COMPREHENSIVE COMMUNITY BASED NONINSTITUTIONAL LONG-TERM CARE FOR THE ELDERLY AND DISABLED

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

S. 2809

A BILL TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE FOR A PROGRAM OF COMPREHENSIVE COMMUNITY-BASED NONINSTITUTIONAL LONG-TERM CARE SERVICES FOR THE ELDERLY AND THE DISABLED

AUGUST 27, 1980

Printed for the use of the Committee on Finance

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COMPREHENSIVE COMMUNITY-BASED NON-INSTITUTIONAL LONG-TERM CARE FOR THE ELDERLY AND DISABLED

WEDNESDAY, AUGUST 27, 1980

U.S. SENATE,
COMMITTEE ON FINANCE,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:10 a.m., in room 2221, Dirksen Senate Office Building, Hon. Spark M. Matsunaga (chairman of the subcommittee) presiding.

Present: Senators Matsunaga, Nelson, Bradley, Dole, and Packwood.

[The press release announcing this hearing and the bill S. 2809 follow:]

Press Release #H-42

PRESS RELEASE

FOR IMMEDIATE RELEASE
July 28, 1980

UNITED STATES SENATE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
2227 Dirksen Senate Office Bldg.

SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON S. 2809, COMPREHENSIVE COMMUNITY BASED NONINSTITUTIONAL LONG-TERM CARE FOR THE ELDERLY AND DISABLED

The Honorable Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will hold hearings on the provisions of S. 2809, a proposal to provide for a program of comprehensive community based noninstitutional long-term care services for the elderly and disabled. Senator Talmadge stated that the initial hearing would be scheduled to begin at 9:00 A.M. on Wednesday, August 27, 1980 in Room 2221 of the Dirksen Senate Office Building.

The Chairman pointed out that, "we must carefully examine the barriers which exist in the Medicare and Medicaid programs which can result in placing people who can live at home into nursing homes."

The aged population in this country is expected to exceed 32 million persons by the year 2000. Talmadge said, "It is time to begin examining ways of developing an effective system of services designed to avoid unnecessary institutionalization of elderly and disabled." Talmadge noted that S. 2809, introduced by Finance Committee members Bob Packwood (R., Ore.), Bill Bradley (D., N.J.), Spark Matsunaga (D., Hawaii), Gaylord Nelson (D., Wisc.), and John Heinz (R., Pa.), will provide a sound point of departure for the Committee's deliberations.

The hearing on August 27 will be the first in a series of hearings to look at various aspects of the long-term care problem. Testimony on August 27 will be heard from invited witnesses with experience in providing noninstitutional services, as well as witnesses experienced in preadmission screening and professional review of long-term care services.

Legislative Reorganization Act. -- Senator Talmadge stated that the Legislative Reorganization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress "to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument."

Witnesses scheduled to testify should comply with the following rules:

(1) A copy of the statement must be filed by noon the day before the day the witness is scheduled to testify.

(2) All witnesses must include with their written statement a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 100 copies must be submitted by the close of business the day before the witness is scheduled to testify.

(4) Witnesses are not to read their written statements to the Committee, but are to confine their ten-minute oral presentations to a summary of the points included in the statement.

(5) Not more than ten minutes will be allowed for oral presentation.

Written testimony. -- Senator Talmadge stated that the Committee would be pleased to receive written testimony from those persons or organizations who wish to submit statements for the record. Statements submitted for inclusion in the record should be typewritten, not more than 25 double-spaced pages in length and mailed with five (5) copies by Friday, September 12, 1980 to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D. C. 20510

II

96TH CONGRESS
2D SESSION

S. 2809

To amend the Social Security Act to provide for a program of comprehensive community-based noninstitutional long-term care services for the elderly and the disabled.

IN THE SENATE OF THE UNITED STATES

JUNE 10 (legislative day, JANUARY 3), 1980

Mr. PACKWOOD (for himself, Mr. BRADLEY, Mr. NELSON, Mr. HEINZ, Mr. MATSUNAGA, Mr. COHEN, Mr. COCHRAN, Mr. JAVITS, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend the Social Security Act to provide for a program of comprehensive community-based noninstitutional long-term care services for the elderly and the disabled.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Noninstitutional Long-
4 Term Care Services for the Elderly and Disabled Act".

1 NONINSTITUTIONAL LONG-TERM CARE SERVICES FOR THE
2 ELDERLY AND THE DISABLED

3 SEC. 2. The Social Security Act is amended by adding
4 at the end thereof the following new title:

5 "TITLE XXI—NONINSTITUTIONAL LONG-TERM
6 CARE SERVICES FOR THE ELDERLY AND
7 THE DISABLED

8 "PURPOSE OF TITLE

9 "SEC. 2101. It is the purpose of this title to provide a
10 comprehensive system of noninstitutional medical and social
11 services for individuals aged 65 or over and individuals with
12 chronic disabilities, to ensure that such individuals are
13 assisted in remaining functionally independent in their own
14 communities, and therefore avoid unnecessary placement of
15 such individuals in institutional facilities.

16 "SCOPE OF BENEFITS

17 "SEC. 2102. (a) Each eligible individual (as determined
18 under section 2103) shall be entitled to the following benefits:
19 "(1) Home health services.
20 "(2) Homemaker-home health aide services.
21 "(3) Adult day services.
22 "(4) Respite care services for up to 14 days, or
23 336 hours, in any calendar year.
24 "(b) For purposes of this title—

1 "(1)(A) The term 'home health services' means
2 the following items and services furnished to an indi-
3 vidual, who has been referred by a physician or by a
4 social or health organization, by a home health agency
5 or by others under arrangements with them made by
6 such agency, under a plan established and periodically
7 reviewed by a preadmission screening and assessment
8 team (PAT) (as defined in section 2104) which items
9 and services are, except as provided in clause (vi), pro-
10 vided on a visiting basis in a place of residence used as
11 such individual's home—
12 "(i) part-time or intermittent nursing care
13 provided by or under the supervision of a regis-
14 tered professional nurse;
15 "(ii) physical, occupational, or speech
16 therapy;
17 "(iii) medical social services under the direc-
18 tion of a PAT;
19 "(iv) medical supplies (other than drugs and
20 biologicals), and the use of medical appliances,
21 while under such a plan;
22 "(v) in the case of a home health agency
23 which is affiliated or under common control with
24 a hospital, medical services provided by an intern
25 or resident-in-training of such hospital under a

1 teaching program of such hospital approved as
2 provided in section 1861(b)(6) of this Act; and
3 "(vi) any of the foregoing items and services
4 which are provided on an outpatient basis, under
5 arrangements made by the home health agency,
6 at a hospital or skilled nursing facility, or at a re-
7 habilitation center (within the meaning of section
8 1861(p)) which meets such standards as may be
9 prescribed in regulations, and—
10 "(I) the furnishing of which involves the
11 use of equipment of such a nature that the
12 items and services cannot readily be made
13 available to the individual in such place of
14 residence, or
15 "(II) which are furnished at such
16 facility while he is there to receive any such
17 item or service described in division (I), but
18 not including transportation of the individual
19 in connection with any such item or service;
20 excluding, however, any other item or service if it
21 would not be included under section 1861(b) if fur-
22 nished to an inpatient of a hospital.
23 "(B) The term 'home health agency' means a
24 public agency or private organization, including a
25 center or agency for the handicapped (as defined in

1 subparagraph (D)), or a subdivision of such an agency
2 or organization, which—
3 "(i) is primarily engaged in providing skilled
4 nursing services and other therapeutic services;
5 "(ii) has policies, established by a group of
6 professional personnel (associated with the agency
7 or organization), including one or more physicians
8 and one or more registered professional nurses, to
9 govern the services (referred to in clause (i))
10 which it provides, and provides for supervision of
11 such services by a physician or registered profes-
12 sional nurse;
13 "(iii) maintains clinical records of all
14 patients;
15 "(iv) in the case of an agency or organization
16 in any State in which State or applicable local
17 law provides for the licensing of agencies or orga-
18 nizations of this nature, (I) is licensed pursuant to
19 such law, or (II) is approved, by the agency of
20 such State or locality responsible for licensing
21 agencies or organizations of this nature, as meet-
22 ing the standards established for such licensing;
23 "(v) has in effect an overall plan and budget
24 that meets the requirements of section 1861(z);
25 and

1 "(vi) meets such other conditions of partici-
2 pation as the Secretary may find necessary in the
3 interest of the health and safety of individuals
4 who are furnished services by such agency or
5 organization.
6 "(C) The term 'social or health organization'
7 means any organization or agency providing social or
8 health services directly or indirectly to individuals eli-
9 gible to receive services under this title.
10 "(D) The term 'center or agency for the handi-
11 capped' means—
12 "(i) a single- or multi-purpose facility the
13 function of which is to assist individuals having
14 physical, mental, developmental, or emotional im-
15 pairments to become more functional members of
16 the community by providing programs or services
17 which may include (but are not limited to) recrea-
18 tion, education, health care, social development,
19 independent living, and physical rehabilitation (but
20 excluding any facility the primary function of
21 which is to provide residential care on a 24 hours
22 per day basis); or
23 "(ii) any agency certified or licensed by the
24 State as being an agency designed to assist indi-

1 viduals eligible for services under this title to
2 reach their maximum level of independence.
3 "(2) The term 'homemaker-home health aide serv-
4 ices' means services provided by a homemaker-home
5 health aide to an individual in such individual's home,
6 which are designed to maintain the personal care of
7 such individual and such home (not including the struc-
8 ture of the home) in a manner which promotes the
9 functional independence of the individual and to avoid
10 the need for institutionalization or other more compre-
11 hensive services. Such services shall include—
12 "(A) personal care services designed to assist
13 such individual in the activities of daily living
14 such as bathing, exercising, personal grooming,
15 and getting in and out of bed; and
16 "(B) household care services such as main-
17 taining a safe living environment, light housekeep-
18 ing, and ensuring good nutrition (including the
19 purchase and preparation of food).
20 "(3) The term 'adult day services' means services
21 provided (other than care provided for the primary ob-
22 jective of providing medical or physical services) on a
23 regular basis, but less than 24 hours per day, to an in-
24 dividual in a multipurpose senior center, intermediate
25 care facility, hospital, rehabilitation center, center or

1 agency for the handicapped, or other facility licensed
2 by the State, which are provided because such individ-
3 ual is unable to be left alone during the daytime hours
4 but does not require institutionalization. Such services
5 may include (but are not limited to) provision of meals,
6 personal care, recreation and educational activities,
7 physical and vocational rehabilitation, and health care
8 services.

9 "(4) The term 'respite care services' means serv-
10 ices for an individual who is unable to care for himself
11 on a full-time basis, which are provided on a tempo-
12 rary basis to such individual because of the absence of
13 the person who normally cares for such individual, but
14 only if such individual is a dependent of such other
15 person for purposes of the Internal Revenue Code of
16 1954. Such services must be provided by persons who
17 have been trained to provide homemaker-home health
18 aide services, and such services must be provided in
19 the home of the dependent individual under the super-
20 vision of a registered nurse who is employed by a cer-
21 tified home health agency, homemaker-home health
22 aide agency, or local public health department. Such
23 services shall, when necessary and appropriate, be pro-
24 vided in addition to other services under this title to
25 ensure that such individual receives a coordinated

1 system of services designed to help him reach his
2 maximum level of independence.

3 "ELIGIBILITY FOR BENEFITS

4 "SEC. 2103. (a) Every individual who—
5 "(1) has attained age 65, is a resident of the
6 United States, and is either a citizen or an alien law-
7 fully admitted for permanent residence;
8 "(2) is disabled and is eligible for benefits under
9 title II, XVI, or XVIII of this Act;
10 "(3) is disabled and is eligible for medical assist-
11 ance under a State plan approved under title XIX of
12 this Act; or
13 "(4) was an eligible individual under this title by
14 reason of paragraph (2) or (3) but ceased to meet the
15 requirements of such paragraph, but only if it is deter-
16 mined by a PAT designated under section 2104 that—
17 "(A) loss of benefits under this title would
18 seriously jeopardize such individual's ability to
19 continue to live in a noninstitutional community
20 residence, and
21 "(B) such individual's income is not sufficient
22 to allow him to provide for himself a reasonable
23 equivalent of the services available to him as an
24 eligible individual under this title;
25 is an eligible individual for purposes of this title.

1 "(b) Certification of eligibility under this section
2 shall be made by the Secretary.

3 "PREADMISSION SCREENING AND ASSESSMENT

4 "SEC. 2104. (a)(1) No eligible individual as defined
5 under section 2103 shall be eligible to receive any benefits
6 under this title, or any long-term care benefits under title
7 XVIII of this Act, or any long-term care under a State plan
8 approved under title XIX or XX of this Act, unless such
9 individual has been screened and assessed in accordance with
10 the provisions of this title, and has a plan of care (as defined
11 in this section) under which the provision of such care or
12 benefits is determined to be appropriate.

13 "(2) The purpose of such assessment and screening is to
14 provide, through the use of a preadmission assessment and
15 screening team (PAT), a thorough evaluation of each individ-
16 ual's health status and functional capabilities to determine
17 the types and frequency of services required by such individu-
18 al in order to assure the achievement of the maximum level
19 of independence by such individual.

20 "(b)(1) The PAT services shall be provided to every eli-
21 gible individual who has been referred for such services by a
22 physician or by a social or health organization (as defined in
23 section 2102(b)(1)(C)). Such individual's physician shall be
24 consulted with and kept informed by the PAT with respect to
25 the plan of care developed by such team for such individual

1 and shall be consulted before the plan of care is implemented.
2 Such screenings and assessments shall include the following:
3 "(A) An initial screening to determine the need
4 for and appropriateness of any long-term care, provided
5 for or reimbursed under this title or title XVIII, XIX,
6 or XX of this Act, that may be required by the individ-
7 ual at the time of initial referral.
8 "(B) The preparation of a plan of care for the in-
9 dividual based upon a thorough assessment of the indi-
10 vidual's health status and functional capabilities. Such
11 plan of care shall determine those long-term care serv-
12 ices (if any) which are most appropriate for the individ-
13 ual, and only those long-term care services approved in
14 the plan shall be eligible with respect to payment of
15 benefits or provision of services under this title and
16 title XVIII, and under State plans approved under
17 title XIX or XX of this Act. Such plan shall also indi-
18 cate the types of services required by such individual,
19 the frequency of such services, and the frequency of re-
20 assessments by the PAT.
21 "(C) An ongoing assessment of the individual's
22 status and appropriate update of the plan of care. An
23 initial reassessment shall be made within 30 days after
24 the initiation of the plan of care and ongoing assess-
25 ments shall be made at such times as the PAT deter-

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1 mines to be necessary. Assessments shall be made in
2 cooperation with any agency providing services to such
3 individual under this title.
4 "(D) Supplying the individual with a list of all
5 providers of services in the area who are qualified to
6 provide services under this title which such individual
7 may require, and, if such individual is unable to con-
8 tact such a provider, contacting such a provider on
9 behalf of such individual. If such individual's personal
10 physician recommends a qualified service provider, the
11 PAT will contact such provider first.
12 "(E) Referral to any other appropriate services
13 specifically designated for the elderly or disabled and
14 available to such individual in his community.
15 "(F) The collection, at the time the PAT per-
16 forms the assessments and screenings, of relevant in-
17 formation with respect to such individuals for the pur-
18 pose of developing a national data base. Such data
19 shall be used to make comparisons with respect to the
20 average number of visits required, the average length
21 of a visit, the average cost per visit, the average cost
22 per individual and per case, and any other information
23 deemed necessary. Such data shall be broken down by
24 age, sex, marital status, race, disability, type of resi-

1 dence, and place of residence (urban or rural) of such
2 individuals.
3 "(2) Such screenings and assessments shall be provided
4 by a preadmission screening and assessment team (PAT) des-
5 ignated under subsection (c) without charge to the individual.
6 "(c)(1) The Governor of each State shall designate the
7 State's department of health (or equivalent agency), the State
8 agency designated under the State plan under title XIX of
9 this Act, the State's department on aging (or equivalent
10 agency), or the State's department on mental retardation or
11 developmental disabilities as the lead agency for purposes of
12 this title, and such lead agency shall work in cooperation
13 with such other three agencies to coordinate the designation
14 of at least one preadmission screening and assessment team
15 (PAT) to serve each unit of general purpose local govern-
16 ment in the State. In designating a PAT for an area the
17 State's lead agency may designate a Professional Standards
18 Review Organization (PSRO), an area agency on aging, a
19 hospital, a local government's department of health, a rural
20 health clinic, a health maintenance organization (HMO), a
21 center or agency for the handicapped, or any similar entity,
22 as the PAT, if such entity meets the requirements of this title
23 for a PAT. No hospital having a hospital-based home health
24 care agency, and no free standing home health agency, may
25 be designated as a PAT except in a rural area where the

1 State's lead agency determines that no other entity has the
2 capacity to provide the PAT services.
3 "(2) Each preadmission screening and assessment team
4 (PAT) must be under the general supervision of a physician
5 who has the responsibility to certify each plan of care, and
6 must consist of at least (A) a registered nurse or nurse practi-
7 tioner, (B) a physical therapist, (C) a social services worker,
8 (D) where necessary, a qualified professional in the field of
9 mental retardation or developmental disabilities, (E) a volun-
10 teer senior citizen advocate or volunteer advocate for the dis-
11 abled (whichever may be appropriate), and (F) where neces-
12 sary, an occupational therapist. In any case where a rural
13 health clinic has been designated as a PAT, a physician as-
14 sistant or nurse practitioner (as defined in section
15 1861(aa)(2)) may be a member of such PAT instead of a
16 registered nurse.
17 "(3) Each PAT within a State shall collect data with
18 respect to individuals receiving services under this title or
19 referred for other services by the PAT, utilizing a statewide
20 uniform assessment instrument. Each State shall determine
21 the type of uniform instrument it will use, but such instru-
22 ment must contain all information required under subsection
23 (b)(1)(F).
24 "(d)(1) The Secretary shall reimburse any designated
25 preadmission screening and assessment team (on a per visit

1 basis), and any State, for the reasonable costs incurred by
2 such PAT or State in carrying out its duties under this title.
3 The per visit reasonable cost for providing services under this
4 title shall be determined on a State-by-State negotiated rate
5 basis between the Secretary and the appropriate State agen-
6 cies, but the Secretary shall make the final determination of
7 such rates.

8 "(2) If a State fails to carry out its duties under this
9 title, the Secretary shall assume such duties and shall desig-
10 nate preadmission screening and assessment teams in such
11 State.

12 "COPAYMENTS BY ELIGIBLE INDIVIDUALS

13 "SEC. 2105. (a) Subject to the provisions of subsection
14 (b), any eligible individual shall be required to make copay-
15 ments with respect to benefits received under this title in the
16 following amounts:

17 "(1) 10 percent of the reimbursable amount (as
18 determined under section 2106(a)) with respect to
19 home health services for visits in excess of 50 visits in
20 a calendar year.

21 "(2) 10 percent of the reimbursable amount with
22 respect to homemaker-home health aide services for
23 visits in excess of 50 visits in a calendar year.

1 "(3) 10 percent of the reimbursable amount with
2 respect to adult day services for visits to an adult day
3 center in excess of 50 visits in a calendar year.

4 "(b)(1) No eligible individual shall be required to make
5 copayments under subsection (a) in any calendar year which
6 are in excess of the applicable percent of his income for such
7 calendar year as determined under the following table:

"Income:	Applicable percent
$0 to $3,500	1
$3,501 to $5,000	2
$5,001 to $8,500	3
$8,501 to $10,000	4
$10,000 or over	5

8 "(2) For purposes of this subsection the term 'income'
9 means the following:

10 "(A) Income as determined under section 1612(a)
11 of this Act.

12 "(B) Benefits paid under title II of this Act, or
13 under the Railroad Retirement Act of 1974.

14 "(C) Unemployment compensation paid by gov-
15 ernment or by private employers, and strike benefits
16 paid from the funds of a labor organization.

17 "(D) Amounts paid periodically by the Veterans'
18 Administration to disabled veterans or to survivors of
19 deceased veterans, subsistence allowances paid to vet-
20 erans for education or training, and refunds paid to
21 veterans as GI insurance premiums.

1 "(E) Pensions or retirement benefits paid to a re-
2 tired individual or his survivors by a former employer
3 or by a labor organization, either directly or through a
4 pension fund or insurance company, including pensions
5 paid by the State, local, or Federal Government.
6 "(F) Workmen's compensation benefits.
7 "(G) Temporary disability benefits.
8 "(3) All income determinations under this title shall be
9 made by the Secretary.
10 "(4) The Secretary shall collect such copayments as
11 may be appropriate and shall deposit the amounts collected
12 into the Federal Long-Term Care Trust Fund established
13 under this title.
14 "PAYMENT OF BENEFITS
15 "SEC. 2106. (a)(1) The Secretary shall pay, on behalf of
16 each eligible individual who incurs expenses for services with
17 respect to which benefits are payable under this title,
18 amounts as determined under paragraph (2).
19 "(2) The amount payable for home health services,
20 homemaker-home health aide services, adult day services,
21 and respite care services shall be determined on the basis of a
22 schedule of fees for each particular service in each State or
23 area of such State, by the Secretary, in cooperation with the
24 appropriate State agencies, as he determines to be appropri-

1 ate. Such schedule of fees for a State or area of a State shall
2 be determined as follows:
3 "(A) The average weekly direct wage in such
4 State or area for a person providing such service on a
5 full-time basis shall be determined.
6 "(B) The average number of visits per week in
7 such State or area by a person providing such service
8 on a full-time basis shall be determined.
9 "(C) The average direct wage cost per visit shall
10 be determined by dividing such average weekly direct
11 wage by such average number of visits per week.
12 "(D) There shall be added to such average direct
13 wage cost per visit an amount equal to the average
14 transportation cost per visit in such State or area.
15 "(E) The indirect wage costs paid with respect to
16 persons providing such services by the entities employ-
17 ing such persons in such State or area shall be deter-
18 mined as a percentage of the direct wages paid to such
19 persons by such entities. Indirect wage costs include
20 only (i) taxes paid by the employing entity under the
21 Federal Insurance Contributions Act, (ii) taxes paid by
22 the employing entity under the Federal Unemployment
23 Tax Act or State unemployment compensation law, (iii)
24 workmen's compensation contributions made by the
25 employing entity, (iv) payments made by the employing

1 entity for liability insurance and bonding, (v) health in-
2 surance costs, and (vi) other fringe benefits.
3 "(F) The average direct cost per visit as deter-
4 mined under subparagraph (D) shall be added to an
5 amount equal to (i) the percentage determined under
6 subparagraph (E), multiplied by (ii) the amount deter-
7 mined under subparagraph (D), and such total shall be
8 the 'total cost per visit'.
9 "(G) The amount of the fee payable under this
10 title for any visit shall be equal to (i) the total cost per
11 visit, plus (ii) a reasonable administrative cost allow-
12 ance per visit, but such administrative cost allowance
13 may not exceed an amount equal to 20 percent of the
14 total cost per visit.
15 "(H) Such fee schedules shall be developed jointly
16 by the Secretary and the appropriate State agencies as
17 determined by the Governor. The costs shall reflect
18 urban and rural differentials and must be submitted to
19 each unit of general purpose local government to allow
20 providers in such area 30 days for comment on such
21 fee schedules. The schedules shall be accompanied by
22 an explanation of how the schedule was determined.
23 The State shall issue final fee schedules within 60 days
24 after reviewing and evaluating public comment re-

1 ceived with respect to such schedules after they have
2 been approved by the Secretary.
3 "(b) No payment shall be made to any person under this
4 title unless there has been furnished such information as may
5 be necessary in order to determine the amounts due such
6 person under this title for the period with respect to which
7 the amounts are being paid, or for any prior period.
8 "(c) No payment may be made under this title with re-
9 spect to any service provided to an individual unless such
10 service is approved by a preadmission screening and assess-
11 ment team in accordance with section 2104.
12 "USE OF CARRIERS AND STATE AGENCIES
13 "SEC. 2107. (a) The Secretary may enter into agree-
14 ments with carriers for the purpose of administering the
15 benefits available under this title in the same manner in
16 which such agreements are entered into under section 1842
17 for purposes of administering part B of title XVIII, to the
18 extent consistent with the provisions of this title.
19 "(b) The Secretary shall make an agreement with any
20 State which is able and willing to do so, in the same manner
21 as under section 1864, under which an appropriate State
22 agency shall make determinations as to whether an agency
23 or organization meets the requirements of this title as a pro-
24 vider of services.

1 "FEDERAL LONG-TERM CARE TRUST FUND

2 "SEC. 2108. (a) There is hereby created on the books of
3 the Treasury of the United States a trust fund to be known
4 as the 'Federal Long-Term Care Trust Fund' (hereinafter in
5 this section referred to as the 'Trust Fund'). The Trust Fund
6 shall consist of such gifts and bequests as may be made as
7 provided in section 201(i)(1), and such amounts as may be
8 deposited in, or appropriated to, such fund as provided in this
9 title.

10 "(b) With respect to the Trust Fund, there is hereby
11 created a body to be known as the Board of Trustees of the
12 Trust Fund (hereinafter in this section referred to as the
13 'Board of Trustees') composed of the Secretary of the Treas-
14 ury, the Secretary of Labor and the Secretary of Health,
15 Education, and Welfare, all ex officio. The Secretary of the
16 Treasury shall be the Managing Trustee of the Board of
17 Trustees (hereinafter in this section referred to as the 'Man-
18 aging Trustee'). The Administrator of the Health Care Fi-
19 nancing Administration shall serve as the Secretary of the
20 Board of Trustees. The Board of Trustees shall meet not less
21 frequently than once each calendar year. It shall be the duty
22 of the Board of Trustees to—

23 "(1) hold the Trust Fund;

24 "(2) report to the Congress not later than the first
25 day of April of each year on the operation and status

1 of the Trust Fund during the preceding fiscal year and
2 on its expected operation and status during the current
3 fiscal year and the next 2 fiscal years;

4 "(3) report immediately to the Congress whenever
5 the Board is of the opinion that the amount of the
6 Trust Fund is unduly small; and

7 "(4) review the general policies followed in man-
8 aging the Trust Fund, and recommend changes in such
9 policies, including necessary changes in the provisions
10 of law which govern the way in which the Trust Fund
11 is to be managed.

12 The report provided for in paragraph (2) shall include a state-
13 ment of the assets of, and the disbursements made from, the
14 Trust Fund during the preceding fiscal year, an estimate of
15 the expected income to, and disbursements to be made from,
16 the Trust Fund during the current fiscal year and each of the
17 next 2 fiscal years, and a statement of the actuarial status of
18 the Trust Fund. Such report shall be printed as a House
19 document of the session of the Congress to which the report
20 is made.

21 "(c) It shall be the duty of the Managing Trustee to
22 invest such portion of the Trust Fund as is not, in his judg-
23 ment, required to meet current withdrawals. Such invest-
24 ments may be made only in interest-bearing obligations of the
25 United States or in obligations guaranteed as to both princi-

1 pal and interest by the United States. For such purpose such
2 obligations may be acquired on original issue at the issue
3 price, or by purchase of outstanding obligations at the market
4 price. The purposes for which obligations of the United
5 States may be issued under the Second Liberty Bond Act, as
6 amended, are hereby extended to authorize the issuance at
7 par of public-debt obligations for purchase by the Trust Fund.
8 Such obligations issued for purchase by the Trust Fund shall
9 have maturities fixed with due regard for the needs of the
10 Trust Fund and shall bear interest at a rate equal to the
11 average market yield (computed by the Managing Trustee on
12 the basis of market quotations as of the end of the calendar
13 month next preceding the date of such issue) on all marketa-
14 ble interest-bearing obligations of the United States then
15 forming a part of the public debt which are not due or call-
16 able until after the expiration of 4 years from the end of such
17 calendar month; except that where such average market
18 yield is not a multiple of one-eighth of 1 per centum, the rate
19 of interest on such obligations shall be the multiple of one-
20 eighth of 1 per centum nearest such market yield. The Man-
21 aging Trustee may purchase other interest-bearing obliga-
22 tions of the United States or obligations guaranteed as to
23 both principal and interest by the United States, on original
24 issue or at the market price, only where he determines that

1 the purchase of such other obligations is in the public
2 interest.
3 "(d) Any obligations acquired by the Trust Fund (except
4 public debt obligations issued exclusively to the Trust Fund)
5 may be sold by the Managing Trustee at the market price,
6 and such public-debt obligations may be redeemed at par plus
7 accrued interest.
8 "(e) The interest on, and the proceeds from the sale or
9 redemption of, any obligations held in the Trust Fund shall
10 be credited to and form a part of the Trust Fund.
11 "(f) The Managing Trustee shall transfer to the Trust
12 Fund on a periodic basis amounts from the Federal Hospital
13 Insurance Trust Fund and the Federal Supplementary Medi-
14 cal Insurance Trust Fund in accordance with the provisions
15 of section 2109.
16 "(g) There shall be transferred on a quarterly basis to
17 the Trust Fund from the general fund of the Treasury the
18 amounts withheld from payments to States under titles XIX
19 and XX of this Act as required under section 2110.
20 "(h) The Secretary of Health, Education, and Welfare
21 shall deposit into the Trust Fund all copayment amounts col-
22 lected under section 2105.
23 "(i) There are authorized to be appropriated for each
24 fiscal year to the Trust Fund such additional sums as may be

1 necessary to ensure that sufficient funds are available in the
2 Trust Fund to make all payments provided for by this title.
3 "(j) The Managing Trustee shall pay from time to time
4 from the Trust Fund such amounts as the Secretary of
5 Health, Education, and Welfare certifies are necessary to
6 make the payments provided for by this title, and the pay-
7 ments with respect to administrative expenses in accordance
8 with section 201(g)(1).

9 "TRANSFER OF FUNDS FROM TITLE XVIII TRUST FUNDS

10 "SEC. 2109. There shall periodically be transferred to
11 the Federal Long-Term Care Trust Fund, from the Federal
12 Hospital Insurance Trust Fund and from the Federal Supple-
13 mentary Medical Insurance Trust Fund, as the secretary de-
14 termines to be appropriate, amounts which the Secretary es-
15 timates to be the amounts which would have been expended
16 from such Trust Funds for services defined in section 2102
17 during such period if this title had not been enacted and title
18 XVIII was in effect during such period in the same manner
19 as it was in effect during fiscal year 1980.

20 "REDUCED PAYMENT TO STATES FOR LONG-TERM CARE
21 SERVICES

22 "SEC. 2110. (a) The amount of the payment for each
23 fiscal year under title XIX of this Act to be made to any
24 State shall be reduced by an amount equal to—

1 "(1) the amount expended by such State for fiscal
2 year 1980 under its State plan approved under title
3 XIX for services defined in section 2102 provided to
4 individuals who were, at the time they received such
5 services, individuals described in section 2103(a);
6 minus

7 "(2) the amount reimbursed to such State with re-
8 spect to such services by the Federal Government
9 under section 1903 for fiscal year 1980.

10 "(b) The amount of the payment for each fiscal year
11 under title XX of this Act to be made to any State shall be
12 reduced by an amount equal to—

13 "(1) the amount expended by such State for fiscal
14 year 1980 under its State plan approved under title
15 XX for services defined in section 2102 provided to in-
16 dividuals who were, at the time they received such
17 services, individuals described in section 2103(a), and
18 for which Federal reimbursement was made under title
19 XX; minus

20 "(2) the amount reimbursed to such State with re-
21 spect to such services by the Federal Government
22 under section 2002 for fiscal year 1980.

23 "(c) An amount equal to the total amount of the reduc-
24 tions made under the provisions of subsections (a) and (b)

1 shall be deposited into the Federal Long-Term Care Trust
2 Fund in accordance with the provisions of section 2108.

3 "REGULATIONS OF SECRETARY

4 "SEC. 2111. The Secretary shall issue regulations as
5 may be necessary to carry out the provisions of this title.
6 Such regulations shall, to the extent feasible and consistent
7 with this title, be coordinated with regulations issued under
8 titles XVIII, XIX, and XX of this Act.

9 "ADMINISTRATIVE PROVISIONS

10 "SEC. 2112. Except where otherwise provided, the
11 Secretary shall carry out the provisions of this title in the
12 same manner as the Secretary is authorized to carry out the
13 provisions of title XVIII of this Act, and any individual or
14 other person shall have the same rights with respect to deter-
15 minations made by the Secretary as are provided under title
16 XVIII.".

17 MEDICARE AMENDMENTS

18 SEC. 3. (a) Title XVIII of the Social Security Act is
19 amended by adding at the end thereof the following new
20 section:

21 "COORDINATION WITH TITLE XXI

22 "SEC. 1882. Notwithstanding any other provision of
23 this title, no payment shall be made under this title to or on
24 behalf of an individual who is an eligible individual under title
25 XXI of this Act—

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1 "(1) for any service defined in section 2102 of this
2 Act; or

3 "(2) for any extended care services unless such
4 individual undergoes a preadmission screening and as-
5 sessment as provided in section 2104 of this Act, and
6 the need for such services has been approved under
7 such individual's plan of care under such section
8 2104.".

9 (b) Section 1861(e) of such Act is amended—

10 (1) by striking out "and" at the end of paragraph
11 (8);

12 (2) by redesignating paragraph (9) as paragraph
13 (10); and

14 (3) by inserting after paragraph (8) the following:

15 "(9) provides an adequate referral service for pa-
16 tients with respect to services available to them under
17 title XXI of this Act; and".

18 (c) Section 1861(j) of such Act is amended—

19 (1) by striking out "and" at the end of paragraph
20 (14);

21 (2) by redesignating paragraph (15) as paragraph
22 (16); and

23 (3) by inserting after paragraph (14) the following:

1 "(15) provides an adequate referral service for pa-
2 tients with respect to services available to them under
3 title XXI of this Act; and".
4 (d)(1) The following sections of title XVIII of such Act
5 are repealed: 1812(a)(3), 1812(d), 1814(a)(2)(D), 1814(i),
6 1832(a)(2)(A), 1834, 1835(a)(2)(A), 1861(m), 1861(n),
7 1861(o), and 1866(b)(4).
8 (2)(A) Section 1812(e) of such Act is amended by strik-
9 ing out ", and post-hospital home health services" and by
10 inserting "and" after "psychiatric hospital services,".
11 (B) Section 1833(a)(2) of such Act is amended by strik-
12 ing out "—with respect to home health services, 100 per-
13 cent, and with respect to other services (unless otherwise
14 specified in section 1881)" and inserting in lieu thereof ",
15 unless otherwise specified in section 1881".
16 (C) Section 1861(u) of such Act is amended by striking
17 out "home health agency,".
18 (D) Section 226(c)(1) of such Act is amended by striking
19 out ", and post-hospital home health services" and by insert-
20 ing "and" after "inpatient hospital services".
21 (E) Section 7(d)(1) of the Railroad Retirement Act of
22 1974 is amended by striking out "posthospital home health
23 services,".

1 MEDICAID AMENDMENTS

2 SEC. 4. (a) Section 1902(a) of the Social Security Act is
3 amended—
4 (1) by striking out "and" at the end of paragraph
5 (39);
6 (2) by striking out the period at the end of para-
7 graph (40) and inserting in lieu thereof "; and"; and
8 (3) by inserting after paragraph (40) the following:
9 "(41)(A) provide that no service defined in section
10 2102 of this Act shall be provided or paid for under
11 the State plan for any individual who is an eligible in-
12 dividual under title XXI of this Act; and
13 "(B) provide that no long-term care services shall
14 be provided or paid for under the State plan for any
15 individual who is an eligible individual under title XXI
16 of this Act unless such individual has undergone a
17 preadmission screening and assessment as provided in
18 section 2104 of this Act, and the need for such serv-
19 ices has been approved under such individual's plan of
20 care under section 2104.".
21 (b) Section 1903 of such Act is amended by adding at
22 the end thereof the following new subsection:
23 "(r) The amount otherwise payable under the preceding
24 provisions of this section for each fiscal year shall be reduced
25 as provided in section 2110 of this Act.".

1 (c) The first sentence of section 1905(c) of such Act is
2 amended by striking out "and" before "(4)" and by inserting
3 before the period at the end thereof the following: ", and (5)
4 provides an adequate referral service for patients with re-
5 spect to services available to them under title XXI of this
6 Act".

7 SOCIAL SERVICES AMENDMENTS

8 SEC. 5. (a) Section 2002 of the Social Security Act is
9 amended by adding at the end thereof the following new sub-
10 section:

11 "(c) The amount otherwise payable under the preceding
12 provisions of this section for each fiscal year shall be reduced
13 as provided in section 2110 of this Act.".

14 (b) Section 2003(d)(1) of the Social Security Act is
15 amended—

16 (1) by striking out "and" at the end of subpara-
17 graph (I);

18 (2) by striking out the period at the end of subsec-
19 tion (J) and inserting in lieu thereof "; and"; and

20 (3) by inserting after subparagraph (J) the follow-
21 ing:

22 "(K)(i) provide that no service defined in sec-
23 tion 2102 of this Act shall be provided or paid for
24 under the State plan for any individual who is an
25 eligible individual under title XXI of this Act; and

1 "(ii) provide that no long-term care services
2 shall be provided or paid for under the State plan
3 for any individual who is an eligible individual
4 under title XXI of this Act unless such individual
5 has undergone a preadmission screening and as-
6 sessment as provided in section 2104 of this Act,
7 and the need for such services has been approved
8 under such individual's plan of care under section
9 2104.".

10 LIMITATION ON FEDERAL PARTICIPATION IN CAPITAL EX-
11 PENDITURES WITH RESPECT TO PROVIDERS OF SERV-
12 ICES UNDER TITLE XXI

13 SEC. 6. (a)(1) Section 1122(a) of the Social Security Act
14 is amended by striking out "title V, XVIII, and XIX" and
15 inserting in lieu thereof "titles V, XVIII, XIX, and XXI".
16 (2) Section 1122(d)(1) of such Act is amended by strik-
17 ing out "titles, V, XVIII, and XIX", by striking out "titles
18 V, XVIII, and XIX", and by inserting in lieu thereof in each
19 instance "titles V, XVIII, XIX, and XXI".
20 (3) Section 1122(d)(2) of such Act is amended by strik-
21 ing out "title V, XVIII, or XIX" and inserting in lieu there-
22 of "title V, XVIII, XIX, or XXI".
23 (4) Section 1122(e) of such Act is amended by striking
24 out "titles V, XVIII, and XIX" and inserting in lieu thereof
25 "titles V, XVIII, XIX, and XXI".

1 (b) Section 1122 of such Act is amended by adding at
2 the end thereof the following new subsection:
3 "(j) For purposes of this section the term 'health care
4 facility' includes any entity providing services for which pay-
5 ment may be made under title XXI, and the term 'capital
6 expenditure' includes the establishment of any such entity
7 providing services for which payment may be made under
8 title XXI without regard to the dollar amount involved.".
9 INTERNAL REVENUE CODE AMENDMENTS
10 SEC. 7. (a) Subpart A of part IV of subchapter A of
11 chapter 1 of the Internal Revenue Code of 1954 (relating to
12 credits allowable) is amended by adding after section 44C the
13 following new section:
14 "SEC. 44D. CREDIT FOR CARE OF ELDERLY DEPENDENT.
15 "(a) GENERAL RULE.—In the case of an individual
16 who meets the requirements of subsection (b), there shall be
17 allowed as a credit against the tax imposed by this chapter
18 $100 for the taxable year.
19 "(b) ELIGIBILITY FOR CREDIT.—In order to be eligible
20 for a credit under subsection (a) the individual taxpayer must,
21 for the taxable year, be entitled to a deduction under section
22 151(e) with respect to a dependent who has attained age 65
23 prior to the end of the taxable year.".
24 (b) Section 6401(b) of such Code is amended—

1 (1) by striking out "and 43 (relating to earned
2 income credit)" and inserting in lieu thereof "43 (relat-
3 ing to earned income credit), and 44D (relating to
4 credit for care of elderly dependent)"; and
5 (2) by striking out "39 and 43" and inserting in
6 lieu thereof "39, 43, and 44D".
7 (c) The table of contents of such subpart is amended by
8 adding the following item after item 44C:

"Sec. 44D. Credit for care of elderly dependent.".

9 EFFECTIVE DATES

10 SEC. 8. (a) Except as provided in section 9, the amend-
11 ments made by this Act, other than section 7, shall become
12 effective on January 1, 1982.
13 (b) The amendments made by section 7 shall become
14 effective with respect to taxable years beginning on or after
15 January 1, 1982.

16 DELAYED EFFECTIVE DATE FOR PAT PROGRAM;
17 DEMONSTRATION PROJECTS

18 SEC. 9. (a)(1) Except in States designated by the Secre-
19 tary as demonstration projects under subsection (b), the use
20 of, and requirement for approval by, preadmission screening
21 and assessment teams under titles XVIII, XIX, XX, and
22 XXI of the Social Security Act, shall not become effective
23 until the date specified in subsection (c).

