

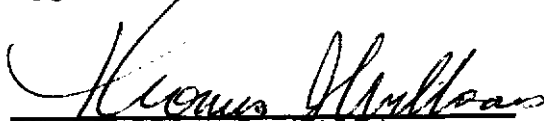
AN EVALUATION OF THE FAMILY CARE PROGRAM
IN TRAVIS CCUNTY, TEXAS

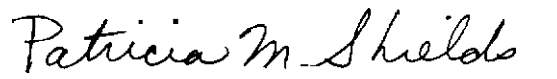
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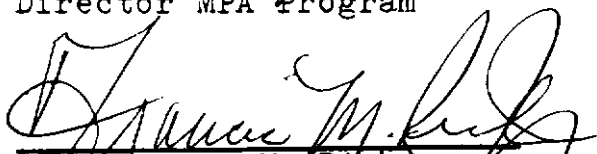
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PREFACE

I would like to take this opportunity to express my gratitude to Dr. Patricia Shields for her assistance in completing this paper. Without her guidance and encouragement, it could not have been written. Credit is also due to Dr. Thomas Williams His careful editing was instrumental in achieving the final product presented here.

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INTRODUCTION

The purpose of this paper is to evaluate the family care program in Travis County, Texas. Family care is a homemaker-type service administered by the Texas Department of Human Resources (TDHR) through its field offices. It is provided via the Community Care for the Aged, Blind and Disabled Program (CCABD). This program, as it exists today, came into being with the passage of the Social Service Amendments of 1974.

The family care program is designed to provide an alternative to institutionalization for the aged, blind, or disabled individual who is no longer able to maintain a completely independent lifestyle. By employing family care services, help can be provided for these people in their own homes. This paper will assess the family care program in terms of its impact, efficiency, and distribution of services.

The efficiency measure will reveal the cost of family care in relation to comparable and alternative types of service. The least expensive service that can meet the needs of the family care population is defined as the most efficient service.

The impact of the service can best be measured by a study of the population receiving family care. By measuring how long family care clients receive services and the basis for their separation from the program, one can ascertain the impact of the program on its participants.

BACKGROUND

The development of family care services has been based on a perceived need for an alternative to institutional care for the aged, blind, or disabled individual who is unable to maintain his/her independence unassisted. Family care is an alternative through which personal care and household chores are provided for the infirm at home. Family care and institutional care are both provided to this population by the Texas Department of Human Resources (TDHR). Thus, conflicts between interests representing institutional care (e.g., nursing home industry) and proponents of family care have developed.

In order to understand the disagreement, it is necessary to describe the funding mechanism for publicly provided nursing home care. The basis for the funding of this program is a set fee for services provided. The unit of service for nursing home care is one day.

Upon seeking payment from TGHR, an individual is assigned a level of care by the Patient Care Unit of the Texas Department of Health. This level of care is based on the applicant's physical condition and is intended to reflect the cost to the nursing home providing the necessary care. There are three levels

of care. The rates for these are:

Intermediate Care Facility (ICF) II	\$18.91/day
Intermediate Care Facility (ICF) III	\$20.82/day
Intermediate Care Facility (ICF) Skilled	4/24.55/day

After admission, for as long as a nursing home can justify continuing to provide care, and a person is willing to continue to live within the facility, TDHR is obligated to continue payment to the vendor. This method of conducting business has apparently been perceived as very profitable as evidenced by the uncontrolled, precipitous growth of the nursing home industry. However, the unregulated growth has led to a situation where an increasingly large number of nursing home beds are available to a relatively stable supply of eligible applicants. A very competitive atmosphere has developed not only among institutions, but between institutions and the family care program.

Title XIX, or Medicaid, is the federal funding source for the nursing home program. The amount of federal match money provided by Title XIX is dependent on the state's median income. Through fiscal year 1975, Texas received the maximum 9:1 federal/state match. However, due to increases in the per capita

income, this amount will be reduced to approximately a 6:4 match by fiscal year 1979. Title XIX carries an open-ended match, so that the more state funds are available, the more federal funds are generated. Thus, the only limit on the amount of funds available for Medicaid is the state's willingness to meet the match. Homemaker services are an allowable, optional program according to the federal guidelines. However, TDHR has chosen to provide this service via another funding source, Title XX.

Title XX was passed by Congress to fund social services programs. TDHR has defined family care as a social service and provides it via this funding source. Since its inception, the Title XX program has had a 3:1 matching ratio. Federal money is made available to the states on a per capita basis from a \$2.5 billion allocation. The fact that Title XIX has unlimited federal funds and Title XX is limited to a \$2.5 billion federal expenditure is of critical importance. The Texas State Constitution (Sec. 51-A) states "the maximum amount paid out of state funds to or on behalf of any needy person shall not exceed the amount that is matchable out of federal funds." Thus, by law.

the size of the family care program is limited by the ceiling on available federal funds. The nursing home program, on the other hand, has essentially unlimited growth. Because of this Constitutional limitation, Title XIX has been the more popular object of state funds. As result, at no time during the last three years were nursing home services not available to all applicants within the eligibility guidelines. During thia same period, family care was able to serve all potentially eligible clients in Travis County only 30% of the time.

Because the legislature has not provided adequate state revenue to generate the available federal Title XX funds, TDHR has sought local money. These funds are used by TDHR to generate federal funds which are used to supplement the local match to provide locally administered social service programs. The state/local ratio is 7:3 with TDHR keeping the difference in the two ratios for administrative costs.

Juxtapositioning family care and nursing home care without providing comparable funding has left the two programs with unequal abilitiea to meet the need of their clients, while proporting to provide alternative

types of care. Because of limited funding, clients who meet the eligibility criteria for family care services can not always receive them. Therefore, a disabled individual with income too high to receive welfare benefits often does not have the family care option and must enter a nursing home. The inequities in the programs often leave an individual with no choice. On the surface, he is eligible for both, however, inadequate family care funding has made that service unavailable. (This topic is more fully discussed in the chapter on Distribution of Services.)

DESCRIPTION

The passage of the Social Services Amendments of 1974 (PL 93-647), or Title XX, led to the creation of the Community Care for Aged, Blind, and Disabled Program (see Appendix 1). Through this legislation, Congress designated that \$2.5 billion be annually appropriated to fund social service programs.¹ These funds were made available to the states through a 3:1 matching program on per capita basis.

Congress passed the law as a carrot and stick measure to encourage states to develop solid social service programs which reduced individual dependence on the state and encouraged the collection of child support payments from fathers of households receiving Aid To Families with Dependent Children (AFDC). The legislation listed five goals to which services would be directed:

- (1) "achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency,
- (2) "achieving or maintaining self sufficiency, including reduction or prevention of dependency,

- (3) "preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families,
- (4) "preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care,
- (5) "securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions."

Congress required that the funds be spent to create services for "children, the aged, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts." 3 In addition, states were required to spend at least half of their social service money on current welfare recipients, including individuals receiving Supplemental Security Income (SSI). Supplemental Security Income is the federal program that replaced the states' Old Age Assistance (OAA) and Aid to the Permanently and Totally Disabled (APTD) programs.

TDHR currently seeks to provide services to residents of the state whose income is equal to or less than 60% of the state median income. This is below the federally allowable 80%, but limited funding requires that the eligibility be adjusted downward.

Texas provides services directed at the five

Title XX goals through four TDHR programs: 1) Community Care for Aged, Blind, or Disabled, 2) Protective Services for Abused and Neglected Children, 3) Family Planning, and 4) Employment Services. Services are provided either through direct delivery by TDHR staff or through contracted purchases of service.

TDHR uses contracted purchase of service agreements to provide services not available from TDHR or other agencies. Family care is provided through this device. TDHR's direct delivery staff determines eligibility, volume, characteristics and duration of the service. The staff person contracts with an individual in the community to provide the designated services. These services are designed to create a support system so that the client will not be forced to seek a premature or inappropriate institutionalization (Title XX, goal 4).

Family care services are provided by contracts with relatives, friends, neighbors, or anyone else who can establish a family-type relationship with the client. Homemaker service is a similar program provided by TDHR. The primary difference between the service provided is that "homemaker services involve a trained

homemaker, and family care services are provided by a family member or person with a family-like relationship with the adult."4 However, this distinction is not adequate when one actually examines the services. Often, in the family care program, the client has never met the provider before the implementation of the service. The actual difference between family care and homemaker services is at the administrative level rather than at the service delivery level. Thus, except for administrative differences, the distinction between the programs is artificial and so they can be looked at together.

Homemaker services are paid on a cost reimbursement basis. The amount of reimbursement is based on anticipated or actual expenditures and fixed at that rate. The services are provided by contracts with provider agencies. These agencies maintain homemaker staffs to provide services as client needs are identified either by TDHR staff or social workers within the contracted agencies.

The unit by which homemaker services are measured is one hour compared to the half hour unit of service used by the family care program. When a fraction

of a unit results, the unit is rounded to a full unit and paid at the designated rate. Hence, the family care unit is more cost effective than the whole hour home-maker unit.

