REPORT TO THE TWENTY-FOURTH LEGISLATURE
STATE OF HAWAI‘I
2007

PURSUANT TO SENATE CONCURRENT RESOLUTION 115 S.D.1, REQUESTING THAT THE STATE EXECUTIVE OFFICE ON AGING CONVENE A FOCUS GROUP WITH OTHER STAKEHOLDERS TO ASSESS YEARLY SERVICE DELIVERY NEEDS AND LONG-TERM STRATEGIC PLANNING FOR KUPUNA CARE

PREPARED BY:

State of Hawai‘i
Department of Health
Executive Office on Aging
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The 78 individuals who participated in the county focus groups:

Lito Asuncion
Liz Bailey
Rita Barreras
Cindy Boltz
Charlene Burgess
Bernard Carvalho
Michael Cheang
Norma Circle
Rob Leigh Clark
Merlita Compton
Nathan Cutler
Richard Detucci
Linda Dullin
Horace Farr
Sandy Freeman
May Fuji Foo
Pauline Fukunaga
Charlotte Fusato
Marc Gannon
Debbie Gray
Warren Haight
Naomi Hamamura
Brenda Ho
Barbara Ideta
Deborah Jackson
James Kam
Shim Kanazawa
Joan Kawakone
Carol Kikkawa-Ward
Tony Kreig
Lot Lau
Kathy Lewis
Bruce McCullough
Sumi Mackey
Leonard McGhee
Lynette Madrano-Stein
Laura Manis
Bob Masuda
Mary Matayoshi
Fred Maximo
Elizabeth Meahl
Karen Miyake
Faith Muraoka
Charlene Nakamine
Layne Narimatsu
Kathleen Olson
Neva Olson
Bobbie Onzuka-Anderson
Josh Oxentine
Candy Papalii
Iris Parangao
Alan Parker
Ken Rainforth
Janine Rapozo
Michael Ratcliffe
June Renaud
Jo Reyes
Sandy Rongitsch
Caryn Sakahashi
Dennis Shigeta
Claire Shimabukuro
Gary Simon
Janice Smith
Linda Spratt
Ruth Stephanopolis
Naomi Sugihara
Kealoha Takahashi
Ken Takeuchi
Diane Terada
Toni Torres
Healani Trempack
Azi Turturici
Mililani Villanueva
Sally Wehrsig
Tony Wong
Craig Yamaguchi
Valerie Yontz
Maile Young

EXECUTIVE SUMMARY

The population of Hawai‘i is aging at a dramatic pace. Today, more than 231,000 of our citizens are 60 years of age or older. By 2020, one of every four Hawai‘i residents will be in this age group. Although not all older adults require assistance, the prevalence for frailty increases with age, as does the need for care. Present and projected population demographics and real and potential need for services have led legislators, policy makers, and others to question if the state's allocation for KUPUNA CARE (KC) funds would be "unlikely to meet future demands due to increases in the cost of service delivery, increases in living wages, increases in the longevity of the elderly population, and a decrease in voluntary contributions to supplement static funding."

In response, Senate Concurrent Resolution 115 SD1 (SCR 115) was passed by the Twenty-Third Legislature of the State of Hawai‘i, Regular Session of 2006. SCR 115 requests that the Executive Office on Aging (EOA) convene a focus group with other stakeholders to review yearly service delivery needs and long term strategic planning for KC. Thus, this report's goal is to provide legislators and policymakers with information and recommendations in the context of: 1) a broad overview of KC today, and 2) the foundation EOA will use to begin a strategic planning process to properly place *KC* within the long term care system, which encompasses a complete continuum of services from in-home to institutional care.

Launched in 1999, KC's goal is for Hawai‘i's na Kupuna to have access to affordable and quality home and community based long term care services (HCBS), which are client centered and family-supported and allow them to live with independence and dignity. KC is designed to assist, not totally support, Hawai‘i's older adults to remain in their homes as long as possible. KC targets older adults, age 60 and over, in the gap group, who are not eligible for government support like Medicaid, but who do not have sufficient income to pay for all needed services.

KC, administered by the Executive Office on Aging (EOA) through the County Offices on Aging or Area Agencies, is one alternative to meet Hawai‘i's demand for home and community based long term care services, as part of the larger long term care system. Other long term care options not funded by KC include hospitals, Intermediate Care Facilities, Skilled Nursing Facilities, adult residential care homes (ARCH), extended ARCHs, adult foster family homes, hospice, Nursing Home Without Walls, housing, public guardianship, and other programs licensed by and/or administered under other state offices e.g., the Department of Health, the Department of Human Services, Hawai‘i Housing Authority, and the court system. The large payers of these long term care options include Medicare, Medicaid, and the State.

The KC program offers the following eight HCBS for frail older adults statewide:

1. Adult Day Care
2. Assisted Transportation and Transportation
3. Attendant Care

4. Case Management
5. Chore
6. Homemaker
7. Home-delivered meals
8. Personal Care

(Please refer to Attachment 4 for the complete service definitions.)

Method. Drs. Colette V. Browne and Kathryn L. Braun of the University of Hawai'i at Manoa were contracted by the EOA to conduct focus groups and complete a report. Preceding the focus groups, a thorough review of the literature was conducted. The review examined evidence about the aging demographic and "best practice literature" to meet the needs of an aging society.

During the months of August and September, 2006, nine focus groups were convened in the counties of Kaua'i, Honolulu, Maui and Hawai'i to discuss the present and future needs of older adults and to identify new directions that have implications for KC and the long term care system. Across the state, 78 Key Informants representing the County Offices on Aging or Area Agencies, current and potential service providers, faith-based and private organizations, and actual and potential consumers (older adults and caregivers) participated in these focus groups.

Focus group questions solicited information on how older adults of the future would want to live, how we can respond to this preferred vision, what individuals and the public and private sectors can do to prepare for the future, ideas for specifically optimizing KC, and other data related to the development of a comprehensive long term care system, of which home and community based long term care services (HCBS) like KC play a major role. Each focus group was two hours in duration. Conversations were transcribed in full, and transcripts were examined for themes and sub themes.

***Conclusions*.** Conclusions can be drawn from the focus group data about KC services as well as the long term care system for older adults. These conclusions concur with the findings from the literature review on aging and eldercare in the United States.

- Hawai'i's aged population will continue to grow, especially the oldest-old (those 85 and older) who are most at risk for dementia and increasing dependence. Based on demographics alone, more eldercare services will need to be provided.

- Older adults, regardless of disability, want to live at home for as long as possible, supported by family and a comprehensive system of home and community based long term care services (HCBS).

- The costs of supporting families and HCBS for older adults are many times much less than paying for nursing home care. States are experimenting with a number of ways to support caregivers (e.g., more services, family caregiving tax credits), empower older adults (e.g., through consumer-directed long term

care programs), and expand community based options (e.g., through adult foster homes and assisted living communities).

- Direct care workers (DCW) earn a low wage. Many agencies hire part-time workers to save on benefits. To meet the escalating demand for HCBS, wages for DCW and funding for HCBS will need to be increased.

- Hurdles and disincentives for service providers and new businesses prevent new players from entering the eldercare marketplace. The public and private sectors need to examine ways to eliminate current barriers.

- Government needs to examine strategies to fund not only KC, but other HCBS and the long term care system. Each potential source of funding has its advantages and disadvantages. Universal-coverage models are seen as more cost effective and equitable and less open to fraud and confusion than private-pay models.

Recommendations. As a first step, EOA and County Offices on Aging need to engage in increased resource development, capacity building, and training. To further develop the needed infrastructure, EOA and County Offices on Aging would also support capacity building and training for all state and county offices that have programs for older adults, including Departments of Health, Human Services, Housing, Transportation, Parks and Recreation, Commerce and Consumer Affairs, etc. Public and private sectors will need to collaborate and work together to lead the State in preparing for an "older" Hawai'i.

The six recommendations that follow are listed in priority order based on the discussion of focus group questions with Key Informants. The first recommendation had the greatest number of responses; the second recommendation had the second greatest, and so on. Overall, these recommendations speak to the need to optimize the planning efforts of the State and County Offices on Aging for an aging society, some of which EOA has begun to address in initiatives described in Section IV on pp. 13-14.

While all recommendations indicate the need for continued support from the public and private sectors, as well as The Twenty-Fourth Legislature of the State of Hawai'i, each recommendation may have strategic planning issues not only related to KC, but to the further development of the continuum of care in the long term care system.

The recommendations are:

1. Expand resources and funding for KC and other HCBS. Reexamine all funding alternatives, including universal long term financing and insurance models (e.g., Family Hope and Care Plus).

2. Support family caregivers, volunteers in eldercare, and direct care workers.

a. Increase access to and funding for KC to keep people in their homes and in the community.

b. Support family caregivers by examining potential tax treatment options of caregiver expenses, expanding Family and Medical Leave benefits, and providing caregiver education.

c. Expand support for volunteering by increasing funding for existing volunteer programs, e.g. RSVP, Project Dana, and fund technical assistance to agencies that wish to start volunteer programs.

d. Support direct care workers (DCW) by providing a fair wage.

e. Support additional strategies by: 1) providing DCW with information about eligibility for federal tax credits; 2) encouraging the development of employer health insurance purchasing pools; and 3) linking in-home workers to existing supports for taxes, health care, childcare and other services for low-wage workers.

3. Fund training programs in gerontology and geriatrics.

a. Provide training for DCW including family members, volunteers, or unrelated paid workers. All DCW need to know: 1) how aging affects people physically, mentally, and socially; 2) how to distinguish normal aging from disease (and when to seek professional help for the elder); and 3) proper care techniques (how to lift, how to feed, how to bathe).

b. Support professional education in gerontology and geriatrics to insure an adequate workforce.

4. Encourage personal, health, and financial planning for aging and long term care needs for all and with a special focus on Baby Boomers.

a. Continue to increase collaboration and coordination between the network of public/private health and aging agencies to promote healthy lifestyle practices across the lifecycle.

b. Launch a public awareness program to promote physical activity among older adults and implement Evidence-Based Programs/Models.

c. Conduct a major public awareness campaign to better inform the community about HBCS and programs currently in place, the strengths and shortcomings, and government and personal responsibility for aging and for meeting long term care needs.

5. Identify ways to streamline state and county procedures for procurement, licensing, certification, and contracting, which discourage new businesses from entering the eldercare market.

6. Pilot alternative care models as follows:

   a. Consumer-Directed Long Term Care (CDLTC), which provides payments directly to older adults and family members so that they can shop for, purchase, and monitor their own services. It may not be cheaper, because of the need to build the infrastructure to help older adults/caregivers manage payroll taxes, monitor appropriate use, and prevent fraud and abuse. However, this model may help address the workforce issue, as older adults may hire and pay a family member or neighbor to provide care.

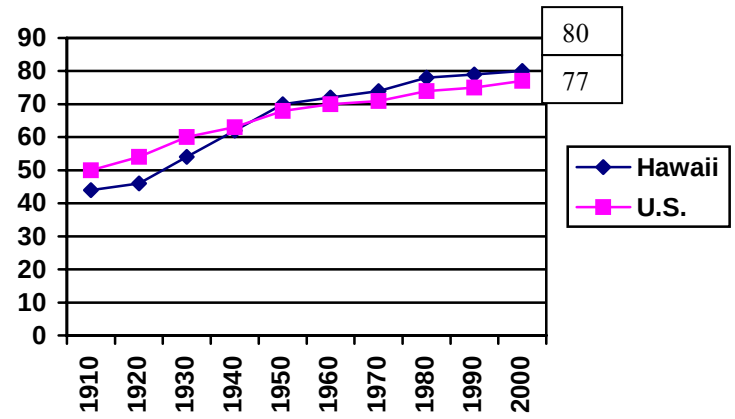
   b. One-Stop Center or Aging and Disability Resource Center (ADRC), where older adults and caregivers can be empowered to learn about all their service options at one place, rather than going to each service provider to find out about eligibility and service availability. (EOA is already working in partnership with County Offices on Aging on Oahu and Big Island to establish an ADRC. (See Section IV, p. 13.

