Theo Jung, 1935

Services to Aged and Disabled

Services to Aged and Disabled

As recently as 1900, the average person was fortunate to survive to age 50. As public health measures and medical technology advanced, increasing numbers of people survived disabilities and advancing years. Those who survived often lived with chronic health problems that limited their abilities to care for themselves, thereby placing added burdens on the primary caregivers, families.

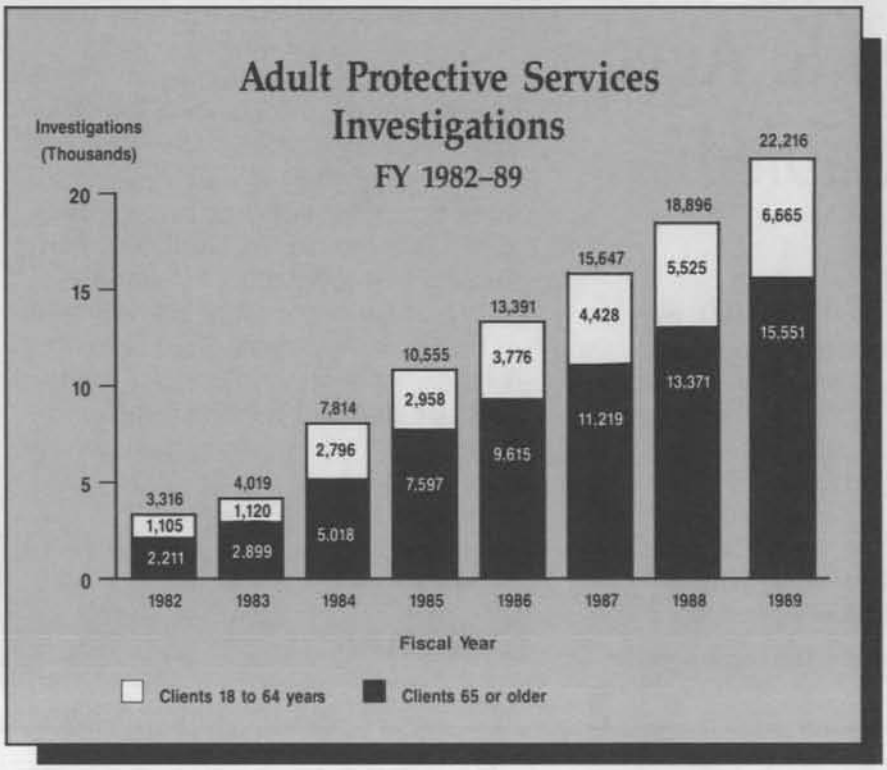
John Vachon, 1940

Through the generations, families have continued to meet the challenge of caring for their elderly or disabled members. The task has become more difficult, however, as families scatter throughout the nation for employment and most or all of the adults in a family work outside the home. To help families provide care for their aged or disabled members, support services have been developed over the past 20 years.

Adult Protective Services

In comparison with other department programs, Adult Protective Services (APS) is relatively new. The concept of protecting adults gained impetus in the mid-1970s when federal regulations required states receiving Title 20 funds to provide protective services to elderly and disabled adults and to children. At that time, APS functions were incorporated into the job responsibilities of social workers in Services to the Aged, Blind and Disabled, in what is now called the Community Care program.

In 1981, with the passage of Chapter 48 of the Texas Human Resource Code, APS became formally recognized. This law made reporting of suspected cases mandatory and required the department to investigate and intervene in situations of abuse, neglect and exploitation. At first applicable only to people over age 65, the law was amended in 1983 to include protection for disabled people ages 18 through 64. Also in 1983, the



Texas Legislature directed the department to conduct a public awareness campaign and establish a toll-free, 24-hour hotline for reporting abuse. Concurrently, the APS Division in state office was created, and statewide specialization of APS field staff began. APS was separated functionally from the Community Care program because of growing caseloads and the need for specially trained staff.

In 1987, the Human Resource Code was amended again to clarify state agency roles and responsibilities and to authorize DHS to oversee and review complaints about investigations conducted by other state agencies in residential facilities. This oversight responsibility includes identifying trends and systemic problems and recommending solutions in an annual report to agency boards, the governor, the Legislature and advocacy groups. The second annual report on facility investigations will be completed in November 1989.

Among the 50 states, Texas has the fifth largest population over age 60. The fastest growing segment of this population is the age group over 85, in which incapacitating conditions escalate rapidly. The number of younger disabled people in the population is also increasing. The need for protective services for vulnerable adults can be expected to rise well into the 21st century as the "baby boom" generation passes into old age.

