for Healthy Aging & Longevity

Hunter College / The City University of New York

The Value of Daily Money Management:

An Analysis of Outcomes and Costs

Debra Sacks, LPN, JD
Dhiman Das, PhD
Raquel Romanick, JD
Matt Caron, MS
Carmen Morano, PhD, MSW
Marianne C. Fahs, PhD, MPH

June 2009

HUNTER IS CUNY

"Brookdale Center for Healthy Aging and Longevity of Hunter College is a multidisciplinary center of excellence dedicated to the advancement of successful aging and longevity through research, education, advocacy, and evaluation of evidence-based models of practice and policy."

****

We gratefully acknowledge the generous support of
The Isaac H. Tuttle Fund, The Altman Foundation,
The Jarvie Commonweal Fund, and
The Jacob Reingold Endowment for the Prevention of Elder Abuse.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Table of Contents

Page

Executive Summary 4

About the Jacob Reingold Institute 5

Introduction....................6

Background – What is Daily Money Management? 7

Prior Studies....................8

Research Methodology 10
- Sample Population.................... 10
- Client Data 11
- Economic Cost Data.................... 12

Results.................... 12
- Sample Characteristics 12
- Crisis Intervention 15
- DMM Services Provided.................... 16
- Client Outcomes 18
- Economic Costs 18

Discussion.................... 19
- Addressing Study Limitations – PSA Comparison Group.................... 19
- Additional Benefits: DMM as Possible Deterrent for Elder Financial Abuse 21
- DMM Quality of Life....................23
- Banks an Integral Part of the DMM Process.................... 23
- Policy Options....................24

Recommendations 26

Appendix A. Research Participants and Advisory Board Members.................... 28

Appendix B. Economic Cost Calculations.................... 31
- Table 1: Average Service Costs per Client and per Month 31
- Table 2: DMM Use Profile.................... 32
- Table 3: Hours per Month per Client.................... 34
- Table 4: Hours Required and Cost of Providing DMM Services per Month per Client.... 35
- Table 5: Hours Required and Weighted Average Costs of Providing DMM Services per Month per Client.................... 36

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Executive Summary

Serious concerns have surfaced in the past decade over the financial exploitation of frail and vulnerable older Americans. Most recently, the Brooke Astor case brought the issue to the forefront of public attention. Adults aged 85 years and over, the group at highest risk for physical and cognitive health decline, constitute the fastest growing population group in the U.S. For vulnerable older adults, management of daily financial obligations can become an overwhelming burden, quickly spiraling into adverse behaviors and at-risk situations such as unpaid bills, un-deposited checks, and the terrifying consequences of cut-off utilities, bank foreclosures, evictions, and financial exploitation.

To prevent the devastating consequences associated with the loss of financial independence and stability, social service agencies have developed community-based Daily Money Management (DMM) Programs to assist vulnerable and frail older adults in protecting their financial security and serve as a deterrent to potential elder abuse. To date however, there is a dearth of information concerning these programs, their value, outcomes, and costs, which limits public support, utilization, and dissemination.

In this study, we present the first economic estimates of the value and costs of DMM programs. The results are striking. This research, a first of its kind, uses standard microeconomic costing techniques to estimate the costs of DMM programs, compared to current alternatives such as nursing home placement or publicly supported Protective Services for Adults (PSA) programs. We find DMM programs to be significantly cost saving, DMM/case management programs save $60,000 per individual, compared with nursing home placement. Moreover, the incremental costs of DMM are less than $250 per month per individual, making them highly cost effective. Most importantly for quality of life, individuals are able to remain in their homes and their communities.

This study is part of a larger effort to address the current gap between cost-effective community-based practice and public policy support. The Brookdale Center for Healthy Aging and Longevity is partnering with AARP Foundation and social service agency partners in a collaborative approach to create an evidence-based bridge to help connect programmatic value with public support. The process began in January 2007 when the AARP Foundation launched a three-year pilot project in New York City in collaboration with the Council of Senior Centers and Services. Also, in February 2007, a state-wide needs assessment of DMM programs, services and needs was launched by the AARP's Knowledge Management unit. Finally, in 2009, a conference is planned to disseminate the results to policy makers and program leaders across the state. It is hoped that the findings of this research and evaluation project will contribute in helping inform public policy makers seeking to support and improve healthy aging in our communities.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

About The Jacob Reingold Institute
at Brookdale Center for Healthy Aging & Longevity
of Hunter College
The City University of New York

The Brookdale Center for Healthy Aging & Longevity is a multidisciplinary center of excellence dedicated to the advancement of successful aging and longevity through research, education, and evaluation of evidence-based models of practice and policy. It has been a leader in exploring and developing solutions related to financial exploitation, mismanagement, and abuse of the elderly through its Jacob Reingold Institute, established in 1993 by an anonymous donor.

The Institute's first initiative, the Elderly Financial Management Project (EFM Project), surveyed NYC agencies to collect information on financial elder abuse in the NY metropolitan area--the first survey of its kind. Based on this survey, AARP conducted a nationwide survey that described the practices of 360 programs, concurring with the EFM survey conclusion that DMM would not only help vulnerable older adults stay in the community and out of costly long-term care settings, but also could help prevent or stop financial abuse of older adults. To promote DMM as a service option for clients of care management agencies, the Institute continues in its leadership role on issues related to elder abuse, conducting research, convening conferences, developing educational curricula, leading trainings, and providing technical assistance throughout New York State. Its user guide for care management agencies shows the way to develop comprehensive DMM programs.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Introduction

The population of older adults facing unstable and insecure financial futures is increasing dramatically. While national and local data are not yet available, the current recession is certain to have devastating effects among large numbers of older adults. Given the expected 117% increase in the population of persons aged 65 years and older by 2030[1], policy makers face enormous challenges. Without policy initiatives and programs to prevent economic and health distress, vulnerable populations of low-income older adults are likely to increase substantially with distressing consequences for themselves, their families, and their communities.

One of the most frightening scenarios for an older person is the possibility of financial ruin.[2] In the absence of effective preventive measures, older populations will face alarming increases in the likelihood of financial ruin and risk of poverty. Currently federal poverty formulas estimate 18.1% of elderly are living below the poverty line in New York City. Yet this estimate is highly conservative, using poverty formulas based on spending patterns from the 1960s. In July 2008, Mayor Bloomberg adopted an updated alternative estimate, developed by the Center for Economic Opportunity (CEO).[3] The CEO measure more accurately reflects real poverty in New York City and other urban communities, taking into account contemporary spending patterns for food and other items, such as housing and transportation.

The result is striking, almost one-third (32%) of adults aged 65 years and over were living in poverty in New York City in 2005. Furthermore, income for most older adults remains fixed, or worse, declines (Schulz, 2001). Living on a limited or fixed income causes many older adults increasing difficulty as health care and other expenses increase and they try to manage their already strained budget (Ropers, 1991). The 2008-2009 recession and financial collapse will cause increased hardship for many retirees, whose health benefits already are being cut by many employers who face rising health care costs and decreased profits.[4] For adults aged 85 years and over, the risk of financial distress is compounded by the increasing risk of financial mismanagement associated with cognitive decline. According to the National Institutes of Aging, over 25% of the population aged 85 and over face the debilitating condition of dementia.[5]

Daily money management (DMM) community-based programs can help prevent the devastating consequences of financial mismanagement and poverty. Developed by AARP and others over twenty years ago, DMM programs are designed to identify sources of financial distress among vulnerable older adults, reduce financial exploitation, address risk behaviors such as unpaid bills and un-deposited checks, and prevent adverse financial outcomes such as cut-off utilities, bank foreclosures, evictions. Several models currently exist to meet this need including:

---

[1]US Bureau of the Census. 1996. Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050. US Department of Commerce.
[2] Dessin CL. 2000. Financial Abuse of the Elderly. *Ida Law Rev.*36:203-226.
[3] New York City Center for Economic Opportunity. 2008. The CEO Poverty Measure. A Working Paper. NY, NY..
[4]Walsh MW. 2006. Paying Health Care from Pensions Proves Costly. *New York Times*. NY, NY.
[5] Plassman BL, Langa KM, Fisher GG, Heeringa SG, Weir d DR, Ofstedal MB, Burke JR, Hurd MD, Potter GG, Rodgers WL, Steffens DC, Willis RJ, Wallace RB. 2007. Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study. *Neuroepidemiology.* 29:125–132.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

- Service Model – DMM is a service within the agency case management function;
- AARP Model – This “stand alone” model uses volunteers to perform bill paying services;
- Collaborative Model - Case managers would refer clients to stand alone DMM programs such as the AARP Money Management Program;
- Informal DMM Model – Family or friends assist with bill paying;
- Private Pay Model – Persons needing assistance hire a professional to provide DMM services. There are a growing number of these services being offered by professionals.

