HEALTH CARE FOR OLDER AMERICANS: THE "ALTERNATIVES" ISSUE

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Health Care for Older Americans: The "Alternatives" Issue:
Part 1. Washington, D.C., May 16, 1977.
Part 2. Washington, D.C., May 17, 1977
Part 3. Washington, D.C., June 15, 1977.
Part 4. Cleveland, Ohio, July 6, 1977.
Part 5. Washington, D.C., September 21, 1977.
(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

HEALTH CARE FOR OLDER AMERICANS: THE "ALTERNATIVES" ISSUE

TUESDAY, MAY 17, 1977

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m. in room 6226, Dirksen Senate Office Building, Hon. Lawton Chiles, presiding.

Present: Senators Chiles and Percy and Representative Claude Pepper.

Also present: William E. Oriol, staff director; Kathleen M. Deignan, professional staff member; Caroleen L. Silver, minority staff director; David A. Rust, minority professional staff member; Patricia G. Oriol, chief clerk; Alison Case, assistant chief clerk; and Eugene R. Cummings, printing assistant.

Senator CHILES. We will convene our hearing today. This is a continuation of the hearings started yesterday into home health care services. At that time I made an opening statement.

We are delighted to have with us today the chairman of the House Select Committee on Aging, Congressman Pepper, who has done much, much work and much good work in the whole area of aging and has long been especially interested in home health care.

I want to call on Congressman Pepper now for opening remarks.

OPENING STATEMENT BY HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA, AND CHAIRMAN, HOUSE SELECT COMMITTEE ON AGING

Representative PEPPER. Thank you very much, Chairman Chiles.

I have a special interest in that subject of the aging so I thank you very much for your kind references.

Senator CHILES. My interest is gaining in that everyday. [Laughter.]

Representative PEPPER. As chairman of the House Aging Committee and its Subcommittee on Health and Long-Term Care, I commend my distinguished colleagues on the Senate Special Committee for undertaking this important series of hearings on alternatives to institutionalization and appreciate your inviting our participation.

I am grateful to Representative Cohen, ranking minority member of our Subcommittee on Health, for representing the committee at your opening hearing yesterday, and we are very grateful for your kind invitation extended to our committee to participate with you.

This is yet another example of the way our two committees can work together for the benefit of older Americans. I was gratified by the result of our efforts together last year, which included joint hearings on the subjects of nursing home fires and proprietary home health agencies. As a result of our work on home health care, the Department of Health, Education, and Welfare withdrew poorly drafted regulations which would have brought profitmaking home health agencies into the medicaid program without sufficient criteria to govern their conduct.

Among the highest priorities of our House committee is the removal of barriers which force so many of our elderly citizens into long-term care institutions simply because there are no acceptable alternatives.

Last year our committee adopted a number of recommendations which could make alternative care available to millions of older Americans so that they may remain in their own homes, in their own communities, and close to their friends and families.

I have often quoted, if I might do so again, my mother who, in the last years of her life, said, "Son, don't ever let them put me in one of these nursing homes." She didn't know anything about nursing homes, so she was not intentionally disparaging their quality or their value. She had lived in her own home for many, many years. They knew that house, every foot of it. She liked the flowers of her own that she tended in the backyard. She cooked in her kitchen, she ate in her dining room, she relaxed in her living room, she slept in her bed, and she visited with and loved her neighbors across the street. Her family and friends could come whenever she and they wanted to come; they didn't have to subject themselves to the discipline of some sort of a strange institution. She didn't want, at an advanced age, to have to live with or to adapt herself to a lot of strange people whom she never knew before.

So we proposed, among other steps, that the restrictive limits on home health care benefits under medicare be removed and that the prior hospitalization requirement be deleted.

We have proposed that the definition of home care under medicare and medicaid be expanded to include a full range of homemaker and home health aid services, and that the "skilled" nursing requirement be removed.

We have called for, and we have won, additional funds for the establishment of nonprofit private and public home health agencies and the training of personnel to work in these agencies. Legislation creating this public health service program was sponsored by my distinguished colleague, Senator Church. This, again, is an example of the kinds of victories that result from our cooperative efforts.

A Crazy-Quilt Arrangement

We believe that some order must be brought to the crazy-quilt arrangement of home health services at the Federal level. Some form of home care is now provided under at least nine Federal authorities, and this must be cleared up if we are to assure that any of these services are actually delivered to those who need them.

I have proposed, for example, that a home health clearinghouse be established within the Department of Health, Education, and Welfare to collect and disseminate information concerning the benefits which are available to our elderly people. I think all of us hope the reorganization plan is eventually developed, that we will have a coordination of activities into government respecting the elderly people of the country, including an HEW Assistant Secretary in Charge of Aging Affairs to coordinate and manage policies and programs concerned with the health and well-being of the elderly.

Finally, our committee proposes the creation of a system of community long-term care centers to coordinate the provision of a wide range of health services on a community-wide basis for those suffering from chronic illness or disability.

I would also like to suggest to my friend and the chairman, Senator Chiles, to give more staff to the area agencies on aging. As I understand now they have on an average of two to four staff, and they come the nearest to being capable of coordinating at the local level of any agency that we have been able to define so far. It may be that if we give them more staff, they could do a pretty good job under the machinery that we already have of coordinating all the activities for the elderly.

These services would include home health and homemaker services, long-term institutional care services, day care, foster home, and nutrition services, and a community mental health center for outpatient services. We must also continue to promote multipurpose senior centers and outpatient clinics which specialize in geriatrics.

We have much to do. But our efforts will result in a national health policy which restores dignity and well-being to older Americans. And by making a full range of alternatives available, we can realize a substantial saving in the $55.4 billion we spent on hospital care and the $10.6 billion we spent on nursing homes last year.

I am confident that our Senate and House committees will continue to exert a strong, unified voice in behalf of the 23 million older Americans who deserve the compassion and care of their Government.

It is a privilege, Mr. Chairman, to be with you.

Senator CHILES. Senator Pepper, we are delighted to have you with us this morning, and thank you for that opening statement.

I think we have a distinguished panel of witnesses today. We have Mr. Stanley Brody, professor for social planning, departments of physical medicine, rehabilitation and psychiatry, school of medicine; and professor of health care administration, Wharton School, University of Pennsylvania; Monsignor Charles W. Fahey, Syracuse, N.Y., chairman, Task Force on Frail Elderly, Federal Council on the Aging; Ms. Marie Callender, president, Connecticut Health Plan, Bridgeport, Conn.; Ms. Terry Bloom, director of social work, San Francisco Home Health Service; and Mr. Peter D. Archey, executive director, Berks County, Pa., Office of Aging.

We are going to call on you all for short statements and then we will have some questions from Senator Pepper and myself.

Dr. Brody will start off. We will let you lead off for us today.

STATEMENT OF STANLEY J. BRODY, PROFESSOR FOR SOCIAL PLANNING, DEPARTMENTS OF PHYSICAL MEDICINE, REHABILITATION, AND PSYCHIATRY, SCHOOL OF MEDICINE; AND PROFESSOR OF HEALTH CARE ADMINISTRATION, WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA

Mr. BRODY. Thank you very much, Senator Chiles.

If you will allow a personal comment, my first professional act was writing a letter for a man by the name of Roosevelt to Senator Pepper, and I won't say how many years ago, although I am very pleased to age along with you, Senator Pepper. Even in those days you were coming up with progressive and new ideas in terms of health for the aged.

Senator CHILES. The Chair will take notice that both of you must have been boys at that time. [Laughter.]

Mr. BRODY. My name is Stanley J. Brody. I am professor for social planning in the departments of physical medicine, rehabilitation, and psychiatry, in the Medical School of the University of Pennsylvania.

I am also professor of health care administration in the Wharton School and a senior fellow in the Leonard Davis Institute of Health Economics which has been designated by HEW as the National Center for Health Care Management.

The characterization of provision of services to the elderly as "alternative," obfuscates and confuses their real service needs. The issue is that of offering the aged a choice of services providing different levels of support, including that of skilled nursing facilities.

For many, the services offered in the community are identical with those offered in a SNF: namely 24-hour, 7-day-a-week support and care. The community providers are called daughters and other kinfolk and, increasingly, neighbors, aided by a small amount of health and/or social services. Those offered in the SNF are for a population who have been admitted because they no longer have or never had a viable system of support in the community. They are either without adult children, never marrieds, or widows.

The services afforded, unfortunately, are not responsive to their social needs, but are medically oriented and a poor replication, by public requirement, of the acute-care hospital.

I might point out in passing that in 1971, and before the White House Conference, we issued a paper which pretty much said exactly what we are talking about today, and the longer things are it seems the less they change.

A MULTIPLE SERVICE SYSTEM

Accordingly, any attempt to provide for the support of the chronically disabled, and particularly the old-old, must be within the context of a system offering multiple services. The outline of such a system was prepared for the Committee on Mental Health of the Elderly of the Secretary of HEW, a committee convened and currently proceeding in response to the authorization of Congress in Public Law 94–63. An excerpt of one report written by the testifier is submitted

for your consideration at this hearing. This deals with the criteria for such a support system and a brief discussion of functional assessment which is a key aspect of the determination of the need for services.

The pattern of losses, whether health, social, or economic role, physical or interpersonal, which is characteristic of the aging process, is one of interaction and multiplicity. The supports necessary to modify or help cope with these losses and multidisciplinary and involve a complex of public and private service systems.

It is suggested that the phrase "long-term care" is not sufficiently descriptive of a set of programs whose goal is primarily preventive rather than of sustaining. While part of the focus of a support system is to maintain the level of functioning as a preventive measure, the affirmative and positive goal of prevention is compromised when considered in the context of "care."

For the purpose of clarity and to reinforce the goal of the support services grouped in this proposed arrangement, the system described will be termed the long-term support system.

Mr. Chairman, if you will permit me, I will leave my material for the record.

Senator CHILES. It will be inserted in the record at this point.

Mr. BRODY. Thank you.

[The material referred to follows:]

CRITERIA FOR A SUPPORT SYSTEM

A model service system providing long-term support should:

(1) Be a community system in which each aspect of community health, mental health, educational, and social services are seen as part of the preventive mental health enterprise.

(2) Provide easy access to the system.

(3) Consider the individual in his own context and in that of the family, and view the family as the primary support institution.

(4) Provide linkages between medical, health-social services, residential programs, income maintenance, transportation, legal, and other public and private programs.

(5) Develop special programs to meet the unique requirements of certain disadvantaged groups such as minorities and the rural and urban poor.

(6) Assure continuity of support commencing with the preretirement population.

The goal of a long-term support system is to provide, on a sustained basis, those services that will enable individuals whose functional capacities are chronically impaired or vulnerable to such losses to achieve maximum levels of mastery and control. Such a system would relate preventive, treatment, and care services to each other. The systems concept involves the organization of the service entities into relationships which promote the achievement of a common goal. Thus, in a model program, the services provided should be both community and institutionally based and consider the individual and the family in their total setting. It would take into consideration the interdisciplinary and multiagency nature of the services which respond not only to the medical needs of the chronically disabled individual but to psychosocial and environmental needs as well.

"The conditions of long-term care patients and clients are multiple in origin and interacting in their manifestation; in principle, if not in practice, no clear boundary exists between somatic and psychiatric services, or between medical and nursing services on the one hand, and social welfare services on the other. Successful management of the individual's problems depends upon the cooperation of many disciplines, services, and support systems." ("Long-Term Care Data," Medical Care, vol. 14, No. 5, May 1976, p. xii.)

The process of long-term support is based on services that may be performed in the home, in the community, or in institutions, and may be episodic or continuous as need alters over time. It seeks to match resources to the needs of the particular individual rather than individual need to the existing resource. "The distinction between short-time and long-time care is tenuous at best and patients with problems of long duration are frequently treated not only in nursing homes and other long-term care settings, but also in acute-care hospitals, physicians' offices, and out-patient clinics" ("Long-term Care Data", idem.); (and, one might add, in Senior Citizen Centers, Settlement Houses, voluntary recreational agencies, home health agencies, and other community social and health agencies).

The significance of the family and its role as a major support resource should be acknowledged and reinforced throughout the long-term support program. Not only is the family currently the major source of home health care (80 percent of home health care is given by the family), but the involvement of the family can be an important factor in achieving individual well-being both in acute and long-term care institutions. Indeed a case is made for payment by third party payers to the family rather than to a provider so that the individual can be cared for at home with the family recognized as the provider.

In short, in addition to the criteria of accessibility, availability, and acceptability, all long-term support services should meet the additional criteria of adequacy, affordability (either personally or by third party) and accountability. . . .

ASSESSMENT

"Provisions of care (support) should be the result of assessment and planning by medical, nursing, social work, and therapeutic personnel. The plan of care should be based upon the needs of the individual and family/care-taker who participate in decisions regarding the care plan." ("Long-Term Care Data", op. cit.)

(1) The outcome of assessment should be:

(a) A description of the individual's functional health status;

(b) Identification of the service needs required to ameliorate his functional health problems;

(c) Determination of appropriate referral to institutional or community based resources for satisfaction of those needs; and

(d) The provision of short-term medical, health, and social services necessary prior to or parallel with referral.

(2) Locus of assessment: Assessment may occur in a variety of community service agencies depending upon the health status, circumstances and wishes of the individual and his family. Where an ambulatory assessment is indicated, a senior citizen center, CMHC, SNF, or out-patient hospital clinic may be appropriate. For others, only those facilities offering a residential resource would be suitable dependent upon the needs and desires of the elderly applicant. A home visit is an important ingredient in order to evaluate the home environment. The degree of centralization is an important issue which to a great extent may depend on local demography and resources. Staff attitudes of therapeutic optimism for individuals in need of long-term support are key to any assessment procedure, whether performed centrally or locally, in an acute care or community service setting.

(a) Criteria for locus:

(i) An existing agency to avoid further service fragmentation;

(ii) Availability of as many of the appropriate disciplines as possible;

(iii) Experience with an elderly and chronically disabled population;

(iv) Capable of giving short-term treatment;

(v) Accessible to area served by public transportation.

(b) Centralization: The elderly vulnerable individual should have access to the assessment service through a variety of sites, particularly where there is a lack of transportation or where multidisciplinary staff are available in several locations. The use of common forms and uniform procedures may assure uniformity of assessment. A paper review by a central group may insure the consistency and quality of the assessment together with the appropriateness of disposition. Thus, assessment may be performed as a part of discharge planning at acute general hospitals and be reviewed by a regional PSRO-type interdisciplinary peer group. On the other hand, a centrally located, well staffed facility

serving the aged, such as a senior citizen center, CMHC, or public or voluntary nursing home may provide a superior and more optimistically oriented diagnostic and planning service. For those seeking to be screened, assessed, or to enter the care system, the assessment site publicized as an intake point may augment system accessibility for the community.

(c) An in-patient assessment provides an opportunity for short term treatment and for time to develop appropriate support services for the individual and/or family. Many of the limiting aspects of the functional level of the chronically disabled or vulnerable are "excess disabilities." "Excess disability" describes the gap between the actual level of functioning and the potential level of functioning. These arise from problems of coping which may be the result of emotional or social limitations, or from unavailability of rehabilitative treatment. Furthermore, it is characteristic of this group that multitude disabilities are often clustered and interact to mask and exacerbate each other. An in-patient procedure can bring to bear, in a controlled environment, an array of professional services which may resolve many problems through short time physical, mental, and social treatment. It is hypothesized that as treatment proceeds, the mental health diagnosis and therapeutic objectives may change as a result of disabilities being coped with and managed; limitations perceived by patient and provider are identified as barriers which can be overcome, rather than as constraints to which adaptation is the only choice. Rehabilitation procedures episodically administered have not been proven effective. However, if rehabilitation treatment is preferred within a setting which has an ambience of optimism continuously reinforced, both by professional staff and family, it is suggested that positive results may be anticipated.

(d) An out-patient assessment may be more appropriate for individuals who do not appear to be seriously disabled or vulnerable. Such an evaluation should replicate the same in-depth assessment, not require multiple return visits, and, insofar as possible, be available at one site.

(e) Funding: None of the major medical third-party payers, public or private, provide for funding of the assessment outlined in this section on an ambulatory or in-patient basis. An extension of title XVIII (a) and (b) would be a direct method of funding the assessment procedure whether provided by a CMHC or other unit. If the procedure were to be offered by the CMHC, they would have to be certified by the medicare intermediaries. This may require a review of the medicare regulations to assure that CMHC's may qualify as providers.

Th need for an in-patient unit, both for the purposes of emergency care and assessment, can similarly be supported by medicare program modification. Since most medical services for the indigent are already covered by the buy-in provisions under title XIX, other program extensions are not necessary.

Assessment Content

(3) Assessment content: Comprehensiveness and quality in assessment must be the first consideration.

(a) Medical assessment should be complete, including laboratory and X-ray data, on primary and secondary medical conditions:

(b) Functional assessment includes levels of mobility, instrumental activities of daily living, and physical self-maintenance;

(c) Psycho-social evaluation includes socialization behavior, communication, intellectual (cognitive) function, emotional and mental function, and family interview;

(d) A home visit is mandatory for an environmental evaluation. Additional information as to socio-economic and demographic data and housing arrangements should be obtained. An initial exploration of available alternative living arrangements should be conducted with the individual and the family;

(e) The life-style and preferences of older person and family must be evaluated if the plan of treatment is to succeed.

(4) Personnel: The group participating in the assessment should include a physician, social worker, rehabilitation nurse, and psychologist. Each discipline prepares that part of the assessment which is appropriate to that professional skill. Since the plan of treatment is concerned with living arrangements, medical care and socio-health supports to reinforce the desired life-style, the assessment should represent an interdisciplinary effort.

(5) Uniform system of functional assessment: With federally promulgated guidelines, each State should develop and standardize assessment instruments to measure individual functional capabilities which would match individual needs to available services. Many of these instruments are currently available. Diagnostic labels have not proven relevant and should not be used for referral purposes. (For a definitive discussion, see "Long-Term Care Data," op. cit.)

A functional capability assessment of a sample base of the population would provide a data base for CMH, AAA, and HSA planners to anticipate service responses and their cost, as well as to evaluate the current response within the planning area to preventive service needs.

(6) Disposition: The basic principle controlling disposition is the right of the individual to receive and refuse services and to make the basic disposition decision. A second principle is that the service to be provided is the least restrictive alternative. The AAA responsibility is to assure the availability of a choice from among a full array of accessible and adequate service arrangements. The provider's role is to counsel the individual and the family in choosing the appropriate service option which would allot the support necessary to maximize the individual's mental health. The counseling process should include the mutual setting of goals, the identification of that service or services most cogent and acceptable for their achievement and the preparation of the individual so that the services are acceptable and affordable.

Mr. BRODY. Older people with broad chronic health social service problems are limited to publicly supported, narrowly focused, acute medical resources. This issue, as I have pointed out, was fully outlined in 1971 before the White House Conference. As recently as last year, the Anglo-American Conference put on by the Institute of Medicine and the Long-Term Data Conference in Tucson repeated this observation and the inappropriateness of the medical focused system that we now have.

Currently, in any discussion of long-term support systems, the issue of cost benefits emerges as the controlling issue. I would suggest to you that, too, is a red herring and that the issue really is: How do we maximize the way of life for older people? In the West Philadelphia Mental Health Consortium, where we have pulled together a system such as I have described in my written testimony, we have three multiple-purpose centers which deliver a variety of services: Transportation, social services, social recreation, nutrition, chore services, telephone reassurance, a food co-op, and health education.

In addition to that, we provide, just like all other mental health agencies, a very limited amount of direct mental health services. We provide these services as part of our service package.

GERIATRIC DAY HOSPITAL

Recently, we have instituted a geriatric day hospital; it is only 3 months old but it already has emerged as a focal piece of help and support and also gives us some insight into the system.

The geriatric hospital provides therapy, special services, socialization, and medical services.

Senator CHILES. How would it differ from what we call an outpatient clinic?

Mr. BRODY. For one thing, it is a full-day experience. In other words people are picked up in the morning on vans with lifts and brought into the center where 2 days a week there is full medical care. We have nurses, social workers, occupational therapists, and physical therapists working with them all day long.

One of the problems about rehabilitation is that it is given usually in response to the fiscal supports for very small periods of time. Old people cannot sustain physical therapy intensively for more than 10, 15, or 20 minutes. What we do is to repeat the physical rehabilitation experience several times during the day and the whole ambiance of the experience supports the delivery of those services so that if the problem is walking, we see to it that during the day, through other kinds of activities the rehabilitation program continues.

Senator CHILES. I know it would vary from patient to patient, but how often would you expect that some of your patients would be in to this day hospital?

Mr. BRODY. I might point out to you the testimony before this committee many years ago by Lionel Cosins related to the Oxford, England, experience, and our experience is somewhat the same. We find that you reach a sort of a maximum input in about 30 days. That varies from individual to individual.

We may be able to do the best we can in a week or take 2 months.

Senator CHILES. But they could come in sort of every day for a week?

Mr. BRODY. Not every day, because of their own limitations, but we are available every day. Usually they get in about 3 days a week. I will give a very quick vignette. I will report two or three experiences which highlight this and also point out one of the major issues, which is that virtually 100 percent of the individuals we are dealing with now are people who have been in an acute care hospital within the last year.

About 17 percent of all older people go to the hospital at least once a year and 25 percent of that group go to the hospital more than once a year, so there is a funnel point there. Let me start off with a negative experience.

A 73- or 74-year-old lady had both of her hips superbly mended by my medical associates—absolutely a marvelous job—but what happened was that when we saw her she was totally wiped out as an individual. She showed up with decubitus ulcers which we eventually could not deal with; they just were so badly into her body that we were not able to rectify it. Despite our efforts she went downhill very quickly and within a week we recognized that she needed 7-day-a-week, 24-hour skilled nursing home care.

SUCCESSES IN DAY HOSPITAL

On the other hand, let me give you an 82-year-old gentlemen who was in a skilled nursing facility and was sent to the psychiatric ward of one of our general hospitals because he had become difficult to manage. In the course of that treatment, he became incontinent of bowel and bladder; in addition, he was a very confused and a very severely disabled person. We were able to intervene in that situation and we brought him into our geriatric day care. Within 10 days—and I exaggerate not—he was playing chess. He was no longer incontinent. We were now able to make plans for him to be discharged from the hospital and go to a retirement apartment house where he will have relatively independent living.

The third person was a 300-pound elderly lady who had had five operations on her knees. She was a walking medical record. The net result was that she had not been out of her house for months.

She was virtually housebound and almost bedridden. In order to get her out of the house we had to send two crews around to lift her out and get her into the lift and sort of shoe-horn her out of the house. I might say the first medical emergency that we experienced within an hour of her arrival was her need to urinate. She didn't know how to use a toilet, it had been so long since she had used one. We were able to work on that problem successfully and from there it flowed. She is now able to get out of the wheelchair, manage stairs on crutches, and on her way to starting to lose weight. All she needed was that affirmative therapeutic attitude toward her. We are considering terminating our services and moving her over to one of our senior citizens centers.

Senator CHILES. How are you funding your geriatric day hospital?

Mr. BRODY. Deceptively. [Laughter.]

Because, as you will hear from all of us today, anybody who is in the business of giving services to old people must live by his wits. The name of the game is how to massage the Federal system of medical support.

Since we are a community mental health center and since all chronically ill people have mental health problems, we reimburse ourselves through the day hospital system of mental health under medicaid. If we were not under that umbrella, we could not finance the program.

In addition, of course medicare pays for the physical therapy and for the medical care.

Senator CHILES. Thank you very much, Doctor.

Monsignor Fahey.

STATEMENT OF MONSIGNOR CHARLES W. FAHEY, SYRACUSE, N.Y., CHAIRMAN, TASK FORCE ON FRAIL ELDERLY, FEDERAL COUNCIL ON THE AGING

Monsignor FAHEY. Thank you very much, Senator Chiles. It's nice to be with Senator Pepper again. We spend a lot of time together these days at one place or another.

I have a number of identities that sometimes confuse me as well as others. Today I am wearing the hat of the Federal Council on Aging and not of the chairman of its Task Force on Frail Elderly. Lest I be accused of going beyond what the task force has concluded, I will make my other identities known as well. I am president of the American Association of Homes for the Aging and do a considerable amount of work with the State of New York as it goes through its excruciating period of retrenchment in trying to rationalize the health care system. I am a member of Governor Carey's health advisory council.

On the local level where I basically get paid, I am the director of Catholic Charities in the Diocese of Syracuse. Like the previous speaker, we try to live with our wits and use the whole gamut of Federal and State programs in the field of aging through the Older Americans Act, title XVIII and title XIX of the Social Security Act, and so on.

We would submit to you for your consideration the reports of the Federal Council on Aging of 1975 and 1976, each of which addresses

itself to the frail elderly. We feel that these reports will be of help to you.[1]

The Federal Council, recognizing its responsibilities to deal with intermediate range public policy issues as well as current ones, has chosen this type population for special consideration. Even as we use the name "frail," we have done so with a considerable amount of reluctance lest we create a situation of self-fulfilling prophecy.

Correlation: Age and Frailty

Not all frail people are elderly, nor are all elderly people frail. Yet inescapably there is a correlation between age and frailty. The way we are using that term in this context is the difficulty of an individual to cope with the vicissitudes and realities of life. Whether it be because of the loss of a spouse or lack of income, whether it be because of changing neighborhoods or the movement of one's family, whether it be physical or mental deterioration or, more likely, a combination thereof, there are a number of elderly people who today find it increasingly difficult to cope, to say nothing of enjoying life.

In looking at the demographics of the situation, we became doubly concerned as we recognized that that group which is most frail and most vulnerable is growing at a rate far beyond the general population of elderly people.

In the main we are talking about people 75 and older. Again you are as familiar, as are we, that the incidence of institutionalization of such persons over 75 is much higher than that of those under 75. The figure that we often cite of 1 out of 20 over 65 being involved in an institution, becomes 2 out of 5 or 3 out of 5 the older you get, and it is that population we are concerned about.

To short circuit the process a bit, may I merely note that we have developed for testing purposes—testing in the sense of conceptually testing in the academic world as well as among providers for yourselves as well—the hypothesis that we should develop a common Federal strategy specifically dealing with the frail. As we look at Government policy at the present time, whether in the area of income maintenance or health or social services or housing, we see a lack of cohesiveness. This is almost inescapable in that these various statutes and administrative initiatives have been taken at different times in a different historical context.

The underlying philosophy, however, seems to be that the elderly are in need of income maintenance—period. Further, if they become ill, they are in need of income assistance to utilize the currently existing pattern of care that prevails for the rest of the population. Granted, there are modest funds under the Older Americans Act and modest funds under title XX, but they hardly represent a coordinated commitment to be supportive of individual frail elderly people.

We feel that there is a real necessity to develop a much more constructive strategy of intervention.

While we are thoroughly in accord with the necessity of extending home health type services, we are in disagreement that that is

[1] Retained in committee files.

the fundamental or primary way in which we should go. Merely adding on in a mindless way to home health services will be very costly. Just as the inpatient long-term care facility can, in reality, be dependency creating—actually making a person sick—so, too, the addition of extensive care may inadvertently do the same thing.

A Systemic Approach

For testing purposes we are suggesting that there should be a systemic approach to frailty, one that makes available to all elderly persons the opportunity for someone else to know them and assess with them their current situation as well as those things that are part of their lives that could help them to "cope."

The first element is assessment.

The second is the question of helping the person manage that situation within which he or she finds himself or herself. Help them to mobilize family and neighborhood as well as to utilize the various entitlements which are theirs.

The third element in our suggested approach touches that person for whom there are no supports of family or neighborhood. We propose a nonprofessional, "significant other" to supply at least some assistance which might otherwise come from family or friend.

This general approach is outlined in considerable detail in our reports. Various facets of it are being tested out in a variety of ways. We call upon you folks to give serious consideration to this approach if it seems reasonable to assist us in field testing it.

Now recognize what we are saying. I concur with the previous speaker, Dr. Brody, in that it is almost a misnomer to speak of alternatives to institutional care. For those who need special nursing care there is no alternative for many of them. We don't want to go back to 1967 where the social services folks said, "Give us more services and we will take people off welfare." We don't want to unduly promise that which we cannot deliver.

There is an intrinsic merit to service to people in their own homes, but it is my judgment that probably the most we can do is stabilize the costs to some extent in the provision of health care in an institutional setting. There is little opportunity for a dollar-for-dollar transfer. Much of the data which has been utilized in hearings up to this point tends to have been somewhat stale and not reflective of the current scene. A variety of techniques have been developed toward the appropriateness of levels of care: utilization review, PSRO, independent professional reviews, and fiscal intermediaries, among others, which are drastically reducing medically unnecessary placements in SNF's and ICF's.

We are finding that a population in the existing facilities is becoming sicker by the day because of the more stringent policing of the common definition under title XVIII and title XIX of skilled nursing facilities.

The provision of home services will be useful, but they are not going, in my judgment, to reduce costs considerably. Homes may reduce or slow the escalation costs in skilled nursing facilities as a

whole, but actually increase them in the individual facility as the population becomes sicker.

Social Support From Social Service

Furthermore, we have concern that we would reach out to people whose basic problem is frailty and difficulty with coping socially rather than making them patients. The one way we can cut costs in the health system is by not using the system. The actual cost of health is just so extraordinarily high, and it will go higher. We suggest that a better way to take would be to try to develop programs of social support within the culture of social service rather than health.

One last point, if I may. While we are proposing a program for consideration and for testing, perhaps more importantly we are evolving principles which may find themselves actually articulated in a variety of statutes.

This, perhaps, is a more personal reflection than that of the Federal Council but, hopefully, it is founded in good practice. If we were to do a single cost-beneficial thing in public policy, I would suggest it would be in the area of subsidized housing, whether it be housing that is sponsored by local housing authorities or under section 8. We should redefine what we mean by management services. We should recognize that in housing we need to supply some modest, albeit extremely important, services. That is:

First, that management know the people in the facility.

Second, it would have the capability of facilitating the social interaction of people in the facility.

Third, it would be able to institutionalize connectedness with other community resources and actually see to it, as an advocate of the people, that residents be able to utilize their title XVIII and title XIX benefits in community health services.

Also, that it would be a function of management to provide modest nutritional and health consultation.

Were such a change in management philosophy adopted, that enormous population that is already out there in subsidized housing could be sustained in a much more dignified manner for a much longer period.

I would also suggest that before 1965 the way in which most voluntary organizations cared for the frail elderly was in the area of socially intense building oriented programs.

However, as medicare and medicaid evolved, the model that prevailed, in terms of the financing vehicle, was that which was known in the area of hospitals and doctors. We decided we would pay for those kinds of programs and activities that followed the acute care model.

I would suggest to you now in retrospect that this was a serious error. Rather than paying for a socially intense building-oriented program we skewed the whole field. We saw the development of many freestanding skilled nursing homes. We saw the programs that heretofore have operated with basically social components of care at a relatively modest cost turned into nursing facilities. This has worked both to the detriment of the people and been extremely costly.

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Today there is a growing recognition that there are some people who need a congregate setting of one sort of another by whatever name you call it. They need social support and they need meals.

There is no current Federal public policy to support such facilities. At best, we have a number of States going through contortions of utilizing the supplemental security income technique without adequate kinds of rules and regulations that assure quality of care. Only 16 States utilize this at the present time.

Frankly, the long neglected but necessary domiciliary field is going to be the next area of scandal, as Val Halamandaris and Bill Oriol well know. Nonetheless, it represents an important alternative which demands our attention.

So, Mr. Chairman, these are my general remarks to you this morning.

Senator CHILES. Thank you, sir, for your statement.

We will now go to Ms. Callender.

STATEMENT OF MARIE CALLENDER, PRESIDENT, CONNECTICUT HEALTH PLAN, BRIDGEPORT, CONN.

Ms. CALLENDER. Thank you, Senator Chiles and Representative Pepper, for inviting me to testify before the committee today.

If I were asked if I believe that this Nation had progressed toward providing alternatives since the White House Conference on Aging in 1971, I would be compelled to respond negatively. The reality is that we are faced with potentially decreasing those chances, rather than expanding the opportunity, if we define "alternatives" as non-health-care institutions.

I was probably asked to respond to questions on national policy because of my previous associations. I was associate director, Moreland Act Commission, consultant to the assistant secretary for Planning at HEW for national health insurance, as well as being director of Research and Manpower for AoA, and prior to that the special assistant for Nursing Homes Affairs under Secretary Richardson in HEW.

Now I make this statement in light of the ever-increasing cost of institutional health care and the need to conserve, if not restrict, the dollars going into pay for health care in the medicare and medicaid programs. If we are to make any headway, it will mean some politically different and difficult decisions by this committee and those of Senate Finance, House Ways and Means, and House Commerce.

These decisions are ones of reallocation or redistribution of resources from health care institutions to living alternatives and, second, of removing the health care dollar from subsidizing non-health-care institutions.

Whether we can ever effect these changes will mean making many health care providers very unhappy—unhappy because of the capital investments that have been made in institutions.

NO ALTERNATIVES CREATE DEMAND

New nursing homes and intermediate care facilities continue to be built in most States where there are too many. The demand for insti-

tutional health care continues because there are no non-health-care alternatives. We have bought beds and buildings with the health care dollar for what is known to be for basically supervised housing.

How did this come about? There is no doubt that most nursing homes and the then adult homes were poor when medicare and medicaid were enacted. They needed to be improved. But then nursing homes were seen to be alternatives to hospital care.

The regulations surrounding eligibility for home health were seen in exactly the same light: as alternatives to hospital care. What is more important, they still are by medicare. So, to be eligible for home health care you need to look as if you could be in a hospital bed.

But, as you know, less than 5 percent of nursing home patients are medicare patients and only around 1 percent of the total expenditures are for home care. The vast majority are medicaid patients. Medicaid patients can be less ill or disabled than medicare patients and can stay longer in the nursing home.

More recently came the intermediate care facilities, which were supposed to be lower level care for less money, for less ill medicaid and private patients. Because adult homes—and even, purportedly, lower level—were State or privately funded, many converted or rebuilt themselves as intermediate care facilities to take advantage of the higher medicaid reimbursement and Federal dollar. But their populations remained the same.

There has never been a concerted effort to develop noninstitutional alternatives to the level of nursing homes or intermediate care facilities in any Federal regulations nor any congressional intent in statute.

Why is this so important? Because people are not staying too long in institutions, they are going in too early. They go in too early because there are not the support systems in the community to prevent it, and those who make the placement decisions are institutionally oriented.

If you find yourself in a hospital, you have almost no chance of going home if an institution is available and continued help necessary. Once there, you probably don't have a home to go to, because it has been liquidated. If an elderly person does not have strong family support, they pretty much automatically go to a health care institution.

Study after study has shown that most of our elderly go into institutions, not for health reasons, but for lack of family or community support systems. But this supportive living is paid with a health care dollar.

SSI has only added to the problem. SSI living arrangements can't provide health care and are now filled with mental hospital discharges. We have little or no elderly housing under that name. I would suggest that we have much of it under the name of intermediate care facilities.

To discharge people with certification, recertification, utilization and review, and now with PSRO, is pure folly. What is not folly is to not go into the institution too early. I suggest we have been examining the care spectrum from the wrong end. It may not be cost effective to discharge earlier, but it is certainly cost effective to prevent admission.

RECOMMENDATIONS

Therefore, I would recommend that this Congress and administration examine:

One: To explore deinstitutionalizing the lower level of care institutions by recognizing that they are basically supportive housing and pay for the housing with non-health-care dollars.

Two: To recognize that supportive housing is an alternative to higher level health care institutions and the private home.

Three: To allow health services to be brought to this supportive housing by home health agencies, rather than providing it totally themselves. Some additional traffic could provide greater visibility and perhaps more honesty.

Four: To require that hospital discharge offices regard home care with the same equality as nursing home care.

Five: To allow nursing homes and intermediate care facilities to gradually close beds and phase out some institutions where false demand keeps them open. Many went into the business because it was profitable: Let us not be embarrassed politically if they no longer find it profitable.

Six: To enact legislation that would allow community services to be an alternative to intermediate care facilities and supportive housing.

Seven: To allow SSI to include supportive housing as a category, but require that ambulatory care also be provided.

Eight: To explore the greater use of HMO's to provide total care to elderly persons without it jeopardizing the HMO's early precarious financial structure.

I recognize that the charge is made that alternatives are an "add-on" to health care expenditures. I also recognize that the charge has been levied that studies have not shown them to be cost effective. But where is the bases to such statements? They are back in the days when medicare was first enacted. The add-on and cost effectiveness was to hospital care. Since then, we have allowed intermediate care facilities to be the true add-on, without seeming concern.

Home services have constantly been required to prove they cost less money. Less money than what? Hospital care, nursing home care, intermediate care? Hospital and true skilled nursing home care, yes; but why intermediate care? If intermediate care is the true add-on in size of expenditures, why would home services be required to prove they cost less money?

If we were to divert even a portion of the resources of this program to home care, it would be better use of the health care dollar. Because Government has become a willing partner in the capital investment of building these facilities, it will not be easy to hear about the closings or the conversion to housing. But the reality that they are too numerous and enormously expensive housing must be recognized at some point.

To continue our present posture into the foray around national health insurance will only serve to delay an alternatives program and spend many more billions of dollars inappropriately.

We have, to date, articulated a national policy on alternatives in spite of the statements that we have none. What present policy so dra-

matically displays is that alternatives is not a program we wish to pay for, as long as that alternative is a person's private home, or if it is a living expense rather than a health care expense.

Thank you, again, for your invitation. I hope that my comments may serve some useful purpose.

Senator CHILES. Thank you, Ms. Callender.

Senator Pepper has to leave and he wanted to ask a couple of questions.

SERVICE FROM NURSING HOMES

Representative PEPPER. This point is very critical to the whole question. Monsignor Fahey, would it be possible to get nursing homes who do have a considerable expertise in dealing with the elderly people to render home care services provided they were compensated in a fair way for those services?

Monsignor FAHEY. Yes. Under section 222 of Public Law 92-63, there has been called for a number of experiments in the area of delivery of home care in various ways. Actually it is more along the line of day hospitals. The Senate Committee on Aging last year put together a document on the various types of ambulatory care. I think we are demonstrating a variety of ways in that area that nursing homes could provide some alternative intense health care.

Representative PEPPER. The second question: How can we get for the elderly people the right of having a checkup at least once a year? In our Miami area, which the good Senator Chiles is familiar with, more and more of the hospitals are willing to take elderly people in on the basis only of what medicare would pay, because they have extra beds and they come out a little bit better economically by taking somebody just for what medicare pays than to have a vacant bed. How are we going to get the right for elderly people as a means of community health care to have an annual checkup?

Monsignor FAHEY. This may be against the common wisdom, but I think there is little indication that intervention in a clinic will affect anybody's health. While the medical profession, at least for a while, seemed to indicate that that was a highly desirable thing to do, I think it is becoming more and more recognized that we would have every doctor in the United States doing nothing else but checkups every year. Whether that involved symptomatic people is of any validity, I think, is highly questionable, so I guess I am not sure it is such a good idea.

I think it is probably a better idea to say we have to have a way for people who have symptoms to have access promptly to health care.

Representative PEPPER. My last question is, would it be possible to amend the law to allow medicaid and medicare, as a preventive measure—in the long run saving funds that would otherwise be spent in nursing homes and in hospitals—to provide home care for the elderly?

I would like any of you to comment on that.

Monsignor FAHEY. Whether or not we can, how much you can really prevent in these areas I think is highly questionable. How much you can prevent overutilization of costs of facilities, I think you can do it, and to the degree in which you provide home care that

enables a person to stay out of a very costly dependency-creating situation. So to that degree I think we can prevent, at least, too costly kinds of things.

Representative PEPPER. I think the Senate committee has information from many sources that in many instances home care would be less expensive than nursing home or, of course, hospital care.

Have you any comment to make, Dr. Brody?

Mr. BRODY. Yes; I would like to just reinforce what Monsignor Fahey said about the annual examination. I would suggest perhaps a different tack. One of the most expensive services we give, of course, is hospital care. I would suggest to you that instead of having what we euphemistically call discharge planning in hospitals, that we turn the hospital around and suggest to them—or really require of them—that they do intake to the community when they release a person from the hospital so that when people go from the hospital, as Ms. Callender pointed out, they can consider the entire range of living arrangements. They prepare people to move into the community instead of being cast out forthwith.

HOSPITAL, NURSING HOME USE CUT

I mentioned that some 17 percent of people over 65 go into the hospital at least once a year. That is probably a large number of the frail elderly that Monsignor Fahey is referring to. In one attempt to do this in New Brunswick, N.J., at Middlesex General Hospital we were able to cut down the return to the hospital by 50 percent and nursing homes placement by 50 percent. It is a question of putting the incentives into the system which would encourage the use of home health services and which would encourage a meaningful assessment.

If you would amend your question to include "meaningful assessment," perhaps annually or periodically, I would be in agreement. I would also suggest to you that physicians can't do it alone, that they are not trained to do it because the problems that the older people are presenting are not medical problems. The problems they are representing are problems of living, social arrangements, problems of emotional stress. The physician must be supported and aided by the social work, nursing, and rehabilitation professions.

Representative PEPPER. Thank you, Senator.

Senator PERCY. Mr. Chairman, before Congressman Pepper leaves I would like to say that I don't imagine many men saw your appearance this morning on "Not for Women Only." [Laughter.]

But I saw it. I had a tennis game this morning and while I was getting dressed I turned on the television and saw Claude Pepper. I thought you did an absolutely remarkable job. We are very, very proud of the leadership you have provided in this field. I want to commend the Chair for inviting you to be over here because every time you come over we learn something from you, just as I did this morning on the tube.

Representative PEPPER. I learned when I come back to my old home I am always refreshed.

Senator PERCY. And you are always welcome.

Representative PEPPER. Thank you, Senator, very much.

Senator PERCY. Mr. Chairman, I wonder if I could add just one question. Are you anxious to go ahead with the testimony?

Senator CHILES. Well, you can go ahead. Our scheme here, of course, is to let the panel have their testimony and then we can ask questions.

GREATER USE OF HMO'S?

Senator PERCY. I am not going to be able to stay unless I can come back after 11:15. I wanted to first say how discouraged I was by Ms. Callender's testimony that we really are off base in our consideration of alternatives. Could you expand a little on what you meant by making greater use of the HMO's to provide total care to elderly persons? You mentioned that as a real possibility. You mentioned the possibility it would put financial strain on them, but what did you mean as to how you could expand the use of HMO over total care?

Ms. CALLENDER. I guess I cautioned my comment a little bit with, now that I am head of the HMO in Connecticut and knowing the somewhat early precarious strain on these organizations, to have any congressional mandate be levied on HMO's, about 15 percent of membership—I think that we would have to look at this with a great deal of caution.

However, looking at the kind of benefit structures that are required of a qualified HMO, they obviously not only are more comprehensive than other kinds of health insurance programs but, because of the concept of prepayment, there is a great deal of incentive to the organization to use the least costly types of health care within the system but, at the same time, have access to all of those categories of care.

So within an HMO one has the opportunity to say, yes, we will apply a home health benefit or we will apply a rehabilitation benefit or we will apply a hospital or other kind of institutional care benefit.

There are no cost incentives in this organization or in this type of care to over-use institutional care, whether it be nursing home care or hospital care.

The other real advantage that I think this offers, not only in terms of the incentives for preventive care or using ambulatory rather than institutional services, is that you have an opportunity to see a member of the organization on a long-term basis rather than periodically or acute care conditions. You are always saying we really want to prevent that disability or other kind of activity and you are seeing people more frequently and more continuously, with an eye toward longitudinal care rather than sporadic care.

Senator PERCY. Thank you very much indeed.

Thank you, Mr. Chairman.

Senator CHILES. Ms. Bloom.

STATEMENT OF TERRY BLOOM, DIRECTOR OF SOCIAL WORK, SAN FRANCISCO HOME HEALTH SERVICE, SAN FRANCISCO, CALIF.

Ms. BLOOM. Thank you. My name is Terry Bloom. Ten of my twenty years as a professional person have been in the field of aging. One of the few benefits of being last is that while some of the material may

sound repetitious, it is significant for your deliberation that certain situations are prevalent from one end of the United States to the other.

You have already heard testimony of corruption in home health agencies that are receiving medicare and medicaid reimbursement. Witnesses have also told you about certain homemaker organizations where scandalous activities, fraud of the Government, abuse of patients, and excessive expenditures have cost taxpayers millions of dollars under the title XX program.

There is a third type of home care program that is fraught with unnecessary expenses and characterized, at best, by poor care. It is the individual provider who gives what is often referred to as chore service or, as we heard yesterday, what is termed the "home attendant" in the State of New York.

For a perspective on the scope of this program, let me share a few statistics. Most of us tend to think of the field of home care as a medicare program. To the contrary, less than 1 percent of in-home services are currently being reimbursed from this source.

In California alone, last year more money was spent on homemaker-chore services under title XX than was spent for home care under the medicare program in the entire United States. Most of us also tend to think of in-home services as emanating from agencies, companies, or organizations. To the contrary, the largest bulk of in-home services is being given by individual providers under the title XX program. Again, in California, 20 percent of the elderly and disabled receive homemaker services under this title, while 80 percent receive home services from individual providers.

I would add, unlike New York, as we heard yesterday, individual providers do not receive reimbursement for individual care under medicaid in California.

Let us examine these chore services and see who receives them. You are well aware of the restrictive policies governing eligibility for medicare funds for home health services through licensed home health agencies. Recipients must need skilled nursing services, must have their diet preparation and personal care done by licensed, professionally supervised home health aides, et cetera.

Chore Services: Administering Personnel

In contrast, chore services under title XX are provided, as defined by States' regulations, by persons with no training, who do not receive any supervision except that provided by the patients themselves. This would be analogous to a hospital which contains two floors: on the top floor, sick, elderly persons receive the full complement of services from trained, supervised, licensed personnel; whereas a similar population is housed on the first floor, receiving comparable services from untrained, unsupervised, and unlicensed personnel.

Chore workers are hired directly by patients after receiving authorization from a worker at the local welfare department who directs them to employ anyone of their choosing to assist them with the tasks necessary to remain in their homes. Individual providers are paid with title XX funds which are routed in a complicated system from the Federal Government: 75 percent to the State, from the State; 25 percent to the

county welfare department, from the county welfare department, to the patient who, in turn, pays the employee.

Duties of these individual providers vary greatly. To quote from the California regulations, chore services consist of the performance of household tasks, essential shopping, simple household repairs, or other light housework necessary to enable the individual to remain in his own home when he is unable to perform such tasks himself if the services of a trained homemaker or other specialist are not required.

The decision as to who needs trained and supervised services versus who does not is left to the county welfare worker who applies criteria that vary from State to State and often from county to county within the same State.

In California, there are 58 counties with 58 different types of homemaker-chore programs that cost over $100 million in 1975 alone. Typically, the deciding factor as to the appropriateness of homemaker versus chore service is the number of hours of service needed per week.