1 (2) Until the date specified in subsection (c) the Secre-
2 tary of Health and Human Services shall carry out the pro-
3 grams under such titles without regard to any requirements
4 relating to preadmission screening and assessment teams.
5 For purposes of services provided under title XXI of such
6 Act the Secretary shall retain any requirements for approval
7 or certification of such services as such requirements were in
8 effect with respect to such services under title XVIII of the
9 Social Security Act prior to amendment by this Act.
10 (b)(1) The Secretary shall designate one State in each of
11 the ten regions of the Department of Health and Human
12 Services in which the provisions of titles XVIII, XIX, XX,
13 and XXI of the Social Security Act relating to preadmission
14 screening and assessment teams shall become effective in ac-
15 cordance with section 8 of this Act. The Secretary shall mon-
16 itor the effect of such teams with respect to any changes in
17 the utilization of inpatient services, any changes in the utili-
18 zation of the various types of services provided under titles
19 XVIII, XIX, XX, and XXI of the Social Security Act, and
20 any other trends in costs or utilization rates of various serv-
21 ices, and shall also test and evaluate the effects of imple-
22 menting a copayment requirement beginning with the first
23 visit as compared to a copayment requirement beginning
24 after fifty visits. The Secretary shall submit a report to the

1 Congress with respect to such monitoring not later than Jan-
2 uary 1, 1984.
3 (2) The Comptroller General of the United States shall
4 also conduct an ongoing evaluation of the effect of the use of
5 preadmission screening and assessment teams with respect to
6 utilization of services, and shall submit a report to the Con-
7 gress with respect to such evaluation not later than January
8 1, 1984.
9 (3) The reports submitted under paragraphs (1) and (2)
10 shall each include a recommended strategy for implementing
11 title XXI of the Social Security Act on a national basis, with
12 particular emphasis on implementation at the State and local
13 levels. Such reports shall include—
14 (A) an analysis of potential obstacles to such im-
15 plementation;
16 (B) suggested legislative changes which may be
17 necessary to ensure effective and efficient implementa-
18 tion; and
19 (C) a detailed plan for such implementation.
20 (4) The Office of Management and Budget shall prepare
21 an analysis of the budgetary impact of the implementation of
22 such title on a national basis, and shall submit a report to the
23 Congress with respect to such analysis not later than Janu-
24 ary 1, 1984.

1 (c) The provisions of titles XVIII, XIX, XX, and XXI
2 of the Social Security Act relating to preadmission screening
3 and assessment teams shall not become effective until one
4 year after Congress has received evaluations from the De-
5 partment of Health and Human Services, the Comptroller
6 General of the United States, and the Office of Management
7 and Budget.

Senator BRADLEY. The subcommittee will come to order.

A number of weeks ago, Senator Packwood and I, and a number of other Senators, introduced S. 2809, the noninstitutional long-term care services for the elderly and disabled. This morning we are holding hearings on that bill.

I have a prepared statement which I will submit to the record, and I will ask the other Senators present if they would do likewise, after their initial statement.

[The prepared statement of Senator Bradley follows:]

PREPARED STATEMENT OF SENATOR BILL BRADLEY

"A number of weeks ago Sen. Packwood and I introduced S.2908, the Noninstitutional Long-Term Care Services for the Elderly and Disabled Act. As stated in the bill, our purpose is 'to provide a comprehensive system of noninstitutional medical and social services for individuals aged 65 or over and individuals with chronic disabilities, to ensure that such individuals are assisted in remaining functionally independent in their own communities, and therefore avoid unnecessary placement of such individuals in institutional facilities.'

"To realize this purpose, the bill consolidates, under a new title -- Title XXI -- of the Social Security Act, existing home care services now financed by Medicare, Medicaid, and Title XX of the Act. The bill would also make available a broader range of home care services for all elderly and disabled, including homemaker, home health care, adult day care and respite care services. Funding for screening, assessment and case management would also be provided.

"A number of important considerations have led us to propose the approach embodied in Title XXI.

"First, the United States is undergoing significant demographic changes -- one of the most notable being the increase in both the numbers and proportion of the population over 65 years of age. While the elderly constituted 9.8 percent of the population in 1970, the proportion increased to 11.2 percent this year and is projected to increase to 12.2 percent by the end of the century.

"Second, there is a growing appreciation that the range of living situations available to the elderly and disabled is insufficient at present. The choice too often hinges on the ability of the elderly and disabled to live totally independently in their own homes or face being placed in a nursing home or other institutional setting. An elderly or disabled individual in need of modest or temporary assistance may find that assistance only upon permanent placement in an institution -- needlessly traumatizing the individual.

"Third, experience has shown that for the elderly and disabled, the road into nursing homes or other institutional care is too frequently a one-way street; that a return to the community becomes increasingly difficult the longer one is institutionalized, especially because community support services are in short supply or nonexistant.

"Fourth, there is a bias in public and private sources of health care funding for the elderly and disabled, since Medicare, Medicaid and private insurance will reimburse certain services only if they are delivered in an institutional setting. They will not reimburse those same services provided to otherwise eligible individuals in their hom[illegible]

"Institutional care is expensive, and unnecessary institutional care is wasteful. The societal overreliance on and overuse of nursing homes has serious economic effects, as well as undesirable psychological and social effects, on the elderly and disabled, their families and other third party payers, including all levels of government.

"Our intent, then, is to provide the elderly and disabled with services which will allow them to remain as self-sufficient and independent in their living situation as possible. In our judgment, the provision of a comprehensive package of community-based health and social services is an essential step in achieving this goal.

"Title XXI redesigns and adds to existing federally funded services. We expect:

-- To increase the availability of services and stimulate additional groups in the community to provide Title XXI services by extending federal reimbursement to

community-based providers.

-- To assure a continuum of services available to the elderly and disabled under the Social Security Act by combining these services under one title and providing for service delivery on a comprehensive basis.

-- To secure needed care for the elderly and disabled and also to prevent the unnecessary and inappropriate placement of these individuals in institutions by funding screening, assessment and case management services.

"Title XXI is a very ambitious program. Even as I have great hopes for the Title XXI approach, this bill was fashioned with the awareness that its concepts must be fully tested and that changes will likely be made as we proceed with its implementation. For these reasons, the bill provides that three-year demonstration projects be conducted in ten states to test and assess the effectiveness of the Title XXI approach at the statewide level.

"These hearings are an important part of the process of accumulating experience and evaluating the Title XXI approach. Many of the witnesses we will hear from have relevant local experience to what we are proposing to do on a larger, national scale. While I recognize that we may not be able to provide full funding for all these needed new services at once, I think we can now move toward the goals of this legislation. I would like to hear from our witnesses what they consider to be the most important immediate 'next steps' we should take to enable states to develop comprehensive long-term care systems. It may be, for instance, that we should move immediately to provide reimbursement for screening and assessment.

"I would also like to hear from witnesses how their programs have been able -- or unable -- to affect the nursing home bed supply. The Inspector General of the Department of Health and Human Services recently estimated, in a draft report to the Secretary, that there are approximately 41,000 elderly and disabled patients in acute care hospitals, waiting for nursing home beds, on any one day in the United States. The nursing home beds are simply not available. I would like to know what impact programs such as those represented here today can have by diverting more elderly from nursing homes to home care programs.

their programs and the utilization of different services. I know that several of the programs represented here include payments to nursing homes as well as to home care providers, while others are set up to divert actual and potential nursing home patients into home care through pre-screening programs. The experience with different funding sources, both public and private, will interest us as well.

"It is so obviously to our advantage as a society to assist our elderly and disabled citizens to remain as independent as possible in their -- and our -- communities. If we can provide, in the community, a range of services which can help the elderly and disabled meet their needs for limited or temporary assistance, we will enrich their lives and our own.

"I look forward to hearing from our distinguished witnesses and thank them for taking the time to share their experience and insights with us."

Senator PACKWOOD. Mr. Chairman, I have a lengthy opening statement, and I would simply insert it in the record following yours.

[The prepared statement of Senator Packwood, as well as the prepared statement of Senator Spark Matsunaga, follows:]

HEARING ON

PACKWOOD-BRADLEY

LONG-TERM HEALTH CARE BILL FOR

THE ELDERLY AND DISABLED

S. 2809

MR. PACKWOOD. MR. CHAIRMAN, I AM VERY PLEASED THAT THE HEALTH SUBCOMMITTEE OF THE SENATE FINANCE COMMITTEE HAS AGREED TO HOLD A SERIES OF HEARINGS ON S.2809-THE PACKWOOD BRADLEY LONG-TERM CARE ACT. THIS BILL REPRESENTS A MAJOR STEP FORWARD ON AN ISSUE WHICH BOTH THE CONGRESS AND THE ADMINISTRATION HAVE IGNORED FOR TOO LONG, AND WHICH STILL REMAINS UNRESOLVED. S. 2809 IS SPECIFICALLY DESIGNED TO ESTABLISH A NEW TITLE--TITLE XXI UNDER THE SOCIAL SECURITY ACT AS THE "ONE" COMPREHENSIVE TITLE PROVIDING BOTH SOCIAL AND MEDICAL CARE SERVICES TO ENSURE THAT SENIORS AND PERSONS WITH DISABILITIES RECEIVE THOSE SERVICES NECESSARY TO HELP THEM REMAIN IN THEIR OWN HOMES AND COMMUNITIES, AND AVOID UNNECESSARY PLACEMENT IN A NURSING HOME. THE TITLE XXI APPROACH WAS SPECIFICALLY DESIGNED TO AVOID "TINKERING" WITH EITHER THE MEDICARE OR MEDICAID PROGRAMS, BECAUSE BOTH PROGRAMS HAVE AN INHERENT INSTITUTIONAL BIAS, THAT IS, THEY WOULD RATHER PLACE PEOPLE IN HOSPITALS OR NURSING HOMES AS OPPOSED TO KEEPING THEM IN THEIR OWN HOMES.

MEDICARE AND MEDICAID ARE THE MAJOR FUNDING SOURCES OF LONG-TERM CARE SERVICES FOR THE ELDERLY. THE SEPERATE RULES, REGULATIONS AND ELIGIBILITY CRITERIA GOVERNING SUCH

PROGRAMS CONTINUE TO ENCOURAGE (1) INSTITUTIONALIZATION, (2) INAPPROPRIATE TYPES OF CARE, AND (3) IN SOME CASES SERVICES NOT REACHING THOSE IN NEED. FURTHER, SINCE INSTITUTIONAL CARE FINANCING IS EMPHASIZED AND COMPREHENSIVE COMMUNITY HEALTH CARE OPTIONS ARE NOT GENERALLY AVAILABLE, THE PRESENT HEALTH CARE SYSTEM FOSTERS INCREASED RELIANCE UPON INSTITUTIONAL CARE.

PROBLEMS OF THE CURRENT SYSTEM

WHILE IT IS UNDERSTOOD THAT BOTH MEDICARE AND MEDICAID PROGRAMS HAVE A DEFINITE BIAS TOWARDS PLACING AN INDIVIDUAL IN A HOSPITAL OR NURSING HOME, MEDICARE OFFERS ONLY ONE PROGRAM TO ASSIST SENIORS AND PERSONS WITH DISABILITIES TO AVOID PREMATURE PLACEMENT IN A NURSING HOME--THE HOME HEALTH CARE PROGRAM. YET, THE ELIGIBILITY FOR THIS PROGRAM CONTAIN RESTRICTIONS THAT FORCE PEOPLE INTO HOSPITALS BEFORE THEY CAN QUALIFY FOR HOME HEALTH CARE.

THE MEDICAID PROGRAM PRESENTS YET ANOTHER PROBLEM. EXPENDITURES FOR NURSING HOME CARE UNDER THE MEDICAID PROGRAM HAVE INCREASED FROM APPROXIMATELY $800 MILLION IN 1967 TO $6.4 BILLION IN 1977, AND ARE EXPECTED TO INCREASE TO $11.0 BILLION BY 1981. DURING THIS TEN-YEAR PERIOD(1967-1977), THE NUMBER OF NURSING RECIPIENTS HAS MORE THAN DOUBLED. FURTHER, WHILE IN 1964 14.7%

OF PERSONS AGE 85 AND OVER WERE IN NURSING HOMES, IN 1974 25.3% OF THE 85 AND OVER POPULATION WERE IN NURSING HOMES. THIS PROBLEM IS COMPOUNDED BY THE FACT THAT AN ESTIMATED 10-25% OF NURSING HOME RESIDENTS DO NOT REQUIRE THE LEVEL OF CARE PROVIDED, BUT CANNOT RE-ENTER THE COMMUNITY BECAUSE OF:

(1) THE LACK OF SUPPORTIVE SERVICES NECESSARY TO ASSIST THEM;

(2) A SHORTAGE OF AFFORDABLE HOUSING IN THE COMMUNITY;

(3) THE ABSENCE OF ANY SAVINGS AVAILABLE TO THE INDIVIDUAL-- MOST OF WHICH HAS BEEN USED TO PAY FOR NURSING HOME CARE;

(4) THE INADEQUACY OF THE INDIVIDUAL'S FAMILY'S FINANCIAL RESOURCES TO PROVIDE ASSISTANCE, DUE IN PART TO COST AND RESPONSIBILITY; AND

(5) INABILITY OF A SPOUSE TO PROVIDE ASSISTANCE OFTEN ATTRIBUTABLE TO THE FACT THAT PROLONGED INSTITUTIONALIZATION OF ONE SPOUSE OFTEN PREPARES THE REMAINING COMMUNITY SPOUSE FOR ENTRY INTO A NURSING HOME.

WHILE DISCUSSION OF THE PROBLEMS ABOUT THE ELDERLY AND LONG-TERM CARE COULD CONTINUE AT LENGTH, THE REMAINDER OF MY STATEMENT WILL FOCUS ON ISSUES WHICH I BELIEVE WE MUST CAREFULLY EXAMINE DURING THE COMMITTEE'S WORK ON THE PACKWOOD-BRADLEY LONG-TERM CARE SERVICES ACT.

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I RAISE THESE ISSUES BECAUSE OF MY GENUINE CONCERN THAT FOR TOO LONG THEY HAVE BEEN OVERLOOKED, AND MUST NOW BE CAREFULLY ASSESSED AS PART OF THE COMMITTEE'S WORK IN THIS AREA.

FIRST, THE CURRENT HEALTH CARE SYSTEM OFTEN PLACES PEOPLE INTO SPECIFIC ENTITLEMENT GROUPS. THOSE ELIGIBLE FOR MEDICARE ARE ONE ENTITLEMENT GROUP, THOSE WHO QUALIFY FOR MEDICAID REPRESENT ANOTHER, AND THOSE ELIGIBLE FOR TITLE XX ARE YET ANOTHER. WHILE IT IS TRUE THAT THERE MAY BE LIMITED OVERLAP AMONG THE DIFFERENT ENTITLEMENT PROGRAMS, FOR THE MOST PART WHAT WE HAVE ESTABLISHED IS A SOCIAL AND MEDICAL CARE SYSTEM FOR THE ELDERLY AND DISABLED THAT SEPERATES PEOPLE BY AGE OR INCOME CLASS. THEREFORE, WHILE PERSONS 65 AND OVER ARE ELIGIBLE FOR BOTH MEDICARE AND MEDICAID, ONLY VERY LOW-INCOME SENIORS CAN QUALIFY FOR MEDICAID, AND THUS BENEFIT FROM BOTH PROGRAMS.

THE TITLE XXI APPROACH ELIMINATES THIS SEPARATE ENTITLEMENT PROBLEM IN TWO WAYS: (A) IT COMBINES UNDER ONE TITLE THOSE NON-INSTITUTIONAL LONG-TERM CARE SERVICES WHICH ARE PRESENTLY PROVIDED UNDER THE MEDICARE, MEDICAID, AND TITLE XX PROGRAMS; AND (B) MAKES ALL PERSONS OVER 65 ELIGIBLE AS WELL AS

PERSONS WHO ARE DISABLED WHO QUALIFY FOR BENEFITS UNDER EITHER TITLE II, XVI, XVIII, OR XIX OF THE SOCIAL SECURTY ACT. THIS EXPANDED DEFINITION OF ELIGIBILITY ELIMINATES THE PROBLEMS EXPERIENCED UNDER SEPERATE ENTITLEMENT PROGRAMS.

SECONDLY, TOO LITTLE ATTENTION HAS BEEN FOCUSED ON THE ROLE OF THE FAMILY IN PROVIDING LONG-TERM CARE SERVICES. THE CHARACTERISTICS OF THE AMERICAN FAMILY TODAY HAVE CHANGED DRAMATICALLY FROM ALMOST A DECADE AGO. FOR EXAMPLE:

* THE DIVORCE RATE HAS DOUBLED BETWEEN 1955 AND 1975;
* THE NUMBER OF SINGLE PARENT FAMILIES HAS GROWN; AND
* THERE IS AN INCREASED TREND TOWARDS LABOR FORCE PARTICIPATION OF WOMEN.

WHILE FAMILIES WERE ONCE ACTIVE AS "CARETAKERS", MANY HAVE ASSUMED THE ROLE OF A "CARESIFTER", THAT IS, THE FAMILY DETERMINES WHAT AMOUNT OF CARE THEY WILL PROVIDE TO A SENIOR BASED ON THE FAMILY'S NEEDS AND NOT NECESSARILY ON WHAT THE SENIOR NEEDS.

BECAUSE THE MEDICARE-MEDICAID SYSTEM IS NOT DESIGNED TO ASSIST FAMILIES IN CARING FOR ELDERLY AND DISABLED PERSONS, MORE FAMILIES HAVE BEEN FORCED TO ASSUME A "CARESIFTER" ROLE. THE IMPORTANCE OF THE TITLE XXI LEGISLATION IS ITS EMPHASIS TOWARDS HELPING THE FAMILY. UNDER TITLE XXI, THREE IMPORTANT NEW SERVICES HAVE BEEN ADDED:

(1) ADULT DAY SERVICES WOULD ENABLE FAMILIES TO TAKE A SENIOR LIVING WITH THEM AND UNABLE TO CARE FOR HIMSELF OR HERSELF TO AN ADULT DAY CENTER DURING THE WORK DAY. THIS TYPE OF SERVICE IS PARTICULARLY HELPFUL TO FAMILIES WHERE BOTH PARENTS WORK FULL-TIME, AND CANNOT CARE FOR SOMEONE DURING THE DAYTIME HOURS.

(2) RESPITE SERVICES WOULD ALLOW FAMILIES WHO ARE CARING FOR AN AGED OR DISABLED PERSON TO TAKE A VACATION OR LEAVE ON AN EMERGENCY. A TRAINED RESPITE WORKER WOULD COME INTO THEIR HOME AND CARE FOR SUCH INDIVIDUAL(S). AN IMPORTANT ASPECT OF A RESPITE SERVICE IS ANOTHER OLDER PERSON COULD BE TRAINED TO PERFORM SUCH SERVICES.

(3) $100 TAX CREDIT UNDER TITLE XXI IS GIVEN TO FAMILIES WHO CARE FOR DEPENDENT ELDERLY RELATIVES.

WHILE THESE THREE SERVICES WILL GREATLY ASSIST FAMILIES, I CAN NOT EMPHASIZE ENOUGH THE IMPORTANCE OF THE FAMILY ROLE. AS THE COMMITTEE CONDUCTS FURTHER HEARINGS ON S. 2809, WE MUST CAREFULLY EXAMINE THE ROLE OF THE FAMILY, PARTICULARLY SINCE IT HAS BEEN ESTIMATED THAT BETWEEN 60%-85% OF ALL IMPAIRED PERSONS ARE HELPED BY THE FAMILY IN A SIGNIFICANT WAY. BUT IT IS ALSO IMPORTANT THAT THIS COMMITTEE EXAMINE OTHER WAYS TO AIDE FAMILIES CARRYING FOR IMPAIRED PERSONS. SPECIFICALLY, WE MUST:

(1) EXAMINE THE PRESENT TAX SYSTEM TO DETERMINE WHERE POSSIBLE CHANGES COULD BE MADE TO HELP FAMILIES;

(2) BEGIN TO FORMULATE A POLICY POSITION ON WHAT IS A FAMILY'S RESPONSIBILITY AS A "CAREPROVIDER";

(3) ANALYZE THE IMPACT OF THE "AMERICANIZATION" PROCESS OF SUBSTITUTING PRIVATE RESPONSIBILITY WITH PUBLIC FUNDS.

(4) ASSESS THE WILLINGNESS OF FAMILIES TO CARE FOR SENIORS IN THEIR HOMES---TO HELP RELIEVE THE FINANCIAL PRESSURE ON PUBLIC PROGRAMS; AND

(5) ANALYZE THE FINANCIAL IMPACT OF INSTITUTIONALIZATION ON THE SPOUSE THAT CONITNUES TO BE AT HOME.

THE TIME HAS COME, FROM A HUMANE STANDPOINT, FROM A COST STANDPOINT, AND FROM A FAMILY STANDPOINT TO SEE WHETHER WE CAN TILT BACK TOWARD HELPING PEOPLE REMAIN IN THEIR HOMES, WHERE IT IS POSSIBLE. TITLE XXI WOULD PROVIDE THE KIND OF ANSWERS WE NEED TO BETTER MEET THE HEALTH NEEDS OF THE ELDERLY AND DISABLED.

OPENING REMARKS OF SENATOR SPARK MATSUNAGA
AT THE HEARING ON S. 2809, THE NONINSTITUTIONAL
LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED ACT,
IN THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE,
UNITED STATES SENATE

WEDNESDAY, AUGUST 27, 1980

As a co-sponsor of the bill, I am pleased that this hearing is being held by the Subcommittee on Health of the Committee on Finance to receive testimonies on S. 2809, the Noninstitutional Long-Term Care Services for the Elderly and Disabled Act, introduced by Senator Bob Packwood, a member of this Committee, and co-sponsored, besides myself, by Senators Bradley, Cochran, Cohen, Heinz, Javits, and Williams.

S. 2809 represents a new and innovative approach to making needed improvements in the delivery of non-institutional long-term care services provided by the Medicare and Medicaid programs. Its dual intent of improving the coordination of authorized long-term care services under Medicare, Medicaid, and Title XX of the Social Security Act, as well as preventing unnecessary and costly institutionalization of elderly and disabled citizens is a fundamental view which I believe is shared by all of us here today in this room.

With the prospect of having an estimated 32 million senior citizens in the country by the end of this century and an estimated 55 million senior citizens by the year 2030, the time has come to begin a careful and deliberate examination of the barriers which exist in the Medicare and Medicaid programs that can result in the placement of elderly and disabled persons in nursing homes and other institutional facilities, who with the appropriate services could otherwise remain at home for their care.

My own State of Hawaii has an elderly population today of about 74,000, or 7.8 percent of the State's population. Nationally, the population of aged 65 or older is 25 million, or about 11 percent of the total population. However, while the population of elderly in Hawaii is currently the lowest among all states, the current growth rate of Hawaii's elderly population is three times the national average. With its geographic insularity and the longest life expectancy of any state in the Nation (in fact one of the longest in the world), Hawaii faces a very significant long-term health care delivery problem in the not too distant future.

To their great credit, several major hospitals in Hawaii--Kuakini Medical Center, Queen's Medical Center, and St. Francis Hospital--have already begun significant

long-term care programs in anticipation of future needs in this area. Moreover, because the State cannot support extensive institutional facilities even in its acute health care delivery system, these three facilities have focused their efforts in long-term care precisely in the direction which is embodied in S. 2809. I anticipate receiving written testimonies from these facilities on S. 2809 and will have them inserted into the Subcommittee's hearing record.

I believe that S. 2809 represents a promising approach to the appropriate and efficient delivery of long-term care services for our Nation's elderly and disabled citizens. I am looking forward to hearing the testimony of the witnesses here today on this first of a series of hearings on proposals to improve long-term care services authorized by the Social Security Act.

Senator BRADLEY. I know that Senator Nelson wanted to make a statement at this time.

Senator NELSON. Mr. Chairman, I have another commitment right now. I will attempt to come back. I simply would like to say that on the second panel, Ms. Elizabeth Benson is here as a witness from the Wisconsin Community Care Organization, she has a lot of experience and expertise in this field, and I am delighted to welcome her here this morning.

I would ask the chairman, in order to economize on the time, that my statement be printed in full in the record at the appropriate place.

[The prepared statement of Senator Nelson follows:]

U.S. SENATOR GAYLORD NELSON
Opening Statement
Hearings on S. 2809 -- Long Term Care legislation
Room 2221, Dirksen Senate Office Building
9:00 a.m. August 27, 1980

Mr. Chairman, as a member of the Finance Committee and a cosponsor of S. 2809, the Long Term Care Act, I am very pleased that hearings on this important legislation have been scheduled today.

Without question, one of the most important areas of concern to older Americans is health care. More than any other group in our society, older people need and use medical, hospital and nursing home care.

Although the health and hospital insurance provided by Medicare and Medicaid has done much to reduce health care expenses for senior citizens, the scope of coverage provided by these programs, especially for long-term health and social care services, remains far less than what most older people need. Moreover, the health and hospital coverage that is available encourages institutionalization of our elder and disabled populations, rather than less expensive and more effective social and medical services to allow them to remain at home.

A recent study by the Library of Congress concluded that the current Medicare and Medicaid programs "fail to go beyond a limited home care approach in service delivery" and that "a comprehensive system of long-term health care services which are desperately needed to sustain older Americans in their own homes continues to be unavailable."

That's particularly unfortunate because all the studies indicate that access to home health care, adult day care, homemaker-home health aide services, respite care as well as services offered through a skilled nursing facility or an intermediate care facility make the difference between dignity and independence in one's own home and institutionalization.

This stark realization inevitably leads to the conclusion that a new long-term care policy must be adopted, a policy which addresses itself to the needs of our older and disabled populations. Statistics on our population clearly demonstrate the challenge confronting this country:

At the beginning of 1980, there were an estimated 25 million Americans over age 65 or 11 percent of the nation's population -- every ninth American. Future projections are that the number of older persons, as well as the number of persons over age 75, in the U.S. population will increase to record high levels as will the percentage of older people in our society. By the year 2000, for example, it is estimated that there will be 32 million older Americans.

In Wisconsin, there are approximately 550,000 individuals 65 years of age or older; 39 percent are over age 75. The Wisconsin Board on Aging predicts that there will be 630,000 people over 65 in the year 2,000 with 45 percent of them over age 75.

Right now, approximately 5 percent of persons age 65 and over reside in nursing homes. They comprise 85 percent of all residents of such institutions. Without any changes in present long-term care policies, upward of one half million new nursing home beds would be needed in just the next 20 years to accomodate the increasing elderly population.

But constructing new nursing home beds is not the right answer. Forcing our older and disabled citizens into nursing home and hospital facilities when they can remain in their own homes is a tragic waste of money and deprives them of their independence, self-reliance and in many cases their will to live. Senior citizens clearly prefer alternatives to nursing home placement, and the government has an obligation to make sure that alternatives are available.

The long-term health care bill before us today, S. 2809, would establish a comprehensive system of noninstitutional long-term care services on a demonstration basis in ten States. The services provided in this legislation would insure that senior citizens receive the social and medical services necessary to help them avoid placement in nursing homes or hospitals unless absolutely needed.

The legislation would require that a pre-admission screening assessment be made before a person could be institutionalized and would mandate that a variety of supportive services be available, including home health, homemaker-home health aide, adult day care, and respite care services.

The new pre-admission screening and admission provision will eliminate unnecessary services from being automatically provided to older persons and also will assist families in cutting through the confusing maze of procedural red-tape that now exists.

After the demonstration program is concluded in three years, the Comptroller General of the United States will conduct an evaluation and issue a report and a budgetary impact analysis by the Office of Management and Budget will be made. Thereafter, appropriate changes will be made in the long-term care program initiated in the ten States, and a universal long-term care program will be implemented throughout the remaining States. This approach will provide careful scrutiny of the initial long-term care program and result in an effective and carefully designed solution to the current hodge-podge of long-term care services.

In Wisconsin, the wisdom of the long-term care approach suggested in S. 2809 has been clear for some time now. An expert witness from Wisconsin on this subject, Ms. Elizabeth Benson, will testify this morning on Wisconsin's experience. Ms. Benson has an extensive background with community-based long-term care, most recently as Director of the Wisconsin Community Care Organization (CCO).

The Community Care Organization was initiated in 1974 as a demonstration project to forestall where practical institutionalization of the aged and disabled. It provided a system of managed home care for clients who had, through an assessment process, been determined to be in need of in-home services. This successful program was similar in many ways to the demonstration program the legislation before us, S. 2809, would establish. Although the funding for CCO expired, I understand that the clients who were served by the program have continued to receive services through a combination of State and federal resources.

I want to personally welcome Ms. Benson to the Committee this morning knowing that her testimony will be helpful to the Committee.

Senator BRADLEY. Thank you, Senator Nelson.

When Senator Matsunaga comes, he will be chairing the hearings. In his absence, I will get the hearings started. I think we might as well begin with the first panel, which is composed of Keith Putman, Oregon Adult and Family Services, Department of Human Resources, State of Oregon; Charlotte C. Carnes, social work consultant, nursing home preadmission screening program, Virginia State Department of Health; and Constance Azzi, director, New Hampshire Foundation for Medical Care.

Would those three individuals please come forward to testify?

Senator PACKWOOD. While the witnesses are coming forward, Mr. Chairman, I might particularly welcome Keith Putman. He was a fraternity brother of mine in college, a longtime friend, and even in those days he was a rock of stability in the fraternity, and I would say that he has become probably Oregon's outstanding public administrator in any division of government. I am delighted to have him here.

Senator BRADLEY. I would like to welcome all three witnesses to the committee, and acquaint you briefly with the committee procedures. We abide by a 10-minute rule here, which allows 10 minutes for your oral presentation. I hope that you will abide by that. Certainly your full statement can be submitted to the record, and will be made a part of the record in full.

Let's begin with Mr. Putman.

STATEMENT OF KEITH PUTMAN, OREGON ADULT AND FAMILY SERVICES, DEPARTMENT OF HUMAN RESOURCES, STATE OF OREGON

Mr. PUTMAN. Thank you, Senator.

Let me express my great appreciation to Senator Packwood for his very kind comments. I don't recall that his opinion of my stability, while we were fraternity brothers, was such as it is now, but I thank you, Senator, for those kind comments.

In Oregon, we believe the concepts of this bill are very valuable and should be very seriously considered. I am here primarily to offer a few statistics on the value of it, and offer some suggestions which would further the objectives of the bill, which I see as being those of avoiding unnecessary or unneeded institutional care.

Our agency, since February of 1980, has been conducting a preadmission screening program very similar to that contemplated in

your title XXI. We first began operating it in Lane County, which is a metropolitan area consisting of two large cities and a rural area surrounding it. We have slowly begun expanding the project elsewhere in the State, and we hope to be statewide within the next year.

Our program includes title XIX which is the medicaid program, and title XX which is the social services program. We also cover people who are bound to go into nursing homes who are likely to become eligible for title XIX within the next 90 days. The reason for that, of course, is to try to prevent people from going into a nursing home who do not need to, who are not yet eligible for welfare, but would become so once they got in.

Our experience indicates that we should also screen title XVIII patients because they, too, can lose their XVIII benefits and still be in the nursing home.

We believe that the screening of all nursing home facility admissions would be extremely beneficial. But in order for the program to be fully effective, we need a larger array of community services and support services than those that are currently listed in S. 2809.

Those additional services need not be more expensive. For example, a housekeeper could provide nonmedical chore services, rather than using the more expensive services of a trained homemaker under a physician's direction, or under the auspices of the Home Health Agency.

Another such example would be using nonmedical institutional care, such as adult foster care, which when properly augmented with medical type services can keep people out of the more expensive nursing homes.

Oregon developed its program because of a perceived need to provide better and earlier identification of persons who needed only short-term nursing facility services, and we wanted to also divert persons in long-term care facilities whenever a lower level of care was possible in the community.

I might add, although it is not in my written comments, that conversations within the last few days seem to indicate to us that the major cost savings feature of this program is in shortening the nursing home stays rather than in the diversions, though I think in diverting people out of nursing homes, you will also save money in the short run.

I think, too, when I use the word "savings," I wish to be understood not only as talking about money, but savings in human misery, in dealing with people in circumstances other than that which gives them the greatest satisfaction.

Let me give you an example of some of the earlier results from Lane County. Of the first 281 screens, which we did from the first of March to the end of July, 50 people who were otherwise bound to go into nursing homes did not go. An additional 48 were identified as needing care for less than 90 days. That is nearly a third of those people who might otherwise have been long-term nursing facility patients. We think that those statistics speak for themselves.

Our PAS Team, preadmission screening, includes a master's degree social worker and a registered nurse. Supporting that team

is a case manager. Medical personnel are available to the team as needed.

There are serious barriers to our PAS program—primarily a lack of a full range of community services available to meet the needs of patients who would be diverted from institutional care. It does not matter much that a person could be served in an adult foster home if none exist. We believe that this handicap results from two primary reasons.

First, the Federal funding for title XX has been under a ceiling which has not kept pace with either inflation or the potential for using title XX services in lieu of title XIX. The people in the Federal title XIX agency seem to be not the least bit interested in saving total Federal dollars, but rather in saving only title XIX dollars. This has kept funding low, and has impeded the growth of community based care.

Prior to the existence of title XX, when we had other funding sources, most of our funding went into children services. Federal matching was available at 75 percent without imposing any ceilings, but in those days nursing homes and other institutional care did not make up nearly as large a portion of a typical State budget as is now the case.

In the last few years nursing home costs have skyrocketed. Social services funding has not been available anywhere nearly to the same extent.

The second cause of the barriers is that the laws, rules and regulations of the medicaid program are heavily biased toward the provision of institutional care. Let me give you just one example, and there is correspondence attached to my written testimony to back this up.

In May we wrote to our Federal regional office pointing out the existence of several families who were caring for severely, profoundly disabled children in their own home. We asked for an amendment to our title XIX plan to allow for provision of care to those children in their own home. Because of the parents' income and various regulations, we could not get the plan amendment. But these same children, if they were but to leave their home and enter an institution, were instantly eligible at a far, far greater cost. Title XXI would help to get rid of that kind of a problem.

It is for those reasons that we are encouraged to see a major thrust in this bill, which is to provide alternatives to institutional care, and not for just medicaid eligibles but for the broad range of individuals you have in your bill.

We are also in favor of the concept of testing this program rather than jumping right into it. We are also in favor of the revisions of policy concerning home health agencies, which we think should make their services less costly in the long-run.

We think the bill could be strengthened in a number of ways. One of the main problems that we see in the bill currently is that PAT teams are not linked to the State medicaid agency. We have found through many years of experience that if a problem exists, and in this case the problem is one of runaway institutional costs, the financial resources to address that problem should be with the agency that is responsible for solving it.

What I am really saying is, if the responsibility for keeping people out of nursing homes is placed with someone else, and my agency still has the responsibility for paying nursing home costs, I pay the penalty for lack of performance by the other agency.

I think it makes good sense to combine into one unit the entire continuum of care rather than to snip it in segments as is currently being done with title XX and title XIX, and which is only partially remedied by your title XXI, which we think could be remedied more completely.

We think that that remedy also lies in the area of allowing for funding for a larger array of services which are not in the medical model. I mentioned already such things as housekeeper services, and nonmedical substitute homes services. What I am really saying is, take that whole continuum of care and put it under one single umbrella, so performance over the whole continuum is easily identified as to who is responsible for it.

We would emphasize that our problem, at least in Oregon, has been one of developing alternatives to nursing home care because of the way the title XX funding structure is set up, and we believe that if title XIX funds were available to save medical dollars, even though it were not for medical services, the objectives of this bill would be furthered.

Thank you, Mr. Chairman.

Senator BRADLEY. Thank you, Mr. Putman.

Ms. Carnes.

STATEMENT OF CHARLOTTE C. CARNES, SOCIAL WORK CONSULTANT, NURSING HOME PREADMISSION SCREENING PROGRAM, VIRGINIA STATE DEPARTMENT OF HEALTH

Ms. CARNES. Thank you, Mr. Chairman.

We are particularly pleased to have been invited to appear before you today to relate our experience with the Virginia nursing home preadmission screening program.

I will, in very short order, look at the program purpose, the program policy and procedures, the results that we have of the program, and some of the barriers to implementation and development of the program, all of this based on the Virginia experience. I did not come here to comment on the bill that has been proposed.

On May 15, 1977, the Virginia medical assistance program, Medicaid, of the Virginia Department of Health implemented the nursing home preadmission screening program.

The purpose of the program was to delay or avoid unwanted and/or inappropriate nursing home placements through the use of interdisciplinary team approach and the mobilization of community resources.

A second purpose of the preadmission screening program was to identify services required in the community to meet the needs of elderly and disabled persons.

As far as the program policy and procedure, the Virginia program is relatively inexpensive yet incorporates many of the advantages of the multidisciplinary team approach. The program has several features which distinguish it from most other multidisciplinary team efforts.

First, it is a statewide program, with local screening committees responsible for local areas. The local committees are comprised of a public health physician, a public health nurse, and an adult services social worker drawn from the local social service department. These persons perform their screening duties in addition to other agency assignments.

Second, while many committee members have received at least some specialized training in long-term care assessment, few have been formally educated in geriatrics or gerontology.

Finally, the program is based on the mobilization and utilization of existing community services.

The committees screen those applicants for nursing home admission who are not in a community hospital or another nursing home at the time of nursing home application and who are already Medicaid eligible or who will become Medicaid eligible within 90 days subsequent to nursing home admission.

Preadmission screening is a part of Virginia's admission certification requirement, and Medicaid payment for nursing home care will not be made without the preadmission screening committee approval.

The Virginia preadmission screening approach is based on the importance of individual needs and the exploration of available community services to meet those needs. Therefore, local screening committees are expected to:

One, evaluate the medical, nursing and social conditions of the applicants;

Two, decide what services are required;

Three, determine whether necessary services are available in the community;

Four, make placement recommendations; and

Five, refer the applicant to any of the required community services.

In reaching a decision, the committees are required to take into account the total person including social, medical, and emotional factors as well as available formal and informal support systems.

If we could look briefly now at program results. During the first 3 years, 6,259 screenings statewide have been conducted by the local committees; 1,247 or 20 percent have been found able to remain in the community.

At this time, definitive data on cost savings are not available. At present no one can conclusively prove cost savings in every case, empirically yes, perhaps, but cost savings must be subjected to scholarly research. However, we can make a reasonable projection of estimated cost savings using figures from the GAO study on home health care, and our best estimate of intermediate nursing home care in Virginia.

Home Health Services, of course, do not include such services as chore, companion, homemaker and day care services. If the cost of intermediate care in Virginia averages about $32.05 a day, a monthly estimate of expenditures for this care would be $960 per month. This is based on $32 a day with a 30-day month.

The GAO study estimates that there is a break-even point, depending on the person's level of impairment, after which home

health care costs exceed institutional costs. The cost of providing care in the home at this level is approximately $400 per month.

Therefore, if an individual could use home health services, instead of ICF services, possible savings of $560 per patient per month could be realized. If we apply this to the results of the first three years of the Virginia program, maintaining 1,247 individuals in the community would save the State $698,320 per month, or approximately $8.4 million over a 3-year period.

While these figures are by no means firm and represent only projections, they do indicate potential savings that could be realized from preadmission screening programs such as Virginia's.

Benefits in terms of social values are more immediately visible. Wherever possible, disabled and elderly persons are not uprooted from their homes and communities and placed in institutional settings. Inappropriate and often unwanted nursing home placements have been delayed or avoided through use of community resources.

We have contributed to the well-being of our elderly and disabled recipients and we will continue to help them maintain their self-esteem. We believe this can be accomplished only if they remain part of, and feel they are contributing to the community, instead of being dependent upon it.

The screening program thus supports directly our goal of assuring the dignity and rights of the elderly and disabled. The emphasis placed on the human factor and the need for support and communication with other agencies is key to the program's success.

A 2-year study of the preadmission program is currently being conducted by the Virginia Commonwealth University's Center on Aging. This study is funded by the Administration on Aging and will specifically address the issue of cost as it relates to preadmission screening and community services versus institutional services.

As to the barriers to implementation and development of a preadmission screening program, there are four potential critical barriers that we have realized in Virginia. These are:

One, receiving support and cooperation from other agencies and organizations;

Two, securing staff to conduct the evaluations;

Three, the availability of community services;

Four, inclusion of the acute care population in the program.

In Virginia, we have been fortunate in having the continued enthusiastic support of the Commonwealth of Virginia's Secretary of Human Resources, the Virginia Office on Aging, the State department of welfare, the State department of mental health/mental retardation, the Virginia Health Care Association, and the Virginia Commission on the Needs of Elderly Virginians.

