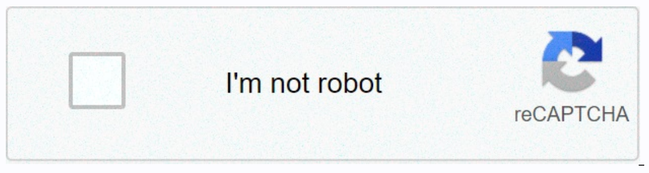

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What is formal and informal communication channels

U.S. Department of Health and Human Services John B. Kristianson Mathematics Policy Research, Inc. May 1986 The report was prepared under a #HHS-100-80-0157 contract between the U.S. Department of Health and Human Services (HHS), the Office of Social Services Policy (currently the Office of Disability, Aging and Long-Term Care Policy) and Mathematical Policy Research, Inc. For more information about the study, you may visit DALTCP Home at or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Street, Southwest, Washington, DC 20201. The email address is: Web Manager. DALTCP@hhs.gov was DALTCP project officer Robert Clarke. In September 1980, national long-term care demonstrations - known as canaling - were initiated by three units of the U.S. Department of Health and Human Services. It was to be a tough test of comprehensive case management of community care as a way to rein in the rapidly rising costs of long-term care for the elderly while providing adequate care to those in need. A. The intervention channel was designed to use comprehensive case management to allocate appropriate community services to the poor elderly in need of long-term care. The particular goal was for older people to stay in their homes whenever appropriate, rather than entering nursing homes. It had no direct control over the costs of caring for a medical home or the elderly. It finances direct community services, to a lesser or greater degree according to the channeling model, but always as part of a comprehensive plan for care in the community. Canaling was implemented to work through local canaling projects. The core of the intervention consisted of seven features: development to identify and attract potential customers who had been standardized at high risk of entering a long-term eligibility screening care institution to determine whether an applicant met the following pre-established criteria: a) Age: must be 65 years or older. b) Functional disability: it should have two moderate disabilities in daily living activities (ADL), or three severe impairments in the ability to perform instrumental daily living activities (IADL), or two severe IADL disorders and one severe ADL disability. Cognitive or behavioral problems affecting the ability to perform ADL can be considered as one of the severe IADL disorders. c) Unmet needs: Must meet the unmet requirement (expected to last at least six months) for two or more services or an informal support system at risk of collapse. d) Residency: Must live in the community or (if institutionalized) the certificate is likely to be discharged within three months. Comprehensive in-person assessment to identify individual customer problems, resources, and service needs in preparation for the development of a primary care planning plan to identify a variety The amounts of care needed to meet the identified needs of customers arrange services to implement the care plan by providing both formal and informal at-home and on-under-performing community monitoring services to ensure that services are delivered appropriately and continue to meet the customer's need for periodic reassessment to regulate care plans to changing needs. Two channeling models were tested. The basic file management model relied primarily on the main features. The Canaling Project took responsibility for helping customers access the required services and coordinating the services of numerous providers. The model provided a small amount of additional funding to fill gaps in existing apps. But it generally uses the resources currently available in any community, thereby testing the assumption that major problems in the current system are information and coordination problems that can be largely solved by customer-centric case management. The financial control model was different from the basic model in several way: it expanded service coverage to include a wide range of community services. It created a funding pool to ensure that services can be allocated based on need and suitability than in the eligibility requirements of certain decisive programs. It powers case managers to license the amount, duration, and scope of services paid from pool funds, holding them accountable for the full package of community services. Two restrictions were imposed on pool funds costs. First, the average customer cost cannot exceed 60 percent of the average nursing home rate in the area. Second, fees for an individual customer could not exceed 85 percent of that rate without special approval. It requires customers to share in service costs if their income exceeds 200 percent of the state's Supplemental Security Income (SSI) eligibility level plus the amount of food stamp duty bonuses. B. Demonstrations and evaluations of ten sites across the country participating in demonstrations: Base Case Management Financial Control Model Baltimore, Maryland Miami, Florida Houston, Texas Lane Grand, Massachusetts County Middlesselaer, New Jersey City Rensselaer, New York Eastern Kentucky Cleveland, Ohio South Maine Philadelphia, Pennsylvania in September 1980, ten participating states, technical assistance contractor, and national evaluation contractor were awarded contracts and began planning. Then a local project was selected in each state. It is now well established divisions in existing human services organizations (typically area agencies in aging or private nonprofit service providers). Ten local projects opened their doors to customers between February and June 1982, and were fully operational by June 1984. Local projects derailed The program was sponsored in March 1985, although most continue to operate under the government or other. The purpose of the assessment, in addition to documenting the implementation of the channel, was to identify its impact on: the use of formal health and long-term care services, particularly hospital and elderly home care and social services of