Because chore workers earn very low hourly wages, it is generally concluded that patients who need the most help should have chore service, whereas clients needing less help should have homemaker services, which cost more per hour. The irony of this is that the sickest patients—the ones who would benefit most from a coordinated and comprehensive program of professional and trained paraprofessional services—actually receive their home services from providers who are without training and who receive no supervision. It should be obvious that the deficiencies and abuses of this system affect elderly patients, the individual providers, and the American taxpayers.

Basic Philosophy of Title XX

The basic philosophy of title XX is to develop and support the services most likely to assist the individual in attaining and maintaining the greatest possible degree of independent functioning. Here again, it is ironic that a program designed to prevent institutionalization, reduce dependency, and promote self-sufficiency often violates these very aims. The abuses of individual providers to the patient group should be examined.

Sending in untrained personnel to assist elderly persons who are ill may, in some instances, actually be more detrimental than helpful to the patient. Due to ignorance rather than intent, chore workers may do too much for patients, stifling rehabilitation, or may do too little, forcing patients to extend themselves unnecessarily. For example, a chore worker, untrained in the specifics of a diabetic diet, may actually be preparing food that is damaging to the patient's health. Individual providers who are familiar with the services of other health professionals, such as occupational therapists or physical therapists, will fail to see to it that these services are enlisted when they might be appropriate.

Other non-health-related community services which could assist the patient and, by the way, reduce the hours of chore service are also not utilized because the untrained provider is unaware of their existence.

The examples of the unreliability of this group of frequently marginal employees are legion. Often, they fail to appear for work, they

may be drunk or on drugs, and may actually abuse clients who are in the vulnerable position of living alone.

As an example, a call was received from Miss W the day before I left for Washington, D.C. Miss W was a former client of the homemaker agency by which I am employed but, because she needs approximately 25 hours of home services per week, was told by the county welfare department to find her own independent provider, Miss W was in tears when she told me that she has been through nine chore workers in the past month.

Miss W is a little over 4 feet tall, has a hunchback, and suffers from a bone condition which makes her appearance, at least, unattractive. Mentally, she is alert and intelligent. Many chore workers, as she reports "come to the door, take one look at me, and are never seen again."

Miss W told me that she had not had a bath in a month and that her hair also had not been combed during this period. She has been surviving on TV dinners and the help of a neighborhood friend. She told me that one of her chore workers was given a key to her apartment, since she can't get to the door readily, and used it to steal her money and much of her food. It cost Miss W $26 of nonreimbursable funds to buy a new lock for her front door.

It is obvious that Miss W meets the criterion in State regulations of being self-directing and, therefore, must hire her own individual provider. The glaring deficiencies of this system are obvious in her case.

Patients who could be rehabilitated if they were to receive the full complement of in-home health services by trained personnel are often victims of a system that promotes unnecessary dependency. The lonely patients who grow accustomed to the daily visits from their chore workers are not motivated to reduce the hours of service. The individual providers, in turn, who are earning their living from this work in an effort to stay off of the welfare rolls, are also not motivated to reduce the number of hours of service in the home.

The service worker from the welfare department, burdened with monumental caseloads, does not reevaluate the original assignment of hours until a home visit is made, which may be a year or two apart.

Exploitation of Individual Providers

The individual provider is also a victim of the system. Contrary to Federal and State labor laws, the Government has failed to enforce the provisions that make the county the employer in these situations. Therefore, the patients who live on SSI income are declared the employer. The independent providers do not receive any of the benefits to which they are entitled, including sick leave, vacation pay, holidays, et cetera.

In many instances, even when the patient may agree to pay the employer's share of social security to these providers, neither of them is capable of completing the required paperwork. As a consequence, when the individual providers turn 65, they usually end up on SSI themselves.

In many counties, chore workers may be earning salaries far below the minimum wage. In California, for example, because there is a

State ceiling of $380 per month per client for chore services, the individual provider who works many hours per week to care for a very sick person may be actually earning well under $1 per hour.

If the individual providers are lucky, they get their checks a month or two after they have delivered the services. If they are unlucky, the forgetful older patient loses the check or spends it.

The system also exploits individual providers by asking them to perform tasks which they have not been trained to do. In California, for example, the regulations allow chore workers to provide limited personal care, such as care of the teeth and mouth, care of hair, shaving, ordinary care of nails, assistance in getting client in and out of the bathtub or shower, moving about, eating, dressing, and help with bowel and bladder care. Should untrained, unsupervised workers be irrigating catheters?

Needless to say, many individual providers do physical injury to themselves in the performance of their work, and may actually become patients themselves. People employed in a system that does not require training and supervision have no opportunity to learn on the job, to develop themselves, or to advance to more skilled levels of service.

In the system just described, misguided attempts to save Government dollars by buying a service that appears inexpensive at an hourly rate actually costs taxpayers unnecessary millions of dollars in the long run.

First of all, with little monitoring, there is a great deal of dishonesty. It is well known that some individual providers are collecting unemployment benefits on one hand and are working as individual providers on the other, just to make ends meet. Since patients, who are elderly and ill, are required to submit the necessary forms to the welfare department each month for payment, there is a natural temptation for some chore workers to pad the number of hours of service given.

Second, the many unnecessary hours of service given to patients who are already at a point where they could perform various tasks themselves cost Americans an untold amount.

Third, patients who actually deteriorate because of untrained and unsupervised personnel are often forced into acute hospitals or nursing homes, costing the Government a much higher price tag than a professional home service delivery system.

And, finally, by not providing benefits to providers themselves for their long hours of work, we are forcing them to be dependent upon society when they become ill, when they are out of work, and when they are aged or disabled themselves.

Needed: Total Overhaul

What can we do about this? As I listened yesterday, there has been a thread of common themes woven throughout the testimony. As you heard then and over the past year, the problems and issues are not just with the medicare program, just with the homemaker agencies, or just with the individual provider program. The problems exist in the entire delivery system of in-home services. This system needs a total overhaul which will bring the diverse funding mechanisms of several different

pieces of legislation together and which will also unite the administration of a wide variety of Government agencies under one appropriate roof.

Standards of quality home care have been established.[1] The Government must institute a uniform system of imposing and monitoring these standards in all of the different home care programs financed by Government. There must be well-qualified staff, in sufficient numbers, to see that these plans are implemented.

Time is of the essence if we are to develop programs which prevent the kinds of fraud and abuse we have observed in the nursing home industry. Congress should not wait for the results of diverse studies currently being undertaken across the country. These revisions must be legislated now.

Thank you.

Senator CHILES. Thank you, ma'am.

Mr. Archey.

STATEMENT OF PETER D. ARCHEY, EXECUTIVE DIRECTOR, BERKS COUNTY, PA., OFFICE OF AGING

Mr. ARCHEY. Thank you, Senator. Good morning.

I am Peter D. Archey, executive director, Berks County Office of Aging, Reading, Pa.

I appreciate the opportunity to present comments from an area agency responsible for the development and administration of an annual coordinated, comprehensive plan for aging services in a local community.

I am privileged to work with and serve a reasonable, responsible, and caring group called senior citizens. Berks County has one of the higher percentages of 60-plus population of any standard metropolitan area of the country.

The Pennsylvania Office of Aging made a critical decision to implement the area agency legislation by utilizing county governments as the single local unit responsible for annual community plans for titles III and VII of the Older Americans Act, title XX of the Social Security Act, and State and local appropriations. This State-level decision has produced a practical, integrated funding philosophy and operation without necessity of any Federal waivers.

Pennsylvania also allocated significant title XX funds for the elderly and provided State appropriations for the majority of non-Federal match. Individuals and services covered under title XX are so reimbursed. Services or individuals not eligible or individuals not wishing to voluntarily provide title XX financial eligibility information are covered with funds from title III, title VII, State funds, or a variety of local funds. These services are then related primarily to client need rather than to income level.

INTEGRATION OF FUNDS

While emphasizing target priority groups, rich and poor can be served by unified programs. Integration of the Federal Older Ameri-

[1] See appendix 1, item 2, p. 210.

can Act titles and title XX also allows the office of aging to relate to influence, and use services of titles XVIII and XIX, mental health/retardation, and other appropriate systems in the community.

For example, for a county population of 300,000, approximately $450 million a year is expended for human services, including $20 million with medicare, $22 million with medicaid, and $27 million with Blue Cross-Blue Shield.

The office of aging has developed an aging system rather than an aging agency. Designation of central legal responsibility to the county commissioners, office of aging, for funding and system responsibility is absolutely critical to the development of a system.

We are not a direct service agency. The contract services are provided through 12 contractors with 3 more proposed for additional services.

With a 1977 budget of $1,557,000.

Contract services include the following: adult day care, bookmobile for elderly, camping, center, recreational, socialization, and educational activities, chore services, congregate meals, counseling, domiciliary care, early detection health clinics, emergency fuel, home delivered meals, home health aides, homemakers, some information and referral, legal services, outreach, personal care assessments, skilled nursing supplementing other titles, specialized transportation, and summer recreation activities.

The use of existing agencies is both politically and fiscally sound, and is especially important for allowing the office of aging to retain the objective third-party role to insure that clients are able to get in and through the system. Funds are provided only through annual formal contracts. Monthly fiscal, program, and client reporting is a condition of contracting.

As agencies are used to this process and aware that it is simply good business, formal contracting is a positive, rather than a negative, process. The office of aging has initiated with other funding sources, single, unified, annual program budgets for four agencies monitored through the office of aging and then shared with all other funding sources. One of these agencies is the Certified Home Health Agency, a strong and cooperative participant in our system. A single budget has helped these agencies save time and paper handling, encouraged internal agency planning, and provided identical data and information for the funding sources.

A Centrally Responsible System

With pilot project funding and consultation by the State office of aging, the Philadelphia Geriatric Center and Pennsylvania State University data sources, Berks County has developed a multiple-access, centrally responsible system. A client can seek services at any one of several access points which include the office of aging, direct service agencies, and neighborhood centers, but the central responsibility resides in the office of aging.

This responsibility is maintained through monthly reporting and invoicing from the contract agencies; monthly client-based, auto-

mated service data; central service registry; case conferences; standardized assessment and service plan information sharing; and randomly selected, inhome client evaluations by office of aging staff to monitor contractors' client assessment and service provision.

This process builds on, strengthens, and adapts the assessment capacity of community-based agencies, moves that assessment capacity into a multidisciplinary view, minimizes evaluation visits by multiple agencies, and increases communication. Most importantly, it is all directed to offer clients the right service, at the right time, at the right place, at the right cost, by the right agency.

As an objective, nondirect service agency, the office of aging insures people access into and through the aging and related systems. No responsibility is more important. The elderly and their friends and relatives need a place in their community where the buck stops. Often the service agencies also need a place where service differences can be resolved.

The second phase, now underway, will adapt standardized assessment and service plan forms using the medicare certified home health agency base, adding those ingredients which the rest of the system may need for good multidisciplinary client assessment and community service. It appears possible to standardize forms sufficiently so that agencies can better understand and better serve clients and also meet Federal and State regulations. It can also serve as a base for more detailed institutional entry assessments.

Recommendations

The elderly, like all of us, want to stay at home. The elderly, like all of us, need a responsive range of services including, as suggested earlier, an appropriate use of nursing homes. They built this country; they have earned responsive services. What changes are needed to assure more responsive services? I see the need for: (1) Adequate income for the elderly; (2) increased housing subsidies, especially for supervised group living situations; (3) a national policy shift in reimbursement patterns to a home care focus rather than institutional care; (4) one Federal and one State agency responsible for all home care, including the development of reasonable standards, which local communities can relate to; and (5) a philosophy of continuity of care so people are served where, when, and how they need service with reimbursement available. The dollar must follow the client's needs.

I have attached a letter [1] reflective of the current regulatory fragmentation. There is only one sentence in all those regulations on professional standards review organizations on discharge planning. Others today have talked about the necessity to relate discharge planning to a community care system.

(6) sufficient funding, either through expansion of current titles or changes in the type of services and reimbursement that are available through medicare and medicaid, and I add title XX. This would provide in-depth medical assessments and a sufficient inventory of services, including nursing homes, to reward good assessment. Without an adequate range of inventory, assessments are limited in their effect.

[1] See p. 163.

(7) elimination of coinsurance and deductible provisions of medicare. It is a barrier for many. Elderly do not abuse the system. Our experience has been that many older people are very reluctant to use services. We have attempted to work with them, not as with some younger groups where services are a right, but trying to explain to people who have paid taxes for 40, 50, or 60 years, built this country, that it is not wrong to take proper advantage of an appropriate service that they need.

(8) an experiment with area agencies responsible for the sample monitoring capacity for Certified Home Health Agency cases in pilot communities as part of a broader community care system. This is similar to Senator Pepper's opening comment. This is now possible in Berks County because of local authority and the cooperation of the Certified Home Health Agency, Visiting Nurse Association, and would not require regulatory change. This is being discussed with the State health agency. It would provide total, formal, community-based, client-focused, alternative-related monitoring and evaluation. A number of other medicare/medicaid-related home care changes are also suggested in our home care report.

[The excerpt of the report referred to follows:]

EXCERPT[1] FROM HOME CARE MODEL PROJECT REPORT OF THE BERKS COUNTY OFFICE OF THE AGING, READING, PA.

RECOMMENDATIONS

General

(1) There should be continuity of this Home Care Project to test the operational effectiveness for a two year period of a client based, central responsibility, multiple-access, integrated funded, system.

(2) The Project continuity should include formal designation by the appropriate offices of H.E.W., Pennsylvania Department of Public Welfare and Pennsylvania Department of Public Health. The designation should provide the County Commissioners, through the Berks County Office of Aging, the formal authority to perfrom third party client evaluations of the Certified Home Health Agency system, both for Titles XVIII (Medicare) and Title XIX (Medical Assistance). This designation of the monitoring authority is consistent with the current Certified Home Health Agency regulations and does not require regulatory change.

(3) The Project continuity should emphasize client analysis, including but not limited to identifying and evaluating the following:

(a) Service costs per client as compared to institutional cost.

(b) Over-service and under-service provided for individual clients.

(c) Problem and/or disability indicators suggesting service need and the type therein.

(d) Client service coordination if served by more than one agency.

(e) Extent of services according to Federal priority areas.

(f) Use of common assessment and service plans when more than one agency is serving the client.

(4) The functions of Public Health Assistant, Homemaker/Home Health Aide, should be placed in one rather than two agencies. The Area Agency should continue to convene the agencies involved to work out transfer alternatives for 1977.

(5) Additional funding should be available for continuing the project to support or expand the following:

(a) The above listed transfer for centralization of the functions of Public Health Assistant, Homemaker/Home Health Aide in one agency.

(b) Additional monitoring of clients as suggested for the Medicare/Medicaid system.

(c) Expansion of client tracking, using computer analysis, such as is now being done for the Area Agency contractors.

[1] Full report retained in committee files.

(d) Expanded involvement of the hospital discharge planning, outpatient, and mental health operations will require demonstration funding of one position for each of the hospitals involved.

(6) There should be continuing liaison between the Aging & MH/MR systems, especially in the area of Protective Services and specialized housing for vulnerable clients.

(7) The Veteran's Administration should develop a central computer registry, at least regionally, so referral sources do not have to contact each individual unit for service availability information.

Medicare-medicaid

The following recommendations are specific to Medicare and Medicaid in-home services:

(1) The Medicare/Medicaid Certified Home Health Agency system should be client-based, rather than the currently designed provider-based, nursing oriented Certified Home Health Agency system.

(2) The Medicare/Medicaid system should require use of service options other than in the Certified Home Health Agency if contracting for such options is more cost effective and client effective from other agencies.

(3) Certified Home Health Agencies should be allowed to expand services or add services only if documentation is provided that such services cannot be provided more appropriately and at less cost from other community agencies.

(4) Medicare/Medicaid should provide for third party external client review of Certified Home Health Agencies, through a legally designated third party organization, which is primarily non-direct service in its own operation.

(5) The current review system by Certified Home Agencies should require formal involvement of agencies serving the elderly, namely Area Agencies on Aging, as part of the Certified Home Health Agency program and client review process.

(6) Planning and service areas for Certified Home Health Agencies should be formally designated using population as a primary indicator. For example, if the suggested population per service area is 300,000, only one Certified Home Health Agency should be certified. If more than one is certified, extensive documentation supporting service need and feasibility for more than one should be required.

(7) Quality standards should be adopted for all agencies, public, private, nonprofit, proprietary. Meeting or not meeting quality standards should be the reason for certification, or denial of certification, rather than organizational auspice.

(8) Training programs on Medicare/Medicaid for staffs of agencies serving the elderly should be increased and made available for local training. Local Social Security office staffs, already under-staffed, need assistance in expanding their training capability for other agencies.

(9) Title XIX (Medicaid) should reimburse for reasonable cost rather than the current reimbursement pattern. E.G. nursing visits are reimbursed for a maximum $10 per visit rather than higher reasonable cost.

Funding

(1) The ceiling for Title XX, a major source of Home Care Funding in many states, should be increased to meet the growing service needs; many states, such as Pennsylvania, have already reached the Federal allocation within the Federal ceiling. (Recent allocations for Child Day Care funds suggest a move to change the Title XX ceiling.)

(2) Title III of the Older Americans Act should be used for any service consistent with the legislation and approved service plans and should not have a three year renewable requirement for individual services.

Mr. ARCHEY. There is a national challenge to provide appropriate options and choices for the elderly. Aging is literally in its infancy. Home care is most effective as part of a client-based, continuity of care system, rather than separate systems, with clearly defined responsibility and regulatory authority. Berks County has made a step in the right direction, but only a small step. The progress has been greatly helped by the interest, participation, and experiences of older people themselves. They want to do their share; they care. Let us care; let us do our share.

Thank you, Senator.

[The letter submitted by Mr. Archey follows:]

COUNTY OF BERKS,
OFFICE OF THE AGING,
AREA AGENCY ON AGING,
Reading, Pa., March 10, 1977.

DIRECTOR, BUREAU OF QUALITY ASSURANCE,
HEALTH SERVICES ADMINISTRATION,
Rockville, Md.

DEAR DIRECTOR: We would like to provide several comments regarding proposed Professional Standards Review Organization (PSRO) regulations in the January 25, 1977, Federal Register. The comments are as follows:

(1) While understanding the logistics for publishing separate regulations, it is difficult to relate to hospital PSRO regulations in isolation from those of long-term care institutions and ambulatory care units.

(2) The proposed regulations reinforce the basic health care system problem of lack of continuity of care. For example, in the proposed regulations, only one section (101.708) speaks to discharge planning and only then on a basis of informing that hospital care is not appropriate. There is still no requirement to insure that those not needing hospital care receive what is needed and can be reimbursed. While this is a matter of needing significant change in both process and service availability through reimbursement patterns, these regulations indicate again the fragmentation of health care.

(3) The relationship, particularly regulatory, of PSRO health systems agencies, and State departments involved with medicare and/or medicaid is very unclear. What is the monitoring role, if any, of State regulatory units?

We hope these comments are helpful and appreciate the opportunity to provide them.

Sincerely,

PETER D. ARCHEY,
Executive Director.

Senator CHILES. Thank you for your statement.

I would like to ask whether you think trying to set up a model like the Berks County model would get around most of the problems that you have raised, or are you still going to face all kinds of problems?

Mr. BRODY. I would suggest to you the model that basically goes to the issue of well-being is a goal not clearly enunciated by Congress. But assuming that we are talking about well-being as the goal, then how do you achieve it? Berks County suggests a system which emphasizes three aspects.

One is the issue of how do you manage people through these services? We have been focusing on the service as it is done at this point.

The second is the assessment to which we have all referred. We are talking now about broad assessment, narrow medical.

Third, we talked to the array of services. The issue of array of services I think is a very sound point. The nature of our society is that we are going to have multiple deliveries of services; they are already in place. Let's not invent the wheel, but use existing services.

I think that whether it is done through the AAA agency or another agency is really up to the local community. It depends upon whether the strengths are in the community and who wants to take those responsibilities. It seems to me that you could set up a system which allows a local community certain kinds of options as to how they manage it, but the content of what the Berks County plan illustrates is universal.

Senator CHILES. Anybody else care to comment on that?

Cost Control Assurance?

I would like to hear from any of the panel; how do we set some kind of cost control over items? Title XX is one that comes to mind and the for-profit home health care agencies that are now set up, which basically are allowed to charge "reasonable" services. Reasonable services turn out to be anything they can justify in the area, and as soon as any one goes up, then it becomes reasonable charges for everyone else to go up. We see this going all through medicare and all through medicaid. There is no precedent working, and we see that all the way through hospitalization where we are using this term "reasonable" charge or "reasonable" service charge.

How can there be some kind of check on that, or something that would work? Do you see anything working, kind of like the marketplace, or any way of holding that down? That can only go one way, and we see these tremendous increases in hospitalization and nursing care. All of these are steadily going up; they go up faster than inflation; they go faster than any index; and I think it has to be because of the very nature of how you set the charge.

Mr. Archey. Senator, I think the issue of reasonable charges needs definition so that the criteria allow a reasonable rate to be documented without the concerns you mentioned.

One of the other issues is that the certified home health agency regulation has to look at competition, whether that is with a bidding process or by geographical limits. For example, unlike a number of counties in our State, we are fortunate in having one certified home health agency for 300,000 population. There are not four or five or six or seven certified home health agencies all with different rates, all with different levels of quality and capacity, serving a small population.

A third item is that the use of service options in a community, available through subcontracting on a lower cost basis, should also be a requirement for certified home health agencies. The main thing is that standards have to be developed so that standards then become the criteria for bids. Cost is one factor within it; whether an agency is proprietary, not for profit, or governmental, it should have to meet good standards that are regulated and monitored.

Standards: Key to Question

Ms. Bloom. I would like to second his comments by saying that I think most of the speakers have alluded to the term "standards." The more the regulations are spelled out that specify the amount of staffing, the role of staffing, assessment and reassessment of the patient's needs so that we are constantly monitoring the system and altering it as the patient's needs change, the better the service will be and the better position we'll be in to look at cost factors.

Again, I think that in building the standards we will find that we do have these cost factors protected and we will find a more common measurement than we have at the moment. Whereas, you have heard there are such extreme levels of care at present that there is no way

to compare apples and oranges, and I think that standards are the key to this question.

Senator CHILES. Yes. If that is true, how do we arrive at those standards?

Ms. BLOOM. These standards have been written. The National League of Nursing, the National Council of Home Maker-Home Health Aide Services, and various State groups have already written these standards. Some agencies have actually been in this field 20 or 25 years, even though medicare legislation only came out 10 or 15 years ago, and the standards are there. They are no longer written into many of the laws, and this is part of the problem. Again, we have the situation with medicare, with very strict, stringent standards, and other larger programs under title XX with absolutely none.

We have to find a common meeting ground where these standards are reviewed and implemented on a broad base, covering all the in-home service programs.

Senator CHILES. Ms. Callender.

Ms. CALLENDER. I just wanted to respond from a slightly different point of view. From the number of studies I have tried to engage in on the question of home health, probably the greatest frustration that any of us have encountered is the very lack of doubt—that there really is no uniform way of looking at services that are rendered by whom, for whom, and in what manner. This is true not only with the county and city areas, but also true with the State as well as those of the Federal system. If we are going to look at the costs of providing health care, we can only conclude that we are looking at apples and oranges rather than at both the same—that the unit by which a cost is reported can vary tremendously from agency to agency and from State program to State program, as well as who the reimbursing agency would be.

For example, if one reports a home health visit as being a nursing visit, in very many instances we are not able to tell whether that was an LPN or an aide for the homemaker, because such categories do not exist. The other difficulty in looking at unit costs is that they are not reported in the same kind of way. One might report them in terms of an hourly charge, one might report them in terms of a visit, a time length that is not determined, or one might report them as a per diem charge.

UNIVERSAL REPORTING SYSTEM

So I would say that one of the greatest steps that we could take would be to develop some kind of universal reporting system so we can look at whether or not there really is an inflationary factor or whether there are costs that are being incurred that are not really attributable to legitimate home health service. We desperately need some kind of uniform data reporting mechanism.

Monsignor FAHEY. If I may add another comment. I think from a generic way we ought to keep this program out of health. I think that health is uncontrollable as far as costs are concerned, and the only way you can surely control the mega system point of view is to use the health care culture as little as possible. Once you start with a

$100,000 a year doctor, the whole system is inflated, it has inflationary elements built with it and there is just no way technically to be able to control the costs within that program except not use the program. It should be used only for health care kinds of activities.

Those things that have to do with the support of people are better developed outside. On the part of the Reading experience, I find that basic management of the system lies outside of health. Health is brought in as needed if I heard it correctly, but that is not the captain of the team. If you have health providers, whether it be group health providers or nurses or doctors, that whole system brings with it that whole culture—so many elements that cannot help but be an extraordinarily costly system. Being an Administrator of both health agencies and social welfare agencies, it is incredible the difference between the two fields. If we keep them within the social welfare, we are better off than in the health field.

Mr. BRODY. I would suggest very briefly that an industrial model would be a good model to follow. Ms. Callender pointed out that a nurse could go into the identical thing as a chore worker, whatever that is, in the way that California is using it. You have to get a task oriented industrial study of what the job is and what the specifications are in terms of qualifications for doing the job and, hopefully, a method of evaluation.

Senator CHILES. What would you set, doctor, as specific goals for a national program for long-term care for the elderly if you were going to write this?

Mr. BRODY. If I could give you a piece of rhetoric that somebody else wrote, that instead of adding years to life, let's add life to years. We are talking about maximizing the functioning of people in accordance with lifestyles that they prefer and they seek out.

Where does an older person want to live? How can society offer the aged full freedom of choice from among an array of living styles, and at the same time maximize the level of functioning through services?

SOCIALIZED HEALTH CARE

Monsignor FAHEY. I think something we should recognize is that health care is virtually socialized at the present time, with the notable exception of behavior of doctors in their own offices. Among the avowed purpose of 93–641 is limiting health care providers through the development of franchises. I think this is the inevitable process of socialization of health.

With this highly socialized, expensive system of health and long-term care, it is best that we minimize caring for people when their needs are for social support.

In reference to something that Marie Callender noted earlier—I don't want to put words in her mouth—probably we have come to the point where we should do away with ICF/SNF distinction. We ought to have one level of medical, long-term care. If a person has needs which require, on a long-term basis, an inpatient medical management, call it one thing and reimburse it in one way. If he needs social support, place him in a nonmedical program and finance in a different way.

As we evolve the system of socialized medicine, there is little need for this kind of two-level medical approach. By the same token, to the degree in which people clearly need health care, either in their own home or in an ambulatory care setting, that is fine, but if what is needed is basically social management, then for Heaven's sake keep it out of a medically oriented center. Have it dealt with within a socially oriented kind of program.

Mr. BRODY. If I might take a diametrically opposite point of view from my good friend Monsignor Fahey, nursing homes are not medical institutions. Let's not make them that. Let's not make the residents there patients. They need only medical care for a brief period of time. For that time only, they are patients. A nursing home is a long-term care residence where medical care is available.

I like to distinguish between medical and health. I think medicine is an important part of health, and so are social services and all the other services. Long-term care institutions are essentially residences and their focus should be on social supports, on activities and the medical input when it is necessary—and when it is necessary should be seen within that context.

Ms. BLOOM. I would like to answer your question in very specific terms. I think we are discussing the alternatives issue and we have to look at the question that was asked the panel yesterday; they were asked why we use nursing homes now with such great frequency, with their acknowledged inappropriateness, and I think the answer is that we have an umbrella of services there, available under one roof. I think if we develop a model for the alternative of home care that brings together under one umbrella all of the services in the home—the attendant, the chore worker, the paraprofessional, the professional, the social worker, the non-health-related people, the friendly visiting program, the meals-on-wheels, the drug delivery program, the janitorial service, the laundry service, the whole ball of wax—this will help.

It can be done and it is being done in some experimental programs. Once we have all the home services under one roof, I think we will find less need to use the institution inappropriately.

Mr. ARCHEY. The distinction between health and social, or social and health, becomes a very basic issue in local communities. Many communities are rightly saying, "We are talking about home care." Home care is both social and health; it is part of the long-term care system.

For example, a homemaker service, in a generic sense, can be funded through a medical or social stream. Sometimes it is a health-related service: sometimes it is social.

The same with meals. The distinction between medical and health, and medical, health, and social may be more operationally usable than the arguing on health and/or social.

HEALTH-SOCIAL SERVICES

Mr. BRODY. Let me be very tangible on this issue in a suggestion that there are basically three problems that old people face: income maintenance, medical care, and what I would like to call health-social

services. It seems to me that we can separate the funding for those three items if we remove home health services from the medical framework and if we change title XX perhaps into some form of insurance entitlement.

To the extent that people don't qualify, you can then use a device similar to title XIX, which we now call title XX. But if we take a look at those three things, identify them, take out the inappropriate relationship between home health services and the medical services and be sure that the prescription for the home health services does not depend upon the medical system—for one thing there is no understanding of it; for another there is no interest; there is no training that is relative to the utilization of that service. The prescription for home health service ought to come out of an assessment which includes the entire range of human functioning.

Senator CHILES. What would be your estimates of the number of elderly that we would be talking about if we had such a program as this?

Mr. BRODY. That is relatively simple, mostly because enough work has been done now. I think both in the Cleveland study of the GAO and from the Durham study one could talk about some specific proportions in the population. Certainly you can anticipate that 7 to 8 percent of the population is severely impaired and will need a major input of services; between that group, there is another 16 percent that will need a moderate amount of services, and perhaps another 17 percent which needs a similar amount of services. The rest of the aging population would need some services but with very, very minimum aid, and the senior citizens centers may already be providing it.

The real problem is the severely impaired group. They may require services which some people might not call cost beneficial.

I might suggest, by the way, that in any study that you are doing, death probably is the most cost beneficial event that might happen. If that is the framework in which we are operating, that becomes a very difficult thing to relate to.

WHAT IS THE NEED?

Senator CHILES. What percentage of the need would you say we are now touching? In other words, what is the unmet need? You have given me the perimeter of what is out there. Of that 7 percent, what percent of that is getting service now?

Mr. BRODY. Probably about 1 or 2 percent. Most of the services—80 percent of the services—are given by the family, so not only do we want to focus on servicing the elder person but also the family that is supporting them.

Senator CHILES. We certainly don't want to discontinue the family giving that service.

Mr. BRODY. No; that is correct.

Senator CHILES. If there were 100 percent of the families giving the service we would be better off, and so would the aging.

Mr. BRODY. Right. But the family giving the service, as one of my colleagues pointed out this morning very nicely—while the family

gives services 7 days a week and 24 hours a day, just as a nursing facility does, there is a weekend off when you are working at the skilled nursing facility and vacation pay and sick pay and so forth. One of the problems we have is when the family breaks down; under this burden, there is no alternative. Many of the admissions to skilled nursing facilities comes when the daughter has a heart attack or when her husband becomes incapacitated and she has to take care of him.

Again getting back to basic proposition in terms of dollars, I would not answer off the top of my head, but I would suggest to you that it is not unmanageable. It may well be through the transference of funds within the medical system now of $130 billion that if we transferred $30 billion of that—I am trying to be as logical as I possibly can—we probably could accomplish it. I would suggest that $30 billion for these kinds of services is not an unreasonable figure if we include special housing as well as health and social services. Some of this may be a one-time expenditure for housing with services.

Monsignor FAHEY. Senator, may I suggest that the material from the Federal Council does identify very specifically, by age, the kind of population to which we would address ourselves. There are estimates of numbers and dollars to provide the service. I would suggest that you might give some consideration to that.

Senator CHILES. Thank you.

Ms. Bloom, I understand that your agency is conducting one of the section 222 demonstration projects in the relative cost and benefits of day care and in home service versus the skilled home health care now reimbursable under the medicare and medicaid. Could you tell us anything about your findings or have you reached that point?

Ms. BLOOM. Only in a preliminary way. I think the final report should be out in the next month or so. I think some of the exciting data that has come out of the study is that we have been able to follow a group of patients who receive these benefits, such as the day health services—Dr. Brody referred to this program as the geriatric day hospital. It is basically the same program he described, and many also receive homemaker services without meeting the skilled nursing requirement that currently exists. We followed that group and we are following another similar group of patients who did not get the expanded medicare benefits, but only the current medicare benefits; the results are turning out to be very dramatic in that the patients in the control group obviously, as one might have guessed, are turning out to receive inadequate care, in many instances. I think when the material from the six 222 projects across the country comes out, that this body should take a very close look. I think it will lead to some very useful legislative guidelines.

I would point out one more item relating to the testimony yesterday. There seems to be some concern about the removal of responsibilities from the family. First of all, I don't think anyone would advocate this as a plan of choice, but we also have to recognize how many elderly people are living alone. They may have family, but they may be living at opposite ends of the country. One of the parts of the 222 project in San Francisco that was so valuable was to see that the patients who went to the day health services program really gave the family some respite.

A Family Strengthening Factor

As a matter of fact, the family then was free mentally and physically to take care of many of the household chores—the homemaker duties if you will—while the patient was out of the home and was picked up and brought to some of the social and rehabilitation programs. So it really served as a great family strengthening factor.

Senator Chiles. When we try to measure the cost and service benefits we usually see, as Ms. Callender pointed out, hourly rates and number of visits are used as a cost measure.

How can we measure the relative cost and benefits of home services? Ms. Callender, Ms. Bloom, you may both try to answer that.

Ms. Bloom. Since the mike is here I will start with one specific suggestion, again from our experience in San Francisco.

It seems like a complex issue, yet it isn't. We feel that the unit of measurement should be computed as the total cost per month per patient, or total cost per patient during the life of the service that is being given in the home. Our State requires that we only look at hourly costs, and California says that only one bidder under title XX for homemaker services must receive the contract, and it must be the one with the lowest hourly cost, without regard to quality. The more costly hourly service with a lot of rehabilitative effort and professional care costs $30 or $40 less per month per patient than the untrained choreworker service that I mentioned.

To give you a statistic, the monthly cost in San Francisco County for chore service for a comparable patient comes out to about $230 a month with a very low hourly rate paid to the choreworker, whereas the professional service averages about $174 per month per patient for a complement of professional and paraprofessional service and gets the patient off the service, I might add, a lot faster.

So I think the suggestion from Ms. Callender that there be only one potential uniform rate of measurement is a valid one. We are using too many criteria.

The Totality of Cost

Ms. Callender. I suppose if you are really to effectively equate the cost effectiveness of home care not only would you have to take into consideration the unit cost which I mentioned before, but obviously there are other kinds of living costs that we would have to take into account. If a person is going to remain at home, obviously not the only costs that they have is that for a person's home, but for food and living and other expenses.

There are some demonstration projects around the country that are now looking at the totality of that cost, but I would again urge one to look at cost effectiveness of what? Cheaper than what? Or equal in cost to what? We need to make clear as to what our demonstrator there is in terms of cost effectiveness.

One, I think, could be short-sighted, if you only look at a per diem cost for a very short period of time. If one were to take a look at the substitute of home health service for institutional services, you obviously would have to give the home health services an equal chance at providing services to a person for a period of 3 or 4 years, which is the average length of stay of most individuals in an institution. So I

think not only determining uniform cost accounting mechanism but taking a look at all of the other cost implications as well as looking at the provision of these services longitudinally over time would really be the only fair way of doing it, and then asking how effective to what?

Senator CHILES. Cost effective to what?

Ms. CALLENDER. Well, that is the question. It has been said that home health services are not cost effective, but when one looks at the usual reference point there has been hospital care. In other words, did you save hospital days by providing home health care services, which is a very narrow definition of the kind of alternative to institutional care that we are talking about here? Are we really saying that by providing home health services one can prevent institutional care, in lieu of institutional care, or discharge sooner from institutional care when we really have never had any clear perimeters of those three distinctions?

Monsignor FAHEY. We too have a 222 experiment. It has a very intense health focus and these units of cost are perhaps comparable to in-patient nursing care. On the other hand it is very hard to underestimate the value of keeping continuity with one's family and the environment within which one finds himself. In working with the situation in which the person is living—that is, helping both the family and making modifications of the physical environment—the person is enabled to return or continue on an ongoing basis. Second, in such an arrangement you avoid creating an institutional psychology in the patient and in his family; rather there is the continuing expectancy of returning or staying home.

CONSIDER COMPOSITE COST

In regard to the cost benefit, I don't know how we can escape including hospitals, skilled nursing and home care all on the same package. You have to look at them all together in one kind of a unit. New York is struggling desperately with this—75,000 acute-care hospital units. We have roughly 80,000 skilled nursing and ICF units plus another 40,000 domiciliary type units in the State. We spend half of the Federal matching money that is utilized under medicaid for noninstitutional services. It is only when these pieces are all put together that we can recognize what our options and alternatives are. National public policy must take cognizance of all these patterns and new interaction. The medical techniques of intervention, long term and short, must find a complementary in the techniques of social intervention, and vice versa.

The more acutely ill a person is, the more in need they are of intense medical types of intervention, the easier it is to deal with the question. In long-term care, much of the problem is social—not medical, management, and support.

Ms. CALLENDER. Mr. Archey, how have you dealt with the problem of cost effectiveness, compared to your health care, as to institutional care in the situation that you are dealing with?

Mr. ARCHEY. As part of our home care project we did a cost assessment of several agencies, reviewing all services to the individual.

We have had a variety of inventory options or services in the community, combined with more in-depth assessments as we go along. The more options that are available, the better your cost situation,

because you tend to use options appropriately. You don't tend to underuse or overuse what is available. The issue of sufficient variety of services and good assessment is also critical in light of how you do cost effective situations. Our experience has been, or was, in this study that even adding on suggested fixed costs—for example, housing costs—until the client was in a situation where an assessment recommended nursing home care, in most cases it was cost effective to serve the people in their home.

Cost Effectiveness a "Red Herring"?

Senator Chiles. Mr. Brody, you have told us that home care cost effectiveness is a red herring, so you better tell us why.

Mr. Brody. Yes. It depends again on what your goals are. What value when your son visits his grandfather—your father—in a nursing home or in the community whether he sees him in one setting or another setting? I can't put a dollar on that, but I would suggest to you that that is not a bad goal for him to see his grandfather or his great-grandfather at his maximum possible level of functioning now. The issue should be, what are the needs of the elderly and how are they to be matched to services?

I was very much bemused by the New York Times asking for people who were high achievers about their three wishes in last Sunday's magazine section. Almost all of these very high achievers were very concerned with their picture in old age. I think that having old age to look forward to, to grow old with "The best is yet to come"—it is very difficult to put a cost-benefit analysis on that one.

Senator Chiles. We thank you very much for your testimony. Mr. Oriol may want to ask a few more questions if you are not all totally exhausted. I am going to have to leave to get to another meeting now, but if you could stay a few minutes longer. Thank you for helping us make this record.

Mr. Archey. Thank you.

Senator Chiles. Hopefully we can get somewhere with these hearings.

Mr. Oriol. Thank you, Senator.

Senator Chiles. I should have mentioned that our hearings tomorrow in which we were going to have the officials from HEW, we are going to cancel those hearings and just keep the time open and recess until we can get a proper witness, because we felt that we were not able to get the witnesses that we needed tomorrow.

Mr. Oriol (presiding). Mr. Archey, you heard everybody say that perhaps you have the answer in Berks County, yet I wonder how far you feel that you are going in meeting the needs as you see them. How is your budget situation? How many people who need the services you provide are receiving them?

Mr. Archey. Several answers. First of all, we have a good start and sense of direction. We by no means have what would be defined as a full answer. All we have been able to prove is that we have been very fallible people—we make a lot of mistakes. We are serving the centers, excluding information and referral and excluding general hospitals which would include the long-term care facilities, home care service

centers, et cetera. It is approximately 15 percent of the eligible 60-plus population. We really don't know at this stage whether that is good, bad, or indifferent. That is one of the things we will be looking at.

We would like to see a change in the title XX ceiling. It would be better to have the lid off or a higher ceiling so Pennsylvania, which is at the maximum use like a lot of the larger States in the country, can have the availability of more title XX. We would like to see that changed so we get our share in Pennsylvania for the elderly.

Medicare Coverage for Homemakers

I would like to see homemaker services, nonpersonal care, included in medicare as several other people suggested. Our funding patterns right now are significantly limited in the residential area; we are part of the pilot program in domiciliary care in our community. We are starting to look at that; we are hopeful.

One of the issues that occurred recently in housing nationally was a suggestion to meet the fiscal crisis, a very difficult situation for housing authorities. There were regulations published that suggested housing authorities begin to mix income groups, which is good for service and begins to deal with the issue of more income. However, it makes housing authorities more limited in their ability to serve the most vulnerable people; namely, low-income elderly.

The area of medical assessments talked about, either through medicare or medicaid, is limited.

Any specialized transportation is a continuing issue, especially for medical visits. We have a core inventory of services. If we could have one major thrust which would do more for us, than any other, it is a sufficient supply of group living situations, the so-called nonmedical supervised settings. We would be able to turn the system around, as would other communities.

Mr. Oriol. What forms of group living do you now have in Berks County?

Mr. Archey. Some boarding homes, a fairly good number of housing authority buildings, high-rise buildings, group living, nonmedical, but a heavy demand for them with waiting lists. There has been a good increase recently by the county housing authority with building outside the city. Some section 8 subsidy housing is being built which will help. We have a very high rate of home ownership in our country; I think it is indicative of elderly. It is a security issue. Even though they are paying more than we think people should pay as part of their income for housing, it is security, a roof over head they own. They don't want to worry about alternatives with higher costs, or not available. Group living settings in sufficient numbers and reasonable cost would help greatly. Other changes we suggest in home care are additional funding and a lot of flexibility with it.

Mr. Oriol. When we had this discussion before where the Berks County might have an important key to the problems we are all talking about, Dr. Brody said that it really did not matter whether it was an area agency or some sort of other agency, or whatever—that is, the coordinator or the pooling of funders. I have a little trouble in applying to other agencies what the area agency on aging has done.

The key does seem to be having the say on how title XX money is spent.

Now, maybe Ms. Callender would feel that a health maintenance organization or HMO should have that key. How do you feel?

Diverse Funds Utilized

Mr. Brody. I can only relate that in west Philadelphia, the mental health consortium performs the same function. Interestingly enough, we serve the same proportion of our elderly as the Berks County program. We use something like 15 different funding services, ranging from alcoholism to title VII of the Older Americans Act, as well as title XX. We use Veterans funds, CHAMPUS, and so forth.

Mr. Oriol. But you said you were deceptive.

Mr. Brody. Pardon?

Mr. Oriol. But you said you were ingenious.

Mr. Brody. Well, entrepreneurial; let's put it that way. When Berks County totals up where its moneys are coming from, they will be similarly entrepreneurial. Almost any witness who comes up here and says that they are doing something will cite the same litany of management of these funds and, therefore, they have access to them. In my particular community it happens to be the mental health consortium. It seems to me an HMO headed by Ms. Callender could easily perform the same kind of function. I think it is safe it is a question of what the local resources are, who takes the initiatives, and who is willing to assume the responsibility.

Mr. Oriol. Did Ms. Callender want to comment?

Ms. Callender. Yes. I would like to respond somewhat in defense of myself that I think what we are really saying is that there are a number of very categorical programs that need to be brought together for persons who don't have either the ability to bring them together for themselves or don't have any recognition of the fact that those particular programs exist. I don't know that it makes a great deal of difference as to what that coordinating unit is as long as they don't allow their own particular philosophy to dominate the system, the kinds of things that Father Fahey refers to as having the health care system dominate the social system or service. I think we need to remain somewhat interested and honest there, but one of the other things I think that we are really talking about, in this coordinating mechanism of various and sundry categorical programs, is that we need some other individual to legitimatize what the elderly person needs in addition to the elderly individual.

Income for Purchase of Services

Now, I think that all of the kinds of categorical programs that we have developed and proliferated is in many ways saying that the elderly individual does not have the right nor the capability of making choices themselves. So I would offer that, if there is some kind of an approach to long-term care, one of those approaches might be an income maintenance approach rather than a categorical health care or other kind of programmatic approach where some professional

makes the decision about whether a person legitimately needs that service and whether that service that they are purchasing is a legitimate kind of service. If we were to allow some free choice of selection on the part of the elderly by increasing their purchasing power, my guess is that some of the cost effective questions that we had might very well be solved by the elderly themselves.

Mr. ORIOL. But in order to make use of the purchase power, he has to have something to purchase and he cannot purchase from confusion.

Ms. CALLENDER. Yes; I think there is an official responsibility to make sure that the consumer is not purchasing a fraudulent service. I think that is a very good thing for one to get into, but to say that that person then must choose that service and if you happen to choose the service of a nursing home, we can no longer provide you with income. In other words, there are punishments that have dealt with the kinds of choices that an individual makes.

Monsignor FAHEY. As reluctant as I am to say it, unless we change the whole system I think the only place this can reside is in the public service agency since it controls the medicaid as well as the title XX dollar in most States.

Assessment is coming in the back door. The assessment is a fiscal tool and centers around the appropriateness of placement levels of care. That is where the action is at this moment.

New York, as you may or may not be aware, is speaking to the development of an assessment process for private patients as well as publicly supported patients who reside in publicly franchised programs.

Mr. ORIOL. Is that the point?

Monsignor FAHEY. Yes.

Mr. ORIOL. And that is statewide?

Monsignor FAHEY. Statewide, universally applied to any people in a domiciliary facility, nursing home, department of mental hygiene facility, board of social welfare facility, or health facility. It will be on any home care agency as well. I say that now, stating that New York's problems are a harbinger of things to come throughout the country.

I think around the freedom of choice issue, for example, there is virtually no freedom of choice anymore. In health we are creating techniques to allow access but not freedom of access. Franchising is defacto designed to create shortages. Today, one who has money can choose a doctor, but there is little choice in acute care or longterm care from that position.

Mr. ARCHEY. Several issues in the State of Pennsylvania—the department of public welfare includes the State office of aging. A decision was made, primarily because of the advocacy groups, that any individual income determination is done through office of aging and not through the public assistance system.

Some other issues are important, regardless of where things are placed. Designated authority and responsibility is absolutely essential. That is absolutely critical.

The second issue is consideration to responsibility and authority, particularly on a monitoring basis, fitting more appropriately with nondirect service agencies than direct service agencies. That also is a personal preference in our organizational style.

The third is an issue with every area agency in this country as part of a national, State, and local network. There is a legislative mandate to develop comprehensive and coordinated programs for people 60-plus. If that is going to be our function, and I believe it should be, it has to be clearly designated and clearly defined. If that is not our function for people 60 and older, I am not sure how appropriate we are in relation to all the other systems serving the elderly and needing coordination. We need some national definition and legislative agreement.

Overlap of Laws and Programs

Legislation and regulations tend to overlap one mandate on another and another, and it just does not work. It goes back to the main issue of legally designated authority, in this case the function of a service system for 60 and over, to get people into and through systems effectively in local communities.

Mr. Oriol. Speaking of mandates, how do you comply with the provision in the Older Americans Act amendments that home health shall be one of your priority services, transportation shall be another, home health care still another, and legal services?