   Note: The Twenty-Third Legislature of the State of Hawai‘i, Regular Session of 2006 is recognized for its leadership in passing three important bills: 1) SB 3252 (Act 262), which appropriates $500,000 to EOA for KC expansion and $80,000 to coordinate family caregiver support services and policies statewide; 2) HB 1900 (Act 160), which appropriates $206,000 to Kapiolani Community College to establish a Long-Term Care Training initiative for paraprofessional and family caregivers; and 3) SB 3253 (Act 285), which facilitates the development of a comprehensive public policy to strengthen support for family caregivers by establishing a Joint Committee on Family Caregiving. These bills moved the Hawai‘i Aging Network forward in addressing some of the older adult and family caregivers’ needs, as described above.

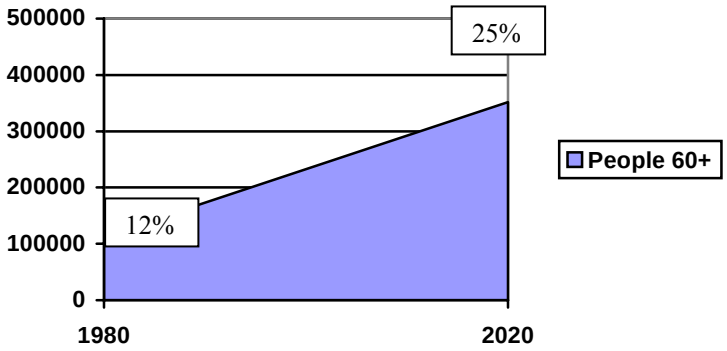
I. INTRODUCTION

Federal and State governments face a critical challenge in addressing and meeting the diverse long term care service needs of an aging population. In Hawai‘i, the elder population will double in size between 2000 and 2020. In response to the changing demographics, this report summarizes the findings from a review of the literature, data from nine focus groups held statewide, and presents six conclusions and recommendations that will address the issues related to an aging Hawai‘i and the role KC may play.

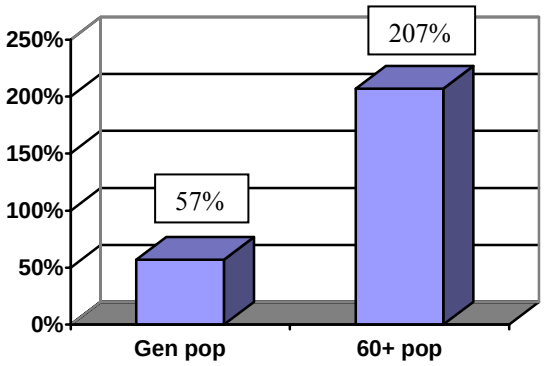
The following three charts show how Hawai‘i’s population is aging. The first chart shows Hawai‘i’s increasing life expectancy, compared to the United States as a whole.



The second chart shows that adults, age 60 and older, will comprise 25% of Hawai‘i’s total population in 2020. Just looking at adult residents, older adults will comprise one-in-three adults by 2030. (State of Hawai‘i Department of Business, Economic Development, and Tourism, 2004)



The third chart shows that the general population increased by 57% between 1970 and 2000. However, the population age 60 and older increased by 207% during the same time period.



Background: KUPUNA CARE (KC)

The State Executive Office on Aging (EOA), as an attached agency to the Department of Health, is the designated lead agency for aging programs under the Older Americans Act of 1965, as Amended (OAA). The mission of the EOA is to promote dignity and independence of older adults and to help prepare the State for the rapid expansion of its aging population.

To serve the needs of older adults, age 60 and older, OAA and state funds are appropriated to the EOA, which EOA allocates to the four County Offices on Aging on Oahu, Hawai‘i, Maui (includes Molokai and Lanai), and Kaua‘i. Then, the four County Offices on Aging use the state and federal funds to procure and subcontract with service providers to fund a variety of programs and direct services for older adults and their families according to State and area plans. These programs and services support healthy aging, family caregiving, information and referral, and home and community based long term care services.

On July 1, 1999, the EOA, working in partnership with the County Offices on Aging, reorganized the statewide service delivery system to meet the growing numbers of older adults with home and community based long term care needs. KC, funded by State General Funds, was made available to meet the needs of older adults who cannot live at home without adequate help from family and/or formal, paid services. It is designed to assist, not totally support, Hawai‘i’s elderly to remain in their homes as long as possible. KC targets older adults in the gap group, who are not eligible for government support like Medicaid, but who do not have sufficient income to pay for all needed services.

KC is only one alternative to fulfill the home and community based long term care needs (HCBS) of older adults in Hawai‘i. KC is complemented by other long term care options such as hospitals, nursing homes (Intermediate Care Facilities and Skilled Nursing Facilities), adult residential care homes (ARCH), extended ARCHs, adult foster homes, hospice, Nursing Home Without Walls, senior housing, public guardianship, and other programs licensed by and/or administered under other state offices (e.g., the Department of Health, Human Services, Hawai‘i Housing Authority, and the court system). The large payers of these long term care options include Medicare, Medicaid, and the State.

To qualify for KC services, an individual must meet the following requirements: a) be U.S. citizen or legal resident; b) 60 years of age or older; c) not covered by any comparable government program (Medicaid) or private home-and community based care services; d) not residing in an institution, such as a hospital, nursing home, care home, adult foster homes, or hospice; e) have an impairment in performing at least two or more ADLs or activities of daily living (e.g. eating dressing, bathing, toileting, transferring, and mobility), IADLs or instrumental activities of daily living (e.g., preparing meals, shopping, managing money, doing light and heavy housework, using public transportation), or have a substantive cognitive impairment; and f) have an unmet need of at least one or more ADLs or one or more IADLs.

KC, as a statewide home and community based long term care service (HCBS) program for frail older adults, age 60 and over, offers the following eight services through the County Offices on Aging:

1. Adult Day Care
2. Assisted Transportation and Transportation
3. Attendant Care
4. Case Management
5. Chore
6. Homemaker
7. Home-delivered Meals
8. Personal Care

(Please refer to Attachment 4 for the complete service definitions.)

History and Intent of the Resolution

Federal and State governments face a critical challenge in responding and meeting the long term care needs of an aging population that will double in size between 2000 and 2020. One response is the federally sponsored Medicaid Waiver Program that funds HCBS as an alternative to Medicaid funded nursing home care. Another response is the State KC program. Nonetheless, and in response to growing concerns over the rapidly increasing number of older adults in the State and the aging of the Baby Boomers, the Senate of the Twenty-Third Legislature of the State of Hawai‘i, Regular Session of 2006, the House of Representatives concurring, passed Senate Concurrent Resolution 115 SD1 (SCR115).

In this resolution, the EOA was requested to convene a stakeholder focus group to review yearly service delivery needs and long term strategic planning for KUPUNA CARE (KC). The concern, voiced by legislators, was that the state's allocation of funds would be "unlikely to meet future demands due to the increases in the cost of service delivery, increases in cost of living wages, increases in the longevity of the elderly population, and a decrease in voluntary contributions to supplement static funding." Thus, this resolution seeks from the EOA information and recommendations in the context of: 1) a broad overview of KC today, and 2) the foundation EOA will use to begin a strategic planning process to properly place KC within the long term care system, which encompasses a complete continuum of services from in-home to institutional care.

Community assessment of present and future needs of older adults has and continues to be an ongoing process by the "Aging Network." The "Aging Network" refers to the network established and funded by the Older Americans Act of 1965, as Amended (OAA) including the U.S. Administration on Aging (AoA), State Units on Aging like EOA, County Offices on Aging or Area Agencies and their service providers, Native Americans Grantees, and institutions of high education (when funded). But, the Aging Network must include and respect the critical role of older adults to provide input, as an advocate, partner, consumer, or advisor.

A prime example of combined federal, state, county, and community assessment and planning was the White House Conference on Aging (WHCOA) 2005, which EOA and County Offices on Aging participated in locally and nationally. In December 2005, President George W. Bush hosted delegates from all 50 states and territories to discuss aging Americans and their needs. Hawai‘i sent delegates to this Conference, and they agreed with the following top ten resolutions from the WHCOA:

1. Reauthorize the Older Americans Act with increased funding.
2. Develop a coordinated, comprehensive long term care strategy.
3. Ensure transportation options that assure mobility and independence.
4. Strengthen and improve the Medicaid program.
5. Strengthen and improve the Medicare program.
6. Support geriatric education and training for workforce, paid and unpaid.
7. Promote innovative models of non-institutional long term care.
8. Attain adequate numbers of health care professionals who are skilled, culturally competent, and specialized in geriatrics.
9. Improve State and local based integrated delivery systems to meet the needs of 21st Century seniors.
10. Establish principles to strengthen Social Security (strategies included "no" to privatization).

It is important to note that these resolutions are consistent with this report’s conclusions and recommendations, based on the literature review and Key Informant data from the nine focus groups to follow. (See Section III. Literature Review, V. Focus Group Methodology and Findings, VI. Conclusions, and VII. Recommendations.)

II. CURRENT EXPENDITURES AND UTILIZATION OF KUPUNA CARE (KC) SERVICES

In SFY 2006, EOA allocated $10, 944,698 of state and federal funds to the County Offices on Aging to support home and community based long term care services (HCBS). Nearly one-half of this total or $4,960,668 of state funds was allocated to County Offices on Aging for KC alone. Program income of $378,113 from consumers who voluntarily contribute and help defray the cost of KC services was collected by KC service providers. Thus, total funds available for KC services consisted of the allocated state funds and program income or $5,338,781.

Preliminary data from the County Offices on Aging indicate about 7,217 older adults were served. Based on the state funds and program income available ($5,338,781), each of these older adults could received an average of about $739 per year or about $62.00 per month, which pays for direct services and a 10% administrative cost.

Although the KC amount received by each older adult monthly is very small, the following consumers submitted written testimony about the impact KC had on their lives to Chair, Senator Brian T. Taniguchi and Vice-Chair Senator Shan S. Tsutsui, of the Senate Ways and Means Committee in support of SB 3252 on February 24, 2006 as follows:

D.B. re need for housekeeping services: I am unable to bend over for any sustained effort on the floor. Severe arthritis and leg pain prevent much activity. I would lose my ability to live alone and enjoy independence.

M.C. re need for housekeeping services: I have arthritis and can't do much. I have breathing problem. I have back and spine trouble. I would not be able to live by myself.

P.C re need for housekeeping services – I am a leg amputee and wheelchair bound so it is very difficult to do chores like change my bed linen, do my laundry. It's very difficult for me to be able to thoroughly clean the floor, shower or toilet. I'd be devastated if I didn't receive help with my housekeeping. I'd have to find someone to help me. I cannot afford to hire an outside chore person. This service is invaluable to people like myself.

S.W. re need for transportation to go grocery shopping: It (transportation) would be very difficult and expensive. Taxi too expensive. I have no one to help me! I live by myself and have no family!

The County Offices on Aging provided the following preliminary data of estimated utilization of services of older adults under KC in SFY 2006 (July 1, 2005 to June 30, 2006):

Services	Persons Served*	Units of Services
Personal Care	823	45,148 Hours
Homemaker	563	16,193 Hours
Chore	169	819 Hours
Home Delivered Meals	3,790	415,412 Meals
Adult Day Care	108	31,983 Hours
Case Management	1,631	34,983 Hours
Assisted Transportation	186	8,957 One-way trips
KC Transportation	1,220	55,468 One-Way Trips
Attendant Care	603	39,052 Hours

Note: The accuracy of the numbers served and units of service provided may be affected by two factors. First, a KC service like home-delivered meals is supplemented by a combination of funds from the Older Americans Act of 1965, as Amended (OAA), the County, and program income. Second, multiple services provided to one person may lead to an overestimation of the number of persons served. Thus, while the number of persons served by each service is an unduplicated count, e.g. each person is counted only once, the estimated number of persons served across all services is adjusted for multiple funding sources and multiple uses of services by one person. The total number of persons served will not be equal to the sum of the number of persons served per service.

III. LITERATURE REVIEW

This section includes a brief summary of the literature on five issues related to the planning of service delivery to older adults and the "Best Practice" literature. These are: (1) Ideal visions of preferred lifestyles for older adults now and in the future; (2) Methods for increasing efficiency and effectiveness of programs; (3) Incentives to increase numbers of agencies providing elder care; (4) New service delivery options and related issues of; and (5) Strategies for the Aging Network to respond to Aging in Place. While the Older Americans Act and U.S. Administration on Aging (AoA) focus on older adults 60 and over, data found in the literature search from the Census Bureau and other studies uses 65 and older, as the benchmark. This why supporting data in the following section will be based on those 65 and over.