Experience to date, documented by descriptive surveys of programs and clients and case reports, suggests that daily money management programs are a cost effective approach to financial risk reduction among vulnerable seniors, possibly even preventing or delaying the need for institutionalization. However, there is a paucity of scientific evidence supporting this conclusion. To address this information gap, the Brookdale Center for Healthy Aging and Longevity developed an evidence-based assessment of the value of daily money management (DMM) by conducting an evaluation of the costs and outcomes of program interventions for clients living in the community, which were managed by agency staff and volunteers.

Background – What is Daily Money Management?

Many older and vulnerable persons need help with their finances to live safely in the community, a need that becomes more common with increasing age. Prior estimates revealed that 5-10% of the community-based elderly population would benefit from some form of money management assistance.[6] Community-based agencies that provide care management services to elderly clients often see a long-term client physically decline over time, losing the mental and physical dexterity or mobility or both to deal with complicated bill paying, insurance claims, and banking. Others endure memory loss and exhibit periods of confusion and disorientation, leading to financial self-neglect and often the possibility of eviction. As these problems increase, so too does the risk of financial abuse and exploitation. The common thread in these situations is the need for assistance with finances. Whether it is to keep a client at home, to prevent a crisis such as eviction or to stop or prevent financial abuse, money management becomes an essential needed service.

New York is fortunate to have agencies both in NYC and upstate that provide Daily Money Management (DMM) to their clients as part of their broader care management service package. Most of these agencies have "backed into" assisting their clients with money management as their clients have aged or declined. Often agencies cautiously initiate informal money management services as part of a broader care management function, using whatever resources they have

[6]Wilber KH, Buturain L. 1992. Daily Money Management: An Emerging Service in Long Term Care. In Larue G, Bayly R (Eds.). *Long-Term Care in an Aging Society: Choices and Challenges for the '90s*. pp. 93-117. Prometheus Books Inc. NY, NY.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

available. Money management programs have emerged in this ad hoc manner all across the country and have been the subject of national discussion (Wilber and Buturain 1992).

The term "Daily Money Management" has evolved to encompass the full range of money management services that may be offered. Daily Money Management may consist of supportive assistance or surrogate decision-making. Supportive decision-making services are tasks such as information/education, public benefits advocacy, budgeting, bill paying, banking assistance, credit management and medical insurance billing. These services support clients in their decisions when the client is presumed to have capacity and thus is able to act as the "decision maker". The agency, as money manager, becomes the "decision implementer" since the client has the ability to consent to services and to direct or oversee the tasks performed by the provider. Surrogate decision-making services, on the other hand, occur when an agency is authorized to make decisions on behalf of a client who no longer has the capacity to do so. Surrogate decision-making authority may have been given to the agency by the client prior to the client's incapacity, as when a client signs a power of attorney or voluntarily requests or agrees to the appointment of a representative payee or a guardian,. It may also be given after a client becomes incapacitated by the appointment of a representative payee by the Social Security Administration or of a guardian by a court. The money manager in these situations becomes the "decision maker", acting according to the previously expressed wishes of the client or, if the client's preferences are unknown, in the best interests of the client.

Prior Studies

The Brookdale Center for Healthy Aging and Longevity received an endowment in 1993 to establish the Jacob Reingold Institute for the Prevention of Elder Abuse (the Reingold Institute) to address problems of abuse of the elderly. The first initiative of the new institute was the Elderly Financial Management Project (EFM Project), which addressed problems of financial abuse and neglect of elderly people. The project conducted a survey of NYC agencies in 1994 to gather information on financial elder abuse in the metropolitan region. This was the first survey of its kind with results uncovering valuable information about the existence of and need for daily money management services in NYC, along with revealing financial abuse of the elderly to be a significant problem.[7] In 1995 the AARP national office in Washington, DC conducted a national survey on Daily Money Management, based upon the 1994 Reingold survey. The AARP Survey described the practices of 360 programs nationwide, including nonprofit organizations (59%), for-profits (19%) and government agencies (15%)[8]. Both surveys reported the need for DMM to keep vulnerable individuals in the community and out of expensive long-term care settings and the potential for DMM to prevent or stop financial elder abuse. Seventy-four percent of the respondents to the AARP survey (1996) included financial abuse or exploitation among the primary reasons clients need money management and 55% cited self-neglect.

---

[7]Sacks D, Arnason S, 1994. "Elderly Financial Management Project – Year One Report 1994", Reingold Institute, Brookdale Center on Aging of Hunter College, City University of New York.
[8]AARP. 1996. Report - National Survey of Daily Money Management Programs. Wash D.C.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

The 1994 Reingold survey revealed that 83.9% of care management agencies had encountered cases of financial abuse by others and self-neglect. Unfortunately, the survey found that only one-third of the NYC agency respondents were offering Daily Money Management as a service option for clients. The primary reasons given for this reluctance to become involved with client money management were: 1) the liability risks were too high; 2) agencies didn't have the knowledge to set up and run such programs; and 3) they were not funded to provide these services. Consistent with these findings, a major goal of the Reingold Institute has been to provide assistance in DMM to care management agencies to enable them to initiate DMM services more comfortably. Over the past 12 years, numerous conferences, training seminars and ongoing technical assistance have been offered throughout NYS by the Reingold Institute to achieve this end.

The need for and benefit of daily money management programs are well known by those who work with the elderly. Social workers and case workers often find themselves having to assist older adults with their finances when it becomes clear that they are having difficulty with money management, but otherwise desire and are able to remain in the community. Often these professionals find themselves in the uncomfortable position of taking on these financial matters and do so quietly, without access to uniform protocols or oversight while trying to protect their clients and their clients' desire to remain at home.

Given the recognized need for such programs, it is surprising that such a limited amount of research has been done. Much of the literature that does exist focuses primarily on Daily Money Management as a potential alternative to guardianship (also known as conservatorship). One prior study revealed that 5% - 10% of older people living in the community need assistance with money management[9]. Focusing specifically on those 85 years and older, another study revealed that 24% require assistance.[10] Yet these estimates date back over a decade; as more adults are living longer with chronic illnesses, the current percentage of older adults living in the community needing assistance may be significantly greater.

There are many reasons why an individual might require assistance with DMM. Individuals turn to DMM due to lack of knowledge or practice with money management; physical or mental illness or frailty; problems with memory; very low income or large debt; or victim or potential victim of financial abuse or exploitation.[11] Other studies, including a 1995 AARP Report on National Survey of Daily Money Management Programs, found that three-quarters of DMM programs reported that DMM services were required by clients because of mental impairment, physical disability or frailty, or financial abuse or exploitation.

---

[9] Amerman E, Schneider, B. 1995. Clinical Protocols For Problems with Money Management (Clinical Protocol Series for Care Managers in Community Based Long-Term Care). Philadelphia Corporation for Aging, Phil.Pa.
[10] Wilber KH, Buturain LM. 1993. Developing a Daily Money Management Service Model: Navigating the Uncharted Waters of Liability and Viability. *Gerontologist* 33:5;687-691.
[11] Amerman E, Schneider B. 1995, op.cit.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Early research also focused on whether DMM may prevent older people from needing court-appointed guardians.[12] Obtaining a court-appointed guardian is an expensive, time-consuming process. This initial research stemmed from the fact that guardianships, also known as conservatorship, focus on the protection of older adults, often sacrificing their rights to freedom and self determination.[13] The hypothesis was that DMM could prevent the need for such restrictive legal intervention. While there are differences in the missions and legal authority between guardianships and DMM,[14] the findings show that supportive interventions such as DMM may delay the need for the appointment of a guardian.[15]

Moreover, studies to date have found that DMM has "the important outcome of securing benefits and services, stabilizing finances and reducing financial exploitation. While these aspects don't affect conservatorship, they do affect quality of life."[16] Thus, DMM should be an important component of case management. Yet there are many barriers that programs face in setting up a DMM program. Many potential DMM providers are deterred because of the perception of ambiguity in the field and the lack of consistent, uniform practice standards.[17]

The current research is the first to attempt to determine the impact of DMM on quality of life issues – increased financial security, the ability to remain at home – and to correlate improved quality of life for those adults receiving DMM services with quantitative estimates of economic costs and benefits.

In addition to the research reported in this document, Brookdale has created a DMM User Guide, complete with program guidelines, tips and standardized sample forms. The purpose of the manual is to provide uniform program guidelines and eliminate or reduce the fear of setting up adequate accounting systems and appropriate client relationships. Finally, a short brochure has been developed for widespread dissemination to increase understanding of the issues among program managers and policy makers. Taken together, it is our hope that these efforts will help contribute to further development of comprehensive DMM programs.

Research Methodology

Sample Population

The study methodology is interdisciplinary, drawing from gerontology, nursing, social work, and economics. Detailed primary data were collected from eight NYC agencies providing DMM services along with full case management. In-depth retrospective case record reviews were conducted for 114 community-based clients referred for DMM services during the study period 2001-2006.

