U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

National Long-Term Care Channeling Demonstration:

Summary of Demonstration and Reports

March 1991

Office of the Assistant Secretary for Planning and Evaluation

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Office of the Assistant Secretary for Planning and Evaluation
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SUMMARY OF DEMONSTRATION

The U.S. Department of Health and Human Services (DHHS), in recognition of the large and rapidly growing need for long-term care for the functionally impaired elderly, funded a major demonstration to test the feasibility and cost-effectiveness of an alternative community-based long-term care service delivery concept integrating health and social services.

Ten community projects in ten different States participated in the National Long-Term Care Channeling Demonstration. Participating States were Florida, Kentucky, Maine, Maryland, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas.

A. PROGRAM MANAGEMENT

The Channeling demonstration was an intra-departmental long-term care initiative funded by the Health Care Financing Administration (HCFA), the Administration on Aging (AoA), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Assistant Secretary for Planning and Evaluation was responsible for the coordination and implementation of overall program policy in cooperation with the Administrator of the Health Care Financing Administration and the Assistant Secretary for the Office of Human Development Services.

B. EARLY FEDERAL PLANNING EFFORTS

Planning for the Channeling demonstration began at the Federal level in 1978. The initial Federal concept of a service planning and coordination agency (as originally identified in a government briefing memorandum dated July 14, 1978) entailed creating new agencies with three inter-related functions: (1) to channel all or part of the long-term care population--that is, to match those in need with appropriate long-term care service settings; (2) to plan for the long-term care service system to ensure that sufficient supplies of needed services and settings would be available; and (3) to coordinate directly or indirectly the provision of long-term care services.

In fiscal year 1980, Congress appropriated $20 million for a long-term care initiative to be designed and implemented by three groups within DHHS. Funding for such a research and demonstration effort was included in the research budgets of AOA and HCFA. The responsibility for managing the initiative was lodged in ASPE, reflecting statements in the congressional committee report on the budget and in a letter from the Appropriations Committee as to the intent of Congress.

The Federal planning efforts culminated in the issuance in April 1980 of a request for proposals from States interested in operating a Channeling project. The States, a technical assistance contractor, and an evaluation contractor were selected in September 1980.

DHHS had overall responsibility for the demonstration. The technical assistance and evaluation contractors had demonstration-wide responsibilities carried out under DHHS' direction. The fact that these activities were all demonstration-wide was crucial to the establishment of uniform procedures across sites, the commitment of State and site staff to the evaluation objectives of the demonstration, and the faithfulness of program operators to the operational procedures imposed on them by the research requirements.

DHHS announced the selection of 12 States in September 1980: Florida, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania, and Texas. (Hawaii and Missouri were later dropped for budgeting reasons from the group of research sites included in the national evaluation of Channeling, although they continued to operate their Channeling programs.)

C. OVERVIEW

Channeling was the provision of community-based long-term care services to people 65 and older who are functionally impaired and are unable to manage the essential activities of daily living (ADL) on their own, and who lack adequate informal supports. The core purposes of the Channeling demonstration were:

- To marshall and direct long-term care resources in a community in ways that contain overall costs.
- To increase access to a wider range of services than is currently available.
- To match services used to the identified needs of the client.
- To concentrate public resources on those persons with the greatest need for subsidized long-term care.
- To stimulate the development of needed in-home and community services which do not exist or are in short supply.
- To reduce the unnecessary use of publicly-subsidized long-term care services, including costly medical and institutional services.
- To promote efficiency and quality in community long-term care delivery systems.
- To promote a reasonable division of labor between informal support systems (including families, neighbors, and friends), privately financed services and publicly-financed care.
- To maintain or enhance client outcomes, including physical and mental functioning and quality of life.

Two models of Channeling were tested in the demonstration: a Basic Case Management Model and a Financial Control Model (or Complex Model). Although initial

plans had called for a second round procurement to select the financial control model projects, Federal resource limitations ruled out this strategy. As a result, it became necessary to select from among the Channeling projects already chosen those that would implement the financial control model.

D. DESCRIPTION OF CHANNELING MODELS

The Basic Case Management Model superimposed a coordinating and accountability mechanism--case management--onto the present system of services and client eligibilities. It accepted the features of the present long-term care system as given and introduced a mechanism responsible for helping clients gain access to and coordinate the services they need to continue to live in the community. The Channeling organization assigned to each client a case manager, who performed a comprehensive assessment of service needs; developed a plan of care that responded to those needs; arranged for the provision of needed services, relying on family and friends where feasible; followed up to see that they are provided and monitored their provision on an ongoing basis; and reassessed needs periodically or when circumstances changed. Thus, the case manager was accountable for identifying the entire package of services needed by the client and served as a client advocate in negotiating the complex array of programs and service providers.

The Basic Case Management Model, therefore, tested the premise that the major difficulties in the current long-term care system are problems of information, access, and coordination, which can be essentially solved by client-centered case management.

The Financial Control Model (or Complex Model) modified the Basic Model to control costs and to strengthen the projects' ability to access needed services. Projects were provided with fixed budgets, set at 60 percent of the average Medicaid Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) rate in the catchment areas, designed to help gain control over rising costs and increased demand for long-term care services. Federal and State waivers provided reimbursement for a variety of services that offered clients and care planners the opportunity to design more appropriate and efficient care plans than is generally possible under the current fragmented system of categorical programs. Services for which coverage was extended included:

Day Health and Rehabilitative Care	Day Maintenance Care
Home Health Aide Services	Homemaker/Personal Care Services
Housekeeping Services	Chore Services
Companion Service	Home Delivered Meals
Respite Care	Skilled Nursing
Physical Therapy	Speech Therapy
Occupational Therapy	Mental Health Services
Housing Assistance	Adult Foster Care
Non-routine Consumable Medical Supplies	Adaptive and Assistive Equipment

These services were paid for from a pool of service dollars primarily comprising Medicare and Medicaid funds, made available through waivers of some requirements of those programs. Services reimbursed out of the services pool were not dependent on a client's eligibility for particular categorical programs. Case managers had the power to authorize the amount, duration, and scope of services paid for from the funding pool. This vested in the case manager the power to limit, alter, or terminate services in response to changes in client needs. The power to authorize community-based services, irrespective of funding source, enhanced the case manager's ability to obtain services and control the cost of care plans, making the case manager accountable for the full package of services funded. In addition, clients whose income was above a protected amount (200 percent of SSI, plus State supplement, plus food stamp bonus) were required to share in the cost of services for which they would be subject to an income test outside of Channeling.

E. CORE FUNCTIONS

Both the Basic and the Complex Model included the following core clinical functions.

1. Screen. The process during which information was collected and recorded on the screen instrument, and a preliminary determination made whether an applicant was appropriate for the demonstration by comparing that information to standard selection criteria. The information needed for this comparison included age and nature of the applicant's problems, available formal and informal supports, extent of unmet needs, the probable duration of the needed care, and performance on ADL's (activities of daily living) and IADL's (instrumental activities of daily living).

2. Assessment. The collection of in-depth information about a person's situation and functioning which allows identification of the person's problems in the major functional areas, and permits the development of a plan of care. The Baseline Assessment Instrument was used both for research and clinical purposes.

3. Care Planning. The process of developing an agreement between client and worker regarding client problems identified, outcomes to be achieved, and services to be provided in support of goal achievement.

4. Arranging for Services. The process of negotiating with service providers, including formal and informal resources, for the delivery of needed services to the client in the manner described in the care plan.

5. Follow-up and Monitoring. The continuing contact the case manager has with providers and clients to ensure that services are being provided in accordance with the care plan and to ascertain whether these services continue to meet the client's needs.

6. Reassessment. The scheduled or event-precipitated re-examination of the client's situation and functioning to identify changes which occurred since the initial or most recent assessment and to measure progress toward the desired outcomes outlined in the care plan.

F. CASE MANAGEMENT

The case manager assessed need, developed a plan of care, coordinated and arranged for services, monitored services provision, reassessed need and revised care plan as the client's condition changed, and served as the client's advocate.