Further, the program was initiated and has continued without the addition of staff at the local level. Lastly, the program has delayed and/or avoided nursing home placement in 20 percent of the cases screened without expanding or creating new services.

While we believe that the program thus far has been successful in delaying or avoiding unwanted and/or inappropriate nursing home placements, we have realized a critical barrier to further development of the program.

69-362 O - 81 - 5

This barrier has been the expansion of the program to include screening of acute care patients who are at risk of nursing home placement. This barrier has seemingly developed for several reasons:

One, hospitals believe that the preadmission screening program will serve to negate the role and function of the discharge planner;

Two, philosophically, hospitals have traditionally viewed themselves as self-contained and have not been totally integrated with the community services system;

Three, communication between the community and the hospital systems has not been totally satisfactory; and

Four, we—we meaning the State department of health—did not involve hospitals in the initial discussions and planning phases of the preadmission screening program.

As a result of our unsuccessful attempt to include screenings of acute care facility patients, a preadmission screening program planning committee has been established, and includes representatives from various agencies and organizations directly or indirectly involved with long term care.

Senator MATSUNAGA. Thank you very much.

Are there any questions? Since you are from Oregon, Mr. Putman, I will give the Senator from Oregon the first opportunity to ask questions.

Senator PACKWOOD. I thought that we would wait until we had heard from the next panelist. We have heard from the first two, and if we would take the third one, then I do have some questions.

Senator MATSUNAGA. Then, we shall hear from Ms. Constance Azzi.

STATEMENT OF CONSTANCE AZZI, DIRECTOR, NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE

Ms. AZZI. Thank you, Mr. Chairman.

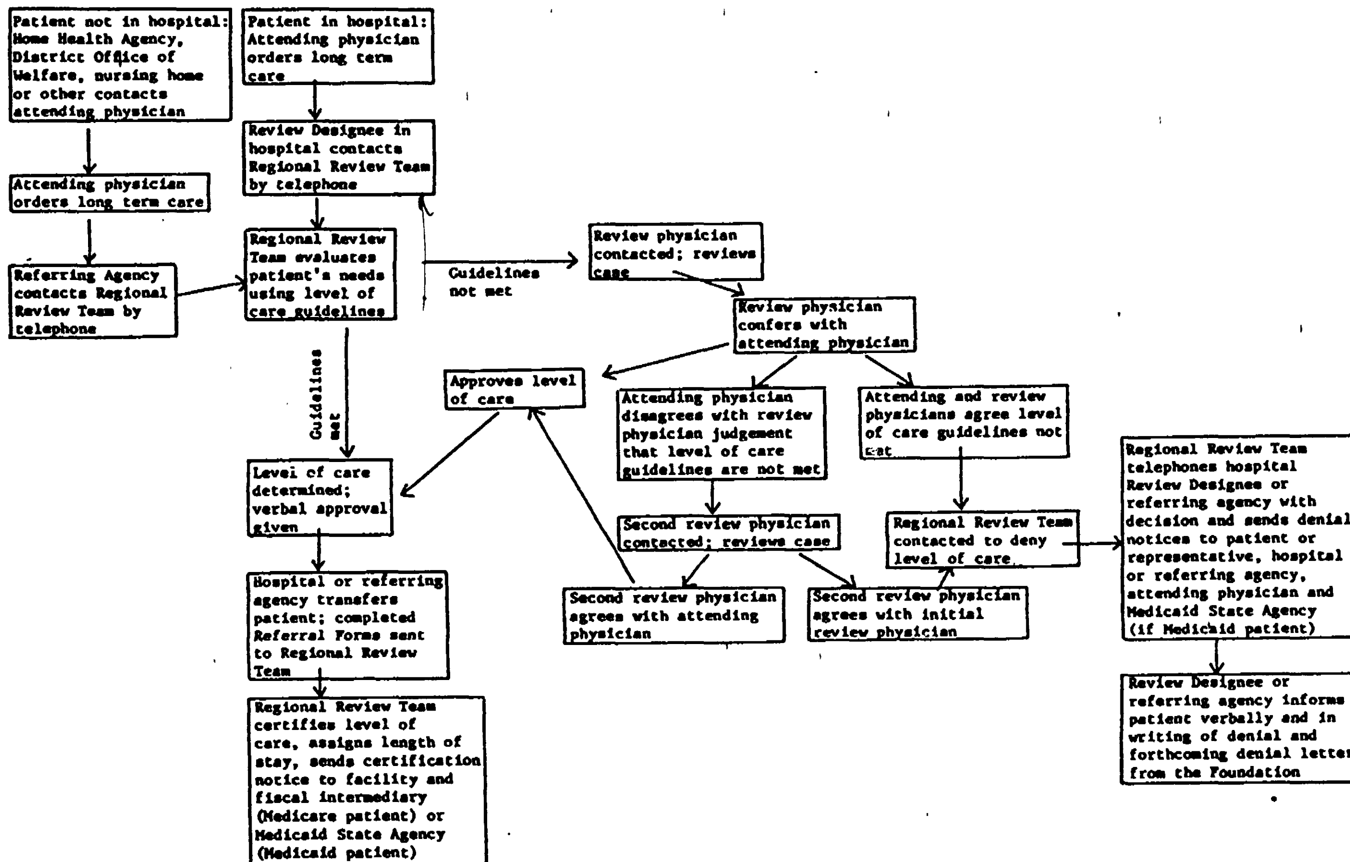
I appreciate the opportunity to describe our experience in long term preadmission review as it applies to S.2809.

Although our experience is in the institutional arena we feel that the same concepts apply to noninstitutional care. Our experience is respectfully offered as it may be applicable to the preadmission screening and assessment team concept addressed in S. 2809.

The New Hampshire Foundation for Medical Care has been involved in conducting preadmission screening and assessment of persons prior to entering nursing homes for 2½ years. A flow chart of the preadmission review process is included as appendix A.

[Appendix A follows:]

PRE-ADMISSION REVIEW PROCESS



NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE

APPENDIX A

Nonbinding review began on January 16, 1978, in one region of the State of New Hampshire. Full and binding review statewide was begun on May 15, 1978. It took approximately 6 months to become fully operational statewide.

Included in my text are numbers which I will not read now in order to maintain the 10-minute time period.

Although we are able to report the number of persons who did not enter a nursing home, under medicare and medicaid guidelines, because of our preadmission review process, we have not captured the information on the disposition of these persons and, therefore, are unable to report it.

A special mention of the effect of preadmission review is in order. The preadmission review process has a validating effect on the reliability of the awaiting placement hospital data. For example, the New Hampshire Foundation has identified that for the period July 1, 1979, through March 31, 1980, there were 8,473 days in hospitals awaiting skilled nursing facility beds and 8,658 days in hospitals awaiting intermediate care facility beds in New Hampshire.

Using the same dollars that were used for our 1979 long term care impact statement we can, therefore, calculate that if beds at the appropriate level of care had been available $1,030,635 of unnecessary expense could have been avoided. Appendix B shows our calculations. This conclusion can be drawn because the long term care preadmission review process is used to validate the hospital information.

Preadmission screening and assessment is the key to continuity of care. A note of caution is in order. An accurate assessment of a patient's needs, which our experience shows can be accomplished through preadmission review, does not make the necessary resources available.

Our experience has indicated that PSRO's conducting both acute and long term care review are in a unique position to assume the role of the preadmission screening and assessment team because PSRO's have already demonstrated capability to accomplish what is described in Senate bill 2809.

If the New Hampshire foundation's program of preadmission screening did not exist, some patients whose condition actually did not meet the level of care guidelines would be admitted to skilled nursing facilities and intermediate care facilities under titles XVIII and XIX. This would result in increased program cost and possible subsequent denial of the patient's stay in the facility because the patient's condition did not meet the level of care guidelines.

As an example, prior to the New Hampshire foundation conducting PSRO preadmission review, facilities made decisions about whether to accept patients. The patient would be admitted to the nursing home, and then medicare or medicaid would authorize or deny the level of care. The ramifications included unnecessary movement of the patient and unnecessary expenditures. In addition, as previously noted, if the preadmission review were not in place, the link to the hospital data and the validation of awaiting placement days would not occur.

The PSRO screens only Title XVIII and XIX eligible patients. However, if all prospective admissions to nursing homes, inclusive

of private pay patients, were to undergo the same comprehensive screening and assessment that would now apply to medicare and medicaid patients, we believe the following effects would occur:

(*a*) Assurance that the person is aware of alternatives to nursing home placement, allowing the person to live in a less restrictive and less costly manner;

(*b*) determination whether all persons regardless of pay source actually need the level of care provided in the long term care facility;

(*c*) avoidance of the present two-class by pay source system;

(*d*) accrual of needed data for State health planning;

(*e*) uniform utilization control.

It is our experience that private pay elderly persons are often placed in nursing homes prematurely. The PSRO is then requested to review persons currently in a nursing home because their personal funds are exhausted, and they are requesting level of care certification under the medicaid program.

Some of the preadmission denials noted for medicaid reflect persons who were referred for level of care certification as their personal funds were becoming exhausted. It is the impression of our team performing review that many of the persons whom they visit in nursing homes would have preferred to remain in their own homes if community health resources had been available to permit this.

The New Hampshire foundation uses a multidisciplinary review team. Our team conducts a thorough evaluation of each individual's health status and functional capabilities. Elements of this evaluation are detailed in appendix C.

[App. C follows:]

NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE

APPENDIX C. REFERRAL FORM Page 1

PATIENT INFORMATION
NAME ____________________

ADDRESS No & Street ____________________
City ____________________
Zip Code __________ Telephone __________

MEDICARE NO.	MEDICAID NO.	OTHER INS.

DATE OF BIRTH	MARITAL STATUS	SEX	RELIGION

RESPONSIBLE PERSON RELATIONSHIP TO PATIENT
NAME ____________________

ADDRESS No. & Street ____________________
City ____________________
Zip Code __________ Telephone __________
SEND NOTICES TO ☐ PATIENT ☐ RESPONSIBLE PERSON

PROVIDER INFORMATION (CURRENT LOCATION)

FACILITY NAME ____________________

DATE ADMITTED	DATE TRANSFERRED	TRANSFERRED BY
/ /	/ /	☐ Car ☐ Amb.

TRANSFERRED TO:
☐ SNF ☐ ICF ☐ HOSPITAL ☐ HHA ☐ OTHER

FACILITY TRANSFERRED TO:
NAME ____________________

ADDRESS No. & Street ____________________
City ____________________
Zip Code __________ Telephone __________

ATTENDING PHYSICIAN ____________________

PATIENT PROBLEMS & PLAN OF CARE:

FUNCTIONAL STATUS	INDEP.	W/ASSIST.	UNABLE TO DO
BATHING			
TOILETING			
EATING			
DRESSING			
MOBILITY.			
Transfers			
Walking			
Wheelchair			
Stair Climbing			

MENTAL STATUS	NEVER	SOMETIMES	ALWAYS
ORIENTED			
DEPRESSED			
WANDERS			
AGGRESSIVE			

IMPAIRMENTS	NONE	PARTIAL	TOTAL
VISION			
SPEECH			
HEARING			
LOSS of SENSATION			
DENTITION			

PATIENT USES: ☐ GLASSES ☐ HEARING AID ☐ CANE ☐ WHEELCHAIR ☐ PROSTHESIS ☐ CRUTCHES ☐ WALKER ☐ DENTURES

DISABILITIES	NONE	PARTIAL	TOTAL	LOCATION
PARALYSIS				
CONTRACTURE				
AMPUTATION				
JOINT MOTION				
FRACTURE				

BOWEL FUNCTION: ☐ No Problem ☐ Incont. ☐ Colostomy
BLADDER FUNCTION: ☐ No Problem ☐ Incont. ☐ Catheter

SOCIAL SERVICES:

SIGNATURE ____________________ DATE __________

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NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE

REFERRAL FORM – PHYSICIAN REPORT & ORDERS

Page 2

PATIENT NAME: MEDICARE NO.

PHYSICIAN IN CHARGE AT TIME OF TRANSFER

NAME: ______ TEL. ______

FOLLOW-UP PHYSICIAN ______ TEL. ______

DIAGNOSIS:
PRIMARY
SECONDARY:
1.
2.
3.
4.
5.

ALLERGIES

SURGICAL or ORTHOPEDIC PROCEDURES PERFORMED:
PROCEDURE: DATE:

ADDITIONAL IMPORTANT CLINICAL INFORMATION AT TIME OF TRANSFER:

REHABILITATION GOALS:

NURSING CARE NEEDS:
TYPE FREQUENCY
☐ DECUBITUS CARE
☐ STERILE DRESSING
☐ IRRIGATIONS
☐ TUBE FEEDING
☐ BOWEL ☐ BLADDER TRAINING
☐ PARENTERAL FLUIDS/MEDS
☐ PATIENT/FAMILY EDUCATION
☐ RESTRAINTS
☐ OTHER

PHYSICAL THERAPY MODALITY FREQUENCY
☐ EVALUATION
☐ HEAT
☐ EXERCISE
☐ GAIT TRAINING
☐ WEIGHT BEARING
☐ OTHER

OCCUPATIONAL THERAPY FREQUENCY
☐ ADL
☐ PERCEPTUAL EVALUATION
☐ OTHER

SPEECH THERAPY FREQUENCY
☐ YES ☐ NO

DIET ☐ REGULAR ☐ THERAPEUTIC. SPECIFY
COUNSELLING ☐ YES ☐ NO

☐ HOME HEALTH SERVICES NECESSARY ON AN INTERMITTENT BASIS – PATIENT HOMEBOUND
☐ NURSING ☐ OCCUPATIONAL THERAPY
☐ AIDE ☐ SPEECH THERAPY
☐ PHYSICAL THERAPY ☐ OTHER

CARE ESTIMATED MEDICALLY NECESSARY
SNF ______ WEEKS OR ______ MONTHS
ICF ______ WEEKS OR ______ MONTHS
HHA ______ WEEKS OR ______ MONTHS

PHYSICIAN PLAN OF CARE:

CERTIFICATION: I CERTIFY THAT THE CARE PRESCRIBED IS MEDICALLY NECESSARY FOR PROPER CARE OF THE PATIENT.

PHYSICIAN'S SIGNATURE ______, M.D. DATE ______

VERBAL APPROVAL ☐ YES ☐ NO DATE ______ BY ______

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NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE

PATIENT ASSESSMENT FORM Page 1

I. BASIC DATA:

DATE THIS ASSESSMENT: ______

PROVIDER NAME: ______ NO. ______

PATIENT NAME: ______ SEX ______

PATIENT ID: ______ OTHER INS. ______

DATE OF BIRTH __/__/__ DATE OF ADM. __/__/__ TOTAL DAYS STAY TO DATE ______

PURPOSE OF REVIEW ☐ SNF CSR ☐ ICF CSR

PHYSICIAN SERVICES. PHYS. # ______

ATTENDING: ______

DATE LAST VISIT ______

DATE LAST SIGNED PROGRESS NOTE ______

CONSULTING: ☐ YES ☐ NO

TYPE ______ DATE ______

II. DIAGNOSIS:

PRIMARY: ______

SECONDARY: ______

III. PROBLEM IDENTIFICATION:

FUNCTIONAL STATUS	IND.	ASSIST DEVICE	ASSIST PERSON	ASSIST BOTH	UNABLE
1. ADL					
Bathing					
Dressing					
Toileting					
Eating					
2. MOBILITY					
Transfers					
Wheeling					
Walking					
Stair Climbing					

3. BOWEL HABITS: ☐ NO PROBLEM ☐ INCONT. ☐ COLOSTOMY
BLADDER CONTROL: ☐ NO PROBLEM ☐ INCONT. ☐ CATHETER

4. IMPAIRMENTS: 1. NONE 2. PARTIAL 3. TOTAL
☐ VISION ☐ SPEECH ☐ HEARING
☐ LOSS OF SENSATION ☐ DENTITIAN

5. PATIENT USES: ☐ GLASSES ☐ HEARING AID
☐ DENTURES ☐ WHEELCHAIR ☐ WALKER
☐ CANE ☐ PROSTHESIS ☐ CRUTCHES

6. VITAL SIGNS & WEIGHT: Give latest recorded vital signs & weight
1. NO PROBLEM
2. INCREASE
3. DECREASE
4. UNSTABLE

T	P	R	S BP	D BP	WEIGHT

7. MENTAL STATUS: 1. NEVER 2. SOMETIMES 3. ALWAYS
☐ ORIENTED ☐ DEPRESSED ☐ WANDERING
☐ AGGRESSIVE

8. SOCIABILITY/ACTIVITY PARTICIPATION
1. ACTIVE PARTICIPATION
2. PASSIVE PARTICIPATION
3. NEVER PARTICIPATES
☐ SEDENTARY ACTIVITIES ☐ ARTS/CRAFTS
☐ RELIGIOUS ☐ PHYSICAL ☐ SOCIAL

9. DECUBITI Number ______

	DECUBITUS STAGE SUP.	MED.	SEV.	CONDITION IMP.	NOT IMP.	DETER.
1.						
2.						
3.						

PLAN OF CARE ______

10. PLAN OF CARE—OTHER WOUNDS ______

IV. REHABILITATIVE SERVICES:

	SPEC. MOD.	FREQ. qd	FREQ. 2-3x	RESULTS IMP.	NO IMP.	DETER.
PT						
HEAT						
EXERCISE						
GAIT TRNG.						
WHIRLPOOL						
OTHER						
OT-ADL						
PERCP. EVAL						
OTHER						
SPEECH THER.						

PROGRESS REPORT BY THERAPIST:

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NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE

PATIENT ASSESSMENT FORM

PATIENT NAME: NO

V. NURSING SERVICE: CHECK WHERE APPROPRIATE

- ☐ ROM
- ☐ BLADDER TRAINING
- ☐ BOWEL TRAINING
- ☐ REALITY ORIENTATION
- ☐ SPECIAL SKIN CARE
- ☐ DECUBITUS CARE
- ☐ TUBE FEEDING
- ☐ PARENTERAL FLUIDS/MEDS
- ☐ MEDICATION REG
- ☐ INTAKE & OUTPUT
- ☐ ISOLATION
- ☐ VITAL SIGNS MONITOR
- ☐ STERILE TRACH CARE
- ☐ SUCTIONING
- ☐ STERILE DRESSING
- ☐ RESPIRATORY THERAPY
- ☐ OSTOMY TEACHING
- ☐ HEAT TREATMENTS
- ☐ FOLEY CATHETER CARE AND IRRIGATION
- ☐ PATIENT/FAMILY EDUCATION
- ☐ WOUND IRRIGATION
- ☐ OVERALL MANAGEMENT

VI. RESTRAINTS: ☐ SAFETY ☐ BEHAVIOR MODIFICATION
1 PHYSICAL 2. CHEMICAL 3 COMBINED 4. OTHER

VII. DIET: ☐ REGULAR ☐ THERAPEUTIC
DIET COUNSELLING ☐ YES ☐ NO

VIII. PREVENTATIVE/SCREENING PROCEDURES SINCE LAST ASSESSMENT (i.e., LAB, X-RAY, SPEC TESTS, ETC) WITH RESULTS ______

IX. PATIENT STATUS
☐ 1 IMPROVING 2. STABLE 3 UNSTABLE 4 DETERIORATING 5 CRITICAL 6 TERMINAL

X. REHABILITATION POTENTIAL:
☐ 1. OPTIMAL 2 MODERATE 3 SLIGHT 4 NONE

XI. DISCHARGE PLANS: DATE OF LAST DOCUMENTATION ON RECORD ______
☐ 1. HOME 2. HOME/HHA/HOMEMAKER 3 HOME/OPD 4. SHELT. HOME 5 SNF 6 ICF 7. OTHER

XII. SIGNIFICANT MEDICATIONS:

	MEDICATION	DOSE	FREQ	ROUTE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

COMPLICATIONS OR PROBLEMS ______

XIII. DRUG REVIEW RESULTS:
☐ ALLERGY ☐ INTERACTIONS ☐ TOXICITY
☐ 2+ MEDS WITH SAME Rx EFFECT

XIV. ADDITIONAL COMMENTS: ______

FACILITY REVIEW DESIGNEE: I CERTIFY THAT TO THE BEST OF MY PROFESSIONAL JUDGMENT THE INFORMATION ON THIS FORM IS A TRUE PATIENT ASSESSMENT AND PLAN OF CARE AND IS DOCUMENTED IN THE MEDICAL RECORD

SIGNATURE ______ DATE ______

XV. FOUNDATION REVIEW ☐ ON-SITE ☐ PAPER
REVIEW COORDINATOR SIGNATURE ______ DATE ______
CERTIFIED LOC ☐ SNF ☐ ICF LOS ASSIGNED FROM ______ THROUGH ______
PHYSICIAN REFERRAL DATE ______
1st PHYSICIAN ______ DATE ______ ☐ CERT ☐ DENIED
2nd PHYSICIAN ______ DATE ______ ☐ CERT ☐ DENIED
GRACE PERIOD ASSIGNED ______
REASON

LTC-PAF 6/78

Our review teams are comprised of physicians, registered nurses, social workers, and consultants such as registered physical therapists, registered pharmacists, and occupational therapists who can be called upon as needed for patient assessment and discussion of problems related to care provided.

The consultants are not employed full time since to keep a full time complement of consultants would be unnecessarily expensive. In addition, the Foundation works with the medicare designated ombudsperson. The PSRO, therefore, is using the full complement of health care professionals defined as the preadmission screening and assessment team in S. 2809.

For a PSRO there are variety of role perceptions. The reality is that PSRO's are nonprofit organizations of physicians incorporated for the purpose of assuring quality care. Whatever the legal derivation of the PSRO, the PSRO has a quasi-regulatory function that in the eye of the beholder, such as nursing homes, is often viewed as a solely cost containment function.

Under the present system, we do not calculate per unit costs for each assessment visit. Such a unit cost is of course dependent on the variable mix of elements which comprise the assessment and may be different depending on each patient's specific needs or may even be different between like programs.

There are applicable models in econometrics that can be applied but only if there is a clear understanding that there are variables between programs and variables within individual applications of the preadmission review process.

The foundation, under the existing medicare and medicaid guidelines, has insured that persons are not placed unnecessarily in nursing homes. Further than this, however, the foundation has taken the initiative to develop standards of care.

Since our authority is for the assurance of quality, we have convened 1 year ago a standards of care task force composed of the various agencies and professional personnel involved in long term care.

We have developed standards of care in New Hampshire for restraint use and for the treatment of decubitus ulcer. We are presently working on a comprehensive annual assessment and have scheduled development of other standards of care to be used statewide.

Thank you again for the opportunity to provide information about preadmission assessment and screening to the committee.

[The prepared statements of the preceding panel follow:]

TESTIMONY OF KEITH PUTMAN

Administrator, Oregon Division of Adult and Family Services

COMMITTEE ON FINANCE

Senate Bill 2809

Mr. Chairman, members of the Committee:

I am Keith Putman, Administrator of the Adult and Family Services Division for the State of Oregon. We administer both Title XIX and XX Programs. We appreciate the opportunity to provide testimony regarding Senate Bill 2809.

We believe the concepts behind this bill are valuable and should be seriously considered. We also would like to offer suggestions which we believe will further the objective of avoiding unneeded institutional care.

Our Division has, since February of 1980, conducted a Pre-Admission Screening project (PAS) similar to that contemplated in the proposed Title XXI. We first began operating the project in one geographic area (Lane County) and have slowly been expanding the project through the state. We began Pre-Admission Screening in Multnomah County, the most populous area in the state, on August 1 of this year. We expect the program to become fully operational statewide by next February or March. Our program includes, Title XIX (Medicaid), eligible persons, and those who can be expected to become Title XIX eligible within 90 days. We also provide screening to other persons at their request.

Our early experience indicates that there is a need to screen Title XVIII (Medicare) eligibles also. Many of those persons subsequently

become eligible for Medicaid. We feel that PAS screening of Title XVIII individuals might have provided a diversion or earlier planning toward community placement. The screening of all nursing facility admissions would be extremely beneficial, but in order for the program to become fully effective, a larger array of the community resources and support services of the types contemplated under Senate Bill 2809 are needed. Those other services need not be more expensive services. For example, a housekeeper can provide needed non-medical chore services rather than using the services of a trained homemaker under a physician's direction.

Oregon developed its PAS program because it perceived a need to provide better and earlier identification of persons who need only short-term nursing facility services. We also wanted to divert persons in long-term care facilities including skilled and intermediate nursing facilities and hospitals to community base care whenever a lower level of care was more appropriate.

Two hundred eighty-one screenings occurred in Lane County between February 26, 1980 and July 30, 1980. Of this number, 50 persons were identified for diversion from institutional facilities to community base services. An additional 48 persons were identified as needing nursing facility services for 90 days or less. These statistics speak for themselves. Our PAS Team includes a Masters Degree Social

Worker and a Registered Nurse. Supporting the team is an Adult Service Worker (Case Manager) who is responsible for implementing and monitoring the plan for the patient. Another worker who deals mainly with cash assistance is responsible for establishing and maintaining financial eligibility. Funding for the program has come through Title XIX, Title XX (Social Services) and State General Funds.

The most serious barrier to success in the PAS program has been the lack of a full-range of community resources available to meet the needs of patients who could be diverted from institutional care into lower levels of care. This handicap exists for two primary reasons:

1. Federally matched funding for Social Services under Title XX are placed under a ceiling which has not kept pace with either inflation, or with the potential for using Title XX services in lieu of Title XIX services. This has kept funding low and has impeded the growth of community based programs. Prior to the existence of Title XX when Social Services were funded through Title IV-A of the Social Security Act the bulk of funds went to provide children's services. Federal matching was available at the 75% level without any imposition of a ceiling. In those days, nursing home and other institutional care costs did not make up such a large portion of a typical state human services agency's budget. However, in the past six to eight years nursing home costs have skyrocketed. In the meantime,

we have had to operate our Social Services Programs with proportionately less federal money and more state money.

2. The laws, rules and regulations governing the Medicaid Program (Title XIX) are heavily biased toward the provision of institutional care with very few opportunities to provide alternatives to that type of care. I have attached two peices of correspondence which will serve to illustrate this point.

   On May 28, 1980, we wrote our federal regional office pointing out a situation in which a number of families were taking care of severely disabled children in their own homes. While in their own homes these children were not eligible for Medicaid. They could only become eligible by being moved to some type of institutional setting. We sought approval of an amendment to our Medicaid Plan which would allow us to provide Medicaid coverage to such individuals. The response to our question, dated June 27, 1980, is self-explanatory. Federal funds were not available under Medicaid to care for these children in their own homes, but is available for the much nore costly institutional care.

For the above reasons we are encouraged to see that a major thrust of Senate Bill 2809 is to provide alternatives to institutional care, not only for Medicaid eligibles but for a broad range of individuals.

In addition to the fact that the proposed Legislation would offer PAS and would encourage alternatives to institutionalization, several other

of its provisions appeal to us. We are in favor of the concept of testing the program instead of jumping right in to it. No program is perfect and the experimental period provided in the law will help identify shortcomings which cannot be foreseen at present. We are also in favor of the revisions in policy governing Home Health Agencies which should make their services less costly in the long run.

We feel however, that the Bill could be strengthened in a number of ways. One of the main problems with the proposal is that the PAT Teams would not be linked to State Medicaid Agencies. We have, through several years of experience, found that if a problem exists (the problem in this case being runaway costs in institutional care), the financial resources to address that problem should be placed with the agency that is responsible for solving the problem. It was pointed out in testimony at the time Senate Bill 2809 was introduced that State Medicaid Agencies are paying for over 50% of the nursing home beds currently being occupied. They also pay for a fairly substantial portion of hospital beds. We feel strongly for this reason that PAT Teams should be closely linked to State Medicaid Agencies and preferably should be directed by them. The Legislation does not appear to allow the Medicaid Agency to designate itself to operate the PAT Teams when appropriate to do so. Also, it is not clear if the PSRO could be required to participate, nor their funding would continue to be 100% federal if they were utilized in the PAT Team.

In order for PAS to be successful and in order to control nursing home utilization it is important that not only the PAT mechanism but also the

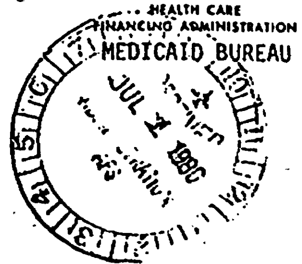
nursing home payments function, as well as the function of providing alternatives to nursing home services be controlled through <u>one</u> structure. To do otherwise could prevent the expeditious placements contemplated in this Legislation. Title XXI as presently written would put some states in the position of having to deal with at least 5 different placement decision makers including Professional Standards Review Organizations (PSRO), Medicaid Programs, Social Services Programs funded under Title XX, the PAT Teams, as well as placement mechanisms funded under Title III.

We also feel that the Legislation would be strengthened by providing for the funding of more alternatives to institutional care than are presently included. Few persons would question that Home Health Care, at least as presently provided, is often at least as expensive and perhaps more expensive than institutional care. There is also some evidence (Weissert) indicating that homemaker and adult day care services have not been cost effective. We feel that <u>personal care</u> services as well as <u>housekeeper</u> services and <u>non-medical substitute home services</u> should also be funded under the Legislation. At least during the initial testing phase, it would seem wise to allow some experimentation in order to determine which types of alternatives to institutional care are the most cost effective.

In summary we applaud the objectives of Senate Bill 2809. Our own experience with the PAS has indicated to us that this mechanism can be very effective in reducing unneeded institutional care. I should emphasize however, that the states' main problem in developing alternatives to institutional care has been a lack of financial resources targeted to these services. Insofar as Title XXI would provide funding for such alternatives we feel that it would be very effective.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION X
M/S 709 ARCADE PLAZA BUILDING
1321 SECOND AVENUE
SEATTLE, WASHINGTON 98101

JUN 27 1980



Keith Putman, Administrator
Adult and Family Services Division
Department of Human Resources
417 Public Service Building
Salem, Oregon 97310

Dear Mr. Putman:

This is in response to a May 28, 1980 letter from Richard Arbuckle of your staff in which he asked if Medicaid coverage of the following group of individuals under 21 is allowable: "Persons under age 21 living in the same household with financially responsible relatives who are not eligible while living in the household of such relatives because of the relatives' income and/or resources but who would be eligible if residing in a medical facility reimbursable from Title XIX."

Although we fully appreciate the state's arguments for allowing such coverage, we must abide by current federal regulatory constraints with regard to coverage under Medicaid.

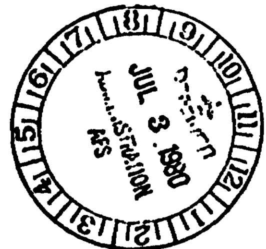
42 CFR 435.222 is clear in its requirement that all individuals under 21 must meet all AFDC eligibility requirements with the exception of that of dependent child. Among those requirements is consideration of legally responsible family members' income and resources in cases where individuals under 21 reside in the same household with such relatives.

Since the state's proposed coverage group would exclude such considerations, it is our opinion that such a group would not qualify for Medicaid coverage.

Sincerely,

David M. [illegible], Acting
Albert J. Benz
Regional Medicaid Director

cc: Richard Arbuckle
Liza Barnes



Department of Human Resources

ADULT AND FAMILY SERVICES DIVISION

PUBLIC SERVICE BUILDING, SALEM, OREGON 97310

May 28, 1980

Albert J. Benz
Regional Medicaid Director
Department of Health, Education and Welfare
Region X
Arcade Plaza Building
MS 709-1321 2nd Ave.
Seattle, Washington 98101

Dear Mr. Benz:

Maureen Reyes, our Medicaid Eligibility Specialist, has discussed the situation described below with Ken Call of your staff.

Recently we have become aware of a number of families who are taking care of severely disabled children in their own homes. These children are not eligible for Medicaid while living in the household of their parents but would be eligible in a medical facility where only their own income and resources and voluntary contributions from their parents would be taken into consideration.

We feel certain that the Federal government would not want to perpetuate such an inequity which will ultimately result in these children being moved from their homes and placed in nursing facilities. Such a development can be avoided if the following reasonable classification of persons under age 21 could be approved.

> Persons under age 21 living in the same household with financially responsible relatives who are not eligible while living in the household of such relatives because of the relatives' income and/or resources but who would be eligible if residing in a medical facility reimbursable from Title XIX.

Please let us know in writing if such a group could be approved.

Sincerely,

M. R. Arbuckle
Acting Assistant Administrator

MRA:JMR:bd

TESTIMONY BEFORE UNITED STATES SENATE

Committee on Finance

Sub-Committee on Health

August 27, 1980 - 9:00 A.M.

Mr. Chairman, I am Ms. Charlotte Carnes, employed by the Virginia State Health Department and I appear before this sub-committee at your invitation. I am responsible for directing the Virginia Nursing Home Pre-Admission Screening Program. Accompanying me today is Miss Ann Cook, Director of Medical Social Services for the Virginia Medical Assistance Program (Medicaid).

We are particularly pleased to have been invited to appear before you today to relate our experience with the pre-admission screening program which we implemented Statewide in May 1977. This presentation will speak to the Pre-Admission Screening Program's background and purpose, policy and procedure, results of the program and implications for implementation of similar programs.

BACKGROUND AND PURPOSE

Virginia's Medicaid Program is administered by the Department of Health. In July 1976, the Department of Health, working through four local health departments, began to test a nursing home pre-admission screening program. This pilot project was conducted over 9 months in both urban and rural areas. The pilot project demonstrated that 26.3 percent of the 167 individuals screened could be successfully cared for in the community. Based on the success of the pilot project, the Virginia Medicaid Program implemented the pre-admission screening program statewide. Including the nine months of the

pilot project, it took approximately one year for the program to become fully operational.

The purpose of the pre-admission screening program is to delay or avoid unwanted and/or inappropriate nursing home placements through the use of the interdisciplinary team approach and the mobilization of the community resources. A second purpose of the program is to identify services required in the community to meet the needs of the elderly and disabled persons.

POLICY AND PROCEDURE

Persons screened are those who are in the community or in a State facility of Mental Health or Mental Retardation at the time of nursing home application. Screening occurs if the individual is, or will become, Medicaid eligible within 90 days subsequent to nursing home admission. This screening requirement is a part of the State's nursing home admission certification and Medicaid payment is not made without the screening committee's approval.

Community based persons are assessed by the screening committee of the local health department where they live. The committee is composed of a public health physician, a public health nurse and a social worker. The social worker is employed by the local welfare department. In addition, the committees are encouraged to work with other community agencies offering services to the elderly and disabled. In some areas, other agencies which participate on the committee include an area office on aging, a mental health clinic, a private he health agency, a ministerial association, nursing homes and homes for adults. The Program is funded from Medicaid Administrative funds. The local health

department is reimbursed at a rate of $44.00 per screening. Persons screened by the screening committee do not pay for the assessment.

The local screening committees are to: (1) evaluate the medical, nursing and social needs of each individual referred for pre-admission screening; (2) analyze what specific services the individual needs; and (3) evaluate whether a service or a combination of existing community services are available to meet the individual's need. The committee's assessment of services availability depends upon whether the needed service exists in the patient's community, the individual's financial eligibility for the service, and whether the service can be delivered at the time and in the amount necessary to meet the individual's need.

Services which can be possibly used to help an individual remain in the community are home health services, chore and companion services, congregate or home delivered meals, adult day care, homemaker services, protective service for adults, and sheltered living arrangements, such as homes for adults or foster homes. (See attachment 1)

Upon receiving a screening referral, usually from the welfare department or family, the committee's social worker and public health nurse interview the individual and complete the Nursing Home Screening Certificate. The social worker prepares a social evaluation of the individual and the nurse evaluates the person's nursing needs, and obtains the medical history. The full committee meets and the evaluations are presented and discussed. If additional medical information is needed, the individual's private physician is contacted.

The committee carefully reviews each person's case to determine if nursing home admission is appropriate or if he or she can be cared for adequately at home or in the community through local services.

When the committee has reached a decision, the referring agency or individual is informed by letter, with a copy to the local welfare department and a copy to the nursing home, if placement is approved.

Referral and follow up are vital parts of the program. Virginia stresses the human aspect from the initial personal contact with the individual by the nurse or social worker, through referral and follow up. Depending on the type of services needed, either the social worker or nurse will make the referral to the appropriate agency and assure that the individual and family understand how to receive services. In some instances, the nurse or social worker will make a phone call or visit the individual after that to determine if his or her needs are being adequately met. From time to time, the screening committee will discuss the individuals previously screened, evaluate their progress, and receive information on these individuals' status.

Pre-admission screening of prospective nursing home candidates from facilities of the State Department of Mental Health and Mental Retardation are conducted by the State Department of Health's central office Pre-Admission Screening Committee composed of a psychiatrist and a social worker representing the State Department of Mental Health and Mental Retardation, and a social worker and a registered nurse representing the State Medicaid Program. A Medicaid Program physician and a social worker specializing in mental retardation are consultant members of the committee.

The referring facility prepares medical, nursing and social information on potential nursing home candidates which is reviewed and discussed by the central office Pre-Admission Screening Committee. The basic considerations for determining the need for nursing home placement are the individual patient's medical needs; the specific services required to fill these needs; and the health personnel required to adequately provide these services. The referring facility is advised in writing of the Committee's decision.

PROGRAM RESULTS

During the third year of the pre-admission screening program, 2,065 local screenings occurred statewide, compared to 2,062 the first year, and 2,132 the second year. Third year reporting reflects that 365 individuals have been maintained in the community (18%), as compared to 444 (22%) the first year, and 438 (21%) the second year. Statewide reporting continues to indicate that the service most often "unavailable" (unavailable is defined as needed for the individual to remain in the community, but the service is not available to the individual or is not available in the community) to maintain individuals in the community is companion service. The "unavailability" of companion services was reported in 31% of the cases during the program's second year and third year and 28% during the first year. (See attachments 2, 3, 4, 5, and 6)

During the third year of the program, 208 patients in State Mental Health and Mental Retardation facilities were screened. Eighteen percent were not approved for nursing home care. This compares with 197 patients screened during the first year with 22% not approved for nursing home care and 181

patients screened during the second year and 17% not approved for nursing home care. In those cases not approved for nursing home care, the most appropriate placement was considered to be continued hospitalization or movement into a licensed home for adults or a foster home.

At this time, definitive data on cost savings are not available. At present no one can conclusively prove cost savings in every case, empirically yes, perhaps, but cost savings must be subjected to scholarly research. However, we can make a reasonable projection of estimated cost savings using figures from a GAO study[1] on home health care, and our best estimate of intermediate nursing home care in Virginia. Home Health Services, of course, do not include such services as chore, companion, homemaker and day care services. If the cost of intermediate care in Virginia averages about $32.05 a day, a monthly estimate of expenditures for this care would be $960 ($32 a day x 30 days a month).

The GAO study estimates that there is a break-even point, depending on the peron's level of impairment, after which home health care costs exceed institutional costs. The cost of providing care in the home at this level is approximately $400 a month. Therefore, if an individual could use home health services, instead of ICP services, possible savings of $560 per patient per month could be realized. If we apply this to the results of the first three years of

[1]Comptroller General's Report to Congress-Home Health-The Need for a National Policy to Better Provide for the Elderly (HRD-78-19, 12/30/77)

the program, maintaining 1,247 individuals in the community would save the State $698,320 per month, or approximately 8.4 million over a 3 year period. While these figures are by no means firm and represent only projections, they do indicate potential "savings" that could be realized from pre-admission screening programs such as Virginia's.

Benefits in terms of social values are more immediately visible, however. Wherever possible, disabled and elderly persons are not being uprooted from their homes and communities and placed in institutional settings. Inappropriate and often unwanted nursing home placements have been delayed or avoided through use of community resources. We have contributed to the well-being of our elderly and disabled recipients and will continue to help them maintain their sense of self-esteem. We believe this can be accomplished only if they remain part of, and feel they are contributing to the community, instead of being dependent upon it. The screening program thus supports directly our goal of assuring the dignity and rights of the elderly and disabled. The emphasis placed on the human factor and the need for support and communication with other agencies are keys to the program's success.

A two year study of the pre-admission screening program is currently being conducted by the Virginia Commonwealth University's Center on Aging. This study is funded by the Administration on Aging and will specifically address the issue of cost as related to pre-admission screening and community services versus institutional services.

BARRIERS TO PROGRAM IMPLEMENTATION AND DEVELOPMENT

When initiating any program, it is critical to consider the barriers to implementation and to development of the program. Potential barriers to implementation of a pre-admission screening program include difficulty in securing staff, cooperation and support from other state and local agencies and organizations and the availability of community services.