---

[12] Wilber KH. 1995. The Search for Effective Alternatives to Conservatorship: Lessons from a Daily Money Management Diversion Study. *J Aging Soc Policy*7:1;39-56.
[13] Ibid.
[14] Ibid.
[15] Wilber KH, Reynolds SL 1995. Rethinking Alternatives to Guardianship. *Gerontologist* 35;248-257.
[16] Wilber KH, Buturain LM. 1993, op.cit.
[17] Ibid.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Client Data

Comprehensive information on client characteristics, services, and outcomes was obtained using standardized data abstraction forms. This data was supplemented by discussions with program leaders, expert review and consensus. The data collection instrument was developed building on the surveys conducted in1994 by the Reingold Institute and the 1995 AARP national DMM Survey. The data categories included: general demographics, entitlements, legal directives, housing, Activities of Daily Living and Independent Activities of Daily Living, mobility, home care, social function, health, income/resources, expenses, reason for DMM referral, DMM services received, and outcomes, including institutional placement or death at home. The instrument also included open-ended memo fields for several of the categories to allow the investigators to include additional data or explanations of individual circumstances. The added variables included: eviction proceeding, isolation, receipt of 24-hour home care, receipt of grants/stipends, appointment of representative payee, delinquent bills, debt management receipt, advance directives, legal referrals, mental health referrals, family takeover of financial management, undiagnosed mental health issues, placement in a nursing home, and death at home. Summary variables, constructed for the study, are defined below:

- Housing Crisis: Letter of intent issued, rent/mortgage in arrears, hoarding problem
- Benefits Crisis: Failure to obtain public benefits
- Financial Crisis: Self-neglect, self-endangering behavior, financial exploitation by others, delinquent bills
- Health Crisis: Health status rated fair or poor
- Mental Health Crisis: Diagnosed mental illness or diminished mental capacity/dementia; undiagnosed mental illness (identified by social worker)
- Social Isolation: No visitors or does not leave home for social purposes.

Data were extracted from three different times periods in the case trajectory: 1) when the case was opened; 2) when the financial problem developed; and 3) during the ensuing outcomes phase. Figure 1 below describes the sample progression by phase. The data abstraction process was done in collaboration with the DMM agency director or social worker who was given a comprehensive, in-depth client case review protocol to use in preparing each case for the interview sessions. Interviews of agency representatives were conducted in-person (a small number were interviewed via the phone) with the research investigator visiting each agency. To maintain total client anonymity the agency representative read the information out of each file while the interviewer recorded it on the data collection instrument. The total population of eligible clients was selected in each agency. A total of 114 cases were reviewed.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Economic Cost Data

Economic costs of DMM services were estimated using standard economic methods of resource valuation for all services received by each individual client over the trajectory of his or her care. All services provided per client were identified during the client chart review. Hours per service were based on estimates provided us through a standardized protocol reviewed by our DMM Advisory Panel. Final estimates of hours used per specific DMM service are based on our constructed weighted averages of estimates provided to us by four service providers who responded to our costing protocol. Total costs are estimated as a product of average hours(/days) and average hourly(/daily) rates.

We use the DMM survey data to estimate average hours of home care use and National Nursing Home Survey[18] to estimate average length of stay (in days) in nursing homes. Cost estimates for hourly rates of home care providers are obtained from the Occupational Employment Statistics (May 2007)[19] and nursing home costs are estimated from per-diem charges for individuals with both general health crisis and physical health crisis, from the NNHS (2004) survey. All costs are adjusted to 2007 prices, using the Producer Price Index[20].

Results

Sample Characteristics

Of 114 referrals, 93 clients accepted DMM services. Sixty-three clients received DMM services until institutionalization or death; 30 clients left the program and were lost to follow-up. The main reasons for leaving the program were: moved out of state, family took over of finances, guardian appointment, or client refusal. Table 1 on the next page presents the demographic characteristics of the full sample.

[18]National Nursing Home Survey, 2004 National Center for Health Statistics. Centers for Disease Control and Prevention. U.S. Department of Health and Human Services. http://www.cdc.gov/nchs/nnhs.htm
[19] U.S. Bureau of Labor Statistics http://www.bls.gov/oes/current/oes311011.htm
[20] U.S. Bureau of Labor Statistics http://www.bls.gov/pPI/

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Table 1: Distribution of Individuals using DMM Services by Demographic and Socioeconomic Status

	Female		Male		Total	
	N	%*	N	%*	N	%*
Age Group						
Below 70	6	6.7%	3	3.3%	9	10.0%
70 - 80	14	15.6%	8	8.9%	22	24.4%
80 - 90	31	34.4%	10	11.1%	41	45.6%
above 90	12	13.3%	6	6.7%	18	20.0%
Total (Missing 3)	*63*	*70.0%*	*27*	*30.0%*	*90*	*100.0%*
Marital Status						
Married	0	0.0%	1	1.1%	1	1.1%
Divorced	13	14.3%	4	4.4%	17	18.7%
Widowed	31	34.1%	11	12.1%	42	46.2%
Single	19	20.9%	12	13.2%	31	34.1%
Total (Missing 2)	*63*	*69.2%*	*28*	*30.8%*	*91*	*100.0%*
Education						
High School or less	39	52.0%	17	22.7%	56	74.7%
Some College/Trade School	4	5.3%	1	1.3%	5	6.7%
Bachelor	5	6.7%	5	6.7%	10	13.3%
Masters	3	4.0%	0	0.0%	3	4.0%
Doctorate	0	0.0%	1	1.3%	1	1.3%
Total (Missing 18)	*51*	68.0%	*24*	32.0%	*75*	100.0%
Income (Annual in $)						
Less than 10,000	29	31.9%	15	16.5%	44	48.4%
10,000 - 20,000	29	31.9%	9	9.9%	38	41.8%
20,000 and above	5	5.5%	4	4.4%	9	9.9%
Total (Missing 2)	*63*	69.2%	*28*	30.8%	*91*	100.0%

* Percent of non-missing cases

Overall, women comprised 70% of the sample and two-thirds of clients were 80 years of age and over. Most clients (75%) had a high school education or less. Ninety percent of clients had annual incomes of less than $20,000. Most DMM referrals were for clients living alone (single, widowed or divorced).

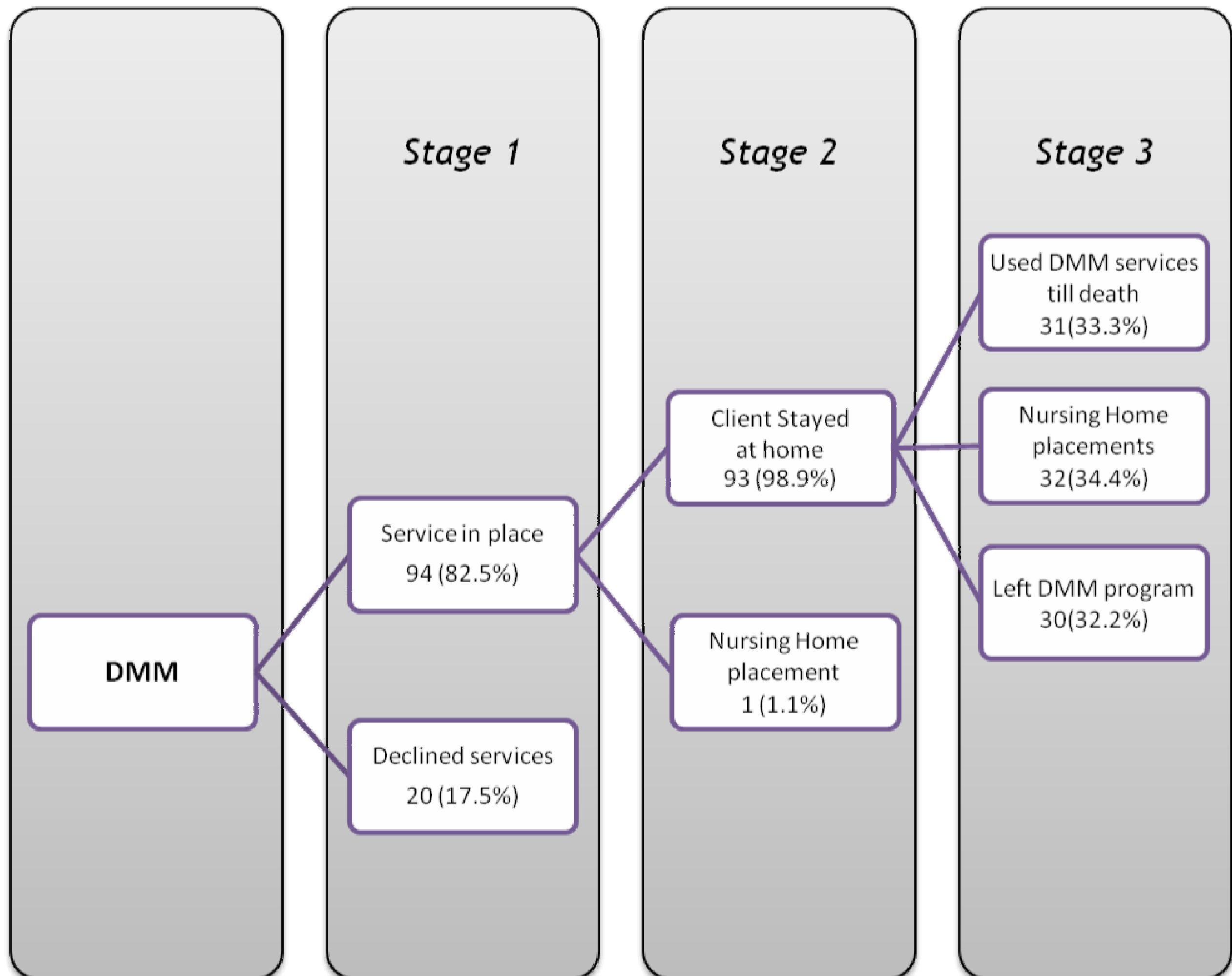
We compared the demographic characteristics of sample clients with those who left the program and were lost to follow-up. Age and gender distributions do not differ significantly. However,