Mr. Archey. We started and have continued as a contract agency. The Pennsylvania Office of Aging channels Federal money through our office in addition to some State appropriations. A fairly significant flow of local money is run through our office, also. With an adequate base, we started with a very large homemaker contract, a contract with the American Red Cross, for doing our specialized transportation and with several others. We were already at and beyond that service and funding level, so it was no great problem.

Mr. Oriol. Monsignor Fahey, you asked, I think, that there be Federal action taken to develop processes to test out ideas now under development.

Now, Ms. Callender, in an article with Judy LaVor entitled "Home Health Cost Effectiveness, what are we measuring?" Several of the comments she had were about how we try to compare things when we don't have a basis for comparison, and yet our conclusions seem to suggest that the only way to arrive at the answers we seek is an expansion of our present system to provide such services. It I read it correctly, the article said the immediate effect of program expansion would likely be an increase in aggregate program expenditures, but you added: "It would take some time, possibly up to 3 to 5 years, to counteract the current threat toward increased hospital and nursing home utilization in costs."

How Do We Proceed?

Now, both of you seem to be calling for application of what we know. First, how do we find out what we know and how do we apply it even while building a system? I don't think any of us want to sit around and wait for the final results to come in from all research; we want to be moving in a direction. Now, what do both of you envision in this area?

Monsignor Fahey. Speaking for the Council, we are in the process of trying to evolve a research proposal which ultimately will build

upon existing knowledge but yet have enough specificity to contribute to testing our approach. There are several aspects of our elderly approach we feel are not being tested out at the present time. We feel it should be, so I would hope within the next 6 months or so we would have available for your consideration, and the other appropriate committees, some very specific areas to be tested.

Ms. CALLENDER. That was a long question, Bill, but let me see if I can go back and pick up on a couple of things. I think in the context of the paper that Judy and I wrote on home health services, the question about cost effectiveness and why do we go ahead and expand services, really referred back to the original committee reports on the placement of a home health benefit and medicare and medicaid legislation. The comment, as I recall, from the committee at that time was that we would anticipate that, as the program progresses, there would be an increase in the number of home health agencies available as well as the number of people who were taking advantage of those home health services. With the expansion of that kind of benefit and resources we would be in a better position to have more data to make available and to make comparisons between home health and nursing homes. I think our statement was that this, in fact, did not happen—that we did not see enough home health services being utilized either under the medicaid or medicare program. This was equally true of other types of health insurance programs where you had any meaningful statistics to be able to make any kind of cost-effective comparisons from one point of a program. It was our feeling that since it was the original interest of the committees to have an expansion of the home health benefits under those two programs that we ought to get about doing that, if that is what we really intended.

Mr. ORIOL. Is that similar to that expanded benefit period which has been suggested by some quarters within HEW? Are you familiar with that?

Ms. CALLENDER. I think that is probably somewhat more contemporary thinking than what we were referring to at that time. I really just felt that the committee, though—that the provision of a home health benefit in that original legislation would allow more people to take advantage of that benefit and not what happened because of the very restrictive eligibility requirements that were built into the regulations. It was just that that kind of thing did not happen. If one wants to look at whether or not a program is cost effective or beneficial, obviously you have to have enough statistical data to make that kind of comparison. So I think that some of the experimentations that are going on under section 222 are certainly beneficial. However, I must say that where some of those experimentations are taking place in only one segment of the health care industry, we probably are not going to get the kind of effective results that we would want. Say, for instance, if we are only going to be looking at home health services and making sure that the total spectrum is available to make choices for placement or care, we would be losing the kind of thing Father Fahey has alluded to.

Mr. ORIOL. We have not noted here today that you served as Special Assistant for Nursing Home Affairs at the Department of Health, Education, and Welfare from 1971, was it, through 1973, and you

dealt with many proposed initiatives and saw several things get started.

Now, one of the things you saw get started was a division of long-term care within HEW, and that has undergone a number of organizational changes and, in fact, it is difficult sometimes to keep up with exactly where it is. Now, there is some speculation that this will become a component of the new Health Care Financing Administration. Now what, would you say, is the job of this division and where do you think it should be placed within HEW?

No Dialog Among Decisionmakers

Ms. Callender. One of the things that always troubled me when I was working in HEW was that the persons who were making the money decisions and the persons who were making the programmatic decisions very often did not either know one another or have any frequent dialog with one another. If there was one thing that could have assisted this kind of gap between the moneylenders and programmatic people it was the creation of an office that would have some kind of a responsibility to bring these two activities together. I, quite frankly, do not know whether the inclusion of the division of long-term care in the Health Financing Administration will bring together the programmatic people with the ones who did the actuarial work if that kind of function is not carried by the office. If it does not bring the programmatic people and the fiscal people together, then I would feel that it has not served its mission. This is the kind of thing that I would hope to take on as a charge and would continue to do. Like you, Bill, I really don't know at this point in time what the message to all of us was.

Mr. Oriol. This is one of the points we want to take up with HEW later.

I would like to go back, Ms. Bloom, to the individual provider issue. We have not noted in the record today, even though we had discussions from New York yesterday and discussions from California today, that means of providing in-home services is not limited to those States. The one survey indicated that 12 out of 24 States surveyed did use the individual provider system. Now, you said that millions of dollars are lost, if I understand you correctly, in California alone because of the present system, but yet we have a number of people providing care. You heard yesterday from the New York witness that perhaps positive results could occur if we could somehow channel this type of help and make it part of the system.

How would you go about that?

Varied Levels of Care

Ms. Bloom. I think it was Miss Kinoy yesterday, and I would be taking a similar stand on one major way of cutting funds, and that is, as you see, there are several different levels of paraprofessional care we are talking about and the semantics are confusing—home attendant, homemaker, chore assistant, et cetera. I think we are both saying we want a trained component and I think that the training and the different degrees can be worked out.

She points out that in New York, for example, there is a system where there is a pool and they are trying—I presume in their welfare departments—to get some minimum level of training in that pool of resources. In California, we don't have such a pool, and people are left to fend for themselves and find the best help that they can. I think if we agreed, at the point of being repetitious, in the concept of trained health workers, the mechanics of the differentiation would work themselves out. You know, a lot of the differences in the way we look at health care is whether the patient is prone or not. When the patient is lying down they get all kinds of trained people and they all have to be licensed and in uniform. When the patient is standing up and ambulatory, we have another whole set of ethics.

I would just say that it goes back to the earlier question: Who should make the decision? We know that when the patient is prone, the physician is making the decision and we cannot seem to decide today who should make the decisions about coordinating the effort for this alternative delivery system outside of the institution.

I wish to say here, I don't think it is that relevant who it is or what governmental body. I think the important point that several people have alluded to in both days of this hearing is that it be some sort of a multidisciplinary professional approach involving the patient, the person who is least involved, and I think several speakers have alluded to the same point.

Mr. ORIOL. Dr. Brody.

LESSONS FROM THE ENGLISH EXPERIENCE

Mr. BRODY. We never take a full look at some of our own foreign colleagues' experience. While it is obviously not completely comparable, nevertheless the English experience is good to examine. They have come finally to recognize this dichotomization between what Father Fahey calls social but I call health and medicine. What they have done in their 1974 white paper was to try to build up the health/social service component until it becomes equal and able to deal with the very clearly powerful medical components. That may be the way we have to go, to start to build up health/social services, define the services, take them out of the medical umbrella, put them into a health/social service umbrella, start the funding on a parallel basis the same way, perhaps by capitation, perhaps by a third-party reimbursement. Our system can then evolve over a period of time until we build up an even array of these two services; that is, medical and health/social services. At the same time build in a management focus in every community where an assessment is invariably required over a period of time which would justify the giving of a particular service at a given time.

Mr. ORIOL. As we discussed earlier today, one way or another what we have been talking about for 2 days is being provided or will be provided. There are so many people now involved in trying to deliver the services or to solve the problem, but I think our task is to try to make that problem-solving process as efficient as possible.

I am collecting opinions on something that I asked the group yesterday. I asked and I very much appreciate getting some more today. This is my last general question.

Why Prefer Institutional Care?

I asked yesterday: What is the cause of this bias in favor of institutional care? Everybody says we suffer from it; everybody says that noninstitutional care is definitely at a disadvantage in this country. So I asked yesterday: Why is this so? Is it simply a matter that doctors don't want to run the risk of being sued for not performing enough tests? Is it more complicated than that? Is it just force of habit?

I received some good views yesterday and I would like to go down the table today on that question. You have an advantage; you were here yesterday.

Ms. Bloom. I also have the microphone.

Mr. Oriol. That is control.

Ms. Bloom. I will start with three. I am not sure that they were mentioned yesterday.

First of all, I think we cannot deny the importance of the lobbying influence of the nursing home industry and I don't think that point needs to be belabored.

Second, the convenience to the physician of dropping into the neighborhood nursing home and making 10 visits, and comparing that to the time involved in making 10 home visits.

Third, I think ignorance about the whole home care system—I heard reports of a study done with physicians. I am not sure where. In a particular community, more than 50 percent of the doctors were unaware of the home care resources in their own community. And that ignorance goes beyond just the figures, it even goes——

Mr. Oriol. I missed where this occurred. Was that one community?

Ms. Bloom. I am sorry; I don't have the information at this time.

Finally, the lack of information is not limited to physicians, but even to the discharge planners themselves. We cannot underestimate the fact that the patient has such a small role in saying for himself or herself where they want to go, usually at the point of leaving a hospital facility.

Mr. Oriol. Is that the patient's fault or somebody else's? Are we also cowed by the medical establishment—we don't ask questions and we don't insist on things?

Ms. Bloom. I think it is both. I think older people are frightened that they are rocking the boat and will lose some services. They are ignorant of the system. They look to their professionals, and the system perpetuates itself.

Mr. Oriol. On that point of professional ignorance—and I see Mr. Archey wants the microphone here—you have worked for some time now to develop a system. Who would you say has the level of professional understanding in the medical community of what is available?

Mr. Archey. One of the things we try to do which has been effective is have regular meetings that involve not just our contract agencies but the bureau of vocational rehabilitation, board of assistance, hospital discharge planners, and so forth; in other words, contract providers and just as importantly, people who have to make referrals into the system. People who are not funded by that system but have to use

it, say, "How do I get my people into the system?" It helps clarify and identify our strengths and weaknesses.

Another item is that the elderly themselves have done advocacy wonders at centers—nutrition, some income issues. They have not been heavily into the home care areas because it is complicated and difficult to understand. Elderly involvement in home care advocacy is needed. Funding patterns have tended to be facility-related rather than home-care-related; therefore, we have not had the options to talk about until a few years ago.

We have talked about having an easy access system. Some of the people that we find very pleased with the access to services are under-60 people who care for elderly friends and relatives. They primarily think about a nursing home because that is what they see; they did not see a lot of community alternatives. When they understand there are options, they are happy people. It is a whole public education, public information effort both for the elderly and people under 60, including the medical community.

Mr. BRODY. First, I would like to challenge the question. I think that since everybody is putting so much faith in dollars, I would point out to you from a historical point of view that we spend a tremendous amount of money for the support of old people in the community; that is, the OASDI and the SSI program, the veterans' benefits program, and so forth. So, in fact, we do put a lot of money into support.

On the other hand, when we talk in terms of moving over to services, other considerations come in. I would like to suggest three considerations.

THREE CONSIDERATIONS

One, of course, is our religious belief in scientific medicine, and I want to quote from a recent issue of Science—a lead article by a doctor in Rochester who points out that scientific medicine is folklore of western civilization. I think that what we see in medical institutions is what was seen in the 14th century, when 50 percent of the gross national product was spent in building the cathedrals. Perhaps the new cathedrals are the hospitals; in which case, the emergency room also becomes a chapel which is open 24 hours a day for all entrants. The second consideration is the fear of death. Our value structure seems to be longevity, and I think that reinforces this whole emphasis on scientific medicine.

The third piece, I think, is a sociological factor. We have not caught up yet with the change in demography. We had the same disaster when we had the sudden bulge of youngsters coming from the baby boom. We are experiencing an old-age boom and we are having the same kinds of problems in responding to that as we had in responding to youth in the sixties.

Monsignor FAHEY. I tend to think this is more a slogan than a reality. The enormous commitment to income maintenance is a home support as well as payment under XVIII and XIX for such things as doctor service. Even the description of the problem is fuzzy. What is an institution, an SNF, an ICF, a congregate setting, subsidized housing?

Positively, I think the desire of people has something to do with it. The reason people end up in some sort of congregate medical setting

is because there is a fundamental need for people to be other than in their own homes, because their own homes are no longer appropriate. While they have a deep psychological commitment to their own homes, many are prisoners. They cannot afford them; the neighborhood has changed, and so forth. We find people who are in need of a more protective setting. The provision of more discrete services of a nurse or a choreperson does not meet the more fundamental need for companionship, security, and good nutrition.

Also, many are looking for continuity of care and for a sense of security, partially exacerbated by our very utilization review-exigencies that apply themselves to home health types of things; there is no assurance that I am going to be taken care of on an ongoing basis.

Of course, you cannot discount the fact that institutions were there and that we recognized the need of people to have income support to utilize them.

This highlights one of the critical elements; that is while we will pay for medically intense institutions we will not pay for socially supportive institutions.

Mr. ORIOL. All I had in mind was hospitals, nursing homes, and boarding homes. I draw a distinction, as I think you do, between an institution and a residence. You can have a residence at an apartment in a congregate housing site in which there are certain rules and certain times of day when people do get together and so forth, but when you close the door of your unit at night, that is your residence. Is that what you apply?

Monsignor FAHEY. Yes. We both heard that definition over in Paris a year or so ago and it was a good one. Control over the door is the control, whether it is a residence or institution. But I think it is not a simplistic question as many would pose it.

Ms. CALLENDER. Well, what can I say, except all of the above.

The only thing that I really would like to add is perhaps something that I have not heard, and that is the very human dimension—the reality is to put together a program which is other than institutional, but it is very difficult. It is very difficult for the individual who is trying to do it; it is very difficult for the individual for whom you are trying to put it together. This is not a case that you can bring up, flip out a chart, fill out a form, and send the person on their merry way. This is a person that you are going to be seeing rather continuously over a longer period of time, which has some implications or management or fiscal implications for the number of persons that one takes care of.

The other is that most of the persons who are making most of the decisions about whether a person should go into a health care or health-related institution or some other kind of area happens to be the hospital, and there are all kinds of incentives in the hospital to get people out of there as rapidly as possible. So if one is looking at the possibility of discharge for an individual, it certainly is much faster and much easier for the hospital discharge plan to put that person in a nursing home than to fuss around with the 4 or 5 or 10 days that it would take for an individual's other alternative program to be put together. Not infrequently, in that time period the home has been dissolved, so they have nothing to go back to anyway.

Mr. ORIOL. This is what Dr. Brody referred to, not as discharge planning, but community intake. We are not very skilled at community intake.

Ms. CALLENDER. So I think there are all of these kinds of things.

Another point I would like to add is that there is very little incentive on the part of the State medicaid agencies to have persons go into noninstitutional types of care. You know, it is a rather open system of expenditures and budgeting unless you want to put an arbitrary limit on the amount of expenditures that one is going to have, rather than saying column A for hospitals, column B for nursing homes, column C for something else and, therefore, they come up with their annualized budget. It is far easier to take a look at those programs where there is a nice Federal health match, and add onto those budgetary items what are at stake than to do this in some other fiscal way.

So I think there is not the kind of prepayment incentive, which I referred to with Senator Percy, about how one distributes resources in the internalized system.

Monsignor FAHEY. Would it not also be true to say this is a strong disincentive? At least in New York this is referred to as the bottomless pit. We do not have the assessment tools for utilizing appropriations. The state of the art is not well developed to cost of a unit of service. You have x number of hospital units and y number of nursing home beds and you can at least put a line up someplace. There is the fear that you are just not going to be able to control the expenditure in home care.

Mr. ORIOL. Do you all have that same fear?

Mr. BRODY. No, I don't know. I gave a very high figure before and I did it deliberately because it may eventually come to that figure. I am thinking very much of the dialysis program. If we analyzed, on a cost basis, the dollars spent on dialysis, the $30 billion is cheap if we factored it to the number of people affected. We are willing to subscribe to dialysis.

I happened to be in Ways and Means Committee testifying the day that happened. They marched in all the scientific medicine, the bells rang, and it was very impressive. It is a shame we don't have the power of visible miracles anymore.

Monsignor FAHEY. Many of us do.

Mr. BRODY. It must be visualized. You put a patient's head in a coaxial computer and you get a three-dimensional picture and a technician says you have a tumor. That is seen as a miracle. In our technical world people don't die, the plug gets pulled.

Essentially, I think we are into a value issue. That is why the cost benefit is such a difficult thing to face, and unless we face that I would have to comment with the classic phrase that "We have met the enemy, and they is us."

Mr. ORIOL. I would like to ask Mr. Archey whether he is presiding over a bottomless pit.

"An Unmanaged System"

Mr. Archey. The basic problem we have now is that much of our discussion today is talking about a national system of care that is unmanaged. I don't think it is necessarily a mismanaged system or a fraudulent system; it is an unmanaged system. I am not sure if $30 billion or $100 billion or $10 billion is needed until we get a handle on how we are spending it and what it provides. Then we can definitively look at alternatives and options. It also means regulating the current system and changing where needed. It is an unmanaged care system with very little definition and responsibility. If there is not a definition of responsibility on a local level, State level, or national level, decisions do not get made. If decisions do not get made, people do not get the right kind of care.

Mr. Brody. You just described the medical system where we expanded the amount of money we spend on medical care from $40 billion to $140 billion in 10 years.

Mr. Oriol. That is a bottomless pit.

Mr. Brody. There is no resultant extension of life that is significant. We haven't emphasized well-being at all.

Mr. Oriol. Have we been willing, or just fallen into it?

Mr. Brody. I think we are willing.

Mr. Oriol. Everybody says they don't want to go to the hospital; they don't want to go to the nursing home.

Monsignor Fahey. Until they are sick.

Mr. Archey. I think the systems have to be regulated and monitored. We have to decide to do that.

Mr. Brody. Bill, the day you go to a doctor—I hope you just go to say hello if you do go—and when he says, "I see a little bit of a shadow there; I think you ought to go to the hospital," I will send you flowers in the hospital since that is where you are going to be because you are not going to challenge his judgment. The point is you still accept medical technology as the only option. We don't yet accept social services in that sense.

Mr. Oriol. I think most all of you have had a hand in describing what is almost an impatience with the complexity of the issue and a falling back, not on just one habit of thought, but many habits of thought. Yet, as I think Dr. Brody pointed out, the sheer increase in the number of old persons and, as you, Father Fahey, said, the old elderly are either going to force us to change our habits of thought or we will have new kinds of gigantic problems. So I am very glad that you have come here today and have brainstormed as well as testified. We are looking forward very much now to the testimony from the Department of HEW because we are anxious to get a reading fairly early in this new administration of what exactly will be the official attitudes to many of the items we discussed today and yesterday.

Thank you once again.

Mr. Archey. Thank you.

[Whereupon, at 12:55 p.m. the hearing recessed.]

APPENDIXES

Appendix 1

MATERIAL SUBMITTED BY THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., NEW YORK, N.Y.

ITEM 1. LETTER AND ENCLOSURES FROM FLORENCE MOORE, EXECUTIVE DIRECTOR, NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., TO SENATOR LAWTON CHILES, DATED JUNE 7, 1977

DEAR SENATOR CHILES: This comes in response to your letter dated May 18, 1977, and to the testimony enclosed with that letter. We appreciate very much your statement about our assistance in helping the committee prepare for its recent hearing. We are grateful that your committee is giving careful attention to the issue of the individual provider because of the very serious problems with this form of care as illustrated in the testimony by Ms. Bloom and by Mrs. Kinoy, and also because it appears to be one of the fastest growing forms of in-home service across the country.

We would be pleased indeed if you would print the full text of the Quantico Report, sent to Ms. Dianna Porter some months ago. In lieu of the letter sent by Mrs. Flemming dated February 16, 1977, we enclose more recent information in the form of a final summary of the results of our foundation-funded Advocacy Project. We would be delighted to have Dr. Winston's article "Rx for Independent Living," which appeared in the January/February issue of *Perspective on Aging*, included in your proceedings. We are enclosing excerpts from the National Council's statement given last September to the Department of Health, Education and Welfare at its hearings on home health issues. Enclosed also is a short, additional statement prepared by the National Council for inclusion in your hearing record. Several other recent papers and one publication are enclosed for your information. Some of this might be useful for inclusion in the record.

The users of in-home services, the providers of in-home services, and organizations such as the National Council which promote quality in-home services are all indebted to the Senate Special Committee on Aging for the leadership it has taken and continues to take in this field of service so essential to the welfare of older people and others.

Sincerely,

MRS. FLORENCE MOORE.

[Enclosures.]

MEMORANDUM

From: Mrs. Gilbert W. Humphrey, President;
Mrs. Florence Moore, Executive Director.
Re: Quantico "Dialogue" Report, attached

At a recent meeting about in-home services attended by Federal, State and voluntary agencies, several issues were identified and are discussed in the attached report. There was a consensus that the following matters urgently need attention:

Clarification of various in-home service definitions now overlapping, including homemaker-home health aide and chore service.

Recognition of a marked trend toward employment of self-employed providers in lieu of accountable agency service and the serious implications that this has for consumers and providers.

Adoption of clearly defined standards for homemaker-home health aide services under Social Security Act Titles XIX and XX and the monitoring of those standards to protect against abuses.

More coordination in Federal funding available for homemaker-home health aide service to reduce the tendency to fragment service along funding lines (i.e. homemaker and home health aide) and more Federal leadership generally in regard to in-home services.

Development of a uniform accounting and reporting system for homemaker-home health aide service.

Significant expansion of homemaker-home health aide services throughout the country.

We urge that you read the report with care and contact the National Council if you need more information. We urge further that you do what you can to help bring about a resolution of these issues.

[Attachment.]

QUANTICO "DIALOGUE" REPORT

On June 21–23, 1976, the National Council for Homemaker-Home Health Aide Services, Inc., sponsored an in-home services dialogue among federal and state administrators, homemaker-home health aide agency administrators, and National Council board members. The meeting was an activity of the National Council's Advocacy Project, funded by the Edna McConnell Clark Foundation. It was planned as a practical working session to delineate key issues affecting homemaker-home health aide services and to prepare suggestions or recommendations toward the resolution of these issues. The following report includes a brief summary of the major issues discussed and recommendations made in the course of the two-day session. The six issues summarized below are: clarification of service definitions, the self-employed provider, basic standards, fragmentation of funding, uniform data collection and reporting, and expansion of services.

CLARIFICATION OF SERVICE DEFINITIONS

Clarification of definitions—particularly of homemaker-home health aide and chore services under various Social Security Act Titles, including Titles XVIII (Medicare), XIX (Medicaid), and XX (Social Services), and under Title III of the Older Americans Act—was seen to be of critical importance, because presently the definitions of homemaker-home health aide and of chore services overlap. This is resulting in many states in inappropriate use of chore service with potentially serious implications for consumers. In most instances the clarification of definitions can be accomplished through revisions in federal regulations.

Title XX authorizes the states to determine, define, and set priorities for the social services they will provide. Definitions for homemaker and chore services vary widely in published Title XX plans from state to state. For example, chore services—which in no state require specially trained or skilled workers—run the gamut from heavy, "hands-off" activities such as wood-chopping or winterization, which are appropriate, to personal care duties involving physical contact which are inappropriate because personnel lack the needed training and supervision.

A representative from California reported that 30 percent of the state's expenditures for in-home services was arbitrarily allotted to homemaker service, while the majority (70 percent) was allocated to the lower-cost-per-hour chore services. The chore workers, who are not required to be trained or supervised, are authorized under California's Title XX Comprehensive Annual Services Plan to perform such personal care duties as "care of the teeth and mouth . . . assistance in getting in and out of bathtub or shower . . . and help with bowel and bladder care."

On the other hand, the definitions of home health services, including home health aide services, in federal regulations for Titles XVIII and XIX are highly restrictive, requiring specific, time-limited services under the orders of a physician. Under Title XIX, an additional "personal care" category is authorized under a physician's orders and the supervision of an R.N., but no other policy statement, standard, or guideline clarifies against what criteria and in what manner these services shall be delivered. A representative from the Medical Services

Administration which oversees the Medicaid program asserted that it is not known what kinds of services are being provided.

Some states are delivering personnel care services through a network of individual (self-employed) providers who are, in some instances, recruited, selected and reimbursed by the client. This gives rise to such significant problems and is increasing so rapidly, not only under Title XIX but Title XX as well, that it was treated as a separate topic.

Throughout the discussion on definitions a representative from the National Center for Health Statistics consistently underscored the need for clear and common definitions as fundamental to adequate reporting and to research that has integrity. On behalf of the National Center, eagerness to work with the National Council toward this goal was expressed.

THE SELF-EMPLOYED PROVIDER

The growing trend for states to use individual self-employed providers (as against agency-employed personnel) to perform chore and homemaker services surfaced as one of the most serious issues to be confronted. A D/HEW study of the Medicaid program revealed a strong trend toward the use of self-employed persons paid for from Title XIX funds. A National Council telephone survey of 24 states in May 1976 documented that half of them are currently involved to some extent with an individual provider program for chore and/or homemaker services under Title XX. Three of the 12 states directly reimburse the client who is responsible for finding his or her own provider and for handling items such as Social Security payments on behalf of the provider.[1]

A National Council representative reported having been told that in New York City possibly as many as 9,000 untrained and unsupervised "home attendants," some of them aliens illegally living in the United States, are providing chore services paid for by Medicaid under informal arrangements with individual clients.[2] In Texas, it was documented that untrained, infrequently supervised workers—most of them family members of the patients and with an average education of sixth grade—were providing personal care services, including, in some instances, injections and tube feeding. The Texas Department of Social Welfare is trying to counter the situation by specifying that individual family-member providers are not to perform personal care and medically related tasks without training and professional supervision. Texas is contracting now with a voluntary health agency in a demonstration "Family Care Program." Through this program it has tightened up procedures, including mandating assessment, plan of care determinations and ongoing supervision. This is also being done in a project in a 15-county rural area in East Texas. However, the reimbursement, training and monitoring of family members remain sticky issues which have not yet been fully resolved.

To date the Texas Department of Social Welfare has been able to provide initial orientation and training under Title XX to home care providers employed by community action agencies in three project communities. Training is provided through local community colleges with Red Cross and nursing input. The projects are funded by Title X, Job Opportunity Program, of the Public Works and Economic Development Act of 1965. The Department hopes to replicate these training programs throughout Texas for individual providers. The Department contracts with home health agencies, where they exist, for nursing, assessment, plan of care and supervision.

There was a clear consensus among the participants that states' increasing reliance upon self-employed providers, who are paid minimally and who often fail to obtain Social Security and other benefits, constitutes an exploitive policy which harms both the consumer and the provider. Indeed, findings from a California study indicate that the emergence of the self-employed provider—coupled with the trend toward providing services without requiring adherence to standards—is fast creating a system of downward career mobility. Trained homemakers who had achieved full-time employment and adequate salaries are being forced to seek work at the minimum wage and without guarantee of a full week's

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[1] These three states, who reported to the National Council that clients are being directly reimbursed under the self-employed provider program, are New York, Vermont, and Washington.

[2] Subsequent to the meeting a story exposing some of the grave problems in the New York City home attendant program appeared in the July 16, 1976, edition of the New York Times.

work. A sizable number of these workers are former welfare clients, some of whom may be forced back on the rolls.

Special concern was expressed that, under present widespread arrangements which lack minimum protections, vulnerable ill or elderly persons may become victims of abuse and neglect. There are already known cases of both in situations where final responsibility for accountability is not clear or is inappropriately placed with an ill or elderly person whose coping ability is limited by age or frailty. The worker also has little or no legal or administrative protections.

BASIC STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE AND OTHER IN-HOME SERVICES

While the participants agreed that it is important to safeguard standards for the delivery of homemaker-home health aide services, agency and state administrators alike attested to the fact that the competitive undertone of Title XX has given rise to bidding for contracts on the basis of hourly cost factors alone. Agencies offering very little in the way of training or supervision for their homemaker-home health aides and minimal (if any) professional input are, in state after state, being awarded Title XX contracts. However, a San Francisco-based cost reviewer found higher total case costs within the proprietary agencies. More data are needed to determine whether or not agencies which meet basic standards of training and supervision are, in fact, more cost-effective on a case basis than those claiming lower hourly cost and meeting few, if any, standards. Basic to such a study would be a review of service utilization practices which would reveal whether service was given beyond the need for it in agencies not meeting basic standards of training and supervision.

Furthermore, the recent scandal in California in which it was revealed through a new audit that there were, at the least, unsupported billing claims by certain proprietary home health agencies, dramatically underscores the need for more stringent monitoring of provider agencies. The dearth of substantive federal and state standards and guidelines for homemaker-home health aid services under Title XX provides little guidance for auditors or others attempting to evaluate effective fiscal and program management under this Title of the Social Security Act. Although the National Council standards were required under regulations for Titles IV–A and VI of the Social Security Act, under Title XX (which replaces most of IV–A and VI), they are no longer mandated. This regression reflects the overall movement to loosen federal requirements upon the States.

Several participants suggested that representatives of the National Council confer with the newly appointed Administrator of the Social and Rehabilitation Service, Mr. Robert Fulton, about the need for clearly defined standards for homemaker-home health aid services under Titles XIX and XX. It was felt that a requirement that agencies meet standards monitored and promptly enforced would protect both the consumer and the general tax-paying public from the kind of abuses which have already been documented as being widespread within the nursing home industry. It was observed that the simultaneous trends toward the use of self-employed providers and toward the lack of requirements for adherence to standards which safeguard the consumer are based upon expediency and not upon principle and that the National Council should develop a statement of principles to guide the field.

FRAGMENTATION OF FUNDING

The fragmentation of funding sources for in-home care was viewed by many of the participants as one of the most critical issues. Funds under Titles XIX and XX are allocated to the self-same population of public assistance recipients in many instances, and yet the individual's health and social needs are artificially divided. While Title XIX requires a primary medical diagnosis and provides for short-term care, Title XX specifies that medical care must be subordinate to social service objectives. Moreover, the arbitrary time limitation for home health care under Titles XVIII and XIX may cut off services to a recuperating patient at a crucial stage in recovery. There was also expressed frustration with the artificial split emanating from the definitions of homemaker (funded under Title XX) and of home health aide (funded under Titles XVIII and XIX), a split which promotes duplication of services and inefficient use of staff time and resources.

It was pointed out that currently only the bookkeeping for the various funding sources must be segregated while services can be legally integrated under the position of a homemaker-home health aide. This obviously calls for detailed record-keeping and cost-accounting on the part of the agency.[3] North Dakota's Title XX plan authorizes one unified homemaker-home health aide program which is functioning smoothly in 30 of the state's 53 counties through close cooperation with the State Departments of Health and Social Services. Detailed data for analysis are being generated by the program. Yet Pennsylvania, for one, received a ruling from HEW that such a program was not acceptable within the framework of Title XX. This inconsistency reflects the lack of coordination among HEW's regional offices.

UNIFORM DATA COLLECTION AND REPORTING

A persistent problem plaguing the homemaker-home health aide field is that reliable statistics covering the total field of service have not been collected or published nationally in either the program or fiscal areas. The Social Security Administration, for example, publishes home health care statistics from the Medicare program, but individual services such as home health aide are not broken out although provider agencies do keep and report such data.

Because of the lack of hard statistical documentation, thus, many of the problems confronting the in-home services field have had low visibility and so have received little attention from top-level governmental administrators. A uniform accounting and reporting system for homemaker-home health aide service is badly needed.

The National Council currently is working on a study to identify and define the components of case management. When completed it will be one step taken toward that goal. The National Council *is seeking the financing* which will enable it to develop an overall system of uniform accounting and reporting. In the meantime, the Council will continue to be alert to the various cost and management studies underway across the country and will share whatever it learns from them.

EXPANSION OF HOMEMAKER-HOME HEALTH AIDE SERVICES

A number of the participants commented on the need for a significant expansion of homemaker-home health aide services throughout the country. It was reported that some national insurance carriers are beginning to offer aspects of home health care as part of their benefit packages and that some unions are moving to negotiate for them as benefits. These moves will significantly increase consumer demand for these services and in turn lead to the development of more programs.

One barrier to the present expansion of in-home services is that seed money has not been made available in recent years from federal and state sources. A second barrier is that the professional schools, such as schools for physical, occupational and speech therapy, nursing, social work and medicine, have not yet recognized the full role that paraprofessionals can assume under professional supervision and training. There was felt to be a great need for broad-based education of the professional community on the multi-faceted role of the homemaker-home health aide.

Many participants felt that the homemaker-home health aide's role has, in recent years, been largely restricted to care of the aged, and that it is important that more in-home care for families and children become available. Such a need exists particularly for children with disabilities, for families in which there is found to be a situation of abuse or neglect and for severely deprived families needing help to learn good child care and home management.

CONCLUSION

At the close of the two-day session the participants recommended that a number of concrete steps be taken toward the resolution of the issues which had been set forth:

(1) A meeting should be held before the end of September 1976 with representatives from appropriate departments within D/HEW to work on service

[3] Reference: April 1976 *Executive's Memo*, National Council for Homemaker-Home Health Aide Services, Inc.

definitions, particularly those for homemaker-home health aide and chore services, and to work on standards for in-home services.

(2) A national advisory committee in the home care field should be formed to advise D/HEW on how to deal with the issues. The committee should include representatives from state and local public programs, other provider agencies, national agencies, and consumer groups.

(3) Advisory committee should be generated at the state and county/regional level (if none currently exists) to offer input into the local planning and budget processes, particularly for Title XX, and to help educate legislators to the importance of in-home care.

(4) The results of Region II's interagency management study on home care should be shared with all of the participants. The coordinated effort reflected in this regional office's approach to home care might become a model for the nine other regions, all of which are confronting similar issues in this field. Representatives of the National Council offered to meet with the Region II D/HEW Task Force to be helpful in any way that they can.

(5) Participation in a uniform cost accounting and reporting system should be required of all approved agencies of the National Council and its use should be recommended throughout the homemaker-home health aide service field as a means of generating reliable and comparative data.

(6) The National Council should undertake a program for collection of data from individual states and from special national projects on program and fiscal implications of in-home care.

(7) The National Council should develop immediately a statement of principles (over and above its basic national standards) upon which the provision of in-home services should be based.

(8) The National Council should continue to encourage inclusion of clear service definitions and of requirements for standards in Federal regulations for in-home services.

(9) The National Council and the National Center for Health Statistics should work cooperatively as that department of the Public Health Service begins to collect and generate data in the in-home service area.

(10) The National Council should intensify its interpretation of the multifaceted role of the homemaker-home health aide to the lay and professional communities.

(11) Adequate sources of funding for homemaker-home health aide services, including government sources of start-up and operating capital and third-party payments, should be sought, encouraged, and made known within the in-home care field.

ADVOCACY PROJECTS: SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS

The National Council for Homemaker-Home Health Aide Services, Inc., financed by a two-year grant from The Edna McConnell Clark Foundation, beginning January 1, 1975; created a model which will be adapted by states and communities to develop and expand homemaker-home health aide and supplementary services in communities; and created 1,500 new positions, more than half through the application of the model.

Fourteen homemaker-home health aide programs were established in eight localities in seven states with the aid of a 379,615 grant to the National Council plus $74,117 in start-up funds to seven of the eight localities. The fourteen programs were located as follows: Georgia (5 programs); Tulsa, Okla.; Delaware, Ohio; Anderson County, Tenn.; Watertown, N.Y. (2 programs); Sunnyside, Queens; Benton-Linn Counties, Oregon; Lincoln County, Oreg.; and St. Bernard Parish, La.

In addition, supplementary services, such as telephone reassurance, friendly visitors, and meals-on-wheels, were established in 12 communities in those states.

THE ADVOCACY MODEL: A BRIEF DESCRIPTION

The advocacy model centered on the use of individual volunteer "advocates." Most of them were older adults. With the assistance of representative community committees they rallied interest and action to develop or expand homemaker-home health aide and other home support programs. Subsequently, personnel were hired to administer and provide service. These included older workers.

The National Council provided technical assistance and consultation to the communities and states, conducted management training for new administrators, prepared materials and evaluated the project.

ACHIEVEMENTS OF THE PROJECT

(1) Nearly 6,000 persons were involved in the project including recipients and applicants for service as well as volunteer and paid workers delivering the services:

700 permanent positions were created, some paid and some volunteer, which during the project were filled by older persons as follows: eighteen percent by those aged 50–59 and twenty percent by those sixty years of age and older.

800 additional persons were involved in some way in establishing or providing these supplementary services. Of these, sixty-five percent were 50 years of age or older and fifty percent were 60 years of age or older;

Nearly 800 persons in all who were 50 years of age or older were involved in the project in the eight localities; or expressed in another way, an average of 100 persons per locality aged 50 or older were involved in the project.

Close to 500 different organizations and government agencies and over 650 individuals were contacted about the service in the eight localities.

Over 350 people from local, state or national organizations attended advocacy project-sponsored education sessions.

3,000 persons applied for service, of whom 2,520 were 60 and over.

(2) Over one million dollars was generated in the eight localities during the two years to develop in-home services, with public funding accounting for approximately 85% of the total.

(3) Nearly 85,000 hours of homemaker-home health aide service were delivered to almost 2,000 persons, primarily older persons.

(4) Conservative projections, based on growth estimated by local agencies themselves, but allowing for no legislative changes to expand funding for the service, indicate that in these project communities a total of over 15,000 persons will be involved in volunteer or paid positions over a 10-year period, of which nearly 6,000 will be 50 years and over, serving approximately 14,000 individuals. This does not include projections for supplementary services.

(5) The nearly 800 persons 50 years and over were provided paid and volunteer jobs at a cost of $580 per position placement. Over a ten-year period, based on the above projections, and adding a turnover factor for supplementary services, the cost figure is $47 per position.

The project also had an impact in these other ways:

(1) The direction on in-home services was influenced positively in the seven states where the programs were located;

(2) An awareness of problems in the delivery of other in-home services was created. In one community (New York City), this heightened awareness resulted in a city-wide study of a program under question (the attendant care program);

(3) The seven states involved were helped to bring about communication among various state agencies such as social services, aging and health, each of which is responsible for an aspect of in-home care;

(4) Awareness of in-home services and the need for standards for those services was created in individuals, some of whom became involved in policy development for the services at the local and/or the state level;

(5) D/HEW regional officers were provided with information about in-home services; representatives of D/HEW departments in Washington were informed of problems affecting the quality of in-home services throughout the country (the Quantico Dialogue);

(6) Peer organizations of the National Council were enabled to bring to bear their expertise in developing the Advocacy Project (largely through the Advocacy Advisory Committee).

Technical materials were developed which benefited not only the fourteen advocacy programs but the entire homemaker-home health aide field. They are: an eight-minute-59-second 16mm color and sound film entitled *A Better Answer;* a National Council publication entitled "Resource Book on Financing for Homemaker-Home Health Aide Services" which was updated during the project; public service TV and radio announcements; a resource booklet, *Supplementary Services Guidelines*; a film guide for homemaker-home health aide services; and a media resource guide for aide training.

The project was designed to demonstrate actions that might be taken toward meeting the following needs:

To expand safe, efficient and effective in-home services to help meet a national ideal of over 300,000 homemaker-home health aides, growing from an estimated 50,000 today. Homemaker-home health aide service helps families to remain together and elderly persons to remain in their homes when a health and/or social problem occurs or to return to their own homes after specialized care. The trained homemaker-home health aide, who works for a community agency, carries out assigned. tasks in the family's or individual's place of residence, working under the supervision of a professional person who also assesses the need for the service and implements the plan of care. Other programs which supplement this service include telephone reassurance, friendly visitors, meals-on-wheels and chore service.

To develop a sound national policy to give direction to the in-home services movement, developed by the government in concert with the voluntary sector, calling for an increase in available funds and a decrease in fragmentation in the federal administration of present resources for services coordinated on the local level.

To develop paid and volunteer opportunities for increasing numbers of men and women, the "young-old," who, forced into early retirement, are seeking second careers or mature women entering the work force for the first time.

MAJOR RECOMMENDATIONS FOR FUTURE ACTION

The National Council should expand and market its technical assistance and consultative services to the field.

The National Council should increase its efforts to educate the general public, including consumers and public officials, on the components of safe, effective and efficient in-home services and on the need for expansion funds and coordination mechanisms so that 24-hour seven-day service can be provided in every community.

The National Council should continue research and other programs aimed at increasing agency efficiency and the development of management skills.

The National Council should refine the advocacy model and help the states and communities to use the model to develop and maintain quality in-home services.

Rx for Independent Living

by Ellen Winston*

Homemaker-home health aide service, in all of its aspects, helps all kinds of older adults, including the single adult living alone. Its goal is to help older adults with some type of social or health problem to remain in their own homes or return to their homes after specialized treatment, when that is the best plan, and to foster as much continued independent functioning as their capabilities permit. The service may prevent unnecessary institutionalization or at least delay care in an institutional setting.

Development in U.S.

Many years after most Western European nations had established programs for helping the frail, ill or disabled aged to continue to live comfortably and safely in their own homes, programs for homemaker-home health aide services for the aged began to be developed in the United States. While homemaker services for families with children had been part of the broad service delivery system of child welfare since the nineteen-twenties, similar widespread help at home for older individuals and couples did not develop until the forties and fifties, with acceleration in the sixties and a major spurt forward in the seventies.

Much of the current rapid expansion across the nation under public, private nonprofit and for-profit auspices is due to several interrelated factors. In 1962, the major national public and private nonprofit health and welfare agencies,[1] concerned over the need for expanded in-home services, joined together to establish a new national nonprofit agency to serve both the health and welfare fields. After name changes over the years, the agency is now the National Council for Homemaker-Home Health Aide Services, Inc.[2] The agency has provided strong leadership along with related agencies in promoting the development of in-home services for older adults. The enactment of Medicare and Medicaid in 1965 (Titles XVIII and XIX of the Social Security Act), provided Federal funds specifically for home health services, though they have not been widely used to date.[3]

Just prior to the 1971 White House Conference on Aging, the increasingly recognized need for homemaker-home health aide services led to the establishment of a broad-based national organization to promote in-home services. Now known as National Voluntary Organizations for Independent Living for the Aging (NVOILA),[4] it has some 150 national private, nonprofit organizations as members and maintains close ties with related Federal agencies. A semi-autonomous NCOA program unit, NVOILA provides information and other services to several hundred coordinating community groups in the field of aging. Most recently, Title XX of the Social Security Act (effective October 1, 1975) and the 1976 amendments to the Older Americans Act have provided additional funds for and additional emphasis on in-home services.

Definition of Terms

Today the best available data indicate there are an estimated 2,000 U.S. agencies with approximately 50,000 homemaker-home health aides, serving both the aged and families with children. With an established measure of one aide for every 100 individuals aged 65 and over, the actual need is for at least 200,000 aides to adequately meet the needs of the older population.

Because of the similarity of terms and the use of

*Dr. Winston, NCOA vice president and former U.S. Commissioner of Welfare, is a board member of the National Council for Homemaker Home Health Aide Services, Inc., Raleigh, North Carolina, and its past president; a member of the advisory committee for NVOILA, an NCOA program unit, and past president of Operation Independence.

[1] Represented by the National Health Council and the National Social Welfare Assembly.

[2] 67 Irving Place, New York, N.Y. 10003.

[3] For example, expenditures for home health services amounted to less than one percent of total Medicaid expenditures in calendar year 1975.

[4] NVOILA, The National Council on the Aging, Inc., 1828 L Street, N.W., Washington, D.C. 20036.

the word homemaker to designate the woman caring for her own home and family, it is essential to clarify the meaning of a homemaker-home health aide as a direct service provider in the community. A simple definition, often used in testimony before Congressional committees, is as follows:

> Homemaker-home health aide service helps families to remain together and elderly, ill or disabled persons to remain in their own homes when a health and/or social problem occurs, or to return home after specialized care. The trained homemaker-home health aide who works for a community agency carries out assigned tasks in the family's or individual's home under the supervision of a professional person, who also assesses the need for the service and implements the plan of care.[5]

Duties of the aide involve both home management and personal care. Aides perform essential household tasks such as cleaning, laundry, preparing meals and marketing when needed. Working under professional direction, they can give bed baths, change dressings, prepare special diets and help with prescribed exercises. Often there is a teaching component as the aide helps the older person to make the necessary adjustments in his/her daily routine to become more self-sufficient.

The professions usually involved are social work, nursing and home economics, with a range of other professional assistance as needed in individual cases. A responsible agency which meets national standards, initial and ongoing training of aides, professional supervision and skilled case assessment and reassessment are the key elements of this basic health-welfare service. There are often supplementary services around this care program which enhance the safety and well-being of the older individual or couple at home. The supplementary services may range from the skilled services of visiting nurses, therapists and social workers to programs provided primarily by volunteers working under professional direction, such as telephone reassurance, friendly visitors, chore services, meals on wheels and transportation and escort services. For each of these related services, there are in turn carefully developed, nationally recognized definitions.

Who Are Homemaker-Home Health Aides?

For any field of employment which already involves some 50,000 workers and has the potential of many times that number, it is important to look at the personnel qualifications. Homemaker-home health aides are paraprofessionals who work as part of an agency team which includes appropriate professional members.

Though most homemaker-home health aides are qualified women, there is a well-recognized need for men, especially to provide essential services to older men living alone. Educationally, aides range all the way from those who have only the basic skills necessary to follow written instructions and prepare simple reports to those who are college graduates. The majority have the equivalency of high school graduation.

In age, aides range from young women with only a few years of housekeeping and other experience to women well into their sixties. Aides usually are middle-aged, often women who have reared their families and thus are free to help others with the household management and personal care skills they have largely acquired from experience in their own families. However, this is not a simple "helping out" service. The aides, carefully selected, must also receive a well-planned initial training course and continue in-service training as paid employees of the responsible agency.

Besides the requirements for training and supervision, aides must have personal qualifications that enable them to relate comfortably to older individuals. Often the aide's role in coping with the loneliness and isolation of an older person living alone is complementary to the actual tasks to be performed.

There is a large, unmet need for older individuals to become homemaker-home health aides. They have much in common with the persons to be served. For many, the supplement to Social Security payments represents welcome income. The fact that many aides work only part-time means that older women—and men—can work the number of hours per day or week that they find convenient. In fact, the current Advocacy Project of the National Council for Homemaker-Home Health Aide Services places special emphasis on recruiting aides in the older age brackets.

What About Financing?

Cost is a major factor in all services for older adults. Actually, the cost of this economical service varies widely from one section of the country to another and from small communities to large metropolitan areas; a national average is not realistic. Rather, the matter of cost must be approached by comparing the cost of the needed amount of homemaker-home health aide service for a particular case in a given community with the cost of nursing home, hospital or other out-of-home care for the same geographic area.

