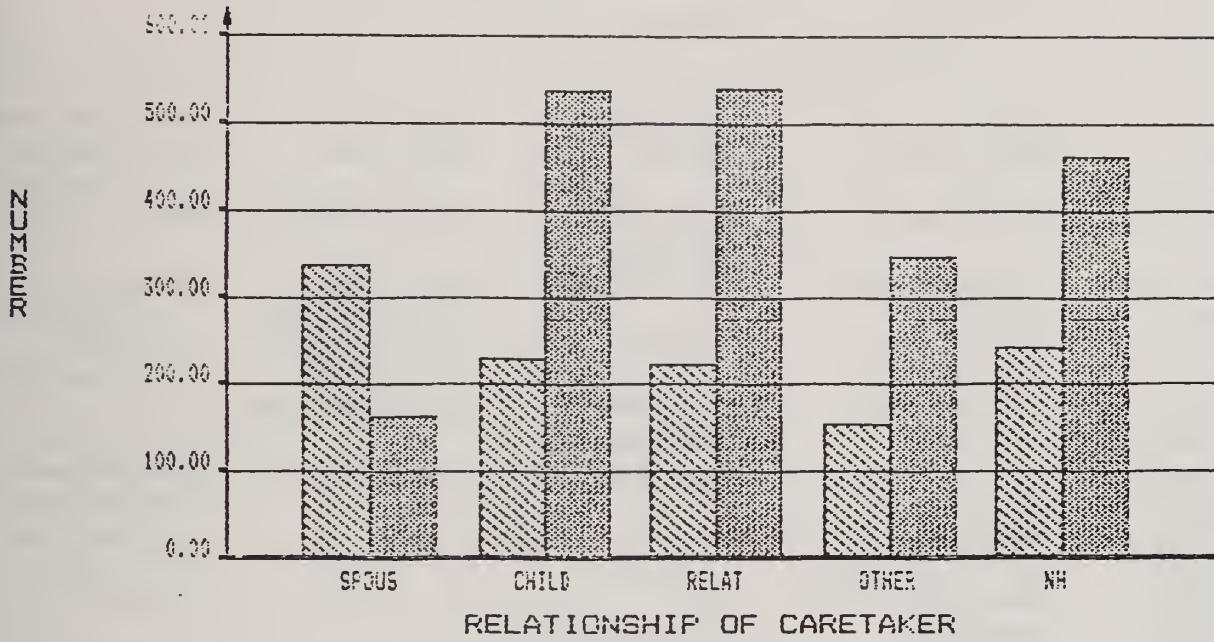


NEED OF COMMUNITY CARE VS NURSING HOME CARE



CARE PROVIDER FOR THOSE AGE 65 - NEEDING CARE

■ : MEN ■ : WOMEN



CONTINUUM OF CARE DEMONSTRATION PROJECT, REGION XI

MODEL FOR INTEGRATED CONTINUUM OF LONG-TERM CARE SERVICES FOR THE AGING

By SOURCE OF FUNDS

COORDINATION AND MANAGEMENT	SUPPORTIVE COMMUNITY SERVICES	HOME & COMMUNITY BASED CARE	ALTERNATIVE COMMUNITY CARE	NURSING HOME CARE AND INSTITUTIONAL CARE
OLDER AMERICANS ACT:	OLDER AMERICANS ACT:	SOCIAL SERVICES BLOCK GRANT:	OLD AGE ASSISTANCE:	MEDICAL ASSISTANCE:
REGIONAL SERVICE AGENCY-- ADVISORY BOARD ADMINISTRATION STAFFING/SITE BUDGETING/FUNDING AUTHORIZATION/ALLOCATION CONTRACT MANAGEMENT PAYING/ACCOUNTING PROJECT MONITORING PROBLEM RESOLUTION PLANNING AND EVAL RESOURCE DIRECTORY CASE TRACKING SYSTEM CASE ASSESSMENT SYSTEM COUNTY/STATE INTERFACE	SENIOR SERVICE CENTERS ACCESS POINT INFO & REFERRAL CLIENT ADVOCACY SOCIAL AND EDUCATION PROGRAMS CONGREGATE MEALS HOME DELIVERED MEALS TRANSPORTATION NON-MED LEGAL SERVICES OMBUDSMANSHIP HEALTH CLINICS EMPLOYMENT SERVICES	PROTECTIVE SERVICES NON-WAIVERED ----- OLD AGE ASSISTANCE: HOME HEALTH CARE CHORE SERVICE 2176 WAIVERED ----- OLD AGE ASSISTANCE: HOME HEALTH CARE MEDICAL ASSISTANCE:	ALTERNATE CARE FACILITY (8 HOMES) ADULT FOSTER CARE (PRIVATE HOMES) TERMINAL HOSPICE CARE	INTERMEDIATE CARE FACILITY SKILLED NURSING CARE FACILITY ACUTE SHORT-TERM HOSPITALIZATION ACUTE LONG-TERM HOSPITALIZATION ACUTE TERMINAL HOSPITALIZATION STATE AGENCIES: STATE HOSPITAL VETERAN'S HOMES ETC.
COMMUNITY ORGANIZATION-- RESOURCE INVENTORY NEEDS ASSESSMENT RESOURCE DEVELOPMENT COORDINATION AND NETWORKING OUTREACH AND PUBLIC INFORMATION	OTHER STATE PROGRAMS: LOCAL PROGRAMS: PRIVATE AGENCIES:	2176 WAIVERED ----- OLD AGE ASSISTANCE: HOME HEALTH CARE MEDICAL ASSISTANCE: PERSONAL CARE HOMEMAKER SERVICE ADULT DAY CARE RESPIRE CARE CHORE SERVICE		
SOCIAL SERVICES BLOCK GRANT:				
CASELOAD MANAGEMENT-- INTAKE & REFERRAL CASE ASSESSMENT CRISIS INTERVENTION FINANCIAL ELIGIBILITY FEE SCHEDULE FOR SERVICE SERVICE ELIGIBILITY CASE ASSIGNMENT CASE MANAGEMENT CASE PLANNING PLAN IMPLEMENTATION MONITORING & FOLLOW-UP PROGRESS ASSESSMENT CASE CONFERENCING REPLANNING/TERMINATION (MAY BE CONTRACTED)				

CONTINUUM OF CARE DEMONSTRATION PROJECT, REGION XI

WORK PLAN: _____ (DATE)

COORDINATION AND DEVELOPMENT:

PRIMARY RESPONSIBILITY: CURRENT STATUS: PLANS:

REGIONAL PARTICIPATION

REGIONAL DATA COLLECTION

REGIONAL CONFERENCE

REGIONAL COMPACT

REGIONAL PRIORITIES

LIABILITY/INSURANCE

STATE RULES & REGS

REGIONAL SERVICE AGENCY:

ADMINISTRATION--

STAFFING/SITE

BUDGETING/FUNDING

ALLOCATION

CONTRACT MANAGEMENT

PAYING/ACCOUNTING

PROJECT MONITORING

PROBLEM RESOLUTION

PLANNING AND EVAL

RESOURCE DIRECTORY

CASELOAD MANAGEMENT

CASE TRACKING SYSTEM

CASE ASSESSMENT SYSTEM

COUNTY/STATE INTERFACE

COMMUNITY ORGANIZATION--

RESOURCE INVENTORY

NEEDS ASSESSMENT

RESOURCE DEVELOPMENT

PROGRAM COORDINATION

PUBLIC INFORMATION

INVENTORY

CONTINUUM OF CARE DEMONSTRATION PROJECT, REGION XI

AVAILABILITY CODE:
 1--USUALLY AVAILABLE
 2--OFTEN UNAVAILABLE
 3--NOT AVAILABLE AT ALL

CASE IDENTIFICATION:

INVENTORY: _____ (COUNTY)

RESPONSIBILITY: _____

SERVICE ACTIVITY:	RECEIVING	PROVIDER:	CHARGE/HR/VISIT/ETC	AVAILABILITY CODE	NEEDED/NOT RECEIVING
ADULT DAY CARE	Y		\$	1 2 3	Y
ADVOCACY	Y		\$	1 2 3	Y
ALCOHOL/DRUG SERVICES	Y		\$	1 2 3	Y
ASSISTANCE GETTING HELP	Y		\$	1 2 3	Y
BOARDING HOME CARE ACC	Y		\$	1 2 3	Y
CASE MANAGEMENT	Y		\$	1 2 3	Y
CHORE SERVICE	Y		\$	1 2 3	Y
COMPANION	Y		\$	1 2 3	Y
CONGREGATE MEALS	Y		\$	1 2 3	Y
CONSERVATORSHIP	Y		\$	1 2 3	Y
COUNSELING/CASEWRK	Y		\$	1 2 3	Y
CRISIS INTERVENTION	Y		\$	1 2 3	Y
DENTAL SERVICES	Y		\$	1 2 3	Y
ELECTRONIC MONITORING	Y		\$	1 2 3	Y
EMERGENCY FOOD/SHELTER	Y		\$	1 2 3	Y
EMPLOYMENT SERVICES	Y		\$	1 2 3	Y
FAMILY COUNSELING	Y		\$	1 2 3	Y
GUARDIANSHIP	Y		\$	1 2 3	Y
HOMEMAKER	Y		\$	1 2 3	Y
HOME DELIVERED MEALS	Y		\$	1 2 3	Y
HOSPITALIZATION	Y		\$	1 2 3	Y
HOUSING COUNSELING	Y		\$	1 2 3	Y
INCOME ASSISTANCE	Y		\$	1 2 3	Y
INFORMATION/REFERRAL	Y		\$	1 2 3	Y
LEGAL SERVICES	Y		\$	1 2 3	Y
LIVE-IN COMPANION	Y		\$	1 2 3	Y
MEDICAL EQUIPMENT	Y		\$	1 2 3	Y
MEDICAL EXAMINATION	Y		\$	1 2 3	Y
MEDICATION MONITOR/ADMIN	Y		\$	1 2 3	Y
MONEY MANAGEMENT/PAY BILLS	Y		\$	1 2 3	Y
NON-MED TRANSPORTATION	Y		\$	1 2 3	Y
NURSING HOME CARE	Y		\$	1 2 3	Y
NURSING SERVICE	Y		\$	1 2 3	Y
NURSE S AIDE	Y		\$	1 2 3	Y
NUTRITIONAL COUNSELING	Y		\$	1 2 3	Y
OCCUPATIONAL THERAPY	Y		\$	1 2 3	Y
OMBUDSMANSHIP	Y		\$	1 2 3	Y
PERSONAL CARE	Y		\$	1 2 3	Y
PHYSICAL THERAPY	Y		\$	1 2 3	Y
PHYSICIAN, HOME VISIT	Y		\$	1 2 3	Y
PHYSICIAN, OFFICE VISIT	Y		\$	1 2 3	Y
PROTECTIVE SERVICE	Y		\$	1 2 3	Y
PSYCHG/SOCIAL COUNSELING	Y		\$	1 2 3	Y
PSYCHOTHERAPY	Y		\$	1 2 3	Y
RECREATION	Y		\$	1 2 3	Y
RESPIRE CARE	Y		\$	1 2 3	Y
SERVICE REFERRAL	Y		\$	1 2 3	Y
SPEECH THERAPY	Y		\$	1 2 3	Y
SOCIAL ACTIVITIES	Y		\$	1 2 3	Y
SUPPORT GROUP	Y		\$	1 2 3	Y
24 HR. PERSONAL CARE	Y		\$	1 2 3	Y
VOLUNTEER/FRIENDLY VISITOR	Y		\$	1 2 3	Y
OTHER:	Y		\$	1 2 3	Y

RECORD

CONTINUUM OF CARE DEMONSTRATION PROJECT, REGION XI
RECORD OF SERVICES PROVIDED

HR NO: _____

CLIENT

NAME: _____ ADDRESS: _____ CITY: _____ ZIP: _____ PHONE: _____

Provider Agency: _____ Agency Supervisor: _____ PHONE: _____

A. SERVICES TO BE PROVIDED AND NAME OF SERVICE PROVIDER: _____ PHONE: _____

- 00 MEAL PREP 01 HOUSEKEEPING 02 SHOPPING 03 MONEY 04 TELEPHONE 05 LAUNDRY 06 DEEP CLEANING
 - 10 EATING 11 TRANSFER/WALKING 12 TOILET 13 DRESSING 14 BATHING 15 EXERCISE 19 MEDICATION
 - 20 HAIR/SKIN CARE 21 CARE OF NAILS/FEET 22 NON-MED TRANS 23 ESCORT 24 PROTECTIVE SUP 25 CASE MANAGEMENT
- COMMENTS: _____

B. SERVICE: _____ FREQUENCY: _____ INSTRUCTIONS: _____

C. SCHEDULE OF AUTHORIZED WORK HOURS (SCHEDULE TIME TO NEAREST 15 MINUTES):				D. RATE PER HOUR: \$ _____			
DAY OF WEEK	TIME IN	TIME OUT	TOTAL	DAY OF WEEK	TIME IN	TIME OUT	TOTAL
SUNDAY	_____	_____	_____	THURSDAY	_____	_____	_____
MONDAY	_____	_____	_____	FRIDAY	_____	_____	_____
TUESDAY	_____	_____	_____	SATURDAY	_____	_____	_____
WEDNESDAY	_____	_____	_____	TOTAL AUTHORIZED HOURS PER WEEK: _____			

E. PLAN AGREEMENT. PLANNER: _____ Supervisor: _____ Provider: _____ Date: _____

F. RECORD OF HOURS WORKED, MONTH: _____, YEAR: _____, (REPORT TIME TO NEAREST 15 MINUTES):											
DAY	TIME IN	TIME OUT	TOTAL	DAY	TIME IN	TIME OUT	TOTAL	DAY	TIME IN	TIME OUT	TOTAL
1	_____	_____	_____	12	_____	_____	_____	23	_____	_____	_____
2	_____	_____	_____	13	_____	_____	_____	24	_____	_____	_____
3	_____	_____	_____	14	_____	_____	_____	25	_____	_____	_____
4	_____	_____	_____	15	_____	_____	_____	26	_____	_____	_____
5	_____	_____	_____	16	_____	_____	_____	27	_____	_____	_____
6	_____	_____	_____	17	_____	_____	_____	28	_____	_____	_____
7	_____	_____	_____	18	_____	_____	_____	29	_____	_____	_____
8	_____	_____	_____	19	_____	_____	_____	30	_____	_____	_____
9	_____	_____	_____	20	_____	_____	_____	31	_____	_____	_____
10	_____	_____	_____	21	_____	_____	_____	TOTAL HOURS WORKED DURING THE MONTH: _____			
11	_____	_____	_____	22	_____	_____	_____	AMOUNT EARNED: \$ _____			

This is to certify that I worked the number of hours recorded above and have completed the assigned tasks: Provider's signature: _____ Date signed: _____

This is to certify that above provider has worked the hours recorded, and has completed the assigned tasks: Supervisor's signature: _____ Date signed: _____

REQUEST

CONTINUUM OF CARE DEMONSTRATION PROJECT, REGION XI
CLIENT SERVICE REQUEST

HH NO: _____

CLIENT

NAME: _____ ADDRESS: _____ CITY: _____ ZIP: _____ PHONE: _____

SERVICES REQUEST: _____ SOURCE OF REFERRAL: _____ PUB AST. WORKER: _____ HOME COUNTY: _____

H. NEEDS HELP WITH:

- 00 MEAL PREP 01 HOUSEKEEPING 02 SHOPPING 03 MONEY 04 TELEPHONE 05 LAUNDRY 06 DEEP CLEANING
- 10 EATING 11 TRANSFER/WALKING 12 TOILET 13 DRESSING 14 BATHING 15 EXERCISE 16 MEDICATION
- 20 HAIR/SKIN CARE 21 CARE OF NAILS/FEET 22 NON-MED TRANS 23 ESCORT 24 PROTECTIVE SUP 25 CASE MANAGEMENT

COMMENTS: _____

B. MEDICATION: _____ FREQUENCY: _____ PURPOSE: _____

C. MEDICAL DIAGNOSIS: _____

D. DOCTOR / CLINIC: _____ LAST EXAM DATE: _____ NEXT EXAM DATE: _____

- E. PHYSICAL AND/OR MENTAL LIMITATIONS: 40 GENERAL WEAKNESS 41 DIZZINESS 42 BLACKOUTS 43 FALLS
- 44 TROUBLE STANDING 45 USES CANE/CRUTCH 46 USES WALKER 47 USES WHEELCHAIR 48 CHAIRFAST 49 BEDFAST
- 50 RUNS AWAY 51 TIME/PLACE ORIENTATION 52 SUSPICIOUS 53 DEPRESSIVE 54 COMBATIVE 55 IMPASSIVE
- 60 VISION 61 HEARING 62 SPEECH 63 SLEEPING 64 EATING 65 NAUSEA 66 INCONTINENT: Urinary Bowel
- 70 DEXTERITY 71 MOTION 72 NUMBNESS 73 PARALYSIS 74 CONTRACTURES 75 SPASTICITY 76 MISSING LIMBS

COMMENTS: _____

F. LIVING SITUATION: 80 WITH SPOUSE 81 LIVES ALONE 82 WITH RELATIVES 83 FRIEND/NEIGHBOR 84 NH 85 OTHER

G. PRIMARY CARETAKER: _____

H. ABILITY OF FAMILY/COMMUNITY TO MEET CLIENT'S NEEDS: _____

I. SERVICES CURRENTLY RECEIVED (Show provider): _____

J. PLAN: 90 INFO/REF 91 HOME CARE ALLO 92 HOME HEALTH CARE 93 HCBC 94 AFC 95 ACF 96 OTHER

K. OTHER SERVICES AND REFERRALS: _____

L. FLANNER'S SIGNATURE: _____ PLAN DATE: _____ PLAN REVISION DATE: _____ SUP INIT: _____ INIT DATE _____

M. SIGNATURE OF CLIENT (or agent): _____ DATE: _____

FINAL REPORT

of

STATUTE/REGULATORY REVIEW

for

Associated Governments of Northwest Colorado

Northwest Colorado Area Agency on Aging

Post Office Box 351

Rifle, Colorado 81650

Prepared by

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with

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November 1987

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Introduction

Planning and Service Area XI is composed of Rio Blanco, Moffat, Mesa and Garfield Counties in northwest Colorado. Region XI is a sparsely populated area covering 14,306 square miles with an estimated population of 133,416 persons. In 1986, the Aging and Adult Services Division, Colorado Department of Social Services estimated the region to have approximately 18,667 residents over the age of sixty years. The elderly population in the Region is experiencing a rapid increase as a result of the attractiveness of the environment and availability of suitable housing. Many of the region's residents reside on farms, ranches or in communities of less than 5,000 population. The region's population centers are Rifle, Glenwood Springs, Craig, Fruita, Meeker, Rangely and Grand Junction which serves as the informal center of commerce for the region with a population of 50,000.

The major barrier to the delivery of services to the elderly in Region XI is the great distances involved in providing human services from the population centers. Over 45% of the older persons in Region XI live in rural areas which do not have facilities to accommodate service delivery according to the Area Agency on Aging. The region is characterized by either a lack of or fragmentation of health and social services which, when they are available may vary in quality, quantity and cost. Senior health and social service programming has been impacted by a general decline in local government revenue as a result of the the shutdown of the mineral industry which is a large part of the area's economic base.

Planning priorities for the region identified by the Area Agency on Aging include:

1. Accessibility of services...
2. Participation in a demonstration program with Aging and Adult Services Division (CDSS) to develop a special district program that would utilize a modified block grant with a client centered case management approach to administer programs...

The demonstration project is a part of a larger statewide effort titled the Continuum of Care Systems Development (COCSA) Project. A partnership between the Aging and Adult Services Division (AAASD), Area Agencies on Aging and local communities, COCSA aims to develop and demonstrate new models for community-based long term care delivery systems and has a special focus on increasing service accessibility and accountability.

Funding for the COCSA Project comes from a grant from the Office of Human Development Services, U.S. Department of Health and Human Services, state/local public matching and support from the Commonwealth, Piton, Colorado Trust and the Anschutz Foundations.

Under the terms of the COCSA Project, the Region XI demonstration will include the following:

1. The creation of a Social Services District, through capitated, block granted state funds. The funds identified to be blocked include Social Services Block Grants, the State funded Home Care Allowance and Adult Foster Care Program and Older American Act Programs.
2. The Social Services District will establish priorities for service delivery, integrate intake mechanisms, aggregate information on client needs, services and costs of service, and equitably distribute funds for services.
3. The district will develop procedural agreements to leverage county funds, fees for service, and charitable contributions of cash and volunteer time from a variety of sources into the continuum of care, and to coordinate a variety of public and private service providers, including a health maintenance organization and a rehabilitation center.
4. The development of this block-granting system will be supervised by an advisory committee, composed of elderly consumers and county commissioners.

This statute/regulatory review has been prepared for the Northwest Colorado Area Agency on Aging as partial fulfillment of the COCSA objective to determine feasibility of such a district, while operating under the various federal and state program requirements.

Methodology

Preparation of this document involved the use of a two phase research methodology.

During Phase I, the authors reviewed state and federal government documents identified by the Northwest Colorado Area Agency on Aging. Appendix A offers a detailed list of the documents reviewed. Upon completion of the literature review, Phase II activities focused on interviews with staff from the Colorado Department of Social Services, county departments and other organizations. These interviews were intended to clarify information obtained during the first phase of the research and to identify systems, formal or informal, which might exist which would be an impediment to the creation of the pilot project. A listing of individuals interviewed can be found in Appendix B. The authors wish to thank these individuals for their assistance.

Upon the conclusion of the research, a draft summary of the research findings was forwarded to the Northwest Colorado Area Agency on Aging for review and comment.

The format of this report is to provide a section for each major document. Data will be provided concerning the legal basis of the document; eligibility criteria overlapping between programs; allowable and required program services; and specific issues seen as being applicable to the formation of the Region XI Social Service District. A general discussion and concluding remarks will be provided in a separate section.

RESULTS

No major obstacles to developing a social services district in Region XI appeared in the review of pertinent state and federal statutes and regulations. In fact coordination of benefit benefits is strongly encouraged by many of the programs. The authors conclude that obstacles, if they do exist, will be found at the local and/or state levels with regard to procedural requirements which have been developed to assure regulatory compliance. State staff, responsible for the management of the relevant programs, and county officials will need to approach the concept of a social services district from a position of flexibility. Flexibility is not intended to mean that the basic regulatory requirements of each of the programs to be included under the block grant can be compromised. The Colorado Department of Social Services has sufficient regulatory and statutory authority to assist creating a social services district which would essentially overlay the various programs with their diverse requirements. Consultations with state staff have given the authors the feeling that a positive attitude towards the creation of the project exists. It would appear that the proposed district would serve to more efficiently plan and organize service delivery, while maintaining the regulatory integrity of each program.

The Federal Register notice of proposed rule making outlines the parameters for the operation of the Social Services Block program. This serves as a major facilitator for the proposed social service district. Programmatic requirements will vary depending if the district functions under the social services or community services block grant program, i.e. a program plan versus a public hearing by the legislature, etc. However, state and county staff consulted did not foresee the inability of the region to satisfactorily comply with requirements of all the programs in question.

Changes in state statute do not appear to be indicated. However, implementation of auditing procedures which satisfy legislative oversight are clearly necessary.

If the pilot project is established under the Social Services Block Grant, provisions regulating the use of funds for room and board and medical care should be satisfactorily addressed, by developing an accountability system, which would clearly provide an audit trail to forego confusion with similar payments authorized by the Medical Assistance Program. A comprehensive accountability system would, of course, be of value, and required by all programs operating within the pilot district.

Creation of the proposed district should not be hindered by the Medicaid regulations outlined in the Social Security Act, Part 42 of the Code of Federal Regulations, the Colorado Revised Statutes or CDSS Staff Manual Volume VIII.

Medicaid, strictly a medical program, was established to assist beneficiaries in accessing needed medical care. Responsibility for eligibility determination and redetermination lies with the county departments in Colorado. However, once eligibility has been established, the client retains control over choice of the provider to be used. Clients and county departments are encouraged to utilize such other services and resources which might be available to the recipient prior to activating the Medicaid benefits. It is possible that a social services district as proposed, would facilitate the coordination of available benefits, resulting in more efficiently expending state and federal funds.

Coordination of available resources is a central function of the Medicaid Waivered Home and Community Based Services case manager. Focused on the health and social service aspects of the clients needs, HCBS is intended to maintain client independence and minimizing expenditure of Medicaid revenues. In cases of HCBS ineligibility, the case manager is encouraged to refer individuals to other programs for assistance. Staff Manual Volume VIII is very specific regarding the case managers role in coordinating services with other resources and services. The proposed social service district would be in a strong position to enhance and facilitate these activities.

As with other programs considered for the district, Medicaid program and fiscal reporting requirements would need to be negotiated between the district members and state department to assure compliance and accountability, while establishing efficient administration and service provision. Medicaid requirements such as Medicaid being the "payor of last resort" and use of "county transportation" to access services covered by other programs may serve to confuse benefit status. Once again, state staff consulted did not see this as an insurmountable obstacle, as long as all program regulations were adhered to. This would suggest that the district develop a comprehensive training program for staff to minimize errors in service decision making.

State staff indicated that members of the proposed district would be intricately involved with state staff in the development and/revision to all relevant regulations. In addition to district staff knowledge of changes to existing regulations, it would be essential for state staff responsible for monitoring these programs to understand the changes and assist the district during the transition period.

The principles identified above regarding Medicaid also apply to the Home Care Allowance and Adult Protective Services programs. Nothing within the program regulations would prohibit them from being included in the proposed district. The HCA is intended to facilitate client care, maximize client independence through accessing needed services, while minimizing expenditures to the state. Coordination of benefits is a central tenet of this program. County expenditure and reporting requirements, once again, may appear to be an obstacle to consolidation with the other programs, but redesigning reporting routines, with the assistance of the state department, should satisfactorily resolve any concerns.

Adult Protective Services operate with none of the income eligibility requirements of other programs. Therefore no conflict between eligibility and service delivery requirements is seen.

The presence of a social district could aid in the provision of service by improving access to services and information transfer between programs.

No obstacles to inclusion in the proposed district were identified in the OAA or in Volume X. Attention to fiscal and programmatic reporting requirements is important, as previously discussed in the other programs under consideration.

Older American Act programs, as with the other programs under consideration for the block granted social services district, are under the administration of the Colorado Department of Social Services. Coordination with other programs and the goal of maximizing personal independence of beneficiaries, as with the other programs, is strongly encouraged by the OAA. Although preference for serving lower income persons is required, OAA programs have no income criteria for eligibility. The OAA specifically prohibits the use of "means testing", an issue which will require careful attention to assure compliance with all other programs.

The OAA specifically identifies transportation services, available through Titles XIX and XX of the Social Security Act, as possibilities for pooling of resources to serve the common need of older persons.

In summary, no insurmountable obstacles were identified in the review of statutes and regulations of the programs under consideration for inclusion in the social service district in Region XI. The programs specify coordination with other federal, state, local and private programs to accomplish maximum utilization of available resources and achieve the greatest level of independence for beneficiaries. This is consistent with and supported by the CDSS initiative on welfare reform which emphasizes family independence.

CDSS staff expressed a positive attitude towards the proposed project, indicating that through a cooperative effort all regulatory, administrative and legislative issues could be effectively addressed during calendar year 1988, possibly before the start of the state's fiscal year on July 1, 1988.

