HEALTH CARE FOR OLDER AMERICANS: THE "ALTERNATIVES" ISSUE

HEARING

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SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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PART 5—WASHINGTON, D.C.

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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.
Part 6. Holyoke, Mass., October 12, 1977.
Part 7. Tallahassee, Fla., November 23, 1977.
(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

HEALTH CARE FOR OLDER AMERICANS: THE "ALTERNATIVES" ISSUE

WEDNESDAY, SEPTEMBER 21, 1977

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

The committee met, pursuant to call, at 9:40 a.m., in room 1224, Dirksen Senate Office Building, Hon. Lawton Chiles presiding.

Present: Senators Chiles and DeConcini.

Also present: William E. Oriol, staff director; Kathleen M. Deignan, professional staff member; Margaret S. Fayé, David A. Rust, and Tony Arroyos, minority professional staff members; Patricia G. Oriol, chief clerk; Marjorie J. Finney and Theresa M. Forster, assistant clerks; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR LAWTON CHILES, PRESIDING

Senator CHILES. This morning the committee will continue its hearing on "Health Care for Older Americans: The 'Alternatives' Issue."

We have already conducted four hearings on this subject. We have heard impressive testimony about: the inability of current medicare long-term care policy to meet real differences in the needs of our elderly population; the importance of expanding long-term care options and bringing them all together into a comprehensive system; and the problems faced by many struggling to develop these "alternatives" without a national policy.

Today, we hope to pull together the information obtained from medicare cost-savings experiments authorized under section 222 of the Social Security Amendments of 1972, concerning alternative long-term care services. We are particularly interested in demonstrations to measure the effectiveness of homemaker services and intermediate care facilities as alternatives to the current posthospital medicare benefits. Our hearing will also examine an experimental program to provide day care and day hospital services for medicare and medicaid beneficiaries.

Many of these programs have completed their research and demonstration phase. We are pleased to have with us today representatives from three of these programs to present an interim report to the committee.

I hope their testimony will help to answer questions about the value of homemaker and day services to improve living conditions for thousands of the frail elderly.

We are also very interested in your cost projections for expanding medicare to include these services. The cost issue has confounded our attempts to move forward in this area for too long.

The committee has been presented with evidence that in-home health and social services, as well as those on an outpatient basis, are much less costly for elderly patients than the most prevalent alternatives—hospitalization and nursing home care. However, some authorities have challenged the methods employed to measure the costs of these alternative services.

The section 222 demonstration projects were specifically charged with examining this question of cost, and we hope that today's testimony will make an important contribution to this information gap. We need to know more to develop legislation for the broad range of long-term care options which we know are essential to an acceptable quality of life for ever-increasing numbers of frail elderly.

Mr. Robert Derzon, Administrator of the Health Care Financing Administration, is appearing before the committee today for a second time. During a hearing in June, he cited these experiments as the all-important "missing link" in the Department's information on long-term care alternatives. We are happy to have him with us again today to take part in this hearing and to discuss what our next steps should be.

We are also glad to have Dr. Joyce Lashof, the Deputy Assistant Secretary for Health Programs. The Public Health Service, I understand, maintains overall responsibility for these programs. But, I am still uncertain as to who will be responsible for evaluating these programs and for developing recommendations based on their results.

Consequently, I am very interested in hearing from Mr. Derzon and Dr. Lashof concerning what progress has been made during the last 3 months in assigning responsibility for long-term care program alternatives within HEW. Mr. Derzon agreed with me 3 months ago that long-term issues should receive top priority in the new administration. It appeared at that time, though, that responsibility was split between the Health Care Financing Administration and the Public Health Service. I'd like to raise this question again, and I'm glad that we have representatives from both these offices here today.

I think we have the ingredients for a good working session. I'm confident it will produce the kind of information we need to move ahead prudently.

Dr. Lashof, I understand you have a prepared statement to make.

Mr. Derzon, do you have an opening statement?

Mr. DERZON. No, sir. In conversations with your staff, we agreed that my last statement came relatively recently and, therefore, this time around we are going to have Dr. Lashof, who is representing Dr. Richmond, present a statement for the Public Health Service.

Dr. Lashof is the chief deputy to Dr. Richmond.

Senator CHILES. Doctor.

STATEMENT OF JOYCE C. LASHOF, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH PROGRAMS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. LASHOF. Thank you very much, Senator.

I am delighted to appear today before this committee, which has long provided leadership in focusing national attention on the needs and concerns of older persons in America. We who are new at the

Department of Health, Education, and Welfare are benefiting from your years of research, investigation, and probing of difficult problems in aging—problems which I believe have not yet been adequately grappled with in our society as a whole.

The high costs of long-term illness and disability, unnecessary institutionalization, and inappropriate utilization of our health resources raise challenges both to policymakers and practitioners. I believe that your continued hearings and the information generated by your committee on the alternatives issue will be extremely useful as the administration begins to recommend major changes in our national health policies.

I believe that the testimony presented in June covered a broad spectrum of various funding authorities and programs within the Public Health Service and the Department as a whole. Therefore, I will focus my testimony only on your specific concerns relating to our long-term care research and demonstration effort.

SECTION 222 RESEARCH

Specifically, I will first discuss the section 222 research. At the outset, I want to emphasize that we share your concern regarding the importance of the experiments and demonstrations being conducted under the authority of section 222 of the 1972 amendments to the Social Security Act. Congress authorized these experiments to provide valuable information prior to long-range policy decisions both in alternative means of reimbursement to hospitals as well as alternatives to institutional care, such as day care, day hospitalization, and homemaker services. We are only now beginning to receive and evaluate the beginning of essential information on the findings of these experiments. Such data are crucial as we start to grapple with national health insurance and future planning of the health service delivery system in this country.

Over the past decades, people with chronic health conditions have turned increasingly to health care providers for assistance with their diverse health and social problems. The health sector, unfortunately, is organized for the most part to deal with discrete health problems. For people requiring prolonged multiple health services—and the elderly are an important segment within this group—medical care is being provided in a fragmented, inadequate, and impersonal manner.

Despite the fact that we all recognize the need to improve the services in this area, there is no consensus on what course of action to take. Nevertheless, these research activities will hopefully provide some new alternatives for public policy.

We emphasize that research in this area, like any demonstration effort which involves offering services on a research basis to needy persons, is difficult. However, there has been good cooperation among agencies within our Department. Our demonstration contractors have been extremely dedicated to this study and generously have given extra efforts to alter procedures and assume additional tasks as needs arose.

This research certainly will not provide responses to all of the complex and difficult questions we wish answered in our discussion of the long-term alternatives issue. We should, however, greatly advance our knowledge of adult day care and homemaker services.

Under the authorization provided in section 222 of the 1972 amendments to the Social Security Act, we initiated six contracts [1] in June 1974—two day care, two homemaker, and two combination day care and homemaker. A seventh contract was let to a research consulting firm which collected research data from the demonstration contractors. The methodology development, OMB clearance of forms and instruments, setting up community networks for referral of patients, et cetera, took several months; the first patients began receiving care during May 1975.

Admissions continued through March 31, 1976, to get population numbers up to study group size plans; services were then provided to patients for 1 year from their individual start dates. The last of the demonstration services were delivered March 31 of this year. Most data are now in from the individual demonstration contractors. Still to come are some bills from individual physicians who provided services outside the demonstration. We expect to have virtually all data by December 31, 1977. Nevertheless, the preliminary data presented today, although subject to revision, should give you some flavor of what we can expect.

Altogether, approximately 1,800 patients were involved in these demonstrations. Patients in each of these projects were assigned on a random basis to a control group and a group which received expanded benefits not previously available. These new benefits were provided over a 12-month period. They included day care and homemaker services not typically covered by Federal programs.

The day care services consisted of both basic and ancillary services. The basic services included transportation to and from home, general-care nursing, social services, meals, and nutritional counseling; the ancillary services for this group included physical, occupational, and speech therapy, and special examinations for and attention to problems with sight and hearing.

To be eligible for the homemaker services, an individual must have been hospitalized within the 14 days preceding enrollment in the program. Prior hospitalization was required for only one of the day care demonstrations.

The demonstrations provide data on the impact of these expanded benefits on the physical status of the participants, their general well-being, the costs of providing these extraordinary services, and the patterns of utilization of these services. This experiment will for the first time provide data that can be used to analyze the impact of these programs with regard to use, cost, and, hopefully, consequence.

Roughly two-thirds of the study population were female, 20 percent were nonwhites, and one-half lived alone. Overall, one-third of the group was handicapped in a manner that limited or interfered with the activities of daily living. Those patients included in the day-care group relative to those in the homemaker demonstration were somewhat more limited in their ability to carry on the activities of daily living, were more likely to have someone else living with them, and had lower rates of hospitalization prior to participating in the experiment. In contrast

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[1] See part 3, appendix 1, item 4, p. 311.

to the medicare over-65 population, the study group was somewhat older, had a higher number of females, was somewhat poorer, was more disabled, and had a greater concern over their general level of well-being.

USE OF SERVICES

The use of the day care and homemaker services provided in these demonstrations varied considerably by site and by characteristics of the individual patient. Overall, about two-thirds of those who were offered the new services made use of the benefits. This finding is obviously important and needs to be examined in more detail in our analysis of the data. A greater percentage of the males and of the nonwhites took advantage of the availability of the day care services. The opposite was true for the homemaker services. In this instance, more females than males and more whites than nonwhites used these services. With regard to the intensity or amount of use, whites on the average appear to use more of the day care services than nonwhites.

Differences among sites greatly affect utilization rates, making it difficult to determine the effects of particular patient characteristics on utilization. The average days of care provided varies from 30 to 100 across the several demonstrations. This pattern of variation in utilization also prevailed in the homemaker demonstrations. The average number of hours per patient of homemaker service that was used varied from 30 to 400.

The data on the overall utilization of the benefits are incomplete at this time. Nevertheless, the results now available are at least suggestive. It would appear that use of day care and homemaker services results in lowering use of and charges for traditional services such as outpatient department and physician visits. However, this reduction is more than offset by charges for the new services. Once again, I emphasize to you the preliminary nature of these findings and the fact that our evaluative analysis is just beginning.

With regard to the important issue of provider service costs, the findings at this time are tentative because of the incompleteness of the data. For the homemaker services, provider costs per service-hour ranged from $4.82 to $17.23. Visits ranged from 1 to 4 or more hours. The cost per visit ranged from $13.96 to $30.47. With regard to day care, the cost per patient-day ranged from $18.66 to $76.31.

While I feel it is important to provide this committee with these preliminary figures, I believe it is also important to note that they cannot be interpreted until the costs are related to the service components, the intensity of the services provided, and the degree of patient impairment. These factors will obviously affect the costs of particular providers in different ways.

The intensive analysis that will be required to make this information useful to the Congress and to the Department will be undertaken by the intramural staff of the National Center for Health Services Research. It is anticipated that by summer 1978 the Center will be able to provide this committee with a more detailed analysis of the service costs and estimates of the overall program costs should these benefits be provided to the population generally.

It is important to note that previous research supported by the National Center for Health Services Research found that adult day care is cheaper on a period-of-care basis than nursing home care, despite the fact that day care costs more per day than nursing homes. This remains true even when rent, food, clothing, transportation, and other expenses of living at home are added to the cost of day care. The reason is that day care is attended only part time, 2 to 5 days per week, while nursing home care is provided round the clock, 7 days a week.

The 1975 comparative study of 10 adult day care centers funded by the National Center for Health Services Research contrasted with published data for nursing homes and showed that the third-party payer could save between 37 and 60 percent of the cost of nursing home care if patients could be cared for in adult day care rather than nursing homes. The degree of savings is, of course, dependent on the frequency of day care attendance. When the comparison is made on the basis of total life support costs—day care plus living at home versus full-time nursing home care—the total savings in day care drops to between 12 and 35 percent, again depending upon frequency of attendance.

ACTUAL COSTS SOUGHT

There are a number of issues that can be addressed using the data provided through this demonstration effort. Further analysis of the information should indicate with some degree of reliability the actual cost of providing homemaker and home health aide services. Answers may be forthcoming on the question of whether patients fare as well or better when provided with additional day care or with homemaker services in lieu of nursing home care. We have reason to think that day care, if used as a substitute for inpatient or nursing home care, would be less costly. If this benefit were to be provided, however, in addition to those services currently covered, they would actually increase the overall expenditures for care. It is significant to note that such an increase may be associated with better health and well-being, and that crucial question will also be examined with the data that will be available from this experiment.

More specifically, we should learn the following from this research effort:

One: Which patients benefit from homemaker or day care services, and what kinds of benefits they receive. This will be provided by changes in health and functional status especially, and possibly in differential mortality rates, although 1 year is short for that.

Two: How many patients use day care and homemaker services as an alternative to institutional care and how many use it instead of outpatient visits or physician visits.

Three: What day care and homemaker services would cost if we take the most efficient ways each of the demonstration contractors organized and delivered their service packages and how they might be designed into optimum packages.

If the committee desires, I would like to submit for the record summaries of the individual section 222 projects.[1] I am sure that the testimony of the project directors also appearing before you today will be very informative in providing you with useful information

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[1] See part 3, appendix 1, item 4, p. 311.

and, I suspect, will give you a more dynamic feel in what goes on in the projects than I have been able to give you in this kind of an overview.

OTHER PROMISING RESEARCH

Let me just review a couple of related research projects.

The Triage project developed by the Connecticut State Department of Aging is one such research effort. An experiment with a transportation system for the elderly in New York City being conducted by the Vera Institute of Justice is another. No less important than the studies mentioned above are the studies now underway within the Public Health Service to examine whether and how the chronic illness of a member in a household affects the behavior of other members of the family in such areas as labor force participation, and how poor health and chronic illness affect the economic well-being of the family.

Another effort involves studies of skilled nursing homes and intermediate care facilities. These providers account for the majority of long-term care in this country and the costs of their services are borne largely by taxpayers through medicare and medicaid. We are funding a number of projects that describe the structure and behavior of the nursing home industry, and specifically their response to public regulation and reimbursement policies. Such studies include, for example, examination of the determinants of cost variation among nursing homes, particularly the impact on cost of differing modes of ownership and differing methods of reimbursement. Another study deals with the problem of correlating variations in the kinds of patients served by nursing homes with the differences in the costs of such institutions.

One project looks at the value of specially designed housing which is intended to make it easier for frail and impaired elderly persons to live at home or in a congregate housing facility rather than in institutions. The housing is designed with special aids to ambulation and is free of steps and other barriers to movement. Another study is designed to measure the effects of an emergency alarm and response system on the psychological and social well-being of physically disabled adults and elderly persons living alone.

This committee has had a sustaining commitment to and interest in the home health demonstrations authorized under Public Law 94–63, a program which supports the establishment and initial operation of public and nonprofit private home health agencies that provide home health services in areas where services are otherwise not available. Of the 132 grant applications received for fiscal year 1977, 56 grant applications were approved and, of these, 14 are new or developmental.

The committee is aware that discontinuance of medicare advanced certification posed a special problem to certain of these grantees who are required under the program's grant regulations to be certified by the State agency as in compliance with the conditions of participation prior to using these funds for the provision of patient care services. This situation has been remedied by the Health Care Financing Administration's agreement to grant a waiver of this policy to all grantees receiving awards authorized under Public Law 94–63.

Senator CHILES. We are delighted to see that that has taken place.

This is something that Senator Church and I have been interested in, and I didn't think these demonstrations could continue unless that was done.

EVALUATION OF HOME CARE SERVICES

Dr. **LASHOF.** Because of the committee's interest in evaluation of these health services demonstration projects, I would like to mention one final item. We are now in the concluding stages of negotiating a contract to acquire, process, analyze, and present available service and financial data that provides the basis for decisions regarding the appropriate means of promoting home health service capacity.[1]

Data will be used to assess (1) the impact of the home health grant program on the ability of grant recipients to develop or expand home health services within their service area and to sustain this increased level of service capacity independently after grant moneys have been exhausted, and (2) the relative importance of factors of community health organization and grantee characteristics in the development of home health service capacity. Also, available data will be acquired, processed, and presented regarding the cost per episode of illness.

As the elderly population increases and as more people of all ages with chronic health problems survive longer, public decisionmakers will be under increasing pressure to expand or reorganize long-term care assistance programs. Yet, we are all acutely conscious of the escalation in medicare costs and of the growing economic burden of long-term care. The research program of the Department is designed to examine the two critical aspects of this program—how and where improvements can be made in the current delivery of services and how adequate long-term care services might be provided to those who need them without exhorbitant expenses to those who get them.

I appreciate the opportunity to testify before this committee and I welcome any questions you may have.

Senator **CHILES.** Thank you very much, Doctor. I notice that you say, on page 8, that the answers "may" be forthcoming on whether patients fare as well or better with additional services.

We had hoped that the research was going to tell us whether they would or not. The word "may" kind of frightens me a little bit if we are going to do all this and we don't have the answer.

Dr. **LASHOF.** Well, the fact that the projects were funded only for 1 year is one of the problems and why I think we must say "may." How can you project a long-range policy when you have studied 1,800 people out of a huge population? I am a little cautious about whether, from 1,800 people studied for 1 year, we can draw the far-reaching conclusions that we would like to.

How far we will be able to project that "may" to something stronger will depend upon whether the analysis shows very strong directions or whether it is just slightly better—in which case if you try to project it, you don't know. If it shows something very dramatic, then our ability to project with a firmer answer will be much more

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[1] Subsequent to this hearing, the home health services evaluation project was awarded to the Center for Health Services Research, Medical School of the University of Colorado.

solid. I think we will have to wait, examine the data, and see how consistent it is in all the demonstrations. The specific and dramatic differences will be crucial. If differences are borderline, then it is going to require more data before you get an answer. It is almost impossible to predict these variables before you start the analysis.

Senator CHILES. What can you tell us now about how many patients used day care and homemaker services as an alternative to institutional care or visits to the physician?

STATEMENT OF ROBERT DERZON, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. DERZON. We can provide to you, Senator, figures from the medicare program which maintains very precise data about home care visits paid for under that public program. Also, I think the National Center for Health Statistics provides some overall national figures. However, we cannot give you very good data from the medicaid program—which indeed offers broad coverage of home health services—because many States do not have information systems yet that can provide that kind of data.

We just don't have data to answer that question precisely, or to give you a general figure at this point in time.

Dr. LASHOF. From these demonstration projects, of course, we will have data from the control group and the experimental group with respect to what number in each of those two groups did indeed end up being institutionalized. Again, we may face problems in using that data to project long-range policies. Until we have that data analyzed—and it is not analyzed yet—I cannot tell you how solid it will be, but we will have that data for the 1,800 individuals in our demonstrations.

Senator CHILES. Do you have any indications as to what an efficient service package might be?

Dr. LASHOF. I think it is premature for us to determine that. We keep emphasizing that the data we gave you is preliminary, and that the differences between the six projects greatly affected intensity of use. The kind of detailed analysis we need to undertake includes separating out how much was different in patient characteristics and how much were differences in organization of services. It requires a much more complex analytical process.

I think you have to realize that the demonstrations themselves only completed giving services last spring. The data is now on computer tapes in our office and my testimony represents findings from some of the first ones. We have not yet begun an analysis which looks at complexities of the variables and we do not have all of the data in yet on the physicians.

The contract from the Medicus Corp. was for data correction, not analysis. The analysis is now just really beginning and our intramural staff will be devoting time until next spring or early summer to answer just those kinds of questions you are asking, Senator.

Senator CHILES. But you cannot say that day care is less costly?

Dr. LASHOF. It is dependent on how much day care people have to use. Let me illustrate by saying that if, in order to keep someone out of an institution, a person had to go to a day care setting 7 days a week, then it would not be less costly. By providing 2 or 3 days a week of day care services, the family or other support systems may be able to work and keep the family members at home for the rest of the time.

Senator CHILES. Basically, this data, when you get it completed, is going to tell us whether it has in fact kept people from being full-time institutionalized?

Dr. LASHOF. Well, as I said, what we will have is what people in each control group versus the experimental group did end up in an institution. It will depend very much on how great those numbers are. At this time I cannot project whether we will have sufficient data or not.

COORDINATION WITHIN HEW

Senator CHILES. The National Council of Homemaker and Home Health Care Services has suggested that an HEW official be put in charge of the continuum of care and of developing a mechanism to implement it. Does the Department have any plans to do this?

Mr. DERZON. Senator, this brings us to the larger question that you mentioned in your opening statement concerning the coordination of long-term care in HEW. In that context, I would like to start with one statement that I think is germane to this discussion.

After a few weeks in office, I testified before this committee that we in the Health Care Financing Administration were committed to a course of action within HEW of joint ventures and integration of program and policymaking with other HEW components. I recall that I discussed some of the organizational issues involved in doing that.

Dr. Richmond and his staff feel very much the same way, and so, in the area of long-term care, we are developing a timetable and working out organizational responsibilities with regard to problems in long-term care.

I could give you a couple of examples of these joint efforts. We might start with the whole issue of the section 222 authorities. The Health Care Financing Administration and the health components within HEW have reached an agreement on how we will continue to develop research and evaluation activities under this authority. The way the Department will proceed, as I understand it, is that the basic delegation of authority is essentially assigned to the Health Care Financing Administration, but decisions on what projects shall be undertaken and what methods of evaluation should be used will be in the hands of a small staff committee composed of the chief policy people from each agency. I will be working with this committee to determine which areas of emphasis the Health Care Financing Administration should tackle.

Senator CHILES. I don't understand that.

Mr. DERZON. Well, let me give you some examples of the types of projects we've been discussing.

Senator CHILES. Who has the responsibility for the section 222 demonstration project now?

Mr. DERZON. At present, this is not clear because all the delegations of authority relating to the health care financing activities are awaiting final approval in the Secretary's office.

The last of those delegations still to be approved, as I understand it, are the section 222 delegations—the very ones that we are talking about.

Senator CHILES. It sounds like we are right where we were 3 months ago.

Mr. DERZON. I don't think so. First of all, those delegations could not have been prepared and forwarded to the Secretary until a few weeks ago. There were many legal intricacies that had to be settled. The point is that the area of greatest discussion was the section 222 delegations, and the chief point at issue concerned how the Department was going to decide which projects were of greatest importance and which projects should be managed by various components within HEW.

Now there is good reason in my view, and I think in Dr. Richmond's and Dr. Lashof's view, that certain projects should be managed in different places.

UNANSWERED QUESTIONS

Let me give you a couple of examples. You asked a number of questions this morning about the economics of home care. Now the economics of home care are examined in some of these section 222 projects, but not all. There are major questions being asked about how we should reimburse a home health agency. We in the Department are reimbursing home health agencies in a variety of different ways, all of which have some advantages and some of which have some disadvantages.

I think you know about the experience with home health agencies in Florida; there are lots of disadvantages in the way we have been reimbursing the 100-percent medicare agencies in Florida.

Those projects tend to emphasize the importance of economics. In our view financing issues should be within the purview of the people in HEW who are most involved in financing health care, and that group represents those involved historically in reimbursement issues in the Department.

You also raised the question as to whether there is an efficient high-quality package of home health services that produces a good result for the patients receiving care. That is a question that the Health Care Financing Administration would have to examine in conjunction with the Public Health Service.

Now there may be questions concerning the use of broader-scope social services where we would have the section 222 projects managed somewhere else in HEW. The important thing is that there be a coordinated research and demonstration approach, and I think we have a mechanism to do that. We have a mechanism, I think, for evaluating those findings and we have a Secretary who is determined to have consolidated policy formulation. In our view, the policy formulation on this issue cannot be developed in its entirety until we have some answers to some of the questions that we are discussing today.

In regard to policy, I will just make one brief comment and that is that, in the Health Care Financing Administration——

Senator CHILES. Mr. Derzon, when you start talking about important things, the important question is the one that we talked about at our last meeting. When and where are we going to have a focal point for long-term health care development within the Department of Health, Education, and Welfare? I think you agreed with me last time that this was essential. Our frail and elderly population is growing every day, and in trying to develop alternatives, the planning is already overdue.

It seems since our last meeting in June the only development I am aware of seems to be a further diffusion of responsibility. You are telling me how you are going to divide this up between this group and that group within the Department, and there are good and valid reasons for dividing it up; but I want to know who is going to be the captain of the ship and who do we look for and who do the people look for as the focal point?

Unless we can find that, we see the division of long-term care abolished and the staff transferred to many different units. The Office of Management and Budget recommended the abolishment of the Long-Term Advisory Committee and it appears that the future of the research is unclear. It seems that all we are getting is further diffusion.

Mr. DERZON. Senator, I can understand your concern about that. I will assure you, first of all, though, the functions of that particular organization have been divided up; they have not been eliminated. People are still working on long-term care in the Department and in critical areas where they are carrying on essentially the same work they were carrying on before. The Department's approach to the issue of long-term care decisionmaking is going to be placed on the timetable. I assured you we would give you a timetable. I think there is more activity on long-term institutional care than there has been in this Department for several years, and more people engaged in it.

FOCUS STILL MISSING

Senator CHILES. There may be more people engaged in it, but I still want to know where the brain is—where the head is. I want to make sure it is not just a running-around activity without a focal point.

Mr. DERZON. The focal point for actual, single-person responsibility for long-term care in the Department of HEW has not been awarded to any one branch. There is no one person in the Department short of the Secretary who has the ultimate responsibility for that issue at the present time.

Senator CHILES. Is that good management practice?

Mr. DERZON. I have not made up my mind about that, Senator, because I have only been at HEW——

Senator CHILES. Well, I have made up mine. [Laughter.]

Mr. DERZON. And you have been around on this issue a lot longer than I have.

We promised you that we would deliver you a timetable on long-term care and how the Department is developing its approaches, and we are going to give you very specific timetables and very specific points of responsibility on those timetables. It is my view that there are going to be responsibilities assigned for long-term care decisionmaking, and it would be my recommendation at the present time that we do not assign all of the work to a single office.

Dr. LASHOF. Let me try to supplement that and attempt to give you a picture of how I view the interrelationship between the two of us and why I believe it will work. Maybe I can also philosophize about some of the background experience I have had in this area before, if you want me to, Senator.

Each of our offices has a policy planning unit. Within our policy planning unit, each of us will have someone whose clear responsibility will be to look at long-term care issues from the particular perspective that our two different units bring, and I believe there are different perspectives between financing, Health, and even the Secretary's Office. That group of key people in each of the policy units will be meeting regularly to develop joint positions that can be put forward. The principals will then be meeting and putting forth what we then concur is a joint policy that goes to the Secretary.

Now part of the necessity for that approach is because, in addition to the 222 demonstration authority, we also have the National Center for Health Services Research which is in the Assistant Secretary for Health's Office. What we have further agreed is that there will be a joint committee made up of a representative at the Deputy Assistant Secretary or Deputy Administrator level from the Office of the Assistant Secretary for Planning and Evaluation, the Assistant Secretary for Health, and the Health Care Financing Administration who will form a committee that will review and set priorities for research in this overall area.

In summary, Health will be looking at what the priorities ought to be in HCFA for carrying out 222 experiments. HCFA, in turn, will be bringing its perspective to what we should be doing in the Assistant Secretary for Health's Office so that consistent policies and the priorities will be developed and recommended to the Secretary.

In terms of carrying out and monitoring the programs, the 222 research authority will be in HCFA, and NCHSR research authority will be in Health. We have further agreed that there will be a technical review committee that will review proposed projects for the technical aspects. Once we have agreed upon the policy issues that need to be examined and under which authority they can be most appropriately studied, then the grant and contract applications are to be technically reviewed jointly by representatives who are most knowledgeable in the specific areas under review. I really believe that this mechanism will yield a more coordinated and a better policy approach than trying to find one brain that knows it all. At least we think it is worth a try.

DAY CARE

Senator CHILES. Who has the responsibility for day care development?

Mr. DERZON. Basically the responsibility for the section 222 day care development demonstrations has been under the Assistant Secretary for Health. When it comes to major reimbursement issues and major economic analysis, there will not be a project that is assigned to Health that won't have an HCFA participant on the staff of the steering committee that runs that project. A Health representative will be assigned to the health care financing projects. We each have know-how that has to be brought to bear on each other's projects. The Secretary, during the budget planning period for 1979, assigned to the Health

Care Financing Administration the responsibility for the analysis of the home care benefits. We will gather data, and we will rely heavily on the experiments currently under the Public Health Service aegis.

There are a number of questions still open on national health insurance in HEW. As you know, we are preparing materials for Congress on national health insurance, and we hope to have a proposal ready early next year. One of the questions to be addressed is what kinds of extended care benefits we are going to have under our proposal.

So these questions, I can assure you, are being addressed and they are being addressed rigorously.

Senator CHILES. Who has nursing home improvement?

NURSING HOME RESPONSIBILITY

Mr. DERZON. In terms of nursing home improvements—if we are discussing now the development of standards for nursing homes and the strengthening of standards for nursing homes—basically that is the responsibility of the Health Care Financing Administration as part of its function of monitoring covered services. Those standards in the Health Care Financing Administration are developed in consultation with people in Health who have had experience in this area.

We have a working agreement with the Assistant Secretary for Health that the certification standards for nursing homes and certification standards for other facilities which public programs pay for should be developed in consultation with Health. The basic responsibility for development of those standards, however, lies with the Health Care Financing Administration.

Senator CHILES. Home health services?

Mr. DERZON. It is the same thing as under the development of standards. The whole area of standards—with the exception of the clinical labs, where we have a slightly different working agreement with Health—requires the Health Care Financing Administration to develop and implement standards for those providers which participate in medicare and medicaid. This is done by consultation with the Public Health Service, under the Assistant Secretary for Health. If there are major disagreements over what those standards ought to be—there have not been any yet, but if there were—those would be adjudicated by the Secretary.

Senator CHILES. What about long-term care program development? Who is going to help the communities develop programs?

Mr. DERZON. That area has been and will continue to be the responsibility of the Public Health Service in its various branches. The reason for that is that the capacity—building strategies have always been a responsibility of the Health Services Administration and other agencies within the Public Health Service.

Senator CHILES. Well, from what I hear, it sounds like you have taken each one of these items and there is mixed responsibility in each one of them to some extent. That really then brings me back to the main thing that I need to know, which is, who is going to be the umpire; who is going to be the referee?

Mr. DERZON. The referee in HEW now, when we need one, is the Secretary. He is a very aggressive, active one, but by and large, we have not needed a referee for issues quite like this because by and large——

Senator CHILES. Then you are telling me that the Secretary is the focal point for the problems of the elderly that we are looking at and there is going to be no one; I just deal with the Secretary if I want to find where the focal point is?

Mr. DERZON. No, I think that your staff, hopefully, have been able to get quick responses to their questions from the parties that are working in Government on this, and I think Dr. Richmond and I—either one of us—or Dr. Lashof, can very quickly get for you the focal point of the organization that is clearly responsible for any of these activities.

FASTER PACE

I think it is clear to say that, on the issue of long-term development and strategies, both Health and the Health Care Financing Administration are intimately involved, and both are working very, very closely, and we are having fewer troubles now in trying to set the pace on this than my people tell me they had before.

Senator CHILES. Senator DeConcini, do you want to add to that?

Senator DECONCINI. No, I don't.

Dr. LASHOF. Long-term care illustrates the reason why there is an HEW and why you don't want a focal point in either HCFA or Health. If either were given the total responsibility, it could not carry it out.

Senator CHILES. I hope you understand I am not trying to select.

Dr. LASHOF. I know you are not.

Senator CHILES. Nor am I saying it has to be either/or, but I think there has to be a focal point or there has to be someone with responsibility. Now if it is the Secretary, then you know that is where I will address all of my problems. I have a feeling if I start doing that, there is going to be some other focal point developed.

[Laughter.]

Dr. LASHOF. We were faced with the choice that either we develop this team approach and make it work between the agencies and we pull together our policy and we work out which areas each of us ought to be overseeing, or we end up choosing one or the other or else creating a brandnew entity in the Secretarys Office, something which, I submit, would be counterproductive because it really is a much more complex and difficult situation.

I think you know our staff can work with your staff in terms of the different problems, but if you don't know which ones of us to address a specific concern or question to, send them to both of us and one or the other of us will get you the right answer or together we will send you a joint answer. I think the whole long-term care area is complex enough that it takes that kind of team approach, and I would hate to see Health trying to do this without the complete involvement of HCFA, or vice versa.

I think we both have expertise to bring to bear. If I can recall previous experience for a moment, although I would not think that we were that successful at the State level, but prior to coming to my position in HEW, I was director of the Public Health Department for the State of Illinois, and no subject consumed a larger portion of my time than long-term care. Certainly it involved a complex arrangement between mental health, public health, and the welfare department. We had lots of unsolved problems, but it was clear that trying to put one person in charge of solving all problems was not going to work either.

The problems are complex, and often at the State level this is complicated by the necessity of relating to the multiple agencies of the Federal Government. When I was involved at the State level I had that same feeling you describe of not knowing who I should be going to in the Federal Government. With my Federal perspective, I think the kind of mechanism we described previously should work.

Senator CHILES. Mr. Derzon, you promised me this timetable. When are we going to get the timetable?

TIMETABLE FOR POLICY DEVELOPMENT

Mr. DERZON. I am going to give you today some of the ingredients of that timetable. We are still in the process of rounding this out because, I hope you will appreciate, the development of a new agency of Government takes longer than either of us would like. We have had some obvious problems, as any new organization would have, in getting all of our activities into place and on the road.

We intend to provide to you over the next 3 weeks—possibly even sooner—a fairly detailed timetable of the full range of home health, day care services, long-term care and national health insurance regarding long-term care, and a schedule on research and demonstration activities.

Now some of these schedules will be coupled with the national health insurance initiatives and also to the proposal in H.R. 3. In section 18 of H.R. 3—which is the medicare and medicaid fraud and abuse amendments—as you know, there is a requirement that HEW provide to Congress, and to the appropriate committees of Congress, a report analyzing, evaluating, and making recommendations with respect to all aspects of home health care, including administration and reimbursement procedures and the costs of the delivery of home health and other in-home services as authorized under, not only titles XVIII and XIX, but also under title XX.

Now we feel confident that H.R. 3 will pass. If that provision passes—we have no reason to believe it will not—we will try to clearly meet and, if at all possible, advance that timetable. In fact, Senator, I hope we can bring you some proposals well ahead of many deadlines on the timetable that we are going to provide to you. We, for example, are very, very concerned right now about the inability of the Medicare Bureau to control the determination of intermediaries for the home health agencies. We hope we won't have to take a year to get that straightened out.

There are many things that we would like to bring to you well in advance of the master schedule.

Senator CHILES. Well, we hope that will be done. Within 3 weeks you will be getting your master schedule in here?

Mr. DERZON. That is correct, and that will be a response not just from the Health Care Financing Administration, but from HEW. I think you have the concern still—and probably will have after this hearing—that HEW does not have its act together, that it is too divided up and that we cannot get a job done. We are here to show you we can get a job done.

Senator **Chiles**. Senator DeConcini.

Senator **DeConcini**. No questions.

Senator **Chiles**. We thank you very much for your appearance here. We will probably have some other written questions and you can answer those.

Mr. **Derzon**. Thank you. I was glad to be here.

Senator **Chiles**. Next we will hear from a panel in regard to our section 222 demonstration projects. We will hear from Mrs. Joan Quinn, executive director of Project Triage; Dr. Neville Doherty, the research director of Project Triage; and Charlotte Hamill, the director of Burke Rehabilitation Center. Also on the panel will be the American Public Health Association, represented by Dr. Philip G. Weiler, director, Lexington-Fayette County Health Department, Lexington, Ky.

I understand several of you will be giving statements. We hope we can limit the time of those statements to 5 minutes or less so we will have some time for some questions.

Joan, I think you are going to go first and then Miss Hamill will follow.

STATEMENT OF JOAN QUINN, R.N., M.S.N., EXECUTIVE DIRECTOR, PROJECT TRIAGE, PLAINVILLE, CONN.

Miss **Quinn**. Thank you.

Mr. Chairman and members of the Special Committee on Aging, I am Joan Quinn, executive director of Triage, Inc., a research and demonstration project for older persons who reside in a seven-town area in central Connecticut. Dr. Neville Doherty, the principal research investigator, here present, will respond to research questions. Any of our findings are preliminary in nature.

Triage is a model project for the coordinated delivery of health and social services to the elderly. Central to the model is the provision of comprehensive, humane, and appropriate long-term care. All services are reimbursed and are organized around the client, rather than bending the client to fit what is available and reimbursable. The purpose of the project is to test the effectiveness and measure the costs of this system to delivering care to the elderly.

Project Triage is part of a broader Federal initiative under section 222(b) of the Social Security Amendments of 1972—Public Law 92-603—which was prompted by growing national concern about ways in which to meet the following goals:

(1) To serve the growing numbers of elderly people in need of health and supportive services and to determine how to meet their health care needs.

(2) To contain the steadily increasing cost of health care.

(3) To demonstrate the effectiveness of alternatives to institutionalization for elderly persons in need of long-term care.

(4) To develop alternative public policy to solve the complex problems of long-term care, consistent with the public's ability and willingness to pay for humane and effective care.

The project itself is funded under a grant to the Connecticut State Department on Aging from the National Center for Health Services, U.S. Department of Health, Education, and Welfare. The department on aging in turn contracts with Triage, Inc., for operations and with the University of Connecticut Health Center for evaluation.

This evaluation has possible implications for governmental health care reimbursement and financing policy and may help determine what benefits should be included in potential national health insurance programs or under expanded medicare coverage.

The project, which began in 1974, is located in central Connecticut—New Britain and six surrounding towns. All adults 60 years of age or older who are eligible for medicare are eligible for the Triage expanded medicare services on a first come, first served basis, without regard to financial status.

"SINGLE-ENTRY" MECHANISM

The project's objectives are:

(1) To provide a single-entry, single-assessment mechanism to coordinate delivery of institutional, ambulatory, and in-home services on behalf of the client.

(2) To develop necessary preventive and supportive services and to demonstrate the value of these services.

(3) To develop an integrated service delivery system at the local level.

(4) To obtain public and private financial support for the full spectrum of services.

(5) To demonstrate the cost effectiveness of coordinated care, including (*a*) care to prevent illness, compensate for disability, and support independent living at home; (*b*) care prescribed appropriate to need rather than according to third-party payor service restrictions; and (*c*) the use of gerontological nurse-clinician social worker team to assess the needs of the whole person and arrange for appropriate services.

The fiscal intermediary for Project Triage is the Division of Direct Reimbursement, Bureau of Health Insurance of the Social Security Administration.

The Division of Direct Reimbursement is authorized to act as fiscal intermediary by agreement between the Social Security Administration and the Health Resources Administration, Department of Health, Education, and Welfare. Triage provides the complementary service of verifying the eligibility of clients to receive services authorized by the Triage teams and there is where the element of control is. All bills for prescribed services flow to the Triage office for review and approval and then are forwarded to the Division of Direct Reimbursement, which issues payment to the provider. Reimbursement is limited to those services specifically authorized in writing by the Triage clinical teams.

The type of reimbursement made available through Triage is directly related to current coverage under social insurance programs. Title XVIII—medicare covered services—are reimbursed under the procedures and rate—cost reporting and reasonable charge criteria—

established under the medicare program. In addition, Triage covers payment for a wide array of services not currently covered under medicare. Such services as companion, homemaker, and intermediate care facilities are being reimbursed on a cost reporting basis.

Services such as pharmaceuticals and optical care are being reimbursed using rates established by the State of Connecticut Department of Social Services. For other services and providers without the capability of preparing cost reports, Triage has sought charge screens—fee schedules—from government and industry sources; for example, State of Connecticut Public Utilities Commission rates for transportation. Rates are negotiated with each provider for services such as meals-on-wheels and chore services. The reimbursement methods established for all contracted services have been reviewed by DDR in its function as fiscal intermediary.

POOR EXPERIENCE WITH PUBLIC INSURANCE

Generally, providers have been satisfied with the contractual requirements and reimbursements paid. Due to poor past experience with public insurance programs, their primary concern was the long delay between billing and payment for services. However, the working relationship and efforts of Triage and the Division of Direct Reimbursement is resulting in a satisfactory payment period.

Providers of service have felt that they have better accessibility to us, the assessors, monitors, and coordinators of service, rather than the traditional third-party reimburser whom they do not have as much direct contact with. In addition, there can be negotiation and communication about service, both in terms of amount of service and quality of that service. The interaction between us and the provider does not only involve the submission of a claim for reimbursement that is reviewed very arbitrarily by the intermediary who happens to be acting in that capacity.

Senator CHILES. I am not sure I completely understand that. You are also saying that they do not feel threatened by the fact of your service; in other words, a long-term nursing home or care facility. I would like to find out whether they feel threatened that you are going to take someone out of the hospital and put them on the day care services rather than having them go to the nursing home where they might remain forever and receive services they didn't need. These long-term service providers, are they feeling threatened by your service?

Miss QUINN. Not at all. In addition to removing people we also place people when it is appropriate. Therefore, their goal of keeping their beds full is not going to be hampered or impinged upon that much by the Triage delivery system. In addition, Triage has developed contractual arrangements with all of our providers prior to the delivery of service and they are aware of the fact that we will be removing people as well as placing persons in nursing homes if that is what you are talking about. I can relate that of 1,300 active cases that we have there are 91 people that are in nursing homes at the present time, but the mobility within the nursing home is much greater. People do not go there with the thought that this is their final stop. There is the ability for using that nursing home appropriately.

Senator CHILES. They are passing through the nursing home.

Miss QUINN. They are passing through as part of the continuum of care, yes.

PROJECT COSTS

Project Triage has received financial support from various agencies of the State and Federal Governments since its inception in 1974. In the State of Connecticut, sources included are: the Council of Human Services; the Department of Aging; and the Department of Social Services. At the Federal level of government, the Department of Health, Education, and Welfare has supported Triage through its Administration on Aging, Health Resources Administration, and the Social Security Administration. Total grant dollars allocated to the demonstration for the period of February 1974 through March 31, 1978, are $2,162,363. The State and Federal shares are $1,024,105 and $693,276, respectively. These costs are for the operational aspect of the Triage demonstration only.

Funding is provided for the following three categories of activity: operations, service, and research. The cost to operate the Triage system through March 1978 is $1,835,035 of the total. However, in addition to pure operational functions, this amount includes all costs for data collection and various other research functions as well.

Service costs for the Triage demonstration are funded from the Social Security Administration's medicare trust fund. Social Security Administration's Division of Direct Reimbursement reimburses for the client service costs of Triage, as well as the other section 222 projects.

Listed below are the sources of funding and the amount of support from the project start February 1974 through March 31, 1978:

Administration on Aging	$230, 962
Health Resources Administration	447, 279
Comprehensive Employee Training Act	15, 035
State of Connecticut	1, 024, 105
Total	1, 717, 381

Persons eligible to become clients of Triage are those 65 years of age and older, regardless of income, and those 60 years of age and older who are disabled and eligible for medicare. There are no income eligibility criteria. This has caused some consternation for the project. We looked at incomes of 1,194 clients and found that 69.4 percent had incomes of less than $3,900 per year; 17.5 percent had incomes between $3,900 and $6,900, and that 2 percent had incomes of over $7,000. Under the terms of the grant, a maximum of 3,000 clients may be served.

An eligible person may become a Triage client by self-referral or by being referred by someone else. The most frequent sources of referral are self, family, friends, visiting nurses, hospital discharge planners, physicians, and social workers. Other sources of referral include clergy, senior centers, retired seniors' volunteer program and volunteer organizations such as the Red Cross, Cancer Society, Lung

Associations, and so forth. It is not uncommon to have an 85-year-old with a 65-year-old child when they begin to experience problems with their health.

3,766 REFERRALS

Referrals to date number 3,766, as of August 31, 1977. The number of clients assessed since March 1, 1974, by seven nurse-clinician/social service coordinator teams number 1,715. The total number of active clients as of August 31, 1977, is 1,288. Those waiting to be seen number 2,020.

The intent of the demonstration through the services provided is to offer participants a continuum of care which includes traditional medical services and ancillary life-support and social services. The available services include: Short-term acute hospital care, long-term chronic or convalescent care, visiting nurse, home health aide, day care, meals-on-wheels, chore, homemaker, transportation, volunteer visiting, telephone reassurance; and the traditional physician, dental, podiatry, laboratory, radiology, physical therapy, and pharmacy services.

This array of extensive services makes available the traditionally nonreimbursable services which may be appropriate to client independent functioning, and the financial provisions arranged between Triage and the fiscal intermediary provide a better financial accessability to the more traditional services when they are appropriate. Further, many of the nontraditional services such as nutrition—meals-on-wheels—have a high client maintenance or preventive value; they keep people out of institutions, and something as simple as a daily delivered meal does that in many cases. Other services such as taxi transport rather than ambulance transport is certainly financially more beneficial and it is an advantageous alternative to current medicare reimbursement for transportation.

We have been asked about the impact of the Triage system and what will happen after the Triage project is terminated. The persons that are on the project will be re-entered back into the traditional system but it will have many constraints because the traditional system does have many constraints. For instance, medicare reimburses much differently for home health aides than medicaid does and than title XX does and there are different income eligibility types for each type as well as other eligibility requirements, so we anticipate that it is going to be very difficult.

In addition, the patchwork system of medicare/medicaid and limited services available through title XX leave much to be desired as far as a comprehensive care plan and services for the elderly. We think that the patchwork of funding sources for health care services only mirrors the fragmentation within the broader health care system and that at Triage we refer to this health care system as the nonsystem system because if you try to break into that home care system, for instance, it is very rigid even though it is very fragmented. We have found that people who can afford to pay for services don't know where to go for them even if they have the financial means to pay for service. We believe that funding in and of itself will not assure that persons who need these services will receive them.

"Patchwork System" Won't Work

Creating patchwork systems for the financing and delivery of health care services will not meet the health care needs of the elderly. What we feel is equally as important as the funding for the health care services is the mechanism for the evaluation of health service needs and coordination and monitoring of service and that perhaps an agency that is best able to do this is one that does not have a vested interest in outcomes that they are not providing the service themselves and that they can then use the broad array of providers without having any, as I said, vested interest.

We found many gaps in service. We found that service providers were saying that services were available, "but." Services are available but we don't provide services on evenings and weekends. Services are available but you have to be 21, green eyed, and blond haired to receive them, and it has been as blantant as that. So even though providers say they are providing service, there are many constraints in how and where even they will provide the service.

Senator DeConcini. Mr. Chairman, if I may ask a question.

When you say as blatant as that example, can you give us a real example of how blatant?

Miss Quinn. I certainly feel that one of the problems that was very prevalent when we first started the project was a problem of visiting nurse agencies in our particular area of our State. I have to preface it that way. They gave service from 8 to 4, 5 days a week, and if you fell on Friday night and fractured your arm, your alternative was, if you were an elderly person, to either be hospitalized even though it might be inappropriate, or be institutionalized in a larger care facility even though that might not be appropriate, because no one was there to cover the service at that time.

Also, in our particular area, home health aide service is a covered service and there are constraints on the amount of service so that the V.N.A.'s traditionally cover for short-term, short-time home health aid service, so if you needed service 4 hours a day, 7 days a week, that would keep you deinstitutionalized. I think through the process of education that is changing. The V.N.A.'s are being very sensitized to the fact that they do have to offer their service 7 days a week and at least for a major portion of the day or have someone available on call to provide service.

Senator DeConcini. Thank you.

Miss Quinn. I would like to turn this over to Dr. Doherty because we have some very preliminary research findings and he will address those.

STATEMENT OF NEVILLE DOHERTY, PH. D., RESEARCH DIRECTOR, PROJECT TRIAGE, UNIVERSITY OF CONNECTICUT

Dr. Doherty. I am Neville Doherty. My degree is in economics. I am on the faculty of the University of Connecticut.

I am in charge of the design and implementation of the research on and evaluation of Project Triage. The research started last year, approximately 1 year ago. We plan to work for 3 years in data collection and analysis. The 3-year period is predicated on the idea that 1 year is too short to be able to detect useful changes in the health of the elderly and it is too short to overcome possible experimental effects.

The main goals of our research or evaluation are to evaluate how Triage increases the effectiveness of health services for the elderly, how or whether it reduces the cost of health care services for the elderly, and how effective it is in reducing unnecessary institutionalization. There are other goals which support these, such as the study of the coordination of services and providers and of the necessary increases in services. But the primary focus is on the cost and effectiveness, and I want to stress the word "effectiveness" because I have a nasty feeling that too many projects are solely looking at costs.

There is another half of the coin which is really the outcome of care—what happens to the elderly person as a result of the service provided—which defines the effectiveness. Unfortunately, it is much too early to report findings from our study. I am sure we have heard this too many times this morning. But we started exactly 1 year ago. It takes 6 months to collect an initial wave of data because we assess people on a 6-months rotation basis and there are no firm data available to report on the results of the study at this time.

PRELIMINARY FINDINGS

In our prepared statement there are some very preliminary findings and I would not want to back them up with anything firmer than I have stated. We have shown that Triage clients are using far more nontraditional services than are covered under medicare. We have a large reduction in hospitalization expenditures and physician expenditures, and a big increase in other services which are, in effect, substituting certain home health services for hospital and physician care.

We did do a little comparison with the use of traditional medicare services for the general population. It is not a particularly good comparison because of the estimates we had to base it on; however, it does suggest that for those people using services Triage is able to provide a more comprehensive array, and certainly it does not cost any more than the traditional services. Whether or not these will result in greater effectiveness to the elderly it is just too early to tell.

Basically we are comparing a sample of the Triage clients with a sample in another region of the State who received services in a traditional system, and the focus of the research is primarily on this comparison: On the relative effectiveness of the two systems, the relative costs and the impacts on institutionalization. I hesitate to go any further because, frankly, we do not have data, but I will be very willing to answer questions; I think it might be a more constructive use of our time, sir.