The service is flexible as to the time involved; two three-hour visits per week is a reasonable basis for computing average cost. Some situations will require less time; others may require emergency or short-term help on an eight- or even 24-hour basis. While the

[5]For a useful expansion of the definition, see *Addenda to Standards for Homemaker-Home Health Aide Services*, National Council for Homemaker-Home Health Aide Services, Inc., New York, N.Y., 1969, and Shinn, Eugene B. and Robinson, Nancy Day, "Trends: In Homemaker-Home Health Aide Services," *Abstracts for Social Workers*, National Association of Social Workers, Vol. 10, No. 3, Fall 1974, Washington, D.C., pp. 3-8.

average case is served for approximately six months, some older individuals require long-term supportive services for many months or even years. Careful professional initial assessment and periodic reassessment not only assure the specific types of help needed but also guarantee holding the amount of service, and hence costs, to the minimum required for responsible care.

Many older adults can afford to pay for this service, and others can pay part of the cost. Still others must receive the service on a free basis. For the part-pay and free cases, increasing sources of public and private funding are available.[6] Today the largest amounts come from Titles XIX and XX of the Social Security Act, Medicaid and Social Services respectively. Increasingly, though slowly, both commercial and Blue Cross insurance carriers are moving toward coverage of home health services. It is important for older individuals to seek such coverage as they evaluate their individual health insurance.

The Necessity for Standards

Though most older adults continue to be fully in control of their lives, others are often highly vulnerable. This is especially true if there is increasing frailty, progressive illness or periods of disorientation. Hence it is of first importance that there be strong national standards, adequately monitored, for homemaker-home health aide and related in-home services, regardless of the auspices under which they are provided. Only by careful adherence to standards, such as those developed and successfully implemented by the National Council for Homemaker-Home Health Aide Services, Inc., can quality of care be assured.

[6] See *Resource Book on Financing for Homemaker-Home Health Aide Services*, National Council for Homemaker-Home Health Aide Services, Inc., New York, N.Y.

With well over 100 health and social welfare agencies providing this service now approved as meeting national standards, every person seeking homemaker-home health aide service should inquire whether the local agency has such approval. This basic protection requires that the service agency either have achieved or be in the process of obtaining approval. Other community services, such as restaurants, beauty parlors, etc., must meet standards. They are even more crucial when it comes to providing in-home care to an older person living alone.

Who Among the Aging Needs the Service?

Finally, who among the aging needs homemaker-home health aide service? To give overall statistics is not enough. It is necessary to look at the needs of a given individual at a given time. Actually, homemaker-home health aide service will be needed sometime in his or her life by every older person or by someone he or she knows. It will be needed by individuals in all income brackets, from the very rich to the very poor, in every community across the nation.

The situations in which a homemaker-home health aide can support continued independent living are legion. The aide may make it possible for the elderly person to live at home alone instead of going into some kind of group living; to leave the hospital or nursing home when intensive care is no longer necessary; to remain in the family group even though younger adults are employed full-time; to have respite from caring for an ill or disabled husband or wife; to receive essential care when the nearest relative is many miles or even states away.

This flexible service can meet these and other circumstances of need. Older adults in turn should know about the service and recognize when and how it can help them to live more comfortably, thus contributing to the quality of their daily lives. □

Excerpts from National Council for Homemaker-Home Health Aide Services, Inc. Statement to Department of Health, Education, and Welfare on Home Health Care

MAJOR POINTS COVERED IN THIS STATEMENT

Both expansion of homemaker-home health aide services and a broader range of home health services are urgently needed to serve the nation adequately.

The National Council is deeply concerned that there be assurance of the quality of in-home services necessary to protect consumers and the public purse.

There is urgent need for additional Social Security Act Title XX funds to enable states to expand services.

There is a need for more home health care to be made available under Medicare and Medicaid through the relaxation of current inhibiting restrictions on its use.

ASSURANCE OF QUALITY SERVICE ESSENTIAL

Our written comments return again and again to the need for standards and monitoring procedures which assure that the in-home services given are safe, effective and efficient. The National Council believes that it is the assured meeting of standards rather than agency auspice which is a major issue in this field.

Although there are many existing in-home services that have demonstrated accountability to the community, there are a growing number of agencies that appear to be accountable to no one but themselves. We urge that attention be given now not only to requiring that agencies meet basic national standards but also to requiring that the monitoring procedures used assure that, in fact, the services are being delivered according to the standards. This is of critical importance as, finally, the "climate" is leading us to an urgently needed expansion of in-home services.

In addition to the fact that the community often does not hold health services accountable today, another trend is developing rapidly which has marked negative implications for the delivery of safe, effective and efficient service. This is the use of self-employed providers. Originally funded only under section 249.17 (vi) of Medicaid, Title XIX of the Social Security Act, but now also by Title XX, there are growing numbers of individuals who, in effect, are providing some aspect of homemaker-home health service outside the structure of an agency. Procedures vary from state to state but frequently the individual or family served recruits their own provider, and often pays him too. The Department of Social Services which provides the funds may provide some supervision or may contract for it from another agency or may fail to provide any safeguards. Use of many of the check points necessary for providing safe, effective and efficient service obviously are missing. There is little or no training or supervision, inadequate assessment or reassessment of need and little care given to selection of the provider.

The workers often do not get Social Security and at times payment of their wages, usually at minimum wage, is late or not made. When the Department gives the money to the client, it is so needed for essentials by them that the workers have great difficulty collecting it from their "employer."

ADDITIONAL TITLE XX FUNDS ARE NEEDED

One of the reasons for the trend toward the self-employed provider is the inadequate federal appropriation for states to provide social services under Title XX of the Social Security Act. The imposition several years ago of the $2.5 billion cap on federal dollars available for social services has put most states in an impossible situation with respect to funding of services. Costs have escalated sharply and the population has continued to increase. This means there actually has been a substantial shrinkage in the dollars available to the states for services including dollars for homemaker-home aide services. The goals set out for Title XX seem well articulated and sound but without adequate funds they are difficult or impossible to achieve for many individuals, as the majority of the states are now at or over their ceiling of Title XX dollars.

In fact, turning to programs such as that of the self-employed provider which may appear less costly because of the lower hourly costs, when viewed on a case basis. Will often be more costly. This is because a quality service, through assessment and implementation of a plan of care, includes protection against

over-utilization, and nonachievement of optimum rehabilitation—both clear routes to costly inefficient service.

MORE HOME HEALTH CARE IS NEEDED THROUGH RELAXING CURRENT RESTRICTIONS ON THE USE OF MEDICARE AND MEDICAID

In addition to the need for better coordination between Social Security Act Title XVIII (Medicare), Title XIX (Medicaid), Title XX, the Older Americans Act, and other Federal programs which include in-home services, there is an urgent need to relax some of the current restrictions on Medicare and Medicaid so that more home services can be provided under these programs.

The Medicare law refers only to home health aide and not homemaker-home health aide and that has been used to place restrictions on the definition of the service that are unwise from an administrative and service standpoint. At times, the restrictions on the ability of agencies to deliver homemaker care results in two paraprofessionals having to go into the same home during the same time period to provide services that could readily be provided by one properly trained and supervised paraprofessional—a wasteful, duplicative situation which also causes considerable confusion for consumers.

Other inhibiting restrictions include allowing reimbursement for home care only following institutional care and then requiring that the need for skilled nursing care (very restrictively defined in Federal regulations), or physical or speech therapy are prerequisites to home care, which can only be for the same illness for which the person was hospitalized. Unfortunately, most insurance carriers follow this overly-restrictive Medicare model.

STATEMENT OF THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES

All of us in the in-home services field are indebted to the Senate Special Committee on Aging for holding hearings in the area of in-home care and thereby helping to bring to light practices and programs which need correction if those in need of in-home services across the country and those who provide them are to receive the needed protections. The issues raised in the delivery of in-home services through individual providers as exemplified in statements by Mrs. Susan Kinoy from the Community Council of Greater New York, and by Terry Bloom, the Director of Social Work from the San Francisco Home Health Service, before the Senate Special Committee on Aging May 16 and 17, 1977, are particularly serious because this type of care in the home appears to be one of the fastest growing forms of in-home service across the nation. There is and must continue to be room for new types of service but there should be no room for services which allow frail, ill or handicapped individuals to suffer at the hands of the very persons sent to help them and there should be no room for services which are harmful to the providers who may be equally at the mercy of the type of service which offers no protections.

The National Council for Homemaker-Home Health Aide Services maintains that there must be accountability for in-home services so that the consumer, the provider, and the payer are each protected from fraud and abuse. It is unconscionable for any funds to be used to provide services which creates fear and worse among those it is intended to help. It is particularly unconscionable for large sums of public tax money to be used to pay for such service. An organized community agency must be involved in the delivery of in-home service and must be held accountable for the calibre of service it gives, for its use of funds, and for its safeguards for its employees.

The National Council repeats in this statement its often stated recommendations that:

Better coordination is needed among the various departments responsible for the delivery of in-home services, beginning at the federal level. Common definitions for the various in-home services, including homemaker-home health aide service and chore service, must be delineated and promulgated to the field through regulations or by other appropriate means so that there is a common understanding in all sectors and in all parts of the country of the role and function of particular services. Only then can national standards, already in existence, be responsibly applied and the resulting accountability be assured. The

common definitions which should be agreed to among the concerned federal departments should be worked out so that the public and the voluntary sectors are helping the field work toward the same ends.

The scope of the existing funding mechanisms for in-home services should be broadened. A case in point is Medicare where "home health aide" service should become "homemaker-home health aide" service.

Additional funds should be made available under Title XX of the Social Security Act for the delivery of social services. Federal matching funds available for social services during the last several years have in fact declined since there has been a cap on funds for social services and we have experienced serious inflation during the same period. There should be a substantial increase in the amount of federal funds available for social services, including provision in the yearly appropriation for escalation in the cost of living.

Each agency, public, voluntary non-profit, or voluntary for-profit should be required to undergo an objective review based on clearly defined standards on a regular basis by a qualified body which is under voluntary non-profit or public auspices. Only then will there be responsible assurance of the ongoing accountability for the service that is provided to older people and to others.

Attention must be given to the need for in-home services for the chronically ill and aged in need of long-term care. Only when this segment of our population is receiving the in-home services needed will the pressure to increase the number of costly institutions diminish or be kept to a minimum. Compared with Western European nations, the United States is seriously behind in its development of in-home services for the aged population and for others. The difference appears to be directly related to the leadership provided by the European governments and to the level of government support for in-home services. Holland, for example, has almost 90,000 persons employed in the home helps (homemaker-home health aide) field for a population of 13,000,000 compared with perhaps 50,000 in this country for a population of over 200,000,000.

The home health field should be included in certificate-of-need regulations; granted that this is an imperfect process and that there is no final agreement on how to establish a community's need for home health services. Failing precise methods, we must rely on the judgment of community people and bring the home care sector into full partnership in the broad social and health care systems.

New Issues for In-Home Services

by Florence M. Moore

Definitions

The following brief definitions of homemaker–home health aide and of support services are provided for reference as these various services are referred to several times in the text:

Homemaker–home health aide service. Helps families to remain together and elderly persons to remain in their own homes when a health and/or social problem strikes or to return to their own homes after specialized care. The trained homemaker–home health aide, who works for a community agency, carries out assigned tasks in the family's or individual's place of residence, working under the supervision of a professional person who also assesses the need for the service and implements the plan of care.

Friendly visitor. A program in which volunteers visit on a regularly scheduled basis handicapped, chronically ill or older persons who live alone or are lonely for companionship.

Telephone reassurance. A program in which volunteers call seven days a week at a prearranged time ill, disabled or elderly persons who live alone to determine their condition and to provide community contact over a sustained period of time.

Chore service. A program which provides help with minor home repairs, or heavy house and yard tasks which need to be carried out intermittently to maintain a person safely in his or her own home.

Meals-on-wheels. A program in which prepared nutritious meals are delivered directly to the residences of ill, handicapped or elderly homebound persons who are unable to prepare or obtain their own meals.

Transportation and escort service. A program which provides assistance to an individual requiring help to get where he or she needs to go, including, when necessary, an escort to help secure the needed service and to return safely home.

NOTE: For further information on the support services as provided by an agency also providing homemaker-home health aide service, see National Council for Homemaker–Home Health Aide Services, *In-Home Services Supplementary to Home Health and Homemaker–Home Health Aide Services* (New York, 1977).

The critically important roles that in-home services have to play in the human service systems in this country are being increasingly recognized. These services include social, health, and supportive services such as homemaker–home health aide services, meals-on-wheels, telephone reassurance, and others. Among the many factors resulting in this new status is the knowledge that care at home protects children from the trauma of being uprooted from their families, homes, schools, and communities. It helps sick people to recover more quickly, and most people simply prefer to be at home. It is less costly in many cases, especially because of the rapidly escalating costs of institutional care. In addition, the continuing increase in the proportion of older and handicapped people to the total population and concern about the quality of nursing homes have helped focus attention on home care. Insufficient and fragmented funding for the services, inadequate attention to quality assurance, and the need to coordinate the various in-home services are also becoming the focus of attention and are discussed in this article.

Almost all professionals know of situations where ill people have been institutionalized unnecessarily, have made incomplete recoveries, and, in some instances, have been permanently disabled or have even died because of inadequate resources for home care. If those with less acute problems are not helped, they too may fall ill, whether the problem is the lack of a nutritious diet, extreme loneliness, or having no way to care for their home or person. These problems can and do touch any family, but the burden falls, of course, most heavily upon those who lack financial resources and who may also lack access to family or friends who might supply personal support in times of crisis.

An even more basic factor underlying this recent interest in in-home services is the shift to the commu-

Florence M. Moore, M.S., is executive director of the National Council for Homemaker–Home Health Aide Services, New York.

Photos courtesy National Council for Homemaker–Home Health Aide Services

nity of the protecting and caring-for functions formerly carried by members of the extended family. This shift, to date, has been an inevitable accompaniment of every society as it became industrialized and urbanized. It is now clear that the total caring-for burden of the very young and of others who are partially dependent and need help from the community cannot be met alone by out-of-home modes of care. Governments, voluntary agencies, and consumer groups are recognizing that from a quality of life standpoint, as well as from an economic one, the in-home and out-of-home health and social service delivery systems must be brought into a better balance. As Alfred Kahn and others have noted, industrialized nations seem to be approaching a consensus that some large-scale network of services which would include home care is necessary to support a reasonable quality of life in complex societies.[1] There is no doubt that the United States is lagging behind some other countries in meeting the need for home care.[2] The contrast between the United States and the achievements of some European countries is startling. For example, the Netherlands reports over fifty-eight thousand full and part-time home helps (homemaker–home health aides) for a population of more than 13 million compared to some fifty-thousand aides in the United States for a population of more than 200 million.[3] The Scandinavian countries have an even larger number of home helpers in relation to population. Sweden has the highest proportion with approximately one aide for each 200 persons.[4]

The more extensive in-home service support systems abroad is reflected in decreased rates of institutionalization. Consider the data, from recent HEW hearings, in Table 1. Clearly, the United States is far more dependent upon institutions than needs to be the case, as seen in much lower rates where other options are available. These patterns are evident, also, in the Medicare and Medicaid programs where less than 1 percent and .9 percent, respectively, of available funds are spent on all covered home health services.

TABLE 1

INSTITUTIONALIZATION AND HOME HEALTH AIDE RATES

(Per 1,000 Aged)

	Scotland	United States
Institutionalization	43.7	75.7
Home health aide	8.4	1.1

SOURCE: U.S., Department of Health, Education, and Welfare, *Home Health Care: Report on the Regional Public Hearings*, Publication no. 76-135 (Washington, D.C., 1976), p. 53.

No thoughtful proponent of home care would suggest eliminating nursing homes, hospitals, day care or foster care. What is needed, however, is a balanced approach so that in-home care can take its rightful place in a continuum of health and social services. Increased interest in the status, funding, and quality of home care services has been expressed recently by a number of organizations. In fall 1976, the Department of Health, Education, and Welfare (HEW) held five regional hearings to obtain information about home health needs. Response was substantially greater than anticipated, with testimony covering a broad scope of services —certified home health agencies, homemaker–home health aide services, support services such as meals-on-wheels, and telephone reassurance—and covering issues ranging from quality of care through cost containment.

The hearings' summary states:

> The primary concern expressed by the witnesses was for an expanded, coordinated range of high quality home services as a part of an essential continuum of health, social and support services. The greatest consensus about expanded benefits was for broader coverage of homemaker–home health aide services by all third-party payment programs. A second area of consensus was the need to include transportation services, home-delivered meals and nutrition services, and some mechanism for coordinating the delivery of round-the-clock services at the local level. . . . The need to eliminate artificial distinctions between health and social services was also strongly urged by many witnesses.[5]

Other recent significant developments in the field include activities of the National Voluntary Organizations for Independent Living for the Aging (NVOILA) under the National Council on the Aging, especially the project Operation Independence; guidelines to home health care as a model benefit program issued by the Blue Cross Association to local plans; and guidelines issued by the American Cancer Society to assist communities to develop home health programs. The Public Health Service under Public Law 92-603 Sections 222(h)(E) and (H) is conducting an expanded Medicare benefits program to test the usefulness cost-effectiveness of homemaker services and adult day care. The Senate Special Committee on Aging and the House Select Committee on Aging have conducted hearings and prepared materials on home care which have provided leadership to the whole field.

While these and similar developments and materials reflect the growing needs for in-home services and identify basic areas of concern, specific questions about the range of services, financing, quality, and accountability require attention if in-home services are to develop to their full potential.[6] What services are to be included as a part of in-home care: Strictly those of the Medicare model, such as nursing and physical therapy? Or are supportive services, such as meals-on-wheels and transportation to be included as well? Where will funding come from—the government, the voluntary sector, or both? How can adequate funding be assured on a continuing basis? How will funds be accounted for, and what is the extent of need? What are the cost-saving implications of in-home services? When will a broadly based uniform accounting and reporting system be delivered and by whom? Under what auspice(s) will

service be delivered—public, voluntary, proprietary, or all three? How are consumers to be protected against neglect, abuse, and fraud? How are non-professional workers to be protected against exploitation? Will the services available be remedial only, or will supportive, rehabilitative, and preventive services be included? For example, when will the benefits of home care, including homemaker–home health aide service, in infant and maternal care and in mental health be given the kind of support that each area warrants?[7] What workers will be involved, and who is preparing them for delivery of services in the home? What role will the upgraded paraprofessional have in supervision of homemaker–home health aides?[8] How can the artificial dichotomy between the social and health services be overcome? How can consumers identify services of reasonable quality? How will services be coordinated at the community level so that an individual or family can benefit from the services of a number of organizations?

Some of these issues cannot be resolved. But others could be approached through the establishment of a clear and consistent national policy on in-home services which would be based on recommendations from all concerned parties. The need to arrive at a consensus on the definition and range of in-home services is clearly of great importance, and will result in the resolution of some of the other issues. In addition, it is imperative that those working in the field understand the direction and the significance of current trends in in-home care. Finally, there are at least three areas of concern which will require priority attention if in-home services are to develop constructively. The remainder of this article will deal with the questions of definition, current trends and problem areas.

Toward a Definition

A workable and coherent national policy on in-home care services will involve reaching agreement on the definition and range of such services. Home health services have generally been understood to include nursing; medical assistance; medical social work; physical, occupational, and speech therapy; and medical supplies and equipment. Limited home health care is also included under Medicaid. At issue is whether or not support services such as the homemaker aspect of homemaker–home health aide services, meals-on-wheels, friendly visiting, telephone reassurance, escort, and chore services are to be funded as a part of home health care or, at the very least, funded and administered so that they can be closely coordinated with home health care. Wherever strictly medical services shade over into social areas, difficulties in funding, coordination and administration occur. Yet, health practitioners and social workers know that it is often these support services which make all the difference. Aside from simplifying administrative and coordination issues, broadening the current definition could be cost-effective, in allowing appropriate needed in-home supports in contrast to lengthy, costly institutionalization in many cases.

In recent years there have been several significant attempts to broaden the definition of home health to include the type of social services enumerated above. The 1976 HEW hearings quoted earlier obviously focused on this need, but the issue has been discussed for some time. In 1972, an HEW-sponsored conference used the following definition:

> The term "in-home services" is used as an inclusive term in order to broaden the concept of such services. It is meant to describe an array of services which can be brought into the home, singly or in combination, and which can be adapted to meet the needs of persons in all age groups, in all diagnostic categories and in all economic and psychosocial situations when such services can be used therapeutically, or to prevent or arrest illness and disability, to supplement limited function and to protect and support those whose capacities for optimum development, function and participation in family and community life are threatened. In this context, many services which have been considered innovative possibilities but not yet developed, are included. The concept is not tied to existing payment sources, to regulations which limit the scope and duration of services, or to auspices. It is intended to describe a community-wide, coordinated network of services, a complex which can be considered a community institution and an essential component of the health and welfare system.[9]

A definition of home health services adopted by four national home health organizations in 1973 also would broaden substantially the current Medicare scope of services.

Home care protects children from being uprooted from their families, homes, schools, and communities.

Home Health Service is that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated and made available by an agency/institution, or a unit of an agency/institution, organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.

These services are provided under a plan of care which includes appropriate service components such as, but not limited to, medical care, dental care, nursing, physical therapy, speech therapy, occupational therapy, social work, nutrition, homemaker-home health aide, transportation, laboratory services, medical equipment and supplies.[10]

Although not definitions, per se, some interesting concepts have been developed by the National League for Nursing (NLN) and the New York State Coalition for Home Health Services. The NLN's model is based on three tiers of service: (1) basic essential, (2) other essential, and (3) desirable environmental.[11] The coalition's approach is to group the services according to how frequently they are needed.[12]

In material published in 1974 by the National Council for Homemaker–Home Health Aide Services, need for service is categorized according to three clusters: cluster I, need for professional and personal and/or environmental service; cluster II, need for personal and environmental or personal services only; and cluster III, need for environmental services only.[13] Homemaker–home health aide and other supportive services are then related to need clusters.

These efforts point the way toward agreement and are in sharp contrast with the realities of today's limited and chaotic nonsystem. Clearly, new thinking, beginning with serious attempts to meld such ideas into a workable consensus, is necessary if the United States is to develop a social services system allowing maximum independence and promoting health and growth for all its citizens. The advent of a new administration in Washington makes this an ideal time for a bold new approach, and the examples above indicate that the private sector is ready to make its contribution. It is essential, however, as we look forward, to clearly understand the present trends and problem areas in the field of in-home services.

Trends in In-Home Service

Two trends in in-home care are particularly clear: (1) service growth patterns follow availability of federal funding; and (2) provider agencies have shifted from voluntary to public auspice, with proprietary agencies growing rapidly.

Federal funding. The number of home health agencies certified to participate in Medicare grew from 1,275 at the initiation of the program in 1965 to 2,311 in 1970.[14] By 1975, narrowing interpretations of covered benefits had reduced the number to well under 2,300; in 1976, because of some easing in restrictions, the number of programs had increased again, this time to 2,361. (See Table 2.)

In 1961 there were only 208 administrative units of homemaker–home health aide services in the United States; by 1973 this number had grown to 1,700.[15] The National Council for Homemaker–Home Health Aide Services estimates that now there may be as many as three thousand such units. An unduplicated count of the certified home health agencies plus homemaker–home health aide services totals an estimated four thousand units. While this is a "soft" figure, it is accurate enough to indicate that substantial growth has occurred. Homemaker–home health aide service funds come primarily from Titles XVIII, XIX and XX of the Social Security Act and Title III of the Older Americans Act, although United Ways are of major importance in some communities.

There appears to have been a similar growth among such support services as meals-on-wheels, telephone reassurance, friendly visiting, chore, transportation, and escort. These programs have gained financial backing from Title XX, the Older Americans Act, and from United Ways and other voluntary sources. In its 1972–73 survey of homemaker–home health aide programs, the National Council for Homemaker–Home Health Aide Services found that transportation and shopping were each provided by 35 percent of the agencies and telephone reassurance by 31 percent, questions about these services were not asked in earlier surveys because the development of agencies which provide homemaker–home health aide services and also administer these ancillary services has been a relatively recent trend.

Shift in auspice. Since the early 1960s there has been a marked shift in auspice from voluntary to public among both homemaker–home

TABLE 2

PARTICIPATING HOME HEALTH AGENCIES, JUNE 30, 1971–76

Type	1971	1972	1973	1974	1975	1976
Visiting nurses association	559	534	540	531	525	515
Combined government and voluntary	67	59	54	47	46	42
Official health agency	1,311	1,277	1,259	1,257	1,228	1,218
Rehabilitation based	12	11	11	10	9	10
Hospital based	209	219	244	267	273	280
Skilled nursing facility based	10	7	7	6	5	5
Proprietary	50	42	41	39	47	68
Other[1]	66	73	55	91	109	223
Total	2,284	2,222	2,211	2,248	2,242	2,361

SOURCE: The information was made available by the Bureau of Health Insurance, Social Security Administration, HEW, to the Council of Home Health Agencies and Community Health Services, National League for Nursing. It appeared in *Community/Home Health News*, December 1976, p. 3.

1. A majority of agencies in this category are private nonprofit.

health aide agencies and home health agencies. In addition, there is a strong recent growth in the number of agencies with proprietary auspices. The proprietaries appear to be particularly active in the provision of homemaker–home health aide services, especially through Title XX contracts.[16] The December 4, 1975, change in Medicare regulations that allows certified home health agencies to contract with proprietary agencies has, no doubt, been another major factor in the growth of services under this auspice. Sixteen states have licensing laws allowing the for-profit groups to participate in Medicare if they meet Medicare certifying requirements.[17]

In July 1963, HEW reported that there was a total of 1,163 agencies offering nursing care of the sick at home. Of these, 692 were visiting nurse associations, 384 were official health agencies, 85 were combination (voluntary and official), and 2 were hospital-based programs.[18] In 1976, of the 2,361 certified home health agencies, 515 were visiting nurse services (due in part to mergers), 1,218 were official health agencies, 42 were combined, 280 were hospital-based, 10 were rehabilitation facility–based, 5 were skilled nursing facility–based, 68 were proprietary, and 223 were "other." Those in the "other" category are largely private nonprofit agencies, a fast growing new development on the home care scene (see Table 2). The American Hospital Association reports that about five hundred hospitals are offering home care services. Some of this number are reflected in the table and are certified to participate in Medicare.

In 1958, three-fourths of all homemaker programs were provided under voluntary auspices, one-fourth under public auspices, and none under proprietary ownership. In 1973, however, 56 percent of the agencies were operated under public auspices, 28 percent by voluntary agencies, 7 percent by public-voluntary agencies, and 9 percent under proprietary ownership.[19] In a new survey being undertaken by the National Council for Homemaker–Home Health Aide Serivces, preliminary data show that the marked increases in the proprietary and governmental sectors are continuing.

In addition to these two major trends in in-home care, there has also been a shift in the type of client receiving service. Until recently the majority of homemaker–home health aide services were provided to families with children. Thus, families experiencing temporary stress were assisted until the crisis had passed. Today the preponderance of the service goes to the elderly and the ill. Advocates of services to families has not kept pace with the overall growth, especially since it is a sorely needed preventive program.

Three Priority Needs

Three areas deserve priority attention in setting up a home care system. If an effective program is to be developed, it is imperative (1) to increase available funds for in-home services while decreasing the extreme fragmentation in the federal administration of present resources; (2) to require and maintain reasonable quality assurance for in-home services; and (3) to coordinate the various in-home services and help agencies address common problems.

Funding and Administration

The principal funding sources for in-home services are Titles XVIII, XIX, and XX of the Social Security Act, and to a lesser degree Title III of the Older Americans Act. A host of other resources are available for pieces of services or for a narrowly defined social or health condition.[20] Lacking an overall policy or coordinating procedure, the result at the delivery level is often what might be expected—chaotic.

Service to the consumer is often fragmented and frequently inadequate to the need. Obtaining these disparate funds, putting them together like a jigsaw puzzle to provide comprehensive service for the consumer, and accounting for them to various sources can become a nightmare to the agency administrator. Some agencies do not even try, and so needs go unmet. The most efficient use of tax or voluntary dollars clearly is not possible when executives, particularly of voluntary agencies which are trying to meet need, spend more than fifty percent and often as high as eighty percent of their time in fund raising.[21]

Other inefficiencies include the fragmentation of federal funding, forcing separate services to be provided when one could do the job. Homemaker service is funded for those eligible through Title XX of the Social Security Act. Home health aide service is funded, although under very limiting regulations, through Titles XVIII and XIX of the same act. An example from Greenwich, Connecticut, illustrates the problem.

During the decade and a half before 1970, the Greenwich Department of Social Services provided homemaker service and the same community's hospital provided home care, including home health aide service. Between 1970 and 1975 these two services were gradually merged, at the request of the Greenwich United Way, under the administration of the Department of Social Services, with the supervision of personal care provided by the Public Health Nursing Division of the Department of Health. The hospital entered into contractual arrangements with the Town of Greenwich for the purchase of the services of the aides in their home health care function. In the year before the merging began, the Department had provided 16,132 hours of homemaker services, and the hospital 28,378 hours of home health aide service, making a total of 44,510 hours. During the first year of completely integrated service, the same community was served by the delivery of 32,952 hours of service, which is 11,558 fewer hours than had been delivered by both agencies under the dual delivery system.

The reason given by the United Way for recommending the merger was that there was too much overlap and inefficient use of aides. This saving of better than 30 percent in hours of service provided when both the homemaker and home health aide aspects of the service were performed by one person going into the home instead of two surely lends credence to the United Way's reasoning. If even a fraction of the saving achieved in this one community could be replicated in the vast rural areas of this country or in the crowded urban areas, many more persons might be provided in-home service *with the same*

number of dollars as are being spent currently—or there could be a substantial saving in dollars spent.

Clearly the fragmentation in federal funding of this service is costly to the consumer, to the taxpayer and other third-party payers, and to the agency which administers the service. The extra bookkeeping and statistical costs inherent in accounting to so many funding sources can certainly be counted among the burdensome expenses that this wasteful system generates. The Greenwich community reports further that while this merger was cost saving, it was costly to bring about because of the extensive staff time involved in working it out.

The rapid expansion of in-home services, especially the homemaker–home health aide and ancillary support services, is creating great pressure to resolve such situations. An overall in-home services policy at the federal level is urgently needed to bring about a rational coordination of the various funding sources and administrative offices and to facilitate the delivery of coordinated services to consumers. Change short of that can be helpful but will be patchwork in nature.

The insurance industry, both commercial and nonprofit, is gradually being forced by the high cost of hospital care to experiment with providing more coverage of these in-home services. Generally they have followed the Medicare model and, for example, have limited covered benefits to posthospital care. The federal government's leadership role is important, therefore, not only in terms of the services it supports directly but also in the model it provides for the nongovernmental sector.

The overlapping between Titles XIX and XX funds, at least for in-home services, is becoming apparent. In California, maintenance-type services to the aged and chronically ill are funded under Title XX and in New York under Title XIX. In New York they are called "attendant services," in California "homemaker/chore." In short, the needs are so great that the same services are funded from wherever the resources can be found and without apparent rhyme or reason from one state to the next. With the present shortage of Title XX federal matching dollars, more and more states are trying to fit services under Title XIX which at least draws 50 percent federal matching money and has an open-ended appropriation.

Another rapidly developing problem, particularly under Titles XIX and XX, is the confusion in definitions between homemaker–home health aide and chore services. This becomes especially serious when definitions permit the assignment of chore service workers without training or adequate supervision to cases that not only need assessment and reassessment by appropriately prepared professional personnel but also require the services of trained and supervised homemaker–home health aides. The confusion stems largely from the lack of clear federal definitions. This problem, and that of individual self-employed providers discussed in the following section, are both being caused in part by the serious need of most states for more federal matching dollars under Title XX. Just to keep pace with inflation and increases in population, the cap on social services should be raised substantially. For any additional services to be provided, more dollars must be made available or present dollars must be used differently, or both.

> What is needed is a balanced approach so that in-home care can take its rightful place in a continuum of health and social services.

Homemaker services should be added to home health aide service under Medicare. The definition of skilled nursing under Medicare should be broadened so that it includes supervision, care planning, and coordination, not just "laying on of hands." The three-day hospital stay should be eliminated in Medicare Part A so that individuals can be referred directly to home care without first having had to be in the hospital. Of course, Part B of Medicare can be used without the prior three-day hospital stay but the deductible feature limits its use. The interpretation of "homebound" should also be broadened under this title of the Social Security Act. These changes would enable additional persons to receive appropriate care while more dollars would flow into agencies. Along with these changes, agencies receiving federal funds should be required to demonstrate conformity with basic national standards. Requirements for Medicaid reimbursement for in-home services also need to be made less stringent.

Quality Assurance and Cost Control

There is some evidence to indicate that assurance of quality not only helps to protect consumers but that it also helps to assure cost-effective service. One illustration follows: In a six-month review of costs of homemaker–home health aide service provided under its five different contracts, the San Francisco Department of Social Services discovered that the two agencies with the highest hourly costs had the lowest per case costs. Of the five contracting agencies only these two had undergone reviews of their performance standards and been recognized as meeting national standards.

One explanation of this finding is that higher hourly costs can reflect higher case management capability and adequate case management can result in lower total case costs. Why? Because there are enough well trained case managers to carry out the assessment and reassessment functions so essential to assure that the service is provided for as long as it is needed but for no longer. In addition, being able to keep in sufficiently close touch with the situation can result in the use of different services as needs change. For example, once an immediate crisis has passed, a homemaker–home health aide may be needed only two or three times a week instead of every day so long as meals-on-wheels (a less costly service) is

available on the alternate days. In short, overutilization of in-home services, that is providing service beyond need or inappropriate to need, can be very costly.

The following actual case example shows how costly in monetary as well as in human terms overutilization and inappropriate service can be. And please note the lack of case management by the provider agency or other service.

Mrs. A, an elderly woman, was discharged from the hospital with a recommendation from her doctor that she purchase homemaker-home health aide service. She chose a local commercial service, which proceeded to deliver 24 hours of service a day to her for five and a half months. She had only one contact with her physician during those months, and that was a telephone call.

Mrs. A came to the attention of the local social welfare authorities at the end of this period when her pastor contacted them to report that Mrs. A had incurred unpaid bills for homemaker-home health aides running into five figures and was without any remaining resources.

The welfare authorities requested a conservation hearing. The probate judge called together the social welfare director, the woman's lawyer, her doctor, a representative of the service in question, and a representative of the hospital. It developed that although the provider said that nursing supervision had been supplied, there had been no monitoring of the service either by the doctor or by any social agency, public or private. Mrs. A's resources had gone to pay for 24-hour service, which her doctor now claimed had, in part, been unnecessary, and had, in fact, prevented Mrs. A from recovering her maximum mobility by making it unnecessary for her to perform small chores. In addition, although light cleaning should have been part of the homemaker-home health aide's responsibilities, a regular cleaning woman had been employed.

By this time, matters had progressed too far for the downward spiral to be reversed, and Mrs. A is in a nursing home on Medicaid. The matter of the unpaid bills was finally settled out of court, at public expense.

Who knows how many other Mrs. A's may be receiving inappropriate or damaging use of in-home services, and at what cost to themselves and/or the taxpayer? No one does. Far too many agencies providing in-home services have gone through no external review of their standards of performance and have not established utilization review or similar procedures routinely. It will not take too many cases like the one involving Mrs. A to move the in-home services field into the situation of intensive investigation of fraud and abuse, as has happened with some other health services. When that happens, the good services often go down with the bad.

The special need for and challenge of assuring the quality of service provided in a home setting was of deep concern to many testifying at the HEW 1976 regional hearings. One person stated succinctly that which troubled many: "By its very definition of being offered in the patient's place of residence, it lacks even the surveillance which the four walls of an institution facilitate."[22] There are many signs that the challenge of preserving quality in-home care is not being met under present programs and that this field may fast become as scandal-ridden as the nursing home field.

> Provider agencies have shifted from voluntary to public auspice, with proprietary agencies growing rapidly.

The fact that five hundred or more of those who testified at the HEW hearings spoke of the need to do more now to assure quality in-home care indicates that there is already something wrong. It will get worse unless there is intervening action soon. It will get worse by quantum leaps unless as much attention is paid to assuring safe, effective and efficient in-home services as is paid to the expansion of these services.

This burgeoning problem was not addressed adequately by those responsible within HEW who would have published the August 21, 1975, Medicaid regulations on home care allowing proprietary agencies to participate directly in the program without the government at the same time—or, far better, ahead of time—having in place the standards, trained personnel, and other resources needed, to monitor agency performance adequately.[23] To require careful surveillance as a condition of participation is not an antiproprietary position. It is a recognition of reality. When Senator Frank Moss addressed the 1976 annual meeting of the Council of Home Health Agencies and Community Health Services of the National League for Nursing, he reviewed an astounding number of areas in the health field, such as nursing homes and clinical laboratories, that are currently under investigation because of the lack of proper guidelines and adequate enforcement requirements and procedures, especially where the proprietary sector was involved. He expressed serious concern about the same thing happening in the home health field, particularly if the Medicaid regulations described above were to be published in their proposed form. He indicated, too, the extreme efforts that were necessary even to begin to bring about changes once abuses had occurred and multiplied, such as in the nursing homes. Legislative hearings and investigations of nursing homes were conducted over a three-year period and only after that did they finally culminate in indictments in New York and elsewhere.[24] Now many bills are being introduced in Congress to try to right these wrongs. Obviously, even though the rate of expansion of home care would be slowed down as a result, concern for standards and monitoring cannot safely be ignored now or in the future.

The rapid growth of private nonprofit agencies was noted earlier in this article. In a paper examining this trend Amitai Etzioni of Columbia University and an associate, Pamela Doty, point out that "omissions, ambiguities and loopholes in the laws and regulations governing not-for-profit corporations presently make it possible for the trustees and staff of not-for-profit corporations to engage in a variety of financial practices which bring them personal profits over and above fees, salaries and fringe benefits due them for work performed."[25] Obviously, this situation requires the attention of the Social Security Administration, the Internal Revenue Service, and other government officials for corrective action.

Requirements for meeting basic national standards and the monitoring of performance against those standards should be applied to all agencies regardless of auspice. The current rapid growth of proprietary agencies and the so-called private nonprofit group in the in-home services field only underlines the urgency for this area to receive the priority attention it needs for promoting the adoption of standards and for undertaking monitoring programs.

Fraud and abuse. HEW and the Congress are giving attention to protections against fraud and abuse in the Medicare and Medicaid programs. Such discussions have not yet begun in regard to Title XX, but, as Donald D. Trautman, then the chair of the legislative committee of the National Association of Home Health Agencies, said in testimony before the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging: "We cannot control quality by increasing the fraud staff within the Department [of HEW]."[26] The first routine line of defense against fraud and abuse should be the standards and monitoring approach. Only when that fails should a unit on fraud and abuse be called in. An old saying puts it well, "a stitch in time saves nine."

Currently, monitoring of home health agencies is a state responsibility. Before there is any major expansion of agencies (such as would have occurred had proprietary agencies been allowed to participate directly in the Medicaid program), states must be provided with the guidelines and the resources they need to carry out this function properly. For example, basic national qualifications for the selection of surveyors (those persons carrying out the monitoring function) should be established. The Bureau of Health Insurance training program for surveyors should be continued and further strengthened for home health agency surveyors. Additional information and guidance should be provided to them at least annually. Research should be undertaken into the reasons for high turnover among surveyors. The question of generalist-versus-specialist training for surveyors should be reviewed, as should the advisability of surveyors working alone or in teams.

As noted earlier, quality assurance was one of the key issues identified at the HEW hearings. Former HEW Secretary David Mathews had requested that a discussion paper on the issues be prepared by his staff. To be included in this paper were: professional standards review organization (PSRO), utilization review, medical audit, medical review, licensure, and accreditation. Coordination of the various quality assurance mechanisms needs early attention in a national policy on in-home services.

Strong endorsements of the importance of the home care standards-monitoring programs of the voluntary sector were made at the HEW hearings. The Joint Commission on Accreditation of Hospitals, the National League for Nursing/American Public Health Association, and the National Council for Homemaker–Home Health Aide Services conduct the national programs which are in place. The National Association of Home Health Agencies has also developed home health standards. Maximum use should be made of these voluntary programs by the federal sector in the same way that accrediting programs of the voluntary sector have been utilized for years in education.

Self-employed providers. A new development of special concern threatens the erosion of safe, effective, and efficient homemaker-home health aide programs in some states: the move from service provided under agency auspices to utilization of individual self-employed providers. The regulations promulgated for Title XIX of the Social Security Act permits the funding of self-employed providers and Title XX of the same act gives states almost total leeway in defining and establishing services. The motivation for increasing use of self-employed providers by states undoubtedly is the desire to find ways to serve more people with limited funds. However, the trend raises serious questions about (a) the calibre of direct service that vulnerable people are getting and the personal abuse and neglect that may occur; (b) the specter of exploitation of workers; and (c) whether this form of service delivery is penny wise and pound foolish. Let us examine each of these points briefly.

Calibre of services. At a meeting convened by the National Council for Homemaker–Home Health Aide Services in June 1976 and attended by representatives of federal, regional, and state governmental staff and of parallel groups from the voluntary sector, it was reported that in some states self-employed individuals were performing not only maintenance and supportive tasks but were also undertaking personal care of a medically oriented nature. These care-givers were untrained and usually had infrequent, if any, supervision from anyone, let alone an appropriate professional person. Such personal care activities as irrigation of colostomies, tube feeding, and injections were included in their duties.[27] Medicaid regulations prohibit the employment of family members. There is no such restriction in the Title XX statute or regulations and it is believed that relatives are an important source of self-employed providers when these programs are funded under Title XX.

While in-home services can and should vary, such as between homemaker–home health aide and chore services, properly defined, there are basic safeguards that should be observed.

The provision or coordination of various supplementary services by a homemaker–home health aide (or other) agency to help maintain families and individuals in their own homes requires that an agency:

1. be responsible for seeing that assessment and reassessment is undertaken by professional personnel so that the appropriate persons are provided supplementary services;
2. be responsible for the careful selection of persons who are to be sent into the homes of those in need of service;
3. be responsible for orientation and direction of personnel, appropriate to the service to be provided;
4. be accountable to the community for all

of the services provided or coordinated under its auspice.[28]

Exploitation of workers. The self-employed providers sometimes do not receive their pay for up to six weeks and few receive fringe benefits, not even such basic benefits as Social Security and workmen's compensation coverage.[29] It is apparent that some states are trying to avoid usual agency responsibility through the device of self-employed as opposed to agency-employed persons. Some workers do not even receive the minimum hourly wage and must pay for their own transportation and other job-related costs.

In most of the programs using self-employed workers, the locus of accountability, while sometimes specified, in actual performance is a grey area on all fronts—for the quality of service provided to the consumers, for the workers, and for the tax funds that pay for it.

Case cost information needed. Information is urgently needed on the cost implications of these self-employed provider programs as are case examples illustrative of the problems cited above.[30] As indicated earlier, without adequate assessment, reassessment, and overall case management, overutilization will abound and lead to inflated weekly, monthly, and, finally, per case costs which are the true determinants of how economical a service is. A cheaper hourly cost can well be a will o' the wisp leading to an exorbitant total cost.

An example might clarify the point. A young mother with multiple sclerosis suddenly gets worse and needs part-time help daily to maintain herself and her children at home. After a few weeks her critical symptoms gradually disappear. In the meantime, the provider has become accustomed to the family and vice versa. All concerned are willing to let the arrangement continue even though the circumstances have changed. Unless the agency keeps in close touch with the situation, and with the physician, service may be provided long after it is needed or desirable and chronic dependency can develop. Or a different kind of service may suffice, such as transportation to a medical clinic. For an older or handicapped person, use of meals-on-wheels for part of the week or daily telephone calls by a volunteer and periodic reassessment may be all that is needed once an immediate crisis is over which required homemaker–home health aide service.

Finally, in assessing the need for quality assurance in the burgeoning field of in-home services to protect consumers as well as dollars, National Urban League executive director Vernon Jordan's belief that the real threat to our society is our increasingly casual acceptance of human misery should be considered.

More extensive in-home service support systems abroad are reflected in decreased rates of institutionalization.

Getting It All Together

While some people need only one in-home service—perhaps homemaker–home health aide, nursing, physical therapy, or another service—most need several and, as their conditions change, they require different combinations. In many, if not most, communities, the various services are provided by different and separate organizations. One reason more physicians do not use home care is that they do not have time to establish and implement a plan of care to include the various services needed that must be assembled from the galaxy of community resources.

Some communities are looking to structural mergers of agencies as a way to deal with this problem. For some, this is a feasible solution. For most, however, it will prove difficult, time-consuming, and perhaps impossible. To bring into one corporate whole even some of the fifteen and often many more separate services needed, unless a very careful and lengthy process is followed, can be a bruising, damaging experience for all concerned. One result frequently overlooked in mergers is the loss of the various services' advocates, their boards of directors.

An alternative approach is to provide physicians, consumers, and others in the community with one telephone number to call for any kind of home care—in other words, to create a functional rather than a structural merger. Cincinnati, Ohio, has developed such a plan. In 1974, an Association of Home Care Agencies (AHCA) was formed. Today fifty-two separate agencies

and organizations are working through it to provide coordinated home care in that community. Participants include, among others, visiting nurse service; homemaker–home health aide service; public welfare and public health departments; twenty hospitals; disease-oriented groups—cancer, arthritis, and multiple sclerosis; Red Cross; several meals-on-wheels programs; and several organizations providing counseling, transportation, and medical equipment.

The association set up a central intake system, making one telephone number available to physicians and other referral sources. An annual home care institute, as well as legislative and public relations committees, help the agencies to address common problems together. Standards were developed for the agencies approved as providers to AHCA. This year additional methods of monitoring the quality of care are being developed. Routine consumer and physician evaluations conducted after cases were closed reveal an exceedingly high rate of satisfaction with the service given.

A study of the reduced hospital stay that could be achieved through utilization of home care services was undertaken by the association between January 1 and June 30, 1976. The study states that 613 persons were referred from ten area hospitals. One thousand one hundred and ten hospital days were saved and a net dollar savings of $146,150 was realized through the use of home care coordinated by the association, because fifty-three of those persons were enabled to leave the hospital earlier.[31]

The report states further that "During the first six months of 1976 a total of 383 different local physicians authorized home care coordinated for their patients by the Association of Home Care Agencies central intake team. The services of 50 organizations were used to coordinate 735 service referrals to community health resources to serve 572 persons with home care."[32] Early 1976 year-end reports indicate that 549 different physicians made use of the service last year. Surely this is an enviable record of achievement.