County department staff consulted, representing both urban and rural areas, expressed a similarly positive attitude to the project. It was expressed by county staff, as well as state staff, that this project could serve as a model for the state.

Fiscal and programmatic reporting of all programs would need a great deal of attention to assure clear audit trails in what is already a complex, and at times, confusing system. Additionally, local responsibilities for funding of matching requirements and client eligibility determination will have to be assessed and resolved to the satisfaction of district members and the state agency.

Colorado Revised Statutes
Social Services Code
Title 26

Purpose

The purpose of the Social Services Code is "to promote the public health and welfare of people of the state of Colorado" through state department and county departments of social services. Programs are intended to assist individuals and families "to attain or retain capabilities for independence, self-care and self-support, insofar as possible" (26-1-102).

The county department is an agent of the state board by design of the General Assembly.

Definitions

"County Board" - means the county or district board of social services (26-1-103).

"Executive Director Rules" - are rules, and regulations, promulgated by the executive director governing matters of internal administration in the state department and the county departments, **"including organization, staffing, records, reports, systems, and procedures, and governing fiscal and personnel administration for state department and establishing accounting and fiscal reporting rules and regulations for disbursement of federal funds, contingency funds and proration of available appropriations"** 26-1-108).

"County Departments" - **"District Departments** - Two or more counties may jointly establish a consolidated social services district, with the approval of the state department (26-1-115).

"Granting of assistance payments and social services" - The state department prescribes **"procedures for handling applications or requests for social services"**. These procedures include **"eligibility determination, services to be provided, verification and record and notice to applicants and state department"** (26-2-108-2).

"Colorado Medical Assistance Act" Title XIX (Medicaid) provides for age verification by the county department of social services (26-2-201 & 26-4-107).

"Duties of the state department" - is to **"seek and utilize any available federal, state, or private funds available to carry out purposes of this article, including, but not limited to Medicaid funds"**. The department must also **"provide a system for reimbursement for services provided pursuant to this article"**, and **"which system shall encourage cost containment"** (26-4.5-105 (b)(c)).

Federal Register

Volume 46 (190), the October 1, 1981 issue of the Federal Register outlines the rules necessary to implement seven block grant programs established by the Omnibus Budget Reconciliation Act of 1981. The intent of the law was to transfer primary administrative responsibility from the Federal Government to the states and to "confer substantial discretion on the States as to the use of block grant funds(pp.cc-40)." The two block grants of primary relevance to the creation of a social service district are the Community Service Block Grant and the Social Service Block Grant.

Specific provisions of the rule notice that are of important to the proposed project are:

1. "A State must assume operation of block grant in its entirety. A State may not assume control only over a portion (pp.cc-40)."
2. "The Act requires a State to make an annual submission to the Secretary with regard to each block grant prior to receiving funds...The submission consists of an application containing specified assurances and (for CSBG) a plan describing how the State will carry out the assurances...the Social Services Block Grant requires only a report on intended uses of the funds (pp.cc-41)."
3. "The Act requires the States to subject the various plans and uses to public comment... The Act also requires the States to conduct public hearings on the proposed use and distribution of funds under the Community Services Block Grant (pp.cc-41).
4. "A basic purpose of the block grant legislation is to **simplify** State grant administration and **minimize** Federal involvement by placing greater reliance on State government. Accordingly the block grants will be exempt from the usual Departmental grant administration requirements found in 45 CFR Part 74." In the case of block grants "the State's laws and procedures covering the expenditure of its own revenues will govern."(pp.cc-42)
5. Administration of the block grant program is intended to operate with "the fundamental check on the State's use of block grant funds" to be consistent with "the State's accountability to its citizens."
6. "The Act contains a general prohibition on the use of funds to provide room and board or medical care **but** allows use of the funds if the room and board or medical care is an "integral but subordinate" part of another State authorized service.

Staff Manual Volume VIII

The Colorado Department of Social Services Staff Manual, Volume VIII provides regulations for the Colorado Medical Assistance Program, more commonly known as Medicaid. Medicaid provides a broad spectrum of health care services to individuals determined to be eligible by meeting criteria set forth in a "financial means test". Funding is provided for these services jointly by the State of Colorado and the federal government according to criteria outlined in the Social Security Act, the Code of Federal Regulations and the Colorado Medical Assistance Act.

In addition to mandated and optional services, Federal statute allows for a waiver of regulation to enable states to offer services that would be cost effective but outside the scope of the original legislation. These waived services are more commonly known in Colorado as the Home and Community Based Services Program.

Legal Basis

1. Title XIX - The Social Security Act
2. Sections 1902 (a) 10 and 1915 (c) Social Security Act
3. Volume 45, Code of Federal Regulations Sections 216, 248 and 249
4. Volume 42, Code of Federal Regulations
5. Colorado Revised Statutes, Article 26
6. Colorado Department of Social Services Staff Manual Volume IV-A (Administrative Procedures, Eligibility, Standards)

Eligibility

Individuals residing in the State of Colorado, irregardless of age, may be determined eligible to receive medical services under Medicaid depending on income, other medical coverage, assets, liabilities, marital status and functional status.

In addition to meeting financial eligibility criteria established by the Medicaid Waiver, candidates for the Home and Community Based Services Program must meet necessary functional assessment criteria, be capable of being served safely and cost effectively within the community.

Responsibility for determination of all candidates for Medicaid benefits lies with the county departments of social services or with a social service district, where one exists.

Services

- | | |
|--|---|
| 1. Inpatient Hospital Services | 10. Clinic Services |
| 2. Outpatient Hospital Services | 11. Dental Services (Under 21) |
| 3. Laboratory and Xray Services | 12. Pharmacy Services |
| 4. Skilled Nursing Facility | 13. Transportation |
| 5. Family Planning Services | 14. Medical Equipment Supplies |
| 6. Physician's Services | 15. Intermediate Care Facility |
| 7. Home Health Care | 16. Inpatient Psychiatric Care |
| 8. Early Periodic Screening and
Diagnosis of individuals under
21 years of age | 17. Home and Community Based
Services under the waiver
for EBD & DD |
| 9. Outpatient Mental Health Care | 18. HMO Services |

Funding

Services are funded through federal and state allocations administered by the Colorado Department of Social Services. In most cases reimbursement for services is made directly to the health provider. The exceptions are the case management and individual provider services through the Home and Community Based Services Program and medical transportation services through the county departments.

In those instances in which a recipient has other health insurance coverage, including Medicare, Medicaid is to be the payee of last resort. Following payment for services by Medicaid, a provider may not bill a recipient unless the service provided was not a benefit of the Medicaid program.

Relevant Regulatory Citations

Sections:

- 8.010.12 Individuals freedom to choose provider
- 8.010.31 County departments role in eligibility determination and redetermination.
- 8.011.02 Guarantee of benefits to recipients
- 8.061.01 Utilization of additional resources by recipient
- 8.061.02 Condition of non-duplication of benefits
- 8.486.52 Funds other than Title XIX (Medicaid)
- 8.486.54 (c) Personal care services support by HCB-EBD and home care allowance
- 8.494.12 Non-medical transportation

Staff Manual Volume VII

The Colorado Department of Social Services Staff Manual Volume VII provides regulations for Program Area I, the Home Care Allowance and Program Area II, Adult Protective Services (Title XX of the Social Security Act).

Home Care Allowance (Program Area I)

Legal Basis

Code of Federal Regulations, Volume 45, Sections 96.70-96.72

Colorado Revised Statutes 1973 Article 26 Sections:

26-1-108 (1)(b)(c)

26-1-109 (1), (2)(a), (3)

26-1-111 (1), (2)(a)(c)(h)(i)

26-2-114 (2)(a)

Eligibility

Eligibility for the Home Care Allowance is generally restricted to recipients of OAP, AND/SSI/CS, AB/SSI/CS, HCBS, or State AND. Clients must be at least 18 years of age and in need of in-home services to assist with activities of daily living. Eligibility may also be extended to DD or MI clients and to individuals under 18 years who are receiving SSI benefits.

The Home Care Allowance is available when:

1. The individual is not eligible for Medicare or Medicaid.
2. Medicare or Medicaid services are not available.
3. Medicaid is available but the cost of the service is less than 50% of those services when purchased by Medicaid, or
4. With prior approval of the county department of social services, when the cost is greater than 50% of the cost to Medicaid.

Referrals for the Home Care Allowance are made by the county department of social services. The need for services must be documented by the clients physician.

Funding

The Home Care Allowance program is funded 100% with state funds. The recipient may receive up to \$319.00 per month for approved services.

Services

Services are those necessary to maintain the individual in their own home. They may involve assistance with activities of daily living, self-maintenance task, personal care and/or supervision. The county department is responsible for authorization and coordination of services. **Payment is made directly to the recipient**, who is responsible for payment of services received.

Relevant Regulatory Citations

Sections:

- 7.101.4 County determination of provider and rate negotiation.
- 7.101.5 County staff coordination with HCBS case manager.

Adult Protective Services (Program Area II)

Legal Basis

1. Title XX - Social Security Act
2. Colorado Revised Statutes
 - 26-3.1-101
 - 15-14 (Guardianship)
 - 27-10 (Mental health hold and treat)

Eligibility

Individuals over 18 years of age who have been determined to be unable to protect their own interests and who are:

1. In need of assessment for protection or in need of short term services due to potential abuse, neglect or exploitation, or
2. In need of protection as the result of founded, documented evidence of neglect, abuse or exploitation.

Income and resource availability are not a consideration for eligibility of adult protective services.

Services

Supportive and advocacy services may include court ordered guardianship or conservatorship. Services are coordinated and provided by the county department of social services.

Funding

The Adult Protective Services program is supported by federal funds.

Relevant Regulatory Citations

No specific regulatory sections were found to be applicable to the development of the proposed social services district pilot. However, procedural arrangements between the county department and the Colorado Department of Social Services regarding fiscal and program reporting accountability would need to be assessed.

Staff Manual Volume X

The Colorado Department of Social Services Staff Manual, Volume X, provides regulations for programs authorized by Title III Older Americans Act. Administered at the local level by area agencies on aging under a mandate to develop a comprehensive, coordinated service delivery system. Title III funds are used to purchase and/or provide services designed to maintain maximum independence for older persons over the age of 60 years.

The general responsibilities of the area agency on aging include:

1. Administer Older American Act programs and responsibilities.
2. Develop and update an area plan to meet the needs of older persons.
3. Administer the region's area plan.
4. Coordinate the development and utilization of resources in order to develop a comprehensive and coordinated system of services for older persons.
5. Provide leadership and advocacy for older persons.

Title III services are covered by the following programs:

1. Title IIIB - Supportive Services and Senior Centers
2. Title IIIC(1) - Congregate Nutrition Services
3. Title IIIC(2) - Home Delivered Nutrition Services

Legal Basis

1. Older Americans Act of 1965 as amended by P.L. 98-459-October 9, 1984.
2. Colorado Revised Statutes, Articles 26-11-101 to 26-11-105, CRS 1982, as amended and 26-11-201 to 26-11-206, CRS 1982, as amended.

Eligibility

All individuals aged 60 years and older, irregardless of income, are eligible for services under OAA programs. When resources are insufficient to serve all eligible individuals, preference will be given to those in greatest social or economic need.

Provisions are made for persons physically disabled or blind between the ages of 18-59 years to receive congregate or home-delivered meals and nutrition support if they meet at least one of the following criteria:

1. Be physically disabled or blind residing in a housing facility which is primarily occupied by elderly persons and which has a Title III congregate meal site.

2. Be physically disabled or blind and be a client of the Home and Community Based Services Program if nutrition services are included in the approved care plan. Only preference over other fee paying participants is provided for.

Services

Services authorized under Title III cover a wide variety of administrative, planning and direct services which may be provided by the area agency on aging directly, or purchased from community based organizations.

Administrative services required by Volume X center on administration of Title III grants or contracts, accountability and compliance activities required by the OAA and planning or coordination of community based programs and services.

The area agency is required to allot an adequate portion of its funding to support the following services:

1. Access Services
 - Information & Referral
 - Outreach
 - Transportation
2. In-Home Services
 - Homemaker
 - Home Health
 - Personal Care
 - Chore Maintenance
 - Other
3. Long Term Care Services
 - Advocacy
 - Coordination
4. Legal Assistance

The area agency on aging has great discretion in providing or supporting other services which are consistent with the goal of developing a comprehensive and coordinated community-based health and supportive service system within the planning and service area. These services are great in number and generally fit into one of the following categories:

1. In-Home
2. Access
3. Employment
4. Education
5. Nutrition
6. Health
7. Case Management
8. Home Modification
9. Assessments
10. Advocacy
11. Protective
12. Casework
13. Other

Funding

Allocation of Title III funds is made based on a statewide allocation formula and is awarded annually to the planning and management region, i.e. Region XI. These funds, allocated by program area, i.e. Title IIIB, C-1 and C-2, has provisions for transferring funds between program areas based on local needs.

Cost-sharing is required at no less than twenty-five (25%) local funding for administrative costs and no less than fifteen percent (15%) for supportive and nutrition services. Local funding includes at least five cents, appropriated by the Colorado General Assembly for each eighty-five cents of federal funds expended.

Additional funding is provided by the U.S.D.A. Surplus Foods program which provides commodity foods and/or cash payments to support the Title IIIC programs.

Voluntary contributions are accepted from recipients of services from Title III supported grants or contracts. These funds must be used to increase the availability of services.

Relevant Regulatory Citations

Sections:

10.302	General Responsibilities	10.110	Legal Basis
10.220	Statewide Allocation Formula	10.130	Eligibility
10.350	Required Support Services	10.355	Allowable Services
10.410	Allotment of Title III, Part B and C Funds		
10.411	Cost Sharing Requirements For Title III		
10.365	U.S.D.A. Program Participation		
307(13)(C)	OAA - Client contributions		

Code of Federal Regulations

Volume 42 of the Code of Federal Regulations outlines the specific regulations developed for the Medical Assistance Program. There in are defined the scope of services, exceptions, limitations, terminology, eligibility criteria, and administrative requirements (appeals, billing, hearings, etc.).

The Code of Federal Regulations passes reporting and accountability functions to the single state agency, i.e. the Colorado Department of Social Services, which would maintain responsibilities for regulatory compliance with the proposed social service district.

Colorado Department of Social Services Staff Manual VIII is based on CFR 42, therefore no further report on this section will be provided.

Appendix A
Research Phase I
Literature Review

1. Code of Federal Regulations, Part 42
2. Colorado Revised Statutes
3. Colorado Department of Social Services Staff Manual Volume VIII: regulations for the Colorado Medical Assistance Program (Title XIX).
4. Colorado Department of Social Services Staff Manual Volume VII: regulations for Program Area I (Home Care Allowance) and Program II (Adult Protective Services).
5. Colorado Department of Social Services Staff Manual Volume X: regulations for services authorized by Title III of the Older Americans Act.
6. Colorado Department of Social Services, County Letter #86-273-A "AASD Program Descriptions: Client Assistance Information", October 10, 1986.
7. Federal Register, Volume 46, #190, October 1, 1981. Rules pertaining to block grant programs established by the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).
8. Kowal, Tom "Option Paper - LTC System Integration and Financing (Discussion Draft)." CDSS, AASD, November 24, 1986.
9. Region XI Area Agency on Aging, Annual Plan, 1987.
10. Colorado Continuum of Care Systems Development Project, CDSS 1986.
11. CDSS "Eligibility Technician Training - Program Overview." 1987.
12. Hughes, C.S and Kowal, Tom "The Home and Community Based Services Block Grant/Continuum Overview and Discussion." CDSS, September 27, 1985.
13. Older Americans Act of 1965, as amended.

Appendix B
Research Phase II
Interviews

1. Gary E. Angerhofer - Director, Aging and Adult Services, CDSS.
2. Tom Kowal - Manager, Policy Evaluation and Development, CDSS.
3. Joan Bell - Program Administrator, Continuum of Care Grant, CDSS.
4. David Norman - Director, Region XI Area Agency on Aging.
5. Sandra Hernandez - Director, Home and Community Based Services, The Myron Stratton Home, El Paso County, CO.
6. Jean Bress - Assistant Director, Income and Support Services, CDSS.
7. Gretah Dussart - Program Administrator, Community Long Term Care, CDSS.
8. Pat Barnett - Executive Director, Northwest Colorado Visiting Nurse Association.
9. Andy Feldman - Field Administrator, Division of Field Administration, CDSS.
10. William Hanna - Legislative Liaison, CDSS.
11. Robert Van Cleave - Deputy Director, El Paso County DSS.
12. Lynn Slaven - Director, Teller County DSS.
13. Jan Yeoman - Administrator, Adult Services, EPCDSS
14. Cindy Manzaneres - Eligibility Supervisor, EPCDSS

Appendix II

WELD COUNTY AREA AGENCY ON AGING

CARE LINK BROCHURE

DEVELOPMENTAL PROCESS OF CARELINK

CASE MANAGEMENT PRE-SCREENING FORM

CASE MANAGEMENT ASSESSMENT TOOL

REASSESSMENT FORM

CLIENT CONSENT FORM

Share the Care

Whether you need help or give help, you're a precious asset – to your family and the community. The responsibility for caring can be shared with the community – because all of us will benefit tomorrow from the valuable contributions of yesterday and today. Support is a phone call away.

Share the caring.

Call CareLink at 353-3816.



*Coordinated caregiving
for quality independent
lifestyles.*

CareLink



Weld County Area Agency on Aging
Help Source for Seniors
1551 North 17th Avenue
Greeley, Colorado 80631
353-3816

CareLink services are funded in part by Older American Act funds, Medicaid and third party payors.

Sponsored by the
Weld County Division
of Human Resources

Sharing the Caring

Caring for loved ones – as a parent, as a spouse, as a child – the importance of dignity and independence in our lives is ageless.

Throughout life, there are times when we need help with food, shelter, clothing, medical care – or just everyday chores. Sometimes these needs can be varied and overwhelming.

CareLink wants to share the caring with those who need help and those who give help. We coordinate community resources to help our clients enrich their lives at home.

Caring Families

When someone in your family reaches out in need, you want to help. Often, it's someone who has provided care for you in the past.

Today, the average American couple has more parents than children. As a caregiver, you're juggling various demands – kids, work, spouse, parents.

Yet, as a family caregiver, you are dedicated, committed and vulnerable. Your responsibilities for caregiving can be shared. CareLink works in partnership with clients and families by coordinating community resources to meet their needs.

Employees as Caregivers

One third of the community's workforce are caregivers for senior family members. As employees they are dedicated, organized, efficient and effective – qualities that employers want to keep in their companies. These skills are walking out the door to take on full-time caregiving for family members.

As a result, growing numbers of companies are starting to add employee benefit programs to keep caregivers in the work force. CareLink can work with Weld County employers to address this emerging need.

A Caring Partnership: How CareLink Works

CareLink Care Managers work in partnership with families and the community. We coordinate community resources to help our clients maintain quality lifestyles in their homes.

These resources provide a means of preserving independence for those individuals who may have temporary or permanent physical and/or psychological impairments. We identify and coordinate services to meet their special needs.

These special needs can be varied and overwhelming – from everyday tasks such as personal care and housekeeping – to basic needs, like food preparation, medical care, and transportation – to counseling and respite care.

Personal care managers help you sort through these needs and arrange the services to fit and enhance your life using the five-step CareLink program.

Assessment

We do a complete in-home evaluation of social, emotional and physical functioning; support systems, including family needs; and economic considerations.

Personal Care Plan Development

Our personal care manager works with the client and family to identify community services to meet their individual needs.

Coordination of Services

We schedule and customize services according to your Personal Care Plan using community resources.

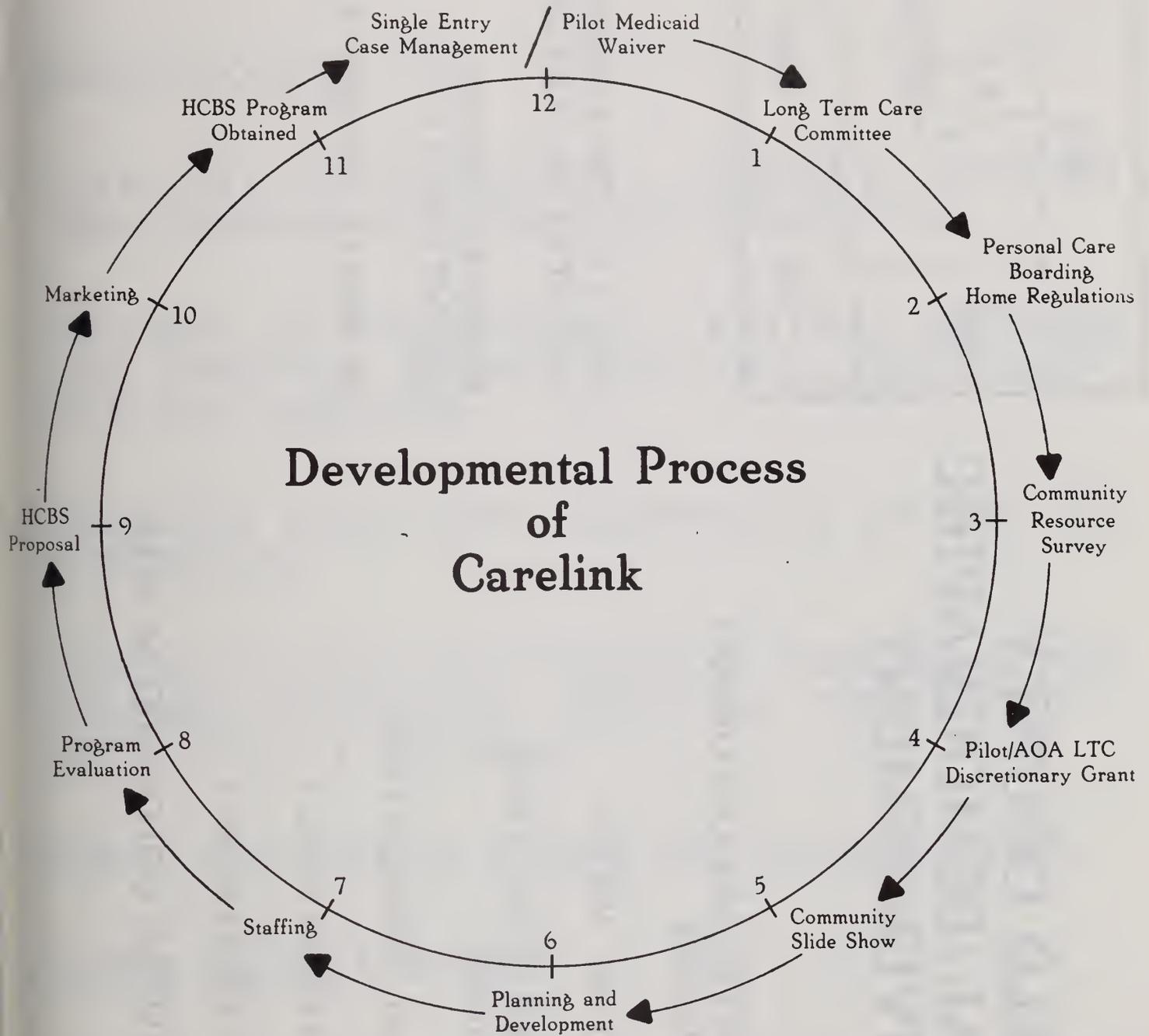
Follow-up/Evaluation

We assure that the services are properly provided according to your care plan. Additionally, we provide continuing assessment to meet changing needs.

Assistance and Guidance

Our care manager provides on-going emotional and social support to clients and family members.

Developmental Process of Carelink



WELD COUNTY PHYSICAL/DEMOGRAPHIC ENVIRONMENT

RURAL, NORTHEAST COLORADO
EASTERN PLAINS

LARGE, 4000 SQ. MILES

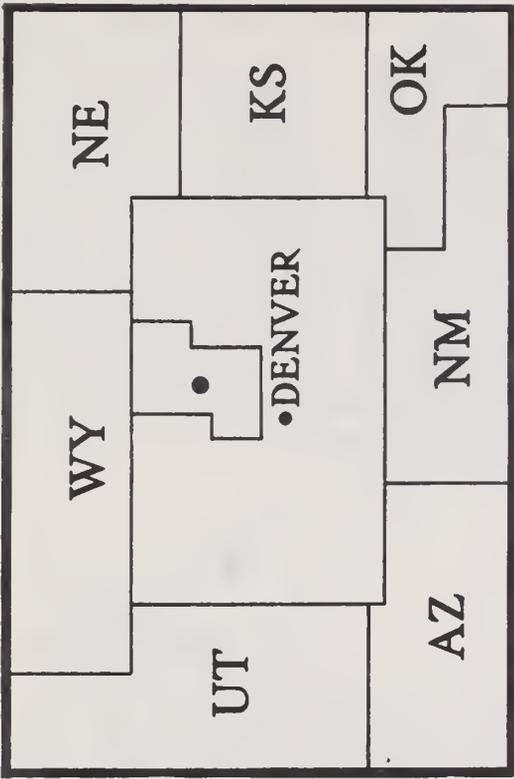
FIVE MEMBER, FULL TIME
COUNTY BOARD

140,175 TOTAL POPULATION

17,555 60 PLUS ELDERLY

5,552 75 PLUS ELDERLY

4% OF TOTAL COLORADO 60 PLUS



ONE OF TOP AGRICULTURAL
COUNTYS IN NATION

GREELEY (60,700)
COUNTY SEAT

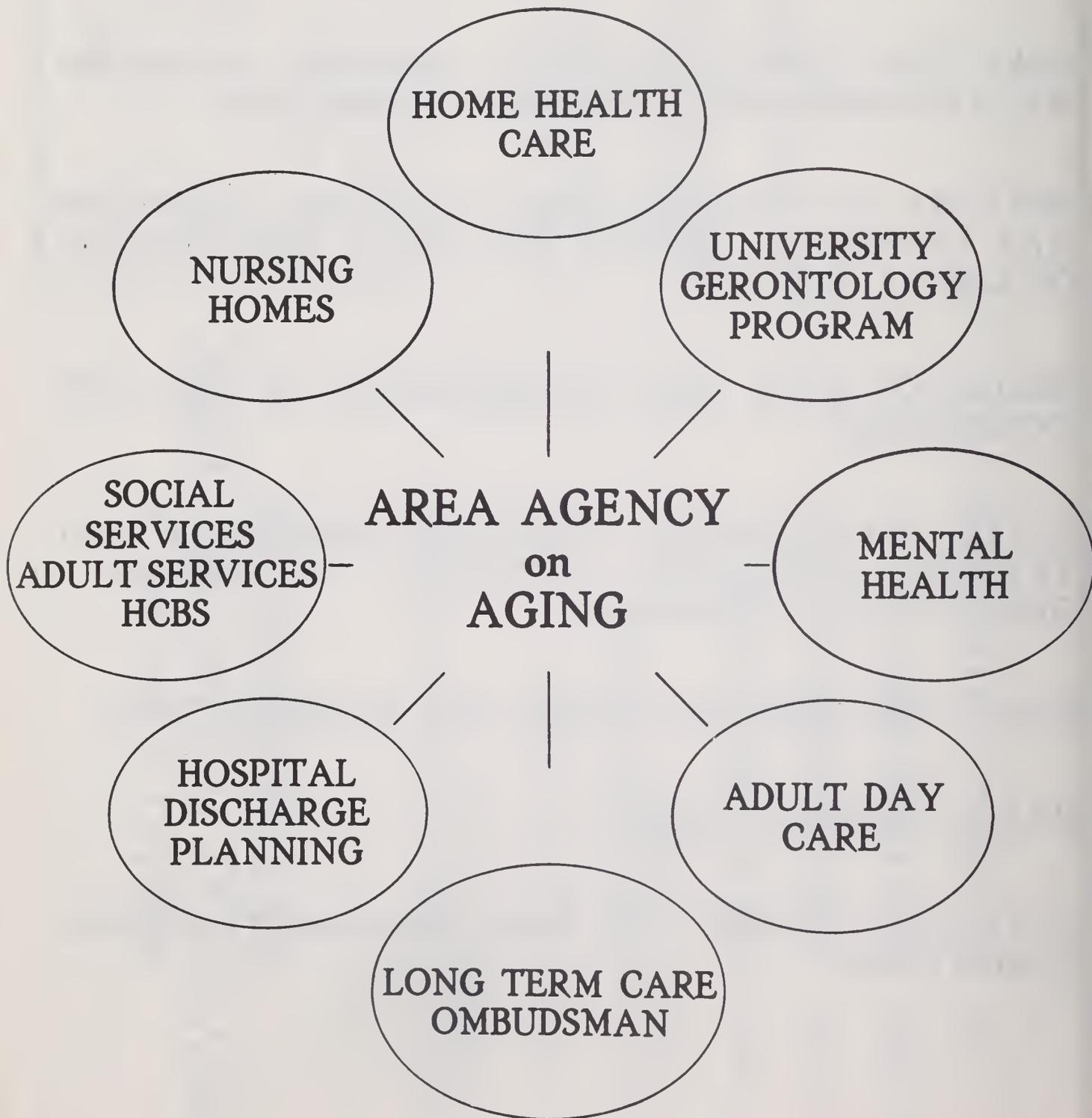
28 SMALL TOWNS AND CITIES

WELD COUNTY AGING NETWORK ENVIRONMENT

- SINGLE COUNTY AAA
- AAA HAS HIGH VISIBILITY, POSITIVE WORKING RELATIONSHIP WITH PROVIDER COMMUNITY
- HISTORY OF COOPERATIVE VENTURES BETWEEN AAA UMBRELLA AGENCY AND LOCAL DEPARTMENT OF SOCIAL SERVICES
- RESOURCE RICH, MOST COMPONENTS OF THE LTC CONTINUUM.
- ACCESS TO RESEARCH, TECHNICAL ASSISTANCE AND TRAINED PERSONNEL THROUGH UNIVERSITY GERONTOLOGY PROGRAM
- RURAL NETWORK OF SENIOR AIDE COORDINATORS
- MAJOR MEDICAL CENTER
- ACTIVE 25 MEMBER LTC (Long Term Care) PLANNING COMMITTEE.

