FOIA Number: 2018-0756-F

FOIA MARKER

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Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member: Kristine Gebbie

Subseries:

OA/ID Number: 3772

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Folder Title:
Meeting with Physicians Association for AIDS Care 2/3/94

Stack:	Row:	Section:	Shelf:	Position:
S	66	5	5	3

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. form	re: Travel Order; [Personally Identifiable Information] [Partial] (1 page)	01/31/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3772

FOLDER TITLE:
Meeting with Physicians Association for AIDS Care

2018-0756-F
jp4834

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

TRAVEL ORDER

XX ☐ Original ☐ Amendment No. _____ ☐ Cancellation
(See HHS Travel Manual, Part 3, for Detailed Instructions)

1. TRAVEL ORDER NO. 0017094077

2. APPROPRIATION NO. 7541101

3. ESTIMATED COST*

	TO DHHS	TO OTHERS
TRAVEL	$	$ 461.00
PER DIEM	217.00	
OTHER	60.00	
TOTAL	$277.00	$461.00

4. NAME AND POSITION OR RANK
Kristine M. Gebbie, RN, MN (b)(6)

6. CONSTITUENT/BUREAU/DIVISION/REGION
DHHS/PHS/OASH/NAPO

7. PRESENT OFFICIAL STATION
Washington, D.C.

8. APPROX. DATE OF DEPARTURE
February 1,1994

9. APPROX. DATE OF RETURN
February 5, 1994

10. ITINERARY AND PURPOSE OF TRAVEL *(Show city, state or country, dates and reasons—use continuation sheet if necessary)*

FROM: Washington, D.C. to San Diego, CA, from San Diego, CA to Los Angeles, CA, from Los Angeles, CA to Sacramento, CA, from Sacramento, CA to Los Angeles, CA and return to Washington, D.C.

PURPOSE: To meet with city officials and to speak before the California School Nurses Organization. Speaking will involve AIDS prevention in schools.

CASH/KIND Travel - 348 attached

Prepared by: Retina Holmes, 632-1090

NOTICE: TRAVELERS ARE RESPONSIBLE AND LIABLE FOR UNUSED GTR'S — TICKETS RECEIVED UNTIL THEY HAVE BEEN PROPERLY ACCOUNTED FOR ON A TRAVEL VOUCHER OR RETURNED TO THE AGENCY.

11. SPECIAL AUTHZTN

TRAVEL BY PRIVATELY OWNED AUTO IS AUTHORIZED ON MILEAGE BASIS RATE SPECIFIED BELOW FOR: ☒ EMPLOYEE AND/OR ☐ DEPENDENTS

___¢ PER MILE AS MORE ADVANTAGEOUS TO GOVT — 25¢ PER MILE NOT TO EXCEED COMMON CARRIER COSTS — ___¢ PER MILE NOT TO EXCEED COSTS BY GOVT-OWNED AUTO

☐ GSA AUTO ☐ AUTO RENTAL UNDER GSA CONTR ☒ OTHER *(Specify below)* Taxi/Limo

☐ EXCESS BAGGAGE ☐ REGISTRATION FEE

11A. CHANGE OF STATION

TRANSPORTATION OF ☐ DEPENDENTS ☐ H/H GOODS & PERS. EFFECTS

☐ TEMPORARY QTRS ☐ RESIDENCE TRANSACTIONS ☐ TEMPORARY STORAGE

☐ HOUSE HUNTING TRIP ☐ MISC. EXP. ALLOWANCE ☐ OTHER *(Specify)*

HHS 355:
☐ SIGNED ☐ NOT REQUIRED

[001]

12. TRAVEL & PER DIEM IS AUTHORIZED IN ACCORDANCE WITH DHHS POLICY AND:

XX FTRs ☐ JTR'S ☐ OTHER *(Specify)*

PER DIEM: ☐ NONE XX IN U.S. ☐ OUTSIDE U.S. ☐ VARYING RATES PER ABOVE REGS.

RATE $_____ XX LODGINGS PLUS ☐ ACTUAL EXPENSE ☐ FIXED

LA, CA 102/38
San Diego, CA 78/38
Sacramento, CA 67/34

FUNDS AVAILABLE Sally A. Jones

13. FOREIGN TRAVEL

TO BE PERFORMED FOR *(DHHS, UN, etc.)*

EXPENSES TO BE PAID BY

SECURITY APPROVAL GRANTED FOR TRAVEL OF
☐ 90 DAYS OR LESS ☐ OVER 90 DAYS DATE _____

RESPONSIBLE FOR SECURITY CLEARANCE OF TRAVELER ASSUMED BY

14. ACCOUNTING DATA *(See HHS Acct'g Manual & Acct'g Code Book)*

1 RECORD TYPE	2-7 EFF. DATE	8-10 TRANSACTION CODE	11 REVERSE CODE	12 MODIFIER	ORIGINAL OBLIGATION 13-15 DOC. REF. CODE	ORIGINAL OBLIGATION 16-25 DOCUMENT NO.	OTHER DOCUMENTS 26-28 DOC. REF. CODE	OTHER DOCUMENTS 29-38 DOCUMENT NO	39 GEO. CODE	40 FISCAL YEAR	41-47 COMMON ACCOUNTING NO	48-51 OBJ. CLASS CODE	52-63 AMOUNT DOLLARS & CENTS	64 FED/NON FED	65-79 VENDOR/ CUSTOMER CODE (PRIMARY RECIPIENT)	95-100 PAYMENT COLLEC-TION DOC	101-108 PPBS 101-106 CATE-GORY	101-108 PPBS 107-108 ACTIV-ITIES	109 CASE II
2					130	0017094077			XX	4A734318 XX		21.25	$277.00	1	(b)(6)				2
2																			
2																			
2																			

5. NAME AND TITLE OF OFFICER RECOMMENDING ABOVE TRAVEL
Dr. Philip Lee, M.D., Assistant Secretary for Health

AUTHORITY IS HEREBY GRANTED TO PERFORM TRAVEL AND TO INCUR SUCH EXPENSES AS MAY BE NECESSARY UNDER THE CONDITIONS SET FORTH ABOVE

AUTHORIZED BY Arthur J. Lawrence, Ph.D. TITLE Acting Director, NAPO

DATE 1/31/94

*To be completed by Office Initiating Travel Order; Other Accounting Data to be Completed by Fiscal/Accounting Office

C.1 (REV. 7/80)

Time	Location	Activity
8:00 a.m.	Bel Age Hotel 1020 San Vicente Blvd. West Hollywood 90069	Breakfast meeting to discuss activity schedule for the day. Attending the breakfast meeting will be PAAC trustee Victor Beer, MD.; the LA. AIDS IPA co-chair, Jayson Hymes, MD.; Gordon Nary, media consultant (to be named), and other members of coordinating staff to be determined.
9:30 a.m.	Kraus-Beer Medical Group 5901 W. Olympic Blvd., #420 Los Angeles 90036	A review of a typical Los Angeles group practice model that contracted directly with pharmaceutical manufacturers to conduct clinical trials. Note: In Los Angeles, the increase in community-based trials are through the large group practices rather than through community-based organizations. This integration of clinical trials and treatment has proven to be a significant cost-containment strategy.
10:30 a.m.	Midway Hospital 5925 Olympic Blvd. Los Angeles 90019	A meeting with John Fenton, Midway's CEO, and others, to review their AIDS unit, a prototype facility that has significantly reduced the cost of inpatient care.
12:00 noon	Bel Age Hotel 1020 San Vicente Blvd. West Hollywood, CA 90069	A luncheon meeting with a proposed address by Ms. Gebbie to third-party payers, hospital administrators, pharmaceutical manufacturers, community leaders and union representatives. The luncheon would also be used as a fund-raiser for LA./PAAC's IPA project and community standards of care project. Partnership HCR
2:30 p.m.	Minority AIDS Project 5149 West Jefferson Blvd. Los Angeles, CA 90016	A meeting with the Rev. Carl Bean and board members to review case management program to access community social and medical services. coordination
3:30 p.m.	Country Villa South 3515 Overland Ave. Los Angeles, CA 90034	Meeting with Steve Reissman, CEO, Country Villa Service Corporation, to examine a facility that will reduce the need for and cost of certain types of hospitalization care by 50-70%.
5:00 p.m.	Century City Hospital 2070 Century Park East Los Angeles, CA 90007	A dinner meeting of LA./PAAC physicians who will be developing a working draft of community standards for anti-retroviral treatment. An address by Ms. Gebbie would precede the meeting.
6:30 p.m.	Schedule completed.	

Attached is some additional information about the PAAC healthcare reform initiative. Your interest in these initiatives, we believe, reflects many of the administration's concerns will help unify the Los Angeles medical community in this ambitious project.

Sincerely,

Gordon Nary
Executive Director

cc: Steve Lee
Sam Shekar, MD, MPH
Victor Beer, MD

Encl.: AHA News reprint
Highlights of the PAAC HIV/AIDS Healthcare Initiative
California Home and Attendant Case Management Project

[13] From: Kristine Gebbie 12/6/93 9:36AM (3512 bytes: 53 ln)
To: Sam Shekar, John Gurrola, Warren Buckingham, Andrew Barrer, Arthur Lawrence, Steve Lee
Subject: Potential Feb Visit to Los Angeles HIV Managed Care Network
---------- Forwarded with Changes ----------
From: Sam Shekar 12/3/93 4:13PM (2522 bytes: 43 ln)
To: Kristine Gebbie
cc: Arthur Lawrence
Subject: Potential Feb Visit to Los Angeles HIV Managed Care Network
---------- Message Contents ----------

Text item 1:

Potential Site Visit: LOS ANGELES, CA.
Time : February 1994 - one-half to one day
Organization: Physicians Assoc. for AIDS Care

Kristine, the Los Angeles chapter of the Physicians Association for AIDS Care (PAAC) (150 docs with 45,000 patients, or over 90% of all HIV patients in the greater L.A. area) would like to invite you to spend one day in February '94 attending their board meeting, an anti-retroviral therapy protocol meeting at Cedars-Sinai Hospital and/or a managed care HIV clinic site sometime in the first two weeks of that month, per your availability.

I met the Executive Director of their organization (Gordon Nary) at the recent Indigent Care/Managed Care Reimbursement Conference here in D.C., where we discussed their program.

They are creating a non-profit managed care health network which will treat persons with HIV/AIDS in the greater L.A. area, at an expected 20-30% lower cost (with same or greater services) than traditional health care delivery models, through the use of standardized care protocols, extensive case management services, increased use of nutritional/behavioral care, greater off-label use of drugs, and expert provider referrals.

This may prove to be a good early "model" of how the health care delivery system can be modified to continue to provide appropriate or even better care for PWA's while still accomodating the potential expenditure limitations of a managed health care system. As you know, this is very important as managed health care is likely to become the dominant form of health care delivery in the nation.

I think this could be a GOOD opportunity to publicly link your concern for specific problems PWA's may have with the reformed health care system (access to care, enabling services, right-to-choose expert provider, off-label drug use, etc.), with a potential SOLUTION, in the nation's second-largest metropolitan area.

Special Report

AIDS/HIV program could lead to national practice guidelines

In the uncharted waters of health care reform, a group of Los Angeles physicians is mapping out a standardized system for delivering care to the city's HIV/AIDS patients and, eventually, to the rest of the country.

The ultimate goal of the program, according to the physicians, is the nationwide implementation of community-based medical-practice guidelines to help reduce costs and improve the quality of health care for patients infected with HIV.

Earlier this month, the Los Angeles chapter of the Physicians Association for AIDS Care (PAAC) convened the first in a series of monthly meetings at local hospitals to define practice guidelines for treating HIV/AIDS patients.

Nary

"This is the first time, to our knowledge, that a medical community that treats HIV has joined together to meet the complex moral and political challenges of improving our patients' lives while addressing the economic considerations involved in providing aggressive, cutting-edge care," said Victor Beer, M.D., of the Kraus-Beer Medical Group, Los Angeles.

Los Angeles was chosen for the project because the predominance of group practices there have kept the number of physicians who treat most of the city's HIV/AIDS patients relatively low (about 25 to 30), according to Gordon Nary, executive director of PAAC's national office in Chicago.

"If we tried to do something like this in New York, we'd have 1,000 physicians at every meeting," he said.

Nary said the "real challenge" for the Los Angeles physicians will be to examine protocol cost/benefit ratios for the first time.

According to Beer, most of Los Angeles' HIV/AIDS patients covered un

(continued on page 5)

AHA News®

American Hospital Association Vol. 29 No. 47 November 22, 1993

CA AIDS/HIV program

(continued from page 1)

der Medi-Cal eventually end up in large university or crowded county hospitals. However, many of those patients initially receive care from private physicians.

"What we wind up doing is providing pro bono-type work here in the office, bu yet we can't follow it through to the hospital," Beer said. "The patients get reasonable care, but it's a very inefficient system."

Many Los Angeles physicians believe that the type of medical care being given to patients in physicians' offices is extremely variable and depends, in part, on the patients' ability to pay, according to Eric Daar, M.D., director of the AIDS and Immune Disorder Center at Cedars-Sinai Hospital, Los Angeles.

Physician care in Los Angeles, he said, is broad-based. It can be provided in large, private practices that care for well-insured patients, in HMO settings, in facilities that treat Medi-Cal patients, or in centers for indigent patients, Daar noted.

"The hope is that we can come to a consensus by putting all these [physicians] together in one room and decide what really is appropriate and what should be the standard of care as best you can do that," he said.

PAAC officials contend that, if universal coverage is accomplished under health reform, the need for HIV/AIDS patients to seek specialized care at university or at county facilities will be eliminated. The same holds true for the perception that some providers determine the course of care based on patients' ability to pay. And, as more physicians in the community treat HIV/AIDS patients, the need for clinical-treatment guidelines becomes greater.

In addition to developing a consensus on protocols for managing HIV infection and related opportunistic diseases, the guidelines will address alternative therapies and nutritional interventions.

Daar said physicians will have to supply more than simple anecdotal evidence to get protocol proposals approved.

"My gut feeling is that the standards are going to be based more on science than on art," he said. "People are going to have to defend why they are doing things for them to end up in the recommendations."

Currently, some affluent patients are asking for and are receiving aggressive HIV/AIDS care regardless of whether the treatments have proven to be effective, according to Daar. When such care is offered by physicians who treat thousands of infected patients, these treatment methods are incorrectly perceived as accepted "standards."

The questionable, more-expensive treatments now being offered to HIV/AIDS patients include the use of anabolic steroids, Daar said.

"Some day, there may be a real role for anabolic agents with this disease, but right now there are no studies to support their use," he said. "They're just being given to people because they think it works."

Requiring scientific justification for treatment protocols likely will be important in garnering support from third-party payers, according to PAAC's Nary. Payers, he said, are looking for something objective upon which to base their reimbursement policies.

However, Nary said the Los Angeles PAAC will challenge in court third-party payers that refuse to reimburse for treatments that are within the approved standards for HIV and AIDS.

AHA Associate General Counsel Margaret Hardy noted that the issue surrounding when a treatment moves from being experimental to an accepted standard often creates legal dilemmas.

"Medicare and insurers will not pay for things that they deem experimental, and there's fight after fight about when something becomes accepted care," she said.

Next year, the Los Angeles PAAC is expected to begin developing an AIDS Independent Practice Association (IPA), which would contract with employers to provide care for HIV workers.

Recognizing payers' concerns about the development of objective standards, a key element in the IPA model is the creation of outcome studies for various HIV therapies. The studies, along with the community-practice guidelines, will be used to design centers of excellence for HIV-specific hospital services.

The IPA would charge an annual fee to cover all medical care, diagnostic tests, consultant care and oral medications. Hospitalization, transitional care, hospice and home care would be covered under a separate preferred-provider organization (PPO). Following the practice guidelines and negotiating special discounts through the PPO would reduce private care costs by as much as 30 percent, according to PAAC.

Top five metropolitan areas in number of AIDS cases through September 1993

New York City	55,899
Los Angeles	21,850
San Francisco	17,424
Miami	9,563
Washington, DC	9,504

National total of AIDS cases: 339,250

Source: Centers for Disease Control and Prevention, 1993
Graphic by AHA News

Once the project is completed, the Los Angeles PAAC hopes to ultimately standardize the type of care given to HIV-infected individuals.