The Virginia program has been fortunate in receiving the enthusiastic support of the Commonwealth of Virginia's Secretary of Human Resources, the Virginia Office on Aging, the State Department of Welfare, the State Department of Mental Health/Mental Retardation, the Virginia Health Care Association, (the State Nursing Home Association) and the Virginia Commission on the Needs of Elderly Virginians, thereby increasing its acceptance.

When the program was implemented in 1977, community based services such as home health services and Title XX were underutilized. Therefore, the program was able to maximize the use of existing community services in maintaining individuals in the community without expanding services or creating new services. However, it is now apparent that limited funding for community services is a barrier to maintaining individuals in the community. Most of the Title XX adult services are not mandated services, the ceiling on Title XX and the local option with Title XX create barriers to the expansion of needed community services.

The Pre-Admission Screening Program is not currently evaluating persons who are transferred from acute care facilities to nursing homes. When the

program began, we intended to expand the program to include screenings of acute care facility patients. We believe that our attempts to include this population have been unsuccessful for several reasons: (1) hospitals believe that the pre-admission screening program will serve to negate the role and function of the discharge planner; (2) philosophically, hospitals have traditionally viewed themselves as self-contained and have not been totally integrated with the community service system; (3) communication between the community and the hospital systems has not been totally satisfactory and (4) we did not involve hospitals in the initial discussions and planning phases of the pre-admission screening program.

As a result of our unsuccessful attempt to include screenings of acute care facility patients, a pre-admission screening program planning committee has been established. This committee includes representations from agencies and organizations who are involved directly or indirectly with disabled or elderly persons, including representation from the Virginia Hospital Association and the Virginia Society of Hospital Social Work Directors. This committee's charge is to study the feasibility of expanding the pre-admission screening program.

The inability to expand the program has been the greatest barrier to the program. We believe that if the acute care population becomes subject to pre-admission screening and if community services are expanded, the program could effectively reduce the number of patients who remain in acute care hospital beds beyond what is necessary as well as ensuring a more appropriate nursing home admission.

The Pre-Admission Screening Program has continued without requiring additional staff at the local level and only one staff position was added at the State Health Department level. However, if the program is expanded to include acute care, an increase in State and local staff would be necessary.

We believe that if the Pre-Admission Screening Program did not exist there would be a loss of coordination of community services, loss of individual and family awareness of and use of community services and increased inappropriate nursing home admissions.

CONCLUSION

At this point, it is not possible to know precisely the financial benefits of the Pre-Admission Screening Program. In many cases, home care is much less expensive than institutional care. Actual figures on potential cost savings are not available. While cost savings may occur it can not be assured that such will occur in all cases. Research is currently being conducted in this area. Savings in terms of social cost are much more visible. The Pre-admission Screening Program provides single entry point for delivery of services and wherever possible, assists disabled and elderly persons in securing the most appropriate services to meet their needs in their homes and communities. Inappropriate and unwanted nursing home placments have been delayed and/or avoided through mobilization of community services. In addition, the Pre-Admission Screening Program is specifically identifying services that are required in the community and measuring service availability to meet the needs of its disabled and elderly citizens.

This information has become a vital component in Virginia's evaluation of long term care needs and services. We believe that through demonstration of need of services, community based services which today are not available to the disabled and elderly, will become available in the future.

Thank you, Mr. Chairman. This concludes my presentation and I will be pleased to answer questions.

SERVICE **SPECIAL SERVICES TO THE BLIND AND VISUALLY HANDICAPPED**

DEFINITION

Arrangement for and assistance in using services provided by Commission. These services consist of evaluation of capacity for habilitation, rehabilitation, and training in specific skills related to needs of blind and visually handicapped individuals. Special counseling is provided to enable adjustments to take place. Provision of certain special services which assist visually handicapped children and adults in maximizing their ability to function as normally as possible.

GOAL	OBJECTIVES
I	To increase employment capacity and capability.
II	To increase personal living functioning by stressing independence.
III	To assist blind and visually handicapped children and adults to enter and participate in existing social systems and functions. To resolve, reduce, or ameliorate problems related to blind or visually handicapped persons.

MANDATORY BASIC ELEMENTS OF THE SERVICE

See above-referenced Section

SERVICE **SHELTERED LIVING ARRANGEMENTS**

DEFINITION

Arrangement for locating and supervising the individual in a living situation outside of his own home, such as room and board arrangement, relatives home, domiciliary care or nursing home. Recruiting suitable community based care is a component.

GOAL	OBJECTIVES
III	To correct living situations of the adult when his need for protection results from failure to receive adequate shelter.
IV	To assist the adult to move from independent living to community based care appropriate to their needs.
V	To assist the adult to move into institutional placement appropriate to their needs.

SERVICE **NUTRITION SERVICES**

DEFINITION

Provision of information, advice, and counselling about nutritional needs, meal preparation, purchasing wisely to meet daily nutritional needs. The service includes instruction and educational fees are a component of the service for classes or courses related to nutrition.

GOAL	OBJECTIVES
II	To improve eating habits and nutritional intake for increased physical and mental functioning.
III	To remove or reduce physical neglect of individuals caused by a lack of adequate quantity and quality of food intake.
IV	To maintain or upgrade the knowledge of nutritional needs of the individual in independent living situations to avoid institutional placements.

SERVICE **INFORMATION AND REFERRAL**

DEFINITION

Provision of information about Title XX services and other related social and financial service programs, brief assessment to facilities referral to community resources and follow-up, as appropriate.

GOAL	OBJECTIVES
I, II, III, IV, and V	To enable individuals to find and use resources which promote economic well-being, self-determination, protection of interests; provision of suitable living arrangements in their community and to obtain necessary institutional care.

The service includes:

Brief assessment - Identification of the nature of the request.

Advice and communication - Information on availability and accessibility of the agency program or outside community resource appropriate to the need for Title XX and other related Social Service programs.

Referral - Communication with the resource within and outside of the agency and preparation of the client to use it.

Follow-up - Assurance that the client made contact with the resource.

MANDATORY BASIC ELEMENTS OF THE SERVICE

See next section: "Mandatory Services"

SERVICE | **HOME DELIVERED MEALS**

DEFINITION

Approved providers prepare and deliver a maximum of two meals a day to any individual who is homebound or unable to prepare his own meals because of health, disability or advanced age, and has no one to provide them without costs.

GOAL	OBJECTIVES
II	To provide the aged, blind and/or disabled invididual a means of maintaining his independence to the fullest extent possible.
III	To assure that the nutritional needs of the homebound aged, blind and/or disabled individual are met.
IV	To provide means for the aged, blind and/or disabled individual to maintain or regain their living situation in the community.

Criteria of Need for Service

1. An eligible individual must be in need of home delivered meals for one or more of the following reasons:

   a. an individual is confined to his home and unable to prepare nourishing meals due to an ongoing health condition, disability or advanced age.

   b. an individual is unable to prepare his meals due to a short term illness.

   c. a regular participant in congregate meals is unable to continue attending due to sickness.

2. An eligible adult is not to be considered in need if his meals are provided for him through his particular living arrangements, e.g., nursing home, institution, homes for adults a room and board situation, or provided by his family.

3. An eligible adult is not to be considered in need if his only cost is for raw food and he has someone to prepare his meals at no charge.

SERVICE — CONGREGATE MEALS

DEFINITION

Provision to the blind, the aged or disabled individual a maximum of two meals a day and opportunities for nutrition, education, fellowship and recreation in approved group setting.

GOAL	OBJECTIVES
II, III	To reduce isolation and encourage socialization and communication in order for them to remain in their own home and to improve or maintain their personal and social functioning levels.

Criteria of Need for Service

1. An eligible individual must be in need of congregate meals for one or more of the following reasons:

   a. Due to limited mobility an individual is unable to shop and/or cook for himself.

   b. An individual has attitudes, such as depression, rejection, loneliness which result in a lack of incentive to prepare nourishing meals and eat alone.

   b. An individual lacks the knowledge and/or skills to select and prepare nourishing meals.

2. An eligible individual is not to be considered in need if his meals are provided for him through his particular living arrangement, e.g. nursing home, institution, home for adults, room and board situation, or as a member of a family.

SERVICE **DAY CARE TO ADULTS**

DEFINITION

Services provided for a defined portion of the 24 hour day as a supplement for family care in a protective setting approved by the State agency for purposes of personal attention, care and supervision.

Medical care is a component of the service when medical examinations are a requirement for participation.

A total of _______ individuals will be served for achievement of:

GOAL	OBJECTIVES
II	To enable the adult to improve his social, health and emotional well being through opportunities for companionship, self-education and satisfying leisure time activities.
III	To provide protection for the adult during these hours of the day when family members with whom he lives are not available to provide care and supervision because of employment or other necessary reasons.
IV	To supplement home based care for the adult to continue his living arrangement outside of an institutional setting.

SERVICE **HOME MANAGEMENT**

DEFINITION

Services consist of help with household management, including areas such as maintenance and care of home; money management, including areas such as household budgets, consumer buying; consumer education and protection, including activities such as advice and guidance programs, informal or formal training, consumer fraud and investigation, child rearing and health maintenance practices.

GOAL	OBJECTIVES
I, II	To reinforce economic independence and individual/family functioning by improving the skills of home management. To prevent or lessen abuse or exploitation by others of individual/family.

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SERVICE **PROTECTIVE SERVICES TO ADULTS**

DEFINITION

Services available without regard to income to the adult 18 years of age or older consist of certain basic components for, or on behalf of an individual who is unable to protect himself without help from neglect, abuse or exploitation. The components, which are required for determining need for protection are: (a) response to request, (b) investigation and determination, and (c) assessment of service needs if services offered are voluntarily accepted in conformity with State law. Services also include counselling to the individual, his family and other responsible persons, arrangement without cost for alternative living arrangements, needed medical care, legal representation, and assistance in guardianship/commitment, if needed.

GOAL	OBJECTIVES
II	To reestablish and/or maintain a stable level of functioning within their maximum potential.
III	To assure that the adult who wishes them receive services that will afford proper care, necessary supervision, and protection from himself and/or negative environmental surroundings harmful to his well-being.
IV	To assist the individual at risk to remain in the community.
V	To assist the individual to obtain appropriate institutional care if the intensity of the situation requires it.

TARGET POPULATION

Any adult (18 years of age or older) is eligible for services. The authority to provide such services shall not limit the right of any individual to refuse to accept any of the services offered according to Section 63.1-55.1 of the Code of Virginia.

MANDATORY BASIC ELEMENTS OF THE SERVICE

See next Section: "MANDATORY SERVICES".

SERVICE **HOME HEALTH SERVICES**

DEFINITION

Provision by local health departments of (a) instruction in preventive/restorative health measures in caring for the ill and disabled in their homes; (b) relief for the family member who cares for the sick; (c) rehabilitation services through use of physical, occupational and speech therapists; (d) direct home nursing care; and (e) on-going community educational programs in care of the individual in the community.

GOAL	OBJECTIVES
I	To restore functioning to the extent an individual will be able to return to his current job or be trained for something more suitable.
II	To promote, maintain or restore health through minimizing effects of illness and disability.
III	To strengthen and safeguard health of an individual at risk.
IV	To facilitate and maintain living situations in the home through preventive and restorative health measures.

SERVICE **HOUSING IMPROVEMENT**

DEFINITION

Assistance in locating housing and obtaining necessary household furnishings; working with landlords to upgrade housing; assistance in property purchase; securing or providing for special modifications in building related to disability of occupants; payment for minor housing renovations or repairs is included in the service for items such as leaky roofs, nonexistent or malfunctioning toilet facilities, broken windows.

GOALS	OBJECTIVES
I, II III, IV	To enable individuals/families to live in more adequate and safe housing and to improve housing hazardous to their health.

SERVICE **HOMEMAKER**

DEFINITION

Performance of or instruction in activities such as personal care, home management, household maintenance, nutrition consumer education, hygiene and child rearing, by a person trained in homemaking skills and supervised by an agency. Direct agency services are available to any eligible individual. Purchase is to be made from other homemaker agencies only for the blind, disabled or elderly adult under specified conditions.

GOAL	OBJECTIVES
I	To upgrade household, home management and child rearing skills of parents to enable them to attain economic independence.
II	To provide a means whereby an individual/family attain, regain or maintain capacity to function responsibly and achieve a maximum level of independence and self-determination.
III	To provide care, guidance, and/or instructions to an individual at risk.
IV	To supplement the capacity of an individual to function in his own living situation.

EXPLANATORY NOTES OR INSTRUCTIONS FOR USE

Purchased homemaker services for the SSI/State Supplemental Income target population are defined as specialized activities performed by a skilled person trained and supervised in homemaking services which assist the blind, aged and/or disabled adult in maintaining or regaining functioning capacity to take care of himself and homemaking responsibilities in his own home. Instruction is to be included as a component of the purchased service in situations where the adult is able to benefit.

When an adult is at minimal functioning level or unable to function on his own, services provided on an emergency basis are defined as those in which the homemaker is required to assume direct personal and/or home management responsibilities and activities when no other responsible person is available, without cost for this service.

Direct agency homemaker services are available to individuals, both child and adult, based on income maintenance status or income-level status as determined by geographic areas.

SERVICE **CHORE**

DEFINITION

Performance of home maintenance tasks and heavy housecleaning such as window washing, floor maintenance (scouring and polishing); outdoor work consisting of yard maintenance, snow removal; and minor repair work on furniture and appliances in the home. Chore services are to be provided to an adult who because of advanced age, disability or infirmity is unable to perform such tasks himself and has no one available to provide these services without cost.

GOAL	OBJECTIVES
II	To enable the adult to improve his living standards.
III	To provide safety and security for the adult in his own living situation.
IV	To maintain independent home or living arrangements where age or disability threatens capacity.

EXPLANATORY NOTES AND INSTRUCTIONS FOR USE:

Purchased chore services include heavy housecleaning duties and home maintenance tasks which are performed to assist the blind, aged and/or disabled adult in maintaining his independent home and living arrangements.

Chore services shall be provided only to those persons living in an independent situation where they are responsible for maintenance of their own home or apartment and have no one available to provide this service without cost.

The rate of payment for purchased chore services shall be at the minimum hourly wage and services shall not exceed 16 hours a month for any recipient. This is a new policy which will take revision in State Board Rules and Regulations.

Standards for purchase from chore providers have been established by State Board of Welfare.

SERVICE **COMPANION**

DEFINITION

Companion service is the provision of personal aid, light housekeeping and/or companionship services by an authorized person to an adult, who because of advanced age, disability or infirmity, is unable to care for himself without assistance and has no one to provide such care without cost.

GOAL	OBJECTIVES
II, IV	To supplement the capacity of the adult maintaining or returning to his own home who is unable to assume total responsibility for personal and/or household tasks.
III	To reduce self harm or self neglect, through supplemental task performance.
II, IV	To provide a resource for the performance of personal tasks to the adult not maintaining his own home but living as a member of another household.

EXPLANATORY NOTES AND INSTRUCTIONS FOR USE:

An eligible adult who is in need of companion service may receive any one or a combination of any or all of the three components of the service, e.g., personal aid, light housekeeping and companionship.

The adult maintaining his own home is eligible to receive all three components of the service. Light housekeeping shall not be provided to the adult who is living in another household. A medical evaluation (physical and/or mental) shall be required to verify the need for personal care and/or light housekeeping tasks. Payment can be made for the evaluation provided it does not exceed 25% of the total cost.

When the adult is at minimal functioning level or unable to function on his own, companion services may be provided on an emergency basis to include up to thirty (30) days in any one fiscal year.

Policy established twenty (20) hours of service a week as the maximum allowable for provision of companion services except for the December, 1973 recipient of OAA or APTD who received services in excess of 20 hours a week and whose service level must be maintained under Social Security Regulations governing SSI.

The rate of payment shall be at the minimum hourly wage for all levels of care or combinations of the service components being provided except where companionship is the only service required. In this situation, the rate of payment shall be the prevailing rate in the community up to the minimum hourly wage.

Standards for providers and policy governing purchase will be presented to State Board.

Under existing policy prior to July 1, 1976, companion services are limited to adults. If local agencies wish this service to be provided to the SSI child, recommendations should be made for inclusion in the final plan.

The basic Components of companion service include:

a. Personal Aid Services

- help with individualized activities such as bathing, bed-making, personal cleanliness and hygiene, roomcare, dressing, preparation of light meals, feeding client

b. Light Housekeeping Tasks

- routine housework, such as cooking, cleaning, personal laundry, washing and ironing

c. Companionship Services

- essential errand running and personal shopping
- sitting with client and providing general supervision
- escort services

LEVELS OF CARE OF COMPANION SERVICE AND RATE OF PAYMENT

1. Maximum Level - This level of care provides for personal aid services, light housekeeping tasks and companionship services.

   a. The rate of payment for this level of care shall be at the minimum hourly wage.

   b. A medical evaluation (physical and/or mental) shall be required to verify the need for this care.

2. Median Level - This level of care provides for personal aid services and/or light housekeeping tasks.

   a. The rate of payment for this level of care shall be at the minimum hourly wage.

   b. A medical evaluation (physical and/or mental) shall be required to verify the need for this care.

3. Minimum Level - This level of care provides for companionship services only.

   a. The rate of payment for this level of care shall be the prevailing rate in the community up to the minimum hourly wage.

NURSING HOME PRE-ADMISSION SCREENING

MAY 15, 1977 - MAY 31, 1978

PURPOSE

On May 15, 1977, the Virginia Medical Assistance Program implemented the Nursing Home Pre-Admission Screening Program. The purpose of the Program was to delay or avoid unwanted and/or inappropriate nursing home placements through the use of the interdisciplinary team approach and the mobilization of community resources. A second purpose of the Screening Program was to identify services required in the community to meet the needs of elderly and disabled persons.

PERSONS WHO ARE SCREENED

Persons screened are applicants for nursing home admission who are not in a community hospital or another nursing home at the time of application. Screening occurs if the individual is or will become Medicaid eligible within 90 days of nursing home admission.

Persons who are applying for nursing home admission are screened by the screening committee of the local health department in the area in which they reside. This committee is, at a minimum, composed of a local health department physician, a public health nurse and an adult service social worker. Local committees are encouraged to seek participation of other community agencies which offer services to the elderly and disabled.

In addition to screening those persons previously described, screening of prospective nursing home candidates from facilities of the Department of

Mental Health and Mental Retardation is done by the Utilization Review Section of the Virginia Medical Assistance Program.

PROGRAM RESULTS

In order to capture information which is reflective of the individuals being screened and to identify the kinds of services that are available and not available throughout the state, a form is submitted by the screening committee to the Virginia Medical Assistance Program on each individual screened.

During the first year of the Screening Program, 2,062 individuals statewide have been screened by the local screening committees; 444 individuals have been maintained in the community (22%).

Reporting indicates that the service most often "unavailable" to maintain individuals in the community is companion service (28% of the cases), followed by chore service in 21% of the cases, homemaker services in 21% of the cases, meals in 19% of the cases, and adult day care in 18% of the cases. Only home health services were available in all areas of the state and in sufficient quantity to meet the need in most cases. (See attached report by locality.)

Reporting reflects several reasons that needed services are not available. One reason is that the individual does not meet the income eligibility requirements for the services. This is particularly true for individuals whose income is in excess of the allowable amount for Supplemental Security Income eligibility and who are, therefore, ineligible for such services as chore and companion services under Title XX in Virginia.

In many instances, the service "needed" does not exist in the community. The most striking example of this is adult day care. Another reason is that the service is not offered a sufficient number of hours to meet the need.

In addition to the service needs previously cited, reporting reflects a need for sheltered living arrangements, such as homes for adults and foster homes.

During the first year of the program, 197 patients in State Mental Health and Mental Retardation facilities have been screened. Twenty-two percent were not approved for nursing home care. In those cases that were not approved for nursing home care, it was felt that the most appropriate placement would be continued hospitalization or movement into a licensed adult home or foster home.

CONCLUSION

At this time, it is not possible to know the financial benefits of the Screening Program. In many cases, home care is much less expensive than institutional care. Actual figures on cost savings are not available. Savings in terms of social cost are much more visible. Disabled and elderly persons are not being uprooted from their homes and communities and placed in the unfamiliar and dependent living arrangements of nursing homes whenever alternative solutions exist. Inappropriate and unwanted nursing home placements have been delayed and/or avoided through the mobilization of community resources.

In addition, Virginia is beginning to specifically identify the services that are required in the community and to measure the service availability to meet the needs of its elderly and disabled citizens. It is hoped that through demonstration of need for services, community based services which today are not available to the elderly and disabled, will become available in the future.

NURSING HOME PRE-ADMISSION SCREENING

STATE MENTAL HEALTH/MENTAL RETARDATION FACILITIES

MAY 15, 1977 - MAY 31, 1978

Facility	Number Screened	Nursing Home Approved	Nursing Home Not Approved
Catawba	2	2 (100%)	0
Central State	39	32 (82%)	7 (18%)
Eastern State	34	27 (79%)	7 (21%)
Lynchburg Training School	1	1 (100%)	0
Northern Va. Mental Health Institute	1	1 (100%)	0
Piedmont State Hospital	52	46 (88%)	6 (12%)
Southeastern Va. Training Center	3	2 (67%)	1 (33%)
Southside Va. Training Center	7	3 (43%)	4 (57%)
Southwestern State Hospital	9	2 (22%)	7 (78%)
Western State Hospital	49	38 (78%)	11 (22%)
Totals	197	154 (78%)	43 (22%)

Nursing Home Pre-Admission Screening
May 15, 1977 - May 31, 1978

Health District	Nursing Home Not Approved	Number of Screenings
Central Virginia	43%	118
Eastern Shore	39%	57
Pittsylvania/Danville	35%	77
Alleghany	34%	70
Roanoke City	33%	45
Chesterfield	33%	30
Lenowisco	31%	32
Arlington	26%	35
Chesapeake	26%	23
Piedmont	25%	40
Richmond City	25%	172
Central Shenandoah	24%	130
Fairfax	24%	126
Norfolk	24%	89
Henrico	23%	30
Southside	21%	61
Thomas Jefferson	19%	72
Tidewater	19%	144
Franklin	17%	48
Peninsula	17%	83
Northern Neck	16%	25
Mount Rogers	15%	56
Lord Fairfax	15%	75
Rappahannock	14%	44

Health District	Nursing Home Not Approved	Number of Screenings
Hampton	13%	32
Rappahannock/Rapidan	13%	30
Prince William	10%	20
Charles City	6%	16
Virginia Beach	6%	52
Crater	5%	78
New River	4%	57
Middle Peninsula	2%	49
Alexandria	-0-	14
Cumberland Plateau	-0-	15
Loudoun	-0-	17

NURSING HOME PRE-ADMISSION SCREENING

May 15, 1977 - May 31, 1978

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
ALEXANDRIA HEALTH DISTRICT																	
Alexandria	14	14 (100%)	0	1 (7%)	3 (21%)	3 (21%)	3 (21%)	4 (29%)	3 (21%)	5 (36%)	0	0	0	0	0	0	13 (93%)
ALLEGHANY HEALTH DISTRICT																	
Alleghany-Covington	17	10 (59%)	7 (41%)	6 (35%)	6 (35%)	5 (29%)	4 (24%)	0	1 (5%)	0	3 (18%)	6 (35%)	4 (24%)	0	2 (12%)	2 (12%)	8 (47%)
Botetourt County	10	9 (90%)	1 (10%)	1 (10%)	1 (10%)	5 (50%)	9 (90%)	1 (10%)	0	0	3 (30%)	1 (10%)	3 (30%)	0	2 (20%)	0	4 (40%)
Craig County	6	3 (50%)	3 (50%)	0	0	1 (17%)	2 (33%)	0	0	1 (17%)	0	0	0	0	0	0	1 (17%)
Roanoke County	34	23 (68%)	11 (32%)	2 (6%)	2 (6%)	1 (3%)	3 (9%)	1 (3%)	0	8 (24%)	2 (6%)	2 (6%)	2 (6%)	0	2 (6%)	0	22 (65%)
Clifton Forge	3	1 (33%)	2 (66%)	0	0	0	0	0	0	2 (66%)	1 (33%)	0	0	0	0	0	3 (100%)
District Total	70	46 (66%)	24 (34%)	9 (13%)	9 (13%)	12 (17%)	18 (26%)	2 (3%)	1 (1%)	11 (16%)	9 (13%)	9 (13%)	9 (13%)	0	6 (9%)	2 (3%)	38 (54%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
ARLINGTON HEALTH DISTRICT																	
Arlington	35	26 (74%)	9 (26%)	6 (17%)	6 (17%)	7 (20%)	7 (20%)	9 (26%)	12 (34%)	1 (3%)	1 (3%)	0	1 (3%)	1 (3%)	0	2 (6%)	14 (40%)
CENTRAL SHENANDOAH HEALTH DISTRICT																	
Augusta-Staunton	40	27 (68%)	13 (32%)	7 (18%)	2 (5%)	9 (23%)	7 (18%)	5 (13%)	1 (3%)	1 (3%)	5 (13%)	5 (13%)	9 (23%)	1 (3%)	6 (15%)	8 (20%)	8 (20%)
Bath County	3	2 (66%)	1 (33%)	1 (33%)	1 (33%)	1 (33%)	1 (33%)	0	0	1 (33%)	0	0	0	0	0	0	2 (66%)
Highland County	2	1 (50%)	1 (50%)	0	0	0	0	0	0	0	1 (50%)	2 (100%)	1 (50%)	0	1 (50%)	2 (100%)	1 (50%)
Lexington-Rockbridge	8	7 (89%)	1 (13%)	2 (25%)	0	0	0	0	0	0	2 (25%)	3 (38%)	5 (63%)	3 (38%)	5 (63%)	4 (50%)	2 (25%)
Rockingham-Harrisonburg	49	40 (82%)	9 (18%)	13 (27%)	3 (6%)	4 (8%)	4 (8%)	8 (16%)	3 (6%)	3 (6%)	24 (49%)	21 (43%)	22 (45%)	2 (4%)	13 (27%)	6 (12%)	9 (18%)

Central Shenandoah continued on next page

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Buena Vista	3	3 (100%)	0	0	0	0	1 (33%)	0	0	0	0	1 (33%)	2 (66%)	0	2 (66%)	1 (33%)	2 (66%)
Waynesboro	25	19 (76%)	6 (24%)	0	0	3 (12%)	3 (12%)	0	1 (4%)	2 (8%)	2 (8%)	4 (16%)	2 (18%)	1 (4%)	1 (4%)	4 (16%)	2 (8%)
District Total	130	99 (76%)	31 (24%)	23 (18%)	6 (5%)	17 (13%)	16 (12%)	13 (10%)	5 (3%)	7 (5%)	34 (26%)	36 (28%)	41 (32%)	7 (5%)	28 (22%)	25 (19%)	26 (20%)
CENTRAL VIRGINIA HEALTH DISTRICT																	
Amherst County	18	10 (56%)	8 (44%)	3 (17%)	0	1 (5%)	4 (22%)	0	0	0	5 (28%)	7 (39%)	9 (50%)	2 (11%)	0	2 (11%)	1 (5%)
Appomattox Co.	2	2 (100%)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Bedford County	13	6 (46%)	7 (54%)	7 (54%)	1 (8%)	3 (23%)	7 (54%)	1 (8%)	1 (8%)	1 (8%)	4 (31%)	4 (31%)	1 (8%)	1 (8%)	4 (31%)	4 (31%)	3 (23%)
Campbell County	25	10 (40%)	15 (60%)	1 (4%)	0	10 (40%)	6 (24%)	0	0	1 (4%)	9 (36%)	3 (12%)	3 (12%)	2 (8%)	3 (12%)	4 (16%)	2 (8%)

Central Virginia continued on next page

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Lynchburg	60	37 (62%)	23 (38%)	24 (40%)	12 (20%)	13 (22%)	9 (15%)	3 (5%)	2 (3%)	4 (7%)	9 (15%)	8 (13%)	15 (25%)	1 (2%)	7 (12%)	12 (20%)	13 (22%)
District Total	118	65 (57%)	53 (43%)	35 (30%)	13 (11%)	27 (23%)	26 (22%)	4 (3%)	3 (3%)	6 (5%)	27 (23%)	22 (19%)	28 (24%)	6 (5%)	15 (13%)	22 (19%)	19 (16%)
CHARLES CITY HEALTH DISTRICT																	
Charles City Co.	5	5 (100%)	0	1 (20%)	0	0	2 (40%)	0	0	0	1 (20%)	1 (20%)	1 (20%)	0	2 (40%)	2 (40%)	3 (60%)
Goochland Co.	2	2 (100%)	0	0	0	0	0	0	0	0	2 (100%)	1 (50%)	2 (100%)	1 (50%)	0	1 (50%)	0
Hanover County	7	7 (100%)	0	2 (29%)	1 (14%)	4 (57%)	3 (43%)	1 (14%)	1 (14%)	0	2 (29%)	3 (43%)	3 (43%)	0	2 (29%)	1 (14%)	2 (29%)
New Kent Co.	2	1 (50%)	1 (50%)	0	0	0	0	0	0	0	2 (100%)	0	1 (50%)	0	0	1 (50%)	0
District Total	16	15 (94%)	1 (6%)	3 (19%)	1 (6%)	4 (25%)	5 (31%)	1 (6%)	1 (6%)	0	7 (44%)	5 (31%)	7 (44%)	1 (6%)	4 (25%)	5 (31%)	5 (31%)

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	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CHESAPEAKE HEALTH DISTRICT																	
Chesapeake	23	17 (74%)	6 (26%)	9 (39%)	5 (3%)	1 (4%)	14 (61%)	3 (13%)	0	1 (4%)	0	1 (4%)	0	0	4 (17%)	0	12 (52%)
CHESTERFIELD HEALTH DISTRICT																	
Chesterfield Co.	25	15 (60%)	10 (40%)	1 (4%)	2 (8%)	3 (12%)	6 (24%)	0	0	3 (12%)	6 (24%)	11 (44%)	12 (48%)	2 (8%)	9 (36%)	5 (20%)	10 (40%)
Powhatan County	3	3 (100%)	0	0	0	1 (33%)	0	0	0	0	2 (66%)	0	2 (66%)	0	1 (33%)	1 (33%)	0
Colonial Heights	2	2 (100%)	0	0	0	0	1 (50%)	0	0	0	2 (100%)	2 (100%)	0	0	2 (100%)	0	1 (50%)
District Total	30	20 (67%)	10 (33%)	1 (3%)	2 (7%)	4 (13%)	7 (23%)	0	0	3 (10%)	10 (33%)	13 (43%)	14 (47%)	2 (7%)	12 (40%)	6 (20%)	11 (37%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CRATER HEALTH DISTRICT																	
Dinwiddie Co.	4	3 (75%)	1 (25%)	0	2 (50%)	2 (50%)	1 (25%)	0	0	0	1 (25%)	1 (25%)	1 (25%)	0	1 (25%)	1 (25%)	1 (25%)
Greensville-Emporia	15	14 (93%)	1 (7%)	1 (7%)	2 (13%)	1 (7%)	2 (13%)	0	0	1 (7%)	0	1 (7%)	3 (20%)	0	0	0	10 (67%)
Prince George Co.	4	4 (100%)	0	1 (25%)	1 (25%)	1 (25%)	0	0	0	0	0	0	0	0	0	1 (25%)	0
Surry County	2	2 (100%)	0	0	0	0	0	0	0	0	0	1 (50%)	1 (50%)	0	0	0	0
Sussex County	7	7 (100%)	0	1 (14%)	1 (14%)	3 (43%)	2 (29%)	0	0	0	1 (14%)	1 (14%)	3 (43%)	0	1 (14%)	1 (14%)	0
Hopewell	24	24 (100%)	0	1 (4%)	5 (21%)	3 (13%)	11 (46%)	0	0	0	7 (29%)	7 (29%)	3 (12%)	0	1 (4%)	1 (4%)	5 (21%)
Petersburg	22	20 (91%)	2 (9%)	0	2 (9%)	1 (5%)	2 (9%)	0	0	0	0	2 (9%)	0	0	0	0	5 (23%)
District Total	78	74 (95%)	4 (5%)	4 (5%)	13 (17%)	11 (14%)	18 (23%)	0	0	1 (1%)	9 (12%)	13 (17%)	11 (14%)	0	3 (4%)	4 (5%)	21 (27%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CUMBERLAND PLATEAU HEALTH DISTRICT																	
Buchanan Co.	4	4 (100%)	0	2 (50%)	2 (50%)	1 (25%)	1 (25%)	0	0	0	1 (25%)	1 (25%)	1 (25%)	0	1 (25%)	2 (50%)	3 (75%)
Dickenson Co.	5	5 (100%)	0	0	0	0	3 (60%)	2 (40%)	0	0	4 (80%)	3 (60%)	4 (80%)	0	0	4 (80%)	2 (40%)
Russell County	1	1 (100%)	0	0	0	0	0	0	0	0	1 (100%)	0	0	0	1 (100%)	1 (100%)	1 (100%)
Tazewell Co.	5	5 (100%)	0	0	0	2 (40%)	3 (60%)	3 (60%)	0	0	4 (80%)	4 (80%)	2 (40%)	0	1 (20%)	4 (80%)	0
District Total	15	15 (100%)	0	2 (13%)	2 (13%)	3 (20%)	7 (47%)	5 (33%)	0	0	10 (67%)	8 (53%)	7 (47%)	0	3 (20%)	11 (73%)	6 (40%)
EASTERN SHORE HEALTH DISTRICT																	
Accomack County	49	33 (67%)	16 (33%)	5 (10%)	11 (22%)	11 (22%)	21 (43%)	1 (2%)	0	0	5 (10%)	11 (23%)	13 (27%)	1 (2%)	6 (12%)	3 (6%)	10(20%)
Northampton Co.	8	2 (25%)	6 (75%)	1 (13%)	2 (25%)	4 (50%)	0	1 (13%)	0	0	3 (38%)	1 (13%)	1 (13%)	0	0	0	2 (25%)
District Total	57	35 (61%)	22 (39%)	6 (11%)	13 (23%)	15 (26%)	21 (37%)	2 (4%)	0	0	8 (14%)	12 (21%)	14 (25%)	1 (2%)	6 (11%)	3 (5%)	12 (21%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
FAIRFAX HEALTH DISTRICT																	
Fairfax County	126	96 (76%)	30 (24%)	6 (4%)	1 (1%)	16 (13%)	7 (6%)	0	0	4 (3%)	1 (1%)	5 (4%)	9 (7%)	0	2 (2%)	0	83 (66%)
FRANKLIN-HENRY .. HEALTH DISTRICT																	
Franklin County	5	4 (80%)	1 (20%)	1 (20%)	0	2 (40%)	0	0	0	0	1 (20%)	2 (40%)	0	0	2 (40%)	2 (40%)	2 (40%)
Henry - Martinsville	39	33 (85%)	6 (15%)	0	1 (3%)	6 (15%)	16 (41%)	1 (3%)	0	3 (8%)	11 (28%)	12 (31%)	18 (46%)	2 (5%)	13 (33%)	13 (33%)	9 (23%)
Patrick County	4	3 (75%)	1 (25%)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
District Total	48	40 (83%)	8 (17%)	1 (2%)	1 (2%)	8 (17%)	16 (33%)	1 (2%)	0	3 (6%)	12 (25%)	14 (29%)	18 (38%)	2 (4%)	15 (31%)	15 (31%)	11 (23%)
HAMPTON HEALTH DISTRICT																	
Hampton	32	28 (87%)	4 (13%)	4 (13%)	3 (9%)	11 (34%)	9 (28%)	6 (19%)	1 (3%)	0	3 (9%)	6 (19%)	13 (41%)	0	6 (19%)	2 (6%)	8 (25%)

	Total Number Screened	Recommended: Nursing Home	Recommended: Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
HENRICO HEALTH DISTRICT																	
Henrico County	30	23 (77%)	7 (23%)	6 (20%)	0	7 (23%)	9 (30%)	0	2 (7%)	2 (7%)	0	11 (37%)	11 (37%)	1 (3%)	11 (37%)	4 (13%)	6 (20%)
LENOWISCO HEALTH DISTRICT																	
Lee County	3	1 (33%)	2 (67%)	0	0	0	1 (33%)	0	0	0	0	0	0	0	0	0	0
Scott County	8	7 (88%)	1 (12%)	0	0	0	3 (38%)	0	0	0	0	0	1 (12%)	0	2 (25%)	0	2 (25%)
Wise County	21	14 (67%)	7 (33%)	0	0	0	1 (5%)	0	0	3 (14%)	1 (5%)	1 (5%)	2 (10%)	4 (19%)	1 (5%)	0	0
District Total	32	22 (69%)	10 (31%)	0	0	0	5 (16%)	0	0	3 (9%)	1 (3%)	1 (3%)	3 (9%)	4 (13%)	3 (9%)	0	2 (6%)
LORD FAIRFAX HEALTH DISTRICT																	
Frederick - Winchester	31	24 (77%)	7 (23%)	19 (61%)	16 (52%)	17 (55%)	16 (52%)	0	4 (13%)	0	10 (32%)	11 (35%)	11 (35%)	0	21 (68%)	14 (45%)	2 (6%)

Lord Fairfax continued	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Page County	11	11 (100%)	0	6 (55%)	8 (73%)	6 (55%)	8 (73%)	0	0	0	4 (36%)	1 (9%)	3 (27%)	0	9 (82%)	9 (82%)	1 (9%)
Warren County	11	8 (73%)	3 (27%)	10 (91%)	10 (91%)	10(91%)	11 (100%)	0	0	0	3 (27%)	2 (18%)	2 (18%)	0	10 (91%)	8 (73%)	0
Shenandoah Co.	17	16 (94%)	1 (6%)	7 (41%)	7 (41%)	7 (41%)	6 (35%)	1 (6%)	1 (6%)	0	5 (29%)	5 (29%)	7 (41%)	0	11 (65%)	5 (29%)	4 (24%)
Clarke County	5	5 (100%)	0	3 (60%)	5 (100%)	5 (100%)	4 (80%)	1 (20%)	1 (20%)	0	2 (40%)	0	0	0	4 (80%)	4 (80%)	1 (20%)
District Total	75	64 (85%)	11 (15%)	45 (60%)	46 (61%)	45 (60%)	45 (60%)	2 (3%)	6 (8%)	0	24 (32%)	19 (25%)	23 (30%)	0	55 (73%)	40 (53%)	8 (11%)
LOUDOUN HEALTH DISTRICT																	
Loudoun County	17	17 (100%)	0	2 (12%)	3 (18%)	2 (12%)	6 (35%)	1 (6%)	0	0	1 (6%)	3 (18%)	5 (29%)	0	4 (24%)	1 (6%)	9 (53%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
MIDDLE PENINSULA HEALTH DISTRICT																	
Essex County	4	4 (100%)	0	0	0	0	1 (25%)	0	0	0	0	0	3 (75%)	0	0	0	0
Gloucester Co.	20	20 (100%)	0	0	0	3 (15%)	1 (5%)	0	0	0	4 (20%)	1 (5%)	9 (45%)	0	2 (10%)	6 (30%)	0
King William Co.	1	1 (100%)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1 (100%)
King & Queen Co.	5	5 (100%)	0	0	0	0	0	0	0	0	1 (20%)	2 (40%)	0	0	1 (20%)	1 (20%)	0
Mathews County	7	6 (86%)	1 (14%)	0	0	0	0	0	0	0	1 (17%)	3 (50%)	1 (17%)	0	1 (17%)	1 (17%)	3 (50%)
Middlesex Co.	12	12 (100%)	0	0	0	1 (8%)	0	0	0	0	6 (50%)	2 (17%)	5 (42%)	3 (25%)	10 (83%)	4 (33%)	5 (42%)
District Total	49	48 (98%)	1 (2%)	0	0	4 (8%)	2 (4%)	0	0	0	12 (24%)	8 (16%)	18 (37%)	3 (6%)	14 (29%)	12 (24%)	9 (18%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
MT. ROGERS HEALTH DISTRICT																	
Wythe County	6	4 (67%)	2 (33%)	0	2 (33%)	3 (50%)	2 (33%)	0	0	0	3 (50%)	3 (50%)	2 (33%)	2 (33%)	2 (33%)	4 (67%)	1 (17%)
Smyth County	15	14 (93%)	1 (7%)	2 (13%)	2 (13%)	1 (13%)	8 (53%)	0	0	0	14 (93%)	14 (93%)	13 (87%)	1 (7%)	9 (60%)	8 (53%)	3 (20%)
Washington Co.	2	2 (100%)	0	0	0	0	2 (100%)	0	0	0	1 (50%)	2 (100%)	1 (50%)	0	1 (50%)	0	0
Grayson County	4	3 (75%)	1 (25%)	0	2 (50%)	2 (50%)	2 (50%)	0	0	0	3 (75%)	3 (75%)	2 (50%)	0	3 (75%)	2 (50%)	1 (25%)
Carroll County	11	8 (73%)	3 (27%)	3(27%)	1 (9%)	1 (9%)	3 (27%)	2 (18%)	3 (27%)	0	2 (18%)	7 (64%)	5 (45%)	0	5 (45%)	4 (36%)	2 (18%)
Galax	12	11 (92%)	1 (8%)	0	4 (33%)	4 (33%)	5 (42%)	2 (17%)	0	0	7 (58%)	4 (33%)	4 (33%)	0	4 (33%)	7 (58%)	5 (42%)
Bristol	6	6 (100%)	0	0	0	0	1 (17%)	0	0	0	2 (33%)	3 (50%)	2 (33%)	0	1 (17%)	2 (33%)	2 (33%)
District Total	56	48 (85%)	8 (15%)	5 (9%)	11 (20%)	12 (21%)	23 (41%)	4 (7%)	3 (5%)	0	32 (57%)	36 (64%)	29 (52%)	3 (5%)	25 (45%)	27 (48%)	14 (25%)