Of those Texans found to be in need of protective services, approximately 30 percent are disabled people between the ages of 18 and 64, while about 70 percent are elderly people. Since fiscal year 1982, the first year that APS statistics were tracked, the number of reports and the resulting caseloads have increased 570 percent. Almost 19,000 cases were investigated in fiscal year 1988; this year the number will exceed 22,200.

Of the 22,200 reports, more than 18,000 cases were found to be valid, or in need of adult protective services. Still, conservative estimates by researchers and advocates place the number of abused adults in Texas in 1989 as exceeding 203,700. Considering these numbers, only one in 11 victims who needed services this year was able to get help.

While the caseload in fiscal year 1989 increased by more than 19 percent over the year before, the number of caseworkers increased by only 18 percent. Staffing this growing program continues to be a major issue, especially as burnout and turnover appear to increase in step with escalating workloads. Given the demographics cited earlier, staffing to meet the demands of 1990 and beyond will remain a program priority.

APS caseworkers rely heavily on other services for their clients, such as Community Care for the Aged and Disabled and Medicaid-funded institutional care, as well as on services managed within the APS program. Respite care services temporarily relieve caregivers from the demands of caring for an elderly or disabled family member as a means of reducing serious stress and burnout that could lead to abuse and neglect. In fiscal year 1989, 1,454 clients received 109,284 hours of respite care at a cost of $599,042. Emergency client services, which include the short-term provision of shelter, food, medications, nursing care, medical care, utilities and home cleanup, were provided to 1,027 clients at a cost of $90,719.

Russell Lee, 1951

A third service within APS, and a major issue for the program, is guardianship. Guardians help those people who cannot manage their affairs and take care of themselves alone. Guardianship services were reconfigured this fiscal year to move from a statewide volunteer model to one in which contracted staff will serve as guardians in selected counties in each region.

Another issue confronting the program is increasing caseloads resulting from the deinstitutionalization of mentally ill and mentally retarded people. The problems become acutely evident in many board and care facilities that house elderly and disabled people who are not eligible for nursing home or other institutional care but who still require some level of custodial care.

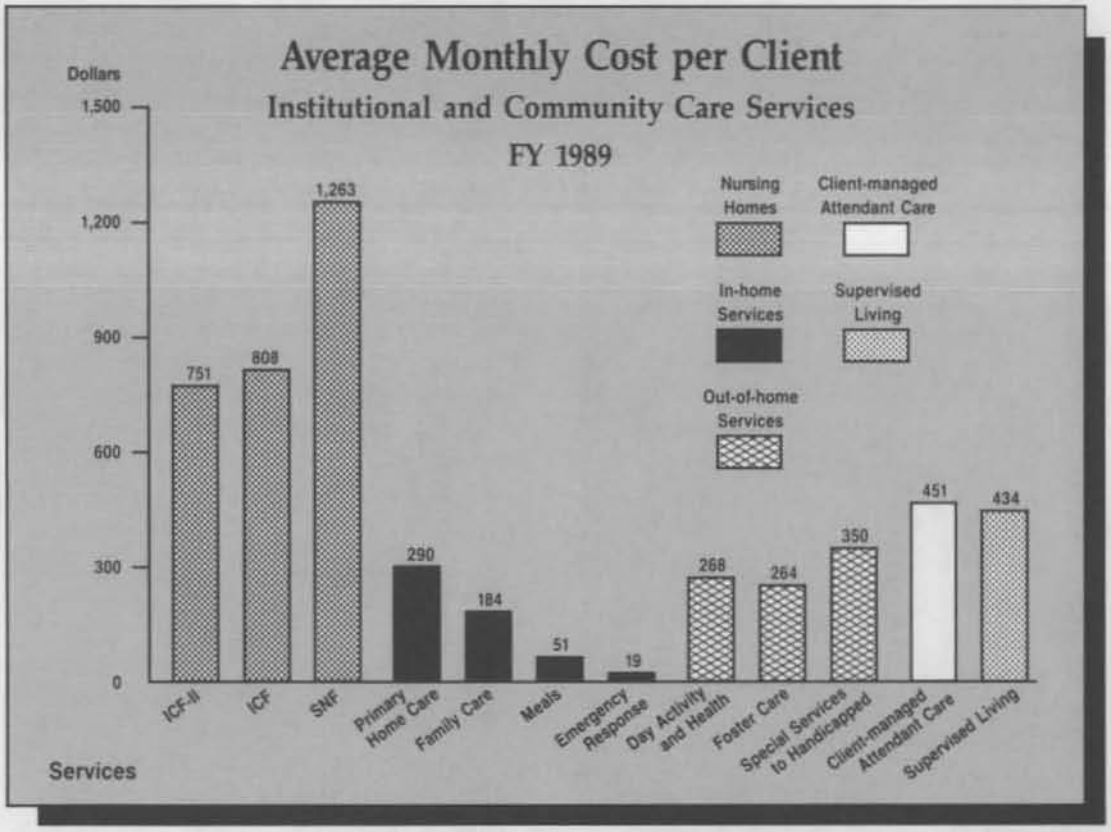
Services in board and care homes may be marginal; abuse, neglect and exploitation of elderly and disabled residents are reported frequently. Unfortunately, acceptable placement alternatives are scarce for low-income clients or those with behavioral problems. Legislators and staff from several state agencies began a combined effort this fiscal year to explore solutions to this problem.