"What we're trying to do is provide the same level of care for all people with HIV," PAAC's Nary said.—*Jeffrey Green*

Highlights of the HIV/AIDS Healthcare Initiative

1. Pharmaceutical industry reforms. PAAC has suggested two pilot studies in Los Angeles by the pharmaceutical industry that are designed to contain and reduce costs for AIDS drugs. PAAC will be holding a meeting in Los Angeles on March 9, 1994, for industry representatives to discuss the details of the proposals.

   a. A lifetime cap on HIV/AIDS drugs, after which drugs would be provided free of charge. This proposal will help both contain the costs of healthcare as well as provide better actuarial data upon which annual and lifetime costs can be projected.

   b. A reform of indigent patient programs that provide free drug to persons who are unable to pay for the drug when other reimbursement sources do not exist. Even with a fairly liberal prescription drug benefit for universal coverage, there are many drugs, especially for off-label indications, that would not be covered under a traditional insurance plan. We therefore anticipate that there will continue to be a need for an indigent drug program.

      PAAC has recommended that the industry join together to decide on a common eligibility requirement for free drug, after which all specified drugs not reimbursed by a universal insurance plan, will be provided free of charge. This would eliminate the complex and often disparate eligibility requirements and paperwork currently required for each individual drug. PAAC estimates that these complex requirements and at times overwhelming paperwork are limiting access to free drugs by a majority of patients who need them.

2. A Managed Care Model for HIV/AIDS PAAC is organizing an AIDS-specific IPA and PPO model for Southern California. The model is described in the enclosed article from AHA News.

3. Community standards of care. PAAC's community standards of care project is designed to help standardize and improve care for people with HIV/AIDS and to establish a new legal basis for third-party payment of off-label drugs, the use of which is central to many patients' continued survival and quality of life. In general, the reimbursement for these drugs can result in significant cost savings by more effectively treating and preventing opportunistic infections. Examples of such savings can be furnished if this is of interest to you.

4. The role of case management in HIV/AIDS care. Comprehensive case management is central to the effective utilization of service with appropriate cost savings. A study on the effectiveness of the California home and attendant care project is attached. This is the model upon which the Los Angeles AIDS IPA is considering basing its clinical management program.

5. Community support for social and medical services. Regardless of the comprehensiveness of the Administration's universal healthcare policy, there will always be medical services not covered by a policy. There is also a need for many patients to access social services such as housing, transportation, etc., that are central to the proper implementation of medical services.

   The LA/PAAC healthcare model includes community support for the development of supplemental funds for investigational research and alternative therapies--a fund in which 100% of donations goes directly to the reimbursement for such treatment. Additional funds for housing, transportation, and other services that the patient cannot afford and for which local agency support is not available, will also be created.

CASE MANAGEMENT NOTES

AIDS Home Health, Attendant and Hospice Care Pilot Project

Prepared for the California Department of Health Services Office of AIDS by Jack Little, Ph.D., Anna Long, M.P.H., Kevin B. Kehoe, California State University, Los Angeles, CA.

Executive Summary

The Acquired Immune Deficiency Syndrome (AIDS), first described by the Centers for Disease Control (CDC) in 1981, is currently recognized as the number one threat to the public health of the nation and of the world. The number of people who have contracted the Human Immunodeficiency Virus (HIV) is unknown. As of January, 1990, the CDC has reported 119,590 diagnosed cases of AIDS in the nation and 23,752 cases in California.* These figures do not include the estimated 1.5 to 2.4 million persons believed to have HIV infection, but who have not been diagnosed as having AIDS.

In recognition of the growing crisis, California Senate Bill 1251 (Roberti) was passed and signed into law (Chapter 767, Statutes of 1985). Section 1, Chapter 1.11, commencing with Section 199.7, which was added to part 1 of Division 1 of the Health and Safety Code, required the Department of Health Services, Office of AIDS (DHS/OA) "to fund pilot projects to demonstrate the value of noninstitutional healthcare services such as hospice, home health, and attendant care in controlling costs and providing human care to people with AIDS and AIDS-Related Complex" (ARC).

The first five projects (Alameda, Los Angeles, San Diego, San Francisco and Santa Barbara) were funded, effective April 1986 through June 30, 1987 and provided the basis for the development of operating procedures, service delivery systems and data collection, reporting and management, while providing services to 356 persons with AIDS (PWAs) or persons with ARC (PW/ARCs). The DHS/OA Home Health, Attendant, and Hospice Care Pilot Project enrolled a total of 867 clients between July 1, 1987 and May 31, 1988 at 14 California sites. Of the 867 clients enrolled during the second phase of the study, 87.9 percent were diagnosed with AIDS at the time of study enrollment. The remaining 12.1 percent of the client pool entered the study with a diagnosis of ARC. The client pool was predominately white, other than Hispanic, (79.1 percent). The majority of the study sample were male (93.7 percent), and reported a transmission category of homosexual or bisexual contact (75.9 percent). Intravenous drug users (IVDUs) comprised 11.4 percent of the total client pool.

The majority of the study clients were assessed at the early or late chronic stages (Karnofsky Performance Status Scale) of AIDS at study enrollment (84.5 percent of the total client pool). While the total number of days clients spent on the study ranged from one to 335 days, clients spent an average of 116.60 days on the study. At the conclusion of the 11 month study period, 30.4 percent of the total client pool had died (264) with 603 clients remaining in the active study pool.

During the 11 month study period, a total of 242,319.61 hours of service were provided to the 867 clients through the efforts of the DHS/OA, and participating organizations. The majority of these hours (65.78 percent of all hours of service provided) were for attendant care. Attendant care was utilized by 46.14 percent of the total client pool. During the 11 month study period, a total of 15,882.25 hours of in-home skilled nursing services were provided to 46.48 percent of the total client pool. A significant number (358) of the total client pool utilized volunteer services (41.29 percent of all clients). A total of 25,551.03 hours of volunteer services were provided. All 867 clients were provided comprehensive case management services, with each client averaging 12.22 hours of direct case management service.

Analyses of factors which may have related to service utilization revealed that, on the average, clients who died during the study, those clients entering the study at the later stages of AIDS, and those clients experiencing more AIDS-related infections, utilized services more intensely than did clients with different medical histories. Factors such as transmission category, ethnicity and living arrangements, did not significantly impact service utilization.

Prior to study enrollment, clients spent an average of 22.47 days in the hospital. During the study, clients averaged 8.20 days of hospitalization, with 54.67 percent of the total client pool never being admitted to the hospital during their time on study. During the study, clients who died had averaged hospital stays of 8.55 days, compared to a mean of 8.05 days for clients living at the end of the study. In addition, clients who died utilized almost three times the amount of services on a daily basis when compared to clients who did not die (5.89 and 1.98 hours, per client, per day, respectively). This more intense utilization of home health services by clients at the later stage of the illness may have contributed to maintaining the low levels of hospitalization observed in the study.

The provision of home healthcare appears to have reduced the mean length of hospital stay when compared to that previously reported for PWAs in California. This suggests savings in inpatient care costs. While the data are insufficient to allow for statistical validation of this observation, these findings indicate that project clients, on the average, experienced fewer hospital admissions and total days of hospitalization when home health services were utilized.

* *Original report included June, 1988 CDC data.*

CASE MANAGEMENT NOTES

Introduction

The Acquired Immune Deficiency Syndrome (AIDS), first described by the Centers for Disease Control (CDC) in 1981, is currently recognized as the number one threat to the public health in the nation and the world. The number of people who have contracted the Human Immunodeficiency Virus (HIV) is unknown. As of January, 1990, the CDC has reported 119,950 diagnosed cases of AIDS in the nation and 23,752 cases in California.*[1] These figures do not include the estimated 1.5 to 2.4 million persons believed to have HIV infection, but who have not yet been diagnosed as having AIDS.

In recognition of the growing crisis, California Senate Bill 1251 (Roberti) was passed and signed into law (Chapter 767, Statutes of 1985). Section 1, Chapter 1.11, commencing with Section 199.7, which was added to part 1 of Division 1 of the Health and Safety Code. The intent of the Legislature regarding the Home Health Attendant and Hospice Care Pilot Projects was specified in Section 199.7 (b): "to fund pilot projects to demonstrate the value of noninstitutional healthcare services such as hospice, home health, and attendant care in controlling costs and providing human care to people with AIDS and AIDS-Related Complex"[2] (ARC).

Section 199.74 directed that "Pilot projects to demonstrate the cost effectiveness of home health, attendant, or hospice care" were to be initiated through a block grant program. The development of the direct service demonstration projects, by contract agencies, were specified in subsections "d" and "e". That is, contractors were to "develop a comprehensive service system" which included:

1. Provision for hospice, skilled nursing facility, home healthcare, and homemaker chore services.
2. Individual consultation, health planning and assessment.
3. Information for people with AIDS or ARC regarding death and dying.
4. Evaluation and referral services for medical care.
5. Referral services for mental health services, as appropriate.
6. Assistance in applying for financial aid or social services which are available and for which clients qualify.
7. An ongoing quality assurance program.
8. Confidentiality assurances and methods for developing interagency confidentiality agreements.

It was also required that, "Contractors accepting block grant funds shall compile comparative cost data reports for transmission to the department and the Legislature."

This report is a presentation of the aggregated data of the 14 operational Home Health, Attendant and Hospice Care Pilot Projects of the 22 projects which were authorized during the period of July 1, 1987 though May 31, 1988 (see Appendix A). These data represent the types and units of service provided to the 867 study participants. The demographics of the sample and comparisons of units of service utilized by different subsets of the sample are presented. Further statistical analysis was accomplished to determine if any statistically significant differences existed among sample subsets and to specify these differences.

This was a descriptive study. That is, it was an attempt to define the current level and types of services received by persons with AIDS (PWAs) or persons with ARC (PW/ARCs) at the fourteen sites. A discussion of the cost effectiveness of home health, attendant, or hospice care and the value of noninstitutional health care services in controlling costs and providing human care to people with AIDS and ARC is included in the "Discussion" section of the report.

Scope of the Study

The legislative mandate required that the State Department of Health Services (DHS) issue contracts to demonstrate the value of noninstitutional health care services in controlling costs and providing human care to PWAs or PW/ARCs. This was to be accomplished through block grant direct service demonstration projects (pilot projects). Contractors were required to "encourage broad-based community involvement and support for PWA programs and involve charitable, other nonprofit, and other agencies as well as healthcare professionals as providers of essential services." Additionally, contractors were required to:

- ensure against duplication of services within the community;
- maximize use of other federal, state, and

* *Original report included June, 1988 CDC data.*

CASE MANAGEMENT NOTES

local funds and programs;

- provide culturally and linguistically appropriate services;
- compile and transmit comparative cost data to the Department and the Legislature.

The Department of Health Services, Office of AIDS (DHS/OA), facilitated the accomplishment of the mandate by:

1. Preparation and distribution of a "request for proposals".
2. Designating contractors and negotiating contracts based upon the recommendations of the proposal review panel.
3. Specification of project operational parameters.
4. Specification of data to be collected.
5. Distribution of a computer program and standardized data catchment formats to all selected sites.
6. Provision of training in data collection, data reporting, and data management support to all sites.
7. Ongoing project monitoring and operational support.

Contracts were let to community-based service organizations, home healthcare agencies (e.g., Visiting Nurse Associations, hospice programs), hospitals, and county public health departments. The contractors represented both rural and urban California.

The research questions to be addressed were formulated in consultation among the Office of AIDS Pilot Project staff, the project directors and the project data management staff. The research questions identified were:

- What are the demographics of the clients?
- What are the units of service utilized by PWAs from among those available?
- Are there statistically significant differences in units of service used among subjects of the sample?
- If statistically significant differences in units of service exist among subsets of the sample, what are they?
- Is there a relationship between level of functional capacity of project clients and utilization of services, if so, what is it?
- Are clients satisfied with the services received?
- Are days of hospitalization reduced as a result of the availability of home healthcare?
- Can the cost of home healthcare be documented as a result of this study?

The data from the 14 sites were arranged and analyzed to provide quantified responses which support, affirm, or negate the research questions and provide descriptive client data. The issues of cost effectiveness and cost containment, as well as the value of home healthcare services in the accomplishment of such, could only be addressed indirectly. A valid database against which to compare the costs for the provision of services to persons receiving home healthcare services does not exist. The measure most frequently proposed, reduced days of hospitalization, is confounded by so many variables that any reduction could not be solely attributed to the utilization of home healthcare services. The changes in medical practice, new medications, and different approaches to treatment may be as significant to reduction in the length of hospital stays and total days of hospitalization as the availability of home healthcare. Consequently, while days of hospitalization prior to entering the study and days of hospitalization while on the study are reported, differences cannot be assigned to the pilot projects alone.

Methods

Introduction

The development and field testing of the model used for the pilot projects was accomplished between April 1986 and June 1987. This model included the design and testing of a standardized data catchment system including a computer software program used to track client service utilization and provide a systematic approach for reporting and the analysis of data. The model and program was field tested at five sites which provided services for 356 clients. After extensive review and modification of both the model and computer program, based on input from the field, project monitors and the data management team, a data management handbook was prepared. The Home Health, Attendant and Hospice Care Pilot Project Handbook included standardized data catchment formats, computer programs and tutorials. Each site selected for participation during the 1987-88 fiscal year was provided with copies of the handbook and has received on-site instruction in data collection, use of the computer program and reporting.

The Model

This project was designed to collect data specific to units of services provided to PWAs and PW/ARCs through community-based home health, attendant, and hospice care programs. A comprehensive care management approach served as the model for the project. the design which emerged was that of an interdisciplinary team with registered nurses providing case management in consultation with, and supported by, social workers.

CASE MANAGEMENT NOTES

Comprehensive case management was a consistent factor site to site. Case managers served as the primary contact persons for all clients and their significant others. Case managers provided an access route to all available services, as well as serving as advocates for the clients. Case managers identified or developed community resources and provided AIDS prevention and healthcare education to both the client and significant others. They also provided insurance information, assisted in accessing public benefits and arranged for housing and food based on ongoing client needs assessments. Additionally, case managers monitored the quality of services being provided though regular contacts with both the clients and service providers and were responsible for data collection and reporting.

Selection of Project Sites

Selection of site participants in the Home Health, Attendant and Hospice Care Pilot Projects was based upon a competitive proposal procedure. That is, DHS/OA, announced the availability of funds to support pilot projects throughout the state and all interested parties meeting eligibility criteria were invited to apply. An impartial review panel was seated and reviewed each proposal. Recommendations for funding were submitted to the DHS/OA.

During the 1987-88 fiscal year contracts were negotiated with 22 organizations to participate in the pilot projects. Thirteen of the projects began July 1, 1987 and nine projects were funded to begin January 1, 1988. However, only one of the projects funded in 1988 became fully operational during this reporting period. Consequently, only 14 of the sites were sufficiently operational to provide data for analysis by May 31, 1988 (see Appendix A). All projects were provided with standardized data management materials and technical assistance, including site visitations by project monitors as well as data management staff, as necessary. Each site was supplied standardized data catchment formats, computer programs, and data input and reporting instructions. While there was no attempt to use a randomized approach to site selection, the variables of location, urban/rural, number of diagnosed cases, and minority/non-minority were considered as a part of the selection process.

Selection of Study Participants

Persons participating in the Home Health, Attendant and Hospice Care Pilot Project were self-selected. That is, announcement of the projects were distributed to physicians, hospitals, AIDS service organizations, the media and through outreach to minority communities. Individuals with a diagnosis of either AIDS or ARC were invited to apply for enrollment. Those individuals who met selection criteria were enrolled on a "first come, first served" basis.

The population from which the participants were selected was defined as all persons within the service area of each project diagnosed with AIDS or ARC with a functional status index of 70 or less (early chronic or critical) on the Karnofsky Performance Status Scale as modified by the Visiting Nurses Association of San Diego County, Inc.[3](assessed on a scale of 0 to 100, with 0 indicating death) (see Appendix B). In areas of low incidence or extreme need, exceptions were made which resulted in 10.4 percent of the total sample being enrolled at Diagnosis (Stage I of the Karnofsky scale). Participants were enrolled regardless of their ability to pay for services or source of payment. However, the pilot projects were considered as payment source of last resort. That is, all available sources of payment were exhausted prior to use of pilot project funds.