Family care services are contracted on an individual basis according to the amount of service recommended by TDHR staff. The rate for each unit of service is \$1.05. The monthly contract rate is obtained by adding the number of units of service contracted by 81.05 (per unit) by 4.333 (weeks in a month).

Two criteria are used to determine eligibility for family care. First, the potential recipient's income must be equal to or less than 60% of the state's median income. Second, the implementation of family care must be perceived as preventing the premature or inappropriate institutionalization of the applicant. However, due to limited funding, eligibility for services is no guarantee they will be received. Services are provided according to four priorities:

- (1) Aged, blind or disabled adults who are recipients of SSI or Medical Assistance Only (MAO), and who are released from nursing homes or other institutions,
- (2) All persons not included in the above group who are recipients of SSI who are age 65 or older,

- (3) Other adults who are 18 to 65 years old who are recipients of SSI,
- (4) Other aged, blind, or disabled adults with income equal to or less than 60% of the state's median income. 5

NOTES—CHAPTER TWO

'This amount was chosen because **it** was the federal expenditure for social service programs as of 1972.

²United States Code; Congressional and Administrative News, 93rd Congress, Second Edition. West Publishing Co., St. Paul. Minn., Vol. 2, p. 8148.

³Ibid.

⁴comprehensive Annual Social Services Program for Texas. Texas Department of Human Resources, John H. Reagan Bldg., Austin, Texas, Vol. 1:3.

⁵Social Services Handbook. Texas Department of Human Resources, Austin, Texas, 1978, section 5141.

EVALUATION

The purpose of the evaluation is to determine how well the family care program is able to achieve the goals for which the program was created. The primary goal of the program is to allow the aged, blind and disabled to avoid a premature or inappropriate institutionalization. The relative achievement of the goal is the index of the program's effectiveness with which the family care program has achieved this goal.

By measuring the effect, one goes beyond simply measuring the input/output ratio. Of equal importance is the quality of the ~~output~~ ~~product~~. It is completely possible for a program to exist and provide a satisfactory input/output ratio, but if the product is useless or counterproductive, the program is not viable. This paper will consider the efficiency with which the program operates.

The family care program has existed for three years. Therefore, there are not pre-program data to develop a longitudinal study. Statutory limitations restrict the manipulation of recipient groups or availability of services. Therefore, the researcher must seek

to evaluate the program in terms of the efficiency with which the service is delivered, its impact on the target population, and the equity with which the service is made available, or distributed.

Admittedly, the post study design has many limitations and leaves some question as to the validity of the findings, However, in this study, the strength of the findings lends credibility to them.

The efficiency of the program can be measured in relation to equivalent and/or alternative types of services. This comparison does not give an absolute measure of the efficiency of the program, but does indicate the relative value of alternatives to the program. Because the measure is relative, the greater the difference the more significant the result. For this measurement, locally contracted agencies providing equivalent services were compared in terms of cost per unit of service to determine the efficiency of the family care program in relation to similar services. The cost of nursing home care per client was used to determine the cost of alternative services.

The impact of the program is revealed by its effect on the target population. Family care is available only to those who are judged likely to require institutionalization within thirty days if the service is not provided. Thus, the very fact that these clients are not in institutions thirty days after they begin to receive services reveals some of the success of the program. A study over time of a sample of family care clients gives further insights into the impact of the program because it reveals how many family care clients were able to forestall institutionalization until they were no longer in need of services as compared to the number **of** family care clients who were simply putting off entering an institution.

The distribution of services reveals something of the reality of the program. It indicates the goals of the program in terms of who received the services. Thus it indicates the output of the program in terms of where the service went rather than the efficiency with which it was delivered.

Thus the evaluation seeks to answer how efficiently funds were translated into services, what effect the services had, and who benefited from the services.

Because of the large number of individuals who have participated in the family care program, a sample was created for purposes of evaluation. This was accomplished by picking first every tenth and then every fifteenth client from a file of all family care clients in Travis County over the life of the program. Thus, a sample of 330 was created.

EFFICIENCY

Efficiency is the measure of how well the program is able to deliver services in a cost effective manner. The target population for family care is the aged, blind, or disabled who face the spectre of premature or inappropriate institutionalization. TDHR has provided funds that are translated into staff salaries and payments to purchase units of family care services. Efficiency is the measure of the cost of providing family care relative to the cost of providing comparable services.

The level of funds designated for family care is shown in chart 1. By dividing the funds budgeted to purchase units of family care by the funds provided for staff salaries, the administrative overhead can be measured as:¹

Fiscal Year 1378:	19%
Fiscal Year 1977:	15%
Fiscal Year 1976:	19%

As one might expect, the administrative cost began to decline after the first year of the program. However, due to increases in staff salaries and travel expenses, the administrative costs of the third year have risen to match those of the first.

The cost for each unit of service can be calculated by adding the cost of administrative overhead to the contract unit rate. Thus, the cost per unit of service delivered is:²

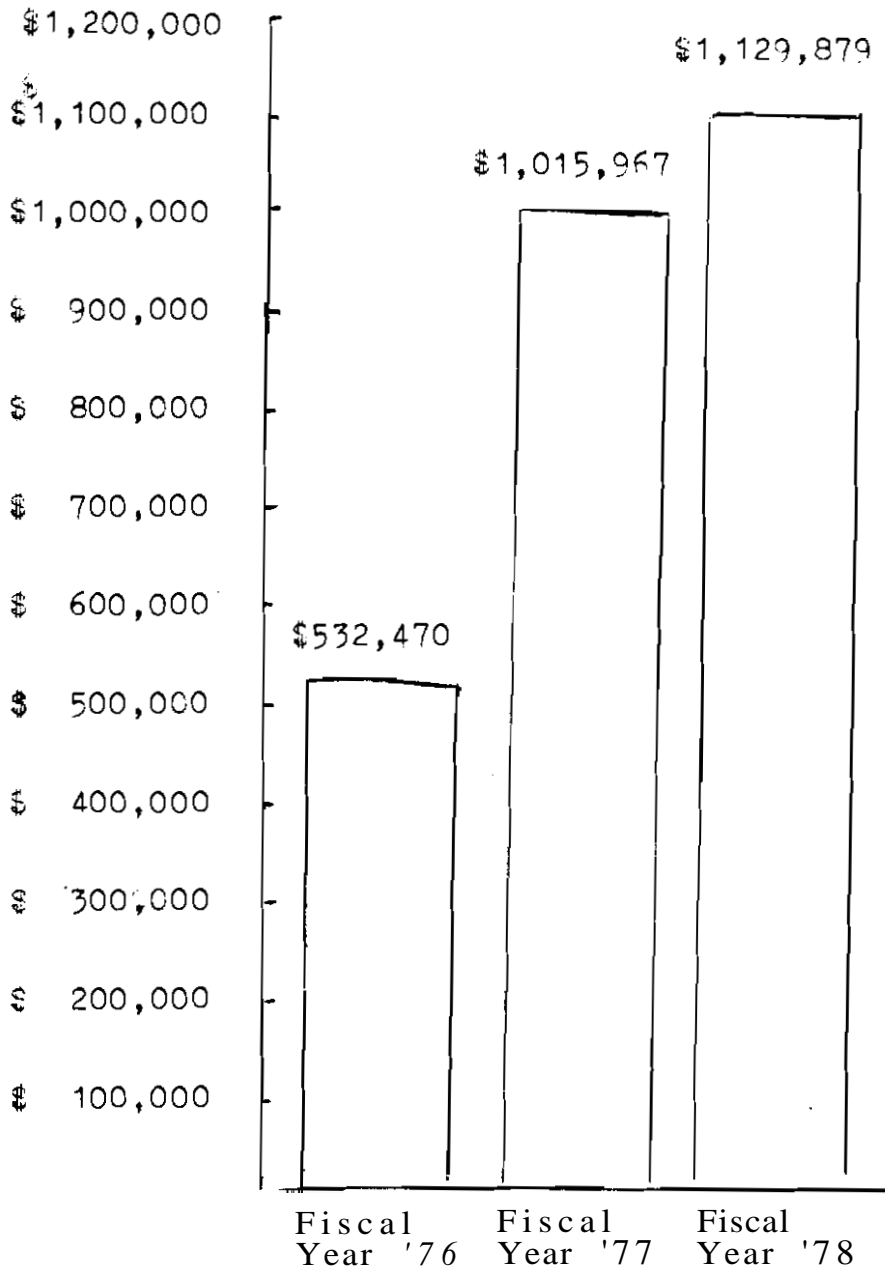
Fiscal Year 1978:	82.50	per hour
Fiscal Year 1977:	\$2.30	per hour
Fiscal Year 1976:	\$2.38	per hour

The actual cost per unit of service delivered in fiscal year 1978 is greater than that of the preceding two years. Half the increase in cost, however, is due to an increase in the contracted unit rate. Thus, most of the increase was due to a policy change (the contracted unit rate) rather than a change in the service delivery system. Even so, the increase from 1977 to 1978 is only 8%. From 1976 to 1977 the cost per unit of service actually decreased 3%. Thus, the total increase in cost per unit of family care over the program's life is only 5%.