There were several factors involved in Channeling case management:

1. The Population. The clients were frail, vulnerable, severely impaired, often isolated, in need of long-term care services for an extended period of time, and in the absence of Channeling, were at high risk of being institutionalized. More detailed information on the Channeling population is attached in a series of tables (see below).

2. Cost Consciousness. The case managers, usually social workers and nurses, followed procedures that maintained awareness, and allowed control, of the costs of services that comprised plans of care.

3. Work with Informal Supports. The case manager worked with the family, family members, and other informal supports in order to arrange for formal providers to augment what the informal support system was capable of doing.

4. Health and Social Services. The case manager attempted to establish a new set of relationships between health and social service providers to substitute services provided in the community--both formal and informal--for institutional care, wherever community care is appropriate.

G. PHASES OF THE DEMONSTRATION

There were four major phases in the Channeling demonstration: demonstration planning, buildup, steady state, and demonstration closeout.

1. Demonstration Planning Phase. DHHS signed contracts with the participating States in September 1980. The planning phase lasted from this date until the local projects became operational. During this phase the sites were selected, detailed administrative and operational procedures designed, staff hired and trained, relationships with local providers and referral sources established, Medicare and Medicaid waivers obtained, financial arrangements for reimbursement of providers completed, data collection instruments designed, and research procedures affecting

the local projects defined. The planning phase ended when local projects began accepting clients, which occurred on a staggered basis between February and June 1982.

2. Buildup Phase. The buildup phase was marked by intense outreach and screening efforts to build project caseloads in order to achieve both the planned research sample size and the planned scale of operations at each site. There were two distinct time periods within this phase. The first, the randomization period, generally started when projects began accepting clients, and was the period during which applicants to Channeling were randomly assigned to the treatment or control group.[1] Randomization ended at a project when it achieved its planned research sample; for all projects this occurred in May-June 1983. The second, the residual buildup period, started at this point and was the period during which the projects continued to add clients to their caseload totals in order to meet the target caseload sizes established by DHHS for their planned scales of operation. During the residual buildup period, the projects adjusted their staffing patterns to accommodate the requirements of the steady state phase. The buildup phase ended in September 1983.

3. Steady State Phase. During the steady state phase, which began in October 1983, the projects were required to maintain a steady caseload size. As clients left the caseload because of death, institutionalization, improvement in condition, and so on, new applicants were screened and accepted to the caseload if eligible. This period most nearly resembled the operation of an ongoing program. There was continual turnover in caseload composition, but caseload and staff sizes were relatively stable. The steady state phase lasted until June 1984.

4. Demonstration Closeout Phase. During the demonstration closeout phase the projects stopped accepting new clients and implemented their plans for the closeout of the federally funded demonstration. The evaluation data do not cover this phase. The nature of the phaseout activities varied greatly from project to project: some went out of operation entirely, but most continued in some fashion with different funding arrangements. This phase extended from July 1984-March 1985, which was the end date of the States contracts with DHHS. (Fiscal staff in financial control projects were continued to June 1985 to close out their books for reimbursement of services.)

H. THE TECHNICAL ASSISTANCE CONTRACT

The technical assistance contractor for the Channeling demonstration was Temple University. Major responsibilities included: training screeners, assessors and case managers; responding to the needs of the sites; maintaining the communication network; assisting the government on program issues; and conducting an exploratory

[1] The four projects which were the first to begin accepting clients (Southern Maine, Baltimore, Houston, and Middlesex County) operated for one to two weeks without randomizing in order to test administrative and clinical procedures.

study of care planning. A number of program-related materials were developed during the planning and implementation of Channeling. The DHHS contract with Temple University ran from September 30, 1980 through December 1985.

I. THE EVALUATION

Mathematica Policy Research, Inc. (MPR), under contract to DHHS was responsible for evaluating the demonstration. This included the development of the research design, data collection instruments and procedures, the collection of the data and the performance of the analysis. MPR is an independent policy research and evaluation firm based in Plainsboro, New Jersey.

The evaluation employed a randomized experimental design to compare what happens under the demonstration with what would have happened in its absence. Applicants judged appropriate for the demonstration, based on a functional impairment screen, were randomly assigned to either a client or a control group. This permitted a direct comparison of the impact of the demonstration on participants with the outcomes of the control group members who received their services through the conventional delivery system. Participants in the research, both clients and controls, received comprehensive initial and follow-up interviews designed to gather data about their health, quality of life, use of formal and informal services, and expenditures for services. Additional information on costs and use of formal services were obtained from Medicare/Medicaid records and service provider interviews with informal caregivers. The evaluation also included an analysis of the actual implementation experience of the project, its relation to the existing service delivery system, its costs and its clientele. This analysis was based on interviews with key provider and project staff in the demonstration communities, as well as on data from the instruments used in the impact analysis, project reports, and existing public and project documentation.

All data collection activities involving information about individuals were reviewed and approved by MPR's Institutional Review Board established for protection of human subjects involved in research. All data about individuals remain confidential. Individuals who agreed to participate in the demonstration and research signed an informed consent, as well as releases for access to their records. Data collection forms and instruments were reviewed and approved by the U.S. Office of Management and Budget, and they, along with the project's record-keeping system, have received clearance under the Federal Privacy Act. The DHHS contract with MPR, Inc. ran from September 30, 1980 through June 15, 1986.

J. MAJOR DATA COLLECTION ACTIVITIES

- Screening data on all appropriate applicants.
- Baseline and two six-month follow-ups on full sample of treatments and controls. An 18 month follow-up on half the sample.

- Medicaid and Medicare claims data on full sample.
- Extracts from provider billing records of services utilized by a 20 percent subsample of treatments and controls.
- Baseline validation interviews by MPR interviewers of about 400 treatment group members.
- Check of death records for sample members who do not have a completed follow-up interview.
- Baseline and two six-month follow-up interviews with primary informal caregivers for a subsample of late enrollees.
- Process analysis interviews with staff of States, sites, Temple University, and DHHS.
- Channeling project cost and caseload reports.

K. MAJOR FINDINGS

Major findings from the demonstration include the following:

- The population served by Channeling was extremely frail, had low incomes and reported many unmet needs. The average age was 80 years, the average income was $542 a month and 84 percent were restricted in their ability to perform ADL. The remainder, while having no ADL impairments, had multiple impairments with respect to the IADL. A large majority of respondents (82.5 percent) reported their overall health as fair or poor.

- A high proportion of the Channeling sample was female (70.8 percent). Slightly more than 30 percent were married at the time of their baseline interview. With respect to ethnicity, blacks constituted approximately 24 percent of the sample while Hispanics comprised approximately 4.5 percent. Over one-third of the sample members (37 percent) lived alone and 47 percent had been hospitalized in the two months prior to enrollment in Channeling.

- Channeling's comprehensive case management services were implemented largely according to plan for the treatment group, but a substantial minority of the control group also received case management from other sources.

- Channeling substantially increased the receipt of formal community services; this increase was particularly noteworthy in the Financial Control Model.

- Despite the increase in case management and formal community services, Channeling did not affect hospital use under either model. For example, at the end of the twelfth month after the baseline interview, 3.6 percent of the treatment group and 4.1 percent of the control group in the Basic Model were in a hospital. For the Financial Control Model, 6.2 percent of the treatment group and 5.1 percent of the control group were in a hospital. The treatment-control differences in all cases are not statistically significant.

- Channeling did not affect nursing home use under either model. At the end of the twelfth month after baseline, 11.5 percent of the treatment group and 12.6 percent of the control group in the Basic Model were in a nursing home. For the Financial Control Model, 11.3 percent of the treatment group and 13.5 percent of the control group were in a nursing home. There differences are not statistically significant.

- Channeling did not have a significant effect on the longevity of the sample members under either model. The mortality rate for the sample was about 17 percent six months after random assignment, 27 percent after 12 months and 36 percent after 18 months. There were no statistically significant differences observed between treatment group and control group members.

- There is no evidence that Channeling led to substitution of formal for informal care in the Basic Case Management Model. There was evidence of some substitution in the Financial Control Model. However, it resulted from reductions in caregiving by some friends and neighbors rather than primary caregivers such as spouses or daughters.