Senator CHILES. The prepared statement of Miss Quinn and Dr. Doherty will be inserted into the record at this time.

[The statement of Miss Quinn and Dr. Doherty follows:]

PREPARED STATEMENT OF JOAN L. QUINN AND DR. NEVILLE DOHERTY

Mr. Chairman and members of the Special Committee on Aging, I am Joan Quinn, executive director of Triage, Inc., a research and demonstration project for older persons who reside in a seven-town area in central Connecticut. Dr. Neville Doherty, the principal research investigator, here present, will respond to research questions.

DESCRIPTION OF PROJECT

Triage is a model project for the coordinated delivery of health and social services to the elderly. Central to the model is the provision of comprehensive, humane, and appropriate long-term care. All services are reimbursed and are organized around the client, rather than bending the client to fit what is available and reimbursable. The purpose of the project is to test the effectiveness and measure the costs of this system to delivering care to the elderly.

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This evaluation has possible implications for governmental health care reimbursement and financing policy, and may help determine what benefits should be included in potential national health insurance programs or under expanded medicare coverage.

The project, which began in 1974, is located in central Connecticut—New Britain and six surrounding towns. All adults 60 years of age or older who are eligible for medicare are eligible for the Triage expanded medicare services on a first-come, first-served basis, without regard to financial status.

The project's objectives are:

(1) To provide a single-entry, single-assessment mechanism to coordinate delivery of institutional, ambulatory, and in-home services on behalf of the client.

(2) To develop necessary preventive and supportive services and to demonstrate the value of these services.

(3) To develop an integrated service delivery system at the local level.

(4) To obtain public and private financial support for the full spectrum of services.

(5) To demonstrate the cost effectiveness of coordinated care, including: (a) care to prevent illness, compensate for disability and support independent living at home; (b) care prescribed appropriate to need rather than according to third-party payor service restrictions, and (c) the use of gerontological nurse-clinician/social worker terms to assess the needs of the whole person and arrange for appropriate services.

REIMBURSEMENT PROCEDURES

The fiscal intermediary for Project Triage is the Division of Direct Reimbursement (DDR), Bureau of Health Insurance of the Social Security Administration.

The Division of Direct Reimbursement is authorized to act as fiscal intermediary by agreement between the Social Security Administration and the Health Resources Administration, Department of Health, Education, and Welfare. Triage provides the complementary service of verifying the eligibility of clients to receive services authorized by the Triage teams. All bills for prescribed services flow to the Triage office for review and approval and then are forwarded to DDR, which issues payment to the provider. Reimbursement is limited to those services specifically authorized in writing by the Triage clinical teams.

The type of reimbursement made available through Triage is directly related to current coverage under social insurance programs. Title XVIII (medicare covered services) are reimbursed under the procedures and rate (cost reporting and reasonable charge criteria) established under the medicare program. In addition, Triage covers payment for a wide array of services not currently covered under medicare. Such services as companion, homemaker, and intermediate care facilities are being reimbursed on a cost reporting basis. Services such as pharmaceuticals and optical care are being reimbursed using rates established by the State of Connecticut Department of Social Services. For other services and providers without the capability of preparing cost reports, Triage has sought charge screens (fee schedules) from government and industry sources. (For example, State of Connecticut Public Utilities Commission rates for transportation.) Rates are negotiated with each provider for services such as Meals-on-Wheels and chore services. The reimbursement methods established for all contracted services have been reviewed by DDR in its function as fiscal intermediary.

Generally, providers have been satisfied with the contractual requirements and reimbursements paid. Due to poor past experience with public insurance programs, their primary concern was the long delay between billing and payment for services. However, the working relationship and efforts of Triage and the Division of Direct Reimbursement is resulting in a satisfactory payment period.

FUNDING SOURCES

Project Triage has received financial support from various agencies of the State and Federal governments since its inception in 1974. In the State of Connecticut, sources included are: the council of human services; the department of aging; and the department of social services. At the Federal level of government, the Department of Health, Education, and Welfare has supported Triage through its Administration on Aging, Health Resources Administration, and Social Security Administration. Total grant dollars allocated to the demonstration for the period of February 1974 through March 31, 1978 are $2,162,363. The State and Federal shares are $1,024,105 and $693,276 respectively.

Funding is provided for the following three categories of activity: operations, service, and research. The cost to operate the Triage system through March 1978 is $1,835,035 of the total. However, in addition to pure operational functions, this amount includes all costs for data collection and various other research functions as well.

Service costs for the Triage demonstration are funded from the Social Security Administration's medical trust fund. Social Security Administration's Division of Direct Reimbursement reimburses for the client service costs of Triage, as well as the other section 222 projects.

Listed below are the sources of funding and the amount of support from the project start February 1974 through March 31, 1978:

Administration on Aging	$230,962
Health Resources Administration	447,279
Comprehensive Employee Training Act	15,035
State of Connecticut	1,024,105
Total	1,717,381

REFERRALS AND ELIGIBILITY

Persons eligible to become clients of Triage are those 65 years of age and older, regardless of income (and those 60 years of age and older who are disabled and eligible for medicare). There are no income eligibility criteria. Under the terms of the grant, a maximum of 3,000 clients may be served.

An eligible person may become a Triage client by self-referral or by being referred by someone else. The most frequent sources of referral are self, family, friends, visiting nurses, hospital discharge planners, physicians, and social workers. Other sources or referral include clergy, senior centers, retired seniors' volunteer program, and volunteer organizations such as the Red Cross, Cancer Society, Lung Association, etc.

Referrals to date number 3,766 (as of August 31, 1977). The number of clients assessed since March 1, 1974 by seven nurse-clinician/social service coordinator teams number 1,715. The total number of active clients as of August 31, 1977 is 1,288. Those waiting to be seen number 2,020.

EXPANDED SERVICE BENEFITS

The intent of the demonstration through the services provided is to offer participants a continuum of care which includes traditional medical services and ancillary life-support and social services. The available services include:

short-term acute hospital care, long-term chronic or convalescent care, visiting nurse, home health aide, day care, Meals-on-Wheels, chore, homemaker, transportation, volunteer visiting, telephone reassurance; and the traditional physician, dental, podiatry, laboratory, radiology, physical therapy, and pharmacy services. This array of extensive services makes available the traditionally nonreimbursable services which may be appropriate to client independent functioning, and the financial provisions arranged between Triage and the fiscal intermediary, provide a better financial accessibility to the more traditional services when they are appropriate. Further, many of the nontraditional services such as nutrition (Meals-on-Wheels) have a high client maintenance or preventive value and others such as taxi transport provide a financially advantageous alternative to current medicare reimbursement for transportation.

ASSESSMENT PROCESS

After a client has been contacted by Triage staff, a nurse-clinician/social service coordinator team makes a home visit to fully assess the needs of the client. The team uses a comprehensive assessment form developed and refined by the project director, the research team, and a geriatric physician consultant. The assessment consists of a modified physical exam and an extensive health interview, which includes a complete health history, physical, mental and social, as well as information on the client's functioning status, nutrition and environment, and living expenditures.

The assessment provides the data base for the problem-oriented record, which is prepared at the completion of the assessment. A problem list is constructed for each client. A plan of care appropriate to meet the individual's specific needs is then developed in conjunction with the client and his or her family.

To meet the needs of each individual client, the Triage team begins "to pick, to sort, to choose" which of the 64 different types of services available are appropriate and which of the 191 providers should be asked to provide the services. The scope of potential services is extensive. To remain independent, a client may need as humble a service as snow shoveling in the winter or lawn mowing in the summer, or, at the other extreme, such high technology services as open heart surgery. The services available by contract or referral include, but are not limited to, home health aide, homemaker service, nursing or physician visits, psychological and family counseling, transportation, home-delivered meals, chore service, companion service, hospital care, dental care, financial counseling, drugs, medical supplies and equipment, physical, occupational, and speech therapy, and nursing home care.

After the initial service orders are written by the Triage teams, the task of coordinating the delivery of services commence. The Triage team maintains continual contact with the client and provider in order to assure that the quantity and quality of the services being delivered are meeting the elderly person's current needs. Progress notes are made in the record on the basis of telephone calls and/or home visits.

Five physician advisors are available to the Triage nurse-clinician for consultation when medical problems arise. They include a geriatrician, two internists, a physician whose speciality is chronic disease and rehabilitation, and a psychiatrist. Two dentists and a pharmacist also act in a consultative capacity to the nurse-clinician/social service coordinator teams.

In addition to client contact, the Triage teams consult regularly with the service providers. The teams meet monthly with the home health agencies in the region and with other providers as needed.

RESEARCH DESIGN

This research project is designed to investigate a model system of health care for the elderly. The system, Triage, provides for the assessment of health status, and the prescription, organization, delivery, and financing of appropriate, comprehensive services. It is perceived, potentially, as an effective and economical alternative to the existing system, in which care is fragmented and, at times, prescribed according to financial considerations rather than health status or appropriateness of care.

In research terms, the goals of Triage are to:

(1) Increase the effectiveness of health services.

(2) Reduce per capita expenditures for health care.

(3) Reduce institutionalization.
(4) Increase the number and availability of homebased services.
(5) Increase coordination among service providers.

In the research, the first three are conceived as primary goals or objectives that Triage is to fulfill. The last two are identified as system requirements, i.e., enabling goals essential for the attainment of the objective.

The experiment is being conducted in a seven-town region in central Connecticut. At the 1970 census, there were 19,500 residents aged 65 and over in the region. While all 19,500, regardless of health or financial status, are eligible for Triage, the projected enrollment for the experimental period is approximately 3,000.

The research is being conducted in two parts: (1) An analysis of the ability of Triage to reach its primary goals, and; (2) a description of the operation and organization of Triage.

Part 1 is a comparative analysis of Triage and the "existing" system. These are posed, in a cost-effectiveness sense, as alternatives, and the research directed towards testing a series of hypotheses derived from Triage's major goals. The main hypotheses are that Triage will be more effective and less costly than the alternative. For research purposes, effectiveness is defined in terms of the outcome of care, and the retarding of institutionalization. Costs are total life-support expenditures.

This part of the study is focusing on two samples: (a) An experimental group of 307 Triage clients and (b) a comparison group of 153 elderly people from another part of the State. The two samples were obtained over the same time periods—August 1976–January 1977; and were matched on the basis of four factors: age, sex, marital status, and functioning ability. Data, which is being collected for the duration of the experimental phase of the study, will be analyzed both statistically and in the context of a cost-effectiveness model.

Part 2 is a descriptive study of the operation and organization of Triage. It will address the development and setting of Triage, its organization and costs, the people it serves, their sociodemographic characteristics, and changes in their health and other factors over time, the services it prescribes and their costs, and the providers it uses and their relation to the system.

Data collection for the experimental phase of the study began in August 1976, and will—assuming continued funding—extend into 1979 for both the comparative and descriptive sections of the analysis. Final results will be reported in 1980, with interim findings presented as data become available.

EXPECTED RESULTS

By the end of the experiment, we expect to identify, at a minimum:
(1) All costs of a single-entry, full-service care system for the elderly.
(2) Cost and effectiveness of expanded medicare benefits.
(3) Effectiveness of the Triage concept and system in improving client functioning outcomes, preventing or retarding institutionalization, and reducing health care costs.

MEASUREMENT OF EFFECTIVENESS

To measure the effectiveness of Triage, three variables are being assessed semiannually for the experimental and comparison group. These are: incidence of institutionalization, rates of death, and functioning status. These measures are directly related to two of the primary goals of Triage: to reduce institutionalization, and to improve the health of the elderly.

Institutional days and death are self-explanatory; functioning status is assessed according to the clients' abilities in terms of physical, mental, and social categories, and is viewed both as an outcome of the care process, and also as an indicator of the level at which a person can and does function in society.

FINDINGS

Preliminary results pertaining to the measures of effectiveness are just starting to become available for analysis. For the first months, the death rate was slightly lower for the experimental group (2.9 percent) than for the control group (3.3 percent). There is no information on institutional days and, as was expected for such a short period, there were no statistically significant differences—between the groups—in functioning status. We should note, however, that on a practical basis, the changes in functioning status that have been observed tend in the direction of greater effectiveness in the experimental group. All these findings are preliminary, however, so no conclusions may be drawn. All that can be monitored at this point are trends that develop as data become complete. We know that changes in levels of functioning must be analyzed for several periods in order to determine true levels of effectiveness for both groups, and we know that the concept of reduced institutionalization is only meaningful in the context of a fairly lengthy period. Once repeated measures can be analyzed, the research should be able to provide a predictive model for health care service organizations similar to Triage.

MEASUREMENT OF COST

The purpose of the cost aspect of the research is to compare the health care expenditures of Triage clients to that of the control group. So that a thorough comparison can be made, the cost of program operation and the living expenditures of the elderly are being examined in addition to the costs of services.

The service costs for the Triage clients are obtained from the Social Security Administration. This information will include payments for regular medicare covered services and previously noncovered services which are covered by medicare waivers. Program operation costs, adjusted so that research and development costs are excluded, are collected from Triage's account books and included as expenditures for the Triage population. Service costs for the control group will be received in the form of printouts from several sources, including medicare expenditures from the Social Security Administration and medicaid expenditures from the State welfare department. Living and other health expenditures for both groups are collected directly from the clients.

FINDINGS

The research group has just started to receive cost data for the experimental group, but no cost information is available for the control group. To obtain a preliminary analysis, Triage service expenditures, were compared to national figures on health expenditures for the elderly. To make the comparison as realistic as possible, several steps were taken. First, because only 42.5 percent of the elderly utilize their medicare coverage whereas Triage is designed for 100 percent utilization, the national figures were weighted to reflect 100 percent utilization.[1] Second, the Triage service categories were grouped to approximate the national service categories as closely as possible. However, because Triage covers social services as well as medical services, a special category was created. Unfortunately, there are no national figures upon which a comparison of spending for social services could be based. Finally, because the pay lists did not start until January 1976, the comparison is between the costs of calendar year 1976 for Triage and the costs of fiscal year 1976 for the Nation. Table 1 shows the percentage distribution for both groups, and table 2 the distribution of actual expenditures. Table 2 shows that per capita spending for Triage clients was lower than that estimated for the Nation—even when social services are included in the Triage total. Furthermore, the tables reveal that both proportionately and absolutely Triage spending for hospital care and physicians' services was less than that estimated for the Nation, but that spending for other services was higher. The "other" health services category in table 1, however, includes many social services provided by Triage which are not included in the national figures.

Overall, while it is too early to judge effects of specific sets of services, preliminary indications (see tables 1 and 2) point to a substitution effect, i.e., other health and social services are substituting in part for institutional and physicians' services, substantially lowering expenditures for these types of care. What appears interesting at this point, is that Triage has been able to provide a comprehensive array of both health and social services at a cost comparable to that spent for health services alone on a national level.

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[1] Gornick, Marian, "Ten Years of Medicare: Impact on the Covered Population." *Social Security Bulletin,* July 1976. The 42.5 percent is a 1977 figure. There is no figure available for more recent years.

TABLE 1.–PERCENTAGE DISTRIBUTION OF SERVICE COSTS FOR TRIAGE IN CALENDAR YEAR 1976 AND THE NATION IN FISCAL YEAR 1976

Type of expenditure	Triage	Nation [1]
Hospital care	28.1	45.3
Physicians' services	6.0	16.8
Dentists' services	1.3	2.1
Other professional services	1.4	1.5
Drugs and drug sundries	4.1	8.0
Eyeglasses and appliances	2.5	1.2
Nursing home care	22.2	23.0
Other health services	[2] 34.4	2.1

[1] Source: Robert M. Gibson, Marjorie Smith Meuller, and Charles R. Fisher, "Age Differences in Health Care Spending, Fiscal Year 1976," Social Security Bulletin, August 1977.

[2] Includes: Home health aide, ambulance and laboratory, and the following services: Meals, residential care, transportation, chair car, chore, companion, escort, and homemaker services.

TABLE 2.–PER CAPITA COST BY TYPE OF EXPENDITURE FOR TRIAGE IN CALENDAR YEAR 1976 AND FOR THE NATION FOR FISCAL YEAR 1976

Type of expenditure	Triage	Nation [1]
Hospital care	$978.34	$1,620.21
Physicians' services	209.12	602.16
Dentists' services	44.98	74.19
Other professional services	48.75	54.85
Drugs and drug sundries	142.72	285.22
Eyeglasses and appliances	88.46	44.38
Nursing home care	771.41	824.96
Other health services [2]	645.01	73.67
Subtotal	2,928.79	3,579.64
Social services [3]	552.02	(4)
Total	3,480.81	3,579.64

[1] Source: Robert M. Gibson, Marjorie Smith Meuller, and Charles R. Fisher, "Age Differences in Health Care Spending, Fiscal Year 1976," Social Security Bulletin, August 1977.

[2] Other health services include: Home health aide, ambulance, and laboratory.

[3] Social services include: Meals, residential care, chore, chair car, transportation, companion, escort, and homemaker.

[4] Not available.

IMPACT ON MEDICARE COVERED SERVICES

Triage believes that the costs derived from the demonstration can be useful in the development of alternative benefit packages for the medicare program. For example, we are informed that there are proposals for the elimination of the 3-day prior hospital stay requirement for skilled nursing facility and home health benefits under medicare. Triage supports this proposal, as we have frequently found such services to be appropriate without the prior stay. On a broader basis, the service utilization and costs associated with the demonstration are directly related to the Triage staff's determination of appropriateness, monitoring, followup and coordination of service. Redesigning the medicare benefit set alone would probably not achieve the same result.

PROVISION OF SERVICE AFTER THE EXPERIMENTAL PERIOD

Provision of care or services to the Triage extended benefit group after the experiment is over depends upon funding for services not presently covered by the standard medicare system, agencies or persons available to provide these services, and agencies to coordinate and monitor these services so that individual needs are appropriately met. The comparison group does not receive any additional services outside of those provided in the traditional system.

The inability of the standard medicare system to cover those services presently offered through the waiver system available to Triage is a very real constraint in extending services beyond the experimental period. It is clear that without a formal mechanism to pay for these extended services, they will be available to very few people. The patchwork system of medicare, medicaid, title VII meals, and limited services available through title XX, offers minimal hope for coverage of the services currently available to Triage clients. Each of these systems has different eligibility requirements for participants and different constraints in the delivery of services. For example, the availability of home health aide service under medicare is different from the coverage available under medicaid. Further, the coverage of home health aide services is significantly different under title XX than either under medicare or medicaid.

The patchwork of funding sources for health care services only mirrors the fragmentation of services within the broader health care system. At Triage, we refer to this health care system as the "nonsystem system." People who can afford to pay for available services often do not get them because they do not know where to go to get these services. Attempting to manipulate the various systems through which services are provided is frequently frustrating for the individual. He or she often gives up and goes without a needed service rather than cope with the red tape required to procure needed services.

As it now stands, once the Triage waivers terminate, health care service will be available to the Triage population only as these services are available within the traditional system. If Triage itself terminates, there will be no agency to coordinate those available health care services. It is our experience that the individual in the community cannot do this by himself or herself, regardless of ability to pay either through insurance or out-of-pocket.

Funding in and of itself will not assure that persons who need these services will receive them. Creating patchwork systems for the financing and delivery of health care services will not meet the health care needs of the elderly individual in the community. Transportation, coverage of pharmaceutical costs, chore services, companion services, homemaker/home health aide services, Meals-on-Wheels, and similar services will only be minimally available once the Triage project concludes. What we feel is equally as important as the funding for health care services, is the mechanism for evaluation of service need and coordination and monitoring of services. One without the other will not accomplish the delivery of appropriate health care services to the elderly. Local communities do not have the resources to provide these expanded services themselves. At the State government level, it is likely that such services will be made available only to those elderly who become medically indigent. It is our contention that by the time one becomes medically indigent, home care services are "too little, too late."

We urge that the Federal medicare system be modified to include a broader spectrum of health care services, including those services which have been determined to be essential through the demonstration, and that agencies be established to evaluate client need and coordinate and monitor appropriate services to the elderly. Health care services cannot be effectively offered to the elderly through the current fragmented system.

GAPS IN SERVICE

The predominant gaps in care or services which were identified at the onset of the demonstration were the lack of availability of the social and life-support services, lack of availability of services on a 24-hour basis, and financial accessibility of the more traditional health and social services. Actual services which were not available in the region covered by Triage were: Meals-on-Wheels, chore, companion, escort, day care, transport, and mental health counseling in the home. There has been, and still exists, a severe manpower shortage in the availability of homemaker and home health aides. In addition to those services available, such as the visiting nurse, physical therapy, and physician, their access was limited by the inability to pay for the service and the hourly constraints of the agency. Triage has initiated the development of unavailable services including those mentioned above. The mechanism utilized in the service development was through existing service providers and the development of new service providers. In order to maximize the benefit of the expanded service, unusual nontraditional groups, such as a sheltered workshop for developmentally disabled individuals, were assisted in providing chore, companion, homemaking services, and meal preparation. Voluntary agencies, such as retired seniors' volunteer program, Red Cross, American Cancer Society, and the Lung Association, were aided in the development of transport systems, friendly visiting services and patient education programs. A community guidance clinic for youth with minor mental health problems was aided in the development of a chore/companion/escort service. Benefit of this program was a positive outcome for both the older adult and youth. The effect of the development of these services has been felt by the Triage clients, the community, and the elderly at large. However, it should be emphasized that complementing available services alone would probably not result in substantial benefits as the client and family would have a problem with selection of the appropriate services.

RECOMMENDATIONS FOR FUTURE POLICY

It is hoped that recommendations for future policy will come from the operation of the Triage project as well as the research findings. Based upon operational experience, thus far, the following recommendations are suggested:

(1) Fund a comprehensive array of services through a single organization which does not provide direct service, but assesses the individual for appropriate service, prescribes the service, and evaluates and monitors service for quantity and quality.

(2) Authorize and reimburse nonphysician personnel to develop client plans in cooperation with physicians.

(3) Fund long-term care center development as introduced in bills by Representatives Claude Pepper and Barber Conable.

(4) Involve the private sector in a cooperative effort to expand home care benefits.

It is expected that more detailed recommendations will be forthcoming once the experimental phase of the project is completed.

CASE HISTORY NO. 1

Client is a 68-year-old widow, American born of eastern European parents living in her own five-room, single-family, cluttered house. At the time of initial assessment, she appeared obese, pale and disheveled, dressed in a robe. She moved in a hesitant, unsteady fashion. Her speech was slow and slurred. She displayed flattened effect and readily admitted feelings of depression.

Her primary problems resolved around feelings of nausea and dizziness and an unsteady gait resulting in decreased mobility. She was not maintaining a therapeutic regime for diabetes, and her diet was nutritionally deficient. Her limited visual acuity caused her to read with difficulty using a magnifying glass. She was aware of her unsafe environment created by outside steps overgrown with vines and by icy, snow-covered ground. The dirty clutter inside her house inhibited her movements and constituted a fire hazard. Pervasive throughout her conversation were expressions of loneliness, isolation, and depression. She described a worry about money and health and was especially fearful of cancer. Day and night had been reversed for her. She slept most of the day and was up all night attired constantly in bed clothes. Isolation stemmed from alienation of her only son and daughter-in-law as well as from her inability to socialize with peers due to lack of transportation. Reading and sewing, previously enjoyed activities, were no longer possible because of her poor sight. She was upset that her nearby church was inaccessible during the winter months. Lack of transportation inhibited her shopping trips so that she was unable to maintain an adequate diet and prevented contact with her friends. Client stated she was ready to give up the struggle of maintaining herself and felt inadequate to cope with her problems.

Services provided for this client included first of all, investigation of her medication regime and discontinuation of the tranquilizer. Thus, the client indicated she no longer experienced nausea or ataxia (having trouble with balance) and felt less depressed. Snow shoveling was provided and contributed to the client's safety in negotiating her front stairs. Help with inside housecleaning was offered, but by that time the client felt better able to attempt this herself. Cab transportation was made available for grocery shopping, which enabled the client to purchase more appropriate food; for medical appointments during which an appropriate medication regime was initiated; for trips to city hall regarding increased veteran's benefits to relieve financial stress. This transport was offered for attending religious services, but because the client felt better, she managed to walk to church and obtain a ride home from a fellow church member creating for herself a social encounter. Finances were eased somewhat as Triage began to pay for medications and additional health care services. Client's eyes were examined and new lenses obtained so that she could again read and sew. Counseling services were instituted to help client work through her feelings of depression to help her plan and spend her limited funds more carefully and to improve her self image so that she could initiate and maintain a healthier lifestyle. Client was able to reorganize her time schedule, take responsibility for housecleaning to make her surroundings more comfortable and safe and is beginning to take pride in her own home. She is preparing more nutritionally adequate and therapeutic meals because "she is able to spend more money for proper food." She has also made some rapprochement with her daughter-in-law and son by attempting to prepare and deliver a birthday meal to him.

Time spent for this client to date includes about 2 hours for the initial team assessment, an hour in followup visit, an hour in arranging and rearranging services, and 1½ hours in telephone contact totaling about 6 hours.

Cost of services to client are as follows:

Medications	$41.30
M.D. visit	12.00
Chore service	17.60
Optometric care	57.60
Mental health counseling	140.00
Cab transportation	16.60

A total expenditure of $224.80 over a period of 3 months.

In summary, the client may have experienced continued deterioration resulting in acute care hospitalization and a change in housing that would inhibit her independence had Triage not intervened.

CASE HISTORY NO. 2

The client was referred by her son for home health aide and homemaker assistance just after her discharge from a convalescent home in late 1974. She had been placed in the convalescent home following a stroke with right-sided paralysis. According to the family, the client had demanded her discharge because she felt herself going downhill and was afraid she would "die" if she did not leave that environment and return to her own apartment. The family confirmed her deteriorating status and agreed to the discharge although they did not feel able to provide the care she needed at the time of discharge. At this time, the client was unable to get out of bed unassisted and was dependent in all activities of daily living. The client had a short-leg walking brace but was unable to put it on unassisted. She was assessed within 2 days of her discharge from the convalescent home. She was a 74-year-old Caucasian female of Armenian descent who had lived alone in an elderly housing project.

The problems encountered at the time of assessment were dependence in self care because of a right-sided paralysis secondary to a CVA of October 1974. Client had some movement of the fingers of her right hand and walked very slowly with the use of a short-leg brace and a quad cane. Her blood pressure was within normal limits, and she was not taking any medications for cardiac condition. Other problems included diabetes controlled by an oral medication and diet, and arthritis affecting her finger joints and relieved by Aspirin.

Client's inability to manage her care presented the most immediate problem in her attempt to remain within her home. A home health aide from a proprietary agency was placed daily for 6 hours for a 2-week period. A physical therapy evaluation was requested for initiation of a home therapy program and placement of appropriate assistance devices which included a trapeze for the bed, tub bench, and straps for her shoes. The client was also referred for a podiatry evaluation and followup. At the end of the 2-week period, the client was making good progress in beginning to manage her care and the home health aide was decreased to 6 hours, 2 days a week for 1 week, then increased to 1 to 2 hours weekly to assist with bath. For approximately 1 month during this time, delivered meals were also provided. Client soon became able to manage most of her activities of daily living, including ambulation, dressing, cooking, and some light housekeeping. The home health aide continued to provide her assistance with a tub bath one–two times a week with visiting nurse supervision, and the family assists her with shopping, laundry and heavy housekeeping. The client was hospitalized briefly in September 1975 because of a low blood sugar, but this was corrected by decreasing her diabetic medication. Client has a fasting blood sugar drawn every 3 months in the home.

Client made a marked and dramatic change in her functional abilities within 4 to 6 weeks of her discharge from a convalescent home with an initial intensive level of home services which enabled her to regain much of her independence. By her own and her family's description, she changed from an individual, deteriorating in an institutional environment, to one of independent functioning, well supported by her family and minimal outside services. Client has remained in her apartment for the past 2 years, independent and content in her environment.

The time expenditures consist of an initial assessment of approximately 2½–3 hours, arrangement of services approximately 8 hours. This client has been with Triage since December 27, 1974, and has had continued followup interaction by visits and phone calls.

The cost of services to this client starting at the time of the medicare waivers, December 1975, are as follows:

Skilled nursing care	$196.50
Home health aides	608.80
Outpatient care	13.25
Physicians	92.00
Dentist	25.00
Meds	131.02
Grand total	1,066.57

Without the assistance of the Triage project, client would have returned to the institutional environment. Triage was able to provide client with enough support and home service initially to increase her functional level to the point where she is presently living in her own apartment safely with minimal assistance.

CONCLUSION

Both the demonstration and research aspects of the Triage project were designed to yield experience and administrative and actuarial information about expanded services for the elderly. It is anticipated that the research findings will be studied to determine where the information can be used, either for recommending new programs or modifications in existing programs.

Senator CHILES. Before we get to the questions, we will hear from Miss Hamill.

STATEMENT OF CHARLOTTE HAMILL, CODIRECTOR, BURKE REHABILITATION CENTER DAY HOSPITAL, WHITE PLAINS, N.Y.

Miss HAMILL. I appreciate the opportunity to present this report on the results of our demonstration at Burke Rehabilitation Center conducted under section 222(b) of the Social Security Act. A more detailed report[1] has been submitted for your review, but in the period of time available to me this morning I would like to present a brief summary of this section 222 project with some of our findings and recommendations.

The Burke Day Hospital is a division of the Burke Rehabilitation Center located in White Plains, N.Y. The center is a 150-bed voluntary, nonprofit rehabilitation hospital affiliated with the Cornell University Medical Center. We provide comprehensive, multidisciplinary physical medicine and rehabilitation services to both inpatients and outpatients at our center.

Our day hospital is a medical model of day care with goals similar to those of the British day hospital; namely, rehabilitation of patients, the provision of ongoing medical-nursing supervision, socialization, and temporary relief of family stress and strain. The major goal is to enable a patient to remain living in his community as independently or semi-independently as possible for as long as he is able and wishes to do so. I might add, in view of this morning's earlier discussion, we have a very special advantage in that we do have a treatment team with a captain, who facilitates the delivery of the services that we

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[1] See p. 519.

offer in the day hospital and coordinates them with services offered in other parts of the community. This results in maximum service to the patient with a minimum amount of "red tape."

The geographical area served by our section 222 project encompassed about 132 square miles. The total population in that area is slightly less than 800,000 and about 92,000 residents are 65 years of age or older.

TEST OF DAY CARE SERVICES

I believe Dr. Lashof has clearly described the experimental design of the section 222 project. On July 1, 1974, Burke was awarded a contract to test day care services as post and non-post-hospital benefits. Persons eligible for the demonstration were those adults covered by part B of medicare who did not require 24-hour institutional care and yet, due to physical impairment, were not capable of full-time independent living. This basic criterion was used in accepting referrals from general hospitals, rehabilitation hospitals, home health agencies, private physicians, skilled nursing facilities, other community agencies, and individuals. If the patient agreed to participate, he was invited to sign an "informed consent" document which was carefully interpreted to him and/or a responsible relative.

The information was gathered as outlined by the evaluation contractor; namely, it was gathered using the "patient status instrument," a uniform document that was used in all 222 demonstrations. Individualized health care plans were developed for each patient as well as the anticipated treatment outcomes. Costs of day care treatment were reported to the Social Security Administration as part of the contract and out-of-pocket health care expenses were reported to the evaluation contractor. The assessment team consisted of a physician, a nurse, and a social worker, who carried out the mandated tasks. The assessments were repeated on four additional occasions and the data was submitted to the evaluation contractor.

The Burke Day Hospital has been in existence for 4½ years. We had established the day hospital prior to the beginning of the section 222 project. During the past 4½ years we have treated 738 different individuals, representing a total experience of 42,141 patient treatment days. Based upon our total experience in delivering this form of day treatment, including our experience within the section 222 demonstration, we offer you the following recommendations and observations.

First, there is a need to define nationally what "adult day treatment" is and what "health-related services" are if we are to gain greater public understanding and awareness of our goals and services as a new health care option.

FULL SYSTEM NEEDED

Second, we feel that adult day treatment facilities are essential as an option within a comprehensive community based system. No one set of services, however, can meet all the health care needs of the community. A day hospital such as ours can provide a continuum of care for chronically ill, physically disabled adults, and we can effectively treat those elderly individuals who might be considered "at risk" because of the complex nature of their illnesses. But that same complex illness may also require access to the private physician, to the acute care hospital, to a rehabilitation inpatient facility, or a home health agency to assist the patient to maintain his semi-independence. If the adult day treatment care facility is available as one of a number of options, then its utilization is more likely to be appropriate and cost effective.

I would like to say here that I really don't think you can measure a program's cost, or its effectiveness, unless it is being measured as part of an entire network of services. A service is likely to be overutilized, or misutilized, if the community lacks an adequate spectrum of quality services.

Third, a preliminary comprehensive physical and psycho-social assessment and an individualized care plan developed by a qualified assessment team should determine the suitability for any form of treatment, including day treatment services. There should also be provision for periodic reassessments to review the patient's progress toward the initial treatment goals and at the same time build in some quality control. The instruments used for this purpose in the section 222 demonstration were useful and could be modified to provide a uniform data reporting system, which in turn could be linked to appropriate public and private reimbursement mechanisms. At the present time in our day hospital we must first admit a patient and then evaluate him if we want to be reimbursed for that evaluation. The admission could be inappropriate if the paper screening and the initial interview are not sufficient to determine suitability for day hospital care, but that is where the present system leads us.

PATIENT GAINS

Fourth, a day hospital can provide different levels of care. For some of our patients, their inpatient length of stay was reduced because we were able to provide "intensive" rehabilitation and they no longer required the "hotel element" of inpatient care.

We found that stroke patients, for example, had averaged 65 treatment days over a period of 6 or 7 months and had made substantial gains in the direction of functional independence. Many of them continued to make or to maintain those gains following discharge.

Patients with musculoskeletal disorders, especially rheumatoid arthritis, also made functional gains during their day hospital stay. However, these gains were not necessarily maintained once the patients had been discharged. This type of disability requires an ongoing "maintenance" rehabilitation program in order to avoid further deterioration. But, unfortunately, maintenance therapy is not reimbursable under our present health insurance system.

Patients with neuromuscular disorders, such as multiple sclerosis, made only small gains. Their families, however, gained the benefit of a comprehensive medical evaluation of the patient plus some temporary relief from the responsibility for managing the patient. The physical gains achieved by this group were not maintained following discharge—a finding that is not surprising, given the degenerative nature of the disease. For these two latter groups of patients, a home treatment program designed to help maintain their functional status, with periodic monitoring at the day treatment facility—possibly twice a month—might provide the necessary support and continuing motivation for patients and their family members.

Fifth, we found that most family members responsible for the ill and disabled person wanted to avoid or delay institutionalization of that individual as long as possible, and they were willing to continue providing care at home, given the backup support and intermittent relief from management of the patient that the day treatment program can provide. The members of the patient's "social support system"—whoever and wherever they may be—should be involved in the overall treatment process. Unless they are willing to participate, it is unlikely that the patient, when discharged to their care, will maintain whatever gains are achieved, and if they are not sufficiently involved they may be reluctant to resume their responsibility for that patient. Some system of family care incentives might help to reimburse families who are willing and able to retain responsibility for their dependent disabled members. Such a system would hopefully include provision for respite care which would free families for occasional weekends or even a yearly vacation.

TRANSPORTATION ESSENTIAL

Sixth, transportation for the physically disabled and chronically ill to and from day health care programs is an essential ingredient which must be included in any approved package of day care services. Current community efforts to provide a public transportation system to accommodate the handicapped are important, but they do not meet the needs of transporting a daily hospital population of 50 severely handicapped persons on a door-to-door tight schedule. The major gap in transportation is the lack of control over the profit margin commanded by the commercial, for-profit vendor with little or no competition in his community.

Seventh, adult health care and social care are interdependent. Once a patient has been rehabilitated to the point where he can function semi-independently at home it is difficult, if not impossible, to locate a community program that will meet his continuing need for socialization following discharge. We call that the "third level of care," and we feel that is one of the programs most sorely needed in our community at the present time. By the way, in a recent visit to many British hospitals we found that they are faced with exactly the same problem in discharging day hospital patients.

Most communities have programs for the ambulatory, healthy, active older person. Very few have services geared to the needs of the severely disabled, chronically ill, nonambulatory person who is forced back into isolation from the mainstream of society and is likely to deteriorate. This person does not need a multitude of expensive services, he may need only limited socialization plus periodic monitoring of his health status. At the present time, this third level of care is not part of our network of community services.

One of the most significant components within the section 222 demonstration was the availability of reimbursement from a single source. This reimbursement was based upon an individualized health care plan developed from a comprehensive physical and psychosocial assessment of the patient. Equally significant was the fact that this reimbursement made it possible for the patient to receive an integrated package of treatment services appropriate to his individual needs. Another major feature was the periodic comprehensive reassessment of the patient's treatment needs by an independent assessment team. If incorporated into a day treatment program, this feature would permit evaluation of the patient's progress and, at the same time, would constitute a quality control.

Future demonstrations designed to test the effectiveness of adult day treatment would, in our opinion, be fruitful if designed as one part of a network of community health care options. We also recommend that such demonstrations utilize existing health care facilities with experience, recognized expertise, and a proven commitment to the target patient population.

Thank you.

Senator CHILES. The prepared statement of Miss Hamill, describing the operation of the day hospital, will be inserted into the record now.

[The prepared statement of Miss Hamill follows:]

BURKE REHABILITATION CENTER DAY HOSPITAL REPORT

DESCRIPTION OF THE PROJECT

The Burke Rehabilitation Center was awarded a contract on July 1, 1974,[1] totaling $296,000, under the authority of Public Law 92–403, section 222(b) to study day care services as post-hospital and non-post-hospital benefits. The contract was for a research and demonstration project using an experimental design developed by Medicus Systems Corp. and described in detail in the request for proposal. According to the design, patients who were referred to the demonstration contractor and who agreed to participate in the study were to be randomized into an expanded benefits (experimental) group or into a control group without expanded benefits. In accordance with the research protocol, Burke Rehabilitation Center as the demonstration contractor was charged with the following tasks:

(1) To collect information on the demographic, physical, economic, and psychosocial characteristics of patients assigned to both groups.

(2) To conduct an initial assessment and four reassessments of patient needs.

(3) To develop individual health care plans for each patient based on these assessments.

(4) To specify anticipated outcomes of treatments.

(5) To report the costs of all services provided to the patients in the expanded benefits group who entered day care.

To carry out these tasks, the Burke Rehabilitation Center employed an assessment team as required by the contract. The team consisted of a social worker, a nurse, and a physician. This team followed the methodology developed by the evaluation contractor, Medicus Systems Corp., using the assessment instruments prescribed by the contract. The required data were transmitted to Medicus.

COMMUNITY SERVED BY THIS DEMONSTRATION

The catchment area as originally conceived was central and southern Westchester County. The major constraint was that the area to be served had to permit transportation of the accepted applicants within a reasonable time period. Subsequently, the catchment area was redefined and expanded southward to include some northern parts of the Bronx.

The expanded catchment area was approximately 132 square miles with a population of 788,736 persons (1970 Census). Approximately 12 percent of this population (or 92,058) were 65 years of age or older.

The distribution by age, sex, and race of the population over 65 in the catchment area appears in table 1.

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[1] Originally written as an 18-month contract but extended to 26 months.

TABLE 1

	Percent
Age:	
65 to 74	64
74-plus	36
Sex:	
Male	41
Female	59
Race:	
White	89
Black	11

DESCRIPTION OF THE BURKE DAY HOSPITAL

The day hospital is a division of the Burke Rehabilitation Center. The center, a 150-bed voluntary, nonprofit rehabilitation hospital, is affiliated with the Cornell University Medical Center and is joint commission-accredited. Located in White Plains, N.Y., it offers comprehensive multidisciplinary physical medicine and rehabilitation services to inpatients and outpatients. The day hospital is a medical model with goals similar to those of the British day hospital, viz., rehabilitation of its patients, ongoing medical-nursing supervision, socialization, and relief of family stress and strain. The day hospital program, during the research phase of its development, called for an initial as well as periodic assessment of the physical and psychosocial functioning of those patients deemed eligible for its services. Following the initial assessment, patients were assigned to either an experimental or control group by a scientific randomization process. It was this experience in the provision of day care services on an experimental/demonstration basis that motivated the codirectors of the day hospital to become involved in the 222 program.

EVOLUTION OF THE DAY HOSPITAL

In 1963, the Burke board of directors' long-range planning committee established a chronic illness study group for the purpose of assessing the unmet health needs of aging and chronically ill adults in Westchester County, and to determine Burke's future role in meeting some of those needs. The major recommendation of this study was that Burke establish a day hospital. These conclusions were based on a needs analysis, a survey of community programs, and the experience gained in coordinating an 18-month pilot community home care program as part of the chronic illness study. The Burke board postponed action on the establishment of the recommended day hospital program because of insufficient space and lack of necessary funds.

Four years later, however, a study of the center's physical facilities resulted in the construction of a new three story building which provided for the total replacement of Burke's 150 inpatient rehabilitation beds. Upon completion of the new building in September 1972, two former inpatient buildings were vacated. One of these was scheduled to be modernized for expanded administrative services, thus leaving one building for which no immediate plans had been made. With the availability of physical space imminent, and the need for day care services more apparent than ever, a survey was made in 1971 by the center's planning and program development staff to update the information gathered 8 years earlier. The findings of 1963–64 had not changed substantially. The aging, chronically ill population had increased, services had become more fragmented, and the need for a day hospital had become more urgent. More evident than before was the need to coordinate and make accessible a comprehensive package of health care services for those chronically ill, physically disabled aging persons who did not require 24-hour institutionalization.

With this goal in mind, the DHEW Medical Services Administration Office of Innovative Programs was approached for funding of a research/demonstration project which would test the viability of the day hospital concept in this rehabilitation setting. They were responsive to the idea and suggested that it be co-funded by the Administration on Aging. A 3-year research/demonstration grant was awarded on July 1, 1972. As previously noted, the research design developed by the day hospital staff was very much like the design called for in the 222 contract. During the first 18 months of operation patients were accepted on a random basis and 50 percent of the patients deemed eligible did not receive day hospital services. The intake and randomization of patients which were essential to the research study ended in August 1974. The day hospital then began accepting all patients who were deemed admissible.

INTENT OF THE PROJECT

A discussion with the Federal project officer for this demonstration, shortly after the contract was awarded, focused on the nature of the day care services Burke would provide. It was agreed that the day hospital would serve patients in need of posthospital and non-post-hospital continuing care on a short-term basis and that referrals would be accepted from the following sources: General hospitals, rehabilitation hospitals, home health agencies, private physicians, skilled nursing facilities, community health and welfare agencies.

The purpose of the demonstration was to determine the types of patients who would take advantage of these services. Initial screening for acceptance into the demonstration employed the following criteria:

(a) The individual who was eligible had a physical illness causing functional limitations for which some improvement could be reached through such day care services as physical therapy, occupational therapy, speech therapy, nursing service, or social service; was able to live at home and be transported to and from the day hospital; may have had psychological problems but not to a degree that would interfere with participation in the program; required continuous therapy to maintain his functional level and/or reduce the rate of decline of function.

(b) The individual who was ineligible had functional limitations caused by a mental disorder rather than a physical illness; had a mental disorder which would prevent effective participation in a rehabilitation program for a physical illness; was as functionally independent as possible given the nature of the disease; had a physical illness causing functional limitations which required more nursing care than could be provided in a day care center; had a family situation which would prevent compliance with all aspects of the study.

SAMPLE SIZE

The final Burke sample consisted of 95 patients, of whom 70 were awarded expanded benefits and 25 were assigned to the Control Group.

SOURCES OF REFERRALS

The number of referrals from each source is shown in table 2.

TABLE 2.– TOTAL NUMBER OF REFERRALS (222 DEMONSTRATION)

Sources	Number of referrals	Percent
Acute care hospitals	8	6.3
Adult day care centers [1]	1	.8
Burke Rehabilitation Center in-patient division	18	14.3
Community service agencies (i.e., office of aging, multiservice center, etc.)	28	22.2
Extended care facilities	4	3.2
Home health agencies within acute care hospitals-home care departments	14	11.1
Other home health agencies (e.g., AVNS, Westchester County Health Department)	12	9.5
Private physicians	23	18.2
Self/family/friend	17	13.5
Skilled nursing facilities	1	.8
Total	126	100.0

[1] Burke Day Hospital.

SERVICES PROVIDED BY THE DEMONSTRATION

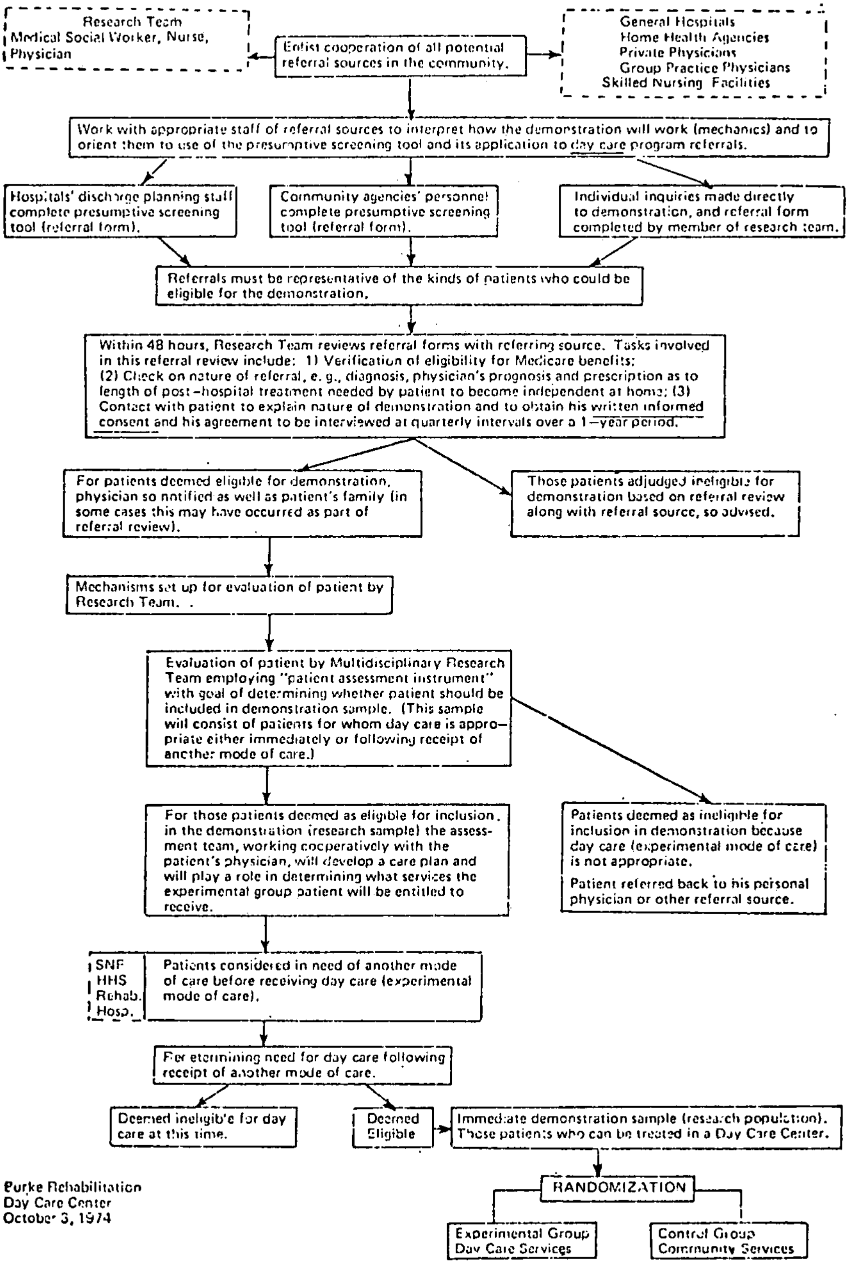
The 222 demonstrations, through a waiver, provided services not ordinarily covered by Medicare, viz., transportation, medical/nursing care, social casework, preadmission assessment, midday meal, and recreation therapy. The contractor considers all of these to be essential for effective delivery of medically oriented day treatment. They should be combined with the therapies currently covered by medicare—occupational therapy, physical therapy, and speech therapy—into an integrated service package. Reimbursement should be for those parts of the service package which the patients need as specified in the care plan.

INTAKE PROCESS

The intake process is described in figure 2.

Figure 2

INTAKE PROCESS FOR RESEARCH DEMONSTRATION UNDER SECTION 222



Burke Rehabilitation
Day Care Center
October 3, 1974

ASSESSMENT PROCESS

The assessment team consisted of a physician, a registered nurse, and a medical social worker. A physical therapist was added as a consultant on a short-term basis (3 months) to instruct the nurse and social worker to do range of motion assessments.

The nurse or the social worker conducted all face-to-face interviews with patients. On some occasions they interviewed in tandem to check inter-rater reliability of interpretations used in coding. Once the patient status instrument had been administered and coded, the team member who had conducted the assessment drew up a tentative care plan. The entire team met weekly to discuss each case, and the tentative care plan was refined through this group interaction. The physician was especially helpful in determining additional medical information needed to develop a truly comprehensive assessment team care plan.

The patient status instrument in general proved to be easy to code but it was cumbersome. As an assessment tool it encompasses all broad aspects of data collection. The items most useful in terms of care planning and indices of health status were those on physical functioning and instrumental activities of daily living. These items seem to have potential as a worthwhile addition to most existing patient medical records.