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

marital status does differ somewhat between the two groups, with single or widowed clients more likely to remain in the program, compared to married or divorced clients.

The final study results reported below are based on the complete sample of 63 clients who remained with the DMM program from initiation through either death or nursing home placement. Figure 1 describes the stage progression of individuals in the sample.

Figure 1: Progression of Individuals Referred to DMM Services

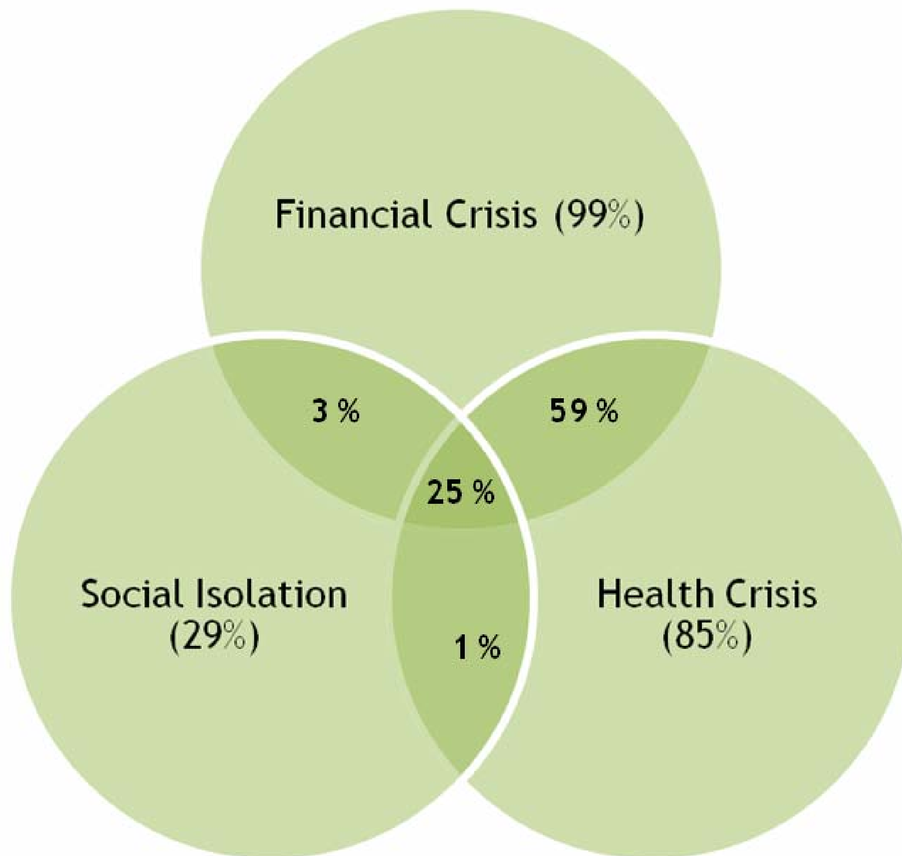


© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Crisis Intervention
As shown in Figure 2 and Table 2 below, 99% of DMM users endured a financial crisis, 85% were in poor health, and 29% were socially isolated. Most individuals faced multiple difficult crises. The largest proportion (88%) faced at least two of the following three crises at the same time: 1) financial; 2) health (physical or mental); and 3) isolation. Disturbingly, *26% of individuals were facing all three of these crises simultaneously (financial, health and social isolation).*

Among those in financial crisis, 5% also had a housing crisis, 22% also had a benefits crisis, and 25% had at least two financial crises at once. Among those with health crises, 72% had a general health crisis, 81% had a mental health crisis, and over one-half (53%) had both mental and physical health crises.

Figure 2: Distribution of Financial, Health and Social Isolation Crises among DMM Program Participants



© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Table 2: Distribution of Crises, by Gender and Age Among DMM Program Participants

Crisis	% Among Male	% Among Female	% Among those below 70	% Among those between 70 & 80	% Among those between 80 & 90	% Among those above 90
Housing Crisis	**0.0**	**7.9**	**10.0**	**4.6**	**7.3**	**0.0**
Benefits Crisis	**14.3**	**25.4**	**10.0**	**27.3**	**17.1**	**33.3**
Financial Crisis	**96.4**	**100.0**	**90.0**	**100.0**	**100.0**	**100.0**
Self-neglect	17.9	20.6	22.7	12.2	12.2	16.7
Self-endangerment	3.6	6.4	20.0	0.0	4.9	5.6
Financial Exploitation	10.7	14.3	10.0	9.1	19.5	5.6
Delinquent Bills	21.4	12.7	10.0	22.7	17.1	5.6
Need Assistance	55.6	63.5	11.1	63.6	63.4	77.8
General Health Crisis	**57.1**	**65.1**	**70.0**	**50.0**	**58.5**	**83.3**
Mental Health Crisis	**71.4**	**69.8**	**60.0**	**72.7**	**73.2**	**66.7**
Dementia	42.9	44.4	0.0	31.8	58.5	50.0
Diagnosed Mental Illness	14.3	14.3	30.0	27.3	4.9	11.1
Undiagnosed Mental Illness	25.0	27.0	30.0	40.9	19.5	22.2
Social Isolation	**21.4**	**30.2**	**40.0**	**27.3**	**19.5**	**38.9**
Do not have visitors	57.1	63.5	40.0	63.6	68.3	55.6
Do not leave home for social visits	42.9	30.2	30.0	36.4	39.0	22.2

* Non-missing cases only

DMM Services

Among individuals with financial crisis, the most common DMM services were bill paying followed by budgeting and checkbook balancing. In addition to the standard DMM program protocol (organizing, budgeting and bill paying), agencies also managed debt, assisted with banking, balanced checkbooks, applied for grants and stipends, increased home care, applied for entitlements (benefits), made referrals to mental health, legal and protective services, and facilitated nursing home placements when appropriate. Thus DMM was fully integrated with case management services for individuals in our sample. Table 3 presents a summary of services received by individuals in response to economic, social, and health crises.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Table 3: Distribution of Services Delivered to DMM Program Participants, by Crisis

Crisis	Number of individuals	% of total cases*
Basic DMM Services		
Organize Finances	48	51.6
Budgeting	58	62.4
Bill Paying	86	92.5
Additional Crisis-Specific Services		
For Individuals with Housing Crisis (Total 5)		
Referred to PSA	2	40.0
Debt Management	5	100.0
Referred for Legal Help	5	100.0
For Individuals with Benefits Crisis (Total 20)		
Apply for Entitlements	20	100.0
Benefit Improvement	14	70.0
For Individuals with Financial Crisis (Total 92)		
Balancing Checkbook	51	54.4
Assist with Banking	27	29.4
File Income Tax	1	1.1
Safeguard Valuables	1	1.1
Enable home health aide (HHA) to access money	31	33.7
Referral to district attorney (DA)	1	1.1
Debt Management	14	15.2
Grant Stipend Received	28	30.4
Agency applied to become Rep. Payee	12	13.0
Family Took Over Care	10	10.9
For Individuals with General Health Crisis (Total 57)		
Enable HHA to access money	25	43.9
Apply for Entitlements	16	28.1
Nursing Home Placements	21	36.8
Home care Increased to 24/7	5	8.8
For Individuals with Mental Health Crisis (Total 64)		
Enable HHA to access money	21	32.8
Referred to PSA	5	7.8
Referred to Mental Health Service	3	4.7
For Individuals in Social Isolation (Total 27)		
Referred to Mental Health Service	3	11.1

* Total cases with a particular crisis, non-missing cases only

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Client Outcomes

Among individuals with benefits crises, 70% had benefit improvement. These circumstances were associated with a higher probability of dying at home. A high percentage of those who died at home (51%) had grants or stipends to supplement their income. Compared with those who died at home, those who were placed in nursing homes had a higher rate of social isolation. Overall, however the number of crises was similar among both groups, i.e. persons who died at home and those who were placed in nursing homes.