- Channeling led to an increase in the total subsistence, medical and long-term care costs per client over the 18 month observation period. The Basic Case Management Model appeared to increase these costs by about $1500 per client or approximately 8 percent above the $18,000 in costs that would be expected without Channeling. In the Financial Control Model, the cost increase was $3500 or 16 percent over the $23,000 that would otherwise be expected.

- Public expenditures for subsistence, medical treatment and long-term care services for the first 18 months after enrollment increased under both models. In the Basic Model, government costs rose by 10 percent (approximately $1900 per client) and in the Financial Control Model by 17 percent ($3900) per client. These increases were due mostly to the costs of Channeling case management and for the extra formal community services arranged by Channeling.

- Channeling improved the well-being of caregivers by some measures, especially in terms of satisfaction with care arrangements and overall life satisfaction.

- Channeling reduced reported unmet needs, increased confidence in receiving needed services and increased satisfaction with service arrangements for clients. There were small but generally beneficial effects on social and psychological well-being.

TABLE 1: MILESTONES IN THE PLANNING AND IMPLEMENTATION OF THE CHANNELING PROJECTS	
Date	**Event**
December 1979	DHHS published Notice of Intent in the ***Federal Register*** to develop a coordinated long-term care Channeling demonstration.
April 1980	DHHS issued Request for Proposals for Channeling States.
May 1980	DHHS issued Requests for Proposals for both the national technical assistance contractor and the national evaluation contractor.
Planning Phase (September 1980-Spring 1982)	
September 1980	DHHS selected 12 Channeling demonstration States and the national technical assistance and evaluation contractors. Start of the planning phase.
November 1980	Demonstration States submitted site proposals.
January 1981	DHHS selected 12 Channeling project sites.
June 1981	DHHS issued guidelines for Channeling States wishing to implement the Financial Control Model.
August 1981	DHHS reduced from 12 to 10 the number of national research States and sites.
September 1981	DHHS designated 5 Financial Control Models; the other 5 as Basic Case Management Models.
December 1981	Channeling projects submitted detailed operational plans to DHHS.
Buildup Phase (Spring 1981-September 1983)	
February 1982	First of the Basic Case Management Models began operations after hiring staff; going through screening, assessment and case management training; negotiating referral agreements with priority referral sources; and implementing internal management information and recordkeeping systems.
May 1982	First of the Financial Control Models began operations for completing same tasks as Basic Case Management Models, as well as negotiating provider contracts, implementing the financial control system, and completing funds pool arrangements.
June 1982	All projects were operational.
May 1983	First project reached research sample target.
June 1983	All projects achieved adjusted research sample target. Randomization ended.
July-September 1983	Sites continued to increase their caseloads in order to achieve their target sizes.
Steady State Phase (October 1983-June 1984)	Projects maintained their caseloads at the levels agreed to with DHHS.
Demonstration Closeout Phase (July 1984-June 1986)	
July 1984-March 1985	Projects carried out their plans to end federally supported operations. Some transferred clients to other care arrangements while others prepared to continue under different auspices. Fiscal support staff in Financial Control Models continued until June 1985 to process final provider billings.
December 1985	End of DHHS contract with Temple University.
June 1986	End of DHHS contract with MPR and formal end of the Channeling demonstration.

TABLE 2: CHANNELING SITES AND HOST AGENCIES	
Site	**Host Agency**
Basic Case Management Model	
Eastern Kentucky--*Included Clay, Harlan, Jackson, Knott, Laurel, Leslie, Letcher and Perry counties*	State Department of Social Services, Department of Human Resources
York and Cumberland Counties, Maine--*Included Portland*	Southern Maine Senior Citizens, Inc.
Baltimore, Maryland	City of Baltimore Council on Aging and Retirement Education (is the Area Agency on Aging in Baltimore)
Middlesex County, New Jersey--*Included New Brunswick*	County Department of Human Services
Houston, Texas--*Included most, but not all, of Houston*	Texas Research Institute for Mental Services
Financial Control Model	
Miami, Florida--*Included Miami Beach, but not all of Miami*	Miami Jewish Home and Hospital for the Aged
Greater Lynn, Massachusetts	Greater Lynn Senior Services, Inc.
Rensselaer County, New York--*Included Troy*	Rensselaer County Department on Aging
Cuyahoga County, Ohio--*Included Cleveland*	Western Reserve Area Agency on Aging
Philadelphia, Pennsylvania	Philadelphia Corporation on Aging

TABLE 3: CHANNELING DEMONSTRATION ELIGIBILITY CRITERIA	
	Criterion
Age	Must be 65 or over.
Residence	Must reside within project catchment area; must be living in community or (if institutionalized) certified as likely to be discharged within three months.
Functional Disability	Must have at least two moderate ADL disabilities, or three severe IADL impairments, or two IADL impairments and one severe ADL disability. a
Unmet Needs or Fragile Informal Support	Must need help with at least two categories of service affected by functional impairments for six months (meals, housework/shopping, medications, medical treatments at home, personal care), or have a fragile informal support system that may no longer be able to provide needed care.
Insurance Coverage	Must be Medicare Part A eligible (for the Financial Control Model).

a. The six ADLs include bathing, dressing, toileting, transfer, continence, and eating. The seven IADLs are housekeeping, shopping, meal preparation, taking medicine, travel, using the telephone, and managing finances. For the purpose of the IADL eligibility criterion, the first two and the last three IADLs were aggregated into two combined categories. Thus there are four possible IADL areas under which applicants can qualify, plus the cognitive/behavioral impairment category which counts as one IADL item.

TABLE 4: EVALUATION OF THE NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION PRINCIPAL ELEMENTS OF THE RESEARCH DESIGN		
Research Component	**Research Questions**	**Primary Data Sources**
Service Use	Did Channeling reduce institutionalization and hospitalization for clients? Did it increase clients' utilization of formal health and social services provided in the community? Do informal services increase or decrease? Do formal services substitute for informal ones?	Individual interviews Provider records (20% sample) Medicare/Medicaid records Informal caregiver interviews
Costs	Did Channeling increase or decrease the public and private costs of long-term care with respect to nursing homes and hospitals, formal community-based services, housing and living expenses, and case transfers?	Individual interviews Provider records (20% sample) Medicare/Medicaid records
Individual Outcomes	Did Channeling result in greater longevity, reduced functional deterioration, improved social and psychological well-being, lower unmet need, and increased service satisfaction?	Individual interviews Death records
Informal Caregiver Outcomes	How did Channeling affect caregivers' stress and well-being, satisfaction with care, employment and income, and financial support provided to Channeling clients?	Individual interviews Informal caregiver interviews
Implementation and Process	How were the projects implemented? What were the characteristics of Channeling clients? What were the costs of Channeling? What approaches would be most effective for implementing future programs like Channeling?	Process interviews Research instruments (screen and others above) Project cost and client tracking reports Public and project documents
Cost Versus Benefits	Were the costs of Channeling out-weighted by its benefits? Was one model relatively more cost-effective than the other?	Based on findings of other research components.

ABSTRACTS OF CHANNELING REPORTS

The Channeling demonstration has generated an extensive amount of information on the characteristics of a community-based long-term care system. The research findings are contained in the following evaluation and technical reports. The Public Use Tapes and Documentation that accompanies them and also described. DHHS no longer has copies these reports. However, they can be obtained through the organizations at the end of this list.