Project Operations

Certification of eligibility was provided by each client's primary physician who also reported the initial Karnofsky status. Certification forms were provided directly to potential clients or were provided to physicians upon requests. All clients signed informed consent and medical information release forms prior to enrollment. Client confidentiality was maintained through the assignment of study code numbers for identification purposes and keeping client records and reports in locked files. Once a certificate of eligibility was received from the physician, with the physician's verification on the diagnosis and Karnofsky status, the individual became eligible for enrollment into the program.

Upon acceptance as a study participant, case managers completed an intake interview and record review. This included recording of all demographic data as well as a physical and psychological needs assessment. The intake procedure allowed for the establishment of a baseline against which ongoing status and needs could be compared. At the conclusion of the enrollment procedure, a study number was assigned and an individual care plan developed. If it were determined (as a result of the initial needs assessment) that home healthcare was required, care providers were notified and physical and/or psychological evaluations completed. Services were initiated based upon these evaluations.

Data on all services, both paid and volunteer, were collected and reported on a regular basis for inclusion into a site specific database. The data were then reported on a monthly basis to the data management team for review and aggregation into the master database.

Each case was reevaluated on a regular basis at a weekly interdisciplinary case management team meeting. The case manger chaired these meetings which included social workers, all direct service care providers and other individuals involved with the case. Clients and significant others were invited to participate

CASE MANAGEMENT NOTES

in the case conference meetings. The case management team was designed to function as an interdisciplinary team to assist in the development of individual care plans, including hospice care plans (as appropriate) for each client. The care plan was monitored and services accessed through the case manager.

Client satisfaction was monitored on a biweekly basis through the completion of a written biweekly client satisfaction report. Additionally, all clients receiving home healthcare services were contacted by telephone on not less than a weekly basis by the case manager and all clients were interviewed, face-to-face, on a monthly basis.

Data were collected on an ongoing basis and all client contacts were charted by the case managers. Nursing and attendant charts were maintained by the service providers and reviewed by the case managers.

Quality assurance of services provided and data recording were monitored by the case managers. The overall project administration, data reporting and fiscal accountability was the responsibility of the project director. All billing for services provided was reviewed by the case manager and the project director to ensure accountability and to serve as a verification of service data which was reported.

Clients were afforded the opportunity to withdraw from the study at any time, with assurances that any services which the participating agency provided outside of the project would remain fully available to them.

Upon the death of a client, physicians were requested to complete a physician satisfaction report. This report was designed as a way of determining the physician's perception of the appropriateness of the services being provided through the projects and the degree of satisfaction with those services.

Data Collection and Analysis

Each of the 14 project sites was responsible for the collection, verification of data accuracy, entering and reporting of client data. The data were entered into two separate databases using the Home Health Care (HHC) Data Entry Program. The DIAGNOSIS database contained information on each client's demographic and medical history at the time of diagnosis and was entered into the HHC program at the time of the client's enrollment in the study. As necessary, clients' DIAGNOSIS data was updated throughout the study to reflect new diagnosis of AIDS-related infections, date of death or withdrawal from the study, and physician satisfaction ratings. The HISTORY database contained information regarding clients' current medical status, units of service, and cost data for each recording period during the study.

"There appears to be a decrease in both length of hospital stays and the number of hospital admissions. . . . The apparent reduction in hospital admissions and reduced length of hospital stay (days) tend to support the cost effectiveness and the value of home healthcare services as a way of containing costs for persons with AIDS."

Each month, sites sent diskette copies of their entire, current DIAGNOSIS and HISTORY database to the data management office for inclusion in the aggregate database. Hard copy printouts of both datasets were usually included along with the diskettes. When printouts were unavailable, the datasets were printed by the data management office. Upon receipt of the site data, these printouts were reviewed for accuracy. Sites were contacted for clarification and/or correction of data when accuracy was in question. Following review of the site data, the previous month's databases were deleted from the aggregate database and the new data added.

At the end of the data collection period, both the aggregate DIAGNOSIS and HISTORY databases were subjected to cleaning and review using dBASE-III+.[4] These dBASE databases were translated into two ASCII files for use in data analysis. The Statistical Program for the Social Sciences, Personal Computer Version 2.0 (SPSS)[5] was used for all data analysis. Two SPSS data sets were compiled, one corresponding to each of the HISTORY and DIAGNOSIS databases. Since the HISTORY dataset contained multiple observations for each client (a total of 5,124 records for the aggregate database), a smaller dataset was created by aggregating each client's data across recording periods. This produced one record per client, containing sums of all units of service, and cost throughout their time on the study.

In order to facilitate comparisons of units of service based on demographic and medical status data, the DIAGNOSIS and HISTORY datasets were merged to create one database. This final dataset was used in analyses.

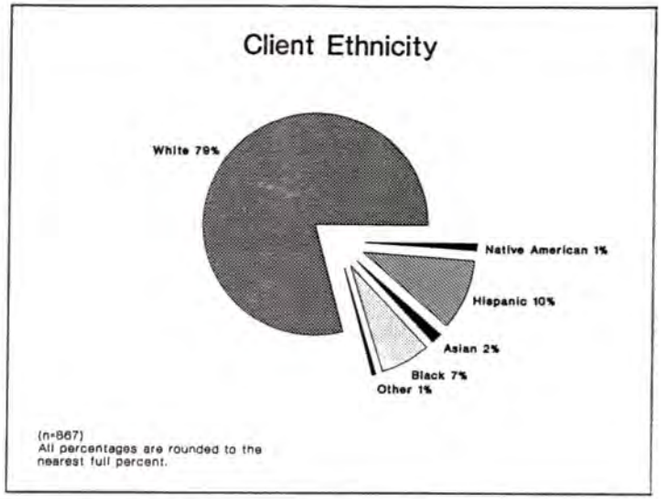
Limitations of the Study

The data generated as the result of this study represents an attempt to quantify the units of home healthcare provided to a highly heterogenous sample of the population of individuals with an AIDS or ARC diagnosis in the state of California. This was accomplished only with the cooperation of many organizations and individuals throughout the state, some with little prior experience in data collection. The diversity of organizations participating, the lack of prior experience in data collection, general and specific lack of knowledge of the needs of persons with AIDS or ARC, wide geographic distribution of study sites, and frequently experienced lack of resources limit the reliability and validity of this study. However, it is believed that given these restraints, the data presented are sufficient to allow for the development of estimates of both the units of care necessary to provide adequate, not optimal, care for persons with AIDS or ARC and to serve as a basis for the estimation of the cost of such care.

Specific factors limiting the ability to generalize the results of this study are:

- The availability of funds for the purchase of services varied from site to site. This resulted in some sites having resources with which to purchase relatively high levels of services while others were required to rely more heavily upon volunteers.
- The requirement that all case managers be registered nurses and the inability of some sites to hire nurses due, in part, to the nurse shortage resulted in some projects not being fully staffed.
- Limited resources in some areas of the state resulted in limited availability of services or substitution of services, to some clients, at some sites. That is, lack of attendants, home healthcare agencies willing to work with PWAs, housing, etc.
- The inability of one of the largest sites to provide complete or valid data resulted in the reduction of the number of clients across a number of fields.
- "Case Management Hours" captures only that time spent in direct contact with clients or with individuals or organizations on behalf of specific clients and the recording of those contacts. It does not capture the hours spent in the identification or development or resources, negotiations with service providers or general administrative responsibilities.
- In recognition that community-based organizations rely heavily upon volunteers as a source of service personnel, every effort was made to capture the hours of service provided through volunteer staff. However, it is acknowledged that some volunteer hours of practical support, transportation and other services may not have been reported. It should also be noted that services provided by family, spouses, or significant others living in the home of the client were not captured.
- Insufficient data was reported to justify any conclusions as to physician satisfaction with services provided through the project.

FIGURE 1



Results

The Home Health, Attendant and Hospice Care Pilot Project enrolled a total of 867 clients between July 1, 1987 and May 31, 1988, at 14 California sites (see Table 1). Of the clients enrolled, 762 clients (87.9 percent) were diagnosed with Acquired Immune Deficiency Syndrome (AIDS) at the time of study enrollment. The remaining 105 clients (12.1 percent) had been diagnosed as having AIDS-Related Complex (ARC). All diagnoses were consistent with the criteria established by the Centers for Disease Control (CDC), Atlanta, Georgia, 1987.[6] At the conclusion of the study period, 264 clients (30.4 percent) had died with 603 clients remaining in the active study group. During the 11 month study period, a total of 242,319.61 hours of service were provided to the 876 clients (average: 279.49 hrs/client) through the efforts of the Department of Health Services, Office of AIDS, and the participating organizations.

CASE MANAGEMENT NOTES

CASE MANAGEMENT NOTES

FIGURE 2

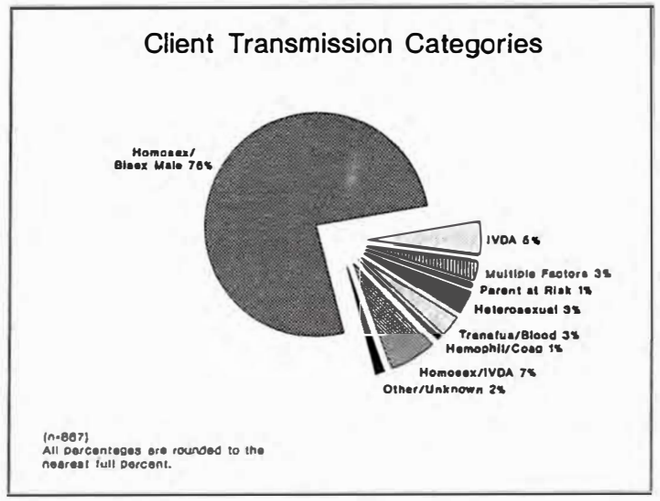
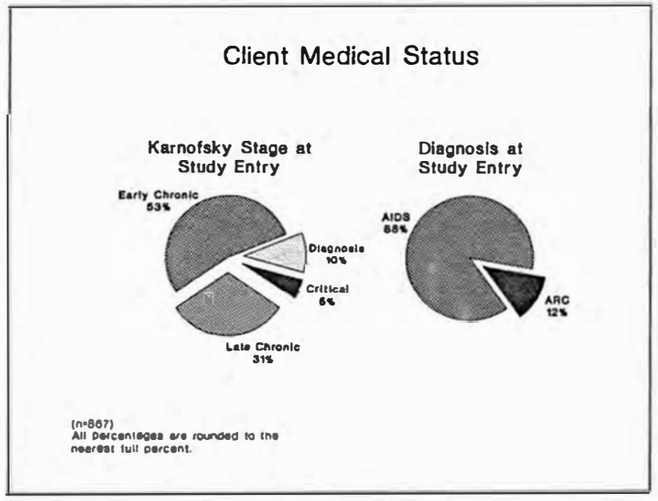


FIGURE 3



Client Characteristics

The majority of the study clients (812) were male, (93.7 percent). There were 55 females in the study sample. The project sample was predominately white, other than Hispanic (686 clients or 79.1 percent). Hispanics (89) accounted for 10.3 percent of the total sample. There were 61 black clients (7.0 percent) and smaller proportions of Native American and Asian clients, (1.2 and 1.7 percent respectively) (see Figure 1).

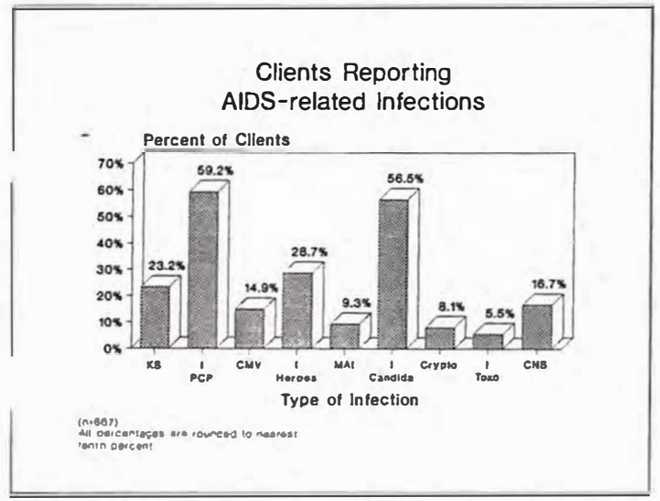
The majority of project clients clustered in one transmission category (see Figure 2). Over 75 percent of the sample identified themselves as homosexual or bisexual males. Intravenous drug users (IVDUs) comprised nearly 12 percent of the client pool. Forty-two of the total 99 clients in this group indicated that they were also homosexual (IVDUs = 4.8 percent, homosexual/IVDUs = 6.6 percent). Clients with hemophilia and other coagulation disorders represented 0.8 percent of the total sample. Three percent of the total client pool indicated that they had contacted the HIV virus during transfusions. No known risk category could be identified for 12 project clients (1.4 percent of the total sample). Smaller proportions of the sample (less than five percent) fell into the three remaining risk categories (parent at risk, multiple factors, and other) (see Figure 2).

The mean age of the study clients was 38.7 years, with 44.9 percent of the total sample falling into the 30 to 39 years of age category. There were 15 children (under the age of 19) enrolled in the study. Eighty percent of these children were under the age of six years. Twelve of these were reported as being in the "parent at risk" transmission category.

At the time of entry into the study, the majority of project clients reported that they resided with a relative, friend, lover or spouse (65.7 percent). Slightly over 25 percent of the clients lived alone (25.7 percent). Fourteen clients (1.6 percent) reported unstable living arrangements at the time of study enrollment. Fifty-eight clients (6.7 percent of the entire client pool) reported living in a residential, hospice-type, facility.

CASE MANAGEMENT NOTES

FIGURE 4



Client Status Prior to and During the Study Period

Upon entry into the study, 87.9 percent of the sample had a diagnosis of AIDS. The remaining 12.1 percent of the sample had an ARC diagnosis (see Figure 3). No clients were entered into the study without prior physician certification of one of these two conditions. Study clients spent an average of 1116.60 days on the study, with total days on the study ranging one to 335 days.

The Karnofsky Scale (originally developed for use with cancer patients) was used to assess client's functional status prior to admission into the study. The majority of study clients fell into either the Early Chronic (Stage II) or Late Chronic (Stage III) classification (84.5 percent). Forty-five clients (5.2 percent) were assessed as Critical (Stage IV) at time of entry into the study. Ninety clients (10.4 percent of the total sample) entered the study at Diagnosis (Stage I) of theillness.

In addition to recording AIDS and ARC diagnoses at study entry, client data was updated during the study to reflect diagnoses of AIDS-related infections. During the 11 month study period, over 90 percent of the total client pool experienced at least one AIDS-related infection. The specific conditions examined were Kaposi's Sarcoma (KS), Pneumocystis Carinii (PCP), Cytomegalovirus (CMV), Herpes, Candida, Mycobacterium Aveum Intercellular (MAI), Cryptococcus Neoformans, Toxoplasma and Central Nervous System (CNS) Disorder. When aggregated over the total sample, clients averaged 2.22 different infections while on the study with a maximum of six infections reported by any one client. Over 50 percent of the total client pool experienced PCP infections (59.2 percent) (see Figure 4).

At the time of entry into the study 30.0 percent of the total client pool evidenced at least mild mental deterioration. In addition to examining mental status, client's emotional status at time of entry into the study was assessed. Less than half of the total client pool was assessed as having a stable mental status at study entry (38.3 percent). Twenty-one percent of the study clients were assessed as depressed during the initial intake.

The majority of the sample (74.5 percent) had been hospitalized at least one day prior to entry into the study. The entire sample averaged 22.47 days of hospitalization prior to entry into the study, with a range of 0 to 252 days of hospitalization.