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
NEW RIVER HEALTH DISTRICT																	
Montgomery Co.	19	19 (100%)	0	4 (21%)	1 (5%)	4 (21%)	0	0	0	0	3 (16%)	1 (5%)	1 (5%)	1 (5%)	2 (11%)	7 (37%)	11 (58%)
Giles County	16	15 (94%)	1 (6%)	3 (19%)	0	0	0	0	0	0	4 (25%)	2 (13%)	3 (19%)	0	3 (19%)	12 (75%)	10 (63%)
Floyd County	4	3 (75%)	1 (25%)	1 (25%)	2 (50%)	0	1 (25%)	0	0	0	1 (25%)	1 (25%)	1 (25%)	0	1 (25%)	4 (100%)	0
Pulaski County	10	10 (100%)	0	0	0	1 (10%)	0	0	0	0	1 (10%)	0	7 (70%)	0	0	0	4 (40%)
Radford	8	8 (100%)	0	1 (13%)	3 (38%)	3 (38%)	0	0	0	0	1 (13%)	0	1 (13%)	0	1 (13%)	1 (13%)	7 (88%)
District Total	57	55 (96%)	2 (4%)	9 (16%)	6 (28%)	8 (14%)	1 (2%)	0	0	0	10 (18%)	4 (7%)	13 (23%)	1 (2%)	7 (12%)	24 (42%)	32 (56%)
NORFOLK HEALTH DISTRICT																	
Norfolk	89	68 (76%)	21 (24%)	20 (22%)	3 (3%)	17 (19%)	4 (4 %)	3 (3%)	6 (7%)	5 (6%)	21 (24%)	19 (21%)	14 (16%)	6 (7%)	24 (27%)	26 (29%)	53 (60%)

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
NORTHERN NECK HEALTH DISTRICT																	
Lancaster Co.	8	6 (75%)	2 (25%)	0	0	3 (38%)	2 (25%)	0	0	0	4 (50%)	1 (13%)	2 (25%)	0	3 (38%)	0	0
Northumberland	8	6 (75%)	2 (25%)	0	0	3 (38%)	2 (25%)	0	0	0	3 (38%)	2 (25%)	3 (38%)	0	1 (13%)	3 (38%)	5 (63%)
Richmond County	4	4 (100%)	0	0	0	0	1 (25%)	0	0	0	4 (100%)	4 (100%)	4 (100%)	0	3 (75%)	3 (75%)	0
Westmoreland Co.	5	5 (100%)	0	0	0	0	0	0	0	0	5 (100%)	2 (40%)	3 (60%)	0	3 (60%)	1 (20%)	1 (20%)
District Total	25	21 (84%)	4 (16%)	0	0	6 (24%)	5 (20%)	0	0	0	16 (64%)	9 (36%)	12 (48%)	0	10 (40%)	7 (28%)	6 (24%)
PENINSULA HEALTH DISTRICT																	
Newport News	62	51 (82%)	11 (18%)	4 (6%)	5 (8%)	6 (10%)	9 (15%)	1 (2%)	1 (2%)	4 (6%)	2 (3%)	1 (2%)	25 (40%)	0	3 (5%)	0	36 (58%)
Williamsburg - James City	20	18 (90%)	2 (10%)	0	0	1 (5%)	1 (5%)	0	0	0	0	1 (5%)	1 (5%)	0	11 (55%)	0	13 (65%)
York County	1	0	1 (100%)	1 (100%)	0	1 (100%)	0	0	0	1 (100%)	0	0	0	0	0	0	0
District Total	83	69 (83%)	14 (17%)	5 (6%)	5 (6%)	8 (10%)	10 (12%)	1 (1%)	1 (1%)	5 (6%)	2 (2%)	2 (2%)	26 (31%)	0	14 (17%)	0	49 (59%)

	Total Number Screened	Recommended: Nursing Home	Recommended: Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
PIEDMONT HEALTH DISTRICT																	
Charlotte County	9	7 (78%)	2 (22%)	4 (44%)	3 (33%)	4 (44%)	0	2 (22%)	2 (22%)	0	0	5 (56%)	4 (44%)	0	5 (56%)	1 (11%)	0
Nottoway County	16	14 (88%)	2 (12%)	6 (38%)	5 (31%)	7 (44%)	0	3 (19%)	3 (19%)	0	1 (6%)	5 (31%)	4 (25%)	0	4 (25%)	2 (12%)	8 (50%)
Prince Edward	5	3 (60%)	2 (40%)	2 (40%)	2 (40%)	1 (20%)	1 (20%)	0	1 (20%)	0	0	1 (20%)	1 (20%)	0	2 (40%)	1 (20%)	2 (40%)
Cumberland Co.	3	0	3 (100%)	1 (33%)	0	2 (66%)	0	0	0	0	0	0	0	0	0	0	0
Buckingham Co.	1	1 (100%)	0	1 (100%)	0	0	0	0	0	0	0	1 (100%)	1 (100%)	0	0	1(100%)	1 (100%)
Amelia County	6	5 (83%)	1 (17%)	0	3 (50%)	1 (17%)	0	0	0	0	5 (83%)	0	5 (83%)	0	6 (100%)	0	0
District Total	40	30 (75%)	10 (25%)	14 (35%)	13 (33%)	15 (38%)	1 (3%)	5 (13%)	6 (15%)	0	6 (15%)	12 (30%)	15 (38%)	0	17 (43%)	5 (13%)	11 (28%)

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
PITTSYLVANIA-DANVILLE HEALTH DISTRICT																	
Pittsylvania Co.	44	29 (66%)	15 (34%)	11 (26%)	9 (21%)	5 (12%)	5 (12%)	5 (12%)	4 (9%)	1 (2%)	6 (14%)	7 (16%)	8 (19%)	0	9 (21%)	4 (9%)	8 (19%)
Danville	33	21 (64%)	12 (36%)	11 (33%)	13 (39%)	6 (18%)	8 (24%)	1 (3%)	1 (3%)	2 (6%)	4 (12%)	2 (6%)	8 (24%)	0	5 (15%)	8 (24%)	10 (30%)
District Total	77	50 (65%)	27 (35%)	22 (29%)	22 (29%)	11 (14%)	13 (17%)	6 (8%)	5 (7%)	3 (4%)	10 (13%)	9 (12%)	16 (21%)	0	14 (18%)	12 (16%)	18 (24%)
PRINCE WILLIAM HEALTH DISTRICT																	
Prince William	11	9 (82%)	2 (18%)	6 (55%)	6 (55%)	4 (36%)	5 (45%)	2 (18%)	1 (9%)	2 (18%)	0	0	2 (18%)	0	0	3 (27%)	4 (36%)
Garfield Branch	5	5 (100%)	0	4 (80%)	2 (40%)	0	0	0	0	1 (2%)	0	3 (60%)	4 (80%)	0	2 (40%)	1 (20%)	1 (20%)
Manassas	4	4 (100%)	0	3 (75%)	2 (50%)	2 (50%)	2 (50%)	1 (25%)	1 (25%)	0	0	0	0	0	0	0	1 (25%)
District Total	20	18 (90%)	2 (10%)	13 (65%)	10 (30%)	6 (30%)	7 (35%)	3 (15%)	2 (10%)	3 (15%)	0	3 (15%)	6 (30%)	0	2 (10%)	4 (20%)	6 (30%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
RAPPAHANNOCK AREA HEALTH DISTRICT																	
Fredericksburg	10	8 (80%)	2 (20%)	6 (60%)	2 (20%)	1 (10%)	1 (10%)	0	2 (20%)	0	2 (20%)	3 (30%)	4 (40%)	0	2 (20%)	2 (20%)	4 (40%)
Caroline County	16	15 (94%)	1 (6%)	2 (13%)	3 (19%)	7 (44%)	13 (81%)	1 (6%)	0	0	8 (50%)	8 (50%)	5 (31%)	0	5 (31%)	8 (50%)	2 (13%)
Stafford County	8	7 (88%)	1 (12%)	3 (38%)	2 (25%)	0	1 (13%)	0	0	0	2 (25%)	3 (38%)	5 (63%)	0	2 (25%)	5 (63%)	0
Spotsylvania Co.	9	7 (78%)	2 (22%)	0	0	0	2 (22%)	0	0	0	2 (22%)	1 (11%)	8 (88%)	0	1 (11%)	1 (11%)	1 (11%)
King George Co.	1	1 (100%)	0	0	0	0	0	0	0	0	1 (100%)	1 (100%)	1 (100%)	0	0	1 (100%)	1 (100%)
District Total	44	38 (86%)	6 (14%)	11 (25%)	7 (16%)	8 (18%)	17 (39%)	1 (2%)	2 (5%)	0	15 (34%)	16 (36%)	23 (52%)	0	10 (23%)	17 (39%)	8 (18%)
RAPPAHANNOCK/RAPIDAN HEALTH DISTRICT																	
Fauquier County	9	8 (89%)	1 (11%)	3 (33%)	0	0	5 (56%)	1 (11%)	0	0	2 (22%)	3 (33%)	8 (89%)	0	3 (33%)	3 (33%)	3 (33%)
Culpeper County	8	6 (75%)	2 (25%)	3 (38%)	0	0	2 (25%)	1 (13%)	0	0	2 (25%)	3 (38%)	4 (50%)	1 (13%)	3 (38%)	1 (13%)	0

Rappahannock-Rapidan (continued):	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Orange County	6	6 (100%)	0	0	0	0	2 (33%)	0	0	0	6 (100%)	5 (83%)	6 (100%)	1 (17%)	5 (83%)	5 (83%)	1 (17%)
Madison County	5	5 (100%)	0	0	0	3 (60%)	3 (60%)	1 (20%)	0	0	5 (100%)	4 (80%)	2 (40%)	0	3 (60%)	4 (80%)	0
Rappahannock Co.	2	1 (50%)	1 (50%)	0	1 (50%)	1 (50%)	2 (100%)	0	0	0	0	1 (50%)	1 (50%)	0	1 (50%)	0	0
District Total	30	26 (87%)	4 (13%)	6 (20%)	1 (3%)	4 (13%)	14 (47%)	3 (10%)	0	0	15 (50%)	16 (53%)	21 (70%)	2 (7%)	15 (50%)	13 (43%)	4 (13%)
RICHMOND CITY HEALTH DISTRICT																	
Richmond City	172	129 (75%)	43 (25%)	10 (6%)	3 (2%)	3 (2%)	21 (12%)	7 (4%)	1 (.5%)	10 (6%)	0	0	0	0	0	0	118 (69%)
ROANOKE CITY HEALTH DISTRICT																	
Roanoke City	45	30 (67%)	15 (33%)	9 (19%)	11 (23%)	13 (27%)	2 (4%)	6 (12%)	4 (8%)	8 (16%)	15 (31%)	16 (33%)	17 (35%)	0	15 (31%)	4 (8%)	5 (10%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
SOUTHSIDE HEALTH DISTRICT																	
Brunswick Co.	21	12 (57%)	9 (43%)	2 (10%)	1 (5%)	3 (14%)	0	0	1 (5%)	2 (10%)	1 (5%)	3 (14%)	2 (10%)	1 (5%)	2 (10%)	0	4 (19%)
Halifax - South Boston	27	23 (85%)	4 (15%)	2 (7%)	1 (4%)	2 (7%)	4 (15%)	0	0	0	5 (19%)	4 (15%)	11 (41%)	0	3 (11%)	0	12 (44%)
Mecklenburg Co.	13	13 (100%)	0	1 (8%)	1 (8%)	4 (31%)	2 (15%)	0	0	2 (15%)	2 (15%)	0	3 (23%)	0	1 (8%)	1 (8%)	8 (62%)
District Total	61	48 (79%)	13 (21%)	5 (8%)	3 (5%)	9 (15%)	6 (10%)	0	1 (2%)	4 ((7%)	8 (13%)	7 (11%)	16 (26%)	1 (2%)	6 (10%)	1 (2%)	24 (39%)
THOMAS JEFFERSON HEALTH DISTRICT																	
Albemarle - Charlottesville	41	32 (76%)	9 (24%)	23 (55%)	8 (19%)	6 (14%)	14 (33%)	3 (7%)	4 (10%)	1 (2%)	9 (21%)	13 (31%)	18 (43%)	3 (7%)	15 (36%)	15 (36%)	21 (50%)
Fluvanna County	4	3 (75%)	1 (25%)	0	0	0	2 (50%)	0	0	1 (25%)	2 (50%)	2 (50%)	2 (50%)	0	1 (25%)	3 (75%)	2 (50%)
Greene County	3	3 (100%)	0	1 (33%)	0	1 (33%)	1 (33%)	0	0	0	1 (33%)	1 (33%)	1 (33%)	1 (33%)	1 (33%)	0	1 (33%)
Louisa County	5	5 (100%)	0	0	0	0	3 (60%)	0	0	1 (20%)	1 (20%)	0	1 (20%)	1 (20%)	0	2 (40%)	1 (20%)

Thomas Jefferson (continued):	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Nelson County	19	15 (79%)	4 (21%)	3 (17%)	2 (11%)	3 (17%)	3 (17%)	1 (6%)	1 (6%)	2 (11%)	1 (6%)	1 (6%)	3 (17%)	1 (6%)	1 (6%)	2 (11%)	8 (44%)
District Total	72	58 (81%)	14 (19%)	27 (38%)	10 (14%)	10 (14%)	23 (32%)	4 (6%)	5 (7%)	(7%)	14 (19%)	17 (24%)	25 (35%)	6 (8%)	18 (25%)	22 (31%)	33 (46%)
TIDEWATER HEALTH DISTRICT																	
Franklin City	9	9 (100%)	0	2 (22%)	0	2 (22%)	2 (22%)	0	0	0	4 (44%)	4 (44%)	5 (56%)	1 (11%)	5 (56%)	5 (56%)	3 (33%)
Isle of Wight	20	18 (90%)	2 (10%)	3 (15%)	1 (5%)	2 (10%)	4 (20%)	0	0	0	13 (65%)	17 (85%)	17 (85%)	2 (10%)	11 (55%)	10 (50%)	7 (35%)
Portsmouth	70	53 (76%)	17 (24%)	0	3 (4%)	4 (6%)	10 (14%)	3 (4%)	0	0	15 (22%)	25 (36%)	34 (49%)	1 (1%)	24 (36%)	9 (13%)	11 (11%)
Southampton Co.	22	18 (82%)	4 (18%)	1 (5%)	1 (5%)	5 (23%)	6 (27%)	0	0	0	14 (64%)	16 (73%)	13 (59%)	3 (14%)	15 (68%)	16 (73%)	6 (27%)
Suffolk	23	19 (82%)	4 (18%)	1 (5%)	2 (9%)	3 (14%)	1 (5%)	0	0	0	9 (41%)	7 (32%)	13 (59%)	3 (14%)	7 (32%)	6 (27%)	0
District Total	144	117 (81%)	27 (19%)	7 (5%)	7 (5%)	16 (11%)	23 (16%)	3 (2%)	0	0	55 (38%)	69 (48%)	82 (57%)	10 (7%)	62 (43%)	46 (32%)	27 (19%)

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
VIRGINIA BEACH HEALTH DISTRICT																	
Virginia Beach	52	49 (94%)	3 (6%)	22 (42%)	3 (6%)	5 (10%)	31 (60%)	5 (10%)	12 (23%)	1 (2%)	0	14 (27%)	20 (38%)	0	2 (4%)	0	11 (21%)
STATE TOTAL	2062	1618 (78%)	444 (22%)	341 (17%)	248 (12%)	352 (17%)	442 (21%)	104 (5%)	85 (4%)	91 (4%)	388 (19%)	435 (21%)	567 (28%)	57 (3%)	432 (21%)	362 (18%)	732 (36%)

Nursing Home Pre-Admission Screening

July 1, 1978 - June 30, 1979

PURPOSE

On May 15, 1977, the Virginia Medical Assistance Program implemented the Nursing Home Pre-Admission Screening Program. The purpose of the program was to delay or avoid unwanted and/or inappropriate nursing home placements through the use of the interdisciplinary team approach and the mobilization of community resources. A second purpose of the Pre-Admission Screening Program was to identify services required in the community to meet the needs of elderly and disabled persons.

The purpose of this report is to summarize the program's second year (July 1, 1978 through June 30, 1979) and to compare the program's first year (May 15, 1977 through May 30, 1978)* and second year.

PROGRAM RESULTS

During the second year of the screening program, 2,132 local screenings occurred statewide, as compared to 2,062 during the previous year. Second year reporting reflects that 438 individuals have been maintained in the community (21%), which is a slight decrease from the 444 (22%) who were maintained in the community during the previous year.

Statewide reporting continues to indicate that the service most often "unavailable"** to maintain individuals in the community is companion

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*The Program began on May 15, 1977; therefore, the first year's report was reflective of 12 months. The second year's report is reflective of the State Fiscal Year.

**Unavailable is defined as needed for the individual to remain in the community, but the service is not available to the individual.

service. The "unavailability" of companion services was reported in 31% of the cases during the program's second year as compared to 28% during the first year.

The "unavailability" of chore services remained the same for both years (21% of the cases). The "unavailability" of meals on wheels or congregate meals increased from 19% in the first year to 23% in the second year. Homemaker service "unavailability" decreased by one percent in the second year; 20% as compared to 21% in the first year. Adult day care "unavailability" also decreased during the second year by 1% (18% during the first year and 17% during the second year). Home health services continue to be the services available in all areas of the State and in sufficient quantity to meet the need in most cases. (See attached report by locality.)

Reporting for both years of the program reflects several reasons that needed services are not available. One reason is that the individual does not meet the income eligibility requirements for the service. This is particularly true for individuals whose income is in excess of the allowable amount for Supplemental Security Income eligibility and who are, therefore, ineligible for such services as chore and companion service under Title XX in Virginia.

In many instances, the service "needed" does not exist in the community. Adult day care continues to be a striking example of this reality. Another reason that "needed" services are not available continues to be that the service is not offered a sufficient number of hours to meet the need.

During the second year of the program, 181 patients in State Mental Health and Mental Retardation facilities were screened. Seventeen percent

were not approved for nursing home care. This compares with 197 patients screened during the first year and 22% not approved for nursing home care. In those cases that were not approved for nursing home care during both years, it was felt that the most appropriate placement would be continued hospitalization or movement into a licensed home for adults or a foster home.

CONCLUSION

In comparing the first and second years of the Nursing Home Pre-Admission Screening Program, there does not seem to be a significant difference in terms of number of screenings, recommendations, or identification of service needs. While local screenings reflect a 1% decrease in non-nursing home recommendations, there have also been some increases in the "unavailability" of community services, particularly companion services. This reported "unavailability" of services would suggest that for some persons, nursing home placement became the only alternative.

The program has continued to contribute in the specific identification of services that are required in the community and to measure the service availability to meet the needs of Virginia's elderly and disabled citizens. Moreover, disabled and elderly persons are not being uprooted from their homes and communities. Inappropriate and unwanted nursing home placements continue to be delayed and/or avoided through the mobilization of community resources.

NURSING HOME PRE-ADMISSION SCREENING

July 1, 1978 - June 30, 1979

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
ALEXANDRIA HEALTH DISTRICT																	
Alexandria	17	16(94%)	1 (6%)	3(18%)	3(18%)	8(47%)	8(47%)	4(24%)	5(29%)	1(6%)	0	0	5(29%)				13(76%)
ALLEGHANY HEALTH DISTRICT																	
Alleghany-Covington	18	15(83%)	3(17%)	1(6%)	5(28%)	6(33%)	6(33%)	2(11%)	0	1(6%)	10(56%)	3(17%)	9(50%)	3(17%)	10(56%)	1(6%)	7(39%)
Botetourt County	5	5(100%)	0	0	0	1(20%)	2(40%)	0	0	1(20%)	2(40%)	1(20%)	1(20%)	2(40%)	0	1(20%)	3(60%)
Craig County	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Roanoke County	44	33(75%)	11(25%)	2(5%)	1(2%)	4(9%)	10(23%)	0	0	5(11%)	0	0	6(14%)	0	1(2%)	3(7%)	30(68%)
Clifton Forge	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DISTRICT TOTAL																	
	67	53(79%)	14(21%)	3(4%)	6(9%)	11(16%)	18(27%)	2(3%)	0	7(10%)	12(18%)	4(6%)	16(24%)	5(7%)	11(16%)	5(7%)	40(60%)
ARLINGTON HEALTH DISTRICT																	
Arlington	27	20(74%)	7(26%)	3(11%)	2(7%)	9(33%)	4(15%)	11(41%)	9(33%)	2(7%)	0	0	2(7%)	0	0	0	19(70%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Compt Svcs.	Home Health	Home-maker	Day Care	Other
CENTRAL SHENANDOAH HEALTH DISTRICT																	
Augusta-Staunton	27	26(96%)	1(4%)	11(41%)	1(4%)	14(52%)	5(19%)	6(22%)	2(7%)	0	2(7%)	1(4%)	2(7%)	0	1(4%)	5(19%)	8(30%)
Bath County	4	4(100%)	0	0	0	0	0	0	0	0	1(25%)	0	0	0	0	0	4(100%)
Highland County	2	0	2(100%)	0	0	0	0	0	0	0	1(25%)	1(25%)	1(25%)	0	1(28%)	0	0
Lexington-Rockbridge	3	3(100%)	0	0	0	1(33%)	0	0	0	0	1(33%)	0	0	0	0	0	3(100%)
Rockingham-Harrisonburg	27	27(100%)	0	3(11%)	0	3(11%)	4(15%)	1(4%)	0	0	23(85%)	11(41%)	17(63%)	0	6(22%)	4(15%)	13(48%)
Buena Vista	3	3	0	1(33%)	0	0	0	0	0	0	0	1(33%)	1(33%)	1(33%)	1(33%)	1(33%)	1(33%)
Waynesboro	17	14(82%)	3(18%)	5(29%)	0	3(18%)	6(35%)	1(6%)	2(12%)	2(12%)	6(35%)	4(24%)	6(35%)	3(18%)	6(29%)	5(29%)	9(53%)
DISTRICT TOTAL	83	77(93%)	6(7%)	20(24%)	1(1%)	21(25%)	15(18%)	8(10%)	4(5%)	2(2%)	34(41%)	18(22%)	27(33%)	4(5%)	14(17%)	15(18%)	38(46%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CENTRAL VIRGINIA DISTRICT																	
Amherst County	8	6(75%)	2(25%)	3(38%)	0	0	4(50%)	0	0	0	3(38%	2(25%)	5(63%)	0	2(25%)	2(25%)	2(25%)
Appomattox County	1	1(100%)	0	1(100%)	1(100%)	0	1(100%)	0	0	0	0	0	0	0	0	0	0
Bedford County	8	4(50%)	4(50%)	2(25%)	0	0	3(38%)	0	0	0	3(38%)	3(38%)	3(38%)	0	1(13%)	2(25%)	1(13%)
Campbell County	17	11(65%)	6(35%)	2(12%)	0	6(35%)	0	0	0	0	1(6%)	1(6%)	1(6%)	1(6%)	2(12%)	1(6%)	9(53%)
Lynchburg	53	31(58%)	22(42%)	16(30%)	3(6%)	5(9%)	6(11%)	1(2%)	2(4%)	7(13%)	8(15%	15(28%	11(21%)	2(4%)	6(11%)	8(15%)	14(26%)
DISTRICT TOTAL	87	53(61%	34(39%)	24(28%	4(5%)	11(13%)	13(15%	1(1%)	2(2%)	7(8%)	15(17%	21(24%	10(11%)	3(3%)	11(13%)	13(15%	26(30%)
CHARLES CITY HEALTH DISTRICT																	
Charles City Co.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Goochland County	4	4(100%)	0	0	2	0	2	0	0	0	2	1	1	0	0	0	3
Hanover Co.	20	13(65%)	7(35%)	2(10%	1(5%)	6(30%)	7(35%	1(5%)	2(10%)	0	2(10%	3(15%)	3(15%	0	2(10%)	4(20%	5(25%)
New Kent Co.	4	4(100%)	0	1(25%)	0	1(25%	1(25%)	0	0	0	3(78%	4(100%)	3(75%	1(25%)	2(50%)	2(50%	1(25%)
DISTRICT TOTAL:	28	21(75%)	7(25%)	3(11%)	3(11%)	7(25%	10(36%	1(3.5%	2(7%)	0	7(25%	8(28%)	8(28%	1(3.5%	4(14%)	6(21%	9(32%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CHESAPEAKE HEALTH DISTRICT																	
Chesapeake	57	32(56%)	25(44%)	30(53%)	1(2%)	3(5%)	13(23%)	1(2%)	1(2%)	6(10%)	3(5%)	3(5%)	9(16%)	1(2%)	3(5%)	8(14%)	14(25%)
CHESTERFIELD HEALTH DISTRICT																	
Chesterfield County	27	23(85%)	4(15%)	3(11%)	0	6(22%)	3(11%)	1(4%)	0	1(4%)	8(30%)	8(30%)	8(30%)	2(7%)	5(18%)	7(26%)	14(52%)
Powhatan County	2	2(100%)	0	0	0	0	0	0	0	0	2(100%)	1(50%)	1(50%)	1(50%)	1(50%)	1(50%)	2(100%)
Colonial Heights	11	8(73%)	3(27%)	0	0	3(27%)	7(64%)	1(9%)	1(9%)	1(9%)	10(91%)	9(82%)	6(54%)	0	9(82%)	9(82%)	1(9%)
DISTRICT TOTAL	40	33(82%)	7(18%)	3(7%)	0	9(22%)	10(25%)	2(5%)	1(2%)	2(5%)	20(50%)	18(45%)	15(37%)	3(7%)	15(37%)	17(42%)	17(42%)
CRATER HEALTH DISTRICT																	
Dinwiddie County	11	10(91%)	1(9%)	0	0	0	6(54%)	0	0	0	6(54%)	10(91%)	10(91%)	2(18%)	6(54%)	4(36%)	1(9%)
Greensville-Emporia	9	5(55%)	4(45%)	3(33%)	4(45%)	2(22%)	2(22%)	0	0	2(22%)	2(22%)	4(45%)	4(45%)	0	1(11%)	0	5(55%)
Prince George County	3	1(33%)	2(67%)	0	2(67%)	0	1(33%)	0	0	1(33%)	1(33%)	0	1(33%)	0	0	0	1(33%)
Surry County	1	0	1(100%)	0	0	0	0	0	0	0	1(100%)	1(100%)	1(100%)	0	1(100%)	1(100%)	0
Sussex County	2	2(100%)	0	0	0	0	1(50%)	0	0	0	0	0	2(100%)	0	0	0	0

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Hopewell	10	9(90%)	1(10%)			2(20%)	1(10%)	0	0	0	1(10%)	1(10%)	6(60%)	0	0	1(10%)	5(50%)
Petersburg	20	16(80%)	4(20%)	2(10%)	0	4(20%)	2(10%)	0	0	2(10%)	0	6(30%)	6(30%)	4(20%)	0	1(5%)	9(45%)
DISTRICT TOTAL	56	43(77%)	13(23%)	5(9%)	6(11%)	8(14%)	13(23%)	0	0	5(9%)	11(20%)	17(30%)	30(54%)	6(11%)	8(14%)	7(12.5%)	21 (37.5%)
CUMBERLAND PLATEAU HEALTH DISTRICT																	
Buchanan Co.	3	3(100%)	0	1(33%)	2(67%)	1(33%)	2(67%)	0	1(33%)	1(33%)	1(33%)	0	0	0	1(33%)	1(33%)	2(67%)
Dickenson Co.	3	2(67%)	1(33%)	0	0	0	3(100%)	0	0	0	3(100%)	2(67%)	3(100%)	0	2(67%)	2(67%)	1(33%)
Russell Co.	2	2(100%)	0	0	1(50%)	0	2(100%)	0	0	0	1(50%)	1(50%)	0	0	1(50%)	0	0
Tazewell Co.	6	6(100%)	0	0	2(33%)	3(50%)	5(83%)	4(67%)	0	0	4(67%)	2(33%)	2(33%)	0	2(33%)	1(17%)	3(50%)
DISTRICT TOTAL	14	13(93%)	1(7%)	1(7%)	5(36%)	4(29%)	12(86%)	4(29%)	1(7%)	1(7%)	9(64%)	5(36%)	5(36%)	0	6(43%)	4(29%)	6(43%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
EASTERN SHORE HEALTH DISTRICT																	
Accomack Co.	48	34(71%)	14(29%)	5(10%)	1(2%)	13(27%)	20(42%	0	0	2(4%)	3(6%)	1(2%)	14(29%	2(4%)	6(12.5%)	1(2%)	26(54%
Northampton Co.	12	7(58%)	5(42%)	0	0	3(25%)	4(33%)	1(8%)	0	1(8%)	0	0	2(17%)	1(8%)	0	0	7(58%
DISTRICT TOTAL	60	41(32%)	19(32%)	5(8%)	1(2%)	16(27%	24(40%	1(20%)	0	3(5%)	3(5%)	1(2%)	16(27%)	3(5%)	6(10%)	1(2%)	33(55%
FAIRFAX HEALTH DISTRICT																	
Fairfax Co.	165	130(79%)	35(21%)	1(.6%)	3(2%)	26(16%)	20(12%)	10 (06.5%)	4(2%	20(12%	1(.6%)	1(.6%)	7(4%)	0	7(4%)	1(.6%)	33(20%
FRANKLIN-HENRY HEALTH DISTRICT																	
Franklin Co.	9	9(100%)	0	7(78%)	4(44%)	8(89%)	0	0	0	0	2(20%)	5(55%)	5(55%)	0	5(55%)	3(33%)	6(67%)
Henry-Martinsville	31	29(93%)	2(7%)	0	1(3%)	4(45%)	4(45%	1(3%)	1(3%)	0	14(45%)	12(39%)	17(55%)	3(10%)	14(45%)	12(39%)	5(16%
Patrick Co.	7	6(86%)	1(14%)	0	0	2(29%)	6(86%	0	0	0	4(57%)	4(57%)	3(43%)	0	5(71%)	5(71%)	1(14%
DISTRICT TOTAL	47	44(94%)	3(6%)	7(15%)	5(11%)	14(30%)	10	1(21%)	1(21%)	0	20(42%)	21(45%)	25(53%)	3(6%)	24(51%)	20(42%)	12(25%

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
HAMPTON HEALTH DISTRICT																	
Hampton	28	25(89%)	3(11%)	1(4%)	5(18%)	8(29%)	3(11%)	2(7%)	2(7%)	0	0	9(32%)	8(29%)	1(4%)	4(14%)	0	14(50%)
HENRICO HEALTH DISTRICT																	
Henrico County	36	29(80%)	7(20%)	5(14%)	1(3%)	6(17%)	2(5%)	1(3%)	1(3%)	2(5%)	1(3%)	1(3%)	7(20%)	0	0	0	9(25%)
LENOWISCO HEALTH DISTRICT																	
Lee County	10	7(70%)	3(30%)	0	0	1(10%)	4(40%)	0	0	0	2(20%)	0	2(20%)	0	2(20%)	2(20%)	7(70%)
Scott County	8	5(62.5%)	3(37.5%)	0	0	0	1(12.5%)	0	0	0	0	0	2(25%)	0	0	1 (12.5%)	7 (87.5%)
Wise County	3	0	3(100%)	0	0	0	0	0	0	0	0	0	0	0	0	0	2(67%)
DISTRICT TOTAL	21	12(57%)	9(43%)	0	0	1(5%)	5(24%)	0	0	0	2(9.5%)	0	4(19%)	0	2(9.5%)	3(14%)	16(76%)
LORD FAIRFAX HEALTH DISTRICT																	
Frederick-Winchester	30	26(87%)	4(13%)	0	0	0	0	0	0	1(3%)	23(77%)	24(80%)	21(70%)	0	19(63%)	21(70%)	2(7%)
Page County	10	8(80%)	2(20%)	0	1(10%)	1(10%)	0	0	0	0	7(70%)	3(30%)	2(20%)	0	3(30%)	1(10%)	6(60%)
Warren County	18	15(83%)	3(17%)	0	0	0	1(5.5%)	0	0	0	15(83%)	16(89%)	16(89%)	1(5.5%)	16(89%)	2(11%)	0

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Shenandoah Co.	18	17(94%)	1(6%)	2(11%)	0	1(5.5%)	0	0	1(5.5%)	6(33%)	8(44%)	7(39%)	9(50%)	0	8(44%)	8(44%)	5(28%)
Clark County	7	6(86%)	1(14%)	2(29%)	0	1(14%)	3(43%)	0	0	0	5(71%)	7(100%)	6(86%)	0	6(86%)	3(43%)	0
DISTRICT TOTAL	83	72(87%)	11(13%)	4(5%)	1(1%)	3(4%)	4(5%)	0	1(1%)	7(8%)	58(70%)	57(67%)	54(65%)	1(1%)	52(63%)	35(42%)	13(16%
LOUDOUN HEALTH DISTRICT																	
Loudoun County	13	11(85%)	2(15%)	0	5(38%)	1(8%)	9(69%)	0	0	0	1(8%)	0	0	0	1(8%)	0	11(85%
MIDDLE PENINSULA HEALTH DISTRICT																	
Essex County	4	4(100%)	0	0	1(25%)	1(25%)	2(50%)	0	1(25%)	0	3(75%)	3(75%)	1(25%)	0	1(25%)	3(75%)	1(25%
Gloucester Co.	12	12(100%)	0	1(8%)	0	3(25%)	1(8%)	0	0	0	6(50%)	1(8%)	9(75%)	0	6(50%)	2(17%)	3(25%
King William Co.	7	7(100%)	0	1(14%)	1(14%)	2(29%)	6(86%)	0	0	0	1(14%)	2(29%)	5(71%)	0	2(29%)	3(43%)	1(14%
King & Queen Co.	3	3(100%)	0	0	0	1(33%)	0	0	1(33%)	0	0	1(33%)	2(67%)	0	0	0	0
Mathews Co.	16	14(87.5%)	2(12.5%)	0	0	1(6%)	10(62.5)	0	0	0	3(19%)	1(6%)	8(50%)	0	3(19%)	4(25%)	4(25%
Middlesex Co.	8	8(100%)	0	0	0	1(12.5)	1(12.5)	0	1(12.5)	1(12.5)	2(25%)	2(25%)	2(25%)	0	1(12.5)	0	5(62.5%
DISTRICT TOTAL	50	48(96%)	2(4%)	2(4%)	2(4%)	8(16%)	20(40%)	0	3(6%)	1(2%)	15(30%)	10(20%)	27(54%)	0	13(26%)	12(24%)	19(38%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
MT. RODGERS HEALTH DISTRICT																	
Wythe County	21	13(62%)	8(38%)	1(5%)	1(5%)	1(5%)	17(81%)	0	1(5%)	0	17(81%)	14(67%)	18(86%)	0	18(86%)	11(52%)	1(5%)
Smyth County	13	9(69%)	4(31%)	3(23%)	3(23%)	2(15%)	4(31%)	2(15%)	0	0	8(61%)	7(54%)	6(46%)	1(8%)	7(54%)	7(54%)	2(15%)
Washington Co.	54	42(78%)	12(22%)	5(9%)	2(4%)	2(4%)	14(26%)	3(5%)	5(9%)	0	9(17%)	10(18%)	16(30%)	0	3(5%)	4(7%)	16(30%)
Grayson Co.	2	1(50%)	1(50%)	0	0	0	1(50%)	1(50%)	0	0	2(100%)	2(100%)	0	0	1(50%)	2(100%)	0
Carroll Co.	7	4(57%)	3(43%)	0	0	2(29%)	2(89%)	0	0	0	7(100%)	4(57%)	2(29%)	0	7(100%)	4(57%)	0
Galax	5	4(80%)	1(20%)	0	1(20%)	3(60%)	0	0	1(20%)	1(20%)	2(40%)	2(40%)	2(40%)	0	3(60%)	4(80%)	4(80%)
Bristol	1	1(100%)	0	0	0	0	1(100%)	0	0	0	1(100%)	1(100%)	1(100%)	0	1(100%)	1(100%)	1(100%)
DISTRICT TOTAL	103	74(72%)	29(28%)	9(9%)	9(9%)	10(10%)	35(39%)	6(6%)	7(7%)	3(3%)	36(35%)	40(39%)	45(44%)	1(1%)	30(29%)	33(32%)	24(23%)
NEW RIVER HEALTH DISTRICT																	
Montgomery Co.	22	18(82%)	4(18%)	8(36%)	1(4%)	4(18%)	7(32%)	3(14%)	1(4%)	1(4%)	7(32%)	1(4%)	11(50%)	4(18%)	5(23%)	7(32%)	7(32%)
Giles Co.	15	15(100%)	0	0	2(13%)	0	2(13%)	0	0	0	1(7%)	0	1(7%)	0	1(7%)	2(13%)	11(73%)
Floyd Co.	2	2(100%)	0	0	0	0	1(50%)	0	0	0	0	1(50%)	0	0	1(50%)	0	2(100%)
Pulaski Co.	9	8(89%)	1(11%)	0	0	1(11%)	2(22%)	0	0	0	2(22%)	2(22%)	3(33%)	1(11%)	2(22%)	2(22%)	4(44%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Radford	7	6(86%)	1(14%)	0	0	1(14%)	0	0	0	0	0	1(14%)	2(29%)	0	1(14%)	1(14%)	4(57%)
DISTRICT TOTAL																	
	55	49(89%)	6(11%)	8(14%)	3(5%)	6(11%)	12(22%)	3(5%)	1(2%)	1(2%)	9(16%)	5(9%)	16(29%)	5(9%)	10(18%)	12(22%)	28(51%)
NORFOLK HEALTH DISTRICT																	
Norfolk	107	70(65%)	37(35%)	35(33%)	11(10%)	34(32%)	17(16%)	12(11%)	12(11%)	16 (15%)	14(13%)	15(14%)	19(18%)	10(9%)	22(21%)	24(22%)	50(47%)
NORTHERN NECK HEALTH DISTRICT																	
Lancaster Co.	11	11(100%)	0	0	0	0	7(64%)	0	0	0	7(64%)	2(18%)	8(73%)	0	2(18%)	0	4(36%)
Northumberland	7	7(100%)	0	0	0	0	2(28%)	0	0	0	2(28%)	2(28%)	3(43%)	0	0	1(14%)	4(57%)
Richmond Co.	13	10(77%)	3(23%)	0	0	4(31%)	6(46%)	0	0	0	10(77%)	8(61%)	5(38%)	3(23%)	8(61%)	3(23%)	2(15%)
Westmoreland County	4	3(75%)	1(25%)	0	0	0	0	0	0	0	4(100%)	1(25%)	3(75%)	2(50%)	2(50%)	2(50%)	0
DISTRICT TOTAL																	
	35	31(88%)	4(12%)	0	0	4(12%)	15(43%)	0	0	0	23(66%)	13(37%)	19(54%)	5(14%)	12(34%)	6(17%)	10(28%)