KEY PLAYERS

CARELINK PLANNING PROCESS for WELD COUNTY AREA AGENCY ON AGING



CARELINK PRE-SCREENING FORM

Referred By: _____ Date _____

(AGENCY)

Phone No. _____

(AGENCY STAFF SIGNATURE)

1. What is your current housing situation?
 Own home/apt. Personal care boarding home
 Senior housing Nursing home
 Living with relatives Other

2. Do you have difficulty with daily tasks?
 Shopping Bathing
 Housework Getting dressed
 Cooking Other

3. Do you have any physical limitations?
 Walker/cane Vision
 Wheelchair Other
 Hearing

4. Do you have help taking your medications? yes no
Comments: _____

5. Have you experienced any major changes in your life lately?
 Hospitalization Nursing home placement/housing change
 Death of spouse Loss of friends
 Children moved Other

6. Source of income:
 SSI Wages
 OAP Private Pension
 Social Security Medicaid HCBS
Medicare A B Other

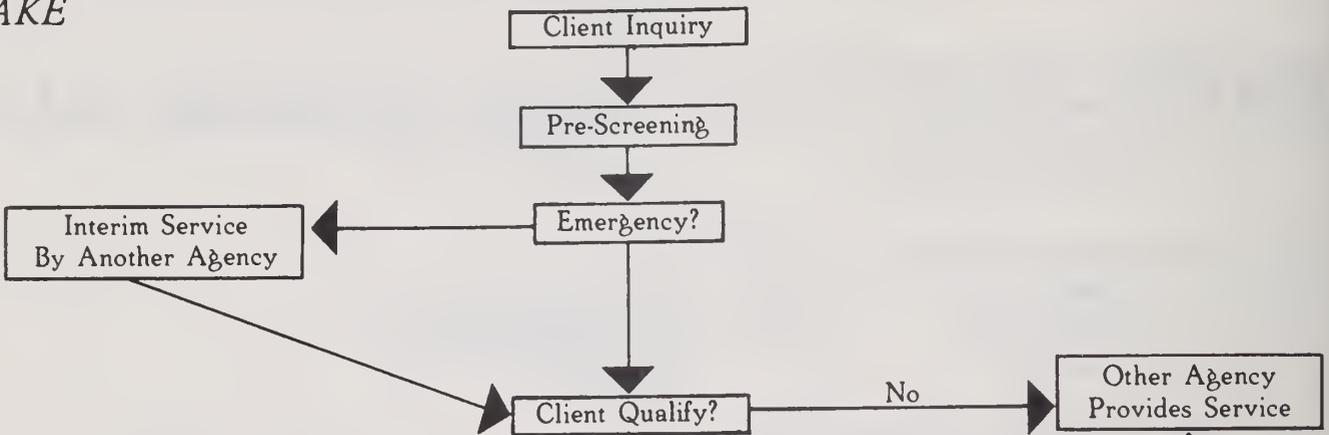
7. Overall reason for referral:
 Client's inability to provide self-care
 Client has multiple needs
 Client has diverse needs
 Client has a lack of support systems

8. Additional comment section:

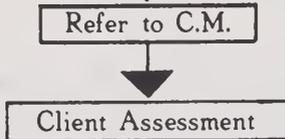
9. Client Name _____ DOB _____ Age _____
Address _____ Telephone _____
Social Security Number _____
Contact Person _____ Telephone _____

CARELINK FLOW CHART

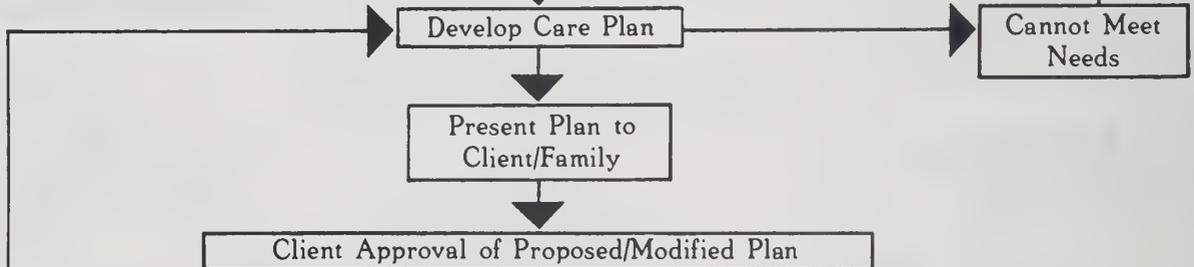
INTAKE



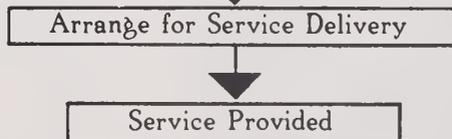
ASSESSMENT



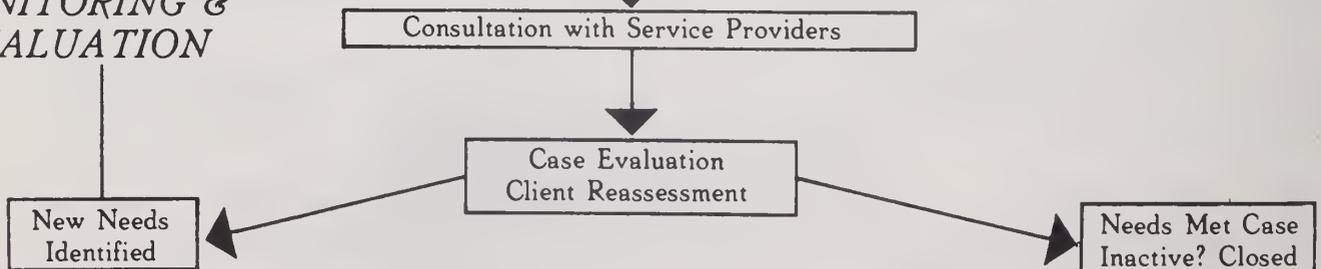
PLANNING



DELIVERY



MONITORING & EVALUATION



WELD CASE MANAGEMENT PRE-SCREENING FORM

REFERRED BY: _____ Date: _____
 (Agency)

Telephone: _____
 (Agency Staff Signature)

1. What is your current housing situation?
 Own home/apt. _____ Personal care boarding home _____
 Senior housing _____ Nursing home _____
 Living with relative _____ Other _____
 Comments: _____

2. Do you have difficulty with daily tasks?
 Shopping _____ Bathing _____
 Housework _____ Getting dressed _____
 Cooking _____ Other _____
 Comments: _____

3. Do you have any physical limitations?
 Walker _____ Hearing _____
 Wheelchair _____ Vision _____
 Cane _____ Oxygen _____
 Transportation _____ Time limitations _____
 Other _____
 Comments: _____

4. Do you need any help taking medications? Yes _____ No _____
 Comments: _____

5. Have you experienced any major changes in your life lately?
 Hospitalized _____ Nursing home placement _____
 Death of a spouse _____ Loss of friends, neighbors _____
 Death of a pet _____ Housing change _____
 Children moved _____ Other _____
 Comments: _____

6. Are you receiving help from:

	Daily	Weekly	Monthly
Friends	_____	_____	_____
Family	_____	_____	_____
Neighbors	_____	_____	_____
Church	_____	_____	_____
Agencies	_____	_____	_____

Comments: _____

7. Source of income: SSI _____ Private Pension _____
 OAP _____ Private Insurance _____
 Wages _____ Other _____
 Social Security _____
 MEDICARE _____ A _____ B MEDICAID _____

Name _____ DOB _____ Age _____
 Address _____ Telephone _____
 Contact Person _____ Telephone _____

CASE MANAGEMENT ASSESSMENT TOOL

Weld

Date _____

Case # _____ Intake Person _____

Client Name _____ Phone _____ Sex _____

Address _____ Birthdate _____ Age _____
Street & No. City State

Spouse _____ Birthdate _____ Age _____

Directions to above address _____

Communication Needs _____ Race _____

Religious Preference _____

Referring Source _____

Address _____ Phone _____

Contact Person _____ Title _____

Present Service Agencies _____

Past Service Agencies _____

Secondary Contact _____ Phone _____

Address _____ Relationship _____

Financially Responsible Party _____

Legally Responsible Party _____

Who Has a Key to Your Home _____

Physician's Name _____ Phone _____

Physician's Address _____

Social Security Number _____ Medicare A B # _____

Medicaid _____ Other Insurance _____

Date of Interview _____ Time Interview Began _____

Interviewer's Name _____ Time Interview Ended _____

Relationship of Informant to Client _____

Place of Interview _____
(Specify home or proper name and official type of institution)

6. Activities in which you are currently participating or have participated:

Responses: 4 - very often
3 - often
2 - sometimes
1 - hardly ever
0 - never

	<u>Present</u>	<u>Past</u>
Clubs/Meetings	_____	_____
Visiting with friends	_____	_____
Caring for members of the family	_____	_____
Political activities	_____	_____
Watching TV	_____	_____
Doing volunteer work	_____	_____
Going for walks	_____	_____
Gardening	_____	_____
Listening to the radio/stereo	_____	_____
Church activities	_____	_____
Traveling	_____	_____
Visiting with family members	_____	_____
Working on hobbies	_____	_____
Going to the movies	_____	_____
Sporting events	_____	_____
Going out to eat	_____	_____

7. About how many times did you talk to someone on the telephone in the past week (either you called them or they called you)?
(If subject has no phone, question still applies)

- a. once a day or more
- b. 2 to 6 times
- c. once
- d. not at all
- e. not answered

8. Do you have someone in whom you can trust and confide?

- a. yes
- b. no
- c. not answered

9. If you were sick or disabled, who would help you?

- a. friend
- b. relative
- c. neighbor
- d. other
- e. no one

Who is this person? Name _____
 What type of help and for how long? _____

10. What family members, neighbors, friends, or other volunteers are providing care in the home?

Name	Address	Telephone	Relationship	Days/Hours	
				Available	Which Tasks

ACTIVITIES OF DAILY LIVING/SELF CARE

Instructions: Each time client indicates that assistive device or help is needed/received, indicate the following in the RIGHT margin:

- 1. Type of assistance needed
- 2. Assistance that is needed but NOT provided (N+)
- 3. Who provides assistance:
 - C = caregiver (informal source, i.e., spouse, relative, friend volunteer provides on a regular basis)
 - A = agency based personnel (note which agency and how paid for)

11. Transferring: Can you get in and out of bed or chairs?

- a. without help, no impairment _____
- b. requires adaptive device only _____
- c. requires supervision or help only _____
- d. requires both device and help _____
- e. not determined _____

12. Walking: Can you walk? go up and down steps?

- a. without help, no impairment _____
- b. requires adaptive device only _____
- c. requires supervision or help only _____
- d. requires both device and help _____
- e. not determined _____

13. Ambulatory Aids: (if individual is independent with adaptive device or uses both adaptive device and human help as of date of assessment)

- a. Wheelchair (manual) _____
- b. Wheelchair (power) _____
- c. Cane _____
- d. Crutches _____
- e. Walker _____
- f. Artificial arm/leg _____

- g. Brace of any kind _____
- h. White cane _____
- i. Handrail _____
- j. Furniture _____
- k. Special shoes _____
- l. Elevated toilet seat _____
- m. Toilet grab bars _____
- n. Shower/tub grab bars _____
- o. Other (specify): _____

14. Mobility Outside Household: Can you get around to places within walking distance from your home?

- a. without help, no impairment _____
- b. requires adaptive device only _____
- c. requires supervision or help only _____
- d. requires both device and help _____
- e. not determined _____

15. Shopping: Can you do your own shopping?

- a. without help, no impairment _____
- b. requires adaptive device only _____
- c. requires supervision or help only _____
- d. requires both device and help _____
- e. not determined _____

16. Meal Preparation: Can you prepare your own meals (cook, open jars, cans, and bottles; etc.)?

- a. without help, no impairment _____
- b. requires adaptive device only _____
- c. requires supervision or help only _____
- d. requires both device and help _____
- e. not determined _____

17. Eating/Feeding: Do you have any difficulty feeding yourself or with eating?

- a. without help, no impairment _____
- b. requires adaptive device only _____
- c. requires supervision or help only _____
- d. requires both device and help _____
- e. not determined _____

18. Nutrition:

Have you had any recent changes in your eating habits? Yes _____ No _____

(If yes, describe)

Are you on a special diet? Yes _____ No _____

If yes, what type? Circle applicable diet: (a) soft, (b) bland, (c) diabetic, (d) low-salt, (e) liquid, (f) other _____

Do you follow your diet? Yes _____ No _____

Was the diet ordered by the doctor? Yes _____ No _____

Source of meals?

number of times per week

- Prepared at home _____
- Home-delivered (by whom?) _____
- Senior Center _____
- Restaurant _____
- Other (describe) _____

19. Light Housekeeping: Can you do your own general housekeeping (dusting, sweeping, washing dishes, or vacuuming)?

- a. without help, independent _____
- b. requires help with some tasks _____
- c. requires much help _____
- d. done by another _____

20. Laundry: Can you do your own laundry at home?

- a. able to do laundry completely _____
- b. launders small items: socks, stockings, etc. _____
- c. all laundry must be done by others _____
- d. not determined _____

21. Bathing: Do you have difficulty taking a bath or shower (including shampooing your hair)?

- a. without help, no impairment _____
- b. uses adaptive device only _____
- c. requires help or supervision only _____
- d. requires adaptive device and help/supervision _____
- e. not determined _____

22. Dressing: Can you dress yourself?

- a. without help, no impairment _____
- b. requires adaptive device only _____
- c. requires help or supervision only _____
- e. requires adaptive device and help _____

(Worker observation) Client is dressed _____ not dressed _____

23. Toileting: Do you have trouble using the toilet?

- a. without help _____
- b. requires adaptive device only _____
- c. requires help or supervision only _____
- e. requires adaptive device and help _____
- f. unable to use toilet room _____

Bowel Control: Do you have any problems controlling your bowels?

- a. voluntary control _____
- b. occasionally involuntary _____
- c. frequently involuntary _____
- d. colostomy/ileostomy, self care _____
- e. colostomy/ileostomy, not self care _____

Bladder Control: Do you have any problems controlling your bladder?

- a. voluntary control _____
- b. occasionally involuntary _____
- c. frequently involuntary _____
- d. catheter, self care _____
- e. catheter, not self care _____

24. Grooming and Hygiene: Can you do your own grooming (comb hair, brush teeth, shave, trim nails, etc.)?

- a. without help, independent _____
- b. requires some help _____
- c. requires much help _____
- d. must always have help _____

Note present appearance:

- a. poorly groomed (unshaven, uncombed, etc.) _____
- b. adequately groomed _____
- c. very well groomed _____

25. Medications: Can you take your own medicine (open bottles, take on time, etc.)?

- a. without help, independent _____
- b. requires some help _____
- c. requires much help _____
- d. done by another _____

26. Financial Management: Can you manage your own money (pay bills, cash checks, do banking, etc.)?

- a. without help _____
- b. only with help _____
- c. done by another _____

27. Telephone use: Can you use the telephone?

- a. without any help (dial, carry on conversation) _____
- b. uses specially adapted phone (describe) _____
- c. requires help or supervision to dial phone correctly or carry on conversation _____
- d. uses specially adapted telephone and receives help/supervision _____
- e. does not use telephone _____
- f. does not have telephone _____

28. Transportation: How do you get around to places outside walking distance from your home?

- a. travels independently on public transportation or drives own car _____
- b. arranges own travel via taxi or senior citizens' bus _____
- c. travels with escort service from senior center or other volunteer _____
- d. travel limited to assistance from others: specify _____
- e. does not travel at all _____
- f. not determined _____

29. Home Maintenance: Can you perform necessary repairs in your home?

- a. home repairs not needed _____
- b. home repairs needed, but can do or arrange them _____
- c. home repairs needed, but requires assistance _____
- d. identify who will help with home repairs _____
- e. not determined _____

30. Yard Maintenance: Can you perform necessary maintenance of your yard (snow removal, mowing, etc.)?

- a. yard work not needed _____
- b. snow removal not needed _____
- c. yard work needed, but requires assistance _____
- d. identify who will help with home repairs _____
- e. not determined _____

31. Safety in the Environment - Home:

Are the following potential safety hazards in your home? (ask client, but use own observations as well)

	Yes	No	Needs Action
Lack of telephone	1	2	3
Overloaded electrical outlet	1	2	3
Slippery steps	1	2	3
Pipes, radiators, and cords exposed	1	2	3
Insufficient lighting	1	2	3
Loose or waxed flooring	1	2	3
Frayed or worn carpeting	1	2	3
Protruding, pointed, broken furniture	1	2	3
Furniture on wheels	1	2	3
Worn walker or cane tips	1	2	3
No wheelchair access	1	2	3
Gas leaks	1	2	3
Loose railings or grab bars	1	2	3
Broken or unsecured windows	1	2	3
Broken or unsecured doors/locks	1	2	3
No fire detection device	1	2	3
No fire escape	1	2	3
Improper food storage	1	2	3
Insufficient/improper cooking facilities	1	2	3

Home Assessment: (check if present)

- Housing adequate in terms of SPACE _____
- Heating adequate and safe _____
- Cooling adequate and safe _____
- Cooking facilities and refrigerator on premises _____
- Washer & dryer on premises _____
- Toilet facilities accessible and suitable _____
- Telephone accessible and usable _____
- Pets (describe type & number) _____
- House "winterized" _____

Comments on household conditions: _____

32. Safety in the Environment - Neighborhood:

Do any of the following present safety hazards in the client's neighborhood?

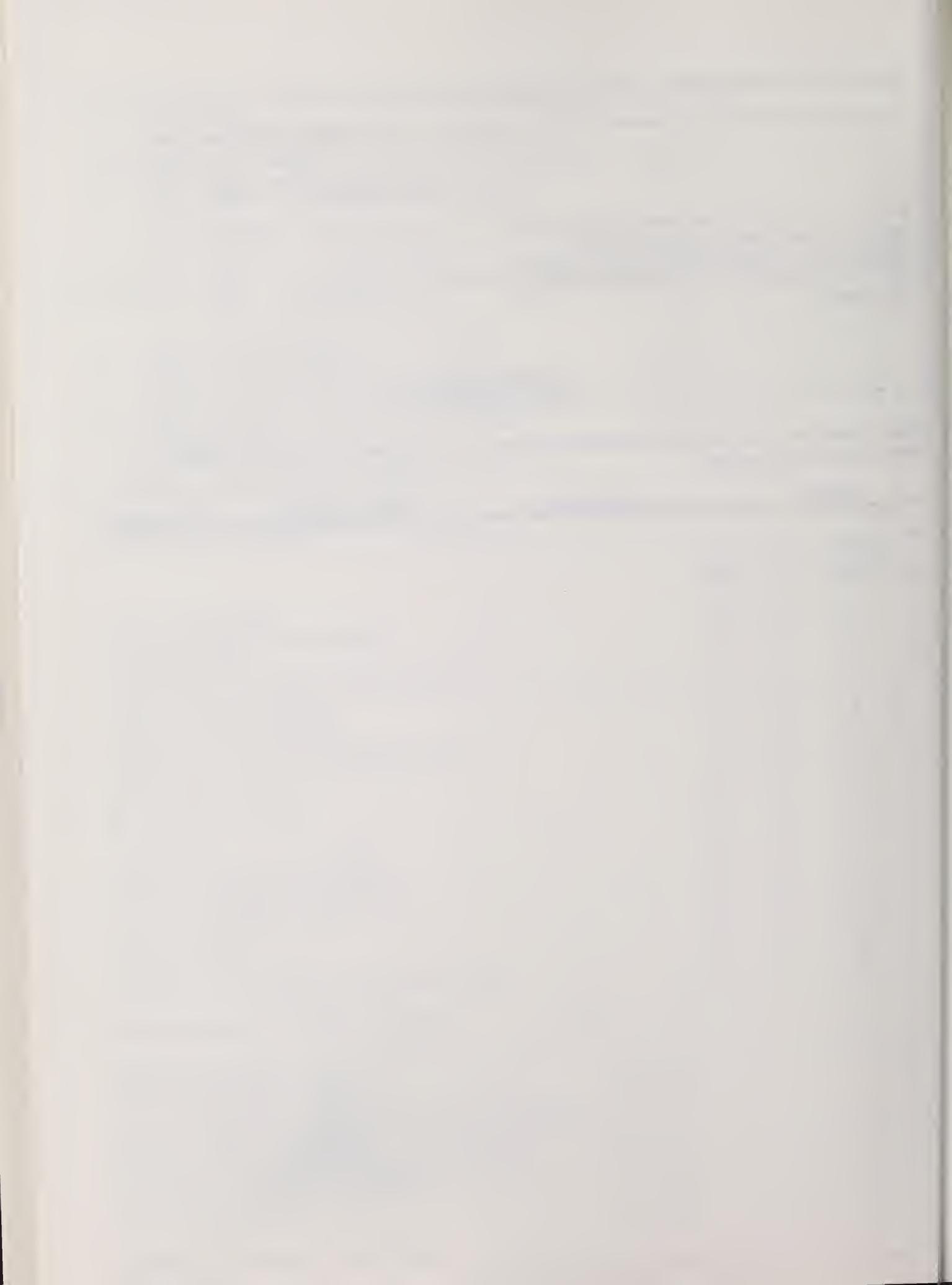
	<u>Yes</u>	<u>No</u>
Hills (is it hilly or steep in the area?)	1	2
Traffic (how heavy is the traffic?)	1	2
Crime risk (is this a high crime area?)	1	2
Lack of sidewalks or pedestrian pathways	1	2
Harassment	1	2

 AGENCY SERVICES

33. What agencies have provided services to you in your home or in the community in the past three months?

<u>AGENCY</u>	<u>TELEPHONE</u>	<u>CONTACT PERSON</u>	<u>SERVICE(S)</u>
---------------	------------------	-----------------------	-------------------

- a.
- b.
- c.
- d.



Reassessment Form

Client Name _____

Case Number _____

Address _____

Prior Assessment _____

Change in residence yes _____ no _____

Source of information _____

Location of the reassessment _____

I. Psycho-social Status

a. Has the client's mental status changed since the last assessment?
No _____ Yes _____ If yes, explain.

b. Has the home environment remained stable since the last assessment?
No _____ Yes _____ If yes, explain.

c. Has there been a change in the client's informal support system?
No _____ Yes _____ If yes, explain.

d. Did the client indicate any new problems?

II. Physical Status

a. Did the client indicate changes in ADL skills? No _____ Yes _____
If yes, explain.

III. Review of Services

Services in place

Client satisfaction

Changes in services

yes	no

Care plan revision _____

Client Status: Open Inactive Closed

Clearly state all unmet needs _____

Appendix III

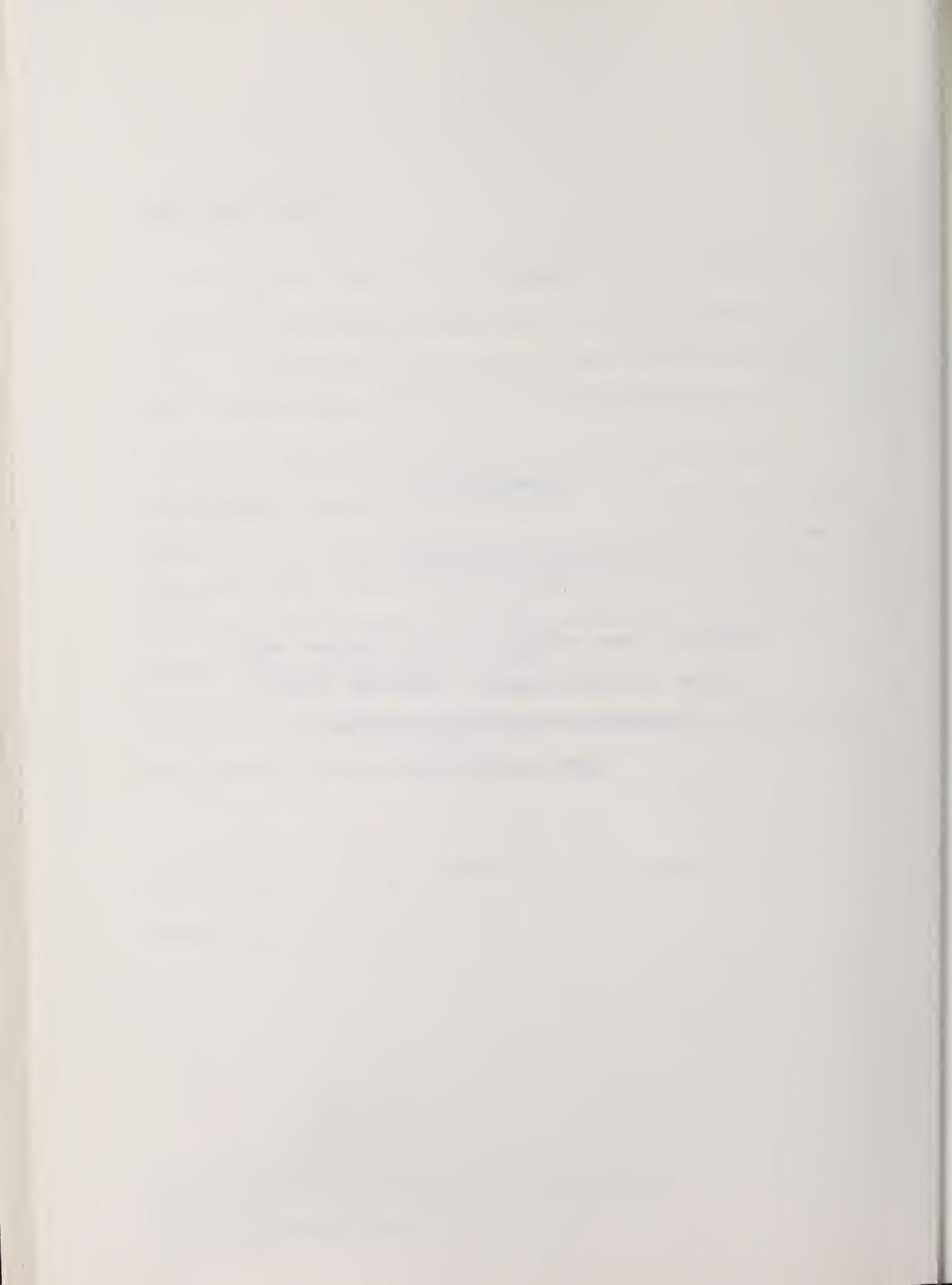
ADULT CARE MANAGEMENT, INC.

