Adult Day Care Programs in the United States: Current Research Projects and a Survey of 10 Centers

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ALTHOUGH ADULT DAY CARE has functioned as an alternative to nursing home inpatient care for almost two decades in England, this community-based mode of long-term care for the elderly has just come under study in the United States. Much of the cause for its slow growth here can be attributed to unanticipated (and now unwanted) consequences of private and public health insurance policies, particularly Medicaid and Medicare, which long favored payment only for institutional care as a way of discouraging frivolous entry into the health care system. For years, many of the most commonly needed services for aged adults (diagnosis, supervision, assistance with activities of daily living) could be reimbursed only if they were obtained in an institutional setting such as a hospital or nursing home. Home care services usually were not available except following release from an inpatient facility.

But as health care costs, particularly institutional costs, began to threaten the public purse, alternatives were sought. Late in 1972, Congress formally directed the Secretary of the Department of Health, Education, and Welfare to undertake a study of alternatives to institutional care. The Social Security Amendments of 1972 (Public Law 92–603, section 222) specified that adult day care would be one of the alternatives considered. The law states, in part, that the Secretary shall:

> establish an experimental program to provide day-care services, which shall consist of such personal care, supervision, and services as the Secretary shall by regulation prescribe, for individuals eligible to enroll in the supplemental medical insurance program established under Part B of Title XVIII and Title XIX of the Social Security Act, in day-care centers which meet such standards as the Secretary shall by regulation establish:

Several efforts were mounted by the Department to carry out the congressional mandate. Among them was the funding in 1974 by the National Center for Health Services Research (NCHSR) of a study of 10 existing adult day care programs, a first attempt at describing this new care mode. Instrument design, site selection, team training, and scheduling began immediately.

Design of the Baseline Study

Site selection required a three-step process: the universe was defined by adopting minimum inclusionary and exclusionary criteria, characteristics of agencies essential for inclusion in the sample were identified, and subsequently 10 centers were selected from the 18 which constituted the known universe of those which met the minimum criteria.

To be included, a center had to provide the services of the equivalent of one full-time health care professional per week. Several health care professionals—each providing part-time services—could fulfill this requirement, but their total work hours had to equal 35 or more per week. This criterion assured that senior centers that might be visited occasionally by a nurse or podiatrist would be excluded from the sample. Each center had to offer a program of activities, either social or recreational, or both, thus excluding simple health care clinics.

Centers were excluded from the sampling universe if they provided overnight care to the day care participants. Day care programs in nursing homes could be included, but not a program labeled as day care which was indistinguishable from a short institutional stay. Also excluded were programs offering exclusively psychiatric care or serving a population comprised predominantly of patients with psychiatric diagnoses. Psychiatric day care is a well-established

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service, but this survey was focused on agencies which were engaged predominantly in the innovative effort of providing day care to adults who suffered primarily from physical disabilities. Psychiatric care might or might not be one of their services.

In the final selection, a quota sample was developed that insured representation of agencies with a maximum range of various organizational characteristics deemed important in the task of model development. Two selections were made by coin toss to choose among alternatives.

Characteristics considered in making the selections included type of affiliation (health care facility or other type of agency), location (rural or urban), size of client population (fewer or more than 30 participants attending per day), ethnicity of population served (ethnically homogeneous or heterogeneous and black or other nonwhite minority), and single and multisite operations.

Site visits began in the fall of 1974, and by early spring of 1975 each of the 10 centers was visited for 3 to 5 days by an interdisciplinary team of health care professionals, research methods specialists, accountants, and others. At the sites, patient population data were collected by means of an adaptation of "Patient Classification for Long-Term Care" (*1*). A sample of 30 participants' records was drawn randomly at each center and, with the aid of the supervising nurse or other health professional at the center, information was extracted from the record and supplemented with the professional's knowledge of the participant to provide data for the descriptors in the classification manual. Staff time allocations, content of the center's service components, and costs by function were determined through task analysis interviews with staff and examination of fiscal records.

Summary of Findings

The history, goals, admission criteria, intake procedures, staffing, services, population characteristics, referral sources, type of affiliation, and daily costs of operations were examined for each center. A summary of the resulting observations follows.