Long-term Care

People who have chronic health problems that limit their abilities to care for themselves often need long-term care services. Although chronic health problems can strike people of all ages and income groups, the most likely people to need help are elderly people who are over age 85, younger people who have survived traumatic accidents or life-threatening illnesses and children who were born with serious health problems.

Prior to 1967, when the Medicaid program was implemented in Texas, there was little public support for people with long-term care needs. In the mid-1930s, the Social Security Act did allow the addition of up to $6 a month to old age assistance payments to help cover medical costs. By the 1950s, that sum was up to $30 a month and was eventually raised to $46.75 a month in the latter part of the decade.

Since 1967, the Medicaid program has offered more extensive services to people with long-term care needs.



The first long-term care service, skilled nursing facility (SNF) care in nursing homes, was implemented in Texas in September 1967. Fifteen months later, in January 1969, intermediate facility care (ICF) was implemented. Throughout the 1970s, nursing home care was the only Medicaid program available to meet long-term care needs. As a result, the program grew rapidly.

In 1974, the national Supplemental Security Income (SSI) program was implemented to provide a uniform public assistance payment for all qualifying aged or disabled people. Because the SSI program did not provide any additional support for people with long-term care needs, Texas began developing the first phases of the Community Care for Aged and Disabled (CCAD) program, then called Services for Aged, Blind and Disabled. A program called Family Care, which contracted with individual care providers, supplied some long-term care services in clients' homes on a priority basis—elderly SSI recipients got first priority; disabled SSI recipients got second. Elderly and disabled people who met the higher income requirements for nursing home care were last priority.

In 1975, Title 20 Social Services funds became available to "prevent or reduce inappropriate institutional care by providing for community-based care, home-based care and other forms of less intensive care." Using these flexible funds, the department initiated new community care programs such as home-delivered meals, foster family care, day activities, homemaker services and chore services, which were contracted to local

community organizations. Because there was a federal cap on available Title 20 funds, however, these services did not expand as quickly as the nursing home program.

During the late 1970s, projections indicated that if the nursing home program continued expanding at its then current rate, there would be more than 86,000 Medicaid recipients in nursing homes by 1989 at an annual cost of almost $1 billion. At the same time, the similarity between the clients receiving the least-intensive level of nursing home care, ICF-II, and those served by the Title 20-funded community care program was becoming clear. The Joint Committee on Long-term Care Alternatives, after exploring this situation in an extensive two-year study, concluded that Texas needed to expand the community care program to meet a larger share of the long-term care need in Texas.

As a result of the study, the Legislature in 1979 directed the department to phase out the ICF-II nursing home program and expand the community care program using Medicaid funds whenever possible. Although current recipients continued to be covered, no new clients were enrolled in the ICF-II program after March 1, 1980, when the department received a federal waiver of Medicaid rules to carry out the mandated plan. A part of the federal waiver allowed the new Medicaid community care program, called Primary Home Care (PHC), to serve all people who met the income criteria for nursing home care, not just SSI recipients.

In fiscal year 1980, more than 65,000 Medicaid recipients were in nursing homes and 31,000 were receiving community care services. At that time, the ICF-II program served more than 16,000 people; PHC served about 1,000.

By fiscal year 1989, the restructure of the nursing home and community care programs initiated in 1980 had been substantially accomplished. Only 250 recipients remained in the ICF-II program at the end of the year, and the PHC program had expanded to serve nearly 32,400 clients. Almost 5,000 PHC clients are served through federal waiver authority. The total mix of nursing home and community care clients today is 50-50, instead of the heavy institutional focus of the long-term care program of the 1970s.