public and private expenses for health services and long-term care individual outcomes including mortality, physical functioning, the need for unmet services, and social/mental health care by family and friends, including the amount of financial care provided, the amount of financial support provided, and the stress of caregivers, satisfaction, and bioavailability. To compare the results of channeling with what was happening in the absence of canalization, the assessment relied on an experimental design. The elderly referred to each canaling project were interviewed to determine their eligibility for canalization. If eligible, they would be randomly assigned either to a treatment group whose members had the opportunity to participate in channeling or to a control group whose members continued to rely on any services otherwise available in their community. In this study, 6340 subjects were randomly divided. Given the significant mortality rate among this population as well as the lack of incomplete interviews, these research samples are from 3,372 to 6,326 elderly people, depending on the analysis. c. The results on informal care in the channeling demonstrations of two data sources are the basis of informal caregiver analysis. The first includes answers from elderly sample members to questions about receiving care and donations from all informal caregivers. The second involves answering a more detailed set of questions asked of the person designated by the sample member as their primary informal caregiver. They ediced care activities and financial assistance from primary caregivers, as well as their bioavailability. According to the timing of the decision to conduct a caregiver review, the caregiver sample is smaller than the elderly sample. 1. The patterns of care at the onset of demonstrations informal care patterns and the characteristics of caregivers of the channel population matched those that were supposed to be expected from the literature. Most of the elderly (83-78% for basic models of case management and financial control, respectively) reported that some informal caregivers had an average care network of slightly less than two members. Helping with housework, laundry, or shopping (79.0% and 74.0%) and food preparation (69.7% and 64.4%) were the most common types of informal assistance received by sample members in their homes; Sample members received about four visits a week from the visit Caregivers. These were a total of 10 to 11 hours a week, more than half of which were dedicated to providing a combination of personal care and housekeeping. Three-quarters of the primary caregivers were women, most of them girls or spouses. They tend to be elderly themselves (on average 58-60 years old) and in good health. Although more than half were not employed a year earlier, very few reported that care limited their employment opportunities. On the days they helped, primary caregivers devoted 4 to 5 hours a day to care activities, and an extra 2 hours to socialize with the sample member. Personal care was the most care provided. About 45 percent also provided some donations to sample members, with an average of $80 to $85 a month (about twice as many if only those aid provider caregivers were included). About two-thirds of caregivers reported restrictions on their social lives due to care, and half reported that sample members sometimes get upset, yell at them or refuse to cooperate, and this is a significant behavioral problem. Nevertheless, about three-quarters reported that they got a perfectly good companion with the sample members they cared for, although about half had very much concern about getting enough help for them. The stress experienced by early informal caregivers seemed remarkable, with more than a third reporting that they had experienced severe emotional stress, and expressed about the same proportion expressing dissatisfaction with their lives. 2. The effects on informal care channel demonstrations were intended to increase the use of formal, community-based long-term care by the poor elderly. Clearly, this can result in the replacement of formal services for care provided informally by family and friends. Such an alternative, if it had occurred, could imply that the public sector would pay for services that would otherwise be provided by family and friends. There was no evidence that channeling under the basic case management model would lead to an official replacement for informal care. Channeling under the financial control model resulted in an average replacement of some services, but there is no evidence of an overall replacement on a massive scale. Nor is there evidence of a reduction in informal care provided by primary caregivers. The effect appears primarily due to the departure of some friends and neighbors. Services for which there was evidence of some substitutions under the financial control model included: food preparation; housework, laundry, or shopping; public oversight; delivery of ready meals; and help with transportation. In all cases the replacement rate was modest. To prepare food and housework, laundry, and shopping, for example, a significant increase in the percentage of members of the treatment group receiving official services in the neighborhood 20 to 25 percent were paired with a significant decrease in the percentage of receiving informal services by 3 to 6 percent. These estimates show that an approximate 4-5% increase in the percentage of sample members receiving official services identified above has been accompanied by a 1% decrease in the percentage of sample members who informally receive the same services. Alternative evidence was also found under the financial control model for three broader informal care measures: the number of different services provided, the percentage of sample members with caregivers, and the number of visitor caregivers. For these measures, the reduction in informal care was again small and was accompanied by much larger increases in formal care. In addition, no alternative effect was