Facilities, affiliation, and size. The adult day care programs varied widely in physicial facilities, size, and affiliation (table 1). One program, On Lok Senior Health Services Center in San Francisco, Calif., is unaffiliated. Its administrative offices are located in a county health department building, but the center operates in a converted cocktail lounge. Arm exercise pulleys hang from the ceiling and a T-bar exerciser stands in the common activity room next to folding

Table 1. Characteristics of 10 adult day care programs

Agency and location	*Average daily attendance* [1]	*Principal funding source*	*Months in operation*	*Affiliation*
Athens (Ga.) Brightwood Day Care Center	11	Title VI, Social Security Act	36	Social service organization
Burke Day Hospital, White Plains, N.Y.	40	Title IV, Older Americans Act	27	Rehabilitation center
Levindale Adult Day Treatment Program, Baltimore, Md.	25	Medicaid	60	Geriatric center
Lexington (Ky.) Center for Creative Living	29	Title VI, Social Security Act	25	County health department
Mosholu-Montefiore Geriatric Day Care Program, Bronx, N.Y.	28	Title IV, Older Americans Act	26	YMHA-HWHA, hospital
On Lok Senior Health Services Center, San Francisco, Calif.	47	Title IV, Older Americans Act	27	Free standing
San Diego (Calif.) Senior Adult Day Care Program	52	Revenue sharing	20	Social service organization
St. Camillus Health Care by the Day Program, Syracuse, N.Y.	18	Medicaid	34	Skilled nursing facility
St. Otto's Day Care Program, Little Falls, Minn.	11	Medicaid	79	Nursing home
Tucson (Ariz.) Senior Health Improvement Programs	115	Model Cities	92	Nursing home, hospital
Average daily attendance	37.6			

[1] On Lok Center operated 7 days a week; all others, 5 days a week.
SOURCE: Average daily attendance reflects study team findings from a count of attendance on site-visit days and program records of lunches consumed in sample months. Tucson program officials disagree with the count for their program. Their estimate is 143.

tables and chairs used alternately for crafts, eating meals, and free-time relaxation.

The Burke Day Hospital is in stark contrast to On Lok. It operates in a separate wing of the Burke Rehabilitation Center, a voluntary, nonprofit rehabilitation hospital in White Plains, N.Y. Burke has its own X-ray and laboratory facilities and well-equipped therapy rooms. Like most other agencies in the study, it also has the services and equipment of the rehabilitation center's inpatient facilities for backup support if needed.

St. Camillus Health Care by the Day Program in Syracuse, N.Y., contrasts with both Burke and On Lok in being totally integrated into the services and facilities of an extended care facility, with no special quarters for the adult day care program and no segregation between the facility's inpatients and those in adult day care.

Patient loads ranged from 11 participants attending on an average day at the Athens (Ga.)-Brightwood Day Care Center and St. Otto's Day Care Program in Little Falls, Minn., to 115 participants per day at the six sites of the Tucson (Ariz.) Senior Health Improvement Programs. Average attendance for the 10 programs was 37.5 participants per day.

Funding. Four programs were funded as demonstration projects under Title IV, part B, of the Older Americans Act (table 1). For On Lok, Mosholu-Montefiore Geriatric Day Care Program, and Burke, these grant funds constituted the principal source of program support. The Levindale Adult Day Treatment Program in Baltimore used these funds exclusively to support the program's research component; operating funds came mostly from Medicaid reimbursement payments.

Funds allocated under Title VI of the Social Security Act comprised the principal revenue for the Athens center and the Lexington (Ky.) Center for Creative Living, while revenue sharing funds supported the San Diego (Calif.) Senior Adult Day Care Program. Medicaid reimbursement comprised the major revenue source for only three programs; all were affiliated with a long-term care facility. These three and most others received some in-kind or direct support from affiliated facilities.

Demographic characteristics of participants. Participants in adult day care were as varied demographically as the programs themselves. Some sample data follow.

Several programs served a catchment area dominated by a particular racial or ethnic group; On Lok was a typical example. (None of the programs, of course, excluded persons because of race, creed, or national origin.) More than three-quarters of On Lok's participants were Chinese; the remainder were Filipinos or Italians. Some 95 percent were immigrants. At several other programs, most participants were Jewish.

The average age of the participants also varied by program. Although the average for the 10 centers was 71 years, Burke had many participants under 60 and one, a paraplegic, was only 22. The other nine programs refused admission to anyone under 60 years old.

Participants' impairments. Participants in the survey sample had between two and five diagnosed medical problems. By agency, they varied substantially in the level of dependency as computed according to an activities of daily living (ADL) index. The average number of chronic conditions per participant and the mean ADL scores are given by program in table 2.