	Total Number Screened	Recommended: Nursing Home	Recommended: Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
PENINSULA HEALTH DISTRICT																	
Newport News	67	57(85%)	10(15%)	19(28%)	11(16%)	16(24%)	15(22%)	2(3%)	2(3%)	3(4%)	15(22%)	25(37%)	28(42%)	8(12%)	3(4%)	2(3%)	13(19%)
Williamsburg James City	10	8(80%)	2(20%)	8(80%)	0	1(10%)	10(100%)	3(3%)	2(20%)	0	0	3(30%)	8(80%)	0	1(10%)	0	0
York County	6	5(83%)	1(17%)	2(33%)	2(33%)	1(17%)	0	2(33%)	2(33%)	0	1(17%)	0	0	0	0	0	4(67%)
DISTRICT TOTAL	83	70(84%)	13(16%)	29(35%)	13(16%)	18(22%)	25(30%)	7(8%)	6(7%)	3(4%)	16(19%)	28(34%)	36(43%)	8(10%)	4(5%)	2(2%)	17(20%)
PIEDMONT HEALTH DISTRICT																	
Charlotte Co.	2	2(100%)	0	1(50%)	1(50%)	0	1(50%)	0	0	0	1(50%)	1(50%)	1(50%)	1(50%)	1(50%)	1(50%)	0
Nottoway Co.	15	13(87%)	2(13%)	1(7%)	0	1(7%)	1(7%)	0	0	2(13%)	4(27%)	3(20%)	4(27%)	2(13%)	4(27%)	3(20%)	2(80%)
Prince Edward	3	1(33%)	2(67%)	2(67%)	2(67%)	2(67%)	1(33%)	1(33%)	0	0	0	0	1(33%)	0	0	0	1(33%)
Cumberland Co.	9	7(78%)	2(22%)	3(33%)	3(33%)	5(55%)	2(22%)	0	0	0	2(22%)	2(22%)	3(33%)	0	2(22%)	2(22%)	4(44%)
Buckingham Co.	4	1(25%)	3(75%)	1(25%)	1(25%)	1(25%)	0	1(25%)	0	1(25%)	2(50%)	0	1(25%)	0	2(50%)	1(25%)	3(75%)
Amelia Co.	6	2(33%)	4(67%)	4(67%)	5(83%)	1(17%)	1(17%)	0	0	0	0	0	0	0	1(17%)	1(17%)	1(17%)
Lunenburg	6	2(33%)	4(67%)	0	0	4(67%)	2(33%)	0	0	0	1(17%)	2(33%)	1(17%)	0	2(33%)	2(33%)	3(50%)
DISTRICT TOTAL	45	28(62%)	17(38%)	12(27%)	12(27%)	14(31%)	8(18%)	2(4%)	0	3(7%)	10(22%)	8(18%)	11(24%)	3(7%)	12(27%)	10(22%)	24(53%)

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	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
PITTSYLVANIA - DANVILLE HEALTH DISTRICT																	
Pittsylvania Co	19	16(84%)	3(16%)	7(37%)	2(10%)	4(21%)	3(16%)	2(10%)	0	0	3(16%)	3(16%)	5(26%)	1(5%)	1(5%)	4(21%)	9(47%)
Danville	37	27(73%)	10(27%)	16(43%)	4(11%)	4(11%)	1(3%)	2(5%)	2(5%)	6(16%)	2(5%)	1(3%)	3(8%)	0	5(13%)	0	10(27%)
DISTRICT TOTAL	56	43(77%)	13(23%)	23(41%)	6(11%)	8(14%)	4(7%)	4(7%)	2(4%)	6(11%)	5(9%)	4(7%)	8(14%)	1(2%)	6(11%)	4(7%)	19(34%)
PRINCE WILLIAM HEALTH DISTRICT																	
Prince William	30	29(97%)	1(3%)	8(27%)	5(17%)	4(13%)	10(33%)	0	1(3%)	0	0	1(3%)	7(23%)	3(10%)	3(10%)	1(3%)	11(37%)
RAPPAHANNOCK AREA HEALTH DISTRICT																	
Fredericksburg	12	11(92%)	1(8%)	7(58%)	1(8%)	2(17%)	1(8%)	0	1(8%)	0	2(17%)	4(33%)	6(50%)	1(8%)	1(8%)	6(50%)	6(50%)
Caroline Co.	6	5(83%)	1(17%)	0	4(67%)	3(50%)	3(50%)	4(67%)	0	0	4(67%)	1(17%)	2(33%)	1(17%)	2(33%)	4(67%)	1(17%)
Stafford Co.	15	14(93%)	1(7%)	5(33%)	5(33%)	2(13%)	5(33%)	2(13%)	0	0	10(67%)	3(20%)	11(73%)	0	8(53%)	4(27%)	2(13%)
Spotsylvania Co.	3	2(67%)	1(33%)	0	0	2(67%)	2(67%)	0	0	1(33%)	0	0	1(33%)	2(67%)	0	0	0
King George Co.	2	2(100%)	0	0	0	1(50%)	0	0	0	0	1(50%)	0	0	0	1(50%)	2(100%)	0
DISTRICT TOTAL	38	34(89%)	4(11%)	12(31%)	10(26%)	10(26%)	11(29%)	6(16%)	1(3%)	1(3%)	17(45%)	8(21%)	20(53%)	4(10%)	12(31%)	16(42%)	9(24%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
RAPPAHANNOCK/RAPIDAN HEALTH DISTRICT																	
Fauquier Co.	7	6(86%)	1(14%)	4(57%)	1(14%)	0	3(43%)	0	0	0	2(28%)	3(43%)	6(86%)	2(28%)	4(57%)	5(71%)	1(14%)
Culpeper Co.	10	8(80%)	2(20%)	2(20%)	0	7(70%)	6(60%)	0	0	0	7(70%)	6(60%)	4(40%)	0	6(60%)	5(50%)	2(20%)
Orange County	8	8(100%)	0	2(25%)	0	0	7(87.5%)	0	0	0	6(75%)	5(62.5%)	6(75%)	1(12.5%)	6(75%)	6(75%)	3(37.5%)
Madison County	2	2(100%)	0	0	1(50%)	1(50%)	2(100%)	0	0	0	2(100%)	1(50%)	1(50%)	0	2(100%)	1(50%)	0
Rappahannock Co.	1	1(100%)	0	0	0	0	0	0	0	0	0	0	0	0	1(100%)	0	0
DISTRICT TOTAL	28	25(89%)	3(11%)	8(28%)	2(7%)	8(28%)	18(64%)	0	0	0	17(61%)	15(53%)	17(61%)	3(11%)	19(68%)	17(61%)	6(21%)
RICHMOND CITY HEATLH DISTRICT																	
Richmond City	185	135(73%)	50(27%)	30(16%)	11(6%)	6(3%)	20(11%)	4(2%)	5(3%)	23(12%)	3(2%)	5(3%)	12(6%)	0	0	0	139(75%)
ROANOKE CITY HEALTH DISTRICT																	
Roanoke City	74	63(85%)	11(15%)	17(23%)	8(11%)	8(11%)	10(13%)	5(7%)	6(8%)	3(4%)	25(34%)	26(35%)	25(34%)	1(1%)	10(13%)	7(9%)	47(63%)
SOUTHSIDE HEALTH DISTRICT																	
Brunswick Co.	5	5(100%)	0	3(60%)	1(20%)	2(40%)	1(20%)	0	0	0	0	2(40%)	2(40%)	0	2(40%)	2(40%)	3(60%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Halifax-South Boston	20	17(85%)	3(15%)	3(15%)	0	0	0	0	0	0	0	4(20%)	9(45%)	1(8%)	1(8%)	0	11(55%)
Mecklenburg	12	12(100%)	0	3(25%)	1(8%)	2(17%)	5(42%)	0	0	0	2(17%)	3(25%)	4(33%)	0	3(25%)	2(25%)	8(67%)
DISTRICT TOTAL	37	34(92%)	3(8%)	9(24%)	2(5%)	4(11%)	6(16%)	0	0	0	2(5%)	9(24%)	15(40%)	1(3%)	6(16%)	5(13%)	22(59%)
THOMAS JEFFERSON HEALTH DISTRICT																	
Albemarle-Charlottesville	46	32(70%)	14(30%)	19(41%)	5(11%)	6(13%)	9(19%)	3(7%)	0	7(15%)	4(9%)	5(11%)	14(30%)	1(2%)	7(15%)	6(13%)	13(28%)
Fluvanna Co.	8	8(100%)	0	1(13%)	0	4(50%)	0	0	0	0	2(25%)	0	3(38%)	0	1(13%)	1(13%)	5(63%)
Greene Co.	4	2(50%)	2(50%)	1(25%)	0	1(25%)	2(50%)	0	0	0	2(50%)	0	2(50%)	0	2(50%)	1(25%)	1(25%)
Louisa Co.	9	8(89%)	1(11%)	1(11%)	0	2(22%)	3(33%)	1(11%)	0	0	5(56%)	4(44%)	7(78%)	0	2(22%)	3(33%)	1(11%)
Nelson Co.	19	16(84%)	3(16%)	0	0	3(16%)	2(10%)	1(5%)	0	0	7(37%)	4(21%)	6(32%)	1(5%)	4(21%)	6(32%)	12(63%)
DISTRICT TOTAL	86	66(77%)	20(23%)	22(26%)	5(6%)	16(19%)	16(19%)	5(6%)	0	7(8%)	20(23%)	13(15%)	32(37%)	2(2%)	16(19%)	17(20%)	32(37%)
TIDEWATER HEATLH DISTRICT																	
Franklin City	12	11(92%)	1(8%)	4(33%)	3(25%)	5(42%)	6(50%)	0	0	0	8(67%)	7(58%)	3(25%)	2(17%)	11(92%)	7(58%)	2(17%)

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
Isle of Wight	24	21(87%)	3(13%)	4(17%)	1(4%)	3(12%)	13(54%)	2(8%)	0	0	18(75%)	17(71%)	20(83%)	1(4%)	19(79%)	15(62%)	6(25%)
Portsmouth	45	36(80%)	9(20%)	0	1(2%)	1(2%)	8(18%)	0	0	2(4%)	9(20%)	33(73%)	33(73%)	0	33(73%)	11(24%)	4(9%)
Southampton Co.	24	24(100%)	0	1(4%)	2(8%)	5(21%)	6(25%)	2(8%)	1(4%)	0	21(87%)	18(75%)	21(87%)	3(12%)	19(79%)	16(67%)	1(4%)
Suffolk	38	36(95%)	2(5%)	4(10%)	2(5%)	15(39%)	10(26%)	0	2(5%)	2(5%)	19(50%)	17(45%)	18(47%)	8(21%)	14(37%)	13(34%)	2(32%)
DISTRICT TOTAL	143	128(89%)	15(11%)	13(99%)	9(6%)	29(20%)	43(30%)	4(3%)	3(2%)	4(3%)	75(52%)	92(64%)	95(66%)	14(10%)	96(67%)	62(43%)	15(10%)
VIRGINIA BEACH HEALTH DISTRICT																	
Virginia Beach	48	42(87%)	6(13%)	4(8%)	1(2%)	0	5(10%)	0	2(4%)	1(2%)	1(2%)	1(2%)	18(37%)	1(2%)	2(4%)	1(2%)	20(42%)
STATE TOTAL	2132	1694 (79%)	438 (21%)	348 (16%)	146 (7%)	349 (16%)	468 (22%)	107 (5%)	83 (4%)	137 (6%)	482 (23%)	457 (21%)	670 (31%)	93 (4%)	430 (20%)	364 (17%)	836 (39%)

NURSING HOME PRE-ADMISSION SCREENING

July 1, 1979 - June 30, 1980

PURPOSE

On May 15, 1977, the Virginia Medical Assistance Program implemented the Nursing Home Pre-Admission Screening Program. The purpose of the program was to delay or avoid unwanted and/or inappropriate nursing home placements through the use of the interdisciplinary team approach and the mobilization of community resources. A second purpose of the Pre-Admission Screening Program was to identify services required in the community to meet the needs of elderly and disabled persons.

The purpose of this report is to summarize the program's third year (July 1, 1979 - June 30, 1980) and to compare the program's third year and the program's first two years.

PROGRAM RESULTS

During the third year of the pre-admission screening program, 2,065 local screenings occurred statewide, as compared to 2,062 during the first year, and 2,132 during the second year. Third year reporting reflects that 365 individuals have been maintained in the community (18%), as compared to 444 (22%) during the first year and 438 (21%) during the second year. Statewide reporting continues to indicate that the service most often "unavailable"(unavailable is defined as needed for the individual to remain in the community, but the service is not available to the individual) to maintain individuals in the community is companion service. The "unavailability" of companion services was reported in 31% of the cases during the program's second and third year and 28% during the first year.

The "unavailability"of chore services was 21% for both the first and second year as compared to 18% for the third year. The "unavailability" of meals on wheels or congregate meals was 19% during the first year, 23% during the second year and 16% during the third year. Homemaker service "unavailability" remained the same (20% of the cases) for both the second and third years, as compared to 21% in the first year. Adult Day Care "unavailability" has remained essentially the same (18% during the first year, 17% during the second year and 18% during the third year). Home Health services continue to be the service available in all areas of the State and in sufficient quantity to meet the need in most cases. (See attached report by Health System Agencies and locality)

Reporting continues to reflect several reasons that needed services are not available. One reason is that the individual does not meet the income eligibility requirements for the service. This is particularly true for individuals whose income is in excess of the allowable amount for Supplemental Security Income eligibility and who are, therefore, ineligible for such services as chore service and companion service under Title XX in Virginia. Another reason that "needed" services are not available continues to be that the service is not offered a sufficient number of hours to meet the need.

During the third year of the program, 208 patients in State Mental Health and Mental Retardation facilities were screened. Eighteen percent were not approved for nursing home care. This compares with 197 patients screened during the first year with 22% not approved for nursing home care and 181 patients screened during the second year with 17% not approved for nursing home care. In those cases that not approved for nursing home care during both years, it was felt that the most appropriate placement would be continued hospitalization or movement into a licensed home for adults or a foster home.

CONCLUSION

In comparing the first two years of the Nursing Home Pre-Admission Screening Program and the third year of the Program, there does not seem to be a meaningful difference in terms of number of screenings and identification of service needs. Third year reporting reflects a 3% decrease in non-nursing home recommendations from the second year of the program. While the "unavailability" of community services, particularly companion services, continues to suggest that for some persons, nursing home placement seems the only alternative, there is some indication that the pre-admission screening program has contributed to greater coordination and use of community services. In addition, some pre-admission screening committees report a difference in the persons being evaluated during the third year. This difference has occurred because community services are being utilized more effectively prior to the point of Nursing Home Pre-Admission Screening and some individuals who might otherwise enter the formal Nursing Home Pre-Admission Screening process are being diverted from nursing home placement without entering the formal pre-admission screening process. The program has continued to contribute in the specific identification of services that are required in the community and to measure the service availability to meet the needs of Virginia's elderly and disabled citizens. Moreover, disabled and elderly persons are not being uprooted from their homes and communities. Inappropriate and unwanted nursing home placements continue to be delayed and/or avoided through the mobilization of community resources.

July 22, 1980

Facility	Number of Screenings	Approved	Not Approved
Catawba	11	10	1
Central State	20	17	3
Eastern State	28	26	2
Lynchburg Training School & Hospital	14	10	4
Northern Virginia Mental Health Instititute	1		1
Piedmont	11	6	5
Southern Virginia Mental Health Institute	2	1	1
Southeastern Virginia Training Center	4	3	1
Southside Virginia Training Center	0	0	0
Southwestern State Hospital	18	18	
Western State Hospital	99	79	20
Total	208	170(82%)	38(18%)

Nursing Home Pre-Admission Screening

July 1, 1979 - June 30 1980

HEALTH SYSTEMS AGENCY I

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CENTRAL SHENANDOAH HEALTH DISTRICT																	
Augusta-Staunton	10	7(70%)	3(30%)			2(20%)	6(60%)				2(20%	1(10%)	5(50%)		3(30%	3(30%)	
Bath County	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Highland County	1		1(100%)														
Lexington-Rockbridge	4		4(100%)	2(50%				2(50%				1(25%)		1(25%			1(25%)
Buena Vista	4	4(100%		2(50%			1(25%)	3(75%			2(50%	2(50%)	2(50%)				3(75%)
Waynesboro	37	33(89%)	4(11%)	2(5%)	3(8%)	15(41%)	14(30%)	9(24%			13(35%	8(22%	10(27%)	6(16%	8(22%	11(30%	4(11%)
DISTRICT TOTAL	56	44(79%)	12(21%)	6(11%	3(5%	17(30%)	21(38%)	14(25%			17(30%	12(21%)	17(30%	7(13%	11(20%	14(25%	8(14%)

Health Systems Agency I

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
RAPPAHANNOCK HEALTH DISTRICT																	
Fredericksburg	6	4(67%)	2(33%)	2(33%)			1(17%)				1(17%)	2(33%)	4(67%)		2(33%)	2(33%)	1(17%)
Caroline Co.	7	6(86%)	1(14%)	1(14%)		1(14%)	3(43%)				3(43%)	3(43%)	3(43%)	2(29%)	3(43%)	2(29%)	
Stafford Co.	9	9(100%)		1(11%)		3(33%)	1(11%)				7(78%)	1(11%)	6(67%)		4(44%)	4(44%)	1(11%)
Spotsylvania Co.	3	2(67%)	1(33%)	1(33%)							2(67%)	1(33%)			1(33%)	1(33%)	
King George Co.	3	2(67%)	1(33%)	1(33%)							2(67%)	1(33%)			1(33%)	1(33%)	
DISTRICT TOTAL	28	23(82%)	5(18%)	6(21%)		4(14%)	5(18%)				15(54%)	8(29%)	13(46%)	2(7%)	11(39%)	10(36%)	2(7%)
RAPPAHANNOCK/RAPIDAN HEALTH DISTRICT																	
Fauquier Co.	17	15(88%)	2(12%)	10(59%)	3(18%)	3(18%)	7(41%)		2(12%)		1(6%)	4(24%)	6(35%)		4(24%)	4(24%)	7(41%)
Culpeper Co.	9	9(100%)		1(11%)	1(11%)	3(33%)	5(56%)				4(44%)	6(67%)	5(56%)	1(11%)	7(78%)	7(78%)	
Orange Co.	7	7(100%)		1(14%)	1(14%)		2(29%)			1(14%)	3(43%)	3(43%)	4(57%)	1(14%)	4(57%)	3(43%)	
Madison Co.	2	2(100%)		1(50%)		2(100%)	2(100%)		1(50%)		1(50%)	1(50%)			1(50%)	1(50%)	
Rappahannock Co.	2		2(100%)	1(50%)													
DISTRICT TOTAL	37	33(89%)	4(11%)	14(38%)	5(14%)	8(22%)	16(43%)		3(8%)	1(3%)	9(24%)	14(38%)	15(41%)	2(5%)	16(43%)	15(41%)	7(19%)

Health Systems Agency I

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
THOMAS JEFFERSON HEALTH DISTRICT																	
Albemarle-Charlottesville	36	32(89%)	4(11%)	12(33%)	2(6%)	2(6%)	11(31%)	6(17%)	3(8%)	1(3%)	8(22%)	13(36%)	16(44%)	2(6%)	11(31%)	12(33%)	11(31%)
Fluvanna Co.	5	3(60%)	2(40%)	1(20%)	1(20%)	2(40%)	4(80%)	3(60%)			3(60%)	1(20%)	4(80%)		2(40%)	2(40%)	
Greene Co.	8	8(100%)		2(25%)			5(63%)			1(13%)	5(63%)	3(38%)	6(75%)		3(38%)	2(25%)	
Louisa Co.	6	6(100%)				1(17%)	4(67%)				3(50%)	3(50%)	2(33%)		3(50%)	3(50%)	1(17%)
Nelson Co.	18	16(89%)	2(11%)	7(39%)		1(6%)	5(28%)				1(6%)	5(28%)	5(28%)		4(22%)	5(28%)	16(89%)
DISTRICT TOTAL	73	65(89%)	8(11%)	22(30%)	3(4%)	6(8%)	29(40%)	9(12%)	3(4%)	2(30%)	12(16%)	25(34%)	33(45%)	2(3%)	23(32%)	24(33%)	28(38%)
LORD HALIFAX HEALTH DISTRICT																	
Frederick-Winchester	45	39(87%)	6(13%)	12(27%)		11(24%)	6(13%)	1(2%)		4(9%)	13(29%)	11(24%)	12(27%)	2(4%)	10(22%)	6(13%)	24(53%)
Page Co.	16	13(81%)	3(19%)														
Warren Co.	10	7(70%)	3(30%)	1(10%)		1(10%)	2(20%)				8(80%)	5(50%)	3(30%)		8(80%)	1(10%)	
Shenandoah Co.	16	15(94%)	1(6%)	1(6%)	1(6%)	3(19%)	2(13%)			3(19%)	2(13%)		3(19%)		2(13%)	2(13%)	2(13%)
Clark County	22	15(68%)	7(32%)	1(5%)		2(9%)	2(9%)				1(5%)	1(5%)		1(5%)	1(5%)		
DISTRICT TOTAL	109	89(82%)	20(18%)	15(14%)	1(1%)	17(16%)	12(11%)	1(1%)		7(6%)	24(22%)	17(16%)	18(17%)	3(3%)	21(19%)	9(8%)	26(24%)

NURSING HOME PRE-ADMISSION SCREENING

7-1-79 - 6-30-80

HEALTH SYSTEMS AGENCY II

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
ARLINGTON HEALTH DISTRICT																	
Arlington	34	30(88%)	4(12%)	6(18%)	7(21%)	9(26%)	8(24%)	5(15%)	8(24%)	2(6%)			5(15%)		2(6%)	3(9%)	25(74%)
FAIRFAX HEALTH DISTRICT																	
Fairfax County	131	111(85%)	20(15%)	8(6%)	5(4%)	18(14%)	21(16%)	4(3%)	5(4%)	15(11%)	3(2%)	2(2%)	16(12%)		2(2%)		104(79%)
LOUDOUN HEALTH DISTRICT																	
Loudoun County	18	17(94%)	1(6%)	5(28%)	3(17%)	7(39%)	5(28%)	1(6%)		1(6%)	2(11%)	2(11%)	13(72%)		3(17%)	6(33%)	2(11%)
PRINCE WILLIAM HEALTH DISTRICT																	
Prince William Co.	26	25(96%)	1(4%)	6(23%)	3(12%)	5(19%)	7(27%)	3(12%)	2(8%)	1(4%)	6(23%)	8(31%)	10(38%)	2(8%)	4(15%)	4(15%)	4(15%)
ALEXANDRIA HEALTH DISTRICT																	
Alexandria	26	24(92%)	2(8%)	10(38%)	3(12%)	11(42%)	13(50%)	2(8%)	2(8%)	4(15%)		1(4%)	1(4%)				25(96%)

HEALTH SYSTEMS AGENCY III

NURSING HOME PRE-ADMISSION SCREENING

July 1, 1979 - June 30, 1980

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CUMBERLAND PLATEAU HEALTH DISTRICT																	
Buchanan Co.	2	2(100%)									1(50%)						1(50%)
Dickenson Co.	8	8(100%)			1(13%)	1(13%)	4(50%)	1(13%)			2(25%)	3(38%)	8(100%)		5(63%)	3(38%)	1(13%)
Russell Co.	4	4(100%)					1(25%)				1(25%)	1(25%)	1(25%)		1(25%)	1(25%)	
Tazewell Co.	18	16(89%)	2(11%)	7(39%)	4(22%)	4(22%)	13(72%)	2(11%)			9(50%)	12(67%)	11(61%)		13(72%)	14(78%)	1(6%)
DISTRICT TOTAL	32	30(94%)	2(6%)	7(22%)	5(16%)	5(16%)	18(56%)	3(9%)			13(41%)	16(50%)	20(63%)		19(59%)	18(56%)	3(9%)
MOUNT ROGERS HEALTH DISTRICT																	
Wythe Co.	25	18(72%)	7(28%)		1(4%)	2(8%)	17(68%)	7(28%)	1(4%)		15(60%)	14(56%)	14(56%)		10(40%)	18(72%)	4(16%)
Smyth Co.	13	12(92%)	1(8%)	4(31%)	3(25%)		7(54%)	3(23%)			7(54%)	5(38%)	6(46%)	1(8%)	5(38%)	5(38%)	2(15%)
*Washington Co.	27	19(70%)	8(30%)	1(4%)			2(7%)	1(4%)		2(7%)	1(4%)	1(4%)	3(11%)		1(4%)	2(7%)	1(4%)
Grayson Co.	1	1(100%)				1(100%)	1(100%)				1(100%)	1(100%)			1(100%)	1(100%)	
Carroll Co.	21	18(86%)	3(14%)		3(14%)	6(29%)	2(10%)				16(76%)	3(14%)	3(14%)	1(5%)	9(43%)	9(43%)	3(14%)
Galax	8	7(88%)	1(13%)		1(13%)						2(25%)		2(25%)		2(25%)	5(63%)	5(63%)
*Bristol	9	9(100%)		3(33%)			7(78%)		1(11%)		5(56%)	7(78%)	7(78%)	1(11%)	7(78%)	5(56%)	2(22%)
Bland	4	4(100%)		3(33%)			4(100%)				4(100%)	4(100%)	4(100%)		4(100%)	4(100%)	
DISTRICT TOTAL	108	88(81%)	20(19%)	11(10%)	8(7%)	9(8%)	40(37%)	11(10%)	2(2%)	2(2%)	51(47%)	35(32%)	39(36%)	3(3%)	39(36%)	49(45%)	17(16%)

* Health Systems Agency VI

HEALTH SYSTEMS AGENCY III

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
NEW RIVER HEALTH DISTRICT																	
Montgomery Co.	23	22(96%)	1(4%)	3(13%)	2(9%)	2(9%)	10(43%)	4(17%)			11(48%)	2(9%)	15(65%)	1(4%)	16(70%)	6(26%)	4(17%)
Giles Co.	2	2(100%)					1(50%)				2(50%)						2(50%)
Floyd Co.	16	15(94%)	1(6%)			1(6%)	2(13%)				1(6%)		1(6%)			2(13%)	12(75%)
Pulaski Co.	13	12(92%)	1(8%)			1(8%)	1(8%)			1(8%)	1(8%)						1(8%)
Radford	5	3(60%)	2(40%)				1(20%)							1(20%)			
DISTRICT TOTAL	59	54(92%)	5(8%)	3(5%)	2(3%)	4(7%)	15(25%)	4(7%)		1(2%)	15(25%)	2(3%)	16(27%)	2(3%)	16(27%)	8(14%)	19(32%)
LENOWISCO HEALTH DISTRICT																	
Lee County	4	4(100%)					1(25%)										2(50%)
*Scott County	9	8(89%)	1(11%)			1(11%)	4(44%)										8(89%)
Wise County	15	12(80%)	3(20%)				5(33%)				2(13%)		2(13%)		1(7%)	2(13%)	11(73%)
DISTRICT TOTAL	28	24(86%)	4(14%)			1(4%)	10(36%)				2(7%)		2(7%)		1(4%)	2(7%)	21(75%)

* Scott County-Health Systems Agency VI

HEALTH SYSTEMS AGENCY III

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
* ROANOKE CITY HEALTH DISTRICT																	
Roanoke City	57	57(100%)		7(12%)	2(4%)	2(4%)	5(9%)	1(2%)			9(16%)	10(18%)	20(35%)	4(7%)	12(21%)	14(25%)	8(14%)
ALLEGHANY HEALTH DISTRICT																	
Alleghany-Covington	14	9(64%)	5(36%)	1(7%)		3(21%)	7(50%)	1(7%)			2(14%)	2(14%)	3(21%)		2(14%)		1(7%)
Botetourt Co.	6	5(83%)	1(17%)	1(17%)		2(33%)	2(33%)				1(17%)	4(67%)				2(33%)	1(17%)
Craig Co.	4	2(50%)	2(50%)				1(25%)			1(25%)							1(25%)
Roanoke Co.	48	37(77%)	11(23%)	8(17%)	2(4%)	5(10%)	22(46%)	2(4%)		8(17%)	1(2%)	4(8%)	7(15%)		4(8%)	7(15%)	36(75%)
Clifton Forge	3	2(67%)	1(33%)	2(67%)	1(33%)	1(33%)	2(67%)	1(33%)		1(33%)		1(33%)	1(33%)				1(33%)
DISTRICT TOTAL	75	55(73%)	20(27%)	12(16%)	3(4%)	11(15%)	34(45%)	4(5%)		10(13%)	4(5%)	11(15%)	11(15%)		6(8%)	9(12%)	40(53%)
CENTRAL VIRGINIA HEALTH DISTRICT																	
Amherst Co.	6	5(83%)	1(17%)	3(50%)		5(83%)	3(50%)						1(17%)				1(17%)
Appomattox Co.	6	4(67%)	2(33%)	4(67%)	2(33%)	4(67%)	3(50%)				2(33%)		2(33%)		1(17%)	2(33%)	
Bedford Co.	15	14(93%)	1(7%)	7(47%)	1(7%)	4(27%)	14(93%)	2(13%)			7(47%)	10(67%)	10(67%)		8(53%)	8(53%)	1(7%)
Campbell Co.	19	13(68%)	6(32%)	8(42%)	1(5%)	14(74%)	9(47%)	1(5%)	1(5%)		4(21%)	8(42%)	7(37%)	3(16%)	10(53%)	8(42%)	2(11%)
Lynchburg	29	22(76%)	7(24%)	6(21%)	3(10%)	5(17%)	4(14%)			1(3%)	2(7%)	1(3%)	3(10%)	1(3%)	2(7%)	1(3%)	2(7%)
DISTRICT TOTAL	75	58(77%)	17(23%)	28(37%)	7(9%)	32(43%)	33(44%)	3(4%)	1(1%)	1(1%)	15(20%)	19(25%)	23(31%)	4(5%)	21(28%)	19(25%)	6(8%)

* - Roanoke City included in Alleghany Health District

HEALTH SY[illegible] AGENCY III

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
FRANKLIN-HENRY HEALTH DISTRICT																	
Franklin Co.	14	9(64%)	5(36%)	3(21%)	5(36%)	3(21%)	1(7%)			8(57%)	4(29%)	4(29%)	2(14%)	1(7%)	1(7%)		13(93%)
Henry-Martinsville	42	38(90%)	4(10%)	1(2%)	1(2%)	1(2%)	2(5%)				5(12%)	1(2%)	5(12%)	2(5%)	4(10%)	5(12%)	6(14%)
Patrick Co.	4	4(100%)				1(25%)	4(100%)				1(25%)	1(25%)			1(25%)	1(25%)	
DISTRICT TOTAL	60	51(85%)	9(15%)	4(7%)	6(10%)	5(8%)	7(12%)			8([illegible]3%)	10(17%)	6(10%)	7(12%)	3(5%)	6(10%)	6(10%)	19(32%)
PITTSYLVANIA-DANVILLE HEALTH DISTRICT																	
Pittsylvania	21	19(90%)	2(10%)	3(14%)	1(5%)	3(14%)	7(33%)	1(5%)	1(5%)	1(5%)	3(14%)	7(33%)	12(57%)		5(24%)	4(19%)	
Danville	52	41(79%)	11(21%)	19(37%)	4(8%)	6(12%)	3(6%)		2(4%)	3(6%)	3(6%)	3(6%)	13(25%)	1(2%)	5(10%)		8(15%)
DISTRICT TOTAL	73	60(82%)	13(18%)	22(30%)	5(7%)	9(12%)	10(14%)	1(1%)	3(4%)	4(8%)	6(8%)	10(14%)	25(34%)	1(1%)	10(14%)	4(5%)	8(11%)

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NURSING HOME PRE-ADMISSION SCREENING
July 1, 1979 - June 30, 1980

HEALTH SYSTEMS AGENCY IV

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CRATER HEALTH DISTRICT																	
Dinwiddie Co.	7	3(43%)	4(57%)			1(14%)					3(43%)	3(43%)	4(57%)		1(14%)	1(14%)	
Greensville-Emporia	5	5(100%)		3(60%)	1(20%)		1(20%)										2(40%)
Prince George County	3	2(67%)	1(33%)										3(100%)				
Surry Co.	2	1(50%)	1(50%)	2(100%)	1(50%)	1(50%)											
Sussex Co.	6	6(100%)				4(67%)	3(50%)						1(17%)				
Hopewell	6	4(67%)	2(33%)			1(17%)	4(67%)					2(33%)	1(17%)				
Petersburg	11	9(82%)	2(18%)		1(9%)	4(36%)	3(27%)				2(18%)	2(18%)	4(36%)		1(9%)	1(9%)	4(36%)
DISTRICT TOTAL	40	30(75%)	10(25%)	5(13%)	3(8%)	11(28%)	11(28%)				5(13%)	7(18%)	13(33%)		2(5%)	2(5%)	6(15%)

HEALTH SYSTEMS AGENCY IV

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CHARLES CITY HEALTH DISTRICT																	
Charles City Co.	4	4(100%)		2(50%)	1(25%)	2(50%)	4(100%)				1(25%)	2(50%)	2(50%)		2(50%)	2(50%)	1(25%)
Goochland Co.	2	1(50%)	1(50%)			1(50%)	1(50%)										1(50%)
Hanover Co.	22	10(83%)	2(17%)	3(25%)	2(17%)	6(50%)	5(42%)	1(8%)		1(8%)	3(25%)	2(17%)	3(25%)	1(8%)	3(25%)	4(33%)	1(8%)
New Kent Co.	2	1(50%)	1(50%)	2(100%)		1(50%)						2(100%)	1(50%)		1(50%)	1(50%)	
DISTRICT TOTAL	20	16(80%)	4(20%)	7(35%)	3(15%)	10(50%)	10(50%)	1(5%)		1(5%)	4(20%)	6(30%)	6(30%)	1(5%)	6(30%)	7(35%)	3(15%)
SOUTHSIDE HEALTH DISTRICT																	
Brunswick Co.	5	5(100%)				2(40%)	1(2%)					1(20%)	1(20%)				
Halifax-South Boston	24	23(96%)	1(4%)	1(4%)		1(4%)					4(17%)	1(4%)	12(50%)	3(13%)	7(29%)	4(17%)	7(29%)
Mecklenburg	12	10(83%)	2(17%)	4(33%)		6(50%)	5(42%)					1(8%)			1(8%)	1(8%)	
DISTRICT TOTAL	41	38(93%)	3(7%)	5(12%)		9(22%)	6(15%)				4(10%)	3(7%)	13(32%)	3(7%)	8(20%)	5(12%)	7(17%)

HEALTH SYSTEMS AGENCY IV

	Total Number Screened	Recommended Nursing Home	Recommended Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
PIEDMONT HEALTH DISTRICT																	
Charlotte Co.	6	6(100%)			1(17%)	2(33%)	2(33%)	1(17%)							1(17%)	2(33%)	3(50%)
Nottoway Co.	11	8(73%)	3(27%)	1(9%)		1(9%)	1(9%)	2(18%)	1(9%)		2(18%)	3(27%)	3(27%)		3(27%)		
Prince Edward Co.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cumberland Co.	6	3(50%)	3)50%)	2(33%)		2(33%)					3(50%)	1(17%)	5(83%)	3(50%)	3(50%)	3(50%)	1(17%)
Buckingham Co.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Amelia Co.	1	1(100%)		1(100%)			1(100%)	1(100%)					1(100%)			1(100%)	
Lunenburg Co.	4	2(50%)	2(50%)			3(75%)					1(25%)	1(25%)	1(25%)		1(25%)	(25%)	
DISTRICT TOTAL	28	20(71%)	8(29%)	4(14%)	1(4%)	8(29%)	4(14%)	4(14%)	1(4%)		6(21%)	5(18%)	10(36%)	3(11%)	8(29%)	7(25%)	4(14%)
CHESTERFIELD HEALTH DISTRICT																	
Chesterfield Co.	25	16(64%)	9(36%)	7(28%)		5(20%)	5(20%)		1(4%)	2(8%)	5(20%)	3(12%)	10(40%)	3(12%)	4(16%)	7(28%)	8(32%)
Powhatan Co.	7		7(100%)				1(14%)	1(14%)			1(14%)						2(29%)
Colonial Heights	7	7(100%)		2(29%)		4(57%)	5(71%)	1(14%)			4(57%)	4(57%)	2(29%)		3(43%)	4(57%)	1(14%)
DISTRICT TOTAL	39	23(59%)	16(41%)	9(23%)		9(23%)	11(28%)	2(5%)	1(3%)	2(5%)	10(26%)	7(18%)	12(31%)	3(8%)	7(18%)	11(28%)	11(28%)

HEALTH SYSTEMS AGENCY IV

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
HENRICO HEALTH DISTRICT																	
Henrico Co.	43	29(67%)	14(33%)	35(81%)	33(77%)	35(81%)	13(30%)	24(56%)	10(23%)	1(2%)	3(7%)	2(5%)	4(9%)	2(5%)	1(2%)	1(2%)	1(2%)
RICHMOND CITY HEALTH DISTRICT																	
Richmond City	122	90(74%)	32(26%)	46(38%)	18(15%)	9(7%)	15(12%)	8(7%)	9(7%)	9(7%)	1(1%)	1(1%)	9(7%)	2(2%)	1(1%)	2(2%)	62(56%)

NURSING HOME PRE-ADMISSION SCREENING
July 1, 1979 - June 30, 1980

HEALTH SYSTEMS AGENCY V

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
NORTHERN NECK HEALTH DISTRICT																	
Lancaster Co.	13	12(92%)	1(8%)			7(54%)	5(38%)				4(31%)	1(8%)	2(15%)		1(8%)		6(46%)
Northumberland	10	6(60%)	4(40%)		1(10%)	1(10%)	3(30%)		1(10%)	1(10%)	1(10%)	3(30%)	6(60%)		1(10%)	4(40%)	3(30%)
Richmond Co.	4	3(75%)	1(25%)	2(50%)		4(100%)	4(100%)	1(25%)			2(50%)	4(100%)			2(50%)	3(75%)	1(25%)
Westmoreland Co.	3	3(100%)		1(33%)	1(33%)								1(33%)				
DISTRICT TOTAL	30	24(80%)	6(20%)	3(10%)	2(7%)	12(40%)	12(40%)	1(30%)	1(30%)	1(30%)	7(23%)	8(27%)	9(30%)		4(13%)	7(23%)	10(33%)
EASTERN SHORE HEALTH DISTRICT																	
Accomack Co.	23	18(78%)	5(22%)	3(13%)			9([illegible]%)						13(57%)				
Northampton Co.	15	12(80%)	3(20%)	4(27%)		10(67%)	4(27%)			1(7%)							
DISTRICT TOTAL	38	30(79%)	8(21%)	7(18%)		10(26%)	13(34%)			1(3%)			13(34%)				

HEALTH SYS S AGENCY V

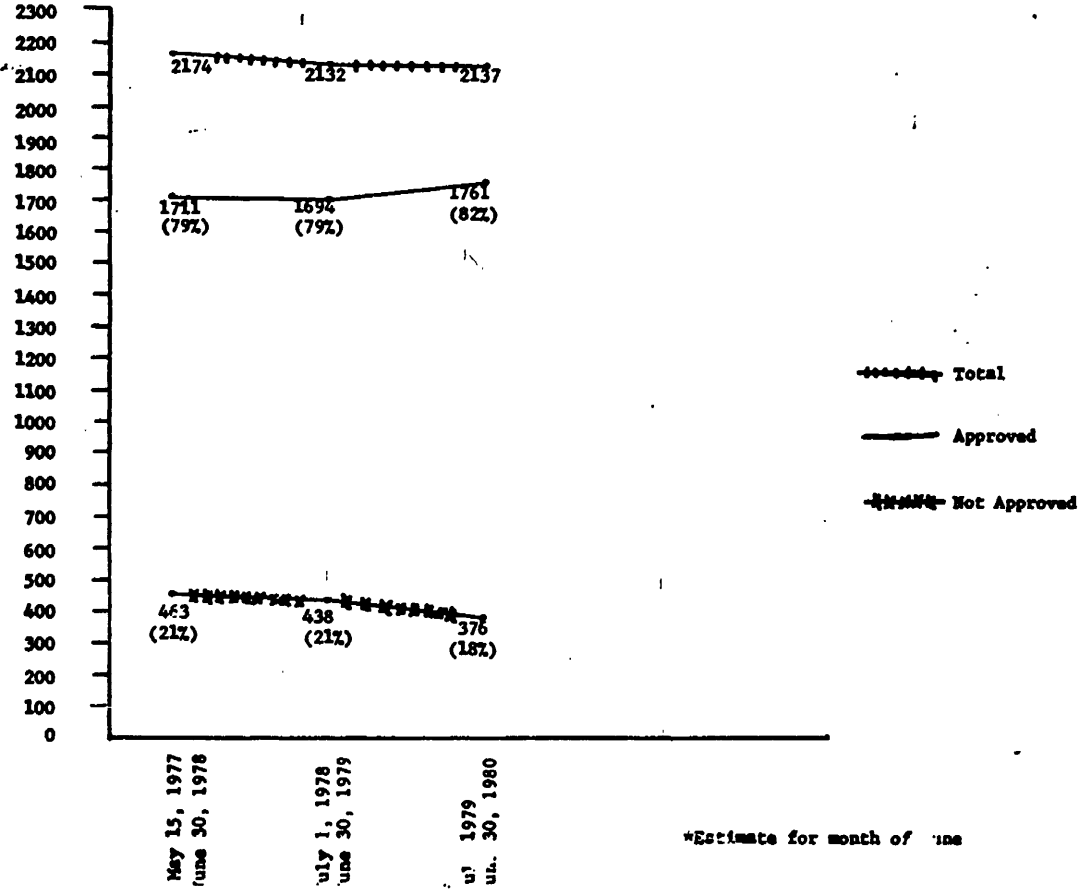
	Total Number Screened	Recommended Nursing Home	Non-NH	Services Required - Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Services Required - Not Available: Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
MIDDLE PENINSULA HEALTH DISTRICT																	
Essex Co.	7	4(57%)	3(43%)	4(57%	2(29%	3(43%	1(14%		1(¨4%			1(14%)	2(29%)		1(14%)	2(29%)	
Gloucester Co.	12	11(92%)	1(8%)	1(8%)		1(8%)	3(25%				1(8%)	1(8%)	3(25%)			3(25%)	
King William Co.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
King & Queen Co.	4	4(100%		1(25%	2(50%	2(50%	2(50%				3(75%	2(50%)	2(50%)		1(25%)	4(100%	1(25%
Mathews Co.	8	5(63%)	3(37%)	1(13%		2(25%	2(25%						2(25%)		1(13%)	1(13%)	
Middlesex Co.	1	1(100%			1(100%)								1(100%				
DISTRICT TOTAL	32	25(78%)	7(22%)	7(22%	5(16%	8(25%	8(25%		1(3%)		4(13%	4(13%)	10(31%)		3(9%)	10(31%)	1(3%)
TIDEWATER HEALTH DISTRICT																	
Franklin City	19	19(100%		5(26%	1(5%)	5(26%	8(42%				7(37%	8(42%)	9(47%)		8(42%)	9(47%)	7(37%
Isle of Wight	10	10(100%		1(10%		1(10%	6(60%	1(10%)	1(10%)	1(10%)	6(60%	5(50%)	7(70%)		5(50%)	5(50%)	4(40%
Portsmouth	69	65(94%)	4(6%)	24(35%	2(3%)	17(25%	47(68%	2(3%)	2(3%)		21(30%	60(87%)	48(70%)	6(9%)	55(80%)	47(68%)	2(3%)
Southampton	19	19(100%					8(42%				6(32%	6(32%)	16(84%)	2(11%	4(21%)	2(11%)	2(11%
Suffolk	23	20(89%)	3(13%)		1(4%)	4(17%	5(22%			2(9%)	4(17%	6(26%)	9(39%)	2(9%)	1(4%)	1(4%)	2(9%)
DISTRICT TOTAL	140	133(95%	7(5%)	30(25%	4(30%	27(22%	74(40%	3(2%)	3(2%)	3(2%)	44(31%	85(61%)	89(74%)	10(8%)	73(52%)	64(46%)	17(12%