Ideal Visions of Preferred Lifestyles

One of the most important changes in the United States is the dramatically increasing number of Americans turning 65 years of age every day. Thirty-five million Americans are 65 years of age and over, and all projections estimate that by 2025, one of every five Americans will be in this age group. The overwhelming sentiment voiced by aging Americans is the desire to remain independent and in their own homes (Hooyman & Kiyak, 2005). Contrary to conventional wisdom, only some older adults are relocating to retirement communities; in fact, those aged 65 to 85 are the least likely of any age group to move. This phenomena, referred to as "aging in place," presents opportunities and challenges to families, government, the community, and to older adults themselves.

For the most part, older adults are living independently, and many are able to remain in their homes. This desire and preference to remain at home can be difficult, in part due to the numerous chronic diseases that impact their independence and well-being. Older Americans are disproportionately affected by a variety of chronic diseases and conditions that collectively account for seven of every ten deaths, and more than three quarters of all health expenditures in the U.S. (Center for the Advancement of Health, 2006). Of those 65 and over, more than 80% have at least one chronic condition. The average 75 year old has three chronic conditions and takes 4.5 medications. More than 65% of those 65 plus have some forms of cardiovascular disease and half of men and 2/3 of women over 70 have arthritis.

Meeting the needs of older adults to remain at home requires the understanding that chronic disease negatively impacts on quality of life and functional status. For policy makers, this is of concern because the prevalence of chronic disease can translate into greater consumption of costly institutional care and less consumption of less costly home and community based services (HCBS).

Much can be done to delay the onset of chronic diseases and functional limitations and to minimize the impact of chronic diseases when they do occur. Therefore, policy and program changes in two areas can support older adults to remain in their own homes, e.g., reducing poverty and increasing health insurance.

Methods for Increasing Efficiency and Effectiveness of Programs

Efficiency can be defined as the cost-effectiveness of the policy compared to alternative policies or no policy. Many state and private agencies work well together in their goal of meeting the needs of the frail. Still, and as noted by Dr. Larry Polivka and Honorable Josefina Carbonell, Assistant Secretary of Aging, DHHS, our "present long term care system is largely characterized by a loosely organized and fragmented process of gaining access to care and a bias favoring institutional care makes it difficult for states to provide easy and timely access to home and community based options. Any effort to improve long term care for the elderly . . . must be focused on developing a more flexible and balanced long term care system that is responsive to consumer choice" (Polivka & Carbonell, 2003).

Research over the past ten years on "Best Practice" efficiency models have produced inconclusive results over cost effectiveness of home and community based long term care services (HCBS). As states attempt to shift the balance of their long term care system from institutional to HCBS, some programs appear to save monies, i.e., Medicaid waiver funded assisted living and foster home programs, while the data on other programs are mixed, e.g., consumer directed long term care models or CDLTC. (NCD, 2004).

Other models have been suggested which may encourage efficiency and effectiveness. These are: (1) the use of incentives for family caregiving, (2) increased collaboration and building capacity with private and faith-based organizations, (3) increased use of volunteers to decrease or stem the costs of a paid workforce, and (4) streamlined institutional policies and practices.

Incentives to Support Family Caregiving. The family has consistently played a major role in eldercare, and research tells us that families provide all the care they can or are able and willing to do. One strategy thought to encourage families to provide caregiving is the provision of tax credits. At this time, the federal dependent tax credit is the largest source of federal assistance to families with employment-related expenses regarding care responsibilities for children, adults with disabilities, frail older adults, or a combination of these (Stone & Keigher, 1994). It reduces the amount of income tax, but not FICA, the worker owes by a percentage of the dependent care costs.

State caregiver tax credits generally range from $500 to $1,500, and build on the federal tax credit. At least 26 states and the District of Columbia have refundable or non refundable dependent tax credits. Other alternatives that may be helpful are those that support older adults and their families through real services, Internet websites, and neighborhood and community development.

However, studies to date suggest that tax credits provide only minimal financial help for employed caregivers who must pay someone to provide care while they are at work (Hooyman & Gonyea, 1995). Moreover, because the tax credit is not refundable, it does not offer benefits to those families who owe no taxes or who do not itemize, e.g., disproportionately lower-income families (Osterbusch, Keigher, Miller, & Linsk, 1987).

Thus, ideas that families will financially benefit or take on more caregiving responsibility because of tax credits should be looked at cautiously.

Increased Collaboration and Building Capacity with Private and Faith-Based Organizations. Private and faith-based organizations provide services to frail older adults in home and community based settings. Faith-based organizations and public sector agencies often find that their financial resources are limited compared to the escalating needs of an aging America. An increased focus on collaboration and coordination efforts among public, private and faith-based organizations is viewed as strategies to help meet the community's long term care needs.

Use of Volunteers. This option for increasing the efficiency of present models holds potential. Many older adults like people of all ages have a desire for community engagement, opportunities for socialization, independent living, and friends and family supports (Best Practices: Lessons for Communities, Center for Home Care Policy and Research, 2003). Well planned volunteer programs that provide ongoing training, supervision, evaluation, and for some remuneration, can make a difference in providing care in some settings.

Streamlining Practices/Promoting Provider Base. The Lewin Group identified a number of effective strategies utilized among three leading states that have established Medicaid Waiver programs for the elderly in Colorado, Washington and Wisconsin, while complying with state and federal regulations for adequate provider rates and reimbursements (The Lewin Group, 2003).

All three states were found to have:

1. Reallocated Medicaid funds and made substantial efforts to shift long term care from institutional to home and community based long term care service (HCBS);

2. Developed controls to manage the growth of HCBS and the impact on the provision of services;

3. Innovated with strong, locally based systems and established a single point of entry through which: 1) level of care and financial eligibility is determined, 2) HCBS and other long term care information are provided to consumers, and 3) help with completing applications or finding out about the status of applications and enrollment is provided. (Lewin Group, 2003).

Incentives to Increase Numbers of Agencies Providing Eldercare

There is limited research conducted on strategies to increase the number of service providers in eldercare. In the Lewin Report, a number of strategies were found to help maintain an appropriate provider base. These included streamlining provider enrollment, simplifying the application process, establishing a recognizable point-of-contact, and tailoring provider requirements (Lewin Group, 2003, pp. 5-6).

In part, activity follows money. When services for older adults are profitable, new business will enter the market. The reality is that federal and state payments for services have become disincentives for recruiting and maintaining eldercare businesses. On the other hand, some states have found that building an infrastructure that assists new businesses to navigate the federal and state procurement system is helpful in encouraging more business to entering eldercare services (Lewin Group, 2003).

The present Aging Network has planned its services around the assumption that there is an available and affordable direct care workforce. Quite to the contrary, workforce shortages point to the need for gerontology training-education of future professionals and paraprofessionals who would be employed in these settings. There is little motivation for new business, if it is known that a labor pool is neither available nor affordable.

Alternative Service Delivery Options

Service delivery options that are getting more attention are the consumer-directed long term care model, evidence-based health promotion programs/models, and the new "one-stop shop" access model for long term care like the ADRC.

Consumer-Directed Long Term Care Model. A newer option in long term care decision-making and care is referred to as consumer directed choice, or consumer-directed long term care (CDLTC). In CDLTC models, consumers are expected to express their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. Consumer direction ranges from the individual making all decisions and managing services independently to an individual, using a representative, to manage needed services. Equal rights, access to care, adequate health coverage, and the option to obtain services in community settings are important prerequisites for consumer directed or oriented health care. A number of states are experimenting with this new option, e.g., New Jersey, Florida, Arkansas.

Evaluation studies are limited, but research to date has generally provided positive results about the quality of care and consumer satisfaction. To date, studies on cost effectiveness are inconclusive, because these studies have been too small to produce definitive results (NCD, 2004). A number of issues need to be addressed and managed prior to any adoption of this model. These issues are related to tax liability, the employer and employee relationship, administrative oversight, and accountability of funds.

Evidence–Based Health Promotion Program. Evidence-Based Health Promotion Programs/Models (EBP/M) are defined as those prevention and treatment interventions that use "science-based" approaches; i.e., they identify what succeeds or works from what does not. The Center for Healthy Aging, NCOA (2006) identifies the purpose of EBP/M as: to recognize and specify individual and community-level health risks and conditions, select interventions or models that directly address those risks, and design interventions or programs that appeal to the people most likely to benefit.

EBP/M emphasizes education around individual and community health practices and the importance of managing chronic diseases and other health and health-related

problems with evidence-based programs or proven strategies. One model is Stanford University's Chronic Disease Self Management Program, which is a six to seven week community based peer led program to help participants with one or more chronic diseases develop self management skills, including improving preventive behaviors such as increasing exercise and eating a healthier diet. Results indicate that participants improved their health behaviors and self-rated health and had significantly fewer hospitalizations and fewer days in the hospital. Similar results with other EBP/M have produced comparable positive results (Center for the Advancement of Health, 2006).

Aging and Disability Resource Center (ADRC) or One-Stop Center. ADRCs are community level programs designed to help people make informed decisions about their long term care service needs and support options. Serving older adults, caregivers, and persons with physical disabilities, the ADRC have been shown to improve access and coordination of services (U.S. Administration on Aging, 2003). ADRCs provide service information, decrease service duplication, and support the empowerment of older adults and their families in meeting long term care needs. (See Section IV, p. 13)

Strategies for the Aging Network to Aging in Place

The Assistant Secretary of Aging, the Honorable Josefina Carbonell and Dr. Larry Polivka, have articulated the preferred goal for the Aging Network as one of making the Network: "…more responsive to the needs and preferences of older people and their families by empowering older people and their families to make informed decisions about their life choices, and creating more flexible service options from which people can choose" (2003).

The Aging Network continues to face challenges in ensuring that the desire for older adults to remain at home is not just a dream for aging Americans. According to Carbonell and Polivka the present challenges are to: (1) improve access to HCBS and balance long term care resources, (2) improve access to long term care in rural and multicultural communities, (3) apply more research-based and Evidence-Based Programs or Models to individual communities, (4) overcome barriers to home and community based long term care services (HCBS), and (5) address workforce issues and shortages.

The overall strategies to meet the challenges of the Aging Network are to:

1. Help people maintain and improve their health as they age,

2. Help families care for their loved ones, and, most importantly,

3. Help older people stay at home (p.315, 2005).

Summary

This section provided a brief review of the literature on five issues related to the planning of service delivery to older adults and the "Best Practice" literature. These are: (1) Ideal visions of preferred lifestyles for older adults now and in the future; (2) Methods for increasing efficiency and effectiveness of programs; (3) Incentives to increase numbers of agencies providing elder care; (4) New service delivery options and related issues of; and (5) Strategies for the Aging Network to respond to Aging in Place.

The literature review identifies a number of challenges and tasks for the Aging Network to increase responsiveness to older adults and their families. These tasks have been summarized aptly by Polivka and Carbonell (2003) and in the 2006 Reauthorization of the Older Americans Act (OAA):

1. Encourage collaboration among public and private organizations for funding for HCBS so older adults can remain in their own homes (their ideal vision or preferred lifestyle),

2. Increase efficiency and effectiveness of programs through the use of "Best Practice" models and incentives to support family caregiving, increased collaboration with private and faith-based organizations, and expanded use of volunteers,

3. Revisit and streamline federal and state procurement policies, procedures, and incentives to help secure a provider base,

4. Examine, pilot, and/or expand new models such as CDLTC, Evidence Based Programs/Models in Health Promotion, and One-Stop Centers (ADRC).

It is interesting to note that the conclusions and recommendations of this report based on the literature review and Key Informant data from the nine focus groups are consistent with the intent of the OAA. (See Section V. Focus Group Methodology and Findings, VI. Conclusions, and VII. Recommendations.)

IV. EOA PLANNING AND PROGRAM INITIATIVES

As early as 1997, EOA identified key issues affecting aging in Hawai‘i through the Hawai‘i Summit: Project 2011. The Hawai‘i Summit: Project 2011 was a multiyear strategic planning project with a focus on 2011 and beyond, when the first of the Baby Boomers would turn 65 years of age. From 1997-1998, EOA engaged the public in three tasks: 1) identifying key issues affecting older adults and aging in our State; 2) developing commonly held visions of the future; and 3) beginning work to chart a course for the Twenty-First Century. The five priority areas identified in this process were: Workforce and Economic Development, Housing including support for "aging in place" programs, Supportive Services, Health Care and Long term Care, and Community Development. Many of these areas centered on keeping older adults in their own homes even when frailty occurred (See Hawai‘i Summit: Project 2011, EOA, 1998).