In evaluating its use for determining suitability for day care intervention it became obvious that more medical information was required. Thus, further medical data was requested from the patient's physician as were reports of any hospitalizations. Those items in the patient status instrument pertaining to social contacts and activities of the patients were so numerous and detailed that they tended to become tiring to the patient and to the assessment team member, creating a "breakdown" in the interview process. Perhaps, in part, this was precipitated by the time consumed for the necessary interpretation of the "informed consent" and the explanation of the study itself. (An explanation of the study and actual assessment should probably be done on separate days.)

In order to develop a comprehensive health care plan, further elaboration of various items was needed. Additional information sought most often and not captured through the PSI related to: Medications; nutritional intake and fluid balance; bowel and bladder problems; their effect on socialization; health status and health practices of significant others (family members, neighbors, etc.); quality of social contacts.

The assessment team had a real question about the usefulness of the colored progressive matrices—Raven test with an older population and particularly with patients who were perceptually impaired.

The assessment team care plan is a well designed form. It compels the assessor to be precise in recording significant information and in formulating long-term and short-term goals. It makes sense to specify treatments, their frequency and duration even though it may be necessary to modify these specifications as the individual moves through the treatment process.

The two following case histories illustrate the typical care delivery plan, goals and progress in the day hospital:

CASE HISTORY OF MRS. B.

Mrs. B. is an 87-year-old black female. She is a widow and lives in an apartment with her daughter. She was referred to the day care demonstration by her granddaughter to see if her mobility could be increased. A known hypertensive since 1970, Mrs. B. suffered a mild stroke in December 1974 which resulted in left-sided weakness. She was seen in an acute hospital emergency room but was not admitted. In March 1975, she was briefly hospitalized to control hyperglycemia. Prior to her referral to the day hospital, Mrs. B. was essentially homebound. Although independent in most self-care activities, she was almost totally dependent in homemaking skills which proved a great burden to her daughter. Since she was unable to climb stairs, her physician saw her at home.

While requesting additional medical information from Mrs. B.'s personal physician, the assessment team learned that he was not familiar with the day hospital and felt his patient was "too old" for the time and expense involved in active therapy. In consultation with the assessment team physician it was decided to send Mrs. B.'s personal physician a more comprehensive description of the day hospital services with assurances that her treatment plan would be individualized to her tolerance with his approval and supervision. He subsequently agreed to the proposed plan "with much skepticism." Mrs. B. was admitted to the Intermediate level of care within the day hospital on February 25, 1976 and was scheduled to attend 2 days per week.

Income: Social Security and SSI amounting to approximately $215 per month.

Health Insurance: Medicare A and B, medicaid.

Referred to 222 demonstration: November 1975.

Admitted to day hospital: February 25, 1976.

Discharged from day hospital: July 2, 1976.

Additional diagnoses: Hypertension, mild stroke with left-sided weakness, diabetes mellitus, arteriosclerotic cardiovascular heart disease, osteoarthritis.

Nursing

Assessment: Mrs. B.'s blood pressure was elevated and her heart rate irregular. She had swelling of both legs. Her vision was impaired. She did not have an adequate understanding of her medications and diet. She used strong laxatives for occasional constipation.

Plan: (a) cardiac evaluation, EKG, followed by close monitoring of her vital signs and her tolerance for day care activities; (b) instruction and counseling regarding medications, diabetic diet, and sodium restriction.

Goals: (1) to prevent deterioration of her cardiac, hypertensive, and diabetic condition; (2) to coordinate day hospital activities within her tolerance; (3) to increase the patient's understanding and responsibility for managing her diet and medication regimen; (4) to improve her visual acuity.

Physical therapy

Assessment: Weakness and limited range of motion in both lower extremities. She did not use her walker reliably, her balance was poor and her endurance limited.

Plan: (a) General strengthening and conditioning exercises to improve her stability and endurance; (b) supervised ambulation with verbal cues to reinforce safety awareness.

Goals: (1) To ambulate safely with an assistive device for longer distances; (2) to climb stairs.

Occupational therapy

Assessment: Mrs. B. had impaired dexterity and coordination of both upper extremities. She was dependent in most homemaking skills and unable to participate in former hobbies.

Plan: (a) Functional exercises with activities aimed at increasing her general strength and finger coordination; (b) evaluation of bathtub transfer; (c) participation in homemaking skills, e.g., Mrs. B. prepared meals with other patients under the supervision of occupational therapist; (d) participation in creative craft activities within her visual limitations.

Goals: (1) To increase strength and dexterity; (2) to increase participation in ADL at home; (3) to resume former hobbies, e.g., sewing, arts and crafts.

Social service

Assessment: Mrs. B. was found to be unhappy about her limited social contacts. She enjoyed socializing and was formerly quite active in church and community activities. It was noted by the staff that Mrs. B. was often partially disoriented to time and that her memory was poor.

Plan: (a) placed in current events group to promote reality orientation and resocialization; (b) long-range planning included assistance in contacting local community programs in which she would be able to participate.

Goals: (1) to improve orientation; (2) to increase socialization.

Mrs. B. attended the Day Hospital for approximately 5 months for 2 days a week, or 31 total treatment days. She was discharged home on July 2, 1976.

Upon discharge, Mrs. B. was able to ambulate safely and independently with a standard cane, indoors and outdoors. She could climb stairs with human assistance. She was independent in all self-care activities, including bathing. With the exception of continued dependence in shopping, she was sharing all homemaking activities with her daughter. She received new glasses. She understood her diet and medication regimen.

The assessment team saw Mrs. B. at home every 3 months until the end of her benefit period. Her final assessment was in January 1977. She had maintained all gains achieved at the day hospital. She was greatly involved in community activities and able to go to her physician's office.

We heard from her physician again when he called to refer another patient because he was pleased with Mrs. B.'s Day Hospital achievements.

CASE HISTORY OF MR. M.

Mr. M. is a 56-year-old white single male who lives with his deaf-mute sister in a first floor apartment. He was essentially in good health and employed as a bartender until 1965, when he suffered a stroke which left him with a right hemisparesis and speech and language difficulties (dysphasia, mild dysarthria). In 1968, he sustained a fracture of the right femur which required pinning. In 1971 he experienced increased gait difficulty. Avascular necrosis of the right femoral head required surgical excision and placement of an Austin-Moore prosthesis. In May of 1975, he suffered a second stroke which again affected his speech and right side. He attempted suicide and was briefly treated at a psychiatric hospital. At the time of entering the demonstration sample, Mr. M. was receiving physical therapy and occupational therapy on an outpatient basis. He was granted expanded benefits for 1 year on December 9, 1975.

Mr. M. was admitted to the day hospital intensive level on Janaury 29, 1976. He attended two times a week for 6 months and utilized all available day hospital services including nursing care, social work counseling, physical therapy, occupational therapy and speech therapy.

Income: Social Security, $240 per month; veterans benefits, $39.50 per month.

Health Insurance: Medicare A and B.

Referred to 222 demonstration: December 1, 1975.

Admitted to Day Hospital: January 29, 1976.

Discharged from Day Hospital: July 15, 1976.

Additional diagnoses: Hypertension; Arteriosclerotic heart disease, S/P myocardial infarction.

Nursing

Assessment: Mr. M. had slightly elevated blood pressure. Although emotionally responsive and cooperative, the patient manifested noticeable anxiety which may also have complicated his speech difficulties. Mild facial motor paresis was observed.

Plan: (a) Monitor his vital signs, (b) monitor his diet and medication regimen, (c) treat a minor foot problem, (d) in general, coordinate his day hospital program.

Goals: (1) Stabilize his medical condition, (2) improve his emotional responses to reduce anxiety.

Physical therapy

Assessment: Patient ambulated with a poor gait pattern using a quad cane and a short leg brace. His right leg was shorter than his left. His right knee and hip had limited range of motion. He was unable to climb stairs without help.

Plan: (a) Evaluate by Burke orthopedist and fit with new brace and shoe lift; (b) ambulation training, general conditioning, range of motion and strengthening exercises.

Goals: (1) To improve gait pattern, (2) to climb stairs independently.

Occupational therapy

Assessment: Mr. M., who is right-handed, had weakness of the right affected upper extremity. His right hand had poor grasp and dexterity, with position and sensory loss. Although he was independent in most self-care activities, they took him longer to perform than reasonable.

Plan: (a) Improvement of right upper extremity performance to better assist his unaffected side; (b) functional and strengthening exercises and activities, both individually and in a group setting.

Goals: (1) To increase his participation in ADL, e.g. meal preparation, housework, etc.; (2) to facilitate his performance in all self-care activities independently; (3) to promote socialization by participation in a group setting.

Speech therapy

Assessment: Mr. M. had mild receptive and mild-moderate expressive dysphasia, as well as mild dysarthria. He spoke hesitantly, with particular difficulty in articulating longer sentences. His speech and language disabilities were more prominent in a group setting, which contributed to his decreased social contacts.

Plan: (a) Individual speech therapy two times a week; (b) conversational group therapy once a week.

Goals: (1) To speak more intelligibly in longer sentences; (2) to use the telephone independently; (3) to increase his self-confidence in a group setting.

Social Service

Assessment: It was felt that Mr. M.'s depression and decreased social contacts were due to a poor self-image and loss of confidence.

Plan: (a) Social work support and counseling throughout his stay at the day hospital; (b) assistance in making community contacts.

Goals: To increase his self-esteem.

Mr. M. attended the day hospital twice a week for 6 months. He was discharged on July 15, 1976 with status as follows: Medical condition stable. Speaking intelligibly in longer sentences and with increased self-confidence, ambulating well with assistive devices. Climbing stairs independently, performing better in all activities of daily living.

Prior to his discharge, a referral was made for part-time employment at a vocational workshop in a nearby town.

The assessment team was unable to reach Mr. M. by telephone to arrange for his fifth and final interview. He was contacted by letter and replied reporting that he was working at the vocational workshop to which he had been referred. "I don't make much money, but you don't realize how much this means to me." He also reported that he had been getting a ride to work but when the driver became ill he was able to take a bus . . "it was a dare to me . . . the job is something to do, something that will keep my mind busy. I like what I am doing . . . Burke Day Hospital did a lot for me. I can ride a bus, use a cane, put a lift on my shoe. My speech is better. I'm satisfied with all this."

Mr. M.'s fifth and final assessment, completed on November 26, 1976, revealed that he had maintained all day hospital gains with significant improvement in the quality of his life.

MEASUREMENT OF THE RESULTS

The single source funding approach enabled the provider to meet the changing needs of patients in an effective manner, as opposed to the fragmented approach which is likely to occur under current reimbursement mechanisms. Single source funding of an integrated package of services was effective from the viewpoint of the provider, the patient, and the family members responsible for payment for services.

Single source management of patient care via a health care team was most effective because it coordinated patient needs with on-site resources as well as with other community health care resources—such as the family physician, the home health agency, consultative services as needed, and the community resources which were to be used when the patient was discharged back to the community.

The actual measurement of the results of these mechanisms, however, is to be carried out by Medicus Systems, the evaluation contractor, on the basis of the national sample.

COST DATA

Cost data for the entire project were collected by the Division of Direct Reimbursement, Social Security Administration through the Accounting Department of Burke Rehabilitation Center and through the fiscal intermediary for medicare utilized by Burke.

EXTENSION OF SERVICES

Day hospital services to patients who were part of the 222 demonstration were extended beyond the life of the contract if the patient required those services, since the day hospital is an ongoing division of the Burke Rehabilitation Center. However, those patients were required to pay for services not covered by medicare, part B and to pay the coinsurance on covered services. Those who could not afford to pay for these services and who were not medicaid-eligible would have had to drop out of the program. Fortunately, there were no patients in that category.

FINDINGS AND RECOMMENDATIONS

The Burke Day Hospital has been in existence for 4½ years. During that time we have treated 738 different individuals, representing a total experience of 42,141 patient treatment days. Based upon our total experience in delivering this form of day treatment—including our experience within the section 222 demonstration—we offer the following observations and recommendations:

(1) *Adult day health care facilities are essential as one option within a comprehensive community health and social care system.* No one set of services can meet all the health care needs of a community. A day hospital such as ours can provide a continuum of care for chronically ill, physically disabled adults and can effectively treat those individuals who might be considered "at risk" because of the complex nature of their illnesses. But the same complex illness also requires a physician, an acute care hospital, a rehabilitation inpatient facility, a home health agency, and a skilled nursing facility within the community. If the day health care facility is one of a number of options, its utilization is likely to be more appropriate and more cost effective.

(2) *A preliminary comprehensive physical and psychosocial assessment and an individualized care plan developed by a qualified assessment team should determine the suitability for any form of treatment, including day treatment services.* There should also be provision for periodic reassessments to review the patient's progress toward the initial treatment goals and at the same time build in some quality control. The instruments used for this purpose in the 222 Demonstration were useful and could be modified to provide a uniform data reporting system. which in turn could be linked to appropriate public and private reimbursement mechanisms.

(3) *Psychosocial services must be integrated with the delivery of health care in any system of long-term care, and all sources of reimbursement should recognize that they are inseparable.* The patient is part of a social environment which must be considered in designing his health care plan.

We found, for example, that stroke patients had averaged 65 treatment days over a period of six or seven months and had made substantial gains in the direction of functional independence. Many of them continued to make gains or to maintain those gains following discharge. Counseling for those patients and their family members proved to be a major determinant in enabling them to cope with their illness and resulting disability.

Patients with musculoskeletal disorders, especially rheumatoid arthritis, also made functional gains during their day hospital stay. However, these gains were not necessarily maintained once they had been discharged from the program. This type of disability requires an ongoing "maintenance" rehabilitation program in order to avoid further deterioration. But, unfortunately, maintenance is a term which lacks reimbursement status under our present health insurance system.

Patients with neuromuscular disorders, such as multiple sclerosis, made small gains during their treatment stay, although their families gained the benefit of a comprehensive medical evaluation of the patient and some temporary relief of management responsibility. The physical gains achieved by this group were not maintained following discharge—a finding that is not surprising given the nature of the disease. For these two latter groups of patients, a home treatment program could be designed to help maintain the functional status of these patients with periodic monitoring at the day treatment facility—possibly twice a month—to provide the necessary reinforcement and continuing motivation for patients and their family members.

We found that most family members responsible for the person-at-risk were willing to continue providing care at home, given the backup support and intermittent relief of management provided by a day treatment program. The patient's social support system—whoever they may be—must be involved in the overall treatment process. Unless they are willing to participate, it is unlikely that the patient will maintain the gains achieved when he is discharged back to their full-time care. And if they are not sufficiently involved, they may be unwilling to resume their responsibility for the patient. Some system of family care incentives might help to reinforce those families who are willing and able to retain responsibility for their dependent disabled members. Such a system would hopefully include provision for respite care which would free families for a yearly vacation.

(4) *Transportation for the physically disabled, chronically ill to and from day health care programs is an essential ingredient which must be included in any approval package of day care services.* Current community efforts to provide special public transportation vehicles to accommodate the handicapped are important, but they do not meet the needs of transporting a daily hospital population of 50 severely handicapped persons on a door-to-door tight schedule. The major

gap in transportation is the lack of control over the profit margin commanded by the commercial, for-profit vendor with no competition.

(5) Once a patient has been rehabilitated to the point where he can function semi-independently at home, it is difficult if not impossible to locate a community program that will meet his continuing need for socialization following discharge. Most communities have programs for the ambulatory, healthy, active older person. Very few have services geared to the needs of the severely disabled, chronically ill nonambulatory person who returns to isolation from the mainstream of society and is likely to deteriorate without some ongoing stimulation. This person does not need a multitude of expensive services, and may only need periodic monitoring of his health status. But at the present time that is not part of the normal community network of services.

One of the most significant components within the 222 demonstration was the availability of reimbursement from a single source. This reimbursement was based upon an individualized health care plan developed from a comprehensive physical and psycho-social assessment of the patient. Equally significant was the fact that this reimbursement made it possible for the patient to receive an integrated package of treatment services appropriate to his individual needs. Another major feature was the periodic comprehensive reassessment of the patient's treatment needs by an independent assessment team. If incorporated into a day treatment program, this feature would permit evaluation of the patient's progress and, at the same time, would constitute a quality control.

Future demonstrations designed to test the effectiveness of adult day treatmen would, in our opinion, be fruitful if designed as one part of a network of community health care options. We also recommend that such demonstrations utilize existing health care facilities with experience, recognized expertise, and a proven commitment to the target patient population.

Senator CHILES. Please proceed, Dr. Weiler.

STATEMENT OF PHILIP G. WEILER, M.D., M.P.H., COMMISSIONER, LEXINGTON-FAYETTE COUNTY HEALTH DEPARTMENT, LEXINGTON, KY.

Dr. WEILER. It is indeed a pleasure to appear before the Senate Special Committee on Aging and testify on behalf of the American Public Health Association and as a public health physician actively involved in the planning, implementation, and delivery of services for the aging.

My activities have included membership on APHA's task force on aging and director of a section 222 project. In addition, as commissioner of health in Lexington and chairman of the department of community medicine at the University of Kentucky, I have attempted to stress the need for more involvement in health care for the aging in both the public health sector and the academic community.

The American Public Health Association is the largest national organization in public health with over 27,000 individual members from various public health disciplines and over 25,000 members in its 50 affiliated associations.

The American Public Health Association is deeply concerned about the inability of the present system to cope with broad human services needs of the elderly and the need for a concerted effort to improve services for the elderly, particularly those in need of long-term care. It is felt that public policy must be directed at major change in the "system" of delivering and financing long-term care. This is essential if we assume that national health insurance will be a reality within the next few years, and if we assume that appropriate care for the elderly will be incorporated into such a proposal. Presently, the presumed high costs of long-term care has prevented the establishment of a basic public policy on long-term care.

The most basic problem appears to be the inability of local communities to organize and manage the provision and payment for long-term care in the face of specific and restrictive requirements imposed by Federal and State statutes and regulations. These restrictions tend to make the community impotent in taking a flexible approach to long-term care geared to patient needs, health care resources, and fiscal constraints.

APHA feels that the present problems in long-term care can be classified as follows:

PATIENT ORIENTED PROBLEMS

One: There are no universally accepted methods of assuring the types of care required by the chronically ill and aged. Frequently the assessment mechanisms are based on a purely "medical" model, when socioeconomic, psychological, and behavioral models may be needed.

Two: Patient status often fluctuates from day to day, making it difficult to judge appropriateness of placement at a point in time. A patient may be placed in one type of facility because intial assessment suggests need for that level of care. A subsequent assessment may determine that the patient no longer needs that level of care, and because of requirements for "medical necessity" determinations and fiscal considerations in paying for "inappropriate" levels of care the patient may be moved to another facility. At some later date, the patient's needs may again change, and another move indicated. This sort of merry-go-round is destructive not only to the health of the patient, but also to his psychological and social adjustment to institutional living.

Three: Patients should have freedom of choice of facilities and services but patients subsidized by public programs are frequently denied any part in the decisionmaking process which affects their lives. Frequently the "choice" is guided by: (*a*) Officials who have a primary objective in saving costs under public programs, (*b*) lack of alternatives, (*c*) availability of beds, and (*d*) ignorance of options available. And yet, there is some evidence that patients who make their own decisions in the health care market may well be more efficient and economical in the choices they make.

PROVIDER ORIENTED PROBLEMS

One: Many communities do not have a full range of facilities and services that would provide alternatives for long-term care. Both institutional and community based outpatient services are required, including home nursing care, day care, meals-on-wheels, homemaker and housekeeping services, foster care placement, and so forth. Even when a range of facilities and services are available, frequently there is no mechanism to coordinate autonomous providers in order to focus on patient needs rather than provider services.

Two: Physicians and other health professionals are not fully knowledgeable about assessing patient needs, availability of community resources to meet needs, or methods of referring patients to appropriate resources. Too often when patients are ready to be discharged from hospital care, the only alternative considered for the aged patient is the nursing home.

Three: Facilities tend to be selective in the patients they will admit, preferring the patients that require minimal care and present no behavioral problems. In some cases, racial discrimination is evident; in others, there may be discrimination against medicaid patients through "quota" systems.

Payments bear no relation to the specific needs of the patient on a long-term care basis.

The standards are increasingly specific in classifying facilities for long-term care and they do not conform to the continuum of care that is needed. Standards need to be more flexible and reasonable. It is perhaps this rigidity that is responsible for the inability of local communities to organize and manage the provision and payment of long-term care and restricts communities from being flexible in their approach to gearing to the individual patient needs.

Coverage under third-party payments is primarily limited to the institutional care and varies widely from location to location, making it very difficult for provider and patient, alike, to understand what is available and what is not.

ADMINISTRATIVE PROBLEMS

The Federal, State, and local administrative responsibility in the area of long-term care for the aging is fragmented and uncoordinated and presents a severe handicap on people at the impact level trying to put together a program. There is need for the responsibility of long-term care to be placed with a specific group.

Furthermore, the certificate of need does not take into consideration, in most areas, the fact that there are alternatives and there is a continuum of care and something outside of the hospital other than a nursing home. Long-term care should not be entirely a health model which has a tendency to escalate costs without a necessary increase in quality.

The recommendations of APHA are as follows:

One: Service supports should be continuous for specific time intervals that extend beyond the normal time of acute trauma or events.

Two: Service access should be flexible and promptly available.

Three: A mechanism is needed for assessing individual need at the community level.

Four: The environmental setting should encourage the individual to make use of functional strengths.

Five: There should be followup on the continuing need of the individual.

Services should be provided in whatever setting is needed to meet the individual's needs, be it in an institution, congregate living arrangements, private home, or the person's own home. The archaic practice of trying to fit individuals into prepackaged service settings leads to a morass of facility definitions and levels of care. This fragmentation could go on indefinitely. The levels of care should be tied solely to an individual and not to a setting, making it possible to provide for a continuum of care tailored to each individual's changing needs.

There should be an emphasis on prevention for long-term care, perhaps similar to the health maintenance organization—HMO—

system approach. This system would be appropriate. It has been shown by known geriatricians in England, for example, that preventive measures could be very effective even after the age of 70.

There should be a mobilization of the educational system to address this problem.

APHA feels that new approaches to financing long-term care need to be explored which address both the medical and nonmedical aspects of the issue. Perhaps an approach would be to split off room and board cost for medical and other service costs.

It is felt that unless a coherent policy of long-term care is reached we will not be able to have an effective national health insurance program in this country.

Finally, APHA feels that public policy should also encourage the design and support of experiments that are community based and address the major policy issues as discussed here, and I have presented an outline for such experimentation in the written documents[1] presented to the committee.

RESEARCH PROBLEMS

Next, I would like to comment on the research under section 222. As I mentioned, I was a project director under that component and commissioner of the Lexington-Fayette County Health Department, which is one of the six demonstration sites. Lexington-Fayette County Health Department serves a population of about 250,000 and is a unique site for a number of reasons.

One, we were testing both services, day care and homemaker/home health aide.

Next, we were the actual providers of these services and did not contract out for them.

Lexington was the only site to include a medicaid sample in the section 222 experiments.

Fourth, the experimental services were part of a network of other geriatric services provided by the health department.

A complete description of our project has been presented in my prepared statement.[2] I would like to emphasize, however, some specific points I think are of special interest to the committee.

First, there were a number of administrative problems concerning the research itself which I think should be taken into consideration in analyzing the data from these projects.

One, there was an unrealistic time schedule established by the legislation.

Second, the written request for proposal was not well designed and resulted in a lot of misunderstanding in the beginning by both the demonstration contractors and the evaluation contractor.

Third, there was a rather lengthy delay from when the contracts were originally awarded and the actual services and demonstration began which resulted in a lot of ill feeling, I think, on the part of local community groups and friction between the local groups, demonstration projects, the evaluator in the Federal agencies involved.

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[1] Retained in committee files.

[2] See p. 534.

Lastly, better coordination definitely needs to be brought about in the Federal agencies involved in these projects.

Furthermore, there were several questions concerning the research which I think still are not fully resolved.

First, should the focus of the experiment be on service or coverage? As it turned out, the research design was set up to test the impact of receiving coverage for services and not set up to evaluate the benefits of the services per se.

Second, should the emphasis be on demonstration or evaluation? At times one or the other was emphasized.

Third, how should the problems of control be handled? It was very difficult to deny services to the control group, especially if they were eligible under other entitlements as a result. I feel many control patients actually got assistance from the project indirectly or directly. There was lots of hostility and friction in the community generated by the randomization of people into control and experimental groups.

Fourth, how should patients receiving the benefits after a year of entitlement be terminated? That is a very, very difficult question that we are all still dealing with. In Lexington, we were fortunate enough to have title XX pick up the funding for the projects. However, title XX is not an ideal title for funding of these programs because of the match required, overemphasis on the social aspects, and because many of the medical services are not funded through that entitlement.

Moving on to another point, an important influence on the research was the instrument used to assess the outcome of the patients. Without the committee being aware of some of the problems there, I think again the results could be misinterpreted. These have been explained in my prepared statement.

I feel the cost data from the experiment was accurate in getting the cost of the services for individual patients but when looking at overall costs of the experimental group versus the control group there are several factors which should be taken into consideration.

One, all the medical costs for the control group I feel were not captured.

Second, there was contamination of the control group by receiving services and benefits from the project.

Third, there was failure to compare subgroups in the control and experimental groups such as day care only, homemaker only, and those with certain disabilities.

Fourth, the experimental group did not all utilize the services. Only about 58 percent of those actually covered utilized the services, which means when you lump all the data together and look at the control group versus the experimental group you will get a misinterpretation of the data. In fact, all of these biases, in my opinion, tend to point toward no difference between the experimental and the control group, so any difference that we do get is heightened in its importance.

EFFECTS OF DAY CARE AND HOMEMAKER SERVICES

I know many people have mentioned that the data is preliminary and I feel it is also, but there is some data that we had in Lexington that I would like to share with the committee. We found under an independent evaluation done before the section 222 actually got started that a larger percentage of day care patients improved in the various levels of functioning measured by an assessment team than the control group. We have also analyzed the data preliminarily on the 222 projects and have found what we feel are significant findings.

Under day care, the experimental group improved in seven areas of functioning over the control group, including, significantly, physical functioning, orientation, activities of daily living, and in the instrumental activities of daily living and bowel functioning. They were maintained in two areas as well as the control group, bladder and contentment, and regressed faster than the control group in only three areas. More significantly, however, if a patient attended day care they had less bed disability days, utilized less hospital days and nursing home days. The control group had twice the number of bed disability days, three times the number of hospital days, and over twice the number of nursing home days.

Under homemaker, the results are not as sharply divided as under day care. The homemaker experimental group improved in six items over the control group; remained the same in two items and actually regressed faster than the control group in seven items. Also, the group who received homemaker services used less nursing home care days per bed disability days but used slightly more hospital days than the control group.

I would like to conclude by saying that I also feel that a network is needed to really efficiently use alternative long-term care services. Sitting in on the assessment team, I have witnessed firsthand many occasions in which day care and homemaker could not be provided for a patient because the other support services such as meals-on-wheels, friendly visitor, social centers were not available or there was no funding for it for a particular patient.

We also feel that a referral mechanism system is essential for any alternatives in long-term care to work. Many hospitals have discharge planners, but how they are functioning in many areas is questionable. In some cases, they are brought in only on the last day of a hospital stay. Usually, it seems the purpose they are requested for is to find a nursing home placement and have little interaction with the physician to really look at all the options involved.

I feel that if we are going to learn anything from these experiments we should not fall into the pitfalls of the past, which would include developing a reimbursement system before we have the capacity system set up, developing alternatives in a vacuum and not having integrated them with other larger health systems such as health departments or universities or some other system. Also, we feel that temptation to overstandardize must be avoided.

Lastly, I feel personally that the era of experimentation with homemaker and day care should be closed, and we should move on now to also establishing these services on a national basis to meet the long-term care needs of this country. I think no other module of delivery has been so studied and so examined and so picked apart as these services in long-term care.

I appreciate this opportunity to present this testimony to the committee and would be pleased to elaborate further on any of the points I have mentioned.

Senator CHILES. The prepared statement of Dr. Weiler will be inserted into the record at this time.

[The prepared statement of Dr. Weiler follows:]

PREPARED STATEMENT OF DR. PHILIP G. WEILER

It is indeed a pleasure to appear before the Senate Special Committee on Aging and testify on behalf of the American Public Health Association and as a public health physician actively involved in the planning, implementation, and delivery of services for the aging.

My activities have included membership on APHA's task force on aging and director of a section 222 project. In addition, as commissioner of health in Lexington and chairman of the department of community medicine at the University of Kentucky, I have attempted to stress the need for more involvement in health care for the aging in both the public health sector and the academic community.

The American Public Health Association is the largest national organization in public health with over 27,000 individual members from various public health disciplines and over 25,000 members in its 50 affiliated associations.

The American Public Health Association is deeply concerned about the inability of the present system to cope with broad human services needs of the elderly and the need for a concerted effort to improve services for the elderly, particularly those in need of long-term care. It is felt that public policy must be directed at major change in the "system" of delivering and financing long-term care. This is essential if we assume that national health insurance will be a reality within the next few years, and if we assume that appropriate care for the elderly will be incorporated into such a proposal. Presently, the presumed high costs of long-term care has prevented the establishment of a basic public policy on long-term care.

The most basic problem appears to be the inability of local communities to organize and manage the provision and payment for long-term care in the face of specific and restrictive requirements imposed by Federal and State statutes and regulations. These restrictions tend to make the community impotent in taking a flexible approach to long-term care geared to patient needs, health care resources and fiscal constraints.

APHA feels that the present problem in long-term care can be classified as follows:

A. PATIENT ORIENTED PROBLEMS

(1) There are no universally accepted methods of assuring the types of care required by the chronically ill and aged. Frequently the assessment mechanisms are based on a purely "medical" model, when socioeconomic, psychological, and behavioral models may be needed.

(2) Patient status often fluctuates from day to day, making it difficult to judge appropriateness of placement at a point in time. A patient may be placed in one type of facility because initial assessment suggests need for that level of care. A subsequent assessment may determine that the patient no longer needs that level of care, and because of requirements for "medical necessity" determinations and fiscal considerations in paying for "inappropriate" levels of care, the patient may be moved to another facility. At some later date, the patient's needs may again change, and another move indicated. This sort of merry-go-round is destructive not only to the health of the patient, but also to his psychological and social adjustment to institutional living.

(3) Patients should have freedom of choice of facilities and services but patients subsidized by public programs are frequently denied any part in the decisionmaking process which affects their lives. Frequently, the "choice" is guided by: (a) Officials who have a primary objective in saving costs under public programs, (b) lack of alternatives, (c) availability of beds, and (d) ignorance of options available. And yet, there is some evidence that patients who make their own decisions in the health care market may well be more efficient and economical in the choices they make

B. PROVIDER ORIENTED PROBLEMS

1. Many communities do not have a full range of facilities and services that would provide alternatives for long-term care. Both institutional and community based outpatient services are required, including home nursing care, day care,

Meals-on-Wheels, homemaker and housekeeping services, foster care placement, etc. Even when a range of facilities and services are available, frequently there is no mechanism to coordinate autonomous providers in order to focus on patient needs rather than provider services.

(2) Physicians and other health professionals are not fully knowledgeable about assessing patient needs, availability of community resources to meet needs, or methods of referring patients to appropriate resources. Too often when patients are ready to be discharged from hospital care, the only alternative considered for the aged patient is the nursing home.

(3) Facilities tend to be selective in the patients they will admit, preferring the patients that require minimal care and present no behavioral problems. In some cases, racial discrimination is evident; in others, there may be discrimination against medicaid patients through "quota" systems.

C. PAYMENT ORIENTED PROBLEMS

Payments bear no relation to individual patient needs, but are averaged on a facility basis assuming an "average" patient need. This tends to provide an incentive to facilities to admit patients needing only minimal care.

D. STANDARDS AND CLARIFICATION PROBLEMS

(1) Federal and State standards are increasingly more specific in classifying facilities for long-term care. The classification of facilities does not conform to the continuum of care required by a population of patients.

(2) Federal and State requirements for certification of facilities, conduct of utilization, review, conduct of periodic medical review and independent professional review, conduct of fiscal and other audits, place additional pressures on local communities and their families and further remove them from the decision-making process. At times, the several processes appear to overlap, to say nothing about the impact on the facilities and their patients of multiple team visits throughout the year.

(3) Standards need to be more flexible and reasonable. Enforcement should be on a local level and monitored on a State or Federal level.

E. THIRD-PARTY BENEFIT PROBLEMS

(1) Coverage of benefits under the various public and private programs varies widely, creating confusion for the patient as well as the providers. The relationship between medicare extended care benefits and medicaid SNF and ICF benefits is particularly confusing, when an individual may be eligible for both programs, and when "medical necessity" determinations for the one are confirmed by intermediaries, and for the other by local medical directors.

(2) Benefits tend to emphasize institutional care and exclude other kinds of services that might help keep patients in the community, e.g., housekeeper services, day care, Meals-on-Wheels. Benefits fragment the patient and force him into certain service circumstances simply because payment is available for those services and not for others.

F. ADMINISTRATIVE PROBLEMS

1. Federal, State, and local administrative responsibility in the area of long-term care for the aged is fragmented and uncoordinated. Currently there are at least a half-dozen categorical and uncoordinated programs at different levels of government that were independently created and funded to deal with a specific piecemeal need of the aged. Facilities have developed to parallel financing mechanisms and there is little understanding of the differences in client populations, service needs, and services provided in different facilities. People are often forced to choose a method of care without considering any of the alternatives because of lack of knowledge, inaccessibility of care of financing arrangements. Although the financing maze for institutional care is confusing and plagued with gaps, the picture for noninstitutional care and alternative care is even more difficult.

What began as a reflexive response to a relatively small need for institutional long-term care has now mushroomed into a huge public responsibility. No policy or strategy has been developed that cuts across medical and social needs. Instead, we have muddled through over the years and have had a continual fragmentation of narrowly and arbitrarily classified sets of institutions to meet preconceived needs. Even the so-called move to "deinstitutionalize" the aged back to the community seems only to have succeeded in creating a web of facilities poorly equipped to provide the needed social, rehabilitative, and mental health services.

(2) Certificate of need control over the expansion of health care facilities does not adequately consider alternatives in long-term care.

(3) The fragmented nature of administrative responsibility makes it almost impossible to have an adequate, usable data base on which to determine needs for beds and other services, control utilization, or control costs.

(4) Long-term care should not be entirely a health model which has a tendency to escalate costs without a necessary increase in quality. The fiscal escalation is in part due to personnel restrictions and its technological demands. Most health models require the use of high salaried licensed professionals which can limit the effective use of less trained and expensive personnel. The medical model also tends to require more testing for routine coverage. This has been called defensive medicine to protect against possible malpractice suits.

RECOMMENDATIONS

Long-term care should have the following characteristics:

(1) Service supports should be continuous or ongoing for specific time intervals that extend beyond the normal time of acute trauma or events.

(2) Service access should be flexible and promptly available.

(3) A mechanism is needed for assessing individual need at the community level.

(4) The environmental setting should encourage the individual to make use of functional strengths.

(5) There should be followup on the continuing needs of the individual.

Services should be provided in whatever setting is needed to meet the individual's needs, be it an institution, congregate living arrangement, private home or the person's own home. The archaic practice of trying to fit individuals into prepackaged service settings leads to a morass of facility definitions and levels of care. This fragmentation could go on indefinitely. The levels of care should be tied solely to an individual and not to a setting, making it possible to provide for a continuum of care tailored to each individual's changing needs.

To assure that the services meet individual needs a method of assessment is needed. This mechanism should provide recommendations for services, referrals, and consumer feedback. Community based counsellors, perhaps older citizens themselves, could act as facilitators and "brokers" of service to follow up on recommendations and complaints. An assessment team composed of medical and social work professionals could develop specific care plans for each individual. Mechanisms for manipulating funding sources could be provided through community long term care coordinating agencies.

APHA feels a coherent Federal policy needs to be developed that brings order and equity to the provision of human services for the elderly. Such a policy should emphasize that care for the elderly needs to be directed toward providing a broad range of community support services that enable the elderly to remain in their homes for as long as possible and with freedom to exercise individual initiative. Since the crowning grace of old age is influence, let's make sure the elderly retain as much as possible, at least over their own lives. The over emphasis on institutions is not only inappropriate from a cost standpoint, but also from a human standpoint.

Community support services in a long-term care policy should include such things as home health services, homemaker services, day care centers, Meals-on-Wheels, visitation systems, transportation systems, preventive and maintenance services. Also, in addition to income maintenance and housing, such services include: Information and referral, nutrition services, recreation, communication services, legal services, and protective services.

There should be an emphasis on prevention, perhaps similar to the health maintenance organization (HMO) system approach. Important preventive measures can be instituted even at 70 years of age and older. Well elderly clinics are presently attempting to do this in some localities.

There needs to be a mobilization of the educational system to address the problem. Too few schools provide training in gerontological settings. Too little is being done to prevent the perpetration of society's myths on aging. Gerontological input into the educational system needs to be given at the State level. More data needs to be collected on the characteristics of the elderly that need support services.

APHA feels that new approaches to financing long-term care need to be explored which address both the medical and nonmedical aspects of the issue. Such an approach could split off room and board costs from medical and other service costs. Social and medical services would be provided and reimbursed in a flexible fashion to support people in any setting be it in an institution, congregate living arrangement, private home or the person's own home.

Separating out room and board from service costs enables a much simpler and more efficient way of finding one's way through the galaxy of financing sources for supporting people. It also gets us out of the morass of facility definitions. Levels of care would be tied solely to an individual and not to an institution, making it possible to provide for a continuum of care tailored to individual client needs.

APHA feels that public policy should encourage the design and support of experiments that are community based and address the major policy issues and problems in the system discussed, see appendix No. 1.[1]

Next, I would like to comment on the research in alternative forms of long term care for the elderly conducted under section 222(b) of the Social Security Act.

The Lexington-Fayette County Health Department is one of the six demonstration sites involved in the evaluation of adult day health care and homemaker/home health aide benefits. The Lexington site was remarkable in several aspects:

(1) The health department was testing both services (day care and homemaker).

(2) The health department was also the provider of these services.

(3) Lexington was the only site to include a medicaid sample.

(4) The experimental services were part of a network of other geriatric services provided by the health department (i.e., home health services, elderly health maintenance program, geriatric clinics, nursing home quality improvement program, elderly nutrition and exercise program). The existing network of services was very beneficial for patient referral and followup.

A complete description of the project is included in appendix No. 2.[1] However, I would like to emphasize certain points.

(1) There were considerable administrative problems with the research which included:

(a) Unrealistic legislative time-frame to complete the projects.

(b) Poorly written and designed requests for proposals (RFP's) which resulted in misunderstandings on the part of the evaluation contractor and the demonstration contractors.

(c) Delays initiating the research from July 1974, when contracts were awarded to March 1975, when patients were actually accepted.

(d) Poor coordination among and in the Federal agencies involved (i.e., Division of Direct Reimbursement, Social and Rehabilitative Services, and the National Center for Health Services Research).

(e) The medicaid sample which can provide valuable additional information was extremely difficult and time consuming for us to initiate. After prolonged discussions with the State and commitments to them for data, NCHSR has threatened to terminate the experiment before it is finished.

(2) Several issues concerning the research do not seem to have been satisfactorily resolved:

(a) Should the focus of the experiment be on "service" or "coverage"? As it turned out the research design was set up to test the impact of receiving coverage for services *not* of the benefits of the services per se.

(b) Should the emphasis be on the demonstration or evaluation part of the project? At times one or the other was emphasized.

(c) How should problems with controls be handled? It was very difficult to deny services to the control group especially if they were eligible under some other entitlement. Also, controls may have received other assistance through the project or a combination of experimental and nonexperimental services. It is esti-

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[1] Retained in committee files.

mated that there was considerable contamination of the control sample. This would tend to bias the result in favor of no difference between the control and experimental groups.

(d) How should patients who are receiving benefits be terminated from the project? As much as possible other sources had to pick up the services. Title XX has been our major source of funding, but is not entirely satisfactory because of the local match involved and the fact many direct medical services are excluded from coverage.

(3) An important influence on the outcome of the research was the instrument used to measure functional status of the patients. Several problems existed here, see pages 25–26 of appendix No. 2.[1]

Although results of the section 222 project have not been completely analyzed yet, our own data analysis has found a large percentage of day care patients were found to have improved levels of functioning in all five areas studied (Health Care for Elderly Americans: Evaluation of an Adult Day Health Care Model, published by Medical Care, August 1976, vol. XIV, No. 8).

(4) I feel the cost data obtained on the experimental services were accurate but when compared to the control group does not provide an adequate analysis because:

(a) All medical costs on the control group were difficult to capture.

(b) Contamination of the control group who received other services and benefits from the project.

(c) Failure to compare subgroups in the experimental group (i.e., those receiving day care only, those receiving homemaker only, and those receiving both). Also, groups should be compared by age and disability status.

(d) Not all of the experimental group utilized the experimental services.

These factors would all bias the results in favor of showing no differences between experimental and control groups.

In looking at the preliminary costs data, it seems that the use of home health services was the only traditional service decreased in the experimental group. This could support the assumption that only the home health agency "pool of patients" (i.e., the ones usually referred for non-nursing home care) was referred to the project.

It is my feeling that unless a network of community backed support systems exist (as proposed by APHA and others), the fragmentation of funding and services will prevent the proper use of any piecemeal part of the system (be it home health or day care) by providers or the elderly. The insecurity of funding and support will be too much of a burden for the elderly person, his family and the physician.

Whether the alternative services studied in the section 222 experiments will reduce health expenditures or even help contain costs is not answered yet. However, for anyone involved in the programs, their cost/benefit is well established.

(5) The assessment team was a very innovative method of approaching patient care. The care plan was truly an interdisciplinary effort and this process should be incorporated into any long-term care system.

(6) The referral mechanisms worked out for the project proved extremely valuable. We used a referral coordinator who worked with physicians and hospitals. The referral process demonstrated many ways the existing system of discharge planning could be improved. Specifically, the project staff learned:

(a) Most physicians were not aware of the post-hospital care needs of patients and were often not involved with discharge planning.

(b) Nursing homes were the primary post-hospital service recommended by physicians.

(c) If physicians did consider post-hospital needs, it was immediately before discharge, allowing for little counseling time with patients.

(d) Physician office nurses were very helpful in discussing possible referrals with physicians.

(e) Physicians have little if any direct involvement in post-hospital care planning.

(f) Consumers are unaware of existing alternative long-term care services that would allow them to remain in their homes.

(g) Little if any screening is done for patients in regard to services they may need after leaving the hospital.

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[1] Retained in committee files.

In regard to future research endeavors, methods of randomization should be more thoroughly evaluated prior to implementation. The method utilized in this study received constant criticism from health care professionals. (What is sound methodology in the laboratory may not always be the best for applied research efforts). Despite the explanations given by staff, most referral sources became discouraged or angry when patients were randomized to the central group.

(7) Although section 222 was for experimentation, the latitude allowed was limited because of the necessity of fitting into the medicare or medicaid model. Experimentation should be allowed to be more flexible.

(8) Benefits to the contractor. The benefits of the long-term care research and demonstration project had a significant effect on the Lexington-Fayette County Health Department. Examples of ways the study benefited the agency include the following:

(a) The experiences with referral sources, particularly the hospitals, provided valuable knowledge about the discharge planning efforts in the community. This knowledge has aided in securing additional referrals for home health care, elderly health maintenance and other services provided by the Department.

(b) The functional assessment tool has been extremely useful in training and education. In 1976, the health department was awarded a Public Health training grant for improving services to the elderly. A 4-hour segment of the 2-, 3-day training sessions were devoted to training functional assessment. Team members were utilized in this training program.

(c) The assessment team care plan has been helpful to other health department services. The emphasis on setting long- and short-term goals has improved the delivery of services to day care and homemaker patients.

(d) Time studies and case management reviews provide independent evaluations of the day care and homemaker programs. Some of the observations noted in these studies were developed into program changes.

(e) The study had an impact on the training of physicians at the University of Kentucky Medical School. Students on community medicine rotations were taught the assessment process and were exposed to community based long-term care services. Also, the physician team member presented grand rounds at the medical center focusing on the study. This was later published in Kentucky Medical Journal.

(f) The project officer in the Division of Long-Term Care, HEW, supplied many Government studies and documents concerning long-term care evaluations and services. These documents have been extremely useful.

(9) Recommendations. Additional studies in the field of long-term care can utilize much of the information acquired through this research endeavor. This knowledge should be applied to future research projects. Additional recommendations or studies and policy changes should address some of the following issues:

(a) Since the "222 research projects" were supposed to test the cost and effectiveness of adult day care and homemaker services, data should be analyzed and compared according to utilizers and nonutilizers rather than expanded benefits coverage. Also the evaluation contractor has considered comparison of C and E groups without regard to the C group's use of experimental services. This should be closely examined since at sites other than Lexington, many control patients utilized those services.

(b) This study will provide policymakers with some insights regarding the utilization of expanded benefits services. However, to determine precisely the rate of utilization, separate studies should be completed.

(c) Adult day health care is a long-term care service. As such, it will not fit easily into the existing medicare model, which is basically acute care oriented. If the medicare program elects to pay for day care services, this will have major implications on existing policies.

(d) Future projects, requiring the coordination of multiple Federal agencies, should have details of the working agreements finalized prior to the solicitation of contracting agencies. Also all OMB clearances should be obtained in advance.

(e) If the patient status instrument is to be utilized in other research efforts, assessment team members from all sites should be consulted regarding their suggestions for further refinements.

(f) Guidelines and regulations for adult day health care should be developed on a national policymaking level.

(g) The assessment team care planning process should be tested and thoroughly evaluated. This concept could prove extremely beneficial in community agencies such as the Lexington-Fayette County Health Department. A diagnostic assessment unit could be established to assess patients in need of long-term care. As a service to physicians, a plan of treatment could be developed for patients being discharged into the community. Although such Triage projects are now being tested, public health departments may serve as the next location for conducting this type of research and demonstration.

(h) Training efforts for health professionals need to include course material in the field of long-term care. Chronic illness requires that professionals address social and mental needs as well as medical care of the patient.

(i) Discharge planning in acute care hospitals should be thoroughly evaluated. The fact that discharge planners are present in hospitals does not always result in thorough discharge planning. In fact, the experience in Lexington showed that discharge planning is usually an afterthought, with little counseling for patients, family, and physician.

(j) Unless future research projects plan to test the assessment team care plan, a professional assessment team is not needed to conduct the research effort. As mentioned, this process became extremely boring and monotonous for well trained professionals.

(k) There is a need to develop a national policy regarding the use of alternative services in the care of chronically ill citizens within the United States. At the present rate of development, institutional care continues to be the only alternative in most communities. The Federal Government should decide if existing health care insurance and assistance programs will reimburse adult day care and homemaker programs.

(10) Policy implications. The section 222 projects are attempts to lead away from the mistakes of the past. The pitfalls that should be avoided are:

(a) Before a national reimbursement mechanism is set up through third-party payers, a satisfactory system of day care and homemaker services must be established. If not, the monetary stimulus may: (1) Cause an inflationary spiral for services by increasing demand faster than supply; (2) cause a boom and bust cycle to develop in which many inferior day centers are established to siphon off the new flood of cash and then, as costs soar and there are cutbacks, a rash of closures result, having a devastating effect on services; (3) cause quality to suffer because of the pressure to provide services and keep up with demand; and, (4) cause overutilization or inappropriate utilization.

(b) Alternatives should not be developed in a vacuum, isolated from the rest of the social and health care delivery system. When this happens quality always suffers. All too often, nursing homes have not been part of a system but only dead ends. To avoid this, the following points should be considered: (1) Alternatives should be an integral part of another system providing either health or social services (e.g., hospitals, health departments, educational centers, social agencies, health maintenance organizations, and group practices); and (2) alternatives should be integrated into the educational model for professionals in the field of human services. Students must participate actively in their training in various settings for the delivery of care for the aged.

(c) There was an overreliance on the physician to correct all the deficiencies in nursing homes. While his participation is critical even in day care centers, it is only part of the effort. Many other professionals are involved and must share the responsibility. Society has, in the past, given the physician moral and legal sanction to practice the healing arts. He has taken this responsibility seriously and tended to view it globally. Thus, a value system cumbersome and superannuated developed. With alternatives, portions of the patient care are delegated to others, so the concept of final medical responsibility is no longer appropriate. The use of nurse practitioners and physician assistants has been stimulated as a result of this new trend. Alternatives have emphasized the need for team or shared responsibility. The physician in this age of specialization cannot possibly meet all the needs implied in a continuum of care. Therefore, to insist on this is only to insure the failure of the system.

(d) The temptation to overstandardize must be avoided. Standards will not cure all the ills in the system and can act to stifle initiative, prevent flexibility to meet local needs and increase cost without improving care. Day care centers especially have not been able to fit into a definite model and, therefore, standards will have to be flexible. The tendency to clarify, label, and categorize both day centers and their patients can be counterproductive. Centers should vary according to local need and the patient mix should vary; these are probably important components of success.

(e) In addition, the issue of proprietary versus nonprofit centers must be addressed. If it is assumed that proprietary institutions are profit maximizers only and nonprofit institutions are quality maximizers then the answer would be simple. However, this is not always the case. If reimbursement could be related to quality the issue of proprietary versus nonprofit may become irrelevant.

Some reasons why day care occupies its present role and has met with success may be because:

(1) The service environment is structured to emphasize function and not diagnoses. One has only to walk into a thriving day care program to observe, feel, and hear the excitement of frail and impaired aged as they participate. "My health problems are risky. I never thought I'd be so sick and still live at home. Coming here gives me a lot of reassurance but I don't think you make me feel helpless. I felt that way when I was staying at home last year."

Day care stimulates capacities for independence while at the same time providing supports for functional limitations. The nursing home experience has shown that it is as untherapeutic to overservice as to underservice the aged patient. A successful day care center strikes a balance so often absent within institutional settings.