During the 1980s, other important changes occurred. CCAD services were expanded, rigorous standards for service delivery were developed and contract monitoring procedures were strengthened. Eligibility rules were changed so that if resources are limited, as they often are for services not funded by Title 19, priority is given to clients with the greatest functional needs. New community care programs were developed to meet the specific needs of younger adults and children with disabilities. In the nursing home program, a payment methodology, case-mix reimbursement, was developed and implemented to base payment on the actual amount and type of care a client needs. This improved match of resources and service need should better support quality service and improve access for heavy-care clients.

As the department enters the 1990s, a number of initiatives and innovations will accelerate the rate of service improvement that occurred in the past decade.

■ The income eligibility ceiling for nursing home care and community care, increased to the federal maximum of $1,104 per month for a single person effective Sept. 1, 1989, from

previous ceiling of $715, will help fill the broad gap between program eligibility levels and the ability of individuals to purchase this care.

- Poverty-level disabled or elderly Medicare beneficiaries will receive help in paying their Medicare premiums, coinsurance and deductibles through a new program called Qualified Medicare Beneficiary (QMB) coverage. Under this program, Medicaid pays Medicare out-of-pocket costs for Medicare recipients with incomes below 85 percent of poverty in 1989, increasing to 100 percent of poverty by 1992.
- Federal nursing home reform provisions mandated in the Omnibus Budget Reconciliation Act (OBRA) of 1987 require increased nursing staff levels; increased nurse's aides training; more attention to recipient rights; preadmission screening of nursing-home applicants to prevent nursing-home placement of people with mental illness, mental retardation or related conditions; and the development of alternate community programs to serve people with these conditions who are already in nursing homes or who can no longer get into them.
- Expansion of the ICF-MR program will serve people with all developmental disabilities.
- Expansion of the In-home and Family Support program from a pilot project in San Antonio to a statewide program will extend services to disabled people.
- A collaborative effort with the Texas Department of Mental Health and Mental Retardation to provide targeted case management services for people with chronic mental illness or mental retardation and related conditions under Medicaid is expected to increase service availability and create substantial state savings through the maximization of federal funds.

Community Care

The department's community care services primarily help clients with activities of daily living such as bathing, dressing, grooming, toileting, meal preparation and related housekeeping tasks. Other services are also available to help clients maintain their independence. Some of the services provide support to families as they provide care and assistance to their elderly or disabled members.

Eligibility for all community care services is limited to those people who have high degrees of functional limitations. Additionally, financial eligibility requirements are similar to those for nursing home care.

The two largest community care services, Primary Home Care and Family Care, provide specific help with the activities of daily living to clients in their own homes. Higher degrees of functional limitations are required for these services than for other community care services.

Primary Home Care, which requires a medical need for personal care assistance and a physician's approval and nursing supervision, is paid for by Medicaid. Family Care provides similar services in a community setting to people who do not qualify for Medicaid. The department contracts with licensed home health agencies to provide these services. Clients in both programs can receive up to 30 hours of service per week. During the fiscal year, Family Care clients averaged about 8.9 hours of care per week. Primary Home Care clients averaged about 12.1 hours per week.

Recollections: The Day the County Poor Farm Closed

Dorothea Lange, 1936

Prior to 1933, the only help for the aged, disabled and poor in most small counties, such as Gonzales, was from the county pauper fund, the county poor farm and what local charities existed. The combined total was quite limited, as the county was in the throes of the Depression that covered the entire country. The local cotton mill, the major source of employment, had closed; and cotton, the major farm crop, had steadily declined for years. Banks had failed. There simply was little money available.

With the federal and state relief programs that started in 1933, there was some help for those able to work or families eligible for commodities. Many of the aged, especially those with no families to help, were placed in the county poor farm located on the outskirts of Gonzales. This was a plot of land owned by the county and managed by a married couple hired by the county to care for a number of aged persons. The residents raised some vegetables to help with food costs because the amount of money supplied by the county was limited. At best, the residents had a meager living. The rambling house was poorly furnished and generally quite depressing.