More than half of the persons attending Burke Day Hospital were partially or totally paralyzed; just under half of St. Camillus' participants were similarly afflicted. Paralyzed participants made up between a tenth and a third of those attending most of the other programs. Three-quarters of the patients at St. Camillus and half of those at Burke used a wheelchair all or some of the time. The other eight programs had far fewer wheelchair users. The proportion

Table 2. Average number of chronic conditions and mean score in activities of daily living index of participants in 10 adult day care programs

Program	Average number of conditions per participant	Mean ADL score [1]
Athens	2.7	0.5
Burke	4.8	2.8
Levindale	2.9	1.1
Lexington	3.3	0.8
Montefiore	3.9	0.5
On Lok	3.5	1.8
San Diego	2.1	1.1
St. Camillus	3.0	3.8
St. Otto's	2.0	0.1
Tucson	3.0	1.4
Average	3.1	...

[1] Activities of daily living score reflects the number of activities in which a participant is dependent and is weighed for extent of dependency. Activities include walking, wheeling, eating, and toileting. Weighting is assigned as follows: 1 = requires assistance of equipment; 2 = requires assistance of a person; and 3 = requires assistance of both equipment and a person.

of participants with fractures or who had experienced a stroke was also highest at Burke and St. Camillus.

Blindness was rare in the study sample of patients, yet every program except St. Otto's and San Diego had at least one blind participant.

Mental illness was the primary diagnosis for nearly three-fourths of St. Otto's participants, and it afflicted between a fourth and a third or more of the participants in five of the programs surveyed.

Admissions criteria. Burke did not accept a participant who did not have a caretaker at home in the evenings if the person needed nighttime supervision. Burke and a few other programs also excluded participants who did not appear likely to benefit from the health care services offered. Burke and other programs did not accept participants who did not qualify for Medicaid but were unable to pay the program's daily charges. Levindale admitted only participants who qualified for institutionalization and reimbursement under the Maryland State Medicaid program.

Several programs required that participants have their own physicians, since most programs had no staff physicians. None accepted participants who were totally disoriented or dangerous to themselves or to others. All excluded bedridden patients and a few accepted alcoholics or drug addicts.

All but one program did not accept residents of mental institutions; St. Otto's was the exception, and the effect of this policy has been profound. St. Otto's began as a geriatric program, but it evolved into a center for those with psychiatric problems after the State began to release massive numbers of residents of mental institutions.

Despite this list of exclusions and restrictions, rigorous criteria regarding health status or medical diagnoses are the exception rather than the rule for admission to adult day care. Most programs required that "a medical need must be established," but they tended not to define this term operationally. Burke Hospital and the St. Camillus program were the exceptions.

Staffing. Several programs depended on affiliated institutions to provide therapy services; others had in-house staff. Tucson had a large total staff of professional, allied, and associated health care personnel, but it also had the largest patient population, giving it, paradoxically, one of the smaller staffs in proportion to its population. Burke had the highest ratio of staff to participants. Overall, the range was from nearly one staff member for every participant at Burke to just over one staff member per five participants at St. Otto's.

Burke also had the largest professional health care staff, the equivalent of 10.5 full-time professionals, but its professional staff was extraordinary when compared to the other programs. The range was from 4 participants per professional at Burke to 33 at the Athens center.

Burke's large staff represented a range of health care specialties; it included a Primex nurse (who offered some primary medical care), registered and licensed practical nurses, and speech, physical, and occupational therapists. The professional staff of Tucson, St. Camillus, San Diego, and On Lok also included several health care specialties, but each lacked a Primex nurse and one other specialty compared to the Burke staff. Montefiore, Tucson, and On Lok were served part time by a physician. The remaining seven required participants to have their own physicians.

Health care services. Data were collected in staff interviews to determine what proportion of staff time was spent in various activities. Of particular interest was the proportion devoted to health care services. This term was defined in the study as medical and nursing services; physical, occupational, and speech therapy services; psychiatric and psychological counseling; and the limited time devoted to conferences and recordkeeping that was directly involved with care giving.

The 10 programs defined their priorities differently. Health care services are reported in total minutes (table 3) and, although they can be disaggregated by specialty (for example, nursing services compared with therapy services), they cannot be disaggregated per participant. The figures in table 3 are averages. Some participants got much more time than the average, some less. Also, group and individual therapy sessions were combined.

At the time of the study, half of the time of staff members at Burke (both professional and nonprofessional) was spent in health care activities, more than 1.5 hours per participant per day. At St. Camillus, with a smaller staff and a slightly smaller proportion of staff time devoted to health care services, participants received 85 minutes of such services per day. The San Diego program ranked third in total minutes per day devoted to such care.