Individuals who died at home used DMM services on average for 30 months, while those who had nursing home placements used DMM services for 24 months. If the individual had received a grant or stipend through the DMM program, those who died at home used DMM for 42 months while individuals who had nursing home placements received DMM services for 36 months.

Economic Costs

Data availability restricted the study design from including a control group. Thus, our economic analysis compares our two groups of individuals, those who were able to die at home and those who were eventually placed in a nursing home, to a hypothetical group placed immediately in a nursing home, following the manifestation of crises detailed above. The detailed steps taken in developing the estimates are presented in Appendix B, Tables 1-4.

The results confirm the cost-effectiveness of DMM programs, as shown below:

Case I – ***Died at Home***	***Average Cost per Individual***	***Average Cost Per Month***
Total home-care cost	$108,810	$3,023
Total DMM cost	$8,656	$240
Total cost	**$117,466**	**$3,263**

Case II – ***Nursing Home placement without Postponement***	***Average Cost per Individual***	***Average Cost Per Month***
Total nursing home care cost	**$178,444**	**$4,957**

Average monthly costs of providing DMM services within the context of Case Management are $240 per individual, a low marginal cost. The total cost of services, including home care and all DMM/Case Management services, is *substantially* lower in both Cases I than in Case II. On average, individuals who initiated DMM services and then were able to die at home with full DMM/Case Management services in place, had substantially lower lifetime costs compared with similar hypothetical individuals placed immediately in a nursing home ($117, 466 vs. $178,444).

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Discussion

These findings are important and challenge current health economic paradigms where nursing home placement is thought to be more cost effective than community-based care, because of economies of scale. Thus, despite the increased homecare necessary for DMM clients to stay in their homes as opposed to nursing home placement, it is much more cost-effective to support individuals who need DMM services in their homes, rather than refer these frail individuals to a nursing home. These are conservative estimates, as DMM/Case Management services also may have averted emergency room use or reduced acute hospitalization stays or both, outcomes not accounted for in this study.

Addressing Study Limitations: PSA Comparison Group

Because the study design could not include a control group, we sought to compare the costs of our study DMM clients with individuals receiving care through the publicly funded Protective Services for Adults (PSA) Program.

New York State law mandates that Protective Services be provided for individuals without regard to income who, because of mental or physical impairments, are unable to manage their own resources; carry out the activities of daily living; or protect themselves from physical, sexual, or emotional abuse; active, passive or self-neglect; financial exploitation or other hazardous situations without assistance from others and have no one available who is willing and able to assist them responsibly.[21]

The NYS Protective Services for Adults[22] (PSA) caseload comprises a diverse population, including the frail elderly and adults with mental illness, drug or alcohol addictions, developmental disabilities, traumatic brain injury or physical disabilities. Over 60% of this population comprises of frail, elderly people living in social isolation and persons suffering from elder abuse and financial exploitation. Specific challenges within this group include frail elderly couples with complex health and mental health needs trying to care for each other and elderly individuals with dementia.[23]
With 53% of the DMM clients in this study having both a general and mental health crisis and 26% living in social isolation, these individuals closely reflect the characteristics of the PSA client.

Contextually, to make this comparison, it is important to note that DMM services were provided by agencies that also provided full case management. Thus in addition to money management services (organizing, budgeting, bill paying, balancing checkbook, assist with banking, file income tax) the agency also provided services such as:

- Enabling the home health aide to access money for household purchases
- Applying for entitlements
- Making referrals to PSA

---

[21] NYS Social Services Law § 473; 18 NYCRR Part 457 (c)
[22] In New York City, the PSA program is referred to as Adult Protective Services (APS).
[23] Harrigan S,. 2007. Building a Shared Commitment to Protect and Support Vulnerable Adults. New York Public Welfare Association. Albany, New York.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

- Making referrals to the DA
- Managing debt
- Making referrals to legal help
- Applying for grants/stipends
- Acting as representative payee
- Overseeing home-care provision up to and including 24 hours, 7 days per week
- Making referrals to mental health services

The PSA program must provide a full complement of services to its clients, including:

- arranging for social, medical and psychiatric services
- arranging for commitment, guardianship or other protective placement
- providing advocacy and assistance in arranging for legal services
- providing relocation services
- working with the courts on behalf of individuals with serious mental impairments
- providing counseling.[24]

It is clear the services provided by the PSA program are analogous to those available through the DMM programs studied.

In comparing DMM agency costs[25] with PSA[26] costs, we took into account start-up costs during the first year and separated those from continuing costs in following years. Due to high start up costs ($731), only minimal savings of $595 accrue for DMM performed by agencies in the first year of service ($3373 vs. $3968 = $595). However, in subsequent years, the annual cost saving is much more pronounced at approximately $1327 per client ($3,968 - $2644 = $1327).

Thus, we find substantial savings per client with DMM/case management services in place, compared with individuals referred to PSA. A savings of one-third the full annual PSA cost is significant for both state and local governments. We conclude that client diversion from state-funded PSA programs to full-service case management agencies could yield considerable savings over time.

---

[24]NYS SSL. op.cit. (d)

[25]Average DMM agency costs were calculated using study data as follows:
Year one = $731 (one time start up cost) + $2641 = $3373
Subsequent annual costs are $220 per month x 12 = $ 2641.44

[26]According to Lynn Saberski, Director of PSA for NYC Human Resources Administration, the annual cost per PSA case in NYC in 2008 was $ 3,968. The Financial Management Unit (FMU) cost extraction is $744 per case per year. However the FMU unit only provides representative payee services. Any other financial issues or problems a client has such as debt, loss of public benefits or eviction are handled by a caseworker. Thus to get a true picture of the cost to PSA of dealing with all financial and case management issues we use the total cost amount of $3,968 per client.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Currently, there is augmented demand for PSA services because of increasing numbers of frail elderly, and policies encouraging deinstitutionalization for persons with disabilities.[27] New York City is experiencing increasingly high caseloads (as high as 81 cases per case worker) leaving little time to care for each of their clients.[28] If individuals at risk of becoming PSA clients could be referred instead to local DMM case management agencies, a full cadre of needed services could be provided with the benefit of reducing the PSA caseload. Our findings confirm the cost effectiveness of private-sector DMM programs as an alternative to public sector PSA programs.

Additional Benefits: DMM as Possible Deterrent for Elder Financial Abuse

Losing assets accumulated over a lifetime, often through hard work and deprivation, can be devastating, with significant practical and psychological consequences[29] Financial abuse can have as significant an impact for an elder person as a violent crime[30] or physical abuse.[31] The National Center for Elder Abuse found that financial abuse accounted nationally for about 12 % of all substantiated elder abuse reports in 1993 and 1994[32]. A subsequent more comprehensive study conducted by the same entity found that 18.6 % of the 115,110 substantiated elder abuse reports submitted to Protective Services for Adults programs nationwide in 1996—which included reports of self-neglect—were reports of financial or material exploitation.[33] Excluding reports of self-neglect, this exploitation appeared in 30.2 % of the substantiated reports. This represented the third largest category of reports, less than neglect (48.7 %) and emotional or psychological abuse (35.41 %), but more than physical abuse (25.6%). New York State is one of a minority of states that does not require mandatory reporting of elder abuse of any kind. However, a study of PSA reports conducted in upstate New York between 1992 and 1997 led to state intervention, after finding financial exploitation was present in 38.4 % of the cases[34]

The most common characteristics associated with being a victim of financial abuse are white, female, and over the age of 80.[35] This is a population very similar to the study population. Many of the cohort of women over the age of 80 have little experience in managing finances, and to

---

[27]Harrigan S. 2007, op.cit.

[28]Gotbaum B. 2006. A Report by Public Advocate : Unprotected –Adult Protective Services Struggles to Serve Vulnerable Clients. p. 13. NY, NY.

[29]Dessin, C.L. 2000 Financial Abuse of the Elderly. *Ida Law Rev.* 36:203–226; Nerenberg, L. 1999 Culturally Specific Outreach in Elder Abuse. In *Understanding Elder Abuse in Minority Populations*, T. Tatara, ed. Phil. Pa.;Brunner M, Smith, RS. 1999 Fraud and Financial Abuse of Older Persons. No. 132 Australian Institute of Criminology. Canberra, Australia.

[30]Deem DL 2000 Notes from the Field: Observations in Working with the Forgotten Victims of Personal Financial Crimes. *J Elder Abuse Negl.* 12(2):33–48

[31]Dessin, 2000, op cit.