Following entry into the study, the sample averaged 8.20 days of hospitalization. The range of days spent in the hospital by clients while on the study ranged from 0 to 151 days. Only 45.33 percent of the sample was admitted to the hospital during the study period compared to the larger proportion observed prior to study entry. When aggregated over the entire study sample, clients averaged approximately one hospital admission while on the study. However, slightly less than fifty percent of study clients were actually admitted to the hospital, with 474 clients showing no hospital admissions following entry into the study. There were a total of 873 hospital admissions during the study, reflecting the multiple admissions of the 393 clients actually entering the hospital during the study. The number of hospital admissions for these clients ranged from one to 14 admissions during the study period with an average of 8.2 days per hospitalization. It should be noted that 12 individuals for whom "days of hospitalization" were reported were never formally admitted. This is assumed to have resulted from some individuals being hospitalized for a portion

CASE MANAGEMENT NOTES

of a day for specific treatments without formal hospital admission.

Units of Service Provided

Table 2, Units of Services Provided —All Clients, reflects the units of service provided to the 867 clients in the Home Health, Attendant and Hospice Care Project conducted by the 14 study sites between July 1, 1987 and May 31, 1988. The average units of service for the entire client pool are presented in Figure 5.

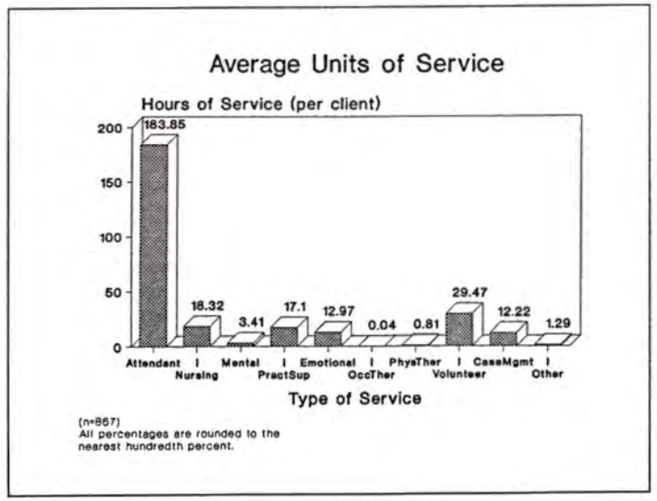
Attendant Care

Attendant care was defined as personal support services. Attendant duties included light housekeeping, meal preparation, assistance with dressing, bathing, toileting, and reminding clients to take medications as appropriate. At times, attendants also accompanied clients to medical appointments and provided other support functions as deemed appropriate by a registered nurse supervisor. Attendants were provided written care plans to follow and were monitored and supervised by skilled nursing staff. Each attendant received specific training in the care of persons with AIDS or ARC from the agencies with whom they were employed. Their training included specific precautions to be exercised as well as psychosocial factors to be considered while caring for persons with HIV infection.

Each attendant was monitored on at least a biweekly basis through on-site visitation by a registered nurse. Client satisfaction reports were submitted to project directors on a monthly basis. In addition, biweekly telephone contacts were made by project staff to further assess client satisfaction.

A total of 159,400.29 hours of attendant care were provided to 400 of the 867 study clients. The mean number of hours of attendant care provided, aggregated over the total sample, was 183.85 hours per client with a range of 0 hours to 3,034.25 hours. This reflects an average of 1.58 hours of attendant care, per client, per day, for the entire sample.

FIGURE 5



In-Home Skilled Nursing Care

The units of in-home skilled nursing (RN or LVN) care were, in many cases, reduced by the extensive use of attendant care. Skilled nursing home visits were combined with attendant care supervision on a biweekly basis. A total of 15,882.25 hours of in-home skilled nursing care was provided during the period of the study for an average of 18.32 hours, per client. However, less than half of the total client pool received in-home skilled nursing care (46.5 percent).

Mental Health and Emotional Support Services

Both mental health and emotional support services were available to project clients participating in the study. A social worker provided input at the weekly case conference meetings to provide guidance and support to the service providers (attendant and nursing staff). In addition, licensed mental health professional and lay emotional support providers (e.g., Shanti-type trained volunteers) were available to see study clients upon request. A total of 2,955.10 hours of mental health care was provided to 296 study clients. The mean, when aggregated over the entire sample was 3.41 hours of service, per client, with a range of 0 to 136.00 hours.

A total of 11,244.25 hours of emotional support was provided to 287 study clients (33.1 percent of the total client pool). An average of 12.97 hours of emotional support was provided, per client, with a range of 0 to 377 hours. These services included provision of an emotional support volunteer to all clients who requested one, and bereavement counseling for families and significant others upon request.

Volunteer Services

Volunteer services included everything from driving clients to medical appointments, to feeding the pets of clients who were hospitalized. Emotional and practical support services which where provided by trained volunteers were reported separately, therefore, excluded from this category. The total number of units of volunteer services provided during the study period were 25,551.03 hours, or 29.47 hours per study client. Volunteer services were utilized by 41.29 percent of the total client pool. These 358 clients averaged 71.37 hours of volunteer services during their time on the study.

Case Management

Case managers, at each study site, maintained face-to-face and telephone contact with each client and his or her significant others. They provided access to all available services, and generally served as an advocate for the client. Case managers attended all case conferences and were the primary "gate keepers" for services and cost containment. A total of 10,596.57 hours of direct contact and case conferencing (or 12.22 hours, per client) were provided during the study period.

Other Services Provided During the Study

During the 11 month study period, 14,828.37 hours of practical support services were provided to 212 study clients (an average of 17.10 hours, per client). Occupational therapy was utilized by less than two percent of total client pool. A total of 38.75 hours of occupational therapy were provided to 10 study clients. Physical therapy was utilized by 7.04 percent of the total sample (61 clients). These 61 clients averaged 11.52 hours of physical therapy (or a total of 703.00 hours) while on the study.

Hospice-type care was utilized by 40 clients (4.61 percent of the total sample). A total of 1,298 days of hospice services were provided during the study period. These 40 clients averaged 32.45 days, per client. In addition, a total of 6,924 days of housing was provided, through the projects, to 81 clients (9.34 percent of the total sample).

CASE MANAGEMENT NOTES

FIGURE 6

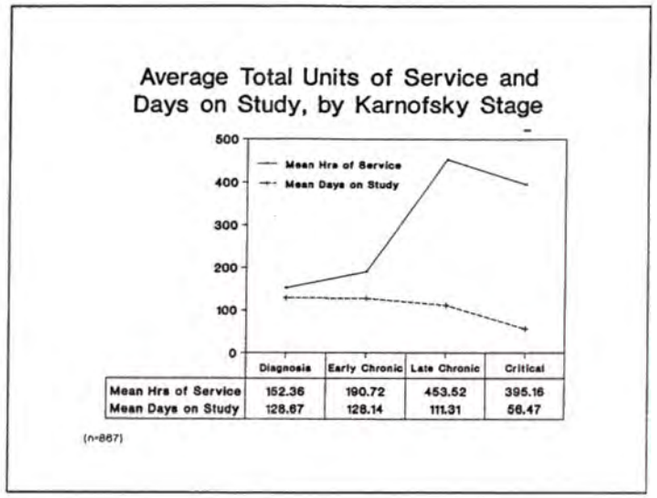
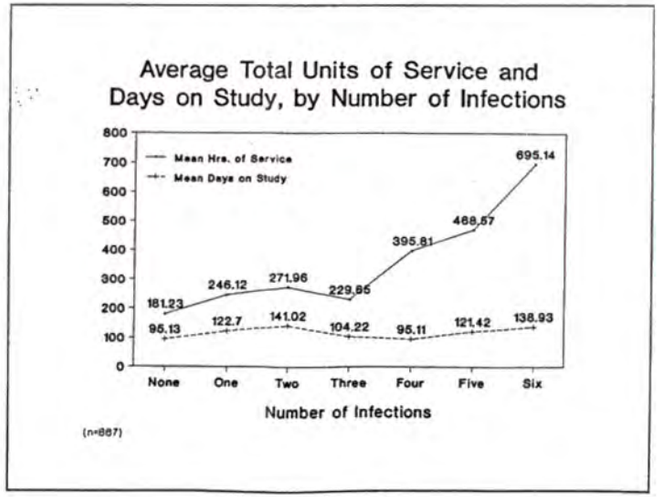
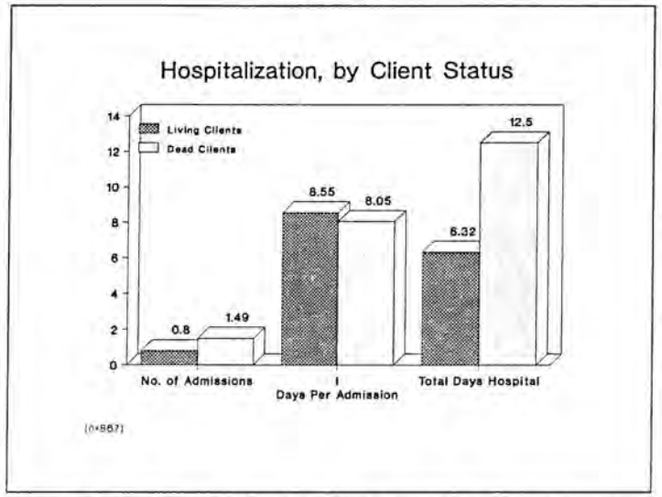


FIGURE 7



CASE MANAGEMENT NOTES

FIGURE 8



A total of 1,120.00 hours of "Other Services" were utilized by 123 study clients (14.19 percent of the total client pool). Included in this category were services such as child and adult protective services, language therapy and pastoral care.

Total Hours of Service

An average of 279.49 hours of services were provided to each client during the study period, with a range of 0.25 to 3,625.25 hours of total service.

Factors Affecting
Total Service Utilization

Preliminary analyses of the data indicated that the length of the time on the study was significantly correlated with the amount of services utilized ($r = 0.3171$, $p < 0.001$). In general, as clients days on the study increased, they accumulated more units of service. Consequently, a statistical method was utilized to control for this covariation during the analysis of other factors potentially related to total service utilization.

When the total number of days clients spent on the study was statistically controlled (using analysis of covariation), total service utilization did not differ based upon differences in the three client background factors examined (race, living arrangement, and transmission category). However, whether or not a client died during the study, the number of AIDS-related infections a client reported, and the client's Karnofsky scale rating at study entry were significantly related to differences in total hours of service utilized during the study.

Karnofsky Stage

As previously discussed, the majority of study clients entered the study with a Karnofsky rating corresponding to the Early Chronic and Late Chronic Stages of the illness. Analysis of covariance revealed significant differences among the four Karnofsky stage groups when total days on study was used as a control factor ($F(4,866) = 29.485$) (see Figure 6). Clients falling into the Critical Stage at time of study entry, averaged a total of 395.16 hours of service. Clients in the Late Chronic Stage averaged a total of 453.52 hours of service compared to those in the Early Chronic and Diagnosis Stages (190.72 and 152.36 hours, respectively).

Number of Infections

The total units of service clients utilized was significantly different based on the number of AIDS-related infections they reported (see Figure 7). During the course of the study, 91.70 percent of the total client pool reported at least one infection. When total days on the study were used as a control factor, clients reporting no AIDS-related infections utilized an average of 181.23 hours of service compared to a mean of 695.14 hours for clients reporting six different infections ($F(6,866) = 5.285$).

There were differences in both total hours and hours of specific services provided to study clients based upon their medical status and number of infections reported. Number of infections (ranging from 0 to a total of six infections) was significantly correlated with Karnofsky stage at study entry ($r = .2281$, $p < 0.001$). This indicates that individuals at more advanced stages of AIDS (e.g., Late Chronic, Critical) experienced more infections than clients entering the study at earlier stages of the illness (e.g., Diagnosis, Early Chronic).

Client Status

During the course of the study, 264 clients died. There were differences in both total hours and hours of specific services provided to study clients based on their medical status and individual service needs. Whether a client died while on the study was significantly correlated to the total days on the study ($r = -0.1910$, $p < 0.001$) indicating that clients who died spent less time on the study. Clients remaining alive at the end of the study averaged a longer period of time on the study than those clients who died during the study (128.42 days and 89.61 days, respectively). Clients who died while on the study utilized an average of 376.48 hours of service compared to those who remained living at the end of the study period (237.03 hours).

Differences in hospitalization and units of service were observed based on clients' status. To briefly summarize these findings, clients who died while on the study showed more days of hospitalization prior to entry into the study than did living clients (27.72 days and 20.21 days respectively). Following entry into the study, clients who died were, on the average, hospitalized more frequently than living clients (1.49 compared to 0.80 admissions, respectively) (see Figure 8). In addition, clients who died while on the study spent almost twice as much time in the hospital during the study than did clients who were living at the end of the study (12.50 days for clients who died compared to 6.32 days for living clients).

There were also differences in the units of service provided to expired clients, as were appropriate to their needs and the severity of their medical condition ($F(4,866) = 29.485$) (see Figures 9 & 10). When total days on the study were controlled, clients who died during the study, utilized significantly more attendant care services than did clients who did not die (263.96 and 148.78 hours respectively). In addition, differences were found in utilization of volunteer services by the two groups. Clients who died, utilized an average 33.34 hours of volunteer services, compared to an average of 27.78 hours for living clients. Hours of practical support also varied by client status. Clients who died during the study utilized an average of 21.93 hours of practical support compared to a mean of 14.99 hours of service for living clients. With the exception of mental health and physical therapy services, clients who died during the study, had utilized more hours of service in all categories than those who remained in the active study pool. The fact

CASE MANAGEMENT NOTES

FIGURE 9

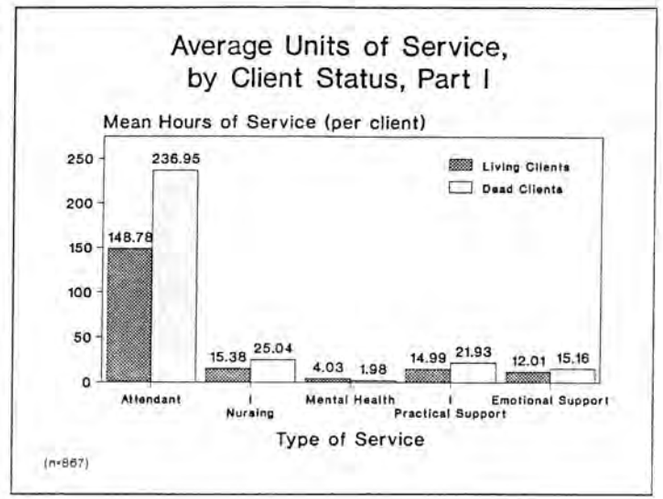
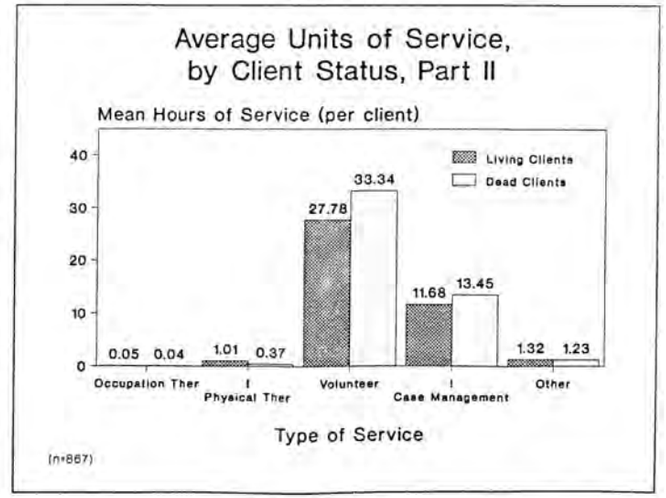


FIGURE 10



CASE MANAGEMENT NOTES

FIGURE 11

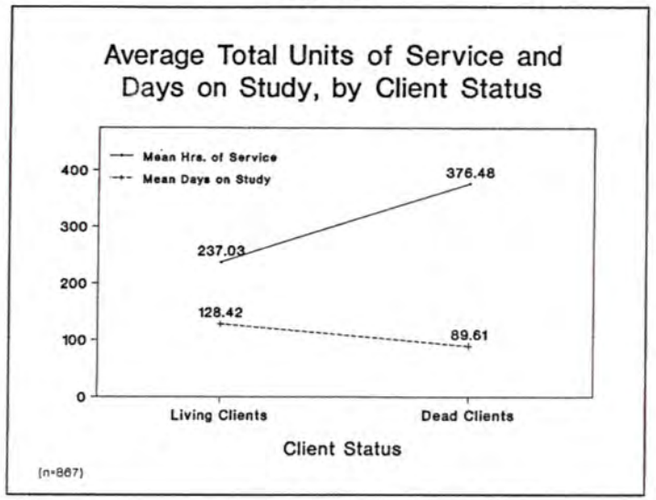
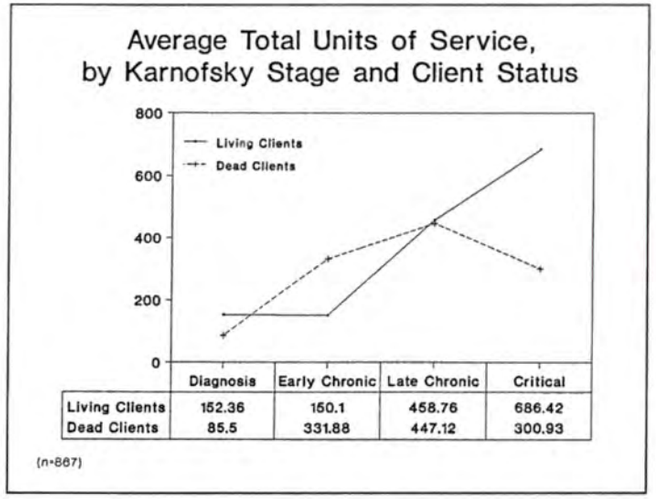


FIGURE 12



	Diagnosis	Early Chronic	Late Chronic	Critical
Living Clients	152.36	150.1	458.76	686.42
Dead Clients	85.5	331.88	447.12	300.93

that clients who died had spent significantly less time on the study, yet utilized more services indicates the intensity of service utilization during the later stages of the illness (see Figure 11).