Other communities are picking up the ball. A plan based on some of the same concepts has been established in Rochester, New York. In Connecticut, Triage, Inc., has developed a program which is structured differently but which also aims at coordination as its end result. Triage describes its program in this way:

> A private, voluntary, non-profit health services organization formed . . . to coordinate the activities of other agencies engaged in providing such services; to gather information and to conduct studies with respect to the conditions of elderly persons and their need for particular services and appropriate means of satisfying such needs; to receive funds from the federal, state municipal, and private sources; and to apply such funds for the purposes herein before stated.[33]

It is stated further that,

> Triage interjects two concepts into human service delivery:
>
> 1. It provides the critical interface between medical and social services resulting in a capacity to respond to the person as a whole. A definition of health emerges which is comprehensive and inclusive;
>
> 2. A management function which goes beyond case management to system management in behalf of the client. There is recognition that the vast array of public and private agencies cannot, and probably should not, be merged into single agencies. The alternative is to provide this management capability which builds a dynamically changing but appropriate interface between client and multiple service agencies. Thus care is organized around the client instead of bending the client to fit what is available and can be reimbursed.[34]

The Triage program has not been in operation long enough to evaluate its effectiveness. However, this program, along with those in Rochester, Cincinnati, and elsewhere are the forerunners of an important development among home care provider organizations.[35]

Conclusion

The in-home services field appears finally to have been recognized as an important part of the health and social services delivery system by a significant group of providers, consumer organizations, third-party payers, federal legislators, and administrative agencies, especially HEW. The general interest in its expansion is most encouraging. The calibre of the programs that will be developed, in terms of quality, is in doubt, however. Unless preventive and corrective actions are taken now, the enormous positive potential of these programs could be damaged for years to come by scandal growing out of abuse of patients, exploitation of workers, and costly overuse or inappropriate utilization of the services.

A sound national policy for the guidance of official agencies and others is urgently needed to give direction to the in-home services movement. The policy should be developed by the federal government in concert with the voluntary sector. It should include approaches for coordinating, if not actually pooling, the current fragmented sources of federal funding, for assuring quality service, and for coordination of delivery of services to the consumer at the community level. And it should be developed this year.

Sooner or later, we will have a national health plan. When that day arrives, we need to have our in-home service system ready and able to assume its appropriate role and share of the responsibility for making the new program a successful and valuable service for our people. In the meantime we must build step-by-step toward that goal while extending and assuring the quality of service that people need today.

Notes and References

1. See Alfred J. Kahn, "National Round Table Conference: New Directions in Social Services," *Public Welfare* 34, no. 2 (Spring 1976): 26–32.

2. There have been several discussions of the need for in-home services. An early one was contained in U.S., Congress, Senate, Special Committee on Aging, *Alternatives to Nursing Home Care: A Proposal*, 92nd Cong., 1st sess., October 1971. These estimates range from just under four million to slightly over eight million including those persons in the population eligible for long-term care. In another estimate, Ethel Shanas arrived at a figure of four million potential home health beneficiaries by adding the institutionalized, bedfast, homebound, and those who walk with difficulty ("Measuring the Home Health Needs of the Aged in Five Countries," *Journal of Gerontology* 26, no. 1 (1971): 37–41. Robert M. Ball, senior scholar, Insti-

tute of Medicine, National Academy of Sciences, and former commissioner, Social Security Administration, HEW, stated that "It seems plausible that the size of the group of primary concern to this conference is from three to four million persons, 14 to 17 percent of the twenty-three million people 65 or over in the United States today" ("U.S. Policy Toward the Elderly" [Paper delivered at the Anglo-American Conference on the Care of the Elderly, Washington, D.C., May 1976]).

3. Membership list, International Council of Homehelp Services, Utrecht, Holland, October 1976.

4. Anne R. Somers and Florence M. Moore, "Essential Options for the Elderly," *Public Health Reports* 91, no. 4 (July/August 1976): 354–59.

5. U.S., Department of Health, Education, and Welfare, *Home Health Care: Report on the Regional Public Hearings*, Publication no. 76-135 (Washington, D.C., 1976). The hearings took place in New York, September 20–21; Arlington, Texas, September 21–22; Atlanta, Ga., September 22–23; Chicago, September 23–24; and in Los Angeles, September 30 and October 1, 1976.

6. For a review of the literature, see the following publications: Blue Cross Association, *Home Health Care: Model Benefit Programs and Related Guidelines* (Chicago, 1976); American Cancer Society, *Service and Rehabilitation: Home Health Care Programs* (New York, 1976); U.S., Senate, Special Committee on Aging, *Home Health Services in the United States: A Report*, prepared by Brahna Trager, 92nd Cong., 2nd sess., April 1972; U.S., Congress, Senate, Special Committee on Aging, Subcommittee on Long-Term Care, *Nursing Home Care in the United States: Failure in Public Policy, Introductory Report* and Supporting Paper no. 1, *The Litany of Nursing Home Abuse and an Examination of the Roots of Controversy*, 93rd Cong., 2nd sess., December 1974; U.S., Congress, House, Select Committee on Aging, Subcommittee on Health and Long-Term Care, *New Perspectives in Health Care for Older Americans*, 94th Cong., 2nd sess., January 1976; U.S., Congress, Senate, Special Committee on Aging, Subcommittee on Long-Term Care, and House, Select Committee on Aging, Subcommittee on Health and Long-Term Care, *Proprietary Home Health Care, Joint Hearing*, 94th Cong., 1st sess., 1975; National Council for Homemaker-Home Health Aide Services, "P.L. 94-63, Section 602, FY 1976," *Executive's Memo*, November 1976, p. 1; U.S., Senate, Committee on Government Operations, Subcommittee on Federal Spending Practices, Efficiency, and Open Government, *Problems Associated with Home Health Care Agencies and Medicare Programs in the State of Florida*, 94th Cong., 2nd sess., August 1976; U.S., Comptroller General, *Home Health Benefits Under Medicare and Medicaid: Report to the Congress* (Washington, D.C.: Government Printing Office, 1974); Louise Plunkert Terlizzi, "Homemaker–Home Health Aides," *Occupational Outlook Quarterly* 20, no. 3 (Fall 1976): 61–65; U.S., Congress, House, Committee on Education and Labor, Subcommittee on Select Education, *Older Americans Amendments of 1975: Conference Report to Accompany H.R. 3922*, 94th Cong., 1st sess., 1975, H. Rept. 670.

7. Violet M. Sieder and Charlotte J. Califf, *Homemaker–Home Health Aide Services to the Mentally Ill and Emotionally Disturbed: A Monograph* (New York: National Council for Homemaker–Home Health Aide Services, 1976).

8. For a discussion of these questions, see Eugene B. Shinn, "Case Management in Homemaker–Home Health Aide Services, A Report on Phase I: The Task Analysis Study," mimeographed (New York, National Council for Homemaker–Home Health Aide Services, 1976).

9. U.S., Congress, Senate, Special Committee on Aging, *Home Health Services in the United States: A Working Paper on Current Status*, 93rd Cong., 1st sess., July 1973, p. 16. The conference, In-Home Services: Toward a National Policy, was held in Columbia, Md., in June 1972.

10. "The Definition and Position Statement on Home Health Services" was developed by a task force composed of representatives of the Assembly of Outpatient and Home Care Institutions (American Hospital Association), the Council of Home Health Agencies and Community Health Services (National League for Nursing), the National Association of Home Health Agencies, and the National Council for Homemaker–Home Health Aide Services. The definition and statement have been endorsed by the parent organizations: American Hospital Association, National Association of Home Health Agencies, National Council for Homemaker–Home Health Aide Services, and National League for Nursing.

11. National League for Nursing, *Proposed Model for Home Health Care Benefits* (New York, 1976).

12. U.S., Congress, Senate, Special Committee on Aging, Subcommittee on Health for the Elderly, *Barriers to Home Health Care for Older Americans*, 93rd Cong., 1st sess., 11 July 1973, p. 389.

13. National Council of Homemaker–Home Health Aide Services, *Costs of Homemaker–Home Health Aide and Alternative Forms of Service* (New York, 1974), p. 16.

14. Ball, "U.S. Policy Toward the Elderly."

15. Eugene B. Shinn and Nancy Day Robinson, "Trends in Homemaker–Home Health Aide Services," *Abstracts for Social Workers* 10, no. 3 (Fall 1974): 5. (Note: The term *homemaker–home health aide services* is used in a generic sense and refers to those programs including only the personal care aspect, only the social care aspect, or both.)

16. National Council for Homemaker–Home Health Aide Services, "Quantico Dialogue Report," mimeographed (New York, 1976), App. B, p. 2.

17. U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, Medical Services Administration, "Report on Medicaid Home Health Services," xeroxed (Washington, D.C., October 1976), Table 1. The sixteen states are Arizona, California, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, North Carolina, Tennessee, and Wisconsin.

18. U.S., Department of Health, Education, and Welfare, Public Health Service, Division of Nursing, *Availability of Services for Nursing Care of the Sick at Home*, Publication no. PHS-1265 (Washington, D.C.: Government Printing Office, October 1964), App. Table 4, p. 19.

19. Shinn and Robinson, "Trends in Homemaker–Home Health Aide Services."

20. National Council for Homemaker–Home Health Aide Services, *Resource Book on Financing Homemaker–Home Health Aide Services*, rev. ed. (New York, 1976).

21. Exceptions to this, of course, are public bodies which use only the available tax dollars and the Medicare-only agency, that is where only covered services are provided to eligible individuals and service ends when benefits are used up.

22. HEW, *Home Health Care*, p. 56.

23. The August 21, 1975, Medicaid regulations on home care were not published in their proposed form because of the large-scale protest by individuals, agencies, and organizations committed to quality care.

24. Senator Frank E. Moss (Paper delivered to the Council of Home Health Agencies and Community Health Services, National League for Nursing, Washington, D.C., 17 March 1976).

25. Amitai Etzioni and Pamela Doty, "Profit in the Not-for-Profit Institutions," mimeographed (New York: Center for Policy Research, 1976).

26. U.S., Congress, House, Select Committee on Aging, Subcommittee on Health and Long-Term Care, *Comprehensive Home Health Care: Recommendations for Action*, 94th Cong., 1st sess., 19 November 1975, p. 77.

27. National Council for Homemaker–Home Health Aide Services, "Quantico Dialogue Report."

28. National Council for Homemaker–Home Health Aide Services, "Policy Statement on Supplementary Services," mimeographed (New York, 1974).

29. Peter Kihss, "Home Care Plan for Oldsters Scored," *New York Times*, 16 July 1976.

30. Staff at the National Council for Homemaker–Home Health Aide Services have talked with some workers with responsibility for the self-employed provider program. These workers get so demoralized that they think nothing they can do will help to bring about desperately needed changes.

31. Association of Home Care Agencies, "Report of Reduced Hospital Stay Based on Utilization of Home Care Services," mimeographed (Cincinnati, 1976).

32. Association of Home Care Agencies, "Can Your Patient Benefit from Home Care?" mimeographed (Cincinnati, 1976).

33. Connecticut, Council on Human Services, "Triage: Coordinated Services to the Elderly," mineographed (Hartford, 1976), p. 2. (Note: The council has been abolished by the state legislature, and ongoing responsibility was passed to the Connecticut Department on Aging.)

34. Ibid., p. 3.

35. Virginia C. Little, "Coordinating Services for the Elderly" (Paper delivered at the Hawaii Governor's Bicentennial Conference on Aging, Honolulu, June 7–14).

ITEM 2. HOMEMAKER STANDARDS SUBMITTED BY TERRY BLOOM,[1] SOCIAL WORK DIRECTOR, SAN FRANCISCO HOME HEALTH SERVICE, INC.

STANDARDS FOR LICENSING OF A HOMEMAKER AGENCY

(Prepared by The San Francisco Coalition for In-Home Services)

DEFINITION OF A HOMEMAKER

A Homemaker is a trained, supervised person who performs the tasks necessary to enable elderly, disabled and/or ill persons to maintain themselves, maximize their functioning in their own homes, and/or to help families remain together in times of crisis.

A Homemaker is employed as a staff member of the Agency and has accountability for her/his performance. The functions of a Homemaker may include: housekeeping, shopping, cooking, laundry, personal care, and teaching in areas such as care and management of the home, and self-care.

A Homemaker should have the ability to make independent decisions, as well as participate on an interdisciplinary team. She or he must have an interest and concern for people, and should have good physical and mental health. A Homemaker should be flexible, objective, and possess skills in communication.

HOMEMAKER TRAINING

A Homemaker's initial training program must be a minimum of forty hours. It should be conducted by professionals with experience in the health field and should be designed to increase understanding of human behavior and skill in working with the elderly, disabled and/or families. Practical knowledge of such areas as health and illnesses, nutrition, child care, homemaking and personal care, should be included. Agencies must provide monthly in-service training and continuous consultation to improve Homemaker skills, and to help Homemakers develop the self-care abilities of clients. Attendance at an accredited Home Health Aide course or other relevant classes should be encouraged.

HOMEMAKER SUPERVISION

Supervisors of Homemaker Services should be selected from a professional group identified with particular goals of Homemaker Services and should have the appropriate qualifications and certifications related to their fields.

The Homemaker-supervisor ratio should be no more than 15 to one.

Functions of the supervisor include:

(1) Making home visits for initial assessment and periodic reassessment of the client's need for in-home services;

(2) Establishing an interdisciplinary care plan in conjunction with the client and family, informing the Homemaker of the plan and seeing that it is effectively implemented;

(3) Monitoring the condition of each client through regular contact with the Homemaker;

(4) Referring the client to appropriate supplementary resources and following up on these referrals;

(5) Maintaining a current confidential record on each client. (These records are legal documents);

(6) Providing for the ongoing education and training of Homemakers;

(7) Offering consultation, mediation and support of Homemakers in their relationships with clients and families;

(8) Evaluating the performance of Homemakers at least once a year.

ELIGIBILITY FOR HOMEMAKER SERVICES

There must be written eligibility criteria for receiving the services. There must be no discrimination based on race, color, creed, gender, age, sexual orientation or national origin. The Agency should be aware of possible sources

[1] See statement, p. 153.

of payment for the services and help the applicant explore eligibility for them before a decision is made regarding the application. If the applicant is not eligible for Agency services, the Agency is responsible for referring the applicant to appropriate alternative resources, where available.

AGENCY'S ADMINISTRATIVE RESPONSIBILITIES

The Agency's duly authorized governing authority shall have ultimate responsibility for all services and shall evaluate, through regular systematic review, its organization and activities in relation to the Agency's purpose(s) and to the community's needs. Provision should be made for client participation in this process.

The Agency must adhere to sound fiscal and management policies. There must be a budget including sources of income and categories of expenditures, a system for cost determination, fee setting and fee collection, bookkeeping and accounting. The Agency must provide for bonding of staff and liability insurance.

Agencies receiving public funding must have their fiscal records open for inspection; all Licensed Homemaker Agencies shall have periodic independent audits by a Certified Public Accountant. These audits shall also be open for public inspection.

AGENCY PERSONNEL PRACTICES AND POLICIES

Agency personnel practices and policies must be discussed with applicants and a copy made available to employees. Personnel practices and policies must include the following:

(1) A statement that there shall be no discriminatory employment practices based on race, color, creed, gender, age, sexual orientation or national origin;

(2) Job classifications and descriptions, including probationary periods, seniority, promotions; and job upgrading;

(3) Salary scale and pay periods, including minimum guarantee of hours and/or pay, raises and provisions for overtime and holiday pay;

(4) Provisions for vacation, sick leave, leave of absence and educational leave, holidays observed by agency;

(5) Fringe benefits such as: Workers' Compensation, Unemployment Insurance, Disability Insurance, Social Security, Health Insurance;

(6) Requirement for physical examination prior to employment and yearly thereafter;

(7) Statement regarding reimbursement for uniforms and transportation costs, and payment for travel time;

(8) Criteria for evaluation of performance, discharge and grievance procedures;

(9) Statement regarding availability and contents of personnel files;

(10) An organizational chart, with clearly defined lines of responsibility;

(11) Agency rules and procedures.

AGENCY'S COMMUNITY RESPONSIBILITIES

The Agency, as an integral part of the community's health and welfare delivery system, shall assume an active role in an ongoing assessment of community needs, and shall work to meet these needs, both within the Agency and in the community at large. The Agency's personnel should reflect the primary ethnic groupings in the community as determined by the Voting Rights Act (PL 94–73).

AGENCY LICENSING

Those Agencies that meet the standards herein are eligible to receive a Homemaker Agency License from the California Department of Health. The Agency must be reviewed annually by the licensing body for compliance with these standards to qualify for renewal of the license.

Every Homemaker Agency receiving public funding must be subject to an annual fiscal and program audit, and must have a current Homemaker Agency License.

Appendix 2

LETTERS AND STATEMENTS SUBMITTED BY OTHER NATIONAL ORGANIZATIONS

ITEM 1. LETTER FROM JAMES H. SAMMONS, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.; TO SENATOR LAWTON CHILES, DATED JULY 18, 1977

DEAR SENATOR CHILES: The American Medical Association welcomes the opportunity to participate in the discussion on health care alternatives for older Americans. As you are aware, the Association has long had interest in improving the health of our older citizens and this interest becomes more acute as the number of older citizens increases in our total population, both proportionately and in absolute numbers.

Each day of the year, about 4,000 Americans reach age 65; each day approximately 3,000 persons in such age group die. In planning, therefore, we must take account not only of a daily "increase" of 1,000 persons per day—but must also recognize that these 1,000 persons are "newcomers" to the ranks of the aged. These newcomers have, on the average, had better nutrition, better health care, and higher living standards than the generations of people reaching older age before them. Technological improvements in health care and easier access to physicians have also contributed substantially to the health of the aged so that those now entering the over-65 age group, and those that will enter this segment of our population, are healthier than those preceding them.

We consider this increase in our aged population an important factor in the planning efforts of the Senate Special Committee on Aging. The 22 million people now over 65 (some ten percent of the total population) obviously include those who are quite ill and those who are impoverished, as does any segment of the population selected on the basis of age alone. It is, however, a myth that the aged are, as a group, fragile, isolated and despairing, and are merely waiting the inevitable. Indeed, in many cases the longevity of people is itself a tribute to the physical, mental and emotional health of the population as a whole, including that of the aged population.

Recent surveys of the aged show, in fact, that only 12 percent complain of loneliness, only seven percent feel unneeded, and only six percent believe they do not have adequate activities to fulfill their lives. Their physical health, too, is better than is generally believed; the overwhelming majority, 83 percent, function with reasonable independence in the community, and less than 20 percent are either confined to their home or have serious difficulty in general mobility.

In short, many of those persons over age 65 are very much like those under age 65—they are active and alert and desire to participate in community life. These facts do not, of course, deny that the chance of having a chronic condition increases for each of us as we grow older as this is one of the recognized results of the wear and tear of daily living.

While the AMA believes that it is necessary to provide that level of care needed by the aged, it is important to emphasize the ability of the vast majority of the aged population to lead useful and meaningful lives with just a little help. Medicare and Medicaid provide billions of dollars in hospital care for the aged, needy and non-needy, and pay for physicians services, limited home health care, and nursing home care. Yet the older person who needs only a little assistance to do personal shopping or the aged person who needs only someone to prepare a hot meal occasionally often is hard pressed to obtain such "basic" assistance. It is indeed ironic that the smallest amount of need is often the hardest to obtain. Choices too often revolve around expensive institutionalization to obtain the needed limited care or no care at all.

We would suggest that the one thing most usually found as a common denominator among aged people is an interest in life, the desire to continue living an active and useful existence among other people. The aged person would much rather, whenever it is possible, remain at home and in the neighborhood among long-time friends and acquaintances than sequestered in an institution; the aged person would rather manage his own life, as much as possible, than be dependent on others. When one has experienced forty or fifty years as an independent person, and often during that time assuming great responsibility for the care of others, it is especially difficult to accept a dependent role just because some "magical" age barrier has been passed.

It is important for the nation to pursue a policy of maximizing the maintenance of aged persons in their normal life style as much as possible. This policy is desirable both because evidence suggests that an individual functions best in a familiar environment, such as one's own home and neighborhood, and also because institutionalization (often the only alternative to no care) is an extremely expensive manner of providing basic food and shelter.

We share with you a concern about the future of the Social Security system and the fiscal aspects of the population's aging. We are concerned about the implications of the prediction that soon there will be one person receiving Social Security benefits for each two people paying into the system. In preparing for this future, we would suggest that it is infinitely practical to seek for the aged means: to keep them out of institutions as much and as long as possible; to keep them working and contributing to society; and to maximize their continued independence.

Clearly, this is one area where the currently sacred "cost-benefit ratio" is obvious and the health benefits equally obvious. The medical profession has, therefore, strongly encouraged the development of expanded home health care programs, including both the strictly health-care segments of that program and the more general homemakers' and meals-on-wheels type of service. Physicians would recommend use of services for their patients if adequate services were available.

We also welcome some of the more recent developments—the establishment of day centers for the older individual, for instance—and would recommend exploration of increased volunteer programs both for and by the aged. The "Foster Grandparent" program initiated by the Office of Economic Opportunity, for example, has provided not only a small income but also a sense of usefulness in the community for the older volunteers involved. Similarly, some businesses are finding a practical asset in the experience of retired executives, acting as consultants in new businesses. The American Medical Association has long held that a fixed retirement age is undesirable and that individuals should have an opportunity to contribute to the community according to their abilities, as long as they are physically and mentally capable of and desiring to make a contribution to society. The Committee may well wish to explore ways to prompt greater use of this wealth of experience and practical knowledge, now largely going to waste. The feeling of "usefulness" is itself often a powerful, effective "medicine."

While we are well aware that not only the aged, but individuals of all ages, can fall victim to individuals who are untrained or poorly trained in the provision of home health services, we are also aware that some of the assistance required by the aged does not require a great deal of training, but simply a desire to help. Some need only a friend to lean on while they walk, some need only a little assistance in keeping a small apartment clean, some need only someone to check with them daily to make sure they are well and safe. The Committee might well explore the possibility of promoting such volunteer programs of "friendly visitors" to supplement or to take the place of the extended family for the aged individual who may be able to live alone but who does need an occasional visit.

Finally, we would recommend for the Committee's consideration one of the suggestions the American Medical Association made to Secretary Califano in response to his request last January for suggestions regarding welfare reform. We suggested to Secretary Califano that the tax laws might be modified to encourage more family support of the needy. The Association believes that the first responsibility for those unable to care for themselves should revert to their families—and most Americans do, we believe, follow this idea to the best of their ability, and often beyond their ability, Nonetheless, the assistance that families can give to the aged might be increased or encouraged by revision in the tax laws.

Appropriate encouragement of family support of aged family members not needing institutional care would not only improve the psychological health of the aged but would also reduce the oftentimes demeaning dependence of the aged on public welfare programs. Again, in the context of an increasing aged population, retention of the aged person as a vital and an integral part of society is an important consideration to the health of the individual.

In conclusion, let us reiterate our concern that *all* appropriate levels of health care and personal assistance necessary to insure a meaningful life be available to our aged population. We emphasize that those approaches which maintain the greatest degree of individual independence for the aged will, in the long run, be best for the aged individual and in the best interests of our nation.

Sincerely yours,

JAMES H. SAMMONS, M.D.

ITEM 2. LETTER AND ENCLOSURE FROM THEODORE CARCICH, JR., PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, D.C.; TO SENATOR LAWTON CHILES, DATED JUNE 1, 1977

DEAR SENATOR CHILES: Thank you for your invitation to submit a statement on behalf of the American Health Care Association for inclusion in the record of the Special Committee's recent hearings on the subject of home health care.

You have correctly assumed that the nation's largest association of long-term care facilities has a vital interest in all forms of health care for older Americans. Nursing homes are frequent participants in the process of arrangement for and provision of home health services.

The experience of our 7,500 member facilities in caring for convalescent and chronically ill persons is a source of considerable knowledge concerning the best approach to meeting the unique needs of these individuals, whether in an institution or in their own homes.

I would appreciate your insertion of the enclosed statement which I delivered at one of last year's regional HEW hearings on this subject.

Please advise us if our association members and staff can be of assistance to you at any time.

Respectfully,

THEODORE CARCICH, Jr.

[Enclosure.]

STATEMENT OF THEODORE CARCICH, JR., PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

I am pleased to have this opportunity to present the views of the American Health Care Association to this hearing. The AHCA is the nation's largest organization representing long-term care facilities. Our membership is made up of some 7,500 licensed institutions with more than 600,000 of the nation's long-term care beds.

While the primary interest of our membership is in patient care, we recognize the great need to address a broader spectrum of issues relating to the health care needs of the elderly and chronically ill. My own interest and experience is indicative of this belief, for I speak today not only as a nursing home administrator in my home town of Moscow, Idaho, but also as president of the Latah County Home Health Agency.

My statement will briefly deal with areas of concern:

(1) Matching services to needs;
(2) Scope of benefits;
(3) Licensure of home health agencies and uniform standards;
(4) Relative cost of services;
(5) Lower barriers to participation by institutional providers.

MATCHING SERVICES TO NEEDS

At the outset, I would suggest that we lay aside the rhetoric about creating "alternatives to institutional care", and begin by agreeing to focus our attention on human beings as individuals. There are no pat answers to be found by setting up an impersonal system of rules and regulations which is bound to be inflexible to unique individuals and community situations.

I have a strong belief that decisions to arrange health services for anyone must begin with a comprehensive evaluation of that individual's medical, social, and financial circumstances. This evaluation should be made by a multi-disciplinary team with the full participation of the subject and his or her spouse or other family members. Once a clear picture can be obtained, an informed judgment can be made based on facts and with proper reverence for human rights. At that point it becomes possible to make arrangements for the best combination of health and social services available in the community.

That process might say that the best way to meet that person's needs is through nursing home care. On the other hand, it might be possible to put together the necessary resources to meet the needs at home. In either case, we must assure ourselves that the decision is based on facts, careful planning, and meaningful consumer choice. This should be the objective of our long-term health care system.

SCOPE OF BENEFITS

While I appreciate that these hearings are intended to focus primarily on home health services, it is difficult to divorce home health care from other modes of service delivery if we are to seriously address the range of needs which individuals experience when long-term incapacity sets in.

In the context of Medicare and Medicaid, and the relatively limited budgetary capacity of these programs at the present time, it is probably realistic to assume that covered services, regardless of where they are rendered, will continue to be limited to medical care, nursing, and therapy, with custodial care permitted only as an adjunct.

Nevertheless, I believe that liberalization of covered services for Medicare in both the extended care and home health benefits is warranted to allow greater ease of substitution for hospital care. Also, special consideration is warranted in the case of the developmentally disabled and the terminally ill.

LICENSURE OF HOME HEALTH AGENCIES AND UNIFORM STANDARDS

AHCA believes that it would be an enormous mistake to dramatically encourage the growth of home health agencies without first considering the adoption of meaningful standards of service and requiring or strongly encouraging state licensure. These standards need to be at least the equivalent in scope and application as present standards for skilled and intermediate care facilities, especially in the areas of administration, patient records, utilization review, and patients' rights.

These standards should apply with equal force to public, nonprofit and for profit agencies. Licensure laws and Federal law and regulations should specifically encourage the growth and development of home health agencies operated in conjunction with existing licensed health care facilities by recognizing that these facilities already are required to satisfy many of the requirements which should be part of any home health service operation.

COST-EFFECTIVENESS OF SERVICES

While our first concern should be with providing the best possible services which can be obtained, the fiscal integrity of any program demands that we avoid excessively costly modes of care unless there is compelling reason to utilize them.

The authorization of intensive forms of home health care over a long period of time can prove astronomically expensive and cannot be justified as an alternative to similar services provided on an institutional basis. Also, the recent revelation of mismanagement and excessive costs in certain nonprofit home health agencies points up the need for carefully structured payment methods and improved management practices.

I strongly recommend the adoption of a limitation similar to that contained in S. 2591 (Bentsen) which would prohibit payments for some health visits which exceed the costs of the same services if provided on a full-time basis in an SNF or ICF.

REMOVE BARRIERS TO PARTICIPATION BY INSTITUTIONAL PROVIDERS

Much of the opposition to lowering barriers against participation of proprietary providers has been emotional and, in some cases, self-serving. However,

AHCA favors a cautious policy toward spurring the growth of new agencies, regardless of ownership, which do not meet uniform Federal standards or comparable state licensure standards.

There is a real need to increase the accessibility of home health services. In my opinion, the best way to begin to deal with this problem is to permit existing licensed health care organizations to experiment with outpatient and home services. Nursing homes, for example, have all the resources necessary to deliver this service, and potentially can do so with very little new capital expenditures. And, as I mentioned earlier, there is a direct link to an established and improving system of quality assurance, financial controls, and utilization review.

Just as importantly, much needed managerial expertise and financial stability is attainable in a nursing home based program which is noticeably absent in many existing home health agencies.

DHEW has made and is continuing to make grants available for start-up costs of new nonprofit home health agencies. I regard this program as an indefensible waste of taxpayers' money, when a much more efficient and effective alternative is available.

The continuation of discrimination against proprietary nursing homes and hospitals in the delivery of home health care is anti-competitive, wasteful, and will guarantee a continuing lack of access to home health services for most of our population.

CONCLUSION

There is much more that I could add that would be pertinent to these hearings. We will continue to provide input to the Department on this issue as your proceedings continue toward the completion of more concrete objectives. AHCA is concerned and eager to be of assistance.

I would like to summarize by saying how strongly I feel that we must use our existing resources more efficiently, while considering the patient first. Our emphasis should be on services—and on finding the best combination of providers who can produce quality services in an efficient manner. I believe this approach will mean that governmental, nonprofit, and proprietary entities will all find an appropriate role to play. To exclude any one of the three on the basis of irrational biases will mean that we shall fall short of the mark.

ITEM 3. LETTER AND ENCLOSURES FROM DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING, WASHINGTON, D.C.; TO SENATOR FRANK CHURCH, DATED JUNE 1, 1977

DEAR SENATOR CHURCH: On behalf of the American Association of Homes for the Aging, I submit the enclosed statement in response to your request for our views with respect to the Special Committee on Aging of the U.S. Senate hearings on the limitations of Medicare and Medicaid policy in regards to "alternatives."

Appendixed to this statement is a copy of our Public Policy Objectives for the 95th Congress. This agenda specifically is germaine to the committee's focus of providing options for older Americans; and therefore, rather than attempt to extract portions of this document, we ask that it be included in the text of the testimony.

We appreciate this opportunity to comment on this important issue, and we pledge our continued assistance to you and the members of the committee in their efforts to improve the quality of life for older Americans.

With best wishes,

DAVID C. CROWLEY.

[Enclosures.]

STATEMENT OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman, I am David C. Crowley, Executive Vice President of the American Association of Homes for the Aging. The American Association of Homes for the Aging (AAHA) represents nonprofit homes for the aging, housing, and health-related facilities. Its 1,500 member homes are located throughout the United

States and are sponsored by community-based religious, fraternal, labor, civic and county organizations. We appreciate this opportunity to reiterate our positions with respect to "alternatives to institutional services."

The preamble to our recently approved Public Policy Objectives for the 95th Congress reads in part:

". . . Revision of the present delivery system to encompass a continuum of necessary services has been stymied by alleged scarce resources, administrative duplication and a lack of policy imagination. Public officials continue to debate the development of alternatives to institutional care, without recognizing that an expanded public commitment to housing services is fundamental to the delivery of community supports. . . ."

Written and approved prior to the announcement of this series of hearings, the above statement summarizes the essence of our remarks with respect to the continuing debate on "alternatives."

Appendixed to this testimony is a copy of our Public Policy Objectives for the 95th Congress. This agenda specifically is germaine to the committee's focus of providing options for older Americans and, therefore, rather than attempt to extract portions of this statement, we ask that it be included in the text of our testimony. The public policy agenda of our association is directed at three basic goals:

(1) Strengthening basic housing programs for the elderly.

(2) Integrating social components of care within medical, long term care settings.

(3) Expanding nonmedical, long term care services for older persons.

The recommendations that we set forth are based on the premise that for many older Americans, suitable housing includes a variety of services. Group living arrangements—ranging from basic housing through skilled nursing care—can offer many elderly the opportunity to overcome social isolation and disabilities.

For an appreciation of our association's position, it is important to dispel two myths which have permeated the recent Congressional policy debate on long term care.

The first myth is that all institutions are nursing homes and, therefore, inherently bad. As we have testified before the committee previously, terms used to refer to housing and living arrangements for the elderly should accurately reflect differences found in those arrangements. Although nursing homes, homes for the aging, elderly housing and personal care homes may have in common the one feature of caring for the elderly, they do so in different ways, different intensities, and with different objectives. There are fundamental differences in the primary purpose of each of these living arrangements.

The term "nursing home" cannot be applied loosely to all types and levels of housing and living arrangements for the elderly without the serious consequence of reducing the capacity of these arrangements for flexibility and variety. The stereotype of institutional living which is reinforced by smoothly written, media-oriented investigative reports cannot and should not be a blanket damnation of housing arrangements for the elderly. Similarly, the term "long term care" should be re-examined. It has come to mean long term nursing care. Distinctions need to be made between long term nursing care and long term social/residential care, as well as between these and the post-hospital, medically necessitated care provided in the acute setting.

We must overcome the fundamental assumption which pervades present policy—that older people are either generally well and primarily in need of income supports, or they are generally sick and primarily in need of intense medical services.

The second myth that must be overcome is that there is an extreme overutilization of certain long term care institutional services, and that the simple solution to overcoming that utilization pattern is to fund "alternatives." This thinking ignores the issue of under-utilization, and assumes that varying service delivery components are competing rather than complementary. Carried to the extreme, these assumptions lead to simplified economic decision-making devoid of consumer preference, individual need assessment or recognition of factors affecting quality and suitability.

We recommend for careful reading by committee members the recent Congressional Budget Office Issue Paper on Long Term Care for the Elderly and Disabled. The most significant contribution this paper offers to the debate of

developing a national policy for long term care is the documented shortfall of present supply of services in light of both present and future demand:

". . . In summary, of the 5.5 to 9.9 million functionally disabled, only 1.9 to 2.7 million persons can be identified as receiving assistance under formal programs. . . ."

We call to your attention tables 1–3 appendixed to this statement which were extracted from the Congressional Budget Office study. Table 1 includes the above quote and provides estimates of numbers served and assumptions about informal care. Table 2 projects estimated supply and potential need for long term care services, and Table 3 breaks down the income distribution among all families, including the disabled and the "institutionalized." These three charts illustrate that in general:

(1) Present medical reimbursement programs (Medicare and Medicaid primarily) have generated a supply—of varying quality—sufficient to meet the estimated potential demand for "nursing home" care.

(2) There is a tremendous demand for congregate services—personal care homes, sheltered living arrangements and congregate housing—and a very limited supply of such services.

(3) There is a tremendous demand for home health and day care services and a very limited supply.

(4) There is a direct relationship between the adequacy of income supports and the ability of the individual to reside within a community setting.

(5) There will be a high utilization factor with respect to any benefit change enacted by the Congress by the multitudes who are without formal services rather than by any transfer of utilization patterns from complementing services.

Our association's policy objectives offer several suggestions which address these problems. We are particularly concerned about and offer recommendations with respect to the public support for congregate services. If we are to pursue policy options to decrease the demand for medical institutions and at the same time to meet the needs of older persons who require personal and environmental supports, i.e., a socially intense protective environment, then we should consider an entitlement program for purchasing supervised group living arrangements. Likewise, if we are to expand our housing commitment to the older person and at the same time ensure that the demand for services which is directly related to age is fulfilled, then we must stimulate a continuing availablity of supports as a component of housing for the elderly.

In sum, if a full continuum of services to meet the long term care needs of the elderly is to be provided, noninstitutional community services must be expanded. We urge the committee to consider policy incentives which build upon the present trend of community-based homes for the aging as the focal point of geriatric services combining group residences with community outreach activities including day care, nutrition services, senior centers and/or home health services. While the committee has commented in the past on the importance of building a campus arrangement of institutional services ranging from independent housing through intense social care to medically-oriented long term care, limited attention has been given to the trend of bringing the community to the facility. We are proud of the innovative activities of our not-for-profit providers who are pioneering programs of a continued community presence. A recent survey of our members indicates that over 200 facilities are engaged in nutrition programs, nearly 50 have developed senior centers, and an equal number are involved in day care and home health services. These programs are increasing, often in spite of government policies, with the provider being forced to comply with competing regulations, multiple funding sources, and vast amounts of apathy.

Finally, we urge the committee to continue its diligent efforts to secure an expanded Federal commitment to housing for the elderly and to obtain improved coverage under Medicare and Medicaid for long term care services. Both of these efforts are essential components of the strategy that must be pursued if we are to meet the needs of older persons. We must continue to work toward a flexible array of services for older Americans.

[Appendix 1]

Since the recipients of noninstitutional care under federal programs may receive services under more than one program and the degree of overlap is unknown, a range of individuals estimated to be served is shown in Table 6.

TABLE 6.—LONG-TERM CARE ESTIMATED SUPPLY AND POTENTIAL DEMAND, FOR CALENDAR YEAR 1976

[Adults in millions]

Source	Estimated potential demand	Estimated number served
Potential demand	5.5–9.9	
Estimated supply:		
Chronic hospitals and facilities for the deaf, blind, and disabled		0.1
Nursing home care (ICF and SNF)		1.3
Personal care or domiciliary care		.2
Sheltered living arrangements		0.1– .6
Home care and day care		[1].3– .5
Estimated total number served under Government programs		[1] 1.9–2.7
Estimated informal care by families		[2] 3.0–6.7
Estimated number receiving no care		[3].8–1.4

[1] Function of range of overlap of persons receiving possible duplicate treatment under medicare and medicaid.
[2] Estimates of the disabled population living with others in private residences, congregate housing, or sheltered living arrangements. These persons may also receive home care under public programs.
[3] Estimated disabled living alone less number receiving home care if home care is assumed to be evenly divided between those living alone and those living with others.

Source: CBO estimates.

Informal basic care is provided to a large degree by the families and friends of the disabled. According to the NCHS survey of the disabled cited earlier, 88 percent of the functionally disabled between 18 and 64 and 70 percent of the elderly disabled live with others. Presumably these other individuals provide whatever assistance is required by the disabled in the way of shopping, cooking, or personal care, although they cannot provide specialized health care. The remaining 30 percent of the elderly disabled and 12 percent of the disabled age 18–64 live alone. If they are not among those receiving home-based services funded under a public program or do not have relatives nearby to provide assistance, they probably receive no care.

In summary, of the 5.5 to 9.9 million functionally disabled, only 1.9 to 2.7 million persons can be identified as receiving assistance under formal programs. Of these, 1.6 million are in institutions and 75,000 to 635,000 are in other sheltered living arrangements. Home health agencies serve up to 500,000 people under medicare and medicaid, but some of these people are probably also receiving help from relatives and not all can be considered to be receiving long-term care. In order to estimate the total number of persons receiving services, it is assumed that the noninstitutionalized disabled living with others are receiving basic services from their families. Under this assumption, an estimated 3 to 6.7 million disabled are receiving some form of informal care. This group may also be receiving home care or may reside in congregate housing so that it is impossible to estimate how many are receiving only informal family care. Moreover, nothing is known about the quality or adequacy of such family services. Similarly, it is assumed that those living alone receive no family care but receive half the home health care under medicare and medicaid (a simplistic and possibly optimistic assumption). Under this assumption, an estimated 800,000 to 1.4 million disabled may receive no form of long-term care.

[Appendix 2]

This last observation is quite significant. Considering that from 3 to 5 percent of the total noninstitutionalized population (12 to 17 percent of the elderly) have levels of disability so high that they are bedridden or require assistance in the most basic functions of daily living, it is easy to see that beds presently occupied by those not needing nursing home care can readily be filled by others. Table 7 roughly illustrates estimated supply and potential need (i.e., demand adjusted for appropriate placement) in calendar year 1976. The figures can be expected to increase significantly over time, but they illustrate the basic mismatch of services with requirements.

TABLE 7.—LONG-TERM CARE ESTIMATED SUPPLY AND POTENTIAL NEED, FOR CALENDAR YEAR 1976

[Adults in millions]

Type of treatment	Estimated potential need [1]	Estimated supply
Nursing home care:		
SNF	0.7	0.9
ICF	.6	.4
Personal care homes, sheltered living arrangements, and congregate housing	1.5–1.9	0.3–.8
Home health care and day care	1.7–2.7	.3–.5
Informal family care only or no care	1.0–4.0	3.6–7.2

[1] Derived in the following manner: Descriptive levels of disability (e.g., cannot bathe) assigned to probably appropriate levels of care based upon Nagi (national), Greenberg (Minnesota), and Berg (New York) studies cited earlier. Estimates of the incidence of disability adjusted to correspond to national distribution of disability levels. National need then calculated on basis of SSA population projections.

Source: CBO estimates.

[Appendix 3]

Medicare covers only a fraction of nursing home costs, so long nursing home stays tend to impoverish the disabled and make welfare support inevitable. In fact, 47.5 percent of nursing home patients whose costs are paid by medicaid in 1974 were not initially poor by state definitions but depleted their resources and qualified as "medically needy."

TABLE 9.—COMPARISON OF FAMILY INCOME DISTRIBUTION AMONG ALL FAMILIES, THE DISABLED, AND THE INSTITUTIONALIZED

Family income	Percent distribution				
	Families [1]		Functionally disabled [2]		Institutionalized,[3] all
	All	65 plus	All	65 plus	
Less than $3,000	5.3	8.3	38.2	43.2	68.7
$3,000 to $4,999	7.8	20.0	18.9	18.6	5.4
$5,000 to $6,999	8.9	19.4	10.8	11.2	1.7
$7,000 to $9,999	13.8	19.0	7.9	7.2	.6
$10,000 to $14,999	24.4	17.3	9.0	6.8	.4
$15,000 and over	39.8	16.0	5.5	6.9	.7
Unknown			9.8	6.1	22.5
Total	100.0	100.0	100.0	100.0	100.0

[1] "Money Income in 1974 of Families and Persons in the United States," U.S. Bureau of Census, Series P–60, No. 101, January 1976.

[2] "Limitation of Activity and Mobility Due to Chronic Conditions, United States—1972," HEW, National Center for Health Statistics, Series 10, No. 96, November 1974.

[3] "Long-Term Care Facility Improvement Study," HEW, Public Health Service, Office of Nursing Home Affairs, July 1975.

[Appendix 4]

Public Policy Objectives for the 95th Congress

ADOPTED MARCH 21, 1977
By the House of Delegates
of the
American Association of Homes for the Aging
1050 17th Street, N.W.
Washington, D.C. 20036

The American Association of Homes for the Aging (AAHA) represents nonprofit homes for the aging, housing, and health-related facilities. Its 1500 member homes are located throughout the United States and are sponsored by community-based religious, fraternal, labor, civic, and county organizations.

Because the public increasingly has expected that government will provide for the needs of older Americans, public policies increasingly have determined who shall receive services, when, where, and in what manner.

In order to insure that the elderly receive the services they need and prefer, it is important that legislators and other public policy makers benefit from the knowledge of those who provide services directly to the elderly. Representatives of our homes are in daily contact with older people. They have daily opportunities to know at first hand what they are like, their preferences, needs, and concerns. Their knowledge can be of assistance in developing public programs conducive to the total welfare of older Americans. This book has been written to provide this assistance to those who make and shape our laws.

Other principal activities of the American Association of Homes for the Aging include those which promote the professional skills and sensitivities of persons who provide services to nearly 250,000 elderly residents in our homes.

Rev. Msgr. Charles J. Fahey, President,
American Association of Homes for the Aging

David C. Crowley, Executive Vice President,
American Association of Homes for the Aging

PUBLIC POLICY OBJECTIVES OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

PREAMBLE

The public increasingly expects that government will provide necessary services to older Americans and encourage community groups to offer additional supports for a safe and healthful environment. The 95th Congress confronts a variety of policy options to accomplish this. Because the fastest growing segment of the population is the elderly, it is imperative that we question how supportive services should be provided if additional years are to be satisfactory for senior citizens.

In the past, justification for developing programs in the name of the elderly has not resulted in public policies significantly benefiting the aging. The rhetoric has far outstripped the commitment of public resources. Where favorable programs have been enacted, cumbersome administrative procedures have blunted their effectiveness.

OF PARAMOUNT CONCERN TO THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING IS THE FAILURE OF PUBLIC POLICY TO ADDRESS THE LONG TERM CARE NEEDS OF THE OLDER POPULATION. EXISTING PROGRAMS ARE PREDICATED ON THE SEPARATE APPROACHES OF INCOME MAINTENANCE, MEDICAL SERVICES, AND HOUSING ASSISTANCE. PROGRAM INTEGRATION IS NONEXISTENT DUE TO CONFLICTING REGULATIONS AND A DISJOINTED, FRAGMENTED BUREAUCRACY.

Revision of the present delivery system to encompass a continuum of necessary services has been stymied by alleged scarce resources, administrative duplication, and a lack of policy imagination. Public officials continue to debate the development of alternatives to institutional care, without recognizing that an expanded public commitment to housing services is fundamental to the delivery of community supports. While some attention has been given to integrating the various elements of the delivery system, intermediate steps necessary to moving in that direction have not been taken.

Several pragmatic approaches are available to facilitate the development of a continuum of programs to meet the long term care needs of older Americans. Congress should explore these intermediate steps, taking into consideration the limited resources and numerous priorities which must be addressed.

The public policy goals of the American Association of Homes for the Aging are: (1) to strengthen basic housing programs for the elderly; (2) to integrate social components of care within the medical, long term care setting; and (3) to expand nonmedical, long term care services for older Americans. The recommendations which follow are based on the premise that for many older Americans, suitable housing includes a variety of services. Group living arrangements — ranging from basic housing through skilled nursing care — can offer many elderly the opportunity to overcome social isolation and disabilities.

HEALTH

The two government programs established to help older persons pay their health costs — Medicare and Medicaid — fail to cover adequately the costs of long term care.

Medicare, the major federal health program enacted to assist the elderly, is so fraught with durational limitations, entitlement preconditions, and service constraints that assistance to individuals needing long term care is severely restricted. Essentially, Medicare covers short-stay, convalescent skilled nursing services following hospitalization.

Medicaid, the federal-state shared program providing health services for the indigent, pays for a limited range of long term care services which are narrowly defined as "medically necessary." Program standards, including rules for utilization review, physician approval, and staffing, have tended to reinforce the view that long term care services are medical services. Management of the program is vested in the states; therefore, eligibility and benefit criteria vary greatly by jurisdiction.

Both programs limit reimbursement to long term nursing and medical services. They ignore the fact that social components of care are necessary to maintaining an individual's active functioning. The medical emphasis of Medicare and Medicaid often impedes the provision of social supports necessary to enhance the quality of life within the institutional setting. Any health program established to meet the needs of the elderly must provide links between medical, health, social, environmental, and other supportive services.

THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING ADVOCATES THE ESTABLISHMENT OF A LONG TERM CARE SERVICE BENEFIT AS A SOCIAL ENTITLEMENT. COVERAGE SHOULD INCLUDE A FULL RANGE OF HEALTH AND SOCIAL SUPPORTS, INCLUDING BOTH INSTITUTIONAL AND NONINSTITUTIONAL SERVICES. ELIGIBILITY FOR SERVICES SHOULD BE PREDICATED ON INDIVIDUAL NEEDS AS ASSESSED BY

COMMUNITY LONG TERM CARE CENTERS (INCLUDING EXISTING FACILITIES), WHICH WOULD SERVE AS COORDINATORS FOR SERVICES TO THE AGED. SUCH A PROGRAM SHOULD OPTIMIZE COMMUNITY RESOURCES, MAXIMIZE THE QUALITY OF CARE OFFERED, AND INSURE PROGRAM FLEXIBILITY.

Pending this comprehensive program revision, we urge that the following remedial actions be taken to improve long term care assistance under Medicare and Medicaid:

(1) The Medicare requirement for prior hospitalization and the restriction on the length of time during which skilled nursing care can be covered under the program should be eliminated. Simultaneously, other changes should be made in the Title XVIII program to strengthen the social components of the delivery system.

(2) Provisions of the Medicare program which base an individual's eligibility for benefits on the characteristics of an institution in which he or she resides, rather than on the person's entitlement to receive the services, must be amended. An individual should not be prevented, solely because of his or her physical location, from receiving services which otherwise would be covered.

(3) The Medicare "spell of illness" rule must be eliminated to allow older persons who reside in institutions to receive long term care benefits under the program.

(4) The "levels of care" concept now embodied in the Medicare and Medicaid programs must be re-evaluated, with a view toward developing a system which encourages greater flexibility and economy in meeting individual needs.

(5) Benefits under Medicare should insure that the elderly's total health needs are met. Additional categories of benefits that should be covered under Title XVIII include preventive care, outpatient drugs, vision care, podiatric care, dental care, audiological services, and prosthetic devices.

(6) The Department of Health, Education, and Welfare must be brought into compliance with the provisions of Public Law 92-603 mandating cost-related reimbursement under Medicaid for skilled nursing and intermediate care facility services. States should be required to make reasonable cost payments retroactive to July 1, 1976, the statutory implementation date.

(7) State Medicaid plans for reimbursing facilities on a cost basis for long term care services should insure that program beneficiaries receive quality care. All services which positively contribute to the health and physical and social functioning of residents should be covered under the Title XIX program. Determinations of "reasonableness" should be sufficiently flexible so as not to deter quality care.

(8) The importance of community involvement in institutional services must be recognized. Government reimbursement policies should include incentives for charitable, philanthropic, and community contributions, and states should not be allowed to assume the availability of such funds in order to lower reimbursement rates. Certainly, state plans should not prohibit charitable and philanthropic contributions to augment covered services.

(9) Consideration must be given to strengthening the federal financing of the Medicaid program. Federal standards for state plans should include provisions for mandatory eligibility for the medically needy, more uniform benefit packages among the states, and greater conformity of eligibility requirements. States must not be allowed to deny Medicaid benefits to those persons who incur medical expenses which, if subtracted from total income, would result in an individual's being eligible for Medicaid assistance. States must also be prevented from deeming income as available from one spouse to another, if either the wife or husband is institutionalized for one or more months. Deemed income provisions impose unreasonable hardships on both spouses, and prevent otherwise eligible persons from receiving needed long term care services.

(10) Government efforts to stem fraud and abuse under the Medicare and Medicaid programs must be continued, but Congress should be aware of the problems associated with current fraud and abuse control programs. Paper compliance and too many layers of administrative oversight can distract from patient care. Regulations for both programs should be simplified and streamlined, and the current emphasis on paperwork and documentation should be minimized.

(11) If Professional Standards Review Organizations are to perform realistic reviews in long term care facilities: (a) persons other than physicians must be involved in developing PSRO formal plans for long term care review; (b) individuals who reflect an understanding of and appreciation for the special health problems of older Americans must be represented on the National Advisory Council for Professional Standards Review Organizations; and (c) the problems likely to be encountered by providers of long term care in making the transition from the present utilization review requirements to the PSRO review process must be recognized and resolved.

(12) Standards established to insure quality care within Medicare and Medicaid facilities must be enforced in a reasonable and uniform manner. There is a need to consolidate and clarify present rules, as opposed to adding new ones. Existing standards are often so general that wide latitude remains for local interpretations. Surveyors should be trained adequately to insure appropriate inspection of all Title XVIII and XIX facilities.

(13) While the cost effectiveness and usefulness of sprinklers within skilled nursing and intermediate care facilities have not been proven beyond doubt, the increasing medical emphasis of the Medicare and Medicaid long term care programs reinforces the need for extraordinary safety measures in these institutions. Provided that grants (for those nonprofit institutions which would otherwise have difficulty paying interest on a loan) and low interest loans are available from the federal government for purchase and installation, fire sprinkler systems should be required for facilities or units of facilities housing the nonambulatory.

SOCIAL CARE

Traditionally, homes for the aging have provided an intense program of social supports required by individuals to participate actively within the institution and the surrounding community. Nonprofit homes are organized and operated to satisfy three primary needs of the aged person: the need for housing, the need for health care, and the need for financial security. Emphasis is placed on programs to assist the elderly resident to live a safe, useful, and independent life. To meet the health needs of the elderly, many homes have developed programs of intermittent and preventive health services. An infirmary is frequently necessary in these homes for those residents who need long term medical care. But the care offered in the infirmary is supplementary to the prime purpose of the facility which is providing social care.

The advent of Medicare and Medicaid has threatened to alter these settings. Because reimbursement is available for medically-oriented services and because rigid standards for physical plants appropriate for medical institutions have been established, homes for the aging are being forced to change the nature and intensity of the services they provide for the elderly. Inasmuch as neither Medicare nor Medicaid meets the social needs of older persons living in care facilities, public support for nonmedical care traditionally available to the elderly does not exist.

The fundamental assumption which pervades present public policy; i.e., that older people are either generally well and primarily in need of income supports, or they are generally sick and primarily in need of intense medical services, must be overcome.

THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING URGES A PUBLIC COMMITMENT TO FUNDING AND DELIVERING SOCIAL CARE WITHIN INSTITUTIONAL SETTINGS. BENEFITS UNDER MEDICARE AND MEDICAID MUST BE BROADENED TO INCLUDE SOCIAL AND RESIDENTIAL CARE. GREATER FLEXIBILITY AND VARIETY IN FACILITIES SERVING THE ELDERLY MUST

BE ENCOURAGED, AND PUBLIC SUPPORT FOR NONMEDICAL LONG TERM CARE SERVICES WITHIN THE INSTITUTIONAL SETTING MUST BE EXPANDED. CONSIDERATION SHOULD BE GIVEN TO ENACTING AN ENTITLEMENT TO A SOCIAL CARE BENEFIT. THE PRIMARY THRUST OF THIS BENEFIT WOULD BE THE PURCHASE OF ENVIRONMENTAL AND NONMEDICAL SUPPORTIVE SERVICES.

Until such time as the Congress acts to provide an entitlement program for a social care benefit, existing programs of nonmedical, long term care must be strengthened. The following intermediate steps to accomplish this should be considered:

(1) Ways of expanding the payment options under the Supplemental Security Income program to insure that states provide assistance to eligible individuals living in group arrangements should be explored. Legislation should be enacted to provide incentives for the states to expand their supplementation programs for the purchase of nonmedical, long term care within institutional settings as an alternative to more costly nursing home care.

(2) The flexibility allowed states in establishing standards for group living arrangements housing (or likely to house) recipients of Supplemental Security Income should be maintained. But the Department of Health, Education, and Welfare should draft, with assistance from representatives of state governments and public interest groups, several model statutes as guides for implementing the provision of Public Law 94-566 which requires states to establish standards for these facilities. HEW should also compile and disseminate to the public a compendium of the various state laws enacted to meet the requirements of Public Law 94-566.

(3) Congress should review the penalty mechanism which punishes the beneficiary of Supplemental Security Income for the failure of an institution to conform to state standards. Alternatives must be found to prevent public funds from subsidizing substandard institutions without restricting the purchasing power of the individual.

(4) When establishing standards for group living arrangements for the elderly as required by Public Law 94-566, states should (a) not interfere with housing and congregate services in settings where group supervision is not the primary purpose of the facility, and (b) not exclude from benefits elderly residents of facilities which provide medical and nursing supervision if this supervision is not the primary purpose of the facility.

(5) Congress must review the definition of an intermediate care facility under Medicaid. The nature of the facility must be clarified, the characteristics of the resident population defined, and an assess-

ment mechanism established to insure that individuals receive services from the facility appropriate to their needs.

(6) A special study should be initiated to determine ways of coordinating present government programs for income assistance, social services, and health care to meet the needs of individuals who reside in nonmedical, long term care facilities. The study should focus on the options available for providing services to older persons within fulfilling and economically feasible environments.

(7) Changes must be made in the application of Department of Labor regulations governing patient-workers to insure that they do not unduly restrict residents of care facilities from participating in meaningful activities of their own choosing. The rules also should be revised so as not to interfere with bona fide therapy programs (where work is of a limited nature) aimed at assisting older persons in completing tasks of daily living. Where such therapy programs exist, they should be documented as such by medical or other appropriate staff of the facility.

(8) With regard to physical plant safety standards, distinctions should be made between facilities providing services to ambulatory persons and facilities providing services to nonambulatory patients. Safety standards which exceed measures necessary for the protection of life and property restrict program flexibility and prove costly to implement.

HOUSING

It has been demonstrated that special housing planned and designed for the elderly, with appropriate supportive services, can serve as a major alternative to premature or inappropriate institutionalization of the elderly. To avoid inappropriate institutionalization, a variety of health, social, nutritional, and other supportive services must be considered an integral and essential part of special housing for the elderly. While some residents of these facilities may be frail, they are not ill nor do they need continuous medical supervision.

TO FURTHER THE OBJECTIVES OF PROVIDING APPROPRIATE HOUSING AND SERVICES FOR THE ELDERLY, THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING URGES CONGRESS TO AMEND CURRENT HOUSING PROGRAMS, TO MANDATE THE PROVISION AND FUNDING OF RENT SUPPLEMENT PAYMENTS AND HEALTH AND SOCIAL SERVICES WITHIN ENVIRONMENTS DESIGNED FOR THE ELDERLY. SERVICE PROGRAMS MUST BE AN INTEGRAL PART OF FACILITIES FOR THE ELDERLY, IF ALL, INCLUDING THE POOR AND MINORITIES, ARE TO BE AFFORDED

OPPORTUNITIES TO RECEIVE NEEDED SERVICES. IN ADDITION, THERE SHOULD BE A FULL FEDERAL COMMITMENT TO DEVELOPING A VARIETY OF SPECIALIZED LIVING ARRANGEMENTS TO MEET INDIVIDUAL NEEDS AND PREFERENCES. FEDERAL FUNDING WHICH ENABLES SPONSORS TO BUILD THE NUMBER AND TYPES OF LIVING UNITS NEEDED BY OLDER AMERICANS IS IMPERATIVE. TO INSURE THAT ELDERLY RESIDENTS OF THESE FACILITIES RECEIVE QUALITY CARE, THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT AND THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE MUST WORK TOGETHER MORE CLOSELY AND COOPERATIVELY TO DEVELOP SUITABLE PROGRAMS FOR THE AGING. ALSO, AAHA ENCOURAGES THE PARTICIPATION OF ITS MEMBERS IN THE NATIONAL PROGRAM TO CERTIFY MANAGERS AND ADMINISTRATORS OF FACILITIES FOR THE ELDERLY.

In working toward these goals to expand housing opportunities for the aging and to strengthen the operation of existing housing for the elderly, the following recommendations should be considered:

(1) The Section 202 Housing for the Elderly direct loan program should be expanded to enable nonprofit sponsors to construct additional housing units needed by older Americans. Minority sponsors especially should be encouraged to participate in this program. Technical application assistance and outreach should be provided minority sponsors and others in need of this service. Housing for the handicapped who are not elderly should be a separate program.

(2) HUD should be required to fully utilize authorized programs to stimulate specialized housing programs for the elderly. The reluctance of the Department to do this in the past has demonstrated the need for vigorous congressional oversight of the implementation process. Agency officials must fully use the resources at their disposal.

(3) Federal programs providing various forms of housing assistance for the elderly must be coordinated at the top federal level, so that programs can be developed by sponsors without the need to "assemble" help from many sources, each with separate (and sometimes conflicting) requirements, and with no guarantee of their continuity.

(4) HUD should be restructured to improve its ability to stimulate housing for the elderly. An Assistant Secretary for Housing for the Elderly should be appointed with line authority over all HUD programs providing housing and services for older Americans. HUD regional office staffs should include an elderly housing specialist, with central control over all aspects of regional housing policy for

older persons. These specialists should be expeditors, problem solvers, advocates, and have line authority in resolving problems involving all projects designated as for the elderly.

(5) Members of the American Association of Homes for the Aging should support and participate in the certification (of managers and administrators) program being developed by HUD, to be administered through AAHA and other organizations. The involvement of nonprofit homes for the aging in the certification process can further professionalize the administration of facilities for the aging.

(6) The federal government should stimulate the development of congregate housing for the elderly. HUD should provide the Congress with draft legislation to accomplish this, based upon its recent congregate housing study. Consideration should be given to developing a variety of mechanisms to finance congregate housing and ancillary services within the congregate setting.

(7) Income assistance programs should be developed to pay all the elderly's housing costs, including the costs of central food services, social services, and limited health care, in order to make them available to all elderly, including the minorities and the poor.

COMMUNITY SERVICES

If a full continuum of services to meet the long term care needs of the elderly is to be provided, noninstitutional community services must be expanded.

There are increasingly high incidences of physical and mental frailty as age increases. Unfortunately, the federal government has failed to commit itself to providing needed community supports to compensate for these frailties. While initial steps have been taken under the auspices of Older Americans Act programs, funding for these service programs has been insufficient to meet growing demands.

THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING ENDORSES THE TENTATIVE RECOMMENDATIONS OF THE FEDERAL COUNCIL ON AGING TO LEGISLATE AN ENTITLEMENT TO PROGRAMS PROVIDING BASIC SUPPORTS FOR THE ELDERLY APPROPRIATE TO THEIR NEEDS. SUCH SUPPORTS SHOULD INCLUDE A PERIODIC ASSESSMENT OF THE TYPES OF SERVICES NEEDED BY THE OLDER PERSON. IN ADDITION, THERE SHOULD BE A DETERMINATION THAT THE SERVICES NEEDED ARE ACTUALLY AVAILABLE AND ACCESSIBLE. COUNSELLING AND IMPLEMENTATION OF A SERVICES PLAN SHOULD ENABLE THE INDIVIDUAL TO LEAD A REASONABLY INDEPENDENT AND SATISFYING LIFE.

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The frail elderly should be targeted to receive priority attention when community supports are developed. Implementing a full continuum of services should involve, and probably will result in, facilitating outreach to minorities and the poor. The following additional recommendations should be considered:

(1) Congress should reauthorize expeditiously the provisions of the Older Americans Act and strengthen the role of the Administration on Aging in serving as the focal point for aging issues at the federal, state, and local levels.

(2) Home health services, which are seriously underfunded in the Medicare and Medicaid programs, should be expanded. Both the availability and scope of these services should be increased. Furthermore, efforts should be undertaken to link, where possible, institutional and noninstitutional services. Consideration should be given to providing incentives to encourage nonprofit providers of facility-based services to develop community outreach programs through in-home care services. The Department of Health, Education, and Welfare should be cautious about opening up the Medicaid program to proprietary home health agencies. The long run implications of changing the character of the home health field from a service-oriented system to a profit-motivated system should be studied carefully first.

(3) Consistent funding for adult day care services must be available. Day care services available through Medicare- or Medicaid-participating providers, or through licensed social care facilities, should be viewed as an option to home health visits for those who need this service.

(4) Laws and regulations governing social service programs must be reviewed to insure that arbitrary definitions do not prohibit the delivery of services to individuals solely because of their living arrangements. Social service programs should be designed to bring the community to institutionalized persons, and to facilitate the return of institutionalized individuals to the community.

(5) In selecting sites for nutrition centers and senior centers, preference should be given to locations adjacent to or within housing and social care facilities so that program linkages can be provided. Both of these beneficial programs should be expanded, and funding should be available on a continuing basis.

(6) Public transportation systems should be designed to be sensitive to and accommodate the needs of the elderly.

PLANNING AND STRENGTHENING THE DELIVERY SYSTEM

A conscious plan for expanding and strengthening the system of delivering services to older Americans must be developed. The

range of programs and other variables that affect the supply of manpower and facilities must be given attention. Among the items that should be considered are: the impact of tax legislation on funding sources for facilties, the availability and training of personnel, the controls upon various financing devices, and the accuracy of the data upon which policy makers base their decisions.

THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING IS DEEPLY CONCERNED THAT INCIDENTAL POLICY DECISIONS HAVE HAD A STRONGER INFLUENCE ON THE DEVELOPMENT OF OUR LONG TERM CARE DELIVERY SYSTEM THAN THE CONSCIOUS POLICY ACTIONS OF OUR LAWMAKERS. WE ENCOURAGE A THOROUGH REVIEW OF GOVERNMENT POLICIES, AND ENCOURAGE THE GOVERNMENT TO STRENGTHEN THE CAPABILITY OF THE NOT-FOR-PROFIT SPONSOR OF SERVICES TO PROVIDE NECESSARY SUPPORTS FOR THE ELDERLY.

While it will take time to reverse the haphazard development of past policies, we recommend the following actions as initial steps in developing our resources:

(1) Caution must be exercised in developing policies which restrict entry into the service delivery system to insure that:

(a) nonprofit facilities which attend to the sectarian, ethnic, and financial needs of the elderly are given ample opportunity for expansion. In addition, personal preferences of the elderly should be considered when deciding what types of facilities should be developed. Sectarian, ethnic, and other nonprofit facilities provide services to a wider population base than served by Health Systems Agencies (and State Planning Agencies) established to review the need for additional health services in areas under their jurisdictions;

(b) norms for facility costs do not become maximums which restrict innovation and integration of service modalities; and

(c) the demand for social care facilities is not confused with the demand for intermediate care facilities, thereby restricting the development of a cost-efficient, socially-oriented program.

(2) Legislation must be enacted to alleviate the financial burden imposed on homes for the aging which are classified as private foundations and subject to an excise tax on net investment income.

(3) Contractual arrangements for continuing care (including life care) offered by some homes for the aging should be reviewed. This review should balance the favorable aspects of such arrangements (the ability of sponsors to develop homes for the aging) with the need for greater protections for those who enter into these contracts. Actions should be taken to protect potential residents and residents by requiring that homes fully disclose significant information as to their ownership, financial condition, and services offered.

(4) Legislation should be enacted to promote the development of campus settings where a continuum of institutional services can be offered older persons in one location.

(5) Professional and support staff for long term care facilities must receive the education and training necessary to perform their jobs. Professional development should emphasize both geriatrics and gerontology. Incentives must be provided for pre- and in-service training. Programs in geriatric nursing and training for nurses' aides, in particular, must be expanded.

(6) There is an immediate need for an accurate data base necessary for assessing the appropriateness, quality, and range of services being provided to older persons. Particular attention must be given to obtaining data on the cost effectiveness of various modalities of long term care, including existing models for service delivery developed by nonprofit sponsors.

(7) A particular weakness in the present delivery system has been the failure of public and private programs to provide adequate services to the most needy, particularly minorities. Steps must be taken to insure that services are provided and accessible to all people. In addition, efforts must be undertaken to recruit and train minority professionals to work with the elderly. Necessary supports to minority sponsors of services must be provided, including facility development assistance.

This booklet reflects the thoughts and work of individual representatives of non-profit housing, homes for the aging, and health-related facilities for the elderly; members of the policy committees of the American Association of Homes for the Aging (AAHA); and members of AAHA's House of Delegates, the official policy making body of the association.

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ITEM 4. POSITION PAPER, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, SUBMITTED BY ROBERT P. LIVERSIDGE, JR., EXECUTIVE DIRECTOR, BATH-BRUNSWICK REGIONAL HEALTH AGENCY, BATH, MAINE

SUMMARY OF NAHHA[1] POSITIONS ON CURRENT FEDERAL ISSUES

NAHHA is aware that major health policy issues such as national health insurance and cost containment measures will be considered by Congress and the Executive Branch in the months and years ahead. Recognizing, however, that the timetable for these matters has yet to be established, and that the issues concerning them are likely to be brought into sharper focus in the future, the Legislative Committee of NAHHA has chosen to concentrate its present efforts on subjects having a more immediate impact on home health agencies and the communities and patients that they serve. The theme that underlies the following specific points is that home health care is an integral and essential part of the health care system—home health agencies provide care similar to that provided by hospitals and nursing homes, but in a different setting—and should be treated as such in the formulation and administration of reimbursement programs by governmental agencies and private insurors.

(1) *Certificate of need.*—Home health agencies should be covered, along with other health services, by Certificate of Need regulations issued pursuant to the Health Planning Act of 1974 (P.L. 93-641) and Section 1122 of the Social Security Act. The inclusion of home health agencies in the planning process would assist in stemming the undue proliferation of agencies in some areas while helping to promote the extension of home health care to unserved areas. The failure to include such agencies in the final Certificate of Need regulations signed by former HEW Secretary Mathews on January 13, 1977 (1-21-77 Federal Register, pp. 4002-4032) was contrary to the intent of Congress in mandating the creation of a comprehensive health planning scheme to require that decisions regarding the establishment and expansion of health facilities and services be made on a rational and systematic basis. The regulations should be revised so as to include home health agencies in their coverage.

(2) *Data collection.*—NAHHA recognizes that there is a lack of data about the extent of the need for home health services and the costs involved in expanding services. It is suggested that the existing legislative authorization for grants to establish and expand home health agencies, which expires at the end of fiscal year 1977, be amended to authorize grants for such data collection.

(3) *Elimination of barriers to home health care.*—NAHHA supports new legislation to improve home health care benefits, such as that which has been introduced in the 95th Congress to increase the number of visits for which Medicare recipients are eligible and to expand the kinds of service for which Medicare reimbursement will be paid. It is clear, however, that more services could be provided to more patients by home health agencies even without the enactment of such legislation if the barriers created by the fragmentation of existing programs could be lowered. Federal support for home services is now authorized by a variety of programs, including those established under Titles 18, 19 and 20 of the Social Security Act and Titles 3 and 7 of the Older Americans Act, each with its own program definitions and eligibility requirements. Realignment of these programs to make them more consistent with each other, or at least a revision of regulations so as to create more usable "crosswalks" from one program to another, would make possible the more efficient utilization of available dollars.

(4) *Fraud and abuse.*—NAHHA supports legislation to curb fraud and abuse in Medicare and Medicaid such as that proposed by Reps. Rostenkowski and Rogers (H. R. 3) and Sen. Talmadge (S. 143). An important adjunct to anti-fraud efforts in the home health field should be the development, adoption and implementation of nationally applicable standards for home health agencies. NAHHA is currently developing a strategy for home health agency standards. The effective inplementation of standards containing measurable criteria, in conjunction with reasonable and appropriate controls to entry of new providers

[1] The National Association of Home Health Agencies (NAHHA) is, as the name suggests, a national organization exclusively devoted to representing agencies which provide health-related services in the home.

such as may be available through certificate of need measures, should help to control those incidents of fraudulent practices that a relatively few agencies have been found to have engaged in.

(5) *Consistency in reimbursement.*—Too often, home health care is regarded by administrators of federal programs and fiscal intermediaries as a different species of care than that rendered by other providers, such as hospitals. NAHHA urges that there be uniform HEW reimbursement practices for all institutional health providers, including home health care agencies.

(6) *Insurance coverage of home health benefits.*—The health insurance industry should include home health care coverage in the basic benefits package. Any state or federal legislation establishing minimum requirements for private health insurance policies should require that coverage of home health care benefits be included.

ITEM 5. LETTER AND ENCLOSURES FROM JOAN E. CASERTA, DIRECTOR, COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING, NEW YORK, N.Y.; TO SENATOR LAWTON CHILES, DATED MAY 25, 1977

DEAR SENATOR CHILES: The Council of Home Health Agencies and Community Health Services wishes to register a protest in that we were not permitted to testify at the Special Committee on Aging's May 16 hearings on "Health Care for the Elderly—the Alternative Issues."

Upon learning of the hearings on May 12, we contacted your committee staff and requested the opportunity to be heard. We were first told that time might be allotted for our appearance and that we should proceed on that assumption. Although time was short, we did prepare testimony and secure a witness to represent the Council.

We were subsequently told (at 4:15 PM Friday, May 13) that witnesses had been invited from among providers and that national organizations were not being asked to testify. One of the (provider) witnesses, however, also serves as chairman of the legislative committee of the National Association of Home Health Agencies and is viewed in this capacity no matter what affiliation is listed.

For this reason we found it most distressing that the organization (Council of Home Health Agencies and Community Health Services) which represents the major home health services in the country should be excluded, in fact ignored, when these hearings were planned and witnesses selected. We are accustomed to operating in an open manner and would appreciate knowing how witnesses were selected by your committee for these hearings.

Enclosed is the testimony which would have been presented by Ms. Ann-Marie Thom for the Council. We hope this will be helpful to the committee and we hope that in the future, witnesses will be selected on an equitable basis.

Sincerely yours,

JOAN E. CASERTA.

[Enclosures.]

STATEMENT OF THE COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING, NEW YORK, N.Y.

HEALTH CARE FOR OLDER AMERICANS: THE ALTERNATIVE ISSUES

Mr. Chairman and Members of the Committee, I am Ann-Marie Thom, Executive Director of the Visiting Nurse Service of New York. VNSNY is the largest Medicare certified home health agency in the country. We provided 660,000 home visits last year to 55,000 people. Our annual operating budget is in excess of 18.5 million dollars.

I appear before you today representing the Council of Home Health Agencies and Community Health Services of which my agency is an active and accredited member. The Council is a coalition of providers which deliver Medicare and Medicaid reimbursable home health services as well as preventive supportive and health education program services. The goals and functions of the Council are attached to the testimony we have submitted for the record. (See attachment No. 1.) When discussing health care for older Americans, we recognize

that we are talking about over twenty-one million people, or ten percent of the population of this country.

In previous testimony, we have discussed home health services and our concerns with the lack of certificate of need and the limitations on reimbursement for these services. We do not intend to reiterate those concerns today except to present to the committee a formula which the Council has developed on determining need for home health services. This formula is based on current knowledge of population trends and utilization of home health services and is being validated by agencies currently providing these services. (See attachment No. 2.)

The focus of this testimony is on the noninstitutional portion of the health care delivery system and its partnership with the supportive in-home services which are classified as social services.

The elderly have many health and social needs which impinge upon them thus preventing or severely limiting their ability to live in their own homes. Some of their needs are for health care, meals, remotivation, socialization, employment, home maintenance and repairs, civic involvement, and religious support. The existing barriers to these other needs are many.

Using the definition that health is the ability to function well enough to carry out normal roles and responsibilities in the community, it is not difficult to come to the conclusion that the aged population in the United States is far from healthy. At least 86 percent of the population over 65 years of age have one chronic condition: 39 percent have major activity limitations and 14 percent are totally limited.

On the average, each of these persons experiences 38 restricted activity days per year and 14.3 bed disability days per year. 75 percent die from heart disease, cancer and stroke. The predominant medical diagnoses they experience are heart disease, arthritis, orthopedic problems, visual deficits and hypertension. On the average, each person over 65 makes 7 physician visits per year. 68 percent of this population visits a physician every 6 months.

In addition to the above physical disorders experienced by aged persons, they also undergo sociological and physiological changes. They age in a social sense because of a decrease in the number and kinds of social roles played. Forced retirement, disability and death of friends all contribute to sociological aging. Psychological aging is essentially related to the capacity to adapt to new situations. Changes in the social and psychological areas can accelerate physiological aging, resulting in increased illness and disability.

It is difficult to assign percentages to these age changes, but there are a few givings. The majority of persons over 65 are forced to retire. Retirement automatically brings with it a decrease in activities and contacts with friends. It also brings with it a decrease in income. A decrease in income frequently means the aged person must relocate. Relocation brings with it a further decrease in contact with friends. Death of spouse means that frequently the aged person lives alone. All of this added together presents a picture of lack of physical and mental well-being in the aged population.

Many health care needs evolve as a result of the above description. Aged persons need physician care to treat physical illness. They need nursing and rehabilitative therapies to learn to cope with the disabilities that develop with age. They need drug therapy to treat their physical illnesses and conditions. They need health care services delivered on an ambulatory and in-home basis to prevent unnecessary institutionalization.

Over one million, about 5 percent, of the elderly are institutionalized in such places as hospitals, mental institutions, nursing homes, old age or retirement homes and the like. The reasons for this are unclear and frequently unjustified. They range from lack of a place to go, lack of family support, emotional and/or financial, confusion and episodic disorientation, and fear. Two recent reports support the view that many older persons are unnecessarily institutionalized—HEW testimony reported that between 15 and 25 percent of the institutionalized elderly were inappropriately institutionalized and could have been managed at home if adequate health and social services were available and utilized. Even more disconcerting are figures from a Massachusetts study of nursing home residents which demonstrated that 40 percent of the residents could be maintained at home with adequate support.

Much of this relates to the lack of adequate assessment of the individuals' needs and resources available to meet them. Planning for and maintaining someone at home cannot be done unless an indepth assessment of their needs is done and resources to meet these needs are identified and/or developed.

Many older persons at home do not seek help for poor physicial conditions or illnesses until it becomes an emergency. Many individuals who are chronically ill do not sustain health services because of lack of finances, lack of energy and lack of transportation.

Many low income handicapped and older persons lack the capabilities to perform essential chores around the house or are unable to pay for the necessary materials and labor for home maintenance. Illness complicates this picture. A poor dilapidated environment is a negative force in the prevention of serious illness and does nothing to improve the climate of older individuals with acute and chronic illnesses.

The use of chore service workers, many of whom are financed through programs funded by state and area agencies on aging need to be expanded.

The inadequate income plight of the elderly is almost legendary. As inflation in this country increases, these individuals slotted to receive fixed incomes are caught in the bind of becoming part of our welfare systems—a situation intolerable to many older Americans whose pride forbids the acceptance of "charity."

Inadequate transportation is the third leading problem of the elderly after income and health. The elderly do not for the most part own private cars, and with today's energy problems, they cannot afford the cost of maintenance and use. Widespread efficient public transportation in this country is lacking. What public transportation is available is dangerous, uncomfortable and inconvenient for the elderly person. The development of adequate transportation and escort services for the sick/frail older person is a necessity.

In attempting to meet the nutritional needs of this population, mobile meals programs and nutrition sites have been instituted across the country. One of the paradoxes in this situation is that while attempting to improve the nutrition status of these persons, well and ill, they are denied access to dental services which have a direct effect on what and how much food can be consumed.

In addition to the transportation, meals and chore services mentioned, the following environmental/social support services are highly desirable and should be made available to augment home health care services through agency-community planning and development: Barber/cosmetology services, legal and protective services, pastoral services, personal contact services, recreation services, and translation services.

Currently, few, if any, agencies exist that can adequately provide this full array of health and social support services. What, then, can be done to assure that these services will be available and accessible to those who need them?

The Council believes that the elderly need both health and social support service and that these two components must form a partnership in caring for the elderly.

One group within the community should act as a "broker" to bring together the essential services needed.

Persons needing service must be guaranteed adequate assessment of their needs by the most appropriate professional for proper placement within the delivery system.

While HEW and the Administration on Aging have systematically attempted to develop a range of in home health and support services for the elderly in general, the elderly person whose problems and need for these supportive services is crucial is unfortunately caught in the middle of the age old questions of what is a health service, what is a social service—and who is responsible for the reimbursement of what?

The current fragmentation of federally-supported health and social programs for the elderly contributes to the confusion faced by providers to say nothing of the beneficiaries or would be beneficiaries.

There must be a blending of entitlement criteria for services funded under Titles 18, 19 and 20 of the Social Security Act as well as some coordination with Titles 3 and 7 of the Older Americans Act.

Attached are descriptions of some operational programs that are attempting to provide the full array of health and social support services.

HOME CARE PROGRAMS CURRENTLY OPERATIONAL [1]

Visiting Nurse Association of Dallas, Texas

Adult Rehabilitation and Maintenance Day Care Centers are providing 8 hour a day services which include nursing, physical therapy, occupational

[1] Home care is defined as a program which blends health and social support services for a target population.

therapy, speech therapy, social work, recreation therapy and nutrition service with meals. Within an average 3 month stay on service, most clients progress from dependent states to complete independence. They graduate to ability to participate in Nutrition Sites under Title VIII. This service should be a mandated service either under Title VII or Title III.

This service enables families to participate in care and helps them keep difficult care patients at home.

Another service, the geriatric nurse clinic, which provides health maintenance service in nutrition sites should be funded in ongoing regulations not for three years only. This service has helped prevent strokes in a number of patients and increased well-being so that more aged people could live alone even with chronic health problems.

Visiting Nurse Association of Metropolitan Detroit, Michigan

Service for aged persons who wish to remain at home and independent as long as possible. The Well Being Service for Aged, a division of the VNA of Metropolitan Detroit provides this service through a social worker-nurse team, outreach workers, home health aides volunteers and chore workers.

The nurse and social worker assess the aged person's needs for health and social services, or support services. Most of the aged clients come to our attention through neighbors, housing superintendents, churches, and community groups. They frequently have health problems which need attention such as edema from chronic heart disease, arthritis, diabetes which is poorly controlled, obesity or malnutrition. Some have very severe problems and others have early symptoms and there is a good chance of treatment and allaying of problems if not cure. There is usually need for health teaching. For both health and social problems the team helps the client get to the services available in the community but unknown to the client.

Social problems found are usually loneliness, lack of knowledge of how to get on social security, other financial assistance, lack of satisfactory relationships with married children, church, or other social groups, fear of dying alone, etc.

Visiting Nurse Association of Boston, Massachusetts

Health Services (Title 18, 19, and private funds) at home are available through the VNA of Boston for patients from the acute, intensive level of those with minimal, basic needs.

Social support services, i.e., homemaker, chore, nutrition, transportation, etc., have been available by contract through the network of home care corporations throughout the state, financed by Titles III, XX, and VII funds.

The VNAs and the Home Care Corporation are developing a plan for dual independent assessments of clients who enter the system through either the home health agency or the home care corporation. Following the assessments a plan of care is developed jointly with services to be provided by either or both agencies. If the resulting plan includes only the support services, arrangements will be made for client to have a periodic reassessment by the VNA so as to assure that the elderly will have health assessments and be brought into the health system for care at appropriate times.

Basic to the effective operation of the plan is the agreement that the VNA will have final decision on matters related to the health care and the Home Care Corporation will have final decision on support services to be provided.

Case management is by one or the other agency—or joint if both are involved.

[Attachment 1]

COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES

PURPOSE

The purpose of the Council of Home Health Agencies and Community Health Services shall be the development and improvement of community health services to the continuing benefit of the consumer.

OVERALL GOALS OF CHHA/CHS

CHHA/CHS will be the organization recognized as the authority in the field for home and community health services.

The home and community health industry will be recognized in the mainstream of the health care delivery system.

Excellence in the home and community health field will be maintained and expanded.

The well-being of consumers of home and community health services will be an overriding concern of the Council.

CHHA/CHS will promote the development of consumer health education programs through identifying with health needs and promoting of positive health attitudes.

FUNCTIONS

The functions of the Council shall be to:

(a) Assist agencies and communities in the development, improvement and evaluation of services,

(b) Represent membership before legislative bodies, governmental agencies, voluntary organizations and others involved in financing community health services,

(c) Represent membership before legislative, governmental and other bodies involved in the development and implementation of regulations, standards and procedures affecting community health services,

(d) Collaborate with other organizations which represent the health disciplines providing community health services,

(e) Promote studies, research and demonstrations in the area of community health programs,

(f) Develop new techniques and approaches in the delivery of community health and health related services,

(g) Collaborate with other membership groups to promote and achieve the object of the National League for Nursing.

[Attachment 2]

ESTIMATE OF HOME HEALTH NEEDS

With the passage of Title XVIII of the Social Security Act in 1965 a newly recognized health care facility was enunciated—a Home Health Agency. For many reasons this facility has been largely undeveloped nor has its full potential for the maintenance of optional health been realized. One of those reasons is the lack of national formulae to determine *need* for the service.

While data do exist from which need for home health can be determined, these sources are largely untapped, rarely utilized and their inter-relationships to *documented* need remains unvalidated. Formulae which do exist manipulate the data in various ways depending upon local experience. Those of the Western Pennsylvania Health Planning Association and the Kentucky Comprehensive Health Planning Council guidelines should be reviewed in conjunction with this document developed by CHHA/CHS' staff consultant-statistician. Further work is being done by the staff to refine the estimates particularly in the area of persons referred to home health from sources other than hospitals.

Development of the formula in this document is based upon current knowledge of population trends and utilization of home health within the mix of the seven services now being provided and funded—nursing, physical therapy, home health aide, speech pathology, occupational therapy, medical social work, medical supplies and equipment.

When consideration is given to social support services, such as homemaker, chore, etc., that enable many people to remain at home, another dimension is added and any formula has to be adjusted and expanded accordingly. No attempt is made here to do that nor is any attempt made here to project future need or to evaluate the efficacy of the present provision of service.

With these caveats in mind we offer the following:

HOUSEHOLD INTERVIEW SURVEY

		Chronic limitation		No limitation	
	Population (percent)	Percent of population	Hospital discharges [1]	Percent of population	Hospital discharges [1]
Under 65	90	10.6	36.4	89.4	10.1
65 plus	10	45.9	39.8	54.1	13.2
Total	100	14.1	37.5	85.9	10.3

[1] Number of hospital discharges annually per 100 persons.

A. Population estimates

For population as a whole, ten percent are 65 or over.

Of population as a whole, 14.1 percent have limitation due to chronic conditions. For the group 65 and over, 45.9 percent have such limitation; for under 65 group, 10.6 percent are limited.

Of the group with chronic condition limitation, 37.5 percent are hospitalized; 39.8 percent for the group 65 and over and 35.4 percent for those under 65.

For persons with no limitation due to chronic conditions, 10.3 percent are hospitalized—13.2 percent for the no-limitation group over 65 and 10.1 for the group under 65.

In terms of total population (P):

	Total	Population with chronic limitation	No limitation
Under 65	0.90	0.095	0.805
65 plus	.10	.046	.054
Total		.141	.859

B. Hospital Discharges

Using hospital discharge rates from Household Interview Survey:

	Percent of population	
	Chronic limitation group	No limitation
Under 65	36.4	10.1
65 and over	39.8	13.2
Total	37.5	10.3

Population estimates of hospitalized persons

Chronic limitation:

Under 65	36.4% of .095P=.035P
65 and over	39.8% of .046P=.018P
Total	37.5% of .141P=.053P

No limitation:

Under 65	10.1% of .805P=.081P
65 and over	13.2% of .054P=.007P
Total	10.3% of .859P=.088P

Total hospital discharges=.053+.088=.141P

C. Referrals to home health

(1) Percent of referrals from hospital to home care may vary from 1.1 to 12.8 percent (see attached schedule of Relationship of Medicare Home Health Starts of Care to Inpatient Hospital Admissions). Attempt should be made to find out figure in community. Where not known, suggest using 5 percent.

.05×.141P=.007P referred from hospital to HHC

(2) Estimate referrals from other sources as equal to those from hospital—.007P where community figure is not known. (Generally used by health planners.)

(3) Estimated home care patients=(1)+(2)=1.4 percent of population.

Suggest rounding this off to *1.5* percent as a rough estimate of usage. Adjust for levels of income, age and race groupings not in proportion to national figures (see attached Exhibit IV).

An estimate of the need for home health services has to be developed in each community according to the demographic data identified, taking into account

not only current usage but also the possibility of saving hospital days by early discharge, providing home care for persons in long-term institutions (it is estimated that 25 percent of persons in nursing homes could be taken care of at home), providing for unmet health needs in the community. Although specific measures are not available for taking these aspects into account, needs as well as usage should be considered in using the formula based on present usage only. In addition, usage figure should be adjusted when the proportions of age, income and other demographic distributions of the community differ from those of the nation as a whole.

If, in the community, the elderly do not represent ten percent of the population, the formula becomes—

(a) Hospital discharges for chronically limited:
Elderly .398×number of elderly_____
Other .364×number of other_____
Total _____
(b) Hospital discharges for those not chronically limited:
Elderly .132×number of elderly_____
Other .101×number of other_____
Total _____
(c) Referred to home care:
.05×(total (a)+total(b))_____
(d) Estimated referred from other sources:
(use (c))_____
Total=(c)+(d)

[Exhibit I]

CRITERIA FOR DETERMINING HOME HEALTH NEEDS

According to "Methods for Determining and Projecting Needs and Demands for Long-Term Care and Home Health Services", H.S.A., DHEW; 1975, criteria for analyzing methods of projection are:

Criterion 1.—Identification of service population:
(1) Geographic or political jurisdiction technique.
(2) Uses of service concept.

Criterion 2.—Identifying circumstances suggesting utilization:
Four common approaches:
(1) Assume actual utilization reflects all true need.
(2) Analyze actual utilization to determine what it should be.
(3) Analyze populations in terms of characteristics associated with utilization, whether appropriate or not.
(4) Employ standard estimators.

Criterion 3.—Projecting future utilization:
(1) Forecasting based on past levels.
(2) Prescribing future levels based on measured need.
(3) Using standard estimates.

Criterion 4.—Identifying resource requirements.

[Exhibit II]

STEPS IN DETERMINING NEED FOR CARE OF SICK SERVICES IN COMMUNITY

Identification of Service Population

A. The analysis of population of designated geographical area by age and sex, ethnicity (including language), income level and education, living arrangements, and employment status.

B. Vital statistics for community are: Infant mortality rate, birth rate, death rate, and primary causes of death.

C. Community health care data are: Number of physicians and surgeons by specality; institutional health facilities—hospitals, SNFs, ECFs, etc.—No. of beds, admissions and discharges by diagnosis and disposition; bed utilization rate, (acute care), bed utilization rate (long term care); noninstitutional—HMO's, home health agencies, rehabilitation centers, day care, other ambulatory—scope of service and composition of population receiving service; unmet needs—geographic, ethnic, age, type of care, etc.; availability of related community services—laboratory, ambulance, sickroom and mobile equipment, dis-

charge planning, welfare and counseling services, etc.; and status of health planning.

D. Other community factors are: Survey of industry in area; unemployment rate; housing information; availability of public transportation; current levels of financing by government and voluntary sources, over-all resources of area, and future outlook for funding—and availability of insurance benefits.

[Exhibit III]

RELATIONSHIP OF MEDICARE HOME HEALTH STARTS OF CARE TO INPATIENT HOSPITAL ADMISSIONS

[Per 1,000 medicare beneficiaries]

State	Fiscal year July 1, 1968–June 30, 1969			Fiscal year July 1, 1969–June 30, 1970		
	Home health starts of care	Inpatient hospital admissions	Percentage [1]	Home health starts of care	Inpatient hospital admissions	Percentage [1]
U.S. total	15.5	302.6	5.1	14.4	306	4.7
Rhode Island	35.2	238.1	14.8	31.4	246	12.8
Delaware	29.2	225.0	13.0	23.3	242	9.6
Connecticut	31.6	253.5	12.5	23.2	248	9.4
Virgin Islands, Guam, American Samoa	26.8	232.0	11.6	8.7	215	4.0
New Jersey	26.3	234.7	11.2	20.6	230	9.0
New Hampshire	29.1	297.6	9.8	28.8	293	9.8
Massachusetts	27.8	286.5	9.7	24.6	284	8.7
Vermont	28.4	320.4	8.9	31.9	320	10.0
District of Columbia	27.1	320.7	8.5	26.9	317	8.5
California	23.3	293.4	7.9	19.4	294	6.6
New York	18.4	237.3	7.8	16.7	241	6.9
Pennsylvania	18.4	262.9	7.0	18.5	266	7.0
Arizona	22.6	355.8	6.4	19.5	349	5.6
Maine	20.0	313.3	6.4	21.8	319	6.8
Nevada	20.7	334.7	6.2	10.5	357	2.9
Oregon	19.0	307.6	6.2	17.9	305	5.9
Ohio	15.5	270.0	5.7	15.9	273	5.8
Idaho	16.7	323.8	5.2	15.9	329	4.8
Colorado	20.3	407.0	5.0	16.0	400	4 0
Washington	16.8	341.5	4.9	13.5	327	4.1
Wisconsin	14.6	315.5	4.6	12.3	317	3.9
Utah	13.5	292.8	4.6	13.0	289	4.5
Maryland	9.7	218.8	4.4	9.9	223	4.4
Louisiana	15.0	340.7	4.4	21.1	358	5.9
Florida	14.1	330.8	4.3	10.0	329	3.0
Missouri	13.9	329.7	4.2	16.1	337	4.8
Michigan	12.0	284.2	4.2	11.4	285	4.0
New Mexico	13.3	329.0	4.0	12.4	327	3.8
Minnesota	14.5	363.1	4.0	15.6	372	4.2
Alabama	11.9	324.3	3.7	12.7	331	3.8
Indiana	10.5	285.9	3.7	9.6	279	3.4
Montana	15.8	439.3	3.6	9.5	437	2.2
West Virginia	12.9	358.0	3.6	12.9	361	3.6
Illinois	11.0	315.5	3.5	8.5	302	2.8
Virginia	10.4	295.3	3.5	9.3	294	3.2
Hawaii	9.5	302.4	3.1	17.3	284	6.1
South Carolina	9.4	300.5	3.1	12.7	301	4.2
Oklahoma	11.4	378.5	3.0	11.2	385	2.9
Kentucky	10.2	342.1	3.0	13.3	338	3.9
Iowa	10.2	346.7	2.9	6.1	351	1.7
Texas	11.4	391.9	2.9	13.6	393	3.5
Tennessee	9.7	365.6	2.7	8.4	362	2.3
Wyoming	10.0	393.3	2.5	9.5	384	2.5
Georgia	7.7	331.2	2.3	6.5	339	1.9
South Dakota	9.0	402.2	2.2	10.3	410	2.5
Mississippi	6.7	341.7	2.0	9.3	367	2.5
Kansas	6.9	362.2	1.9	6.6	374	1.8
Puerto Rico	3.8	224.7	1.7	4.9	240	2.0
North Carolina	5.0	315.2	1.6	5.4	319	1.7
Arkansas	5.6	369.8	1.5	6.7	382	1.8
Nebraska	5.5	360.6	1.5	6.0	373	1.6
North Dakota	5.9	464.	1.3	5.4	474	1.1
Alaska	3.2	328.0	1.0	2.6	243	1.1

[1] Ratio of home health starts of care to hospital admissions.