[32]Tatara T, Blumerman LM. 1996. Summaries of the Statistical Data on Elder Abuse in Domestic Settings: An Exploratory Study of State Statistics for FY93 and FY94. National Center on Elder Abuse. http://www.ncjrs.gov/App/Publications/abstract.aspx?ID=178597

[33] National Center on Elder Abuse [NCEA] 1998. The National Elder Abuse Incidence Study: Final Report. National Aging Information Center. Washington, DC:.

[34] Choi NG, Mayer J. 2000. Elder Abuse, Neglect, and Exploitation: Risk Factors and Prevention Strategies. *J Gerontol Soc Work* 33(2):5–25.

[35] The National Center on Elder Abuse. 2000. op cit.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

many perpetrators, women are perceived as weak or vulnerable.[36] Not having managed one's finances and a lack of familiarity with financial matters also increase the risk of being victimized.[37] Elders residing alone, specifically in their own home, are also more likely to be victimized.[38] Other research has found that poor health status, the loss of a life partner, and social isolation are characteristics shared by many victims[39]. Having family members who are unemployed or who have substance abuse problems have also been identified as placing an older person at greater risk of financial abuse[40]. Among general health impairments, vision and hearing loss, as well as cognitive impairment are additional characteristics associated with being a victim of financial abuse.

In this DMM study, 12 individuals were identified as victims of financial exploitation among the total sample 93 individuals who were referred for and received DMM services. Of these, nine individuals (75%) were female. Most of the exploited individuals (66.7%) were in their 80s. Also a high proportion of the victims (66.7%) had high school or less education A majority (83%) of the victims had incomes below $20,000.

Family members were the abusers in six of the 12 cases. Home health aides, legal guardians, new or long-time friends, neighbors, or dog walkers exploited the others. In five out of the 12 cases, the exploiter was a substance abuser. In six out of the 12 cases, there was misappropriation of cash. In seven out of the 12 cases, someone was living off the elder's income, while in two cases, the exploiter used the victim for illegal financial transactions. One out of 12 cases reported either fraudulent use of a credit card, illegal conveyance of property. or theft by a home-care worker.

It should be noted that the intervention of the DMM provider agency either stopped or lessened the impact of the abuse in many cases. For example, in two of the family abuse cases, the children of the elderly victims wiped out their parents' checking accounts and ran up thousands of dollars in credit card debt. The victims were left with no money to pay bills, including rent. The DMM agency was able to successfully negotiate with the landlords and housing court regarding back rent due and applied for grants to pay these costs, thus avoiding eviction. Referrals to legal services were also made to negotiate the credit card debt which, in some cases, was eventually written off.

The home health aide abusers were making long-distance calls, resulting in hundreds of dollars in phone bills. One aide stole a patient's ring. In half of these cases, the victims/patients were familiar with and close to the caregiver/abuser and had little or no family. The agencies worked

---

[36] Dessin CL. 2000, op cit.
[37] Choi NG, Mayer J. 2000, op cit.
[38] Bernatz SI, Aziz SJ, Mosqueda L. 2001 Financial Abuse. In *The Encyclopedia of Elder Care*. Mezey MD (Ed.). Springer Publishing Co. NY, NY.
[39] Quinn, M.J. 2000 Undoing Undue Influence. *J Elder Abuse Negectl.* 12(2):9–16.; Tueth, M.J. 2000 Exposing Financial Exploitation of Impaired Elderly Persons. *Am J Geriatric Psychiatry* 8(2):104–111.
[40] National Committee for the Prevention of Elder Abuse (NCPEA) 2001 Elder Abuse: Financial Abuse. Available: http://www.preventelderabuse.org/elderabuse/fin_abuse.html

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

with the aides regarding repayment of phone bills and return of the ring. The aides signed an agreement to not use the client's phone in the future. Thus the abuse was rectified without disruption of the established patient-caregiver relationship.

Making DMM services widely available in communities may have a preventive effect on the occurrence of financial abuse among the frail elderly living in those communities. For example, it is likely that the initiation of DMM services among individuals in our sample prevented new or additional financial abuse from occurring. The effect of DMM programs on the prevention of financial abuse should be the subject of further study.

DMM and Quality of Life

In this study, we do not attempt to quantify the value of DMM services on quality of life. Yet it is clear from the literature cited in the preceding section, quality of life is increased with the prevention or amelioration of financial abuse. Thus, DMM services contribute to improved quality of life through the treatment of financial abuse.

Providing DMM services to frail older adults not only keeps them safer in the community, but also helps to postpone and possibly prevent placement in nursing homes, thereby enhancing the quality of life in the client's later years. Keeping people out of institutions is in the spirit of compliance with the provisions of the 1999 Olmstead decision of the Supreme Court. It mandates that states provide more community support services to empower the elderly and persons with disabilities to live more independently and to access services in the most integrated setting appropriate for their overall needs.[41] Thus communities need to further develop existing DMM program models while integrating them in to the long term care plan for persons at home.

Banks as an Integral Part of the DMM Process

Providers considering or already engaged in DMM services need to reach out to the local banking community and develop a professional relationship. In the 1994 Reingold survey of DMM agencies in New York City, only 17% of respondents stated having a link to community banks.[42] The neighborhood banking institutions are integral to the functioning of the agency DMM service programs. However, the banks are generally not familiar with case management agencies. It would be beneficial for agencies to set up meetings with branch managers to introduce the agency and its function. This relationship can act as a preventive and protective device for DMM clients. Following notice to the bank of the agency's fiduciary capacity, bank employees are more able to spot instances of financial abuse by third parties and know whom to contact once abuse is suspected. Developing a system of communication and mutual support will also enable timely bill payment, thus preventing loan defaults and foreclosures. This obviously benefits the agency and the client, but the bank also profits since all institutions, with the exception of small banks, are required to engage in some community development activity. The definition of "community development" includes "activities that prevent defaults and/or foreclosures in loans".[43] Agencies

---

[41] OLMSTEAD V. L. C., 527 U.S. 581. 1999. 138 F.3d 893.

[42] Sacks D, Aronson S, 1994. op.cit.

[43] Part 76 of the General Regulations of the NYS Banking Board.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

should work with the bank's Community Affairs Unit which has primary responsibility for outreach in connection with the Community Reinvestment Act, Fair Lending and other consumer-related concerns. This unit conducts and participates in meetings, seminars and conferences designed to share useful information and resources with banks, community organizations and consumers. [44]

Policy Options

Historically New York has been moving incrementally toward preventing premature institutionalization and enabling individuals to return to the community. To adequately address the need for long term care services the 1970s and 1980s saw the creation of the Long Term Home Health Care (LTHHCP) and Expanded In-Home Services for the Elderly (EISEP) programs. [45] In addition to keeping persons at home these programs work to reduce expenses associated with unnecessary utilization of costly health services. The LTHHC programs are required to provide a broad range of services including medical and non-medical "waivered services" while the EISEP program provides limited amounts of personal care and non-medical services to persons over sixty who are not eligible for Medicaid. [46] Recognizing the importance of case management as a monitoring and safety tool for the functionally impaired elderly, New York incorporated this service into both the EISEP and LTHHC programs.

More recently New York State has taken definitive steps to further transition the state health-care system in the direction of community-based services. These steps not only comply with the Olmstead mandate, but also affect quality of life. The Nursing Facility Transition and Diversion Law, passed in 2004, authorized the New York State Health Commissioner to apply for a nursing facility transition and diversion Medicaid waiver to test the feasibility of providing home- and community-based services to individuals who otherwise would be cared for in a nursing facility. Additionally, the law provided for reimbursement of several home and community-based services not previously included in the medical assistance program.[47]

---

[44] NYS Banking Law, Article 2, Section 28B http://www.banking.state.ny.us/crmu.htm

[45] Social Services Law section 367-c authorizes LTHHCP services to be provided when the total monthly Medicaid expenditures for health and medical services for an individual do not exceed 75% of the cost of care in either a skilled nursing facility or a health related facility located within the local district. N.Y. Exec. Law section 541(2)(e)-(h) implemented the Expanded In-home Services to the Elderly Program.

[46] New York has a 1915 (c) waiver from the federal government that enables the state to provide participants with a number of services that are not available under the state plan for Medicaid services. 42 U.S.C. section 1396 n(d); 42 C.F.R. sections 440.181, 441.300 et seq.

[47] NYS Social Services Law Section 366, subdivision 6a. Enacting statute, Chapters 615 and 627, Laws of 2004

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Services that have been approved by the NYS Department of Health to be provided under this program include:

- Service Coordination
- Community Integration Counseling
- Community Transitional Services
- Environmental Modification Services
- Home and Community Support Services
- Home Visits by Medical Personnel
- Independent Living Skills Training
- Moving Assistance
- Structured Day Program Services [48]

Both Independent Living Skills Training and Structured Day Program Services include training in money management. However, for people who cannot be taught to safely manage their money, there is no alternative service offered. Including DMM in the list of services available would fill this need. To achieve this objective, the Social Services Law Section 366, subsection 6a should be amended to add DMM to the list of home- and community-based services that are reimbursable under the Medicaid waiver program.

