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DEPARTMENT OF HEALTH & HUMAN SERVICES

The Surgeon General of the
Public Health Service

Memorandum

Date February 10, 1983

From Surgeon General

Subject Additional Briefing Materials for Secretary-Designate Heckler

To Deputy Assistant Secretary for Planning
and Evaluation

*Prepared on
Committee Report
to Congress
for
Heckler*

Topic assigned: Item No. 5 Home Health Care

Attached is a summary of efforts which demonstrate a commitment to fairness, compassion, are cost-effective and are innovative.

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Attachment

Item No. 5 - Home Health Care

Overriding principles that affect policy decisions about the provision of home health care:

- o The technology for the home care of the patient must represent a considerable cost saving over in-patient care with no loss of effectiveness.
- o The technology for home care must be designed for incorporation into the normal or average home environment.
- o The home in which the support services are provided must be "nourished" by the community and accepted as normal.
- o Steps need to be taken to ensure adequate, available and accessible health and social services for the patient and the family.
- o Administrative arrangements need to be made to guarantee some level of continued, responsible contact between the discharging institution and the patients at home.

New and Innovative Approaches

o Children with Disabilities

An estimated 1.2 million American children under the age of 17 are limited in a major life activity because of chronic conditions. Some of these children are ventilator-dependent and rely heavily upon essential support services and technical equipment provided in hospitals which is very costly. In Pennsylvania, Illinois, and New York there are specific examples of ventilator-dependent children being cared for successfully at home at approximately less than one-third the cost of hospital care. Using the ventilator-dependent child as a model, the Surgeon General convened a workshop in Philadelphia on December 13-14, 1982 to attempt to answer the question: Can quality care for children with severe medical problems be provided in a home and community setting, rather than in a high-technology medical center? Parents of dependent children, experts in medicine, nursing, health care administration, third-party reimbursement representatives and others worked together to develop a national strategy and specific steps that would need to be taken to make it possible for children with disabilities requiring life-support services to be cared for in a home and community setting.

o Establishment of Intradepartmental Board for Supplementary Security Income (SSI) Deeming Determinations

The PHS through its representative, the Surgeon General, serves on the intradepartmental board which was necessitated and highlighted by the Katie Beckett case. Members of the board make decisions

on a case by case basis and decide if the normal SSI deeming rules should or should not be applied.

The following three criteria must be met in making a determination for eligibility of SSI to continue when the disabled individual (physically or mentally) returns to live at home: 1) the continuation of SSI would permit the individual to be cared for at home; 2) Medicaid home care expenses can be shown to be considerably below Medicaid hospital expenses; and 3) the quality of care necessary for the individual could be maintained in a home and community environment.

During the past year the intradepartmental board has reviewed several cases making it possible for individuals requiring a variety of support services to be cared for in the home and community. Individuals affected have adapted to their home environments and are much happier. This effort has resulted in the savings of millions of Medicaid dollars.

o Behavioral Treatment of Incontinent Elderly Patients to Maintain Them at Home

Incontinence is the second most common cause (next to senile dementia) for institutionalizing an elderly person. Incontinent patients require 50-200% as much nursing time as do continent patients. The total cost of nursing home care is \$22 billion, and about \$8 billion of this amount is the cost for care of the institutionalized incontinent.

The Office of the Surgeon General, the staff of the National Institute on Aging's (NIA) Gerontology Center and the Health Care Financing Administration (HCFA) are collaborating in the support of a demonstration project at the Gerontology Center in Baltimore to determine if biofeedback techniques, which have been used successfully with the ambulatory elderly, can be used with the institutionalized elderly. The goal is to reduce the number of elderly who are institutionalized because of incontinence.

o Hospice Care

Hospice is a concept of care that involves home care as well as in-patient care and focuses on palliation of symptoms and pain rather than curative therapy or treatment.

Authorization is provided for coverage of hospice care for the terminally ill at home through a hospice program (P.L. 97-248, 1982). Medicare beneficiaries are eligible. Core services include physician, nursing, social services and counselling. Participation of volunteers in the program is also encouraged.

HCFA, in consultation with PHS, is developing the regulations to be published this Spring in the Federal Register.

The final report of "Study of Health Services Used and Costs Incurred During the Last Six Months of a Terminal Illness" (DHHS, HEW-100-79-0110) found an average total health care expenditure of \$15,836 for the last six months of life. Hospital in-patient expenses account for 78 percent of this total and physician expenses at sixteen percent constitute most of the remainder. Hospice care was found to be a viable alternative to conventional care. More definitive cost data is being derived from a HCFA funded National Hospice Study.

In addition, a September 1982 PHS/HCFA publication, Report on Hospice Care in the United States by Faye G. Abdellah et al., provides guidelines for health professionals in caring for terminally ill patients.

The National Center for Health Services Research (NCHSR/PHS) is funding a new study to support physicians making house calls to terminally ill patients. (Ann Marie Groth-Juncker, University of Rochester).

o Expansion of Home Health Agencies

The Orphan Drug Act (P.L. 97-414), January 4, 1983 includes a provision authorizing \$14 million for a two year period (FY '83; 84). Ten million dollars is authorized for grants to expand home health agencies and to provide loans for proprietary agencies. Four million dollars is authorized for training of home health aids (preferably 50 years of age or older) to provide homemaker-home health aid services. Curriculum and teaching guides have already been developed.

The Bureau of Health Care Delivery and Assistance (BHCDA/PHS) is developing an implementation plan and redrafting regulations to identify the preference counties (high density populations of elderly, medically indigent and disabled).

Action needed: Funds need to be appropriated to implement the program.

o Life Line Project

NCHSR/PHS through its extramural program is evaluating a life line project in which elderly individuals utilize an emergency alarm system to maintain contact in an emergency. The program is being conducted by Dr. Sylvia Sherwood throughout the Boston suburbs. A recent bill by Heckler/Pepper proposes that the alarm system be funded under Medicare.