LIVING AT HOME PROGRAM - CLIENT INTAKE FORM

LIVING AT HOME PROGRAM - REFERRAL SCREEN

FUNCTIONAL ASSESSMENT INVENTORY

ANNUAL REPORT 1988



LIVING AT HOME PROGRAM

CLIENT INTAKE FORM

CASE #: _____ DATE: _____ AGENCY: _____ ()
NEW CALLER: _____ EXISTING CLIENT: _____ () PHONE: _____ ()
WHO REFERRED: _____ () CONTACT PERSON: _____

*NAME: Last First MI *PHONE: _____

*ADDRESS: _____

*CITY: _____ () COUNTY: _____ () ZIP: _____ ()

*LIVES WITH: ALONE(AL) _____ SPOUSE(HW) _____ FAMILY(FA) _____ OTHER(OR) _____ ()

*AGE: _____ BIRTHDATE: (/ /) *SEX: () SOCIAL SECURITY #: (- -)
mo day yr

MARITAL STATUS: MARRIED(1) _____ WIDOWED(2) _____ SINGLE(3) _____ SEPARATED(4) _____
DIVORCED(5) _____ UNABLE TO DETERMINE(x) _____ ()

ETHNIC BACKGROUND: CAUCASIAN(W) _____ ASIAN(A) _____ BLACK(B) _____
SPANISH AMER(H) _____ AMERICAN INDIAN/ALASKA NATIVE(I) _____
UNABLE TO DETERMINE(U) _____ ()

*PRIMARY LANGUAGE: ENGLISH(EN) _____ SPANISH(SP) _____ OTHER(OT) _____ ()

EMERGENCY CONTACT/NEXT OF KIN: _____ PHONE: _____

FINANCIAL STATUS: INCOME PER MONTH: \$ _____ SOURCE _____ ()
\$ _____ SOURCE _____ ()
\$ _____ SOURCE _____ ()

- CURRENT SERVICE PROVIDERS: 1. _____ ()
2. _____ ()
3. _____ ()
4. _____ ()
5. _____ ()

*PRESENTING SOCIO-MEDICAL PROBLEMS:

FEES/SERVICES QUOTED: _____

FOLLOW-UP DATE: _____ BY: _____

The HCRA Vulnerability Index

- 1. Now I will ask you about your meals. Do you prepare them yourself? ___ Yes ___ No
 IF YES, ASK: Do you have great difficulty doing it yourself?
 IF NO, ASK: Do you need this help? () Yes(P) ___ No
- 2. Do you take out the garbage yourself? ___ Yes ___ No
 IF YES, ASK: Do you have great difficulty doing it yourself?
 IF NO, ASK: Do you need this help? () Yes(P) ___ No
- 3. Are you healthy enough to do the ordinary work around the house without help? ___ Yes () No(P)
- 4. Are you healthy enough to walk up and down stairs without help? ___ Yes () No(P)
- 5. Do you use a walker or 4-pronged cane at least some of the time to get around? () Yes(P) ___ No
- 6. Do you use a wheelchair at least some of the time to get around? () Yes(P) ___ No
- 7. Could you please tell me what year it is? ___ Correct () Incorrect(P)

A. RECORD NUMBER OF (P) SPACES CHECKED FOR Q. 1-7.

A =

- 8. In the last month, how many days a week have you usually gone out of the house or building you live in? ___ Two or more days a week
() One day a week or less(P)
- 9. Are you able to dress yourself (including shoes and socks) without help? ___ Yes () No(P)
- 10. How much of the time does bad health, sickness or pain stop you from doing things you would like to be doing? ___ Seldom, sometimes or never
() Frequently or most of the time(P)

B. RECORD NUMBER OF (P) SPACES CHECKED FOR Q. 8-10.

B =

C. Person is functionally vulnerable if: "A" Box is greater than 1, or
"A" Box = 1 and "B" Box is greater than 0

CHECK IF VULNERABLE: C.

Client Name: _____

Date: _____

Screeener: _____

Referred to: _____

FUNCTIONAL ASSESSMENT INVENTORY

ERIC PFEIFFER, M.D.
UNIVERSITY OF SOUTH FLORIDA COLLEGE OF MEDICINE
TAMPA, FLORIDA

Subject's Name or Code Number _____

Address _____
Street and Number City, State, Zip

Interviewer's Name _____

Informant's Name _____
(Write "None" if none was used)

Relationship of Informant to Subject _____

Place of Interview _____ Date of Interview _____

NOTE: Use of this assessment instrument for clinical or survey purposes requires special training to assure reliability and validity of the assessment.

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(INTRODUCE YOURSELF TO THE INDIVIDUAL) I will be asking you a lot of questions today; about your health, about your family situation, about your income and about how you are getting along in general. But first, I need to ask you a few school-type questions. By the way, how far did you go in school? (RECORD ANSWER AS GIVEN BY SUBJECT HERE, AND CHECK APPROPRIATE SPACE IN QUESTION 6 ON PAGE 3 WHEN YOU COME TO IT.) Number of years of schooling. (WRITE IN) _____.

1. SPMSQ

PFEIFFER
SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE
(SPMSQ)

INSTRUCTIONS: Ask the subject questions 1-10, record answer, and enter in "I" under appropriate column (correct/error). All responses, to be scored correct, must be given by subject without reference to calendar, newspaper, birth certificate or other memory aid.

	CORRECT	ERROR
1. WHAT IS THE DATE TODAY? MONTH _____ DAY _____ YEAR _____ (Score correct only when the exact month, day and year are given correctly.)		
2. WHAT DAY OF THE WEEK IS IT? DAY _____		
3. WHAT IS THE NAME OF THIS PLACE? (Score correct if any correct description of the location is given: "my home", accurate name of town, city, or name of residence, hospital, or institution (if subject is institutionalized) are all acceptable.)		
4. WHAT IS YOUR TELEPHONE NUMBER? (If none, see 4A below. (Score correct when the correct number can be verified or when subject can repeat the same number at another point in questions.)		
4A. WHAT IS YOUR STREET ADDRESS? (Ask only if subject does not have telephone.)		
5. HOW OLD ARE YOU? AGE: _____ (Score correct when stated age corresponds to date of birth.)		
6. WHEN WERE YOU BORN? MONTH _____ DAY _____ YEAR _____ (Score correct only when exact month, date and year are all given.)		
7. WHO IS THE PRESIDENT OF THE UNITED STATES NOW? (Only the last name of the President is required.) _____		
8. WHO WAS THE PRESIDENT BEFORE HIM? (Only last name of previous President required.) _____		
9. WHAT WAS YOUR MOTHER'S MAIDEN NAME? (Does not need to be verified. Score correct if a female name plus last name other than subject's last name is given)		
10. SUBTRACT 3 FROM 20 AND KEEP SUBTRACTING 3 FROM EACH NEW NUMBER ALL THE WAY DOWN. (The entire series must be performed correctly in order to be scored correct. A 1 error in series or unwillingness to attempt series is scored as incorrect.)		

TOTAL NUMBER ERRORS

*ADJUSTMENT FACTORS:

A) SUBTRACT 1 FROM ERROR SCORE IF SUBJECT HAS HAD ONLY A GRADE SCHOOL EDUCATION.....

B) ADD 1 TO ERROR SCORE IF SUBJECT HAS HAD EDUCATION BEYOND HIGH SCHOOL.....

1. TOTAL ADJUSTED ERRORS

SOCIODEMOGRAPHICS

2. Sex of Subject
 - 1 Male
 - 2 Female

3. Ethnic Background of Subject
 - 1 White (Caucasian)
 - 2 Black
 - 3 Oriental
 - 4 Spanish American (Spanish surname)
 - 5 American Indian
 - 6 Other

[GET FROM PRELIMINARY QUESTIONNAIRE IF SUBJECT IS RELIABLE; FROM INFORMANT IF NOT.]

4. When were you born? _____
(Month) (Day) (Year)

5. How old are you? _____

6. How far did you go in school?
 - 1 0-4 years
 - 2 5-8 years
 - 3 High school incomplete
 - 4 High school completed
 - 5 Post high school, business or trade school
 - 6 1-3 years college
 - 7 4 years college completed
 - 8 Post graduate college

7. How long have you lived in this area?
 - 1 Seasonal resident
(more than 1 mo. but less than 6 mos./year)
 - 2 Less than 5 years
 - 3 5-10 years
 - 4 11-15 years
 - 5 More than 15 years

SOCIAL RESOURCES

Now I'd like to ask you some questions about your family and friends.

8. Are you now married, widowed, divorced, separated or have you never been married?
- 1 Now married
 - 2 Widowed
 - 3 Divorced
 - 4 Separated
 - 5 Never Married
9. Do you have any living children? [IF YES, INQUIRE "HOW MANY?"]
- 1 None
 - 2 One
 - 3 Two
 - 4 Three or more
10. Who lives with you? [CHECK ALL APPLICABLE RESPONSES. CHECK 6 IF SUBJECT RESIDES IN AN INSTITUTION]
- 1 No one
 - 2 Husband or wife
 - 3 Other relative(s)
 - 4 Friend(s)
 - 5 Non-related paid helper
 - 6 Resides in an institution
11. In the past week about how many times did you talk to someone—friends, relatives, or others on the telephone (either you called them or they called you)? [IF SUBJECT HAS NO PHONE, QUESTION STILL APPLIES.]
- 1 Once a day or more
 - 2 2-6 times
 - 3 Once
 - 4 Not at all
12. During the past week now many times did you spend time with someone who does not live with you, that is you sent to see them or they came to see you, or you sent out to do things together?
- 1 Once a day or more
 - 2 2-6 times
 - 3 Once
 - 4 Not at all

13. Do you have someone you can trust and confide in?
- 1 Yes
 - 2 No

[IF "YES", ASK 14.]

14. Who is that person? [SPECIFY NAME] _____
- Relationship:
 1. Husband or wife
 2. Other relative
 3. Friend
 4. Non-related paid helper

15. Is there someone who would give you any help at all if you were sick or disabled, for example your husband/wife, a member of your family, or a friend?
- 1 Yes
 - 2 No one willing and able to help

[IF "YES" ASK 16 AND 17.]

16. Would that person (or persons) be able to take care of you as long as needed, or only for a short time, or only now and then, (like taking you to the doctor, or fixing lunch occasionally)?
- 1 Someone would take care of Subject indefinitely (as long as needed)
 - 2 Someone would take care of subject for a short time (a few weeks to a few months)
 - 3 Someone would help the Subject now and then (taking him to the doctor or fixing lunch, etc.)

17. [IF ANSWER TO 15 IS "YES"] Who is this person?

Name: _____ Relationship:

1. husband or wife
2. Other relative
3. Friend
4. Non-related paid helper

ECONOMIC RESOURCES

Now I'd like to ask you some questions about your work situation.

18. Are you presently: [CIRCLE ALL APPLICABLE RESPONSES]
- 1 Employed full time
 - 2 Employed part time
 - 3 Retired
 - 4 Not employed and seeking work
 - 5 Not employed and not seeking work

19. What kind of work have you done most of your life? [CIRCLE THE MOST APPROPRIATE.]
- 1 Never employed
 - 2 Housewife
 - 3 Other [STATE THE SPECIFIC OCCUPATION IN DETAIL.]

-
20. Does your husband/wife work or did he/she ever work? [QUESTION APPLIES ONLY TO SPOUSE TO WHOM MARRIED THE LONGEST.]
- 1 Yes
 - 2 No
 - 3 Never married

[IF "YES" ASK 21.]

21. What kind of work did or does he/she do?

[STATE THE SPECIFIC OCCUPATION IN DETAIL.] _____

22. Now I would like to ask you where your income (money) comes from (yours and your husband's/wife's). [CIRCLE ALL APPLICABLE RESPONSES LISTING THE AMOUNTS EARNED FROM EACH CATEGORY.]

	Dollars/Month
1 Earnings from employment (wages, salaries or income from your business).....	
2 Income from rental, interest from investments, etc. (Include trusts, annuities & payments from insurance policies & savings).....	
3 Social Security (Include Social Security disability payments but not SSI).....	
4 V.A. benefits such as G.I. Bill and disability payments.....	
5 Disability payments not covered by Social Security, SSI, or V.A. Both government & private & including Workmen's Compensation.....	
6 Retirement pension from Job.....	
7 Regular assistance from employed children.....	
8 SSI payments (yellow government check).....	
9 Welfare payments.....	
10 Other.....	
11 Total.....	

[ASK THIS QUESTION OF ONLY THOSE NOT LIVING IN INSTITUTIONS.]

23. How many people including yourself live on your income (that is, it provides at least half of their income)? _____

24. Do you own your own home?

- 1 Yes
- 2 No → [IF "NO" ASK 27 AND 28]

→ [IF "YES" ASK 25 AND 26]

25. How much is it worth?
- 1 Up to \$25,000
 - 2 \$25,000 - \$50,000
 - 3 \$50,000 - \$100,000
 - 4 More than \$100,000

26. Do you own it outright or are you still paying a mortgage?
- 1 Own outright
 - 2 Still paying

27. How much rent do you pay?
- 1 0-\$59 per month
 - 2 \$60 - \$99 per month
 - 3 \$100 - \$149
 - 4 \$150 - \$199
 - 5 \$200 - \$249
 - 6 \$250 - \$349
 - 7 \$350 and up

28. Do you live in public housing or receive a rent subsidy?
- 1 Yes, live in public housing or receive a rent subsidy
 - 2 No, neither

SHORT PSYCHIATRIC EVALUATION SCHEDULE

34.

Eric Pfeiffer, M.D.

Please answer the following questions YES or NO as they apply to you now. Do not skip any questions. Occasionally a question may not seem to apply to you, but please circle either Yes or No, whichever is more nearly correct for you.

- a. Do you wake up fresh and rested most mornings?.....yes NO
- b. Is your daily life full of things that keep you interested?..... yes NO
- c. Have you, at times, wanted to leave home?..... YES no
- d. Does it seem that no one understands you?..... YES no
- e. Have you had periods of days or weeks when you couldn't "get going?"..... YES no
- f. Is your sleep disturbed?..... YES no
- g. Are you happy most of the time?..... yes NO
- h. Is anyone plotting against you?..... YES no
- i. Do you feel useless at times?..... YES no
- j. During the past few years, have you been well most of the time?.....yes NO
- k. Do you feel weak all over much of the time?..... YES no
- l. Are you troubled by headaches?..... YES no
- m. Have you had difficulty in keeping your balance in walking?..... YES no
- n. Are you troubled by your heart pounding and by shortness of breath?..... YES no
- o. Even when you are with people, do you feel lonely most of the time?..... YES no

TOTAL SCORE (NUMBER OF CIRCLED RESPONSES IN CAPITAL LETTERS) _____

SCORING OF THE SHORT PSYCHIATRIC EVALUATION SCHEDULE

- 0 - 3 = HEALTHY PSYCHOLOGICAL FUNCTIONING
- 4 - 5 = POSSIBLE MILD PSYCHOPATHOLOGY
- 6 - 10 = DEFINITE PSYCHOPATHOLOGY
- 11 - 15 = SEVERE PSYCHOPATHOLOGY OR HYPOCHONDRIASIS

35. How often would you say you worry about things--hardly ever, fairly often, or very often?
- 1 Hardly ever
 - 2 Fairly often
 - 3 Very often
36. Taking everything into consideration how would you describe your satisfaction with life in general at the present time--excellent, good, fair, or poor?
- 1 Excellent
 - 2 Good
 - 3 Fair
 - 4 Poor
37. How would you rate your mental or emotional health at the present time--excellent, good, fair, or poor?
- 1 Excellent
 - 2 Good
 - 3 Fair
 - 4 Poor
38. Is your mental or emotional health now better, about the same, or worse than it was five years ago?
- 1 Better
 - 2 About the same
 - 3 Worse

PHYSICAL HEALTH

Let's talk about your health now.

39. During the past six months, how many times have you seen a doctor for your physical health? [THIS SHOULD NOT INCLUDE DOCTORS SEEN WHILE AN INPATIENT IN A HOSPITAL OR NURSING HOME.]

_____ Times

40. During the past six months how many days were you so sick that you were unable to carry on your usual activities--such as going to work or working around the house? [THIS SHOULD NOT INCLUDE DAYS SPENT IN A HOSPITAL OR NURSING HOME.]

_____ Number of Days

41. During the past six months how many hospital stays did you have for physical health problems?

_____ Number of Hospital Stays

42. Do you have any of the following illnesses at the present time?

[IF "YES", ASK: "How much does it interfere with your activities, not at all, a little (some), or a great deal?" AND CHECK THE APPROPRIATE BOX.]

1		(1)	(2)	(3)
YES	ILLNESSES	NOT AT ALL	A LITTLE	A GREAT DEAL
a	Arthritis or rheumatism			
b	Glaucoma or cataracts			
c	Asthma			
d	Emphysema or chronic bronchitis			
e	Tuberculosis			
f	High blood pressure			
g	Heart trouble			
h	Circulation trouble in arms or legs			
i	Diabetes			
j	Ulcers (of digestive system)			
k	Other stomach or intestinal disorders			
l	Cancer or leukemia			
m	Anemia			
n	Effects of stroke			
o	Parkinson's Disease			
p	Epilepsy			
q	Thyroid or other glandular disorders			
r	Pressure sores, leg ulcers or burns			
s	Effects of fracture or broken bones			
t	Speech impediment or impairment			
u	Other disabilities [SPECIFY]: _____ _____ _____ _____			

44. How would you rate your overall health at the present time--
excellent, good, fair, or poor?

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor

45. Is your health now better, about the same, or worse than it
was five years ago?

- 1 Better
- 2 About the same
- 3 Worse

46. How much do your health troubles stand in the way of your
doing the things you want to do--not at all, a little (some)
or a great deal?

- 1 Not at all
- 2 A little (some)
- 3 A great deal

47. Do you exercise regularly, occasionally, or not at all?

- 1 Regularly
- 2 Occasionally
- 3 Do not exercise

48. Do you drink (alcohol) socially? [IF NO, GO TO QUESTION 50.]

- 1 Yes
- 2 No

49. Have you ever been advised by your doctor to cut down on your drinking?

- 1 Yes
- 2 No

50. How is your hearing, excellent, good, fair, poor, or are you totally
deaf?

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor
- 5 Totally deaf

51. How is your eyesight (with glasses or contacts), excellent, good,
fair, poor, or are you totally blind?

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor
- 5 Totally blind

52. Do you have any other physical problems or illnesses at the present
time that seriously affect your health?

- 1 Yes
- 2 No

[IF "YES" SPECIFY.] _____

ACTIVITIES OF DAILY LIVING

Now I'd like to ask you about some of the activities of daily living, things that we all need to do as part of our daily lives. I would like to know if you can do these activities without any help at all, or if you need some help to do them, or if you can't do them at all. {BE SURE TO READ ALL ANSWER CHOICES IF APPLICABLE IN QUESTIONS 53 THROUGH 68.}

Instrumental ADL

53. Can you use the telephone...
- 1 without help, including looking up numbers and dialing
 - 2 with some help (can answer phone or dial operator in an emergency but need a special phone or help in getting the number or dialing)
 - 3 or are you completely unable to use the telephone?
54. Can you get to places out of walking distance...
- 1 without help (can travel alone on buses, taxis, or drive your own car)
 - 2 with some help (need someone to help you or go with you when traveling)
 - 3 or are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?
55. Can you go shopping for groceries or clothes [ASSUMING PERSON HAS TRANSPORTATION]...
- 1 without help (taking care of all shopping needs yourself, assuming you had transportation)
 - 2 with some help (need someone to go with you on all shopping trips)
 - 3 or are you completely unable to do any shopping?
56. Can you prepare your own meals...
- 1 without help (plan and cook full meals yourself)
 - 2 with some help (can prepare some things but unable to cook full meals yourself)
 - 3 or are you completely unable to prepare any meals?
57. Can you do your housework...
- 1 without help (can scrub floors, etc.)
 - 2 with some help (can do light housework but need help with heavy work)
 - 3 or are you completely unable to do any housework?
58. Can you take your own medicine...
- 1 without help (in the right doses and at the right times)
 - 2 with some help (able to take medicine if someone prepares it for you and/or reminds you to take it)
 - 3 or are you completely unable to take your medicines?
59. Can you handle your own money...
- 1 without help (write checks, pay bills, etc.)
 - 2 with some help (manage day-to-day buying but need help with managing your checkbook and paying your bills)
 - 3 or are you completely unable to handle money?

PHYSICAL ADL

60. Can you eat...
- 1 without help (able to feed yourself completely)
 - 2 with some help (need help with cutting, etc.)
 - 3 or are you completely unable to feed yourself?
61. Can you dress and undress yourself...
- 1 without help (able to pick out clothes, dress and undress yourself)
 - 2 with some help
 - 3 or are you completely unable to dress and undress yourself?
62. Can you take care of your own appearance, for example combing your hair and (for men) shaving...
- 1 without help
 - 2 with some help
 - 3 or are you completely unable to maintain your appearance yourself?
63. Can you walk...
- 1 without help (except from a cane)
 - 2 with some help from a person or with the use of a walker, or crutches, etc.)
 - 3 or are you completely unable to walk?
64. Can you get in and out of bed...
- 1 without any help or aids
 - 2 with some help (either from a person or with the aid of some device)
 - 3 or are you totally dependent on someone else to lift you?
65. Can you take a bath or shower...
- 1 without help
 - 2 with some help (need help getting in and out of the tub, or need special attachments on the tub)
 - 3 or are you completely unable to bathe yourself?
66. Do you ever have trouble getting to the bathroom on time?
- 1 No
 - 2 Occasionally
 - 3 Frequently
67. During the past six months have you had any help with such things as shopping, housework, bathing, dressing, and getting around?
- 1 Yes
 - 2 No

[IF "YES" ASK 68.]

68. Who is your major helper? [SPECIFY] Name: _____
Relationship: 1. husband or wife
2. other relative
3. friend
4. unrelated paid helper

UTILIZATION OF SERVICES

69. Now I want to ask you some questions about the kinds of help you are or have been getting or the kinds of help that you need you need. We want to know not only about the help you have been receiving from agencies or organizations but also what help you have been getting from your family and friends. [FOR EACH OF THE ITEMS BELOW, ASK "In the past six months have you received any?" THEN ASK "Do you feel the need?"]

<u>Services Received</u>	<u>In past 6 months</u>		<u>Need this kind of help</u>		<u>Interviewers Comments</u>
	(1)	(2)	(1)	(2)	
a. Physical Therapy?	Yes	No	Yes	No	
b. Prescription medicine for nerves or for depression?	Yes	No	Yes	No	
c. Participated in any planned recreation, group activities or classes?	Yes	No	Yes	No	
d. Had someone help you find a job or given employment counseling?	Yes	No	Yes	No	
e. Any speech training or training to overcome a handicap?	Yes	No	Yes	No	
f. Had someone regularly check on you by phone or in person?	Yes	No	Yes	No	
g. Someone regularly made your meals because you could not?	Yes	No	Yes	No	
h. Someone helped you in legal, business or money matters?	Yes	No	Yes	No	
i. Had a doctor or social worker review your overall health and life condition?	Yes	No	Yes	No	
j. Any treatment or counseling for nerves/emotional/family or personal problems?	Yes	No	Yes	No	
k. Were you hospitalized for any emotional problems?	Yes	No	Yes	No	

70. Do you feel that you need medical care or treatment beyond what you are receiving at this time?
 1 Yes
 2 No

71. What is your main source of transportation to do such things as shop, visit or see the doctor?
1. Yourself
 2. Family/friends
 3. Public transportation
 4. Public agency
 5. Other [SPECIFY] _____

[AT THIS POINT MAKE BRIEF CONCLUDING STATEMENT TO SUBJECT]

Well, that's about all the questions I needed to ask you. I really want to thank you for being so cooperative and I feel we have a much better understanding of your overall situation now. It was a real pleasure talking with you. [THIS ENDS INTERVIEW WITH SUBJECT]

72. Utilization of services questions were asked of:
- 1 Subject
 - 2 Informant
 - 3 Both

QUESTIONS TO BE ASKED OF INFORMANT
BASED ON HIS KNOWLEDGE OF SUBJECT

[IF THE SUBJECT IS UNRELIABLE THESE QUESTIONS MUST BE ASKED OF AN INFORMANT. IF THE SUBJECT IS RELIABLE, THE QUESTIONS MUST BE ASKED IF AN INFORMANT IS AVAILABLE.]

SOCIAL RESOURCES

73. How well does _____ (Subject) get along with his/her family and friends--very well, fairly well, or poorly?
- 1 Very well
 - 2 Fairly well (has some conflict or trouble with them)
 - 3 Poorly (has considerable trouble or conflict with them)
 - Insufficient information about Subject to answer questions
74. Is there someone (Institutions: outside of this place) who could take care of _____ (Subject) if he/she were sick or disabled, for example his/her husband or wife, a member of the family or a friend?
- 1 Yes
 - 2 No
 - Insufficient information about Subject to answer questions

[IF "YES" ASK 75 AND 76]

75. [CIRCLE THE MOST APPROPRIATE.] Would that person be able to take care of him/her as long as needed, or only for a short time, or only now and then (for example, taking him/her to the doctor, fixing lunch, etc.)?
- 1 Someone who would take care of Subject indefinitely (as long as needed)
 - 2 Someone who would take care of Subject a short time (a few weeks to a few months)
 - 3 Someone who would help him now and then (taking him to the doctor or fixing lunch, etc.)
 - Insufficient information about Subject to answer questions

76. Who is this person? Name _____
- Relationship:
1. Husband or wife
 2. Other relative
 3. Friend
 4. Non-related paid helper

PHYSICAL HEALTH

77. How would you rate _____ (Subject's) health at the present time---
excellent, good, fair, or poor?
- 1 Excellent
 - 2 Good
 - 3 Fair
 - 4 Poor
78. How much do _____ (Subject's) health troubles stand in the way of
his/her doing the things he/she wants to do---not at all, a little
(some), or a great deal?
- 1 Not at all
 - 2 A little (some)
 - 3 A great deal

• MENTAL HEALTH

79. Does _____ (Subject) show good common sense in making everyday
judgements and decisions?
- 1 Yes
 - 2 No
80. Is _____ (Subject) able to handle (cope with) major problems which
occur in his/her life?
- 1 Yes
 - 2 No
81. How would you rate _____ 's (Subject's) mental or emotional health
or ability to think at the present time compared to the average
person living independently---excellent, good, fair, or poor?
- 1 Excellent
 - 2 Good
 - 3 Fair
 - 4 Poor
82. Is _____ (Subject's) mental or emotional health or ability to
think---better, about the same, or worse than it was five years ago?
- 1 Better
 - 2 About the same
 - 3 Worse

ECONOMIC RESOURCES

83. In your opinion are _____ (Subject's) needs for the following
basic necessities being well met, barely met, or are they not
being met?