detected for the number of visits and hours of care received, both possibly more comprehensive measures than the overall care effort. The possibility that shorter-term cuts to informal care may be greater was also explored by delayed institutionalization of sample members, which would allow informal care to be delivered over a longer period of time. Canaling was found to have no effect on the percentage of sample members residing in the community at 6, 12 and 18 months. Therefore, the observed replacement in the short term showed a decrease that is not likely to be negated in the long run. The reduction in informal care that occurred under the financial control model was not due to a reduction in efforts from primary caregivers. Rather, the effects appeared in measures that indicated informal care received from all caregivers. For example, for caregivers residing in the community, in six months, the members of the treatment group were on average 1.6 caregivers versus 1.7 for the control group and at 12 months of age, the members of the treatment group were on average 1.4 versus 1.6 for the control group. These cuts apparently occurred primarily through the withdrawal of some friends and neighbors from care. For community-resident caregivers, for example, in six months 19.4 percent of a friend or neighbor's treatment group had a 4.9 percent reduction in their care network versus 24.3 percent of controls. In 12 months it had increased to 5.1 percentage points (16.3 vs. 21.4 percent). Given the type of care, the cuts noted above were concentrated -- as might be expected -- in areas some replacements were found. To prepare food, for example, in six months, 64.5 percent of community-resident treatment groups were receiving help versus 69.7 percent of the control group, a 5.3 percent drop point. For housekeeping, laundry, or shopping, in six months 74.6% of community residents were receiving help versus 80.8% of the treatment group, one From 6.2 percentage points. In order to deliver ready meals, receive transportation, or day care services, 27.8% of the treatment group received help in six months versus 34.5% of the control group, which was a 6.7% reduction point. There was no overall impact on informal donations provided by all caregivers or by primary informal caregivers. Nor is there any evidence of channel effects that differ with sample member features or sites. According to primary caregivers, there is no evidence to suggest that channeling had an impact on their overall informal care provision. This result is not at odds with the average reduction in care received from all informal caregivers. The cuts were accompanied by visits from caregivers and friends or neighbors -- rarely designated as primary caregivers. There are suggestions that channeling caused early caregivers to focus their efforts on certain areas. First, for elderly sample members living in the community, channeling under the basic case management model increased caregiver involvement in regulating services or benefits. For example, in six months, 56.0% of primary caregivers in the treatment group were engaged in this activity versus 45.9% of the primary caregivers of the control group. Second, channeling under the financial control model increased the frequency with which primary caregivers announced the provision of help with eating and cleaning after bowel and bladder accidents and by adjusting services and benefits. For example, for all caregivers at 12 months of age, the daily frequency of helping to eat for the treatment group was 0.38 versus 0.21 for the control group. A possible explanation for this is that increasing the provision of official services under the financial control model would have allowed primary caregivers more time for tasks that are not easily performed by official providers. 3. Effects on the bio-life of informal primary care channel improvements to bio-primary caregivers by some measures. Channeling under the basic case management model reduced the percentage of caregivers who understood restrictions on their privacy and social life. For example, in six months, for example, living in the community under the basic model of case management 8.8 percent of caregivers of the treatment group perceived restricted privacy as a serious problem versus 15.9 percent of the control group caregivers. The treatment/control difference was in the same direction but no longer noticeable in 12 months, possibly suggesting that canaling had a strong initial effect on caregiver perception that declined over time. Channeling seems to have somewhat alleviated carer concerns about getting enough help under both models. In six months under the financial control model, for sample members in the community, 29.2% of caregivers of the treatment group Very concerned about this versus 40.8 percent for the control group. The difference between treatment/control was again in the same direction, but it was no longer noticeable in 12 months. Smaller differences were observed in one direction but not statistically significant for the basic model. Finally, channeling under both models increased the overall life satisfaction expressed by primary caregivers. For example, at six months of age, for example, in the society under the basic case management model, 20.9% of caregivers in the treatment group did not find life in front of 29.9% of primary caregivers in the control group very satisfactory. Comparable estimates under the financial control model were 27.6% versus 35.6%. There is little evidence to suggest that channeling caregiver perceptions has diminished the degree of emotional, physical, or financial pressure they have experienced due to care. Canaling also had no effect on caregiver perceptions of their employment restrictions or their family income and income. Nor does it affect their perceptions of the prevalence of serious protest behavior on behalf of exemplary members, or the quality of their relationship with the person they cared for. Restaurant.

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