In the other seven programs, staff devoted between a fourth and a third of their time to giving health care to participants. This proportion tended to equal about half an hour per participant per day. Levin-

Table 3. Staff time devoted to health care in 10 adult day care programs, in rank order

Program	Percent of staff time	Minutes of staff time per participant per day (average)
Burke	56.6	108.6
St. Camillus	43.7	85.0
St. Otto's	42.1	32.8
San Diego	41.5	70.6
Montefiore	33.2	30.4
Levindale	29.3	15.7
Lexington	27.4	31.0
Tucson	25.8	35.6
On Lok	24.5	28.4
Athens	9.4	20.5
Average	33.4	45.86

SOURCE: Study team computations based upon functional task interviews with staff.

dale and Athens were the exceptions. Levindale gave just 15 minutes per day, but this amount reflected the small size of its staff to some extent. As a proportion of all activities, 15 minutes represented a third of the staff time, or about average for the majority of the adult day care programs studied.

But Athens, at 20 minutes per participant per day, devoted only about 10 percent of its staff time to the administration of health care services. The other 90 percent of the day staff engaged participants in social, recreational, nutritional, and other supporting activities, but not in receiving health care.

Because referrals to therapy services were not included in these data, participant time spent in receiving health care services may not be reflected accurately for the Levindale, Montefiore, Lexington, and St. Otto's programs. Most agencies have a variety of therapy services available in an adjoining facility. The study team was able to determine, however, that only the Tucson program actually engaged in systematic, high-volume, supervised referrals. Its participants were escorted by staff members to the adjacent wing, lower floor, or adjoining facility where therapy was regularly scheduled for specific participants.

Use of nonprofessional staff to provide services differed widely among the 10 programs. San Diego, which ranked high in time spent giving health care services, relied heavily on nonprofessionals. Its participants received 70.6 minutes per day of such services, but nonprofessionals administered them for 56.5 or 80 percent of those minutes. The nonprofessionals or professionals were not licensed, certified, or registered to give the therapy they are administering (for example, a licensed practical nurse may give occupational therapy). In contrast, at Montefiore, for almost 75 percent of the total minutes of health care services, care was given by professionals who acted only in their specialty.

About half of Burke's large volume of health care services were delivered by nonprofessionals, but Levindale' nonprofessional staff gave these services for only a third of the time. This proportion at Athens, St. Camillus, Tucson, Lexington, and On Lok was more than half. In the following list, the agencies are ranked by the proportion of health care time that the care was administered by professional staff rather than nonprofessionals.

Program	Services by professionals (percent)
Montefiore	74.7
Levindale	67.5
Burke	55.2
St. Camillus	46.0
Tucson	45.2
Athens	42.7
Lexington	37.4
On Lok	37.3
St. Otto's	20.7
San Diego	20.0
Average	44.7

Note: Services given on referrals to professionals are excluded except for those in the Tucson program. Source of data is the study team's computations.

Some programs emphasized therapy services, and others stressed nursing services. St. Camillus put almost 90 percent of its health care efforts into therapy, and a mere 1.8 percent in other health care activities. Other programs devoted little time to therapy services; it appeared to the study team's registered physical therapist that some participants needed more professional therapy than they were getting.

Services. Few aspects of adult day care better evidenced its evolving nature than the heterogeneity of service packages among the 10 agencies. Every program offered a core of basic services without which it probably could not function. But the similarities ended there.

Basic services. The basic service package included the following: lunch, general nursing supervision and services, social work services, and personal hygiene.

Marginal or added services. Six programs provided

special diets and seven gave dietary counseling to participants and their families. Only three made a psychiatrist's services available. Half the programs provided physical and occupational therapy, and two offered speech therapy as well.

Transportation. Only 2 of the 10 programs had no provisions for some transportation for participants. Some ferried patients to a range of community social and recreational agencies; others took them only to other facilities providing health services. Some agencies provided or contracted for transportation only between the participants' homes and the adult day care program.

Costs. The wide variations among adult day care programs in physical facilities, staff size, and variety of health care professionals and services may result in differences in their ability to serve different populations. But there can be no doubt that they make a difference in cost per patient.

Per diem costs at Burke were much higher than at any other program. In fact, its costs were nearly twice as high as for the next most costly program (Montefiore, $33.67), and nearly three times the average of the other nine programs ($21.04). But with that exception, costs fell within a fairly narrow range.