	1	2	3
	WELL MET	BARELY MET	NOT MET
a. Food			
b. Housing			
c. Clothing			
d. Medical care			
e. Small luxuries			

{CHECK THE APPROPRIATE BOX
FOR EACH NEED.}

[THE REMAINING QUESTIONS ARE TO BE ANSWERED BY THE INTERVIEWER IMMEDIATELY AFTER COMPLETING THE INTERVIEW.]

84. Length of interview _____
Minutes

85. Factual information obtained from:
1 Subject
2 Relative
3 Other [SPECIFY] _____

86. Factual questions (obtained from Subject and/or informant) are:
1 Completely reliable
2 Reliable on most items
3 Reliable on only a few items
4 Completely unreliable

87. Subjective questions (those in boxes, obtained from Subject only) are:
1 Completely reliable
2 Reliable on most items
3 Reliable on only a few items
4 Completely unreliable
5 Not obtained

[IF 5 ANSWER 88.]

88. Why didn't the Subject answer the Subjective questions? [BE SPECIFIC.]

89. During the interview did the Subject's behavior strike you as:
[CIRCLE "YES" OR "NO" FOR EACH OF THE FOLLOWING.]

- | | <u>1</u> | <u>2</u> | |
|----|----------|----------|--|
| a. | YES | no | Mentally alert and stimulating |
| b. | YES | no | Pleasant and cooperative |
| c. | YES | no | Depressed and/or tearful |
| d. | YES | no | Withdrawn or lethargic |
| e. | YES | no | Fearful, anxious or extremely tense |
| f. | YES | no | Full of unrealistic physical complaints |
| g. | YES | no | Suspicious (more than reasonable) |
| h. | YES | no | Bizarre or inappropriate in thought or action |
| i. | YES | no | Excessively talkative or overly jovial or elated |

SOCIAL RESOURCES RATING SCALE

90. [RATE THE CURRENT SOCIAL RESOURCES OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT CIRCUMSTANCES. SOCIAL RESOURCES QUESTIONS ARE NUMBERS 8-17, AND 73-76.]

1. Excellent social resources. Social relationships are very satisfying and extensive; at least one person would take care of him(her) indefinitely.
2. Good social resources. Social relationships are fairly satisfying and adequate and at least one person would take care of him(her) indefinitely.
OR
Social relationships are very satisfying and extensive; and only short term help is available.
3. Mildly socially impaired. Social relationships are unsatisfactory, of poor quality, few; but at least one person would take care of him(her) indefinitely.
OR
Social relationships are fairly satisfactory, adequate; and only short term help is available.
4. Moderately socially impaired. Social relationships are unsatisfactory, of poor quality; few; and only short term care is available.
OR
Social relationships are at least adequate or satisfactory; but help would only be available now and then.
5. Severely socially impaired. Social relationships are of poor quality, few; and help would only be available now and then.
OR
Social relationships are at least satisfactory or adequate; but help is not even available now and then.
6. Totally socially impaired. Social relationships are unsatisfactory, of poor quality, few; and help is not even available now and then.

ECONOMIC RESOURCES RATING SCALE

91. [RATE THE CURRENT ECONOMIC RESOURCES OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT CIRCUMSTANCES. ECONOMIC QUESTIONS ARE NUMBERS 18-31 AND 83.]

1. Economic resources are excellent.
Income is ample; Subject has reserves.
2. Economic resources are satisfactory.
Income is ample; Subject has no reserves.
OR
Income is adequate; Subject has reserves.
3. Economic resources are mildly impaired.
Income is adequate; Subject has no reserves.
OR
Income is somewhat inadequate; Subject has reserves.
4. Economic resources are moderately impaired.
Income is somewhat inadequate; Subject has no reserves.
5. Economic resources are severely impaired.
Income is totally inadequate; Subject may or may not have reserves.
6. Economic resources are completely impaired.
Subject is destitute, completely without income or reserves.

MENTAL HEALTH RATING SCALE

92. [RATE THE CURRENT MENTAL FUNCTIONING OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT FUNCTIONING. MENTAL HEALTH QUESTIONS ARE THE SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (QUESTION NUMBER 1) AND NUMBERS 32-38, 43 (items o and p), 58, 59, AS WELL AS NUMBERS 79-82 AND 89.]

1. Outstanding mental health. Intellectually alert and clearly enjoying life. Manages routine and major problems in his life with ease and is free from any psychiatric symptoms.
2. Good mental health. Handles both routine and major problems in his life satisfactorily and is intellectually intact and free of psychiatric symptoms.
3. Mildly mentally impaired. Has mild psychiatric symptoms and/or mild intellectual impairment. Continues to handle routine, though not major, problems in his life satisfactorily.
4. Moderately mentally impaired. Has definite psychiatric symptoms and/or moderate intellectual impairment. Able to make routine common-sense decisions, but unable to handle major problems in his life.
5. Severely mentally impaired. Has severe psychiatric symptoms and/or severe intellectual impairment. which interfere with routine judgments and decision making in every day life.
6. Completely mentally impaired. Grossly psychotic or completely impaired intellectually. Requires either intermittent or constant supervision because of clearly abnormal or potentially harmful behavior.

PHYSICAL HEALTH RATING SCALE

93. [RATE THE CURRENT PHYSICAL FUNCTIONING OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT FUNCTIONING. PHYSICAL HEALTH QUESTIONS ARE NUMBERS 39-52, 70, 77 AND 78.]

1. In excellent physical health.
Engages in vigorous physical activity, either regularly or at least from time to time.
2. In good physical health.
No significant illnesses or disabilities. Only routine medical care such as annual check-ups required.
3. Mildly physically impaired.
Has only minor illnesses and/or disabilities which might benefit from medical treatment or corrective measures.
4. Moderately physically impaired.
Has one or more diseases or disabilities which are either painful or which requires substantial medical treatment.
5. Severely physically impaired.
Has one or more illnesses or disabilities which are either severely painful or life threatening, or which require extensive medical treatment.
6. Totally physically impaired.
Confined to bed and requiring full time medical assistance or nursing care to maintain vital bodily functions.

PERFORMANCE RATING SCALE FOR
ACTIVITIES OF DAILY LIVING

94. [RATE THE CURRENT PERFORMANCE OF THE PERSON BEING EVALUATED ON THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT PERFORMANCE. ACTIVITIES OF DAILY LIVING QUESTIONS ARE NUMBERS 53-68.]

- 1. Excellent ADL capacity.
Can perform all of the Activities of Daily Living without assistance and with ease.
- 2. Good ADL capacity.
Can perform all of the Activities of Daily Living without assistance.
- 3. Mildly impaired ADL capacity.
Can perform all but one to three of the Activities of Daily Living. Some help is required with one to three, but not necessarily every day. Can get through any single day without help. Is able to prepare his own meals.
- 4. Moderately impaired ADL capacity.
Regularly requires assistance with at least four Activities of Daily Living but is able to get through any single day without help. Or regularly requires help with meal preparation.
- 5. Severely impaired ADL capacity.
Need help each day but not necessarily throughout the day or night with many of the Activities of Daily Living.
- 6. Completely impaired ADL capacity.
Needs help throughout the day and/or night to carry out the Activities of Daily Living.

.....

SUMMARY OF RATINGS

Social Resources _____

Economic Resources _____

Mental Health _____

Physical Health _____

Activities of Daily Living _____

95. Cumulative Impairment Score _____
(Sum of the five ratings.)



ADULT CARE MANAGEMENT, INC.

1075 S. Broadway, Suite 1000, Denver, Colorado 80202
(303) 733-1111

ANNUAL REPORT 1988

Adult Care Management, Inc., a non-profit Colorado company founded in August, 1985, was incorporated to fill a gap in home services critical to elderly, disabled and chronically mentally ill persons needing assistance. The need was identified by leaders in the aging and mental health fields who determined that the accessibility and maintenance of quality service for persons older than eighteen is provided best through professional case management.

CASE MANAGEMENT COMPONENTS

Comprehensive Evaluation. An assessment is made of how an individual is functioning at home. This information is used to make decisions about the most appropriate services and necessary care for the individual.

Arranging and coordinating services. Selection of services is based on the care plan and is made from all resources available within the Denver Metro area.

Monitoring Services. Contacts with the care providers are made to assure quality services and with the client to assure satisfaction.

Counseling and support. Case managers visit clients in their homes to handle on-going problems or changes and regularly communicate with the family and other care providers.

PROGRAM OPERATIONS

Private Case Management. Adults eighteen and older in the Denver metro areas are provided comprehensive care management on a fee for services basis. Individuals with multiple problems and often little or no support can remain in the community through the coordination of in-home services.

The Denver Living at Home Program. Persons sixty and older who live in the City & County of Denver are served on a sliding-fee scale made possible through funding from The Colorado Trust, The Piton Foundation, The Anschutz Foundation and The Commonwealth Fund, New York. Denver is one of twenty Living at Home Programs nationwide. One year remains in the three-year project.

Home and Community Based Services Program. Adult Care Management, Inc. signed a contract in April, 1988 with the Denver Department of Social Services to manage the HCBS Program for Denver County. This program is for individuals eligible for Medicaid who are at the nursing home care level. They are able to remain within the community with case management and home services. This public-private venture expanded ACMI's case management services to all income groups.

CASE MANAGEMENT CLIENT NUMBERS

	Clients enrolled in 1987	Clients active on 12/31/87	Clients enrolled in 1988	Clients active on 12/31/88
Private (under sixty and living outside Denver County	20	5	19	9
Living at Home	66	32	178	86
<u>HCBS</u>	<u>NA</u>	<u>NA</u>	<u>383</u>	<u>571*</u>
TOTAL	86	37	580	666

*Includes 348 clients transferred with the HCBS program in April.

Case Managers. More than twenty professional case managers, each degreed and experienced in social work, nursing or related areas, have access to specific resources required by clients. As a client advocate, it is the case manager's responsibility to provide the most appropriate, cost effective, and high quality services.

Management Fees. Basic fees are \$350 for the comprehensive evaluation, arranging and coordination of all services and \$80 a month for follow-up to assure satisfaction. The Denver Living at Home Program offers a sliding-fee scale for persons older than sixty in Denver. The HCBS Program provides case management for Medicaid recipients.

Case Referrals. Adult Care Management receives referrals from health care providers such a hospitals, home-health agencies and physicians in addition to attorneys, banks, community service agencies, churches, families, and others.

CORPORATE PROGRAM

Work/Family Elder Directions. Contracting with Work/Family Elder Directions, Inc. in Watertown, Massachusetts, Adult Care Management provides Elder Care referral service to national corporations. With a phone call to Adult Care Management, an employee of a major corporation is able to discuss problems in relation to the care of an older relative and receive information and referral sources. Presently, ACMI is providing this service to IBM and other national corporations for Denver and other front range communities. Since its inception in February, 1988, 45 employees and/or retirees have been served by Adult Care Management. One case manager is the designated Work/Family

Counselor. It is projected that the Work/Family Elder Directions Program will show steady growth in 1989 with a major expansion in 1990.

At the same time, Adult Care Management is pursuing contracts for similar, though less ambitious, services with local corporations.

SPECIAL PROJECTS

The Colorado Continuum of Care Project. In conjunction with the State Unit on Aging, this project completed its second and final year in December, 1988. As one of four sites in Colorado, ACMI demonstrated the development of a free-standing case management organization, computerization of client data for assessment, tracking and management, and mechanisms for combining private and public funding streams. Through the grant, Adult Care Management was able to purchase a computer and software and hire a half-time programmer/analyst.

The Quality Assurance Project. In October, 1988, Adult Care Management was selected as a demonstration site to assess the effectiveness of using the computer for the case management functions of assessment, care planning, and monitoring of services. The project is under the lead of a case manager with the help of a task force of other case managers and staff from the Colorado Department of Social Services. Under the grant, the project manager's salary is covered and a computer and COMPASS software have been purchased.

The Benefits Eligibility Check-up Program. Through matching grants from The Commonwealth Fund and the Colorado Trust, the Benefits Eligibility Check-up Program software has been contracted for by Adult Care Management. This sophisticated software package will report to applicants which of some 35 federal, state, and local entitlement programs they might be eligible for and how to apply for them. The Colorado Trust has also provided funding for a computer for this project. The Program will be fully implemented in 1989 under the direction of a case manager and the intake coordinator.

Money Management Resource Development Project. Adult Care Management was awarded a program grant of \$6,200 from Work/Family Elder Directions to develop in the community the ability to assist older people with bill-paying, check writing, and record-keeping. An important objective is to have a system of checks and balances to protect the individual. This project began in November, 1988, with completion expected mid-year, 1989. The project is being directed by an ACMI case manager, though the actual money management program will be located at another community organization.

BUSINESS OPERATIONS

Expansion was the theme for 1988 at Adult Care Management!

Clients

Total clients grew from 37 active on 12/31/87 to 666 active on 12/31/88.

Most of that growth came with the HCBS contract in April. That Program increased from 348 in April to 571 on 12/31/88.

The Living at Home Program grew from 32 to 86 active at the end of 1988.

The Private program increased from 5 to 9 active clients at the end of the year.

Staff

On 12/31/87, Adult Care had 4 employees equal to 3.5 FTE.

At the end of 1988, there were 32 employees equal to 30.5 FTE.

Office Space

Even after one expansion at our previous office at 1391 Speer Blvd., staff growth necessitated moving into our new space at 655 Broadway in September where we now occupy 5190 square feet.

Revenue

Total fee income in 1987 - \$ 16,964

Total fee income in 1988 - 434,079

Total revenue in 1987 - \$118,488

Total revenue in 1988 - 529,660

Total expenses in 1987 - \$109,878

Total expenses in 1988 - 552,925

BOARD OF DIRECTORS

The Board of Directors grew along with the organization in 1988. It expanded in number of Directors actively involved to 10. It expanded in breadth of community experience, now including consumer representation as well as medical, business, legal, accounting, and human service expertise. Financial support also grew with 70% of the directors having made a contribution. However, it must also be noted that those not contributing had been members for two months or less during the fiscal year. The Board developed an active committee structure and expanded its advisory capacity to additional community members - particularly in the area of marketing and sales.

**ELDER ABUSE:
IDENTIFICATION, REFERRAL AND INTERVENTION AT THE COMMUNITY LEVEL**

**The Colorado Continuum of Care Project Manual for Human Service
Professionals and Laypersons Concerned About Elder Abuse**



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AT THE COMMUNITY LEVEL**

**The Colorado Continuum of Care Project Manual for Human Service
Professionals and Laypersons Concerned About Elder Abuse**

by

**Robert P. Larkin, PhD.
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Department of Geography**

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El Paso County Department of Social Services/Pikes Peak Area Agency on Aging**

**This project was supported by the Administration on Aging Grant #08AM0039-01-02 in cooperation
with El Paso County Department of Social Services/Pikes Peak Area Agency on Aging.**

PREFACE

Elder abuse exists in our rural Western Slope communities, our front range cities and in towns on the eastern Colorado plains. Annually, it affects thousands of older Coloradoans, rich and poor, black and white, competent and not competent.

This manual is the result of the first twelve months of an eighteen month Continuum of Care pilot project in El Paso and Teller counties. The initial goal was to improve the capability of legal, health and social service professionals to identify and refer older adults suspected of being abused, neglected or exploited to county departments of social services.

This goal, and others discussed in this manual, were achieved through the efforts of literally hundreds of human service professionals. Without their generous participation, the increased level of professional and community awareness and support of elder abuse issues could not have been achieved. Paramedics, emergency room nurses, police officers, county health workers, domestic violence personnel, social service departments, senior service providers, home health agencies, case managers and legal service professionals gave their time, expertise and opinions. Advisory council members representing these groups answered surveys and interview questions. As a result of their concern and recommendations, strong community coordination and cooperation have emerged. Special recognition must be given to the El Paso County Department of Social Services adult protective workers. Their daily battle to improve the lives of abused elders represents true professional commitment.

INSTRUCTIONS TO THE READER

This handbook has been designed for professionals in health, social and legal fields, as well as concerned laypersons. It may be used for individual study, group in-service training sessions or as a text for gerontology courses involving elder abuse issues.

Part I is comprised of core text materials pertaining to the elder abuse topic. Part II provides project information and written materials (excluding the video tapes and accompanying materials).

The appendix includes a bibliography compiled by Ms. Mary Joy Quinn, R.N., M.A., and project materials that may be reproduced to replicate the Continuum of Care project in every county in Colorado.

Please address any comments or questions to:

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Adult Protective Unit
105 North Spruce
P.O. Box 2692
Colorado Springs, CO 80905

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About the Authors

Robert P. Larkin has a Master's degree from the University of Colorado and a Ph.D. from Pennsylvania State University. He is currently Professor and Director of the Center on Aging at the University of Colorado at Colorado Springs. Dr. Larkin is actively involved in senior citizen issues and has authored six books and numerous scholarly articles.

Virginia C. Mahoney has a Master's degree in Gerontology from the University of Northern Colorado. She is the former director of the Foster Grandparent Program (Cheyenne, Wyoming) and the Senior Companion Program (Suburban Cook County, Chicago, Illinois). Ms. Mahoney has instructed gerontology courses for the University of Nebraska at Omaha and the College of St. Francis in Joliet, Illinois. Presently, she is the trainer/coordinator for the Continuum of Care pilot project and a gerontological consultant.

INTRODUCTION

Family conflicts resulting in the abuse or neglect of older persons have recently emerged as a significant area of study and analysis. Gerontologists and other social scientists are trying to understand why abuse and neglect occur, as well as what can be done to treat and prevent these problems. Increasingly, the attention of these investigators is focusing on family conflicts, trying to understand both the genesis of the conflict and ways to assess, diagnose, and intervene for effective treatment.

Despite the impression this recent attention may give, elder abuse and neglect is not a new problem. Mistreatment of elders can be traced historically through literary and other sources. Stories about adult children, particularly sons, who abuse or kill their parents are found throughout world literature. From the parricide of Greek mythology to the intense family rivalries exhibited in Shakespeare's *King Lear*, we can find numerous examples of family conflict resulting in the mistreatment of elders. Modern literature depicts children striking out against elders or making fun of helpless, childlike elders. Making fun of or ridiculing elders is perhaps a means of disguising the desire to get rid of them.

Historians have also been interested in family relationships and the treatment accorded elders. The historical record has many examples of elder abuse. How extensive was that abuse? Is abuse today higher or lower than it was in the past? Those questions cannot be answered with any precision. According to the historian Peter J. Stearns, "The extent of previous levels of conflict, even if researchers could agree on a single definition . . . is unknown."

Although social scientists have been interested in intergenerational conflicts for many years, the first research studies that documented abuse and neglect of elders in American homes did not begin to appear until the late 1970's. Most of these early, exploratory studies centered around case studies, mail surveys, or a combination of secondary data analysis with personal interviews. These studies not only used a variety of analytical methods but there also was no agreement on precise definitions of abuse and neglect. There are, however, some common threads that can be found within these studies. Mary Joy Quinn and Susan K. Tomita in their book *Elder Abuse and Neglect* summarize these common threads: "It seems fairly clear . . . that the typical victim of elder abuse is a woman over the age of 75 who is physically and perhaps mentally dependent. Typically, the abuser is a relative, and frequently the adult child of the victim . . . The abuser is often dependent on the victim for financial support and housing. The abuse is often ongoing (not limited to a single incident) and it may take several forms: financial, physical, or psychological."

It has only been in recent years that the phenomenon of elder abuse has been uncovered and brought into the consciousness of Americans. Professionals who have worked on family conflict problems have known that abuse and neglect occur, but the problem has been difficult to define and fully comprehend. Much abuse has been either hidden or denied. As congressman Claude Pepper says, "Elder abuse. The phrase still sends shock waves among the majority of Americans . . . Most would prefer not to acknowledge that elder abuse, which flies in the face of traditional American ideals, exists."

The idea that middle-aged children may emotionally or physically abuse their parents or that they may take financial advantage of them is alien to American culture. All major religions speak of respect for parents. Common decency says abuse is something to be abhorred. Yet the Select Committee on Aging of the U.S. House of Representatives concluded in its report, entitled *Elder Abuse: An Examination of a Hidden Problem*, that "elder abuse is far from an isolated and localized

problem involving a few frail elderly and their pathological offspring. The problem is a full-scale national problem which exists with a frequency that few have dared to imagine.”

There has always been elder abuse and neglect, just as there has always been child and spouse abuse. Now there is a willingness to confront these hidden problems and search for solutions. Suzanne Steinmetz, an expert on family violence, has pointed out that the 1960's were the time for uncovering child abuse, the 1970's brought a greater understanding of spouse abuse, and the 1980's will be the decade for adult abuse to be brought into the consciousness of Americans.

It is essential for those who work with adults and elders to become familiar with the characteristics of elder abuse and neglect. They must be aware of the sociological and psychological background against which abuse and neglect occurs. Further, they must learn the causes, methods of detection, and strategies for intervention and treatment.

The purpose of this manual is twofold: first, to give an outline of the multiple dimensions of elder abuse, and second, to discuss ways that abuse and neglect issues can be brought to those who deal with the elderly on a day-to-day basis as well as the community at large.

Part I — THE DIMENSIONS OF ELDER ABUSE, NEGLECT AND EXPLOITATION

Objectives—

1. To identify and define the various types of abuse, neglect and exploitation.
2. To understand the significance and extent of the problem in America today.
3. To understand the relationship between aging and abuse.
4. To identify and analyze the reasons why elder abuse and neglect occur.
5. To understand the key elements in the assessment and diagnosis of elder abuse and neglect.
6. To understand the key elements in the intervention and treatment of elder abuse and neglect.
7. To identify and discuss the legal aspects of abuse and neglect as they relate to both the professional dealing with the problem and the client and his or her family.

Chapter 1 — TYPES OF ABUSE, NEGLECT AND EXPLOITATION

One of the first problems encountered by a practitioner is figuring out exactly what abuse, neglect, and exploitation mean. There is general agreement that abuse is more serious than neglect, especially as it pertains to the intent of the caregiver. Neglect usually is seen as an act of omission, such as not doing something or withholding goods or services. In general neglect is seen as being less serious than abuse. However, there are times in which neglect can be deliberate and malicious, resulting in significant harm to the elder. Abuse, on the other hand, is usually considered more serious since it is a deliberate or intentional act, an act of commission. The caregiver wants to inflict injury. Although these distinctions have been made between abuse and neglect, particularly as they pertain to the motives of the abuser, it is the effects of the abuse or neglect that are of most concern. In many cases one cannot ascertain whether the abused was injured intentionally.

Recent research on abuse and neglect show that a great variety of definitions have been used. These differences in definitions have led to much confusion. According to the Code of Colorado Regulations, the following definitions are used:

1. "Abuse" means unreasonable confinement or intimidation of a disabled adult or the willful infliction by a caretaker of physical pain or injury to a disabled adult or the failure of a caretaker to take reasonable measures to prevent the infliction of physical pain or injury to a disabled adult.
2. "Neglect" means an act or failure to act whereby a disabled adult is placed in immediate or imminent danger because the disabled adult or his caretaker is unable to secure, or has not provided, those services which are necessary to maintain the physical and mental health of the disabled adult.
3. "Exploitation" means the illegal or improper use of a disabled adult or his resources for another person's profit or advantage.

These different definitions can be somewhat confusing. In many cases the practitioner finds that an elder is the victim of several forms of abuse, neglect, or exploitation at the same time. Also, some kinds of practitioners are more likely to see one form of abuse or neglect than another. Police, medical practitioners and social workers are more likely to see physical abuse or neglect, whereas, lawyers and judges are more familiar with financial abuse or exploitation.

Detecting elder abuse or neglect can sometimes be very difficult but the practitioner must be aware of some of the forms that they can take. In their book on elder abuse, Quinn and Tomita are primarily concerned with the outcomes of abuse and neglect. They set up a very useful continuum of indicators for both physical and mental abuse and neglect. Although these indicators are not diagnostic of inflicted abuse or neglect, they give the practitioner some useful guidelines (Figure 1). This continuum, starting with scratches, cuts, and bruises proceeds to more serious indicators like malnourishment or fractures and finally ends with death or murder. Although many of these indicators may not be the result of abuse or neglect, the practitioner should be aware of this continuum of indicators and carefully ascertain and diagnose elders on an individual basis.

Figure 1 — Physical Abuse and Neglect Indicators

Scratches
Cuts
Bruises

Cigarette burns
Rope burns

Welts
Scalp injury
Gag marks

Sprains
Punctures
Pain on touching

Hypothermia
Abnormal chemistry values
Malnourishment
Dehydration
Contractures

Detached retina
Hematoma
Pressure Sores
Fractures
Choke marks
Dislocation

Paralysis
Injuries from attempted murder

Death
Murder

Source: Mary Joy Quinn and Susan K. Tomita, *Elder Abuse and Neglect*, New York: Springer Publishing Company, 1986, p. 36

Psychological abuse and neglect also has many manifestations. They can range in severity from minor disturbances, such as ambivalence or passivity, through disorientation and confusion, to nervous breakdown and suicide. Psychological abuse is often difficult to prove and the practitioner is advised to proceed slowly. Quite frequently, psychological abuse is an integral part of other types of abuse. A continuum of indicators of psychological abuse (Figure 2) is useful in assessing possible instances where abuse has occurred.

Figure 2 — Psychological Abuse and Neglect Indicators

Ambivalence
Deference
Obsequiousness
Shame

Passivity
Denial
Mild anxiety
Non-responsiveness
Implausible stories

Evasiveness
Isolation
Trembling
Clinging

Cowering
Lack of eye contact

Disorientation
Confusion
Anger
Agitation
Hypervigilance

Fearfulness
Depression
Helplessness
Severe anxiety

Nervous breakdown

Suicide

Source: Mary Joy Quinn and Susan K. Tomita, *Elder Abuse and Neglect*, New York: Springer Publishing Company, 1986, p. 43

All these indicators of physical and psychological abuse or neglect do not occur only from abuse or neglect. The practitioner must be careful in making a thorough assessment as to the exact causes of these indicators. Although physical abuse might be easier to detect and measure than psychological abuse, it is important for the practitioner to understand that the damage from psychological abuse may be equally, if not more devastating, than physical abuse. Some studies indicate that psychological abuse, as opposed to physical abuse, caused the most severe pain, anguish and humiliation.