EVALUATION REPORTS (Prepared by Mathematica Policy Research)

***An Analysis of Site-Specific Results*, Robert A. Applebaum, Randall Brown and Peter Kemper, May 1986**. This report examines the site-specific impacts of the Channeling Demonstration in an effort to determine whether any one site or group of sites was more successful than others in achieving the objectives of the demonstration. Overall, the core case management functions were implemented consistently across the ten sites. Caseload sizes ranged from 36 per assessor/case manager in Baltimore to 54 in Houston. While there were site-specific differences in such areas as time elapsed from assessment to service initiation and overall service expenditures, no overall patterns are obvious. Similarly, the effects of environmental factors such as nursing home bed and hospital bed supply do not manifest patterns that appear to affect Channeling's impacts. There is little evidence that one site or group of sites was markedly more or less effective in achieving the objectives of the Channeling Demonstration. (NTIS Accession No. PB90-244930) [http://aspe.hhs.gov/daltcp/reports/sitees.htm]

***Analysis of Channeling Project Costs*, Craig Thornton, Joanna Will and Mark Davies, May 1986**. This report examines a small but key aspect of Channeling--the costs of operating the demonstration itself. The ten sites incurred costs of $23 million as they prepared for and later provided case management and long-term care services to clients between September 1980 and June 1984. In addition to the project costs, the States spent $2.8 million and the technical assistance contractor spent $1.6 million between September 1980 and June 1984. During the period studied, the Basic Case Management sites enrolled 3,300 clients; the Financial Control sites enrolled 3,900 clients. Over 51,000 ongoing case-months of service were provided by the ten sites. These cost estimates correspond to the demonstration as fielded and therefore reflect the small scale extra administrative and research costs that are part of a demonstration. Based on the available literature, the estimated average costs for Channeling are comparable with those of other demonstrations. (NTIS Accession No. PB86-236742/AS) [http://aspe.hhs.gov/daltcp/reports/projctes.htm]

***Analysis of the Benefits and Costs of Channeling*, Craig Thornton and Shari Miller Dunstan, May 1986**. The principal finding of this report is that Channeling led to an increase in total costs for clients, including costs for medical and long-term care services and costs for shelter, food and other daily living expenses. The Basic Case Management Model appeared to increase these costs by about $1,300 during the 18 month period of the demonstration; this represents an increase of approximately 7 percent over the $18,500 per client costs expected in the absence of Channeling. For the Financial Control Model, costs per client increased by approximately $3,400 for the 18 month period or approximately 15

percent over the $23,000 expected in the absence of Channeling. In both models, these increased costs appeared to produce benefits in the form of reduced unmet client needs and increases in the reported levels of life satisfaction by clients. Primary caregivers also reported more satisfaction with their lives and with the care arrangements for clients. The underlying question is whether the largely intangible benefits of Channeling are worth the net costs of producing them. (NTIS Accession No. PB87-179016/AS) [http://aspe.hhs.gov/daltcp/reports/costes.htm]

***Channeling Effects for an Early Sample at 6-Month Follow-up*, Peter Kemper, Robert Applebaum, Randall S. Brown, George J. Carcagno, Jon B. Christianson, Thomas W. Grannemann, Margaret Harrigan, Nancy Holden, Barbara Phillips, Jennifer Schore, Craig Thornton and Judith Wooldridge, May 1985**. A preliminary analysis of interview data at 6-month follow-up for a sample of approximately 3,000 early enrollees in Channeling indicated the following. (1) The population served was old and frail. (2) The intervention was implemented largely according to design. (3) Substantially more of the treatment group received case management and formal services than did the control group. (4) Treatment-control differences were not statistically significant with respect to hospital use, nursing home use and mortality. (5) There were indications that Channeling improved the self-perceived well-being of treatment group members compared to controls. Channeling did not significantly reduce the amount and type of informal care provided. These findings are subject to modification based on analysis of the full research sample and additional data collection. (NTIS Accession No. PB86-219011/AS) [http://aspe.hhs.gov/daltcp/reports/6monthes.htm]

***Channeling Effects on Formal Community-Based Services and Housing*, Walter Corson, Thomas Grannemann, Nancy Holden and Craig Thornton, May 1986**. Both the treatment group and control group members in the Channeling Demonstration used community services extensively. Channeling increased the use of services by the treatment group compared to the control group. The expectations at the outset of the demonstration were that such increases would be due to the fact that greater numbers of the elderly would remain in the community, as well as increased use of services by those already in the community. In reality, all the observed service-use increases were due to the latter effects, since no impact was observed on mortality or institutionalization. The largest increases in service use were observed for personal care and housekeeping services, which are the ones usually not covered by existing public programs or private insurance. There were increases in public and total costs. At the same time, there is evidence that in the Financial Control Model projects were able to use their purchasing power to reduce the per-unit costs of some services. (NTIS Accession No. PB86-236593/AS) [http://aspe.hhs.gov/daltcp/reports/commtyes.htm]

***Channeling Effects on Hospital, Nursing Home and Other Medical Services*, Judith Wooldridge and Jennifer Schore, May 1986**. The impacts of the Channeling demonstration on hospital, nursing home and other medical service use as well as mortality can be summarized as follows. Channeling had no impact on mortality; death rates for the treatment and control groups were very high but not statistically significant. The population served was not at high risk of institutionalization. Private persons and Medicaid were the major payers for nursing home care. Nursing home use and expenditures were lower for the treatment group and the control group but the differences were not large and generally not statistically significant. Reductions in nursing home use in the Basic Model were concentrated in one site, viz., Southern Maine. Channeling reduced nursing home use for persons in a nursing home at the time of their screen for Channeling eligibility. Control group

hospital use and expenditures were very high, although they fell over time. The control group exhibited a high use of and expenditures on other medical services. Channeling had no impact on the use of or expenditures on hospital, physician and other medical services. (NTIS Accession No. PB86-234341/AS) [http://aspe.hhs.gov/daltcp/reports/hospites.htm]

***Channeling Effects on Informal Care*, Jon B. Christianson, May 1986**. Channeling was expected to increase the use of formal community-based care by the frail elderly. However, if this led to substitution of formal for informal care, the public sector would then be paying for services otherwise provided by family and friends. There was no evidence that such substitution occurred in the Basic Case Management Model. In the Financial Control Model, Channeling did lead to modest substitution of certain services, but there is no evidence of widespread substitution. Nor is there evidence of reductions in informal care by primary caregivers. The effect appears to be due to withdrawal by some friends and neighbors. Additionally, Channeling improved the well-being of primary caregivers by some measures, such as reducing caregiver worry about receiving sufficient help and increasing overall life satisfaction. This report also has an available Appendices. (NTIS Accession No. PB86-240033/AS) [http://aspe.hhs.gov/daltcp/reports/informes.htm]

***Channeling Effects on the Quality of Clients' Lives*, Robert A. Applebaum and Margaret Harrigan, April 1986**. This report presents the impact of the Channeling demonstration on the quality of clients' lives. Channeling was expected to affect life quality through two mechanisms: (1) the provision of case management and expanded services to people who would have stayed in the community even without Channeling and (2) reduced institutionalization. Even though Channeling had no significant impact on institutionalization rates, the results generally bear out these expectations. For both the basic case management model and the financial control model at 6 and 12 months, treatment group members reported more satisfaction with service arrangements, more confidence about receiving needed services and fewer unmet needs than did the control group. There were no substantial differences between the two Channeling models on these dimensions. (NTIS Accession No. PB86-218690/AS) [http://aspe.hhs.gov/daltcp/reports/qualtyes.htm]

***Differential Impacts Among Subgroups of Channeling Enrollees*, Thomas W. Grannemann and Jean Baldwin Grossman, May 1986**. This report examines the variation among subgroups in impacts of the National Long-Term Care Channeling Demonstration. In general there was substantial uniformity of Channeling impacts within the research sample. Differential impacts, where they existed, occurred primarily for nursing home use and expenditure variables. Both the Basic Case Management Model and the Financial Control Model showed reduced nursing home use and/or cost for the small fraction of the sample residing in a nursing home when screened into the program. The Financial Control Model also reduced nursing home use for those on a nursing home waitlist at screen, though this effect appears to be confined to persons not eligible for Medicaid. The cost savings from reduced nursing home use appeared to accrue primarily to private payers rather than to the Medicare and Medicaid programs. (NTIS Accession No. PB86-243532/AS) [http://aspe.hhs.gov/daltcp/reports/enrolles.htm]