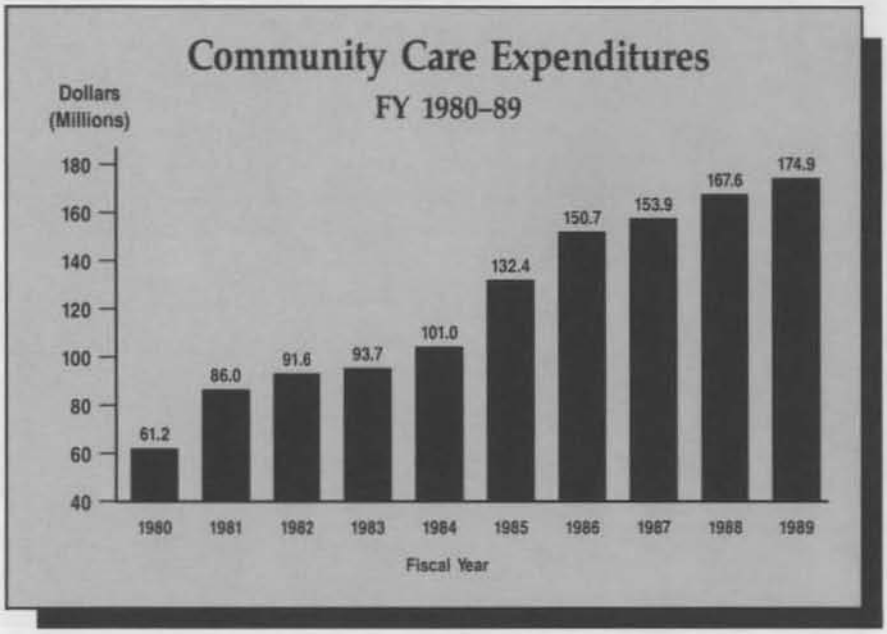
When the Old Age Assistance Program started in 1936, those people over 65 saw a chance to improve their lot in life. Some could move in with relatives since they had a little money of their own.

I remember one little old lady who did not have relatives but was determined to get out of the poor farm. She asked me to help her find a room somewhere so she could live her own life.

We were able to locate a place she could afford on the small OAA Grant she would receive, and the county commissioner agreed to send his truck to move her. She had a few possessions, an old bed and a small clothes cabinet. But I remember she had a rocking chair which she prized above everything else. I can still see her sitting proudly in her chair on the bed of the truck, as they drove away to her new living quarters. No queen ever graced a throne more regally.

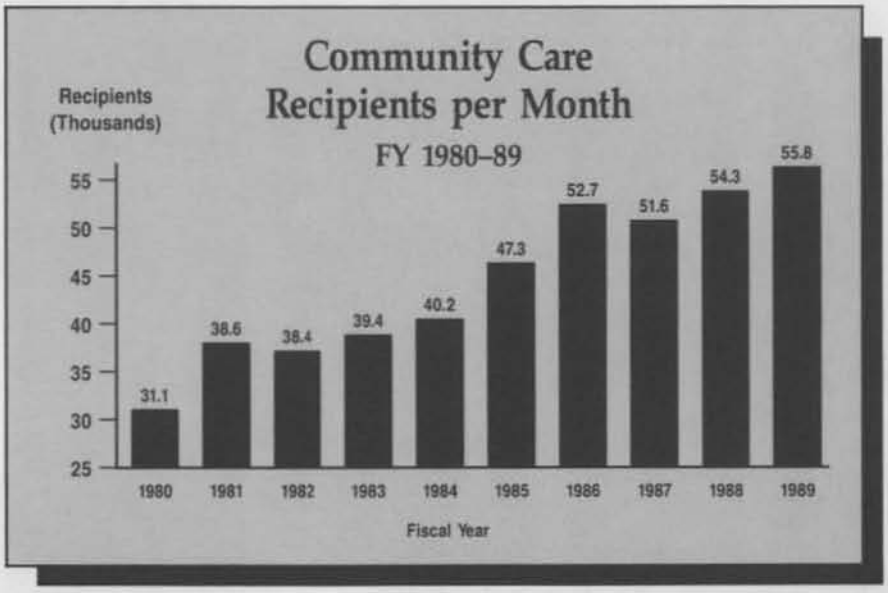
She may have been the last one to leave the poor farm. The county sold the house and land, glad to be relieved of the financial burden, and the former residents settled into their new living arrangements, glad to be living more normal lives. ■

Bill Midkiff, Gonzales



Congregate and home-delivered meals provided hot, nutritious meals in a central location or a client's home through community-based provider agencies. All menus were approved by a registered dietician or nutritionist.

Emergency Response System services provided 24-hour monitoring through qualified community-based agencies. Services were available to functionally impaired elderly or disabled adults who lived alone or who were physically isolated from the community. Eligible clients received an electronic monitoring device which, when triggered, automatically alerted a base station. The base station then had a preselected volunteer check on the person with the problem.



Adult Foster Care provided supervision and assistance with daily living to eligible adults in 24-hour settings. Adult foster care homes provided care for up to four clients, and licensed group homes provided care for five to eight. In Adult Foster Care, the client paid for his own room and board, and the department paid the caregiver for the personal care and supervision services.

Residential Care served larger groups of clients. Services included room, food, protective supervision, personal care, social contact, recreation, housekeeping, laundry, escort and transportation. Living arrangements ranged from apartments to converted nursing facilities.