Chart 2 details both the number of units of family care service provided and the number of clients served in Travis County. The number of units per client per month can be calculated by dividing the number of clients into the number of units of service. These averages are:³

CHART 1

FUNDS EXPENDED FOR FAMILY C A R E



Fiscal Year 1978:	65.96 hours per client per month
Fiscal Year 1977:	68.53 hours per client per month
Fiscal Year 1976:	70.97 hours per client per month

Thus, the number of units the average client required on a monthly basis over the program's life has shown a steady decline.

The average cost per client is:

Fiscal Year 1978:	\$165.90
Fiscal Year 1977:	8157.50
Fiscal Year 1976:	\$168.90

These figures represent the cost to TDHR to maintain an individual in his/her home on a monthly basis. Fere these individuals required to seek institutionalization, they would face monthly vendor rates of:

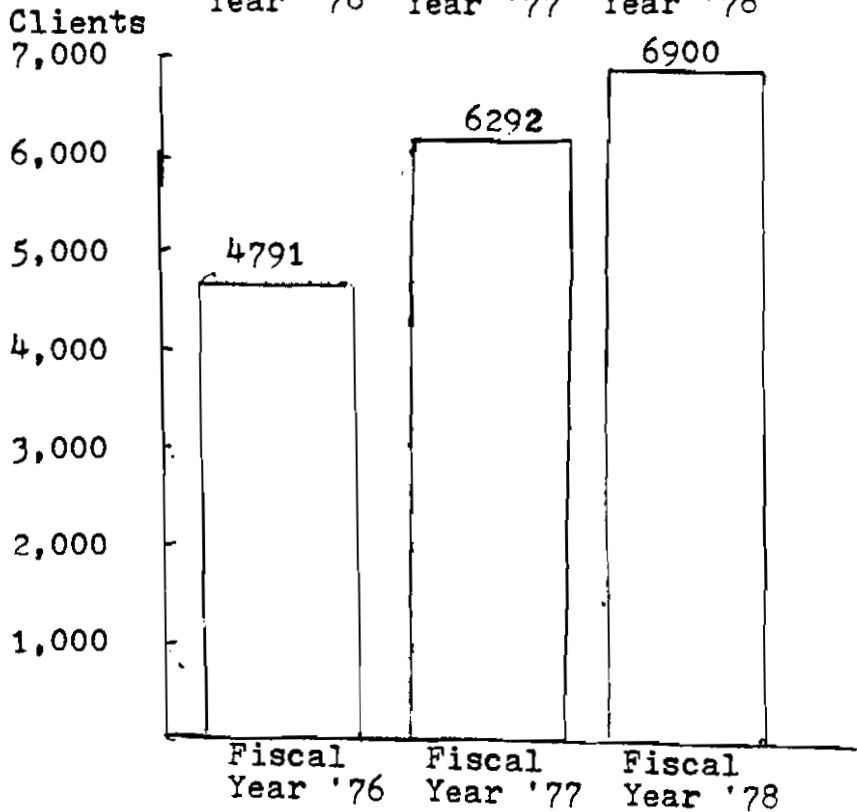
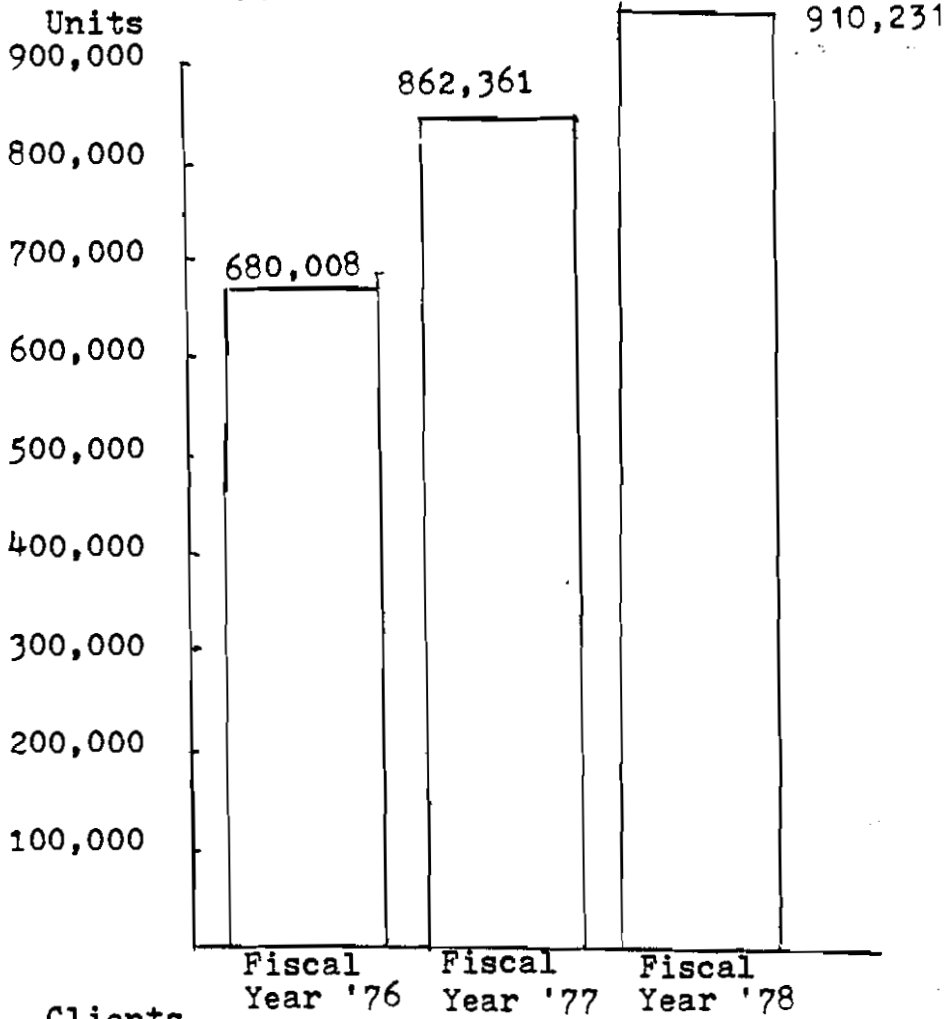
Intermediate Care Facility (ICF) II:	\$567
Intermediate Care Facility (ICF) III:	9624
Intermediate Care Facility (ICF) Skilled:	\$736

A survey of 200 randomly selected Travis County nursing home residents revealed that 12% require ICF II care, 51% require ICF III care, and 27% require ICF Skilled care.

This is particularly relevant when one considers that a survey conducted by TDHR indicated that most recipients of family care have a level of functioning comparable to many nursing home residents (see Appendix 2).

CHART 2

NUMBER OF UNITS OF FAMILY CARE AND CLIENTS^a



afrom PDHR monthly reports

TDHR currently has contracts with two agencies in Travis County to provide homemaker services. These agencies are Services to the Elderly and Austin Housing Authority. The rates for units of service provided through these contracts are \$7.24 and \$7.35, respectively.

In order to minimize costs, the services of the contract agencies are not normally used except when a client requires a half day of service or less per week. Were these agencies to provide services to family care clients at the current level of service, the costs would be:

