Finding the Gaps: A State Inventory of Long-Term Care Services and Needs in Idaho

Conducted by
The Center for the Study of Aging
Boise State University

April 2008

Holly Beard, PhD
Carissa Moffat Miller, MA

The *Center for the Study of Aging*, established in 2004, is a joint project of the Colleges of Health Sciences and Social Sciences and Public Affairs at Boise State University. The Center's mission is to advance the well-being of older people by assuring that Boise State University, our communities, and our society in general prepare for the aging of the population. Such preparation requires research, education, and collaboration to: increase awareness of aging-related issues; build knowledge about how to maintain quality of life as we age; foster expertise among faculty, policy makers, and community organizations; and promote the study of gerontology and careers in aging. *The Center for the Study of Aging* strives to apply an interdisciplinary approach to the study of aging and to serve as a resource for Idaho and the rest of the nation.

Acknowledgements

The initial work to inventory long-term care services in Idaho was funded by the National Governors Association during Governor Kempthorne's tenure. The Center for the Study of Aging continued this work to provide detailed information about aging in Idaho and a comprehensive inventory of available services statewide.

We would like to express our appreciation to the organizations that assisted with this report. The Idaho Commission on Aging and the Area Agencies on Aging who provided invaluable expertise and data. The Idaho Department of Health and Welfare supplied essential information about long-term care services and Medicaid in Idaho. The Social Science Research Center at Boise State University and the State Independent Living Center also provided information about aging with a disability for this report. Special thanks go to all the individuals in Idaho who gave their time to be interviewed and openly shared their experiences with long-term care services in Idaho.

Executive Summary

Long-term care is not always easily accessible for anyone in need – unlike emergency medical care it is not apparent where a person or family can find care or how they will pay for the care. The diversity of services, payers, and providers of long-term care make it difficult to get a statewide comprehensive picture of long-term care and those who need these services.

The purpose of this project is to begin to document the availability and need for long-term care services in Idaho. This project is an initial statewide assessment of a broad range of long-term care in Idaho and will serve as the baseline for continued evaluation of the availability, preferences, and the need for long-term care services. By identifying services and the difference between available services and needs, this report will serve as a basis for future policy and program development.

Information compiled for this report was obtained from a variety of sources. Existing data from national surveys and reports, state statistics and projections, and administrative data from local and regional programs served as the foundation. These were supplemented with interviews and focus groups conducted throughout the state.

There are a variety of long-term care services available in Idaho. The services range from case management, homemaker, chore and respite services to offering meals (home delivered and congregate), transportation, adult day care and ombudsman services. Nursing homes, assisted living facilities, certified family homes and home health care are also options. Long-term care services are available through Medicaid for eligible individuals including nursing home care, waivers to pay for in-home services, or for developmentally disabled individuals. Despite the wide range of services available, the entire range is not available in the same way in each area of the state. Each area in the state is given the latitude to determine how to best meet the needs in the particular area and thus some areas focus more heavily on certain aspects. In addition, funding is limited and the need for the services is greater than the agencies are able to provide.

As the face of Idaho ages, the need for comprehensive long-term care services will undoubtedly increase in the near future. By broadening the definition of long-term care and increasing the public understanding about long-term care options, Idaho can successfully serve both the young and old disabled within this state. Yet, there are a number of challenges that face Idaho in providing long-term care.

- Idaho is rural state and the uniform delivery of long-term care services in each region is and will become more difficult as Idaho ages.
- Consistency of services across the state does not exist.
- There is a lack of systematic data collection on the use, needs, and availability long-term care services on the state and local levels**.**
- There is little information about the preferences of Idahoans about long-term care.

Ensuring equity and consistency in services across Idaho, implementing systematic long-term care data collection and clearly understanding the long-term care preferences for older Idahoans will provide critical information for policymakers in determining long-term care priorities and assist in creating a comprehensive plan for the state.

Table of Contents

List of Figures

List of Tables

Appendices

Emma and Harvey

Emma was only 60 when she had her first stroke. Her husband of 50 years, Harvey, was 10 years her senior and had been diagnosed with cancer earlier that year. With these diagnoses Emma's interaction with long-term care services in Idaho began, which would span many years and numerous services. Emma deeply wanted to be a good caregiver; however, her own symptoms often prevented her from doing all she wanted. Emma and Harvey decided to offer their daughter and son-in-law the use of rental property near their rural home where they might be close enough to provide support. The daughter and son-in-law moved in. However, having a family of their own meant they both needed to work outside the home. Providing care to their parents, while working and caring for their children put an extra strain on the young family and Emma worried about it, but she relied on them because her husband's disease was getting worse and she no longer felt capable of attending to his needs.

After battling cancer for one, long year, Harvey died at home. Emma was satisfied that she and her children had provided the kind of loving care her husband deserved. Support from a local hospice program made this possible. She expressed her gratitude by sending a special thank you card but was distressed that her once lovely signature was now barely legible. After Harvey's death, her grief at the loss of his loving support was intensified as the effects of her stroke grew steadily worse. Her youngest daughter moved back to the rural community to move in with her and take care of her. But to make ends meet, especially with mounting medical bills from Harvey's illness, the daughter had to work during the day. This meant that Emma was still alone while her daughter continued to work.

Home health aides and chore services are in short supply in rural Idaho and her children wondered whether they should trust a stranger with their mother and so they frequently declined these services. One day when Emma was on her way to get the mail she fell and broke her hip. She lay on the ground, waiting in pain, until a neighbor happened to stop by for a visit and found her.

After searching for alternatives Emma's family decided they were unable to provide the care she needed when she was released from the hospital and so she was moved to a nursing home for rehabilitation. While in the nursing home she had another stroke and fell numerous times. Limited financial resources meant she couldn't afford a prolonged stay in the nursing home so when Emma was stabilized, her two daughters knew they would need to provide care in the family home.

Medicare allowed for a physical therapist to provide therapy for six weeks. During this time Emma regained some physical strength and her children noticed she was much happier. But then, after the allowed time frame under Medicare rules, the physical therapy could be continued only if she paid for it. Since that wasn't an option, the therapy stopped and she began to regress until she was worse than when she began the therapy.

Today, Emma is living with an unmarried daughter that left her job in the city to provide care for her mother. Her daughter and son-in-law continue to provide care, but the family worries as she continues to fall and her health seems to be getting progressively worse. They also worry about the cost of care obtained outside of the family and don't feel they can provide the care that would help improve her ability to be more self-sufficient, let alone happier.

This story is fictional and is based on a compilation of numerous stories shared by individuals who were interviewed for this project.

Introduction

Long-term care is complicated; it does not consist of one type of service available in an easily identified location by a specific provider. Long-term care is not always easily accessible for anyone in need – unlike emergency medical care it is not apparent where a person or family can find care or how they will pay for the care. The fictional story of Emma and Harvey illustrates the experiences of numerous Idahoans as they try to navigate the long-term care system of services.

The diversity of services, payors, and providers of long-term care make it difficult to get a statewide comprehensive picture of long-term care and those who need these services. Needing long-term care services is one thing, but obtaining these services can be challenging in a primarily rural state with extended distances and geographical barriers. In the vignette about Emma and Harvey, long-term care describes services and support provided by: family caregivers, neighbors, interdisciplinary hospice team members, hospital personnel, a nursing home, physical therapists and home health aides. Additionally, it illustrates that needs for long-term care services vary over time with changing circumstances of the individual. Due to the aging of the population and advances in medical technology, more people are likely to survive to old age or survive an illness or injury at any point in the lifespan today than in any time in the past. However, these people are also more likely to have a lasting disability or impairment and require some assistance to maintain their function and quality of life. State government, local communities, service providers and individuals all require information about the availability of long-term care services and the differences that exist between what is available and what is needed.

This report is part of Idaho's continued commitment to the Aging and Long-Term Care initiative instituted by former Governor Dirk Kempthorne during his tenure as Chairman of the National Governors Association. The purpose of this project is to begin to document the availability and need for long-term care services in Idaho. This project is an initial statewide assessment of a broad range of long-term care in Idaho and will serve as the baseline for continued evaluation of the availability, preferences, and the need for long-term care services. By identifying services and the difference between available services and needs, this report can serve as a basis for future policy and program development. Lastly, this report provides an outline of data and research needed to enhance planning for future long-term care services to assure the well-being of older people in Idaho and that our communities and our state are prepared for the demographic shift to an older population.

Methodology

Information compiled for this report was obtained from a variety of sources. Since this is an initial effort to compile information about long-term care in Idaho, existing data sources were gathered to evaluate available services, needs, and information gaps. Existing data from national surveys and reports, state statistics and projections and administrative data from local and regional programs served as the foundation. These were supplemented with interviews and focus groups conducted throughout the state. These qualitative data sources were chosen to augment the existing administrative data and to provide information about long-term care services that were needed, but not available and to obtain a better understanding of service use and needs than could be obtained from quantitative data. The focus groups and key informant interviews included a variety of stakeholders including long-term care providers, policy makers, and caregivers.

National Data

Existing national data sources were utilized to obtain information about the demographic characteristics of Idaho's aging and disabled population. The 2000 U.S. Census and the 2005 American Community Survey were the primary sources of population data for this assessment. The 2000 U.S. Census files included in this report were Summary File 1 (SF1) and Summary File 3 (SF3). Summary File 1 contains 100% of housing units and contains demographic questions. Summary File 3 utilized a smaller sample of individuals and housing units and contains more in-depth information about U.S. citizens such as grandparents raising grandchildren, disability, and housing information. To augment the 2000 Census data, the 2005 American Community Survey (ACS) was used for additional state level data. The ACS provided population estimates based on a smaller sample of current residents. Although some of the data in the American Community Survey did not provide information on a county level due to small population size, it was included to provide a more up-to-date assessment of Idaho's population in the more urban areas of the state. Additional population data was obtained from Woods & Poole Economics to provide population projections and estimates based from the 2000 U.S. Census data.

Administrative Data

Administrative data were used to obtain information about long-term care services in Idaho. This data was derived from a variety of sources to include the aging and disability community and publicly available information from the Idaho Department of Health and Welfare.

Statewide information was obtained primarily from surveys fielded by each Area Agency on Aging (AAA) in 2005. In early 2005, each AAA region surveyed program participants to determine the needs of the elderly in Idaho. A convenience sample of 3,998 individuals was surveyed throughout the state. Most often respondents were selected because they participated in a program provided by the AAA. In addition to the participant surveys, community leaders defined as government employees, health care providers, community clubs/association leaders,

business leaders, and education/school employees were also surveyed. A smaller sample was collected from each area resulting in a total of 459 community leaders statewide. The sample of community leaders was obtained differently in each area.

Disability data was obtained from the State Independent Living Council (SILC) survey conducted in late 2004 and early 2005. This survey utilized a random digit dialing methodology to capture individuals with a disability as defined by Americans with Disabilities Act (ADA) guidelines.

Publicly available information and administrative data about long-term care services was obtained from state and national sources. State sources included the Idaho Department of Health and Welfare (IDHW), the Idaho Commission on Aging (ICOA) and the Idaho Department of Insurance (IDOI). Documents from these entities were retrieved from websites and personal communications with agency employees. Information obtained from these sources included annual reports, public listings of services, and general information about the availability of services. Nationally available data from Medicare's search engine Nursing Home Compare was also utilized for this report.

In Idaho, there were two different methods used to characterize regional data. Within this report, the seven Idaho Health Districts used by the IDHW and the six service areas used by the ICOA were used. Regional maps are included in Appendix B and C and are referred to within the report as to whether region or areas are used.

Qualitative Data

The national and administrative data was supplemented with qualitative focus groups and interviews of key providers, coordinators, and caregivers in Idaho. These focus groups and key informant interviews were conducted to augment currently existing information and provide a depth of information not available in national or administrative data. All focus groups and interviews were tape recorded and transcribed for analyses. Identifible information about participants was omitted and transcripts were housed in a secure location. The focus groups and key informant interviews had four main purposes:

1) propose additional sources of data,
2) comment on the estimates of services and need compiled from administrative data,
3) identify needs for which no service currently exists; and
4) discuss to the extent which existing services are available, accessible, and appropriate.

Focus groups were conducted with those service providers, coordinators, and family caregivers who serve the aging population throughout the state. Specifically, these focus groups were conducted with local nurses, Area Agency on Aging staff in different regions, case managers, hospital discharge planners, Department of Health and Welfare staff, and informal caregivers. A total of four focus groups were conducted with 8 to 10 participants in each session. Three focus groups were conducted in person and one focus group was conducted via telephone conference in order to have representation from the entire state.

Key informant interviews were conducted with professionals who work with or provide services to aging and/or disabled populations. Names of the staff persons holding these positions were publically available on their organizations' websites and in directories of employees. Interviews lasted between 1 and 1.5 hours.

Human Subjects

Prior to data collection, approval for the study was received from the Institutional Review Board (IRB), approval #680-05-087, of Boise State University, which is the federally mandated mechanism used to protect human subjects in research.