The NYS legislature created the Commission on Health Care Facilities in the 21st Century (the Berger Commission) with a mandate to study and make recommendations to reform and reconfigure the NYS health-care system. The commission issued their Report in 2006 with a target reduction of approximately 3,000 nursing home beds.[49]

The Governor approved the recommendations and they became binding as a matter of law. The Berger Commission recommendations are currently being implemented. Eight nursing homes closed in 2008 with a loss of 2,300 beds. Another 500 beds will be eliminated by 2011. These beds will be replaced with approximately 1,000 non-institutional slots such as adult-day health care and assisted-living residences.[50] The specific steps New York has taken thus far are commendable in the advancement of community-based services. Adding DMM to the mix of services available will increases the length and stability of staying in the community.

---

[48] http://www.health.state.ny.us/facilities/long_term_care/waiver/nhtd_manual/index.htm

[49] NYS Dept. of Health. 2006. Final Report of the Commission on Health Care Facilities in the 21st Century. A Plan to Stabilize and Strengthen New York's Health Care System. Albany, NY. pp 10-11

[50] NYS Dept. of Health. 2008. Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty First Century. Albany, NY. http://www.health.state.ny.us/press/releases/2008/2008-07-02_berger_commission_measures_implemented.htm

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

The Study concluded by convening a meeting of experts, the DMM Public Policy Advisory Board, to discuss the research findings. The board issued the following recommendations:

Recommendations

1. **Community based agencies should include DMM as part of their case management service package.**
   Providing DMM assistance to clients is not only a means of preventing financial abuse but also of keeping clients in their homes for a longer period of time. Community-based agencies serving older adults should offer a full range of supportive and surrogate money management services.

2. **Agency expansion into DMM services requires specialized training in financial and risk management.**
   To enable agency expansions to take place, providers need to acquire the "know how" to provide efficient and effective money management services and address liability concerns. Providers will need training on how to set up DMM programs and implement safe practice standards. For agencies offering DMM services who do not have the resources to hire financial specialists, it is essential to offer in-house training for staff on financial and risk management procedures.

3. **DMM should be included as a core component of case management service programs funded by the state and federal government such as the Medicaid waivered services under the Lombardi Program (42 CFR 440.181, 441.300) and the Expanded In-Home Services for the Elderly Program (EISEP) (NYS Executive Law section 541 (2) (e)-(h)).** Case management is a service that involves coordination, delivery and monitoring of all services needed to support the individual in the community. Adding daily money management to the enumerated reimbursable services under these programs would mean a substantive improvement in meeting the distinct needs of the elderly in their homes.

4. **Incentives for DMM providers and community banking institutions to collaborate to support DMM services should be implemented.**

5. **Community based agencies should be funded to provide DMM services through the "line item" budget process.**

   - With more community based agencies providing DMM the number of PSA referrals for this service will decrease
   - This service can be provided at less cost by the community based agency than the PSA program
   - The cost of DMM services can be funded yearly through the state or county operating budgets as a line item

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

6. **Quality of life enhancement can be achieved by amending Social Services Law Section 366, subsection 6a (chapter 615) to add DMM to the list of home and community based services that are reimbursable under the Medicaid waiver program for nursing facility transition and diversion.**

    - Services that have been approved by the NYS Department of Health to be provided under this program include Independent Living Skills and Structured Day Programs.

    - Both of these services include training in money management for the person.

    - No provision has been made for persons who cannot be taught to manage their money and pay bills in the community

    DMM assistance by community based agencies, funded by the Medicaid waiver program, will meet this necessity.

7. **Other state DMM program models should be explored for their source of funding and populations served.**

8. **Promote the use of multiple funding sources for DMM services such as:**

- Medicaid funding for case management (which would include DMM) should be extended beyond the current Long Term Home Health Care Program (LTHHCP). Likewise, DMM should be added to the list of services that are reimbursable under the Medicaid waiver program for the Nursing Facility Transition and Diversion Program;

- Federal stimulus money for financial literacy;

- Community Reinvestment Act (CRA) funds from local banking institutions;

- Administration on Aging funding; and

- NYS Office for the Aging funding for a demonstration project.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Appendix A

2007-2008 DMM Research Participants

Rebecca Carel, CSW, Executive Director
Riverstone Senior Life Services
(formerly Fort Washington House
Services for the Elderly, Inc.)
99 Fort Washington Avenue
N.Y., N.Y. 10032
(212) 927-5600 x14
(212) 927-5612 fax
rcacarel@riverstonenyc.org
http://.riverstonenyc.org

Brian Kravitz, Executive Director
Rebecca Hammer, Director DMM
Search and Care
1844 Second Ave.
N.Y., N.Y. 10128
(212) 289-5300
(212) 289-5232 fax
kravitz@searchandcare.org

Joan Mintz, Executive Director
United Neighbors of East Midtown, Inc.
310 East 42nd Street
N.Y., N.Y. 10017
(212) 682-1830
(212) 682-3512 fax
jmintz@unem.org

Mary Dodd, CSW, Director, Homebound Unit
Burden Center for the Aging
1484 First Avenue
N.Y., N.Y. 10021
(212) 879-7400 x303(Velda)
Dionnew@burdencntr.org
muradv@burdencntr.org
doddm@burdencntr.org

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Susan Moritz, CSW, Director, Older Adult Services
Christopher Chin
Lenox Hill Neighborhood House
Department of Older Adults
331 East 70th Street
N.Y., N.Y. 10021
(212) 744-5022 x 1226
smoritz@lenoxhill.org

Pat McNamara, DMM Coordinator
Evelyn Chemouny, Executive Director
The Caring Community
20 Washington Square North
New York, New York 10011
212-777-3555
pat.mcnamara@thecaringcommunity.org
evelyne.chemouny@thecaringcommunity.org

Betsy Smith, Director of NORCS
Self Help Community Services
Big Six Towers
5955 47th Ave., Apt. 26
Woodside, N.Y. 11377
718-565-6569
bsmith@selfhelp.net

Amanda Leis, Money Management Program Coordinator
Council of Senior Centers and Services of NYC, Inc.
49 W. 45th Street, 7th Floor
New York, NY 10036
212-398-6565 ext. 230
aleis@cscs-ny.org

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Appendix A

DMM Public Policy Advisory Board

Marianne C. Fahs	Rose Dobrof Co-Director & Research Director	Brookdale Center / Hunter College
Debra Sacks	Senior Staff Attorney, Sadin Institute on Law	Brookdale Center / Hunter College
Raquel Romanick	Attorney, Sadin Institute on Law	Brookdale Center / Hunter College
Beth Finkel	Manager State Programs and Services	AARP
Igal Jellinek	Executive Director	CSCS
Gillian Francis	Director, Information Systems Program Officer, Grants to Organizations	Isaac Tuttle Fund
Stephanie Ranieri	Executive Director	Isaac Tuttle Fund
Sally Renfro	Deputy Commissioner	DFTA
John Wren	Deputy Assistant Secretary for Policy and Management	AoA
Greg Olsen	Deputy Director	SOFA
Sandra Brown	Deputy Director of Client Services, APS Unit	HRA
Oscar S. Strauss, III, Esq.	Director – Elderly Project	Volunteers of Legal Services
Penny Schwartz	Director Resource, Entitlement & Advocacy Program Department of Social Work Services	The Mount Sinai Medical Center
Sen. Reuben Diaz Marcos Crespo, Chief of Staff	Chair, Senate Committee on Aging	NYS Senate
Jeffrey Dinowitz Kasey Wehrum, Policy Director	Chair, Assembly Committee on Aging	NYS Assembly
Robert Doar Patricia Smith	Commissioner First Deputy Commissioner	Human Resources Administration
Patricia Volland	Senior Vice President Strategy & Business Development	New York Academy of Medicine
Margaret H. Reiff	Executive Director & CEO	Jarvie Commonweal Fund
Karen Rosa	Vice President & Executive Director	Altman Foundation
Alissa Yarkony	Program Officer	Altman Foundation
Ruth Finkelstein	Vice President for Health Policiy	New York Academy of Medicine
Fredda Vladek	Director, Aging in Place Initiative	United Hospital Fund
Marcus Harazin	Assistant Director, Division of Local Program Operations	NYSOFA
Gary Malys	Assistant Director, Division of Community Services	NYSOFA