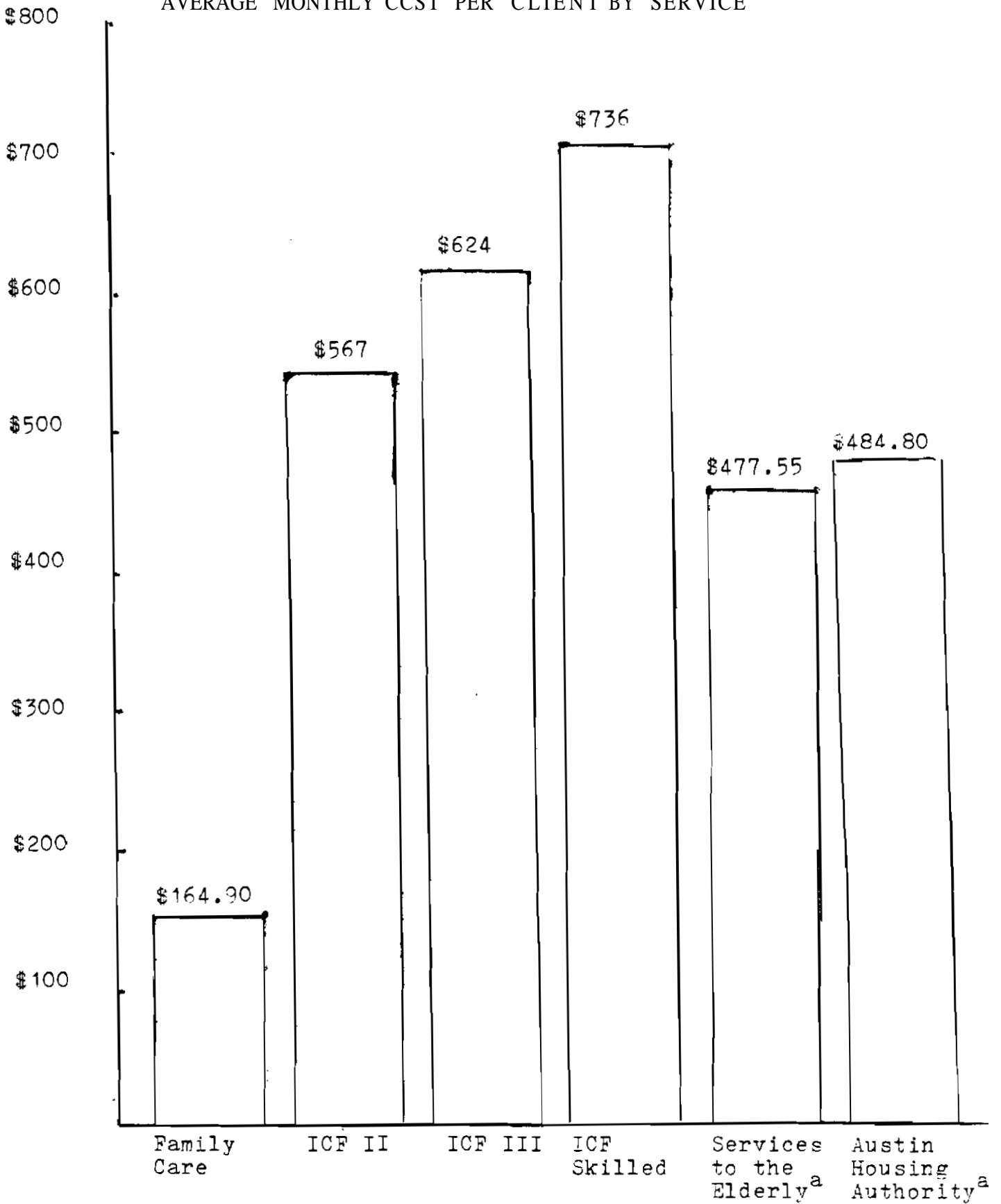
Services to the Elderly:	\$477.55 per month
Austin Housing Authority:	9484.80 per month

Thus, although the cost for these contract agencies is almost triple the cost of family care, the contract agencies, compared to nursing homes are still an efficient type of service. Chart 3 graphs the monthly cost of each service.

Obviously, in-home care is more cost effective than institutional care, and family care is the most efficient in-home service.

CHART 3

AVERAGE MONTHLY CCST PER CLIENT BY SERVICE



^a provided at a volume equal to family care

NOTES—CHAPTER FOUR

1The administrative overhead of the family care program can be calculated:

	Administrative ⁶ Costs	+	Total Program ⁶ Costs	=	Administrative Overhead
Fiscal Year 1978:	\$219,648		/\$1,129,879		= 19%
Fiscal Year 1977:	\$153,606		/\$1,015,967		= 15%
Fiscal Year 1976:	\$102,192		/\$ 532,470		= 19%

2The cost per unit of family care provided can be calculated:

	Cost per Unit	+	Cost per Unit	x	Administrative Overhead	=	Cost per Unit of Family Care
Fiscal Year 1978:	\$1.05		+	(\$1.05	x 19%)		= \$1.25
Fiscal Year 1977:	\$1.00		+	(\$1.00	x 15%)		= \$1.15
Fiscal Year 1976:	\$1.00		+	(\$1.00	x 19%)		= \$1.19

3The average number of units of service provided each client per month can be calculated:

	Total of Units ⁶ per month	÷	Total of Clients ⁶ per month	=	Average Number of Units per Client per month
Fiscal Year 1978:	910,231		/6900		= 131.92
Fiscal Year 1977:	862,361		/6292		= 137.05
Fiscal Year 1976:	680,008		/4791		= 141.94

4The average cost per client per month can be calculated:

	The Average Number of ⁶ Units per Client per month	x	The Cost per Unit	=	The Average Cost per Client
Fiscal Year 1978:	131.92	x	\$1.25		= \$164.90
Fiscal Year 1977:	137.05	x	\$1.15		= \$157.50
Fiscal Year 1976:	141.94	x	\$1.19		= \$168.90

5The monthly cost per client if served by contract agencies rather than family care can be calculated:

	Average Number of Units of Family Care per Client per month	×	Cost per Unit of Contract Agency	=	Monthly Cost to serve Family Care Clients by Contract Agencies
--	--	---	--	---	--

Services to the Elderly: $(131.92 + 2) \times \$7.24 = \477.55
Austin Housing Authority: $(131.92 + 2) \times \$7.35 = 3484.80$

6from DHR monthly reports; Travis County.

*One must divide the family care units (half hour)
by two to convert them to homemaker units (one hour)

IMPACT

The impact of family care is defined as the behavioral changes that result from its implementation. Family care is unique among many governmental programs because of the measure of its success. Other programs, such as training or rehabilitation, can measure their success in terms of the amount of time services were required, and the number of "successful closures"(i.e., the number of service recipients who were able to re-enter the community and become gainfully employed). However, family care deals with the reality that individuals die or may become more ill and require institutional care. Thus, the primary benefit of the program is in providing services so that individuals may remain free from institutionalization as long as is feasible. By creating circumstances that allow the individual to maintain his/her independence, one can expect to see an enhancement of the individual's ability to provide care for his/her self which reflects a motivation to maximize independence.

A survey was conducted by TDHR to measure the

ability of family care clients and nursing home residents to carry on the activities of daily living (see Appendix 2). This survey revealed that although those individuals receiving family care had disabilities comparable to those residing in nursing homes, they were able to maintain themselves with the significantly less intensive level of services that family care provides. Thus, family care provides for an environment in which the client can stay at home and is able to take better care of his/her own needs.

The demand for family care reveals how favorably or unfavorably potential clients view the program. Over the program's life, not for one fiscal year has the appropriation, translated into units of service, been adequate to meet the client demand. (This is more fully discussed in the chapter on Distribution of Services.)

Beyond the beneficial impact to the service recipient, a monetary benefit is accrued to society. This can be measured as:

$$\text{The number of months of family care received} \times \left(\begin{array}{l} \text{Cost of Nursing} \\ \text{Home Care per} \\ \text{month} \end{array} - \begin{array}{l} \text{Cost of Fam-} \\ \text{ily Care per} \\ \text{month} \end{array} \right) = \begin{array}{l} \text{Benefit to} \\ \text{Society of} \\ \text{Family Care} \end{array}$$

Because the program has existed for almost three years at the time of assessment, no data were available to study the population prior to implementation of the program. Ethical considerations precluded developing a control group from which family care could be withheld. Therefore, a random sample from the population of all clients who currently or in the past have received family care was chosen to evaluate the level of benefits. A random sample of 330 clients was drawn from the total population of all individuals who have received family care in Travis County.

Impact of family care can be measured through the analysis of subpopulations within this sample. These subpopulations are defined according to whether they are current or former recipients of family care. The category of former recipients is subdivided according to the status at closure. This classification can be divided into four categories:

- (1) client's physical condition has worsened so that family care no longer was appropriate and institutional care was sought,
- (2) client's physical condition improved so that family care was no longer needed,
- (5) client died, and

(4) client moved out of Travis County and services were denied.

Those clients in category four are considered lost from the sample (see Table 1).

The sample reveals that 64% of all clients who have ever received family care, do so today. Only 36% of the sample are not currently receiving services. Of those not currently family care clients, the majority, 20% of the total sample, received services until death or institutionalization.

In order to understand the dynamics of the sample, one must break down the categories according to the number of months family care was provided (see Table 2).

Those clients currently receiving family care are concentrated in the population receiving services twelve months or less. This indicates a preponderance of short-term care that is consistent with the concentration of clients no longer participating in the program in this same category. On the average, these clients have been receiving services 15.4 months (see chart 4).