(2) Patients need to be prepared to manage through evenings and weekends. This makes it necessary for the staff to have a very specific time-frame to work in to get everything done. It also gives them an objective each day. This differs drastically with the situations in nursing homes in which patients are there 24 hours a day and problems can get passed from one shift to the other.

(3) Many visitors, family, volunteers, students, come to the centers. This constant exposure to new and interested people can act as a very good stimulus for quality control. This is accomplished because:

(a) There is continual incentive for staff to make things presentable.

(b) Problems can't be sequestered from the public view.

(c) Those people less involved are more outspoken about any deficiencies they may find.

(d) The public relations that develop stimulates community involvement and interest.

It is suggested that this approach also be used in nursing homes to improve quality of care.

(4) Patients can more readily report back to family and friends about their care at the center. This, as in item (3) above, can be a method of quality control.

(5) The day care center falls into the patient's routine of life. To spend the day in a setting different from the home and return to the familiar surroundings of the home in the evenings is rarely disturbing since it is similar in many respects to normal previous experience.

The most important implications of the movement to develop day care as a cost-effective long-term alternative include the following factors:

(1) Day care is one of many potential service innovations that can provide the aged and their families with an alternative means of receiving long-term care services.

(2) Day care is a setting very conducive to integrating the social and health service components of long-term care in such a way as to maximize the benefits of each.

(3) Day care is a service that is potentially flexible enough to be used with other personal and professional care resources available to the individual.

(4) Day care is a realistic means of providing the much-needed support to families wishing to provide care for their elderly family members.

(5) Day care is a service vehicle for neutralizing the destructive impact of chronic diseases and impairments insofar as it allows the aged person to be maintained in a living arrangement outside of an institutional setting.

I appreciate the opportunity to present this testimony to the Committee on Aging and would be pleased to elaborate further on any aspect of my presentation.

IMPORTANCE OF SYSTEM MANAGEMENT

Senator CHILES. Project Triage, to my knowledge, is the only research project based on the concept of a single entry, comprehensive, long-term care agency which has been proposed in the House of Representatives. We are delighted to have you share your experiences with us.

Both Miss Quinn and Dr. Weiler suggested that a single management point for all services is important. How would an elderly person receive services if your agency was not there and what does your program do that is not being done by other services?

Miss Quinn. I think that an elderly person, if the program was not there, would either receive the services if he had the resourcefulness to seek them also, and sometimes that resourcefulness might indicate that he make a phone call to eight different agencies to get his six services necessary to maintain him either at home or wherever.

I feel that one of the chief variables and one of the chief functions of Triage is to create an interface between the elderly person and the system. As I mentioned before, one of our objectives is to coordinate the existing system. After having been in the region since 1974, I think I can safely say the system does not want to be coordinated at all, that there is much turf protection, that there is much comment about duplication of service and we do the same thing as that agency does, and so forth; but that there is no effort at coordination between various providers to a tremendous extent. What Triage has been able to do is to act as the coordinator of systems by placing themselves between the system and the client so that when, for instance, Mrs. Jones goes to agency A to receive her service, we know that that is where she does go for it, and that the service will be provided there.

Senator Chiles. Thank you. All of you seem to have made the point that the health and social needs are inseparable in the long-term care situation. Dr. Weiler has even gone further and said that we cannot assume that medical models for long-term care will succeed if they don't take socioeconomic and psychological problems into account.

You have all also pointed out the importance of an assessment process and a mechanism for coordination and monitoring of the care received. Would each of you tell me the reasons for this process and who are the essential people that make up the assessment team?

Dr. Weiler, do you want to start off on that one?

Dr. Weiler. I think the essential components of an assessment team would be a physician or a nurse and a social worker or someone that would be——

Senator Chiles. Excuse me just a minute. I wanted to take this minute to thank Mr. Derzon and Dr. Lashof for remaining here. I think it does show your interest in this area, and we thank you.

Mr. Derzon. Sir, we have to leave.

Senator Chiles. Excuse me for interrupting you, Doctor.

ASSESSMENT TEAMS

Dr. Weiler. A social worker or someone who would be concerned with the social aspects of the patient. We felt that in using the assessment team in the project it was very helpful for some patients. It was only by the interaction of these appropriate professionals that all of the needs of the patient could be addressed with long- and short-term goals set. The services needed could be prescribed by the group as carefully as the physician would prescribe digitalis in an acute care setting.

I think it would encumber the system too much to insist that an elaborate form of the assessment be required for all patients. Some patients' problems were pretty clear-cut and could be handled by one member of the team very well and maybe on an ongoing basis reviewed by the other people in retrospect.

However, in the projects themselves, a weak point was the assessment plan, and had nothing to do with the services the patient actually received.

Senator CHILES. Miss Hamill.

Miss HAMILL. Our experience in our day hospital indicates the importance of a separate evaluation team to carry out periodic reassessment of patients. This constitutes a quality control feature that will guard against overutilization of services. As I indicated, it is easy for families or patients to become overdependent on the day hospital service. The assessment team can assist the treatment team by periodically evaluating the progress made in achieving the goals that were set for a patient at the time of admission. This will determine how much, if any, additional treatment is needed.

Patients are usually admitted to our intensive rehabilitation program. As they improve, they may progress to a less intensive program using group treatment rather than individual treatment. When it is appropriate, we also gradually reduce the number of days of treatment. Eventually the goal is, of course, to discharge them back to the community to whatever resources in the community are needed and available. We find the assessment process for this purpose is very, very useful. It has been one that we have been using and it is not too different from what we do in terms of utilization review in our own inpatient facility even though it does involve the family more and that is the other reason why we feel that the social worker as well as the nurse practitioner and the doctor, as Dr. Weiler indicated, are the key people on this particular team.

Senator CHILES. Miss Quinn.

Miss QUINN. In our assessment process, which is quite elaborate, we use a nurse clinician and a social worker team to perform the assessment. The assessment includes a complete health history in medical terms, as well as social and psychological.

After we have established that data base, which we feel is very complete, an important portion of that assessment is that it is done in the client's home, which I feel is essential to seeing the client and how he interacts with his own environment. After the assessment is completed then a plan of care is written for the client in conjunction with the client and/or their family, if present. Then we are able to provide for the services that were developed in that plan because of our waivered services.

That plan, however, is based on that data base. The plan is not static, it's dynamic; it changes over time and services change over time, depending again on the individual and what his needs are at a particular point in time.

Senator CHILES. Doctor.

INTERACTION WITH PHYSICIANS

Dr. DOHERTY. We found in designing the project that the reason for the social worker on the team was most important because they are qualified to deal with the whole patient, not only as an individual, but also in relation to the patient's family and other aspects of the social setting.

The use of physicians is very limited because most physicians are not trained to deal with the total person in long-term care settings because their education does not extend to this level.

Miss HAMILL. I think one thing, perhaps, that we may have omitted is the tie-in to the patient's personal physician. This is a tie-in that cannot be ignored in our American system of health care delivery. One of the things we found particularly important in the treatment program is that even though the personal physician may be willing to have us do the assessment and has probably not seen the patient in some time, nevertheless, any changes in medication or any changes in protocol related to the patient are prescribed by the personal physician. This is important because the personal physician is indeed responsible for the medical care of that patient and we want the patient to be constantly aware of that. Also, we are not open during evening hours or on weekends, so we cannot provide any medical supervision during those periods.

Senator CHILES. Dr. Weiler, you say in your statement that we are not fully knowledgeable about assessing the patient needs and the availability of service to meet those needs or the methods of getting patients to your alternative services and, therefore, when patients are ready to be discharged from hospital care the only alternative is a nursing home.

I would like to ask you about the experience of your demonstration projects and what is indicated regarding the role of hospital discharge staff physicians and how you got your referral. Are the discharge staffs trained and knowledgeable with regard to referral procedures, and what role did they play in the management of your project and where did you get the referrals?

How did you cope in your project with these problems that you raised, in other words?

Dr. WEILER. These are experiences in Lexington, but I have a feeling from talking with my colleagues, that they are not unique to the area. We hired a referral coordinator for the project that did a great deal of work with the discharge planners, with the nurses in the physicians' offices, who were also another important source to contact. The referral coordinator would go into each hospital and look at all the medicare patients admitted and then bring to the attention of the discharge planner that particular patients were eligible for the project and would it not be a good idea if she suggested that to the physician and the patient were admitted to the project.

We found that not all people that were eligible under medicare were admitted into the project. Furthermore, as I stated, the people that were admitted into the project and then fell into the experimental group did not all use the services.

When the referral coordinator was working with the discharge planner she found that their normal modus operandi was a day or two before the patient was to be discharged, usually on a Friday. She had to decide, hurriedly, where a nursing home bed for the patient could be secured. She spent a lot of time on the phone calling up various nursing homes trying to get the particular level of care and trying to explain to the physician what the particular level of care was.

PHYSICIANS NOT AWARE OF OPTIONS

We found that many physicians were not aware of the options, they were not aware of the proper assessment methods for determining what the options should be. Many physicians had very little direct contact with the services involved. If it were not for the referral coordinator actually going patient by patient through admissions in each of the hospitals, we would have had problems with reaching our quota of referrals for the experimental design.

Senator CHILES. Well, I think several of you have noted that before we could go into a national health care plan we would need to really determine how we were going to control reimbursement. That would also apply to the referral service set up, would it not? We would have to know, nationally, how we were going to set that up.

I have some great concerns there. In my State, we had some assistance being provided to referral service for medicaid patients. Some of the not-for-profit nursing or home health care associations had people who regularly called on the hospital. In fact, they were providing free trips to some of the hospital administrators, they take them to the Bahamas. So they had a great little referral service going. [Laughter.]

They were sometimes providing services that the patients didn't entirely need and we found that to be a tremendous, tremendous cost. I think you all agree that it would be essential to try to set up some proper way of doing this before we could have a national health care model.

I think you also all agree that that national health care model should include the full range of services that we are talking about.

What else have we got to do to set up that national health care system? What about our cost evaluation, how do we set that up? How do we test that?

Dr. DOHERTY. I just would like to make one comment on the cost. I think it is most important that all of these studies look at the total cost of life support for the whole person. We must not be limited to just comparing, for example, nursing home costs and day care costs because, as was pointed out earlier, day care is used less frequently, for a shorter period of time. In looking at these programs before we started on Triage, I found, for example, that some of the cost comparisons of nursing home care and day care were unrealistic. Nursing homes provide care 7 days a week on a 24-hour-a-day basis, whereas day care centers may provide care for a few hours 2 or 3 days a week.

A person in day care may, however, also be using physician and other services at other times of the week. Also, the studies were not including the other life supporting expenditures of the day care clients such as food. I think it is most important that before projections are made on costs that the real alternative cost—that is, the total support of these people—be compared to the total cost of nursing home care. That is the suggestion I strongly urge.

MEDICARE COST RESTRAINTS

Senator CHILES. Well, one of the great problems that we have now with medicare, probably the greatest problem, is that there is no restraint. There is no mechanism that helps to restrain or to hold some kind of lid on the rising cost. This is true really anywhere we are providing services set on a standard of pay on the basis of reasonable costs, even with insurance to the third-party provider for Blue Cross-Blue Shield.

As soon as one goes up, then reasonable costs go up. We see that escalating faster than any other form of inflation and faster than any other sector of the economy.

Now we are talking about including these services. I understand your preliminary figures in Triage are 6-month figures, so there is no way of really putting a great deal of statistical faith in them at this point. But they are indicating that your patients had fewer hospital days, lower physicians' costs, a little bit lower cost for the dentist, and 50 percent of the national drug cost, which looks good if you put that with the other.

Of course, the costs are considerably more under this range of other health services. I cannot tell what the actual costs are, and I don't know whether you know from your program, or how that is going to balance out against the hospital days. We have continually said, many of us, that these costs might balance out, and would probably save money, because certainly it is cheaper not to have people in the nursing home and continue to keep them there in the most extensive service. You have been trying to go to intermediate care. Now we are trying to go to home health care and day care, but we are also running against what your experiments seem to tell us. There are many, many people out there who have never known of these services before, who are not utilizing them. Maybe they could not afford nursing home services, didn't know they were available, or it really is not available to them. Now we are talking about making these services available. We are also going to set up an outreach mechanism to let them know what is available, so when they come out, even if they have a major illness, they are going to be told here are a range of services. That is going to bring many people into the program that we have not had before.

Those people have needs, and we want to bring them into the program.

What I am trying to get to is how can we do this and say that there is any way that we can afford to do it if it is going to escalate? How can we afford these new services we are talking about, and all these new people if the prices escalate over this wide range the way they have escalated in hospitalization and other medical costs?

How are we going to be able to do that? Where do we find any mechanism that operates? I don't think we can have a situation in which we arbitrarily say costs will not go over 9 percent. I don't know how long you can set that. Where do we build a mechanism?

"CHECKS AND BALANCES"

Dr. WEILER. I think, first of all, we have to build in two strong components that act as checks and balances. One is an assessment team approach which would look at whether the services being prescribed by the physician are appropriate and are in the right setting, with the right combination and at the right time. Without this, the patient is going to spend the same time in the hospital anyway and alternatives will just be add-on costs.

The other strong component needed is a good referral system so when the patients first come into the hospital someone screens them and starts thinking about what is the best method for posthospital care, when they should be discharged, and what combination of services may be needed.

Third, we need a single local source to handle funding. Because of funding which is uncertain, because services may or may not be there when they are needed, because of the difficulties and fragmentation involved in putting together a service package, the providers said, "What the heck, it is too difficult and in the nursing home I know the situation, be it good or bad, let's put the patient there." The family says: "Well, I don't know if a nurse is going to come out. I know we need meals-on-wheels and some transportation to get to the day care center. However, I am not sure about the funding and eligibility or continuity. Therefore, I will place my father in a nursing home." The point is the security must be there, the referral system must be there. To control costs, several areas should be explored. A lid could be placed on the overall program similar to what is happening in title XX. One gets paid so much to provide services with a negotiated budget. Anticipated needs of a community could be examined for certain levels of care and the projected costs worked out on a capitation or prepaid basis.

Senator CHILES. Miss Quinn.

Miss QUINN. I think certainly two suggestions or three that I might have would be that there be a single entry point for assessment and that total assessment can be done at the same time and that the person is not fragmented by having to go to a social agency for social meetings and to a physician in meeting his medical needs, but these are part of the continuum of care and after the initial data collection if it is appropriate that that person see a physician, then he should go.

I also think a very important part of our system is the fact that all of the claims for all of the services that are covered under the Triage experiment come to us so that we have a very good idea of total cost of care for each individual that is in the project.

"REFOCUS SERVICE DOLLAR"

I would strongly urge that there be a refocusing of the service dollar from the highly expensive institutional care which is practically in hospital, for example, 100 percent reimbursed by medicare. There is very little that is left for the individual to pay for. At the other end of the spectrum there is very little that is covered in terms of home care for the elderly person so that they really don't have a choice.

It is much easier for the physician, as Dr. Weiler said, to institutionalize somebody; it only takes one phone call. It could take 3 or 4 hours to arrange what that person might need in the array of medical and social services. I think that certainly a physician can't be responsible for all of this. It is an inappropriate use of his time and his talents, and he certainly becomes frustrated very quickly.

Miss HAMILL. I think you do have the review mechanism that is now offered in acute care hospitals. I am sure national statistics show that lengths of stay have been reduced considerably and physicians and discharge planners have been very conscious of their accountability regarding a patient's length of stay. I am sure a similar mechanism can be tied into whatever is set up in terms of other alternative long-term care forms of treatment in a community.

Dr. DOHERTY. I agree with Miss Quinn. I think it is very necessary to modify the authority; that is, possibly to transfer the authority that is presently with the physicians and the hospitals to others such as the nurse clinician who would have the much broader view of the patient's needs, and also the time to care for them.

Along with this, I would suggest that there may be a need for a careful look at the reimbursement system. I believe that before we talk about change in the cost, we really have to find out what is the real cost to these nonusers whom we talk about bringing into the system. We really don't know what they spend on health care at the moment, and it might be rather startling.

Miss HAMILL. The attitude of many of our families is this, regarding nursing home care: "It will take 2 years to use up my father's lifetime earnings and then he will be on public assistance and then the department of public welfare will take it from there." Families are often willing to help with the costs along the way to keep him out of that institution, out of that nursing home, but in the absence of an alternative to institutionalization, then they are likely to decide that institutionalization is the route they must take.

Senator CHILES. I am going to have to leave now, but the staff will stay a few minutes more. I think we might have a few more questions to address, and we do have some in writing. Then we have another witness.

I ask Mr. Oriol, our staff director, to assume the chair for now and to ask a few more questions.

I want to thank each of you on this panel very much for providing some earlier information on what is happening in the demonstrations. It is certainly revealing to us to have all of you speak of your particular demonstration projects and it has been very helpful. We will look forward to getting more details of the results of your demonstration project.

Thank you all very much.

Mr. ORIOL [presiding]. My name is Bill Oriol; this is Kathy Deignan, professional staff member, who has worked on the hearings; Margaret Fayé, from the minority staff, is with us; behind me is Alan Dinsmore, who is with us for a few months and has contributed very much to these hearings.

Kathy, did you want to continue the questioning?

Miss DEIGNAN. I do have a couple of questions I would like to follow up on which Senator Chiles began.

INTEGRATION OF HEALTH AND SOCIAL SERVICES

The Senator noted earlier that all of you had made a point of the necessity of combining both medical, or health, and social services in the long-term care model or, to put it another way, that one could not separate the two.

Dr. Weiler, you made a comment earlier—I think this was before the hearing, actually—that the presence of social services are necessary to make the medical model work. I wonder if I could get comments from the rest of you on that issue, particularly a little more elaboration on how the social services can help make the medical services succeed, or would you agree with that?

Miss **Hamill**. I would heartily agree with it. Joan Quinn mentioned the matter of the social worker, for example, working with the family in the family setting, observing the patient as he related to the rest of the family, and I alluded to that in my earlier remarks—that is, unless you know what the social support system is—whether it be the immediate family, neighbors, friends, whoever it might be—and unless you know how strong that support system is when the patient comes to the day hospital, you have no measure whether you are going to be able to achieve anything for the patient and for the family members.

We have had local agencies assure us that there is a support system only to find out that the patient's support system is at a great distance. For certain patients, overnight supervision by a family member or friend is essential.

A social worker can evaluate the home environment. Our social workers are very, very busy in unearthing the community resources to which we want to discharge the patient. These might include a local program where they might go for socialization, even if it were once a week, or perhaps a community nutrition center where they might go for their midday meal.

We also happen to have two social workers who are volunteers. They spend a lot of time actually going out with the patient prior to discharge, accompanying him to the local program, to see if he can manage the bus trip, can he "make it" in terms of connecting with the resource. Connecting the patient with the resource is time consuming but a terribly crucial detail. As Joan Quinn said, this type of activity cannot be achieved by phone calls. You let your fingers do some of the walking, but there is a lot more walking and resource-finding to be done.

These volunteers work under the supervision of a social worker and discharge planning is part of our social service responsibility.

AREA AGENCIES ON AGING

Miss **Deignan**. Can I take that a little further and ask you, Miss Quinn, are you familiar enough with the area agencies on aging to know if they might be able to perform that same function, or does it have to be a health based agency, or are there a number of agencies which can do that?

Miss **Quinn**. I just think in terms of the level of professionalism in an agency where there are people that we have mentioned such as nurse clinicians and nurse physicians and social workers, that that level is absolutely essential. You may not find that in an area agency on aging. I think they would have difficulty in performing that function. I really do think it takes a high degree of professionalism to deal with the problems of long-term care and chronic illness and old people in general in our society.

Mr. **Oriol**. Suppose they didn't try to perform it, they just paid for it?

Miss **Quinn**. I think there is still a problem of coordination. Someone has to coordinate, someone has to do an assessment for the need for it in the first place. So just paying for it is not going to be a solution and it probably will not work.

Dr. WEILER. In our area, the agencies have not been very effective; they have been outside the social/health system; it is very difficult to get assistance on specific projects—not that the individual people have not been giving it their all. Because the way the agencies are set up, lack of feedback or the support of the State agency and AoA, I think the area agencies on aging have been out of touch and not advocates for the system, and not good coordinators or overall planners.

I am not sure what planning is going on at that level. At least in Kentucky they are totally separate from the health systems agencies, so I don't know what planning component is brought into that system. It would be interesting to know the results of an evaluation done of AAA's, and we had a consultant interview us as part of this evaluation.

Mr. ORIOL. Was this a local evaluation?

Dr. WEILER. No, it was a national evaluation. Just an example of the type of problem that exists. I have several people in my agency dealing with aging and the programs on aging. They sent a national person down from Washington to interview me separately from the other people on my staff, requiring three separate trips, when they could have interviewed us all at the same time that I was being interviewed. Also, the consultant knew nothing about aging or the aging movement.

Getting back to another question now on the methods for limiting costs, I would like to call attention to the recommendations of the APHA, which suggested two things which may help. One is a stop to this endless proliferation of classifying different levels of care. There is no end to that in sight. I think you can go on forever, because people are individuals, and you will never have a system that is classified to meet everybody's needs.

They suggest declassifying the different institutional levels of care and then providing services as needed on an assessment basis, either through fee for service or capitation.

COOPERATION FROM OTHER AGENCIES

Miss DEIGNAN. A general question and I think this relates to what you are talking about. If I could ask you again, Miss Quinn, on effect of Triage on the community, have you gotten cooperation from the AAA's and other agencies in your community in Connecticut? You suggested before that you had not had much problem.

Miss QUINN. We have not had much interaction with the area agency on aging in our community. It covers, I believe, a 29-town area, which is quite large, and we are only in seven of those towns, so we just have not had the interaction with the area agency on aging, as it is in the city of Hartford, which is mileage-wise, as well as availability-wise, some distance. I would be not telling the truth if I said that we got along famously with all providers—we do not.

Mr. ORIOL. Of 191 providers.

Miss QUINN. Yes, I would have to say fairly well, but not all of them all of the time. Some of them some of the time, and all of them some of the time, but I don't think I would be truthful if I said that all providers were liking us and thought that we were doing a terrific job, and so forth.

I think one of the areas that is one of the sorest points, as far as this contention goes, is in the fiscal reimbursement area, and maybe a difference in opinion about service, and should or should we not pay for it, and whether we think it is appropriate or not. That can cause all sorts of construction as well as rate.

Initially, when we started, the physicians were just certainly not happy that we were in the region. However, we have seen an evolution in the turnaround of that through working with them, with individual patients of theirs that are clients of ours, and have really established a much better working relationship with the physicians so that they are now in the top 10 percent of the source of referrals that we get.

When we started the project in 1974, they were in the bottom 10 percent, so I think we have arrived to some extent.

Mr. ORIOL. To follow up on Kathy's question about area agencies on aging. You don't seem to see them as the wave of the future. Are you familiar with Massachusetts' Home Care Corp., or the Holyoke, Mass., Geriatric Authority, and do you see any parallels between what you do and what they do?

Miss QUINN. I am aware of them and that is about all. I would not want to comment on comparability.

Mr. ORIOL. Our next hearing will be October 12 in Holyoke, and it will explore some of the questions I just mentioned.

Miss DEIGNAN. What would you view, all of you, as the essential services in long-term care components? You have talked about it. I think we can assume there are day care and homemaker services and nursing services, but a number of you have been providing other services also. What would you say now, based on what your demonstration has shown, about what essential services would be?

Miss HAMILL. I would mention that with regard to the day care concept you do need several different models. Whether they are all within the same provider setting or not would depend, of course, on the community. We happen to be in an area that could effectively use four levels of care, including the social model, but the social model is not available. We feel it is a very important service and essential as a long-term care component.

I am sure there are many social centers within communities who can be encouraged to develop programs for the chronically ill, for the disabled and for the fragile population, who will require transportation to and from that facility for that social component of care, but I think certainly——

Miss DEIGNAN. You are saying then that transportation is——

Miss HAMMILL. Transportation for any form of day care is a cornerstone whether we be in South Australia, whether we be in the United States, or whether we be in the United Kingdom. I think we are all agreed on that. It would not exist without transportation.

Miss DEIGNAN. This seems to be a great opportunity. I notice in our audience is the director of a section 222 research project that has been studying transportation costs for medical services. Ms. Claire Cooney, are you in a position to give us just a couple of words on what you have been finding out about the cost of transportation services?

STATEMENT OF CLAIRE HAAGA COONEY, PROJECT DIRECTOR, VERA INSTITUTE'S EASYRIDE PROGRAM, NEW YORK, N.Y.

Ms. COONEY. I am glad to have the opportunity to speak with you.

Miss DEIGNAN. If you could further identify yourself for the hearing record.

Ms. COONEY. I am Claire Cooney, the project director for the Vera Institute's section 222 project which is known as Easyride. It is a specialized transportation system for the elderly and handicapped residents of the Lower East Side of Manhattan.

Our project has been operating on a pilot basis for about 14 months. It only became a section 222 project, however, in June of this past year. In July of this year, we received funding to carry out the research. We are in the beginning stages of collecting cost data, so it is very hard to determine exact costs. One preliminary thing we know is that it is more expensive to deliver transportation services to people going to medical facilities than to other facilities. If people are encouraged to make greater use of nutritional programs, you save on transportation costs. The fixed time and the rigidity of the medical system in terms of scheduling appointments, and so forth, makes transportation to those facilities much more expensive.

The waiver for our program covers reimbursement for costs to health facilities, and I will explain that. I hope that the kinds of many studies we do will reveal some interesting things. We are going to be looking at costs of transportation to all kinds of services, some of which are medicare reimbursed, and some of which are not.

The medicare waiver specifically covers trips to what we define as health trips and that includes all of the A and B type covered services, as well as some additional services like pharmacy, purchase of medical supplies, as well as transportation to nutrition programs.

Through other funding sources, we are paying for transportation to other destinations a person wants to go to, so that by the end of our experiment—and hopefully we can do this on an interim basis in about 12 months—we will be able to break out the costs for recreational purchases, social visits, employment.

The costs for these nonhealth trips are paid for by the Administration on Aging, the Urban Mass Transportation Administration, and several private foundations.

LOWER EAST SIDE

Mr. ORIOL. If we can get some idea of the area you are serving. It is the Lower East Side of Manhattan. Several of our staff members have been there. I think one of the techniques you use is when a van pulls up in front of the high rise, the driver gets the person while the persons already in the van stay locked inside for safety, so that gives some idea of the kind of area you are in.

Ms. COONEY. We work in a densely populated area with roughly 20,000 elderly people and another estimated 5,000 people who are handicapped. Our service is available to persons over 60 and handicapped people over the age of 16, including the mentally retarded. So we have a number of different populations.

The service is predicated on the idea that we hope to come up with the most cost-efficient transportation by meshing various people with various kinds of transportation handicaps and various purposes for which they need transportation so as to utilize the vehicles evenly over the course of a day. When people have some flexibility, we suggest the time for making a trip in order that we can schedule efficiently. I think that is probably unique among the transportation services.

We do provide a door-to-door service—depending on the passenger's needs—generally his physical abilities, or his fear of crime. We pick passengers up at the door of their apartments whether it is a fifth floor walkup or an elevator building. We are equipped to handle wheelchair people and our drivers are specially trained.

At the New York University Institute of Rehabilitation Medicine, drivers receive training in handling people with mobility aids, and sensitivity training provided by psychiatrists, social workers, disabled people themselves.

One of our hypotheses is that by putting a transportation system in place we don't automatically create something that is used, that you have to make the system accessible and reliable, and create an aura of trust so that the people will use it. Many people we serve have a great hesitancy about venturing out.

Miss Deignan. As you know, the whole committee is going to be very interested in the results of your research when you complete it. I believe you had suggested earlier that your preliminary figures appeared to show that, because of the way the trips are planned, you were able to provide round trip medical trips, is this not correct, at a cheaper cost than the currently available medicaid transportation?

Ms. Cooney. I think that will be somewhat cheaper than what medicaid is now reimbursing.

Miss Deignan. You don't have that yet?

Ms. Cooney. No.

Miss Deignan. What is medicaid reimbursing on?

Ms. Cooney. In New York City, it varies, but the rate is generally $28 a round trip for an ambulette, as opposed to an ambulance, trip.

Mr. Oriol. Let the record note that there were whistles.

Miss Hamill. Our transportation vendor—the point that I was making in our testimony—is that is for profit and who transports patients within a radius of 16 miles? For our particular program we are probably averaging $12 or $13 a round trip which is not a bad average. However, we feel that that vendor should be audited just as we are audited by medicare and medicaid. Our books are reviewed and their books should be reviewed, and a margin of profit established with limits, so that we can be assured that we are getting the best price possible.

At the present time, there is not that kind of a control mechanism. We feel that there should be governmental control on vendors who are taking people to and from facilities when the major sources of reimbursement are medicaid and medicare.

Miss Deignan. I have one more question and then I will let Mr. Oriol take it over. As section 222 project directors, do you feel in your demonstrations and in your research that you have got hard enough information about the benefits to the consumers of the services you are testing?

SERVICE BENEFITS

Dr. WEILER. I think we have collected enough data to know that the benefits in the experimental group, both homemaker and day care, are impacting on the quality of life of the patients that are receiving those services.

Miss DEIGNAN. You provided testimony earlier listing some of the changes. Now is there a way to compare those changes? For instance, your control group was not a nursing home, was it? So you cannot compare day care to nursing home, or can you, and the benefits to the patients?

Dr. WEILER. Well, the control group actually did spend more time in the nursing homes than the experimental groups, so in that respect you can compare the outcomes at various points in time with the two groups using the group that actually received the experimental services and not the whole expanded group benefit, as was the case in some of the data we originally got from Medicus. When you take out the group that didn't use the services and look at the ones that received the services, they did much better on a majority of the perimeters measured than the control group.

Then if you look at the cost side of it, they also spend less time in the hospital and nursing homes, but there are also some descriptive things that are very important for the project, too.

Actually seeing the patients improve, working with patients that have gone through the day care center and physicians who are aware of the documented improvements and say this service is a tremendous asset to the community. This also is documentation of the program's success.

Although all the data is not in, I think we have enough to know that we can proceed with attempting to build the network. I think the questions now are: How do we build the network? How do we control the costs? What is the best way to set the services up?

Miss HAMILL. I think Dr. Weiler has mentioned now and much earlier all the "ifs" in the data. Reviewing the nursing home data for Lexington and San Francisco, you would see that the network in those communities differs from that in White Plains, N.Y.

So we are looking at material and comparing cost data and utilization data when there was not a complete network. I think that is why we are all reverting to that major premise that you must first have a comprehensive network of services before you can make any precise measurement of the cost effectiveness of a single service.

Mr. ORIOL. Do you try to do that nationwide or do you select the geographic area such as the State for further testing? What are the next steps for establishing a network? Senator Domenici, at an earlier hearing, suggested that perhaps the State could serve as the basis for this.

GROWING COMMUNITY INTEREST

Miss HAMILL. I can only say I think there should be some national effort to capitalize on the growing interest of communities in developing programs and services. We average about 500 inquiries a year at our day hospital alone, asking for help and information and training or visiting for consultations, whatever the case might be, for people who want to develop similar programs. I think that there are many, many untapped local resources in every community, and many of them are ripe for developing and setting in motion a network of services.

I think if we wait to do a statewide demonstration, or to gather all of the data, or to do all the things that we have all sort of labored through, even in discussing today, I think we will have waited too long. I think there are other ways of accomplishing that goal and getting the services delivered.

I think Dr. Weiler's reference to the tremendous fund of human data that we have collected is important. Also the fact that we have had over 4½ years of experience, with 87 percent attendance on their scheduled days by a very fragile population, indicates that patients come for a service that they need and that their family needs. There are many ways of evaluating the effectiveness of these new alternatives without necessarily depending on the limited number of research instruments available for use with this type of population.

Mr. ORIOL. What about another approach which has been thought about at HEW, about relaxing medicare restrictions perhaps on an experimental basis, or having an expanded benefits period? Perhaps this is what Triage had, a more flexible usage of our current system.

Do you think that something like that would be the next step, in terms of giving an incentive for building the network that you are groping for?

Miss HAMILL. I think that might very well be and I think the reference made earlier was to a more flexible reimbursement plan, one relaxed to the point at which it responds to patients' needs as they change from week to week. We could get patients transported, for example, in a station wagon or by a taxicab company because they are considered "ambulatory," even though they happen to be wheelchair patients. If the following week, however, their condition deteriorates, it may take us 2 months to get third-party payor approval for their travel by a wheelchair van. Therefore, a provider is more likely to go to the more expensive service first for fear that doing otherwise will deprive the patient of a needed service.

If the term "flexibility" means being responsive to what the patients need, and you are relying on the technical integrity of the providers, then I would say, "Yes; that sounds like a good idea."

Dr. WEILER. I would reinforce that. If you realize the history of the projects involved, you see what a tremendous community involvement they had from the very start, and only that involvement made it possible on a limited basis, and that is in spite of all the obstacles that presently exist.

I think a relaxation of those restrictions and inhibitions would be most advantageous, but I hope that they would be relaxed not only under medicare but also medicaid, title XX, the Older Americans Act, and the community block grant money.

Concerning the medicaid sample, I am afraid that even though that was part of the original project, as things got rolling, it took a very back seat in the whole area and I don't think that should be forgotten.

Some of the lessons we learned from the medicaid sample will also contribute to the overall knowledge in this area and it is a rather different type of patient involved under different circumstances.

Mr. ORIOL. Miss Quinn, did you want to discuss that, too?

Miss QUINN. I guess I would have to support our system; I think it is functional, it can operate. I am not disfavorably opposed to a geographical region. I think if a geographical region is manageable—and that is also something that should be considered—then a project such as ours can work very effectively, and that means a very localized type of region perhaps at the localized HSA region level.

In our State, which is a small State, that would be manageable. I would hesitate to have a State run program at this point in time because of all the constraints that State agencies have placed upon them, which would also be a constraint at the lower level, where we are at.

Other than that, I agree with Dr. Weiler about relaxing present reimbursement systems and the types of services reimbursed.

NO SINGLE SERVICE MOST ESSENTIAL

Dr. DOHERTY. May I make a comment? I wanted to get back to what do you regard as the most important service. I think if there is anything we have learned and studied from previous research it is that there is no one most essential service. The whole concept of Triage and the other programs is to have an available array of services which can be prescribed according to the individual's need. These services range from the most complicated medical services to straightforward, rather simple, maybe social or other types of services.

The present system does not allow for the provision of the social service when that service is the most appropriate for that person's need, and what happens is that the person is put in a less appropriate setting, such as the nursing home or hospital. It is necessary to have the full array so that the most essential service be available for that person. That is what we are looking at in Triage. I don't think there is one most essential service, but I do know that social services are integral to the total service package.

Mr. ORIOL. Mrs. Fayé, do you have any questions?

Mrs. FAYÉ. I wanted to ask, when you were talking about the extreme community interest that has been coming about as a result of your projects, would it not be possible to have a project like Triage handled across the Nation by a different group of agencies, not necessarily the area agencies on aging, but whatever agency might exist? I can see something like Triage developing very well, but I wonder if we need a whole new structure, or whether we can use one in place if we have the community interest that you say exists?

Dr. WEILER. I am always in favor of using what is there if it is responsive and it is interested and wants to develop in that area. I would agree that in some areas what is already available could be expanded and encouraged and do quite well, and in other areas where nothing exists or there is resistance to developing something, I think something new would have to be developed.

Mr. ORIOL. I just have a few questions. I notice in your report on Triage that you say that in fiscal year 1975 medicare spent 7 percent of its funds on drugs while Triage spent only 4.4 percent. Will Triage be able to pay for prescription drug needs of the participant?

Miss QUINN. Yes.

DRUG EXPENSES LOWER

Mr. ORIOL. What is the significance of the fact that your expenditures were lower than medicare, which just covers prescription drugs in the hospital?

Miss QUINN. I really don't know the reason why. We do cover all prescription drugs. I think that one thing that we have been able to do, though, with that service, is to monitor multiple drug usage by the same person using 7 pharmacies to have his 20 prescriptions filled or refilled because he might have happened to go to several physicians.

Mr. ORIOL. How do you monitor that?

Miss QUINN. Because all of the billing comes to Triage for medication so that you know that a particular client has received 300 Percodan in a month and that is highly irregular. If we can get back to the physician or physicians and say, "Did you know that your patient"—and most of the time they are very unaware of that. I can reference that with an example of one of the clients that was on 17 medications at initial assessment, and was taking them all, felt dreadful, used many physicians. The treatment was to send him to his primary physician who reduced that drug load to two. The comment of the client about a month later was how much better he felt and that he had not felt so well in all of the time previous.

So I think the control of usage of medication is very important. We can do that because of the reimbursement mechanism that we have set up.

Mr. ORIOL. So if medicare ever were to cover out-of-hospital prescription drugs, that would be a good feature?

Miss QUINN. I would suggest that that be built in.

Mr. ORIOL. One of your case histories mentions this very process—how a person's entire physical well-being changed because you were able to monitor what that person was doing with drugs.

Miss QUINN. Yes; drug prescription to the elderly is very heavy in the area of tranquilizers and barbiturates, and even some narcotics, and we have had a tremendous problem with drug addiction in the elderly population unbeknownst to them, that they were addicted to drugs. We really have found severe abuses and multiple prescription by different physicians who do not know that physician A is prescribing something else and having the client take them all. So both from the point of view of welfare to the client, as well as cost, it has tremendous importance.

Mr. ORIOL. I would like to go back to Easyride for a little while and ask you what you think that Easyride is already beginning to show you. You alluded somewhat to the importance, in terms of not only benefit to the person, but benefit to those trying to give service to them, of the vital ingredient of transportation.

ADDED BENEFITS OF TRANSPORTATION SERVICES

Ms. COONEY. In fact, one of the small studies we are doing as a piece of the overall research effort is exactly addressed to your second issue, Mr. Oriol, which is the impact on the social services and health agencies in the area. We are in the process of doing that now.

I think we have found several things. We have found that we have reduced the drain on professional staff considerably in that they no longer have to accompany people to certain destinations. We have also found that we have reduced the time spent in making appointments for clients. We encourage passengers to deal with us directly. We found that social workers and nurses in hospitals were making appointments. We encouraged passengers to do that themselves and we are finding increasing numbers of self-referrals.

I also think we are finding that people are going to a wider variety of destinations. We think our data may also show that people use certain kinds of medical facilities with less frequency—for instance, emergency rooms, where they are really making an emergency room visit perhaps because they need to get out and socialize. Emergency rooms are always open, they can always go there.

We found in the beginning many people would not believe that we could take them to other places. We don't prioritize among trip purposes.

One thing I think we are clearly finding is that passengers are using nutrition programs more frequently; we will try to break out this information in terms of whether specific individuals shift from going to three or four doctors a week to going to a nutrition program every day and to doctors when they are really needed.

We are finding people tend to overuse physicians' facilities by going to multiple doctors. In these cases, we alert the social worker at the relevant agency that a particular client is using several general practitioners. We cannot intervene any further than that, but I think many times the social work staff is not even aware of these patterns.

Mr. ORIOL. Why do people go to a doctor?

Ms. COONEY. I think, again, in my own opinion, one reason is to socialize. A second reason is a certain lack of trust and hoping for some answer that is going to cure them of, say, degenerative arthritis, so they will go and get 100 medications from one and keep going.

I think just as much for our own sanity, we don't want to be called a system where we are just running people around to different medical facilities hoping they will get a different answer. I think, basically, those two reasons are what they are looking for, some answer to their problem, and they want to socialize.

Mr. ORIOL. Are these private doctors or what are sometimes called medicaid mills?

Ms. COONEY. People use medicaid mills and hospital outpatient departments, as well as two or three private doctors, and I doubt that they alert one doctor that they are using the others.

Mr. ORIOL. Miss Quinn, did you have something else?

Miss QUINN. We also think it is important to mention that there is referral among physicians and that because of the specialty areas in medicine, you go to one doctor for your arthritis, perhaps, and go to another doctor for your genitourinary problems, and there is physician referral as well.

"DOCTOR SHOPPING"

I also think that another large problem with the elderly is the fact that they doctor shop or hop. You know, many physicians, in our culture especially, have very negative attitudes and stereotypes about the elderly, and perhaps they do have a very real physical problem which the physician might well tell them, as well as other health professionals—I should not single out the physician—that what do they expect, they are getting old, that sort of commentary, and that is very common.

Dr. WEILER. That is the tie-in with the education system which is critical to prevent the problems and mistakes of the past.

Also, we have instituted, in Lexington, a geriatric clinic because we have found that the needs of the geriatric patient require such a full range of services and skills that these are not usually found in either the adult clinics or the private physicians' offices. What is needed is allied health consultations, dietary advice, socialization advice, recreational advice, occupational therapy advice, and just someone to see that they get through the clinic maze in a reasonable amount of time.

I think this is another reason why the present system is not working well and we have patients going from one doctor to another and getting one drug after the other, without really getting any satisfaction.

Ms. COONEY. I would just like to say one thing that picks up on a point that I think Dr. Weiler made earlier about the variations found in people with types of disabilities. One effect I think we will have on health establishments is the ease with which we can get people to them on a regular basis. It has made it much easier to get stroke victims, for instance, to rehabilitation facilities who otherwise, especially if they are medicare-only beneficiaries, would perhaps not go to physical therapy as regularly because they would have to pay for the transportation. They would spread therapy out over a longer period of time, according what passengers tell us about their impressions of their recovery rates.

Clearly, if someone can begin to walk more rapidly, he will be less of a drain on societal resources. We will be doing special studies looking at the severely handicapped and people with the kinds of chronic problems that Dr. Weiler referred to.

Mr. ORIOL. I would like to ask Miss Quinn and anyone else who might have an answer to this question. You had 191 separate providers that you worked with. Does having that sheer number of providers mean that you actually had the kind of services that you needed to make Triage work at its optimum?

Miss QUINN. Yes.

Mr. ORIOL. Were they already in place?

Miss QUINN. No. You have to understand, of that 191 providers, there are several hospitals that have identical contracts in the region, so that it is cumulative in some. So that for hospital care you might have five or six hospitals, and V.N.A. number five, while pharmacies can number anywhere over the spectrum, so that many of those contracts are duplicates. I would say of those 191 contracts we have approximately 64 different service types, both reimbursable service as well as voluntary, like friendly visiting and transport, volunteer people, volunteer vans, and so forth.

LACK OF TRAINED PERSONNEL

Mr. ORIOL. Did you find you had a sufficient number of people trained to give in-home services that you could draw from?

Miss QUINN. That has been a problem that has escalated as the project has taken on more new clients. I really feel there is a severe manpower shortage in the home health aides, homemakers, chore workers, and companions, and that you are really straining the system even where they are.

Mr. ORIOL. Any other panel members feel that way?

Miss HAMILL. Yes.

Mr. ORIOL. They are all nodding their heads yes.

Miss QUINN. Which again, I think, focuses on the importance of the educational process and educating these people also, and making them feel they are not performing a subservient function, but that their function is very important in relation to the elderly's health.

Miss HAMILL. In interviewing for homemakers in one community, I learned from the proprietary agency that the nonprofit homemaker provider has training requirements which the proprietary agency does not have to meet. So it appears that regulations vary as to what we are reimbursing for in homemaker service.

Mr. ORIOL. This is such a good panel and it is hard to stop, but all of you have submitted additional information and we have submitted information questions to every section 222 provider so the final record will be very complete. I cannot resist just one more question, primarily based on what Dr. Doherty said at one point, that it is time to take the profit out of health care and yet we are all talking about building a continuum, or network, or whatever. I am reading your remarks.

Don't you make use of what is already in place, like proprietary nursing homes, and so forth, while you are building this network or do you have anything else in mind?

Dr. DOHERTY. The answer has nothing to do with the research in Triage. Now, I am wearing the hat I use in my teaching of medical students. I think we know from both our experience in this country and from experiences in other countries that our service system encourages overutilization, misallocation of medical resources, and inappropriate care; and that we should really explore alternatives. I don't know that we have the ultimate answer but all I can say—and we can certainly reflect for many hours on this subject—is that the present system is based more, I suggest, for the benefit of the provider, the economic benefit of the provider, than for the benefit of the patient, and that it is time to study some alternative means of providing other services if they can be shown to be effective and no more expensive.

I think in these experiments we have this opportunity to study these alternatives and to ask and to answer these questions. Can we provide alternative services that are no less effective and what do they cost to do it. I don't want to get into a statement of my recommendations on how physicians and others should be reimbursed.

Mr. ORIOL. You are being nudged.

Did you want to make a suggestion, Miss Quinn?

Miss QUINN. No. I just made a suggestion to Dr. Doherty.

Dr. DOHERTY. She said "don't."

Mr. ORIOL. Well, as I say, we could go on, but I think you have already given us so much and we really appreciate your contribution to these hearings. Thank you very much.

Miss QUINN. Thank you.

Mr. ORIOL. Senator Chiles said that the director of the On Lok senior health services project in San Francisco would be in town today and has information of direct relevance to the subject of today's hearing. Mrs. Marie-Louise Ansak and Dr. William Gee, who have worked on On Lok from the very beginning, are here today and Senator Chiles asked that we take your testimony at this time.

I also spoke to Hadley Hall who is here. Why is everybody here today? The day care conference next week?

Speaking of that conference, the organizer of it, Edith Robins, is in the audience. The flood of inquiries, the information on what White Plains is doing, what Burke Hospital is doing, is this what you are receiving at HEW, too? Is that one reason you are holding the conference next week?

Mrs. Robins. Yes.

Mr. Oriol. How many inquiries are you getting?

Mrs. Robins. In the thousands.

Mr. Oriol. In the thousands? Well, thank you.

Mrs. Ansak.

Mrs. Ansak. I have some information on the figures and costs of which you might be interested. It was interesting.

Mr. Oriol. Before we begin, would you all identify yourselves first.

Mrs. Ansak. Marie-Louise Ansak, director of On Lok Senior Health Services in San Francisco.

Mr. Moore. Tom Moore, consultant.

Dr. Gee. I am Dr. William Gee, practicing dentist in San Francisco's Chinatown, and president of the On Lok Senior Health Services.

Mr. Hall. Hadley Hall, executive director, San Francisco Home Health Service, and also a section 222 homemaker and day care project director.

STATEMENT OF MARIE-LOUISE ANSAK, EXECUTIVE DIRECTOR, ON LOK SENIOR HEALTH SERVICES, SAN FRANCISCO, CALIF.

Mrs. Ansak. It was interesting to hear the testimony from the panel. We also have the same problem. Why we are here today from On Lok is because of the problems that research and demonstration projects experience after their funding comes to an end. I have some strong feelings about our national pastime with research and with reevaluations and with studying the site. I feel that within the research and demonstration projects we ought to develop a method or a means that the experience is evaluated and put forth into action so that projects that are successful now are not abandoned.

First, we would like to share with you the problems of funding that On Lok is experiencing at the present time. Though there has been discussion for years about alternatives, public policy still lags behind the performance of the program and On Lok moves from one funding crisis into the other. Without positive action, On Lok is threatened with a 60-percent cutback by December 31, 1977. It is unlikely that the program can be maintained at that level, and another program for the frail elderly will become a monument to the wastage of demonstration projects and thousands of taxpayers' dollars. This is particularly unfortunate since it appeared that we had finally made some progress.

On Lok got its start 5 years ago with a 3-year research and demonstration grant from the Administration on Aging. It was to be an experiment of day care as an alternative to institutionalization. This appeared as a particularly desirable solution for the Chinese and Filipino elderly of the district. Because of lifelong discrimination, they have little to look forward to when placed in the strange environment of a nursing home. Because of their inability to speak English, their plight is even more tragic than that of their English-speaking counterparts.

WIDE VARIETY OF SERVICES NEEDED

During the first period of our project, we found that any alternative to premature institutionalization had to offer a wide variety of services, including both medical and social day care, sheltered housing, inhome services, portable meals, transportation, evening supervision, and telephone reassurance. In 1975, we applied for a 3-year model project grant from the Administration on Aging to include the development of all these components and further pursue permanent funding. We have now received our third year's award from the Administration on Aging with an allocation of exactly half the dollar amount needed to complete this last year.

From the beginning, On Lok has looked upon the Administration on Aging support as a developmental phase to be replaced by permanent funding sources as soon as these could be mobilized. In keeping with these goals, we started, in 1973, to negotiate with the California Department of Health for medicaid—Medi-Cal—reimbursement. Eighteen months and many trips to Sacramento later, we got a pilot project contract. Today, we are fortunate to report that in spite of the inauspicious beginnings, On Lok has been able to convince the State legislature to pass a law which will make day health services for the elderly a permanent program under Medi-Cal, as of January 1, 1978. I have left a copy of the bill with the staff.[1]

Because of the wide variety of services needed and the many different Federal programs covering the cost, On Lok, like other similar programs, is forced to look to many different Federal, State, and local funding sources for support. Each of these has its own rules and requirements. Instead of getting reimbursement for services offered, programs have to be manipulated to meet the needs of the funding sources and their administrators. In addition, we get caught in a game of musical chairs, where Federal agencies refer us to local and State resources, and they in turn send us right back to Washington. I leave it to your imagination to figure the costs of such games to small projects as ours.

It has been proven by On Lok that quality community based day health services can be offered at reasonable costs. For $25 per day at the day health center, On Lok provides its participants all services needed and recommended by the multidisciplinary assessment team, such as medical supervision, nursing care, social services, physical therapy, occupational therapy, speech therapy, recreation, transportation, meals at the center, diet counseling, as well as in-home services and portable meals on those days the participant does not attend the center.

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[1] Retained in committee files.

FUNDING PROBLEMS

The main problems for On Lok lie in the fact that neither medicare nor title XX are available to cover the cost of those not eligible for Medi-Cal and unable to bear the cost privately. California's title XX program is oversubscribed, and in spite of the interest on the part of the social services department in San Francisco to support On Lok, a large deficit does not permit this option.