More recently, the State Executive Office on Aging (EOA) has been working on a number of initiatives to enhance the well-being of older adults and their families. These efforts have focused on two major areas: long term care systems development and strengthening and expanding the Hawai‘i Aging Network.

Long Term Systems Development

Keeping Older Adults as Healthy as Possible. Beginning in 2003, the EOA partnered with the four County Offices on Aging, the Department of Health, and other community partners and launched the *Hawaii Healthy Aging Project*. This project is helping communities implement evidence-based research programs that test methods to help older adults, who are unable or reluctant to benefit from existing programs. These programs use models to increase physical activity and improved diet that have previously proven effective in the literature in reducing certain injuries, diseases, and long term care needs and costs. In September of 2006, the EOA was awarded a three-year grant from the U.S. Administration on Aging (AoA) to further this work.

Improving Access to Health and Long Term Care - The Aging and Disability Resource Center (ADRC). With a grant from AoA and The Centers for Medicare and Medicaid Services, the State intends to reach three goals: 1) establish a highly visible ADRC that serves as a single, point of entry to long term care services, benefits and programs; 2) streamline the process for screening, intake, assessment and eligibility determination; and 3) develop a statewide long term care access plan that will build the ADRC infrastructure for future replication throughout the State.

The EOA, in partnership with the Hawai‘i County Office of Aging, plans to co-locate services and providers in a centralized facility, offering a one-stop shop for information and resources in Hawai‘i county. At the same time, EOA will work in partnership with the Honolulu Elderly Affairs Division to establish a second ADRC in Honolulu.

Support for Caregivers: Caregiver Resource Initiative. EOA worked in partnership with the University of Hawai‘i, Center on Aging to develop and implement the

Caregiver Resource Initiative (CRI). State General Funds were supplemented by grants from the Brookdale Foundation and Hawaii Community Foundation. CRI has begun laying the groundwork for the development of a comprehensive support system for family caregivers and kincare families. Efforts have been focused on disseminating a quarterly Family Caregiver Newsletter, developing a comprehensive website devoted to caregiver education, and establishing the Hawai'i Family Caregiver's Network, as an added platform for policy and advocacy endeavors. These initiatives are in concert with the National Family Caregiver Support Program (NFSP) established by the 2000 Amendments of the Older Americans Act of 1965, as Amended (OAA).

Strengthening and Expanding the Aging Network

Empowering Users with Data. In 2006, EOA and University of Hawai'i's Center on the Family launched the Data Center on Hawai'i's Elderly on the web. As administered, this center provides a one-stop-shop for data and information related to Hawai'i's elderly adults. The first of its kind in the nation, the site can be accessed at http://www.uhfamily/hawaii.edu/datacenter/aging/.

Enhancing the Capacity of Aging Network in Planning. The EOA is facilitating processes to support the development of the State and County Area Plans on Aging (2008-2011). Following an assessment of educational needs of state and county staff, EOA offered 're-tooling" sessions to state and county planners and program specialists on planning methods.

Preparing for an Aging Society. On November 15, 2006, EOA and the four County Offices on Aging co-sponsored a Conference on Designing Livable Communities for an Aging Society. The conference helps the EOA and the County Offices on Aging to advance the aging agenda forward: Hawai'i's communities will have the necessary economic, workforce and physical capacity for meet the challenges of the aging society. The conference was designed to promote dialog between public and private sector stakeholders to plan for preferred futures. Intended outcomes were to: expand and strengthen the network; create awareness of the issues in other state/county departments; showcase best practices and innovative projects; share existing workable solutions; and identify opportunities for collaborative problem-solving.

Grassroots Planning: Policy and Advisory Board for Elder Affairs (PABEA) Community Forums. EOA and the Legislative Committee of PABEA, which provides advice to EOA on elder legislative issues, hosted nine community forums in Lihue, Central Oahu, Honolulu, Windward, Waianae, Kona, Hilo, and Kahului from September 18, 2006 to October 12, 2006. About 135 persons from public and private agencies, community special interest groups, service providers, and consumers participated. At the end of each forum, participants voted on the issues PABEA should pursue for the 2007 Legislative Session. The issues receiving the most votes from the nine forums were family caregiving, housing, transportation, and aging services and programs. Other issues receiving lesser votes were access to services, long term care resources, elder abuse and neglect, and health and wellness. Additional forums are being planned for Hana, Molokai, and Lanai in early 2007.

V. FOCUS GROUP METHODOLOGY AND FINDINGS

Design. Focus groups, in which small groups of individuals respond to a set of open-ended questions, provide a means of gaining a broad understanding of values, meanings, and perceptions of phenomena (Cresswell, 1994; Morgan & Krueger, 1998). This methodology was appropriate, because it was important to hear views from a diverse group of stakeholders and constituents on aging services.

Sample. Focus group Key Informants were recruited through the EOA and the four County Offices on Aging. The Key Informant pool consisted of adults who were: 1) former and current members of the PABEA; 2) staff from the County Offices on Aging; 3) current service providers; 4) other eldercare providers, including faith-based organizations; and 5) older adults, caregivers, and consumers. The participant pool was a broad cross section representing Hawai'i's diverse ethnic groups and counties.

A total of 100 individuals were invited, e.g., about 12 to the pretest and 20-25 for each of the four counties. As expected, some individuals sent regrets due to other commitments. Two of these individuals requested to respond to the focus group questions by phone or in writing, and these were included. Several Maui County Office on Aging staff members could not come because of worker shortages. Only one Key Informant attended the Big Island afternoon group because most invitees chose to attend the morning session.

The following comments were from 78 out the 100 invited participants who responded by phone or in writing for a 78% response rate. This is an acceptable response rate in qualitative research. Groups ranged in size from 1 to 14 Key Informants.

Table 1. Focus Group Dates and Key Informants

County and Group	Date	Key Informants
City and County of Honolulu		
○ PABEA pretest	August 7, 2006	9
○ AAA staff and current service providers	August 28, 2006	9
○ Other providers and consumers	September 18, 2006	11
Kaua'i County		
○ AAA staff and current service providers	September 14, 2006	14
○ Other providers and consumers	September 14, 2006	8
Maui County		
○ AAA staff and current service providers	September 21, 2006	4
○ Other providers and consumers	September 21, 2006	7
Hawai'i County		
○ AAA staff and current service providers	September 22, 2006	13
○ Other providers and consumers	September 22, 2006	1

Measures. Each focus group session was held during the workday and lasted approximately 2 hours, including the completion of the informed consent process and the demographic survey. One of the facilitators opened the meeting by explaining the purposes: 1) to seek information for SCR 115; and 2) to hear all opinions in the focus group. Then each member introduced him or herself by sharing name, affiliation, and one-two thoughts about role of planning for eldercare.

As individuals responded to focus group questions, the other facilitator typed the conversation directly into MSWord, and writing was projected on a screen for participant review of their words. Questions included:

1. In 2020, 25% of our state's population will be age 60 or older. Many of us will be in this group! How do you think older adults of the future will want to live?

2. It sounds like many of you believe that older adults will want to age in place. What are your thoughts on how the Aging Network should respond to this preferred vision?

3. Some think that caring for older adults should be a family responsibility; others think the government should provide the care, and still others see both have a role. In your opinion, what is the role of the family and government in eldercare? What more can families do? What more can government do?

4. Your county office on aging is being asked to "do more with less." This means that we keep getting less money to help seniors, even though the senior population is growing. Given this reality, can you please share your ideas about how we can meet the needs of older adults and family caregivers?

5. What would be the benefits and challenges of implementing a Consumer Directed Care model in Hawai‘i?

6. In addition to consumer-directed models, other innovations which could encourage the development of HCBS include tax credits for families, or the use of volunteers (as opposed to paid staff) to keep agency costs down. Let's start with your thoughts on incentives for families providing long term care. If you believe this is an option, what kind could be established? What are the potential benefits and challenges?

7. What about increasing our reliance on volunteers? What is your experience in recruiting and using seniors as volunteers in your program? We especially want to hear about your successes.

8. We have all heard about worker shortages in long term care. But some agencies manage to attract and keep good workers. Tell us about your successes in recruiting and retaining good workers.

9. The dramatic growth of the aging population suggests that we will need many more agencies to enter the marketplace to provide the array of services that are and will be needed. How can we stimulate more agencies to enter the marketplace and provide care to older adults and their families? What are the obstacles?

10. Do you think this county is able to provide services to older clients adequately and equitably? If not, what are the barriers to doing this?

11. Given our discussion today, what do you recommend for KUPUNA CARE?

Finally, Key Informants completed a short demographic survey that gathered information on age, gender, ethnicity, work background, and experience caring for their own older adults.

Analysis. The focus group conversations were transcribed, with each remark attributed to its speaker. Analysis was inductive and followed these steps (Cresswell, 1994; Morgan & Krueger, 1998). The two facilitators independently read the focus group transcripts to consider potential themes and structures in the data. In general, there was high agreement between the two facilitators on themes and which individuals spoke to each. Any disagreement was discussed until consensus was reached. The number of Key Informants who spoke to each theme was counted. Because not every individual spoke to every theme and because Key Informants who may have nodded agreement with the last speaker before speaking to a different theme (common in focus group and ordinary conversation) were not counted, individual support for themes is underestimated. County data is presented for each question. Survey data (e.g., age, gender, etc) were managed and analyzed by SPSS.

Findings: Characteristics of Key Informants. Table 2 shows the characteristics of Key Informants in the sample by county and statewide.

Table 2. Characteristics of the Sample

		Honolulu N=29	Kaua‘i N=22	Maui N=13	Big Is. N=14	Total N=78
Type	○ PABEA ○ AAA ○ Providers and consumers	9 (31.0) 4 (13.8) 16 (55.2)	0 8 (36.4) 14 (63.6)	0 2 (15.4) 11 (84.6)	0 6 (42.9) 8 (57.1)	9 (11.5) 20 (25.6) 49 (62.8)
Age	○ Mean ○ Range	61.76 26-90	52.30 26-75	59.38 49-81	53.77 44-63	57.44 26-90
Ethnicity	○ Chinese ○ Filipino ○ Japanese ○ Native Hawaiian	4 (13.8) 2 (6.9) 11 (37.9) 1 (3.4)	0 2 (9.1) 7 (31.8) 3 (13.6)	0 1 (7.7) 3 (23.1) 1 (7.7)	1 (7.1) 1 (7.1) 4 (28.7) 3 (21.4)	5 (6.4) 6 (7.7) 25 (32.1) 8 (10.3)

	○ White ○ Other/Mixed	11 (37.9) 0	8 (36.4) 2 (9.1)	7 (53.8) 1 (7.7)	3 (21.4) 2 (14.3)	29 (37.1) 5 (6.4)
Gender	○ Female ○ Male	18 (62.1) 11 (37.9)	16 (72.7) 6 (27.3)	10 (76.9) 3 (23.1)	8 (57.1) 6 (42.9)	52 (66.7) 26 (32.3)

In general, Key Informants were similar across counties. Of the 78 respondents, about one-third represented government and two-thirds represented non-profit providers and consumers of eldercare services.

The mean age of Key Informants was 57 years; however, Key Informants ranged in age from 26 years old to 90 years old. The ethnic distribution of Key Informants reflected that of the state. About two-thirds of respondents were female, which is consistent with the fact that more women than men: a) live to very old age; b) work in eldercare, and c) are caregivers.

Table 3. Eldercare Experience of Key Informants

	Honolulu N=29	Kauaʻi N=22	Maui N=13	Big Is. N=14	Total N=78
Cared for someone using local eldercare services	14 (48.3)	8 (36.4)	5 (38.4)	6 (42.9)	33 (43.4)
Years of health/human services work experience in Hawaiʻi					
○ Mean	22.68	15.07	15.75	18.69	18.82
○ Range	1-50	1-30	3-35	7-35	1-50
○ Total	658	332	189	262	1,430
Years of health/human services work experience in lifetime					
○ Mean	27.77	19.48	24.92	24.08	24.19
○ Range	1-60	1-50	8-35	7-35	1-60
○ Total	805	429	299	337	1,838

Key Informants had a wealth of experience in eldercare. Almost half had been caregivers for a parent or spouse in Hawaiʻi and had used local eldercare services. Several more had been long-distance caregivers for family members on the continental U.S. More impressively, these individuals had worked in health and human services. Although some were new to the field, having only worked in health and human services for a year, others have been in this field for 30 or more years. On average, Key Informants each worked 18.69 years in Hawaiʻi, represented an accumulated 1,430 hours of local experience! Thus, it was felt that these individuals were eminently qualified as Key Informants in response to SCR 115.