Another category of elder mistreatment is that of exploitation or financial abuse. Exploitation means that the resources of an elder are being misappropriated. This exploitation can take on a variety of forms from stealing small amounts of money to inducing a person to deed over a large estate. Although exploitation can take on many forms there are key indicators. These indicators include:

1. Unusual changes in bank accounts, such as multiple withdrawals for large amounts of money over a limited time.
2. Banking information, such as cancelled checks or bank statements, no longer comes to the elder's home.
3. Important financial documents are signed by the elder without understanding the implications of such changes or signatures on checks and/or documents don't resemble the elders handwriting.
4. The elder has few amenities and unpaid bills while it appears that the estate is easily capable of providing the requisite financial resources.
5. The caregiver is primarily concerned with financial matters and has little interest in the care of the elder. The caregiver may also be evasive about income sources.
6. Valuable personal items such as art, jewelry or furs are missing.
7. An elder who believes he owns his own home gets an eviction notice.

Exploitation is a difficult problem to confront and prove. Most practitioners and clients are not comfortable talking about financial matters, yet it is essential to try to understand financial relationships in order to make sure exploitation is not occurring.

Chapter 2 — SIGNIFICANCE AND EXTENT OF ELDER ABUSE

The Select Committee on Aging of the U.S. House of Representatives said that elder abuse is far from an isolated and localized problem, but is of almost epidemic proportions. The committee also concluded that elder abuse is less likely to be reported than other types of abuse such as that of children or spouses. About one out of every three child abuse cases is reported, while only about one out of six cases of elder abuse comes to the attention of authorities. Their conclusion was that the victims of elder abuse make up at least four percent of the U.S. elderly population. That means that one out of every 25 Americans over the age of 65, over 1 million people, are being abused, neglected, or exploited. The committee also found in 1985 that there was an increase of 100,000 moderate to severe abuse cases annually and that 82 percent of all adult abuse cases reported involve the elderly.

Other studies have also substantiated the figures of the Select Committee. A study by Block and Sinnott concluded that one million cases of elder abuse occur each year and that it is probably less frequent than spouse abuse but at least as frequent as child abuse. Steinmetz, however, estimates that ten percent of the U.S. older adult population is abused (about 2.5 million people). A similar figure of 9.6 percent was determined by Lau and Kosberg. It, therefore, seems that we do not know for certain the exact numbers of elders that are being mistreated, yet all the evidence points to a very significant number. Since much elder abuse goes unreported it makes it very difficult to come up with exact figures. Reporting becomes a very important part of establishing more reliable data on elder mistreatment. Only when we have a better nationwide system for reporting and data collection will we be able to know with some certainty how much elder abuse and neglect occurs in the United States.

Chapter 3 — AGING AND ABUSE

Much of the explanation for this lack of precise data about elder mistreatment has to do with the nature of society and the attitudes people have about the elderly. People are usually doubtful about the extent of elder mistreatment. Although they might think abuses occur in nursing homes, they are skeptical to think that much abuse occurs in the home. There is an increasing awareness that domestic violence touches women and children, but our society has failed to see the extent to which it touches the elderly.

The lack of information and skepticism about the extent of elder mistreatment is also related to the way we view the aged and the aging process, and the isolation of the aged. These attitudes about aging are not the direct cause of most elder abuse but they do create an atmosphere that fosters elder mistreatment.

American society today is primarily viewed as a society centered on the young and healthy. Older people are often seen as having nothing to contribute and as being a burden on society. Old age has become synonymous with loss of faculties and lack of control over one's life. Most people do not want to look to a future where they have lost control of their destiny. Therefore they tend to distance themselves from the aged and thoughts about growing old. Ageism, the systematic stereotyping of and discrimination against old people, has served as a protection to the younger generations against thoughts of impending impairment and especially against death. Unfortunately, as Quinn and Tomita say, "Ageism is a time bomb of the most personal nature because most people also hope to live long lives and will end up as part of a minority group against which they have always harbored prejudice. They become targets of their own internalized myths and stereotypes about aging. Ageism is alive and well, and living in everyone."

These attitudes and stereotypes about the aged can play a significant role in elder mistreatment. Through these myths the elderly are seen as nonpersons. They are valued less than the young and are taken less seriously. Elder mistreatment, therefore, becomes easier to justify. Perhaps even more significant is that these negative attitudes associated with ageism are internalized by the elderly themselves and they then view abusive treatment as deserved or unavoidable.

These negative attitudes toward the elderly are similar to those held by society toward the disabled. The disabled are traditionally viewed as a burden on society and undesirable. This aversion and revulsion is possibly based on one's fear of becoming disabled. Unfortunately, many of the aged can also be disabled, adding a double burden to their lives.

The elderly, especially those with physical or mental disabilities, are among the most isolated groups in our society. Many people shy away from the old, especially if the old are physically or mentally impaired, because they feel uncomfortable around older adults. This isolation makes the elderly almost invisible and thus it is easier for mistreatment to go undetected.

Chapter 4 — REASONS FOR ELDER ABUSE AND NEGLECT

Societal attitudes related to sexism and ageism can play a significant role in the type and amount of elder mistreatment. Current research theories point to multiple causes for elder mistreatment. Much of this research is of an exploratory nature and it will take time and more research efforts to more fully understand the causal factors associated with abuse and neglect. Current theories center on four interrelated factors: 1) impairment and dependency of the older adult, 2) stress on the caregiver, 3) family histories of learned violence, and 4) pathological disturbances of the abuser.

Elder impairment and dependency—

Much of the research on elder mistreatment has focused on the physical and mental impairments associated with many victims of abuse and neglect. The majority of victims of elder abuse and neglect are impaired in some form. Because of these impairments they are dependent upon caregivers to provide vital life-supporting and life-sustaining services. A variety of physical conditions can lead to the impairment of the elderly. The most common physical conditions are rheumatism, arthritis, and heart conditions, which account for half of all conditions that limit activities of older adults (Figure 3). The National Center for Health Statistics conducted a nationwide survey in 1979 in order to ascertain the types of assistance needed by older people. The results of this study point out that about 5 percent of those people aged 65-74 need help with at least one basic activity of daily living such as walking, bathing, dressing, using the toilet or eating. This figure rose to over 11 percent for those between 75 and 84 years of age and to 35 percent for those over age 85. According to the 1982 National Long-Term Care Survey about 19 percent of the 65-plus population have some degree of limitation. Also, the chance of becoming disabled increases with age (Table 1). Males and females 85 years and older are four times more likely to be disabled than those aged 65 to 74.

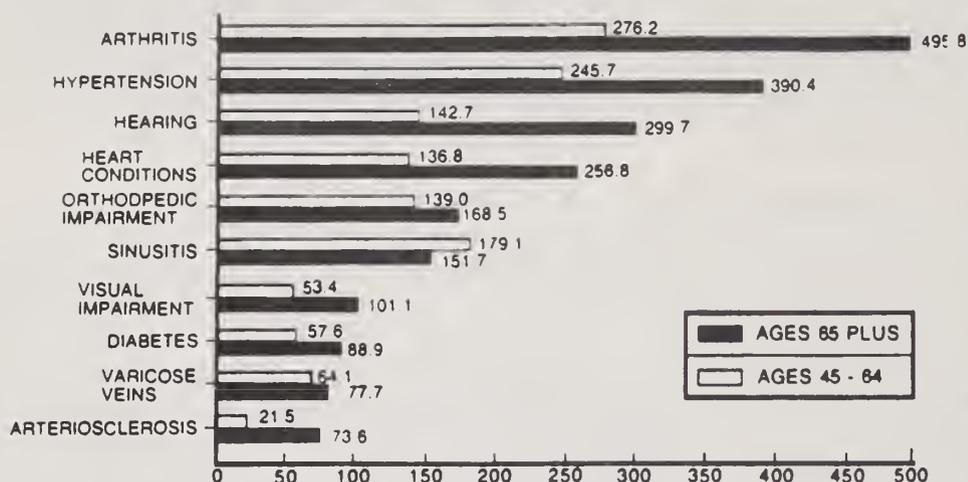
Mental impairments are another problem associated with decreased functioning. Contrary to common belief, older people have fewer mental impairments than other age groups. There are however, a few impairments that can cause significant problems. Depression is quite common among old adults. Estimates are that from 30 to 68% of the over 65 population will have a serious episode of depression that will interfere with daily living activities. Also, suicide rates, although low in comparison to other causes of death, are higher for elderly persons than for all other age groups.

Perhaps the most significant mental impairment has to do with organic brain syndromes or cognitive impairment. Cognitive impairment, whether from Alzheimer's disease or other causes, is one of the principal reasons for institutionalization of the elderly. Alzheimer's disease afflicts almost two million Americans and is responsible for at least 100,000 deaths annually. It has been reported that 20 to 30% of those who reach their mid-80's are likely to develop the disease.

Although recent data point out that the majority of abused elders are impaired in some form, not all impaired elders are mistreated. What then distinguishes those who are mistreated from those who are not? According to several researchers there are two factors other than dependency that must come into play before mistreatment occurs. Those factors are; first, there must be an individual who takes an action and perpetrates the mistreatment, and second, there is usually some kind of triggering event that precipitates a crisis. Many times this triggering event is related to the declining physical or mental condition of the elder. Sometimes adult children who have a good relationship with their parents find that impairment and dependency, particularly if they last for an extended time period, lead to stresses and abuse.

Figure 3

TOP TEN CHRONIC CONDITIONS FOR ELDERLY—RATES PER 1,000 PERSONS
1982



SOURCE: National Center for Health Statistics, 1982 HIS Survey.

Table 1

PERCENT OF THE 65 PLUS POPULATION IN THE COMMUNITY WITH ADL LIMITATIONS

Age/sex	Type of dependency				Total
	Only IADL limited ¹	ADL (activity of daily living limitation) score ²			
		1-2 (mildly disabled)	3-4 (disabled)	5-6 (severely disabled)	
65 to 74	4.5	4.2	1.8	2.1	12.6
Male	4.2	3.4	1.7	2.4	11.7
Female	4.8	4.7	1.9	1.9	13.3
75 to 84	7.9	9.0	3.6	4.5	25.0
Male	7.1	6.5	2.5	4.6	20.9
Female	8.5	10.3	4.3	4.4	27.6
85 +	10.2	17.4	7.8	10.4	45.8
Male	9.9	15.7	7.7	7.5	40.8
Female	10.3	18.2	7.9	11.8	48.2
All 65 +	6.0	6.6	2.8	3.5	18.9
Male	5.4	5.1	2.3	3.3	16.0
Female	6.4	7.7	3.2	3.6	20.9

¹Needs assistance with the instrumental activities of daily living (IADL) managing money, shopping, light housework, meal preparation, making a phone call, and taking medication

²Sum of the number of activities of daily living (ADL) with which respondent requires assistance: eating, bathing, dressing, toileting, etc.

SOURCE: Tabulations from the 1982 Long-Term Care Survey prepared by the Center for Demographic Studies, Duke University. Reported by Soldo, Beth J., and Manton, Kenneth G., Health Service Needs of the Oldest Old, Health and Society, Milbank Memorial Fund Quarterly, Vol 63, No 2, Spring 1983

This dependency relationship has other dimensions. Sometimes it is the abuser who is dependent upon the elder. A significant number of abusers are dependent on their victims emotionally, financially and for housing support. This so called "web of dependencies" is seen by some researchers as a high-risk factor. Physical abuse in particular seems to be associated with heavily dependent people.

Caregiver stress—

Much attention has been given to the role of the stressed caregiver in elder mistreatment. According to Quinn and Tomita, "Nearly everyone has, at one time or another, experienced the feeling, however fleeting, of wanting to strike out at a dependent person who needs a great deal of help with activities of daily living. Most of us have at times felt impatient or intolerant of an older person who walked slowly in our fast-moving world."

Only about five percent of the elderly live in nursing homes. Most of the impaired elders are being cared for in the community, primarily by a family member or friend. Nursing homes are expensive and have negative images for most people. Therefore, families see them as a last resort and try to care for their elderly relative in a home setting. Although family care has in some senses been romanticized and idealized in American culture, it can lead to abusive situations.

In their zeal to "do the right thing," many family members commit themselves to the care of a parent or relative too quickly. The burdens and time commitment associated with caregiving are little understood by most people. For example, dementia, a common cause of mental impairment among older people, can have a long course involving care for as much as ten or twelve years. A recent study pointed out that the average length of time for caregiving was 9.5 years. Over time this level of care increases.

The result of a long-term caregiving commitment is usually the continuing stress and isolation of the caregiver who must focus more and more time on meeting the survival needs of the elder. Feelings of severe isolation and entrapment are common as the caregiver foregoes her own needs for those of the elder.

Caregiver stress can be further exacerbated by the fact that many times the "family" is really one person. Usually a middle-aged woman takes on the major caregiving responsibilities, with little help or understanding from the rest of the family. Estimates are that over eighty percent of the caregivers are women. Many times this "superwoman" has other family responsibilities in addition to the caregiving task, and receives little recognition or reward for her work.

The elder person can also be the source of much stress on the caregiver. Of particular significance are the emotional demands on the caregiver. Although physical care can be a burdensome task, it is the emotional burdens placed on the caregiver that are the source of the most stress. Most caregivers are able to cope with doing household tasks and physical chores associated with care, but find it very stressful to deal with elders who are demented or have emotional problems.

Family Histories and Learned Violence—

Some recent research in elder mistreatment has drawn on research findings associated with other types of domestic abuse and violence. Research on child and spouse abuse points to the importance of family histories and the learning of abusive behavior. Many studies have pointed out that child and spouse abuse are more prevalent with people who had lived in homes filled with violence as a child.

Some research studies have indicated abusive behavior was three times more likely if the abuser came from a family where violence was prevalent.

The evidence to show that violence is learned behavior and that it can be taught in families and perpetuated from one generation to the next, is quite convincing. There is no reason to believe that this type of behavior ceases when one reaches the age of sixty-five. The problems associated with elder mistreatment may be more complex because of the varying physical needs of the elderly. The elderly are also more likely to have financial resources and thus be the target for unscrupulous persons trying to profit from their vulnerability.

Pathological Disturbances of the Abuser—

In some cases of elder mistreatment the abuser is the sole cause of the abuse. In these cases, the abuser has a very serious pathological problem such as drug and alcohol addiction, a psychiatric disturbance, dementia, mental retardation or a sociopathic personality. One study found that 31% of abusers had a history of psychiatric illness and 43% had a substance abuse problem.

Abusers in these categories are obviously very difficult to work with and the practitioner must take special precautions. Many times these types of abusers are unable to see the connection between their actions and the resulting abuse. Some of the most damaging physical abuse cases have been associated with sociopathic-like sons and their elderly mothers. In some cases the caregivers were institutionalized themselves.

In the case of persons with dementia, the caregiver is most likely to be a spouse. In many instances, the elderly couple live together in isolation, with the demented spouse being physically healthy while the physically fragile spouse is mentally competent. Abuse or neglect thus become possibilities and both individuals may need a protective setting.

Preliminary research on elder mistreatment has analyzed a variety of causative factors such as dependency, stressed caregivers, learned behavior, and pathological disturbances. Individual cases vary considerably, yet most people who have worked in the area of elder mistreatment have found combinations of causative factors contributing to abuse rather than one single factor. An understanding of these factors is essential in order to assess, diagnose, intervene and treat elder mistreatment cases.

Chapter 5 — ASSESSMENT AND DIAGNOSIS

Assessment of a client's situation is an essential first step and is to be undertaken with care. This initial assessment will obtain information useful in determining further steps to be taken. This assessment process is usually initiated by a referral. This referral may come from a variety of sources including friends, relatives, neighbors, ordinary concerned citizens or from a practitioner. Obtaining relevant and accurate information is an essential part of the referral process. Details about the person who has been abused and the type of abuse or neglect should be included in this information. Confidentiality is an important aspect of the referral process. The referrer should be told that, although the information is considered confidential and it is highly unlikely that the referrer's name will be disclosed, it is possible for the confidentiality to be broken through a court order.

There are a variety of motivations for reporting a case of abuse or neglect. Often these motivations are a function of the relationship between the referrer, the abuser and the abused person. If the referrer is related to the abuser or the abused person, care must be taken to find out the details of the relationship. It is not uncommon for a relative to be upset or engaged in an argument with another relative and therefore accuse that person of abuse or neglect.

After this initial information has been gathered and assessed, the next step is to plan for the initial contact. The seriousness of the situation should be determined immediately and may involve collateral contacts, particularly with the client's physician.

After reviewing all this information, the practitioner makes the first contact with the client. If it is an emergency situation it might be necessary to make a drop-in visit. However, drop-in visits may alienate the client and lead to resentment and defensiveness. Whenever possible, the practitioner should call ahead and set up a date and time for an appointment. Sometimes access to the client is difficult and may involve the help of a client's friend, neighbor, relative or church member. The assessment of a client may take several visits and involve help from other practitioners.

According to Villamore and Bergman (1981), it is important to conduct this initial interview in a nonjudgmental manner. The practitioner should think of a good interview technique as involving the "five P's." These five P's are: 1) privacy, 2) pacing, 3) planning, 4) pitch, and 5) punctuality.

It is very important that the client be interviewed alone, without the presence of the caregiver. If the client cannot be interviewed with privacy in the home, the practitioner should consider doing the interview where privacy can be assured. Pacing is also very important. The client should not be rushed. The interview should be planned in advance and, if forms are necessary, the practitioner should have them available. The practitioner should speak slowly and clearly and avoid sounding surprised or excited. Finally, the appointment should be kept and the practitioner should arrive on time.

A principle task of this initial contact is to do a functional assessment. The purpose of this functional assessment is to determine whom the client depends on for physical, social, and/or financial support and the persons with whom the client interacts frequently. One way to find out some of this information is to ask the client to describe a typical day. This will often give an indication of the degree of the client's dependency. It is also important to assess the client's ability to conduct normal daily living activities such as grooming, dressing, walking, bathing, toileting and eating. After this has been done, the practitioner may wish to explore the subject of abuse or neglect more specifically.

The next step is to do an injury assessment. This may involve documentation of physical injuries through sketches or photographs. If the client is at home, this may be a more cursory analysis than that which would take place in a hospital setting. The practitioner should be on the lookout for suspicious marks and/or bruises. The practitioner should also try to determine the competency or mental status of the client.

After the client has been interviewed and assessed it is important to immediately interview the family member or caregiver. The caregiver should not have the opportunity to talk with the client and "make-up" a story. A very important means of uncovering elder abuse is to find inconsistencies in stories told by both the client and caregiver. The caregiver interview may be fraught with danger, as the abuser could threaten the practitioner and client. Care must be taken not to provoke the abuser. Often a practitioner may wish to focus on asking the abuser about the client's situation, rather than focusing on the actions or behavior of the abuser directly. If probing and difficult questions must be asked, the practitioner should save those questions for the end of the interview. By then the significant questions have already been asked and the abuser's defensive response will not put the whole interview in jeopardy.

The questions given to the caregiver provide an opportunity for the caregiver to admit frustrations or problems. The practitioner must then assess the sincerity of the caregiver and make a preliminary judgment as to whether the caregiver is primarily stressed or has a pathological problem. After interviewing the caregiver, the practitioner should promptly make collateral contacts to establish the caregiver's behavior patterns.

After carefully reviewing all the information gathered from the client, caregiver and others, the practitioner then makes a tentative diagnosis. This tentative diagnosis could take one of four forms: 1) there is no evidence to support abuse and neglect; 2) there is evidence for a suspicion of neglect; 3) there is evidence for a suspicion of abuse; or 4) there is strong positive evidence for abuse, neglect or exploitation.

Chapter 6 - INTERVENTION AND TREATMENT

After a diagnosis has been made, the practitioner must then decide on a course of intervention and treatment. The first step is to determine whether the client has the capability to consent to intervention and treatment. Sometimes this will involve various assessments from a variety of practitioners. If the client is capable of making competent decisions and chooses to remain in an abusive situation, the practitioner should carefully examine the factors involved in this decision. It is especially important for the practitioner to determine the severity of the abuser's pathology and whether the client's life is threatened. It might be necessary to try to get a court-mandated treatment in some cases.

The Consortium for Elder Abuse Prevention outlined a continuum of intervention strategies ranging from the least restrictive intervention, which was living in one's own home with no assistance, to more restrictive interventions like in-home support services or group home living, to the most restrictive interventions, which included nursing homes, conservatorship, or even prison. The practitioner should try to find the least restrictive option that still protects the welfare and rights of the client.

Treatment in abuse and neglect cases can take on a variety of forms. One must always be cognizant of the fact that it is almost impossible to separate one person, such as the client, and treat that person in isolation. In most cases several people including the client and the abusive caregiver are involved in treatment. Other family members or friends may also be included. Care must be taken to develop a treatment plan that incorporates all persons involved with the abusive situation. In many cases it is a family problem and must be treated as such.

The principal method of treatment involves individual counseling of both the client and the abuser. Many different types of counseling techniques could be selected. Whatever technique is used, it is essential to gain the trust and acceptance of as many persons involved as possible.

Other than individual counseling, group or family therapy has been used successfully. The evolution of groups to help stressed caregivers is a recent development that shows great promise. In some cases, the only way to proceed is by engaging the entire family in the counseling process. One must first establish the dynamics of the family situation and determine whether the family is one that is enmeshed or disengaged. After understanding these family dynamics it is then possible to develop a strategy to cope with the problem.

Chapter 7 — LEGAL ASPECTS OF ABUSE AND NEGLECT

In many cases the elder abuse victim needs legal protection. It is inevitable that a practitioner who works in the area of elder mistreatment will be involved sooner or later in the legal system. Therefore, it is necessary to have an understanding of all the legal options available to a client. This will include familiarity with the court system and the civil and criminal justice systems. Although risks must be taken when working with the court system, it is very rare that a practitioner is sued for work concerning abuse cases. Nevertheless, it is necessary for the practitioner to be working in the "legal mode" at all times.

The primary principle when working in this legal mode is to use the least restrictive option available. The client should not be intruded upon any more than is absolutely necessary. The client should be given the maximum limit of personal liberty and independent control of decisions. The continuum of legal options can range from the least restrictive, such as signing names to checks after someone else has written them, to more restrictive limits such as power of attorney, to the most restrictive such as conservatorship or even prison.

Limited restrictions can be put on financial affairs through such procedures as direct deposit of Social Security checks, joint tenancy of assets and accounts, or a representative payee person designated by the Social Security Administration to receive the check of the client in order to pay the bills.

A more restrictive legal procedure is the appointing of a power of attorney. A power of attorney is a written agreement that authorizes one or more people to act in the stead of the client. It is a voluntary action on the part of the client and the client must be competent at the time of signing the agreement. It is also revokable at any time by the client. Powers of attorney can be of a general nature or more specific to certain issues. Many times the power of attorney is said to be durable, that is, it will continue after the client becomes incapable or incompetent.

It is obvious that the power of attorney can be used by unscrupulous people to take advantage of the client. It can also, however, be a useful tool, especially when the client has trusted friends or relatives.

Protective orders are another legal means to stop abuse and neglect. A client may be moved out of a dangerous situation or treated for a medical problem through the use of protective orders. Strong evidence must be presented to a judge that the client is in a serious situation and must be cared for immediately.

Conservatorships and guardianships are other ways to protect elders from mistreatment. The conservatorship gives authority to handle the client's financial matters whereas the guardianship is concerned with the client's personal affairs. Both can be used in adult protection cases, but the practitioner should understand the role of the court in their implementation.

The most restrictive forms of legal intervention deal with the criminal justice system and criminal remedies. Most of the time the elder abuse case does not reach the criminal court as elderly victims are usually reluctant or unable to prosecute the abuser. In some cases, however, the victim should be encouraged to press charges in order to get the necessary help or counseling for the abuser.

Sometimes the practitioner must work with police officers. It may be essential to have a police officer make a written report of the case so a "paper trail" can be established for further reference.

Legal formalities involve a great deal of time and paperwork. The practitioner should pay close attention to documentation and record all dates, contacts, home visits, telephone calls, or other important events. Due to the complexity of these matters, the practitioner should learn about the laws and legal system and use help from appropriate professionals.



EL PASO COUNTY
DEPARTMENT OF SOCIAL SERVICES

COLORADO
CONTINUUM
PROF CARE
PROJECT



Pikes Peak Area
Council of Governments

PART II — PROFESSIONAL AND COMMUNITY AWARENESS OF ELDER ABUSE

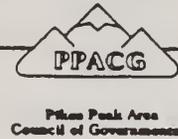
The purpose of this project is clear: Every county in Colorado has need to improve the capability of professionals (social, health and legal services) as well as laypersons to appropriately identify and refer potential elder abuse cases to county departments of social services.

The groundwork has already been done for you: a one-year Continuum of Care pilot project in El Paso and Teller counties (urban and rural models). Professionals in the health, social and legal services received a pre-test, followed by in-service training sessions and a post-test to determine the extent of their awareness of elder abuse. The main areas of concern, as indicated by the written survey, interviews and the testing tools, are included in the discussion questionnaire.

Objectives —

To replicate the Continuum of Care pilot project (Elder Abuse Awareness Project), the following objectives must be met:

1. Create a project coordination effort between the area agency on aging and the county department of social services;
2. Designate someone who will be responsible for the role of trainer/coordinator;
3. Establish and maintain an Elder Abuse Awareness Advisory Council;
4. Identify, contact and provide in-service training of core groups;
5. Identify, contact and provide in-service training of secondary groups;
6. Establish a permanent Adult Protective Task Force and a Guardianship Program.



STEP ONE — PROJECT COORDINATION

County departments of social services are the designated adult protective agencies in the State of Colorado. Area agencies on aging throughout the state are responsible for planning and coordination of older adult programs and advocacy for older adults. The combined experience and expertise of these agencies on aging are unmatched in most communities. The coordination of the efforts of county departments of social services and area agencies on aging to increase awareness of elder abuse issues will produce a project that will:

1. Increase identification and referral of elder abuse cases;
2. Increase prevention and treatment of elder abuse cases.

The initial step of this project should be the preparation of a Memorandum of Agreement between the department of social services and the area agency on aging involved (see example of Memorandum Agreement pages 33-34). A clear explanation of the duties of both agencies should prevent the occurrence of potential misrepresentation and misunderstanding of the management of the elder abuse awareness project.

After joint development of the Memorandum of Agreement, prompt signing by the parties involved will enable the project to begin. The social services representative should be a supervisor or administrator in the adult protective area. The individual must have a comprehensive understanding of the strengths and weaknesses of current adult protective systems. The representative in this project from the area agency on aging should be the director, who possesses the most knowledge of the aging network in the community. The system at large will benefit from the networking and interdependence this project will provide.



EL PASO COUNTY
DEPARTMENT OF SOCIAL SERVICES

COLORADO CONTINUUM OF CARE PROJECT



Pikes Peak Area
Council of Governments

STEP TWO — ROLE OF PROJECT TRAINER/COORDINATOR

The next step is selection of the trainer/coordinator. The department of social services (DSS) and the area agency on aging (AAA) representatives must consider the following:

1. It is advantageous for the trainer/coordinator to work closely with the DSS. The trainer/coordinator will have a clearer understanding of adult protective issues after seeing the adult protective system in action. The trainer/coordinator will then be able to better represent the project while instructing professionals or laypersons.
2. How many hours per month will be devoted to this project by the trainer/ coordinator? This time will include a minimum of two monthly meetings with the DSS and AAA, contacting core and secondary groups, training core and secondary groups, advisory council establishment and maintenance, and Adult Protective Task Force participation.