Differential Impacts Among Subgroups of Channeling Enrollees Six Months After Randomization*, Thomas W. Grannemann, Randall S. Brown and Shari Miller Dunstan, July 1984**. This report, which serves as a supplement to ***Channeling Effects for an Early Sample at 6-Month Follow-up (Peter Kemper, et al., 1985), addresses the issue of variation in Channeling impacts among subgroups of sample members. In general, where Channeling impacts exist, there is not strong evidence that those impacts differ markedly

among various types of clients. For the most part, differences were not highly significant statistically and did not produce consistent patterns of differences across outcome measures and subgroups. The study did provide some insight into factors underlying Channeling impacts and suggested areas for further investigation. (NTIS Accession No. PB86-235348/AS) [http://aspe.hhs.gov/daltcp/reports/difimpes.htm]

***Examination of the Equivalence of Treatment and Control Groups and the Comparability of Baseline Data*, Randall S. Brown and Peter A. Mossel, October 1984**. This report examines the baseline data for treatment group and control group members in the National Long-Term Care Channeling Demonstration to determine whether they are comparable and, if not comparable on some variables, what should be done to ensure that regression estimates of Channeling's impact are not biased by such differences. Although there is strong evidence that there were no true treatment/control differences at randomization due to chance (based on analysis of screening data), a substantial number of large and statistically significant differences emerged between the two groups on baseline variables. It was concluded that differential measurement largely accounted for these differences. In the regression analysis, for non-comparable baseline variables with screen counterparts, the screen version was used as a control variable. Other non-comparable baseline variables (without a screen counterpart) were excluded from the set of control variables with the exception of hospital and nursing home days, which are replaced with information from the screen on whether the sample member was in a hospital or nursing home at screen or referred to Channeling by hospital or nursing home staff. (NTIS Accession No. PB86-236775/AS) [http://aspe.hhs.gov/daltcp/reports/baslines.htm]

***Final Report on the Effects of Sample Attrition on Estimates of Channeling's Impacts*, Randall S. Brown, Peter A. Mossel, Jennifer Schore, Nancy Holden and Judy Roberts, January 13, 1986**. This report results from an investigation of the extent to which differential attrition from the research sample in the Channeling demonstration might have led to biased estimates of program impact. Two analytical approaches were adopted--a heuristic approach and a statistical modeling approach. The results from these approaches lead to the conclusion that, in spite of observed differences in attrition rates between treatment group and control group members, there is very little evidence that such attrition resulted in biased estimates of Channeling's impacts. The occasional bits of evidence to the contrary were scattered and inconsistent across time, Channeling model, and outcome variables. (NTIS Accession No. PB86-234325/AS) [http://aspe.hhs.gov/daltcp/reports/atritnes.htm]

***Informal Care to the Impaired Elderly: Report of the National Long-Term Care Demonstration Survey of Informal Caregivers*, Jon B. Christianson and Susan A. Stephens, June 6, 1984**. This report makes use of baseline data on informal caregivers to explore several issues central to informal caregiving, including the composition of the informal care network, the types and level of care provided by that network, financial assistance provided by informal caregivers, and their well-being. A total of 1,940 primary informal caregiver baseline interviews was conducted between November 1982 and May 1983 with an overall response rate of 87 percent. The caregivers were in most cases the wives, daughters or daughters-in-law of the elderly recipients of care. One-third were active in the labor market, mostly full time; almost 40 percent were 65 years or older. Primary caregivers averaged almost 6 hours per day on care-related activities. In general, the more that care was provided under stressful circumstances, the greater was the perceived burden and the lower the rating given by primary caregivers to their quality of life. (NTIS Accession No. PB86-240058/AS) [http://aspe.hhs.gov/daltcp/reports/impaires.htm]

***Initial Research Design of the National Long-Term Care Demonstration*, Peter Kemper, Robert Applebaum, Raymond J. Baxter, James J. Callahan Jr., George J. Carcagno, Jon B. Christianson, Stephen L. Day, Thomas W. Grannemann, Jean Baldwin-Grossman and Judith Wooldridge, November 1982**. The primary objective of the research in the National Long-Term Care Channeling Demonstration was to determine the impacts of the demonstration on service utilization, public and private costs, clients and caregivers. The demonstration employed a randomized experimental design with random assignment of eligible participants to either treatment group or control group status. The sample was designed so that six percentage points was the minimum reduction in the nursing home institutionalization rate that could be detected (with 90 percent power). The statistical technique used for much of the impact estimation was multiple regression. Potential problems such as non-comparability of baseline data and sample attrition were examined separately. (NTIS Accession No. PB86-234366/AS)
[http://aspe.hhs.gov/daltcp/reports/designes.htm]

***Issues in Developing the Client Assessment Instrument for the National Long-Term Care Channeling Demonstration*, Barbara Phillips, et al., January 1981**. This preliminary report addresses a number of issues pertaining to the development of a combined research and clinical instrument for assessing the functional status of clients in the National Long-Term Care Channeling Demonstration. The report contains an extensive literature review, evaluation of existing instruments and appraisal of the experiences of others--both practitioners and researchers--who have used similar instruments. Recommendations are made with respect to the assessment of physical health, activities of daily living, mental functioning, social functioning, physical environment and living arrangements, service use, and financial resources. (NTIS Accession No. PB86-236759/AS)
[http://aspe.hhs.gov/daltcp/reports/instrues.htm]

***Methodological Issues in the Evaluation of the National Long-Term Care Demonstration*, Randall S. Brown, July 1986**. This report describes the methodology used throughout the evaluation of the National Long-Term Care Channeling Demonstration and documents the major analytical issues that posed potential threats to the credibility of the analysis. It provides a more thorough explanation of the estimation procedures and test statistics employed and summarizes the investigations of specific methodological issues. These issues include sample composition, data collection procedures and estimation techniques. The one issue that might lead to distorted estimates of program impacts is the non-comparability of baseline data, based on differences in collecting data from the treatment and control groups. To avoid this distortion, baseline variables judged to non-comparably measured were excluded from use as control variables in the regression equations; where possible, they were replaced by counterparts from the initial screening instrument. All other potential problems were found to have little or no actual effect on impact estimates or their interpretation. (NTIS Accession No. PB86-239977/AS)
[http://aspe.hhs.gov/daltcp/reports/methodes.htm]

***Survey Data Collection Design and Procedures*, Barbara R. Phillips, et al., March 7, 1986**. This report documents the design and implementation of the surveys which collected data for the evaluation of the National Long-Term Care Channeling Demonstration. The report addresses the manner in which elderly sample member survey data were linked to other data sources, such as service use and cost data, death records, and the survey of informal caregivers. The organization and management of the survey process by the evaluation contractor are also described. (NTIS Accession No. PB86-235330/AS)
[http://aspe.hhs.gov/daltcp/reports/sydataes.htm]

***Tables Comparing Channeling to Other Community Care Demonstrations*, Robert A. Applebaum, Margaret N. Harrigan and Peter Kemper, May 1986**. Over the past decade and a half, a series of demonstrations prior to the National Long-Term Care Channeling Demonstration have been fielded to test some form of case managed, community-based long-term care. Fourteen community care demonstrations funded through Federal Government waivers and similar to Channeling were identified. This report presents a series of tables to facilitate comparisons of the interventions, evaluation designs and estimated effects of these 14 demonstrations with one another and with the two models of community care tested under Channeling. (NTIS Accession No. PB86-246931/AS) [http://aspe.hhs.gov/daltcp/reports/tablees.htm]

***The Comparability of Treatment and Control Groups at Randomization*, Randall S. Brown and Margaret Harrigan, October 27, 1983**. This report analyzes the treatment and control groups in the National Long-Term Care Channeling Demonstration and concludes that the randomization procedure resulted in groups that are very similar on observable characteristics. Even for site level comparisons, where larger differences were expected because of smaller sample sizes, the number of statistically significant differences was no larger than would be expected by chance. These findings imply that the Channeling control group provided a reliable measure of what would have happened to the treatment group in the absence of the Channeling intervention. Additionally they imply that other investigations which rely on screening data to assess other possible sources of non-comparability of data (e.g., non-comparability of baseline assessment data or differential sample attrition) would not be confounded by differences between groups at randomization. (NTIS Accession No. PB86-242690/AS) [http://aspe.hhs.gov/daltcp/reports/compares.htm]