Medicare does not provide for day care. In order to tap some of the medicare home health care funds, On Lok recently applied for a home health agency license, only to find out that compliance with certification requirements would destroy the whole On Lok concept of a highly coordinated program.

Mr. ORIOL. Whose certification requirements were they—State or Federal?

Mrs. ANSAK. Federal. We cannot be certified federally if we want to keep our type of service.

Similar problems exist with AOA funds under titles III, V, and VII. Either they are set up to meet a very specific purpose or are reserved for short-term demonstration projects.

It has generally been recognized that the most efficient and cost effective organizations are those who have access and control over the largest number of services. Particularly the frail elderly living in their communities need a wide variety of supportive services available at an instant's notice. It is this type of support which prevents major breakdowns and costly hospitalizations. It is for this reason that On Lok has in the past and is again at this point attempting to develop an HMO-type of organization for its constituents.

Though there is much skepticism about such a comprehensive program because of experiences with nursing homes and home health agencies, we feel that community-based, nonprofit organizations accountable to their constituents hold the promise for a solution to the problems which has not been sufficiently considered.

The second issue relates to housing, specifically On Lok's experience with HUD. Alternatives to nursing home care cannot be considered without looking at housing and the vital role it plays in keeping the frail elderly in their own communities. This is particularly true in our area, where the majority of the available housing facilities are substandard, and the many related social problems hardly need any further national publicity at this point.

Many of On Lok's participants are forced into an institution such as a nursing home only because a hotel manager gets impatient with the slow, frail tenant shuffling through the hallways. He has no time to give him the kind of reassurance and assistance needed to gain confidence.

On Lok has experimented with communal living arrangements and has found that some of its most disabled clients can happily and successfully stay in the community provided they can live in an accepting and supportive environment and attend the day health center. With this kind of arrangement, many have been able to leave the nursing homes.

INTENSE HOUSING SHORTAGE

Mr. ORIOL. Mrs. Ansak, just to put this housing situation into context, as I think you know, Mr. Philip Corwin of our staff was directed by Senator Church and Senator Domenici, our ranking Republican member, to go to San Francisco when word got out about the actions taken to evict people at the International Hotel. Mr. Corwin's findings, of course, were what everybody else has found—the intense housing shortage—and what housing there is comes at prices people can't afford, especially in the Chinatown area. This has been intensified by business or other kinds of development which displaces people usually without providing a place within their reach.

Just what would you say is the level of intensity of the housing need within the area you serve?

Mrs. ANSAK. It is extreme. Most of our elderly live in very substandard hotels—they have no elevators, they are fire traps. I think you know about the International Hotel, and I think Mr. Corwin saw it. That is sort of an average type of accommodation that our people have.

Now, I did want to point out that there are efforts afoot in the community to develop housing for the elderly and it started in 1972, when HUD organized or founded a 701 project which was to study the housing conditions in Chinatown. I would like to add that they have found a dire need for housing for families and also particularly for the elderly. Since that time not a single unit has been built by HUD.

There are projects presently being planned that have got the reservation of funds. One is the Stockton and Sacramento streets, under section 236, HUD. They have been stymied for the last 5 years, and not only because of objections from the neighbors who have to be impinged upon, which is now being solved, but also because of HUD's innumerable bureaucratic delays.

Under a section 202 reservation of funds last October they are still in the preliminary stages, and the reason for that is that we have innumerable disagreements with HUD. They really don't process their work. For instance, one of the things which I was going to talk about, we want to establish how to get housing with 50 units and the day health center in the same building.

Now HUD does not see the housing the same way we see it. For instance, they demand that each unit have a kitchen. I understand the law prescribed that units could be built without kitchens as long as you had a joint common dining room and eating facilities. Second, they want to prevent us from putting a day health center in.

Now the day health center, which would be in the basement, would serve both the elderly residents in the building and those from the community. This is not included in the loan; On Lok has to raise its own funds for that. We already had to raise $300,000 to buy the property because that is not included in the allocation that HUD gives us. They are very, very low for a very high cost and San Francisco is, particularly Chinatown.

We have to raise this, which we have raised, and even $50,000 more, but now they send us a letter last week and it says in that letter—just kind of a comment on our day health center. On September 14 we received a letter indicating that we have substantially overcome all the objections but they found one. They are now examining the potential legal cost by our proposal to include in the residential structure on a major commercial facility, the day health center. I think I said how precarious our financial situation is and then HUD tells us we are running a facility. I wonder what they were thinking about.

I don't know whether I have any other comments in terms of housing.

Mr. ORIOL. Does that complete your statement?

Mrs. ANSAK. Yes. However, with your permission, I would like to submit for the record a paper entitled "On Lok Senior Health Services."

Mr. ORIOL. Without objection, it will be entered at this time.

[The paper referred to follows:]

ON LOK SENIOR HEALTH SERVICES

INTRODUCTION

On Lok Senior Health Services is now in the fifth year of demonstrating that many elderly and frail persons can be maintained in their communities in better health and spirits and at lower cost than in institutions. First conceived as an alternative to nursing homes, On Lok has gone on to prove that day health care and related supporting services should be added to the catalog of acceptable health services by public financing systems, along with inpatient care and outpatient treatment.

One era as a demonstration and research site is coming to a close for On Lok, but public policy still lags behind the performance of the program. While medicaid now recognizes and reimburses day health services, medicare does not, still another in a long list of discrepancies between the two. And while day health care is fruitless unless part of a system of services that includes transportation, home visits, and meals, among other predictable needs of the dependent elderly, the standards for funding those activities are still fragmented and various payment authorizations produce various regulations from various offices with various objectives.

In a sense, On Lok has become something of a national monument, a sort of Yosemite Park of social services: visitors ranging from cabinet officers to television news teams regularly come by. Candidates for public office consider an On Lok visit essential to demonstrating their concern for the elderly and appreciation of imaginative alternatives to the universally dreaded nursing home. Newspapers, magazines, and research studies describe the successes and hope for a better future for the aged that On Lok inspires.

After 5 years, however, On Lok is still struggling to maintain a hand-to-mouth financial existence, not because of any problems in administration or management nor because the value of its services is not recognized, but because public reimbursement has not followed that recognition.

The following paper informally proposes a demonstration project within the objectives of section 222 of Public Law 92–603, in which On Lok would provide the site for testing methods of consolidating Federal funds available for aiding the dependent elderly: for evaluating the efficiencies of single administration of funds and single management of a wide range of services to the elderly: and a means of setting rates day health services whether narrowly provided or expanded to include the full range of activities needed by the elderly.

ON LOK IN 1977

In addition to being a city of "infinite variety and charm," San Francisco faces a familiar array of social and health problems. The population has declined from 715,674 to 667,700 since 1970 and is aging steadily. Even if the national or State birth rates were to increase, it is unlikely that San Francisco would become a much younger city because the cost of housing and the general shortage at any price of large family units is helping the graying of the city as much as the birthrate. San Francisco has experienced many immigrations from Latin and Asian countries, but the most significant in the long run may well be the quiet but seemingly relentless growth in the percentage of residents who are over 55, now more than 26.6 percent, up from 25.7 percent in 1970.

In a city where hotels are one of the three major industries, it is not surprising that there are few nursing home beds and even fewer available to those dependent upon medicaid (called Medi-Cal in California). Earlier this year, when the California Department of Health was threatening closure of one of the city's skilled nursing facilities for substandard care and patient neglect, department officials admitted they would have to move many patients as far away as San Diego to find beds for them because so few nursing home operators will take additional Medi-Cal patients.

The shortage of local beds at low cost is only one of the reasons On Lok was organized. The others included a search for a civilized alternative to institutionalization for frail and partially dependent residents of the community who badly wanted to stay on familiar ground. Today, day health care as practiced by On Lok and a number of other centers around the country is not only an alternative to nursing homes but an essential ingredient in any comprehensive program of health care for the elderly. The point has been repeatedly made by the On Lok example that to view day health care only as an alternative to nursing homes is to underestimate and misunderstand the medical and social importance of these services.

Space, staff, and financing limitations limit On Lok to no more than 200 participants. On an average day, 100 participants attend. Operating 7 days a week, the center provides:

—Medical and social evaluation and screening to determine the applicant's need for day health services.

—Medical surveillance from a part-time physician and full-time nursing staff. occupational and physical therapy.

—Reality therapy and social work counseling (reality therapy consists mainly of group exercises and understanding what day, month, and year it is, what holidays have just passed or are coming, what meal will next be served, and when the participant will return to On Lok).

—Recreation and group exercise designed primarily to improve and maintain mobility and overcome the lethargy and depression that usually accompany physical limitations.

—Transportation, which in the case of On Lok is not an ancillary or administrative service but a basic ingredient in the program.

—After hours supervision; telephone reassurance; social (as contrasted with service) visiting.

A California Department of Health study of the kinds and frequency of services received by On Lok participants compared with those used by nonparticipants in the community shows significant differences.

—Participants had far fewer days, from one-fifth to one-tenth, in board and care and skilled nursing facilities. Acute admissions were slightly higher but lengths of stay were shorter.

—Physician visits were more frequent for participants but so were physical and occupational therapies. As with the acute inpatient episodes, these probably reflect genuine patient needs that typically go unmet in the community where institutionalization often substitutes for more appropriate care.

Costs contrasts are dramatic:

An elderly recipient of SSI in a skilled nursing home would cost as follows (monthly):

Medi-Cal (medicaid)	$788.70
SSI cash	25.00
Total	813.70

Excluding physician services and all occupational, speech, and physical therapies.

An On Lok participant costs:

Medi-Cal	$335.00
SSI (average)	136.52
Total	471.52

Excluding outside physician services but including physician supervision and all therapies.

Because On Lok can make the most efficient use of personnel, the average cost of therapies is only $6, whereas nursing homes in the area receive $15 from Medi-Cal for each visit. The dollar value of therapies provided in On Lok is conservatively around $3,400 per month, computed at On Lok costs. But when computed at Medi-Cal costs, it would amount to $8,500 per month. That is an additional amount saved by the program.

Clearly, On Lok provides far more for far less to persons who by all current standards would otherwise be in an SNF or, in a few cases, an intermediate care facility. If dollar values could be assigned to such conditions as cheerfulness, a sense of belonging, an awareness of self, time, and place, and the knowledge that one is not alone, then surely the differences would be many times greater.

Financial support is provided from a variety of sources and methods, from reimbursement to project grants. Sources and amounts are (for fiscal year ending June 30, 1978):

Medi-Cal reimbursement	$209, 558
Administration on Aging grant (6 months only)	127, 598
Title VII, meals	12, 000
Participant payments	12, 000
San Francisco Foundation	13, 290

Medi-Cal reimbursement is authorized by amendments to title XIX of the Social Security Act providing capitation or prospectively budgeted payments for day health services. Until this month, California had not specifically authorized day health care as part of the Medi-Cal program so the current payments are made as part of a pilot project to determine facility standards, staffing, and ratemaking elements, while the legislature has been approving without opposition a bill to make day health care programs a permanent part of Medi-Cal.

The grant from the Administration on Aging offers one of those curious examples of a Government strategy that does not add up to policy. The AoA has supported On Lok since 1972 for research and demonstration purposes from which a great deal of information pertinent to the planning of programs for the aging has been drawn. The current grant is to be the last because the AoA authorization does not allow continued support. The letter of grant award from the chief of the Division of Research Applications and Demonstration is attached.[1] Notice that the letter says that the award is terminal and that On Lok is expected to obtain other sources of support for its activities. "The ongoing support of such activities must come from local, State, or other Federal sources." Ironically, medicare does not provide payments for day health care although medicaid does. If medicare reimbursed On Lok as medicaid does through the State, the AoA grant would be unnecessary. Notice also that while the grant award is for a year, the AoA hopes that alternative funding can be found during the first 6 months, clearly an impossible task, since almost by definition the users of On Lok are publicly dependent for most of their income and all of their medical care. Only public sources can be expected to meet these costs. To suggest that State or local sources would be developed replacing Federal contributions for health services to an elderly population for whom medicare was specially designed is to engage in fantasy.

Congress now has before it legislation which would include day health care services as a legitimately reimbursable activity under medicare. In the meantime, it is essential for the AoA to pledge funds for the current grant through next June while On Lok pursues other funding. The pursuit of those funds is the subject of the following sections of this memo.

AN HMO FOR THE ELDERLY

For more than a decade, public health policy has been turning toward the development of comprehensive, coordinated systems of care on the evidence that they are a more effective means of preventing disability and maintaining the health of large populations. Health maintenance organizations, for example, are now promoted by DHEW as a desirable alternative to fragmented fee-for-service medical care prevalent throughout the country.

Ironically, while HMO's are held out as the means of rationalizing medical care delivery and financing and stabilizing the costs for most Americans—indeed,

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[1] Retained in committee files.

HMO's are the only reorganizational tool currently employed by the administration—services to populations known to have special health and socially related needs continue to be fragmented in both structure and financing. This is especially true of services to the elderly and even more especially, the frail elderly, while medicare expenses are rising faster than all other medical budgets, even with benefit reductions in the form of higher deductions and copayments.

On the face of it, it would seem obvious that if organized and comprehensive health systems provide both health and budgetary benefits for the general populations, there ought to be proportionately greater gains in organizing such systems for those populations with the highest exposure to health risk—the elderly and the poor and handicapped of whatever age. Oddly enough, however, the newly developing HMO's in the United States show a remarkable lack of interest in enrolling significant numbers of the elderly and show no interest whatever in enrolling the disabled and chronically ill. The economic pressures on newly developing HMO's are such that they must look to short term income and profits to be gained from their cost comparisons with and price advantage over the indemnity market. They have little or no interest or investment in the long term financial gains to be made from reducing morbidity and hospitalization or other inpatient days among the elderly and the disabled since they cannot see how those reductions will be of financial benefit to them. Only public financing systems—buyers of last resort—will benefit.

In fact, the objectives of the HMO legislation far exceed the realities of program development. In the wake of projects modeled after successful programs, such as Kaiser, is standing a large number of people unwanted by the new entrepreneural organizations, but that does not diminish the arguments to be made in favor of integrated comprehensive services to the elderly.

In addition to the services mentioned in part I, On Lok by early 1979 will occupy a congregate residence built with HUD 202 funds, integrating day health care into the building physically as well as programmatically. By adding and expanding home health care and increasing the amount of direct medical care, On Lok can further reduce the waste of referrals and transporting of patients to physicians for routine medical needs.

In other words, in 2 years On Lok will be in a position to offer housing, day health care, meals, and social support counseling services in a single site. In addition, it will provide transportation, home health care, and manage patients' use of other services, such as specialty care, 24-hour nursing care, and acute hospitalization when necessary. For those so choosing, On Lok House, as the new residence will be called, will also be a hospice in the European sense of a sanctuary for dignified death without the technological struggle that hospitals provide at such pain and expense.

As On Lok moves toward implementing the plan, it seems timely to consider alternative, coordinated reimbursement methods to reduce administrative costs and to provide incentives to control operating expenses.

The problems of existing funding mechanisms are widely recognized. In testimony before the Special Committee on Aging of the U.S. Senate last June, Robert Derzon, Administrator of the Health Care and Financing Administration, said, "At the present time, there are separate funding authorities for various services provided the people in noninstitutional settings. Each program has a different responsibility and often, the criteria for eligibility as established by law are not the same. This makes it very difficult to foster relationships between programs that permit and encourage coordination." In a thoughtful study of long-term care released last April, Judith LaVor from the Office of the Assistant Secretary of Planning and Evaluation, DHEW, said, "A national set of priorities and blueprints for providing 'long-term care' to the populations needing it should be articulated.

"To date, it has not been, and the silence has resulted in increased dependence upon institutions, fragmentation of services, and rapidly rising costs. A policy must be based on examination of both the programmatic structure and financing arrangements for these services, with the services and organization desired dictating the financing and reimbursements as much as possible instead of the reverse."

The extent to which reimbursement mechanisms instead of health needs shape the delivery of medical care is widely recognized but cannot be stated too many times. Nowhere does treatment follow the buck, as the saying goes, more clearly and closely than in long-term care activities. The deliberate decision to finance nursing home care as a separate activity created the nursing home industry which we now are anxiously seeking ways to avoid. Similarly, the reimbursement of home health services has created a home health industry which has also already become the subject of investigations for fraud and abuse and the lowering of public confidence in public programs.

Reimbursement for specific activities has a way of creating industries but not systems of care. Yet as noted earlier, systems of care are clearly needed. The debate over whether long-term care to the elderly and other persons of limited health status should be integrated into communitywide HMO's is interesting but irrelevant at the moment since it is not happening. Perhaps in the future, a smooth transition under national health insurance could be made for persons as they move from the delivery style of HMO's which is suited to healthy populations capable of aggressively seeking care to a lowered health status resulting from old age in which they need increasing support. In other words, the development of comprehensive systems for the elderly will not duplicate or overlap the development of HMO's under the HMO Act of 1973, as amended in 1976, and could become complementary to these community programs as public funding policy is developed and comes into focus.

Meanwhile, On Lok provides an unusual opportunity to experiment with a reimbursement mechanism that disregards categorical funding sources, sets aside rigid program requirements, and lifts the financing relationship above the often arbitrary limitations of narrow program goals.

Using the authorizations of section 222 of Public Law 92-603, we propose a reimbursement experiment in demonstration project with the following objectives:

(1) The development of uniform cost accounting and budgeting format for all long-term care systems of whatever kind that may receive public funds.

(2) The development of a methodology for budget review and rate-setting for long-term care systems.

(3) Demonstration that the objectives of separate programs are more quickly and efficiently realized when they are part of comprehensive management and delivery systems.

(4) Demonstration of the reduced administrative cost when categorical funding is dissolved into a single reimbursement mechanism.

(5) Demonstration of screening and selection processes to assure appropriate use of services by persons needing them to avoid dumping into a reimbursable system.

(6) Demonstration of means to significantly reduce inpatient utilization among frail elderly by more appropriate services.

We list those objectives to be sought by the demonstration project in the light of the following assumptions:

Assumption No. 1: Whether a community long-term care system is designed primarily to coordinate existing services as in Pima County, Ariz., or deliver services and manage patient use of others as in On Lok, the cost elements and budget planning should be the same to provide comparability and analyses of system performance.

Assumption No. 2: Because frail elderly using these systems are, by definition, in need of health services, typical risk and capitation in combination is not appropriate. Nevertheless, the organization should be held to the constraints of budget and program planning.

In legislative hearings on the bills to make the reimbursement of day health care a permanent part of the Medi-Cal program, some legislators have expressed concern that a sudden flood of bored, restless and other elderly will come pouring into the centers, not because they need care but because they have no other place to go. The absence of a comprehensive program of community services may, in fact, encourage just that sort of misuse of a resource, just as many elderly persons whose only need is for residential care are now in nursing homes because there is no other place to go. Recreation and companionship are essential to good health. In time, On Lok House would plan to develop a senior center under the auspices of other State legislation about to be signed into law. We propose, however, to limit the reimbursement experiment and demonstration to those activities related to individuals whose health condition after adequate screening is determined to require the level of care provided in an intermediate care facility.

Development of a reasonable ratemaking system might well be the most important goal or task facing providers and government purchasers alike since the shape of programs, as noted earlier, tends to be governed by the way in which reimbursement is provided. If noninstitutionalized long-term care is desirable, the strategic use of reimbursement systems may develop alternatives more rapidly than project funds or grants since reimbursement, if adequately developed, guarantees a continuing program support.

Without attempting at this point to provide a definitive ratemaking model, the following ingredients are suggested as appropriate subjects for the demonstration project:

(1) In addition to the removal of the risk in the usual sense, the rate must not be inherently inflationary as are typical cost reimbursement systems. Nor should the rates contain elements which tend to escalate costs by having fixed allowances for certain items which may exceed cost. (An excellent example of an inflationary device in what is intended to be a cost control mechanism is in the State of California schedule of maximum allowances in Medi-Cal which frequently exceeds costs of many providers who nevertheless habitually bill to the maximums allowed.) Nor should the rates distort treatment by inadvertently offering incentives to excessive use of certain services.

(2) Rates should be tied to approved budgets. Budget components, in turn, should be designed and approved in roughly the following manner:

> (A) Each system should submit an aggregate expeditures forecast containing an analysis of historical data regarding cost and activities and assumptions regarding cost of service components in the coming budget year. For new programs, obviously, only a forecast is possible, although it should be supported by actual cost data and compared with other projects.
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> (B) Budget review by the purchasing agency should include an evaluation of the relative efficiency of the use of facilities and personnel and approval of the services plan and utilization expectations.
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> (C) The early budget screens would be general. An overall review of documentation and soundness of service plan that should be followed by successive and tighter reviews of the components, such as meals, housing, medical care, therapy costs, in an effort to spot costly or unwieldly financial circumstances. It is possible, for example, to set limits on allowable rates of return on interest, finance charges, and other elements associated with debt service or private investment. It would be possible using this kind of system to highlight excessively costly ancillary or contract services which may be evidence of bad management or of fraudulent financial arrangements. Most important, the use of standardized accounting and bookkeeping coupled with complete disclosure will permit comparisons of both cost centers and utilization of services from program to program, regardless of the organizational model.

We hope this brief summary of present problems and the future needs will provide an agenda for beginning development of a mutually satisfactory reimbursement experiment. Among the assumptions not listed above but overriding all of our planning is that the role of the Federal Government as financier of services to the aged is certain to expand rather than diminish in the coming years and that it is to everyone's advantage for that expansion to be predictable and in a way that makes the most efficient use of the funds. By thoughtful use of reimbursement, health maintenance systems for the elderly can evolve in ways that will not encumber large amounts of project grants and with relatively low overhead costs. As managers and providers of services, we prefer to deal with rational reimbursement formulas and be subject to reasonable quality and management performance audits than to continue the cumbersome and terribly time-consuming process of trying to patch together a program out of a wide range of uncoordinated authorizations scattered throughout State and Federal laws.

Mr. Oriol. What help will this State program, which takes effect in January, give, and could that take up where the AoA support leaves off?

Mrs. Ansak. No; we have already had this funding for the past 3 years. That pays for Medi-Cal; approximately 40 percent of our population. Sixty percent have no Medi-Cal and have to depend on medicare. These people have savings of $2,000, $3,000, $4,000, or $5,000, and they do not wish to part with this. Their monthly income might be $150. How can you charge them an adequate fee if we cannot get any payment for that?

Mr. Oriol. You provided the committee with a statement when we asked for it earlier, but I think one part of it in particular sums up what was said at the very beginning of these hearings—that additional funding sources should be a help. Are they contributing to the problem? By "additional," I mean those added since the 1971 White House conference.

You say, "As part of the total health problem it would not be necessary to involve four different funding sources to provide health care." Title XX for home chore service, title XIX for Medi-Cal care, Older Americans Act, titles II and VII for transportation and meals. Left after all this is the need for funds to do coordination of services. Now, without coordination, the client is confused and gets too little or too much. I think that is a very vivid description of what we have been working with.

Mrs. Ansak. Yes.

Mr. Oriol. I wonder if Dr. Gee would care to comment on that or any other matters we have discussed.

STATEMENT OF WILLIAM GEE, D.D.S., PRESIDENT, ON LOK SENIOR HEALTH SERVICES, SAN FRANCISCO, CALIF.

Dr. Gee. When I first started in this type of activity it was all new to me. As a member of a profession that has always been regarded by the American public as a very elite part of the society—you know, the rich dentist—I am practicing in a ghetto area. I have always thought that perhaps if you obey the laws, pay your taxes, when you get old the Government will take care of you. That is not the reality, and the more I have been in it, the more I see, sometimes it is quite discouraging, but at the same time it makes my colleagues and me who are interested in it more determined to see that these things are put into action—our thoughts, our concepts.

From my own native heritage I believe in honoring thy father and thy mother. As you know, we people of Chinese descent have always honored our elderly people. All through the years, we have always believed that were it not for past restrictions, which I need not go into, that our elderly population would be taken care of in Chinatown, but as I look into the affairs of other organizations—not Chinese, not ethnic, but just plain old Americans who are becoming old—I feel very strongly that they have the same problem that the elderly Chinese have.

We all get old and I am surprised at the obstacles and all the obstructions that I have to face in order to get something done for the elderly population. My question to many of the people whom I feel are obstructing us is, "Don't you realize you are getting old, too, and one of these days you are going to need our services?"

Thank you.

Mr. Oriol. Thank you very much for summing up.

Mrs. Ansak, you talked about fragmented sources of funding. Our committee staff is sort of fragmented. Kathy Deignan deals with health, Phil Corwin deals with housing. I am going to ask them to meet with you after this hearing and see if we can wrack our brains and get some suggestions that could be helpful at this point.

Mr. Moore.

STATEMENT OF TOM MOORE, CONSULTANT, ON LOK SENIOR HEALTH SERVICES, SAN FRANCISCO, CALIF.

Mr. MOORE. If I may, I would like to add a couple of comments about the effect of consolidated management on prices. There is a document [1] that we will leave with you which has been brought here for presentation to HEW tomorrow. We note such things as the ability of On Lok to control costs because it is not a broker buying from a series of vendors, but it is a form of health maintenance organization. It is a small maintenance organization, but the costs can be dramatically reduced. For example, Medi-Cal is now saying $15 per unit of physical therapy statewide, but our costs are only $16.

Any reasonably budgeted system in which a relationship between budgets and service is approved in advance, whether by a private buyer or the Government, should be in a position to pay only for what is received and only for legitimate costs. In this situation, the buy-out for physical and occupational therapies in the State, in San Francisco, is excessive, simply because of the structural patterns. Fee-for-service is inherently inflationary and wasteful.

Wherever the State has had experience with the consolidation of management of health resources, costs have been stabilized. In the HMO's, the savings to the State's Medi-Cal program ranged from 10 to 23 percent, largely because they commanded the resources to bear on the population.

Our transportation costs are $4.50 per trip. I don't think that the costs of moving people in San Francisco are any cheaper than in New York, where a private contractor receives $15 per trip. It is the idea of an HMO, a comprehensive system for the elderly, which can provide a full range of services under a single management, that deserves examination by the Congress.

Mr. ORIOL. We will move on now to Hadley Hall. Mr. Hall has also given us a statement for the record.[2] In this case you had not planned on getting to what you are going to tell us now; a part of that presentation deals with your concern about the fact that in the spring of this year we held a hearing in connection with the operation of the home health care provider in California, and certain others, at the request of Senators for action on matters described at that hearing. Statements were made about State action which would follow.

Would you care to comment on what you say about that matter in your statement?

STATEMENT OF HADLEY HALL, EXECUTIVE DIRECTOR, SAN FRANCISCO HOME HEALTH SERVICE

Mr. HALL. Well, I don't think anything has happened to my knowledge. There has been a press release and lots of promises but that is no different than what we have had in the past. Mrs. Ansak adequately describes the current situation at On Lok, a marvelous program in our community.

The same identical situation was described 10 years ago in "Home Health in Chinatown." I would suggest that the Senators read that

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[1] See p. 565.

[2] See appendix 2, item 4, p. 603.

document, because it describes the very same kinds of fragmentation and discoordination by governmental bureaus that we were fighting then. The booklet describes events leading toward the development and the establishment of an On Lok type of service in our community.

I assume from the letters that this committee has sent to the attorney general and the secretary of health and welfare in California, that the necessary documents have been presented for prosecutions to go forward following the hearings in March 1977. I note that the hearing record is printed. The only thing I can ask is, "Why hasn't something been done?" We say we want to stop fraud and abuse. The States could do it. BHI, the Attorney General's Office, HEW could do it. Cities and counties within States could do it.

Nobody has even been arrested for the passing of bad checks, though there were hundreds of employees in a variety of States that went unpaid. Even Burt Lance gets more than criticized for having overdrafts.

The main point I would like to make is that I am really disappointed in the HEW testimony. I recognize that it is a new administration, but it is now 9 months old. That is long enough for conception and birth, and I think it is time we got better answers than we are getting. We have had enough promises as far as I am concerned.

I am also disappointed that we spent so much time on "cost effectiveness." It is not an argument that is going to change anything we already know. The American public already knows that nursing homes cost too much, that they are not effective, that they are dehumanizing and that they are too profitable.

SLOW PROGRESS

We have had a series of hearings by this committee—reports which probably stack a foot high—showing fraud and abuse, showing inadequacies, of not providing protection for the vulnerable; yet nothing is done. I am tired of hearing that we must prove that the alternatives to hospitals and nursing homes must prove themselves to be "cost effective." I don't care if they are cost effective or not, and I think the American people have already decided that the alternatives to what is being proposed are not effective, are not acceptable, and are too costly.

I think perhaps the myths that go on in some of our apparently equal units in HEW, which don't look at a whole person—whether we are looking at a person's housing, welfare or home health—just cannot continue. I am sure sorry Mr. Derzon is not here, but I will write him a letter making sure he understands my point of view.

Thank you.

Mr. ORIOL. I would like to ask you about one of the points you made in your prepared statement. You make a recommendation on followup to 222, but you want "considerable assurance that vulnerable people will not be abused in institutions. There can never be an army of investigators to monitor home delivered services." Then I think later you say that, "Standards well received and well applied could be more effective than the army of investigators." Why do you say that?

Mr. HALL. Well, you see, it is like both the Sousa and Gottheimer cases. Both were certified for medicare, there was evidence that patients were being abused, and there was fraud and abuse of the taxpayers' dollar. The Government must, by the nature of things, establish standards that are the lowest common denominator. Whether that is true or not, I am convinced that Government standards—with the proper kind of attorney, accountant, and other expert advisors—can always be circumvented if that is what someone wants to do.

I don't think that standards by outside third parties, standard setting bodies, if you will, like the joint accreditation for hospitals, or the National Council for Homemaker-Home Health Aide Services, present a panacea. We heard testimony about the Upjohn Co. attempting to affect regulations under title XIX. Upjohn maintains that they have great standards. I have read them and they sound wonderful, but who verifies them?

I don't believe that people should be making profits on this, but that is not the way our system operates. Doctors make profits, hospitals make profits, we have a lot of nursing homes that make unbelievable profits, judging from the record. If we are going to have profit, let's control it or let's decide what is going to be a reasonable profit, just as we decide what is going to be reasonable cost.

HEW has not done that. They have not proposed guidelines. They have defended themselves by saying, "Well, we don't have any guidelines on whether you can have a Mercedes or a Volkswagen as a company car." That is nonsense. If they need guidelines, then why haven't they proposed them? They know this is going on. They have had their auditors out there and the fiscal intermediaries. I know of no fiscal intermediaries or public servants that have been disciplined, reformed, or fined, for a malfeasance.

The fiscal intermediaries operate almost on a cost-plus basis—the bigger the costs are, the more money they pay out, or the more claims they pay out, apparently, the higher their profit is. In cities of 50,000 or more, Blue Cross-Blue Shield has a building that has been built since medicare. I don't believe Blue Cross-Blue Shield paid for those buildings on the basis of private premiums, they paid for it out of the Federal tax dollars in titles XVIII and XIX. That is where those buildings came from.

Mr. ORIOL. Do you have any questions?

Miss DEIGNAN. No.

Mr. ORIOL. I would like to turn to your section 222 project and see if there are any major points you would like to make about that at the hearing. You also make the point in describing your project that quality homemaker services will not be significantly less costly to provide than quality home health aide services. I think you are saying that homemaker service should not be regarded as second-rate home health care, that it is a special set of skills which these high standards are.

MULTIPLE TITLES FOR HOMEMAKERS

Mr. HALL. They are all the same, Mr. Oriol. This nonsense of describing the paraprofessional first on the basis of who is paying the bill is utter nonsense. The only people that can understand the difference are those of us that work in the programs with the public servants administering these programs. I just came from Dallas, Tex., and they have five different titles: family care worker, attendant, homemaker, chore worker, and home health aide. Yesterday, I talked to the supervisors of those workers. For 15 years we have told HEW that there is no difference—they all do the same thing. It is just that they get paid out of different pots. All of the workers, by the way, are supported by monthly Federal money.

Now that does not make any sense. We cannot afford that, and the American people are not going to allow HEW to continue putting forth proposals that perpetuate that system. I am not sure that Mr. Derzon and the other distinguished representatives from HEW really understand that yet, but we are not going to put up with that, I hope.

Mr. ORIOL. Mrs. Fayé.

Mrs. FAYÉ. Yes. I was very interested in your prepared testimony on that very subject and talking about the possibility of upward mobility for these paraprofessionals. This has been a favorite subject of mine for sometime. I wonder what would be your methods for recruiting people into this profession; what name would you give to it? How would you give the dignity to the chore worker which by his title would express what home care is trying to do? I think this is an extremely important problem that we must address in giving all of them the dignity of being a particular type of needed worker. I am wondering what type of suggestions you have for a community that wants to recruit people.

Mr. HALL. We have not found any difficulty in recruiting people because we pay above the minimum wage. We act as an employer, and we pay employer-paid benefits such as vacation, sick leave, the same thing that you and I get. Yet, in every State in this Union out of title XX we have people working for less than the minimum wage, as little as 16 cents an hour—Government-funded jobs, if you can believe it—where there have been, I believe, criminal conspiracies by public servants—Federal, regional, State, and local—sitting in a room helping each other decide how they can arrange these things, so that they can give the money to an individual—Federal, State, and local money—without accepting responsibility for being an employer. I call that indentured servitude or slavery, and HEW puts up with it.

Mrs. FAYÉ. I can't imagine what kind of individual would accept that kind of situation.

Mr. HALL. I can't either, and I don't know how you are going to get people to take care of our senior citizens with those practices.

Mrs. FAYÉ. What do you call them?

Mr. HALL. We call them homemaker-home health aides.

Mrs. FAYÉ. Regardless of what they do?

Mr. HALL. It is all the same.

Mrs. FAYÉ. I would like to say that in some testimony I have read, whether the aides wash the face or wash the floors, they are the same.

Mr. HALL. That is right, each is equal.

Mr. ORIOL. Coming back to your 16 cents an hour, are you talking about individual providers or home health attendants? We had some testimony on that earlier from New York and from San Francisco.

Mr. HALL. San Francisco; Texas; I can give you examples in every State of the Union.

Mr. ORIOL. Have you heard of any efforts to do anything about that?

Mr. HALL. No.

Mr. **Oriol.** From your own knowledge?

Mr. **Hall.** No; they say, "We cannot do that because that will cost more money," but think of the cost we are going to pay 10 years down the road, when the 55-year-old attendant who has not been covered for social security or workers compensation, who slips and ends up in a county medicaid hospital at 64. That worker will be a charge for the rest of us, for the rest of his or her life, in a nursing home—and if she lives to 80, the cost of that. Think of the cost we are paying out in just AFDC because there are no examples of how to get ahead, the child that sees his parent being treated that way.

WHAT HAPPENS NEXT?

Mr. **Oriol.** I would like to ask one more question; it is not all that general, it is about San Francisco and what happens next. There were several themes referred to here today. One, we are all working to build a continuum of care. Two, the trick is not to make what you are talking about an add-on to existing services, but what is more an appropriate substitute for.

How, in San Francisco, do your programs get together as part of a continuum of care, and how do you make your services a substitute for, rather than an add-on?

Mr. **Hall.** I think, if I am not mistaken, the first nurse and social worker at On Lok were a Chinese staff that had worked for San Francisco Home Health Service, who had actually trained non-English-speaking Chinese women to be home health aides—so, we have shared employees. We have a staff that works together all the time. Staff of San Francisco Home Health Service are assigned to the Chinatown community—are in fact at On Lok, physically. I don't know that it is on a day-to-day basis, but there is certainly day-to-day contact.

Many of our clients are the same, and where they are not there is referring back and forth, where we can get the services to the client. I certainly agree with Mr. Moore's concept that where you have a comprehensive coordinated program that delivers as much of what you can do as possible, including our services, the community is going to be better off, at a cheaper price; but I am not concerned about the price. You know, when we are spending only a few millions in this country for all of the in-home health service programs, it is an absolute drop in the bucket. When I think of what we are spending in hospitals and nursing homes, I am shocked that we don't understand that something else can be considered.

Mr. **Oriol.** Mrs. Ansak.

Mrs. **Ansak.** On Lok is limiting itself and is not going out of that northeast district bounded by the bay. The legislation which you have in your hand is concerned about that and two things it does is, one, it is encouraging nonprofit community organization to start community groups to start day health centers, and second, to not have a proliferation and duplication, and what have you. They have set up a system in that law by which the supervisor is supposed to appoint some representatives or appoint another committee. We are not too happy about that, but there was no other solution.

Essentially, what they hoped to do is to provide the services by districts, the day health services, and then to look at what is in that community and see how it works together but the emphasis is on really the single unit to provide this type of service. I think that does answer your question.

Mr. Oriol. I see what you are working toward.

Do you have any questions, Kathy?

Miss Deignan. No.

Mr. Oriol. Thanks so much for adding to our hearing record. As usual, it is very good to hear from you again.

These hearings will be continued on October 12 in Holyoke, Mass.

[Whereupon, at 1:30 p.m., the committee recessed.]

APPENDIXES

Appendix 1

LETTER AND ENCLOSURE TO SENATOR LAWTON CHILES, FROM ROBERT A. DERZON,[1] ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Dear Senator Chiles: We are pleased to respond to the questions raised in your letter of June 17. The enclosure lists each question and our response.

I have not forgotten my offer to provide you with a timetable for actions to be taken in home health care and other in-home service policy developments within the Department. As soon as these are worked out, we will make this information available to you and the committee.

It was a pleasure to meet you and I, too, look forward to working with you.

Sincerely yours,

Robert A. Derzon,
Administrator.

[Enclosure.]

Day Hospital and Day Treatment Services

Question. 1. We will be glad to have the summary of day hospital and day treatment services which you offered. In addition, who has primary responsibility under the Health Care Financing Administration for this kind of project—not research, but actual operations?

Answer. Section 222 experiments (research).—The day care demonstrations and experiments created by amendments to the Social Security Act of 1972, section 222(b) authorized "an experimental program to provide day care services . . . for individuals eligible to enroll in the supplemental medical insurance program established under part B of title XVIII and XIX of the Social Security Act." This mandate set in motion the program which involved day care experiments in four locations. These are National Center for Health Services Research/Health Resources Administration projects with Health Care Financing Administration (Division of Direct Reimbursement) participating as fiscal intermediary. Medical Services Administration was also actively involved in the reimbursement of services provided in these programs. The demonstrations have been completed and a preliminary report of the findings is due in the fall of this year. A copy of this report will be forwarded to you as soon as it is available. Another project that is just beginning is the day hospital services experiment being conducted by the Albert Einstein College of Medicine under NCHSR/HRA sponsorship.

Covered day care services under the day care experiments carried out under Public Law 92–603, section 222, include: (1) Medical consultation; (2) nursing services; (3) rehabilitation services, including physical therapy, occupational therapy, and speech therapy; (4) social services; (5) dietary, including lunch and snacks plus counseling; (6) personal care services; (7) patient activities; (8) transportation; (9) vision examinations; (10) hearing examinations; (11) podiatry screening.

Covered day hospital services included in the experiment being conducted by the Albert Einstein College of Medicine embrace all services listed above and, in addition, provide for home renovations and resource persons located in home.

Program operations.—Day hospital and day treatment services are reimbursable benefits under the hospital outpatient and clinic service portions of medicaid.

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[1] See testimony, p. 491.

This reimbursement policy, along with definitions of such services, were spelled out in a medicaid information memorandum (SRS-IM-76-3) of January 22, 1976, "Reimbursement Under Title XIX, Social Security Act, for Services to the Chronically Ill and Impaired in Alternative Settings."

The day hospital provides all medical, diagnostic, rehabilitation, and other services, with the exception of bed and full board, normally provided in an inpatient hospital. It is reimbursed as an outpatient service.

Day treatment includes therapeutic and other health services, similar in level to those provided in skilled or intermediate care facilities. This service is covered as a clinic service.

Question 2. Who is responsible for adult day care centers?

Answer. In addition to the experiments and medicaid reimbursement of day hospital and treatment services described in question 1, there are a number of related activities in the development and provision of adult day care centers.

The Older Americans Amendments of 1976 gave a congressional mandate to the Administration on Aging to provide a lead role in the development of model projects for adult day care. AOA plans to expand its role in this area in fiscal year 1978. Among its past activities in this area in fiscal year 1978. Among its past activities in this area was the development of a manual for the development, on a local level, of adult day care centers.

A conference grant has been awarded by the Health Resources Administration, PHS, to assist in developing a national research strategy in day care. The conference will be held in Washington, D.C., September 27-29, and will bring together representatives of Federal agencies, as well as practitioners and researchers from the field.

A potentially significant factor in the development and funding of adult day care is title XX of the Social Security Act, which provides financial assistance to the states for a wide variety of social services. The legislation permits title XX funds to be used to develop adult day care programs if the states include these services in their state plans.

The program is carried out under the auspices of the Office of Human Development, Public Services Administration. An indication of the potential for coordination among the various Federal components concerned with adult day care is the encouraging trend in recent months of using title XX funds to enrich ongoing health-oriented adult day care programs.

Question 3. Will the Division of Long-Term Care, now within the Public Health Service, be transferred to the Health Care Financing Administration?

Answer. The Division of Long-Term Care, which was located in the Office of the Assistant Secretary for Health, has been abolished (*Federal Register*, Vol. 42, No. 124, Tuesday, June 28, 1977, p. 32845). Most of its functions have been transferred to the Health Standards and Quality Bureau and other components in the Health Care Financing Administration.

HOME HEALTH DEMONSTRATION PROGRAM

Question 1. How many requests for funds from the home health demonstration program has HEW received for 1977 grants?

Answer. The regional offices have reported that 132 grant applications were received as requests for 1977 grant funds. This number of grant applications was far less than anticipated. In fiscal year 1976, the Bureau[1] was able to award 56 grants from the $3 million appropriation. Fiscal year 1977 appropriation again remained at $3 million and it is assumed that this limited amount of funds discouraged grantees from making application. $3 million approximates only one grant per State.

Question 2. I note that the majority of grants for the fiscal year 1976 funding went to already established home health agencies to allow expansion of services. Why were so few new development grants made?

Answer. The successful development of a new home health agency requires an applicant to organize community support and engage in preliminary planning activities prior to preparing a grant application. The legislative events which occurred in 1976 did not allow time for most potential new agency applicants to complete a grant application in the short period of time provided to them. The reasons for this are as follows: Public Law 94-63 was enacted on July 29, 1975. The supplemental appropriations bill which provided funds for the home health

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[1] Bureau of Community Health Services (BCHS).

authorization was not enacted until December 18, 1975. President Ford sent his budget rescission request, which included the funds appropriated for home health, on January 23, 1976. The denial of the rescission request was not sent from Congress until March 19, 1976. This uncertainty along with the former administration's objection to the establishment of the program led to a delay in the publication of the home health interim regulations. The Bureau of Community Health Services (BCHS) took rather extraordinary procedures by changing the format of the draft regulations and distributed them as instructional materials for distribution through the regional offices prior to the publication of interim regulations on August 19, 1976. This instructional material was not distributed to the regional offices until May 6, 1976. The grant cycle established called for the receipt of grant applications back within the regional offices by July 1. Therefore, the time frame provided to potential applicants was not sufficient for most communities to complete the necessary developmental steps necessary to make application for a grant to develop a new home health agency.

Question 3. How many new home health agencies do you expect to be established as a result of the fiscal year 1977 demonstration grants?

Answer. The Joint Central and Regional Office Grant Review Committee (JRC) met on August 16–19, 1977, to review home health services grant applications as authorized under Public Law 94–63 and extended by Public Law 94–460. The regional offices received 132 grant applications and sent forward to the central office a total of 64 applications which had been found technically acceptable as they were processed through the respective regional office objective reviews. A total of 56 grant applications were approved for fiscal year 1977, of which 14 are new or developmental.

Regional allocations were based upon the totals of regionally approved budget levels for those grant applications found to be in compliance with the home health services grant regulations.

The Health Care Financing Administration has recently informed State agencies responsible for medicare certification, that advanced certification would no longer be allowed for home health agencies. Advanced certification is when the State agency certifies that the home health agency, applying for a provider agreement, is in compliance with the conditions of participation prior to treating patients. The home health services grant regulations, governing the administration of grant funds authorized under Public Law 94–63, require the grantee to be certified by the State agency to be in compliance with the conditions of participation prior to using home health services grant funds for the provision of patient care services. The Health Care Financing Administration has agreed to grant a waiver of this policy to all grantees receiving awards authorized under Public Law 94–63.

Question 4. How is the Department evaluating the progress of the grants already made?

Answer. The Bureau of Community Health Services (BCHS) has included the home health services grant program under the Bureau's Common Reporting Requirements (BCRR). The BCRR is a data gathering system which was developed for the purpose of evaluating the impact of all BCHS program activities. The BCRR will allow the Bureau to evaluate the impact of the home health services grant program upon the numbers of persons served, the numbers of visits made, and financial information including the sources of third party dollars used to sustain the operation of home health agencies. It will be possible to measure the capacity building impact that the home health services grant program has had on those areas where grants were awarded. In addition, the Office of Planning, Evaluation, and Legislation (OPEL), Health Services Administration, awarded a contract in 1976 to develop an evaluation methodology for the further refinement of measuring the capacity building impact and the factors which sustain financial self-sufficiency of grantees awarded with fiscal year 1976 monies. This methodology will be implemented by the award of another contract by OPEL in 1977. A report on the results of this contract will be available by September of 1978. Interim reports, however, can be expected as a result of information gathered by the BCRR sometime after the close of calendar year 1977.

COLLABORATION BETWEEN HCFA AND THE PUBLIC HEALTH SERVICE

Question. Your description of plans for "collaboration" between the Public Health Service and HCFA should be encouraging. But how exactly will this collaboration take place? Will there be a new round of research projects, or are you going to take more direct action?

Answer. HCFA is now in the process of working out collaboration with the Public Health Service and will keep you informed as this develops.

UTILIZATION AND COST OF ALTERNATIVE SERVICES

Question 1. Can you provide us with additional information on how Secretary Califano arrived at his estimate of an approximate 15 percent inappropriate utilization of acute care hospitals? How much of that cost is being paid by medicare? Medicaid?

Answer. One source was a study which compared hospital utilization between health maintenance organization (HMO) and non-HMO enrollees. The study conclusions were a 30 to 35 percent differential in utilization between the two groups. However, since this study covered only one area, and because HMO's offer ambulatory care services which might have an effect on utilization, the differential was adjusted to 15 percent to account for these factors.

We do not believe the 15 percent inappropriate utilization figure can be directly applied to expenditures for medicare and medicaid due to the differences between the patient populations of the study and Federal program beneficiaries. At this time, information on medicaid and medicare misutilization is not available. A full scale study of the federally funded patient population is required before the cost of misutilization could be estimated.

Question 2. Do you have similar estimates as to the number of persons in nursing homes who do not have to be there?

Answer. There have been several studies, mostly on a localized basis, of those persons in nursing homes who need a higher or lower level of care. The range of estimates is from 15 to 75 percent inappropriately placed in nursing homes. Based on data obtained from surveys of nursing home patients, it may be concluded that approximately 30 percent of these patients could be cared for in alternative settings.

Question 3. I would also appreciate your comments on the estimates of need and overutilization developed by the Congressional Budget Office in their recent report on long-term care. A copy of this report is enclosed.

Answer. The Congressional Budget Office report estimates that "10 to 20 percent of SNF patients and 20 to 40 percent of ICF residents are receiving unnecessarily high levels of care." These figures are based on studies of inappropriate utilization of nursing homes, enumerated in appendix B of the CBO report, and appears to be generally in line with the estimates cited above.

With regard to the estimates of need contained in the CBO report, it would be impossible to evaluate them without knowing exactly how they were arrived at. The technical analysis paper describing this process, "Long-Term Care: Actuarial Cost Estimates," was published only very recently. We regret that we have not yet been able to fully analyze this report, but we will be doing so shortly.

Question 4. A proposal has been made to undertake a national "experimental benefit period" with relaxed medicare guidelines. This could help test the utilization and cost of expanded service under medicare.

Would the Department support expansion of medicare and medicaid reimbursement for home health care and other in-home services on a demonstration basis?

Answer. The Health Care Financing Administration would like to study the impact of such a far-reaching project before endorsing a "national demonstration." Such a demonstration requires a clear understanding of its nature and extent, and tends to create the expectation that experimental services will become part of the basic program. The Department is already engaged in community based demonstrations of this type and we hope to soon have the results of these demonstrations.

Question 5. Another proposal has been to set up a program of ambulatory chronic care service centers at the local level throughout the country. These centers would provide central coordination and purchase of needed services for individuals with chronic conditions and monitor the care provided. Is the Department considering a demonstration program of this type? Would it?

Answer. Ambulatory Chronic Care Service Centers (ACCS) would ensure provision of coordinated health and related services at the local level to a chronically ill and impaired population. The ACCS would not actually provide services, but would be responsible for client assessment, prescription of and referral to services, continued monitoring, and client representation.

The Department currently has five demonstration projects which emphasize the development of community care organizations, similar to ACCS. These projects are being implemented in Connecticut, Colorado, Wisconsin, Washington State, and New York. The Department anticipates funding additional projects on community care organizations as a result of the April 7 announcement in the *Federal Register* on the availability of grant funds under sections 1110 and 1115 of the Social Security Act. None of the currently funded projects has as broad a compass as has been suggested for ACCS's. There has been no involvement by HUD or the SSI program in these projects. The Department plans to evaluate in the future the feasibility of conducting a demonstration project which would integrate all of the components of ACCS's.

CERTIFICATE OF NEED

Question. Why did HEW exempt home health agencies from the certificate of need requirement? What can be done to bring HEW policy in conformity with congressional intent, which specifies that the establishment of new, or expansion of existing, home health services be contingent upon the acquisition of a certificate of need?