Demographic Characteristics of Idaho's Aging Population

The demographic characteristics of Idaho residents are displayed in Table 1. Percentages are displayed for Idahoans over the age of 60 and 65. These age categories were chosen since these ages are used to determine eligibility of many long-term care programs.

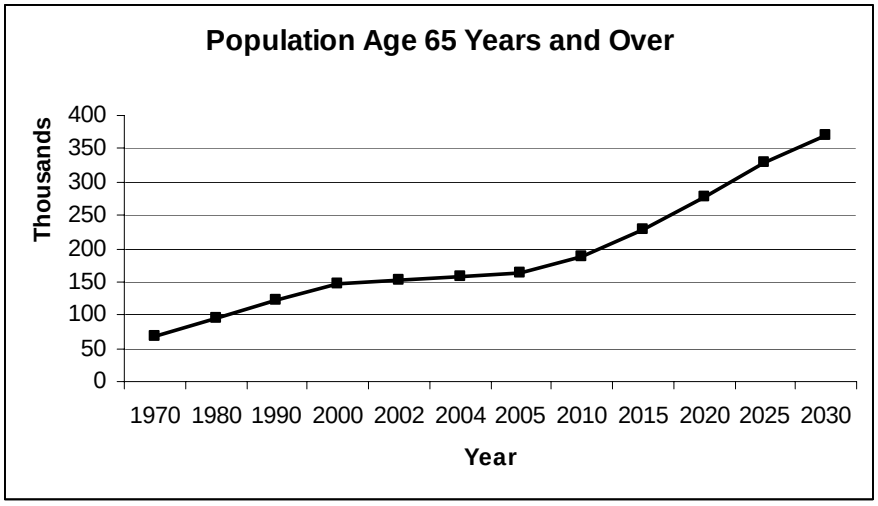
Table 1: Demographic Characteristics

		60+	65+
		218,573	**156,720**
Characteristic		**%**	**%**
Gender			
	Male	46.9	45.6
	Female	53.1	54.4
Race/Ethnicity			
	White	96.6	96.9
	Black	.1	.1
	American Indian and Alaska Native	.7	.7
	Asian	.9	.9
	Hispanic or Latino origin (any race)	2.1	2.1
Marital Status			
	Married	65.8	62.7
	Widowed	20.0	25.5
	Divorced	11.5	9.5
	Separated	0.8	.6
	Never Married	1.9	1.8
Educational Attainment			
	Less than High School	18.9	20.9
	High School Graduate (GED)	35.7	37.4
	Some College or Associates Degree	26.9	25.3
	Bachelor's or higher	18.5	16.4
Poverty Status			
	Below 100 percent of the poverty level	8.3	8.5
	100 to 149 percent of the poverty level	10.7	12.1
	At or above 150 percent of the poverty level	81.0	79.4
Housing			
	Owner-occupied	84.9	84.9
	Renter-occupied	15.1	15.1
Household			
	Living alone	37.6	40.6

Source: U.S. Census Bureau, 2005 American Community Survey S0103 and S0102

The population in Idaho is projected to increase by 52% in 2030 while the population over 65 will increase 147%. The U.S. Census Bureau projects by 2030 the number of adults age 65 and older will increase from 145,916 (11.3% of total population) to 361,033 (18.3% of total population). Similarly, Woods & Poole Economics, a research group that specializes in long-term county economic and demographic projections, estimates the population over age 65 in Idaho will increase to 371,350 by 2030 (Woods & Poole Economics, 2005) (See Figure 1).

Figure 1: Population of Idaho 1970 to 2030



Source: Woods & Poole Economics (2005)

There were 145,916 (11.3%) citizens over the age 65 in Idaho in 2000. Idaho counties vary widely in the percentage of individuals over the age of 65 within county boundaries. The following counties had the largest percentage of adults age 65 and older in Idaho: Adams (16.14%), Idaho (17.05%), Lemhi (16.76%), Nez Perce (16.51%), Shoshone (17.43%), and Washington (17.67%) counties. In contrast, Blaine (7.80%), Elmore (7.14%), Madison (6.04%), and Teton (7.47%) counties had the smallest percentage of adults age 65 and older in Idaho (U.S. Census Bureau, 2000a).

Table 2 displays the percent of the Idaho population over the age of 65 by county[1].

[1] Information was obtained from the 2000 U.S. Census due to the limitations of the 2005 American Community Survey providing data for rural Idaho.

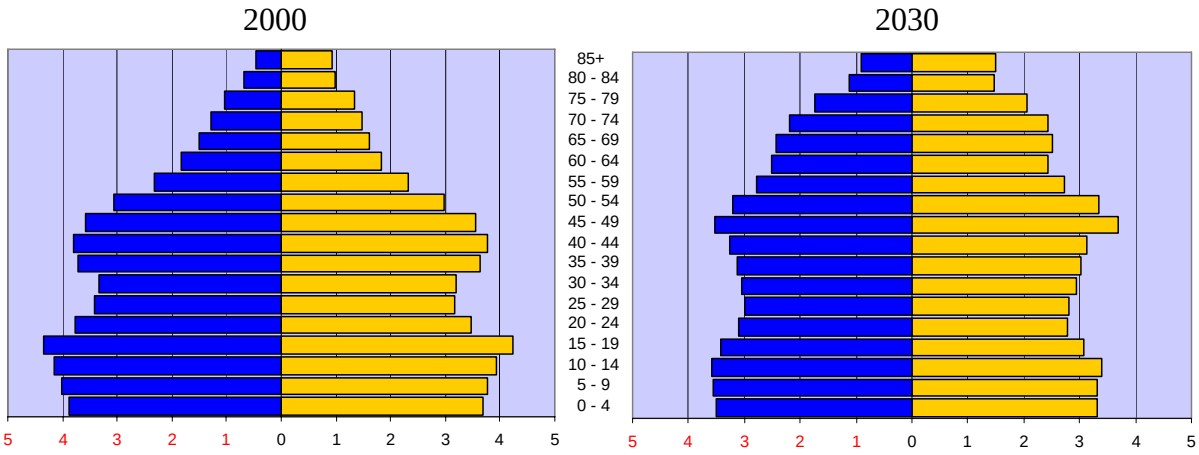
Table 2: Percent of Total Idaho Population 65+

	Total population	Population 65+	% 65+	z score %65
Ada County	300,904	27,301	9.07%	-1.2249
Adams County	3,476	561	16.14%	1.06551
Bannock County	75,565	7,662	10.14%	-0.87917
Bear Lake County	6,411	997	15.55%	0.87497
Benewah County	9,171	1,305	14.23%	0.44654
Bingham County	41,735	4,318	10.35%	-0.8122
Blaine County	18,991	1,482	7.80%	-1.63632
Boise County	6,670	732	10.97%	-0.60855
Bonner County	36,835	4,835	13.13%	0.08885
Bonneville County	82,522	8,398	10.18%	-0.86716
Boundary County	9,871	1,321	13.38%	0.172
Butte County	2,899	433	14.94%	0.67556
Camas County	991	129	13.02%	0.05354
Canyon County	131,441	14,461	11.00%	-0.59968
Caribou County	7,304	994	13.61%	0.24537
Cassia County	21,416	2,730	12.75%	-0.03388
Clark County	1,022	94	9.20%	-1.18449
Clearwater County	8,930	1,393	15.60%	0.89044
Custer County	4,342	630	14.51%	0.53724
Elmore County	29,130	2,079	7.14%	-1.85243
Franklin County	11,329	1,321	11.66%	-0.38625
Fremont County	11,819	1,469	12.43%	-0.13706
Gem County	15,181	2,374	15.64%	0.90303
Gooding County	14,155	2,178	15.39%	0.82162
Idaho County	15,511	2,644	17.05%	1.35941
Jefferson County	19,155	1,775	9.27%	-1.16217
Jerome County	18,342	2,251	12.27%	-0.18787
Kootenai County	108,685	13,345	12.28%	-0.18585
Latah County	34,935	3,312	9.48%	-1.09282
Lemhi County	7,806	1,308	16.76%	1.26554
Lewis County	3,747	693	18.49%	1.82903
Lincoln County	4,044	528	13.06%	0.06625
Madison County	27,467	1,659	6.04%	-2.208
Minidoka County	20,174	2,658	13.18%	0.10482
Nez Perce County	37,410	6,175	16.51%	1.18448
Oneida County	4,125	655	15.88%	0.98109
Owyhee County	10,644	1293	12.15%	-0.22829
Payette County	20,578	2723	13.23%	0.12336
Power County	7,538	783	10.39%	-0.79887
Shoshone County	13,771	2400	17.43%	1.48322
Teton County	5,999	448	7.47%	-1.74516
Twin Falls County	64,284	9172	14.27%	0.45896
Valley County	7,651	1134	14.82%	0.63842
Washington County	9,977	1763	17.67%	1.56189

Source: 2000 U.S. Census (SF 1)

Figure 2 illustrates how the population in Idaho will change between the years 2000 and 2030. The U.S. Census Bureau projects in Idaho the population will increase in residents over the age of 60 while the younger population will remain fairly steady.

Figure 2: Idaho Population Structure



Source: U.S. Census Bureau, Interim State Population Projections (2005)

The dependency ratio is a factor to consider in the demographics of the population. The dependency ratio is a measure of the proportion of a population which is composed of dependents or those to old or too young to work. It is a ratio of individuals less than age 15 and older than 64 divided by the individuals age 15-64. While not a perfect measure of the population structure, this ratio does provide information about the make up of Idaho's growing senior population. Overall for the entire state, the old age dependency ratio (the ratio of those aged 65 and older to those aged 15-64) was 17.27. This indicates there were approximately 17 people over the age 65 for every 100 people ages 15 to 64 in 2000. However, there were differences across the state. Lewis (30.21), Shoshone (27.28), and Washington (29.48) counties have the highest old age dependency ratio. Blaine (10.79), Elmore (10.31), Madison (8.29), and Teton (11.28) counties had a lower old age dependency ratio. Table 3 details the old age dependency ratios by county.

Table 3: Old Age Dependency Ratio

	Total population	Population 65+	Population 15-64	Old Age Dependency Ratio	z score
Ada County	300,904	27,301	205,137	13.31	-1.31025
Adams County	3,476	561	2,254	24.89	0.87901
Bannock County	75,565	7,662	50,432	15.19	-0.95407
Bear Lake County	6,411	997	3,789	26.31	1.14821
Benewah County	9,171	1,305	5,871	22.23	0.37592
Bingham County	41,735	4,318	25,647	16.84	-0.64336
Blaine County	18,991	1,482	13,730	10.79	-1.78566
Boise County	6,670	732	4,512	16.22	-0.75922
Bonner County	36,835	4,835	24,463	19.76	-0.08977
Bonneville County	82,522	8,398	52,528	15.99	-0.80379
Boundary County	9,871	1,321	6,256	21.12	0.16567
Butte County	2,899	433	1,779	24.34	0.77512
Camas County	991	129	673	19.17	-0.20257
Canyon County	131,441	14,461	82,748	17.48	-0.52243
Caribou County	7,304	994	4,481	22.18	0.36735
Cassia County	21,416	2,730	12,758	21.40	0.21909
Clark County	1,022	94	638	14.73	-1.04088
Clearwater County	8,930	1,393	5,922	23.52	0.62066
Custer County	4,342	630	2,823	22.32	0.39271
Elmore County	29,130	2,079	20,172	10.31	-1.87783
Franklin County	11,329	1,321	6,549	20.17	-0.01293
Fremont County	11,819	1,469	7,296	20.13	-0.01987
Gem County	15,181	2,374	9,350	25.39	0.97378
Gooding County	14,155	2,178	8,592	25.35	0.96599
Idaho County	15,511	2,644	9,848	26.85	1.24936
Jefferson County	19,155	1,775	11,718	15.15	-0.96259
Jerome County	18,342	2,251	11,382	19.78	-0.08745
Kootenai County	108,685	13,345	71,039	18.79	-0.27487
Latah County	34,935	3,312	25,827	12.82	-1.40191
Lemhi County	7,806	1,308	4,917	26.60	1.20276
Lewis County	3,747	693	2,294	30.21	1.88478
Lincoln County	4,044	528	2,493	21.18	0.17769
Madison County	27,467	1,659	20,004	8.29	-2.25839
Minidoka County	20,174	2,658	12,381	21.47	0.23234
Nez Perce County	37,410	6,175	23,967	25.76	1.04453
Oneida County	4,125	655	2,451	26.72	1.22586
Owyhee County	10,644	1,293	6,556	19.72	-0.09774
Payette County	20,578	2,723	12,667	21.50	0.23771
Power County	7,538	783	4,674	16.75	-0.65924
Shoshone County	13,771	2,400	8,799	27.28	1.33022
Teton County	5,999	448	3,972	11.28	-1.69396
Twin Falls County	64,284	9,172	40,531	22.63	0.45186
Valley County,	7,651	1,134	5,130	22.11	0.35274
Washington County	9,977	1,763	5,980	29.48	1.74722
Total	1,293,953	145,916	845,030	17.27	-0.56182

Source: 2000 U.S. Census (SF 1)

The population structure of Idaho from 1990 to the 2004 projections is described in Table 4.