Nevertheless, adult day care was more expensive than many people may have expected. Indeed, on a daily basis, the average cost of these 10 programs substantially exceeded the average daily cost of nursing homes which, according to the National Center for Health Statistics, was $15.63 in 1973–74 (*2*).

Two Models of Adult Day Care

The results of this study clearly indicate that the concept of adult day care means different things to different people. Some practitioners regard it essentially as rehabilitative therapy for posthospital patients. Others see it principally as supplying social and nutritional services and some health care, but only for patients who have limited dependency in activities of daily living. Similarly, some program designers target their services expressly to participants of one type, while others accept a variety of client types.

From the patterns that emerge, two types of programs can be distinguished. The first type is narrowly defined in its service objectives and is targeted to a homogeneous group of participants who meet very specific admission criteria which stress health status. The second type includes a variety of subtypes. These programs are more oriented to social needs than the first type, but there is little exclusivity in their goals, participants, or services. They appeal to participants exhibiting a variety of characteristics, including mental problems and differences in health status rather than physical disabilities.

Programs that are clearly targeted toward a specific posthospital, rehabilitation-needing client group serve participants who suffer many limitations in activities of daily living. Those which serve multipurpose goals admit clients who most often need fewer health care services, are less impaired, and often come to the day care program before going to a nursing home rather than after an institutional stay.

Hence, two models of day care can be identified; model 1 programs are predominantly rehabilitation oriented; model 2 programs are multipurpose, usually less health oriented than model 1 programs, but none of them entirely shuns a health care orientation. Likewise, some serve participants with psychiatric problems, others do not. Most model 2 programs have fewer professional staff, and their costs are lower. Principal characteristics of the two models are summarized in table 4.

Other NCHSR Research Related to Day Care

Although the survey just described provided essential baseline data, as does any exploratory study, it raised more questions than it answered. For example, it showed that many kinds of patients or participants are being served in adult day care. As a survey of existing practices rather than an experiment, however, it could not indicate which client populations would show improved outcomes as a result of participating in adult day care.

To answer this question as well as others, the National Center for Health Services Research has funded other demonstration projects, and the results of these endeavors should provide definitive answers once their outcomes have been analyzed.

Day care and home care demonstrations. The Center has funded a seven-site demonstration project in adult day care and home care services. Both day care and homemaker-home health programs are included, and an experimental design is being used to gather data to assess outcomes. Cost effectiveness analyses will also be possible within some limits. The project is being carried out under the waiver provisions of section 222 of the Social Security Amendments of 1972.

Table 4. Characteristics of two models of adult day care

Characteristic	*Model 1*	*Model 2*
Agency		
Admission criteria	Must need therapy	Not explicit. Accept persons with some physical or social dysfunction
Intake procedures	Multidisciplinary teams use standardized forms and procedures	Staff in 1 or 2 disciplines acting informally
Referral sources	Physicians	Welfare departments, social service agencies, churches, mental health clinics, friends, and relatives
Staffing	Many registered, certified, or licensed health care professionals	Many unregistered, unlicensed, and uncertified personnel or referral to outside sources or both
Services	No home care except training of relatives in followup care	Some offering home health care or homemaker services, or both
Affiliation	Inpatient health care facilities	Community service agencies or freestanding
Costs per day	$40 average	$20 average
Funding	Medicaid and private health insurance	Formula grants, revenue sharing funds, model cities funds, demonstration grants
Participants		
Average age (years)	68.0	72.3
Percent living alone	16.7	34.6
Percent with paralysis	61.7	17.1
Percent using wheelchairs	23.3	12.9
Percent with fractures	40.0	9.1
Percent with strokes	25.0	20.0
Percent with neurological disorders	20.0	28.8
Percent with mental disorders	55.0	28.0
Percent with hypertension	6.7	40.0
Percent blind	...	2.5
Average number of diagnosed medical conditions	3.9	2.9
Mean activities of daily living score	3.3	.9

Of the seven contractors in this multisite study, three provide day care, two homemaker-home health services, and two, both day care and homemaker-home health services. The demonstrations are at Burke Day Hospital; the St. Camillus program; the department of rehabilitation of Abraham Jacobi Hospital in the Bronx (N.Y.) Municipal Hospital Center; the Lexington Center for Creative Living; a private-for-profit home health association in Los Angeles, Calif.; a home health service in San Francisco which is also providing day care; and a home health program in Providence, R.I.