Findings: Themes from the Focus Groups. The findings from the focus groups are presented in this section, following the order of the questions posed to focus group participants. First, a table summarizing the key themes for each question based on focus group responses is presented, as well as the number of people from each county and for the state that spoke about each theme. Then, each theme is explained in more detail. Some themes are illustrated by quotes from the focus groups.

Table 4. Why Plan?

	Honolulu N=29	Kaua‘i N=22	Maui N=13	Big Is. N=14	Total N=78
The population is changing.	21	11	7	7	46
The needs of the elderly are growing and diverse.	13	5	8	9	34
We have a serious worker shortage.	5	4	7	14	30
Planning helps us see big picture, look for new solutions, and create a vision and work toward it	19	11	3	11	44
Planning is needed at the individual level.	5	6	6	3	20
Planning is needed at the societal level for best distribution of resources and best coverage.	17	10	4	10	41
Denial of aging interferes with planning and "status" of eldercare.	10	2	2	6	20

Population Characteristics are Changing. In every county, respondents talked about the advancing “tidal wave” of older adults. Because Hawai‘i boasts one of the longest life expectancies in the U.S., Hawai‘i will have more old people and older old people in the coming years. In fact, by 2020, one in four residents will be 60 years of age or older! At the same time, Key Informants talked about changing families. Families are smaller, and increasingly all adults must work to afford today’s life, e.g., at least at one, but often at two or more jobs. Thus, families have fewer human resources to care for dependent members.

Needs of the Elderly are Growing and Diverse. Key Informants noted that older adults will become more, not less diverse. For example, Hawai‘i has increasing numbers of 90 year olds and centenarians (those age 100 or older). They are most at risk for dementia and dependency. Hawai‘i also will have more young older adults like today’s Baby Boomers, who will be more consumer-savvy, computer-savvy, and demanding than the older adults of today.

Worker Shortage Exists. Hawai‘i has a serious shortage of workers in eldercare. Reasons for this include the poor wages and benefits paid to this group of workers, who find they can earn more in the tourist industry.

Planning is Needed. Most Key Informants embraced planning as a way to see the big picture and to look for new solutions. Planning allows us to create vision and work toward it. They noted that individuals have to start doing more planning for their own retirement and old age. More importantly, however, Key Informants viewed the planning

process as a way for society to assure the best distribution of resources so that citizens of all ages can maintain independence and ability to contribute to society for as long as possible.

Aging is Feared. Finally, Key Informants noted that many Americans are afraid of aging. In our youth-oriented society, we are concerned with looking young and hiding our age. When people are unwilling to face their own aging, they are less likely to prepare for their futures or to devote time and resources to deal with eldercare on a societal level. All countries in the world are dealing with, or will deal with, an aging of their populations.

> Quote – "We need to plan because we will all be a part of the older population, whether we want to or not. The shift in population will be so dynamic in the next 20 years. If we don't plan, we won't have the resources to meet the needs of the changing population."

Table 5. How Do You Think Older Adults of the Future Will Want to Live?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
In their own homes or in a community setting with responsive support, affordable options	17	10	11	6	44
With basic needs met --food, shelter, safety	12	4	9	3	28
With social needs met, including the ability to contribute	13	3	9	4	29
With control over their lives in whatever setting	15	2	11	6	34

Live In Their Own Homes and Communities. All groups believed that people will want to continue living in their own homes as long as possible. Barring that, people want to live in home-like settings and in community settings. If they need assistance to stay at home, they want affordable, supportive service options, for example, someone to come in to clean, or someone to shop for them, or someone to drive them to appointments if they can no longer do this independently. Key Informants referred to this as a desire to "age in place."

> Quote – "We need to support everyone's desire to **age in place**."

Meet Basic Needs. Like all people, older adults need to have their basic needs for food, shelter, and a safety met. Although this sounds obvious and simple, some Key Informants work with older adults who are homeless, can't afford to eat adequately, and live in unsafe conditions.

Meet Social Needs. Like all people, older adults cannot "live on rice alone." They have social needs as well. Older adults need to have opportunities to socialize with peers, to be connected across generations, to participate in the community in meaningful ways, and to continue contributing to society.

Have Control over Their Lives, Regardless of Setting. The aging process "slows" people down. With aging, all people experience declines in physical functioning and many people experience declines in cognitive functioning. These changes make it harder for us to meet our basic and social needs independently. We may need help and, at some point, we may not be able to live in our own homes and/or by ourselves. Even when we move to more protected environments, Key Informants noted that most of us will want to maintain autonomy and control to the extent possible. Some Key Informants referred to this as a desire to "age with dignity."

Quote – "We need to support everyone's desire to age with dignity."

Table 6. How Can We Help Older Adults "Age in Place" and "Age with Dignity?"

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
Support independent living and family caregiving.	10	20	9	10	49
Access to HCBS prevents more costly institutionalization.	9	4	7	4	24
Expand resources and funding for KC and HCBS.	13	13	13	10	49
Expand services that have been found useful:					
○ Wellness programs	5	1	1	2	9
○ Opportunities for socialization	7	3	3	5	18
○ Respite care	1	5	3	0	9
○ Transportation	4	2	1	8	15
○ Financial management services	3	3	0	3	9
○ Programs for the "gap group"	2	1	4	3	10
○ Case management	9	5	7	6	27
○ Caregiver training	10	5	2	6	23
○ Community based placement for older adults that cannot stay at home	3	3	1	2	9

Support Independent Living and Family Caregiving. Key Informants said that Hawai'i should support independent living and family caregivers, rather than institutional care. Home-based care is the type of care older adults want, and it is the least expensive option. Many older adults and families just need simple services to stay at home—a home-delivered meal, a friendly visit, help getting to the doctor, or someone to manage the bills. These services are much, much cheaper than institutionalization!

> Quote – "It will be necessary in the future to try to keep people at home because the cost of institutions is so high. "Home" is where they want to be, and "home" is where the state will want them to be because it is so much cheaper. But older adults and families may need a little assistance to "age in place" at home."

Access to Home and Community Based Long Term Care Services (HCBS) Prevents Institutionalization. Key Informants referred to the scientific research that has proven time and time again that access to HCBS can prevent institutionalization. Without these services, people may have a cascade of problems that lead to institutionalization. For example, a man who is widowed may not know how to cook for himself. If he can go to a senior center in the daytime, he will get a meal, he will have an opportunity to socialize, and staff can encourage him to go to the doctor if they see a problem. This package of services may cost the state $200/month. If he does not have access to these services, he may stop eating, which may make him weak and confused, which may cause him to fall and break a hip. If he is hospitalized for long, he may become more and more dependent. If he has no support system at home, he will go to a nursing home. This would cost the state an average of $7,000 per month.

> Quote - "These (KC) services are helping people stay at home, and at such a minimal cost. Otherwise, you have to build institutions, which are very expensive. You don't even have to know math very well to figure this out!...The Legislature needs to know how these services save the state money."

Expand Funding for KC and HCBS. At this time, older adults that qualify for Medicaid, e.g., the poor and low-income older adults, can access HCBS. But these services are very limited for the middle class, which has become the "gap group." Even the "rich" have trouble accessing these services, because services are not very available due to a shortage of agencies and direct care workers.

> Quote – "The County Offices on Aging are responding well, but we don't have enough (KC) money to even begin to meet the need...We have waitlists for all of our services."

Expand Services that Are Useful. Key Informants named a number of services that they have found useful. These run the gamut from wellness programs, to transportation, to respite (programs that send in a volunteer or low-paid worker to "sit" with the elder while the family caregiver runs errands), to financial management programs

(especially important for older adults who cannot manage their own money or are being financially abused), to case management (programs that assess an elder's need and arrange needed services), to end-of-life care. Programs that train people to be better caregivers including family members, volunteers, and paid staff who provide care to older adults are very important.

> Quote – "We need the full continuum of HCBS services so that there our older adults have choices that work for them and their families."

> Quote – "Caregivers need training. They have good intent, but they need to know about aging, what is normal, what is not, how to feed an older adult, how to help them. This is true for family caregivers and volunteers, as well as workers."

Table 7. Who Is Responsible for Eldercare—the Government, Families, or Individuals?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
Individuals have a responsibility for their own health and care, and families should help them.	10	3	8	8	29
Family caregivers burn out.	8	2	5	6	21
Government must care for those with no options.	6	3	10	5	24
Eldercare is a shared responsibility, including broader community (it takes a village)	15	3	11	7	36

Individuals and Families are Responsible. About one-third of Key Informants talked about the need for each and every individual to plan for the future. They felt people should improve their lifestyles in order to minimize development of chronic diseases, many of which can be avoided or delayed through healthy living.

They also felt that people should put aside part of their income for their own retirement and future long term care expenses. Some Key Informants believed that people with income and assets should not get free services or expect Medicaid to pay their bills. If people have income and assets, they should spend it to get the care they need. Reverse mortgages were mentioned as ways individuals could tap their assets to pay for needed care.

However, most Key Informants were very concerned about the growing number of older adults and families in the "gap group, e.g., too rich to qualify for Medicaid and too poor to buy services on their own.

Quote – "There are three kinds of older adults. The rich, who can afford their own care. The poor, who qualify for Medicaid, which offers very good home-and-community based service options. And then the "gap group" or middle class. It seems the "gap group" is growing. We need to support them, or they will join the growing ranks of older adults on Medicaid."

Unfortunately, **long term care is expensive**, with nursing homes costing an average of about $7,000 per month. Income and assets can be quickly depleted. One way individuals can protect against future long term care expense is to purchase long term care insurance. Because long term care is not a required benefit, only those who can afford it are buying it. More importantly, the costs are high, the "risk pool" is small; i.e., costs are not spread out over a broad pool of subscribers, and many users are finding the benefits to be inconsistent and inadequate.

Family Caregivers Experience Burn Out. Families, often women, do continue to care for their older adults, providing hands-on assistance and paying for services. Key Informants talked about how important filial piety and family care values are to the local population in Hawai'i. They also noted that families have shrunk and that living in Hawai'i is so expensive that everyone needs to work and many work two jobs. Coupled with the fact that we are living longer and longer, it is very hard for families to meet all the needs of older family members. Examples were given of family caregivers who worked so hard to care for a loved one that s/he became sick and died before the disabled elder! In staying home to provide care, family members, usually women, sacrifice their own ability to work for wages and to save money for their own retirement and long term care. The relationship between caregiving and poverty is well documented (Hooyman & Kiyak, 2005).

Quote - "I think the family should definitely be called on to help. But it's hard too for them, to give up everything to care…. It seems that more responsibility is being pushed on family. Caregivers are feeling more stress, and more needs to be done to support them."

Government is Key. Key Informants (24) felt that the government needed to step in to care for vulnerable groups, including older adults without families and older adults in abusive situations. It was noted that government can do a lot through creating policies that assure a minimum standard of living and safety for Americans. Key Informants felt the government should assure that adequate eldercare services are available to older adults. Government programs can be good and bad. An example of a good government program is Social Security, which helps keep older adults independent. Several Key Informants worried about the threats to privatize it. Medicare Part D was given as an example of a disastrous federal policy that has increased confusion and reduced coverage for older adults, while serving to enrich private insurance companies.

The "Whole" Community Must Share the Responsibility. One-half of Key Informants said responsibility for eldercare must be shared. The individual must take responsibility for his/her health to minimize future disability. The family must "pitch in" to care for its vulnerable members. The government must take responsibility for two areas: 1) caring for those who have no other options and 2) structuring ways to assure adequate and affordable eldercare services.

> Quote – "It takes a village to raise a child and help an older person. So the community needs to take more responsibility. Not only the caregiver in the community, but everyone…businesses, government, churches, younger people, families."