Answer. Although home health agencies are an important component of the health care delivery system, at the present time such agencies account for a small percentage of total health care expenditures. For this reason, and because States have the authority to regulate home health agencies in any case, it was felt that coverage of these agencies should not be one of the minimum Federal requirements for State certificate of need programs. Therefore, the proposed Federal certificate of need regulations of March 19, 1976, did not include home health agencies in the required coverage of these programs. However, a great number of public comments were received on this issue, and the question of requiring that these agencies be covered by certificate of need programs in each State was reconsidered by the Department.

Despite the arguments put forward by those favoring required coverage of home health agencies, it was decided that the final regulations should not require this. State and local health planning agencies are not precluded from including home health services in their plans, and States are free to require coverage of home health agencies in their own certificate of need programs if they wish to do so. These regulations, published in the *Federal Register* on January 21 of this year, are based on the additional consideration that it would not be equitable to require coverage of home health services in those institutions subject to certificate of need review and at the same time to exclude free-standing home health agencies from required coverage. Therefore, modifications were made to the final regulations to omit home health services from required coverage under certificate of need regardless of whether these services are offered by a free-standing home health agency or by a health care institution that is otherwise covered by certificate of need.

In taking this action, the Department was not acting counter to congressional direction provided either in the National Health Planning and Resources Development Act of 1974 (Public Law 93-641) or the committee reports which accompanied this statute. However, the question of whether to require States to cover home health agencies in their certificate of need programs has been a particularly difficult one for the Department to resolve. At issue is the need to balance the desirability of presenting minimum Federal guidelines to the States with the need to require an effective health planning program. The preambles to both the proposed certificate of need regulations, published on March 21, 1976, and the final certificate of need regulations, published on January 21, 1976, state that the Department will monitor closely the growth and expansion of home health agencies in order to evaluate their impact on the health care system. The result of this monitoring will shape the Department's view as it considers amendments to the certificate of need regulations.

ADVANCE CERTIFICATION

Question 1. It is our understanding that the Bureau of Health Insurance is now in the process of notifying all States that advance medicare certification of new home health agencies is being discontinued. Has this happened? Why was this action taken?

Answer. Our program experience revealed that advance certification (which was never used in the certification of hospitals, nursing homes and other health facilities) resulted in an unacceptable loss of control over the survey and certification process. We found that the program can determine compliance with the conditions of participation only by review of ongoing activities, not by reference to planned activity.

In addition, discontinuing advance certification allows the intermediary reviewing the home health agency's budget and experienced financial transactions to more realistically evaluate and agency's fiscal capability and establish a more realistic cost per visit.

Question 2. How will it affect the development of new home health agencies? It appears that new agencies would have to be providing services for a significant period of time before they could begin to receive medicare reimbursement.

Answer. It is too early to give a projection of how the new policy will affect the development of new agencies. State agencies are being instructed to advise new applicants that although a formal survey for certification purposes will not be done until after the agency is operational to the extent of having provided requisite services for 60–90 days, if such agency is found upon formal survey to meet all conditions of participation. the effective date of such participation can be made retroactive to the date of the request to establish eligibility or the first day of ongoing operation. Thus, for the agencies seriously prepared to provide service in accordance with conditions of participation and become certified providers there may be a delay in reimbursement but not necessarily any loss of payment for services furnished. The 60–90 day rule is not a rigid timetable. Some agencies may become full operational and meet the conditions of participation in a shorter time, and State agencies will use their best judgment in determining which agencies are ready for formal survey and when.

Question 3. Where will new home health agencies get funds to provide services until they begin receiving medicare reimbursement? How long would the "startup" period take?

Answer. A health facility or agency should not expect a single Federal program to meet all of its startup costs. It should have a serious commitment to the community and sufficient resources to provide services to people with various types of health insurance coverage just as all other providers are required to do. Other third party payments for such services are on the increase and we feel that a responsible commitment to a new venture should include a certain amount of risk capital invested by the managers in order to support startup costs.

The "startup" period is that period of development leading to the actual provision of services. The time such a period takes depends largely upon those responsible for establishing the agency.

Question 4. How will this affect the home health demonstration program under Public Law 94–63? Will they be subject to the same rule?

Answer. Regulations implementing the home health demonstration program under Public Law 94–63 (i.e., § 51e.106(b)(2) and (3)) require a home health agency to "(2) obtain certification from the State agency in accordance with 20 CFR Part 405, Subpart S, within 60 days from the date of grant award . . ." and to "(3) be certified by the State agency before utilizing grant funds under this subpart for providing any home health services."

Discontinuing advance certification will, therefore, have the effect of delaying an agency's use of the funds to provide services until it is certified. Such agencies will no doubt recover their costs after having been retroactively certified. Nevertheless, it is expected that these grantees will experience financial problems until certified. Staff members of HCFA and PHS are discussing the possibility of making exceptions (or waivers) in certain instances to minimize these problems of grantees.

Question 5. Since for-profit home health agencies have the advantage of large amounts of cash for startup, it appears that this new ruling, in combination with the advantage they have because of no certificate of need requirements, will encourage the proliferation of for-profit home health agencies and make it even more difficult for nonprofit agencies to get started. What is the Department's policy on for-profit home health agencies?

Answer. The change in the policy on advance certification should not lead to a proliferation of for-profit home health agencies because by statute, for-profit or proprietary home health agencies can only participate in those States which license such agencies. There are 18 such States and only 75 of the 2,365 home health agencies currently particpating are in this category.

FRANCHISING

Question. There is increasing evidence of franchising home health services. This practice consists of corporations soliciting physicians and others, promising to help set up home health agencies for a percentage of the take. In one instance the total cost siphoned off was 30 percent of the funds the home health agency received from medicare. The physician is told he can pay himself a large salary, write off his car, take vacations at the expense of the company, and have the tax-free retirement benefits set up by the home health agency. Whether the agency that is set up is for profit or not, it is questionable that Congress intended 30 percent of medicaid funds to go to franchisers.

Is the Department investigating this practice?

What are the Department's plans for treatment of franchising? Will the Department allow it to continue?

Answer. The medicare program has been sensitive to the issue of franchise fees since its inception. Under medicare program policies and operating instructions, which have been in existence since 1967, franchise and similar type fees incurred by a provider are an allowable cost for medicare reimbursement purposes only to the extent the fee is reasonable in amount and relates to the patient care furnished by the provider. Thus, the services received in exchange for the fee must be of the type considered necessary and proper to the operation of the provider as a health care institution. Any portion of the franchise fee which relates to such things as the value of the national or regional reputation of the franchiser, the expenses of the franchiser to promote the provider as a health care institution, the purchase of exclusive franchise rights in an area, etc., are not recognized as an allowable cost by the medicare program.

You also express concern that franchisers may be advising their clients that salary, travel, vacation and other fringe benefit costs attributable to the new home health agency administrative duties performed by the person(s) who established the home health agency are an allowable cost for medicare reimbursement purposes. Medicare policies do recognize as a cost of home health agency operation the cost the home health agency incurs to compensate its administrative personnel for the necessary and proper administrative duties they perform in the day-to-day operation of the home agency to the extent that such cost is reasonable. The reasonableness of such compensation is determined by comparison to what established home health agencies in the same general area are incurring for like administrative services.

Appendix 2

STATEMENTS OF SECTION 222 PROJECT DIRECTORS

ITEM 1. LETTER AND ENCLOSURE FROM CLAIRE HAGGA COONEY,[1] DIRECTOR, PROJECT EASYRIDE, VERA INSTITUTE OF JUSTICE, NEW YORK, N.Y.; TO SENATOR LAWTON CHILES, DATED SEPTEMBER 16, 1977

DEAR SENATOR CHILES: In response to your request for information on our section 222(b) project, I have prepared the enclosed testimony. The Vera Institute's project—Specialized Transportation Project for the Elderly and Disabled—was approved as a section 222(b) project effective June 1, 1977; therefore, we have just begun the project activities.

I will be available at the hearings on September 21 if you have further questions on this project. Thank you for the opportunity to participate in these hearings.

Sincerely,

CLAIRE HAAGA COONEY,
Project Director.

[Enclosure]

RESPONSE TO QUESTIONS ON SECTION 222(b) RESEARCH

Question 1. Provide a brief narrative of your project.

Answer. Project narrative.—Easyride is a project of the Vera Institute of Justice, a nonprofit corporation, located in New York City. Easyride serves elderly (over 60) and handicapped (mentally or physically) residents of Manhattan's Lower East Side who have difficulty using public transportation.

The Vera Institute was organized in 1961 to develop innovative approaches to problems in the New York City criminal justice system. Since that time, the institute's work has broadened to include problems of various disadvantaged populations, alcoholics, narcotics addicts, and welfare recipients. The institute's interest in creating jobs for ex-addict/ex-offender graduates of a Vera-founded supported work program and in developing ways of reducing unnecessary institutionalization of the elderly and handicapped led to the development of Easyride.

Easyride's objectives can be stated as follows: (1) To increase the mobility of elderly and handicapped residents of the target area; (2) to provide a low-cost (15-cent fare) accessible transportation service to the target population and to analyze the utilization patterns which develop; (3) to develop a model multipurpose paratransit service including a financing plan, outreach scheduling, dispatching, staff training, and data collection systems; (4) to test the effectiveness of rehabilitated ex-addicts and ex-offenders in demanding human service jobs.

Easyride began operations on a limited pilot basis in July 1976 (three vehicles), and expanded in February 1977 with 10 specially designed vehicles (five are equipped for wheelchair-bound passengers). Easyride has delivered 32,000 rides to date, with a present average of 1,000 rides per week. Currently, 1,350 elderly and handicapped persons are registered with Easyride.

Easyride's financing plan is based on receiving income from a variety of public

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[1] See testimony, p. 552.

agencies which purchase transportation. To date, Easyride has received grants/contracts in the following amounts for the following periods:

U.S. AoA, Jan. 1, 1976 to Dec. 31, 1977	$200,000
U.S. UMTA, Jan. 1, 1977 to Dec. 31, 1978	176,000
Medicare (section 222 waiver), June 1, 1977 to May 31, 1978	250,000
UMTA (one time), capital costs	154,000
Helena Rubinstein Foundation (renewable), Oct. 1, 1976 to Sept. 30, 1977	15,000
Citibank (renewable), Jan. 1, 1977 to Dec. 31, 1978	5,000
Henry Street Settlement House, Mar. 15, 1977 to Sept. 30, 1977	10,000

Additional contracts for transportation services not now reimbursable by a third party payor are being pursued.

Question 2. From your own frame of reference, provide a description of the demonstration and its intent.

Answer. Referral/intake process.—Easyride operates in the following manner: (1) Individuals, social service, or health agencies register passengers either by phone or in person. (The registration card includes basic background information, as well as several questions about prior transportation usage); (2) individuals or agencies call Easyride on an advance basis (48 hours preferred, same day served if space available) to reserve a ride.

To date, registration of 1,350 persons has been accomplished largely by developing relationships with the social service and health agencies and word-of-mouth contact among passengers.

Final sample size (control group and expanded benefit).—The nature of the service being provided, transportation, dictates that the service population be larger than the population which is the focus of an in-depth study. The research effort will collect data on all users—an expected group of approximately 5,000. Data to be collected is specified in the attached research and service design. An in-depth study will be conducted on 1,200 individuals: 600 in the Lower East Side target area and 600 in the West Bronx, a geographical area with similar demographic characteristics but without a specialized transportation service. Benefits are expected to accrue to the families of the experimental and user populations and to the social service and health agencies serving the target population.

Services to be provided by the demonstration.—Easyride provides door-through-door transportation for persons who live in the Lower East Side (14th Street to Fulton, Broadway to the East River) and are either elderly (over 60 years of age) or handicapped (physically or mentally and over 16). Service is provided on a demand/response basis: passengers call in advance, preferably 48 hours, and reserve a ride on a subscription basis—passengers call once and reserve a ride for specified regular times (e.g., daily trips to work, three times weekly to physical therapy). Informally, Easyride provides an information and referral service for passengers who are identified by drivers or office staff to need a service other than transportation. Easyride has close working relationships with over 40 agencies in the Lower East Side and with some 20 citywide service agencies to whom we refer passengers.

Assessment process.—Easyride's basic goal is to increase the mobility of users and therefore detailed user records are being kept (type, purposes, and frequency of trip; age and disability of user) in order to develop profiles of the elderly and handicapped users and their transportation needs. The system is open-ended in that trips are not given priority according to purpose in order to discover which kinds of trips are in the greatest demand. The deep sample of 600 Lower East Side residents who are eligible for Easyride will be compared with the 600 West Bronx would-be eligibles to analyze the impact of an accessible transportation system.

This deep sample will focus on mental health status, mobility status, institutionalization rates, transportation patterns.

Specifically, the hypotheses to be tested are:

—A significantly higher percentage of experimentals than of comparisons will increase their mobility by one or more trips[1] per week.

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[1] A "trip" is defined as a departure from and return to a point of origin in the course of which a street is crossed. Trips may consist of rides, walks, or a combination of these two modes, and may be single or multipurpose in nature.

—The change in mean number of trips per week will be significantly higher for experimentals than for comparisons.
—There will be more diversity in trip purposes among experimentals than comparisons.
—The difference between experimentals and comparisons will be most marked for those with a greater degree of physical disability.
—There will be a significantly larger proportion of experimentals than comparisons who move toward a more positive mental health status.
—The mean score of experimentals on a scale of mental well-being will move in a positive[2] direction or remain constant, while the mean score of controls will remain constant.
—There will be a significant and positive correlation between high mobility scores and high mental health scores for experimentals.
—The change in mean number of trips per person to physicians' offices and other outpatient facilities will be significantly higher for experiments than for comparisons.
—A higher percentage of experimentals than comparisons will report eating a nutritionally adequate diet.
—The change in mean number of trips to congregate meal programs and food stores will be significantly higher for experimentals than for comparisons.
—The mean annual number of visits to hospital emergency rooms will be significantly lower for experimentals than for comparisons.
—The mean annual number of incidents of hospitalization and of stays in health-related facilities will be significantly lower for experimentals than for comparisons.
—The mean number of days per stay in a hospital or health-related facility will be significantly lower for experimentals than for comparisons.
—The proportion of experimentals placed in long-term care facilities will be lower for experimentals than for controls, although this trend is not expected to attain a level of statistical significance.

Question 3. Measurement of the result of the provision of care or service in terms of effectiveness of the single source funding approach.

Answer. This point is not applicable to Easyride, since Easyride has multiple sources of funding as described in question 1.

Question 3A. Effectiveness of the single source management of treatment or service provision.

Answer. This item must be specially interpreted in the context of transportation. Easyride was designed to integrate trip purposes and types of passengers in need of specialized transportation in an independent service (i.e., not a part of any one health or social service agency). Although our data are preliminary, we predict that they will indicate that this multipurpose approach is both the most workable and cost-effective. Transportation needs vary by time of day and day of week; therefore, by meshing a variety of people with different trip purposes, minimal dead time exists. Among the elderly and handicapped, most of whom are unemployed, schedules can be flexible (with the general exception of medical appointments). Trip times are negotiated by Easyride's scheduling staff to maximize hourly vehicle utilization.

Question 4. Cost data accumulated by this demonstration.

Answer. Basis of accumulation of cost data for the demonstration project costs are being computed on an actual cost basis by standard accounting methods used by the Vera Institute, which have been found acceptable by the Division of Direct Reimbursement of the Health Care Financing Administration.

Basis of comparison of accumulated cost data to cost of provision of services under medicare. Since nonambulatory transportation is not now reimbursed by medicare, there is no present medicare cost experience for transportation as a regularly covered service. Easyride cost data has not yet been calculated.

Question 5. Do the costs derived from this demonstration provide a basis for designing a set of medicare-covered services based on the demonstration?

Answer. Yes, costs are being calculated according to standard medicare procedures and, therefore, should provide a basis for designing a set of medicare covered services based on the demonstration.

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[2] "Positive" here denotes measures which indicate greater optimism, and increased sense of control over events, and enhanced feeling that one's life has been worthwhile, etc.

Question 6. Do the results of care or service offered by your demonstration provide a basis for judging future combinations of services or care which could prevent or retard institutionalization?

Answer. Yes, we expect the research results to indicate whether or not improved access to transportation and the resultant increase in mobility reduces institutionalization. The clearest impact may be in the impact specialized transportation has on the length of hospital stay. For example, medical staffs at hospitals may be willing to discharge post-surgery patient sooner if they know that the patient can return easily for post operative checkups.

The close working relationships which Easyride has established with health and social service based home care programs in the Lower East Side will provide a basis for study of how the combination of transportation and home care service reduces institutionalization.

To discover any significant impact on long-term institutionalization, a larger sample and longer period of study (e.g., 5 years) would be required, but we expect to discover trends which tend in the direction of a less frequently institutionalized, more mobile population.

Question 7. What provision has been made for the extension of the demonstration care or services to the demonstration control group and expanded benefit group in your community at the conclusion of your demonstration?

Answer. The data collected on the control group population will provide a basis for assessing the needs of that population for specialized transportation services. As explained above, we are attempting to develop a model funding package which will draw on local, State, and Federal support—generally resources which are now expended for the target population, but perhaps not for transportation. This redirection of resources should be possible in other areas in New York City. We participate in the Lower East Side Inter-Agency Council on Aging and through this group in the City Wide Council on Aging and have provided technical assistance to social service and health providers about specialized transportation.

Question 8. Please identify further gaps in care or service which appeared during the course of the demonstration.

Answer. We have not yet identified gaps in care or service which can be fully documented.

Question 9. Based on your experience with this demonstration, what recommendations would you make with regard to future design of such demonstrations or future policy with regard to the care or service provided by this demonstration?

Answer. This demonstration, which operated on a pilot basis from July 1976 through May 1977, and moved into the demonstration phase June 1, 1977, with approval of medicare reimbursement, is not yet far enough along to make policy recommendations.

Question 10. Are there individual client experiences which you would care to relate that lend a more personal impact to the description of the demonstration?

Answer. Individual client experiences are, I think, well expressed by some of the letters sent to Easyride by passengers. Samples of these are attached.[1]

Question 11. What use will be made of research findings from your project?

Answer. Research findings from Easyride will be used to make policy recommendations regarding the type of transportation service needed by elderly and handicapped persons and methods for financing such services.

Question 12. How will your project be evaluated?

Answer. The research program associated with Easyride has four major purposes: (a) To assess the service's effects on its users; (b) to example the service's relationship to, and effect on, the health and social service agencies that constitute the "life support system" for the elderly and disabled residents of the Lower East Side; (c) to measure the service's cost-effectiveness; and (d) to evaluate the service's employees.

A. IMPACT ON USERS

This aspect of the research would seek to determine whether Easyride has a positive impact on mobility (as measured by number and variety of places visited), on physical health (as measured by various health indicators, such as

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[1] Retained in committee files.

hospitalization), and on mental health (as assessed by indices of life satisfaction).

The primary research method would be a "before and after" interview study with elderly Lower East Siders and a comparison group of elderly in the West Bronx, an area of New York City similar to the Lower East Side in ethnicity, income, and crime rate. In each area, personal interviews with 300 elderly would be conducted prior to service use and again a year later. An analysis of variance would be applied to the interview data to determine service effects on the mobility and health of highly disabled and less disabled persons.

Other research methods would include a regression analysis employing project data on registrants and trips; on-board observation; attitude surveys; and other qualitative techniques to assess impact on special user groups including the severely disabled and the younger disabled.

B. IMPACT ON SOCIAL AGENCIES AND HEALTH CARE SYSTEMS

Early in the demonstration, selected personnel in social and health agencies would be interviewed to learn what benefits they expect to derive from Easyride, what problems they anticipate, and what criteria they would use to evaluate the effectiveness of the service. With the help of this feedback, an opinion survey would be developed and administered to personnel in local agencies and hospitals after a number of months of Easyride operations.

Special microstudies would also be conducted to acquire a better understanding of the medical treatment of innercity elderly, and of the potential role of a specialized multipurpose transportation system in making their health care both more humane and less costly. These studies would focus on length of hospitalizations, hospital clinic procedures, and nursing home admissions.

C. COST/EFFECTIVENESS

Research would attempt to test whether a multipurpose transportation system serving elderly and disabled residents in one area could overcome the cost and inefficiency problems of the present limited and fragmented system of third-party payments.

The chief data sources would be:

—Medicaid payment records for transportation.

—Transportation payment records of social service and rehabilitation agencies serving the target population.

—Expenditure records from Easyride transportation service.

This part of the research would be conducted by an accounting firm specializing in this area.

D. SPECIAL RESEARCH ON EMPLOYEES

In addition to these three foci, research would be conducted on service employees who are ex-addicts and ex-offenders. The effect of employment on their lifestyles and job satisfaction would be assessed and compared with similar individuals employed in other kinds of work. Drivers' employment records would be compared with those of drivers for other transportation services, and special management problems and needs of Easyride drivers would be documented.

Along with these studies there will be a full program of operations research, including regular summary reports of trips and riders and a report on the operating issues of the program, to be prepared in conjunction with Applied Resources Management, another UMTA contractee.

ITEM 2. LETTER FROM ROBERT W. MACK, ADMINISTRATOR, ST. CAMILLUS HEALTH AND REHABILITATION CENTER, SYRACUSE, N.Y.; TO SENATOR LAWTON CHILES, DATED SEPTEMBER 15, 1977

DEAR SENATOR CHILES: The following information is in response to your letter of September 1, 1977:

(1) A. The community served by this demonstration:

(1) Patient must have been hospitalized at the time of the referral.

(2) Patient must have medicare Parts A and B coverage.

(3) Patient's condition must have demonstrated a need for day care services within approximately 3 months of discharge from the hospital.

(4) Patient must live within a 25-mile radius of St. Camillus (otherwise transportation to and from facility for services was judged not feasible).

B. Agency description: St. Camillus Nursing Home Inc., opened in March of 1969 as a voluntary nonprofit, 120-bed skilled nursing facility. (At present it has 130 beds). It was the first subacute care facility to be built in New York State under article 28A of State health code. It is located on the west side of the city of Syracuse in Onondaga County. It is a one-story building in the shape of an "E" with the middle of the "E" elongated. Part of the building has a basement that has been converted to house the business office, central supply, and maintenance. There are three nursing units in three wings interconnected with a central administrative wing. In 1972, St. Camillus expanded the scope of services under subchapter H of the State health code. St. Camillus received it's first day care patient in November 1972.

C. Funding structure for the demonstration: The research demonstration project was authorized under Public Law 92–603, section 222. The estimated cost of the project was $179,000.

(2) A. Our sample was restricted to post-hospital patients. Therefore, the referral sources were the six area hospitals, including one Veterans Administration Hospital. The initial contact came after authorization was granted to begin the intake process.

The intake process:

(1) Referrals for the study were obtained from the discharge planning teams of the various hospitals.

(2) Referrals were screened by the assessment team on the staff of the demonstration project, consisting of two physicians, a registered nurse and a social worker.

(3) Those patients selected for further consideration were invited to participate in the project by obtaining their signatures on an "informed consent form."

(4) Patients were interviewed to obtain the required personal and health related information.

(5) The assessment team determined who would be enrolled in the Project, based on this information.

(6) Some of the enrolled patients received medicare coverage for the day care services for a period of 1 year. Such coverage was in addition to the presently covered services by Medicare. This was done by random sampling.

(7) Patients were interviewd four times, once every 3 months, to define their health status at that time.

(8) All patients were asked to keep a health diary noting their contacts with health care personnel and any out-of-pocket expenses incurred on their part during the period of one year.

In addition to having meetings with the social workers and Public Health Nurses in the hospitals and leaving them with documents, brochures and reference materials, meetings were also held with the head nurses, supervisors, and nursing administration in the four general hospitals.

A letter explaining the project and the referral process was sent to all physicians in Onondaga County. Interns and residents in teaching hospitals were also sent project information. A brief article describing the day care services was written for the county medical society bulletin. An information sheet concerning the project was requested to be posted in each hospital on the bulletin boards and on all medical, surgical, nursing stations as well as the doctor's lounges (exhibit 1[1]).

Administration and social service departments of three area nursing homes were also contacted and the project explained to them. This was done to make them aware of the project so that it would not be difficult to contact them to seek permission to reassess a project patient in their facility at a future date.

Referrals came from the hospitals right after the initial meetings with them but very slowly.

With all these efforts and also with an extension of the intake period for an additional 3-month period, the sample size of 100 enrollments could not be reached. The slow rate for referrals can be attributed to several factors: (a) Perhaps not a sufficient time was allowed before the intake period to educate and orient all hospital personnel involved in discharge planning; (b) intake period began dur-

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[1] Retained in committee files.

ing the summer months when staff vacation is at a peak in the hospitals; the summer of 1974 was also a physician malpractice period in New York State; (c) it was confusing to many in the beginning as to why a patient referred to the project did not have to be admitted to St. Camillus or did not have to receive day care services; (d) referral of a patient to the project was not a routine function of the social workers; (e) social service staffs may have been so busy arranging the discharges for patients, that they may not have recalled that a particular patient might be appropriate for the project; (f) not all patients admitted to the hospital and possibly needing long-term care are referred by the physician to the social service department; (g) in many cases, when the referral was made to the social service department about discharge planning for a patient, it was not made sufficiently before the discharge so that the social service department had time to refer the patient to the project; (h) the discharge planning thinking in our general hospitals seems to be toward institutionalization, i.e., discharging to long-term care facilities if long-term care is needed. There did not seem to be sufficient awareness of the noninstitutionalized resources available to patients to rehabilitate or maintain them at home.

B. The final sample size: The total was 89 patients; control group, 45 patients; expanded benefit group, 44 patients.

C. The services to be provided by the demonstration: Nursing services, personal care services, nutritional services, recreational activities, transportation. social services, routine podiatry, physical therapy, occupational therapy, speech therapy, eye examinations, and hearing examinations.

D. Patient assessment process: Once it was determined from the referral that the patient should be interviewed, the timing of the interview was scheduled through the referring social worker. All the interviews were conducted in the hospital, where the surroundings were seldom ideal. There was a limited amount of privacy in semiprivate rooms and almost none in larger rooms. The presence of a collatoral was sometimes helpful to the patient in terms of interpreting and explaining the questions, while in some cases it had a dominating influence over the patient. It was not always possible to conclude the interview in one sitting. This was primarily due to patient fatigue or disturbance due to the presence of many visitors in the room.

The interview procedure was for the social worker to begin the questioning after the informed consent had been signed. She would be the primary interviewer. In most cases, the nurse would also sit through the interview, record the answers and obtain additional information necessary for the abstract as well as for preparing the ideal care plan from the hospital staff and the patient's medical record.

The assessment team consisting of the social worker, nurse, and two physicians, determined whether a patient should be enrolled in the study or not and prepared an "ideal" care plan based on the information collected from the hospital and through the patient's status instrument. These three disciplines contributed towards the care plan preparation. It may very well be that the need for any other consultant was not felt during these sessions due to the experience of all members in the long-term care field. Specific comments pertaining to the patient's status instrument include: (a) The instrument defines the patient's health status at a given time. It is used to measure the changes in the status over a period of time. To prepare the care plan, we need the patient's past history and not just the data defining his status by considering what happens more often than not within the past 2 weeks. It was felt, therefore, that the instrument by itself did not provide sufficient data to prepare the care plan. (b) The instrument does not identify motivation on the part of the patient to improve. (c) It measures social contacts but does not identify what support system the patient may have in family members or friends who are willing to provide some assistance for the patient. This may be important in developing some care plans. (d) For the post-hospital patients, the assessment team felt they should be aware of medications, treatments and therapies that the patient would be receiving. Possible drug reactions, allergies should be also known. The instrument did not provide this information. (e) The design of the form could have been improved at least for care plan preparation. (f) It determines the human equipment requirements but does not go into detail about the degree of assistance needed. (g) Sequence of questioning on the instrument was not always conducive to establishing good relationships with patients. (h) Some of the items, though meaningful in terms of defining the patient's health status, may not be received well by the patient. For example, questions concerning orientation may be humiliating to those who are oriented, while threatening to those who are not. Preparing an "ideal" care plan based on the information collected through the instrument and other hospital sources posed difficulties several times in terms of estimating the duration and frequencies of various treatments (our ideal prescription was for a duration of about 90 days). Many times a more definitive prescription could be prescribed after reviewing the results of a short term, initial prescription.

The concept of objectively preparing a care plan using a multidisciplinary approach based on a systematically derived set of information is very good. Correlating that with the quality of care and reimbursement is an excellent idea. However, it would seem that more research needs to be done in implementing this with the forms that have been used in this experiment.

(3) A. In our experience, we found that the single source funding approach was more effective than billing multiple reimbursement sources for two basic reasons:

(1) After the initial startup period, payment turnaround time under the section 222 project averaged about 30 days. By comparison, outpatient services billed locally through different sources of reimbursement have averaged from 3 to 60 days or more. This greater time lapse causes service providers to incur carrying costs that could otherwise go toward providing more effective patient care.

(2) Assuming that all outpatient services will be billed to a single source, we anticipate that the audit procedures would be greatly simplified and, therefore, less of a patient cost component. Presently, there are several sources of payment that require significant amounts of time from both the service provider and the reimbursement source in periodic audits. Since much of this time is duplicative, it becomes a nonproductive element of providing effective patient services for all parties involved. Additionally, the fact that audit procedures are not uniform among the payment sources creates the potential for reimbursement errors that could be significantly reduced by a single payment source providing a uniform provider manual and a uniform audit procedure.

B. As a result of our experience, we believe that a single source of treatment would provide the most effective patient care possible. We are convinced, however, that prescription of treatment should be made outside the treatment source rather than having prescription and treatment exist as a single unit of patient care. By having a single center manage the treatment from different prescribing sources we believe it is possible to provide a more efficient and better integrated plan of patient care with reduced duplication of services and better review of patient health status and monitoring of health improvement. (See question (4) for a more detailed explanation of this conclusion.)

C. The results of our project 222 experiments in comparing health improvement between the control group and the expanded benefits group leads us to the conclusion that patients with expanded benefits available had significantly greater health improvement during the initial phase of treatment than the control group. Additionally, outpatients involved in a day care plan showed consistently greater health improvement than outpatients not receiving day care. It should be noted, however, that the relatively small sample size involved and the brief time period capable of measurement under the constraints of project limitations prevent us from stating that these are trends that can be firmly relied upon as accurate indicators.

(4) A. and B. In answer to these questions, and in order to facilitate your survey of cost data for effective health care delivery, we are enclosing a table of analyses comparing the cost of providing services under day care, in a skilled nursing facility and at home.

(5) The costs derived from this demonstration do provide a basis for designing a set of medicare covered services. However, though the basic information is presently available, there has not been sufficient time or resources to do a complete analysis of all participants during all phases of their involvement in the day care program. Therefore, we have concluded that, though the basic information collected is correct, the medicare program could derive significant cost benefits and service recipients better health care if the present partial data analysis were to be completed. This would provide a much more detailed basis from which a highly efficient service program can be formulated.

(6) The effectiveness of day care based on the data collected at St. Camillus is clearly demonstrated. Inclusion of day care services in a program of health serv-

ices prescribed for a patient needing long-term rehabilitative or maintenance care after discharge from an acute care, general hospital will not only be less expensive from the service cost point of view but will also be beneficial to the patient in improving his/her health status. Thus, providing medicare coverage for such services will be economical to the medicare program and beneficial to the patient and family. Indications on the limitation of the length of coverage could not be obtained from the limited analyses conducted.

Day care not only benefits the patient but in many instances benefits the family members also.

Whether or not the collective analyses conducted by the evaluation contractor from the data collected by all project 222 contractors provides conclusive information on the merits of providing medicare coverage for day care services or whether additional analyses and research are done, the objective lessons learned from the experiment conducted at St. Camillus, do not leave any doubts in our minds that the time has come to provide medicare coverage for the costs of day care services.

COST ANALYSIS OF IDEAL DAY CARE PRESCRIPTION

Comparison of the costs of providing services to 87 posthospital medicare patients who demonstrate a need for day care services, when the ideally prescribed services are provided (a) in a day care program, (b) in an SNF, and (c) at home.

Service	Frequency	Day care charge	SNF charge	Charge of receiving services at home [1]	Cost of providing services at—		
					Day care	SNF	Home
	(A)	(B)	(C)	(D)	(A)×(B)	(A)×(C)	(A)×(D)
Regular visit	2,212	$22	$41	[2] $11.0	$48,664	$90,692	[2] $28,965
PT	2,047	13	13	16.25	26,611	26,611	33,264
OT	1,312	12	12	19.00	15,744	15,744	24,928
ST	473	7	7	17.75	3,311	3,311	8,395
Eye examination	16	25	25	[2] 30.00	400	400	480
Hearing	7	12	12	[2] 17.00	84	84	119
PT evaluation	2	20	20	16.25	40	40	33
OT evaluation	12	20	20	19.00	240	240	28
ST evaluation	1	35	35	17.75	35	35	18
Nursing	8	NO	NO	17.75			142
Social services	11	NO	NO	[2] 17.75			195
Diet counseling	9	NO	NO	[2] 17.75			160
Psychiatric counseling	4	NO	NO	[2] 17.75			71
Diabetic training	2	20	20	[2] 17.75	40	40	36
Pulmonary therapy	1	7	7	17.75	7	7	18
Thyroid	1	NO	NO	[2] 17.75			18
Skin care	1	NO	NO	[2] 17.75			18
Dental	1	10	10	[2] 15.00	10	10	15
Personal care	1	NO	NO	4.75			5
Total					95,186	137,214	97,109
Cost per visit (2,212)					43.03	62.03	43.90

[1] Charges are obtained from the VNA and the health department.
[2] See explanation below.

(7) With the approval of the project officers, some patients were extended beyond the 1 year of services in the expanded benefit group by 3 months. Those project patients who needed long-term day care to sustain themselves or to slowly improve their condition had to make other arrangements, either to meet their health care needs through other covered sources or to make alternative arrangements for paying for the cost of day care services at St. Camillus. A copy of this was sent to the day care social workers so that they could make suitable arrangements for the patient and be prepared to cope with the situation. For the patient who was not coming to the day care program and to all the control group patients, a letter was sent thanking them for their participation in the study soon after their last day of participation after the last reassessment had been done and the diary had been collected. Social service counselling was available to acquaint them with services available in the community and ways to take advantage of them. This was implemented by writing a letter reminding him or her 1 month before the patient was to terminate from the study.

(8) Gaps in care or service:

A. Non-post-hospital patients who require day care services.

B. Agencies not recognizing day care as a possible alternative to institutionalization.

C. The need for a nonmedical (i.e., social model) for day care or a less intensive medical model. These would not be senior citizen or golden age groups.

(9) The people involved in implementing the data collection protocol should be involved in designing the protocol.

Since all aspects cannot always be satisfactorily considered for all people in implementing a design, it is important that the staff involved have the same objectives and understanding of the study. It would be ideal if everyone could agree about what is required to be done. But in the absence of it, the climate should be created to perform as objectively as possible.

Sufficient time must be allowed in contractor experiments for planning and organizing the required experimental health delivery system.

The agency that is involved in providing experimental services should also be charged with the responsibility of patient assessment and collection of research data. A proper managerial approach can effectively keep the two functions separated and can have better control over the quality of the data collected than in the case where these two functions are divided between two separate agencies.

The people who collect the data can interpret it better than anyone else. The function of the evaluation of data should also lie with the same agency that collects the data.

(10) Individual client experiences:

Case Summary: Mr. D. is a 71-year-old man, native of Syracuse, N.Y., married, with no children, a retired furrier. He had 3 years of high school but dropped out when his father died, changing his plans for a college education.

The patient's wife, Mrs. D., is 59 years old, 12 years younger than our patient and employed as a secretary for the County Department of Social Service in the children's division. Mrs. D. was 47 and her husband 59 when they were married, The patient was then tall, thin, well-groomed, healthy, a good looking man; he is almost a shadow of his former self, dependent on his wife, plagued by repeated hospitalizations, anxiety ridden over his illness, the high cost of medical care, and fear of death by suffocation. Mrs. D., too, is a changed person, adjusting to the role of wife to a now chronically ill man, changing a lifestyle that has become meaningful to her and worried over resources. She had a coronary several years ago and her own health is of concern too. Their plans to retire and travel have long been shelved.

Employed as a furrier-buyer in the fur department of a local ladies department store, the patient had a 38-year career from 1930 to 1968, in this highly competitive business and had established a reputation as a skilled craftsman. He retired in 1973 at the age of 68. For a while he was a volunteer at a local hospital, fulfilling a long-time dream, one he was never able to achieve before because of his long working hours. He would go fishing everyday; especially the trout season which was a favorite. But his health began to fail, he became short of breath with minimal exertion and finally COAD was diagnosed.

In 1975, this patient was hospitalized eight times, for 88 days. He also spent 25 days in an SNF. In October 1975, the patient entered our Federal study. Since that time, he has had only two hospitalizations, a total of 19 days. So we are comparing eight periods of hospital care in a 10-month period with two periods of hospital confinement after his enrollment in the day care program; in other words an 88-day period of care compared to 19 days after enrollment.

This kind of adjustment of poor health is compared to a man who in his 38 years of employment, missed only five days of work; an average of one sick day each 7 and six-tenths years and the sick days, he admits, were for "hangovers."

In his day care treatment, the patient received IPPB treatments, physical therapy for breathing exercises, postural drainage, and occupational therapy evaluation. At home he has moved to a one-floor compact mobile home and out of a two-story apartment with its second floor sleeping arrangement. He has learned greater understanding of his illness and its limitations. We have seen him move from denial that home factors—stresses might cause his hospitalization to a period of blame placing, where his wife was at fault for all his trouble, to the point he is now at—awareness that any anxiety factor can exacerbate and set off the panic cycle. He now has insight into his wife's needs too, recognizing the fact that she has gone through adjustment. Further, Mrs. D. has been relieved of the burden of responsibility of taking care of her husband, thus easing her own apprehension and making her more tolerant and supportive. The patient attended day care three times a week and has a Bennett machine at home which he uses. He is able to drive, limitedly it is true, but this has helped to increase his self-esteem; he has gained some weight and personal identity is returning. As he makes gains in one area, the other areas grow too.

If you were to ask Mr. D. what day care meant to him he would reply, "my life."

We were also fortunate to have produced a 30-minute public affairs documentary by WTVH-5, Syracuse, a CBS affiliate, entitled, "I Want to Go Home." This film can be made available to you.

This documentary has already been selected for presentation by St. Camillus at the annual gerontology meeting to be held in San Francisco, November 19, 1977.

(11) The answer to your question as to the use to be made of the research findings is twofold:

A. In regards to project objectives the findings will be used to demonstrate the cost effectiveness of using day care and home care as viable alternatives to institutionalization. However, as we have previously noted, the collected data has potential use in a number of different ways which only the Department of Health, Education, and Welfare can choose to pursue.

B. In regards to our own personal experiences, we are continuing to utilize our project experiences to:

(1) Provide a better structured program in terms of formulating a more effective system of health care delivery.

(2) Provide better integrated health services.

(3) Effect a higher turnover rate through this evolving program formulation that is continually producing shorter treatment periods that result in greater health improvement for our patients.

(12) Evaluation of the project: Public Law 92–603, section 222, authorized this experimental program to provide day health care services to individuals eligible to enroll in a supplemental medical insurance program established under part B of title XVIII of the Social Security Act. Medicus Systems Corp. was awarded a contract by the National Center for Health Services Research to evaluate the impact of this expanded benefit coverage. The evaluation focuses on assessing the impact of expanded benefit coverage (and/or utilization) on health and functional status as well as on health care services, utilization and expenditures. This is done, primarily, by comparing the outcome and expenditure experience of those who have received coverage for the expanded benefit (day care) to that of a control group, or by comparing the utilizers to those who have not used expanded benefit services.

We have forwarded our final report, dated August 31, 1977, to: Ms. Joyce Johnson, Center Building, Room 8–41B, 3700 East-West Highway, Hyattsville, Md. 20782.

We would be very happy to send you and your committee copies of this report just as soon as the Department of HEW approves.

Very truly yours,

ROBERT W. MACK,
Administrator.

ITEM 3. EXCERPTS FROM STATEMENT SUBMITTED BY EDMOND A. PERREGAUX, JR., PROJECT DIRECTOR, PROVIDENCE, R.I., SECTION 222(b) DEMONSTRATION

HOMEMAKER-HOME HEALTH AIDE SERVICES OF RHODE ISLAND

Homemaker-Home Health Aide Services of Rhode Island employs over 200 aides and offers service to residents of the entire State except for those who live on Aquidneck Island. The agency was incorporated in April 1966, with the following four objectives: First to set and maintain standards for such service in the State of Rhode Island; second, to recruit and train all aides; third, to provide these trained aides to other agencies who needed them for part of a coordinated service; and fourth, to use trained aides to provide service in geographic areas where the service was unavailable.

This was an almost impossible task because the agency had no legal authority under Rhode Island law with which to accomplish the objectives. The situation was further confused because there was, and is, little agreement among professionals, agencies, or the various State and Federal laws as to, "What training should be required of these individuals?"; "What are the specific job functions for each or all of them?"; and "Who or what program(s) should pay for the service provided?"

The agency provides homemaker service to public assistance (welfare) clients through an annual contract with the State. Each case is referred and authorized by a State social worker. This authorization may vary from 2 to 30 hours per week and may be approved for from 1 to 8 weeks (60 days) at a time depending upon the needs of the client. By authorizing service under title XX, the State is reimbursed by the Federal Government with $3 for every State dollar expended. The State does not authorize service under title XIX (medicaid) because of the one-to-one reimbursement feature. The entire case management except for authorization is under the direction of the provider agency. Homemaker-Home Health Aide Service of Rhode Island provided over 134,000 hours of service to approximately 700 clients in 1976. Three smaller agencies provided approximately 20,000 hours to other clients.

The agency also provides "home health aide service" to medicare patients through subcontract with seven of the nine district nurse agencies. In each case, the district nurse authorizes the service, specifies the number and times for each visit, and supervises the aide in the home. The provider agency schedules the aide, takes disciplinary action if necessary, and schedules substitutes if required. Almost 40,000 hours were provided in 1976 to approximately 800 patients under these subcontracts.

"Homemaker-home health aide service" is supplied to Rhode Island residents on a private basis. The client/patient or a member of the family calls directly. Service is either on a full fee or sliding scale (no fee to $4.75 per hour) basis depending upon the individual's ability to pay. The amount of the sliding scale service available each year is dependent upon the United Way of Southeastern New England's allocation. Because the agency's allocation has fluctuated so greatly, the amount of service which could be provided has not been consistent. In 1973 and 1974, approximately 35,000 hours were provided to about 300 clients each year. Because of funding cutbacks, 1975 and 1976 service was reduced to 20,000 hours to 250 individuals. It also provided 9,000 hours to 80 full fee clients. The 1977 allocation is projected to enable the agency to provide 38,000 hours to over 500 clients.

In 1972, there were six nonprofit agencies providing a variation of the services described above in the metropolitan Providence area. Each had from 6 to 45 aides on its staff, but only Homemaker-Home Health Aide Services of Rhode Island had a formal preservice and inservice training program. All aides were hired at, or near the minimum wage, had sick, holiday, and vacation pay, and reimbursed for mileage; and there was a tremendous turnover rate in personnel. On many occasions, three or more agencies were providing service on the same street; and in some cases, two agencies served the same family with different aides through different sources of funding. This meant that travel costs and time were being duplicated and expended needlessly.

A crisis in 1972 was created by several changes in the labor laws. Temporary disability insurance, unemployment compensation, and workmen's compensation became required for all employees when previously nonprofit agencies had been excluded from having to provide them. The board of directors of Homemaker-Home Health Aide Services held a series of meetings with the other agencies to try to persuade them to eliminate the duplication and competition of staff. By unifying the service into one agency, a better benefit package could be offered to all aides, duplication could be reduced, and the impact of the personnel cost kept to a minimum.

Four years later, this agency is providing the bulk of the service to the community. Every aide is fully trained to provide all services. Each one who works over 20 hours per week receives 10 paid holidays, 10 sick days, and 10 vacation days per year. Each of these "benefit days" is prorated based upon hours worked for the previous quarter. All new aides are hired at the minimum wage of $2.30 per hour plus mileage and travel time between cases. Each employee receives a 5-percent increase after 6 months and an annual increase based upon his/her performance each year. The average direct personnel cost including benefits and travel is $3.60 per hour.

In 1975, the agency was one of six programs selected throughout the country to examine two potential expanded benefits, under medicare. Rhode Island and Los Angeles, Calif., would offer "homemaker service"; Syracuse, N.Y., and White Plains, N.Y., would offer "day care for the elderly" and Lexington, Ky., and San Francisco, Calif., would offer both alternatives. At each site, a random sample "control group" would receive the standard medicare package. An equal "expanded group" would receive a years entitlement to the new service(s). Items to be examined for 1 year included all medical expenses, functional ability, patient contentment, services provided, and unmet needs for other services.

ANALYSIS OF THE MEASUREMENT OF CARE AND COST DATA

As previously mentioned in this testimony, the demonstration project contracts specifically excluded any Federal funds for data collection or evaluation at each site. However, there are many observations which can be made based upon the statistical records of Homemaker-Home Health Aide Services and my own professional judgment. These must first be discussed in terms of all programs and sources of Federal funding for health and welfare services for the elderly. It is then, and only then, possible to discuss the provision of "homemaker service" as a potential benefit under medicare.

The key issues to be decided by your committee are the following:

(1) What is the best utilization of the Federal health/welfare dollar?

(2) What are the minimum acceptable standards for each program?

(3) How and by whom will the reimbursement rate and reporting unit of service be decided?

(4) What accounting method recordkeeping and reporting mechanism will be used by service providers?

(5) Who will decide what and how much service each patient will receive?

(6) How should the service(s) be provided?

Medicaid, medicare A, and title XX all offer benefits potential for the elderly to meet their "health" needs. The problems which have been created by the current legislation are that there are too many gaps in terms of coverage, eligibility and requirements which limit who or what organization will authorize and pay for individual's plan of care. The elderly and their service providers are caught in the middle of the conflict between/among the various bureaucracies of these three programs. The problems created and some potential answers will be discussed in response to the rest of the questions I've raised.

Many helpful programs to meet the health care needs of the elderly do not have minimum quality standards; or if they do have them, there is no legal requirement that the source of payment pay all of the cost. This becomes most apparent in trying to compare the relative cost and benefits for institutional versus home health care. For instance, former Gov. Philip Noel of Rhode Island testified that Rhode Island was paying $14 per day for nursing home care while the national average was $22 per day. There are only two ways that these homes can stay in business. The nonprofit ones are supporting the State by underwriting the cost differential. The proprietary homes are reducing the quality of care in the only two variable expense areas, food and staff. If the coverage required full reimbursement for legitimate costs by all programs then it would be possible to make valid comparisons. A medicare, medicaid, and Blue Cross nursing home day for the same services costs the provider the same, but most homes are forced to have three different billing and reimbursement rates.

When discussing "homemaker" and/or "home health aide" benefits, the situation in terms of standards because there are no Federal standards for "homemakers" and those for "home health aides" do not include any minimums for either in-service or pre-service training. The only national ones are voluntary and a part of the accreditation requirements for certification by the National Council, Homemaker-Home Health Aide Services, Inc. Less than one-fifth of the nonprofit providers across the country have been accredited and almost none of the proprietary (for profit) have been. The primary reason that so few have applied and/or been accredited is that it cost more per unit of service to meet the national minimums than many third-party payers are willing to pay under medicaid, medicare, title XX, or others.

A few States have adopted standards for these two programs but there is tremendous variation as to training, level of supervision, and services which may be provided by an individual. Examples of the present range are from no training or supervisory minimum in States without standards to Connecticut's which has a complete manual including job descriptions, a State run training program and separate certification requirements for "homemakers" and "home health aides." Their fully trained "home health aide" may perform many of the duties formerly only authorized to be performed by licensed practical nurses.

The establishment of the reimbursement rate and the reporting unit of service cause confusion and conflict for both the patient and the provider for these in home services. Most rates and units of service authorized for title XX and medicaid patients are established based upon audited financial report from the provider and State budget projections. There are few opportunities for retroactive or midyear increases in rates or reduction in service to needy patients because of factors which the provider and the State cannot control. For instance, the Rhode Island agency in its rate negotiations for 1977–78, has already been informed by the State that if the minimum wage is increased in January 1978, the State will not be able to increase the "homemaker" budget allocation. Therefore, since the agency will have to increase wages across the board and must request a rate increase, the State will be forced to cut back on the units of service it will authorize. This will mean that many needy individuals will have to go without service or at least have their service cut below an already low subsistance level. It will also mean that individual employees will have to be laid off increasing the State's already high unemployment.

The rate for unit of service is also a confusing factor in the homemaker-home health aide field. Most nonprofit providers prefer to use both cost per visit and cost per hour while the proprietary ones prefer the cost per hour only. The reason for this is that it is well documented in many studies that the nonprofit agencies per hour cost are higher because of the higher quality of care which includes case management and only providing the care needed by the patient. However, their per visit and per case costs are lower. A Rhode Island example helps to explain this. My agency's charges and costs are $5 per hour. The six proprietary ones all charge around $4 per hour. We have a 2-hour minimum service while theirs is 4. Therefore, the minimum costs per visit are $10 versus $16. In addition, we only provided the service assessed as need by the supervisor and verified as need by the aide; and we stop service when it is professionally judged to be no longer required. They provide whatever is authorized for as long as it is authorized. The combination of these two factors can be a tremendous savings to the taxpayers and/or patients depending upon who is paying for the service.