A two-way analysis of variance indicated significant main effects of Karnofsky rating and client status. In addition, there was a significant interaction between these two factors (see Figure 12). When clients entered the study at Diagnosis (Stage I), those who died had utilized almost twice the total units of service when compared to those who survived until the end of the study. This pattern was reversed when clients entered the study at the Early Chronic stage of the illness. Among clients assessed at the Early Chronic stage, clients who died during the study, on the average, had utilized less than 50 percent of the total hours of service reported by living clients. At the Late Chronic stage of the illness, service utilization was almost identical for the two groups. The pattern of total units of service utilized by clients entering the study at the Critical stage mirrors that of the Diagnosis stage. Clients who died (entering the study at the Critical stage), on the average, utilized more than twice the total hours of service reported by living clients in this Karnofsky category.

Payment Eligibility Status

Table 5 provides hospitalization and units of service data for clients with three payment eligibility categories: (1) Private Insurance; (2) Medi-Cal/Medicare; and (3) Other/Unknown. Clients who were Medi-Cal or Medicare eligible comprised the largest proportion of the study group (47.3 percent). Approximately one-third of the client pool utilized private insurance as their primary source of payment for services (33.6 percent). Less than 20 percent (19.1 percent) of the total client pool reported other payment eligibility categories (e.g., project funds, out-of-pocket, etc.) However, it should be noted that the majority of private insurance as well as Medi-Cal and Medicare support little or no home health attendant care. Consequently, most of the attendant care units of services were supported through use of project funds.

CASE MANAGEMENT NOTES

These three groups showed slight differences in number of hospital admissions and total days of hospitalization both prior to, and during the study (see Figure 13). Prior to entry in the study, clients in the Medi-Cal/Medicare eligible group reported an average of 23.7 days of hospitalization, compared to 8.66 days during the study. Clients with private insurance averaged 23.33 days of hospitalization prior to the study compared to a mean of 9.02 days during the study.

Clients eligible for Medi-Cal or Medicare on the average, utilized more total hours of service than either of the other groups (a total of 312.46, per client). This figure is more than twice that of clients with other or unknown sources of payment (144.94 hours, per client). Clients with private insurance utilized an average of 303.40 hours of service during the eleven month study period (see Figure 14). Analysis of covariation indicated that total service utilization among the three groups differed significantly when total days on study was used as a control factor ($F(3,866)=7.61$).

Client Satisfaction

Table 6 represents the level of satisfaction with services being provided, as evaluated by clients, across areas. The client received a questionnaire through the mail with a self-addressed, stamped return envelope on a bi-weekly basis. They were requested to check the appropriate scores on a 1 to 5 scale and return the forms. When the client was not able to complete the form, a significant other was requested to complete it with the client's direction. When this was not possible, no report was submitted. Clients reported a mean score of 3.57 on a 5 point scale for

FIGURE 13

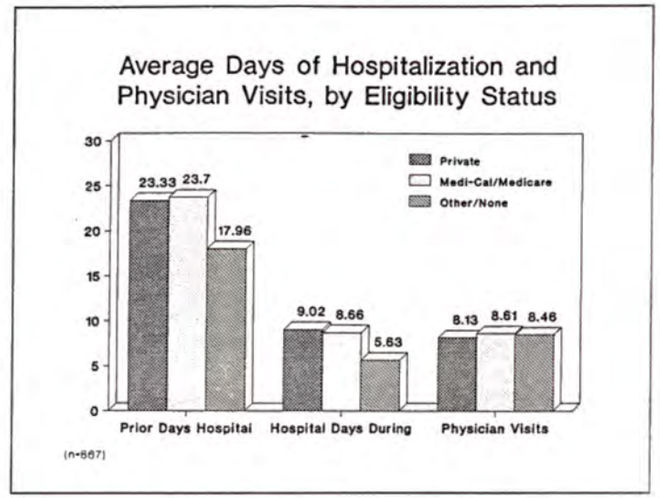
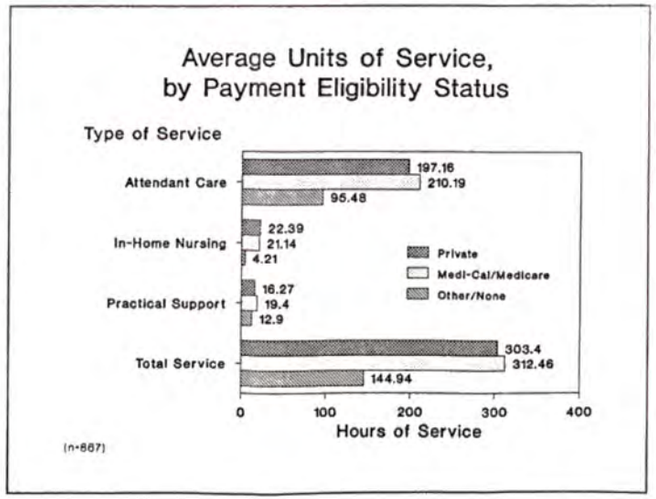


FIGURE 14



CASE MANAGEMENT NOTES

overall satisfaction with services provided during their time on the study.

Discussion

Clients participating in the Home Health Care Study utilized a total of 242,319.61 hours of services during the 11 month period between July 1, 1987 and May 31, 1988. The majority of these hours (65.78 percent of all hours of service provided) were for attendant care services. Relatively large proportions of the total client pool utilized attendant care and in-home skilled nursing care (46.14 and 46.48 percent of all clients, respectively). A significant number of the total client pool utilized volunteer services (41.29 percent of all clients). Mental health and emotional support services were utilized by approximately one-third of the total client pool (34.14 and 33.10 percent, respectively). The large percentage of clients using volunteer services points to the importance of AIDS volunteer programs in the communities studied.

Since the majority of the client pool fell into a homosexual/bisexual male transmission category, it is difficult to determine how service utilization might differ among individuals who contracted AIDS through intravenous drug use. Although the analyses indicated that there were no significant differences in utilization of total services based on transmission category, a larger sample might produce different results.

During the study, slightly less than one-third of all clients died (30.40 percent). There were significant differences in the total hours of services provided to these clients when compared to those clients who were alive at the end of the study period. The majority of clients who died during the study period, had entered the study at the Late Chronic or Critical, Karnofsky stages (59.09 percent of all clients who died). On the other hand, the majority of clients remaining alive at the end of the study were initially assessed at the Diagnosis or Early Chronic Stages (73.47 percent of all living clients). In addition, more than 90 percent of the total client pool reported at least one AIDS-related infection.

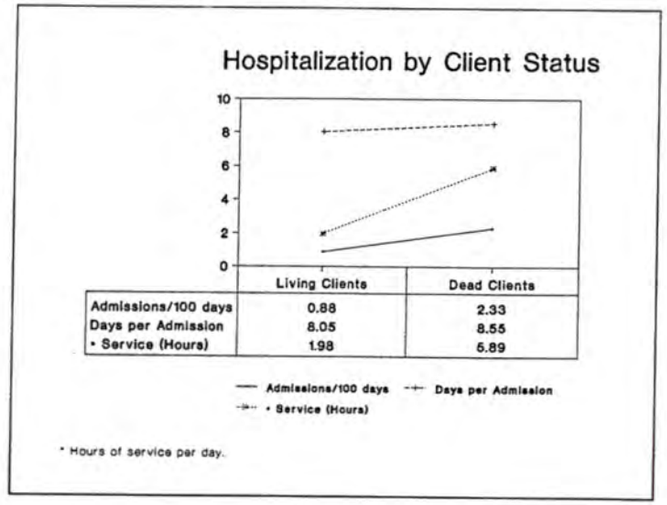
These three factors (client status, Karnofsky stage and number of infections) were each significantly related to utilization of services. *Clients entering the study at the later stages of the illness, those who died during the study, and those who experienced more AIDS-related infections, utilized services more intensely than clients with different medical histories.* However, factors such as race, living arrangements, and mode of transmission did not significantly impact service utilization.

This suggests that medical status is perhaps the most important factor associated with volume of service utilization. If clients are enrolled in the later stage of the illness, or experience more infections during the study period, more services will be used, regardless of their time in the program. These data demonstrate that clients require intensive home health support (attendant, practical support and in-home skilled nursing care) in order to maintain the low days of hospitalization observed in the study.

Cost Effectiveness and Cost Containment

The issues of cost effectiveness and cost containment attributable to home healthcare services can only be approached indirectly. The lack of a valid database against which to draw comparisons limits conclusions. The selection of a control group which did not receive home healthcare services was considered. However, it was noted that the majority of PWAs receive some type of home healthcare services through either private insurance, Medi-Cal/Medicare, AIDS service organizations, HMOs, or volunteers. Any attempt to establish a control group which did not receive home healthcare services

FIGURE 15



CASE MANAGEMENT NOTES

through the pilot projects appeared neither feasible, not ethical. However, a comparison of length of hospital stays for individuals on the study and PWAs not on the study provides limited support for the cost effectiveness of home health care services.

K. Kizer., J. Rodriguez, G.F. McHolland, and W. Weller, reported the average length of hospital stays in California as 14.0 days (1986).[7] Extrapolating from preliminary data for the Total Cost of Care Study, (Lee, Benjamin and Scitovsky, 1988)[8] the mean length of stay, at four of the locations in which pilot care projects were located, for non-study participants was 10.3 days (n=215).

Contrasting these figures are those obtained in the Home Health, Attendant and Hospice Care Pilot Project. These data revealed a reduced average numbers of hospital admissions and shorter hospital stays. The mean length of hospital stays for those on the study who had been hospitalized and who had expired was 8.55 days (n=164) and for those who were living at the end of the study 8.05 days (n=229). It is interesting to note that 100 of the clients who died (264) were never hospitalized while on the study. Figure 15 provides the mean number of hospital admissions per client, for those who were hospitalized during the study, average length of stay and hours of service provided per day, for clients based on their status at the end of the study.

Based on the total client population, clients who died during the study were, on the average hospitalized more frequently (1.49 admissions for clients who died compared to 0.80 admissions for living clients). Average length of stay, per admission did not differ significantly between the two groups. Clients who were hospitalized, who died during the study had however, utilized services more intensely than those clients who did not die during the study. While clients who died had utilized an average of 5.89 hours of service, per client, per day, clients alive at the end of the study utilized 1.98 hours, per client, per day. This more intense utilization of home health services by clients at the later stages of the illness may have contributed to maintaining the low levels of admissions and length of hospital stays observed in the study.

These data provide limited support for the position that home healthcare can reduce the length of hospital stays of the clients. It should also be noted that the average number of hospital admissions reported by Kizer, et. al. (1986) was 6.4 for an 18 month period, while the number of hospital admissions by the study clients was 1.01 for an 11 month period. There appears to be a decrease in both length of hospital stays and the number of hospital admissions.

The apparent reduction in hospital admissions and reduced length of hospital stay (days) tend to support the cost effectiveness and the value of home healthcare services as a way of containing costs for persons with AIDS. However, these data must be generalized with caution. Many uncontrolled variables may contribute significantly to both the reduced length of hospital stay and the number of admission experienced by PWAs.

Implications and Observations

1. Utilization of services does not appear to be influenced by demographic factors. There were no significant differences in the total units of service provided to clients based on racial, transmission category or living arrangement factors.

2. Total volume of utilization was significantly different based on: (a) the severity of illness upon study entry; (b) the number of AIDS-related infections experienced by the client and (c) whether or not the client died during the study.

3. Clients entering the study at the Late Chronic stage of the illness utilized similar volumes of service regardless of their status at the end of the study.

4. The provision of home healthcare appears to have reduced the mean length of hospital stay when compared to that previously reported for PWAs in California. This suggests savings in inpatient care costs. While the data are insufficient to allow for statistical validation of this observation, these findings indicate that project clients, on the average, experienced fewer hospital admissions and total days of hospitalization when home health services were utilized.

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This report was supported by the Department of Health Services contract number 88-94489.

Editor's Note:
Case Management Notes will be a regular feature in PAACNOTES. Future features will include articles developed for the AMRC Case Management Symposium funded by a grant from Sandoz Pharmaceuticals Corporation.