Each project began with a catchment area, a proposed population load, and an experimental design in which each qualified applicant for day care or homemaker-home health services was randomly assigned on a 50 percent probability basis to the demonstration program or to a control group. The control group was returned to the community to receive whatever services were available other than those in the demonstration project. Services were provided through the end of 1976, terminating on the date the client had been in the program for 1 year. The health status of both experimental and control group members, approximately 1,600 persons, was assessed quarterly, using a specially adapted instrument. Cost data were collected.

The Center also contracted with a consulting firm, Medicus, Inc., of Chicago to assimilate the data as it was collected by the staffs of the seven contractors and to prepare data tapes so that outcome assessments and cost analyses can be accomplished. Much of this analytical work will be done in the Center.

The Division of Direct Reimbursement, Social Security Administration, paid for the care rendered under a section 222 waiver, and kept track of the experimental and comparison groups' Medicare records to allow analysis of the nonprogram health care expenditures outside the day care programs.

Each participant signed a waiver authorizing collection of these data. Each contractor is required to

take special steps to insure that rights to privacy are not compromised beyond the degree essential and specifically authorized by the participant.

Initial results of this study should be forthcoming by the end of 1977.

Triage demonstration. Another project, Triage, carried out under the section 222 mandate, also incorporates adult day care, home care, and many other services. Its purpose is to choose, from among various services available, only those appropriate for each client. The population to be served includes all persons over age 65 regardless of income, as well as those under 60 who are disabled and eligible for Medicare. Up to a maximum of 3,000 clients may be served.

A central goal of Triage is to test cost effectiveness when service dollars can be spent for care deemed to be appropriate for client need rather than according to the restrictions imposed by third-party payers. Triage stresses comprehensive continuous integrated care through a single entry point in the system and comprehensive assessment and followup. Services, both social and medical, are given by prescription, without arbitrary distinctions. Management is on both a case and a system basis.

Triage, Inc., which operates the program, is a private, voluntary nonprofit health services organization formed at the beginning of the project through the Connecticut Department of Aging. It coordinates and make provisions for services within the Central Connecticut Planning Region, which includes Bristol and the surrounding seven towns. Triage, Inc.'s headquarters office is in Plainville.

Triage began February 1, 1974, with startup money from the State and the U.S. Administration on Aging. On August 8, 1975, the Department of Health, Education, and Welfare awarded Medicare waivers under section 222 and, in April 1976, the National Center for Health Services Research funded research on the project. The University of Connecticut is conducting the research. Clients will receive services until July 31, 1977.

Triage's stated objectives are to (*a*) reduce per capita expenditures for the health care of the elderly, (*b*) increase the effectiveness of services for the elderly, (*c*) reduce the number and prevalence of institutionalization, (*d*) increase the number and availability of home-based services for the elderly, and (*e*) cause a greater integration of human services in the Central Connecticut Planning Region (*3*).

Essential in the Triage system is the concept of a single entry point. After a referral has been made, a geriatric nurse clinician and a social case worker team visits the client in his or her home to assess needs and decide on an appropriate care plan. They use a comprehensive assessment plan developed as part of the project. The nurse performs a modified physical examination. The data acquired are then organized into a problem-oriented format, and a plan of care is prepared. The team arranges for all needed services, and the social case worker keeps in regular contact with the client. The service continuum includes short-term in-hospital care for critical illness; long-term care for convalescence or chronic conditions both in and out of institutions; in-home health care; life support and such assistance as home health aide, homemaker, day care, nutrition and chore services; transportation; volunteer friendly visiting; and telephone reassurance.

Triage can arrange for services from nonprofit and private profit-making providers of all types. The Social Security Administration's Division of Direct Reimbursement is the third-party payer in this demonstration project; no private insurance companies are involved. Medicare-covered services are reimbursed on a cost-reporting basis. Pharmaceuticals and optical services are reimbursed at rates established by the State's department of social services. For other services, for example transportation, fee schedules from the Public Utilities Commission or industry sources are used. Chore services and meals-on-wheels are negotiated with each provider. The Division of Direct Reimbursement reviews payment arrangements in its role as fiscal intermediary.

Research on the Triage system is focused on outcomes of care and costs, but the relations between systems which are developed are also of considerable interest. Experimental and comparison groups are being established at the point of entry to long-term care facilities, and health status and functional ability of clients are being measured. Life support costs will be computed or estimated, and functional cost analysis will also be conducted. Initial findings from the study should be forthcoming in 1977.

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