Table 4: Idaho's Population Structure

	1990	2000	2004
Under 15 years	260,422	303,007	308,554
Working age (15-64)	625,062	845,030	900,881
Above working age (65+)	121,265	145,916	150,717
Total Population	1,006,749	1,293, 953	1,360,152

Sources: U.S. Census Bureau (1990; , 2000a; , 2004)

Health Characteristics

Table 5 describes the top ten leading causes of death for Idahoans over the age of 55.

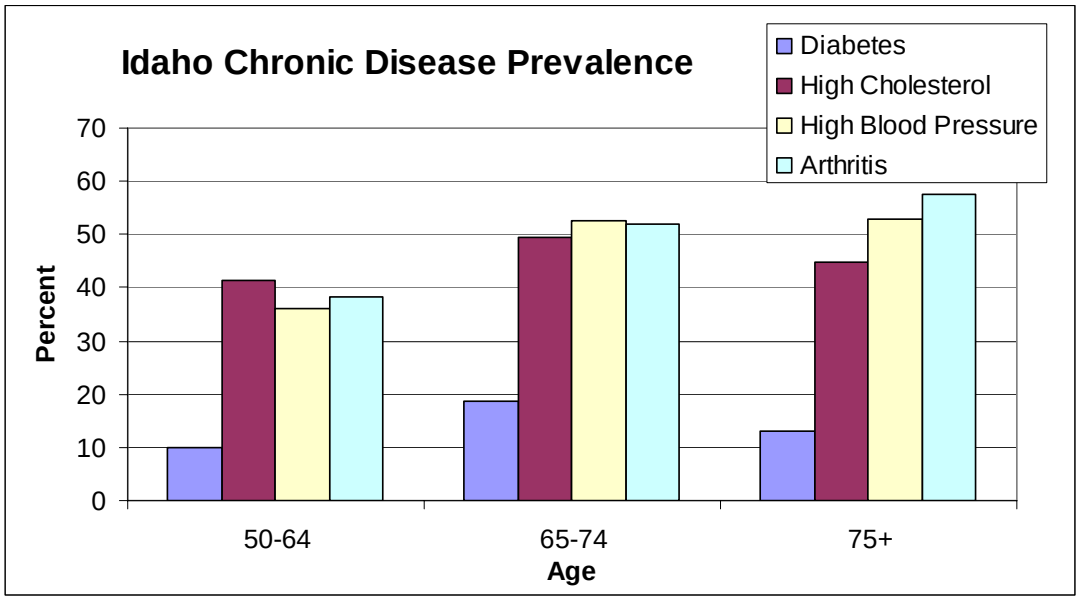
Table 5: Leading Causes of Death

	55-64	65-74	75+
Rank			
1	Malignant neoplasms	Malignant neoplasms	Disease of the heart
2	Heart disease	Heart disease	Malignant neoplasms
3	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Cerebrovascular disease
4	Accidents	Cerebrovascular disease	Chronic lower respiratory diseases
5	Cerebrovascular diseases	Diabetes Mellitus	Alzheimer's disease
6	Chronic liver disease	Accidents	Influenza and pneumonia
7	Intentional self harm	Influenza and pneumonia	Diabetes mellitus
8	Diabetes Mellitus	Alzheimer's disease	Accidents
9	Influenza and pneumonia	Chronic liver disease and cirrhosis	Parkinson's disease
10	Septicemia	Aortic aneurysm and dissection	Nephritis, nephritic syndrome, nephrosis

Source: Idaho Department of Health and Welfare Bureau of Health Policy and Vital Statistics (2007)

In addition to the various leading causes of death, many Idahoans suffer from chronic diseases for many years before death. These diseases, such as diabetes, arthritis and high blood pressure can dramatically affect the quality of life for many older adults. Figure 3 illustrates the percent of Idahoans at various ages over 50 that were afflicted by these conditions in 2004. Almost 50% of Idahoans age 65-74 had arthritis, high blood pressure and high cholesterol.

Figure 3: Chronic Disease Prevalence in Idaho

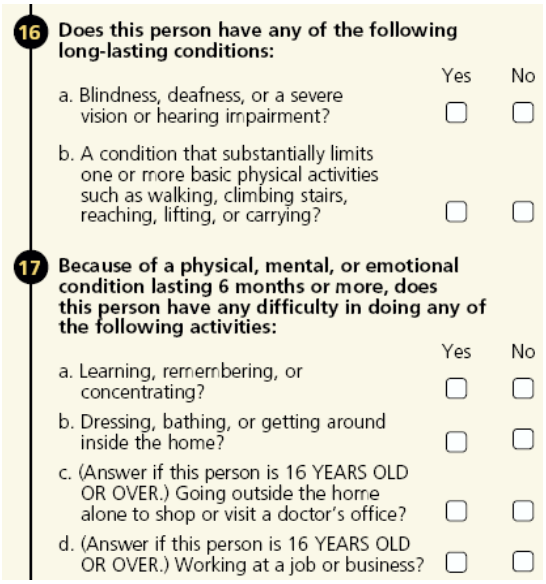


* The data for arthritis, high cholesterol and high blood pressure are for 2003 and the diabetes data is for 2004. Source: Idaho Department of Health and Welfare Bureau of Health Policy and Vital Statistics (2006)

Disability in Idaho

Disability in Idaho from the United States Census

The U.S. Census includes six questions inquiring about disability status. Included were questions about the following: sensory disability, physical disability, mental disability, self-care disability, and whether an individual was able to go outside home alone for routine events such as grocery shopping or doctor's visits.



16 **Does this person have any of the following long-lasting conditions:**

	Yes	No
a. Blindness, deafness, or a severe vision or hearing impairment?	☐	☐
b. A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying?	☐	☐

17 **Because of a physical, mental, or emotional condition lasting 6 months or more, does this person have any difficulty in doing any of the following activities:**

	Yes	No
a. Learning, remembering, or concentrating?	☐	☐
b. Dressing, bathing, or getting around inside the home?	☐	☐
c. (Answer if this person is 16 YEARS OLD OR OVER.) Going outside the home alone to shop or visit a doctor's office?	☐	☐
d. (Answer if this person is 16 YEARS OLD OR OVER.) Working at a job or business?	☐	☐

Source: U.S. Census Bureau, American Community Survey Questionnaire

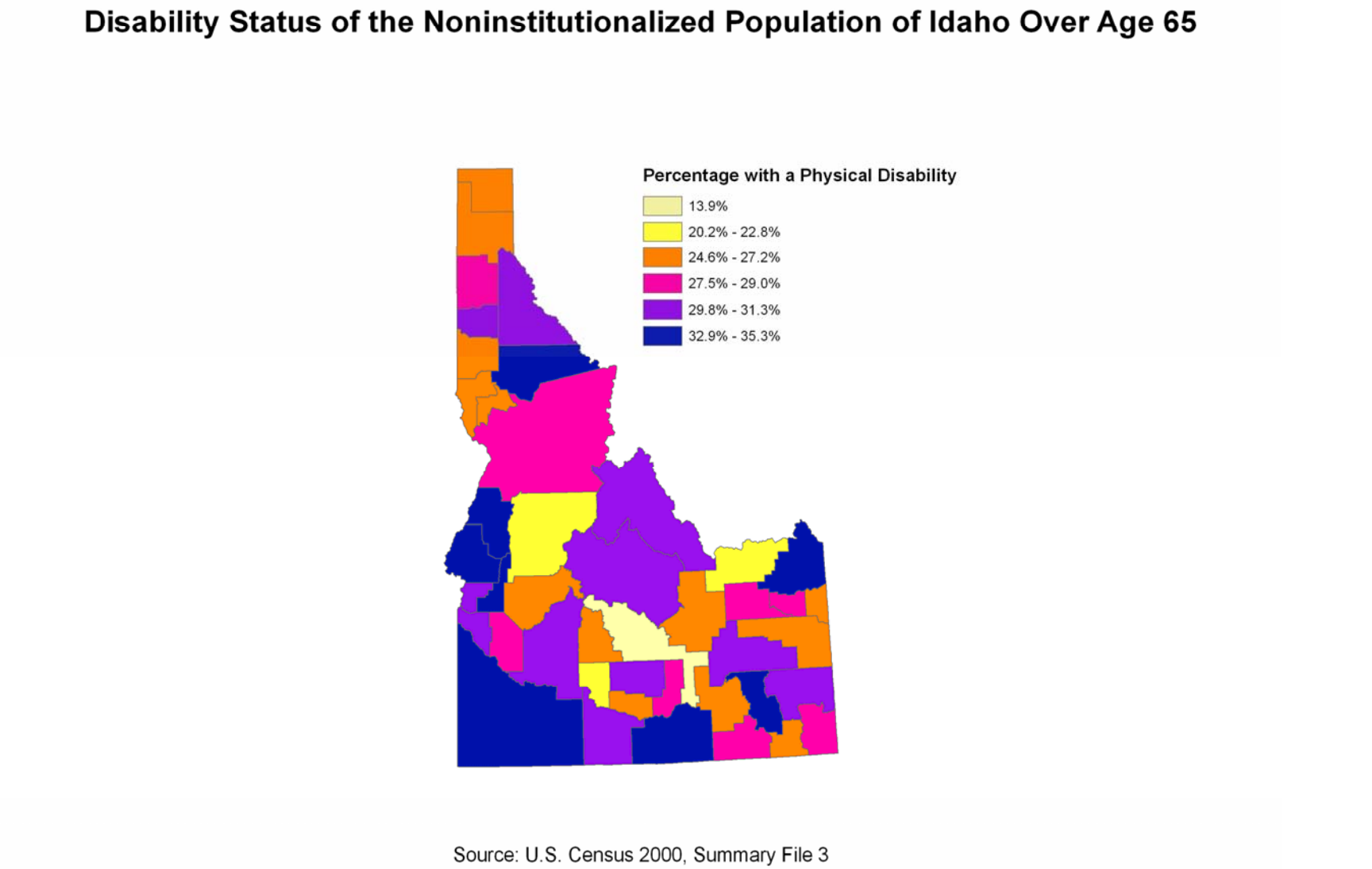
In 2004, 46% of both women and men in Idaho over 65 in Idaho reported having a disability (U.S. Census Bureau, 2004). Separately, 43% of women and 42% of men reported having a disability in the 2000 U.S. Census. A total of 20.7% of men and women reported two or more disabilities and more women have two or more disabilities (58%) than men (42%) (U.S. Census Bureau, 2000b). Figure 4 illustrates the percent of physical disabilities by county. Maps illustrating four other types of disability status (self-care, go outside, mental and sensory disabilities) by Idaho county are included in Appendix D.

Assessment of Idahoans with Disabilities

In order to better understand aging with disabilities, the Assessment of Idahoans with Disabilities, sponsored by the State Independent Living Counsel, was examined. The Assessment randomly surveyed 1,533 households in Idaho to ask questions about disability. Within the sample 13.2% (n=161) were age 65 or older and reported having at least one disability. The average age of respondents over age 65 was 74.6 (sd=6.7). Other characteristics of survey respondents included the following: over half (56.5%) were female; most (77.6%) were retired; most (69.8%) had Medicare coverage; and 5% reported Medicaid coverage. The majority (64.4%) of respondents reported living very independently.

The study asked specific questions regarding the number of disabilities and types of disabilities of respondents. Most respondents (42.2%) reported having one disability. The number of disabilities reported by respondents ranged from 1 to 6. Most frequent disabilities reported include: difficulty walking (47.8%), vision difficulties (23.6%), difficulty hearing (43.1%), chronic heart disease, chronic obstructive pulmonary disease or emphysema (38.4%), and mental illness (17.4%). Of those with disabilities, 39.7% reported they did not have personal assistance services available that allowed them to take care of their needs and 16.2% reported they did not have the ability to choose the services and support they want to receive. In addition, 37.3% (n=60) reported using assistive technology to assist them in their daily activities. Most frequently reported equipment used include: hearing aids or devices (36.7%) and walkers, wheelchairs, scooters, lifts that help with mobility (30.0%).

Figure 4: Physical Disability Status



Paying for Long-Term Care

Long-term care services are financed through Medicaid, long-term care insurance policies, and with individual private funds. Traditional health insurance does not pay for long-term care services. Although Medicare provides limited skilled nursing home and home health benefits to enrollees with a qualifying hospital stay, Medicaid provides funding for most of long-term care services. In addition to Medicaid, the ICOA provided long-term care services to an average of over 25,000 people age 60 and above per month from July 2006 – June 2007. Those services included such programs as congregate and home delivered meals, transportation, public information, ombudsman and adult protection (Idaho Commission on Aging, 2008b).