Source: House Document No. 92-125, "Third Annual Report on the Medicare Program," June 14, 1971 and House Document No. 92-284, "Fourth Annual Report on Medicare," Apr. 24, 1972.

[Exhibit IV]

NUMBER AND PERCENT DISTRIBUTION OF CIVILIAN NONINSTITUTIONALIZED POPULATION BY SELECTED DEMOGRAPHIC CHARACTERISTIC ACCORDING TO AGE: UNITED STATES, 1973

Demographic characteristic	Total	Age				
		0–5 yr	6–16 yr	17–44 yr	45–64 yr	65 years and over
Number (in thousands)	205,799	20,391	43,605	79,016	42,534	20,253
	Percent distribution					
Both sexes	100.0	100.0	100.0	100.0	100.0	100.0
Male	48.2	51.7	50.6	48.2	47.4	41.4
Female	51.8	48.3	49.4	51.8	52.6	58.6
All races	100.0	100.0	100.0	100.0	100.0	100.0
White	87.4	83.5	84.8	87.3	90.1	91.2
Negro and other	12.6	16.5	15.2	12.7	9.9	8.8
Negro	11.5	15.0	14.2	11.2	9.1	8.3
Other	1.1	1.5	1.0	1.5	0.8	0.5
All family incomes [1]	100.0	100.0	100.0	100.0	100.0	100.0
Under $5,000	17.0	14.8	12.3	13.3	14.9	47.8
$5,000 to $9,999	25.1	29.7	23.5	25.5	23.6	25.2
$10,000 to $14,999	24.7	28.7	27.4	27.1	23.1	9.2
$15,000 and over	26.0	19.6	29.5	28.1	29.9	8.7
All regions	100.0	100.0	100.0	100.0	100.0	100.0
Northeast	23.7	22.7	22.8	23.2	25.2	25.3
North Central	27.4	28.0	27.5	27.0	27.3	28.2
South	31.6	32.4	32.2	31.8	30.8	30.8
West	17.3	16.9	17.6	18.0	16.7	15.7
All places of residence	100.0	100.0	100.0	100.0	100.0	100.0
Metropolitan	68.9	68.5	67.9	70.7	68.9	64.1
Central city	30.2	30.3	28.0	30.8	30.4	32.0
Noncentral city	38.7	38.2	39.9	39.9	38.6	32.1
Nonmetropolitan	31.1	31.5	32.1	29.3	31.1	35.9
Nonfarm	27.6	29.0	28.3	26.5	26.2	31.6
Farm	3.6	2.6	3.8	2.8	4.9	4.3

[1] Total includes unknown family income, which is not shown as a separate category.

Source: Unpublished data from household interviews from the Health Interview Survey, National Center for Health Statistics. For official population estimates for more general use, see U.S. Bureau of the Census reports on the civilian population of the United States in Current Population Reports, ser. P–20, P–25, and P–60.

TABLE 1.– TOTAL POPULATION AND NUMBER AND PERCENT DISTRIBUTION OF PERSONS BY AGE AND SEX, ACCORDING TO CHRONIC ACTIVITY LIMITATION STATUS: UNITED STATES, 1974

Sex and age	Total population	With no limitation activity	With limitation of activity			
			Total	Limited but not in major activity [1]	Limited in amount or kind of major activity [1]	Unable to carry on major activity [1]
BOTH SEXES	Number of persons in thousands					
All ages	207,344	178,052	29,292	7,295	15,078	6,919
Under 17 yrs	62,957	60,652	2,305	1,106	1,064	135
17 to 44 yrs	80,782	73,633	7,140	2,606	3,704	838
45 to 64 yrs	42,864	32,536	10,327	2,219	5,715	2,393
65 yrs and over	20,741	11,230	9,511	1,365	4,594	3,552
MALE						
All ages	100,030	85,755	14,275	3,575	5,591	5,109
Under 17 yrs	32,080	30,796	1,283	603	600	81
17 to 44 yrs	38,952	35,384	3,568	1,445	1,567	556
45 to 64 yrs	20,420	15,260	5,160	1,112	2,135	1,913
65 yrs and over	8,578	4,315	4,263	416	1,288	2,559
FEMALE						
All ages	107,314	92,298	15,017	3,720	9,487	1,810
Under 17 yrs	30,878	29,865	1,022	503	464	54
17 to 44 yrs	41,829	38,249	3,580	1,161	2,137	282
45 to 64 yrs	22,444	17,277	5,167	1,107	3,580	480
65 yrs and over	12,163	6,916	5,247	949	3,306	993

See footnote at end of table.

TABLE 1.– TOTAL POPULATION AND NUMBER AND PERCENT DISTRIBUTION OF PERSONS BY AGE AND SEX, ACCORDING TO CHRONIC ACTIVITY LIMITATION STATUS: UNITED STATES, 1974—Continued

Sex and age	Total population	With no limitation activity	With limitation of activity: Total	Limited but not in major activity [1]	Limited in amount or kind of major activity [1]	Unable to carry on major activity [1]
BOTH SEXES	Percent distribution					
All ages	100.0	58.9	14.1	3.5	7.3	3.3
Under 17 yrs	100.0	96.3	3.7	1.8	1.7	0.2
17 to 44 yrs	100.0	91.2	8.8	3.2	4.6	1.0
45 to 64 yrs	100.0	75.9	25.1	5.2	13.3	5.6
65 yrs and over	100.0	54.1	45.9	6.6	22.1	17.1
MALE						
All ages	100.0	85.7	14.3	3.6	5.6	5.1
Under 17 yrs	100.0	96.0	4.0	1.9	1.9	0.3
17 to 44 yrs	100.0	90.8	9.2	3.7	4.0	1.4
45 to 64 yrs	100.0	74.7	25.3	5.4	10.5	9.4
65 yrs and over	100.0	50.3	49.7	4.8	15.0	29.8
FEMALE						
All ages	100.0	86.0	14.0	3.5	8.8	1.7
Under 17 yrs	100.0	96.7	3.3	1.6	1.5	0.2
17 to 44 yrs	100.0	91.4	8.6	7.8	5.1	0.7
45 to 64 yrs	100.0	77.0	23.0	4.9	16.0	2.1
65 yrs and over	100.0	56.9	43.1	7.8	27.2	8.2

[1] Major activity refers to ability to work, keep house, or engage in school or preschool activities.

Note.—For official population estimates for more general use, see U.S. Bureau of the Census reports on the civilian population of the United States in "Current Population Reports," series P–20, P–25, and P–60.

TABLE 5.—NUMBER OF PERSONS WITH ONE OR MORE SHORT-STAY HOSPITAL EPISODES WITHIN A YEAR OF INTERVIEW AND PERCENT OF PERSONS, BY CHRONIC ACTIVITY LIMITATION STATUS, SEX, AND AGE; UNITED STATES, 1974

Sex and age	Total population	With no limitation activity	With limitation of activity: Total	Limited but not in major activity [1]	Limited in amount or kind of major activity [1]	Unable to carry on major activity [1]
BOTH SEXES	Number of persons in thousands					
All ages	22,182	15,255	6,927	1,112	3,454	2,361
Under 17 yrs	3,574	3,215	360	121	171	68
17 to 44 yrs	9,672	7,954	1,718	415	954	349
45 to 64 yrs	5,450	2,933	2,517	356	1,372	789
65 yrs and over	3,486	1,154	2,332	219	958	1,156
MALE						
All ages	8,818	5,513	3,304	449	1,226	1,629
Under 17 yrs	1,901	1,718	184	53	95	36
17 to 44 yrs	2,748	2,042	706	154	340	211
45 to 64 yrs	2,624	1,293	1,331	178	554	600
65 yrs and over	1,545	461	1,084	64	238	782
FEMALE						
All ages	13,364	9,742	3,622	663	2,228	732
Under 17 yrs	1,673	1,497	176	68	75	----
17 to 44 yrs	6,924	5,912	1,012	261	614	137
45 to 64 yrs	2,826	1,641	1,186	178	818	189
65 yrs and over	1,941	692	1,249	155	720	374

See footnote at end of table.

TABLE 5.—NUMBER OF PERSONS WITH ONE OR MORE SHORT-STAY HOSPITAL EPISODES WITHIN A YEAR OF INTERVIEW AND PERCENT OF PERSONS, BY CHRONIC ACTIVITY LIMITATION STATUS, SEX, AND AGE; UNITED STATES, 1974

Sex and age	Total population	With no limitation activity	With limitation of activity			
			Total	Limited not in major activity [1]	Limited in amount or kind of major activity [1]	Unable to carry on major activity [1]
	Percent					
BOTH SEXES						
All ages	10.7	8.6	23.6	15.2	22.9	34.1
Under 17 yrs	5.7	5.3	15.6	10.9	16.1	50.4
17 to 44 yrs	12.0	10.8	24.0	15.9	25.8	41.6
45 to 64 yrs	12.7	9.0	24.4	16.0	24.0	33.0
65 yrs and over	16.8	10.3	24.5	16.0	20.9	32.5
MALE						
All ages	8.8	6.4	23.1	12.6	21.9	31.9
Under 17 yrs	5.9	5.6	14.3	8.8	15.8	44.4
17 to 44 yrs	7.1	5.8	19.8	10.7	21.7	37.9
45 to 64 yrs	12.9	8.5	25.8	16.0	25.9	31.4
65 yrs and over	18.0	10.7	25.4	15.4	18.5	30.6
FEMALE						
All ages	12.5	10.6	24.1	17.8	23.5	40.4
Under 17 yrs	5.4	5.0	17.2	13.5	16.2	----
17 to 44 yrs	16.6	15.5	28.3	22.5	28.7	48.6
45 to 64 yrs	12.6	9.5	23.0	16.1	22.8	39.4
65 yrs and over	16.0	10.0	23.8	16.3	21.8	37.7

[1] Major activity refers to ability to work, keep house, or engage in school or preschool activities.

TABLE 6. NUMBER OF DISCHARGES FROM SHORT-STAY HOSPITALS AND NUMBER OF DISCHARGES PER 100 PERSONS PER YEAR, BY CHRONIC ACTIVITY LIMITATION STATUS, SEX, AND AGE, UNITED STATES, BASED ON DATA COLLECTED IN HEALTH INTERVIEWS IN 1974

Sex and age	Total population	With no limitation activity	With limitation of activity			
			Total	Limited but not in major activity [1]	Limited in amount or kind of major activity [1]	Unable to carry on major activity [1]
	Number of discharges in thousands					
BOTH SEXES						
All ages	29,325	18,333	10,993	1,468	5,095	4,430
Under 17 yrs	4,437	3,963	474	142	207	125
17 to 44 yrs	12,133	9,367	2,766	538	1,490	738
45 to 64 yrs	7,484	3,520	3,965	465	1,983	1,517
65 yrs and over	5,271	1,482	3,789	323	1,416	2,050
MALE						
All ages	12,119	6,752	5,368	590	1,775	3,002
Under 17 yrs	2,400	2,153	247	63	116	68
17 to 44 yrs	3,614	2,467	1,147	199	517	432
45 to 64 yrs	3,698	1,529	2,168	224	778	1,166
65 yrs and over	2,408	602	1,806	105	364	1,337

See footnote at end of table.

TABLE 6. NUMBER OF DISCHARGES FROM SHORT-STAY HOSPITALS AND NUMBER OF DISCHARGES PER 100 PERSONS PER YEAR, BY CHRONIC ACTIVITY LI. ITATION STATUS, SEX, AND AGE, UNITED STATES, BASED ON DATA COLLECTED IN HEALTH INTERVIEWS IN 1974—Continued

Sex and age	Total population	With no limitation activity	With limitation of activity			
			Total	Limited but not in major activity [1]	Limited in amount or kind of major activity [1]	Unable to carry on major activity [1]
Female						
All ages	17,206	11,581	5,625	878	3,320	1,427
Under 17 yrs	2,037	1,810	227	80	91	
17 to 44 yrs	8,519	6,900	1,618	339	973	306
45 to 64 yrs	3,787	1,990	1,797	241	1,205	351
65 yrs and over	2,863	880	1,983	218	1,052	713
	Number of discharges per 100 persons per year					
BOTH SEXES						
All ages	14.1	10.3	37.5	20.1	33.8	64.0
Under 17 yrs	7.0	6.5	20.6	12.8	19.5	92.6
17 to 44 yrs	15.0	12.7	38.7	20.6	40.2	88.1
45 to 64 yrs	17.5	10.8	38.4	21.0	34.7	83.4
65 yrs and over	25.4	13.2	39.8	23.7	30.8	57.7
MALE						
All ages	12.1	7.9	37.6	16.5	31.7	58.8
Under 17 yrs	7.5	7.0	19.3	10.4	19.3	84.0
17 to 44 yrs	9.3	7.0	32.1	13.8	33.0	77.7
45 to 64 yrs	18.1	10.0	42.0	20.1	36.4	61.0
65 yrs and over	28.1	14.0	42.4	25.2	28.3	52.2
FEMALE						
All ages	16.0	12.5	37.5	23.6	35.0	78.8
Under 17 yrs	6.6	6.1	22.2	15.9	19.6	
17 to 44 yrs	20.4	18.0	45.2	29.2	45.5	108.5
45 to 64 yrs	16.9	11.5	34.8	21.8	33.7	73.1
65 yrs and over	23.5	12.7	37.8	23.0	31.8	71.8

[1] Major activity refers to ability to work, keep house, or engage in school or preschool activities.

Source: "Vital and Health Statistics," series 10, No. 112.

Exhibit V

II. Health and Work: Scope of the Problem

Each year, about two million people die in the United States and an estimated 60 million are injured. Another 18 million have chronic conditions that partially or completely disable them. Evidence points increasingly to the place of work as a major contributing source, or the sole cause for all of this sickness, injury, and death.

The charts in this chapter sketch the general dimensions of the occupational health and safety problem in this country. They show clearly that working can be dangerous to your health; particularly when safeguards such as employee medical personnel, health and safety training, and insurance are inadequate, as they so frequently are in this country. Not surprisingly, the charts show that risks to life and health are associated with the kind of work one does. And, since the labor market is still segregated with respect to both ethnicity and race, the health risks of work fall disproportionately on some groups rather than uniformly across the labor force.

Some industries have extremely high rates of accident, injury, illness, and even death. These industries are identified in the chartbook and are obviously prime areas to which remedial occupational safety and health programs should be directed.

The costs of occupationally-related disability and death are enormous: half a *billion* work loss days occur annually, resulting in human suffering as well as a

high social cost in terms of productivity losses for the U.S. economy, an estimated $9 billion annually. Investments in preventive and curative measures for disability associated with employment are not commensurate with the scope of the problem.

Center for Health Statistics in a nationwide sample of 41,000 households and 120,000 individuals in the "Health Interview Survey" of 1973. The population covered in the survey was the civilian non-institutionalized population of the United States.

TABLE 13.—DATA FROM THE "HEALTH INTERVIEW SURVEY": 1973

Characteristic	Total number (thousands)	Disposition
Currently employed population	83,441	
Disability days:		
Restricted activity days	978,739	[1] 11.7
Bed disability days	330,757	[1] 4.0
Work loss days	451,429	[1] 5.4
Hospital discharges	9,684	[2] 11.6
Physician visits	371,288	[3] 4.4
Degree of limitation of activity due to chronic condition	83,202	[4] 100.0
Limitation in amount or kind of major activity	5,194	[4] 6.2
Limitation but not in major activity	3,069	[4] 3.7
No activity limitation	74,939	[4] 90.1
All acute conditions	120,741	[5] 144.7
Infective and parasitic	10,532	[5] 12.6
Respiratory	63,640	[5] 76.5
Digestive	6,354	[5] 7.6
Injuries	25,220	[5] 30.2
All other	14,996	[5] 18.0
Accidents [6]	23,882	[7] 28.6
Moving motor vehicle	2,045	[7] 2.5
While at work	9,027	[7] 10.8
Home	6,117	[7] 7.3
Other	8,682	[7] 10.4

[1] Days per person per year.
[2] Discharge per 100 persons.
[3] Visits per person.
[4] Percent distribution.
[5] Per 100 persons per year.
[6] The sum of data for the 4 classes of accidents may be greater than the total because the classes are not mutually exclusive.
[7] Persons injured per 100 persons.

Source: Data from the "Health Interview Survey," National Center for Health Statistics, U.S. Department of Health, Education, and Welfare, Rockville, Md.

Exhibit VI

Some Additional Relevant Statistics:

The National Arts and the Handicapped Information Services estimates 50 million handicapped persons in the United States, including 11.7 million physically disabled and 12.5 million temporarily injured. 1.7 million are homebound with chronic health disorders (National Center for Health Statistics quotes 1.8 million as homebound).

Of the discharges from hospitals of persons 65 years and over, 52 percent are under 75, 38 percent between 75 and 84, and 10 percent 85 years and over. Of the total 65 and over group, 57.5 had multiple diagnoses and 71 percent were in hospital without surgery. Average length of stay was 12.4 days.

Years	Days
65 to 74	11.8
75 to 84	13.0
85 and over	10.2

Family income and color, as well as age, influence utilization of hospital and home care. The Health Interview Survey indicates that as family income rose, percentage of persons limited in activity and morbidity fell. This is partially, but not entirely, explained by the fact that many elderly persons are in the low income group. Also, "white persons had lower percentages of morbidity limitation, unadjusted as well, as age-adjusted, than did persons of other races. The differ-

ential was still present when income was also taken into account." (From *Vital and Health Statistics*, Series 10, Number 96)

It is estimated that 25 percent of people now in nursing homes could be taken care of at home. In 1973–74, there were 1,074,500 residents of nursing homes in the U.S. (National Center for Health Statistics, *Vital and Health Statistics*, Series 12, Nos. 12 and 19 and unpublished data from Nursing Home Survey). Twenty five percent would add 268,625 persons—roughly 0.1 percent of the total population.

APHA Chart Book states that: "Each year, about *two million* people die in the U.S. and an estimated *60 million* are injured. Another *18 million* have chronic conditions that partially, or completely, disable them."

SPECIFICATIONS FOR LEGISLATION TO EXPAND THE AVAILABILITY AND IMPROVE THE QUALITY OF HOME HEALTH SERVICES UNDER FEDERALLY SUPPORTED HEALTH PROGRAMS

LEGISLATIVE PROPOSAL A

(1) (a) Amend Section 602 of Public Law 94–63 to continue the authorization for appropriations for the establishment and expansion of home health agencies and for the training of home health personnel.

(b) Add a new section to authorize a program of project grants at an annual rate of $10,000,000 to fund research and demonstrations relating to the cost-benefit advantages of home health services, discharge planning, health assessments of home-bound individuals, etc.

(2) Amend Title XV of the PHS Act to mandate coverage of home health services under the certificate of need provisions of the health planning legislation.

LEGISLATIVE PROPOSAL B

(1) Amend Section 1861(1) of the Social Security Act to require hospitals and skilled nursing homes to enter into written agreements for the transfer of patients with home health agencies. (Under existing law such agreements are only required between hospitals and skilled nursing facilities.)

(2) Amend Section 1861(k) of the Social Security Act to require a program of utilization review for home health agencies until the Secretary of HEW determines that the appropriate PSRO is qualified and able to monitor the quality of and necessity for home health services.

(3) Amend Section 1861(m) of the Social Security Act to permit home health agencies to claim reimbursement for the home health visits of registered dietitians who provide nutrition care and counseling.

(4) Amend Section 1861(o) of the Social Security Act to delete the term "skilled" when describing nursing services. The attachment of the label "skilled" to nursing has become a major barrier to the delivery of care under Medicare and the limitations placed on the definition of nursing care has resulted in great variance in interpretation of covered services.

(5) Amend Section 1861(m) of the Social Security Act to permit reimbursement for homemaker/home health aide services provided under the supervision of the appropriate health professional.

(6) Amend Section 1812(a)(3) and 1832(a)(2)(A) of the Social Security Act to permit 200 home health visits with provisos that the limitation may be exceeded only in exceptional circumstances.

(7) Amend Section 1861(n) of the Social Security Act to eliminate the requirement for three consecutive days of hospitalization as a condition of eligibility for home health services.

(8) Amend Title XIX of the Social Security Act to mandate home health services in a state's Medicaid program; such services should include nursing, speech pathology, physical therapy, occupational therapy, medical social work, and homemaker/home health aide services and supplies and equipment and should be reimbursed on a documented reasonable cost basis.

BACKGROUND FOR COST CONTAINMENT PROPOSAL

See attached statement submitted to Council on Wage and Price Stability, August 13, 1976 for use as a working paper.

[Attachment.]

STATEMENT OF THE COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING, SUBMITTED TO THE COUNCIL ON WAGE AND PRICE STABILITY, AUGUST 13, 1976

The Council of Home Health Agencies and Community Health Services accepts the invitation extended by the Council on Wage and Price Stability to submit comments concerning the problem of rising health care costs.

CHHA/CHS is an autonomous unit representing 1500 agencies within the National League for Nursing federation concerned with the development and expansion of quality home health agencies and community nursing services. These agencies provide health services to over 5 million persons outside the institution: in home, school, clinic, senior citizen center and other community settings. The scope of health services provided includes those directed toward care and rehabilitation of the sick and disabled, preservation and restoration of health as well as prevention of disease and disability.

Comparative studies have shown that the cost of providing home health care is significantly less expensive than intitutional care. (Addendum No. 1) However, the cost of providing home health care is also rising—the 1975 cost of $16.32 for a nursing visit was 8.8 percent higher than the $15.00 cost in 1974. (Addendum No. 2) The causes of such increase, what agencies are doing about it, and recommendations which would generally restrain the burgeoning rise are areas to which our comments are directed.

To provide documentation for these comments, we surveyed agencies using the following three questions: What are the major factors responsible for the increase in your per visit costs? What do you believe can be done by the agency to stem the increase in these costs? What do you believe can or should be done, in general, to stem the increase in these costs?

Responses clearly indicate some basic areas of increase which directly contribute to the rise in cost of services provided. (Among the responses, only six percent indicated that the per visit cost had not increased.)

Salary increases was the most often cited reason for the increase in costs—this reported by 64 percent of the respondents. Increase in fringe benefits was listed as a major factor by 23 percent of the respondents.

It must be noted here that home and community health agencies are labor intensive. Employee salaries alone account for over 68 percent of total expenditures and such salary-related items as retirement, social security and other employee benefits are an added eight percent. In addition, contract payments and fees for patient care services amount to nine percent. Therefore, about 85 percent of an agency's expenditures are labor expenses directly related to patient care. (Addendum No. 3)

Virtually all of the agencies surveyed are Medicare-certified home health agencies. To be reimbursed by the Medicare program for services rendered, enormous amounts of documentation are required by the federal government and the fiscal intermediary. This documentation often requires additional agency staff and additional time in the office by agency field staff (which reduces the number of visits per day). It has also forced agencies in some cases to purchase or lease new office equipment—for billing, statistical and other record keeping purposes. Nearly 57 percent of the respondents cited "bureaucratic paperwork" as a major factor responsible for increased costs.

Rising costs in the petrochemical field has had a great impact on the costs in these agencies. Automobiles are crucial to the delivery of health care to people in their homes and other community settings. In most agencies, the nurses and therapists rely solely on their own cars to visit their clients for which the agency reimburses them on a per mileage rate or a flat allowance. (Addendum No. 4) To keep pace with the rapid increase in gasoline costs, the reimbursement rates must be increased. Also, many of the supplies which are used by the worker in caring for patients are made from petrochemical products as in the case of disposable syringes or plastic gloves and aprons. It is not surprising, therefore, that increased transportation costs and costs of supplies were indicated as major factors in cost increases by 28 percent and 38 percent of the agencies, respectively.

A decrease in the number of visits as a cause for cost increase was indicated by 15 percent of the respondents. This is due to such factors as increase in length of visit because the patients need more intense care and time spent in documentation required for third party payors.

What can the agency do to stem the increase in these costs? Although 27 percent of the respondents felt nothing or very little could be done by the agency itself, a larger proportion, 33 percent, indicated that in their opinion increased productivity would keep costs down. Respondents also felt that one way to reduce costs would be to change staff utilization and to reduce office time. Each of these items was reported by 22 percent of the agencies. In 16 percent of the replies, reducing administrative costs was viewed as a way for the agency to help keep costs down. Better planning by the agency as a means to reduce costs was indicated in 15 percent of the responses.

When asked what can or should be done, in general, to stem the increase in costs only 13 percent replied nothing or very little. Nearly half of the suggestions were directed toward the lessening of bureaucratic restrictions, stating such specific suggestions as: have the same reimbursement for Titles XVIII and XIX (of the Social Security Act); require less documentation, cut down on the number of forms required and standardize existing forms. Twenty-two percent of the suggestions were that the nation's general inflation had to be controlled. Other suggestions were: mandate certificate of need for home health agencies thereby preventing costly duplication and fragmentation of services (10%); have uniform evaluation combining licensure, Medicare-certification, and NLN-APHA accreditation (Addendum No. 5) (9%); and require increased efficiency of fiscal intermediaries (9%).

SUMMARY

In general, it is evident that the major causes of increased costs in home and community health agencies are the general economics situation of the country and the increasing demands for documentation. Since the former is a situation which affects all segments of the health care field, and since in-home services are less costly than institutional care, it would follow that more emphasis should be placed on this less costly mode of delivering services when appropriate, Legislative and regulatory changes must be made in the Medicare and other federal programs which would:

Eliminate the three day prior hospitalization requirement.

Delete the 100 visit limitation under both Part A and Part B.

More accurately determine eligibility by defining "homebound" as someone who cannot safely leave his place of residence.

Extend Medicare home health coverage to the terminally ill, the mentally ill and renal dialysis patients.

Our recommendations for easing the increasing demands for documentation are as follows:

One federal regulatory agency must establish one set of certification standards for participation in all programs. The standards must be no lower than the basic minimum now required for Medicare certification.

Fiscal intermediaries must be encouraged to employ nurses with community health background to review claims.

Case documentation requirements in the Medicare program must be streamlined and standardized nationally. The practice of monthly submission of duplicate clinical records to fiscal intermediaries must be discontinued. We would recommend instead the practice of conducting periodic field audits to the facility very much as is done in the institutional setting.

We appreciate the opportunity to submit our views to the Council.

ADDENDA

1. A Dramatic Difference in Cost: Home Health Care vs. Institutional Care
2. Cost and Charge for Home Care-of-Sick Services, 1975
3. Income and Expenditures in Voluntary Community Health Agencies, 1973
4. Automobile Transportation in Community Health Services, 1974
5. NLN-APHA Accreditation Program for Home Health Agencies and Community Nursing Services

RESOLUTION ON UNQUALIFIED INDEPENDENT PROVIDERS OF HOME CARE [1]

Proposed by Council of Home Health Agencies and Community Health Services, National League for Nursing

Whereas, various states have contracted with individuals who are inadequately trained and supervised to provide health and health related services to people in their homes; and

Whereas, there have been documented cases of abuse, and of inappropriate or ineffectual care; and that this practice endangers the health of the public; and

Whereas, various states have contracted with individuals without insuring adequate personnel benefits and protection to them; and

Whereas, there are existing community, home health, and other agencies which employ individuals to render these services, and provide qualified ongoing training and supervision for them; therefore, be it

Resolved, That the NLN recommend to the public departments of social services and other governmental entities that these agencies contract only with certified home health agencies and/or agencies approved or accredited to provide homemaker/home health aide services to make available health and health related services funded under governmental programs.

ITEM 6. LETTER AND ENCLOSURES FROM CONSTANCE HOLLERAN, DEPUTY EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS DIVISION, AMERICAN NURSES' ASSOCIATION, KANSAS CITY, MO.; TO SENATOR LAWTON CHILES, DATED JUNE 7, 1977

DEAR SENATOR CHILES: Earlier we submitted a statement on "Alternatives to Institutional Care" for the hearing record. In that statement we referred to a report prepared by ANA in 1975 (at the request of the Senate Special Committee on Aging).

In reviewing that report again, it seems very appropriate to reiterate our continued support of its recommendations. The topics of day-care services, home care and supporting services are well covered in that report "Nursing and Long Term Care: Toward Quality Care for the Aging."

Perhaps you will want to include our report in the committee hearing record.

Please call me if you have questions or if we can provide additional information.

Sincerely,

CONSTANCE HOLLERAN.

[Enclosures.]

STATEMENT OF SYLVIA H. SCHRAFF, R.N., CHAIRPERSON, DIVISION ON GERONTOLOGICAL NURSING EXECUTIVE COMMITTEE, AMERICAN NURSES' ASSOCIATION AND EXECUTIVE DIRECTOR, HOME NURSING AGENCY OF BLAIR COUNTY, HOLLIDAYSBURG, PA.

My name is Sylvia H. Schraff and I am the Executive Director of the Home Nursing Agency of Blair County and chairperson of American Nurses' Association's Division on Gernotological Nursing Executive Committee.

I would like to share with the committee some of the Division's concerns regarding the health care of the elderly especially in relation to seeking alternatives to institutionalization.

We would first like to commend the committee in attempting to deal with the problems of providing accessible and affordable health care to our aging population. Especially important are your efforts on behalf of approximately 95 percent of our aging population who are not currently institutionalized and for the estimated 20 to 40 percent of those institutionalized who have been suggested as being capable of living ouside those walls if they had sufficient community-based support systems.

One of the health and related support systems proposed as appropriate to deal with the older person's needs outside of an institution is that of in-home services.

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[1] Approved by NLN membership April 1977; similar resolution approved by NCH–HHAS Spring 1977.

The American Nurses' Association's Committee on "Skilled Nursing Care Report"[1] that was undertaken in response to the Senate's Committee on Aging, Subcommittee on Long Term Care request, dealt with this option and I would like to share with you some of their recommendations as well as my opinions and suggestions as to the course of action you might pursue.

The most critical of all issues that must be addressed is that of how to develop and maintain a coordinated approach to the delivery of services outside the institution.

Even today, with the limited availability of home care services, many communities are already experiencing problems caused by a proliferation of single purpose agencies often directly competing with each other and fragmenting the services to the older person. This fragmentation of services many times denies the older person an assessment of the basic underlying cause of his problem and the opportunity to plan jointly with qualified professionals for his needs.

One of the older person's basic needs is that of health. Far too often the health component has been omitted in the planning and development of home care services. An example of this lack of professional health involvement can be seen in the following example:

An elderly gentleman called a homemaker service to request meal preparation and light housekeeping tasks because he was having difficulty managing at home. The worker did a great job and readily had the house in order and the man's meals prepared in a nutritious manner. Two weeks later he was admitted to the hospital with Diabetic Gangrene of the foot which necessitated a mid-thigh amputation. Had there been an assessment of the health status of this individual by a professional nurse, the underlying cause for this man's mobility problem would have been recognized and appropriate treatment instituted before it was too late.

The utilization of professional nurses in making an assessment of the older person's health needs prior to the assignment of workers to provide in-home services assures all concerned that the basic reasons for the need for assistance is not being overlooked.

Professional registered nurses have a broad knowledge of health care and the ability to develop long and short range plans for the care of the older person. Nurses have a long history of successfully working with other members of the health team, such as physicians, social workers, and therapists, in developing joint planning efforts for the client. The majority of the service needs in hospitals and nursing homes is nursing. This same need should hold true when seeking alternatives to institutionalization. I implore you to give your utmost attention as you explore alternatives to institutionalization and remind you that you are planning for the health needs of the elderly and must provide for professional health care in any of these alternatives.

I personally have been involved in the successful planning of home care services for older persons that include this health component as well as a coordination of services by registered nurses. The nursing staff frequently uncovers unrecognized illnesses, medication abuse, poor health habits, and many other problems familiar to those who care for the older persons. These discoveries often lead to physician contact for treatment plans and advice in planning for future services.

In-home services should also be coordinated as well as contain a health component. Nurses have the utmost appropriate knowledge and skills to accomplish this task. They are skilled at coordinating plans of allied disciplines without threatening the autonomy of the professional. I believe the older person has a right to a professional health assessment and a plan developed jointly with him for his service needs.

We are hopeful that your committee will exert influence on affecting legislation and regulations that support this basic concept. In addition, we urge you to do all in your power to require states to develop Certificate of Need legislation for home health services. Health systems agencies and states will need this legislation to control the proliferation of single purpose or duplicative type services serving similar populations. Without such clout, states will continue to be powerless to provide each and every person access to acceptable and affordable home care services.

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[1] "Nursing and Long Term Care: Toward Quality Care of the Aging," American Nurses Association, 1975.

SYNOPSIS

Care of the aged is frequently inadequate and/or inappropriate, failing to meet the needs of America's older population because facilities and services as well as funds are insufficient.

Although long-term patients have unique problems resulting from the aging process, the fact remains that each person continues as a vital, worthy, changing human, with needs best met on an individual basis.

An older person seeking assistance finds a dearth of institutions, services, and personnel trained to provide the help that is needed. If the level of care desired is different than that available in nursing homes with acute care (or skilled care) facilities, the remaining choices are few or nonexistent. This group of aged people must choose between no care or overcare.

The availability of in-home services, day care centers, foster home programs, funding for home care services, and similar options would not only allow the elderly person to remain at home, but would allow him to do so at a lower cost than possible in acute or skilled care facilities.

Reimbursement systems currently encourage the overuse of institutional facilities and discourage home care services through the payment mechanism. Broadening coverage to allow for care in homes and noninstitutional settings would not only reduce the problem but would also provide a broader and better range of services in the appropriate settings.

Health services for this group of people should focus on the attainment and maintenance of a balance of their physical, mental, or social well-being, and not merely on attaining the improved control of diseases or infirmity. Every chronically ill and older person has the right to strive or to be assisted in striving to achieve maximum health potential.

The term "skilled nursing" as it currently exists in the Federal regulations is restrictive and task-oriented and is not descriptive of professional nursing practice. Not only does the term fail to describe good professional practices, it does not describe the services the patients need.

There is an inherent contradiction in the term "skilled" when it is applied to human services which are provided by responsible institutions or by individuals, whether in public or private agencies. The term implies limitations and exclusions in areas of service which are central to standards of competence and to the achievement of excellence in the quality of care. When discussing the quality of any health care service, the use of skills is axiomatic, and therefore the word "skilled" should be removed from the nomenclature describing long-term nursing care.

Of the 815,000 employed registered nurses in the nation, only 65,235 are found in nursing homes, representing an understaffing situation in long-term care facilities. Since a major portion of the professional nurse's working time in these institutions is occupied with administrative duties, from 80 to 90 percent of the care in these facilities is provided by aides and orderlies who have little or no educational preparation for their jobs. Most of the more than 280,000 aides and orderlies are grossly overworked and underpaid, and these positions generally experience a turn-over rate of 75 percent a year.

One reason for the small number of registered nurses in nursing homes is that present staffing standards are unrealistic in relation to the overwhelming needs of the patients. Another reason for the fewer nurses in these institutions is the low status and low pay of these positions when compared to positions for nurses in other areas.

Basic and graduate educational programs for registered nurses need to emphasize gerontology and geriatric nursing care, not only in the classroom but in clinical facilities, so that the graduates understand problems of patients in this area and can plan and supervise both the physical and social care required.

Work standards, pay schedules, and benefits of both professional and nonprofessional staff need to be examined and altered so as to become competitive in the job market. This, combined with improved training, would raise the capabilities of these employees of long-term facilities and would reduce the expense of high turn-over rate.

The rapid increase in America's aged population indicates that a national health policy is needed immediately and that long-term care should properly be considered within the context of national health insurance plans.

On a national basis, the present provision of health services is fragmented, uncoordinated, and incomplete. The current high costs of health care services stand in the way of effective delivery of health services to large numbers of people in the country. This is especially true and has more disastrous effects on the elderly.

If a national health insurance plan is to provide comprehensive health care services, more recognition must be given to the nurse's role in the delivery of primary care. Appropriate preparation and utilization of the nurse practitioner in the primary care role is one important way to extend health services and use health manpower more effectively. Funding for training programs for nurse practitioners is needed.

The Federal government should make provisions for national standards governing health insurance coverage so that each citizen is assured equal benefits, regardless of age.

SUMMARY OF RECOMMENDATIONS

The following recommendations are made by the American Nurses' Association's Committee on Skilled Nursing Care based on the results of efforts, research, and recommendations of three task forces composed of representatives from all areas of the health field. In addition to the work of task forces, six hearings on long-term care were held throughout the country, and information from witnesses' testimony was used in compiling not only these recommendations, but also the document which follows. Complete task force reports are included in the appendices of this volume.

I. A national policy on care of the aging should be developed, within which should be provision for care of the elderly in any kind of setting, the right to high quality care, and the right of the elderly to decision-making in regard to their own care. The national policy on care of the aging should be built on the fact that the aged are vital, dynamic persons who have made and who continue to make contributions to society.

II. Because high costs of essential health care services, coupled with the present provision of fragmented, uncoordinated, and incomplete health services stand in the way of effective delivery of health services to the aged, a plan for national health insurance should be developed to insure that health care services are provided for all citizens, guaranteeing coverage for the full range of comprehensive health services. The national health insurance plan should clearly recognize the distinctions between health care and medical care, and provide options in utilization of health care services.

III. In considering options or alternatives for care, the Committee on Skilled Nursing Care recommends that a range of health and supportive services be made available to all elderly citizens. Thus, whether a person chooses to live in his own home and have services brought to him, to go to the services in a day care setting, or to move to a nursing home, he would have assurance that the needed services would be available.

IV. The word "skilled" should be deleted from the phrase "skilled nursing care" as it currently exists in the Federal standards and as the term is generally applied in actual practice, because it is not measurable nor can it be defined when related to the needs of a patient.

V. Because quality health care will depend primarily upon the competency of the persons providing direct care, all professional persons and workers involved in long-term health care in any setting should have a background in the basic care of the aging. These gerontological concepts should be taught at the educational levels of the individuals in the depth and detail each can understand and use. Preparation in gerontological nursing should be within an open educational system which promotes career mobility. The educational program of registered nurses at all levels should be developed and strengthened to correct specific deficiencies in the area of gerontological nursing.

OPTIONS FOR LONG-TERM HEALTH CARE

The health care industry has experienced tremendous growth in recent years, with total national health care expenditures rising to $80 billion in 1974. The cost of acute hospital care and institutional long-term care has contributed significantly to the rise, and the trend seems certain to continue.

Of the more than 20 million Americans over 65 years of age, 80 percent report one or more chronic illnesses that require medical supervision. However, only

five percent require long-term institutionalization, such as in acute care or nursing facilities. Studies show that there are patients in institutions who do not need to be there, and would not be there if alternative services were available.

The advent of the Medicare program in 1966 provided home health care as a significant alternative to hospital or nursing home care. The number of institutional visits covered by the Medicare regulations are generally adequate for an episode of acute illness if they are judiciously used by the provider and the patient. However, little provision has been made to provide for visits for care of chronic illness or preventive care. There is no incentive to keep the patient well in the present system.

There is a consensus among health care authorities that a significant number of the patient population are treated in facilities equipped for care beyond those patients' needs. The health care system is oriented primarily toward treatment of the acute phase of illness and does not offer a complete spectrum of health care by providing available alternatives to acute care, financing the alternatives, and educating physicians and patients in use of the acceptable alternatives. This problem becomes even more significant for the elderly.

In considering options or alternatives for care, the committee recommends that the national goal be to make available a range of health and supportive services for all elderly citizens. Thus, whether the individual chooses (1) to live in his own home and have services brought to him, (2) to go to the services in a day-care setting, or (3) to move to a nursing home, he would have some assurance that the needed service would be available.

IN-HOME SERVICES

It is the right of every individual to live his life in circumstances which enable him to make the fullest use of his capacities. This right is protected when the society in which he lives provides safeguards which ensure basic economic security in a decent environment and services which are necessary to promote his physical, mental and emotional health. These services are only effective when they are available in a comprehensive system which includes all of the skills and facilities essential to the promotion and maintenance of optimum health.

In-home services are a major component in this system. They utilize the home and the family as a valuable resource: they prevent the unnecessary displacement of persons which occurs when services are lacking; they guarantee the right of the individual to remain in the place of his choice. In the absence of in-home services, no system may be considered either comprehensive or effective and must, therefore, be an integral part of this system. Top national priority must be given to the development of a rational system of comprehensive in-home services for the whole population.

In spite of the increased verbal interest in home-health care, the necessary impetus toward implementation of a national policy with respect to home-health services is still absent.

This delay and this denial has begun to affect our national economy significantly in terms of dollars. Even more significantly, however, it affects the health, the personal freedom, and to a serious extent the future well-being of the whole population.

It has been said that home care is respectable, but it is not yet fashionable. It should be made fashionable. Home care is not second best, and it is not "cut-rate." It provides the best modern medical care, it makes it possible for the chronically ill and certain selected convalescent cases to be looked after in their homes, and it provides patients with a wide range of professional services which are not easily secured through the physician alone.

Coordinated home care has proven its worth and applicability to many medical care problems. Many patients with conditions requiring only a short period of general hospital care would welcome the opportunity to return home at an early date. At home, under proper supervision, a coordinated home care program can successfully provide a continuity of care for these patients.

Any group or agency within a community that has the skill, ability, and drive to set up and operate a home care program is encouraged to do so. Home care is a valuable and essential addition to the totality of medical resources for many patients.

In-home services must be developed as a part of a network of many community services, health, social, and supportive, some of which are provided directly,

and others which are coordinated with an agency's services rather than provided directly. The network must allow freedom of movement back and forth between facilities, hospital, and home. One phone call to the umbrella agency should assure any kind of service available and appropriate transfers as a person's needs change. Services should be developed to promote maximum utilization of resources and to prevent costly duplication of existing services, in collaboration with the area comprehensive health planning agency.

Need for service should be authorized by any professional person involved in the program, rather than limited to authorization by physician only, and the service should be authorized without the requirement for prior hospitalization.

The services which should be provided include those which are necessary to the rehabilitation and recovery of the patient, those which are necessary to prevent deterioration, and those which sustain the patient's current capacity even when full recovery or medical improvement is not expected. Nursing constitutes the major service required to meet such needs of patients in their homes. Nurses should be given more responsibility to determine patients in-home service needs, for the purpose of better patient planning and better utilization of health personnel.

"I believe the nurse's knowledge and judgment in assessment of the patient's condition, establishment of the plan of care and supervision of the personal care given by the home health aide must be part of the accepted definition for nursing care. It is clear that good professional assessment and reassessment of care are key factors in the delivery of appropriate home health services for as long as they are needed and not longer.

"Most hospital bills are paid by some third party mechanism, but to hospitalize must not be a substitute for home health care. Community agencies accept a financial responsibility for part pay or free services to meet patient needs but this is extremely limited. There must be a better reimbursement for home care."

—Testimony presented by Carol Winkler, Executive Director of Community Homemaker Service, Inc. (a nonprofit Mile High United Way affiliate) and home economist, at the hearing on Skilled Nursing Care held in Denver, Colorado, September 16, 1974.

In-home services should not be fragmented because of funding, and therefore coordination of governmental and private resources at all levels is necessary. This principle needs to be applied to the development of regulations, eligibility requirements, data collection, and billing requirements. Reasonable uniformity in all these areas will go a long way toward assuring humane services to people in a cost-effective manner.

The agencies providing in-home services should meet standards as established by national standard setting bodies (i.e. National League for Nursing, American Public Health Association, and National Council for Homemaker-Home Health Aide Services). Efforts should also be made to combine surveys for multi-service agencies so they are not besieged with service and financial surveys and audits by many different groups. Such combination will achieve cost reductions and coordination of the review of an agency.

A management information system should be developed for all in-home service agencies so that comparable data may be collected nationwide for the purpose of analyzing trends and studying specific problems, as well as providing reliable information on costs and statistics for health planning and national health insurance.

The range of services could include a variety of services such as audiologic, handyman, legal, nursing, nutrition, and physical therapy.

An adequate number and variety of staff should be maintained to meet the needs of the community, with innovative patterns of staffing needed to utilize all personnel to provide maximum service.

"To assure quality, the homemaker-home health aide's services must be appropriately supervised by a professionally prepared person who need not be a nurse. But periodically the patient's condition, home situation and care needs should be assessed by the professional nurse to assure that the help provided in the home continues to be appropriate to the patient's needs.

"In Wyoming patients are cared for at home with varying degrees of incapacity. In the home health agencies, nursing services and home health aides, if needed, are provided for years to the stable incapacitated the State pays

for the service to those no longer "medically eligible" by Medicare definition. Many families are keeping members at home to death."

—Testimony presented by Elta M. Kennedy, Home Health Nursing Consultant, Nursing Services, Department of Health and Social Services, Cheyenne, Wyoming, at the hearing on Skilled Nursing Care, Denver, Colorado, September 16, 1974.

The use of nurse practitioners, nurse clinicians or clinical specialists should be encouraged, developed and expanded to provide leadership and to teach other workers and volunteers and to give a variety of services which are greatly needed by disabled people.

DAY CARE

The recent surge in interest in lowering health care costs and enabling long-term disabled persons to live in their homes rather than becoming institutionalized has resulted in intensive efforts to develop a program of day care for aged and long-term disabled persons. A viable day care program for the aged and long-term disabled has economic as well as social, rehabilitative, and preventive advantages.

In Great Britain day care programs for the elderly began in 1962 because of a serious lack of beds in hospitals and long-term care facilities. These programs have been highly successful in maintaining the aged in their homes and as independent as possible. According to testimony presented before the U.S. Senate Subcommittee on Aging in June of 1971, only one percent of the population over 65 in the United Kingdom lives in long-term care facilities. In the United States, five percent of the population over 65 are in long-term care facilities.

The day care is being one link in a chain of services offered the aged and disabled. Day care programs have enormous potential for meeting the long-term care needs of individuals, while delaying or avoiding the need for full-time institutionalization. These programs offer the opportunity for nursing care, monitoring of medications, dietary care, socialization, rehabilitation and social services. They provide a means of helping the aged and disabled to maintain and re-establish their ability to care for themselves. Because of the therapeutic programs offered in such facilities, they may be accurately described as a form of preventive medicine.

Examples of successful day care programs in Great Britain, Canada, and isolated examples of programs in the United States can serve as models for expansion of a coordinated system of day care programs geographically constructed and operated throughout the United States and available to all our elderly and disabled citizens regardless of where they live or their ability to pay.

Experience with the Center for Adults Plus in New York City led Milton Berger to write:

"Day centers can allay the feelings of uselessness, depression, isolation, alienation, helplessness and hopelessness which are so prevalent in this age group. Fear of dependency and of not being needed or wanted, and feelings of loneliness and abandonment can be alleviated in a therapeutic community setting. This setting can provide for nonverbal as well as verbal communication; for spiritual, emotional and physical interaction; and for dialogue and communion in a spirit of mutual interest, trust and intimacy. In an active process of involvement in giving as well as receiving, men and women can find the strength to accept what needs to be accepted existentially while enjoying the excitement and search for self-fulfilling new options or solutions to conflicts and problems that seemed unsolvable."