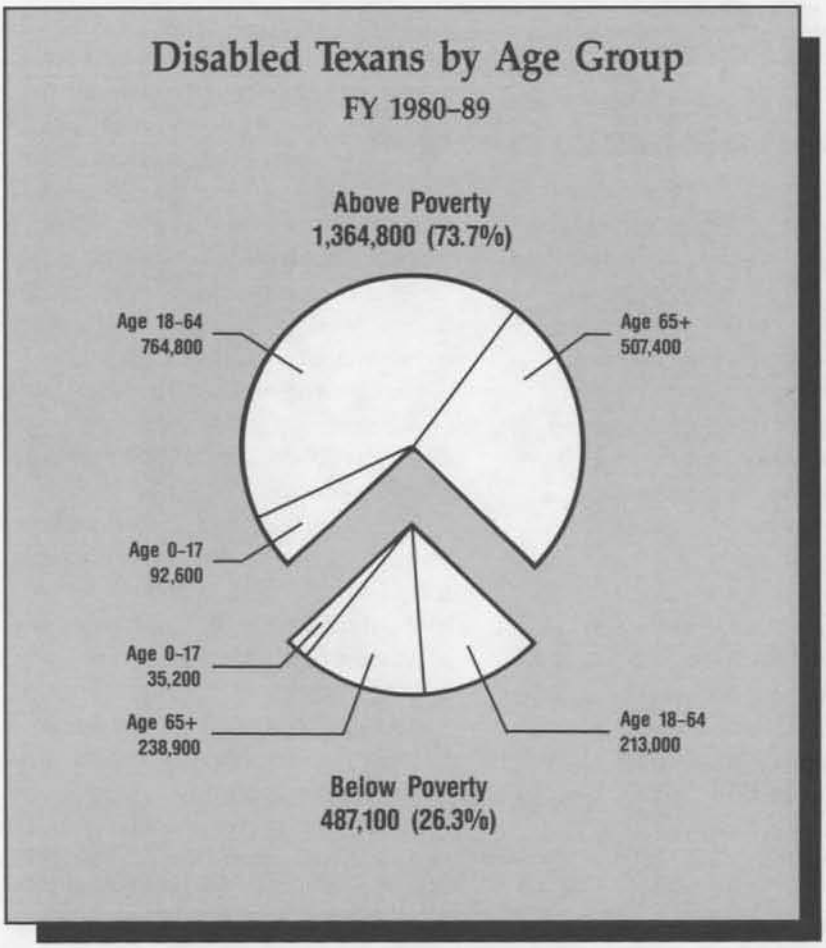
Day Activity and Health Services provided personal care, nursing services, physical rehabilitation, nutrition, transportation and supportive services in adult day-care facilities licensed by the Texas Department of Health and certified by DHS. These services were available at least 10 hours each weekday and could provide respite for clients' families.

The Tel-Assistance program provided assistance with telephone bills for poor and disabled elderly people who are heads of households. During the fiscal year, 28,624 people participated in the program.

Community care served an average of 55,835 clients per month in fiscal year 1989 at a cost of $174.9 million. This compared to 54,314 clients served per month last fiscal year at a cost of $167.6 million.

Special Programs for Disabled People

In addition to the services provided to people with disabilities through CCAD programs, a number of programs have been developed to address the specialized needs of disabled people. The Advisory Committee on Services to Aged and Disabled (ADAC) recommended several ways to improve these services, and many of their recommendations, including statewide implementation of the In-home and Family Support program and services for people with developmental disabilities other than mental retardation, are being implemented. Early in fiscal year 1990, the board approved the establishment of an Office on Disabilities. Department staff are working with a newly formed Task Force on Disabilities, which will prioritize the remaining ADAC recommendations and examine other ways to better serve disabled people.



The In-home and Family Support program began in 1988 as a pilot project in San Antonio with funds from the Texas Planning Council for Developmental Disabilities, as well as from the department. To be expanded statewide in fiscal year 1990, the program empowers individuals with disabilities to select and purchase services or supplies with cash subsidies of up to $3,600 per year. In addition, they may also receive one-time subsidies of up to $3,600 for architectural modifications or a major equipment purchase. There is no income limit for program participants. People with incomes above 185 percent of the poverty level, however, pay for part of the costs of the items purchased.

The Waiver Program for Medically Dependent Children provides in-home skilled nursing care and respite services for up to 120 severely disabled children who qualify for institutional care. Parental income is disregarded in determining eligibility as it would be if the children entered institutions.