CASE MANAGEMENT NOTES

TABLE 1

DISTRIBUTION OF CLIENT CHARACTERISTICS

(n=867)

(all percentages are rounded to nearest 10th; tables may exceed or be less than 100%)

CLIENT DISTRIBUTION

PROJECT SITE	FREQUENCY	PERCENT
AIDS Project Los Angeles	149	17.2
AIDS Service Foundation of Orange County	109	12.6
Alameda County Health Care Services Agency	80	9.2
City/County San Francisco, Dept of Public Health	99	11.4
Contra Costa County Health Services Dept.	22	2.5
Ellipse - Peninsula AIDS Services	40	4.6
Face to Face - Sonoma County AIDS Network	41	4.7
Hospice of Marin	13	1.5
Inland AIDS Project	60	6.9
Sacramento AIDS Foundation	41	4.7
San Joaquin Local Health District	12	1.4
Visiting Nurse Association, Inc. (San Jose)	35	4.0
Visiting Nurse Association of San Diego Co.	139	16.0
Western Addiction Services Program, Inc.	27	3.1

SEX

CATEGORY	FREQUENCY	PERCENT
Male	812	93.7
Female	55	6.3

ETHINICITY

CATEGORY	FREQUENCY	PERCENT
Asian/Pacific	15	1.7
Black	61	7.0
Hispanic	89	10.3
White	686	79.1
Native American	10	1.2
Other	4	0.5
Unknown	2	0.2

SEXUAL ORIENTATION

CATEGORY	FREQUENCY	PERCENT
Homosexual	650	75.0
Heterosexual	107	12.3
Bisexual	93	10.7
Unknown	17	2.0

AGE

CATEGORY	FREQUENCY	PERCENT
0 to 19 years	15	1.7
20 to 29 years	120	13.8
30 to 39 years	389	44.9
40 to 49 years	225	26.0
50 to 60 years	77	8.9
61 years & over	35	4.0
Unknown	6	0.7

Mean	36.37 years
Range	0.32 to 82.37 years
Standard Deviation	± 10.67 years
Standard Error of Measurement	± 0.364 years

Clients with age data = 861
Clients without age data = 6

TABLE 1 (Continued)

TRANSMISSION CATEGORY

CATEGORY	FREQUENCY	PERCENT
Homosexual/Bisexual Male	658	75.9
IV Drug Abuser	42	4.8
Homosexual/IV Drug Abuser	57	6.6
Hemophiliac	7	0.8
Transfusion	27	3.1
Heterosexual	28	3.2
Parent at Risk	12	1.4
Other/None of the Above	2	0.2
Multiple Factors	22	2.5
Unknown	12	1.4

DIAGNOSIS

CATEGORY	FREQUENCY	PERCENT
AIDS	762	87.9
ARC	105	12.1

KARNOFSKY STAGE
(at time of entry to study)

CATEGORY	FREQUENCY	PERCENT
Stage I (Diagnosis)	90	10.4
Stage II (Early Chronic)	461	53.2
Stage III (Late Chronic)	271	31.3
Stage IV (Critical)	45	5.2

FUNCTIONAL CAPACITY
(at time of entry to study)

CATEGORY	FREQUENCY	PERCENT
Ambulatory	489	56.4
Ambulatory with Assistance	165	19.0
Bedridden	104	12.0
Unknown	109	12.6

LIVING ARRANGEMENTS
(at time of entry to study)

CATEGORY	FREQUENCY	PERCENT
Lover/Spouse	244	28.1
Family	192	22.1
Friends	134	15.5
Alone	223	25.7
Hospice	58	6.7
Unstable	14	1.6
Unknown	2	0.2

PRIOR PSYCHIATRIC DIAGNOSIS

CATEGORY	FREQUENCY	PERCENT
Yes	124	14.3
No	323	37.3
Unknown	420	48.4

EMOTIONAL STATUS
(at time of entry to study)

CATEGORY	FREQUENCY	PERCENT
Stable	332	38.3
Depressed	182	21.0
Hostile	5	0.6
Confrontational	3	0.3
Assaultive	1	0.1
Delusional	2	0.2
Denial	13	1.5
Disoriented	24	2.8
Suicidal	2	0.2
Multiple Factors	249	28.7
Unknown	54	6.2

CASE MANAGEMENT NOTES

TABLE 1 (Continued)

MENTAL STATUS AT TIME OF DIAGNOSIS

CATEGORY	FREQUENCY	PERCENT
No apparent mental deterioration	402	46.4
Mild mental deterioration	260	30.0
Moderate mental deterioration	99	11.4
Significant mental deterioration	55	6.3
Unknown	51	5.9

NUMBER OF CLIENT DAYS ON STUDY

CATEGORY	FREQUENCY	PERCENT
1 to 30 days	155	17.9
31 to 60 days	142	16.4
61 to 90 days	111	12.8
91 to 120 days	137	15.8
121 to 180 days	142	16.4
181 to 270 days	90	10.4
271 days & up	90	10.4

Mean	116.60 days
Range	1.00 to 335.00 days
Standard Deviation	± 93.57 days
Standard Error of Measurement	± 3.178 days
Total	101,095.00 days

Clients with Total Days data = 867
Clients without Total Days data = 0

NUMBER OF CLIENT DAYS IN HOSPITAL *PRIOR* TO STUDY ENTRY

CATEGORY	FREQUENCY	PERCENT
None	221	25.5
1 to 5 days	67	7.7
6 to 10 days	117	13.5
11 to 20 days	123	14.2
21 to 30 days	135	15.6
31 to 60 days	125	14.4
61 to 90 days	53	6.1
91 to 120 days	11	1.3
121 to 180 days	9	1.0
181 days & up	6	0.7

Mean	22.47 days
Range	0 to 252.00 days
Standard Deviation	± 30.66 days
Standard Error of Measurement	± 1.042 days
Total	19,488.00 days

Clients with Days in Hospital Prior data= 646
Clients without Days in Hospital Prior data = 221

NUMBER OF CLIENT DAYS IN HOSPITAL WHILE ON THE STUDY

CATEGORY	FREQUENCY	PERCENT
None	462	53.3
1 to 5 days	105	12.1
6 to 10 days	96	11.1
11 to 20 days	81	9.3
21 to 30 days	52	6.0
31 to 60 days	56	6.5
61 to 90 days	10	1.2
91 to 120 days	4	0.5
121 to 180 days	1	0.1

Mean	8.20 days
Range	0 to 151.00 days
Standard Deviation	± 15.56 days
Standard Error of Measurement	± 0.528 days
Total	7,110.00 days

Clients with Days in Hospital data = 405
Clients without Days in Hospital data = 462

TABLE 1 (Continued)

NUMBER OF CLIENT ADMISSIONS TO HOSPITAL WHILE ON THE STUDY

CATEGORY	FREQUENCY	PERCENT
No Admissions	474	54.7
One Admission	191	22.0
Two Admissions	96	11.1
Three Admissions	41	4.7
Four Admissions	31	3.6
Five Admissions	11	1.3
Six Admissions	7	0.8
Seven Admissions	4	0.5
Eight Admissions	3	0.3
Nine Admissions	4	0.5
Ten Admissions	0	0.0
Eleven Admissions	4	0.5
Twelve Admissions	0	0.0
Thirteen Admissions	0	0.0
Fourteen Admissions	1	0.1

Mean	1.01 admissions
Range	0 to 14.00 admissions
Standard Deviation	± 1.69 admissions
Standard Error of Measurement	± 0.057 admissions
Total	873.00 admissions

Clients with Admissions to Hospital data= 393
Clients without Admissions to Hospital data = 474

NUMBER OF CLIENT PHYSICIAN'S VISITS WHILE ON THE STUDY

CATEGORY	FREQUENCY	PERCENT
None	128	14.8
1 to 5 visits	328	37.8
6 to 10 visits	164	18.9
11 to 25 visits	199	23.0
26 to 50 visits	41	4.7
51 to 75 visits	6	0.7
76 visits & up	1	0.1

Mean	8.42 visits
Range	0 to 105.00 visits
Standard Deviation	± 10.14 visits
Standard Error of Measurement	± 0.344 visits
Total	7,300.00 visits

Clients with Physician's Visits data = 739
Clients without Physician's Visits data = 128

NUMBER OF CLIENTS DECEASED WHILE ON THE STUDY

CATEGORY	FREQUENCY	PERCENT
Deceased	264	30.4
Living	603	69.6

TABLE 2

UNITS OF SERVICE PROVIDED - All Clients

(n=867)

ATTENDANT CARE

Mean	183.85 hours
Range	0 to 3,034.25 hours
Standard Deviation	± 406.68 hours
Standard Error of Measurement	± 13.860 hours
Total	159,400.29 hours

Average of 1.58 Attendant Care hours, per client, per day

Clients receiving Attendant Care = 400
Clients not receiving Attendant Care = 467

CASE MANAGEMENT NOTES

TABLE 2 (Continued)

IN-HOME SKILLED NURSING CARE

Mean	18.32 hours
Range	0 to 2,543.00 hours
Standard Deviation	± 106.40 hours
Standard Error of Measurement	± 3.613 hours
Total	15,882.25 hours

Average of 0.16 In-Home Skilled Nursing Care hours, per client, per day

Clients receiving In-Home Skilled Nursing Care = 403
Clients not receiving In-Home Skilled Nursing Care = 464

MENTAL HEALTH CARE

Mean	3.41 hours
Range	0 to 136.00 hours
Standard Deviation	± 12.22 hours
Standard Error of Measurement	± 0.415 hours
Total	2,955.10 hours

Average of 0.029 Mental Health Care hours, per client, per day

Clients receiving Mental Health Care = 296
Clients not receiving Mental Health Care = 571

PRACTICAL SUPPORT

Mean	17.10 hours
Range	0 to 996.00 hours
Standard Deviation	± 66.58 hours
Standard Error of Measurement	± 2.261 hours
Total	14,828.37 hours

Average of 0.147 Practical Support hours, per client, per day

Clients receiving Practical Support = 212
Clients not receiving Practical Support = 655

EMOTIONAL SUPPORT

Mean	12.97 hours
Range	0 to 377.00 hours
Standard Deviation	± 35.73 hours
Standard Error of Measurement	± 1.213 hours
Total	11,244.25 hours

Average of 0.11 Emotional Support hours, per client, per day

Clients receiving Emotional Support = 287
Clients not receiving Emotional Support = 580

OCCUPATIONAL THERAPY

Mean	0.04 hours
Range	0 to 16.00 hours
Standard Deviation	± 0.63 hours
Standard Error of Measurement	± 0.021 hours
Total	36.75 hours

Average of 0.0004 Occupational Therapy hours, per client, per day

Clients receiving Occupational Therapy = 10
Clients not receiving Occupational Therapy = 857

PHYSICAL THERAPY

Mean	0.81 hours
Range	0 to 174.00 hours
Standard Deviation	± 7.78 hours
Standard Error of Measurement	± 0.264 hours
Total	703.00 hours

Average of 0.007 Physical Therapy hours, per client, per day

Clients receiving Physical Therapy = 61
Clients not receiving Physical Therapy = 806

TABLE 2 (Continued)

VOLUNTEER SERVICES

Mean	29.47 hours
Range	0 to 1,281.00 hours
Standard Deviation	± 100.19 hours
Standard Error of Measurement	± 3.403 hours
Total	25,551.03 hours

Average of 0.25 Volunteer Services hours, per client, per day

Clients receiving Volunteer Services = 358
Clients not receiving Volunteer Services = 509

CASE MANAGEMENT

Mean	12.22 hours
Range	0.25 to 171.50 hours
Standard Deviation	± 14.37 hours
Standard Error of Measurement	± 0.466 hours
Total	10,596.57 hours

Average of 0.105 Case Management hours, per client, per day

Clients receiving Case Management = 867
Clients not receiving Case Management = 0

OTHER SERVICES

Mean	1.29 hours
Range	0 to 174.00 hours
Standard Deviation	± 8.33 hours
Standard Error of Measurement	± 0.283 hours
Total	1,120.00 hours

Average of 0.011 Other Services hours, per client, per day

Clients receiving Other Services = 123
Clients not receiving Other Services = 744

TOTAL HOURS OF SERVICE

Mean	279.49 hours
Range	0.25 to 3,625.25 hours
Standard Deviation	± 505.05 hours
Standard Error of Measurement	± 17.254 hours
Total	242,319.61 hours

Average of 2.397 Total Hours of Service, per client, per day

Clients receiving services = 867
Clients not receiving services = 0

HOSPICE SERVICES

Mean	1.50 days
Range	0 to 233.00 days
Standard Deviation	± 11.43 days
Standard Error of Measurement	± 0.388 days
Total	1,298.00 days

Average of 0.013 Hospice Service days, per client

Clients receiving Hospice Services = 40
Clients not receiving Hospice Services = 827

HOUSING SERVICES

Mean	7.99 days
Range	0 to 215.00 days
Standard Deviation	± 31.20 days
Standard Error of Measurement	± 1.060 days
Total	6,924.00 days

Average of 0.069 Housing Service days, per client

Clients receiving Housing Services = 81
Clients not receiving Housing Services = 786

CASE MANAGEMENT NOTES

TABLE 3

UNITS OF SERVICE PROVIDED - Clients Deceased While on Study

(n=264)

TOTAL DAYS ON STUDY

Mean	89.61 days
Range	1.00 to 335.00 days
Standard Deviation	± 78.53 days
Standard Error of Measurement	± 4.833 days
Total	23,657.00 days

Clients with Days On Study data = 264
Clients without Days On Study data = 0

ATTENDANT CARE

Mean	263.95 hours
Range	0 to 2,984.00 hours
Standard Deviation	± 429.49 hours
Standard Error of Measurement	± 26.433 hours
Total	69,684.05 hours

Clients receiving Attendant Care = 187
Clients not receiving Attendant Care = 77

IN-HOME SKILLED NURSING CARE

Mean	25.04 hours
Range	0 to 1,245.50 hours
Standard Deviation	± 92.51 hours
Standard Error of Measurement	± 5.694 hours
Total	6,610.25 hours

Clients receiving In-Home Skilled Nursing Care = 173
Clients not receiving In-Home Skilled Nursing Care = 91

MENTAL HEALTH CARE

Mean	1.98 hours
Range	0 to 136.00 hours
Standard Deviation	± 8.89 hours
Standard Error of Measurement	± 0.547 hours
Total	523.90 hours

Clients receiving Mental Health Care = 87
Clients not receiving Mental Health Care = 177

PRACTICAL SUPPORT

Mean	21.93 hours
Range	0 to 996.00 hours
Standard Deviation	± 89.07 hours
Standard Error of Measurement	± 5.480 hours
Total	5,788.62 hours

Clients receiving Practical Support = 68
Clients not receiving Practical Support = 196

EMOTIONAL SUPPORT

Mean	15.16 hours
Range	0 to 322.75 hours
Standard Deviation	± 39.44 hours
Standard Error of Measurement	± 2.427 hours
Total	4,002.35 hours

Clients receiving Emotional Support = 90
Clients not receiving Emotional Support = 174

TABLE 3 (Continued)

OCCUPATIONAL THERAPY

Mean	0.04 hours
Range	0 to 4.75 hours
Standard Deviation	± 0.34 hours
Standard Error of Measurement	± 0.021 hours
Total	9.75 hours

Clients receiving Occupational Therapy = 4
Clients not receiving Occupational Therapy = 260

PHYSICAL THERAPY

Mean	0.37 hours
Range	0 to 21.00 hours
Standard Deviation	± 1.92 hours
Standard Error of Measurement	± 0.118 hours
Total	97.25 hours

Clients receiving Physical Therapy = 23
Clients not receiving Physical Therapy = 241

VOLUNTEER SERVICES

Mean	33.34 hours
Range	0 to 1,281.00 hours
Standard Deviation	± 112.66 hours
Standard Error of Measurement	± 6.930 hours
Total	8,800.50 hours

Clients receiving Volunteer Services = 32
Clients not receiving Volunteer Services = 232

CASE MANAGEMENT

Mean	13.45 hours
Range	0.25 to 129.00 hours
Standard Deviation	± 13.41 hours
Standard Error of Measurement	± 0.825 hours
Total	3,550.74 hours

Clients receiving Case Management = 264
Clients not receiving Case Management = 0

OTHER SERVICES

Mean	1.23 hours
Range	0 to 174.00 hours
Standard Deviation	± 11.16 hours
Standard Error of Measurement	± 0.687 hours
Total	323.55 hours

Clients receiving Other Services = 115
Clients not receiving Other Services = 149

TOTAL HOURS OF SERVICE

Mean	376.48 hours
Range	0.25 to 3,260.70 hours
Standard Deviation	± 515.48 hours
Standard Error of Measurement	± 31.730 hours
Total	99,390.96 hours

Clients receiving services = 264
Clients not receiving services = 0

HOSPICE SERVICES

Mean	2.06 days
Range	0 to 84.00 days
Standard Deviation	± 9.49 days
Standard Error of Measurement	± 0.584 days
Total	544.00 days

Clients receiving Hospice Services = 23
Clients not receiving Hospice Services = 241

CASE MANAGEMENT NOTES

TABLE 3 (Continued)

HOUSING SERVICES

Mean	5.03 days
Range	0 to 182.00 days
Standard Deviation	± 23.23 days
Standard Error of Measurement	± 1.429 days
Total	1,329.00 days

Clients receiving Housing Services = 18
Clients not receiving Housing Services = 246

TABLE 4

UNITS OF SERVICE PROVIDED - Clients Living at End of Study

(n=603)

TOTAL DAYS ON STUDY

Mean	128.42 days
Range	1.00 to 335.00 days
Standard Deviation	± 97.16 days
Standard Error of Measurement	± 3.957 days
Total	77,438.00 days

Clients with Days On Study data = 603
Clients without Days On Study data = 0

ATTENDANT CARE

Mean	148.78 hours
Range	0 to 3,034.25 hours
Standard Deviation	± 394.50 hours
Standard Error of Measurement	± 16.070 hours
Total	89,716.24 hours

Clients receiving Attendant Care = 213
Clients not receiving Attendant Care = 390