Twelve percent of family care clients are able to recover from their illness or disability and resume their former level of independence. Of this group,

TABLE 1

DISTRIBUTION OF SAMPLE CASES

	Number of Cases (N)	Percentage of Total
Currently receiving services	210	64
Closed Cases	120	36
Entered Nursing Home	35	29
Improved	40	33
Died	34	28
Moved	11	9

N=330

TABLE 2

DISTRIBUTION OF SAMPLE OVER TIME

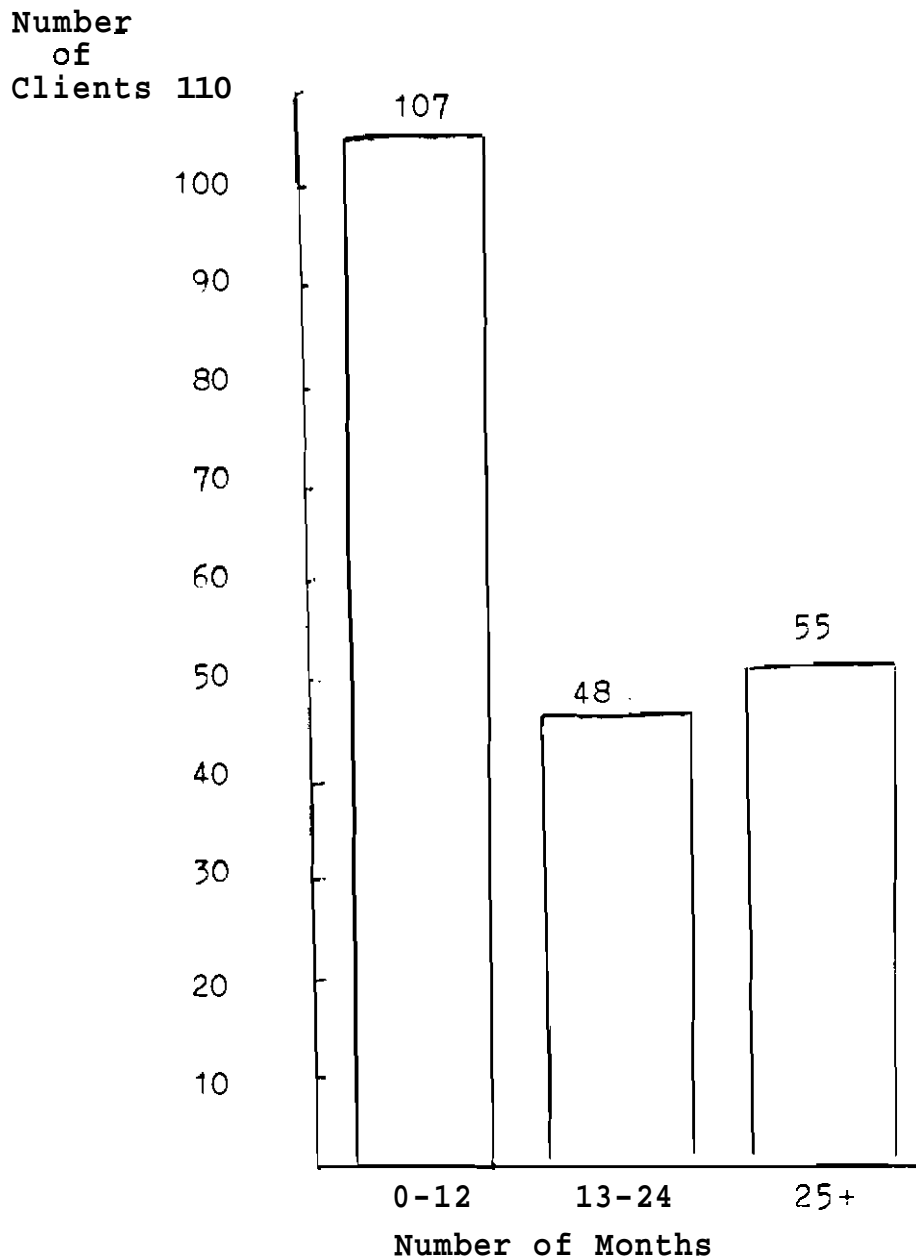
BY CATEGORY

Length of Service (Months)	Current Recipients	Former Recipients				TOTALS
		Nursing Home	Improved	Died	Moved	
0-3	54	5	17	4	1	81
4-6	24	10	6	6	1	47
7-12	29	3	10	8	5	55
13-24	48	9	6	5	2	70
25+	55	8	1	11	2	77
TOTALS	210	40	35	34	11	330

N=330

CHART 4

DISTRIBUTION OF FAMILY CARE RECIPIENTS OVER
TIME^a



^aCurrent Recipients in Sample
N=210

82% were able to recover within the first year of services and 56% recovered within the first six months. The first six months is a critical period. It should be reiterated, that individuals who are served by either the nursing home or family care programs are low income individuals. After six months a nursing home client is required to forego life savings, including their home, as a partial payment of the nursing home bill (see Appendix 3). Due to this financial burden, after six months it becomes increasingly difficult to return to the community. This can result in psychological trauma that can be expressed in numerous somatic complaints and add to the amount of nursing home care required. Many individuals, having lost their life's savings, never return to the community and remain permanently dependent on the institution. These people may be dependent on nursing home care long past their spell of illness. Furthermore, the facilities have an incentive to nurture this kind of dependence. These institutions maximize and guarantee their potential income when they have a large, stable client population.

Of those family care clients ultimately requiring nursing home care, the average family care client was able to forestall institutionalization by 14.6 months. Of this group, 57% were able to avoid institutionalization of twelve months or more, and 86% were able to avoid institutionalization and maintain their independence at least six months. Thus, for those who eventually require nursing home care, family care provides a significant alternative.

Seventy-one percent of clients who died while receiving family care were able to remain in their home a year or more. The average length of time family care was provided to clients in this group is 12.4 months. Thus, family care makes a significant contribution to the ability of this group to maintain its independence.

One can observe that the family care program has a significant impact on the chronically ill or disabled individual. Although no definitive figures are available because the program is still in operation, the trend is clear. For many of all family care clients the service provides an alternative to nursing home care throughout the duration of their need. For the average client, it is an alternative for fifteen months.

DISTRIBUTION OF SERVICES

How well are services distributed according to need? Title XX prescribed that services were to be provided to a number of identifiable groups. The target population was further defined by the requirement that at least half the funds be expended on current welfare recipients. For purposes of the family care program, TDHR has defined welfare recipients as those individuals who receive SSI payments.

As mentioned earlier, TDHR provides services on the basis of four priorities. Three of the four priorities specify that recipients must be aged, blind, or disabled. Priority three, on the other hand, only requires that recipients be eighteen to sixty-five years of age and current SSI recipients. The only way that an individual in this age group can receive SSI benefits is through a disability. Thus, all four priorities require that clients be aged, blind, or disabled, either specifically or by implication. This is consistent with the Title XX requirement that services be directed at individuals who are aged, blind, or disabled, as the other category, children, are served by other programs. Thus, the

family care program distributes services consistent with Title XX requirements.

Chart 4 reveals the times family care has been available, by priority. Over the past three years, services have been available to SSI recipients (priorities 1, 2, and 3) in all but ten weeks. On the other hand, family care has been available to those who do not receive SSI only forty-six weeks, or 29% of the program's life. Family care has never been available to the blind or disabled adult under age sixty-five who does not receive SSI.

At the same time that the family care has only been able to provide a very limited service, its alternative, nursing home care, has not only been available to all four priorities, but to other adults who are beyond the range of the family care program. This has created a situation in which 78% of all family care recipients are also SSI recipients.¹ However, only 27% of institutional care clients are SSI recipients.² Thus for the client group for whom a choice between family care and institutional care was available, family care was more frequently chosen.

No data (i.e., waiting lists) are available to provide any information about those who cannot obtain family care, yet do not seek institutional care.

Thus, it appears that family care has been provided on a definition of financial status rather than need. The emphasis on SSI recipients is in accordance with the spirit of Title XX, but has clearly had a deliterious effect on other applicants. However, the frequent restriction of services to higher levels of priority is more a function of the funding of the program than an administratively determined goal.

Nonetheless, whatever the basis, the effect of this distribution has been to allow SSI recipients to avoid premature or inappropriate institutionalization while other applicants all too often have had few or no alternatives.