The Client-managed Attendant Care demonstration project targeted clients who can hire and supervise their own attendants and schedule care according to their daily routines. The atten-

Dorothea Lange, 1936

dants provide help with personal-care tasks. Clients with incomes above the income eligibility level for community care participate by making copayments toward the costs of their care.

The Special Services for the Handicapped program provides counseling, personal care and help with developing needed independent living skills.

The Medicaid Hospice program serves clients who have a medical prognosis of six months or less to live and have chosen hospice care.

A pilot project in six counties will provide AIDS victims with case management, homemaker and skilled nursing care services, as well as outpatient treatment for narcotic and drug abuse and payment for certain private insurance premiums. Although efforts to secure funding for this project under a Medicaid home- and community-based waiver were not successful during fiscal year 1989, the state-funded project will provide the data necessary to apply for Medicaid funding next fiscal year.

Services through the Intermediate Care Facility for the Mentally Retarded (ICF-MR) program were initiated in 1969 when the Medicaid program was beginning in Texas. Services were initially provided in state schools; however, community-based providers became part of the program in 1977. In fiscal year 1982, as the program began to grow rapidly, new facilities entering the program were limited to those with six beds or less.

The ICF-MR services underwent other changes during fiscal year 1989. New federal regulations require the provision of comprehensive dental services to ICF-MR clients. The department is also testing the new case-mix reimbursement methodology in six ICF-MR facilities that specialize in services to children.

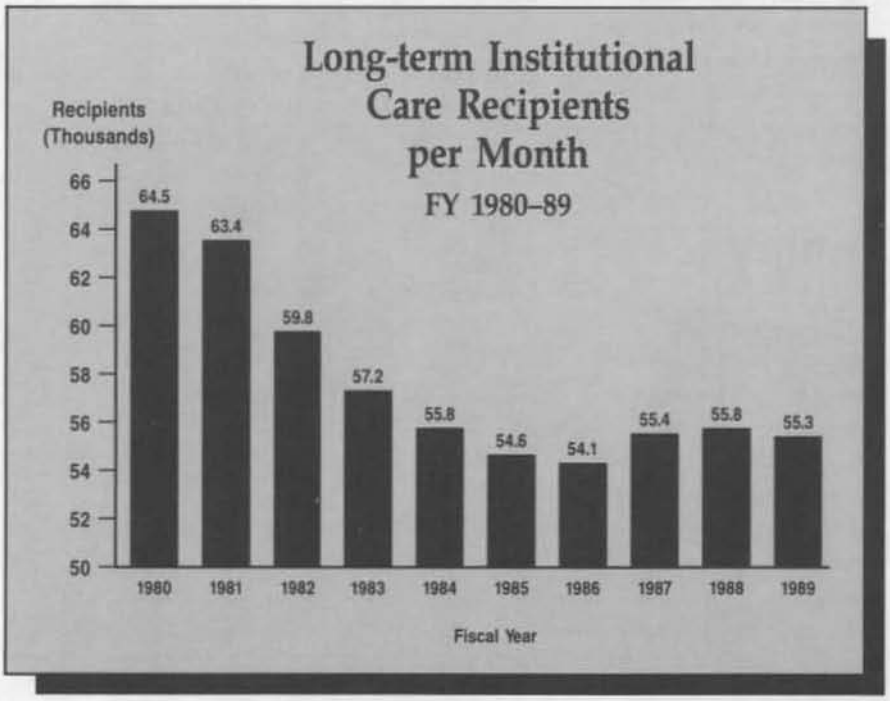
During the year, a monthly average of 4,386 clients received care in community-based facilities at a cost of $88.7 million.

Mentally retarded and developmentally disabled Texans who are eligible for Medicaid also receive care at state institutions. About 7,320 were served in state institutions at a cost of $318.9 million, including the state funds appropriated to the Texas Department of Mental Health and Mental Retardation.

Beginning in fiscal year 1986, the Home and Community-based Services Program for the Mentally Retarded was developed to provide in-home

services as an alternative to institutionalization. This program provided services for 458 mentally retarded clients in fiscal year 1989, and the program has federal approval to serve 1,350 clients by 1993. The client eligibility criteria were expanded to include mentally retarded children under age 18 who live at home, without regard to parental income, and mentally retarded clients who were denied Supplemental Security Income benefits but who are eligible for Medicaid under a protective status granted by the U.S. Congress.

The Texas Legislature authorized $8.5 million in state funds for fiscal years 1990–91 to provide services to people with developmental disabilities other than mental retardation through a new level of care within the ICF-MR program. With the help of a work group composed of consumer advocates, providers and experts in developmental disabilities, the department is developing the program and level of care criteria for this new service.