IN-HOME SKILLED NURSING CARE

Mean	15.38 hours
Range	0 to 2,543.00 hours
Standard Deviation	± 111.88 hours
Standard Error of Measurement	± 4.556 hours
Total	9,272.00 hours

Clients receiving In-Home Skilled Nursing Care = 230
Clients not receiving In-Home Skilled Nursing Care = 373

MENTAL HEALTH CARE

Mean	4.03 hours
Range	0 to 129.00 hours
Standard Deviation	± 13.38 hours
Standard Error of Measurement	± 0.545 hours
Total	2,431.20 hours

Clients receiving Mental Health Care = 209
Clients not receiving Mental Health Care = 394

PRACTICAL SUPPORT

Mean	14.99 hours
Range	0 to 628.50 hours
Standard Deviation	± 53.82 hours
Standard Error of Measurement	± 2.192 hours
Total	9,039.75 hours

Clients receiving Practical Support = 114
Clients not receiving Practical Support = 489

TABLE 4 (Continued)

EMOTIONAL SUPPORT

Mean	12.01 hours
Range	0 to 377.00 hours
Standard Deviation	± 33.97 hours
Standard Error of Measurement	± 1.383 hours
Total	7,241.90 hours

Clients receiving Emotional Support = 197
Clients not receiving Emotional Support = 406

OCCUPATIONAL THERAPY

Mean	0.05 hours
Range	0 to 16.00 hours
Standard Deviation	± 0.72 hours
Standard Error of Measurement	± 0.029 hours
Total	29.00 hours

Clients receiving Occupational Therapy = 6
Clients not receiving Occupational Therapy = 597

PHYSICAL THERAPY

Mean	1.00 hours
Range	0 to 174.00 hours
Standard Deviation	± 9.24 hours
Standard Error of Measurement	± 0.376 hours
Total	605.75 hours

Clients receiving Physical Therapy = 38
Clients not receiving Physical Therapy = 565

VOLUNTEER SERVICES

Mean	27.78 hours
Range	0 to 850.00 hours
Standard Deviation	± 94.27 hours
Standard Error of Measurement	± 3.639 hours
Total	16,750.53 hours

Clients receiving Volunteer Services = 243
Clients not receiving Volunteer Services = 360

CASE MANAGEMENT

Mean	11.66 hours
Range	0.25 to 171.50 hours
Standard Deviation	± 14.75 hours
Standard Error of Measurement	± 0.600 hours
Total	7,045.83 hours

Clients receiving Case Management = 603
Clients not receiving Case Management = 0

OTHER SERVICES

Mean	1.32 hours
Range	0 to 96.00 hours
Standard Deviation	± 6.74 hours
Standard Error of Measurement	± 0.274 hours
Total	796.45 hours

Clients receiving Other Services = 91
Clients not receiving Other Services = 512

TOTAL HOURS OF SERVICE

Mean	237.03 hours
Range	0.25 to 3,625.25 hours
Standard Deviation	± 499.30 hours
Standard Error of Measurement	± 20.333 hours
Total	142,928.65 hours

Clients receiving services = 603
Clients not receiving services = 0

CASE MANAGEMENT NOTES

TABLE 4 (Continued)

HOSPICE SERVICES

Mean	1.25 days
Range	0 to 233.00 days
Standard Deviation	± 12.18 days
Standard Error of Measurement	± 0.496 days
Total	754.00 days

Clients receiving Hospice Services = 17
Clients not receiving Hospice Services = 586

HOUSING SERVICES

Mean	9.28 days
Range	0 to 215.00 days
Standard Deviation	± 34.05 days
Standard Error of Measurement	± 1.387 days
Total	5,595.00 days

Clients receiving Housing Services = 63
Clients not receiving Housing Services = 540

TABLE 5

PAYMENT ELIGIBILITY STATUS - Units of Service

(n=867)

(All percentages are rounded to the nearest 10th; tables may exceed or be less than 100%)

PAYMENT ELIGIBILITY STATUS

CATEGORY	FREQUENCY	PERCENT
Private Insurance	291	33.6
Medi-Cal / Medicare	410	47.3
Other / Unknown	166	19.1

TOTAL DAYS ON STUDY

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	118.74	115.93	114.51
Minimum	3.00	1.00	1.00
Maximum	335.00	335.00	335.00
Standard Deviation	± 88.74	± 92.44	± 104.47
Standard Error of Measurement	± 5.20	± 4.57	± 8.11
Total	34,553.00	47,533.00	19,009.00

NUMBER OF CLIENT DAYS IN HOSPITAL *PRIOR* TO STUDY ENTRY

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	23.33	23.70	17.96
Minimum	0.00	0.00	0.00
Maximum	200.00	252.00	220.00
Standard Deviation	± 30.39	± 32.19	± 26.75
Standard Error of Measurement	± 1.78	± 1.59	± 2.08
Total	6,790.00	9,717.00	2,981.00

NUMBER OF CLIENT DAYS IN HOSPITAL WHILE ON THE STUDY

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	9.02	8.66	5.63
Minimum	0.00	0.00	0.00
Maximum	151.00	101.00	64.00
Standard Deviation	± 18.70	± 14.37	± 11.68
Standard Error of Measurement	± 1.10	± 0.71	± 0.91
Total	2,624.00	3,552.00	934.00

TABLE 5 (Continued)

NUMBER OF CLIENT ADMISSIONS TO HOSPITAL WHILE ON THE STUDY

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	1.00	1.17	0.62
Minimum	0.00	0.00	0.00
Maximum	14.00	11.00	6.00
Standard Deviation	± 1.72	± 1.83	± 1.13
Standard Error of Measurement	± 0.10	± 0.09	± 0.09
Total	291.00	479.00	103.00

NUMBER OF CLIENT PHYSICIAN'S VISITS WHILE ON THE STUDY

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	8.13	8.61	8.46
Minimum	0.00	0.00	0.00
Maximum	60.00	105.00	64.00
Standard Deviation	± 9.38	± 10.29	± 11.02
Standard Error of Measurement	± 0.55	± 0.51	± 0.86
Total	2,367.00	3,529.00	1,404.00

ATTENDANT CARE (hours)

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	197.16	210.19	95.46
Minimum	0.00	0.00	0.00
Maximum	3,029.70	3,034.25	2,948.00
Standard Deviation	± 420.05	± 420.05	± 345.33
Standard Error of Measurement	± 24.62	± 20.75	± 26.80
Total	57,373.44	86,176.35	15,850.50

IN-HOME SKILLED NURSING CARE (hours)

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	22.39	21.14	4.21
Minimum	0.00	0.00	0.00
Maximum	1,245.50	2,543.00	278.50
Standard Deviation	± 93.71	± 132.02	± 22.95
Standard Error of Measurement	± 5.49	± 6.52	± 1.78
Total	6,516.10	8,667.60	698.55

MENTAL HEALTH CARE (hours)

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	3.41	4.22	1.41
Minimum	0.00	0.00	0.00
Maximum	136.00	129.00	87.00
Standard Deviation	± 13.17	± 13.03	± 7.25
Standard Error of Measurement	± 0.77	± 0.64	± 0.56
Total	991.45	1,728.80	234.85

PRACTICAL SUPPORT (hours)

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	16.27	19.40	12.90
Minimum	0.00	0.00	0.00
Maximum	628.50	996.00	362.00
Standard Deviation	± 58.40	± 79.83	± 37.96
Standard Error of Measurement	± 3.42	± 3.94	± 2.95
Total	4,734.27	7,952.60	2,141.50

EMOTIONAL SUPPORT (hours)

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	12.85	12.64	14.01
Minimum	0.00	0.00	0.00
Maximum	377.00	322.75	134.00
Standard Deviation	± 36.06	± 38.58	± 26.93
Standard Error of Measurement	± 2.11	± 1.91	± 2.09
Total	3,738.25	5,161.15	2,324.85

CASE MANAGEMENT NOTES

TABLE 5 (Continued)

VOLUNTEER SERVICES (hours)

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	37.17	32.81	7.72
Minimum	0.00	0.00	0.00
Maximum	1,281.00	850.00	172.00
Standard Deviation	± 120.48	± 102.29	± 25.13
Standard Error of Measurement	± 7.06	± 5.05	± 1.95
Total	10,817.28	13,451.75	1,282.00

CASE MANAGEMENT (hours)

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	14.15	12.07	9.21
Minimum	0.25	0.25	0.25
Maximum	129.00	109.00	171.50
Standard Deviation	± 16.22	± 11.64	± 16.43
Standard Error of Measurement	± 0.95	± 0.58	± 1.28
Total	4,117.42	4,950.63	1,528.52

TOTAL HOURS OF SERVICE

	PRIVATE	MEDI-CAL/ MEDICARE	OTHER/ UNKNOWN
Mean	303.40	312.46	144.94
Minimum	0.25	0.25	1.00
Maximum	3,541.00	3,561.25	3,260.70
Standard Deviation	± 515.70	± 532.70	± 385.82
Standard Error of Measurement	± 30.23	± 26.32	± 29.95
Total	88,288.21	128,108.68	24,060.77

TABLE 6

CLIENT SATISFACTION RATINGS*

	MEAN	STANDARD DEVIATION	STANDARD ERROR	NUMBER REPORTING
1. Attendant Care	3.26	± 1.09	± 0.060	332
2. In-Home Skilled Nursing Care	3.47	± 0.94	± 0.051	338
3. Emotional Health	3.37	± 0.99	± 0.048	426
4. Insurance Counseling	3.14	± 1.16	± 0.070	277
5. Case Management	3.61	± 0.85	± 0.035	587
6. Housing, Transportation and Food Subsidy	3.14			353
7. Overall Program	3.57			568

* Ratings are based on a 5 point Likert-type scale:
1 = Does not satisfy my needs
2 = Satisfies some of my basic needs, but not all
3 = Satisfies all my basic needs
4 = Satisfies more than my basic needs
5 = Completely satisfies me in every way

APPENDIX A

PROJECT SITES

Project Sites with an effective contract date of July 1, 1987

PROJECT SITE	PROJECT DIRECTOR	FIRST REPORTING PERIOD (mm/yy)	NUMBER OF CLIENTS TO BE SERVED
AIDS Project Los Angeles	Michael Heddermen, R.N.	07/87	150
AIDS Service Foundation, Orange Co.	Perrie Graham	12/87	75
Alameda Co. Health Care Service Agency	Jane Riggan	07/87	96
City/County of San Francisco, DPH	Ralph DiClemente	07/87	100
Contra Costa Co. Health Services Dept	Rusty Kelich	12/87	50
Ellipse - Peninsula AIDS Services	Brian Dobrow	09/87	40
Face to Face - Sonoma Co. AIDS Network	Sharon Tomas	10/87	35
Hospice of Marin	Mary Taverna, R.N.	09/87	20
Inland AIDS Project	John Salley, R.N.	10/87	50
Sacramento AIDS Foundation	Chuck Novak, M.S.W.	10/87	30
Visiting Nurse Assoc. of San Diego Co., Inc.	Barbara Verkleeren, R.N.	07/87	110
Visiting Nurse Association, Inc. (San Jose)	Sharron Miller, R.N.	11/87	30
Western Addiction Services Program, Inc.	Geni Cowan	07/87	20

Project Sites with an effective contract date of January 1, 1988

PROJECT SITE	PROJECT DIRECTOR	FIRST REPORTING PERIOD (mm/yy)	NUMBER OF CLIENTS TO BE SERVED
Community Care Management Corporation	Cynthia D. Coale	N/A	5*
El Centro Human Services Corporation	Genevieve G. Lopez	N/A	50*
Hospice Caring Project of Santa Cruz County	JoAnn Siemsen	N/A	6*
Kern County Health Department	Shirley Harrington	N/A	4*
St. Mary Medical Center	Jennifer Andrews, L.C.S.W.	N/A	100*
Saint Agnes Home Health Agency	Yvonne Pinal, B.S.N.	N/A	15*
San Joaquin Local Health District	Charleen Garrell	03/88	14*
Ventura County Local Health District	Ira Schwartz, R.N.	N/A	10*
Westside Community Mental Health Center, Inc.	Terri Moore	N/A	30*

Designates the number of clients to be served for an eighteen (18) month contract period of January 1, 1988 through June 30, 1989

CASE MANAGEMENT NOTES

APPENDIX B

KARNOFSKY PERFORMANCE STATUS SCALE

as modified by

Visiting Nurse Association of San Diego County, Inc.

Stage I *Diagnosis*	100	Normal, no complaints, no evidence of disease.
	90	Able to carry on normal activity, minor signs or symptoms of disease.
	80	Normal activity with effort, some signs or symptoms of disease.
Stage II *Early Chronic*	70	Cares for self. Unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of care needs.
Stage III *Late Chronic*	50	Requires considerable assistance and frequent medical care.
	40	Disabled, requires special care and assistance.
Stage IV *Terminal*	30	Severely disabled, hospitalization is indicated although death not imminent.
	20	Hospitalization necessary, very sick, active supportive treatment necessary.
	10	Moribund, fatal processes progressing rapidly.
	0	Dead.

STAGES: The initial assessment and entry to a Stage is made on admission to the pilot project.

Status is reevaluated every ____ days.

ACTION SCALES:

A: Supportive/Educative: All actions performed to support or promote patient self-care activity.

B: Partly Compensatory: Actions performed to support patient until self-care activity is possible or performed with the patient and S.O. until S.O. is able to complete care procedures.

C: Patient is completely dependent on nursing actions for self-care.

The original assessment is made at the time of initial planning for continuing care. The degree of activity in each area is rated. Status is reevaluated every ____ days.

APPENDIX C

UNITS AND COSTS OF SERVICE PROVIDED

(n=238)

Appendix C, Units and Costs of Services Provided, includes all "pay for service" categories. Cost data were maintained by three Southern California project sites. The data reported reflect units and costs of service only for those clients for whom cost data were maintained. These costs include those which were paid through third party payors as well as funds expended through the Project.

The total cost for attendant care services was $899,573.27, while the mean per client cost was $3,779.72. These 238 clients utilized a total of 90,678.40 hours of service at an average of 381.00 hours, per client, or 3.59 hours, per client, per day. In-Home Skilled Nursing costs totalled $360,795.40, corresponding to the provision of 0.42 hours, per client, per day for the eleven month study period. The total expenditure for Mental Health services was $29,856.50 or $125.45, per client.

The total costs for the approximately 33,758 days of service provided, including all services for which payment was made, was $1,571,440.65. The average amount expended per client was $6,602.69, with an average cost of $61.51, per client, per day, corresponding to a rate of 4.97 hours of service, per client, per day.

These data are included solely for purposes of illustration. While these costs may not be representative of those incurred in other parts of the state, they do provide a basis for estimating the costs which may be incurred by PWAs in some settings. Average costs, per client, per day, as well as the corresponding units of service may provide a basis for the estimation of the costs associated with the provision of home health care. Since the actual rates of services (e.g., attendant care, in-home skilled nursing, practical support, etc.) may differ from area to area, estimations should be based on units of service provided. By multiplying units of service, per client, per day, by local rates, estimations of costs can be computed for specific sites and agencies.