HEALTH SYSTEMS AGENCY V

	Total Number Screened	Recommended		Services Required - Available							Services Required - Not Available						
		Nursing Home	Non-NH	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other	Meals	Chore Svcs.	Comp. Svcs.	Home Health	Home-maker	Day Care	Other
CHESAPEAKE HEALTH DISTRICT																	
Chesapeake	71	51(72%)	20(28%)	9(13%)	8(11%)	5(7%)	34(48%)	2(3%)	5(7%)	3(4%)			25(35%)				
PENINSULA HEALTH DISTRICT																	
Newport News	58	53(91%)	5(9%)	31(53%)	30(52%)	24(41%)	26(45%)	20(34%)	14(24%)	5(9%)	19(33%)	24(41%)	28(48%)	16(28%)	24(41%)	14(24%)	14(24%)
Williamsburg/ James City Co.	12	10(83%)	2(17%)	4(33%)		3(25%)	9(75%)	5(42%)		2(17%)	4(33%)	10(83%)	8(67%)	1(8%)	2(17%)	5(42%)	
York Co.	1	1(100%)		1(100%)	1(100%)	1(100%)	1(100%)	1(100%)									
DISTRICT TOTAL	71	64(90%)	7(10%)	36(51%)	31(44%)	28(39%)	36(51%)	26(37%)	14(20%)	7(10%)	23(32%)	34(48%)	36(51%)	17(24%)	26(37%)	19(27%)	14(20%)
HAMPTON HEALTH DISTRICT																	
Hampton	36	32(89%)	4(21%)	2(6%)	2(6%)	10(28%)	8(22%)		2(6%)	1(3%)	1(3%)	2(6%)	16(44%)		6(17%)	3(8%)	2(6%)
NORFOLK HEALTH DISTRICT																	
Norfolk	147	96(65%)	51(35%)	22(15%)	1(1%)	30(20%)	12(8%)	15(10%)	11(7%)	1(1%)	14(10%)	6(4%)	44(30%)	4(3%)	35(24%)	25(17%)	56(38%)
VIRGINIA BEACH HEALTH DISTRICT																	
Virginia Beach	62	61(98%)	1(2%)	10(16%)	2(3%)	3(5%)	3(5%)			2(3%)		7(11%)	35(56%)		4(6%)	1(2%)	13(21%)
STATE TOTAL	2065	1700 (82%)	365 (18%)	429 (21%)	184 (9%)	404 (20%)	579 (28%)	152 (7%)	87 (4%)	91 (4%)	339 (16%)	375 (18%)	648 (31%)	80 (4%)	407 (20%)	378 (18%)	589 (29%)

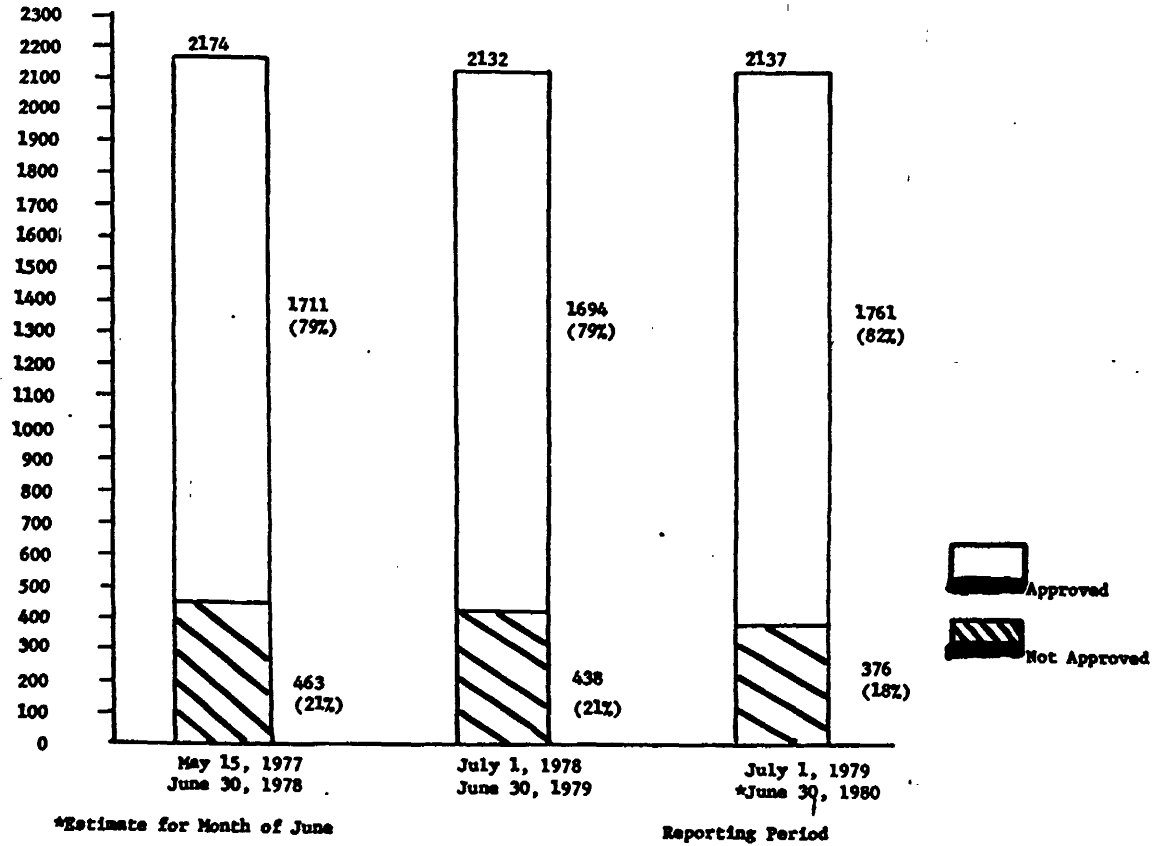
Attachment 5

Nursing Home Pre-Admission Screening



Nursing Home Pre-Admission Screening

Attachment 6



Statement of the New Hampshire for Medical Care

Testimony on S. 2809
August 27, 1980

Mr. Chairman and members of this distinguished Committee, my name is Constance Azzi and I am Executive Director of the New Hampshire Foundation for Medical Care, the Professional Standards Review Organization for New Hampshire. I appreciate the opportunity to describe our experience in long term care pre-admission review as it applies to S.2809.

Although our experience is in the institutional arena we feel that the same concepts apply to non-institutional care. Our experience is respectfully offered as it may be applicable to the pre-admission screening and assessment team (PAT) concept addressed in S.2809.

The New Hampshire Foundation for Medical Care has been involved in conducting pre-admission screening and assessment of persons prior to entering nursing homes for two and one half years. A flow chart of the pre-admission review process is included (Appendix A.). Non binding review began on January 16, 1978 in one region of the State of New Hampshire. Full and binding review Statewide was begun on May 15, 1978. It took approximately six months to become fully operational Statewide.

From May 15, 1978 through June, 1980 the New Hampshire Foundation has conducted pre-admission review on:

4135 Medicare skilled level of care patients
186 Medicaid skilled level of care patients
4270 Medicaid intermediate level of care patients

From May 15, 1978 through June, 1980 the New Hampshire Foundation has denied through its pre-admission review process:

411 Medicare skilled level of care patients
8 Medicaid skilled level of care patients
38 Medicaid intermediate level of care patients

You will note that Medicare reviews apply to the skilled level of care and that Medicaid reviews are divided into two levels of care: skilled and intermediate . In New Hampshire, the level of care guidelines for skilled Medicaid are the same as the level of care guidelines for skilled Medicare. This information is offered against the backdrop of the following demographic information. There are in New Hampshire: 820 skilled nursing facility beds and 5,324 intermediate care facility beds. The total of SNF plus ICF beds in New Hampshire is 6,144.

Although we are able to report the numbers of persons who did not enter a nursing home (under the Medicare/Medicaid

guidelines) because of our pre-admission review process, we have not captured the information on the disposition of these persons and therefore are unable to report it.

A special mention of the effect of pre-admission review is in order. The pre-admission review process has a validating effect on the reliability of the awaiting placement hospital data. For example: the New Hampshire Foundation has identified that for the period July 1, 1979 through March 31, 1980 there were 8,473 days (used by 1035 patients) in hospitals awaiting skilled nursing facility beds and 8,658 days (used by 360 patients) in hospitals awaiting intermediate care facility beds in New Hampshire. Using the same dollars that were used for our 1979 Long Term Care Impact Statement we can therefore calculate that if beds at the appropriate level of care had been available $1,030,635 of unnecessary expense could have been avoided (Appendix B.). This conclusion can be drawn because the long term care pre-admission review process is used to validate the hospital information. Pre-admission screening and assessment is the key to continuity of care. A note of caution is in order. An accurate assessment of a patient's needs, which our experience shows can be accomplished

through pre-admission review, does not make the necessary resources available. Our experience has indicated that PSROs conducting both acute and long term care review are in a unique position to assume the role of the pre-admission screening and assessment team (PAT) because PSROs have already demonstrated capability to accomplish what is described in S.2809.

If the New Hampshire Foundation's program of pre-admission screening did not exist, some patients whose condition actually did not meet the level of care guidelines would be admitted to skilled nursing facilities and intermediate care facilities under Titles XVIII and XIX. This would result in increased program cost and possible subsequent denial of the patient's stay in the facility because the patient's condition did not meet the level of care guidelines. As an example: prior to the New Hampshire Foundation conducting PSRO pre-admission review, facilities made decisions about whether to accept patients. The patient would be admitted to the nursing home and then Medicare/Medicaid would authorize or deny the level of care. The ramifications included unnecessary movement of the patient and unnecessary expenditures. In addition, as

previously noted if the PSRO long term care pre-admission review were not in place, the link to hospital data and validation of awaiting placement days would not occur.

The PSRO screens only Titles XVIII and XIX eligible patients. However, if all prospective admissions to nursing homes inclusive of private pay patients were to undergo the same comprehensive screening and assessment that the New Hampshire Foundation applies to the Medicare and Medicaid patients, we believe the following effects would occur:

a. assurance that the person is aware of alternatives to nursing home placement, allowing the person to live in a less restrictive and less costly manner.
b. determination whether all persons regardless of pay source actually need the level of care provided in the long term care facility.
c. avoidance of the present two-class (by pay source) system.
d. accrual of needed data for State health planning.
e. uniform utilization control.

It is our experience that private pay elderly persons are often placed in nursing homes prematurely. The PSRO

is requested to review persons currently in a nursing home because their personal funds are exhausted, and they are requesting level of care certification under the Medicaid program. Some of the pre-admission denials noted for Medicaid reflect persons who were referred for level of care certification as their personal funds were becoming exhausted. It is the impression of the teams performing review that many of the persons whom they visit in nursing homes would have preferred to remain in their own homes if community health resources had been available to permit this.

The New Hampshire Foundation uses a multidisciplinary review team. The team conducts a thorough evaluation of each individual's health status and functional capabilities. Elements of this evaluation are detailed in Appendix C. The New Hampshire Foundation review teams are comprised of physicians, registered nurses, social workers, and consultants such as registered physical therapists, registered pharmacists, and occupational therapists who can be called upon as needed for patient assessments and discussion of problems related to care provided. The consultants are not employed full time since to keep a full time complement of consultants would be

unnecessarily expensive. In addition, the Foundation works with the Medicare designated ombudsperson. The PSRO, therefore, is using the full complement of health care professionals defined as the pre-admission screening and assessment team (PAT) in S.2809.

Certainly the most difficult barrier the New Hampshire Foundation has faced in developing its program is that of being the front runner. This problem cannot be avoided. It is inherent in the process of establishing a new authority where it so intimately overlaps with existing authorities. The PSRO relationship with already existing authorities for Medicare and Medicaid needed to be clarified. One memorable example was in the area of confidentiality. The definitions for "within systems" and "between systems" took considerable care to work out. Another barrier in establishing any new program is system inertia and the natural human resistance to change. For a PSRO, there are a variety of role perceptions. The reality is that PSROs are non-profit organizations of physicians incorporated for the purpose of assuring quality (Appendix D.). Whatever the legal derivation of the PSRO, the PSRO has a quasi regulatory function that in the eye of

the beholder such as nursing homes is often viewed as a solely cost containment function. For the New Hampshire Foundation, the early issues of overlapping authorities and resistance to change have been satisfactorily resolved. We believe the appropriate balance between quality and cost is addressed in our Long Term Care Impact Statement Part II which is included as Appendix E.

If a state, city or county were to implement a program similar to ours it could expect to face the same kinds of barriers. In the case where a program of pre-admission is already in place one would expect that the barriers would have already been surmounted.

Under the present system we do not calculate per unit costs for each assessment visit. Such a unit cost is of course dependent on the variable mix of elements which comprise the assessment and may be different depending on each patient's specific needs or may even be different between like programs. There are applicable models in econometrics that can be applied but only if there is a clear understanding that there are variables between programs and variables within individual applications of the pre-admission review process.

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Our program is funded annually from the Department of Health and Human Services, Health Care Financing Administration, under the grant mechanism. No person seen by our assessment team pays for the assessment.

The Foundation, under the existing Medicare and Medicaid guidelines, has ensured that persons are not placed unnecessarily into nursing homes. Further than this however, the Foundation has taken the initiative to develop standards of care. For this reason we convened one year ago a Standards of Care Task Force composed of the various agencies and professional personnel involved in long term care. We have developed standards of care in New Hampshire for restraint use and for the treatment of decubitus ulcer. We are presently working on a comprehensive annual assessment and have scheduled development of other standards of care.

Thank you again for the opportunity to provide information about pre-admission assessment and screening to the Committee. Mr. Chairman, I am happy to try to answer any questions you may have.

Appendix D was put in our Committee files.

APPENDIX E.

PSRO news

VOLUME III, ISSUE NO. 8 OCTOBER 1979

The New Hampshire Foundation for Medical Care has been performing PSRO review in skilled nursing and intermediate care facilities for Medicare and Medicaid patients since May 1978. The following report was presented to the Board of Directors at the meeting held in Durham on October 17, 1979. The report was submitted for inclusion in the record of the hearings of the U. S. Senate Subcommittee on Health of the Committee on Finance to review the administration and operation of the PSRO program.

LONG TERM CARE REVIEW IMPACT STATEMENT: PART II

The Long Term Care Review Impact Statement for this past year of review is documented evidence that the Foundation has been successful in achieving the goals established for the long term care review program. The unique characteristics of long term care review have indeed made a significant difference in both the areas of utilization and quality of care for patients in skilled nursing facilities and intermediate care facilities under the Medicare and Medicaid programs.

The Board of Directors approved the development of the impact statement at its meeting of March 6, 1979. When the Long Term Care Committee approved the development and format of the statement at its meeting of March 8, 1979, they noted the increase in dialogue between physicians concerning patient care since implementation of long term care review. Both the Long Term Care Committee and the Long Term Care Advisory Group at its joint meeting of April 12, 1979 noted that bedside review and team approach ave been effective and well received by the long te n care facilities.

The data compiled at both acute and long term care levels give a complete picture of the utilization of beds for both levels of care. Many factors affect the health care environment and therefore the availability of appropriate facilities and services for Medicare and Medicaid patients. Pre-admission review data reveal significant problems with placement in specific areas of the State. The data highlight the problem areas which health planning agencies need to review in depth with the Foundation in order to make informed decisions concerning the need for health care facility beds and health services throughout the State.

Involvement of health care practitioners other than physicians who act as consultants in staff education, direct patient review consultation, and in medical care evaluation studies is effecting improvement in quality of care. Only through motivated and knowledgeable staff and physicians are we able to work effectively for the benefit of the long term care facility patients and residents.

The impact statement addresses the impact which we have made because of the unique characteristics of our program. Each aspect is addressed separately – but each part is not effective alone. It is the review program as a whole – the people in it that made the difference.

NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE

PHYSICIAN INVOLVEMENT
PEER REVIEW

Physicians are directly involved in long term care review in several ways. When Regional Review Team staff are unable to approve a level of care ordered for a patient either before admission or during a continued stay review, a Review Physician is contacted. The Review Physician, after discussion with the attending physician, makes the level of care determination. Review Physicians are contacted by Regional Review Team staff for consultation in quality of care issues. Review Physicians participate in Medical Review – on site sample review of patients to review the quality of patient care and to monitor the effectiveness of the Regional Review Team activities. The process provides for intervention, by physicians, where deficiencies in care either due to the attending physician or other health care professionals are identified.

Objectives:

- Review for level of care determination.
- Review for quality of care and services ordered.
- Increase attending physician involvement with long term care institutionalized patients.
- Assure timely documentation of the patient's status and health care needs.
- Inform physicians of community resources available as alternatives to institutional care.

Examples:

- Regional Review Team staff found physician documentation lacking in a large intermediate care facility indicating that the attending physicians did not visit their patients on at least a quarterly basis. Facility administration and staff identified this as an extremely difficult problem to resolve. The Regional Review Team implemented the following plan of action:

  The Regional Review Team recommended that attending physicians be called by the facility staff.
  Level of care certifications were withheld.
  A follow-up visit was scheduled for the following month.
  A Review Physician was asked to speak with the attending physicians concerning timely physician visits.

  The follow-up visit to check on physician documentation showed attending physicians had visited their patients and updated medical orders and progress notes. Subsequent reviews showed minimal problems with physician documentation.

- In a skilled nursing facility the Regional Review Team noted a patient under review appeared acutely ill. The facility staff had been unsuccessful in contacting the attending physician and the patient was transferred to an acute care hospital to receive appropriate treatment.

- Review Physicians have talked with attending physicians because medications were ordered without proper laboratory studies to monitor t' effects of the medication on electrolyte balance. These cases resulted in appropriate medical orders.

- The Long Term Care Committee identified the importance of knowing the availability of rehabilitation services in the community when discussing cases with attending physicians. A survey of the availability of these services in home health agencies and intermediate care facilities, statewide, was performed. This information was published in a booklet for use by physicians, discharge planners, and the Regional Review Teams in September 1979.

- Review Physician discussion with attending physicians identified difficulty in discharge planning for patients with chronic obstructive pulmonary disease. The Foundation conducted a statewide survey of skilled nursing facilities and intermediate care facilities in June 1979 to determ' conditions under which these facilities would accept chronic obstructive pulmonary disease patients. An educational meeting on chronic obstructive pulmonary disease was held for Regional Review Teams with a consultant respiratory therapist. Level of care and quality of care criteria are being developed in this area, resulting from physician concern.

(Continued Page 7)

TEAM APPROACH

"Team Approach" refers to the multidisciplinary aspect of review. The Regional Review Teams are composed of registered nurses and medical social workers. Review physicians serve as adjunct members of the Teams. Other health care professionals are available as consultants to the Teams – physical therapists, occupational therapists, dieticians, pharmacists and others.

Objectives:

Comprehensive review of the patient's health care needs (level of care and quality of care).

- Identify problems relating to patient care to appropriate persons in the facility and recommend a plan of action.
- Involve facility staff in multidisciplinary care planning, frequent assessment of each patient's status, and discharge planning.
- Involve other health care professionals (pharmacists, dieticians, therapists) as consultants to provide an objective assessment and suggestion as to different approaches with problem cases.
- Involve physicians.
- Address documentation problems from a medical/social standpoint.

Examples:

- In one case a patient had exhibited severe behavior problems. The Regional Review Team discussed the case and drug regimen with a Review Physician, the attending physician and the consultant pharmacist. The attending physician subsequently admitted the patient to the hospital for a complete reassessment. The attending physician also visited and reassessed the drug regimen of several other patients in this facility.
- Consultant pharmacists have been working with Foundation staff on a drug utilization study at the intermediate care facility level and have given several educational presentations to the Regional Review Teams emphasizing important aspects of drug therapy. Impact resulting from the educational sessions with the consultant pharmacist is emphasis on careful review of the drug regimen ordered and the medication administration record. In numerous facilities, recommendations were made that the attending physician and staff completely reassess the drug regimen of each resident reviewed because of inconsistencies between the medication orders and the medication record. Recommendations were followed by all facilities. Many drugs were discontinued as unnecessary. Needed drugs were ordered in a more realistic manner. Review Teams monitor this area during every review; therefore responsible facility staff are becoming more conscious of the need for careful review of the medication regimen with the attending physician on a regular basis.
- Regional Review Teams work closely with facility social service personnel in discharge planning. One intermediate level of care patient was denied. An appeal was requested. Additional time was given for discharge planning for teaching the patient to administer her own medications. The Regional Review Teams work closely with facility staff to effect a smooth transition for patients.
- Regional Review Teams have been asked to address discharge planning and referral form documentation to facilitate appropriate continuity of care at acute care hospital inservice meetings and medical staff meetings. Significant improvement in referral form documentation has occurred in three hospitals where problems in this area had been identified. Varied health care associations have requested that long term care review staff speak at association meetings on the review process and their responsibilities in relation to documentation.

(Continued Page 7)

BEDSIDE REVIEW

During on-site continued stay reviews Regional Review Team staff focus on the patient – his or her health and social needs, and how these needs are met. The medical record is reviewed to ascertain the overall plan of care established by the various disciplines, to assure that physicians and others are documenting on the record in a timely and proper manner, to determine whether the patient continues to require the certified level of care, and to review the discharge plan. During bedside review Regional Review Team staff also observe and communicate with the patient to assess the patient's condition, the quality of the services the patient is receiving, and to compare the stated objectives in the plan of care with the observed outcome.

Objectives:

- Review documentation, or lack of documentation, in the medical record concerning the patient health problems, needs, services ordered and services provided.
- Compare and validate information on referral forms and assessment forms with the medical record for level of care certification.
- Validate that services ordered are provided.
- Observe and communicate with the patient, evaluate quality of care provided, assess the patient environment, and observe relationship between staff and patient.

Examples:

- In one facility Foundation staff discovered through conversations with a patient that physical therapy services were not provided as ordered. After discussion with key facility personnel, another physical therapist was employed and services were provided.
- In one facility Foundation staff noticed mobility of patients was restricted to one area and no stimulation was provided to these patients. After discussion with key facility personnel and related correspondence, the Foundation staff observed attitudinal changes of facility staff resulting in increased social group activities for patients throughout the facility.
- In several instances, patients informed Foundation staff that a medication was not reacting well. Staff informed the attending physicians and medication orders were changed.
- In one facility Foundation staff observed that residents in wheelchairs and geri chairs were not ambulated at intervals. Documentation in the medical record was non-specific in this area. Documentation on follow-up reviews indicate that residents were being ambulated more frequently.
- A Medical Care Evaluation study on the use of physical restraints in long term care facilities has been undertaken for three purposes: (1) to evaluate the current policies and procedures on restraints, (2) to assess the current usage of restraints, and (3) to develop criteria for restraint usage and explore alternatives. A task force established by the Foundation with representation from facilities and the State Survey and Certification Agency has been meeting to discuss these areas.
- In one facility Foundation staff discovered serious problems with documentation of services, particularly with nursing services. Charge nurses demonstrated a lack of understanding of individual patient problems. Foundation staff discussed the problem with key facility personnel, the magnitude of the problem was acknowledged, and the nursing department was decentralized. Charge nurses are now involved with patient care plans using Foundation assessment forms.
- In one facility the Regional Review Team noted that the functional level of some residents had improved considerably in a one year period. The medical records of these residents did not identify any specific plan of care designed to improve functional level, nor did the record note a change in the functional level. The Regional Review Team used this situation to teach the facility the importance of documenting the care which they do provide which affected the well-being of these residents.

(Continued Page 8)

PATIENT SPECIFIC LENGTH OF STAY ASSIGNMENT

Initial length of stay assignment is made after the Regional Review Team receives a completed referral form and is based on the particular needs of the patient. During continued stay review the need for extension of the patient's stay is assessed and, if necessary, an additional length of stay is assigned. Skilled level of care Medicare patients are reviewed at a maximum interval of 14 days. Skilled level of care Medicaid patients are reviewed at a maximum interval of 30 days. Intermediate level of care Medicaid patients are reviewed within the first 30–45 days of admission and then at a maximum interval of 180 days.

Objectives:

- Assure that patients receive the appropriate health care services for the appropriate length of time.
- Monitor complex cases closely, including cases where quality of care is an issue.
- Control the cost of health care through appropriate utilization.

Examples:

- A patient with chronic obstructive pulmonary disease, advanced emphysema, partial pneumothorax of left lung and left thoracatomy was admitted to an SNF for skilled observation of his unstable condition. The patient required vital sign monitoring twice a day, continuous oxygen and diuretic medication. The Team certified seven days for monitoring this unstable condition.
- A patient with terminal cancer was admitted for skilled observation of her rapidly deteriorating condition and to prevent complications. In this instance the Team certified only seven days because the attending physician had not visited the patient for six weeks. After consultation with the attending physician the Review Physician certified a shorter length of stay to assure that the attending physician would visit the patient whose need for medical care was still evident.
- A diabetic patient with an unhealed pacemaker wound was certified for eight days for Betadine soaks and sterile dressings three times a day. It was anticipated that the wound would heal by eight days.
- A patient who was status post Femoral Popliteal Bypass with a draining surgical wound was certified for seven days. The wound drainage was decreasing and it was anticipated that the sterile dressings would decrease from twice a day to once a day. The patient's vital signs were stabilizing. The patient was to be taught to do her own dressings. It was anticipated that these goals could be accomplished in seven days.
- A patient with nephrosclerosis, cardiovascular insufficiency, and anemia was referred for ICF placement for medication administration and supervision due to her disorientation. Upon the initial on-site review no indication of disorientation was found or documented. The patient was certified for 45 days for discharge planning and for teaching administration of medications.
- An alcoholic patient with Wilson's disease and bronchial asthma was referred for ICF placement for assistance with activities of daily living and to monitor functional status. On-site review revealed that the patient's overall health status was improving not deteriorating. General strength was increasing and with continued progress the patient would need only supervision as available in a group home. The patient was initially certified for 45 days and then given a 30 day extension with the goal of promoting continual improvement in health status encouraging self-care and discharge planning.

(Continued Page 6)

PRE-ADMISSION REVIEW

Preadmission review is the process of assuring the need for a patient's admission to a long term care facility at either skilled or intermediate level of care prior to the admission.

Objectives:

- To assure that the patient meets the criteria for the level of care ordered by the physician, therefore assuring the medical necessity of the admission.
- To estimate the length of stay required to accomplish the health care goals as determined by the physician and other health professionals.
- To assure that sufficient pertinent information concerning the patient's health care needs is documented on the referral forms so that the patient's needs can be met adequately in the receiving facility.
- Identification of the need for redistribution of acute and long term care beds.

Statistics:

January 1, 1979 – June 30, 1979

Hospital discharge data shows

504 Medicare patients stayed in acute care hospitals awaiting placement to skilled nursing facilities, for 3,395 days.

145 Medicaid patients stayed in acute care hospitals awaiting placement to intermediate care facilities for 1,457 days.

Long term care discharge data shows

93 Medicaid patients stayed in skilled care facilities awaiting placement to intermediate care facilities for 6,953 days.

If appropriate level beds had been available there would have been an expense avoidance of:

3,395 x \$45 = \$152,775.00

1,457 x \$75 = 109,275.00

6,953 x \$30 = 208,590.00

\$470,640.00

Note: Discharge data does not include the large numbers of patients still awaiting placement.

Expense avoidance dollars were based on \$100/day for hospitals, \$55/day for SNFs and \$25/day for ICFs.

(Patient Specific Length of Stay Assignment Continued)

Statistics:

Average length of stay – skilled level Medicare:

7/77 - 12/77 = 32.2 days (prior to PSRO review)
7/78 - 12/78 = 30.6 days
1/79 - 6/79 = 29.6 days

from 7/78 - 6/79
total days certified = 52,074
total "medically necessary" days = 49,253
total waiver days = 2,053
total grace days = 778
total discharges = 1,728

The cost per patient, per day, for skilled patients varied from \$31.00 to \$96.02. This included both free-standing and hospital based facilities.

A decrease of 2.6 days from the average length of stay in skilled facilities represents 2,277 fewer days in a six month period in 1979 than in a corresponding period in 1977 – prior to PSRO review.

The Foundation does not claim sole responsibility for the decrease, and cannot realistically claim an undisputable dollar amount savings. Nevertheless, days not used are days not directly paid for and 2,277 days not used accounts for \$125,000* expense avoidance.

*This figure is based on an average per diem charge of \$55.

(Team Approach Continued)

- One patient in an ICF had fallen and sustained a fracture of her hip. The patient had a surgical repair in the hospital and was transferred back to the ICF without an order for physical therapy or x-ray recheck. Six months after transfer, when reviewed by the Regional Review Team, the patient had not had any physical therapy and had not been seen by her physician for four months. Shortly after the review and problem identification, the patient's hip was rechecked and she was started on ambulation.

- The Regional Review Team presence in the long term care facilities throughout the year has identified attitudinal and facility team coordination problems which affect the care patterns in some facilities. These have become evident as a result of medical record review and discussions with facility staff. The lack of effective multidisciplinary care planning and follow through, the overuse of restraints, the lack of consideration for stimulating activities, and for discharge planning are a few of the areas where the Review Teams have worked with facility staff to effect attitudinal changes resulting in improved quality of care and cost savings. These problems were addressed during exit interviews, in facility reports, and at educational meetings. Attending physician and facility staff attention to these areas became evident at the time of subsequent reviews both in discussion with facility staff and in medical record documentation.

- The Foundation's physical therapy consultant was requested by the administrator of a long term care facility to perform an on-site review to assess the medical necessity and quality of physical therapy services provided.

- Educational meetings with the physical therapist consultant highlighted the type of physical therapy which can be effectively provided in the home. As a result of this, the Regional Review Teams are working with facility staff to encourage more timely discharge to home with physical therapy being continued through Home Health Agency services. The Foundation also performed a Medical Care Evaluation study at the skilled nursing facility level to determine whether physical therapy certified at skilled level could have been appropriately provided through alternative community resources.

(Physician Involvement – Peer Review Continued)

Statistics:

From July 1, 1978 through June 30, 1979 there were 721 referrals to Review Physicians:

640	referrals for Medicare SNF coverage
182	approvals for Medicare SNF coverage
458	denials for Medicare SNF coverage
72%	denial rate
81	referrals for Medicaid SNF or ICF coverage
42	approvals for Medicaid SNF or ICF coverage
38	denials for Medicaid SNF or ICF coverage
47%	

There were Medical Reviews for:

100	patients, involving
11	physicians, involving
22	facilities (SNFs and ICFs)

NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE

James P. Pilliod, M. D., President
Richard D. Baughman, M. D., Vice-President
Gault M. Farrell, M. D., Secretary-Clerk

Constance Azzi, Director

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(Bedside Review Continued)

- Long term care facility administrators, nursing directors, social workers and physicians have expressed appreciation for the bedside review process:

- "The one outstanding feature of the program so far has been the fact that our patients are considered in a humanistic fashion, not as so much data on a form."

- "Visual judgement as well as documented information makes for a more complete review."

- "...one picture is worth a thousand words. To see a patient is to understand the psychosocial data that would take reams of paper to adequately describe."

- "Our patients have accepted the PSRO representatives as one more person very concerned with their care and welfare. The manner in which they present themselves puts the patient at ease. By their visiting the patient and viewing decubitus ulcers healing, incisions, and talking with and observing CVA patients the representative has a complete picture."

- "We were impressed with the concern shown for the patients and their problems, and appreciate your respect for our assessment of those problems."

- "...this could prove to be very beneficial to the patient as well as another check and balance tool for the facility."

- "This practice should continue as both myself and our nurse coordinator feel it would be to the advantage of the patient."

- "On several residents a medical record review proved inadequate to meet ICF criteria while observation and interaction with the resident justified ICF stay as well as the need for additional documentation."

- "Sometimes the patients themselves can give information which helps to complete the already documented material...in the past Medicare reviewers have felt that if they could have visited with the patient that perhaps the patients would have received a longer certified stay."

- "...our residents enjoyed the visit."

Statistics:

From January 1979 through June 1979 the following numbers of on-site reviews were conducted:

Medicare skilled level patients	2016
Medicaid skilled level petients	207
Medicaid skilled pending placement	158
Medicaid intermediate care patients	2885

Senator MATSUNAGA. Thank you very much.

Mr. Putman, to start the questioning period, what are the major barriers in operating a comprehensive community based program for noninstitutional long term care services?

Mr. PUTMAN. Senator, in my opinion it is the lack of facilities in the community of a nonmedical model, and to a great extent that lack of facilities is based on the funding structure.

In the next biennium in my agency I would like to expand my community based care by $2.5 million. I can do so at a projected reduction in nursing home beds also of $2.5 million. The problem is that the $2.5 million in community based care is 100 percent with State funds because of the way title XX is financed, but the nursing home care is 50 percent federally funded. So it costs me twice as much in State dollars to provide the care in the community as it does to provide it in the nursing home.

That is a major barrier, the way the funding is set up, and the effect that has on community placements.

Senator MATSUNAGA. Thank you very much.

Ms. Carnes, to what extent will the increase in public support for in-home care services tend to supplant care presently being supplied by family and friends?

Ms. CARNES. That is a very tricky question. I don't think that public support necessarily has to decrease the informal support system of family, friends, and neighbors. I think that at the same time that we are perhaps redefining and beefing up the public funding, we also at the same time need to be working with families and friends, the informal support system, to help them to understand what services are available, to give them some relief, but not certainly to take away that family's right to provide care and service, and their responsibility.

I see it as a dovetail effect. The right hand working with the left hand, rather than putting all the money in one pocket and taking everything away from the families in terms of their responsibilities.

Senator MATSUNAGA. You mention in your written text that you have not been successful in preadmission screening for acute patients, but the program could effectively reduce the number of patients in acute beds.

Is home care really a viable option for truly acute care hospital patients, or would home care more likely be a substitute for long term care in nursing homes?

Ms. CARNES. Again, I think that it becomes an individual matter. For some people, I think home care would become a substitute and a stopping point before long term care in nursing homes is realized. In some cases, I think the individual moving from acute care to home care can be stabilized, rehabilitated and maintained in the community.

Senator MATSUNAGA. Ms. Azzi, it is asserted that the increased availability of noninstitutional services will lead to cost savings through reduced institutionalization. Others argue that expanded, noninstitutional services will merely add another level of benefits, and will do little to reduce the cost of institutional services. What does your experience indicate?

Ms. AZZI. Our experience has been in the application of the medically necessary decision for the patient to his medicare or medicaid.

Senator PACKWOOD. Would you speak a little louder. I am very curious about this answer.

Ms. AZZI. Our data, both anecdotal and the hard data, that we have collected do not yield substantive answers to the question about how cost savings might be affected by making available the noninstitutional services.

However, we can speculate from specific cases that we have seen that patients frequently are not at the level of care mandated by the existing medicare and medicaid guidelines for skilled and intermediate, and therefore would benefit if the services were available. These services need to address the severity of illness, the intensity of services by each patient's needs.

We have information to the effect that in particular the patients find themselves in the institution because there are no services available elsewhere in the State. We can, therefore, speculate that a more humane and a more appropriate way to care for people's needs is to enhance their capability to maintain themselves in noninstitutional settings.

Senator MATSUNAGA. Senator Packwood.

Senator PACKWOOD. I want to follow up on that.

This committee got burned on the estimates we received years ago on the projected cost of medicare and medicaid. The estimates were by people by and large involved in the field and they turned out to be woefully low. This was before the rapid inflation that hit this country.

The committee and the Congress are going to be reluctant to adopt this program that Senator Bradley and I have introduced, or any other program if Congress thinks that it is going to cost infinitely more than whatever we presently are paying, or if Congress is not even sure. That is why the answer to the question that Senator Matsunaga asked is so critical.

The presumption is that services provided in a home ought to be cheaper than institutionalized services. One of the statements here has the GAO's study from 1977, and the comparative costs, and how much we could save. I have got to say that all three of your statements are excellent. We could not have people who are better involved in this subject than the three of you. But the answer to that question: "Will it save money?" is a very critical answer. If we are not sure, I can just see what happens when we try to sell this to Congress.

It is not a question, really. I know what is coming in these next 3 or 4 years, and I know with what a wary eye Congress has looked at any new or expanded programs.

Ms. AZZI. Is it appropriate to offer a response?

Senator PACKWOOD. Yes.

Senator MATSUNAGA. That is the question. [General laughter.]

Ms. AZZI. It would seem that the good parts about the existing bill are that there are demonstration projects accommodated in here. If we have one humble experience to offer from being a PSRO, we humbly offer the following: It is incumbent upon us, perhaps the demonstration projects offer this opportunity, to decide

what it is we want to measure at the beginning and attempt to measure it.

What is needed, therefore, to whatever degree it exists, are some baseline data, perhaps from some studies of the GAO, or small studies that may be State or region wide that we may not know about but that do exist, and to use demonstration projects to do a few discrete, achievable things, and to measure the results.

The PSRO program's experience was that the nonprofit organizations of physicians were designed to assure quality, but 3 or 4 years into the program the emphasis changed to become cost containment and cost effectiveness. So that the existence of the systems was not reason enough to be.

I think the demonstration programs offer an opportunity to decide what it is that wants to be accomplished, and to measure it and to, therefore, establish when you know you have accomplished what it is you set out to do. The demonstration programs would offer a fine opportunity to provide the measurement device that Congress might demand.

Senator PACKWOOD. Let me ask another question.

As you look at the demographics and the increasing number of the elderly, another question that is going to be raised if we expand preadmission screening broadly: "Is this program going to become so large that it will simply bog down out of sheer numbers and weight? You will not be able to screen people quickly because you will have simply so many people that you cannot get to them." Is that a fear to be worried about?

Mr. PUTMAN. The question is whether they will be dealt with systematically, or dealt with unsystematically. There is going to be an increasing percentage of our population that is elderly, and who find themselves in this state. The question is how we deal with it, and not whether we have to.

As to the cost, if I might interject in that, in the last 2 years in Oregon, I am drastically overexpanding my community-based care budget—that is these alternatives—but it is more than being offset by the dramatic change in the many years of history of an increase in my nursing home caseload. We have leveled it out.

I am willing to gamble, for the next 2 years, that I can continue to keep that nursing home trendline suppressed and offset what would have been the nursing home cost in community-based care at a drastically reduced cost in Federal money, and just a break-even point in State dollars.

Senator PACKWOOD. That is the kind of evidence we need. As I said, our past experience on many medical programs, and the social service programs, when we started down the road, is that it just expanded geometrically beyond any projection that we ever conceived.