In Idaho, a substantial amount of long-term care services were provided through the traditional Medicaid system and through the Aging and Disabled Waiver. These expenditures paid for such services as nursing home care and community based care for qualified recipients. The elderly constitute 7% of the Medicaid enrollees, but accounted for 21% of the expenditures which totaled $127 million in SFY 2005. In 2005, there were 12,813 elderly and 19,083 adults with disabilities enrolled in Medicaid. The Aged and Disabled Waiver provided community based services to 4,141 individuals (Idaho Department of Health and Welfare, 2006a). Medicaid reimbursement rates for free-standing skilled nursing facilities ranged from $105.08 to $188.76 with an average daily rate of $140.47. Medicaid reimbursement rates for hospital-based skilled nursing facilities were higher than free-standing facilities. The total daily rates ranged from $149.24 to $216.50 with an average daily rate of $180.45 (personal communication, R. Vande Merwe, Idaho Health Care Association, December 7, 2006).

Long-term care insurance is one option available to Idaho citizens to pay for long-term care services. There were approximately fifty companies licensed to sell long-term care policies in Idaho. The actual number of companies currently writing policies varies from month to month. As of December 2006, 932 state employees, retirees and family members were enrolled in the long-term care insurance program provided through the State of Idaho. Only 2.8% of the 25,066 state employees were enrolled as of December 2006 (personal communication, C. Ness, Idaho Department of Administration, December 19, 2006). Despite the low numbers of enrollment in the state program, the Senior Health Insurance Benefits Advisors (SHIBA) program, which answers questions about various types of long-term care insurance programs, received an increasing number of calls. In 2005, SHIBA received 70 calls and in 2006 they received 414 calls (personal communication, G. Hamilton, Idaho Department of Insurance, December 19, 2006).

According to information provided by the Office of Group Insurance in the Idaho Department of Administration, 706 state employees were enrolled with an average monthly premium of $56.50. The premiums, which were based on individual characteristics, ranged from and average of $22.88 to $129.44 per month (personal communication, C. Ness, Idaho Department of Administration, December 19, 2006). As of December 2006, AETNA was the long-term care insurance provider for the State of Idaho.

Table 6 provides a breakdown of the long-term care insurance enrollees in the AETNA plan in Idaho.

Table 6: State Long-Term Care Enrollees

Member Type	Number of Enrolled	Average Monthly Premium
Employees	706	$56.50
Spouses of Employees	153	$55.00
Retirees	36	$129.44
Spouse of Retiree	16	$79.22
Parents	3	$96.15
Adult Children	14	$22.88
Siblings	4	$39.92
TOTAL	932	$68.44

Source: Idaho Department of Insurance (2006)

The Idaho Long-Term Care Partnership Program allows purchasers of long-term care insurance polices with a partnership clause to buy a private long-term care insurance policy that cannot be included in the calculation of assets by Medicaid should they need Medicaid coverage in the future. As of November 2006, 252 policies that work with the partnership program were sold (Idaho Department of Health and Welfare, 2007e). Ten companies in Idaho offer these partnership policies (Idaho Department of Insurance, 2007). Detailed information about these policies was not available.

Reverse mortgages are another way for individuals to finance their long-term care needs but without having to sell their home. Reverse mortgages are home loans for individuals age 62 and older and based on the value of a home. The borrower must live in the home and if the borrower moves or the home is sold, the loan must be repaid with interest. The loans can be paid as a lump sum, regular monthly advances, a line of credit or a combination. Despite the increasing availability of reverse mortgages starting in the 1990's, it is estimated that nationally only about 1% of eligible homeowners have a reverse mortgage (Redfoot, Scholen, & Brown, 2007). There was no information on a statewide basis for the use of reverse mortgages in Idaho.

Long-Term Care Services

Medicaid Spending on Long-Term Care Services[2]

Clients using long-term care services and receiving assistance from Medicaid in Idaho totaled 15,545 in 2006. There was approximately an equal distribution of clients younger and older than 65 years of age; however, more per client was spent on younger disabled clients receiving long-term care services (See Table 7). This includes nursing homes, residential assisted living facilities, Aging and Disability waiver, Developmentally Disabled/Idaho State School Hospital (DD/ISSH) waiver, personal care services, and Intermediate Care Facility/Mental Retardation (ICF/MR) facilities.

Table 7: Idaho Medicaid Long-Term Care Spending in 2006 by Age

	<65	**65+**
Total Spent	$173,998,234.67	$169,546,888.15
Total Number of Unduplicated Clients	7,710	7,835
Average Spent per Client	$22,567.86	$21,639.68

Source: Idaho Department of Health and Welfare (2007c)

Nursing Facilities

In Idaho there were 78 nursing facilities with 6,069 beds as of January 2008. Of the 78 Idaho nursing homes, capacity ranges from less than 50 beds to over 100 beds. Eighteen of Idaho's 78 nursing homes were located within a hospital. The distribution of nursing home beds throughout the state show that urbanized areas contain half of Idaho's nursing homes while the remaining nursing homes were located in rural areas.

In 2006 the largest concentration of nursing home residents were in Health Districts 3 and 4 (southwestern Idaho) with 817 and 1,011 clients, respectively. A majority of the total money spent on nursing homes by Medicaid for clients over the age of 65 is ($110 million vs. $25 million). In total, 116 clients received out-of-state nursing home services, but are paid for through Medicaid funds, resulting in $3 million dollars worth of payments to out-of-state providers in 2006 (Idaho Department of Health and Welfare, 2007c). Table 8 details the nursing home payments by age and region.

[2] The following information broken out by district uses the seven Health District regions in the map in Appendix B.

Table 8: Nursing Homes by Idaho Health District

	Nursing Facility		
Clients	**Age <65**	**65+**	**Total**
District 1	151	569	716
District 2	85	488	570
District 3	147	678	817
District 4	201	817	1011
District 5	195	575	763
District 6	105	430	532
District 7	86	316	399
Out of State	20	96	116
TOTAL[3]	990	3,969	4,924
Unduplicated TOTAL[4]	932	3,856	4,751
Paid			
District 1	$ 4,009,100.64	$ 15,240,853.99	$ 19,249,954.63
District 2	1,861,947.24	13,457,679.04	15,319,626.28
District 3	2,846,286.65	17,301,397.19	20,147,683.84
District 4	5,519,837.99	21,531,070.46	27,050,908.45
District 5	5,932,077.14	16,871,675.50	22,803,752.64
District 6	3,069,983.46	14,916,278.54	17,986,262.00
District 7	1,949,100.48	8,481,777.37	10,430,877.85
Out of State	377,068.74	2,737,239.39	3,114,308.13
TOTAL	$ 25,565,402.34	$110,537,971.48	$ 136,103,373.82

Source: Idaho Department of Health and Welfare (2007c)

[3] The total number of clients represents a duplicated count of clients. Clients may have received services in more than one county and be counted more than once.

[4] The unduplicated total is an adjusted count of clients in each county to account for individuals who receive services in more than one county thus resulting in a duplicated count. If services were rendered in more than one county for a client the total client count would be inflated. This adjusted count ensures that all clients are only counted once.

In 2006, the largest concentration of ICF/MR facilities was in District 4 with 169 clients. A majority of the total money spent by Medicaid was for clients younger than 65 which totaled $33 million in 2006. Of the total money spent ($35 million) on ICF/MR facilities only $2 million was spent on clients over the age of 65 in Idaho. No money was paid to facilities out of state.

Table 9: ICF/MR Use and Payments in 2006 by Idaho Health District

	Private ICFs/MR		
Clients	**Age <65**	**65+**	**Total**
District 1	36	2	38
District 2	23	1	24
District 3	52	42	94
District 4	168	1	169
District 5	61	0	61
District 6	49	4	52
District 7	64	4	66
Out of State	0	0	0
TOTAL[5]	453	54	504
Unduplicated TOTAL[6]	442	54	493
Paid			
District 1	$ 3,086,373.47	$ 120,108.05	$ 3,206,481.52
District 2	1,960,368.00	83,162.13	2,043,530.13
District 3	3,810,816.93	1,599,804.89	5,410,621.82
District 4	12,076,946.09	39,010.24	12,115,956.33
District 5	4,401,385.83	-	4,401,385.83
District 6	3,215,551.20	199,436.17	3,414,987.37
District 7	4,636,527.59	169,993.15	4,806,520.74
Out of State	-	-	-
TOTAL	$ 33,187,969.11	$ 2,211,514.63	$ 35,399,483.74

Source: Idaho Department of Health and Welfare (2007c)

Residential Assisted Living Facilities

There were approximately 276 Residential Assisted Living Facilities (RALF) in Idaho with 7,058 beds as of January 2008. These facilities are multifamily units containing up to three homes to large apartment complexes containing up to 133 units. Thirty-seven percent were located in rural locations throughout the state. There were six counties with no RALF (Adams, Boise, Camas, Clark, Lincoln, Owyhee).

[5] The total number of clients represents a duplicated count of clients. Clients may have received services in more than one county and be counted more than once.

[6] The unduplicated total is an adjusted count of clients in each county to account for individuals who receive services in more than one county thus resulting in a duplicated count. If services were rendered in more than one county for a client the total client count would be inflated. This adjusted count ensures that all clients are only counted once.

Table 10: Adult Residential Care Facilities by Idaho Health District

Adult Residential Care			
Clients	**Age <65**	**Age 65+**	**Total**
District 1	119	295	413
District 2	85	201	282
District 3	135	312	446
District 4	280	451	724
District 5	108	256	361
District 6	235	197	428
District 7	198	267	460
Out of State	0	0	0
TOTAL[7]	1,160	1,979	3,114
Unduplicated TOTAL[8]	1,089	1,918	2,982
Paid			
District 1	$ 1,226,572.65	$ 2,347,375.26	$ 3,573,947.91
District 2	1,145,887.11	1,653,922.24	2,799,809.35
District 3	869,150.61	2,168,067.55	3,037,218.16
District 4	1,807,528.52	3,005,211.99	4,812,740.51
District 5	768,781.39	1,920,336.19	2,689,117.58
District 6	1,654,643.64	1,427,155.14	3,081,798.78
District 7	1,507,377.30	1,684,715.20	3,192,092.50
Out of State	-	-	-
TOTAL	$ 8,979,941.22	$ 14,206,783.57	$23,186,724.79

Source: Idaho Department of Health and Welfare (2007c)

Certified Family Homes

Statewide, there were 1,715 registered Certified Family Homes (CHF) and approximately 2,376 available beds as of January 2008 (Idaho Department of Health and Welfare, 2007b). Most CFH's were operated by family members who were caring for an elderly family member or a family member with special needs or disability, however, not all were run by family members. Some were run by independent community members who have opened up their home to offer this type of care (personal communication, K. Vasterling, Idaho Department of Health and Welfare, March 2007). Idaho State Administrative Code (IDAPA 16.03.19, Section 140) requires that an exception be sought to provide care for more than two people in a home. A CFH can apply to the state to be extended to serve up to four adults. A four-person CFH is subject to all state statutes that apply to two-member CFH. However, four-member CFH's are not subject to the same statutes and licenses as Residential Care Facilities or Assisted Living facilities, even though the former may also provide services for as few as three adults. A CFH must provide room and board for only the 2-4 adults it is certified to serve. However, a waiver

[7] The total number of clients represents a duplicated count of clients. Clients may have received services in more than one county and be counted more than once.

[8] The unduplicated total is an adjusted count of clients in each county to account for individuals who receive services in more than one county thus resulting in a duplicated count. If services were rendered in more than one county for a client the total client count would be inflated. This adjusted count ensures that all clients are only counted once.

can be obtained for married couples who wish to live in the same residence where one partner requires certified family home services.

It is difficult to find information on specific CFHs in Idaho in terms of advertising and availability; however, the Department of Health and Welfare has designated a contact for all state CFH services.

Table 11: Summary of Residential Long-Term Care Options

Type of LTC Service	Number of Facilities	Number of Beds	Occupancy
Nursing Homes	78	6,069	76%[9]
Residential Assisted Living Facility	276	7,058	NA
Certified Family Homes	1,715	2,376	NA

Sources: Idaho Department of Health and Welfare (2007d) and personal communication, T. Rosenthal, Idaho Department of Health and Welfare, February 6, 2008

Home Health Agencies

Home health services were provided by 58 companies in Idaho with a ratio of 15 home health aides per 1000 people over 65 in 2003. The home health aide median hourly wage in 2003 was $8.06 which ranked 42nd in the nation (Gibson, Gregory, Houser, & Fox-Grage, 2004).

Hospice

There were approximately 46 hospice agencies in Idaho. Seventeen counties in Idaho did not have hospice agencies (Idaho Department of Health and Welfare, 2008b). In fact, six adjoining counties in central Idaho (Boise, Clearwater, Custer, Idaho, Lehmi, Valley) which account for over 21,000 square miles (25% of Idaho land area) and 50,000 people, had only two hospice agencies. However, most counties without hospice were still in proximity to hospice services. For example, Shoshone and Benewah counties in North Idaho were both without a hospice agency, yet if a client in these counties was assessed to need hospice services, Idaho Health District 1 refered the client to Hospice of North Idaho.