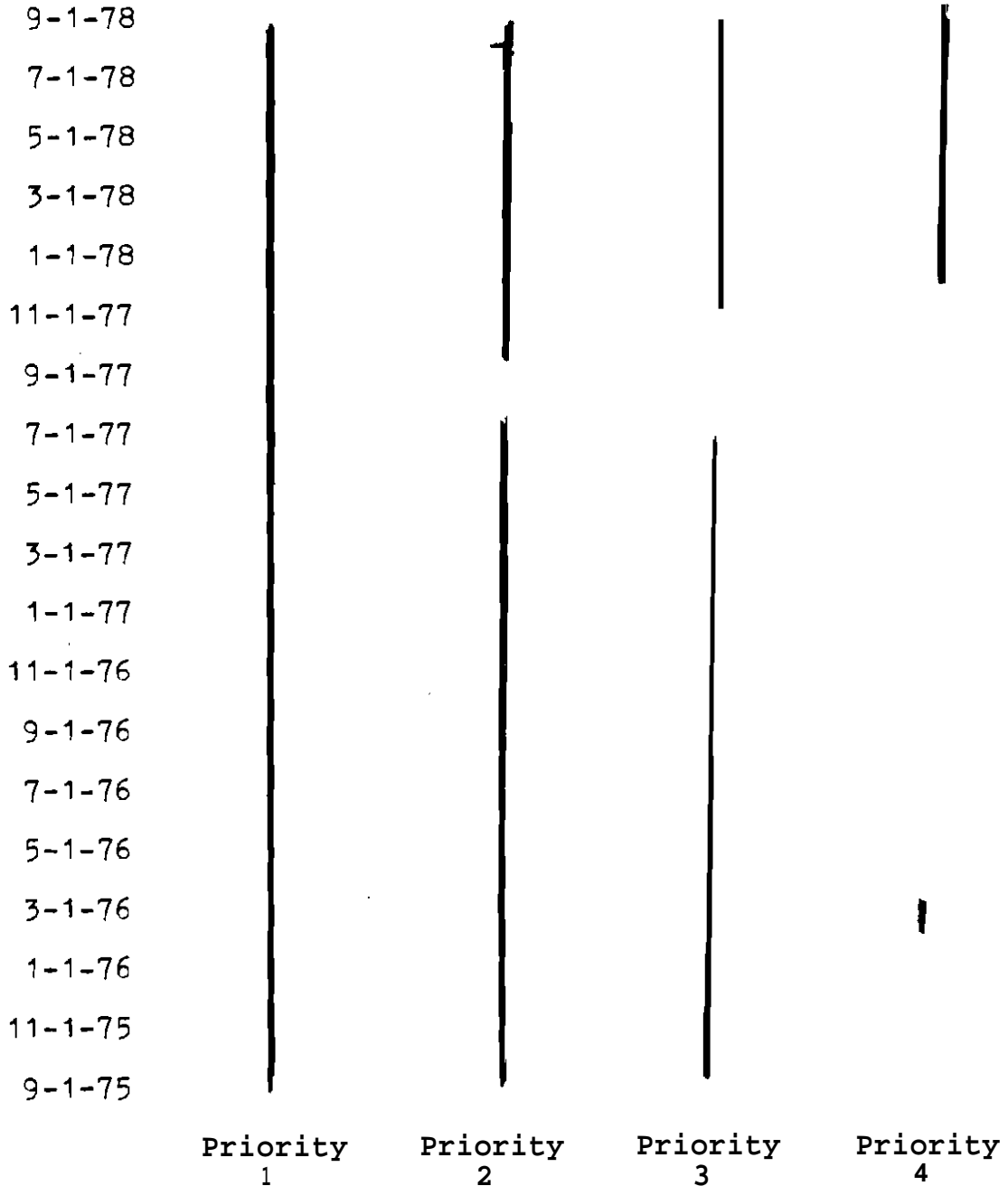
NOTES--CHAPTER 5

¹Based on a May, 1978 survey of all family care recipients in Travis County.

²Based on a random sample of 200 Travis County nursing home residents.

CHART 5

AVAILABILITY OF SERVICES BY PRIORITY



Indicates Services Available

CONCLUSIONS

Family care appears very efficient in relation to comparable and alternative types of care. The monthly cost per client is considerably less than that of contract agencies or institutional care.

The service has provided an effective alternative to those facing premature or inappropriate institutionalization. Over its history of three years, the program has provided 1,101,475 hours of service to 17,987 clients. It has been an option to institutionalized care to an average of five hundred residents of Travis County per month.

The program has met the needs of the SSI population very well. For only ten weeks of the last three years has family care not been available to all members of this population.

Serious inefficiencies, however, in the overall treatment system are apparent. The basis of the problem is rooted in attempting to develop alternative, comparable programs without developing consistent goals, philosophies, or levels of funding. The goal of family care is to enhance the individual's ability to function

in the community. The goal of the nursing home program, on the other hand, is to provide institutional care. Thus, although the two programs are designed to interact with one another, they are striving to achieve opposite ends. The problems inherent in this arrangement become more apparent as one examines the programs more closely. There is a significant philosophical inconsistency in seeking to provide an alternative to a medical program (nursing home care: Title XIX), with a social program (family care: Title XX). This inequity is enhanced because the programs have such different funding sources. Clients are not able to choose between the programs based on their merit or suitability, but rather according to series of regulations. The effect of this dual approach is evident when one considers the comparability of family care and nursing home clients (see Appendix 2). A mechanism that explores the two alternatives and chooses the most efficient and effective does not exist.

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APPENCIX ONE

Prior to the year 1967, services delivered to the nation's poor were provided via a single delivery system. In 1367, services were divided into financial services, which were to establish eligibility for and monitor financial assistance, and social services. With the split came different matching ratios. Financial services received a 1:1 match and social services received a 3:1 match.

In 1967 and 1970 the federal government took actions that liberalized eligibility requirements for social services and broadened the regulations controlling the services that could be provided. In this action, states were given an open-ended appropriation for social services.

By 1970 and 1971, states were looking for ways to take advantage of the liberal federal regulations controlling funds for social services. In many states, education agencies were the primary benefactors. Spring of 1972 found the Texas Department of Public Vielfare, now the Department of Human Resources, filing social service reimbursement claims for \$190 million.

By this time, Congress felt that the expenditures were getting out of control. Federal aid for social services had grown from \$1.7 billion in 1972 to projected outlays of 94.7 billion in 1974. This prompted the addition of a rider to the 1472 General Revenue Act that put a \$2.5 billion limit on the amount of federal money available for social services.

On December 19, 1974, members of the House Ways and Means Committee and the Senate Finance Committee filed their report that cleared the way for the passage of Title XX. This legislation came about through compromises among members of Congress, the Administration, state governments, and forty other local groups over a period of two years.

On December 20, 1974, Public Law 93-647, known as the Social Service Amendments of 1974, or Title XX, was passed in a joint session of Congress by a voice vote.

President Ford signed the bill on January 4, 1975. The regulations took effect July, 1, 1975.¹

NOTES--APPENDIX ONE

¹United States Code; Congressional and Administrative
News, 93rd Congress, Second Session. West Publishing
Company, St. Paul, Minn., Vol. 4, pp. 8133-8160.

APPENDIX TWO

In January 1976, TDHReexamined a random sample of 2,198 recipients of in-home, or family care. As part of this study, the clients were compared with ICF II and ICF III nursing home residents.

This comparison was based on data regarding nursing home residents as provided by a computer print-out entitled: Treatment and Function Norms for Nursing Home Residents - July to December, 1974. The data for in-home care clients were gathered by a survey of the sample. Percentage distribution of clients were developed for each level of functioning.

The study indicated that because most nursing home residents are found in more than one diagnosis or care area, it is likely that they are counted in more than one category. This results in an overstatement of the disability of the nursing home residents.

As part of the study, nursing staff from the Medical Division reviewed a sample of the survey forms to assess the possibility of family care clients receiving nursing home care. The evaluators determined that 62%

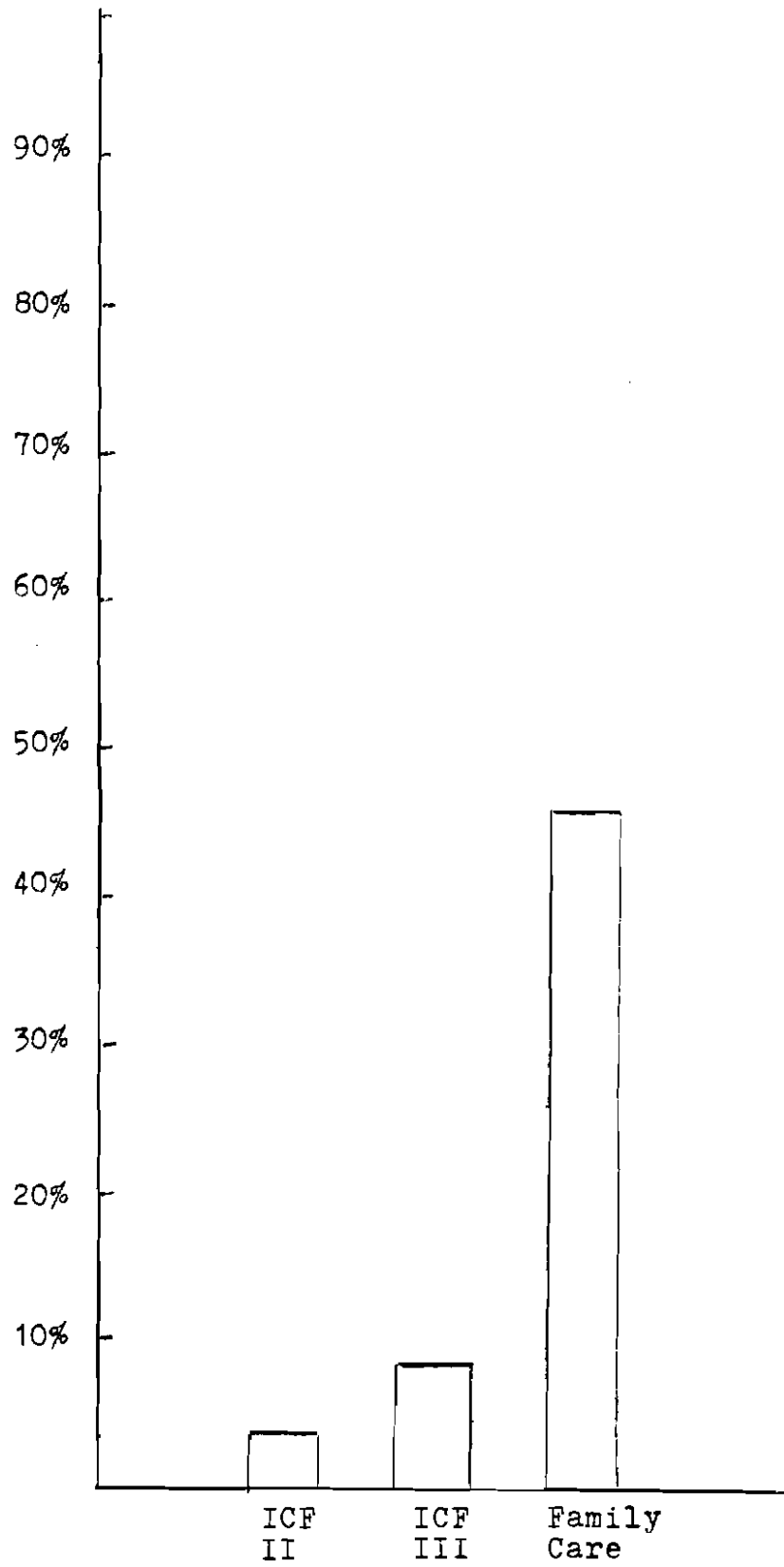
of the family care clients would be eligible for nursing home care. An additional 6% could not be assessed without further information that was not available.