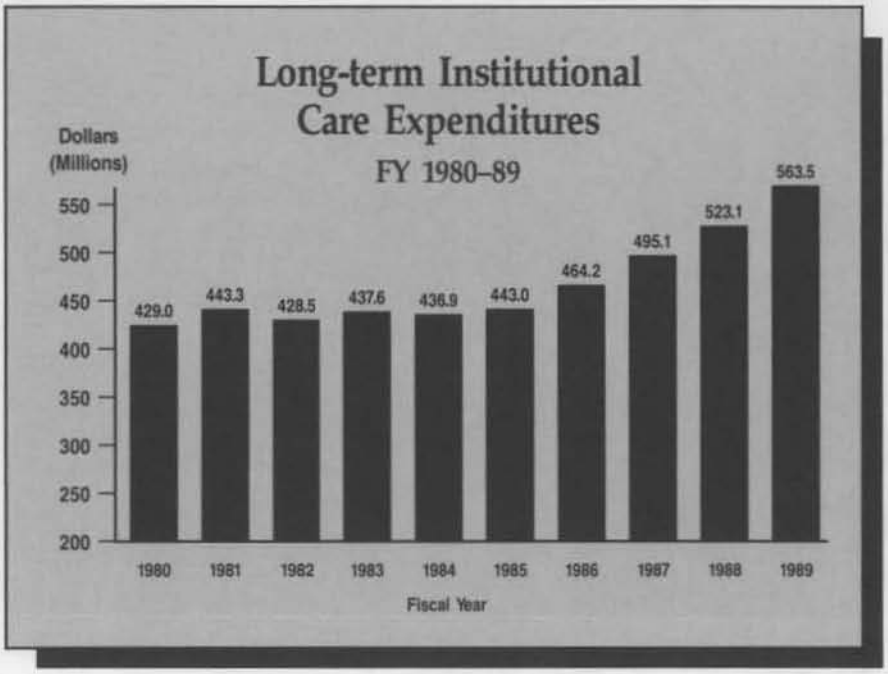
Institutional Care

Nursing home care is provided for those long-term care clients who can no longer be cared for at home and who need daily nursing care in an institutional setting. Care is provided in either skilled nursing facilities (SNF) or intermediate care facilities (ICF). During fiscal year 1989, several major changes were initiated in the nursing home program.

A new method of reimbursing nursing homes was implemented on April 1, 1989. This case-mix reimbursement methodology, called the Texas Index for Level of Effort (TILE), bases payment for the patient-care portion of the reimbursement on the care needs of the clients in each nursing home. The TILE system uses four clinical categories, which are further subdivided on the basis of functional capability or Activities of Daily Living (ADL), to establish classifications of recipients for payment purposes. Targeting resources based on client-care needs is expected to result in an improvement in the client's quality and access of care.

The department also worked closely with TDH and TDMHMR in planning and implementing changes required by the federal nursing home reform provisions included in the Omnibus Budget Reconciliation Act of 1987. These changes, coupled with changes in the financial eligibility criteria for nursing home care, will influence the program for years to come.

During fiscal year 1989, an average of 55,312 people received care each month at an annual cost of $563.5 million. The previous year, an average of 55,800 clients received nursing home care each month at an annual cost of $523.1 million.



Medicaid clients in ICFs and SNFs may be eligible for rehabilitation services through Goal-directed Therapy, which provides physical therapy, occupational therapy and speech language pathology services. During the fiscal year, an average of 63 clients per month received services at a total cost of $300,000 as compared to 55 clients per month served at a total cost of $276,323 in fiscal year 1988.

Client Eligibility

To qualify for the department's community care or institutional services, an aged or disabled person must have a demonstrated need for the service and meet the financial eligibility requirements. Need for service is determined through detailed functional and medical assessments of the person's condition.

Financial eligibility is based on a person's income and resources, such as property, bank accounts and insurance policies. To be eligible for Medicaid during fiscal year 1989, countable resources could not exceed $2,000, and countable income could not exceed $735 per month. The income eligibility ceiling for community care services was $735 per month, and the maximum resource limit was $5,000. More than 61 percent of those who receive community care were eligible for Supplemental Security Income and had less than $368 income per month.

Beginning Sept. 1, 1989, the income eligibility ceiling for institutional and community care services will be increased to the federal maximum of $1,104 per month. Beginning Oct. 1, 1989, a new federal requirement protecting a portion of a couple's income and resources will become effective. Commonly called the Spousal Impoverishment provision, the requirement will allow the spouse living in the community to use a portion of the couple's income and resources if the other spouse is institutionalized. Under this provision, a minimum of $12,000 in resources and $1,500 in income will be protected for use by the spouse living in the community.