Respondents said the schools must teach children about eldercare, instill values about volunteering and helping others, and promote careers in healthcare and eldercare. Others talked about creative partnerships with hotels.

> Quote - "Perhaps hotels can give those individuals providing care to the elderly 50% off their hotel stay when they travel in the islands."

Table 8. How Can the Government Help Assure Adequate Funding for Eldercare Services?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
Tax credits for dependent care	5	6	8	3	22
Tax credits for long term care insurance	2	0	1	1	4
Mandatory medical savings plans	1	2	1	2	6
Universal coverage, like CarePlus or Family Hope	5	4	6	2	17
Affordable housing	4	1	1	1	7

Give Tax Credits for Dependent Care. About one-third of Key Informants thought the government should allow tax credits for dependent care, whether the family is caring for a dependent child or a dependent adult. This would give families some financial relief and serve to reinforce the notion that families should, to the extent possible, care for their own. A number of concerns were raised about the implementing this tax credit, e.g., would caregivers have to save receipts, would a government body need to visit the family to confirm that funds were spent on caregiving, etc.? Tax credits would not help everyone and may not be easy to implement, but should be offered.

Give Tax Credits for Long Term Care Insurance. Only a few Key Informants thought the government should allow tax credits for long term care insurance. There was

general skepticism about the effectiveness of privately offered long term care insurance plans. Without the benefits of a large risk pool, providers allow only the least risky individuals to buy into their plans, and stories were heard about consumers who had trouble claiming benefits from their policies.

Have Mandatory Medical Savings Plans. A handful of Key Informants talked about mandatory savings plans. These are required of individuals in Singapore, and several European countries are considering their advantages and disadvantages. These are funds that would be withdrawn from one's wages and placed in a special account. The individual would use these funds to cover personal and family healthcare expenses. This type of program would work for individuals who are employed, but not for the unemployed, a category that could include family members who give up work to care for a dependent family member.

Provide Universal Coverage. About one-fifth of Key Informants advocated for universal coverage of long term care services. Several had been involved in the design of the Family Hope and Care Plus programs that have been introduced to the Hawai'i State Legislature. Under these programs, a small payroll tax would be levied to create a pool of funds that could be tapped to cover long term care expenses for eligible adults. This would provide a minimum level of services for everyone, regardless of income, and would be especially helpful for the "gap group."

> Quote – "The Care Plus [universal long term care coverage] model would cost the individual less than $20/month. This was to help people receive long term care at home…Each caregiver would have gotten $1,000/month to put toward caring for their loved one"

> Quote – "Universality is key. In countries with universal care, you can assure that all older adults in need will get a basic level of services. And these countries end up spending less of their GNP on healthcare than the US."

Provide Affordable Housing. Seven Key Informants talked specifically of the need for affordable housing for older adults, believing that government had a role in assuring its availability. Homelessness among the elderly is a growing problem.

> Quote – "Unfortunately, my husband and I never could afford to buy a home. Now my husband is disabled, and I've had to quit work to care for him. It's been hard finding a place to live that my husband can get in and out of and that's affordable too. If the rent on our place goes up again, I'm not sure what we will do."

Quote – "I live in a wonderful senior housing community—Manoa Gardens. I am so lucky to have gotten in here. But there are so many other older adults that need a place to live. Can we build more places like Manoa Gardens?"

Table 9. In General, How Can We Expand Eldercare Services with Fewer Dollars?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
Expand resources and funding for KC and HCBS.	13	13	13	10	49
Relax procedures around procurement, contracting, licensing, permits, etc	11	12	6	10	39
Collaborate across agencies, generation, platforms - decrease confusion – 1-stop-shop	16	7	8	7	38
Revisit Medicaid cut-off.	0	1	8	4	13

Expand Funding for KC and HCBS. For the most part, KEY Informants did not think the Aging Network could expand KC services with fewer dollars. Instead, service providers generally thought more resources are needed to be channeled to eldercare. They noted that older adults qualifying for Medicaid can access HCBS fairly easily, while services for the gap group are limited with long waitlists. Families are burning out. Once they put their older adults in a nursing home, even if they start at private pay, the elder quickly depletes his/her resources and goes on Medicaid. Then the state must foot the bill averaging about $7,000 per month.

Quote – "Given our good track record of saving the state money by offering relatively inexpensive (KC) services to keep people at home, we should be provided more funds."

Relax the Procedures around Procurement, Contracting, Licensing, Permits, etc. Key Informants gave examples of the burdens placed on current providers. For example, there is a requirement that eldercare service providers have $2 million in liability insurance. There are numerous permits required to start a new business. State rules make it difficult to recertify Certified Nurses Aides (CNA) working in community settings. There was a general request to re-examine these procedures to see if they were necessary to assure quality or could be relaxed to expand the ability of providers to serve older adults.

Quote – "AAA does training, but I can't recertify my CNAs. If we hire CNAs, we get a discount in our insurance. But by law we cannot recertify the CNAs…you have to be in a "long term care facility" --like a hospital or

nursing home -- in order to be able to recertify. Then I lose workers to the care homes…We need to revisit these bureaucratic requirements. Can we ask the Legislature to look at the reports on the quality measures and other rules to see if they are all still needed or if they have become barriers?"

Increase Collaboration and Ease of Entry into the Eldercare System. Key Informants said that the eldercare system is confusing. This is because different services are funded by different payers (the Administration on Aging, Medicare, Medicaid, etc) and each has different rules and eligibility requirements. It is difficult for the elder or caregiver to understand and access services. All counties have Information and Assistance services and toll-free numbers. Honolulu and the Big Island also are establishing an ADRC as "one-stop shops."

Quote – "The one-stop shop is a great idea and will be a tremendous asset. Educate people so they don't have to learn every Alzheimer's program or care home. They just need to remember one thing…to go to the one-stop shop."

Revisit the Medicaid Cut-Off. Key Informants had issues with the Medicaid cut-off, which is the maximum amount of income one can have to qualify for Medicaid services. A few Key Informants asked that the legislature look at ways to have an equitable sliding fee scale for services.

Quote – If you're poor enough, you get everything paid for—whether at home or in a nursing home. But if you make $1 more, you are not eligible for Medicaid. Then you are in the gap group…and there are not enough services for the gap group!

They felt that older adults and families who could afford to pay something should contribute toward services.

Quote – "Some older adults that use community services (like KC) can afford to pay something. In general, I feel that if people get things for free, they take them for granted. But if they have to pay something, they will be more responsible."

Table 10. What Are Benefits and Challenges of Consumer Directed Long Term Care?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
CDLTC good for a segment of elderly population.	12	9	9	5	35
Safeguards must be in place to reduce risk of abuse and fraud	12	9	9	4	34
CDLTC works with Medicaid, but not sure about KUPUNA CARE	4	1	0	1	6

Consumer-Directed Long Term Care (CDLTC) Is Good for a Segment of Elderly Population. CDLTC is a model of providing services in which the elder or family is given cash or vouchers to purchase home and community based long term care services. About one-half of Key Informants felt this option might be appealing to a segment of the elderly population, e.g., those who were cognitively intact and wanted to do their own hiring, firing, and payroll taxes, and so forth.

> Quote – "CDLTC models have several advantages: 1) they maximize choice for older adults and families; 2) they support family care and independent living; 3) they can increase quality of services through competition; and 4) they can help relieve worker shortages, as older adults may use their allotment to hire a family member or neighbor."

Safeguards Must Be in Place to Reduce Risk of Abuse and Fraud. The CDLTC model must be managed carefully. Mechanisms would need to be in place to: 1) assess older adults for eligibility for services and determine their allotment; 2) teach older adults/families how to interview and hire a "good" worker and attend to payroll taxes; and 3) monitor the situation for fraud and abuse. Key Informants worried that families may decrease their willingness to provide "free" care if payment were available, that ill-intentioned people may become service providers so they can tap this source of "free" money, and that families may use the money for non-caregiving purchases (rent, drugs, etc.) rather than on the elder. They also said it would be hard for the caregiver to complain about a family member, even if he/she were doing a bad job of caregiving.

> Quote - "There are some disadvantages too. Families may decrease their willingness to provide free care if payment were available…Ill-intentioned people may become service providers so they can tap this source of free money…Families may use the money for alcohol or drugs, rather than on the elder…And, how can an elder complain about a family member, even if he/she were doing a bad job of caregiving?"

CDLTC Works with Medicaid, but Not Sure about KUPUNA CARE (KC). CDLTC approaches are being used by Hawai'i's Medicaid program. This program covers HCBS for dependent adults who would otherwise be placed in nursing homes. The average per client cost is capped at a percentage of the cost of nursing home care or an average of $2,300 per month. However, elders in the KUPUNA CARE (KC) program are able to receive much less than this monthly, e.g., $62.00 for services and the 10% administrative cost. Would a CDLTC model work in programs with very small average allotments?

Overall, Key Informants recommended starting with a demonstration project in a small community to work out the bugs and see how many persons this type of program appeals to, and not mandating CDCLTC statewide for all older adults.

> Quote - "The history of the voucher system is one of great use and great abuse. There are administrative costs to run the system, to prevent abuse and fraud, and to maintain quality. Yet this system appeals to our sense of autonomy and self-dependence. So you have to keep options. You can't go all one way because one way will not work for everyone."

Table 11. Can We Increase Reliance on Volunteers?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
Volunteers fill critical roles and make some programs possible	13	2	5	7	27
We know of excellent volunteer programs, sources of volunteers, and volunteer characteristics	16	6	7	5	34
Volunteers are not "free" - need training, supervision, recognition, reimbursement	11	7	7	3	28
Volunteers cannot do all, cannot substitute for all staff, but can supplement	8	4	4	4	20
Need to instill volunteer ethic and skills through lifespan, religious/service motivation	6	1	5	7	19

Volunteers Fill Critical Role. Key Informants were very enthusiastic and excited about the use of volunteers and the impressive roles that volunteers fill to meet the needs of older adults. Several programs that support older adults are dependent on volunteers. These volunteers deliver meals, visit shut-ins, run errands, escort elders to appointments and outings, provide respite to caregivers (watching the elder so the caregiver can run errands), assist in senior centers and adult day care programs, and so on. Simple tasks

performed by volunteers can make the difference in whether or not an elder can remain at home. We even heard examples of how volunteers save lives.

> Quote - "Meals-on-Wheels could not exist without volunteers. This is not the one-shot, feel-good volunteering, but the real commitment to consistency. We have people that have been volunteering for 25 years. One volunteer was the first person to come when someone had fallen the night before. He called for help right away, probably saving this elder's life."

Excellent Volunteer Programs and Sources Already Exist. Key Informants spoke admiringly of several Hawai'i programs that depend heavily or exclusively on volunteers. These included: Project Dana, the Retired Senior Volunteer Program (RSVP), Senior Companions, Meals-on-Wheels, Waikiki Friendly Neighbor, the state's seven hospice programs, and others. Good sources of volunteers are existing clubs (like Rotary, Lions, women's societies), churches, and schools. Retired professionals, like nurses and teachers, often make good volunteers and can fill professional roles as volunteers. Individuals who like to help others and who have had volunteering instilled in them at an early age through their family, school, church, leisure, or work are other likely candidates.

> Quote - "Project Dana (funded by KC) is a success story. They have that commitment through their religion, which is a strong part of the volunteers' lives. This helps them overcome the challenges they face as volunteers. Getting a core group of people like that is not easy, and the coordination is a challenge. But they are a great success."

Volunteer Programs Are Not Free. Even though volunteers can do many wonderful things at no charge, Key Informants noted that volunteer programs were not "free" programs. Several paid staff will need to recruit, train, supervise, and recognize the volunteers. A program should reimburse small expenses the volunteer makes on behalf of the elder. Volunteerism is successful only to the extent that the agencies using volunteers constantly work at it.

> Quote - "Individuals will volunteer as long as what they do is meaningful. The challenge is that many agencies see volunteer management as a one time event when in fact it is a series of steps…recruiting, intake, screening, training, supervising, recognizing, appreciating their contribution, and providing opportunities for leadership roles. So there is a cost to it."

Volunteers Cannot Fill All Roles. Although volunteers can fill many roles, there are some jobs that volunteers may not want to do and there are jobs for which there are not enough volunteers available. For example, it would be hard to provide 24-hour staffing for a nursing home using volunteers.