ATTENDANT CARE

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	381.00 hours	$ 3,779.72
Minimum	0.00 hours	$ 0.00
Maximum	3,034.25 hours	$ 31,859.63
Standard Deviation	± 506.89 hours	± $ 5,152.12
Standard Error of Measurement	± 32.857 hours	± $ 333.962
Total	90,678.40 hours	$ 899,573.27

Average of 3.59 Attendant Care hours, per client, per day
Average cost of $ 36.31 for Attendant Care, per client, per day

Clients receiving Attendant Care = 195
Clients not receiving Attendant Care = 43

IN-HOME SKILLED NURSING CARE

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	47.28 hours	$ 1,515.95
Minimum	0.00 hours	$ 0.00
Maximum	2,543.00 hours	$ 64,665.00
Standard Deviation	± 196.85 hours	± $ 5,245.44
Standard Error of Measurement	± 12.760 hours	± $ 340.011
Total	11,252.25 hours	$ 360,795.40

Average of 0.42 In-Home Skilled Nursing Care hours, per client, per day
Average cost of $ 13.13 for In-Home Skilled Nursing Care, per client, per day

Clients receiving In-Home Skilled Nursing Care = 145
Clients not receiving In-Home Skilled Nursing Care = 93

CASE MANAGEMENT NOTES

APPENDIX C (Continued)

MENTAL HEALTH CARE

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	3.11 hours	$ 125.45
Minimum	0.00 hours	$ 0.00
Maximum	125.00 hours	$ 5,040.00
Standard Deviation	± 12.17 hours	± $ 457.57
Standard Error of Measurement	± 0.789 hours	± $ 29.660
Total	739.00 hours	$ 29,856.50

Average of 0.03 Mental Health Care hours, per client, per day
Average cost of $ 1.11 for Mental Health Care, per client, per day

Clients receiving Mental Health Care = 67
Clients not receiving Mental Health Care = 171

PRACTICAL SUPPORT

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	27.09 hours	$ 274.49
Minimum	0.00 hours	$ 0.00
Maximum	996.00 hours	$ 11,034.00
Standard Deviation	± 102.06 hours	± $ 1,168.91
Standard Error of Measurement	± 6.616 hours	± $ 75.769
Total	6,446.60 hours	$ 65,328.25

Average of 0.36 Practical Support hours, per client, per day
Average cost of $ 3.34 for Practical Support, per client, per day

Clients receiving Practical Support = 37
Clients not receiving Practical Support = 201

EMOTIONAL SUPPORT

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	8.55 hours	$ 34.34
Minimum	0.00 hours	$ 0.00
Maximum	322.75 hours	$ 1,020.00
Standard Deviation	± 34.54 hours	± $ 145.35
Standard Error of Measurement	± 2.239 hours	± $ 9.422
Total	2,034.00 hours	$ 8,171.64

Average of 0.07 Emotional Support hours, per client, per day
Average cost of $ 0.35 for Emotional Support, per client, per day

Clients receiving Emotional Support = 17
Clients not receiving Emotional Support = 221

OCCUPATIONAL THERAPY

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	0.05 hours	$ 3.84
Minimum	0.00 hours	$ 0.00
Maximum	4.75 hours	$ 403.75
Standard Deviation	± 0.39 hours	± $ 31.27
Standard Error of Measurement	± 0.025 hours	± $ 2.027
Total	12.75 hours	$ 913.75

Average cost of $ 0.02 for Occupational Therapy, per client, per day

Clients receiving Occupational Therapy = 5
Clients not receiving Occupational Therapy = 233

APPENDIX C (Continued)

PHYSICAL THERAPY

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	0.47 hours	$ 31.64
Minimum	0.00 hours	$ 0.00
Maximum	16.25 hours	$ 1,300.00
Standard Deviation	± 1.93 hours	± $ 148.13
Standard Error of Measurement	± 0.125 hours	± $ 9.602
Total	112.00 hours	$ 7,530.00

Average of 0.01 Physical Therapy hours, per client, per day
Average cost of $ 0.31 for Physical Therapy, per client, per day

Clients receiving Physical Therapy = 20
Clients not receiving Physical Therapy = 216

VOLUNTEER SERVICES

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	64.91 hours	$ 0.00
Minimum	0.00 hours	$ 0.00
Maximum	1,281.00 hours	$ 0.00
Standard Deviation	± 170.11 hours	± $ 0.00
Standard Error of Measurement	± 11.027 hours	± $ 0.00
Total	15,449.25 hours	$ 0.00

Average of 0.33 Volunteer Service hours, per client, per day

Clients receiving Volunteer Services = 125
Clients not receiving Volunteer Services = 0

CASE MANAGEMENT

	UNITS OF SERVICE PROVIDED	*COST OF SERVICE PROVIDED
Mean	11.90 hours	$ 260.74
Minimum	0.25 hours	$ 5.48
Maximum	50.00 hours	$ 1,096.00
Standard Deviation	± 10.33 hours	± $ 226.49
Standard Error of Measurement	± 0.670 hours	± $ 14.681
Total	2,831.06 hours	$ 62,056.84

Average of 0.14 Case Management hours, per client, per day
Average cost of $ 3.06 for Case Management, per client, per day

Clients receiving Case Management = 238
Clients not receiving Case Management = 0

* Cost of Service Provided for Case Management computed at $ 38,000 per year + 20% benefits

OTHER SERVICES

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	2.31 hours	$ 499.31
Minimum	0.00 hours	$ 0.00
Maximum	174.00 hours	$ 73,000.00
Standard Deviation	± 14.44 hours	± $ 5,109.64
Standard Error of Measurement	± 0.936 hours	± $ 331.209
Total	549.25 hours	$ 118,835.00

Average of 0.03 Other Service hours, per client, per day
Average cost of $ 3.16 for Other Services, per client, per day

Clients receiving Other Services = 47
Clients not receiving Other Services = 191

CONTINUING FEATURES

AIDS Home Health, Attendant and Hospice Care Project

Continued from page 56

APPENDIX C (Continued)

HOUSING SERVICES

	UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	7.76 days	$ 77.23
Minimum	0.00 days	$ 0.00
Maximum	182.00 days	$ 2,400.00
Standard Deviation	± 28.96 days	± $ 327.20
Standard Error of Measurement	± 1.877 days	± $ 21.209
Total	1,847.00 days	$ 18,380.00

Average of 0.07 Housing Service days, per client
Average cost of $ 0.71 for Housing Services, per client

Clients receiving Housing Services = 16
Clients not receiving Housing Services = 222

APPENDIX C (Continued)

TOTAL HOURS AND COST OF SERVICE PROVIDED

	* UNITS OF SERVICE PROVIDED	COST OF SERVICE PROVIDED
Mean	546.66 hours	$ 6,602.69
Minimum	1.50 hours	$ 107.80
Maximum	3,625.25 hours	$ 79,639.60
Standard Deviation	± 655.36 hours	± $ 9,590.05
Standard Error of Measurement	± 42.481 hours	± $ 621.630
Total	130,104.58 hours	$ 1,571,440.65

Average of 4.97 Total Service hours, per client, per day
Average cost of $ 61.51 for Total Services, per client, per day

Clients receiving services = 238
Clients not receiving services = 0

* Units of services provided does not include Housing Services

Toxoplasmosis in Patients with AIDS

Continued from page 14

closer to 6 weeks) is when one should do a CT scan. Obviously if improvement does not occur one needs to work up these patients and a repeat CT scan or MRI is indicated sooner.

Face to Face: A Guide to AIDS Counseling

Continued from page 25

witz and Dunnigan's paper on youth and HIV and Helquist's poignant chapter entitled "Too Many Casualties: HIV Disease in Gay Men."

The major weakness of the book is that is is uneven—both stylistically and in its level of sophistication. This is true throughout the book but is most annoying with the case vignettes. For example, not all of the chapters include a list of references or readings. This absence is somewhat understandable with the more "personal" chapters but is unacceptable for the chapter that addresses strategies for working with substance abusers. Furthermore, some of the chapters are research reports stylistically suited for inclusion in medical or mental health journals.

While the book is very complete there are subjects that need to be addressed more thoroughly to help therapists and counselors deal with this population. Topics to be added or expanded would include the diagnosis and treatment of major depression in HIV disease, major depression as a factor in the assessment and treatment of suicidal behavior, the role of psychopharmacologic agents and their side effects in people with HIV disease and neurotoxicities of commonly prescribed medications used in people with HIV disease. Guidelines on counseling individuals about "whom to tell" and "how to tell" people about their HIV diagnosis needs to be included also.

Despite these minor reservations, I highly recommend this book for mental health professionals who deal with the issues of HIV in their practice. It is an informative, authoritative work which could be of value to therapists and counselors of varying degrees of experience. Much of this book would also be useful to physicians who are looking for a review of the psychosocial aspects of HIV and who find themselves counseling their patients about a wide range of complex and thorny medical, psychological and legal issues. The physician who counsels a patient about whether to take the HIV antibody test or who counsels his/her patient's lover about how to deal with a newly developing dementia or who has grappled with questions about confidentiality will find well-written, useful chapters on these subjects. In sum, this book addresses the challenges of counseling those with HIV-related problems in a practical, clinically useful approach that will appeal to a wide range of healthcare providers.

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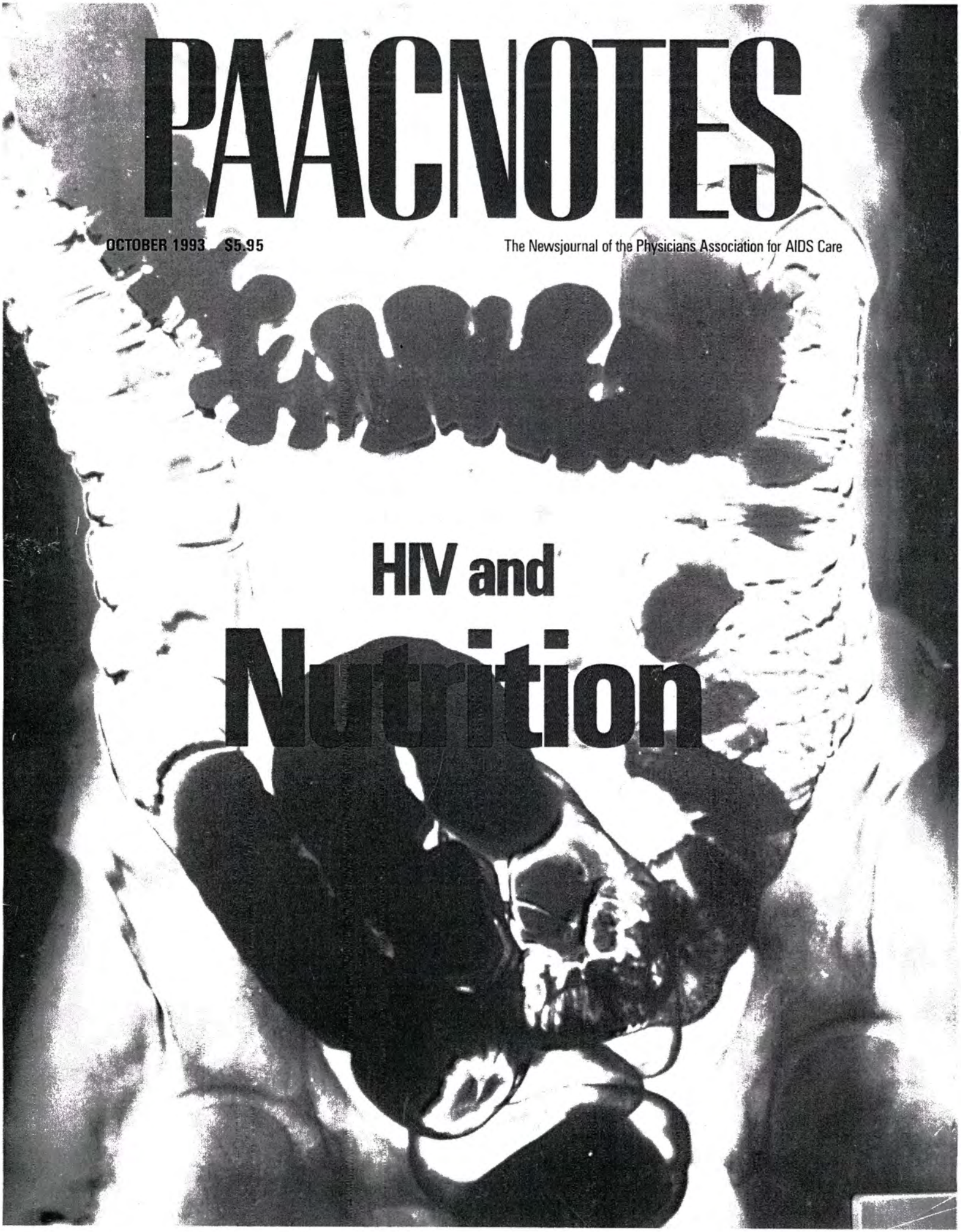
PAACNOTES

OCTOBER 1993 $5.95

The Newsjournal of the Physicians Association for AIDS Care



HIV and Nutrition

THE WHITE HOUSE

WASHINGTON

(213) 310 443 4231

December 29, 1993

Gordon Nary, Executive Director
Physician's Association for AIDS Care
101 West Grand Avenue
Chicago, IL 60610

Dear Gordon:

This letter confirms the visit of Kristine M. Gebbie, National AIDS Policy Coordinator, to Los Angeles to meet with the Physician's Association for AIDS Care and members of the Los Angeles community, on February 3, 1994.

Thank you for your work at putting together a very important meeting as we work to reform our health care system. At this point, the proposed agenda and suggested visits seem to work. Ms. Gebbie will discuss many of the topics outlined in your proposed agenda and others as well. As we discussed, you will need to put your media consultant in touch with John Gurrola in this office to coordinate the media activities.

Please call me at (202) 632-1090 with any questions or for further clarification. Have a pleasant new year.

Sincerely,

W. Steve Lee

W. Steve Lee, Executive Assistant
and Scheduler to the
National AIDS Policy Coordinator

Lunch

AIDS & HCR

1) Quick review of Policy –
   - Research
   - Services
   - Prevention

2) Services & HCR
   - why it's essential
   - "perfect = enemy of the good"
   - Key features –
     - universality / non cancellable / no lifetime limit / community rating
     - benefit package
       - outpt / diagnostics / hospt.
       - prescription drugs
       - home care
       - mental health
       - subst use abuse
     - managed care / outcomes focus
     - confidentiality & data

3) Ryan White Continuation

   Prevention Package

3) Packaging specialist services
   - what's it worth to a managed care system

Century City Hospital - Dinner -

Standards of Care & HCR

1) Expecting more oversight

2) Outcomes vs. Process

3) Primary care / specialist care

4) Packaging special services & special populations -

PAAC
PHYSICIANS ASSOCIATION FOR AIDS CARE

101 West Grand Avenue, Suite 200
Chicago, Illinois 60610
Phone: 312/222-1326
FAX: 312/222-0239

December 13, 1993

RECEIVED
DEC 20 1993

Kristine Gebbie
National AIDS Policy Coordinator
Executive Office of the President
750 17th St., NW., Suite 1060
Washington, DC. 20503

Dear Ms. Gebbie:

I met Dr. Sam Shekar at a managed care meeting for the pharmaceutical industry on December 3, 1993. Dr. Shekar expressed interest in the managed care proposal of the Physicians Association for AIDS Care (PAAC) that I outlined in my presentation at the meeting. I had the opportunity of discussing the PAAC proposal in greater detail with Dr. Shekar and he recommended that I contact you to arrange a site visit in Los Angeles that would illustrate and complement several of the initiatives in the PAAC proposal.

We are inviting you to participate in a series of events in Los Angeles, CA, on February 3, 1994. The series will address the impact of healthcare reform on people with HIV/AIDS. Each of the events that we are suggesting reflects efforts of the Los Angeles community 1) to improve access to healthcare for people living with HIV/AIDS, 2) to develop community standards of care that maximize the length and quality of life of all patients, and 3) to contain costs of such care.

Attached is a schedule of the suggested events as outlined on the next page, and includes recommendations for two speeches by you on the Administration's healthcare reform proposal and the impact of that proposal on people with life-threatening diseases such as HIV/AIDS.

Approximately 200 guests that include third-party payers, pharmaceutical manufacturers, hospital administrators, and Los Angeles-area corporate leaders and union executives would audience the first address. The second address will be to a group of approximately 100 LA/PAAC physicians who are meeting to develop community standards for anti-retroviral therapy as part of our standards of care initiative.

We have recommended an ambitious agenda for February 3, 1994. Each site visit on the agenda is designed to bring media attention to key elements in an effective and cost efficient HIV/AIDS healthcare delivery system. At each of the sites, there is a planned tour of the facilities and a discussion with key facility personnel. The discussion will focus on some of the unique dimensions of the services provided. Your staff will be presented with a comprehensive report at each of the sites with a complete overview of the services provided, cost efficiencies effected and additional information that may help serve as a model for other communities. There will be comprehensive local and national print and television coverage at each of the sites. As a side note, all of the sites are in the West Hollywood area, and the travel time between sites is approximately ten minutes.