The nonprofit providers also have had a problem in the past with recordkeeping and reporting mechanisms and now face a similar situation with the new accounting procedures established by the American Institute of Certified Public Accountants, which are commonly referred to as the AICPA guidelines. There was a tremendous need for upgrading all three, but the AICPA guidelines create real problems for such agencies when they are competitive bidding to provide service or unit cost comparisons for specific services are made with proprietary businesses. Under these guidelines all administrative supervisory and overhead cost must be functionalized by program by each nonprofit agency. No such requirement is applied to a proprietary. Therefore, in establishing a "homemaker" home health aide, or nurse cost per hour or per visit, the nonprofit must assign these costs based upon the number of staff, or units of service. In Rhode Island for instance, the proprietaries absorb all of their now direct service costs to the nurse visits which are reimbursable at 80 percent by Blue Cross major medical and some other coverages. This is why they can charge $4 per hour for homemake-home health aide care and still make a profit. Our direct cost for the aides (salary, benefits, travel, unemployment, etc.) is $3.60, but we have to add $1.40 (the overhead and administrative cost) against every hour.

A major problem in meeting the needs of the elderly is the buckpassing among the three federally supported programs because no one program has the authority to make a decision to meet all of an individual patient's needs. Many times they need support from all three at various times of a given year and it has been left up to the community providers in many cases to work out a plan of care, the necessary support services, and then try to get the financial support to pay for them. A visiting nurse may authorize "nursing" and "home health aide service" under medicare or medicaid and then request the State welfare department to provide "homemaker service" under title XX. It depends upon what State you live in and whether you have medicare as to what if any services you as an elderly person with a health problem can receive. If the State is one of those at or exceeding its title XX limit, you have to be on welfare to receive any help even though the enabling legislation says the State plan cover individuals whose income is up to and including 115 percent of that State's median income. In Rhode Island, the number of persons eligible for "homemaker" service and the number of hours per week that would be authorized both had to be reduced with the advent of title

XX. This occurred because the State formula based strictly upon population did occurred because the State formula based strictly upon population did not take into consideration Rhode Island's population characteristics. Rhode Island does not cover "home health aide service" under its medicaid plan. Therefore the elderly individual who does not need "skilled nursing" medicare requirement and is not on welfare, but is disabled and unable to completely care for him/herself, cannot get help.

The final area to be considered which is really a summary of the preceding five is "How should the service(s) be provided?" There are many methods or combination of methods for delivering the necessary services to meet the health and custodial needs of our elderly citizens. But, for their protection and for the best utilization of the available health care dollars, you must establish minimal guidelines for standards of care, authorization of service, reporting mechanisms, and equitable funding. The final section of this testimony will address the results of the Providence 222(b) demonstration.

Summary of Information From the Providence 222(b) Demonstration

There is no question but what the single source funding approach and management of treatment of service provision in this demonstration provided better continuity of care, less expensive care, and eliminated duplication of supervision, administration and service within the home. The most difficult of these to prove is the cost effectiveness because of the failure of medical expense "diary." We therefore have no record of the out-of-pocket expense for either the "control" or "experimental" groups. The "diary" failed because most of the group found it to be difficult enough just to be able to keep up with their day-to-day problems without having to cope with this document. The "experimental" group was better able to manage activities of daily living and recovered from their illness more quickly. The statistical data from the evaluation contractor may not bear this out at first glance because both groups had a "year's entitlement." Although each individual was in the hospital for a crisis situation, few, if any, had just one problem, and many had recurring or new episodes of crisis during that year. The only way that this could be documented to show the differences between the two groups would be to examine the data by episode by primary reason for hospitalization. For instance, "What is the difference in cost, physical recovery time, and return to activities in daily living between "control" and "experimental" patients for an episode of gall bladder attack? Hopefully these may be done in future studies of the data as proposed by Providence's medical director, Dr. J. D. Keith Palmer.

Almost all of the "experimental patients" were either discharged earlier from the hospital, avoided a nursing home stay, delayed permanent nursing home placement or a combination of two or more of these. The provision of "homemaker service" does therefore prevent, or at least retard, institutionalization.

The demonstration contractor made every effort to try to insure that no experimental patient was denied service at the end of the contract. Fortunately, the United Way of Southeastern New England had increased its allocation in 1977 to Homemaker-Home Health Aide Services of Rhode Island, and so, if no other third-party coverage was available, and the patient could not pay the full cost of continued service, care was provided on a sliding scale. This did mean, however, that other needy individuals who might have received service were denied care.

These demonstrations will provide much useful data for current use and for future studies. In order to assist in the design of future demonstrations, the following comments from my executive summary to the National Center for Health Services Research may be of assistance: The demonstration contractor was not responsible for the hypothesis being tested nor the evaluation of the service provided or the data collected since these were both part of the evaluation contract of the Medicus Systems Corp. However, there are a number of items or problems which the demonstration contractor, the assessment team, the provider staff, or a combination of two or three of these feel should be noted which effected the Providence 222 demonstration.

These include the following two specific team recommendations and then the summary and general recommendations.

(A) Assessment team members believe the patient status instrument (PSI) should be modified in several ways. First, items regarding patient satisfaction or contentment are too vague and few in number to tap "happiness" or "well-being" in a significant way. Second, the Raven's test should not be placed in the middle of the PSI. Rather, it should be separated from all other items and administered as the final segment of the interview. Third, the PSI should contain more information regarding the patient's family situation and physical environment.

(B) The assessment team believes that the advisory committee was an essential component to a demonstration such as this one. It recommends that it be multidisciplinary in composition and that it have a clearly defined and continuous role in the demonstration. Site visits should be scheduled well in advance and be well organized. Followup training sessions are advised in order to insure that the instrument is being administered in the same manner by all site teams. Information concerning the evaluation of a site should be fed back quickly to maximize its utility. Lastly, within the guidelines of practicality, the agenda and staffing for all site visits should remain the same.

(C) Summary and general recommendations:

There are two areas which must be considered. The first is site specific and deals with the local situation. The second is the relationship between the local project and the Federal Government.

The local demonstration from both the team and the provider standpoint has accomplished the minimal goals which the project director and the medical director had hoped for in that we were able to obtain a balanced control and experimental group, make the evaluations on them and provide the expanded homemaker benefit to the eligible group.

If the following recommendations had been a part of this project, it would have been easier to manage.

(1) If a contract is to be signed with a hospital, it must be more specific and spell out in detail the commitment of both parties.

(2) The hospital should have been required to post a bond as to these commitments.

(3) The team, or at least the medical social worker and nurse should have been based from and on the payroll of either the District Nursing Association or the Home Care Association of Greater Providence, Inc. We anticipated having problems securing the patients from the hospital and in actuality there was a greater problem in dealing and coordinating with the other medicare providers.

(4) The check system for the team for procedures was excellent, but a similar one should have been developed for the providers. This is especially important if future studies again contract with non-medicare providers.

The Federal Government's relationship with this demonstration seemed on many occasions to be very haphazard. The following recommendations would have eliminated this objection:

(1) There must be travel money and time in the initial budget for all staff concerned.

(2) The specific requirements in terms of the paperwork, (what, who, how, and how many) should be included in the RFP.

(3) Required forms must be cleared by OMB and the appropriate HEW and DDR offices prior to the contract signing. If this is not possible, then a startup date based on the time this delay will require is absolutely necessary in the contract in order for the project director to negotiate valid subcontracts and letters of employment for staff.

(4) All site visits must be cleared with the project director in advance.

(5) No team site visit should be split up in terms of individual arrivals and departures, especially if it is for evaluation.

(6) All project records are open for inspection and all information is public. However, no team member should be allowed to question individual staff without first ascertaining whether that staff member's job description includes knowledge of the requested data.

(7) Provisions through bonding should be included in all contracts and subcontracts. If the terms of the contract are met, then it can be voided and a new one let to complete the project and protect the Federal Government from dollar and data losses. This should have been done with the evaluation contract as soon as it became apparent that this contract couldn't be fulfilled as written.

(8) If additional "expanded benefit" projects are again considered, some provision for extension must be included after the termination of the project. This would protect against project delays and continued need for service which the local community and third-party payers cannot or will not cover.

My two regrets are concerns as to how the research findings of this project will be utilized, if at all, and how will the project be evaluated. Because of the way in which the projects were terminated, the proposed meetings which had been planned by the demonstration project directors and the Federal project officers were eliminated. It does not seem likely that the data will be as fully utilized or summarized for Congress and the field.

RECOMMENDATIONS

The Providence demonstration clearly showed that most elderly patients need long-term care in their home or institutionalization after the hospital stay. Many do not require skilled nursing as a part of this care if it's provided in the home. I, therefore, strongly urge that you enact the following recommendations:

A. MEDICARE REGULATIONS

(1) "Homemaker service" or long-term care must be a benefit available under medicare.

(2) Minimum standards must be established for homemaker-home health aide services. These should include:

(a) A minimum of 30 hours preservice training.

(b) A minimum of eight formal preservice training sessions per year.

(c) A maximum health professional supervisor/aide ratio of 1:25.

(d) Authorization for one trained individual to provide both the personal and long-term care.

(3) Each patient's needs must be assessed upon intake by a health professional and a plan of care written up. This plan shall include:

(a) Services required.

(b) Anticipated number of visits required for each specialty.

(c) Authorization for number of visits and number of hours per visit.

(4) The requirement for skilled nursing as a prerequisite for other services such as homemaker-home health aide should be eliminated.

(5) In cases where skilled nursing is not required, reassessment visits by a health professional must be made at least monthly (an authorized and reimbursable visit).

(6) The maximum of 100 visits per year entitlement should be eliminated. You will have administrative and fiscal control while providing for the individual's needs.

(7) One agency should be responsible for the development and coordination of a plan for continuity of care for an individual patient.

B. MEDICAID REGULATIONS

(1) Require that all States require homemaker-home health aide services as a component of each State's plan. The standards and qualifications to be the same as those for medicare.

(2) It would be desirable for you and Congress to reconsider the one to one Federal/State match and consider a 3-to-1 match instead. In this way, States will have a truly viable alternative. Why should a State's "health" dollar only be worth one half of its State's "welfare" dollar?

C. TITLE XX REGULATIONS

(1) The Federal dollar formula for maximum allocation for each State must be revised to take into account each State's population mix. Factors which must be considered include:

(a) Percent of population on welfare.

(b) Percent of population on unemployment.

(c) Percent of population over 65.

(d) Percent of population under 18.

If these recommendations are enacted, the most needly health care requirements of the elderly will be met and the rate of increase in the Federal health care dollar expenditure can be checked if not reduced because care for patients will be able to be authorized based upon need; not upon "What coverage does an individual have?"

ITEM 4. LETTER AND ENCLOSURE FROM HADLEY D. HALL,[1] EXECUTIVE DIRECTOR, SAN FRANCISCO HOME HEALTH SERVICE; TO SENATOR LAWTON CHILES, DATED SEPTEMBER 15, 1977

DEAR SENATOR CHILES: The answers to questions asked in your letter of September 1, 1977 are attached.

A project participant stated before the project's advisory committee: "Remember, we are people, not statistics." Three such participants are described in the enclosure.

The "222 projects" have been enormously rewarding and helpful experiences. They came at a time when San Francisco, as well as many other communities, was desperate for "alternatives" to institutions. As you know, many consumer and other groups are unhappy with the "dumping" of the elderly into nursing homes. The elderly who were "transferred" from State-supported mental hospitals into federally financed nursing homes, without assurances of quality care, but with the assurance of federally financed support to relieve State budgets, also concerned many groups. Other groups became concerned about alleged inadequacies of many nursing homes, and still other groups have been dissatisfied with the absence of programs of rehabilitation for our elderly.

San Francisco has been ready for change, and the 222 project has assisted in this process. In the course of these projects, we learned, or again verified, the following:

(1) About 25 percent of those eligible and in need of services, including 222 participants—at absolutely no cost to them—chose NOT to use the benefit(s). For 222, these were people determined by their physicians and a multidisciplinary professional health team, to be in need of services and to be eligible for them.

(2) There is increasing evidence that the lower the unit cost of a service, the more utilization there is; that is, the cheapest service by the unit may be the most expensive service in total.

(3) Health and social needs are inseparable. Services must be designed to treat the spectrum of need.

(4) Assessment of need by a professional person is a critical component of service coordination, service utilization and cost containment. Assessment is not an end in itself. Appropriate services to meet the needs must be available before a realistic care plan can be instituted. The 222 project made this more feasible. Assessment and care planning go hand in hand. Where they do not, needs are not met, utilization of services is not controlled, and costs are not contained.

(5) Providers unable or unwilling to meet government standards and outside accreditation by recognized standard-setting bodies should not be tolerated or sanctioned by government.

(6) The backbone of long-term care is the professionally trained and professionally supervised paraprofessional work force. These paraprofessionals are to be found in acute care settings, long-term institutional settings, in day health settings and in the home. They are the primary providers of long-term care. However, the availability and allocations of funds for these paraprofessionals have followed specific program and reimbursement requirements. Consequently, the functions of the paraprofessionals have become fragmented. Witness the variety of titles—"home health aide," "homemaker," "chore worker," "nurses' aide," "attendant," and so on—and the variety of funding sources—medicare, Older Americans Act, title XX, medicaid, Veterans Administration, and others.

Until the critical issue of the paraprofessional role is confronted, accurately defined and resolved, the current confusion and fragmentation of long-term care will continue. Discussions of alternatives to institutionalization, how they are financed, and other issues, will be circular. The paraprofessional is the key to long-term care—one "body' performing a multitude of tasks (such as washing the face as well as the floor) which enable the elderly with chronically disabling conditions to achieve and maintain the maximum level of functioning, as well as a sense of well-being in the least restrictive environment.

Following the helpful and rewarding experiences of the 222 projects, it would be a great pleasure to be able to recommend, unconditionally, that Congress enact legislation and appropriate funds to assist people who need care in the community. Unfortunately, I cannot make such recommendations without assurances:

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[1] See testimony, p. 572.

(1) Considerable assurance that vulnerable, often homebound, people will not be abused. In institutions, inspectors and others can at least see and hear and smell. There can never be an army of investigators to monitor home-delivered services.

(2) Absolute assurance that those who fraudulently use tax funds will be jailed as the thieves and robbers that they are—thieves and robbers of the poor and the defenseless, as well as of the generous taxpayer.

(3) Assurance that ownership as well as profit will be disclosed and rigidly controlled.

(4) Assurance that the most important group in the work force (the paraprofessional) will be treated with dignity and fairness: recognition that the work is dignified and that fairness requires regular and honest wages; the dignity of training and fairness of professional supervision; employment dignified by the possibility of upward mobility and fairness of employer-paid benefits such as workers' compensation, social security, vacations, and health benefits.

After so many years of hard work, by so many, for a Federal benefit program of home care, why take such a position now? Because, like you, I have heard and read promise after promise, without action. It is not necessary to recount the decade of work of the Special Committee on Aging of the Senate, which has exposed fraud and abuse in nursing homes, in laboratories and, more recently, in home care; programs funded by medicare, medicaid, and title XX. It is not necessary to recount the possible corporate influence of a major pharmaceutical house on Federal regulations—documented in the joint hearing of October 28, 1975. What has NOT happened since the sensational and well publicized joint hearings just six months ago is sufficient to document the major issues:

(A) Responsibilities of the states: The representatives from California who testified in March 1977 promised "sweeping changes," "special prosecutors" and "regulatory actions." What did we get?

(1) The "sweeping changes" were of the civil service staff who prepared the testimony being moved to other civil service positions. Their civil service replacements give little evidence of having any more knowledge, experience, training, competence or incentive to initiate changes than did their predecessors.

(2) No special prosecutor has been appointed. To my knowledge, no prosecutions have been started or filed, in Utah, Washington, D.C., or elsewhere. In California, after notice of this Hearing, another promise was made through a press story (attached).

(3) The promised regulatory actions have not resulted in the adoption of regulations for title XX or for any other home health program by the Department of Health, Education, and Welfare, or California. Instead, hard working paraprofessionals are still being exploited and are not getting required benefits, such as social security and workers' compensation from this taxpayer-supported program in California, Illinois, Texas, most other States, or Washington, D.C.

In short, in my opinion, California and the States have not lifted a finger (let alone pointed a finger) at the criminals. In the bankruptcy of a company providing services in several States, almost exclusively with government funds (75 percent Federal tax dollars), no one was arrested, in any State, for issuing bad checks to the several hundred hard working employees, who have never been paid. The accounts receivable were government money. They went to pay for unsecured bank notes, not to pay the Internal Revenue Service for employee taxes, to pay unpaid employees or to pay for the Small Business Administration loan.

(B) Department of Health, Education, and Welfare: Highly respected, competent and admired representatives of the Bureau of Health Insurance have frequently testified before you. Six months ago, they again recited the Bureau of Health Insurance's "myth" that homemaker services are social services and not the problem or province of medicare or medicaid. The repetition of the "BHI myth" is a shocking disregard for facts. Medicare and medicaid pay for an hygienic environment, clean bed linen, nutritious food, and pleasant and clean surroundings. In institutions, such costs are accepted as a part of the health insurance program. Why are they considered something else when the same services are delivered at home? Since when shouldn't a home health agency patient have medical orders, utilization review and other mechanisms for reviewing the quality of and need for services (p. 1291, Part 9 "Medicare and Medicaid Frauds")? Ethical providers of any service, complete these tasks routinely, regardless of setting—hospital or home.

If such services are not reimbursable, or if they are prohibited by law, why hasn't the Bureau of Health Insurance asked for changes in the law so that in-home services could be more comprehensive, thus reducing institutional costs and the numbers of our people being sent to institutions? The argument that care at home may not be cost effective is not acceptable. The citizens of this country have already decided that nursing homes are too costly, too ineffective, too dehumanizing, and too profitable.

Since the March 1977, hearing, there has been a "paper review—dictated from on high." All home health agencies are filling in the boxes, filing reams of paper, and buying more filing space. However, I am convinced that services have not improved or expanded, and that the unscrupulous provided has not been deterred from financial greed by the increase in paper flow.

(C) The insurance companies who act as fiscal intermediaries have neither been disciplined nor reformed. They continue paying bills at something like cost-plus, without knowing the quality, quantity or costs of service and without liability when they have failed to be fiscally responsible.

Finally, Senator Chiles, there must be acceptance of the fact that agency standards, in themselves, are the best safeguards for good care. Agency standards may in fact be the only safeguards available to us. No army of investigators can guarantee adequate standards as well as the knowledgeable people in the field of in-home health services. We must support national standard-setting organizations.

If we hope the abuses of nursing homes are the most damning about which we will see or hear, let me be candid in stating that the potential for abuse is far greater when caring for people at home. Our many programs are caring for people whose average age is 74, who usually live alone, who are already dependent and ill, and who are at the mercy of others. We are all concerned about crime in the streets; we must prevent crime in the homes of our citizens and beneficiaries. The mandating of standards may be no panacea, but you can make no better beginning.

Cordially,

H. D. Hall,
Executive Dircctor.

[Enclosures]

Response to Questions Presented by Senator Lawton Chiles Regarding Section 222 Demonstration

I. DESCRIPTION OF THE COMMUNITY SFRVED BY THE DEMONSTRATION

The community served by the San Francisco 222 demonstration was the city and county of San Francisco, a compact, densely populated urban area of 49 square miles with a total population of just over 700,000 people. The 1970 U.S. Census indicates that there are 141,000 persons 60 years and over residing in San Francisco. Of the population 60 years and over, 37 percent live alone. Approximately 10 percent of the over-60 population in San Francisco are housebound, making it extremely difficult for them to leave their homes in order to do necessary shopping to get to medical appointments and the like. It it also estimated that about 25 percent of the over-60 year olds in San Francisco exist on incomes below the poverty level, while attempting to reside comfortably in a city where the cost of living ranks among the top ten cities in the United States.

San Francisco has 20 acute care hospitals and 30 skilled nursing facilities to provide acute care and skilled nursing services to the residents of the city and county of San Francisco and to residents of surrounding communities. Like many urban areas there has been excess construction of institutional facilities with the result that census is low in these institutions and the unit cost of care is inflated due to this low census. While there is an excess of acute care and skilled nursing facility beds there are no intermediate care facilities (ICF's) in San Francisco, since medicaid reimbursement rates are too low to allow the ICF's to meet their cost of operation. Consequently, elderly persons requiring nursing home care are uprooted from the community and placed in nursing homes in other, sometimes distant, parts of the Bay Area. This creates a considerable problem for family and friends who often are unable to visit the nursing home patient and poses an additional burden on the already ill and often confused elderly person who is removed from his or her familiar surroundings.

The 222 project in San Francisco studied a population of 1,047 medicare eligible persons who reside in the city and county of San Francisco. Over 500 of the study participants received homemaker services, day health services, or both of these modes of care for a period of 1 year financed by demonstration funds. The group served by this demonstration represents an extremely small proportion of the estimated population in need of these services in San Francisco.

II. DESCRIPTION OF CONTRACTING AGENCY: SAN FRANCISCO HOME HEALTH SERVICE AND THE ASSISTING AGENCY, THE VISITING NURSE ASSOCIATION OF SAN FRANCISCO, INC.

San Francisco Home Health Services was established in 1957, prior to the legislation that established home health agencies under the medicare and medicaid programs. San Francisco Home Health Service, since its inception, has provided professionally supervised paraprofessional homemaker-home health aide services to residents of the city and county of San Francisco. The agency is a voluntary nonprofit organization whose primary objectives is to provide health related in-home supportive services to the chronically ill and elderly in order to prevent or postpone the need for institutional care.

In 1966, San Francisco Home Health Service became a medicare certified home health agency licensed by the State of California. The program is accredited by the National Council for Homemaker-Home Health Services, Inc. SFHHS provides service to over 1,000 patients per year through its staff of homemaker-home health aides, nurses, social workers, and other staff trained in community health services.

The assisting agency in the 222 demonstration was the Visiting Nurse Association of San Francisco, Inc. (VNA). This organization, established in 1926, has as its primary focus the provision of skilled nursing services to the population of San Francisco in addition to physical therapy, speech therapy, occupational therapy, and other therapeutic services. The San Francisco VNA has among its staff a select group of public health nurses who function as hospital discharge planners in several of the San Francisco acute care hospitals. The agency also has developed several areas of nurse specialist services, such as its respiratory nurse specialist program that provides highly skilled and effective special services that are generally unavailable in other communities.

The two organizations have available a range of services and staff, a range of established relationships in the community and a range of services that make them uniquely qualified as providers of a demonstration level of care.

III. THE FUNDING STRUCTURE OF THE DEMONSTRATION

The administrative funds for the 222 project were made available through a contractual relationship between SFHHS and the National Center for Health Services Research; the original contract award for the demonstration was just over $498,000. This budgeted amount was designed to cover the costs of patient assessment, data collection, data analysis and other aspects of the research activity. The service provided under the 222 project, i.e., homemaker services and day health services, were funded separately on a fee for service basis through Social Security Administration. The rate of reimbursement for service was determined by the actual cost of providing service following cost reimbursement criteria similar to that established for use in the medicare program.

IV. DESCRIPTION AND INTENT OF DEMONSTRATION

(A) The referral process: SFHHS received the contract award for the demonstration in June 1974. Between that time and May 1, 1975, when the intake process began, SFHHS and the VNA of San Francisco focused their educational efforts on those areas of the community where potential referral sources were expected to exist. Due to the need to establish a sample of post-hospital medicare eligible persons, the primary thrust of the community education effort was the administrators, medical staff and discharge planners in the acute care hospitals in San Francisco. In addition to the hospitals, the demonstration activity was explained to the physician community, health agencies and social service providers in San Francisco. Despite the many months of preparation and efforts to inform the community about the project there was considerable confusion at the onset of the demonstration among the referral sources as to the intent of the demonstration, types of services being offered and the types of patients who might benefit from the homemaker services or day health services being offered by the project. In order to further clarify the role of the project, a public health nurse was employed full time to accept the telephone referrals and to provide guidance to the referral source at the point of intake, regarding whether this service might be appropriate in view of the needs of the person being referred. The need for a skilled professional to assist in the intake process and to coordinate the services with other community services was found to be critical in the success of the project. During the intake period of the project, a 10-month period, 1,262 persons were referred. Of these, 1,047 became project participants, a significant proportion were found to be inappropriate for project participation in that their need was often for other services, such as nursing home services or traditional home health agency services. However, a number of this group chose not to participate because they failed to understand or were fearful of signing a cumbersome "informed consent" form that was necessary in order for them to participate.

(B) Final sample size of the San Francisco 222 project, 1047; control group participants, 520; expanded benefit participants, 527.

(C) The services to be provided by the demonstration were professionally supervised homemaker services and day health services (adult day care).

(D) The assessment process: Persons referred to the project assumed to be in need of homemaker services and/or adult day health service were referred by the intake nurse to a multidisciplinary assessment team composed of physicians, nurses, social workers, a physical therapist, occupational therapist, and nutritionist. A single member of this team interviewed the potential participant using a standardized assessment tool referred to as the patient status instrument. Following the interview the assessment team member conferred with the remaining team members and established an individualized treatment plan outlining all the necessary services that the participants might benefit from given their particular functional limitations. Following the assessment process and the development of the treatment plan, participants were randomly assigned either to the test group referred to as expanded medicare benefits group, or to a control group. Persons randomly selected to receive the expanded medicare benefits became eligible to receive homemaker services and/or day health services for a period of up to 1 year. The assessment team referred the participant to the provider of homemaker services and/or to the provider of day health services. Those participants who were randomly assigned to the control group did not become eligible for the additional services but were referred back to the referral sources in order to assure that plans could be made for their continuing care given the present benefit structure. Both groups of patients were reassessed by the assessment team at 3 month intervals for a period of 1 year. (The reassessment process was identical to the entry assessment process as described above.) Following each assessment, the information obtained was forwarded to the project's evaluation contractor, Medicus Systems, Inc. The purpose of the reassessments was to detect changes in the participants' individual functional limitations, social interactions, days of bed disability, and other health parameters over their period of participation.

V. RESULTS OF THE SERVICE PROVISION

(A) Effectiveness of the single source funding approach: A single funding source existed for the provision of the project services, administrative time and costs and allowed for more efficient delivery of these services; however many project participants were receiving services concurrently through other funding arrangements, since project participation did not alter eligibility for other programs. For example, some project participants received homemaker services and day health services through the project's funds and nursing services and home health aide services through their existing medicare benefits as well as attendant care or chore services through their eligibility for title XX homemaker-chore services. Consequently, it is misleading to state that there was a single source funding approach in terms of the services needed and received by this project population.

(B) Effectiveness of the single source management of treatment or service provision: As described in (A) above, project services were well coordinated due to the service management provided by the project's assessment team. However, many project participants had other "managers" of other services. For example, 40 percent of the project population were eligible for title XX homemaker/chore services and consequently some service management was provided to many of these participants through the social worker in the local department of social services. In essence, the 222 project could effectively manage the care of those participants whose only eligibility was for project services or for medicare home health agency services provided by the contracting or assisting agency. However, the 222 project existed in the real world where there are many duplicated and fragmented programs with varying eligibility requirements, services and persons charged with case management responsibility and these coexisting systems also managed the care of many project participants. In short, it is another example of fragmentation.

(C) The progress of the project's participants: As stated earlier, both control group and expanded medicare benefits participants were reassessed at 3-month intervals by the assessment team of the project. Data regarding their progress was submitted to the central evaluation contractor, Medicus Systems, Inc. This organization will analyze data that was submitted and document the effects of providing the additional levels of care. The individual project sites can only identify trends or patterns that seem to occur in the two groups and to compare them in a nonscientific manner. Generally it was found that many expanded medicare benefits group participants either improved or were at least maintained in the community as a result of the additional services. Control group participants sometimes also improved but more seemed to deteriorate and to require additional health services such as repeated periods of hospitalization and repeated nursing home stays. Assessment team reports of some of the control group participants show that a lack of case management and the lack of availability of supportive services positively contributed to premature nursing home placement. Many of the control group participants were reassessed after placement in the nursing home and there exists ample documentation of severe deterioration after admission to the nursing home, as well as ample evidence of the inadequacy of many nursing homes in terms of their ability to provide adequate care. Staff of the project have provided documentation of some of the nursing home abuses to the State attorney general's office; however, we are not aware of any further investigations of these abuses by the State.

VI. COST DATA ACCUMULATED BY THE DEMONSTRATION

Cost information for the project's homemaker services and adult day health was collected in accordance with medicare cost reimbursement policies. Cost comparisons between the Project services and the costs of existing Medicare benefits will need to be carefully examined before any conclusions can be made regarding the cost-effectiveness of these services. The following four conditions, in particular, should be considered:

(A) Quality homemaker services will not be significantly less costly to provide than quality home health aide services: If quality care that meets standards is to be provided this must include professional assessment and care planning, periodic reassessment, training and supervision of paraprofessionals as well as adequate income and benefits for paraprofessional staff. The unit cost of this service will be not less than $8 per hour in many areas. However, quality services that meet standards such as those set forth by the National Council for Homemaker/Home Health Aide Services, Inc., have built-in utilization controls that ultimately reduce the total cost of services by assuring that the appropriate level of care is provided in appropriate amounts over the course of an illness.

(B) The costs of homemaker services or day health services should not be compared with the current expenditures being made for nursing home care: In California, Medi-Cal funding for nursing home care is inadequate. Quality nursing home care cannot be provided given present rates of reimbursement. Comparisons between adequately funded and quality homemaker services and day health services and inadequately funded and managed nursing home services cannot be valid comparisons.

Likewise, total costs of homemaker services and day health services must be considered if any comparisons are to be made with any institutional level of care since a resident of an institution is utilizing services 7 days per week, 24 hours per day. If the nursing home is reimbursed at a rate of $25 per day the weekly cost is $175. Average utilization of homemaker service is 28 hours per month (7 hours per week) a cost of $64.75 per week. Day health service utilization averages 2.5 days per week, a cost of approximately $70 per week. The unit cost of day health services could be over $60 per day and yet be less costly than nursing home placement.

(C) The day health centers operating under the 222 project had problems of low census that inflated their unit cost: Due to sample size restrictions and to community unfamiliarity with day health as a mode of care, these services were not adequately utilized. The costs of these services under the project will reflect the low census of the day health care centers and should not be regarded as a projected cost if day health services were to become ongoing medicare benefits.

(D) Finally, the provision of homemaker services and day health services under the project may have offset or prevented other health expenditures. The extent of this phenomena will need to be evaluated to determine the true cost effects of these services.

VII. THE COSTS DERIVED FROM THIS DEMONSTRATION CAN PROVIDE ONLY SOME OF THE BASIS FOR DESIGNING A SET OF MEDICARE-COVERED SERVICES

As stated earlier, the demonstration nature of day health services as well as the research limitations imposed will affect the accuracy of the day health cost figures as a projection of what these costs might be if this mode of care was to be a covered service under the medicare program.

The homemaker services costs under the demonstration are not subject to the low census problems of day health services and are probably very comparable to those that would be incurred under the medicare program if this were a covered service. However, cost should be only one of many considerations in designing a program for care of the elderly. The effect of these services on the recipients, their satisfaction with the services, the satisfaction of families, physicians, and others should be compared with the experiences of persons cared for in other settings and decisions made based on what is best for the Nation's elderly, not just what is "cheapest."

VIII. MORE EFFECTIVE CARE CAN BE PLANNED IF SERVICES ARE DELIVERED IN A COORDINATED MANNER

The results of the service provision studied under the 222 projects show that more effective care can be planned and delivered when homemaker services, day health services, and home health agency services are delivered in a coordinated manner to meet the assessed needs of a population. The central coordinating function served by the multidisciplinary assessment team is critical to the appropriate and effective distribution of service resources.

The available services need further expansion, however, to include Meals-on-Wheels, mental health services, hospital care, transportation, minor household repair services, and other supportive care if a truly comprehensive package of services is to be available.

IX. AVAILABILITY OF FUNDS TO CONTINUE PROJECT SERVICES

Some of the project participants who completed their period of entitlement for services under project's funds are able to qualify for some homemaker services under title XX funds. Day health services are not covered under title XX in California but a bill is presently being considered in the State that would make these services a Medi-Cal (title XIX) benefit. However, if either of these levels of care are to be continued to most of the project participants other Federal funding must become available. This is particularly true for the approximately 60 percent of the project participants who are of limited means, but are not at the poverty level that would enable them to qualify for public programs such as title XIX or title XX.

The homemaker services and day health services providers have assisted these participants to plan for care following their entitlement period. For many, however, other services are not available and the health, as well as the quality of life for these former participants will probably deteriorate. Certainly, some of these former participants may obtain long-term benefits from other programs; however, many participants had long-term care needs that did not cease at the end of 12 months of care and they are not able to obtain alternate services. A substantial number of these persons may be institutionalized at great personal, social, and public cost. In some extreme cases, extensions in the 1-year entitlement period have been granted; however, a large number of persons discharged from the project were in a "borderline" situation so they may or may not be able to continue living safely in the community. We have worked with an extremely vulnerable population some of whom were able to cope, in part, due to the intervention of the project services. We have now "removed their crutches and have asked them to walk," doubting throughout our credentials as miracle workers. Simply put, a long term care population requires long-term care . . . not sporadic, crisis-oriented interventions. Certainly some of our patients will survive and will cope using their own strengths and resources. Others will stumble without the preventive health supervision that was provided to them through day health and homemaker services.

X. EXAMPLES OF INADEQUATE CARE AND SERVICE THAT APPEARED IN THE DEMONSTRATION POPULATION

Further gaps in care and services that appeared in the demonstration population included (but are not limited to) the following:

(a) Housing services.
(b) Meals-on-Wheels.
(c) Mental health services.
(d) Hospital care.
(e) Transportation.
(f) Social model day care.
(g) Increased income maintenance programs.
(h) Coverage for prescription drugs and needed equipment.

XI. CONSIDERATIONS FOR SETTING FUTURE POLICIES FOR CARE OF THE ELDERLY

Future policies for care of the elderly need to take into account the value of preventive health services that particularly focus on prevention of need for institutional placement. Present policies focus on illness intervention often requiring hospital and diagnostic criteria for eligibility. This approach effectively prevents early intervention that might alter the course of illness and prevent further complications and premature deterioration. A preventive approach should be both more humane and cost effective than our present tendency to impose an acute care medical model on a population that requires long-term health and social services.

XII. INDIVIDUAL CASE PROFILES

Three case profiles are attached.

XIII. RESEARCH RESULTS OF THE 222 PROJECTS

The research findings of the 222 project will be compiled by Medicus Systems, Inc. It is our understanding that Medicus Systems, in conjunction with the staff of the National Center for Health Services Research, will analyze these findings and develop a report on the six 222 project sites. That will be shared with members of Congress, HEW policy staff and others.

XIV. PARAMETERS USED TO EVALUATE 222 PROJECTS

In addition to our own efforts at evaluation—which are not yet underway because data is not available—it is our understanding that the 222 projects will be evaluated along two parameters, cost effectiveness and patient outcome effectiveness. Cost considerations were discussed earlier. Patient outcome effectiveness must be judged most carefully as well. The population that was referred to the 222 project was in some ways more fragile and more ill than a generalized population of medicare eligible persons. This phenomenon occurred as the result of present medicare regulations that restrict medicare coverage for chronic, long term, and often terminal care. Many persons who were referred to the project had either exhausted their medicare benefits or failed to meet the stringent "skilled nursing" prerequisites that would provide them with eligibility for home health aide services under medicare. Consequently persons who were referred to the 222 project were often those who had little or no potential for restoration of function, who often were terminally ill and for whom the primary goals of treatment can at best be only supportive or maintenance care. Outcome studies of this population must take into consideration these unique characteristics as it is not a population reflective of the medicare population as a whole. Rather it is a group of persons that was abandoned by the current system.

INDIVIDUAL CASE PROFILE

MR. R.

Mr. R., a 34-year-old former construction foreman, was referred to the 222 day health program approximately 1 year after he suffered a severe stroke. Mr. R. was paralyzed on his left side and confined to a wheelchair. Unable to cope with the traumatic situation, Mr. R.'s wife had left him shortly after the stroke, taking their two young sons with her. Mr. R. was severely depressed and had compensated by overeating. By the time he was referred to day care, Mr. R. weighed over 300 lbs., was very morose and totally dependent on his attendant for care.

During the year and a half he was in the 222 day health program, Mr. R. received a combination of psychological counseling, peer support, physical therapy and diet counseling. As a result, Mr. R. is today 100 pounds lighter, walks with the aid of a cane, is studying to become an accountant and is planning a new life for himself.

MS. A.

Ms. A., a 69-year-old native of Central America, speaks no English and lives with her daughter and infant grandson in a walkup flat. Ms. A. has severe rheumatoid arthritis plus mild adrenal insufficiency and a hiatus hernia. The only function Ms. A. could perform unassisted was eating. Ms. A. spent most of her time in bed although she was occasionally able to sit in a chair. She was extremely isolated and depressed.

Since her daughter had a full-time job Ms. A. did receive attendant care provided by the local welfare department. The turnover rate of the attendant personnel was so high, however, that Ms. A. was unable to establish a trusting relationship with an attendant.

When she joined the 222 day health program, Ms. A. was in extreme danger of institutionalization, as noted in her case record. The 222 day health program provided Ms. A. with physical and occupational therapy and gave her the opportunity to socialize with other Spanish-speaking participants. Ms. A. began knitting. She learned to use crutches. In addition, she reduced the days she spent in bed from 76 to 45 during the first 3 months she was in the program. Ms. A. looked forward to her visits to the day health center where she not only received therapy and was learning to ambulate but could socialize with her new Spanish-speaking friends.

MR. C.

Mr. C. was a member of the 222 control group. He is a 70-year-old Chinese male living alone in a small studio apartment in the heart of Chinatown. Mr. C. suffers from diabetes mellitis, peripheral vascular insufficiency, and arteriosclerotic heart disease. Following a 10-day hospitalization for acute myocardial infarction, Mr. C. was sent home with homemaker services, provided by funds from the local welfare department. The homemaker provided assistance with shopping, cooking, personal care, and Mr. C.'s weekly visits to his physician. Mr. C. was progressing quite well.

After 6 weeks, the 222 assessment team recommended continuation of homemaker service. The welfare department case worker disagreed and ordered "chore" care. As a result, Mr. C. had to try and get friends to buy groceries and run other errands for him. Mr. C. had to cook his own meals but was so wearied with the effort that he was frequently unable to eat. His personal care regime deteriorated to the point where he was unable even to bathe, with no one to assist him, Mr. C. was afraid he would not be able to get in and out of the bathtub.

Mr. C. could not make his worsening plight known to the caseworker in charge. Finally, his condition had weakened so that he required placement in a convalescent hospital for congestive heart failure and vascular insufficiency. Had he received the proper care, Mr. C.'s condition could have been professionally monitored and he could have received homemaker assistance to reduce heart strain and provide proper diet for his heart and diabetic conditions. In short, had homemaker and health monitoring services continued, Mr. C.'s deterioration and rehospitalization probably could have been avoided.

[From the Sacramento Bee, Sept. 13, 1977]

SAN JOSE HEALTH CARE FIRM EXPOSED IN MARCH PROBE LOSES STATE BUSINESS

(By John Berthelsen, Bee Staff Writer)

The State of California, citing "improper fiscal practices," has stopped all its dealings with Flora M. Souza, the operator of several San Jose-based home care companies.

Mrs. Souza's federally funded certified home health care firm, Home Kare, Inc., was the focus of spectacular hearings in March before the U.S. Senate Special Committee on Aging.

During those hearings, it was revealed that Mrs. Souza had used federal funds to buy employees and relatives expensive Mercedes-Benz automobiles, and that she had purchased a $50,000 mobile home on federal funds and charged it off to business expenses.

In a letter to Mrs. Souza, dated Sept. 7, Chief Deputy Health Director Raymond K. Procunier did not cite violations of state law by Unicare Inc., a Home Kare subsidiary that provides homemaker and chore service care to Medi-Cal patients.

But he said reports by the Health Audits Bureau of the State Department of Benefit Payments "verify that altered or otherwise questionable invoices were submitted to the federal government by Home Kare Inc. They further confirm that you are the controlling shareholder and president of both corporations—in fact, the sole shareholder of Home Kare.

"Because of these improper fiscal practices on your part, it is my intention to inform all counties which are now in the process of awarding homemaker-chore contracts that the Department of Health no longer considers Unicare, Inc. to be a qualified bidder."

The department attempted a similar move shortly after the Washington, D.C., hearings. But at that time, Mrs. Souza sued the department in an attempt to prevent the company's removal from the list of qualified bidders. However, Procunier said, the health department is going ahead now because the Senate committee's report is final and "is no longer hearsay."

In the committee's transcript, it is alleged that Mrs. Souza often altered bills to increase illegal profits. In one case, for instance, she allegedly altered a $7.47 lunch tab at the Senator Hotel in Sacramento to read $47.47.

In another instance, she allegedly altered bills of $125.08 and $10.55 to make them look as if they were for business lunches, when they actually were purchases at Grebitus and Son of Sacramento, an exclusive jewerly store.

Still another purchase—$170.20 for a caftan at the Dockside Trading Co., a Sacramento art gallery and decorating studio—was listed as a business lunch for the Sacramento staff of Home Kare.

Dozens of similar purchases and irregularities dot the Congressional transcript.

Appendix 3

LETTER AND ENCLOSURE FROM DR. LESLIE S. LIBROW, ASSOCIATE PROFESSOR OF MEDICINE, HEALTH SCIENCES CENTER, NEW YORK STATE UNIVERSITY AT STONY BROOK, TO SENATOR LAWTON CHILES, DATED NOVEMBER 14, 1977

DEAR SENATOR CHILES: Thank you for your letter of August 23, 1977. I regret the extensive delay in responding to your kind offer to submit a statement for the committee transcript on the subject of outpatient care. Regrettably, the burdens of my schedule did not allow a more prompt answer. The matter is important enough to warrant a response even at this late date.

You have pinpointed the issue quite clearly in your May 16, 1977, Committee on Aging statement when you indicate that the "for-profit home health agencies" have spread, and again there appear to be abuses in accountability. So the issue is how to provide improved ambulatory care for the elderly without running into the obvious abuses. For one thing, ambulatory care for the elderly cannot be considered a simple extension of ambulatory care for the young or middle aged. The time necessary to obtain medical information from the elderly and to deliver health care to the elderly far exceeds that of the middle aged. This coupled with the disinterest of the health care community and the increased susceptibility to abuse of the elderly leads to a very special situation.

I would urge strong consideration for special outpatient model projects emanating from a nonprofit base. Such a base could include a voluntary nursing home and/or voluntary hospital. The goals would be to cut costs and deliver appropriate care. My own past experience at the Mt. Sinai School of Medicine's public hospital was one example. We established a highly effective geriatric outpatient program. The health delivery component was superb and was merely one component of the total system which included long-term and short-term institutionalization and home care. The shortcoming of that program was that we never measured cost effectiveness. Nevertheless, those are the types of models we need before "plunging" into another medicare-medicaid bonanza for private industry.

I look forward to further communication with you and the committee and thank you for the courtesy of your interest in my opinions and our work.

Sincerely yours,

LESLIE S. LIBOW, M.D.

[Enclosure]

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A Geriatric Medical Residency Program

A Four-Year Experience

LESLIE S. LIBOW, M.D., F.A.C.P.; New Hyde Park and Stony Brook, New York

Geriatricians are needed to further improve the health care of elderly Americans. The first formalized geriatric residency program in the United States was developed at the Mount Sinai City Hospital Center in New York, and this has produced a second program at the Jewish Institute for Geriatric Care at Long Island Jewish-Hillside Medical Center, New Hyde Park, New York. The goals of this training are to develop special clinical skills to deal with the medical and psychosocial problems of the elderly, and to achieve the ability to develop health care systems for the elderly. Emphasis is on a multileveled system, including home, outpatient, acute hospital, convalescent unit, and long-term institution care. The training period is 12 to 24 months, after an initial 24 to 36 months of standard internal medicine, thus fulfilling the requirements for board eligibility in internal medicine.

PHYSICIAN INVOLVEMENT and leadership are necessary to further improve the health care of the elderly. Although most physicians give care to large numbers of elderly persons, not enough are involved in efforts to improve their system of health care or the clinical approaches that deal with the changes brought about by the combined effects of time and disease.

By denying that elderly persons have special health needs, we make it difficult to improve their care. Ambulatory care is inadequate, uncoordinated, and in need of restructuring (1). Long-term care is perhaps the "most difficult and intractable" of all health care issues facing the American people (2). Nursing home beds have greatly increased, so that there are now more nursing home beds in the United States than there are general medical and surgical hospital beds (1.2 versus 1 million, respectively) (3). Institutionalization could often be avoided if sensible alternatives, including coordinated health systems, existed (3).

In recent publications of influential medical journals, many leaders in medicine in the United States have called for the development of "geriatricians" to lead the restructuring of our medical approach to the elderly (4-12). Two programs for the training of geriatricians have been developed by the author and will be described here.

Health statistics emphasize the demand for and the cost of services. Although comprising 10% of the population of the United States, those over 65 years of age use more than 27% of the health dollar (13). The elderly comprise about 30% of the adult patients in the general medical and surgical wards of hospitals (14) and about 95% of patients in nursing homes (3). Their hospital stay compared with that of middle-aged persons with similar illnesses is two to three times longer (15). Elderly persons are major users of medications and make considerably more visits to physicians' offices than younger persons. Thus, the elderly often dominate our daily health care efforts by their numbers and multiple needs.

Until 4 years ago, there was no place in the United States where a physician could obtain formalized specialist training in geriatric medicine. At that time, the first geriatric medical residency in the United States, directed at training specialists in this field, was established by the author at the Mount Sinai City Hospital Center at Elmhurst, New York, a major component of the Mount Sinai School of Medicine (16-19). In contrast to the situation in the United States, the British national health plan has had, for many years, hospital consultants and house officer positions in geriatrics (7).

We have received many requests from universities and hospitals, as well as from other health centers, for these trained geriatricians to lead new programs.

The following description of the first residency programs is aimed at assisting other developing programs.

The Residency Program at the Mount Sinai City Hospital Center at Elmhurst, New York

HISTORY

From its inception, the Director of the Department of Medicine supported the geriatric program by the rotation of each "straight medical" intern onto the service for a 2-month period. A total of approximately 125 interns have thus been exposed to geriatrics.

With the belief and hope that there were physicians in-

► From the Jewish Institute for Geriatric Care and Long Island Jewish-Hillside Medical Center; New Hyde Park; and the School of Medicine, Health Sciences Center, State University of New York; Stony Brook; New York.

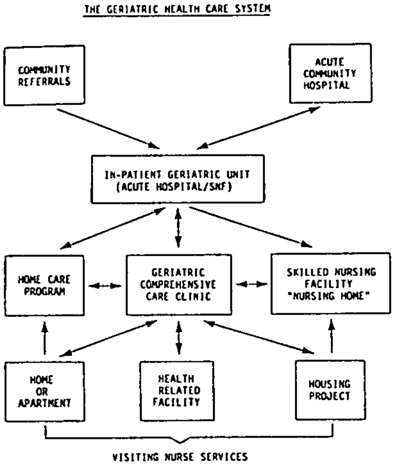

Figure 1. The geriatric comprehensive outpatient clinic and inpatient unit are at the center of this multifaceted, yet simple, health care system. SNF = skilled nursing facility.

terested in careers in geriatrics, we established a formalized geriatric residency program in 1972. The program, originally called a "fellowship," extends over 12 to 24 months of training and serves as part of residency training in internal medicine (16, 17). When appropriate, the program is offered to recent medical school graduates as a 36- to 48-month "package," intermixing training in internal medicine with training in geriatric medicine.

The response and interest have been very satisfying. During the first 3 years, we averaged 10 to 15 applicants per available position. The "fellowship" status was quickly changed to "residency," because the physicians have primary responsibility for inpatient and outpatient care through practically their entire training period.

GOALS

The goals of the program are to achieve a clinical excellence in diagnostic and therapeutic medicine as it applies to the elderly, and an ability to organize and lead a geriatric team serving hospital and community needs, including the training of professionals in this field.

Clinical excellence refers to acquiring skills in two major areas: those problems and diseases common to all age groups but often taking on special presentations, approaches, and therapies in the older age groups, such as fevers, surgical decisions, mental and social problems, arrhythmias, hearing and visual difficulties, and diabetes mellitus; and those problems and diseases that have their highest incidence and prevalence in elderly persons and occur much less frequently, if at all, in younger persons, such as fractured hip, carcinoma of the prostate gland and colon, chronic lymphatic leukemia, calcific aortic stenosis, polymyalgia rheumatica, senile dementia and memory loss syndromes, multiple coexistent health problems, and multiple coexistent medications.

Developing the ability to establish a geriatric team and organize geriatric care for an institution and community is acquired through firsthand participation in the team at the geriatric teaching center and through seminars focusing on the organization and economics of the United States health system for the elderly.

PRIOR TRAINING REQUIREMENTS

The typical training before entering this residency program is 2 to 3 years of internal medicine (postgraduate years 1and 2, occasionally 3).

Another arrangement, mentioned earlier, is the "package" of 36 to 48 months, after medical school or internship. This approach includes at least 24 months of internal medicine in the hospital's Department of Medicine and the remainder in the geriatric medical program.

Twelve months of geriatric training is not adequate, and a second year is offered; with the present shortage of trained personnel, however, the briefer period may have to suffice. The year of geriatric medicine has been approved for credit toward obtaining board certification in internal medicine, by virtue of the support of both the Chairman of the Department of Medicine of the Mount Sinai School of Medicine and the Director of Medicine at the Mount Sinai City Hospital Center.