In Idaho, state licensing is not required for hospice agencies, but state certification is necessary for agencies to bill Medicaid. Thirty-three hospice agencies in Idaho were Medicaid certified (Idaho Department of Health and Welfare, 2006b).

[9] Personal communication, R. Vande Merwe, Idaho Health Care Association, January 2, 2008

Aging and Disability Waiver

The Aging and Disability Waiver offered by Medicaid provides a variety of services to nursing home eligible clients in Idaho who also qualify financially for Medicaid services since 1999. This waiver offers the opportunity for Medicaid clients to receive services in the community instead of an institution such as a nursing home. In 2006, 10,299 clients received waiver services totaling $63 million in payments to providers. Interestingly, there were equal payments for clients under the age of 65 and those over 65.

Table 12: Aging and Disability Waiver by Idaho Health District in 2006

	A&D HCBS Waiver		
Clients	**Age <65**	**65+**	**Total**
District 1	716	949	1,644
District 2	484	604	1,068
District 3	488	743	1,220
District 4	872	1,127	1,974
District 5	875	985	1,840
District 6	636	553	1,174
District 7	463	597	1,043
Out of State	156	188	336
TOTAL[10]	4,690	5,746	10,299
Unduplicated TOTAL[11]	3,438	4,440	7,768
Paid			
District 1	$ 4,632,768.08	$ 4,520,424.48	$ 9,153,192.56
District 2	3,120,526.75	3,729,971.36	6,850,498.11
District 3	4,129,220.11	4,940,359.68	9,069,579.79
District 4	8,541,822.26	8,071,558.99	16,613,381.25
District 5	2,638,679.28	3,685,642.90	6,324,322.18
District 6	4,632,073.42	3,347,239.79	7,979,313.21
District 7	3,416,577.47	3,623,958.80	7,040,536.27
Out of State	47,559.70	57,184.26	104,743.96
TOTAL	$31,159,227.07	$31,976,340.26	$63,135,567.33

Source: Idaho Department of Health and Welfare (2007c)

[10] The total number of clients represents a duplicated count of clients. Clients may have received services in more than one county and be counted more than once.

[11] The unduplicated total is an adjusted count of clients in each county to account for individuals who receive services in more than one county thus resulting in a duplicated count. If services were rendered in more than one county for a client the total client count would be inflated. This adjusted count ensures that all clients are only counted once.

Developmentally Disabled/Idaho State School Hospital Waiver

The Developmentally Disabled / Idaho State School and Hospital (DD/ISSH) waiver provides services to those who would most likely otherwise reside in an ICF/MR facility since 1994. This self-directed program provides community-based services to clients who were Medicaid eligible. In 2006, 2,797 clients received services under this waiver program. Most of the clients served through this program were younger than 64 years of age and resulted in a total of $56 million in payments to providers.

Table 13: DD/ISSH Waiver by Idaho Health District in 2006

	DD/ISSH HCBS Waiver		
Clients	**Age <65**	**65+**	**Total**
District 1	226	1	227
District 2	288	12	300
District 3	480	34	507
District 4	624	23	644
District 5	264	2	266
District 6	273	3	276
District 7	489	11	496
Out of State	79	2	81
TOTAL[12]	2,723	88	2,797
Unduplicated TOTAL[13]	1,947	65	2,001
Paid			
District 1	$ 5,977,817.38	$ 81,803.11	$ 6,059,620.49
District 2	4,914,182.82	218,298.22	5,132,481.04
District 3	7,824,798.47	546,445.04	8,371,243.51
District 4	15,381,011.55	701,341.20	16,082,352.75
District 5	5,954,226.22	107,874.27	6,062,100.49
District 6	3,083,639.75	22,636.97	3,106,276.72
District 7	7,838,664.40	139,582.20	7,978,246.60
Out of State	3,891,135.19	97,142.98	3,988,278.17
TOTAL	$ 54,865,475.78	$ 1,915,123.99	$56,780,599.77

Source: Idaho Department of Health and Welfare (2007c)

Idaho CareLine 2-1-1

The Idaho CareLine 2-1-1 system does allow for one access point regardless of location within the state to access information about services. From July 2006 to June 2007 over 2,200 calls were made to 211 for information about services for someone over the age of 60 (Idaho Department of Health and Welfare, 2007a). It should be noted that often the 211 system may

[12] The total number of clients represents a duplicated count of clients. Clients may have received services in more than one county and be counted more than once.

[13] The unduplicated total is an adjusted count of clients in each county to account for individuals who receive services in more than one county thus resulting in a duplicated count. If services were rendered in more than one county for a client the total client count would be inflated. This adjusted count ensures that all clients are only counted once.

refer the caller to the Area Agency on Aging Information and Assistance system for further assistance about long-term care services.

Demonstration Programs

Stand By You

The Idaho Commission on Aging has received approximately $300,000 every year since 2003 from the Administration on Aging to provide support services for Alzheimer's patients and their family members (U.S. Department of Health and Human Services Administration on Aging, 2006). The Stand By You program provides family advisor, respite (paid and volunteer), counseling, a nine-week training, and family orientation services to early-diagnosed Alzheimer's patients.

Aging Connections

The Idaho Department of Health and Welfare in partnership with the Idaho Commission on Aging and the Area Agency on Aging in North Idaho received $800,000 in grant funding in 2006, from the Administration on Aging and the Centers for Medicare and Medicaid Services, to establish an Aging and Disability Resource Center (ADRC) called Aging Connections. The purpose of this demonstration project established in 43 states nationwide is to "… serve as integrated points of entry into the long-term care system, commonly referred to as a "one stop shops", and are designed to address many of the frustrations consumers and their families experience when trying to access needed information, services, and supports" (The Lewin Group, 2006, pp. ES-1). All ADRC's are expected to serve not only older adults, but younger populations with disabilities to integrate both aging and disability services for all individuals needing long-term care (The Lewin Group, 2006).

Aging Connections opened in October 2006 and currently serves Health and Welfare Region 1 which includes Benewah, Bonner, Boundary, Kootenai, and Shoshone counties. The population served by the three operating resource centers is people over the age of 60, older adults with disabilities, caregivers, and service providers. As of July 2007, the Idaho Department of Health and Welfare reported that 248 individuals have received services with 217 referrals made to long-term care services (2007e).

Services provided by the Area Agencies on Aging[14]

The flexibility afforded to all Area Agencies on Aging (AAA) allows each region to tailor services to the clientele in each service area. While basic services were generally provided throughout the state several exceptions were apparent. The basic categories of long-term care services provided to community-based older persons in Idaho included In-Home Services, Case Management, Support Services, Nutrition Services, and Caregiver Support. These services were available to community dwelling persons in the greatest economic or social need within the state of Idaho. Additional services provided by the AAA include ombudsman, adult protection, legal services and information and assistance services. The availability of services was determined by the examination of Area Plans and budget tracking information submitted by each AAA to the Idaho Commission on Aging (ICOA). Older Americans Act programs administered by the AAA

[14] The following information broken out by areas uses the six areas in the map in Appendix C.

served approximately 22,605 clients in 2005, or 9.9% of the population over the age of 60 in Idaho (Administration on Aging, 2005).

In-Home Services

In-home services provided with Older American Act funds include case management, chore, homemaker, and respite services. These services provided assistance to delay or prevent the entry into institutional long-term care services. The services were provided through contractual agreements between the local AAA and providers throughout the state.

Case Management services were intended to coordinate and assist clients to access long-term care services. From July 2004 to June 2005, 29,691 hours of service were provided to 6,730 clients across Idaho by the AAA. A waiting list did exist in multiple areas for this service and in some regions the waiting list was longer than three months. Area I reported a waiting list of 68 people.

Homemaker services were offered to assist clients with basic home care services such as cooking, light cleaning, and laundry. The homemaker programs served 2,106 clients with 108,458 hours of service from July 2004 to June 2005. There were waiting lists for these services in most areas of the state for these services. Funding from client fees/donations supplied the budget for these services. Federal funds did not cover the cost of providing these services. Area I listed homemaker services as a "great need" and noted a waiting list. Conversely, Area VI had a small waiting list for these services.

Chore services include heavy housework, yard maintenance, sidewalk maintenance, and other household maintenance that an older person has difficulty completing. Chore services were only available in Area III and funded by fees/donations and other non-federal monies. In 2008, Area III was unable to offer chore services because of greater demand for other services such as homemaker services. For this reason other areas of the state were unable to provide chore services. From July 2004 to June 2005, Area III served 244 clients with 2,319 hours of services. Even though these services were not available in other areas of the state they have been requested and were needed. Area V indicated that the greatest need for chore services is in the springtime.

Respite care was provided in most areas of the state, but limitations of available service providers hinder using some services. The respite program served 180 clients with 18,581 hours of service from July 2004 to June 2005. These services were provided across the state and have waiting lists in some areas. However, utilization of respite services did vary by geographical area and some areas did not have frequent respite service use.

Information and Assistance

Information and Assistance (I & A) services were available across Idaho and were housed within each AAA. I & A serves as a repository of valuable information about programs offered through the AAA and other local long-term care services available in the service areas. These databases were not managed on a statewide level and therefore there was not available data that covers the entire state. Each area also utilizes different systems to handle this information from a paper-only book of services to more sophisticated computer systems in other

areas. Of those that had computerized systems, there were several different software systems for the I & A databases.

Nutrition Services

Nutrition services provided through the AAA included three types of services: home delivered meals, congregate meals, and nutrition education/counseling. In 2006, 524,745 home delivered meals and 617,655 congregate meals were served (Idaho Commission on Aging, 2007). In 2005, 5,416 nutritional education presentations were made. While the local AAA provides a large number of meals, many areas were unable to meet the needs or provide the proper amount of meals to clients enrolled in the program designed to fill nutritional gaps among older people. Some sites offered meals on a daily basis and others only offered meals once or twice a week (Idaho Commission on Aging, 2007). Many areas must supplement the cost of meals with local fundraising efforts. In 2006, waiting lists existed in Area III where they were only able to provide two meals per week. AAAs were not the sole providers of home delivered meals. Medicaid contracted with other entities to provide home delivered meals.

Transportation

When the Older Americans Act (Public Law 106-365) was amended in 2006, a stronger focus was placed on providing transportation services as part of the plans for home and community-based services. In addition, the Idaho Rules Governing Older Americans Act Services (IDAPA 15.01.21.23) state that each AAA "shall assure that continuing efforts are made to make transportation services available to older individuals residing within the geographical boundaries of the PSA" and where appropriate, transportation to congregate meal sites shall be made available.

All AAA provided transportation within Idaho; however, the services vary by area. Transportation, while important to ensuring the independence of older adults, often becomes a lesser priority because of limited funding and higher demand for services such as homemaker services. Most of the AAAs were able to provide transportation services by partnering with various transportation options within the region. For example, Area IV used services from RSVP's Seniors Assisting Seniors and senior centers which both utilize volunteer drivers who were reimbursed for mileage, the Trans IV's Dial a Ride and a local taxi service available 24-hours a day for a reduced rate for seniors, both available only in Twin Falls city limits (personal communication, Jim Fields, Area Agency on Aging IV, February 25, 2008). Area II used a mix of federal transportation grants in two rural counties and a public transportation provider (personal communication, Jenny Zorens, Area Agency on Aging II, February 25, 2008). Area I also used a mixture of public transportation (Valley Vista and North Idaho Community Express) (personal communication, Pearl Bouchard, Area Agency on Aging I, February 25, 2008). Details about transportation options in Area III and VI were not available.

The Pocatello area, Area V, had one of the most comprehensive transportation services to rural areas and was able to use just one provider: Pocatello Regional Transit (PRT). PRT provided service to all seven counties in the area including the rural areas. PRT is uniquely benefited by receiving a federal transportation grant each year of $500,000. In addition, the AAA for Region V dedicated approximately $50,000 of their Older Americans Act funding to PRT to provide transportation services (personal communication, Ron Binggeli, Pocatello Regional

Transit, February 26, 2008). The rates for PRT were extremely affordable, even for rural areas. The rate to travel within the 8-mile radius of any of the towns within the service area was $1 one way; any transportation outside of the 8-mile radius was $3 one way. In addition, individuals over the age of 60 were not required to pay the fee but the rate was a "suggested donation" (personal communication, Ron Binggeli, Pocatello Regional Transit, February 26, 2008).

Adult Day Care

Adult Day Care services varied by region and in certain regions were not widely used. Area I and II noted adult day care as a "great need," however, Area V stated that an adult day care program was "tried but not utilized." Area I noted the great need because it was only available in two counties of that region.