The Volunteering Ethic Needs to be Instilled and Supported. Key Informants called for programs in churches and schools that would instill and support a volunteering ethic throughout life. A few Key Informants had been members of Volunteer Credit Banks, to which they donated hours of volunteer labor in their fields (e.g., accounting) and then could ask for volunteer labor from someone with another specialty (e.g., house painting).

> Quote - "The Swedes have a model that incorporates volunteering in the curriculum. In 5th grade the kids start to have volunteer responsibilities, perhaps as visitors in a nursing home. Through their school years, responsibilities increase. So the first few years are training, and the last few years the kids are providing volunteer hands-on services to seniors. This also stops isolation on both sides."

Table 12. With the Worker Shortage, How Can We Attract and Keep Good Workers?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
We have a worker shortage!	5	4	8	14	31
Direct care is hard work. It is not respected, and it doesn't pay well.	8	6	3	6	23
"Good" workers love the elderly and agree with the "mission" of the organization.	6	7	5	7	25
Improving wages, benefits, and job security are important. Providing "extras" can help.	7	12	9	9	37
Agencies that keep workers recognize their contributions and demonstrate value and respect.	4	8	8	9	29

We Have a Worker Shortage! Key Informants were very discouraged about the shortage of direct care workers and social workers in home and community based long term care agencies. One expert said, "We cannot attract social workers to the field because there are not enough resources for them to work with to help older adults and families solve their problems." Another said:

Quote - "You can have all the programs and money you want, but we have no providers. There are no chore workers, home-meal deliverers, personal care workers, nurse aides, etc! With a 2.5% unemployment rate on Maui, we are flying nurses in to keep the hospital and nursing home open."

Direct Care is Hard Work and It Does Not Pay Well. Direct care workers (DCW) are paraprofessionals in home and community based long term care agencies, including certified nurse aides (CNA), van drivers, chore workers, homemakers, friendly visitors, activity aides, meals-on-wheels deliverers, personal care workers, and so forth. These are the workers who bathe, dress, feed, transfer, drive, help socialize, and clean up after older adults who cannot do so for themselves. They usually have no or minimal training following high school. The job can be physically demanding and stressful when caring for an older adult who has dementia, is angry, or is depressed. The pay is low, and the job is not well respected. It is much easier and more lucrative to work in the tourist industry as a maid, waitress, pool attendant, or grounds keeper. Home and community based long term care (HCBS) agencies on Maui and Kailua-Kona on the Big Island have a particularly difficult time recruiting paraprofessional workers away from the hotel industry.

Quote - It is hard work…it is not honored. Nurse aides are poorly paid. They get only $7-9/hours…We have employees at Adult Day Care that have been there 25 years working for $6/hour… But you can get $15-18/hour at the hotel. So they think "why not just go to the hotel and work for more money with less stress?"

"Good" DCW Love the Elderly. When recruiting DCW, Key Informants said they looked for individuals who love working with the elderly. Often, these people were cared for by their grandparents and had good experiences with older people. These individuals feel personally fulfilled by helping others. Many home and community based long term care agencies have "missions" to care for the less fortunate, and "good" eldercare workers certainly agree with this mission.

Quote – "It's a personal commitment to working in this field…it sure can't be the money!"

DCW Need Respect and Recognition. Agencies that keep workers recognize their contributions and demonstrate value and respect. Some agencies have "worker of the month" contests, other agencies have celebrations for workers, and others allow workers to "flex" their schedules to accommodate their own needs for child care, time off, and so forth. Many worksites offer training to workers so that they can improve their skills. Successful worksites are warm, welcoming, and rewarding.

Quote - "At the Adult Day Care, I allow staff to bring children when they have off time. The kids learn at a young age about being volunteers, they have name tags, they paint or color. This keeps my workers at work when they have a childcare crisis. And, I hope that later their children will become CNAs and go into eldercare."

DCW Need Improved Wages, Benefits, and Job Security. In the end, we must look at improving wages, benefits, and job security for HCBS jobs if we hope to increase the number of individuals entering this field. Hawai'i is expensive. Many direct care jobs pay so little and offer so few benefits that caring individuals cannot afford to choose this work.

Quote - "We have to raise wages, first of all. Today we find that someone who has the "heart" to work in eldercare has to leave the field because they cannot support their family on such low pay. So they go to the hotels."

Table 13. How Can We Get More Agencies To Enter the Marketplace?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
Reduce the burdens faced by new businesses that want to enter the eldercare market.	9	2	6	1	18
Reimburse adequately for services and pay on time, so the service provider doesn't go bankrupt	10	1	6	6	23
Offer assistance to existing agencies to improve management, and incubate new ones.	2	8	1	1	12

Reduce the Burdens Faced by New Businesses. Key Informants recounted stories about businesses that have tried to enter the eldercare market, but gave up because of the many difficulties they faced. They asked the Legislature to reduce these burdens.

Quote – "We need to make it easier for a new business. For example, the rules and regulations to start a care home or foster home are awful. We tried to help someone who wanted to start a care home. She found she needed permits from each different department. The departments were not talking to each other, and the permit was stuck in this department then that department. She went months and months losing money…so she finally gave up."

Reimburse Adequately for Services and Pay on Time. Key Informants asked KUPUNA CARE (KC), Medicaid, and other payers to increase reimbursement rates and improve the timeliness of payment.

> Quote – "Adult Day Care is a great service to help families keep older adults at home so they can keep working. But the reimbursement has never increased. We get $25/day to provide Adult Day Care, even though the cost is $55/day. So we can't serve as many, and we are dependent on fundraising so we can provide scholarships. The Legislators need to know that we operate at a loss."

> Quote –"The county and state take forever to pay. This is a problem for small start-up companies who don't have to front a lot of money for their business while they wait for the reimbursement promised in the contract."

Offer Assistance to Existing Agencies and Incubate New Ones. Key Informants asked that the Legislature establish business-assistance programs that offer sessions on government rules related to business as well as sessions on bookkeeping, payroll taxes, supervision, and so forth.

> Quote – "Kapiolani Community College had a contract to provide courses to develop your own eldercare business. I can think of three businesses we have today on Oahu that were "incubated" through this mechanism. It's a good idea to offer this again."

Table 14. Currently, Are Services Being Provided Adequately and Equitably?

	Honolulu N=29	Kaua'i N=22	Maui N=13	Big Is. N=14	Total N=78
KC- not adequately, because of waitlists, lack of services in rural areas, and worker shortages.	14	9	12	8	43
The county does the best it can with limited resources.	3	2	5	1	11
Aging Network must build capacity to engage the broader community, educate, advocate, leverage AoA funds to attract more funds, and really address the problem (focus beyond just dispersing AoA funds)	5	3	2	4	14

KC Services Are not Adequate. Key Informants overwhelmingly agreed that KC services were not adequate for their counties, and gave numerous examples about long

waitlists for services, lack of services in rural areas, and worker shortages. They asked the Legislature to release more funds for eldercare.

> Quote – "If you don't have enough funds, and you don't have enough agencies, and if the agencies have trouble recruiting and retaining workers, it's very difficult to meet the needs of seniors and families…For example, right now we have a waitlist of 40 for home-delivered meals on Kaua'i."

> Quote – "Hilo Hospital has been on "code black" for months—this means they have no room for new patients. The hospital is full of older adults waiting to go to a nursing home or to go home with services, but all the nursing home beds are full and the services have waitlists."

Counties Are Doing the Best They Can. Despite the lack of KC and AoA funds and workers, Key Informants overall were understanding of the predicament facing the County Offices on Aging and the service providers. Both were trying their best to help the older adults by securing public and private funds from other sources and being creative to stretch their resources, albeit thin.

> Quote – "If you are talking about Honolulu, we don't have enough (KC and AoA) money to meet the need. But the Aging Network here is doing an efficient job with the very limited resources. Still, there are waitlists, and the gap group is underserved."

> Quote – "On Maui, I'd say we are doing our best to be equitable. But adequate? No, because of lack of funding and workers."

Aging Network Needs to Build Capacity and Broaden Scope. Key Informants expressed a need for all public and private sector planners in Hawai**ʻ**i, but especially within the Aging Network, to build their capacity to deal with the tsunami of aging that is hitting the state. Housing and community planners need to make living spaces accessible to individuals with physical and mental impairments. Transportation planners need to prepare for a world with more older people, especially those that do not drive. Business planners need to know how to encourage and regulate eldercare businesses.

> Quote – "In this way, Hawai'i is behind other states. We are still operating in silos. County aging offices cannot JUST manage their AoA money; they need to leverage this money to attract more and get other departments and the private sector involved. To do this, they will need to build their capacity to learn from other states and vision a better system for Hawai'i. "

VI. CONCLUSIONS

Conclusions can be drawn from the focus groups about KC services as well as the long term care system of services for older adults. These findings are in concurrence with the findings from the literature review on aging and eldercare in the United States, and the Hawai‘i’s Summit Project 2011, A Strategic Plan for Action (EOA. 1998).

- Hawai‘i’s aged population will continue to grow, especially the oldest-old (those 85 and older) who are most at risk for dementia and increasing dependence. Based on demographics alone, more eldercare services will need to be provided

- Older adults, regardless of disability, want to live at home for as long as possible supported by family and a comprehensive system of home and community based long term care services (HCBS).

- The costs of supporting families and HCBS for older adults is many times significantly less than paying for nursing home care. States are experimenting with a number of ways to support caregivers (e.g., more services, family care giving tax credits), empower older adults (e.g., through consumer-directed programs), and expand community based options (e.g., through adult foster homes and assisted living communities).

- Direct care workers earn a low wage. Many agencies hire part-time workers to save on benefits. To meet escalating demand for HCBS, wages for direct care workers and funding for HCBS will need to be increased.

- Hurdles and disincentives for service providers and new businesses prevent new players from entering the eldercare marketplace. The public and private sectors need to examine ways to eliminate current barriers. Service providers’ ability to respond will be strengthened by knowledge of innovative care models in other states and countries.

- Government needs to examine strategies to fund not only KC, but other HCBS and the long term care system. Each potential source of funding has its advantages and disadvantages. Universal-coverage models are seen as more cost effective and equitable and less open to fraud and confusion than private-pay models.

VII. RECOMMENDATIONS

As a first step, EOA and County Offices on Aging need to engage in increased resource development, capacity building, and training. To further develop the needed infrastructure, EOA and County Offices on Aging would support capacity building and training for all state and county offices that have programs for older adults, including Departments of Health, Human Services, Housing, Transportation, Parks and Recreation, Commerce and Consumer Affairs, etc. We will need to collaborate and work together to lead the State in preparing for an "older" Hawai‘i.

The six recommendations that follow are listed in priority order, based on the discussion of focus group questions with Key Informants. The first recommendation had the greatest number of responses, the second recommendation had the second greatest, and so on. Overall, these recommendations speak to the need to optimize the planning efforts of the State and County Offices on Aging for an aging society, some of which EOA has begun to address in initiatives described in Section IV on pp. 13-14.

While all recommendations indicate the need for continued support from the public and private sectors, as well as Twenty-Fourth Legislature of the State of Hawai‘i, each recommendation may have strategic planning issues not only related to KC, but to the further development of the continuum of care in the long term care system.

The recommendations are:

1. Expand resources and funding not only for KC, but for other HCBS. Reexamine all funding alternatives, including universal long term financing and insurance models, e.g., Family Hope and Care Plus.

2. Support family caregivers, volunteers in eldercare, and direct care workers.

    a. Increase access to and funding for KC to keep people in their own homes and in the community.

    b. Support family caregivers by examining potential tax treatment options of caregiver expenses, expanding Family and Medical Leave benefits, and providing caregiver education.

    c. Expand support for volunteering by increasing funding for existing volunteer programs, e.g. RSVP, Project Dana, and fund technical assistance to agencies that wish to start volunteer programs.

    d. Support direct long term care workers by providing a fair wage.

    e. Support additional strategies by: 1) providing workers with information about eligibility for federal tax credits; 2) encouraging the development of employer health insurance purchasing pools; and 3) linking in-home

workers to existing supports for taxes, health care, childcare and other services for low-wage workers.

3. Fund training programs in gerontology and geriatrics.

    a. Provide training for direct care workers (DCW) including family members, volunteers, or unrelated paid workers. All DCW need to know: 1) how aging affects people physically, mentally and socially; 2) how to distinguish normal aging from disease (when to seek professional help for the elder); and 3) proper care techniques (how to lift, how to feed, how to bathe).

    b. Support professional education in gerontology and geriatrics to insure an adequate workforce.