The researchers found that as of January 1976, an additional cost of \$57.3 million would be incurred if those in-home care recipients who were eligible for nursing home care were required to exercise that option. Since that time the family care caseload has grown by 44% in Travis County and the nursing home vendor rate has increased by approximately 58%.

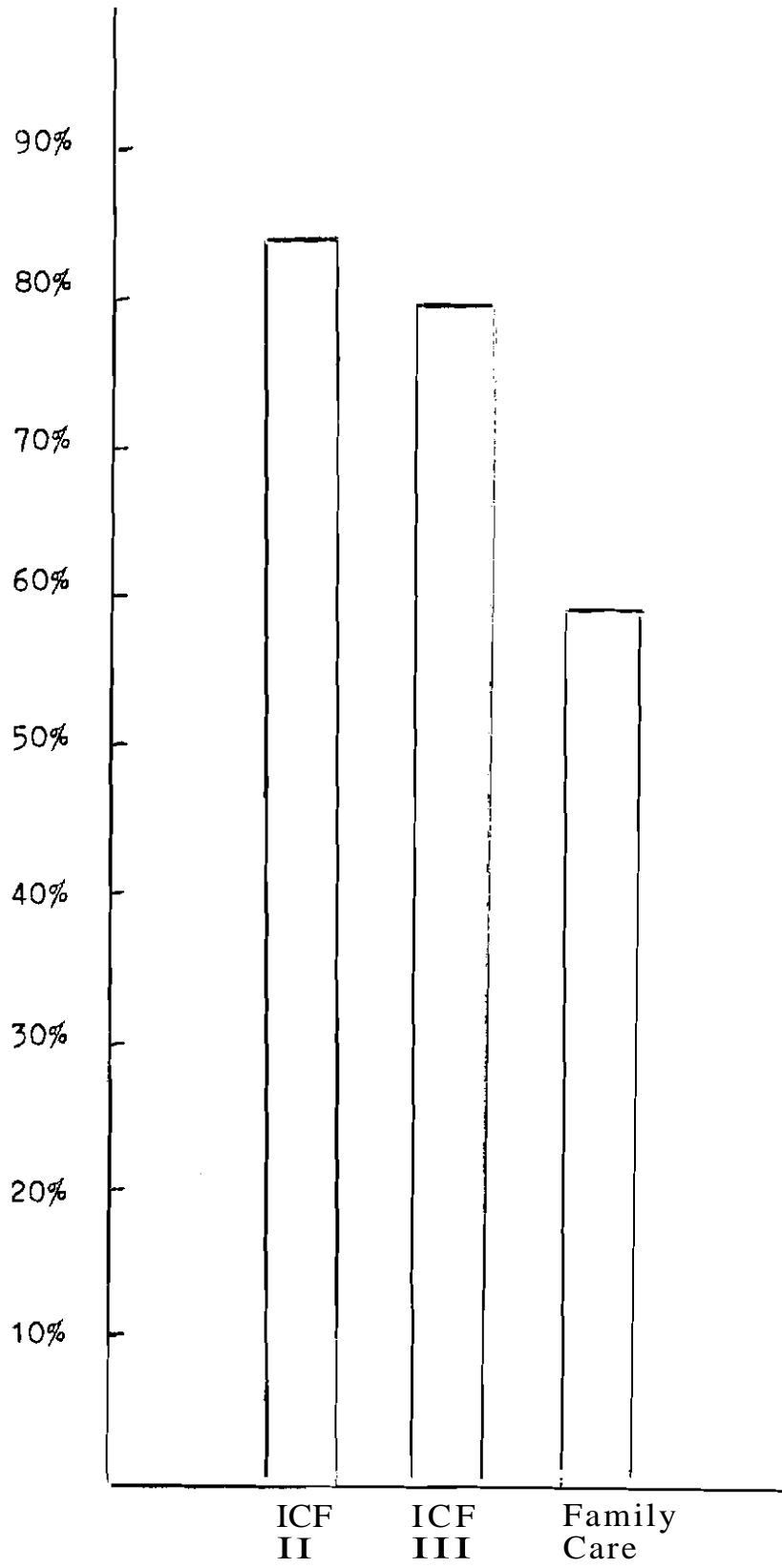
The survey found that there is little direct relationship between the client's condition and the choice between in-home and institutional care. The type of service chosen is more often a matter of availability than appropriateness.

The following pages detail the comparison this study made between family care and nursing home care clients.