***The Effects of Case Management and Community Services on the Impaired Elderly*, Randall Brown and Barbara Phillips, February 1986**. The evaluation of the National Long-Term Care Channeling Demonstration featured a randomized design in which applicants to the program were randomly assigned to either the treatment group, which had the opportunity to receive Channeling services, and the control group, which was barred from participation. Both groups were interviewed at baseline, 6-months, 12-months and--for half the sample--18-months. Under this arrangement, some treatment group members could refuse Channeling case management and services, while some control group members might obtain similar services elsewhere in the community. This report bases its analysis not on treatment/control differences but on differences between those who received case management and those who did not (regardless of whether they were in the treatment or control group). Because of methodological problems, it is not possible to determine unambiguously whether case management and formal community services affect nursing home use or other outcomes. Reliable answers to these issues require data that is collected expressly to address them. (NTIS Accession No. PB87-102786/AS) [http://aspe.hhs.gov/daltcp/reports/casmanes.htm]

***The Effects of Sample Attrition on Estimates of Channeling's Impacts for an Early Sample*, Peter A. Mossel and Randall S. Brown, July 1984**. In the evaluation of the National Long-Term Care Channeling Demonstration, some members of the research sample were lost to the analysis due to sample attrition. Sample attrition could distort the treatment group/control group comparison, depending on the type of attrition that occurred. This report investigates whether there was evidence of bias due to attrition in the preliminary estimates of Channeling's impacts. Essentially, the report describes the pattern of attrition, discusses how attrition bias might arise, outlines the statistical procedures used to correct

for bias and contains the results obtained when this procedure is used to estimate the impacts of Channeling for key outcome measures drawn from the preliminary findings. The report concludes that no global patterns of attrition bias emerge from the analysis. (NTIS Accession No. PB90-228701/AS) [http://aspe.hhs.gov/daltcp/reports/earlyes.htm]

***The Evaluation of the National Long-Term Care Demonstration: Final Report*, Peter Kemper, et al., May 1986**. The National Long-Term Care Channeling Demonstration was designed as a rigorous test of comprehensive case management of community care as a way of containing long-term care costs while providing adequate care to those in need. A randomized experimental design was employed to evaluate the demonstration. Two models of Channeling were tested: (a) Basic Case Management Model (five sites), and (b) Financial Control Model (five sites). Channeling enrolled an extremely frail elderly group whose average age was 80 years. The intervention was implemented largely according to plan. Channeling increased formal community service use. It had no significant effect on nursing home use, hospitalization or mortality. Channeling led to reduced unmet needs, increased client confidence in receipt of care and increased life satisfaction. Neither model had a major effect on the proportion of informal caregivers giving care; however, Channeling increased informal caregivers' satisfaction with service arrangements and satisfaction with life. Overall, the evidence indicates that the expansion of case management and community services beyond what exists does not lead to cost savings. But it does yield benefits in the form of increased home care, reduced unmet need and greater life satisfaction for clients and their informal caregivers who bear most of the care burden. (NTIS Accession No. PB86-229119/AS) [http://aspe.hhs.gov/daltcp/reports/chanes.htm]

The Planning and Implementation of Channeling: Early Experiences of the National Long-Term Care Demonstration*, Raymond J. Baxter, Robert Applebaum, James J. Callahan Jr., Jon B. Christianson and Stephen L. Day, April 15, 1983**. [The Executive Summary is entitled ***Implementation and Early Operation of the Channeling Demonstration: Overview.] This report describes the structure and intent of the National Long-Term Care Channeling Demonstration, the characteristics of the ten Channeling projects, the client and system level activities of the projects, the environments in which they operated, and the factors that influenced the implementation and early operations of Channeling. It represents a status report on the first year of operation of the demonstration and provides background information for the full evaluation of the impact and cost-effectiveness of Channeling. (NTIS Accession No. SHR-0010870) [http://aspe.hhs.gov/daltcp/reports/implees.htm]

***The Planning and Operational Experience of the Channeling Projects* (2 volumes), George Carcagno, Robert Applebaum, Jon Christianson, Barbara Phillips, Craig Thornton and Joanna Will, July 18, 1986**. This report analyzes the process by which the Channeling demonstration was planned, implemented and conducted. The analysis, which is largely descriptive, is intended to: (a) establish whether the intervention was implemented as planned; (b) describe the characteristics of clients served and the costs of case management; (c) provide a basis for informed judgment about the establishment of future Channeling-like programs; and (d) give a sound contextual framework for interpreting the quantitative results presented elsewhere. The report is organized into six parts. First, it provides an overview of the demonstration. Second, it describes the management of the local projects, including cost information. Third, it addresses client recruitment, caseload characteristics, and the practice of case management. Fourth, it describes relationships between Channeling agencies and formal and informal service providers. Fifth, it depicts the long-term care environments of the Channeling sites. Finally, it addresses the implications of its findings for the impact evaluation and for the planning and management of future

community care programs. (Volume 1--NTIS Accession No. PB87-120606/AS; Volume 2--NTIS Accession No. PB87-120598/AS) [http://aspe.hhs.gov/daltcp/reports/proceses.htm]

EVALUATION DATA BASE TAPE AND DOCUMENTATION (Prepared by Mathematica Policy Research)

National Long-Term Care Channeling Evaluation Data Tape and Documentation. Copies of the Channeling Data Tape can only be obtained with a full set of the following documentation (14 volumes and a background piece). However, documentation *only* can be obtained separately (see below for specific documentation accession number); separate copies will *not* be accompanied by a Data Tape. (NTIS Accession No. PB87-139986)

***Part I: Background*, Judith Wooldridge, et al., May 1986**. The research data base on Channeling contains information collected on individual clients, control group members, caregivers and providers. Because of the number of data sources, the data base was designed to manage and link information about individual sample members across a number of data files. The public use data base consists of 14 files. This background report describes the data base structure as well as ongoing data base management procedures. Procedures to assure the confidentiality of data are also described. The construction of analysis files generated from source data to analyze aspects of the demonstration is documented. Finally the report describes the contents of the public use files in more detail, summarizes the information contained in the separate file documentation volumes and spells out the process by which the public use files were selected and drawn from the research data base. (NTIS Accession No.)

***Part II: The Screen File*, Judith Wooldridge and Daniel Buckley, May 1986**. The file is based on data collected in the 20 minute screening interview that was designed to establish the eligibility of the applicant for Channeling. The file includes information on demographic, social and economic characteristics as well as impairment in activities of daily living (ADL) and instrumental activities of daily living (IADL), fragility of the support system and unmet needs. Data are available for the 6,326 members of the research sample. (NTIS Accession No. PB87-140000)

***Part II: The Baseline File*, Judith Wooldridge and Daniel Buckley, May 1986**. The file is based on data collected in the baseline assessment interview conducted shortly after enrollment in the demonstration. The baseline assessment was designed to collect data for both research and clinical purposes. The file includes information on functioning, health status, recent service use, informal caregiving, financial resources, demographic characteristics, and unmet needs. Data are available for 5,626 members of the research sample. (NTIS Accession No. PB87-140018)

***Part II: The Client Tracking and Status Change File*, Judith Wooldridge, et al., May 1986**. The file is based on data collected on the initial client racking form and subsequent change-of-status forms. The client tracking system documented the dates on which critical events such as referral, screening, baseline assessment, care plan development and service initiation occurred. The status change form documented changes from active to terminated status (and reactivation) and the reasons for termination. Data are available for all 7,168 clients of the Channeling demonstration (but not for control group members). (NTIS Accession No. PB87-140026)

***Part II: Sample Member Follow-up Files* *(6, 12, 18 Months)*, Judith Wooldridge and Daniel Buckley, May 1986**. There are three sample member follow-up files among the 14 files created for public use from the National Long-Term Channeling Evaluation data base. These files are based on data collected in the 6, 12, and 18 month follow-up interviews that were designed to measure outcomes of the demonstration. Each file includes data from the interview describing age, marital status, and insurance; health status; living arrangements; housing expenditures; in-home services and support received; community services received; housing related transfers and services; hospital and nursing home use; social and psychological well-being; income and assets; physical activities of daily living (ADL); instrumental activities of daily living (IADL); and interviewer observations about the environment. In addition, each file contains the standard control variables derived from the screen and baseline interviews that were used in the analysis. Data are available for 4,189 sample members in the 6-month file, 3,634 sample members in the 12-month file and 1,409 sample members in the 18-month file. (NTIS Accession No. PB87-140034)