Core Group Phase

Identify core groups

Form advisory council

Interview and survey advisory council members

Contact and provide in-service training discussion questionnaire and video tape

Secondary Group Phase

Identify and contact secondary groups

Provide In-service training (discussion questionnaire and video tape) to secondary groups

3. Professionals from the following human service fields may be considered for the role of trainer/ coordinator:

- a. county health department (ombudsman, management)
- b. sheriff's or police department (victim's services, investigations)
- c. senior service provider (case manager, management)
- d. area agency on aging (volunteer, staff member)
- e. department of social services (volunteer, staff member)
- f. home health agency (staff member)
- g. instructor of aging-related courses
- h. hospital (emergency medical staff, physician)
- i. domestic violence (staff member)
- j. mental health center (staff member)

After appointment of the trainer/coordinator, bi-monthly meetings must occur (at least in the initial six months of the project) to ensure communication between the parties involved.



EL PASO COUNTY
DEPARTMENT OF SOCIAL SERVICES

COLORADO
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OF CARE
PROJECT



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STEP THREE — ELDER ABUSE AWARENESS ADVISORY COUNCIL

The trainer/coordinator and the department of social services and the area agency on aging representatives should select the members of the Elder Abuse Awareness Advisory Council. The advisory council/task force membership should include representatives from the health, social and legal service fields. Recruit community and professional leaders who are genuinely interested in increasing awareness of elder abuse. These members will represent the core groups to a large extent, as they are in key positions to discover potential abuse situations.

Initially, the focus of the advisory council will be on providing current information about represented agencies' awareness of elder abuse issues. (See Elder Abuse Areas of Concern Survey, Interview and Survey/Interview Results, pages 35-38). The focus of the advisory council will gradually evolve toward that of a policy-making and cooperative case-assessment group (Adult Protective Task Force). Therefore, policy-makers as well as practitioners should be included on the council. (See Elder Abuse Awareness List of Council Members, page 39).

The council should meet monthly. The trainer/coordinator should be responsible for contacting the members prior to each meeting to remind them of the date and time. The trainer/coordinator should also draft the meeting agenda. Monthly status reports should be prepared by the trainer/coordinator to brief advisory council members on:

1. The results of the written surveys and interviews of the advisory council members;
2. The progress of the in-service training sessions.

It is mandatory that a confidentiality statement be signed by each advisory council member once the council has been established. This will ensure the maintenance of professional standards while discussing issues concerning clients or potential clients. Confidence of the client must never be violated. The project will suffer a loss of credibility if confidentiality is violated. (See sample Statement of Understanding, Confidentiality of Information, page 40). The signing can be accomplished at the first meeting.



STEP FOUR — IDENTIFICATION, CONTACT AND IN-SERVICE TRAINING OF CORE GROUPS

Once the Elder Abuse Awareness Advisory Council is in place, Step Four may begin. At this point, the core groups have been identified, as the advisory council should have representation from most of the core groups.

Core Groups

Area Agency on Aging	County Department of Social Services
District Attorney's Office	County Sheriff's Department
Police Department	County Health Department
Legal Service	Senior Service Provider
Fire Department	Domestic Violence
Mental Health Center	Hospital
Nursing Homes	

The trainer/coordinator may contact one or more core groups to begin establishing an in-service training schedule. The intensity of the schedule will depend upon:

1. the number of hours the trainer/coordinator provides to the project monthly (each in-service training session lasts approximately 1 1/2 hours);
2. the number of core groups needing in-service training varies from community to community. Training should be completed in six months to one year so the Adult Protective Task Force may begin;
3. the scope of the adult protective system in the county. The project will increase the number of elder abuse referrals received by the county department of social services. Pace the in-service training sessions so that the system will be able to absorb the increase in caseloads. Once the task force is coordinated, the caseloads will be more manageable.

The in-service training sessions are a major component of the project. These sessions heighten awareness of elder abuse issues, resulting in an increase of referrals received from throughout the county. The in-service training module has been designed for clarity and ease of presentation.

TRAINING SUMMARY

In-Service Training

Address needs of core and secondary groups concerning elder abuse identification, intervention and referral as determined by Discussion Questionnaire and video tape accompanying questionnaire. Explain core and secondary groups role in community concerning elder abuse awareness and progressive programmatic participation.

Discussion Questionnaire

Determine core groups knowledge of elder abuse issues by utilization of Discussion Questionnaire. The questionnaire is also designed to pique interest in the subject matter.

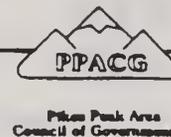
Video Tape

Show video tape and discuss with core and secondary groups abuse identification, intervention or what protective workers do.

The curriculum-unit design provides all the information the trainer/coordinator needs for a successful training session, including description of curriculum, learning objectives, notes to trainer and resources for trainer presentation. (See Curriculum Unit for Elder Abuse Awareness In-service Training, pages 41-43). The video tape and accompanying training material information are also located in this section.

The General Guideline for In-service Training Sessions clearly provides the sequence in which the training session is to be conducted (See page 44). This form illustrates the training session format for those considering training of their particular group (i.e. domestic violence director).

The Discussion Questionnaire must be completed by the in-service participant (See page 45-46). It has been designed to foster interest and to provide elder abuse information from the health, social and legal fields. The oral review of the questions offers an excellent opportunity for the trainer/coordinator to become acquainted with the participants and for the group to become communicative. The Discussion Questionnaire Answer Sheet is provided for the trainer/coordinator's reference (See pages 47-49).



STEP FIVE — IDENTIFICATION, CONTACT AND IN-SERVICE TRAINING OF SECONDARY GROUPS

When the core groups have received the elder abuse awareness in-service training, the secondary group training may begin. There are two main benefits of this procedure:

1. The core groups generally have more human service managers and policy-makers than the secondary groups. By training the core groups first, the trainer/ coordinator will gain knowledge about community elder abuse issues and attitudes which can be shared with the advisory council and secondary groups.
2. Secondary groups are in strategic positions to encounter abused elders, so training these groups is critical to achieving professional and community awareness.

Secondary Groups

nutrition site staff

home delivered meals personnel

police officers

deputy sheriffs and patrolmen

rehabilitation center staff

hospitals (paramedics, emergency room nurses, social workers, discharge planners)

home and community based services (includes HHC, homemakers, adult day care, non-medical transportation, respite care, alternate day care facilities)

senior recreational programs

senior housing staff (retirement housing, room and boards, adult foster care)

The core groups should be represented more directly on the Elder Abuse Awareness Advisory Council than the secondary groups. Core groups are comprised of administrators, directors, case managers, etc., while secondary groups are made up of practitioners. The core group representatives should be heavily recruited for the advisory council in order to meet the policy-making needs of the Adult Protective Task Force.

The in-service training procedure for secondary groups is identical to that of the core group sessions (See pages 41-49). The number of secondary group participants to be trained exceeds the number of core group trainees. Therefore, more time for training the secondary groups should be allotted.



EL PASO COUNTY
DEPARTMENT OF SOCIAL SERVICES



Pikes Peak Area
Council of Governments

STEP SIX— ESTABLISHMENT OF AN ADULT PROTECTIVE TASK FORCE AND GUARDIANSHIP PROGRAM (Implementation Phase)

Step Five will be completed when the secondary training groups have received the in-service training. The role of the trainer/coordinator will then have been completed. As a result of the training sessions, referrals of suspected elder abuse cases will be increasing. In Step Six, the Adult Protective Task Force will begin assuming the role of a cooperative case assessment and policy-making body. The task force will perform case assessments and develop comprehensive case plans in response to the number of referrals to the county department of social services.

Implementation Phase

Redefine goals of advisory council to those on task force

Guardianship, Conservatorship

An evaluation of the advisory council should occur. Include on the task force members who:

1. have been active participants on the advisory council
2. can provide policy-making skills
3. can add to the case assessment ability of the group
4. can provide needed services to client

The criteria for the advisory council/task force are outlined in Step Three (See page 26). This is the time to give new direction and motivation to the task force. Do not hesitate to make the appropriate changes in membership.

A confidentiality statement must be signed by each task force member. (See sample Qualified Service Organization Agreement page 50).

The Adult Protective Task Force should receive a statement of purpose at the onset. Members must have a clear understanding of the purpose of the task force and their particular role in the group. The task force functions through the county department of social services and serves to enhance the quality of adult protective services available in the county. Therefore, it should be guided by a DSS supervisor or administrator in the adult protective area. Organization of the task force involves:

-
1. recruitment of the task force members;
 2. statement of purpose;
 3. providing background information on the DSS and the adult protective unit (e.g. caseloads, number of workers, review several cases);
 4. assistance in determining the needs of the DSS adult protective services unit;
 5. assistance in determining how the agencies, departments, etc. represented can best contribute to the purpose of the task force (e.g. what service can be provided to assist the case plan?);
 6. preparation of monthly agendas;
 7. reminding task force members of next meeting, although this could be delegated to clerical staff;
 8. selection of cases to be presented to the task force.

Guardianship of an older adult usually refers to the handling of the individual's personal needs through the provision of medical care, food, clothing and shelter, according to Mary Quinn's report, *Serving the Victim of Elder Abuse*.

The guardianship program in El Paso County, developed by the El Paso County Department of Social Services and the Myron Stratton Home has provided a comprehensive outline for the formation of the program. This program is a spin-off of the Elder Abuse Awareness Program and could be adapted for replication by any county.

Membership of the guardianship program advisory council may include representatives from the following agencies or fields:

1. area agency on aging
2. county department of social services
3. probate court
4. private, non-profit foundation concerned with older adults
5. gerontological consultants
6. attorney

If you are interested in obtaining further information or have any questions concerning the guardianship program, contact:

El Paso County Department of Social Services
Adult Protective Unit
105 N. Spruce
Colorado Springs, CO 80905
(719) 630-6887

Source: Mary Joy Quinn, *Serving the Victim of Elder Abuse*, San Francisco Institute on Aging at Mount Zion Hospital and Medical Center, p. 25.



EL PASO COUNTY
DEPARTMENT OF SOCIAL SERVICES

COLORADO CONTINUUM OF CARE PROJECT



Pitkin Peak Area
Council of Governments

CONCLUSION

The Implementation Phase, as discussed in Step Six, is the final product of the Continuum of Care pilot project in El Paso and Teller counties.

As national recognition of elder abuse continues to increase, the opportunities for the community to recognize the problem will increase also.

Awareness in the Colorado Springs area and Teller County communities has increased with the help of brochures, interviews with project staff members on radio and television, and, most rewardingly, by word of mouth. College classes, senior citizen education classes, insurance organizations, and many others have heard of this project and have requested the in-service training (which will continue to be provided by DSS adult protective caseworkers following the curriculum unit outlined in this manual).

The process of developing this project has been rewarding. It is the hope of the personnel involved with this project for the past twelve months that the Elder Abuse Awareness Project will be replicated widely throughout Colorado.

MEMORANDUM OF AGREEMENT
BETWEEN
_____ AREA AGENCY ON AGING
AND
_____ COUNTY DEPARTMENT OF SOCIAL SERVICES

SUBJECT: COORDINATION OF ADULT PROTECTIVE SERVICES

1. PURPOSE: To establish and coordinate efforts of the _____ Area Agency on Aging with the adult protective services provided by the _____ County Department of Social Services for the purpose of improving the capability of health systems, social services agencies, service providers and others to appropriately identify and refer suspected elder abuse cases to _____ County Department of Social Services.
2. GENERAL: This agreement does not purport to create additional jurisdiction nor to limit or modify existing jurisdiction vested in the parties. This agreement supercedes all previous memorandums of understanding between the County Department of Social Services and the _____ Area Agency on Aging.
3. AUTHORITY: The State of Colorado, through the _____ County Department of Social Services, under the authority granted in the Social Services Code (Title 26, Colorado Revised Statutes) is responsible for adult protection within _____ County. The _____ Area Agency on Aging is responsible for planning, coordination and advocacy for older adults in _____ County or counties under the aegis of the authority, jurisdiction of ex. Council of Governments).
4. AREA AGENCY ON AGING:
 - a. Shall organize the Elder Awareness Advisory Council with _____ County Department of Social Services.
 - b. Shall have membership on the Elder Abuse Awareness Advisory Council and consequently on Adult Protective Task Force and that member shall be responsible for providing to the Title III subgrant agencies and other service agencies information regarding adult protective issues.
5. COUNTY DEPARTMENT OF SOCIAL SERVICES:
 - a. Shall be responsible for overall management of elder abuse awareness in-service training program.
 - b. Shall be responsible for supervision of the designated trainer/coordinator.
 - c. Shall be responsible for development of guardianship program.
 - d. Shall organize Elder Abuse Awareness Advisory Council with _____ Area Agency on Aging.

e. Shall organize and ensure continued effectiveness of the Adult Protective Task Force.

6. AREA AGENCY ON AGING AND COUNTY DEPARTMENT OF SOCIAL SERVICES JOINT RESPONSIBILITIES FOR PLANNING:

- a. Review of work activities with bi-monthly meetings.
- b. Review of training procedures.
- c. Review of monthly in-service training schedule.

7. COMMUNICATIONS:

Effective execution of this agreement can only be achieved through consistent communication and through dialogue among and between the parties. It is the policy of the members of this agreement that access to all parties will remain open and that the resulting channels of communications will be used whenever questions, misunderstandings or complaints arise.

WHEREFORE, the parties by the signatures below adopt this as their operating agreement.

(e.g. Department of Social Services
project representative)

(e.g. Area Agency on Aging Representative)

Approved as to form:

(e.g. Department of Social Services
Director)

(Deputy County Attorney)

Date: _____

ELDER ABUSE AREAS OF CONCERN SURVEY

PURPOSE: Advisory Council members will provide written information concerning their agency's or department's knowledge of elder abuse issues to determine strengths and potential areas of need to be addressed during in-service training.

I. DEFINITION

Physical abuse, psychological abuse, financial exploitation, active neglect, passive neglect, self neglect, denial of civil rights.

II. DATA AND PROBLEM SIGNIFICANCE

Why and who?

III. LEGAL ASPECTS

IV. IDENTIFICATION, INTERVENTION, AND REFERRAL

V. PREVENTION AND TREATMENT

VI. ELDER ABUSE EDUCATION AND LEGISLATION

Purposes, state and national.

Interviewer: _____
Interviewee: _____
Date: _____
Location: _____

A. ADVISORY COUNCIL INTERVIEW QUESTIONS

1. How do you work with:
 - a. Adult Protective Services
 - b. Area Agency on Aging

2. How do you identify
 - a. Abuse
 - b. Neglect
 - c. Exploitation

3. How do you intervene:

4. How do you refer:

5. What services can you offer those involved:

6. Suggestions, open discussion

B. REVIEW OF FILM QUESTIONS AND DISCUSSION TOPICS

(Trainer/coordinator and group representative decide together which video training group will view.)

1. Determine appropriate training video tape to utilize for in-service training:
 - a. "Hidden Sorrow: An Overview" - (general introduction to elder abuse)

-
- b. "In Pursuit of Life Without Violence: Intervention Strategies" - (roles of protective workers, caseworkers)
 - c. "Difficult Choices: Ethical Issues in Casework" - (central issues for caseworkers and protective workers)

C. ESTABLISH IN-SERVICE TRAINING DATE

Date: _____

Time: _____

Location: _____

(This form should also be used for secondary group information.)

Survey/Interview Results

Interviewees

Definition - Types Abuse-Physical, Psychological Neglect-Active, Passive, Self Exploitation-Financial, Denial of Civil Rights																				
Data and Problem Significance																				
Legal Aspects (Laws, Statutes, Rights)																				
Identification of Abuse, Neglect, Exploitation																				
Intervention (Identification, Procedures)																				
Referral																				
Treatment Services offered to those involved																				
Elder Abuse Education and Legislation																				
Work with DSS (Yes or No) If Yes - Key #																				
Work with AAA (Yes or No) If Yes - Key #																				
Suggestions Open Discussion																				

- Key - 1. recognized and utilized
 2. information received through staff training
 3. expressed need to become more knowledgeable in this area
 4. services providers
 5. DSS
 6. AAA
 7. Handled 'in house'
 8. training necessary in this area
 9. n/a

**ELDER ABUSE AWARENESS
ADVISORY COUNCIL MEMBERS**

Hospital Personnel
(ie. paramedic, physician, EMS office)

Physician

District Attorney's Office

Fire Department Personnel

County Health Department Personnel
(ie. ombudsman, nursing director)

Domestic Violence Personnel

Legal Services Paraprofessional
or Attorney

Mental Health Personnel

Home Health Agency

County Department of Social Services
Personnel

County Sheriff's Department

Police Department Personnel

Senior Service Provider

Nursing Home Administrator

Area Agency on Aging Director

DSS Administrator

Aging-Related Course Instructor

**STATEMENT OF UNDERSTANDING
CONFIDENTIALITY OF INFORMATION**

I understand that as an Elder Abuse Awareness Advisory Council member for the _____ County Department of Social Services, I am subject to the rules and regulations of the Department.

I also understand that: "It is unlawful, except for purposes directly connected with the administration of public assistance, medical assistance, and child welfare services, and in accordance with the rules and regulations of the State Department, for any person to solicit, disclose, or make or acquiesce in the use of, any lists of or names of, or any information concerning persons applying for or receiving, public assistance (this encompasses recipients of Social Services), medical assistance, or child welfare services, directly or indirectly derived from the records, papers, files, or communications of the state or counties or subdivisions or agencies thereof or acquired in the course of the performance of official duties."

I further understand that any person who violates confidentiality shall be "guilty of a misdemeanor and, upon conviction, shall be punished by a fine of not more than five hundred dollars or by imprisonment in the county jail for not more than three months, or by both such fine and imprisonment."

(e.g. area agency on aging director)

(e.g. county health department representative)

(e.g. legal paraprofessional)

(e.g. hospital representative)

ELDER ABUSE AWARENESS

CURRICULUM UNIT FOR IN SERVICE TRAINING

(Please refer to General Guideline for In-Service Training Sessions for step-by-step training procedure, page 44.)

I. Description of Curriculum

Program participants will receive information that will improve the capability of health systems, social service agencies, service providers and others to appropriately identify and refer suspected elder abuse cases to county department of social services.

The curriculum unit covers basic elder abuse issues, caseworker and protective worker roles and ethical issues involved in intervention, depending upon the video tape selected. A discussion questionnaire is presented to provide an overview of elder abuse from legal, social and health aspects.

This model project for the State of Colorado may be replicated in urban and rural communities of various sizes.

II. Learning Objectives

The overall goal of the project is to improve the capability of health systems, social service agencies and legal services to appropriately identify and refer elders suspected of being abused, neglected or exploited.

Participants will become aware of the lack of knowledge the community professionals have concerning elder abuse issues. The specific objectives vary according to the video tape viewed. Information concerning these objectives will be provided with the video tape for the trainer/coordinator's use.

III. Notes to Trainer

1. One trainer is adequate to facilitate the group training.
2. Use a room with seating arrangement adequate to view VCR. (Room need not be dark.)
3. Before training:
 - a. Obtain VCR tape (#1, 2 or 3) and accompanying handouts.
 - b. Set up VCR, video tape and TV ahead of time; test to make sure they are ready to use.
 - c. Assemble handout packets; be sure there are sufficient copies.
 - d. Obtain brochures (the pilot project brochure may be replicated in any county).
 - e. Have discussion questionnaire answers and film guideline accessible.

-
4. Distribute handout material and packets before video tape is shown. Specify to participants the relevant pages for the specific tape they will view (upper right hand corner of handouts).

IV. Resources for Trainer

1. VCR, video tape and TV
2. General Guidelines (video tapes), handout materials (Section B), video tapes accompanying film discussion questions.
3. Questionnaire as discussion tool.

V. Presentation

- 1 1/2 hours (5 minutes to explain session)
(15 minutes discussion questionnaire)
(20 minutes for video tape)
(40 minutes discussing video tape)
(5 minutes for handbook distribution, discussion)
(5 minutes for conclusion)

Video tapes and accompanying in-service training materials may be borrowed by writing or calling:

El Paso County Department of Social Services
Adult Protective Unit
P.O. Box 2692
Colorado Springs, CO 80901

(719) 630-6887

State of Colorado Department of Social Services
Aging and Adult Services Division
1575 Sherman Street
Denver, CO 80203

(303) 866-5910

Video tapes may be purchased from:

The University Center on Aging
University of Massachusetts Medical Center
55 Lake Avenue
North Worcester, MA 01605-2397

GENERAL GUIDELINE FOR IN-SERVICE TRAINING SESSIONS

- I. Introduction (5 minutes)
 - A. Training goals, objectives
 - B. Professional Role and Community Involvement

- II. Discussion Questionnaire (15 minutes)
 - A. Hand-out, complete
 - B. Discussion based upon accompanying True-False answers

- III. Video tape (20 minutes)
 - A. Use appropriate film for in-service training
 - 1. "Hidden Sorrow: An Overview" - (general introduction to elder abuse)
 - 2. "In Pursuit of a Life Without Violence: Intervention Strategies" - (roles of protective workers, caseworkers)
 - 3. "Difficult Choices: Ethical Issues in Casework" - (central issues for caseworkers and protective workers)

- IV. Discussion (40 minutes)
 - A. Based upon questions provided with film(s).
 - B. Additional case samples from county
 - C. Others

- V. Elder Abuse: Identification, Referral and Intervention at the Community Level handbook distribution, explanation (5 minutes)

- VI. Conclusion (5 minutes)

DISCUSSION QUESTIONNAIRE

Answer the questions; oral review

T or F (True or False questions)

- ___ 1) Because of declining mental and physical abilities, it is estimated that approximately 70% of today's elderly population will need to be under a caregiver's care.
- ___ 2) Most elder abuse victims are in institutional settings.
- ___ 3) According to current national estimates, at least 1 million elders are abused annually.
- ___ 4) Neglect refers to an act or failure to act, whereby a disabled or elderly adult is placed in immediate or imminent danger because the adult or the caretaker is unable to secure or has not provided those services which are necessary to maintain the adults physical and mental health.
- ___ 5) Abuse refers to the unreasonable confinement or intimidation of, or the infliction of physical pain, injury or involuntary sexual acts upon an elderly or disabled person in need of protective services.
- ___ 6) Exploitation refers to the illegal or improper use of a disabled or elder adult or his resources for another person's profit or advantage.
- ___ 7) While home health care programs are beneficial, they generally are more costly than institutionalization.
- ___ 8) Because of the large number of adult protective cases, the top priority is to develop the case plan as quickly as possible.
- ___ 9) Adult abuse is primarily defined as a medical problem.
- ___ 10) Bruises and fractures in an older person usually indicate some type of abuse occurred.
- ___ 11) Home Health Care programs may relieve the stresses upon the caregiver, reducing or eliminating potential abuse and neglect cases.
- ___ 12) All suspected abuse cases should be referred to the Department of Social Services, regardless of the severity.
- ___ 13) The person or agency referring a suspected abuse case may be held legally liable if the case is determined to be unrelated to adult abuse, neglect, or exploitation.
- ___ 14) Colorado has a state law requiring mandatory reporting of suspected adult abuse cases.
- ___ 15) Caseworkers acknowledge that the most preferable means of intervention is to remove the victim from the place of abuse.

-
- ___ 16) A high risk situation may involve a caregiver who abuses substances, is socially isolated, or is involved with stressful events.
 - ___ 17) Most elder abuse victims readily acknowledge that they are being abused.
 - ___ 18) Competency refers to the ability to mentally handle one's own affairs and make decisions in one's own behalf.
 - ___ 19) Conservatorship refers to the court appointment of an individual to handle another adult's personal affairs and to make decisions in the other's behalf, including where they live.
 - ___ 20) Guardianship refers to the court appointment of an individual to handle another adult's monetary affairs.
 - ___ 21) Neglect is the most common form of elder mistreatment.
 - ___ 22) Most elder abuse victims are women.
 - ___ 23) At least 50% of the complaints concerning elder abuse are substantiated.
 - ___ 24) Elder abuse victims usually appreciate intervention
 - ___ 25) The caregiving relationship may often lead to neglect or abuse.
 - ___ 26) The elderly with senile dementia are highly vulnerable to abuse, neglect, and exploitation.
 - ___ 27) The adult child who abuses a parent may have been abused as a child.
 - ___ 28) Adequate monitoring of the client by the caseworker is necessary to help prevent abuse, neglect, and exploitation.
 - ___ 29) The goal of case management is to avoid institutionalization of the elderly by utilizing nursing, physical therapy, occupational therapy, homemaking, personal care, electronic monitoring, day care, and/or alternative care facilities.
 - ___ 30) Most human services workers (visiting nurses, paramedics, etc.) are not aware of elder abuse.

Prepared by: Robert P. Larkin, PhD, University of Colorado at Colorado Springs, Geography Department.

Virginia C. Mahoney, M.A., Continuum of Care Trainer/Coordinator, Pikes Peak Area Agency on Aging/El Paso County Department of Social Services

Discussion Questionnaire Answer Sheet

Trainer/Coordinator Reference for Oral Review)

T or F (True or False questions)

- E 1. Approximately 20% of today's elderly population will be under a caregiver's care in an institutional setting, while an approximately 20-25% will receive caregiver's care in the home setting.
- E 2. The majority of elder abuse victims reside in the home setting.
- T 3. The conservative estimate of abuse among over 1 million elders per year would be validated and raised significantly if referrals were made consistently to Departments of Social Services.
- T 4. Definition from the Colorado Social Services Code, used by all Colorado Department of Social Services.
- T 5. Explanation same as number 4.
- T 6. Explanation same as number 4.
- E 7. Institutionalization is generally more costly than provision of home health care services.
- E 8. Although the rapid development of a case plan is very important, a careful assessment is the most essential component of a good case plan and should not be jeopardized for speed.
- E 9. Adult abuse, neglect and exploitation may be defined as social, psychological, legal and medical problems.
- E 10. The bruises and fractures which may indicate abuse of a child or younger adult need not represent abuse of an older adult. Osteoporosis, fragile blood vessels, etc. may provide symptoms resembling abuse.
- T 11. The stress of caregiving may be tremendous. Home health care programs upgrade the level of care provided to the older adult, and provide relief for the caregiver; thereby, lessening the likelihood of abuse to occur or reoccur.
- T 12. As the designated adult protector in each county, the Department of Social Services needs to receive information concerning all suspected cases. A clearer picture of the extent of elder abuse, neglect and exploitation could then be obtained.
- E 13. Referrals are generally considered to be given in good faith. (See CRS 26-3, 1-104 1984)
- E 14. Although Colorado has a law strongly urging referral of suspected adult abuse cases, no law has yet been passed making reporting mandatory.

-
- E 15. Whenever possible, caseworkers prefer to exercise the least restrictive means of intervention possible. This, of course, is not the case when a person may be in imminent danger and may need to be removed from the situation.
- I 16. A situation which could lead to elder abuse may involve caretaker stress, mental illness, alcoholism, drug abuse, family violence, stressful events, or social isolation.
- E 17. Older victims are usually reluctant to acknowledge abuse. Fear (retribution, change, placement in institution), guilt (self-blame) and privacy (family matter) are leading causes for failure to acknowledge abuse.
- I 18. Definition is provided in the question.
- E 19. The definitions for numbers 19-20 are reversed. The definition for conservatorship is the definition in question #20.
- E 20. The definition for guardianship is the definition in question #19.
- I 21. Neglect (active, passive and self) is the most common form of elder mistreatment. The frequency of neglect (versus abuse) increases as adults become older and become less ambulatory.
- I 22. The majority of older adults are women, so abuse of older women is more likely to occur. There is, however, a trend among older women to abuse, neglect or exploit their older spouses.
- I 23. The majority of elder abuse, neglect and exploitation concerns reported may be substantiated, whether reported by older adults, neighbors or professionals.
- E 24. Elder abuse victims generally fear intervention. A fear of institutionalization and loss of family as a result of intervention, are examples of the reason intervention is feared. This is true for abuse, neglect and exploitation.
- I 25. The caregiving relationship, no matter how well intentioned, may lead to abuse or neglect. As adult children age, caregiving becomes more physically difficult to provide and the situation may deteriorate.
- I 26. The more vulnerable (less threatening, childlike) the individual, the more likely abuse, neglect or exploitation will occur.
- I 27. The "cycle of violence" theory indicates adult children who were abused as children may abuse those they care for (offspring, parents) as a result of learned response.
- I 28. Monitoring, although requiring valuable caseworker time, is essential to ensure abuse, neglect or exploitation are prevented.
- I 29. The explanation is provided in the questions.
- E 30. Most human service workers are aware of elder abuse; either through experience or education. However, a problem with consistent reporting of all cases exists among the professional community.