There are two major types of day care centers. The first type is health-care oriented, usually situated within the confines of a long-term care facility and functioning under the same administration. Elderly and chronically disabled persons may come, or be transported, to the center in the morning and spend the entire day, or part of a day, in therapeutic activity. They return on the same day to their homes. Comprehensive services which are available in the institution are available to persons in the day care program. The services offered are determined by assessment of individual needs of each person.

"The goal of the Amherst Adult Day Care Center is to provide viable alternatives to institutional living and enable individuals to remain within the community, who for one reason or another are unable to utilize other community resources such as the Senior Center.

"The concept (of the Amherst Adult Day Center) will permit an individual to participate between peer groupings, offering the advantages of family and day center associates, and will provide an alternative to institutionalization by maintaining the individual at the highest level of physical, social and mental functioning possible."

—Testimony presented at the hearing on Skilled Nursing Care held in Newton, Massachusetts, September 9, 1974.

Socially oriented day care programs exist outside of hospital or licensed long-term care facilities. Their goals are toward social rehabilitation and maintenance. Activity programs, both group and individual, provide a means of socialization and prevention of physical disability from disuse and mental disability caused by loneliness and isolation. Although socialization through activity is the primary focus, other services, such as nursing consultation, dietary instruction, educational and vocational classes, social services, personal care services, and health education, should be available on a part-time basis.

Experience with a day care program at Maimonides Hospital and Home for the Aged in Montreal, Quebec, Canada, has shown it to be a cost-saving program. Of a total of 250 persons cared for in the program, only six percent over a four year period have had to be institutionalized. Ninety-four percent have been able to continue maintaining themselves in the community. Administration attributes this diminution of social isolation, improved nutrition, and continuous health supervision and treatment.

Day care facilities must be accessible to the population they intend to serve. Time needed for transportation from the furthest point should not exceed one hour, if at all possible. The facilities should provide a safe environment with sufficient room for a variety of meaningful and stimulating activities to the group to be served, as well as helping maintain orientation and continued learning.

There should be space to provide opportunity for both group and individual activity, for action, and for rest.

The minimum staff in a day care center would be an administrator who might also provide another professional service in a small center; a nurse clinician with gerontological and/or rehabilitation background; a social worker; a physician; a secretary and attendants or aides. The amount of time worked and kind of input of each staff member would depend on the program needs of the center. For instance, the physician may be hired on a consultant basis and not be physically in the center.

The most common staffing pattern is based on 45–50 day care clients and includes an administrator (usually a nurse), two registered nurses, two social workers, a part-time physician, and four attendants. An occupational and physical therapist are usually available for program development and consultation and are desirable on the basic team.

The nurse clinician could provide the original and ongoing health assessment of day care participants with medical input when necessary. The nurse social worker team could also do family and social assessment and work with both family and client. On the basis of these assessments and input requested from other professionals, the day care program for both the group or individual could be planned.

Other basic staffing that would be necessary for day care center is food preparation and service personnel with dietician consultation, housekeeping personnel and bus drivers or other transportation providers.

"Today I want to describe a little publicized, modest, success story of a program providing an array of health maintenance services for older adults. The program has been conceived and designed by, organized by, and implemented by community health nurses in county community health nursing services and in organized local health departments in Colorado . . . .

"The community health nurse conducts the program in settings wherever older adults congregate. The programs are conducted in church basements, community centers, kitchens of senior citizen centers, retirement homes, and occasionally in overloaded health department clinics . . . .

"We are in great need of funding at the State level for assistance with rational planning, documenting findings, and evaluating the cost-effectiveness of such programs . . . . Funding is needed at the local level not only for providing services but for planning and evaluation . . . . No charge is made to consumers

in any of the programs. Third party payments through insurance mechanisms should be provided as a mechanism to avoid expensive institutionalization."

—Testimony presented by Audrey J. Ostberg, Adult Health Nursing Consultant, Community Nursing Section, Colorado Department of Health, at the hearing on Skilled Nursing Care held in Denver, Colorado, September 16, 1974.

Because of its importance as a major option for care of the elderly, day care should be adequately financed and recognized by reimbursement mechanisms. Among the several possible major financing alternatives to providers of day care services are Medicare, Medicaid, private pay, national health insurance, revenue sharing, Federal and state grants and union health plans.

We recommend that consideration be given to restructuring the Medicare and Medicaid programs in a way which would allow reimbursement of full costs to providers of both institutional and non-institutional day care services to the aged and long-term disabled persons. Eligible costs should include but not be limited to those costs now eligible for reimbursement under the Medicare program. We recommend, further, that for the purpose of financing a day care program, requirements of prior hospital stay be eliminated, and self-admission to day care services be implemented.

We recommend, further, that the benefit eligibility requirements be extended to all persons in need of day care services who do not have the personal ability to pay.

Financial incentives should be given to existing long-term care facilities to encourage use of available space within these facilities for day care services. This alternative would require little restructuring or revision of existing Title XIX rules and regulations, and would decrease significantly expenditures for long-term care. National health insurance proposals must give serious consideration to the importance of day care with the program designed to include it.

Careful study and consideration should be given to the possibility of capital assistance grants to non-profit providers for day care services through revenue sharing.

NURSING HOMES

Contrary to the popular belief that long-term care facilities are "dumping grounds" where children can dispose of unwanted parents, long-term care facilities are needed to provide care for people who cannot be cared for elsewhere and should be an integral part of the care system.

The health care system has been predominately medically oriented—that is, related to cure of disease. Long-term care, on the other hand, has to be of a broader scope, including psycho-social needs, as well as medical needs of patients.

The medical model, while appropriate in the hospital setting, is inappropriate to meeting the total needs of the person in a long-term care setting. The Federal standards must be adapted to recognize this fact. Facilities care for individuals of all ages, with all kinds of problems, and while some may live out their lives in this setting, others may require such services temporarily until they are well enough to return to live in the community. A long-term facility may, in fact, serve as a point of entry to the health care system, and it certainly plays an important role in the delivery of health care by caring for those not in need of hospitalization but unable to remain in their home settings because of extreme disabilities or failure of the system to meet their needs.

Other settings should be considered to meet individual needs and services, including day or night care centers, homemaker services, retirement resident centers, foster homes, boarding homes, and group care facilities.

A setting that is virtually non-existent is one that provides for the care of an individual who is in a terminal phase of illness, who is severely disabled, or who is in a transitional phase of illness. This person requires a complete complement of equipment and/or services as well as a concentration of professional and other staff services to live out his days in relative comfort and dignity. The acute care hospitals at one time provided such care as was needed and desirable. Although some hospitals are continuing to provide such care, many others with a waiting list for beds will not admit terminally ill, chronically disabled, or persons in a transitional phase, stating that their needs do not require hospital care since there is nothing more than can be done to help them.

Even so-called "skilled" nursing homes are reluctant or refuse to accept terminally ill patients, contending that they do not have the services, personnel, or

equipment to meet the needs of these people. Thus a gap exists in options being considered for the continuous care of a patient whose needs cannot be met in the existing health care system.

If the options described as in-home services and day-care services were available in every community, the nursing home would become the appropriate setting for the person who needs continuous nursing care. Thus, with appropriate utilization of other settings, the utilization of the nursing home would become more appropriate and the classification question less significant.

Supportive services, as needed, should be available in whatever setting is most suitable to the individual, his family, and his needs. There are many planning agencies in communities but few action agencies coordinating services, utilizing what is available, and also arranging for the development and provision of services not currently available. An umbrella agency offering services, or contracting for additional services as needed, could be established under the sponsorship of a public or private community group such as a home health agency, a hospital, or an agency with nursing staff available. This umbrella agency, building on what is available in the community, would provide or arrange for the provision of all needed services.

ITEM 7. STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

The American Hospital Association represents some 6,500 member institutions, including most of the nation's hospitals, extended and long-term care institutions, mental health facilities and hospital schools of nursing, as well as over 24,000 personal members. We appreciate this opportunity to present our views and recommendations on alternatives to institutionalization of the elderly, particularly on home health care services.

The Association believes that home health care, provided through a coordinated program based upon qualified professional assessment, is an integral part of a continuum of care that should be available to every individual according to his needs. In certain circumstances, home health care is the most appropriate mechanism for the efficacious and cost-effective delivery of health services to a patient. However, to be effective, such care must be provided according to a carefully developed plan, with adequate financing, within an appropriate range of health services, and workable quality assurance standards. The main issue is, of course, not institutionalization versus home health care; rather, it is the development of a system which permits the efficient and appropriate use of our health delivery system.

The Board of Trustees of the American Hospital Association has adopted a definition of home health care that embodies these prerequisites:

"Home health services is that component of comprehensive health care, whereby services are provided to individuals and families in their place of residence, for the purpose of promoting, maintaining, or restoring health, or of minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated, and made available by an agency/institution or unit of an agency/institution organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administration patterns.

"These services are provided under a plan of care that includes, but is not limited to, appropriate service components such as medical care, dental care, nursing, physical therapy, speech therapy, occupational therapy, social work, nutrition, homemaker home health aide, transportation, laboratory services, and medical equipment and supplies."

This definition also has been endorsed by the boards of directors of the National Association of Home Health Agencies, the National Council of Homemaker-Home Health Aide Services, Inc. and the National League for Nursing.

The AHA believes that health services for the elderly should properly be considered as a continuum of care, with all facets of health services, in both institutional and alternative settings, operating in a coordinated, complementary manner. Moreover, the Association supports home health care services as a vital means of maintaining independence among the elderly and of contributing to their psychological well-being.

If legislative initiatives are undertaken to support the further development of home health care, such efforts should be directed toward facilitating the co-

ordination of institutional and alternative health care. They should be aimed at closing existing gaps in the continuum of health care services.

Unfortunately, Medicare and Medicaid present obstacles to the implementation of treatment plans, which frequently result in inappropriate, incomplete and more costly services. The lack of coverage or the absence of services under home health plans may lead to more expensive inpatient care which could in many instances be postponed or avoided.

For example, Title XVIII of the Social Security Act (Medicare) should be amended to eliminate the requirement for prior hospitalization as a condition of eligibility for certain home health or long-term care benefits. A second example is the need for removal from Title XVIII of the distinction between "primary" and "secondary" health services, which currently prevents beneficiaries from receiving certain health services classified as "secondary" unless other "primary" services are provided simultaneously. Such suggested changes illustrate the types of statutory improvements that could be made in recognition of the fact that home health care is an appropriate mode of delivery whether or not it is related to institutional care. They would facilitate the provision of services in a manner which would prevent or postpone the necessity for a more intensive level of health care.

The AHA also supports the expansion of demonstration projects in Medicare and Medicaid, as authorized by Section 222 of the Social Security Amendments of 1972 (Public Law 92–603), to allow further progress in coordinating health services. This authority, which permits experiments in day care and homemaker services, has not been fully utilized. We urge the Congress to give greater emphasis to the development of "systems of services" for the elderly, rather than isolated benefits which may not fit the needs and circumstances of beneficiaries.

Progress also can be made in streamlining quality assurance programs in home health care. Federal agencies administering health services programs should recognize that there already exist several workable quality assurance programs developed by the private sector. Among them are the American Hospital Association's Quality Assurance Program, which encompasses all aspects of the quality of care delivered by hospitals. More specifically, hospital-based home health agencies are examined and accredited by the Joint Commission on the Accreditation of Hospitals, in which the AHA participates, through specific standards for home health programs. Moreover, the National League for Nursing and the American Public Health Association together have developed an accreditation program for most free-standing home health agencies; and the National Council for Homemaker-Home Health Aide Services, Inc. has an approval program for homemaker/home health aide services that is moving towards an accreditation program.

The development of these voluntary accreditation programs reflects the concern by health care providers that home health care be delivered pursuant to high quality standards, with efficient utilization of resources. Moreover, provider organizations, such as the American Hospital Association, are persuaded that high quality home health care services must become an integral part of any universal health insurance program which is enacted by the Congress.

Attached to this statement are several documents presented at hearings held by the Department of Health, Education, and Welfare in the autumn of 1976, which discuss, in greater detail, definitions of home health, financing mechanisms, standards of service, relationship to state certificate-of-need laws, and the role of hospitals in home health care. Also included is a copy of a letter from the AHA to the Department of Health, Education, and Welfare concerning federal regulations of day care.

We trust that this statement, and the supporting documents,[1] provide the Committee with information relevant to its inquiry. The Association is ready to provide the Committee such further information as may be needed.

[Attachments.]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION ON THE TESTIMONY, "TOPICS OF DISCUSSION," DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE HOME HEALTH HEARINGS, AS PUBLISHED IN AUGUST 25, 1976, FEDERAL REGISTER

The American Hospital Association representing over 7,000 member hospitals appreciates this opportunity to present written testimony relating to the Topics

[1] Portions retained in committee files.

of Discussion, as published in the August 25 Federal Register, Volume 41, No. 166, for the home health hearings sponsored by the Department of Health, Education and Welfare. In our oral testimony, because of time limitations, we were able only to highlight a few of the many major issues in the field of home health. In this material, we will cover more areas and delve further into those highlighted in our oral testimony.

DEFINITION OF HOME HEALTH CARE

The working definition of Home Health Care, as presented in the Federal Register—"services of physicians, nurses, social workers, therapists, home health aides, and medical equipment and supplies, delivered to a patient in his place of residence"—is grossly insufficient. Instead we would like to offer in its place a definition that has been approved by the American Hospital Association Board of Trustees and endorsed by the Board of Directors of the National Association of Home Health Agencies, the National Council of Homemaker Home Health Aides, and the National League for Nursing. That definition is:

"Home health service is that component of comprehensive health care, whereby services are provided to individuals and families in their place of residence, for the purpose of promoting, maintaining, or restoring health, or of minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated, and made available by an agency/institution or unit of an agency/institution organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.

"These services are provided under a plan of care that includes, but is not limited to, appropriate service components such as medical care, dental care, nursing, physical therapy, speech therapy, occupational therapy, social work, nutrition, homemaker home health aide, transportation, laboratory services, and medical equipment and supplies."

This definition is significantly different from the proposed working definition in the Federal Register, because it promotes a comprehensive, coordinated approach to home health care based on patients' needs. The Department of Health, Education, and Welfare's working definition establishes home health care in terms of services. With the HEW approach, many problems follow. We will discuss them further on in the testimony.

SIGNIFICANCE OF HOME HEALTH CARE

The AHA supports the concept of a continuum of care for health delivery. With a continuum (which requires a system) in place, each individual can be provided with the correct level of service to meet his particular needs, and thus efficiency and effectiveness can be enhanced. The proper utilization of health care resources is, of course, desired, but to accomplish that, the spectrum of services must be developed and functioning and available to the health care field and through it to the patient for proper utilization. In this testimony, we are focusing particularly on that aspect of the spectrum of services called home health care.

The significance of home health care to the indiviual can be pointed out by a brief vignette of an 85-year-old gentleman who had cancer of the vocal cords, severe chronic obstructive lung disease, and a laryngectomy. He was discharged early from the hospital because he indicated that he did not want to participate in the hospital's program for his care. He said he refused to stay in the hospital to die. He previously had lived alone, and, when he returned to live in his home, home care was provided consisting of two to three visits per week by an RN, one to two visits per week by a respiratory therapist for post dural drainage, and three visits a week by a speech pathologist. This gentleman's feelings about his care under the home care program and its importance to him were revealed when he put an ad in the personal column of a newspaper, thanking his home care nurse for the care he received. Although all patients don't advertise their appreciation of home care in newspapers, the meaning and the value of this type of service in terms of the individual patient and his family is significant and extensive.

COMMUNITY NEED FOR HOME HEALTH SERVICES

The American Hospital Association has stated its support for community-wide planning and the certificate-of-need concept. We have stated that the latter

should cover all health facilities, including home care programs, be they hospital-based or freestanding. One cannot regulate certification of need for hospital-based programs and not regulate freestanding programs, and visa versa.

Literature does exist on determination of need. However, "need," as related to home health services, has a particular uniqueness. Because many elements go into making up the utilization of a home health program, the measurement of "needs" would have to take these elements into account. For instance, the promotional aspects of home care—how widely and well-known it is by potential patients, or by their physicians or by referral sources within the community has an impact upon how much the program is used. It also has an impact upon whether the referring source—be it physician, institution, or self-referral—understands what home health is and what it can do and thus perceives it as a solution to a particular problem. By this we are saying that some of the traditional means of measuring and examining need may be insufficient when applied to home health. There is room for great expansion in this field by (1) making available a total constellation of services, and (2) educating the public or a potential user about the capabilities of the service and (3) informing the potential prescribers of the service.

Within this general comment on "need," we can say that barriers have operated to slow down the meeting of these needs. HEW is well aware of the barriers, which include, as we said, the public's lack of knowledge and the need for knowledge on the part of referring sources, be they physicians or community providers. Other barriers, such as insufficient funding mechanisms, and requirements, such as being home bound, needing "skilled" care, and having had a three-day prior hospitalization, limit the usage. Utilization also is made more difficult by the lack of a total delivery system. All these elements and more limit the growth and utilization of Home Care. It is vital that in the attempt to promote the growth of home care to meet the demonstrated and expected community need, one must reduce the barriers, while at the same time, not reducing standards. We will discuss standards in more detail later.

ELIGIBILITY FOR CARE AND EXTENT OF COVERAGE: MEDICARE, MEDICAID AND SOCIAL SECURITY

As was mentioned earlier, in order to provide services to meet the restated definition of home health, which relates service to patient needs, a constellation of services is necessary. A variety of services must be available in order to construct a program for an individual's needs. Without this constellation, and when, on the basis of professional assessment, an identifiably indicated service is missing, the patient care plan for home care becomes unworkable. Thus, the Programs of Titles 18, 19, and 20 must be designed to promote this array of services. A payment mechanism must be developed to pay for these services, but, unless programs are integrated, an individual could find himself eligible for services under Title 18, moving to Title 19 for services, and to Title 20, and finding these services are unavailable because of a lack of state selected coverage or caps on coverage costs. Thus, continuity of care is interrupted, destroying the patient care plan that was set up to meet goals to promote, maintain, or restore health, or to minimize the effects of illness and disability. Continuum of care becomes only a phrase, and is not a reality for that individual. In addition, it interferes with the establishment and function of a system.

The key to eligibility for services and limitation of service is to meet the professionally assessed needs of the individual patient. This should not be done on a categorical basis, because further, obviously undesirable, fragmentation would result. Agencies, departments, or institutions should not refuse service to those who can afford to pay. There should be a mechanism whereby payment for home services can be made by those who can afford it, on a sliding scale, if appropriate. Having some money available to pay for services does not reduce the need for this service or ensure their availability. Likewise, when patient funds are exhausted and services are still needed a provider still has a responsibility to that patient.

HOME HEALTH SERVICE DEVELOPMENT

We would hope that government at all levels would contribute to Home Health in the areas of data collection, providing information, and developing model programs. There also can be a relationship to standards, which will be discussed later. Government already has demonstrated a major commitment toward finan-

cing services, and it needs to have the mechanisms function in a more orderly and correct fashion, by paying on an appropriate basis, which is not presently the case. Already the government has taken steps based on legislation regarding Section 222 of Public Law 92-603 in examining program models and financing and these efforts are supported.

Additionally, consumers have a role in identifying and providing feedback on services and pointing out the needs, gaps, and impact of services.

HOME HEALTH SERVICE DELIVERY

The type of agency that should provide and be reimbursed for services is an agency that meets standards. By meeting standards, an agency has shown itself to be concerned with producing a quality service. By requiring standards, proper utilization of services would result because of required professional assessment and controls. This would then impact on costs.

As it is necessary to have an array of services to properly meet the needs of the home health patient, it is also necessary to have coordination of these services to ensure proper access and utilization. These services can be within one agency or be under the auspices of many agencies in the community. What is necessary is that linkages within the community form a "service delivery system." A community needs to plan and interrelate its resources and to develop the resources that it determines are lacking or are of insufficient quantity. There is no need for each agency or institution to duplicate services. There is need to share and link the services wherever feasible and appropriate. The specific method of coordination between services is at the discretion of the local level—suffice it to say that the basic principal is that service should be interrelated and linkages should be developed, if they do not already exist. Of course, this concept goes beyond the development of home health care resources, because it promotes the means for developing and improving the delivery of a full spectrum of health services, such as day care, day hospitals, etc. This is presently exemplified by the Section 222 projects. Also, there are presently vehicles available under Public Law 93-641 to promote the examination of available services and linking those services, as well as developing new ones.

QUALITY ASSURANCE

There are three standard setting programs that relate to home health services for those facilities that wish to voluntarily avail themselves of them. They are the Approval Program of the National Council of Homemaker Home Health Aides, the Accreditation Program of the National League of Nursing, in conjunction with the American Public Health Association, and, in the case of Hospital Based Home Care Programs, the Joint Commission on Accreditation of Hospitals. Beyond these, there are of course, programs that relate to individual disciplines that function within the home health agency.

It should be noted that institutional licensure in and of itself does not necessarily promote quality. What it does allow is the means to revoke a license and therefore prevent an agency or institution from continuing in the provider role.

At this time, it seems appropriate to mention that as a hospital receives deemed status for the Medicare program it should follow, and it is long overdue, that a hospital-based home care program in a JCAH-accreditated hospital, should also receive deemed status by virtue of the hospital's accreditation. There should be incentives that would promote agency/institutional relationships to the various voluntary standard programs that are already in place.

Presently, there are indices available, as were listed, that relate to quality, and these voluntary methods should be supported, encouraged, and not displaced by the government.

The most effective way of dealing with fraud and abuse is by having a standard program in effect and allowing reimbursement to flow only to those services that meet the standards. It must be realized that there are two areas for fraud and abuse—one financing and the other in "program." Methods if appropriately applied exist now to deal with both. To overregulate the majority of home health providers to punish the few who are abusing service delivery and reimbursement mechanisms would be harmful to the continuation of service on the part of the providers, to the patients who need to receive the services, and to the future growth of this method of organizing and delivering services. Present tools should be utilized. Voluntary standards should be enforced. Additional regulation that

limits those who are providing a high quality of service and meet standards should not be promulgated. Those services should not face additional controls.

REIMBURSEMENT

The methodology for reimbursement must allow for the total recovery of costs. The program itself should determine the question of per diem or per visit as the unit of charge. The kind of program that the agency/institution operates. the kind of services it provides will have an appropriate methodology for charging, be it per diem or per visit. As we said and firmly believe, the program itself should be allowed to determine its unit of charge. What the government must ensure is that all costs incurred by an accredited program, which would have a quality review mechanism as part of that accreditation, are allowable for reimbursement under its various programs. At this time we also would like to reinforce the comments we made to the Council on Wage and Price Stability on July 20, 1976, in Chicago, concerning reimbursement: "The Medicare and Medicaid programs consist of the purchase by the government for services rendered patients entitled to benefits under these programs. In fact, non-government purchasers of care many times are forced to subsidize these government programs because Medicare and Medicaid often pay less than the full cost of the care provided . . . We continue to emphasize that the government payment programs are not "subsidy" programs, but in fact are insurance programs being subsidized by other insurance companies and private paying patients."

In terms of authorization for reimbursement, the agency/institution has the responsibility for seeing that the patient care plan is followed. In conjunction with that, an agency/institution that meets standards should have the ability to authorize services that are in keeping with their professionally developed patient care plan. The appropriateness of this is controlled through a quality assurance program in relation to the applied standards.

The American Hospital Association sees the efforts on the discussion of these HEW suggested topics relating to home health as the beginning of further development and refinement toward joint solutions with regard to the developing, financing, quality, and availability of home health services. We look forward to future opportunities for an interchange on these vital issues.

POLICY STATEMENT: FINANCING OF HOME HEALTH CARE SERVICES

This policy statement was developed by the AHA Council on Financing and a task force of the Committee on Home Care of the AHA Council on Professional Services. It was approved by the AHA Board of Trustees on February 1, 1975. The purpose of the statement is to establish the principles upon which plans and programs for home care can be developed and financed. The statement can be used with the AHA publications Health Service in the Home: Definition and Position Statement and The Hospital and the Home Care Program.

(1) Development and growth of home health care services should be based on community planning for such services. Inappropriate duplication of services should be avoided. Hospitals should take the initiative in establishing appropriate and effective linkages among hospitals and other community home health care providers.

(2) The community is entitled to have high-quality care at all three levels of home health care: intensive, intermediate, and minimal.[1] The level of care a patient at home needs is dependent upon the degree of medical, nursing, and other paramedical management he requires. It should be recognized that personal care services are common to all levels of home health care.

Utilization controls are necessary to ensure that patients move appropriately between and within programs to the level of care needed at the time. All home health care providers should not necessarily provide all three levels of home health services.

(3) The benefit structure of health insurance programs should support delivery and financing of the needed continuum of care, including home health care services, with recognition that the patient's needs for care may change during the course of his illness.

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[1] For a description of the three levels, see pp. 5–6 of *The Hospital and the Home Care Program,* published by the American Hospital Association, Chicago, in 1973.

(4) Home health care providers should recover their full financial requirements, including those attributable to start-up, development, growth, research, and education.

Until home health care services are fully recognized as an integral part of the continuation of care, payment from patients, contracting agencies, and other agencies, and other sources may not be sufficient to cover full financial requirements of home health care agencies. In that event, temporary subsidy from public funds may be necessary.

(5) There must be a standards and quality assurance process for determining the quality of services rendered by home health care providers. Nationally recognized professional organizations must have the responsibility for developing such standards, and there must be implementation of these standards through accreditation and certification processes. This responsibility is separate from the functions of reviewing costs of care and determining rates of payment.

(6) It is the responsibility of home health care providers to document the need for home health care services for individual patients, and this responsibility should be recognized by all payers. Review with respect to payment is governed by the establishment of effective and acceptable utilization controls.

(7) Standardization of the definitions of direct and indirect costs, appropriate allocation of these costs, and reporting of statistics and financial data are essential for proper disclosure of provider activities and of services provided and for determination of costs and of growth and development requirements.

(8) Administrative and service records should not place an unnecessary burden on administrative personnel or other staff. All documentation should serve multiple purposes whenever practicable.

Statement: Role and Responsibility of Hospitals in Home Care

This statement was developed by the Committee on Home and Ambulatory Care of the former American Hospital Association Council on Long-Term Care to define home care and to present the role and responsibilities of hospitals in home care programs. The statement was approved by the AHA Board of Trustees in 1964 and became the S15 leaflet, which was revised in 1972. The S15 leaflet is superseded by this statement.

The American Hospital Association and its member hospitals recognize home care as an element of continuing care and as an essential component of comprehensive patient care. They accept their responsibility to foster the availability of home care services of high quality. This responsibility must be fulfilled at the community level and requires the active participation of the Association's member hospitals.

The goal of the Association is to assure each patient adequate care at a cost that the patient and community can afford. For certain patients in certain situations home care is the mode of care that best attains this goal.

Hospitals have long accepted the responsibility to try new approaches to care and to seek methods of controlling costs, but their attention has focused primarily on inhospital services. Home care is an added dimension of health service that has its own intrinsic merit. For certain selected patients home care is more appropriate than hospitalization, and it releases an acute hospital bed for a patient who may have greater need for it. Home care should be put into wider use and its further development encouraged.

Definition of Home Care

In its broadest sense, home care is the provision of health care and supportive services to the sick or disabled person in his place of residence. It may be provided in a wide range of patterns of organization and service. At one end of the range is the simplest form, nursing service. At the other end is the coordinated home care program, which fulfills the concept of comprehensive patient care.

The generally accepted goal of a coordinated home care program is to provide selected patients who do not require all the facilities of a hospital, but otherwise would have to be in a hospital or other institution, with a range of medical, nursing, dietary, social, and rehabilitative services in their own home, the services coordinated through one central administration.

The coordinated program is the ideal. In many communities, it is a practical ultimate objective for programs that begin modestly. In others, particularly in small communities or in large areas with a low population density, the practical objective must remain more limited. The essential requirements for all home care programs, whatever their organization or scope, are high quality of service and proper selection of patients.

SELECTION OF PATIENTS

Successful operation of a home care program demands selection of patients in accordance with their needs and the availability of services. Today it is recognized that home care services are applicable to patients within all categories of illness and disability, including the acutely ill, the convalescent, the long-term ill, and the chronically ill. This recognition has come about as a result of experimental programs that have been extended to include all these kinds of patients. Home care is equally applicable to all ages, infants to the aged, and to all socioeconomic levels. However, because home care services are intermittent, the home situation and family relationships must be capable of supporting the home care program to make it work.

Home care can work for short-term convalescent patients recovering from acute illness, the homebound chronically ill, those who usually receive treatment on an outpatient basis but are temporarily unable to do so, and certain patients with terminal illnesses. For the patient who needs a program of rehabilitation, home care may be superior to inpatient care if the home is suitable and if he does not need continuous nursing attention or use of equipment that cannot practicably be provided outside the hospital.

For the patient with a long-term or chronic illness, medical care becomes a way of life and all too often results in his institutionalization. Although the home is not appropriate for all chronically ill patients in all stages of illness, often it can provide a desirable setting for far more patients that at present. Home care need not be elaborate in order to meet the requirements of thousands of patients now receiving care in hospitals or chronic disease facilities.

THE HOSPITAL'S ROLE

Whether the hospital or another community agency provides the administrative structure, the hospital has a key role to play in stimulating development of home care, in fact finding to determine extent of need, in identifying the desirable and appropriate scope of service, and in helping to secure stable financing.

Another basic function of the hospital is to develop and maintain an effective mechanism for identification of patients potentially suitable for home care and for their prompt referral to the program. Involvement of at least the medical and nursing staff is necessary for succesful performance of this function. Suitability for home care should not be related to the patient's financial condition: many patients who can pay for the service either are unaware of the service or are denied access to home care.

The hospital must also back up the home care program by ensuring that the patient will be admitted immediately or readmitted to the hospital if a change in his condition requires hospitalization. The fear on the part of patient, family, and physician that the patient will need hospital care but will not receive it promptly is an important psychological barrier to their acceptance of home care. Technical services and equipment usually available only in hospitals should be made available to the patient, either by bringing him to the hospital or by taking them to the home.

When the hospital is the administrative agency for the home care program, its role includes direct provision of professional and related services to the patient at home. Nursing, social service, physical therapy, occupational therapy, and, in some programs, physician service are among these. As the coordinating organization, the hospital seeks the participation of other community agencies in planning, staffing, and financing.

THE HOSPITAL'S RESPONSIBILITIES

The responsibilities of the hospital vary in relation to its degree of involvement in the administration of the home care program. Whatever the auspices or

administrative structure of the program, the hospital must ensure that the program is patient-centered. This requires close cooperation and coordination among the several health care and related services that may be called upon to share in this responsibility.

The hospital has a basic responsibility to the community to ensure that services are of acceptable quality, used efficiently, and available to patients who can pay for the service as well as to those who cannot.

When the hospital administers the program directly, its responsibility for the quality of all services, including those supplied by other agencies, and for their proper use is necessarily greater because it is directly accountable for all aspects of the program. As the administrative agency, it must recruit competent personnel and provide for their orientation, training, and supervision. It must work with all funding agencies to effect adequate financing; maintain records—administrative, financial, and medical; and establish and maintain effective communication with other community agencies, both those that participate directly and those that have an interest in all services to the community.

As part of its discharge planning function, the hospital should identify and refer patients who are suitable for home care. A plan for home care after the the patient is discharged should be an integral part of the continuing care plan for the patient.

CONCLUSION

No longer can a hospital's service program be defined in terms of inpatient care alone. The hospital must assume its proper responsibility to ensure a continuum of preventive, acute, rehabilitative, and long-term care to the patient, wherever he may be. The extension of hospital service to the patient in his home is both desirable and feasible when his needs can be met there and the home is suitable.

Home care programs are desirable primarily for the benefit of patients. They advance the goal of adequate care at the right time, at the right place, and at the most economical cost. In addition, the hospital itself benefits from participating in a program that extends services beyond its own walls. Its inpatient beds are utilized more efficiently, and in some instances addition of beds can be avoided. Furthermore, the home care program provides concrete evidence that the hospital is moving toward a broader concept of its role as a health and social agency in the community. Not only is it concerned with the patient's care as an inpatient but with his care after he leaves the hospital.

The hospital is concerned with the health of the community as a whole.

ITEM 8. STATEMENT OF THE NATIONAL COUNCIL OF HEALTH CARE SERVICES, WASHINGTON, D.C.

The National Council of Health Care Services is pleased to offer its comments on the issue of Alternatives to Institutionalization, as addressed by your Committee during hearings held on May 16–17, 1977. In view of the broad scope of services which may be classified as alternatives and which are offered by National Council members, this is a question which very much concerns us.

The National Council is a non-profit association representing proprietary multifacility nursing home firms owning and/or managing more than 80,000 beds in long term care facilities throughout the country. Members of the National Council are also involved in other health related services such as hospitals, psychiatric facilities, home health services and day care centers. As a condition of membership, the National Council's nursing home facilities are required to be accredited or accreditable by the Joint Commission on Accreditation of Hospitals Long Term Care Council, in addition to meeting State and Federal licensure and certification requirements.

When considering the adequacy of health care services to our nation's elderly and our future needs, we should keep in mind that the number of elderly as a percentage of our total population is increasing rapidly. By the year 2000, the over-50 age group will comprise more than 50 percent of our population; the over-65 group will have increased by 45 percent; the 75–84 age group by 65 percent; and the over-85 age group by 52 percent.

These statistics can be viewed as positive evidence of the progressively healthy status of our population. However, we should not be lulled into complacency,

for as the number of eligible beneficiaries increases to these projected levels, the burden and cost to our health care system will become correspondingly more difficult to support. At present long term care facilities which offer skilled and intermediate nursing care are operating at capacity with greater than 90 percent occupancy, and many have waiting lists. Obviously to provide health care to the expanding population of elderly, will require not only more long term care beds, but some innovative alternative approaches as well. In this regard, the National Council commends your Committee for its efforts to explore the area of alternatives to institutionalization and new initiatives in the provision of health services to our elderly.

The National Council firmly believes that there is a place for both institutional and non-institutional care in the continuum of health care services provided to our elderly and disabled. There are, however, some very serious problems inherent in this system, which should be considered in the near future and hopefully corrected prior to any great initiatives for expansion of health services or enactment of national health insurance legislation. As the momentum increases within the Administration and Congress for a national health insurance program, it becomes even more imperative that these issues be addressed immediately so that the problems and deficiencies will not be exacerbated.

These problems and deficiencies in the long term institutional setting were addressed in a report which we recently submitted to your Committee.[1] In addition to identifying the significant problem areas relative to long term institutional care, we attempted to provide some solutions. In our comments which follow in this statement, we would like to follow the same procedure for non-institutional health services.

MISCONCEPTIONS REGARDING INSTITUTIONAL VERSUS NON-INSTITUTIONAL SERVICES

Many people have great expectations for non-institutional health services, but the expectations are based on misconceptions regarding the services themselves. These people will be sadly disappointed that their expectations have not been met when the services become more readily available through the easing of eligibility criteria or increased funding.

A recent article in the New England Journal of Medicine cited a review of 7,700 skilled patients in Massachusetts during 1975, in which the Periodic Medical Review team found that 82 percent of the patients were appropriately placed.[2]

This means that 18 percent of the patients could possibly be more appropriately cared for at a lower level or at home, but this again is an oversimplification of the problem.

While there are unquestionably patients in nursing homes whose needs might be more appropriately met by a greater availability of non-institutional services, we believe the number is nowhere near some exaggerated estimates, and the above cited article seems to bear this out.

Even if services were expanded, a significant portion of the patients would be unable to utilize them because there is no healthy and strong family member to assist full time in caring for them. This factor is not even considered when the virtues of alternative health services are being extolled.

This brings us to the second misconception, namely that alternative services will be cheaper. It may well be that one home health or physical therapy visit will be less expensive when compared with nursing home care, but this is an oversimplified comparison. If one is going to compare costs it is important to compare apples with apples. One day in a nursing home typically costs $20–30 and this includes room, three meals a day and 24 hour nursing supervision. In his own home, the patient may require the assistance of a nurse or aide, meal preparation and homemaker services.

Thus, if the full costs of at home care are calculated, the total in many cases will equal or exceed the cost of nursing home care. The National Council feels strongly that alternative services should be expanded and be made available as a benefit to the elderly and disabled. However, this action should not be taken

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[1] "Comments on the National Council of Health Care Services regarding 'Nursing home Care in the U.S.: Failure in Public Policy; Seven Reports by the Special Committee on Aging.'"

[2] Periodic Medical Review: Assessing the Quality and Appropriateness of Care in Skilled Nursing Facilities; Connellly, Kathleen; Cohen, Philip K.; Walsh, Diana Chapman; New England Journal of Medicine; Apr. 14, 1977, vol. 296, No. 15.

with the expectation of saving program dollars, but rather to provide an alternative to institutionalization which is more appropriate to the patient's needs.

Those who delude themselves into thinking that a significant cost savings will be realized by expanding noninstitutional services and by increasing benefits, will be seriously disappointed. In truth what will occur is an expansion of the population served with more benefits being delivered to more individuals.

PATIENT ASSESSMENT

Our concern for the appropriateness of a given service illustrates the need for a comprehensive patient assessment methodology which could be utilized for every patient in need of long term health care services. If such a system were in effect upon a patient's discharge from a hospital or prior to his utilization of a service, the question of inappropriate utilization would not loom so large.

A number of members of the National Council of Health Care Services have implemented a system of computerized patent assessment which was designed by National Health Corporation of Murfreesboro, Tennessee. The system is presently being used in 38 facilities in 12 states and has yielded over the past two years valuable data on over 4,000 nursing home patients, their condition, medical and health care treatment programs and progress.

Each patient is assessed on a monthly basis or sooner if there is a change in his physical condition and the information generated is such that an inappropriately placed patient is easily identified.

We believe that an increased emphasis on such patient assessment review methodologies would do much to dispel the fears and criticisms of many individuals regarding nursing homes and the appropriate or inappropriate utilization of services. Patient assessment would also do much to improve the quality of patient care in the homes themselves as well as serving as a useful tool for PSROs and State agencies.

BARRIERS TO NON-INSTITUTIONAL SERVICES

As stated earlier, the National Council of Health Care Services is strongly in favor of expanding benefits and availability of non-institutional health care services. We would urge the elimination of many artificial barriers which have been established, such as the requirement for Medicare for a prior 3-day hospitalization in order for a beneficiary to be eligible for Medicare home health benefits. This same restriction is also imposed in order to be eligible for skilled nursing benefits and it is just as illogical and cost inflating.

The Social Security Administration has recently asked for proposals to study the effects of eliminating the 3-day hospital stay requirement, and the results should be quite interesting. We would endorse similar studies of the cost effectiveness of many other regulations as well.

The National Council recommends further the elimination of restrictions placed on participation by proprietary firms in the provision of health care services. Such restrictions tend to be based on emotional issues rather than fact. Any excesses or profiteering which occurred in the past would likely not have taken place were appropriate and effective control mechanisms in place. We believe that there exists within HEW and the industry the level of sophistication required to effect such systems of accountability and that we should not have to wait for Congress to legislate Commissions or regulatory bodies to oversee the delivery of health care.

THE NURSING HOME AS A RESOURCE

Nursing homes offer a unique resource which is readily available for the provision of various outpatient services for the elderly and disabled. These services could include meals on wheels, home health visits, rehabilitation therapists and ambulatory nursing and medical care. The facility could also serve as a patient day care center for those individuals who live at home or with their children and who need to be cared for during the day. Again various program restrictions inhibit the maximization of all the potential resources in the nursing home and necessitate the setting up of separate and more costly operations. The facility may not be used as a base for providing such out-patient services and there seems to be no logical reason for the restriction.

There are a number of advantages to using a nursing home as a base for outreach type programs: start up costs are minimal, personnel and resources are

readily available, various employees (therapists and medical directors) may be utilized on a full-time rather than on a consultant basis, and importantly, the nursing home patients benefit from the addition of ancillary personnel, services and exposure to new faces.

The National Council urges Congress to consider easing these various restrictions so that all might benefit. As we stated in our report to your Committee: "Not only should the community become involved in the nursing home, the home should itself be thought of as a resource for the community's related health needs." [1]

CONGREGATE HOUSING

We believe there is a great need for the type of residential housing arrangement for the elderly, as outlined by Ruth Breslow in her statement before your Committee. This need is largely unmet and the situation will only grow more desperate as our aged population increases.

The elderly today are forced to go to "rest homes" which are unlicensed and have no federal standards to meet. It is ironic that nursing homes are inundated by state and federal regulations and are subject to numerous detailed surveys, yet rest home conditions are completely ignored by Congress and HEW. Many of the residents of these homes become hospitalized due to malnutrition or neglect, which are totally preventable illnesses.

The National Council favors demonstration projects of congregate housing for the elderly. In addition to individual living units, the ideal building should have a central dining room with at least one full course meal offered daily, an activities area with full time staff and planned programs for the elderly. This type of arrangement would provide a logical solution to the many elderly who are able to manage on their own with the assistance of only a few supportive services. In addition, the inclusion of recreational activities and meal services should prevent the occurrence of two of the most common problems of the elderly living alone: loneliness and malnutrition.

The National Council of Health Care Services believes such innovative type programs as we have outlined, congregate housing, day care in nursing homes, etc., are greatly needed if we are to begin to cope with the many needs of our elderly. We urge your Committee to consider ways of making such services more readily available, and exploring methodologies for assuring the appropriate utilization of those services.

ITEM 9. STATEMENT OF THE NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES

The National Federation of Licensed Practical Nurses would like to thank the Senate Special Committee on Aging for the opportunity to express our views as to the need for seeking alternatives to institutional care and to examine some of those alternatives.

The Natioanl Federation of Licensed Practical Nurses is the professional association of Licensed Practical Nurses which seeks to foster high standards in nursing care. Presently, Licensed Practical Nurses are the second largest group of health providers in the United States. There are approximately 600,000 Licensed Practical Nurses throughout the country who are an integral part of the health care team. LPN's play a vital role in the delivery of health care services and perhaps are the most uniquely qualified to provide comprehensive and quality health care outside of institutions because they have many health skills which can be provided at a relatively low cost.

The alternatives to institutional care was discussed with some fervor during the White House Conference on Aging in 1971. Since that time, much discussion has ensued and pilot programs appeared throughout the country. This is part of a major effort to find the best kind of health care for those in need of health services.

One alternative which is proving itself to be the most feasible is home health care. While several initial programs show great promise there are still many obstacles to overcome before it can be said that we have the best possible kind of policies and programs available for those who, for a varied number of reasons, need and seek home health care as a viable alternative to institutional care.

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[1] Ibid.

For years now, LPN's have played a major role in delivery of health care services especially in a home health care setting. Their professional position within the health care delivery team makes LPN's uniquely qualified to fill the gap between the professional registered nurse and the nurse's aide. Not only can a LPN provide much of the same skilled care as a registered nurse but the LPN can do it at a cost which is approximately 30 per cent lower. For example, present costs for a visit by a registered nurse is approximately $13.50 while a nurses' aide receives $7.25 per visit. A LPN has many of the same skills as an R.N. but would receive only $10 per visit. It is the LPN who millions of American turn to to find help when R.N. services are not needed or too costly and when the educational preparation and skills of nurse's aides or homemakers are inadequate.

However, present medicaid and medicare policies are too restrictive and prevent the utilization of many health providers including LPN's. Only in recent months has the Congress recognized the need for a more multi-level and multi-disciplined utilization approach which would use the skills of RN's, LPN's and physician extenders. For sometime now, health providers such as RN's and LPN's have recognized the need to broaden the medicare and medicaid system to include provision in the Social Security Act which would permit reimbursement for services provided by LPN's and RN's.

One such bill, S. 310, introduced by Senator Matsunaga of Hawaii and its companion bill in the House, HR 2851, introduced by Congressman Pepper, would permit LPN's to be reimbursed for services provided to medicare and medicaid patients under Social Security. This concept is particularly important because it has the potential of bringing quality health care to millions of Americans who could otherwise not afford nursing services.

Besides the dramatic numbers of new individuals who would become eligible for such services the federal government could provide this care at a lower cost than it is now doing. LPN's can provide the needed services for which they have been educationally prepared at a lower rate than a physician or a registered nurse. As was pointed out to this Committee earlier by Dr. Constance Friess, LPN's are needed to monitor medications, and diets as well as provide some rehabilitation following fractures, taking temperatures, blood pressures, dressing wounds, etc . . . The only limitations this alternative in home health care has is the educational preparation of the provider.

Also, the distinct advantage of rendering health care in the familiar surroundings of a patient's home, is far better than the stigma of being "put away" in a long-term care facility. Likewise, with fewer people in nursing homes the possibility of abuses and fraud committed by unscrupulous owners will be reduced.

Under the present system of alternatives to institutional care and under the present system of institutional care we find many problems:

(1) Patients are not receiving the kind of care they need. Almost 80 percent of all home health care is given by the family which has neither the skill or experience in health care delivery.

(2) Many senior citizen service centers established under Title XX are inadequate because of the long waiting list of clients who seek their services.

(3) The cost of keeping patients in either nursing homes or hospitals is staggering. Neither the patient nor the government care afford extended stays. For example, it is estimated that less than 5 percent of nursing home patients are medicare patients. Likewise, intermediate care facilities provide the same obstacles for patients.

(4) Present alternatives are too strictly limited. Often a senior citizen will go into a hospital earlier than necessary or stay longer than necessary because he can not receive the level of care he needs at an affordable rate.

(5) Present Medicare and Medicaid regulations prohibit and discourage alternatives to institutional care because of its "skilled" nursing requirement; the restrictions on the type of home health care benefits and the prior hospitalization requirement.

Rendering competent home health care would go a long way in providing care for the estimated 800,000–1.4 million disabled Americans of all ages who are in need of some form of long-term care but for one reason or another do not have access to the delivery system. Likewise, it has been pointed out that between 20 and 40 percent of those in a nursing home would not be there if there was other types of care available.

Clearly, if the present system were expanded to include all professionals and paraprofessionals who are educationally prepared to work in home health

setting the effectiveness of these kinds of programs will substantially increase. If LPN's were permitted reimbursement for services rendered under the Medicare and Medicaid provisions of the Social Security Act Americans would have a more flexible, comprehensive and less costly health care system which would provide greater emphasis on preventive care, greater access to the health care delivery system, and provide services in a familiar surrounding where family and friends are near.

In conclusion Mr. Chairman, we see a need for greater utilization of health care providers who have been educationally prepared to render health services in home settings and who can do it at the lowest possible cost. We join with you in exploring as many alternatives as possible in seeking to find the most suitable health care environment for our older Americans. Whether we are treating the chronically ill, the disabled, the sick or providing preventive health care, health professionals must remember that no system is perfect at its inception and should be subject to constant scrutiny and revision before it functions at its optimum level. For this reason, we must make every effort to approach each problem with an open mind, seek as much technical advice from as wide a group of people as is possible and to begin to create a health system that is of the highest quality. You and your committee are to be commended for your leadership in this area and we want to assure you that the National Federation of Licensed Practical Nurses stands ready to assist in any way.

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