Ombudsman

The Idaho Commission on Aging implemented a volunteer Ombudsman program and from July 2006 to June 2007, 23 volunteers across the state reported 785 visits to long-term care facilities and 846 hours dedicated to the volunteer program (Idaho Commission on Aging, 2007). In addition, a 2006 report by AARP ranked Idaho first in nursing facilities visited by ombudsman at least quarterly in 2004 (Houser, Fox-Grage, & Gibson, 2006). The volunteer program has been critical for the ombudsman services offered across the state. Some areas (Area VI) were only able to provide ombudsman services and meet the needs of institutionalized adults by utilizing volunteers to perform these services. Area I and V both noted ombudsman services as a great need. Area V stated the need has increased because of the additional number of assisted living facilities. Other areas (III & IV) reported that they were able to provide these services adequately with the current level of resources.

Long-Term Care Needs

Within Idaho, the need for comprehensive long-term care services is growing larger due to the documented projected increase in the older population over the next 20 years, increases in chronic disease among the older population, and an increasing need for care for older individuals. This need is not limited to services, but also a heightened understanding of the variety of services that can be provided to individuals needing assistance with everyday activities to include caregiver support services. This lack of understanding was noted during the focus groups and one participant mentioned that "A lot of lay people or adult people out there in the world feel that long-term care means in a nursing home only."

The needs outlined below highlight service areas that may not currently meet the needs of long-term care consumers and their families. While several specific services are highlighted this may not be an all inclusive list due to the data limitations of this inventory and the availability of data about long-term care services.

Transportation

One of Idaho's greatest needs for long-term care services was rooted in the rural nature of the state and how difficult it was to both deliver and receive services over the vast miles of the state. Excluding the Pocatello area which had good access which was extremely affordable, access to affordable transportation was a consistent theme of need in most areas, and access to any transportation services was listed as a high priority. Other AAAs have worked diligently to find as many options for providing transportation as possible, but most were still not able to provide services to the rural areas.

Many transportation options when available were expensive, for example, two different services offered in the Treasure Valley ranged from $25-$35 for the overall transportation plus $2-$2.50 per mile. Funding for these transportation services was a struggle as the increase in demand for other services had created tough budgeting decisions for the AAAs. Transportation funding had been cut in some areas meaning there were even fewer options for seniors who needed access to get groceries and medications or attend doctor appointments and even the social events that can improve the lives of seniors. A focus group participant lamented that transportation funding was reduced in 2007 by the AAA in Area III despite the fact that the current funding was not meeting the transportation needs within that region.

When transportation options were available, they were not always outfitted to serve seniors with disabilities. For example, an interviewee noted that in Canyon County and Nampa, there was only one senior bus that was wheelchair equipped. Specifically transportation outside of the city to medical services can also be a problem. As noted, many areas rely upon "volunteer drivers" but with the increasing price of gas, the remuneration which often does not cover real costs was a disincentive and had made volunteer drivers harder to find.

Home-Based Care

Nearly all of the focus group participants purported the benefits of providing care in the home as long as possible. This theme was consistently conveyed from health care professionals,

service providers and caregivers. The ability to provide care as one ages in the home was an expectation voiced by focus group participants: "There is no reason somebody cannot be at home his or her entire life." However in Idaho there were a number of barriers to increasing the availability, affordability and knowledge about home care options such as the ability to afford these services using available funding streams for long-term care and being offered these types of service by their health care provider.

There was a pressing need for more affordable custodial care to ensure these clients were safe, take medications at appropriate times and avoiding injuries. While this was cited as a great need, little funding was referred to as a barrier to obtaining this type of care "[W]e find that there is a huge need for custodial care out there but there really is not the funding out there for some of these folks to access that." This type of care can cost anywhere from $15 per hour for a homemaker to $20 for a certified nurses aide (CNA) to provide respite for a caregiver, according to a health care provider. A nurse who has experience trying to help find alternatives for families to assist with long-term care said it was difficult to find a mix of services that was affordable. "[T]he cost was $17 an hour for an aide to just come in and maybe bathe them or just be with them until they get home or whatever. The cost was entirely prohibitive to have the kind of help that people needed to have their parents stay in their home," she said. As a result, these financial constraints can limit home care options for many people in Idaho.

Many of the interviewees echoed the sentiment that home care was a critical point to saving state and federal health care dollars by avoiding high cost institutional stays. Participants suggested that "I know we have a fairly large number of individuals that we support within their homes and they're successfully supported within their homes, but there are a lot of people who can't qualify for services that would need help. So they fall between…they fall through the cracks. So what happens is they go directly to the hospital or the nursing homes and then Medicare may pick them up."

And this cycle, according to numerous individuals interviewed, did not represent an isolated case. It was more common for individuals to become so frail, because they did not meet the threshold of financial criteria for state and federal assistance when minimal assistance would have extended the need for the extensive costs of more advanced long-term care.[15]

Adult Day Care

There was mixed information regarding whether there was adequate adult day care services provided across the state. In south central Idaho, the consensus among focus group participants was that this service was highly underutilized. Many consumers did not view this as a beneficial service or as a feasible option on a day-to-day basis. One barrier to utilization was described as the process of just getting someone ready to go to the adult daycare facility and transporting them. A shift in the type and availability of services within adult daycare could increase participation and utilization of this valuable service. For example, a transportation service and the assistance in getting the person ready might make the service more user friendly for informal caregivers.

[15] Medicaid services are means tested while services provided by the Idaho Commission on Aging are not necessarily based on income criteria.

Support Systems for Caregivers

The caregivers interviewed want and need support, but none were able to pinpoint the specific type of support that would be the most helpful. For some, they may need adult day care, and for others, occasional respite might be enough. One of the most concerning things for caregivers was finding good care for the person in their absence. Caregivers relayed stories of a lack of dependable caregivers. "They would write down that they were there until 4:00. You called at 3:00 and they would already be gone," said one caregiver. Not to mention that the person hired to come in each day would most likely be a different person each day so there was no consistency in the care. The issues surrounding elder abuse and exploitation were not explored in detail in this report except to note that the incidents of abuse or exploitation can make caregiving and creating a support system for caregivers even more difficult. Finding quality, reliable and trustworthy care can create an additional burden for caregivers.

There was a strong need to take care of the caregivers early on, not when they themselves become ill. Caregivers lamented the fact individuals were not eligible for Medicaid assistance until people are so ill that they have become classified as disabled, which by then, their health has suffered to the point that they would not get well again. Being a caregiver takes a heavy toll on the health and well-being of the caregiver. For example, one woman who cared for her spouse who was on dialysis died just two years after he did.

Funding

Many of the needed services had reached a crisis level because of inadequate or nonexistent funding structures in the public sector. Both providers and seniors receiving services who were interviewed did not only suggest more funding, but laid out strong arguments where the current funding should be directed and why it is needed. It was noted that services did exist statewide, but "Everything exists out there for a cost, for a price, and so, people who have the finances, there's no problem at all for them to be able to access the services, but the people who have problems are those who don't qualify for personal care in their homes and they are the ones that really need help." There were also individuals who were living month to month on very little money. Any change be it an illness or an additional medication prescribed, can mean the difference between buying food and being able to afford medication. One service provider said: "[A]s long as things are going okay, they're okay, but they truly are making it month to month and they are doing the very best they can… but when they come in and they apply for services and they've been buying $300 to $400…(in) medications and they make $560 a month…it's a pretty precarious situation."

The only answer, according to those interviewed, was not just to increase funding. While more funding will be inevitable in the task of serving more individuals, many individuals involved in long-term care services suggested that current funding streams need to be reevaluated. "I don't say that we ought to throw money at senior programs indiscriminately but obviously some of the programs, the nutrition programs, the transportation programs, homemaker programs, chore service programs, those programs need to be funded adequately so that we can go out and meet the needs of the senior and keep them out of long-term care," said one interviewee. Targeting funding in other ways rather than skilled nursing facilities to meet the needs of older adults that have minimal to moderate needs must be a part of future funding discussions in order to minimize costs.

Preventative Education Services and Education of Services Available

Another key theme was the need for preventative care, or care that addresses needs before they become so drastic that hospitalization or institutionalization is necessary. It was recommended that the focus on reducing the burden of increased state and federal funding for long-term care services might be best achieved by focusing on preventative care such as home health visits and early treatment for mental illness. "[T]he key thing is it takes very little money up front to keep somebody in their home if they just need intermittent help than it does to place them in long-term care where eventually the state will pay 100%, which is thousands of dollars…A little bit of money can go a long ways, if the state would just provide it," noted one interviewee. Several interviewees referred to a "serviceable moment," meaning providing the right type of service during a small window of opportunity. The "serviceable moment [is] when a person is right at that breaking point of where 'I can't do this anymore.' And if you can provide some relief at that time, they will carry on. If you catch them just past that serviceable moment, it doesn't matter that the service might be there; they're done."

Providing good information about available services was just as critical as catching individuals at the serviceable moment. Rules within the Medicare system prevent home healthcare agencies from advertising to the community about the types of services available for home care so providers must provide service information to doctor's offices instead, said a home healthcare provider. This means that the information about home health was most certainly limited. Further, lack of information about long-term care services can be just as much of a detriment. Misinformation received from friends and neighbors take the place of no information and create even more barriers for receiving good long-term care. "So they made choices about even trying to access services based on very poor information and so even if they aren't falling in the cracks, they are pulling themselves out of the system when they really need the services," said one service provider.

Skilled Nursing Facilities

Even though there were fewer skilled nursing facilities in the rural areas, it was also important to note that the current occupancy rate of Idaho nursing homes was only at 76% and nursing home capacity in Idaho decreases every year (personal communication, R. Vande Merwe, Idaho Health Care Association, January 3, 2008). Despite a need to ensure options within rural areas, the needs of older Idahoans who live in rural areas might be best served with services such as with a home health nurse or chore services that allow them to stay in their own homes and to receive support from caregivers. Skilled nursing facilities provide an important service for individuals with high needs, but should not be seen as the sole long-term care option.

Residential Assisted Living Facilities

Again, despite the lack of residential assisted living facilities in some rural areas, it was important to consider what other options could be considered besides large, expensive structures that are many times out of the price range for many older adults. As previously noted, less expensive and more individualized home health options could be part of the solution.

Area Agencies on Aging

An important partner in assisting individuals to find long-term care options were the Area Agencies on Aging (AAA) located in six regions throughout the state and overseen by the Idaho Commission on Aging. The AAA conducted a recent evaluation of the services provided. A Senior Needs Assessment was administered by the local Area Agencies on Aging in all six regions where program participants were surveyed to determine service use and needs of community members. Due to the sampling of respondents, many were already receiving services or are at a higher functioning level therefore did not require some of the long-term care services. The most common needed services were chore services: home repairs, light housekeeping and yard work/snow shoveling. Most of the respondents used the existing yard work/snow shoveling services but also noted the waiting lists or difficulty in obtaining this service regularly.

Table 14: Services Used and Needed by Participants Age 80+

Services Used	**Services Needed**
Friendly Visiting / Telephone Reassurance	Home Repairs
Grocery Shopping and/or Delivery	Light Housekeeping
Home Delivered Meals	Yard Work / Snow Shoveling
Light Housekeeping	
Meal Preparation	
Medication Management	
Transportation	
Yard Work / Snow Shoveling	

Community leaders also completed the AAA Needs Assessment. Most community leaders believe that their community is a good place to grow old. The majority of respondents reported the type of organization which they serve were from government and the medical/health professions. Community leaders saw the most important needs for seniors to be transportation options and ensuring seniors receive information about the services available to them.

Table 15: Community Leaders

Adequate Services	**Needed Services**
Food	Transportation
Help with errands	Information about available services
Housing Options	

Discussion

As the face of Idaho ages, the need for comprehensive long-term care services will undoubtedly increase in the near future. By broadening the definition of long-term care and increasing the public understanding about long-term care options, Idaho can successfully serve both the young and old disabled within this state. Being able to age where you want and have options with a graduation of care or spectrum of services is an attainable goal given the foundation of services outlined in this report. While this may seem like a grandiose goal, the translation and dissemination of demonstration programs and innovative models already in place is the first step. Having said this, Idaho does face many challenges in the future such as:

1) Idaho is rural state and the uniform delivery of long-term care services in each region is and will become more difficult as Idaho ages.
2) Consistency of services across the state does not exist.
3) There is a lack of systematic data collection about use of and availably of long-term care services.
4) There is little information about the preferences of Idahoans about long-term care.

Idaho is rural state and the uniform delivery of long-term care services in each region is and will become more difficult as Idaho ages.

Since Idaho is a frontier state, the availability and feasibility of service delivery is not always easy. The rural features of Idaho draw many to this state to retire and spend those years when long-term care is needed most. Several key themes were discovered in this inventory regarding the delivery of long-term care services in rural locations. Expanding the definition of long-term services in Idaho beyond the traditional placement in nursing homes is particularly important to enhance of the awareness of care alternatives in areas where these traditional services are limited.

The differences in each region should not be dismissed and while regional agencies must be able to maintain the flexibility to determine which services are most needed for a specific area population, there also must be an egalitarian approach where regions without large cities and extensive service providers still find ways to provide long-term care options needed, such as transportation services.[16]

Consistency of services across the state does not exist.