Prepared by: Virginia C. Mahoney, M.A., Continuum of Care Project Trainer/ Coordinator,
Pikes Peak Area Agency on Aging and El Paso County Department of Social
Services

QUALIFIED SERVICE ORGANIZATION AGREEMENT

_____ County Department of Social Services, Adult Protection Unit has organized an Adult Protective Task Force for Adult Protection for the purpose of investigating new avenues to improve the quality of Adult Protection Services.

The Task Force will have regular meetings where case histories and private details of the lives of persons requiring adult protection services will be discussed. This exchange of information is classified as a communication not constituting disclosure of records as such an exchange is communications of information within a program between, or among personnel having a need for such information in connection with their duties as members of the Task Force.

The members of the Adult Protective Task Force recognize that any unauthorized disclosure of case histories or the private details of the lives of persons requiring adult protection services is a misdemeanor and any person convicted thereof shall be punished pursuant to Section 26-1-114 C.R.S. as amended. The Task Force members:

- (1) Acknowledge that in receiving, storing, processing or otherwise dealing with any information from the Task Force about persons needing adult protection are fully bound by the requirements of confidentiality of information received;
- (2) Agree to institute appropriate procedures for safeguarding such information with particular reference to personal identifying information;
- (3) Undertake to resist in judicial proceedings any efforts to obtain access to information pertaining to clients in adult protection program otherwise than as expressly provided for in this agreement.

Executed this _____ day of _____, 19 _____.

signature (e.g. mental health center representative)

signature (e.g. instructor of aging-related course representative)

signature (e.g. police department representative)

APPENDIX

Core Group Phase

Identify core groups

Form advisory council

Interview and survey advisory council members

Contact and provide in-service training discussion questionnaire and video tape

Secondary Group Phase

Identify and contact secondary groups

Provide In-service training (discussion questionnaire and video tape) to secondary groups

Implementation Phase

Redefine goals of advisory council to those on task force

Guardianship, Conservatorship

In-Service Training

Address needs of core and secondary groups concerning elder abuse identification, intervention and referral as determined by Discussion Questionnaire and video tape accompanying questionnaire. Explain core and secondary groups role in community concerning elder abuse awareness and progressive programmatic participation.

Discussion Questionnaire

Determine core groups knowledge of elder abuse issues by utilization of Discussion Questionnaire. The questionnaire is also designed to pique interest in the subject matter.

Video Tape

Show video tape and discuss with core and secondary groups abuse identification, intervention or what protective workers do.

Core Groups

Area Agency on Aging	County Department of Social Services
District Attorney's Office	County Sheriff's Department
Police Department	County Health Department
Legal Service	Senior Service Provider
Fire Department	Domestic Violence
Mental Health Center	Hospital
Nursing Homes	

Secondary Groups

nutrition site staff
home delivered meals personnel
police officers
deputy sheriffs and patrolmen
rehabilitation center staff
hospitals (paramedics, emergency room nurses, social workers, discharge planners)
home and community based services (includes HHC, homemakers, adult day care, non-medical transportation, respite care, alternate day care facilities)
senior recreational programs
senior housing staff (retirement housing, room and boards, adult foster care)

GENERAL PRINCIPLES OF ADULT PROTECTION

1. Clients and collaterals will be approached with honesty.
2. Adults have a right to self-determination and privacy.
3. Adults retain all their civil and constitutional rights unless these rights have been restricted by court action.
4. Clients needs are to be met with the least restrictive placement alternatives.
5. Whenever possible, community based services will be used rather than institutionalization.
6. The first resources for services to the client are the family unit or other informal support systems.
7. Intervention should meet specific needs of the clients shall continue with the safety of the client is assured to the extent possible.
8. Assign responsibility for actions but avoid placing blame.
9. Adult protection issues are a shared community responsibility.
10. Inadequate or inappropriate intervention is more harmful than none at all.

GUARDIANSHIP PROGRAM

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I. INTRODUCTION

A. Synopsis

The Colorado Probate code (Title 15, Article 14, CRS 1973) establishes provisions concerning guardianships for minors and incapacitated persons and the administration of the estates and affairs of minors, protected persons, and incapacitated persons. The Probate Code provides for the appointment of visitors and guardian ad litem to assure due process rights to the allegedly incapacitated adult in the legal proceedings which determine incapacity. The court also determines the scope of the guardian conservator powers and duties.

House Bill 1131, sponsored by Representative Renny Fagan and Senator Jeff Wells, amends the existing provisions of the Colorado Probate Code to incorporate provisions of the national "Uniform Guardianship and Protective Proceedings Act". HB 1131 changes the philosophy of guardianship and conservatorship appointments to seek the least restrictive powers necessary, according to the needs of the individual, rather than giving the guardian or conservator broad powers.

Two new subsections have been added to the existing Probate Code:

- 1) 15-14-303 (2.5) The visitor role is expanded to include court utilization of "the services of any public or charitable agency as an additional visitor to evaluate the condition of the allegedly incapacitated person and to make appropriate recommendations to the court".
- 2) 15-14-304 (6) The court is directed to exercise authority "so as to encourage the development of maximum self-reliance and independence of the incapacitated person" and (7) "upon appointment of a guardian...determine the frequency and scope of its review of the guardianship".

House Bill 1131 also adds a new section to Part 3 of Article 14 of Title 15, CRS, 1987. This new section (1514-315) details, at length, a process for court review of the guardian/ward relationship. House Bill 1131, if passed, will be effective as of July 1, 1988.

To assist the Fourth Judicial District Probate Court and the cooperating agencies and organizations (i.e., Social Services, Mental Health, Health) meet the mandates of the Colorado probate Code and the intent of HB 1131, a proposed project will be developed. The population to be served includes: the developmentally disabled, mentally ill and elderly adults of El Paso and Teller Counties. The proposed project will provide assistance in approximately 100 cases brought before the probate court each year.

B. The Problem

During the process of guardianship hearings, the allegedly incapacitated person can lose many basic rights to self determination, such as the right to vote, determination of place of residency, determination of care and treatment, and other rights related to personal matters. The courts are mandated to assure due process rights and representation of the "best interest" of the allegedly incapacitated individual (Probate Code - Article 14 of Title 15, CRS 1973) and to provide for the least restrictive alternative available to the individual and monitor/evaluate the guardian/ward relationship (HB 1131).

There are five (5) problem areas related to meeting the mandates of the Colorado Probate Code and the intent of HB 1131:

- 1) A network for inter-disciplinary coordination between the judicial, health, and social services systems which serve the vulnerably disabled of our community does not exist.
- 2) The probate court is currently utilizing attorneys in the role of visitor/guardian ad litem. Attorneys, due to lack of training, may not have a comprehensive understanding of the aging process and a working knowledge of how to utilize the social service system to formulate the least restrictive alternative for the allegedly incapacitated individual. There is a need for persons representing a broad base of social, health, education and cultural backgrounds to serve in the capacity of visitors/ guardian ad litem.
- 3) The law establishes priority for appointment of guardianship to relatives of the allegedly incapacitated person (15-14-311, CRS 1973. The availability of persons (relatives or other) to serve as guardians, for persons under 60 years of age and persons who reside in the outlying areas of Colorado Springs, is limited.
- 4) Currently, there is no established system to review a guardian's use of the power bestowed upon him/her by the court as a result of the guardianship proceedings.
- 5) Sufficient, accurate data is not available for use in the development of performance standards for the guardian to assure quality of care and provision of the least restrictive alternatives for the ward within the guardian/ward relationship.

C. The Proposed Solution

To address the five problem areas, as identified above, the proposed project will have the following components:

1) Planning/Coordination

Development of a network for inter-disciplinary coordination and planning efforts to better serve the vulnerably disabled of our community.

Establishment of a broad-based project advisory committee.

Evaluation and analysis of the guardianship proceedings of the Fourth Judicial District Probate Court.

2) Network Development and Training

Development of training programs for visitors/guardian ad litem and guardians.

Recruitment of volunteers to serve as visitors/ guardian ad litem and guardians.

Provision of training to:

- individuals currently functioning in the role of visitor/guardian ad litem.
- individuals currently functioning in the role of guardian.
- volunteers recruited for the positions of visitor/ guardian ad litem and guardian.
- future guardian appointees (relatives of the ward).

Implementation of support groups for visitors/ guardian ad litem and guardians.

3) Monitoring/Evaluation of Guardian/Ward Relationships

Development and implementation of a monitoring and evaluation system of guardianships in conjunction with the probate court.

4) Data Collection

Promulgation of local statistics, performance standards for guardianships and an analysis of the guardianship role.

5) Evaluation

Evaluation of the proposed project's impact on the existing system.

D. The Role of The Myron Stratton Home

The Myron Stratton Home is a private, non-profit foundation located on a 105 acre campus in Colorado Springs. Established in 1909 by the Will of Winfield Scott Stratton, the MSH opened its facilities in 1913 and has been in continuous operation since that time. In 1987, the MSH is operating its programs with 127 staff and annual budget of approximately three million dollars (\$3,000,000).

The MSH continues to provide residential, health, support and social services to approximately 90 lower income senior citizens through the Adult Center Program, as it has done since 1913. The Health Care Center is being licensed for both the Medicare and Medicaid programs.

The MSH serves as El Paso County's designated Case Management Agency under the Colorado Department of Social Services Home and Community Based Services Program. Through this program, over 350 adults are diverted from institutionalization through the development of care plans of supportive community based services which allow the clients to remain in their own homes, in most cases, or in other community based settings.

The Children's Program serves approximately 47 children, ages 5-18 in either a residential or day treatment setting. These children are frequently victims of sexual, physical or emotional abuse. Certified teachers are employed by the MSH to provide an educational component which compliments the treatment module available in the program. Funding for the Children's Program comes from the MSH, the Department of Social Services, participating school districts and the ARB fund.

The MSH has been conducting a major needs determination and community-wide assessment in its continuing effort to determine the most appropriate manner in which it can utilize its resources to best serve the community. The underlying organizational goal is to effectively

serve persons in need through cooperative agency efforts which include the support, involvement, and leadership of the MSH through its resources and staff.

The MSH will play a facilitating role in the planning and development effort of this proposed project. It will provide administrative support, financial management, administrative computer services and host meeting of the Advisory Committee and other meetings as appropriate.

II. THE PROJECT

A. Planning/Coordination

Preliminary planning efforts have begun in a cooperative manner between The Myron Stratton Home, the Fourth Judicial District Court and Probate Court, El Paso Department of Social Services, El Paso County Health Department, Pikes Peak Legal Services, Silver Key Senior Services and the State Legal Services Developer. As a result of these planning activities, an awareness of common interest and needs in the area of guardianship and meeting the requirements of the Probate Code (Article 14 of Title 15 CRS 1973 as amended) arose. It was decided that The Myron Stratton Home should serve as a catalyst in the development and implementation of a project to expand and improve upon the existing system for Probate Court appointed visitors, guardian ad litem and guardians.

An advisory committee will be established to develop effective communication, assure proper project direction, and meet the needs of the court, community agencies and individuals involved in guardianship issues. The Project Advisory Committee will build upon the current group of agencies involved in the preliminary planning as listed above. In addition, representation of professionals from the following agencies will be sought: Teller County Department of Social Services, Cheyenne Village, Nursing Homes, Pikes Peak Mental Health Center, Mid-Regional Commission for the Mentally Retarded (MRC), Association of Retarded Citizens (ARC), Assisted Living Facilities, the Urban League of the Pikes Peak Region, and the City of Colorado Springs Human Relations Committee. The President of The Myron Stratton Home will appoint 15-20 persons to the Project Advisory Committee. The committee will meet monthly throughout the project to review plans, provide input, and assess the progress of the project in meeting its goals and objectives. The committee will also serve in the role of facilitator to improve the level of coordination within the network of systems (judicial, health and social services) which serve the vulnerably disabled of our community.

A comprehensive evaluation and analysis of the guardianship proceedings of the Fourth Judicial District Probate Court is an essential first step in planning for the development of this project. This will document how the court is attempting to reach the least restrictive alternative for elderly, mentally ill, and developmentally disabled persons in the most effective and cost-efficient manner. This process will be composed of six (6) elements:

1. Identification of the individuals currently serving in the capacity of court-appointed visitors, guardians ad litem, and guardians.
2. Development of individual survey instruments for assessing the knowledge, skill level, and training needs of visitors/guardian ad litem and guardians, respectively.
3. Administration of the survey by mail and follow-up by telephone and/or personal interviews.
4. Analysis of the survey results to assist in the development of training materials to meet the needs.
5. Assessment of the system's accessibility to the public, service providers, the disabled and/or their families.

-
6. Assessment of the system's utilization of alternatives for incapacitated persons other than full guardianship and/or institutionalization.

B. Network Development and Training

This segment of the project has three components: 1) development of a volunteer network; 2) provision of training to the existing probate court system and volunteer network; and 3) organization of support groups.

The Volunteer Network will take the form of a two-pronged structure. One component will be comprised of persons trained to function as visitors or guardian ad litem within the Probate Court system. The other component will be comprised of a system of persons trained to function in the role of guardian.

Specific tasks related to the network development and training are as follows:

1. Existing Probate Court System

- a. Visitors/Guardian ad Litem

- Collection/compilation of existing training materials
- Review of surveys to assess training need requests
- Development of new training materials (if needed)
- Development of a training plan/schedule
- Provision of training to visitors/guardian ad litem
- Evaluation of training

- b. Guardians

- Collection/compilation of existing training materials
- Review of surveys to assess training need requests
- Development of new training materials (if needed)
- Development of a training plan/schedule
- Provision of training to guardians
- Evaluation of training

2. Volunteer Network

- a. Visitor/Guardian ad Litem

- Recruitment of a minimum of twelve (12) professional-level persons representing a broad base of social, health, education, and cultural backgrounds to serve in a volunteer capacity
- Collection/compilation of existing training materials
- Development of new training materials specifically in the area of local community resources-the formal and informal support service systems
- Development of a training plan/schedule

-
- Provision of training to include: lectures, group discussions, role playing, on-site visits to institutions, observation of courtroom procedures and an apprenticeship
 - Evaluation of training

b. Guardian

- Recruitment of 5-10 individuals from a diverse social and cultural spectrum (which will enhance the capacity of the system to offer the greatest degree of compatibility in the guardian/ward relationship) to serve in a volunteer capacity.
- Collection/compilation of existing training materials
- Development of new training materials
- Development of a training plan/schedule
- Provision of training to include: local community resources - the formal and informal support service systems, and the role and attendant parameters of the legal authority of a guardian
- Evaluation of training
- Evaluate the potential for development of a core of volunteers with the capability to assure emergency night/weekend protective order temporary guardian appointment

3. Support Groups

Support groups will be established for both the visitors/guardian ad litem and guardians. Each support group will be open to individuals currently performing these functions within the existing system and the volunteers recruited under this project.

The support groups will provide the following:

- Group discussions
- Problem-solving
- Case reviews
- Ongoing training
- Personal/professional growth and development
- Technical assistance with difficult decisions

A system for member input and direction regarding the support groups will be developed.

C. Monitoring/Evaluation of Guardian/Ward Relationship

Guardianship proceedings have the potential to abridge the right to self-determination for an individual in such significant areas as: care, counsel, treatment, service and supervision. The authority granted to the guardian in the guardian/ward relationship is of significant consequence to the allegedly incapacitated person. Currently there is no established system to review the guardians' use of this power. This project proposes to develop a model system of monitoring and evaluation of: 1) the status of the ward (to maintain his/her right to least restrictive setting and relationship possible); and 2) the guardian's fulfillment of the responsibilities and appropriate utilization of authority given to him/her by the court. This process will be developed as follows:

-
- 1) Develop an instrument for reassessment of the ward's status and continued need for guardianship.
 - 2) Develop an instrument for assessment of the guardian's performance related to the fulfillment of responsibilities and utilization of authority as bestowed upon him/her by the court.
 - 3) Develop, in conjunction with the probate court, a time line for frequency of monitoring evaluation and follow-up.
 - 4) Utilize the volunteer network of visitors/guardian ad litem to monitor/evaluate the guardian/ward relationship.
 - 5) Conduct assessments, compare results with court orders, and prepare a report with recommendations for the court.

D. Data Collection

There are many questions regarding the guardianship role which have not been answered because current, accurate data is lacking. Conducting research to ascertain this data from the national, state, and local level will assist this project in further clarification of the guardianship role, development of appropriate performance standards and to locally meet the mandates of the law by representing the "best interests" of allegedly incapacitated persons.

The research component of this project will, at a minimum, focus in on the following areas:

1. Local data collection:

- How long does the guardian/ward relationship exist?
- How many revocations of guardianships take place?
- Is there an increase in the number of relatives willing to become guardians with the availability of training and support?
- Is there an increase or decrease in the number of guardianship proceedings?

2. Analysis of the role of a guardian as a direct provider of services versus a manager of services.

3. Development of performance standards regarding the number of wards a guardian can effectively manage concurrently while assuring quality of care.

E. Evaluation

The entire project will be evaluated by a third party consultant and will take into account the internal feedback and evaluation mechanisms built into this project such as: project advisory committee input and review, evaluation of training components from the trainees, feedback from members of the support groups, and the probate court's assessment of the monitoring/evaluation component of this project.

The consultant will determine:

-
1. To what extent have the objectives been met?
 2. What aspects of the project were the most and least effective?
 3. What components of the project should be continued or discontinued?
 4. Are there new areas to be explored further that have not been developed as a part of this project?

III. STAFFING PLAN

The Myron Stratton Home

Director of
Business Affairs

President

Financial
Management

Project Administrator
(50% time)

Advisory
Committee

Computer
Services

Secretary
(50% time)

Data Collection
Assistant
(320 hours)

UCCS Gerontology
Students

IV. PROJECT BUDGET (12 MONTH)

DIRECT COSTS

Salaries

Project Administrator (50%)	\$
Secretary (50%)	\$7,500
21% Benefits	\$
Subtotal	

Contractual Services

Data Collection Asst. (320 hrs. X \$10/hr)	\$3,200
Evaluation Consultant	\$1,000

Travel (Project Adm.)

(200 M/Mo. X \$.20/M)	\$ 480
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Supplies (office, postage, copying & printing)	\$1,000
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Total Direct Costs

IN-KIND CONTRIBUTIONS

MSH, President	\$2,500
MSH, Dir. of Bus. Affairs	\$1,500
MSH, Computer Services	\$1,500
MSH, Telephone	\$ 200
MSH, Hosting of Meetings	\$ 600
Subtotal	\$6,300

UCCS, 7 Gerontology Students

(\$4/hr. X 2 hrs/wk X 10 wks)	\$ 560
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Staff time, court and community agencies	\$4,000
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Total In-Kind Contributions	\$10,860
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TOTAL BUDGET

**HANDBOOK FOR FREMONT COUNTY
ADULT PROTECTION TEAM
1985**

INTRODUCTION:

This Handbook has been compiled for the purpose of formalizing the goals, procedures and responsibilities of the Fremont County Adult Protection Team. This Handbook provides guidelines for team meetings.

I. PURPOSE OF TEAM:

The purpose of adult protective services is to intervene with or on behalf of a person eighteen years of age or older who demonstrates a continued inability to safely plan and care for self, or who is repeatedly abused, neglected or exploited by a relative or someone else in a care-taking role, and is without outside help, and to whom, as a result of these conditions, serious personal consequences are imminent or actual.

II. RESPONSIBILITIES OF THE TEAM:

- A. To serve as a clearing house for receipt of information concerning suspected or known incidents of adult abuse and neglect.
- B. To provide consultation and advisement to the county department of social services in the area of adult abuse and neglect.
- C. To provide assistance to the department of social services in the assessment process within the limits of the individual team member.
- D. To alert the general public to the reality and existence of adult abuse and neglect in the county.
- E. To provide support to all community agencies involved in the protection of adults.
- F. To support and seek out resources for abusive and neglecting families.

III. INDIVIDUAL MEMBERS DUTIES/RESPONSIBILITIES:

- A. Each member of the team shall be appointed by the agency he/she represents and serve at the pleasure of the appointing agency.
- B. Each agency/discipline represented shall provide an alternate to to the team.
- C. If a team member resigns, a letter advising of this decision and reasons for the resignation shall be submitted to the county director of social services.
- D. A team member may be requested to resign for any of the following reasons: (1) three unexcused consecutive absences, (2) violation of confidentiality, and (3) general incom-

petence in the area of advisement on the issues of adult abuse and neglect. The county department coordinator will keep a record of attendance and excused absences and advise members when they have missed two meetings. Any member of the team may request the resignation of a member for one of the above reasons. When a request is made for termination of a member, it will be put in the form of a motion and must be sustained by a 2/3 vote of the membership.

- E. Total membership of the team shall be no more than fifteen nor less than three.

IV. RESPONSIBILITIES OF CHAIRPERSON:

- A. To maintain structure and time schedule during meeting.
- B. To verbally sum up team recommendations following discussion.
- C. To bring policy issues to the team's attention.
- D. Chairperson is appointed by the team. Term is as long as mutually agreeable to the chairperson and the agency.

V. DUTIES/RESPONSIBILITIES OF COUNTY SOCIAL SERVICES COORDINATOR:

- A. Develop an agenda for each meeting and ensure that caseworkers are prepared to make presentations.
- B. Arrange for notifying members of meetings (as necessary).
- C. Secure a meeting room.
- D. Keep records of attendance.
- E. Responsible for admission of non-team members to meetings. Members should clear with the coordinator when they plan to bring "guests."
- F. Record team recommendations as important minutes from team members.
- G. Screen cases which are to be presented. Not every complaint call is appropriate for team review.
- H. Establish a system for tracking cases to be reviewed.

VI. TEAM DECISIONS:

Each member shall secure sanction from his/her agency to act in a decision making role while serving as a team member. There shall be a consensus reached on all cases presented as to whether the report is felt to be substantiated. Each member may be asked to validate his/her opinion so that caseworkers may have the benefit of that team member's expertise. The result

of the voting will be recorded by numbers voting, not by names of persons and how they voted. Recommendations by the Team are not mandates to social services staff but will be followed to a great extent. A decision to not abide by team recommendations will be made jointly by the caseworker and his/her direct supervisor and the rationale for this action will be reported back to the team. In voting situations, each team member will have one vote.

VII. REVIEW FUNCTIONS OF TEAM:

The team shall decide whether to close a case to further team consideration at the time of initial presentation. Team can ask that a case be reviewed at any later date. Cases will not automatically be updated.

VIII. ISSUES OF CONFIDENTIALITY:

It is extremely important that members understand the law as it relates to confidentiality in adult abuse/neglect cases.

**FREMONT COUNTY
ADULT PROTECTIVE TEAM**

CLARIFICATION OF INTENT

The purpose of adult protective services is to intervene with or on behalf of a person eighteen years of age or older who demonstrates a continued inability to safely plan and care for self, or who is repeatedly abused, neglected or exploited by a relative or someone else in a care-taking role, and is without outside help, and to whom, as a result of these conditions, serious personal consequences are imminent or actual. The terms used above are defined as follows:

- 1) Plan and Care for Self means making informed decisions or performing those functions to meet the necessities of life such as food, shelter, clothing and medical care.
- 2) Abused means the willful inflictions by a caretaker or physical harm, unreasonable confinement or restraint, improper use of medication or the failures of such caretaker to take responsible measures to prevent the inflictions of physical harm.
- 3) Neglected means actions or failures to act whereby the adult is placed in a convincing risk of immediate and serious physical harm because the caretaker is unable to secure, or has not provided those services which are necessary to maintain the physical health or the adult.
- 4) Exploited means the misappropriations or improper use of an adult's person, labor, income, belongings, or property by a caretaker for monetary or personal benefit.
- 5) Without Outside Help means without friend, relative or other private individual both willing and able to provide the kind and degree of support and supervision needed to avoid serious personal consequences.
- 6) Serious Personal Consequences include physical harm, illness, death, loss of property or funds, and inappropriate relocation against the adult's will.

Some signs which should be regarded as suspicious and grounds for referral are:

Signs of Abuse - (by self or others): Malnutrition, dehydration, burises (especially on upper arms and around wrists or ankles, from restraints), lacerations, burns, welts, evidence of excessive drugging, lack of personal care, locked up or left alone for extended periods of time.

Signs of Neglect - (by self or others): Inadequate heating, lack of food and water, unclean clothes and bedding, lack of needed medication, lack of eyeglasses, hearing aids, or false teeth. Lack of adequate financial and medical benefits.

Signs of Exploitation - Theft or misuse of an adult's pension checks, disability benefits, savings, jewelry or other resources and property for another person's gain.

Additional Signs - Caregiver threatens, insults, gives harsh orders, or shows lack of concern for the adult. Caretaker displays exaggerated overconcern, defensiveness, or denial. Adult appears fearful, depressed, confused, agitated, overly passive or quiet, lack of eye contact.

REPORT: Any incident of risk regarding an incapacitated adult living in the community or in nursing homes within the county. Also, refer any incidents in Fremont County nursing homes, involving the police, which might impact the residents.

CALL: Fremont County Department of Social Services
275-2318 - ask for Adult Protection Team Representative

PROPOSED GUIDELINES FOR CASE PRESENTATIONS.

The committee discussed a variety of cases that might fit guidelines of the team's mandate to intervene with or on behalf of persons over the age of 18 who are unable to safely plan and care for themselves or who are repeatedly abused, neglected or exploited by a relative or someone in a caretaking role.

Examples are:

1. Someone who, due to memory or other cognitive problems, is unable to safely provide for themselves the basic necessities of life, and for whom arrangements to receive those necessities have not been made.
2. Someone who is being physically abused, and who seems unable for whatever reason to get out of the abusive situation.
3. Someone who is being exploited, financially or physically.
4. Someone unable to plan and care for themselves, for whom the process of making sure the basic necessities of life are received has been started, but who is involved with several agencies so that communication and coordination are needed. This is especially desirable when such an effort has been previously unsuccessful.
5. Persons who are being exploited, but who are facilitating the process, e.g. in order to get his bills paid, an elderly person signs a power of attorney for a child and the child uses the funds for his or her own purposes. This is especially important in cases where it's likely to recur.
6. Someone needs legal intervention and help is required to access it.
7. Cases in which a guardian/conservator or family member is acting contrary to the client's best interest, e.g. a guardian/conservator who has an interest in maintaining a person's resources intact refuses to help them get health care at the level needed.

This is not an exhaustive list, and if someone wishes to present a case and is not sure of its appropriateness, it's recommended that they check with the Team's chairperson, who may wish to describe the case in general terms for the team's approval.

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San Francisco Superior Court

In Collaboration with
The San Francisco Consortium for Elder Abuse Prevention
Mount Zion Hospital and Medical Center,
Coordinating Agency

June 1986

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