***Part II: The Status File*, Judith Wooldridge, et al., May 1986**. This is principally a reference file, documenting for each sample member which interviews were completed and reasons for noncompletion, death rate, Medicare and Medicaid coverage, and which analysis samples the sample member is included in. Data are available for the 6,326 research sample members. (NTIS Accession No. PB87-140042)

***Part II: Caregiver Baseline*, Judith Wooldridge and Daniel Buckley, May 1986**. The file is based on data collected in the baseline interview of informal caregivers of the elderly sample members. The file includes information on types of informal care services provided by caregivers, including frequency and level of effort, financial contributions made by informal caregivers to the elderly sample member, economic and family behavior of the caregiver, and social and psychological well-being of the caregiver. Data are available for 1,929 informal caregivers. (NTIS Accession No. PB87-140059)

***Part II: Caregiver Follow-up Files* *(6 and 12 Month)*, Judith Wooldridge and Richard Ross, May 1986**. There are two informal caregiver follow-up files among the 14 files created for public use from the National Long-Term Care Channeling Evaluation data base. These files are based on data collected in the 6 and 12 month caregiver follow-up interviews that were designed to help measure outcomes of the demonstration. Each file contains data from the interview describing care provided by the primary and other informal caregivers, caregiver expenditures, caregiving provided since institutionalization (if applicable), caregiver stress and behavior, and caregiver demographic and employment information. In addition, both files contain caregiver control variables developed from the caregiver baseline and elderly sample member control variables developed from the sample member screen and baseline interview that were used in the analysis. Data are available for 1,667 caregivers at 6 months and 1,537 caregivers at 12 months. (NTIS Accession No. PB87-140067)

***Part II: Formal Community Services Analysis File*, Judith Wooldridge, et al., May 1986**. The file includes information on formal community services, case management, housing, and transfer payments provided to elderly sample members. Data were drawn from the sample member follow-up interviews, Medicare and Medicaid claims, Channeling records, and provider records. In addition, the file contains standard control variables used in the analysis that were developed from sample member screen and baseline interviews. The precursors files were used in the analyses of formal community services, housing, transfers

and case management. Data are available for 5,607 elderly sample members. (NTIS Accession No. PB87-140075)

***Part II: Informal Care Analysis File*, Judith Wooldridge, et al., May 1986**. The file was developed from the elderly sample member follow-up interviews. It includes information on the types and amounts of services provided by informal caregivers and the relationship of caregivers to sample members. In addition, the file contains standard control variables used in the analysis that were developed from the sample member screen and baseline interviews. The precursors file was used in the analysis of informal care. Data are available for 5,408 sample members. (NTIS Accession No. PB87-140083)

***Part II: Hospital, Nursing Home and Other Medical Service Analysis File*, Judith Wooldridge and Daniel J. Buckley, May 1986**. The file includes information on hospital, nursing home, and other medical services provided to elderly sample members over a 12 or 18 month follow-up period. Data were derived from Medicare and Medicaid claims, provider records, and sample member follow-up interviews. In addition, the file contains standard control variables used in the analysis that were developed from the screen and baseline sample member interviews. The precursors files were used in the analysis of hospital, nursing home and other medical services. Data are available for 5,554 sample members. (NTIS Accession No. PB87-140091)

***Part II: Quality of Life Analysis File*, Judith Wooldridge, et al., May 1986**. This file includes information on elderly sample member satisfaction with care, social-psychological well-being and functioning. Data were derived from sample member follow-up interviews. In addition, the file contains standard control variables that were developed from sample member screen and baseline interviews. Data are available for 4,177 persons 6 months after enrollment, 3,623 persons 12 months after enrollment, and 1,405 persons 18 months after enrollment. The precursor file was used for the analysis of well-being for the evaluation. (NTIS Accession No. PB87-140109)

NOTE: In addition to the 14 original files, new Public Use Files were created in 1988 and 1989 by Mathematica Policy Research, Inc. and are also available from NTIS. A brief description follows.

***Part III: Hospital and Nursing Home Stay File*, Shari M. Dunstan and Joan Mattei**. At the request of various users of the Channeling data base, this file was created to provide information on each continuous stay in a hospital or nursing home. The file provides information on a maximum of 27 hospital and nursing home stays for each individual. The Public Use File sample member identification numbers are included so that users can link individual data on the file with other public use files. (NTIS Accession Number PB90-184524)

***Part III: Augmented Medicare Claims Files*, Shari M. Dunstan and Daniel J. Buckley, November 1988**. A Medicare claims data file was created for the Channeling sample. Both Medicare Part A and B claims for the period from September 1983 through December 1988 were obtained from the Health Care Financing Administration. This covers a period prior to the sample members' enrollment in Channeling as well as a period after the demonstration ended. The claims were drawn from the Medicare Automated Data Retrieval System (MADRS) maintained by HCFA. Three files are available providing claims for services occurring in (respectively): 1983 and 1984; 1985 and 1986; and 1987 and 1988. (Data

Tape--NTIS Accession Number PB90-501602, Documentation--NTIS Accession No. PB90-184516)

SAS Versions. SAS versions of several Public Use Files were generated at the request of data base users. These files are: (a) Baseline File; (b) Formal Community Services Analysis File; (c) Informal Care Analysis File; (d) Hospital, Nursing Home Use and Other Medical Services Analysis File; (e) Hospital and Nursing Home Stay File; and (f) Augmented Medicare Claims Files. Each SAS file was created as an exact image of the corresponding EBCDIC file. Consequently, the basic EBCDIC file documentation will be used as the primary source of information on these files.

TRAINING AND TECHNICAL ASSISTANCE REPORTS (Prepared by Temple University/Institute on Aging)

***A Guide to Memorandum of Understanding Negotiation and Development*, M. Johnson and L. Sterthous, 1982**. This paper describes a practical step-by-step approach to negotiating memoranda of understanding. Although they were written for channeling agencies, the techniques as described would be useful for any social service agency interested in developing formalized interagency agreements. The documents includes model agreements. (NTIS Accession No. PB86-244779/AS) [http://aspe.hhs.gov/daltcp/reports/mouguide.htm]

Applicant Screen Set*, 1982**. This set contains the standardized instrument that was used to screen applicants to the Channeling project according to specific criteria thought to contribute to being "at-risk" of institutionalization. The screen was usually conducted over the telephone with the person referring the applicant. Completion of the screen over the phone generally took from 15-25 minutes. Some screens were done in-person when the respondents could not use the telephone. Included in this document are the ***National Long-Term Care Demonstration Applicant Screening Instrument Training Manual and ***Screening Training for Screeners: A Trainer's Guide***. (NTIS Accession No. PB86-229101/AS) [http://aspe.hhs.gov/daltcp/reports/appscset.htm]

***Assessment and Care Planning for the Frail Elderly: A Problem Specific Approach*, Elizabeth Solen, Marilyn Grannemann, Elsie Carter, Helen Wells-Hunter, Patricia Decker, Suzanne Bulvanoski, Carol Coleman, Maryellen Kluxen and Tambria Johnson, 1986**. This problem-specific approach describes various circumstances likely to be encountered among frail elderly persons in the community. Each problem area includes a comprehensive list of items that should be considered by a case manager. Model care plans are also included. This document can be used for training case managers in the specifics of effective assessment and case management. (NTIS Accession No. PB87-141073/AS) [http://aspe.hhs.gov/daltcp/reports/asmtcare.htm]

Assessment Training for Case Managers: A Trainer's Guide*, 1985**. The is guide provides trainers with materials for a three-day training program on use of the National Long-Term Care Demonstration Clinical Baseline Assessment Instrument (C-BAI) utilizing a case-study method designed to give workers experimental training in the techniques of effective assessment. The ***Clinical Baseline Assessment Instrument Set, consisting of blank forms and the Training Manual designed for individual workers is included (the C-BAI Set is also

available separately). (NTIS Accession No. PB86-239993/AS) [http://aspe.hhs.gov/daltcp/reports/asmttran.htm]