4. Encourage personal, health, and financial planning for aging and long term care for all and with a special focus on Baby Boomers.

    a. Continue to increase collaboration and coordination between public and private health and aging networks to promote healthy lifestyle practices across the lifecycle.

    b. Launch a public awareness program to promote physical activity among older adults, and implement Evidence-Based Programs/Models.

    c. Conduct a major public awareness campaign to better inform the community about long term care programs currently in place, the strengths and shortcomings of these programs, and government and personal responsibility for aging and for long term care.

5. Identify ways to streamline state and county procedures for procurement, licensing, certification, and contracting, which discourage new businesses from entering the eldercare market.

6. Pilot alternative care models as follows:

    a. Consumer-Directed Long Term Care (CDLTC), which provides payments directly to older adults and family members so that they can shop for, purchase, and monitor their own services. It may not be cheaper, because of the need to build the infrastructure to help older adults/caregivers manage payroll taxes, monitor appropriate use, and prevent fraud and abuse. However, this model may help address the workforce issue, as older adults may hire and pay a family member or neighbor to provide care.

b. One-Stop Center or Aging and Disability Resource Center (ADRC), where older adults and caregivers can be empowered to learn about all service options in one setting, rather than going to each service provider to find out about eligibility and service availability. EOA is already working in partnership with and County Offices on Aging on Big Island and Oahu to establish an ADRC.

Note: The Twenty-Third Legislature of the State of Hawai‘i, Regular Session of 2006 is recognized for its leadership in passing three important bills: 1) SB 3252 (Act 262), which appropriates $500,000 to EOA for KC expansion and $80,000 to coordinate family caregiver support services and policies statewide; 2) HB 1900 (Act 160), which appropriates $206,000 to Kapiolani Community College to establish a Long-Term Care Training initiative for paraprofessional and family caregivers; and 3) SB 3253 (Act 285), which facilitates the development of a comprehensive public policy to strengthen support for family caregivers by establishing a Joint Committee on Family Caregiving. These bills moved the Hawai‘i Aging Network forward in addressing some of the older adult and family caregivers’ needs, as described above.

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THE SENATE

TWENTY-THIRD LEGISLATURE, 2006

STATE OF HAWAII

S.C.R. NO. 115

SENATE CONCURRENT RESOLUTION

Requesting the executive office on aging to convene a focus group with other stakeholders to assess yearly service delivery needs and long-term strategic planning for kupuna care.

WHEREAS, in 1999, the Executive Office on Aging, in partnership with county area agencies, launched the Kupuna Care program to address the long-term care needs of the aging population; and

WHEREAS, Kupuna Care, designed to assist older adults living independently, has proven to be very successful, cost-effective, and in high demand; and

WHEREAS, although the allocation for fiscal year 2005-2006 is able to meet the current demands, it is unlikely to meet future demands due to increases in the cost of service delivery, increases in cost of living and wages, increases in longevity of the elderly population, and a decrease in voluntary contributions to supplement static funding; and

WHEREAS, as a first critical step to ensure an efficient service delivery system, long-term strategic planning is needed before embarking on service expansion for Kupuna Care; and

WHEREAS, successful long-term strategic planning requires a comprehensive review of state- and federally-funded service delivery systems for the federal initiatives currently under consideration for

2008, including budget reductions in funding for state and community-based services; and

WHEREAS, in order to forecast the need for caregiver services on a state-wide basis, development of a population-based needs assessment caregiver survey for each county is essential; and

WHEREAS, additionally, a strategic plan that integrates new complementary services and methods of service delivery, volunteer-based community organizations, and incentives for providers and agencies that will stimulate competition is imperative for successful service expansion; now, therefore,

BE IT RESOLVED by the Senate of the Twenty-third Legislature of the State of Hawaii, Regular Session of 2006, the House of Representatives concurring, that the Executive Office on Aging is requested to convene a focus group with other stakeholders to assess yearly service delivery needs and long-term strategic planning for Kupuna care; and

BE IT FURTHER RESOLVED that the Executive Office on Aging is requested to report findings and recommendations to the Legislature twenty days before the convening of the Regular Session 2007; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of the Executive Office on Aging and the Director of Health.

OFFERED BY: _____

Report Title:

EOA to analyze long-term care goals for Kupuna Care.

LINDA LINGLE
GOVERNOR OF HAWAII

CHIYOME L. FUKINO, M.D.
DIRECTOR OF HEALTH

PAT SASAKI
EXECUTIVE DIRECTOR

Telephone
(808) 586-0100

Fax
(808) 586-0185

STATE OF HAWAII
EXECUTIVE OFFICE ON AGING
NO. 1 CAPITOL DISTRICT
250 SOUTH HOTEL STREET, SUITE 406
HONOLULU, HAWAII 96813-2831

Dear

In response to Senate Concurrent Resolution 115, the State of Hawai'i Executive Office on Aging (EOA) is embarking on a process to assist the State to respond to the needs of elders now and through 2020, when it is projected that older adults will comprise 25% of our population. To this end, we have contracted with Drs. Colette Browne and Kathryn Braun from the University of Hawai'i at Manoa to conduct and summarize the information to be gathered in focus groups to be held on Oahu, Maui, Kauai, and the Island of Hawaii. In each of these focus groups, we hope to hear from a diverse group of individuals about their preferred visions for eldercare, their thoughts on potential new service alternatives, and other pertinent issues for the counties and the State. Information gathered will help the EOA prepare for the strategic planning process for KUPUNA CARE services.

We believe that you, as a member of the State's Policy Advisory Board for Elder Affairs (PABEA), are in a unique position to provide us with your views on these topics. We cordially invite you to attend a special meeting at EOA on Monday, August 7, 2006 from 9:30 a.m. to 11:30 a.m. in Room 410 as a participant in this important process.

We hope you will be able to join us on this day. Refreshments will be served. Enclosed is a parking pass that is valid from 9:00 a.m. to 2:00 p.m. on August 7. Should you have any questions, please do not hesitate to contact Dr. Colette Browne at (808-255-7930) or Ms. Elvira Lee (808-586-7297).

We look forward to seeing you there.

Sincerely,

Pat Sasaki
Executive Director

EL:ta

Enclosure

ATTACHMENT 3

Focus group questions for Area Agency on Aging Providers, Current Providers, and Others

(August/September 2006)

Introductions

- Thank you for coming to this group. My name is Colette Browne, and together with Kathryn Braun, we will be facilitating the group today. We are with the University of Hawaii at Manoa. We have been selected by the State Executive Office on Aging to complete this project.
- This effort today is in response to Senate Concurrent Resolution 115, which requests that the EOA convene focus groups to assess yearly service delivery needs and long-term strategic planning for Kupuna Care.
- Our purpose today is to: Talk to professionals from the county Offices on Aging, current service providers, and others to get ideas about the kinds of services that older adults and their family caregivers need and want on this county in order to maximize their health and well-being.
- Before we start, we want to assure you that:
    - We are VERY interested in what you have to say
    - There are no right or wrong answers, so tell us whatever you really think or feel.
    - Because we want to hear from each of you, I may call on you if you are quiet. And if you are talkative, I might ask you to "hold that thought" while we hear from some of the quiet ones.
    - Everything you say is confidential; in other words, what you say will not be attached to your name in our report.
    - But from the answers from this group and others, we will learn how the State can improve services to seniors.

Q1 Icebreaker: Give us your name, the agency that are you from, your present position in this agency, and share with us one good thing about planning for services for older adults.

For the past thirty years, researchers have been studying older adults in attempts to learn how people want to live in their later years.

Q2: In 2030, 25% of our state's population will be age 60 or older. Many of us will be in this group! How do you think older adults will want to live?

Q3: It sounds like many of you believe that older adults will want to Age in Place. What are your thoughts on how the Aging Network should respond to this preferred vision?

Q4: In order for older adults to "age in place," some people think that caring for older adults is a family responsibility while others believe the government should be responsible. In your opinion, what is the role of government in helping older adults and family caregivers? What more should government do? What more should families do?

- Possible PROMPTS: tax-credits, stipends, other.

Q5: Your county office on aging, similar to all County Offices on Aging across the country, is being asked to "do more with less." This means that we keep getting less money to help seniors, even though the senior population is growing. Given this reality, can you please share your ideas about how we can meet the needs of older adults and family caregivers?

Prompts:

- Target services to fewer seniors

- Offer fewer services
- Streamline agency practices
- Increase suggested donations for services
- Expand use of volunteers
- Advocate for more funds
- Caregiver tax credits
- Look at options like Consumer Directed Long-term care programs

Let's look a little more closely at some of these ideas. As you know, a number of states are experimenting with Consumer directed long-term care programs. In Consumer directed programs, older adults eligible for some type of federal/state funds for services are given choice and control over their care through the respective State Office that has responsibility for those funds. In other words, older adults can express their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. One of the major differences between this model and what many agencies currently do is that the older adult individual (or representative that they choose to work with them) is responsible for choosing, managing and dismissing their care providers. Research is now ongoing to find out if these new programs actually do empower older adults to direct their own care and result in improved care and cost effectiveness for the state. (If necessary, briefly sum up similarities of some of these programs (can use New Jersey and Florida as examples).

Q6: What are the benefits and challenges of implementing a Consumer directed care model in Hawai'i?

Prompts:

- Bookkeeping/tax liabilities
- Employer/employee relations and responsibilities
- Degree of administrative oversight and accountability
- Quality of care
- Client safety issues

Q7: In addition to consumer-directed models, other options at service delivery alternatives include tax credits for families, or the use of volunteers (as opposed to paid staff) to keep agency costs down. Let's start with your thoughts on tax credits for families providing long-term care. If you believe this is an option, what kind could be established? What are the potential benefits and challenges?

Q8: What about increasing our reliance on volunteers? What your experience in recruiting and using volunteers in your program? We especially want to hear about your successes.

Q9: We have all heard about worker shortages in long-term care. But some agencies manage to attract and keep good workers. Tell us about your successes in recruiting and retaining good workers.

Q10: The dramatic growth of the aging population suggests that we will need many more agencies to enter the marketplace to provide the array of services that are and will be needed. How can we stimulate more agencies to enter the marketplace and provide care to older adults and their families? What are the obstacles?

Q11: Given our discussion today, do you think this county is able to provide services to older clients adequately and equitably? If not, what are the barriers?

Q12: What would you like to recommend for Kupuna Care?

Q13: That is the end of our questions. Is there anything else you'd like to share on this subject? Or perhaps you have questions for us. [Take questions]

II. Wrap up

- Many thanks for your participation today. We learned a lot from you, and we appreciate your help.
- We will be holding one focus group with each county office on aging, and also groups with seniors, caregivers, and other services providers. When we finish, we will compile the data. Our findings will be provided to the State Office on Aging and will help the State to better understand the issues and concerns of older adults in preparing for a strategic planning process. If you think of anything else you want to tell us, please call me at _____.
- Thanks again, and aloha.

ATTACHMENT 4

DEFINITIONS OF KUPUNA CARE

1. Personal Care: Personal assistance, stand-by assistance, supervision or cues.
2. Homemaker: Assistance such as preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.
3. Chore: Assistance such as heavy housework, yard work or sidewalk maintenance for a person.
4. Home Delivered Meals: A meal provided to a qualified individual in his/her place of residence. The meal is served in a program administered by SUAs and/or AAAs and meets all of the requirements of the OAA and State/Local laws. As noted in Section IIA, meals provided to individuals through means-tested programs such as Medicaid Title XIX waiver meals or other programs such as state-funded means-tested programs are excluded from the NSIP meals figure in line 4a; they are included in the meal total reported on line 4 of Section IIA. Certain Title III-E funded home delivered meals may also be included – see definition of NSIP meals below.
5. Adult Day Care/Health: Personal care for dependent older adults in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance and home health aide services for adult day health.
6. Case Management: Assistance either in the form of access or care coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.
7. Assisted Transportation: Assistance and transportation, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation.
8. KC Transportation: Transportation from one location to another; may involve a helpful driver. Does not include any other activity
9. Attendant Care: The service provides primarily stand-by assistance, supervision or cues, and may include other activities to help maintain the independence of older adults.