While there are several federally-funded demonstration programs active in various parts of the state accounting for some of the inconsistency in service delivery, basic long-term care services are not generally uniform across the state. This means that if an Idaho resident receives a community long-term care service in Pocatello the same service may not be available or may be different in Coeur d'Alene. This has primarily resulted from differing definitions and funding sources. Examples of this inconsistency include adult day care, information and assistance databases, nutrition services, and hospice services.

[16] This report does not address the physician or nurse shortage that can also exacerbate long-term care needs.

Adult day services differ by region in several respects. This service was not widely used across the state and in one region the service was only available in two counties. The second example of regional differences is in the format of information and assistance databases. Several AAAs compiled this database in different formats ranging from a simple Word document to more sophisticated database software program. A consumer would not necessarily have access to a catalog of services available statewide due to the regional differences in information collection.

Nutrition services vary greatly by region. Some regions offered a reduced number of meals per week which greatly affects the availability and consistency of nutritious foods to homebound older adults in Idaho.

Lastly, hospice services do not exist in 17 counties in Idaho. This leaves a large service gap for dying patients and their families. While Idaho has made many advances in end-of-life care in the past few years, the availability of services needs to improve.

There is a lack of systematic data collection the use, needs, and availability long-term care services on the state and local levels.

Idaho does not have a systematic system to catalog information about a variety of long-term care services available to consumers. An integrated system of statewide data collection could provide policymakers with information to base short and long-term planning decisions. Additionally, this type of data collection would also provide valuable information to consumers about long-term care choices. The lack of systematic data collection that covers a variety of types of services is evident in this inventory. Statewide, there appears to be a reliance on national data sources to provide information about the characteristics of people needing long-term care services. Data collection on the state and local levels about the utilization of long-term care services and of the characteristics of those needing these services should be considered a statewide priority. This collection will not only assist in better determining the needs, but will provide critical information for policymakers in determining long-term care priorities as needs increase.

Cataloging services available in Idaho would not only benefit Idaho policy makers, but will eventually enhance choices for consumers. Integration of information systems could occur on a statewide level by enhancing 2-1-1 and other data collection systems within the aging services network. Data collection should occur beyond Medicaid and Medicare paid facilities. The aging services network is guided by the Idaho Commission on Aging; however, each AAA is subcontracted and maintains their own regional system of providing service information to their clients. Additionally, Idaho has a statewide information access number 2-1-1 to distribute information about services to the public. However, the information about aging services is not available. 2-1-1 operators refer callers to the AAA Information & Assistance service. A statewide information and assistance database would not only provide uniform information on a state level, but will provide another avenue to for policymakers and service providers to assess the availability of aging services in Idaho.

There is little information about the preferences of Idahoans about long-term care.

There is an information gap about the preferences of older and disabled Idaho residents on a statewide level. While some data was made available through the Senior Needs Assessment provided by the AAA and does provides useful information about current users of senior services in Idaho, it was not able to provide information about individuals that were not associated with their local AAA or who may need but are not currently receiving services. This survey could be enhanced to include random sampling techniques of seniors throughout the state, consistent questions and answer selections, and questions pertaining to services or long-term care information. Currently, the Idaho Commission on Aging is in the process of planning another statewide needs assessment based on the information garnered from the previous needs assessment administration.

References

Administration on Aging. (2005). FY2005 Profile of State OAA Programs: Idaho. Retrieved November 15, 2007, from http://www.aoa.gov/prof/agingnet/NAPIS/SPR/2005SPR/profiles/ID.pdf

Gibson, M. J., Gregory, S. R., Houser, A. N., & Fox-Grage, W. (2004). *Across the States, Profiles of Long-Term Care: Idaho*. Washington, DC: AARP Public Policy Institute.

Houser, A., Fox-Grage, W., & Gibson, M. J. (2006). *Across the States, Profiles of Long-Term Care and Independent Living*. Washington, DC: AARP.

Idaho Commission on Aging. (2007). *Healthy Choices for a Healthier Future, Idaho Commission on Aging Annual Report*. Boise, ID: Idaho Commission on Aging.

Idaho Commission on Aging. (2008a). About ICOA. Retrieved February 27, 2008, from http://www.idahoaging.com/abouticoa/index.htm

Idaho Commission on Aging. (2008b). *Report to the Governor*. Boise, ID: Idaho Commission on Aging.

Idaho Department of Health and Welfare. (2006a). Facts/Figures/Trends 2005-2006. Retrieved December 20, 2007, from http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=4163&MId=10385&wversion=Staging

Idaho Department of Health and Welfare. (2006b). *Hospice*. Boise, ID: Idaho Department of Health and Welfare Facility Standards.

Idaho Department of Health and Welfare. (2007a). *2-1-1 Idaho CareLine Annual Report, State Fiscal Year 2007*. Retrieved January 4, 2008. from http://www.idahocareline.org/About%20211/SFY2007Annual%20Report.pdf

Idaho Department of Health and Welfare. (2007b). Certified Family Homes Master. Pocatello, ID: Idaho Department of Health and Welfare.

Idaho Department of Health and Welfare. (2007c). Long-Term Care Numbers 2006. Boise, ID: Idaho Department of Health and Welfare.

Idaho Department of Health and Welfare. (2007d). *Long Term Care/Skilled Nursing Facility Statewide Listing*. Retrieved February 7, 2008. from http://www.healthandwelfare.idaho.gov/DesktopModules/Documents/DocumentsView.aspx?tabID=0&ItemID=4274&MId=11609&wversion=Staging.

Idaho Department of Health and Welfare. (2007e). *Medicaid Initiatives -- Status Report July 2007*. Retrieved December 15, 2007. from http://healthandwelfare.idaho.gov/DesktopModules/Documents/DocumentsView.aspx?tabID=0&ItemID=6254&MId=11697&wversion=Staging.

Idaho Department of Health and Welfare. (2008a). Home Care. Retrieved February 27, 2008, from http://www.healthandwelfare.idaho.gov/site/3357/default.aspx

Idaho Department of Health and Welfare. (2008b). Hospice. Retrieved January 3, 2008, from http://www.healthandwelfare.idaho.gov/site/3628/default.aspx

Idaho Department of Health and Welfare Bureau of Health Policy and Vital Statistics. (2006, May). Senior Health Report. Retrieved December 18, 2007, from http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=4949&MId=10760&wversion=Staging

Idaho Department of Health and Welfare Bureau of Health Policy and Vital Statistics. (2007). Idaho Vital Statistics 2005. Retrieved December 20, 2007, from

http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=7360&MId=10768&wversion=Staging
Idaho Department of Insurance. (2006). Long-Term Care Insurance Numbers (pp. email communication). Boise, ID: Department of Insurance.
Idaho Department of Insurance. (2007). Long-Term Care Companies. Retrieved December 12, 2007, from www.doi.idaho.gov/company/LTC_companies.aspx
Redfoot, D. L., Scholen, K., & Brown, S. K. (2007). *Reverse Mortgages: Niche Product or Mainstream Solution?* Washington, DC: AARP.
The Lewin Group. (2006). The Aging and Disability Resource Center (ADRC) Demonstration Grant Initiative. Retrieved December 15, 2007, from http://www.adrc-tae.org/documents/InterimReport.pdf
U.S. Census Bureau. (1990). *Profile of General Demographic Characteristics: 1990, Summary File 1 (SF 1)*. Retrieved January 20, 2006. from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=DEC&_tabId=DEC2&_submenuId=datasets_1&_lang=en&_ts=217427357437.
U.S. Census Bureau. (2000a). *Profile of General Demographic Characteristics: 2000, Summary File 1 (SF 1)*. Retrieved January 20, 2006. from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=DEC&_tabId=DEC2&_submenuId=datasets_1&_lang=en&_ts=217427357437.
U.S. Census Bureau. (2000b). *U.S. Census Long Form Questionnaire*. Retrieved January 18, 2007. from http://www.census.gov/dmd/www/pdf/d02p.pdf.
U.S. Census Bureau. (2004). *Idaho General Demographic Characteristics: 2004 American Community Survey* Retrieved January 9, 2007. from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS.
U.S. Census Bureau. (2005). *Interim State Population Projections*. Retrieved November 17, 2007. from http://www.census.gov/population/www/projections/statepyramid.html.
U.S. Department of Health and Human Services Administration on Aging. (2006). Compendium of Active Grants FY 2006. Retrieved November, 2007, from http://www.aoa.gov/doingbus/comp/compendium-2006.pdf
US Code: Public Health Chapter IV, Title 42
Sec. 418.3 (1990).
Woods & Poole Economics. (2005). *2005 MSA Profile: Metropolitan Area Projections to 2030*. Washington, DC: Woods & Poole Economics.

Appendices

Appendix A
Definitions and Program Descriptions

Idaho Commission on Aging: The Idaho Commission on Aging (ICOA) is the sole state agency designated under the Older Americans Act to administer programs and services for Idahoans 60 years of age and older. Since 1965 the Older Americans Act (OAA) has provided funding for services to meet the diverse needs of older persons in the United States through the National Aging Services Network. The Aging Network consists of six service areas from which services are provided under the guidance of the OAA. Each Area Agency on Aging (AAA) has an office which serves multiple counties within Idaho (Idaho Commission on Aging, 2008a).

Medicaid Aged and Disabled Waiver Program: This waiver allows physically disabled persons over the age of 18 who meet the nursing facility level of care to remain living at home and in the community. The program is both federally and state funded. Waiver participants must meet Idaho specific eligibility requirements for services (Idaho Department of Health and Welfare, 2008a).

Residential and Assisted Living Facilities (RALFs): Residential care and assisted living facilities are designed to provide a level of care for those not needing extensive skilled nursing care and who can function relatively independently, but require services which include: personal care services, medication assistance, bathing and toilet facilities, dressing changes, private cooking, homemaker services and single occupancy. Residential facilities are licensed by the state of Idaho as are many assisted living residences; however, some assisted living facilities are not licensed.

Certified Family Home: A Certified Family Home is "a family-style living environment in which two or fewer adults live who are not able to reside in their own home and who require care, help in daily living, protection and security, supervision, personal assistance and encouragement toward independence" (Idaho Code §39-3502(8)).

Nursing Facility: "'Nursing facility' (nursing home) means a facility whose design and function shall provide area, space and equipment to meet the health needs of two (2) or more individuals who, at a minimum, require inpatient care and services for twenty-four (24) or more consecutive hours for unstable chronic health problems requiring daily professional nursing supervision and licensed nursing care on a twenty-four (24) hour basis, restorative, rehabilitative care and assistance in meeting daily living needs. Medical supervision is necessary on a regular, but not daily, basis" (Idaho Code §39-1301(a)). All nursing facilities in Idaho must be licensed by the state. Participation in the Medicaid and Medicare programs (or Certification) is voluntary.

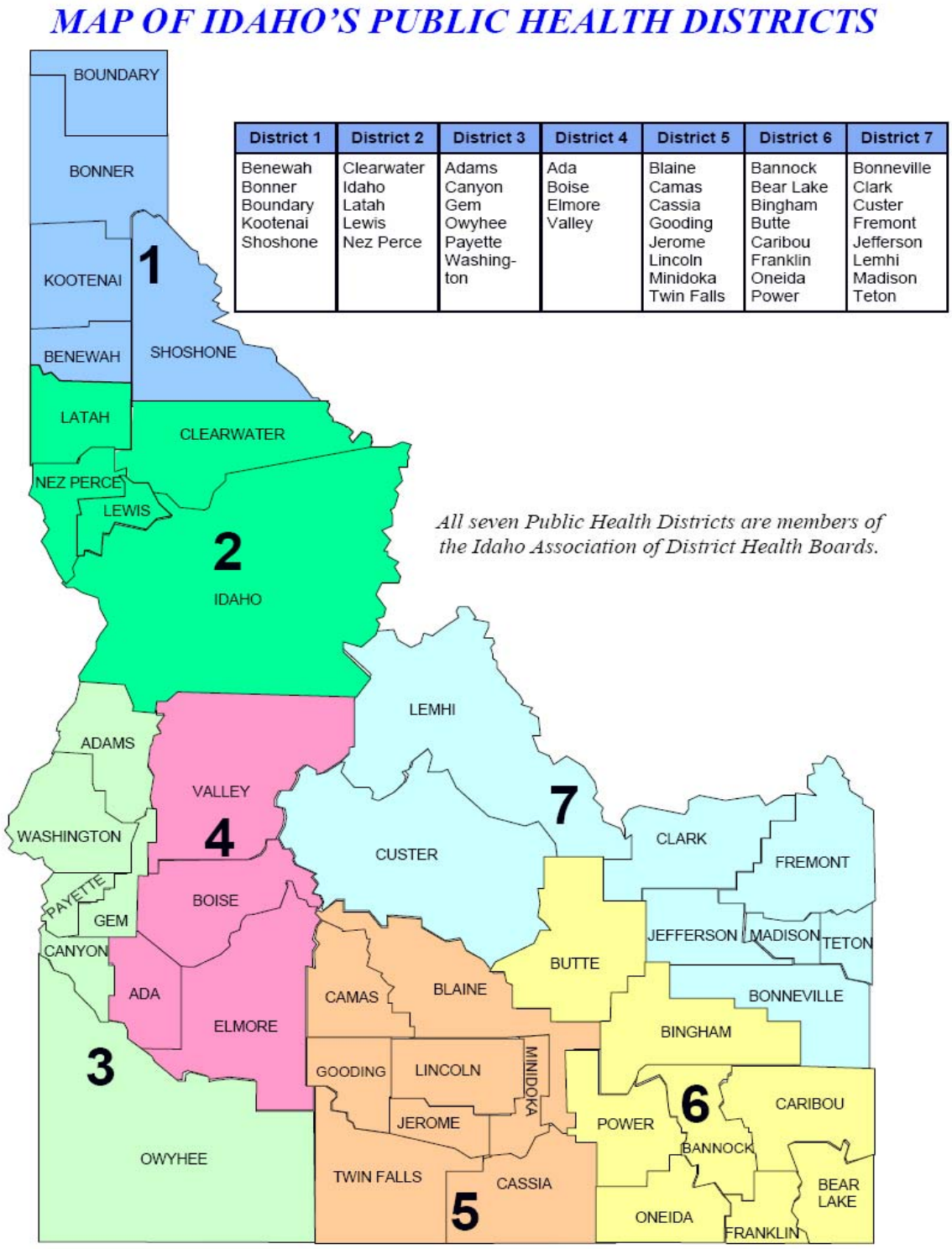
Hospice Program
Hospice program means a public agency or private organization (or a subdivision thereof) which is primarily engaged in providing care and services for terminally ill individuals and makes such services available (as needed) through an interdisciplinary team approach on a 24-hour basis. Hospice programs also provide bereavement counseling for the immediate family ("US Code: Public Health Chapter IV", 1990).