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Appendix B

Table 1: Average Service Costs per Client and per Month

Case I: Died at Home	Per Service Cost Estimate	Mean	Median
Home-Care Costs			
Hourly cost (BLS)	$10.12		
Average home-care hours (DMM)		11,967	10,752
Total Home-Care Cost		$121,104	$108,810
DMM Costs			
Months under DMM (Average)		32	36
One-time costs (Average)	$731.19		
Recurring costs (Average)	$220.12		
Total DMM Cost		$7,775	$8,655
Total Cost for Died at Home		*$128,879*	*$117,466*
MONTHLY DMM Cost		*$243*	*$240*
Case II: Nursing-Home Placement without Postponement			
Nursing-Home Care			
Per-diem charges (NNHS)	$194.38		
Average LOS (NNHS)		918	
Total nursing-home care cost		$178,444	
Total Cost for Nursing-Home Placement		*$178,443.87*	

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Steps in calculation of cost of providing DMM services

Step I: ***Identify amount of each DMM service consumed by an average client.***

Table 2: DMM Use Profile

	Average Use of DMM services
Basic DMM Services	
Organize Finances	0.52
Budgeting	0.66
Bill Paying	0.90
Additional Crisis Specific Services	
Balance Checkbook	0.45
Assist with Banking	0.34
File Income Tax	0.03
Enable HHA to access money	0.41
Apply for Entitlements	0.31
Referral to PSA	0.14
Referral to DA	0.03
Debt Management	0.28
Referred to Legal Help	0.21
Grant Stipend Received	0.38
Agency applied for Rep. Payee	0.14
Homecare Increased to 24/7	0.14
Referred to Mental Health Svc.	0.07

Notes: For example, 90% of the individuals in our sample use bill-paying services. This would imply on an average each individual use 0.9 unit of bill-paying services.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Step II: ***Identify average (among all DMM service providers) hourly cost per month per client for each of the service identified.***

This is done based on information from the four service providers who responded to our survey (Appendix B, Table 3 through 5). The tables also show the average (minimum, maximum and average) cost per month per client using information on hourly wage rate for DMM service providers (Averaged over Burden ($27.95/hr), Self Help ($24/hr) and Lenox Hill ($25/hr) = $25.65).

Hours used for a specific DMM service may vary due to the practices (/protocol) of the individual DMM agency or the specific condition of the client they are serving or both.
An average of the time required to provide a service by each agency may be skewed by a few extreme cases in a particular agency. To avoid that problem, we weight the information on (average, minimum and maximum) hours by the proportion of clients served by the service provider to obtain a weighted average of hours used.

Lastly, **Table 4** presents the final weighted average costs of services per client per month.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Appendix B

Table 3: Hours per Month per Client

	Burden (Total 22)				Caring Community (Total 4)				Lenox Hill (Total 10)				Self Help (Total 20)			
	Clients (i)	Min (ia)	Max (ib)	*Avg* (ic)	Clients (ii)	Min (iia)	Max (iib)	*Avg* (iic)	Clients (iii)	Min (iiia)	Max (iiib)	*Avg* (iiic)	Clients (iv)	Min (iva)	Max (ivb)	Avg (ivc)
Basic DMM Services																
Organize Finances	19	10	60	*35.0*	3	8	8	*8.0*	9	2	7	*4.5*	1	4	6	*5.0*
Budgeting	19	3	13	*8.0*	3	8	8	*8.0*	8	2.5	6	*4.3*	2	2	3	*2.5*
Bill Paying	21	8	8	*8.0*	4	8	12	*10.0*	8	0.33	0.75	*0.5*	19	0.75	1.5	*1.1*
Additional Crisis-Specific Services																
Balance Checkbook	12	0.5	1	*0.8*	2	2	2	*2.0*	7	0.33	0.66	*0.5*	14	0.25	0.5	*0.4*
Assist with Banking	11	3	5	*4.0*	1	12	12	*12.0*	4	1	2	*1.5*	0	0.08	0.25	*0.2*
File Income Tax	0			*0.0*	1	4	4	*4.0*	0	1	2	*1.5*	0	1	3	*2.0*
Enable HHA to access money	7	1	2	*1.5*	0			*0.0*	6	1	2	*1.5*	0			*0.0*
Apply for Entitlements	3	5	40	*22.5*	1	1	4	*2.5*	4	5	13	*9.0*	1	13	57	*35.0*
Referral to PSA	4	15	24	*19.5*	0			*0.0*	0	2	6	*4.0*	0	10	25	*17.5*
Referral to DA	0	5	5	*5.0*	0			*0.0*	0	1	3	*2.0*	0			*0.0*
Nursing Home Placements	9	10	10	*10.0*	1			*0.0*	4	2	5	*3.5*	4	3	10	*6.5*
Debt Management	1	15	35	*25.0*	0	1	8	*4.5*	3			*0.0*	3	1	8	*4.5*
Referred to Legal Help	5	2	3	*2.5*	0			*0.0*	1			*0.0*	0	2	15	*8.5*
Grant Stipend Application	10	10	15	*12.5*	0			*0.0*	4	2	5	*3.5*	1	1	15	*8.0*
Agency applied for Rep. Payee	1	10	10	*10.0*	0	5	5	*5.0*	4	1	3	*2.0*	1			*0.0*
Home Care Increased to 24/7	7				0			*0.0*	0	1	5	*3.0*	0	2	8	*5.0*
Referred to Mental Health Services	0	20	20	*20.0*	1			*0.0*	4	1	3	*2.0*	0	2	10	*6.0*

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

<u>Appendix B</u>

Table 4: Hours Required and Cost of Providing DMM Services per Month per Client

	Min. hours per month per client	Max. hours per month per client	Average hours per month per client	Min. hourly cost per month per client	Max. hourly cost per month per client	Average hourly cost per month per client
	i	ii	iii	i x $25.65	ii x $25.65	iii x $25.65
Basic DMM Services						
Organize Finances	7.4	38.5	23.0	$189	$988	$589
Budgeting	3.3	10.2	6.7	$84	$261	$172
Bill Paying	4.2	4.8	4.5	$107	$124	$115
Additional Crisis Specific Services						
Balance Checkbook	0.5	0.8	0.6	$12	$20	$16
Assist with Banking	3.1	4.7	3.9	$79	$120	$99
File Income Tax	4.0	4.0	4.0	$103	$103	$103
Enable HHA to access money	1.0	2.0	1.5	$26	$51	$38
Apply for Entitlements	5.4	25.9	15.7	$140	$664	$402
Referral to PSA	15.0	24.0	19.5	$385	$616	$500
Referral to DA	3.0	4.0	3.5	$77	$103	$90
Nursing Home Placements	6.1	8.3	7.2	$157	$214	$185
Debt Management	2.6	8.4	5.5	$66	$216	$141
Referred to Legal Help	1.7	2.5	2.1	$43	$64	$53
Grant Stipend Application	7.3	12.3	9.8	$186	$316	$251
Agency applied for Rep. Payee	2.3	3.7	3.0	$60	$94	$77
Home Care Increased to 24/7	1.5	6.5	4.0	$38	$167	$103
Referred to Mental Health Svc.	0.8	2.4	1.6	$21	$62	$41

Note: Column i through iii in Appendix B Table 3 are obtained by weighted average of minimum hours reported by different agencies with the number of client visiting each agency as weights.

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY

Appendix B

Table 5: Hours Required and Weighted Average Costs of Providing DMM services per Month per Client

	Average Use of DMM services	Min hourly cost per month per client	Max hourly cost per month per client	Average hourly cost per month per client	Min hourly cost for an average client	Max hourly cost for an average client	Avg hourly cost for an average client
	i	ii	iii	iv	v = i x ii	v = i x iii	v = i x iv
Basic DMM Services							
One Time							
Organize Finances	0.52	$189	$988	$589	98	511	305
Budgeting	0.66	$84	$261	$172	55	171	113
Recurring							
Bill Paying	0.90	$107	$124	$115	96	111	103
Additional Crisis Specific Services							
One Time							
Apply for Entitlements	0.31	$140	$664	$402	43	206	125
Referral to PSA	0.14	$385	$616	$500	53	85	69
Referral to DA	0.03	$77	$103	$90	3	4	3
Referred to Legal Help	0.21	$43	$64	$53	9	13	11
Grant Stipend Application	0.38	$186	$316	$251	71	120	95
Agency applied for Rep. Payee	0.14	$60	$94	$77	8	13	11
Recurring							
Balance Checkbook	0.45	$12	$20	$16	5	9	7
Assist with Banking	0.34	$79	$120	$99	27	41	34
File Income Tax	0.03	$103	$103	$103	4	4	4
Enable HHA to access money	0.41	$26	$51	$38	11	21	16
Debt Management	0.28	$66	$216	$141	18	60	39
Homecare Increased to 24/7	0.14	$38	$167	$103	5	23	14
Referred to Mental Health Svc.	0.07	$21	$62	$41	1	4	3
Total One Time Cost					339.82	1122.56	731.19
Total Recurring Cost					167.28	272.97	220.12

© 2009 Brookdale Center for Healthy Aging & Longevity of Hunter College / CUNY