***Case Management Forms Set*, 1985**. This set of materials includes the care plan and reassessment forms and guidelines for their use. These should be useful to persons actually engaged in case management as well as their trainers. The care plan is organized to describe problems, outcome measures, types of help needed and informal/formal service providers. Reassessment in channeling was done every six months or when an event triggered a need for re-evaluation of the care plan. The reassessment form, organized for easy clinical use, is significantly shorter than the clinical baseline assessment instrument. (NTIS Accession No. PB86-236106/AS) [http://aspe.hhs.gov/daltcp/reports/cmforms.htm]

Case Management Training for Case Managers: A Trainer's Guide*, Linda M. Sterthous, 1985**. Case management involves working with a client and family to agree upon problems, goals, and services necessary to support the client in the community. Data collected from an assessment is used to develop a care plan. Case management includes arranging services, monitoring the client's situation on an ongoing basis and adjusting the service package as needed. This guide presents an outline and course content for a three-day training program in case management utilizing the tools, documents and techniques developed for the channeling demonstration. The course utilizes a case study method designed to give workers experimental training in the techniques of case management. Included is the ***Case Management Forms Set (also available separately) containing the care plan and reassessment forms and guidelines for their use. (NTIS Accession No. PB86-242633) [http://aspe.hhs.gov/daltcp/reports/cmtrain.htm]

***Clinical Baseline Assessment Instrument Set*, Temple University, 1983**. The National Long-Term Care Demonstration Clinical Baseline Assessment Instrument (C-BAI) is a modification of the original clinical and research baseline assessment instrument used in the demonstration. The instrument was used to conduct face-to-face interviews of elderly clients who wanted to remain in their own homes. Assessment interviews usually took 1-1½ hours to complete. Two versions of the form were used: one for clients being interviewed in their community residence and one for clients being interviewed in an institution. This set includes both institutional and community versions of the instrument and a training manual designed to introduce workers to the instrument. (NTIS Accession No. PB86-241114/AS) [http://aspe.hhs.gov/daltcp/reports/cbainstr.htm]

***Community Services and Long-Term Care: Issues of Negligence and Liability*, Elias S. Cohen and Linda S. Sterthous, 1982**. Agencies operating under the National Long-Term Care Channeling Demonstration program had complex assignments to assess the needs of older people requiring long-term care, to determine what services met such needs and to arrange for the delivery of services. Responsibility for a client was spread across several agencies, organizations, and individuals. This paper examines the liability, and avoiding or minimizing risks of negligence. (NTIS Accession No. PB86-244753/AS) [http://aspe.hhs.gov/daltcp/reports/negliab.htm]

***Informal Services and Supports*, Linda M. Sterthous, 1985**. This is a collection of practice-oriented papers dealing with the various ways in which informal services and supports were encouraged and utilized in channeling. Written primarily by case managers and supervisors from the channeling sites, topics range from the development of family support groups to the development of a volunteer network. An extensive bibliography on informal supports is

included. (NTIS Accession No. PB86-244233/AS) [http://aspe.hhs.gov/daltcp/reports/infserv.htm]

Screening Training for Screeners: A Trainer's Guide*, 1985**. A standardized instrument was used to screen applicants to the National Long-Term Care Channeling Demonstration according to specific criteria thought to contribute to being "at-risk" of institutionalization. The screen was usually conducted over the telephone beginning with the person referring the applicant. Completion of the screen generally took 15-25 minutes. This trainer's guide contains all the materials needed to train staff members of a long-term care program to conduct the screening process using the Channeling Applicant Screen. Included is a detailed lesson plan for a two-day training program, lecture notes, handouts, scripts and the ***Applicant Screen Set (1982), which contains blank forms and the manual for screeners (screen set available separately). (NTIS Accession No. PB86-241593/AS) [http://aspe.hhs.gov/daltcp/reports/scretrai.htm]

***The Channeling Case Management Manual*, 1986**. Case management is the process of integrating and synthesizing information from an assessment into a care plan. It involves working with a client and family to agree upon problems, goals, and services necessary to support the client in the community. Case management also includes arranging for services, monitoring the client's situation on an ongoing basis, and adjusting the service package as needed. This manual contains an overview of the core functions of the channeling program and the role of the case manager and describes support functions such as record keeping. It is a basic primer covering the principles of good practice for case managers. (NTIS Accession No. PB86-229093/AS) [http://aspe.hhs.gov/daltcp/reports/cmmanual.htm]

***The Channeling Financial Control System*, Marilyn Grannemann, 1985**. The ten sites of the National Long-Term Care Channeling Demonstration provided case management to very impaired elderly clients who wished to remain in the community. Five of the sites that developed the financial control model could pay for services from a pool of waiver dollars and state and local funds. This report describes the computerized and manual cost control system that was used by the five financial control model sites to keep service expenditures for clients below a pre-determined level or "cap." The system's strengths and weaknesses are described and recommendations are included. (NTIS Accession No. PB86-240041/AS) [http://aspe.hhs.gov/daltcp/reports/chanfcs.htm]

DEMONSTRATION INSTRUMENTS

***Applicant Screen*, December 1981**. [http://aspe.hhs.gov/daltcp/instruments/AppSc.pdf]

Client Contact Log. [http://aspe.hhs.gov/daltcp/instruments/ClConLog.pdf]

***Client Tracking Form*, March 1982**. [http://aspe.hhs.gov/daltcp/instruments/ClTracFm.pdf]

***Clinical Assessment and Research Baseline Instrument: Community Version*, January 1982**. [http://aspe.hhs.gov/daltcp/instruments/carbicv.pdf]

***Clinical Baseline Assessment Instrument: Community Version*, June 1983**. [http://aspe.hhs.gov/daltcp/instruments/cbaicv.pdf]

***Clinical Baseline Assessment Instrument: Institutional Version*, July 1983**.
[http://aspe.hhs.gov/daltcp/instruments/cbaiiv.pdf]

***Eighteen Month Followup Instrument*, February 1983**.
[http://aspe.hhs.gov/daltcp/instruments/18mfi.pdf]

***Followup Instrument*, November 1982**. [http://aspe.hhs.gov/daltcp/instruments/FolInst.pdf]

***Informal Caregiver Followup Instrument*, August 1983**.
[http://aspe.hhs.gov/daltcp/instruments/ICFolIns.pdf]

***Informal Caregiver Survey Baseline*, January 1983**.
[http://aspe.hhs.gov/daltcp/instruments/ICSurvey.pdf]

***Screening Identification Sheet*, March 1982**.
[http://aspe.hhs.gov/daltcp/instruments/ScrIDSh.pdf]

Time Sheet. [http://aspe.hhs.gov/daltcp/instruments/TimeSh.pdf]

***Twelve Month Followup Instrument*, February 1983**.
[http://aspe.hhs.gov/daltcp/instruments/12mfi.pdf]

HOW TO OBTAIN INFORMATION

You can contact any of the following organizations to obtain additional Channeling information. **Please Note**: A fee for each item may be charged to cover the costs of reproduction.

National Technical Information Service (NTIS), U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161 (703-487-4650). Evaluation Reports, Training and Technical Assistance Reports, and the Data Tape and Documentation can be ordered from NTIS. When ordering, give them the NTIS Accession Number (if available) and the complete title. If you are ordering the Data Tape, a full set of the Data Tape Documentation (all volumes and a background piece) must also be ordered.

Mathematica Policy Research, Inc. (MPR), Office of Publications, Room 158, P.O. Box 2393, Princeton, New Jersey 08540 (609-275-6024). MPR was the Evaluation contractor for the Channeling demonstration. Evaluation Reports and Data Collection Instruments can be ordered from MPR. When ordering, give them the complete report/instrument title.

Office of Social Services Policy (now the Office of Disability, Aging and Long-Term Care Policy), U.S. Department of Health and Human Services, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201 (202-245-6172). This office held lead responsibility for the Channeling Demonstration. This office can answer questions on the Channeling demonstration or specific reports.