Home Health Services
Home Health Agencies provide a variety of in-home medical and non-medical services to seniors who would prefer to stay at home rather than enter an Assisted Living or Skilled Nursing facility. Home Health Agencies provide services such as: skilled nursing and therapy, medication management, coordination of care for multidisciplinary care givers, injections, wound care and assessments, physical therapy implementation and ongoing rehabilitation, personal care and homemaker services, food preparation & shopping, personal hygiene (grooming), assisting with oxygen, evening assistance, administering medication, assisting with bathroom requirements, and attending to bedridden patients.

Adult Day Care (ADC) Services
Adult day care is a structured day program which provides individually planned care, supervision, social interaction and supportive services for frail older persons in a protective setting, and provides relief and support for caregivers (Idaho Code §67-5006).

Respite Care
Respite is a short-term home and community based service designed to encourage and support the efforts of caregivers to maintain functionality or cognitively impaired persons at home. Paid respite staff and volunteers provide companionship and/or personal care services when needed and appropriate for the care recipient and the caregiver. Respite services include meeting emergency needs, restoring or maintaining the physical and mental well-being of the caregivers and providing socialization for the care recipient.

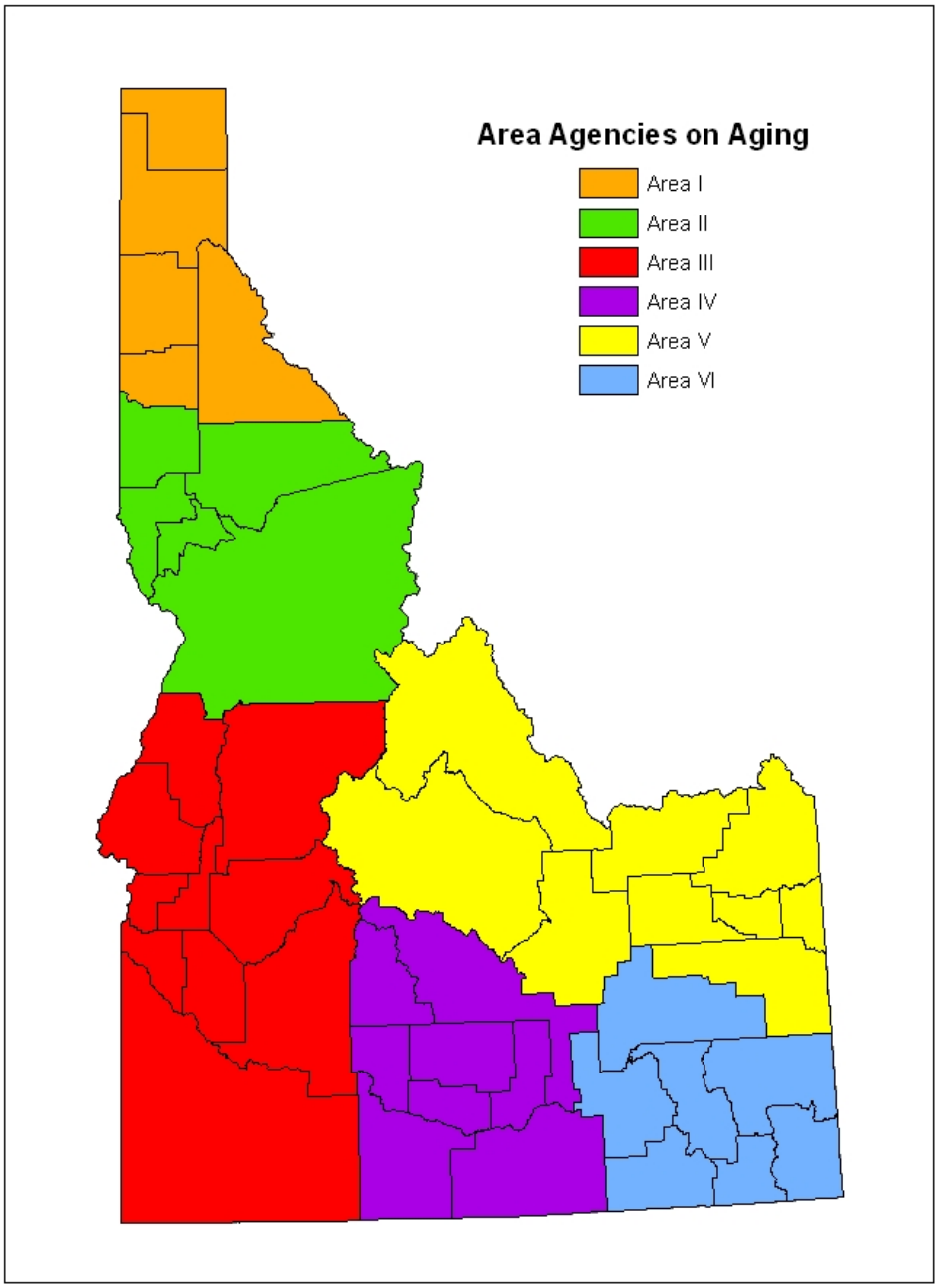
Appendix B
Department of Health and Welfare Health Districts



17

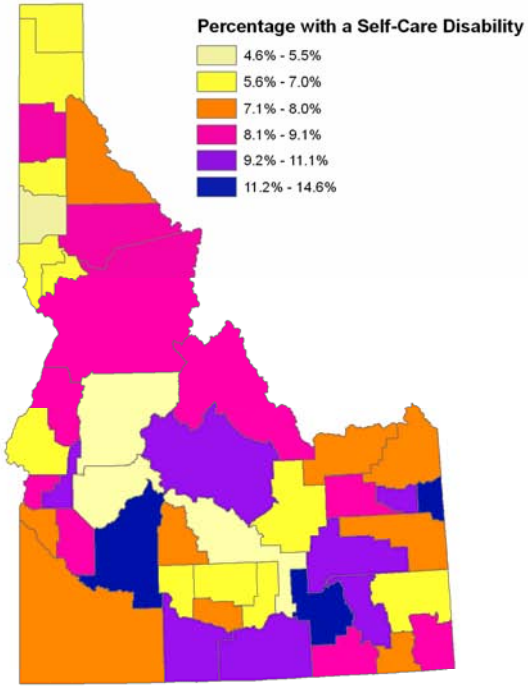
[17] Retrieved from: http://www2.state.id.us/phd7/About%20Us/Health%20Districts%20Map%20-%20Counties2.pdf.

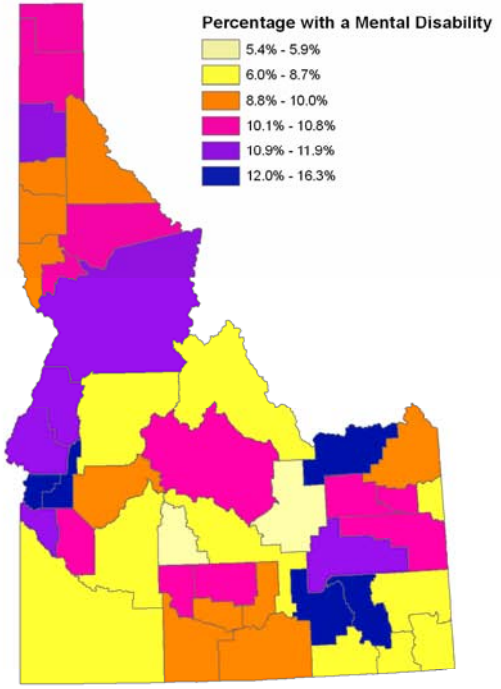
Appendix C
Idaho Commission on Aging Areas



Appendix D
Disability Status Maps

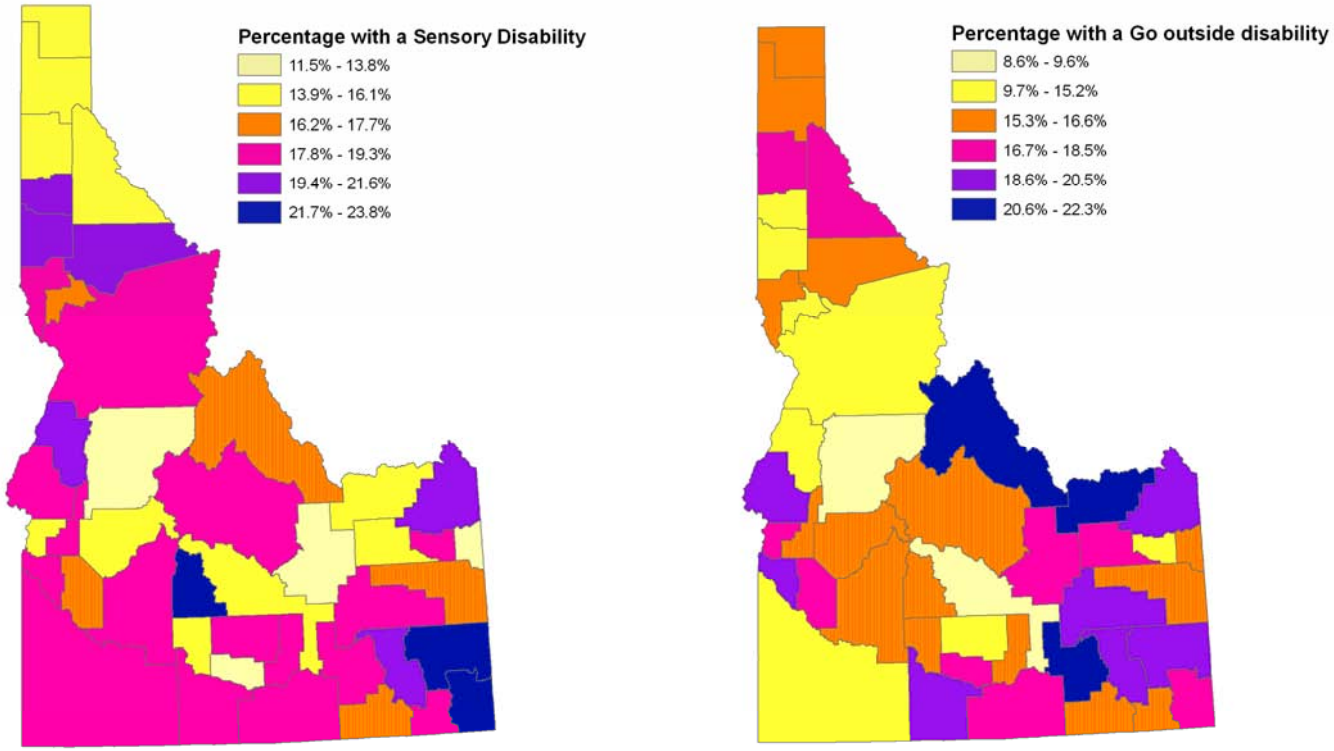
Disability Status of the Noninstitutionalized Population of Idaho Over Age 65





Source: U.S. Census 2000, Summary File 3

Disability Status of the Noninstitutionalized Population of Idaho Over Age 65



Source: U.S. Census 2000, Summary File 3