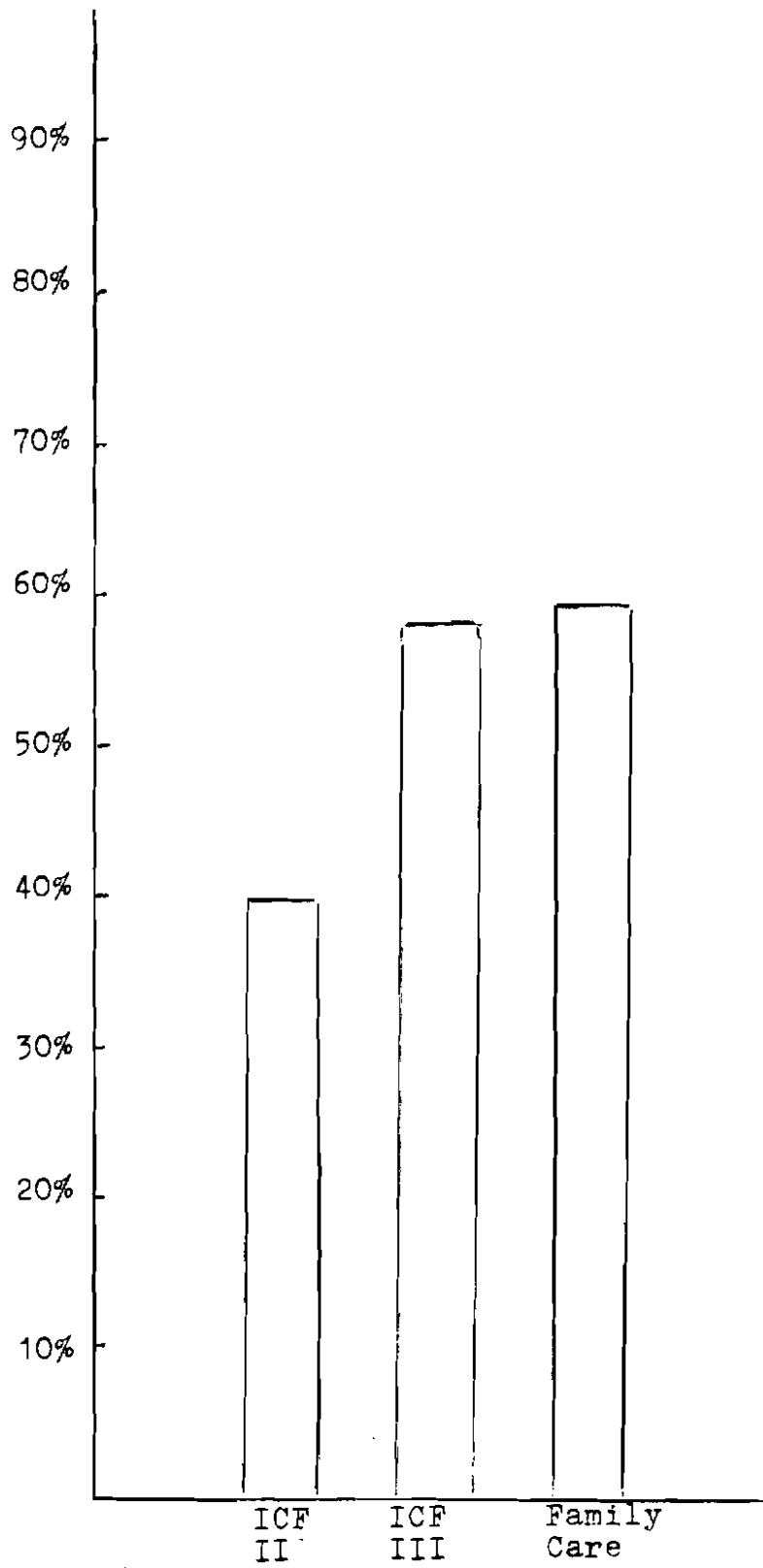
Requires Mobility Equipment



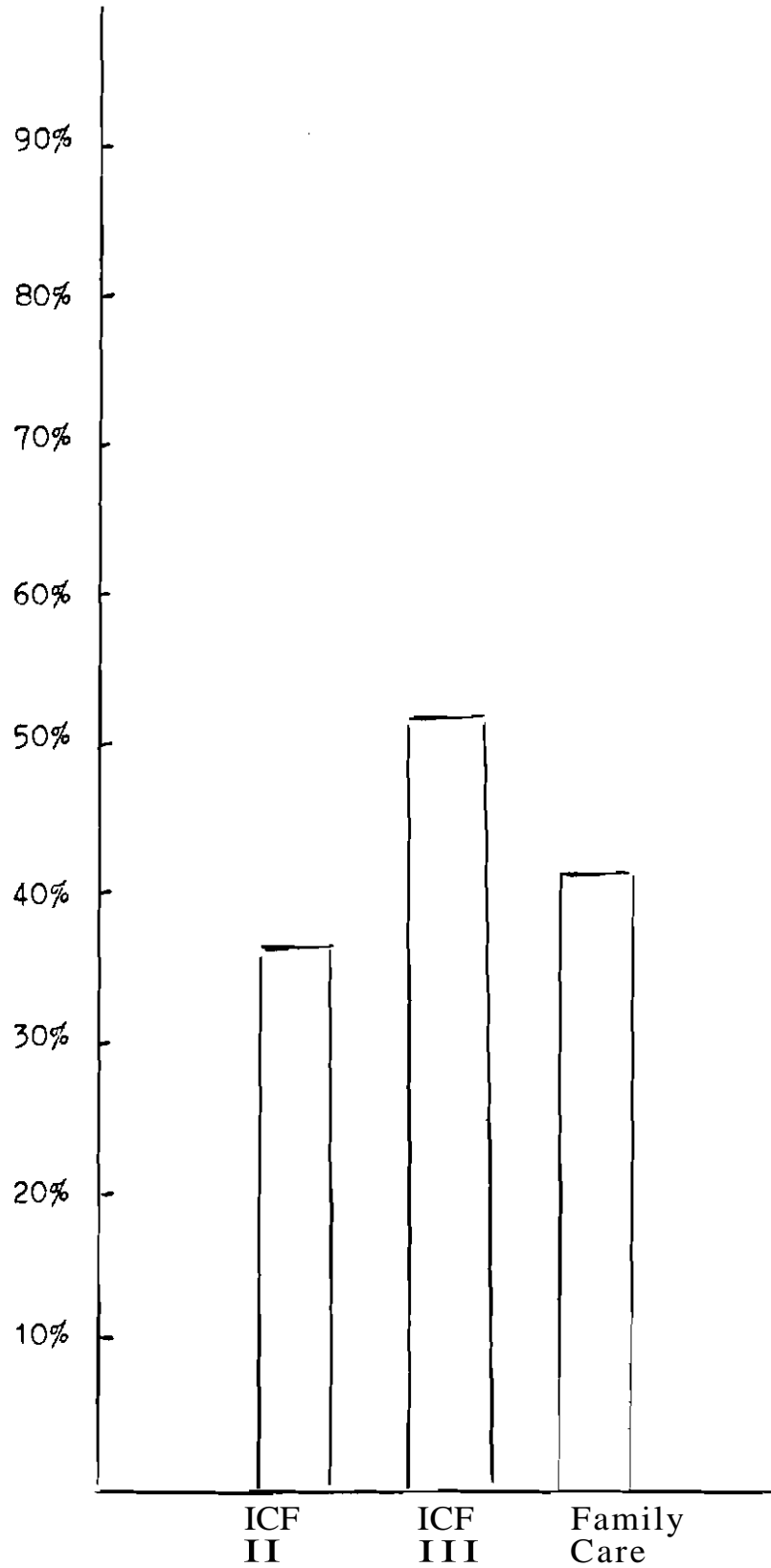
Requires Assistance in Bathing



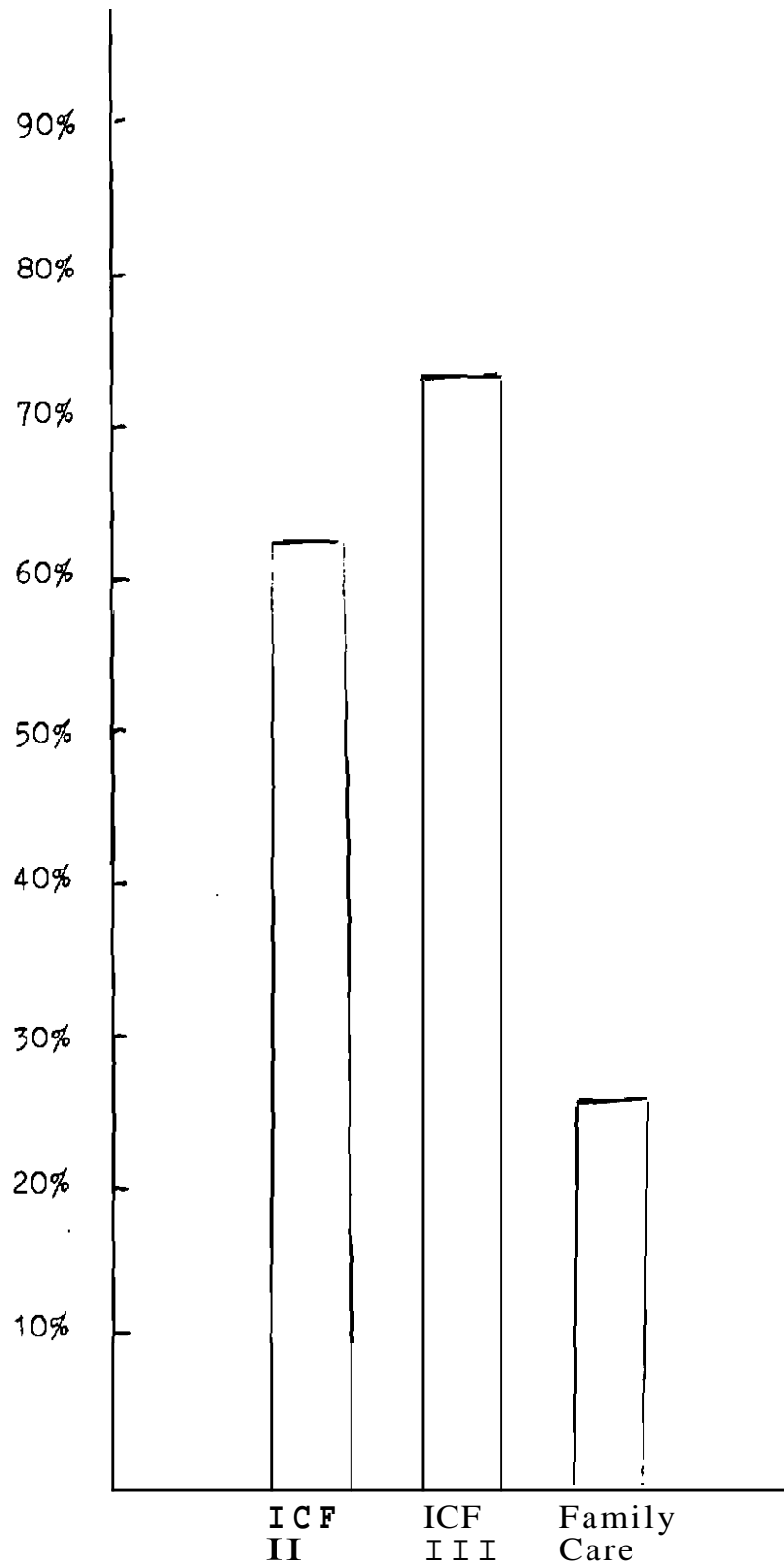
Impaired Vision or Blind



Impaired Hearing or Deaf



Mentally Confused and/or Disoriented



APPENDIX THREE

The requirements for participation in the nursing home vendor program are very thorough and complicated. However, it is appropriate to mention several salient, relevant requirements.

The program requires that prior to becoming eligible for participation, applicants must divest themselves of all assets in excess of \$1500. Additionally, were these individuals dependent on the SSI program, as 78% of the participants in the family care program are, they would find their income reduced as SSI benefits are terminated upon admission to a nursing home. It takes a minimum of sixty days to resume receiving benefits after discharge from a facility, hence a severe financial strain can result. Nursing home residents can scarcely hope to save enough money to finance their discharge as they are required to apply all their income, save \$25, toward the cost of their nursing home care. After six months residence in a nursing home, all participants in the vendor program are required to either sell or rent their homes. Should the home be

sold and the proceeds provide 51500 or more to its former owner, the client must pay the full vendor rate, until the resource is reduced to the allowable \$1500.

Thus admission to a nursing home can effectively deny an individual his/her income, savings and even home.