THE GERIATRIC CARE SYSTEM AS THE BASIS FOR THE TRAINING PROGRAM: THE "TEAM" AND THE "HEALTH CARE SYSTEM"

Often, no "individual" professional can realistically get the job done properly when dealing with sick elderly persons. The need for a "team" is particularly evident for those patients with limited financial and health resources. The team offers not only multidisciplinary skills and personnel but also multilevels of health care. Thus, outpatient, acute hospital, convalescent, long-term, and home care levels are all part of the geriatric system. Essential to its working are personnel such as the community visiting nurse, resident physician in geriatric medicine, nurse practitioner (or physician associate, or both), social worker, nurse-coordinator, and transportation component. This team and system have been more extensively described elsewhere (16-19). Once a week, all team members meet for a conference that focuses on the struggle of sick elderly persons and their families. The interrelationships of the components of the "system" are presented in Figure 1.

THE INPATIENT UNIT

This unit has three functions: to serve the medical and surgical rehabilitation phase of illness of patients transferred from acute hospital beds; to serve community-residing elderly persons needing transient hospital admission rather than long-term nursing home placement for problems often considered inappropriate or unacceptable for acute hospital units but which cannot be handled at

Table 1. Weekly Schedule for Geriatric Medical Residents*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday/ Sunday
Unit work, rounds and patient care 0800-1000 h	Unit work, rounds and patient care 0800-1000 h	Geriatric clinic: diagnostic and comprehensive care 0800-1100 h	Unit work, rounds and patient care 0800-0930 h	Unit work, rounds and patient care 0800-0900 h	Unit coverage and home visits†
Clinics: Ophthalmology, Otolaryngology, and Gynecology‡			Team-patient-family conference: "The Struggle of the Ill Elderly" 0930-1100 h	Medical Grand Rounds 0900-1000 h	
Medical department teaching conference 1100-1200 h	Geriatric and gerontologic seminar 1100-1200 h	Geriatric and gerontologic seminar 1100-1200 h	Medical department teaching conference 1100-1200 h		
Attending teaching rounds 1330-1500 h	Attending teaching rounds 1330-1500 h	Attending teaching rounds 1330-1500 h	Attending teaching rounds 1330-1500 h	PM & R§ rounds, psychiatry rounds, or neurology rounds 1300-1400 h	
Unit work, rounds and patient care, and consultations on acute hospital units 1500-1800 h	Radiology conference or journal club 1500-1600 h				
	Unit work, rounds and patient care 1600-1800 h	Unit work, rounds and patient care 1600-1800 h	Unit work, rounds and patient care, and consultations on acute hospital units 1600-1800 h	Unit work, rounds and patient care 1600-1800 h	

* This schedule represents an integration of the initial program developed at the Mount Sinai City Hospital Center and a newly developed program at the Jewish Institute for Geriatric Care and the Long Island Jewish-Hillside Medical Center.

† Approximately every third week.

‡ Periodically attended by geriatric medical residents.

§ Physical Medicine and Rehabilitation.

home; and to serve the long-term care (nursing home) patient.

These geriatric beds (80 skilled nursing facility beds in the 900-bed Mount Sinai City Hospital Center at Elmhurst) provide the inpatient focus for team development. An average of 10 patients per week are admitted, and 66% return home after an average hospital stay of 8 to 12 weeks. At home, they continue to receive health care from our geriatric team or the family physician, or both. The remaining one third of the patients who do not respond successfully to this geriatric team effort go to long-term beds, either in our unit or in the various skilled nursing facilities in the community.

The patients on the geriatric unit present multiple and complicated problems, averaging four to eight major diagnoses. They simultaneously are taking approximately six different medications.

Most of the patients come from acute hospital beds on medical and surgical services throughout the hospital; many come directly from the community.

Of the two thirds of the patients who do return home, all are offered continuing lifelong outpatient care in the geriatric outpatient department. Some (5% to 10%) are homebound and are given care through the home care division of the hospital.

THE GERIATRIC OUTPATIENT DIVISION

The geriatric residents, with supervision from the attending staff, lead the team effort in the outpatient division, aimed at total health maintenance of our discharged patients and diagnostic evaluation and health maintenance of new referrals from the community. The hundreds of patients in this outpatient program are often marginal in their ability to remain in the community and to avoid nursing home placement. Simultaneously present at all clinic sessions are the physician, community nurse practitioner, social worker, and nurse coordinator. Continuity is evident because this same team of professionals also provides the inpatient and home health services to these patients. The resident physicians supervise the work of the geriatric nurse practitioners, who are part of the Visiting Nurse Service of New York (Queens) and have been formally trained as nurse practitioners at the Cornell Medical program and at the Mount Sinai City Hospital (20).

The telephone is used to further health care maintenance. After a missed clinic appointment, an immediate phone follow-up is made by the nurse-coordinator. In addition, the patient is encouraged to call us about any significant problem.

Both in the clinic and the home, we emphasize health education for patient or family, or both. This includes matters of medication, diet, symptoms, dressing, and activity.

Emphasis is placed on medications with regard to teaching accuracy of self-administration (21), to reducing the quantity of drugs and hazardous interactions, and to reducing the difficulty of obtaining a continuing supply of medications.

THE TEACHING ROUNDS: CLASSIC AND GERIATRIC ASPECTS

Work rounds on the inpatient unit are made on a daily basis by the residents and interns, and they are often joined by the social worker, unit nurse, and community nurse practitioners. Teaching rounds are conducted daily by the attending geriatricians, and all new or problem cases are reviewed. In addition to the classic medical approaches, there is considerable emphasis on the geriatric aspects of the patient's illnesses.

The resident is expected to be completely aware of the patient's social and emotional situation. Emphasis is put on careful mental status evaluation, particularly because a number (5% to 15%) of elderly persons are misdiagnosed as "senile," when in fact they represent "pseudosenility" (22). Skill in psychiatric diagnosis and treatment is essential for the geriatrician.

Additionally, regular weekly training rounds are made with the consultant in physical medicine and rehabilitation and biweekly rounds with the neurologic consultant. The weekly schedule of activities for the geriatric residents is presented in Table 1.

THE TEACHING CONFERENCES AND JOURNAL CLUB

One advantage of locating a geriatric program at a general teaching hospital campus is the ready availability of all teaching conferences. Additionally, our own seminars and journal clubs focus on the geriatric and gerontologic aspects of the subject*.

HOUSE CALLS AND HOME CARE

For a selected number of patients discharged to the home and remaining homebound, follow-up care is given by the resident physicians in coordination with the geriatric nurse practitioner and under the supervision of the physician in charge of the home care program. This home care exposure enables the resident to further grasp the problems of the homebound elderly, who comprise 5% to 10% of the total population of elderly persons.

UNDERSTANDING THE PRIVATELY OWNED ("PROPRIETARY") NURSING HOME

Because the Elmhurst geriatric unit is located in a nonprofit municipal institution, the residents have to be exposed to the private, "for profit" nursing homes, which, after all, comprise 67% of the 1.2 million beds in the long-term care ("nursing home") industry (23). Thus, regular visits by our resident physicians are made to a local proprietary nursing home. These visits include an open discussion with the entire professional staff of that institution, focusing both on their general and specific problems. Visits are made to patients' bedsides, and cases are evaluated with the nursing home staff. The private ownership and administration of these facilities have welcomed this arrangement, and it has also helped to reduce the barriers existing between the nursing home and the hospital.

THE VISITING NURSE SERVICE

The success of our community health maintenance program and the proper training of our geriatric residents require a close working relationship with the Visiting Nurse Service. This community agency offers regular nursing and nurse practitioner home visits, as well as the long-term placement of home health aides. Additional home services offered are physical therapy, speech therapy, and social worker assistance. Many of these services are available 7 days a week.

The visiting nurses often participate in our weekly team conference, which focuses on patients struggling to return home after acute illness. This early input from the community nurse allows for more realistic planning. Institutionalized patients apprehensive about their ability to maintain themselves at home feel very encouraged when they meet these nurses and learn of their supportive services.

Many of the patients seen by the visiting nurses are not necessarily permanently homebound. Large numbers of ambulatory outpatients are seen at home by the visiting nurse for temporary problems such as wound dressing or surveillance of dietary and medication regimens. The visiting nurse, on a routine visit, will often note a significant change in health status or may detect errors in medication or diet. After consultation with the geriatric resident, there may be new treatments, tests, a home visit by the resident, or even hospitalization. This collaboration also serves as an educational mechanism for the team and the visiting nurse.

COMMUNITY HEALTH EDUCATION AND CONSUMER GROUPS

Our periodic health conferences for the lay community have been very well attended. Hundreds of older and middle-aged people have participated in meetings focused on physical and emotional problems and socioeconomic and ethical aspects of health care. The staff has also been invited to participate in similar efforts initiated by the community. Resident physicians are often surprised at the enthusiastic response of elderly citizens and their questions, complaints, and demands. Some of our physicians have become actively involved in consumer advocate groups like the "Gray Panthers," whose efforts focus on various health and economic issues. Certainly, in addition to our health education contributions to the community, these experiences serve to enhance the education and identification of our physicians as geriatricians.

THE CAREER STATUS OF THE FIRST PHYSICIANS TRAINED IN THE PROGRAM

Of the five physicians who have trained in this program to date, three are Americans and two are foreign-born. One of the American physicians has been in charge of the geriatric program at the Mount Sinai City Hospital Center, and the others are, or will soon be, leading programs concerned primarily with health care of the elderly. The two foreign-born, American-trained physicians are completing their second year of geriatric medical residency, having moved with the author to a new

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* A listing of geriatric and gerontologic textbooks and journals is available from the author upon request.

program (to be described below). One will return to Kyoto, Japan, where he will establish a new geriatric medical department at the Kyoto-Katsura Hospital, part of Kyoto University, and the other will return to a medical school in Bangkok, Thailand, as the first geriatrician in that nation.

Development of the Second Residency Program in Geriatric Medicine: Growth and Contrasts

In February 1975 the author assumed leadership of the geriatric program at the Jewish Institute for Geriatric Care in New Hyde Park, New York, a new 525-bed geriatric institution. Although financially autonomous, it is physically linked with and professionally related to the Long Island Jewish-Hillside Medical Center, a major teaching campus of the State University of New York School of Medicine at Stony Brook, New York. This geriatric institution gives care to patients admitted from either a large number of community hospitals or directly from their homes.

This new program provides an opportunity for further development of geriatric health care and training approaches. In contrast to the acute general hospital, this institution's entire budget is obviously committed to geriatric efforts, which allows for significant innovative programs. A geriatric outpatient, home care, and diagnostic center is currently developing.

The medical teaching staff consists of full-time physician specialists in geriatric and internal medicine, psychiatry, physical medicine and rehabilitation, and dentistry. Additionally, there are approximately 30 part-time practitioners serving as consultants and teachers in medical and surgical specialties (all from the Long Island Jewish Hospital staff), as well as 25 part-time voluntary dentists and three podiatrists. The acute hospital's entire special skills, such as intensive care areas, surgery, special laboratories, and teaching conferences, are also easily accessible through the tunnel connecting the two institutions.

Working with the resident physicians and assisting with patient care are large numbers of senior medical students from various schools. In addition to students from many U.S. medical schools, there are 40 U.S.-born foreign medical school graduates who each spend at least 1 month per year on the geriatric medical service. They are in a "5th pathway" of training, having received their M.D. degree after 4 years of school. There are also 25 physician-associate students, each spending 1 month at this institute (*see* Involvement of Medical Students).

Table 2. The Geriatric and Gerontologic Seminars[*]

1. Organization and economics of the American health care system for the elderly (5-7)[†]
2. Geropsychiatry (20-24)
3. Geroneurology (20-24)
4. General surgical problems (6)
5. Vascular surgical problems (6)
6. Orthopedic problems (6)
7. Rehabilitation medicine (20-24)
8. Urologic problems (4)
9. Gynecologic problems (3)
10. Dermatology (4)
11. Hearing and Otolaryngology (2)
12. Speech pathology and treatment (2)
13. Theories and mechanisms of aging (2)
14. Special medical problems (10)
15. Ophthalmology (4)

[*] Included are patient interviews, demonstrations, and so forth. Two to three seminars are conducted each week. The full outline of topics of each set of seminars is available upon request.

[†] The numbers in parentheses represent the projected number of seminars throughout the year.

Table 3. Geropsychiatry—Seminar Series

Psychology of normal aging (2)[*]
The psychiatric interview of the older patient (2)
The family (1)
Diagnostic clues and evaluation (1)
Depression (2)
Mania (1)
Paranoid states (1)
Other "functional" disorders (1)
Pseudosenility: acute and chronic reversible organic brain syndromes (2)
Chronic organic brain syndromes (2)
  [a] Classification
  [b] Treatment
Psychopharmacology and electroconvulsive therapy for the elderly (3)
Psychotherapy: individual and group (2)
Death and dying (2)
The aphasias, agnosias, and apraxias (1)
Feelings about working with the elderly in the community and in the long-term institution (1)

[*] Numbers in parentheses represent the projected number of seminars throughout the year.

This new residency program, like the initial one, needed the strong support of the Director of the Department of Medicine, since it exists within that department. This program has led to an expansion of the training curriculum through the geriatric and gerontologic seminars that occur two to three times each week throughout the academic year. They are intended to further broaden the geriatrician's base of knowledge. Some of the categories covered in the seminars are listed in Tables 2, 3, and 4.

The interest in this new residency program has been very active. In response to advertisements and announcements in three national journals, we have received numerous applications for the five available positions.

COST EFFECTIVENESS

The cost effectiveness of this new geriatric program has been impressive during the first year of experience. The new program has produced a 55% increase in discharges to the community (from 160 to 250 patients) and a 40% increase in admissions from acute hospitals (from 350 to 500 patients), as compared to the preceding year. In this first year, we have trained five geriatric residents, 45 medical students, and 25 physician-associate students. These increased health services have been provided without any large increase in the medical or nursing budgets.

The cost effectiveness is explained by several factors. The medical budget has not increased because the salaries of our third-year residents are 40% less than those of the untrained house doctors previously staffing this large geriatric institution. This paradox is easily explained by

Table 4. Organization and Economics of the American Health System for the Elderly: Seminar Series

1. Demography—who, where, what are the elderly: income, marital status, and so forth
2. Cost of health care for the elderly: individual, hospital, long-term facility
3. Medicare: as it affects the patient, practitioner, institution, and government
4. Medicaid: as it affects the patient, practitioner, institution, and government
5. Other financial aspects of health care affecting the elderly: time spent in rendering care to the elderly, and so forth
6. The long-term institutions:
    - [a] Types: skilled nursing facility, health-related facility, and chronic disease hospital
    - [b] Proprietary "power" in a public health area
7. The long-term institutions:
    - [a] The "voluntary" long-term institution as both the geriatric and chronic disease hospital of the U.S.
    - [b] Comparison with the long-term "proprietary" institutions
8. Organized "systems" for the community-residing elderly:
    - [a] United States:
        - [1] Elmhurst system, and so forth
        - [2] Health maintenance organizations ("HMOs"): Kaiser, Puget Sound, and Health Insurance Plan of New York ("HIP")
    - [b] Great Britain, Scandinavia
    - [c] Soviet Union and other eastern European nations
9. Understanding government regulations affecting the elderly: outpatient, hospital, and long-term care:
    - [a] Federal and State:
        - [1] Utilization review, and so forth
        - [2] Patient care plan
10. Community service programs—what they provide
    - [a] The Visiting Nurse Associations
    - [b] The social service agencies and the homemaker-health aide agencies (profit and nonprofit)
    - [c] The private practitioner (medical, nursing, physical therapist)
11. Visit to "health-related facility"
12. The experience of health care systems from the point of view of the older consumer: elderly "activist" groups
13. Transportation: the problems and the response
14. Psychiatric treatment: the unavailability
15. Home care: an excellent answer for 5% to 10% of the elderly
16. Legal aspects of late life
17. The pharmaceutical industry and their leading client: the elderly

the attractive force of a training program. The lack of increase in the nursing budget may be related to the increased efficiency of having resident-caliber colleagues on the premises at all times. The modest and anticipated increase in laboratory costs has been offset by the increased average daily census generated by this new active discharge and admission rate.

INVOLVEMENT OF MEDICAL STUDENTS

The resident physicians are very involved in teaching geriatrics to medical and physician-associate students at many levels of their development. Freshmen medical students at Mount Sinai were involved in a regular seminar in geriatrics. Electives were available to those beyond the first year. Thus, a recent second-year student has been a coproducer of video tapes used for the teaching of geriatric medicine to medical students at Mount Sinai and other medical schools. His interest brought large numbers of sophomore students into an involvement with geriatrics.

Contrary to published pessimistic reports on the lack of medical students' interest (24, 25), it is our impression that a high percentage of freshmen and sophomore students are interested in health care problems of the elderly but that they lose interest during their student clinical years. It is a unique student who can withstand his teacher's many negative feedback responses to his interest in the elderly. It is also the author's experience that in each medical school class of 100 students, there is one student, (perhaps two) who is not only interested in a general sense but would also pursue a career in geriatric medicine if given the opportunity and proper role models with which to relate and identify. Freeman (26, 27) has previously documented the interest of interns and resident physicians in obtaining more geriatric education during their medical school experience, as well as the paucity of such opportunities.

FAMILY PRACTICE RESIDENTS IN THIS GERIATRIC PROGRAM

Physicians in family practice residencies at various hospitals have taken electives with us. This has been a mutually beneficial experience and promises to remain so, since most family practice programs are including geriatric training.

Discussion

Certain conclusions drawn from these 4 years of experience lead the author to express optimism about the growth of this new field and its benefits to older Americans.

There is no doubt about the need for geriatricians, the interest of young physicians, or the career opportunities available to these trainees. There is considerable demand for the skilled geriatrician to lead new programs.

The training attempts much in perhaps too little time. The geriatrician must be both generalist and specialist, both for specific health problems and for development of the team and the appropriate health systems.

The resident physician's identification with this new and emerging role has been very clear. The point of such training programs is not to proselytize among those with negative attitudes toward working with the elderly. There are more than adequate numbers of interested physicians and students who, if formally trained in geriatrics, could fill the necessary leadership positions.

Several teaching institutions are now at the point of establishing such a residency program. These interests usually derive from a serious, perhaps overwhelming, responsibility for care of institutionalized and community-residing elderly persons. Further impetus derives from the new federal law requiring the more than 7000 skilled nursing facilities to create a medical director's position.

The lessons learned in developing this residency training program are summarized as follows.

1. Before attempting the residency, establish a system of health care encompassing outpatient and inpatient care, and base this on a team approach.

2. The training program should not be focused solely on long-term care, as this is an inadequate definition of

geriatrics and is not too appealing to young physicians seeking a career identity.

3. Establish a 1- to 2-year residency-fellowship program, open to physicians who have usually had 2 previous years of internal medical training.

4. Support of the program by the chairman of the department of medicine at the medical school and hospital is crucial, especially in providing accreditation of the year toward eligibility for "board certification" in internal medicine.

5. Medical residents should not be obligated to rotate onto the geriatric service; rather an elective opportunity should be established for medical or family practice residents.

6. Interns (PGY-1) should rotate onto the service for 1 to 2 months, since we have found them to be quite positive about their geriatric experience.

7. As much as possible, establish independent funding of the residency and geriatric team positions, because in hospital cutbacks there is an unfortunate tendency to make first cuts of programs giving care to elderly or chronically ill persons.

8. Locate the geriatric unit within or adjacent to a general hospital, as this provides patient care and residency training benefits.

9. Advertisements in leading medical journals are necessary each July, August, and September to make physicians aware of the existence of these programs, since they are not listed in any directory.

10. The experience of students in the training program has been positive and serves as a source of stimulation to residents and other team members.

11. Leadership of the program must be by individuals who identify with geriatrics, because anyone not convinced of the existence and importance of this field cannot effectively lead trainees.

It is believed that the two programs described herein will serve as a useful model for other newly developing programs and will ease the way for further progress in this essential, pervasive, and demanding area of health care.

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Appendix 4

REPORT ON COMMUNITY CARE CLIENTS OF THE TEXAS DEPARTMENT OF HUMAN RESOURCES [1]

SSI AND SERVICE POPULATIONS

As of August of this year there were 268,000 recipients of supplementary security income (SSI) in the State of Texas. Of those, 181,000 are elderly and, as depicted in table 1, about 31,000 of them receive services from the Community Care for Aged, Blind and Disabled (CCABD) Division of the Department of Human Resources (DHR). The table below illustrates that this Division serves 11.6 percent of all the SSI recipients in Texas, yet that group represents almost all of the clientele (81.3 percent). Within the range of services offered by the Division (see tables 2 and 3 and attachment 1 which describes the services) the greatest number are served by the family care program, 13.0 percent by agencies and 55.5 percent by individual providers (see table 2). Thus, 68.5 percent of this Divisions' clients receive family care services. Most of them are SSI recipients (17,721) and they represent 6.6 percent of the total State SSI population (see table 1).

TABLE 1.—POPULATION AND PROGRAM DATA

Recipients	Number	Percent of 268,000	Percent of 38,130
State SSI population	268,000		
State elderly SSI population	181,000		
Total community care population	38,130		
Community care/income eligibles	7,126		18.7
Community care/SSI	31,004	11.6	81.3
SSI/family care services	17,721	6.6	
SSI/all other services	13,286	5.0	

BUDGET AND CONTRACTS

The scope of the community care program is represented in tables 2 and 3. Table 3 is excerpted from the current Comprehensive Annual Services Program Plan for Texas (CASPP) which is enclosed. Both present estimates of expenditures and clients. You will note that table 3 breaks down the categories of clients served and that all of the programs serve SSI and income eligible clients (see p. 13 of the CASPP) except for protective services which also includes clients "without regard to income."

TABLE 2.—SCOPE OF THE COMMUNITY CARE PROGRAM (FISCAL YEAR 1977)

Protective services	Number of agencies	Clients served per month	Percent of total	Annual expenditure
Contract services		1,544	4.0	$900,000
Agency contracts:				
Type of service:				
Family care	9	4,949	13.0	11,043,000
Homemaker	13	2,063	5.4	3,168,000
Chore	8	2,986	7.8	1,721,000
Day activity	14	843	2.2	1,062,000
Health assessments	17	3,065	8.0	2,101,000
Congregate/delivered meals	14	1,361	3.6	667,000
Individual providers-family care		21,155	55.5	31,757,000
Alternative living plans		164	0.4	
Total		38,130		52,419,000

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[1] Submitted by Merle E. Springer, deputy commissioner, Financial and Social Programs, Texas Department of Human Resources.

TABLE 3

ESTIMATED STATEWIDE EXPENDITURES AND CLIENTS TO BE SERVED FOR COMMUNITY CARE FOR AGED, BLIND AND DISABLED ADULTS

ESTIMATED PROGRAM EXPENDITURES AND RESOURCES	
Federal	$47,659,888
State	13,362,770
Certified Public Expenditures	922,165
Local	1,601,694
Total	$63,546,517

COMPARISON OF ESTIMATED CLIENTS SERVED AND COST FOR 1977 AND 1978 PROGRAM YEARS

YEAR	NUMBER OF CLIENTS	TOTAL COST
1977	114,446	$56,804,436
1978	127,704	$63,546,517

ESTIMATED PROGRAM EXPENDITURES BY REGION

Region	Estimated Expenditures
1	$ 912,032
2	1,417,445
3	1,570,350
4	3,824,799
5	10,938,494
6	7,078,535
7	7,194,283
8	9,049,511
9	6,808,120
10	3,992,895
11	7,371,541
12	929,676
Sub-total	$61,087,681
STATE OFFICE SUPPORT	2,458,836
TOTAL	$63,546,517

ESTIMATED EXPENDITURES AND CLIENTS TO BE SERVED BY CLIENT CATEGORY

SERVICE	Aid to Families with Dependent Children Recipients		Supplemental Security Income Recipients		Income Eligibles		Without Regard to Income		Total	
	Clients to be Served	Cost	Clients to be Served	Cost	Clients to be Served	Cost	Clients to be Served	Cost	Clients to be Served	Cost
Protective							12,772	$2,111,840	12,772	$2,111,840
Chore			8,969	$3,120,866	3,428	$1,167,744			12,397	4,288,610
Family Care			52,353	36,359,038	10,276	8,279,368			62,629	44,638,406
Homemaker			12,169	4,688,535	3,528	1,383,602			15,697	6,072,137
Day Activity			2,140	1,120,819	1,157	376,995			3,297	1,497,814
Congregate and Home Delivered Meals			3,202	600,959	2,360	356,398			5,562	957,357
Alternative Living Plans			1,514	715,547	297	162,299			1,811	877,846
Health Assessment			10,486	486,719	3,053	156,953			13,539	643,672
State Office Support										
TOTAL			90,833	$47,092,483	24,099	$11,883,358	12,772	$2,111,840	127,704	$61,087,681

Regarding protective services, which are directed toward preventing or remedying neglect, abuse, or exploitation of adults unable to protect their own interests (see attachment 1), this Department is currently handling 1,785 cases per month. This figure, however, is not representative of the population in need; it consists only of the people who have come to the Department for help.

Returning to table 3, it is apparent that most of the budget of the CCABD Division is allocated to contracts. The Department of Human Resources currently has 106 contracts with 76 contract agencies throughout Texas to provide Title XX Community Care to Aged, Blind, or Disabled Services. Illustrated in table 4, those contracts range in size from $2,250 to $4 million. Some agencies contract to provide only one service—homemaker service, for instance—while others may provide multiple services.

TABLE 4.—SUMMARY OF TITLE XX COMMUNITY CARE CONTRACTS

Service	Number of contracts for service	Annual Contracted amount
Protective	8	$583, 204. 72
Protective training	1	44, 428. 00
Peer counseling	1	40, 000. 00
Chore	8	1, 191, 351. 80
Family care	10	8, 801, 517. 59
Homemaker	17	3, 338, 281. 55
Day activity transportation	3	107, 381. 30
Day activity	14	1, 273, 513. 26
Home delivered meals	21	898, 620. 55
Congregrate meals	5	87, 445. 18
Health assessment	17	695, 436. 84
Health assessment transportation	1	36, 358. 00
Total	106	17, 097, 459. 79

FOOD STAMPS AND MEDICAL TRANSPORTATION

This department does not have information on the number of food stamp recipients who are age 65 and over. However 229,758 households, consisting of 789,486 persons, are currently receiving food stamps in the State.

The information collected by the medical transportation program is not broken down along urban and rural lines. The reporting measure required by HEW is the number of one-way trips provided to people. In fiscal year 1977, that number was 1,150,136.

COMPARISON OF NURSING HOME AND COMMUNITY CARE COSTS

In comparing nursing home and community care cost the entire public cost must be taken into consideration. The largest portion of community care clients (81.3 percent) in Texas are SSI recipients. A comparison of costs for these clients (including purchased service, supplemental medical insurance benefits—SMIB—medicaid premiums, and SSI) indicates that nursing home care is more expensive than community care. The following table 5 gives State and Federal costs for the primary types of nursing home and community care provided in Texas.

Most community care clients (21,000 per month) in Texas receive individual provider family care at a monthly average cost of $108 for the purchased service and a total cost of $302.53. The majority of nursing home residents (43,000 per month) receive ICF III care at a monthly rate of $590.10 and a total cost of $642.13. Therefore, the total cost for nursing home care for most clients/recipients is more than twice that of community care. (See table 5–A)

The increase in cost for nursing home care falls disproportionately on the State. As table 5–A shows, Texas expends six and one-half times as much for the average client in nursing home care compared to community care. However, Federal costs are only one and one-half times greater. The Federal ceiling on title XX funds has limited the State's ability to expand community care services even though both client preference and cost containment indicate that it is in the State's interest to do so.

For fiscal year 1978, Texas has budgeted a total of $442.2 million to provide ICF II, ICF III, or skilled nursing home care to an average of 64.000 persons per month. During this same fiscal year, Texas has budgeted a total of $63.5 million to provide community care for an average of 38,000 clients per month.

Approximately the same number of elderly Texans are financially eligible for title XIX nursing home care and title XX community care. About 680,000 aged Texans have incomes below 60 percent of the State's median income which is $410.85 per month for an individual.

UTILIZATION OF COMMUNITY CARE OR NURSING HOME CARE BY TEXAS CLIENTS

Surveys of community care clients in Texas have indicated that virtually all of the clients preferred living in the community to living in the nursing home. One of those surveys of client conditions in nursing homes and in community care indicated that over 60 percent of community care clients had health problems that would qualify them for nursing home care. Such data seem to indicate that, at least for some clients, community care, when available, is a viable alternative to nursing home care. (See figure 1 for a comparison of specific client characteristics.)

TABLE 5.—COMMUNITY CARE/NURSING HOME CARE

[Average cost per SSI client in 1 mo]

Service	Purchased service	Monthly premium	Monthly SMIB	SSI	Total
Nursing homes (XIX):					
ICF II nursing home care:					
State	181.39	7.22	2.62		191.23
Federal	279.71	12.61	4.58	25.00	321.90
Total	461.10	19.83	7.20	25.00	513.13
ICF III nursing home care:					
State	232.14	7.22	2.62		241.98
Federal	357.96	12.61	4.58	25.00	400.15
Total	590.10	19.83	7.20	25.00	642.13
Skilled:					
State	289.73	7.22	2.62		299.57
Federal	446.77	12.61	4.58	25.00	488.96
Total	736.50	19.83	7.20	25.00	788.53
Community care (XX):					
Individual provider-family care:					
State	27.00	7.22	2.62		36.84
Federal	81.00	12.61	4.58	167.50	265.69
Total	108.00	19.83	7.20	167.50	302.53
Contract family care (pilots):					
State	37.50	7.22	2.62		47.34
Federal	112.50	12.61	4.58	167.50	297.19
Total	150.00	19.83	7.20	167.50	344.53
Homemaker:					
State	25.75	7.22	2.62		35.59
Federal	77.25	12.61	4.58	167.50	261.94
Total	103.00	19.83	7.20	167.50	297.53
Chore:					
State	9.75	7.22	2.62		19.59
Federal	29.25	12.61	4.58	167.50	213.94
Total	39.00	19.83	7.20	167.50	233.53
Day activity:					
State	21.00	7.22	2.62		30.84
Federal	63.00	12.61	4.58	167.50	247.69
Total	84.00	19.83	7.20	167.50	278.53
Health related:					
State	11.50	7.22	2.62		21.34
Federal	34.50	12.61	4.58	167.50	219.19
Total	46.00	19.83	7.20	167.50	240.53

TABLE 5.—COMMUNITY CARE/NURSING HOME CARE—Continued

[Average cost per SSI client in 1 mo]

Service	Purchased service	Monthly premium	Monthly SMIB	SSI	Total
Congregate/delivered meals:					
State	7.75	7.22	2.62		17.59
Federal	23.25	12.61	4.58	167.50	207.94
Total	31.00	19.83	7.20	167.50	225.53
Special services in foster homes:					
State	20.25	7.22	2.62		30.09
Federal	60.75	12.61	4.58	167.50	245.44
Total	81.00	19.83	7.20	167.50	275.53

Note: State match rate: Nursing homes (XIX), 39.34 percent; community care (XX), 25 percent.

TABLE 5-A.—COMPARISON OF TOTAL STATE AND FEDERAL COSTS FOR COMMUNITY CARE (XX) AND NURSING HOME CARE (XIX)[1]

	Individual provider family care cost	ICF III nursing home care cost	Increased cost for nursing home care (percent)
State	36.84	241.98	657
Federal	265.69	400.15	151
Total	302.53	642.13	212

[1] These 2 services are the most widely used nursing home and community care services.

FIGURE 1.--COMPARISON OF NURSING HOME PATIENTS' HEALTH CHARACTERISTICS WITH HOME CARE CLIENTS

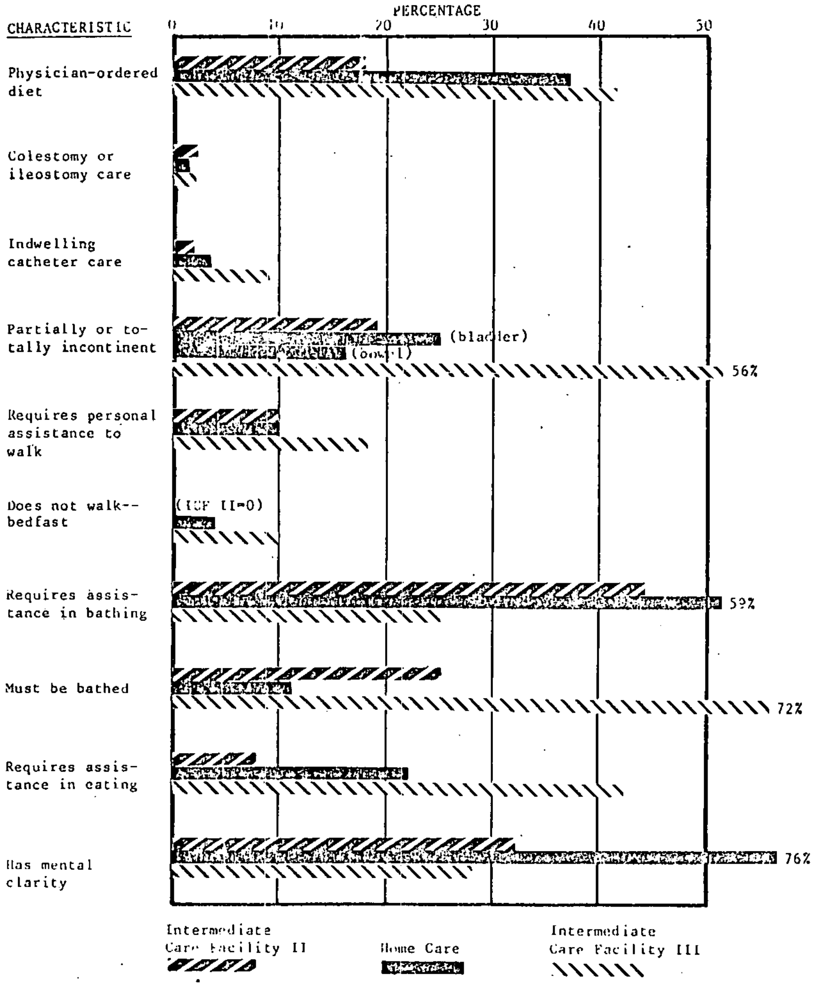
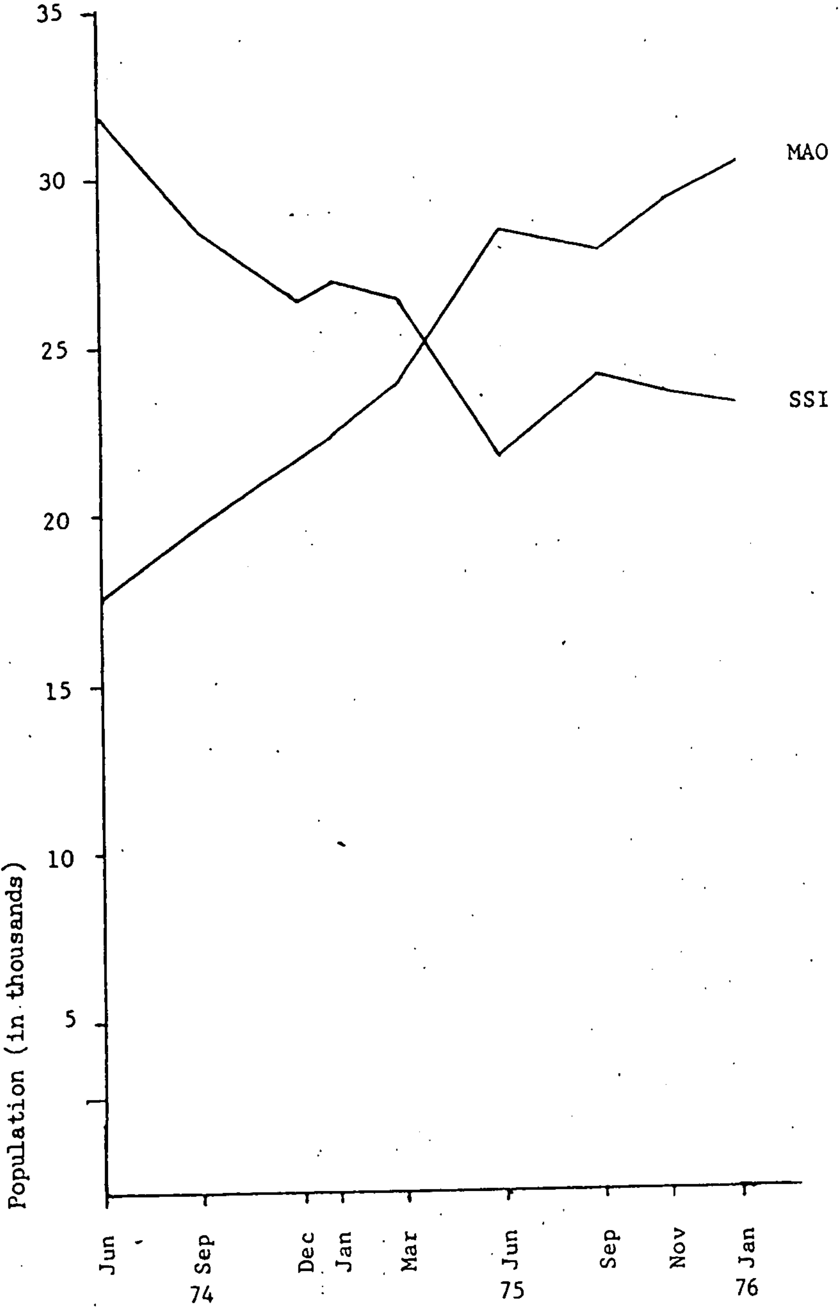


FIGURE 2.--COMPOSITION OF NURSING HOME POPULATION BY INCOME STATUS (JUNE 1974-JANUARY 1976)



Because of title XX budget limitations, service priorities have been established for community care services. The priorities for service are:

(1) Current adult recipients of SSI and ABD income eligibles who are released from nursing homes or institutions.

(2) All persons not included in the above group who are recipients of SSI who are 65 years or older.

(3) Other adults 18–64 years old who are current recipients of SSI.

(4) Other ABD adults with incomes below 60 percent of the State's median income.

As a result, 81.3 percent of title XX community care clients are SSI recipients. Thus, the portion of SSI recipients receiving community care services is much higher than the portion of income eligibles (18.7 percent) receiving the service. The converse situation has developed for nursing home care. Nursing home recipients with incomes at or below the SSI eligibility level had decreased 27 percent from June 1974 to January 1976. During this same time period nursing home recipients with incomes above the SSI level (medical assistance only/ income eligibles) increased 71.5 percent (see figure 2).

This data tends to indicate that the SSI elderly population, in many cases, is choosing and receiving title XX community care services rather than nursing home care even if their health condition might qualify them for nursing home care. Whether the aged income eligible population would do the same is not known because of the limited availability of community care for this group.

No Texas data is available to indicate what portion, if any, of the current nursing home population could be cared for in the community if resources were available. However, national literature on the subject suggests that 15 percent of the residents of nursing homes are inappropriately placed there. If this holds true in Texas, over 9,000 nursing home residents could return to the community if appropriate resources were available.

TITLE XX AND THE OLDER AMERICANS ACT

Services rendered under the Older Americans Act (OAA) are primarily provided under title III and title VII. A portion of title III funds are used to provide "supporting services" and "gap-filling services." Actual services provided to the elderly under title III may include a wide variety of services including transportation, employment, housing, education, health, nutrition, etc. Each area agency on aging determines the priorities for funding within their area. Title VII provides funds for congregate meals for the elderly and limited home delivered meals.

Priorities for title XX services for the elderly are set in each set in each State through the development of the State and sub-State regional comprehensive annual services program plan. No limitations on the type of services provided are made by title XX law or regulation as long as the services address the following title XX goals:

(1) Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency.

(2) Achieving or maintaining self-sufficiency to reduce or prevent dependency.

(3) Preventing or remedying abuse, neglect, or exploitation of children and adults unable to protect themselves, or preserving, rehabilitating, or uniting families.

(4) Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care.

(5) Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to persons in institutions.

Under the Older Americans Act services must be available to all the elderly, age 60 and over, without an income test. However, priority must be given to the low-income and minority elderly. Under title XX, at least 50 percent of the services in a State must go to SSI recipients who are age 65 and over or who are blind or disabled. Each State may set an income eligibility maximum for title XX services within certain limits. In Texas, this is 60 percent of the State's median income. All aged clients receiving title XX services must meet the income eligibility test unless the service is a protective service to prevent or remedy abuse, neglect, or exploitation (see p. 13 of the CASPP).

These differences in the eligibility criteria for title XX and for services under the Older Americans Act create some problems when funds are commingled in joint projects. Accounting procedures must be more comprehensive under title

XX in order to assure that ineligible clients are not served. Elderly with incomes above 60 percent of the State median income are not eligible for most services provided with title XX funds. In addition, title XX regulations require that SSI recipients who are blind and disabled adults, age 18 to 64, be served, as well as the aged.

UNIFORM AVAILABILITY OF SERVICE

Title XX requires uniform availability of service to identified subgroups of the eligible population. Title III and II of the OAA do not require that uniform availability of services be provided to the eligible client population (persons 60 years of age or older). This makes it easier to pilot programs under the OAA. However, many such piloted programs, even though proven to be feasible and beneficial, cannot be replicated under title XX because budget constraints do not permit the provision of the service to the entire title XX eligible population.

NEED FOR SERVICES

Findings from statewide survey of elderly SSI recipients, conducted by the center for social work research at the University of Texas at Austin, indicate a great need for transportation. Approximately two-thirds of the population were not managing to do that themselves. This need is particularly acute in rural areas where accessibility of medical care is a problem. A task force for evaluation of medicaid in Texas reported the following in March of this year: "The evidence is clear that too few physicians participate in the medicaid program . . . and the eligible poor cannot receive adequate medical care without physician participation. This problem is even more acute in the rural areas where scarcity of medical care already exists.

A need for chore type services was also illustrated in the SSI survey by between one-fifth and one-third of the population receiving help with laundry, shopping, housekeeping, and meal preparation. The need for chore and homemaker services of all types was underscored by the fact that three-fourths of the elderly SSI recipients were receiving assistance with one or more of the tasks maintained above. In addition, 52 percent of the elderly recipients had one or more illnesses that interfered a great deal with their daily activity (see figures 3 and 4). Figure 4 depicts the percentage of elderly with selected illnesses that interfered a great deal with their daily activities. Figure 5 illustrates the various daily activities in which the elderly recipients have selected limitations.

There was a cash flow or income problem for about one-fifth of the population, and 17.7 percent responded that they did not always have money for medicine. Although more than half (51.1 percent) of the respondents needed dentures, the greatest need was for eyeglasses (69.2 percent). Minor home repairs, although not one of our services, proved to be a task that would be most helpful to many persons. One-third of the population needs some household repairs, and the majority have arthritis which could prevent them from doing these things.

The survey concludes that the need for transportation is certainly the greatest of all the service needs investigated in the study. The second priority for social services should be chore services, such as shopping, laundry, housekeeping, and meal preparation, and this is underscored by the fact that almost half of the population lives alone.

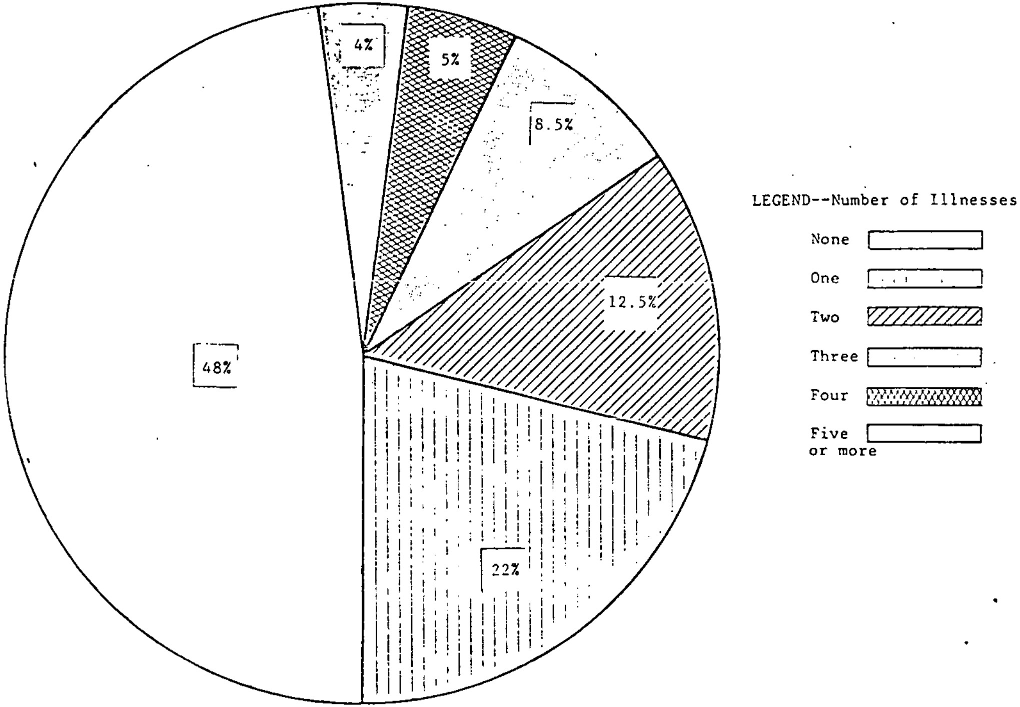


Figure 3. Percentage of noninstitutionalized SSI/Medicaid elderly recipients with one or more illnesses that interfere a great deal with daily activity

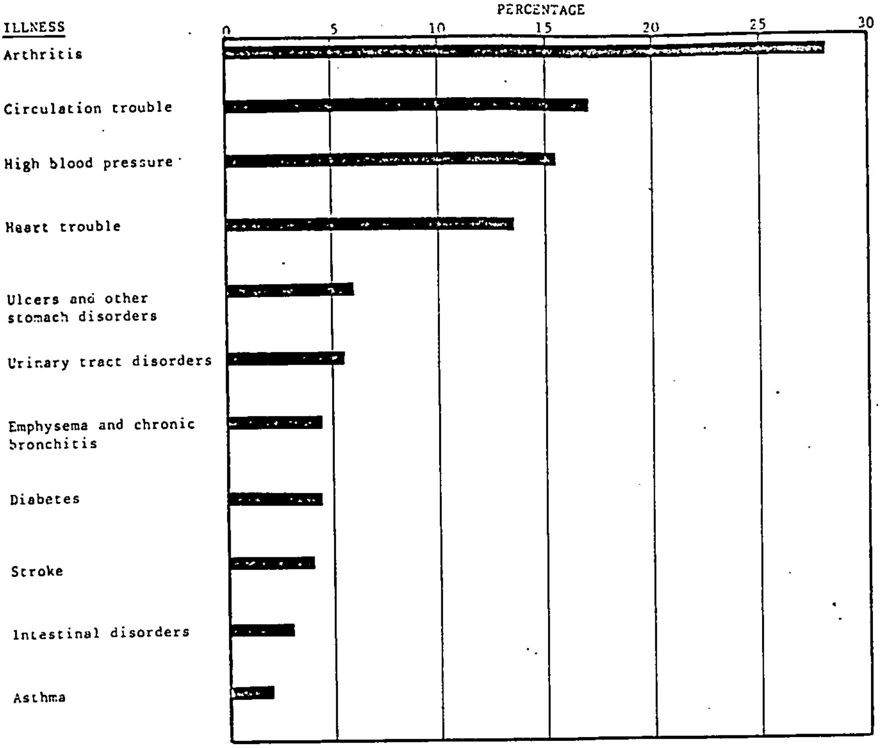


Figure 4. Percentage of noninsitutionalized SSI/Medicaid elderly recipients with selected illnesses that interfere a great deal with daily activities.

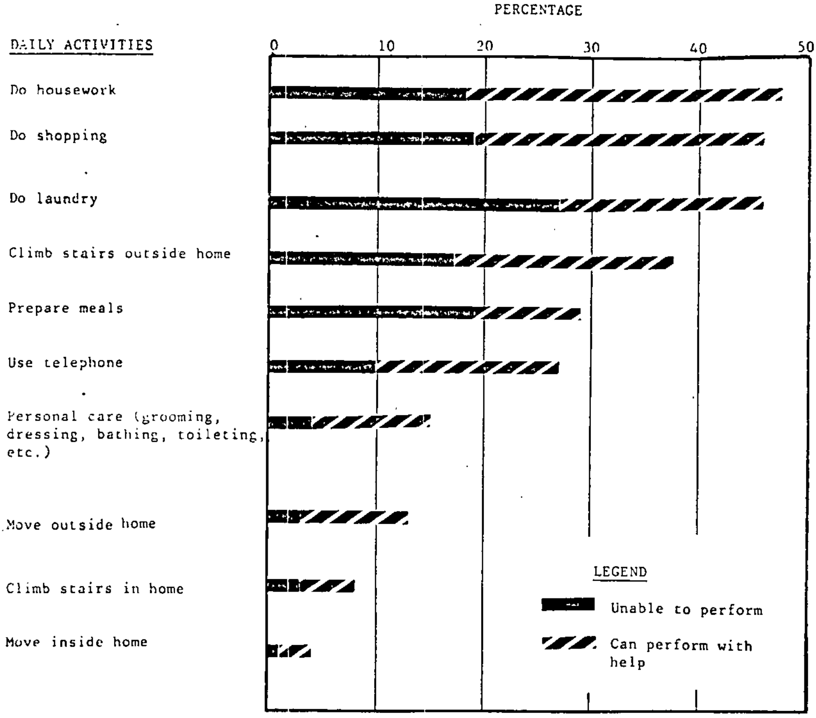


Figure 5. Percentage of noninstitutionalized SSI/Medicaid elderly recipients with selected limitations in daily activities