Mr. PUTMAN. If I might respond again, Mr. Chairman, what you have just said to me is the essence of my comment that the committee should consider putting that entire continuum of care under one umbrella, so that a single accountable source is there. Not here for the medical and not there for the nonmedical, because they simply will not meet. They will pass in the night, and you are back with what plagued this committee in 1969.

Senator PACKWOOD. I made a note of that, as a matter of fact, when I went through your statement. This is one of the reasons why the panelists that we have today are so valuable, because we could not draw upon any group, other than the seven of you who are going to testify, that can give us more practical information as to how to sharpen and change, and hone this bill. We could not get a better group any place in the Nation.

Ms. AZZI. There are models for decreasing 100 percent review of anything, be it acute care hospital stay, or the intermediate level of care, called focused review. We have done that successfully in both areas. The basic premise is that after developing screens, it is possible to sort out those cases that need to be looked at more intensively, and to put the resources and energy into those cases.

So there are available models of focused review. They generally follow on the heels of the beginning 100 percent review, but it would be possible to develop an experience in 100 percent review in an abbreviated period of time, and then move to a focused review system.

So there are models that are available.

Ms. CARNES. From a very practical standpoint, in Virginia something has happened that we thought might happen. Once we put a system into place, we noticed that over the three-year period the percentage of keeping people at home dropped from 22 percent the first year to 18 percent the third year.

I have spent a good part of the summer with local committees asking the questions: "What is going on? Why are we dropping percentage points?" In many instances I have found that there is a pre-prescreening going on. Those social workers and nurses, and other agency people know that preadmission screening has to be done, so in essence, they are doing a better job than they were 3 years ago.

So that there is a possibility, I think a real possibility, that your question of how many more people are we going to be filtering in through the system, how many more people will we have to put on staff, and so forth, a part of that may not occur because any time you tell somebody that they have got to do something, they will, in essence, figure out a way how to not do it, and to really do their job better on the front end.

Senator PACKWOOD. Thank you.

Senator MATSUNAGA. Senator Bradley.

Senator BRADLEY. Thank you, Mr. Chairman.

I would like to ask Ms. Azzi a question. You say in your statement that your PSRO prescreening program denied nursing home placement to about 460 people out of 8,500. Do you know what happened to those 460 people?

Ms. AZZI. No; we do not. Our task was to screen under the existing medicare and medicaid guidelines. I think that having reported that, we are going to start to capture that information to see where they go.

Senator BRADLEY. Do you think that the PSRO could basically expand its nursing home program to make the decision about home health care?

Ms. AZZI. Certainly, yes. The knowledge that we have because we work with regional review teams of a particular region of our State is really quite exhaustive about the available resources.

One of the parts that I did not get to address in the oral testimony, but is in the written testimony, is that of areas of authority. We have been prevented by a limited area of authority from making the natural next step to what it is we do now.

The area of authority now is to screen to make the medical necessity decision, to make a level of care decision. The natural next step to do would be to follow the patient, and see that the patient went to the right place even though it might be an institution.

The point is that when there are overlapping authorities in protocols and memoranda of agreement are established, we sort out whose portion of the responsibility that is. Presently, in the sorting of who has what authority in our State, the facilities still own the authority for discharge planning and appropriate placement of the patient.

Senator BRADLEY. So you think you could handle placement and case management?

Ms. AZZI. Yes.

Senator BRADLEY. I see you shaking your head, Ms. Carnes.

Ms. CARNES. You are very observant.

In Virginia, and I can only speak for Virginia, given the present state of PSRO's. We have five PSRO's in the State of Virginia and they all function somewhat differently. They are in the medical model and I would be a little bit hesitant to turn the preadmission screening role and function over to PSRO's as they currently exist in Virginia.

Senator BRADLEY. Where would you like to see it?

Ms. CARNES. For Virginia, I would rather it stayed just as it is, locally based through health and welfare departments, because I think health and welfare departments already are very much aware of how to conduct an assessment as well as how to begin to mobilize community services. I really believe that it becomes an individual State matter because what works for Virginia will not necessarily work for California.

Senator BRADLEY. Let's get to the question of cost in the specific sense. There are a lot of professionals in the field who would like to see case management and assessment for long-term care. Yet, they frequently fear that this will require a very large expenditure, and that less money will be available for providing direct services.

How do you come down on that? How would you measure the cost of case management and assessment for long-term care? Do you think that funds would be taken away from direct services?

Ms. AZZI. It might provide a more appropriate reallocation of needs.

Senator BRADLEY. So you fear that you are going to have a whole class of professionals that will be created at the expense of the people out there who need the direct care.

Mr. PUTMAN. At the point of being boring, if you combine into a single agency the responsibility for both the services and for the institutional care, I think the problem you are addressing will be minimized.

You asked, should it be with the PSRO, should it be; I think any entity can run it. It is going to vary by State as to who can do the better job. But surely the whole continuum has to be under that one umbrella so that one does not get outweighed against the other.

In our particular State most of the services we provide now are already addressed at preventing institutionalization, or preventing or slowing down deteriorating functioning. So we are already heavily into that area, and I would not see a big change.

Other States that are providing services that go far beyond what we are doing would still, I submit, have the same problem to deal with if one administrator, one agency were accountable for the continuum rather than try to snip segments out of human life and deal with them in different pockets.

I am aware of the jurisdiction problems that the Congress has as to what committees can do what, but that jurisdiction problem gets translated into programs in States and causes the bifurcation that you are talking about.

Senator BRADLEY. Do either of the two of you have any comments on that?

[No response.]

What effect do you think locating this function, or all these functions in one agency or one body would have on fraud and abuse—which is another concern that we have—on the problem of people getting payment for home health care from three or four different sources?

Locating all functions in one agency is the most frequent response to counteracting fraud and abuse. Do you agree with that? Or are there other ways you think we might provide in this bill to prevent fraud and abuse?

Mr. PUTMAN. I had not considered that. I think that it would have some helpful effect, but I would not see it as a major one. It would have some. If you are auditing an entity for the full continuum of services, you would get away from such little niceties as putting 100 percent of the same overhead in four different bills. I mean claims for reimbursement. It would help.

Ms. AZZI. I disagreed last night, and I disagree again. I am not convinced putting it all under one roof accomplishes anything more than the present legislation. In fact, I think the manner in which it is addressed on page 13 allows one of four agencies within a State to become the lead agency, and so to designate a PAT.

Although I represent a PSRO, not all PSRO's are doing all varieties of review. The legislation as presently drafted appears to address the need for variety, and I think that that enhances the legislation.

The present delivery of health care is not as fragmented and asystematic as people like to think. Housing functions and authorities in different agencies and organizations frequently has two effects. One, it provides a nice cross-check and counter-balance feature; and, two, it provides the most capable to do the appropriate service.

Senator BRADLEY. What do you think of the minimum professional requirements for those who are performing screening and assessment?

One of you mentioned that you had M.A.'s and other people performing the screening and assessment functions. What do you think of the requirements?

Mr. PUTMAN. I think that you do need some requirements. I hate to see them specified in the bill. The particular array that you have here is not particularly objectionable. The problem you have in a State such as Oregon, which has large rural areas, you simply cannot get that kind of team up. The best professional you might have in Coos Bay, Oreg., might be the public health nurse who has been dealing with these problems for 17 years.

Senator BRADLEY. So you would not say that a number of people are required. Could it be one person? How large should the team be that is going to be making this judgment as to who gets the services.

Mr. PUTMAN. I think that more than one person is important so that you get the expertise from more than one field. But you can always call for help. If you need the help of a physical therapist, try to get it. If you need the help of an occupational therapist, try to get it.

Senator BRADLEY. Who is calling for help?

Mr. PUTMAN. The case manager and/or the team.

Senator BRADLEY. That is my point: Who should be on this team?

Mr. PUTMAN. I would tend to put an RN and a medical social worker on there, and then augment as need be. In a large area, I could go with a more specialized team. In a small area, I would not try to.

Ms. CARNES. I would tend to agree with Mr. Putman in terms of the nurse and the social worker. But in Virginia we felt that the medical input was also important. The physician is actually a member of the committee, and we seek consultation from other specialists on an as needed basis—we meaning the committee itself.

The public health nurse and the social worker go into the home. They do a home evaluation, a nursing assessment, and a social evaluation. They will contact the private physician, if there is a private physician, for his or her input.

If it is a case, as an example, where they are dealing with an individual who has a behavior problem, they may well call the local mental health clinic and say, "This is the situation we have, can you do an evaluation of this person, or do you have some services from your area?"

I think that the committee, the team, whatever you want to call it, for us anyway it has worked that the committee has that responsibility to seek other professional input where necessary.

In some areas of the State, from the State level, we have stood on our heads, clapped, whistled and done everything else, if the committees have engaged other community agencies as a part of the functioning committee or in a consultation fashion, because we strongly believe that when you are looking at an individual in order to capture as much objective information about that individual in the total sense, it really helps to have input from different areas of expertise.

In some areas, one committee, for instance, has a person from the Ministerial Association, a person from the Area Agency on Aging and a person from the mental health clinic. But again it

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becomes the prerogative, if you will, of that local committee as to who they include, how they use other agencies because if you are talking about a program that is based on the use of community services, then you have got to be able to talk to whomever is sitting in the next agency.

I think that at a minimum we are talking about the nurse, the social worker, and the physician input.

Senator BRADLEY. Thank you, Mr. Chairman.

Senator MATSUNAGA. Senator Dole, any questions?

Senator DOLE. Mr. Chairman, I just have a few questions.

I would first like to have this statement that I have prepared placed in the record following the questions.

Ms. Carnes, are patients screened only once?

Ms. CARNES. No, not necessarily. If an individual is screened today, and we do not approve nursing home placement, the person might be screened again 3 months down the road, 6 months down the road. We have to remember that we are dealing with an at risk population at best, when we are talking about elderly and disabled individuals and their condition can certainly change, No. 1.

No. 2, the community service package that we have put in place could certainly change and not work for whatever reason. So if the circumstances change, a second screening and maybe even a third screening can be done.

Senator DOLE. You do follow up to determine if the circumstances have changed, right? There is a followup in every case?

Ms. CARNES. We do not have a strong followup component. If the decision is that that person should stay in the community, the committee is responsible for connecting that individual with appropriate community services. That is the referral piece.

They are responsible for some followup. It is not a highly structured followup. We do not say, "You have to go back in 30 days and check to see what has happened." It has worked very informally.

Most of the services that are going to be community based are going to come out of the health and welfare departments, title XX services particularly. So the social worker on the committee really takes that referral back in house, if you will, and many times that social worker is the one that is following up on the case.

The committees instruct the individual and the family, or significant other person who is involved with the individual that is being screened that if anything is going awry, if things change they should get back in touch with us, and you can bet your bottom dollar that 99 percent of the time if something has gone wrong that committee is going to be recontacted.

We did a followup study about a year ago. We looked at 170 individuals statewide where the screening committee had said no to nursing home placement. We literally picked them up at the point of referral and tracked them through until the point when we were doing the telephone survey.

What struck me as almost incredible, out of 170 people only 1 person had not gotten connected to the appropriate service, and had not received a service. Some people had been screened twice and had been approved from nursing home placement on the second go-round.

The point is, services had been offered, and nursing home had been delayed in all of the cases through community services, and in most of the cases nursing home had been avoided.

Senator DOLE. You don't screen private patients; is that right?

Ms. CARNES. Yes, we do in the sense that if a person is medicaid eligible at the time of nursing home application, they have to be screened and if the person is potentially medicaid eligible within 90 days after going into the nursing home, they are screened.

Senator DOLE. What about medicare-only patients?

Ms. CARNES. In the stricter sense of the word, we don't screen medicare only, but most of the elderly people and disabled people that are medicaid eligible or potentially medicaid eligible are also medicare eligible.

Senator DOLE. You may have touched on this with Senator Bradley, but who makes up the local screening committees; how are they chosen?

Ms. CARNES. We, meaning the State medicaid program, and in Virginia the State medicaid program is administered by the State health department, we have a local health department in every county and major city in the State. The local health department is also administered by the State health department.

So the State health department—medicaid—if you can get that concept—sought the support, cooperation and participation in this program of local health departments. In essence, the lead agency in the community at the local level is the health department. The health director, who is a physician, has responsibility for organizing and getting that committee together.

From the State level, we say that at a minimum the committee must be composed of the public health physician, the public health nurse, and an adult social service worker from the local welfare department. We encourage and support local committees in their efforts to engage other community agencies, such as AAA agencies and mental health clinics, in that committee effort, either as a formal committee member, if you will, or in a very close consultation fashion.

In Virginia we believe that communication is really one of the critical things you have to pay attention to.

Senator DOLE. What is the reaction from private physicians; are they supportive?

Ms. CARNES. We have not had that much difficulty with private physicians. They are kind of out here somewhere in left field. [General laughter.]

No, I am really not being fair about that. We have found that private physicians are not too much atuned to community services. They have not given us that much difficulty.

Senator DOLE. They just have not given you anything.

Ms. CARNES. They have not given us too much of anything.

What I would like to do is engage in a real effort to help to educate physicians in terms of community services. There are those physicians that say, "I believe that the person should be in a nursing home, period." But the committee really has the controlling piece if there is going to be a medicaid payment.

Senator DOLE. I agree with Senator Packwood that you are excellent witnesses. We will certainly learn something from these hearings.

Senator MATSUNAGA. Thank you very much.

Ms. Azzi, I was very much impressed with appendix B attached to your statement wherein you indicate a savings of $45 a day between hospital and SNF cost and a $75-a-day difference between hospital and ICF costs.

APPENDIX B

Estimated Costs

SNF - $55 per day - ($45 per day difference between hospital and SNF cost.)
Hospital - $100 per day
ICF - $25 per day - ($75 per day difference between hospital and ICF cost)

For the period July 1, 1979 through March 31, 1980:

8,473 (days used awaiting SNF placement)
X $45 (cost difference between Hospital day and SNF day)
$381,285

8,658 (days used awaiting ICF placement)
X $75 (cost difference between hospital day and ICF day)
$649,350

If appropriate level beds had been available there would have been an expense avoidance of...
$ 381,285
649,350
$1,030,635

Do you have a day care program in New Hampshire, and if you do, have you any figures on the cost savings you have had from the program?

Ms. AZZI. Not of any magnitude.

Senator MATSUNAGA. We do have a very successful day care program in Hawaii where in working children take their elderly parents to day care centers, just as working parents take their infants to day care centers. In this way, the day care service seems to keep the family unit together. In the evening when the children come home from work, they share the experience and skills their parents have learned at the day care center.

I have seen the elderly patients, for want of a better word, before and after going to a day care center over a period of 30 to 60 days. The improvement in the self-esteem of the patients is so dramatic, it is truly a program you should consider implementing. If you want to have a good excuse to go to Hawaii, this is a program you should go to study.

Ms. AZZI. Thank you. We will look into that matter.

Senator MATSUNAGA. If there are no further questions of this panel, I wish to thank you all. I join with Senator Packwood in observing that with your testimony, and the amount of work that has gone into the appendixes, you have really done this committee, and I am sure this country, too, a great service.

Thank you very much.

The next panel of witnesses consists of Ms. Betsy Benson, Wisconsin Community Care Organization; Dr. Jerry Eggert, Monroe County Long-Term Care Project, Inc., Rochester, N.Y.; Dennis Kodner, director, Nursing Home Without Walls Program, Metropolitan Jewish Geriatric Center, New York, and Joan L. Quinn, R.N., M.S., executive director, Triage, Inc., Plainville, Conn.

Senator MATSUNAGA. If you will all come forward to the witness desk, we would appreciate it.

I understand that Ms. Quinn has a plane to catch, so we will hear from you first.

Ms. Quinn, we will be happy to hear from you.

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

Ms. QUINN. In view of the time limit, I would like to submit my full testimony for inclusion in the record, but just speak to your bill.

Senator MATSUNAGA. Your statement will appear in the record as though delivered in full. If you will summarize, we would appreciate it.

Ms. QUINN. We feel that the strength of S. 2809 lies not just in its consolidation of noninstitutional services under a single reimbursement system, but it lies in the establishment of interdisciplinary preadmission screening and assessment teams.

PAT's outlined in S. 2809 are designed to assess the comprehensive health care needs of title XXI eligible persons to determine appropriate types of care and to assist the individual in securing care that is appropriate to his needs.

This concept contrasts sharply with the current system, which reviews for appropriateness of care often in a post hoc fashion and provides no assurance that care appropriate to individual needs is actually received.

The PAT function, we feel, is a highly skilled, highly technical task which requires knowledge of community and individual resources, a specific knowledge of the consumer's medical and social needs, and an understanding of that client's value system. The PAT must then directly and objectively formulate these elements into a specific plan of care.

To be effective, each PAT must, we believe, perform a function that goes beyond individual case management to systems management and systems oversight. I think that when we are talking in terms of long-term care, the current system is not constructed to meet those needs. The current system is really biased, as you have heard before, toward institutional care, and it is usually acute, intermittent, short-term crisis institutional care.

Further, when this function is tied in closely with a reimbursement claims review, the PAT can be an effective control for fraud

and abuse. This role is one which Triage performs daily, and has been an unanticipated benefit of the Triage single entry model.

The effectiveness of the PAT's will obviously be enhanced or limited by the type of assessment and reassessment instruments which are used. It is imperative that such instruments have high reliability and validity. They must be comprehensive enough at a minimum to accurately evaluate the medical, functional, psychosocial, environmental, and economic needs of the individual consumer.

The increasing use of functional status to evaluate alternative methods of treatment and models of service delivery indicate the need for reexamination of several validity issues. There is a likelihood of agreement between formal assessment devices and the independent, professional judgment of health clinicians in the evaluation of basic mobility and self-help functions, such as transfer, bathing, dressing, feeding, etc.

It is an individual's performance of the more complex tasks that is critical to the ability of that person to live independently in the community. The use of interdisciplinary PAT's in conjunction with a reliable, valid assessment tool will assure the ability of PAT's to accurately and objectively evaluate the individual's health needs, his/her resources, and his/her home environment. This is the key, we feel, to the successful implementation of title XXI.

Within the scope of benefits offered under S. 2809, it must be noted for the record that services such as meals-on-wheels, transportation, chore, and companion services are not covered. These services frequently serve as less expensive substitutes for other forms of care and should not be overlooked within the parameters of this legislation.

I would also suggest that provision be made to include short-term, goal-specific counseling services. Such services can be used to facilitate an individual's adjustment to the community if he has been in an institution for a long time, and also mediate supporter stress.

Often supporters are so stressed with caring for the elderly individual that what, in essence, happens is that the elderly person is very well taken care of, or the disabled person is very well taken care of, but the family or the support system is the one that needs the assistance.

Respite care services should be expanded to include short-term placement in a skilled nursing or intermediate care facility. There are people cared for at home who would meet all of the criteria to be placed in a skilled nursing facility; however, when respite care is offered to their supporters, the institutionalization is not necessary. For others, patient respite care is given in an institutional setting, such as a nursing home, and is appropriate.

Such an option may prove necessary, again, when manpower shortages prevent 24-hour live-in coverage, and often it is less expensive than 24-hour home health aide coverage.

The data collection procedures associated with the assessments and screenings of the PAT's are an important function in developing a rational, controllable, noninstitutional long-term care service program. I would recommend that functional status be included as a data category. I also think it is imperative to integrate this data

base with sources of service payment and fiscal intermediary reimbursement activity.

The establishment of a statewide lead agency to coordinate the designation of local PAT's is important in beginning to define clearly the roles of State and local governments in the provision of long-term care to the elderly and disabled population.

I suggest that the legislation include wording to establish a formal long-term care planning group to facilitate ongoing statewide PAT activities, to define State agency roles, and to see that a formal statewide long-term care plan is instituted in a manner consonant with title XXI. Membership should permit individuals with a demonstrated long-term care expertise who are not associated with State government to participate.

The composition of preadmission screening and assessment teams that is contained in S. 2809 is important in assuring an interdisciplinary review function. To enhance the efficiency and effectiveness of the roles of all the PAT members, I suggest that physicians' responsibility specify only that he/she shall certify the "plan of medical care." Requiring physicians to certify the nonmedical plan of care—for example, nursing or social services—is likely to prove as cumbersome and inefficient as it has within the current medicare system.

Finally, it has been our experience at Triage that, whenever possible, payment for home care services should be determined on a per hour basis rather than a per visit basis. This provides a greater ability to control for the cost of care and limits potential abuse. It will also tie costs more accurately to the data collection procedures mentioned earlier permitting effective health care planning.

Mr. Chairman, I believe that the experience of Triage indicates that the noninstitutional long-term care service delivery system is feasible. The population served by Triage includes chronically disabled elderly persons which this legislation addresses.

Interdisciplinary professional assessment teams, which can accurately determine client needs and mobilize consumers and community resources in the provision of care, are the correct way to go in initiating health care reform.

These functions, as they have been performed by Triage, have included a claims review and reimbursement process. The cost of these functions compares favorably with the costs of the fiscal intermediaries within the traditional system.

The Triage experience indicates that concepts embodied in title XXI can, in fact, lead to a humane, consumer centered health care delivery system that has the capacity to control costs in a rationale fashion. We also believe it is the only moral thing to do.

Legislation such as S. 2809 represents a bold attempt at reforming the complicated long-term care system. The experience of Triage would indicate that the title XXI concept can work successfully.

Thank you.

Senator MATSUNAGA. Since Ms. Quinn will be leaving, do you have any questions that you would like to ask her?

Senator BRADLEY. Yes, I would like to ask her just two questions.

One is if she could elaborate a little bit more on how she thinks that we could address the question of fraud and abuse. How do you think we can protect against fraud and abuse in title XXI?

Ms. QUINN. I think that if you combine the assessment with a claims review function—in our organization all claims for services delivered to the clients that we serve come to our office and are reviewed against the actual prescription of service—prevention of fraud and abuse is possible.

If there is any digression or any dichotomy between the service prescription, and the bill that is submitted, it is taken care of by sending the bill to the assessment team, and eventually back to the provider. For instance, if 4 hours of home health aide service was ordered 5 days a week, and the provider provided 4 hours a day in the morning and in the evening, there would be dichotomy between the bill and the original prescription.

Senator BRADLEY. What do you think of the idea of the cap; is that a problem? Do you think that if there is a cap, providers might quickly reach the cap level and not go further?

Ms. QUINN. I don't know. It depends on what the cap is, and how realistic it is in terms of what types of services it would cover in the home care arena versus the institution.

If it is an unrealistic cap, you are then stuck with the same problem that we have currently, and that is that the third party reimbursement and the parameters for reimbursement really dictate the type of care that an individual gets. It is not necessarily based on the individual's needs.

Senator BRADLEY. Here we are dealing primarily with consolidating home health care. Do you think it makes sense to include nursing home reimbursement in title XXI?

Ms. QUINN. Absolutely; I believe in the continuum as Mr. Putman does. I think that you have to have at least some oversight function on institutional care whether it be in a nursing home or a hospital, as well as home care, and really look at the continuum of services that are available and where the person appropriately fits in that continuum.

Senator BRADLEY. What has been the community's reaction to your efforts—the nurses, the hospitals, the physicians?

Ms. QUINN. Varied, some positive and some negative. I think that turf is something that everyone experiences. You can get into the whole issue of turf, "We are doing that assessment already, and you are duplicating our service." This type of situation is very common and I don't think unique to our project.

I think that provider relations is something that has to be worked at. I think you have to respect the provider, and realize that the provider has integrity also and use them in the care planning.

Senator BRADLEY. Thank you, Mr. Chairman.

Senator MATSUNAGA. Ms. Quinn, do you believe that the Connecticut-type program could be or should be carried out nationally?

Ms. QUINN. I think that with variation it could be. I think the concept of a single entry model and an assessment capability and reassessment capability, coordinating services for individuals, and then evaluating the services as to both quality and quantity, is a concept that can be transferred to other States. How it is physical-

ly set up in other States depends on geographic variations within the State.

Senator MATSUNAGA. Do you feel that we know enough about the problems and the options to carry it out at a national level?

Ms. QUINN. We know a lot more than national people think we know. There have been demonstrations that have been around for a long time. I know that Dr. Eggert's and Wisconsin's have been, and ours has been since 1974. We have gathered data, and I think people should take a closer look.

Senator MATSUNAGA. Thank you very much. I hope you catch that plane, and if you are fortunate it may go to Hawaii. [General laughter.]

Ms. QUINN. Thank you.

Senator MATSUNAGA. We will now hear from Ms. Betsy Benson, Wisconsin Community Care Organization.

STATEMENT OF BETSY BENSON, WISCONSIN COMMUNITY CARE ORGANIZATION

Ms. BENSON. Thank you, Senator.

Joan Quinn noted that we dressed alike this morning, I don't know whether that means that we think alike, but I assure you that we did not coordinate our dressing efforts so it may be some indication of something.

I am, indeed, from Wisconsin. I have been the director of a long-term care demonstration project funded jointly by the W. K. Kellogg Foundation, and a very important waiver of medical assistance that was granted to the State in 1975 by the health care financing administration. The project is called the community care organization, and is both a research and demonstration project.

To the extent that time allows, I will describe the program briefly, but I will also give you some sense of what our outcomes have been because we do bear, I hope, the blessing but also the distinction of having had a research component onboard with us from the day we began, which means that we did develop a whole series of assessment and client methodologies which have yielded, in fact, some outcomes which I think will be of interest to the committee.

Each community care organization, and we have three in Wisconsin, is a local entity. Wisconsin is basically a State with a strong county system of services, State supervised and locally administered. I think you need to understand that because obviously each State is somewhat different in its organization.

Our three projects—one in Milwaukee County, which is obviously our largest community in Wisconsin, a community of over 1 million people; the second one, which is in a medium-size urban/rural area, La Crosse County; and the third in a rural area called, perhaps appropriately, Barron County.

Nonetheless, we have had three very different experiences in some ways, and yet very similar in other ways because they are all, obviously, within the State of Wisconsin.

Each of the projects is, as I think you may see in some of the testimony of this particular panel, a single point of entry for clients to community based long-term care. Its central function is to manage service for clients, and to purchase services for clients.

It is not in any of the communities a direct service provider, but rather it has the capacity to purchase services from existing providers which in the case of Milwaukee County is a purchase system of approximately 43 different service providers that this organization has under contract to it, approximately 19 in La Crosse and, of course, a much smaller number, approximately nine, different contracts in our rural county.

The organization is run basically through a very strong case management model. We screen, assess, and identify services through a comprehensive mechanism. We use prevalidated and tested assessment methodologies both for screening and for assessment.

We do this partially because it seemed to be a good thing to do for practice, but I would like to also say that we did it mainly because we needed to do it for research purposes in order to develop what we hoped would be a valid data base on which to ultimately base judgments.

What we were trying to do in the project, ultimately, was to determine whether individuals who reached the project could be maintained in the community at a cost equal to or less than that which would have been expended had they otherwise been in institutions. We found that it is a very easy thing to say, and it is considerably more difficult to operationalize, but nonetheless in the 5 years of the project we, in fact, did it.

The organization, as I said, is a very strong case management model. We do all the things that I think you have heard this morning, which are really a part of good practice. The difference being that our case managers follow the clients very closely.

When I get to some of the outcomes of the project, you will see some of the potential effects, and why I believe and the project believes that case management, rather than being an administrative add-on service, is in fact a hard service to which I think some strong outcome measures can be attributed.

As I mentioned, also, the CCO's are not direct service providers. They purchase services from existing agencies. They do this through a contracting procedure which is in some ways not unlike the way title XX operates with one major difference and that is because they are using medical assistance. They, in fact, certify providers.

By virtue of our medicaid waiver, we were able to provide a series of services that were not generally allowable under our medicaid State plan. Consequently, you will see that we provided a series of services which tend to be at the lower level of skill. We provide a lot of transportation services, nutrition services, home chore services, and personal care services.

Each service is purchased by unit. By virtue of the fact that we contract with an organization does not mean that we provide them with $20,000, $30,000, or $40,000 to forward fund their program. We do, in fact, unit purchase. Each case manager, then, if an individual client requires this specific service, orders that specific service for that individual.

It operates somewhat similarly to the system that you heard described by my colleague Joan Quinn from Triage. The particular provider has to, in order to get paid, bill the local CCO, and the

local CCO compares the services that it authorized against those that are billed.

Initially, the State paid each organization on a fee for service reimbursement system. As we gained experience, however, we did develop what really, I think, can be termed a modified capitation system based on current caseload projections, certain general economic trends which are somewhat difficult to calculate as everybody in this room knows, as well as various service costs.

In other words, we just went back and attempted to determine from our experience what the average cost would be. Currently the State reimburses each site on a per client, per day mechanism.

We reimburse Milwaukee County at a rate of $8.58 per client, per day; La Crosse at $7.84 per client, per day; and our rural county at $5.21 per client, per day. This translates for all clients into approximately, for Milwaukee, $300 per month; for La Crosse, approximately $235; and for Barron obviously somewhat less.

This does not mean that all clients receive services up to $235 per month. It means that many clients receive services at a lower level, other clients receive more. It is an average, annualized reimbursement mechanism that is used.

I mentioned the project was evaluated. We did have a separate evaluation component that was operated by Faye McBeath Institute, which is a part of the University of Wisconsin at Madison. Our research needs required the project to define and to target its client population, to assess and monitor consistently and accurately, to measure it over time, in other words, an experimental period, and to establish and maintain equivalent experimental and control groups.

In our two smaller counties we did this through a comparison county. In our Milwaukee project, we were able to achieve a random assignment of clients, and I really have to say, achieve it. It was not, needless to say, a very easy thing to do within the population, but it did, I think, allow us within the best tradition of research to have this kind of comparison.

The data that I am going to refer to briefly here are reported for Milwaukee, and are based on 223 experimental and 104 control clients who were randomly assigned in that community.

The cost-effectiveness data were based exclusively on medical assistance. They are not based on medicare, which is a weakness, perhaps, but the data and the information do lend themselves to comparative analysis, if we were able to get at that data base. However, I think they are very encouraging, and they are certainly very interesting.

We found that over the 18-month period of time when we were doing this test, the total monthly cost to the regular medical assistance program—that is the nonwaivered services—was substantially less for our clients than for control clients, the difference being $197.87 to $325.42.

I see that I am going to run out of time, and that is too bad. However, let me just say briefly that we did find that when you added the project costs back in that there was a difference of approximately 15 cents per client, per day more for our clients.

I want to say that the place we showed substantial differences was in nursing home and hospital lengths of stay. We showed a

modest decrease in the number of days that our clients spent in nursing homes over the controls.

I want to add here that we did not have a preadmission screening assessment, which I think is critical, and I think simply points to the fact that we were able to forestall institutionalization without it. I think that had we had it, it would have helped.

However, the most important and interesting data which we did not anticipate is that we had a substantial decrease in the number of hospital days of our clients over control clients. The difference for our clients being an average of 2.95 days to our control clients of about 14.26.

I will only say one more sentence, and it is that it has potential implications for medicare. Unfortunately, we do not have access to medicare data. That might be of more interest, frankly, to the Federal Government than it is to the State, since the State does not pay medicare benefits.

Senator PACKWOOD. Mr. Chairman, let me ask one question because that was the point I was most struck with in your testimony. Why that incredible difference in hospital stays?

Ms. BENSON. To be perfectly honest with you, I am not certain, except that the only real difference in the intervention is that our case manager—you have to, in a sense, go back at some of this anecdotally—our case managers tell us that they maintain a much closer relationship with the clients when they go in hospitals. I should add that this did not decrease the number of admissions to hospitals. It decreased the length of stay.

Senator PACKWOOD. The difference between 14 days and 3 days is just such an incredible difference that it almost seems statistically impossible. Although I will take your word for it, and I believe your testimony.

Ms. BENSON. Fortunately, you see, I am not the person who did the research, so I cannot even be claimed to have bias in this particular case.

Senator PACKWOOD. I am delighted with that testimony, and I plan to use it frequently.

Ms. BENSON. Senator, frankly, as I indicated we did not initially anticipate a decrease in hospitalization. I think that logic might suggest that there would be some. This is not only significant, but it is obviously so statistically significant that it is almost frightening.

You might expect that our legislature is equally as curious as to why that occurred, and one of our State senators suggested—fortunately there were no press around—that we close all hospitals and go to community care. But I assure you that he was kidding.

[General laughter.]

Ms. BENSON. At any rate, the data do lend themselves to further analysis of the question that you ask. At this time we have the data. I believe they are solid and based on a good data base.

Senator PACKWOOD. Could you send me the data base?

Ms. BENSON. I could certainly send you a copy of the report. In fact, Mr. Lewis of your staff and I have had some communication on that as well.

Senator PACKWOOD. Thank you.

Senator MATSUNAGA. We will now hear from Dr. Gerry Eggert, Monroe County Long Term Care Program, Rochester, N.Y.

STATEMENT OF GERALD M. EGGERT, PH. D., EXECUTIVE DIRECTOR, MONROE COUNTY LONG TERM CARE PROGRAM, INC.

Mr. EGGERT. Good morning.

What I would like to do is to submit my full testimony for the record, and briefly discuss some of the points that I have got in the summary.

Senator MATSUNAGA. Without objection, your statement will appear in the record, as though presented in full. You may summarize your statement.

Mr. EGGERT. The Monroe County Long Term Care Program is kind of a unique venture in this field in that it is a systems intervention model. We, working with the local department of social services and the various State agencies have responsibility for administering the entire medicaid program within Monroe County that deals with long-term care.

Monroe County has approximately 720,000 people. The elderly population is about 70,000 people. We are responsible for approving the medical necessity for both institutional and noninstitutional services, in addition to reviewing claims for noninstitutional services. We approve payment for both noninstitutional and institutional services.

I think, in going through 31 months of operational experience in terms of running the program, we have come across some interesting findings. Certainly some of them are subject to various interpretations, but at least we are beginning to develop the data base that will allow us to make some better decisions in the future.

One of the interesting findings was that a grater proportion of medicaid patients were able to return home from the hospitals directly than were private pay patients. This is an interesting finding.

We have the ability to approve medical necessity and payment for medicaid patients on a somewhat quasi-mandatory basis. We do not have the ability to approve payment or medical necessity for private pay. That is a voluntary basis.

Yet, in the first 31 months, 49 percent of the medicaid patients that we reviewed in hospitals, whose needs were at the skilled level, returned home. Only 21 percent of the private pay patients returned home. Conversely, 79 percent of the private pay patients who were reviewed on a voluntary basis went directly to nursing homes; and 51 percent of the medicaid patients went directly into nursing homes.

We also provide assessments to a similar patient population in the community. We review all persons who apply for medicaid, and who need long-term care services. Of the community group that was assessed at the skilled level, 92 percent of the medicaid people were able to stay home; of the private pay group in the community, 84 percent were able to stay home.

The point is that a much higher proportion of nonmedicaid or private pay people enter facilities than medicaid patients. There are two major reasons. First, private pay patients are more attrac-

tive to nursing homes because they charge them a higher rate. The second reason is that private pay patients basically have no third party reimbursement for noninstitutional services.

If they are not medicaid eligible, medicaid is not going to pay. Medicare provisions are very restrictive. Medicare is not a viable payment source. In all probability they are above the limits of title XX, and that is not a payment source. So given the option of no reimbursement for community services, we find a greater proportion of private pay patients entering nursing homes.

I think that this is one of the attractive parts of title XXI. If some type of copayment provision could be set up so these private pay patients have some opportunity for some limited third-party reimbursement, one may be able to reduce the rate at which they enter nursing homes.

This gets into the second point. Why are we trying to reduce the rate of private pay patients entering nursing homes?

We have a situation in Monroe County in which all the nursing home beds are filled, and we still have people in acute hospitals who cannot be placed in a nursing home in a timely manner. I think that this is the opportunity that title XXI, if it can be designed appropriately, has to reduce cost in long-term care.

The 200 patients in the hospital that we have—We have 2,400 hospital beds, and we have 200 people who should not be there, yet medicare or medicaid is paying the full hospital rate. That represents an enormous opportunity to reduce the cost in the hospital, and to trade off those costs for expanded community services.

The problem is that the 200 people in the hospitals in all likelihood cannot go home. Their care needs are so heavy that a nursing home is the most appropriate place. But nursing homes will not admit them in a timely fashion because they have other opportunities for admissions, such as lower care private pay patients from the community, or lower care private pay patients from the hospital.

So the point about title XXI that has some appeal is that if the preadmission assessment for nursing home placement can be more than voluntary for nonmedicaid patients, the opportunity exists to reduce the rate at which they enter nursing homes, thus potentially freeing up some beds for people who are in hospitals inappropriately.

In New York, perhaps, we have been aware of the hospital problem a little more than the rest of the country. It is my understanding that the statewide PSRO has made a press release to the newspapers asserting that approximately $240 million per year could be saved for the medicare/medicaid programs if people in acute hospitals could be placed in a timely fashion in nursing homes. That is more money than the State spends in home care.

So the trick is to place people who cannot go home from the hospital in an appropriate manner in nursing homes, and then spend the money that you are basically going to save by not having those hospital days on your expanded home care services, and you also probably should be able to pay for your administrative costs that you are going to incur with your patient assessment teams and case management teams.

I can say that in Monroe County we have had an independent evaluation that is in its third year. The indications are that we have not been able to substantially reduce the numbers of people who are backed up in hospitals. I think that we have been able to abate the increase, but we have not been able to reduce the absolute numbers. Again, I attribute that to the fact that nursing homes still have the ability to select private pay patients who have low care needs as first priority to fill their beds.

So basically what is needed is a communitywide placement system that offers nursing home beds to patients on the basis of need first, and not payment. In that manner, I think heavy care patients who are in hospitals will be able to be placed in the nursing homes in a more timely manner.

There are other points that I think title XXI has the opportunity to address. I think the fact that if one could consolidate the existing home care services that currently exist under titles XVIII, XIX, and XX in a single agency that, certainly, to some extent would reduce a lot of hassle for consumers who have to go to at least three different places or through three different eligibility processes.

I think that it would make it administratively a lot easier for providers of service because there would be one source, one agency that would work with them in terms of approvals, in terms of service needs. It would be very good, I think, in terms of regulators because there would be one agency that could be monitored as far as claiming, as far as eligibility determinations and as far as management efficiency.

There may be some savings on an administrative basis in consolidating those three programs into one single agency.

I think one of the other things that we found is that even though patients enter nursing homes—I am going back to the nursing home admission of private pay patients—as private pay patients, they do not stay private pay very long. We also approve conversions from private payment source to medicaid, and we have noticed a trend. In the first couple of years—1978-79—at the skilled level, of those who applied for medicaid, 40 percent had been in the nursing home for less than 6 months, and in the last 6 months—January to June 1980—that proportion has increased to 50 percent.

So even though people enter as private pay patients, given the fairly high nursing home charges and the inflation associated with that, and given the fact that older people are on a fixed income, they are running out of money sooner.

A great proportion of the private pay admissions are potentially medicaid eligible, and that speaks to the Virginia preadmission assessment program, but also, I think, adds some strength to the argument that private pay patients should be subject to some type of assessment, especially if you are not going to stay private pay forever.

Thank you.

Senator MATSUNAGA. Thank you very much, Dr. Eggert.

We will now hear from Mr. Dennis Kodner, director of planning and community services, Metropolitan Jewish Geriatric Center in New York, speaking for the nursing home without walls program.

STATEMENT OF DENNIS KODNER, DIRECTOR OF PLANNING AND COMMUNITY SERVICES, METROPOLITAN JEWISH GERIATRIC CENTER OF NEW YORK, ON BEHALF OF THE NURSING HOME WITHOUT WALLS PROGRAM

Mr. KODNER. Good morning.

Metropolitan Geriatric Center, which is located in Brooklyn, N.Y., is a large, multilevel, long-term care institution providing services to well over 1,000 older people in a wide range of institutional and community based settings in a number of urban neighborhoods comprising almost one-third of New York City's elderly population.

Our present continuum of care consists of a 915-bed skilled nursing and intermediate care facility, day hospital, hospice, senior center, transportation services for the elderly and handicapped, Institute for the Study of Aging and Long Term Care, and a nursing home without walls or long-term home health care program.

The nursing home without walls is one of our most recent outreach efforts. It is part of a larger State-sponsored initiative, called the long-term home health care program, which has generated considerable interest among our policymakers and planners because of its potential to rationalize health services for the elderly.

At this point, I think it is appropriate to emphasize that all nursing homes are not alike. In fact, many of us are involved in the development of the kinds of noninstitutional services and coordinating structures that are proposed in S. 2809.

In our view, S. 2809, although it might require some rethinking in certain areas, represents a well-thought-out approach to restructuring the financing and provision of long-term care services. It goes to the heart of the problem of long-term care in this country.

As expressed so succinctly by Senator Packwood in introducing the bill, health care for the elderly is a hopeless maze of services, facilities, and financing that fail to meet the needs of individuals and their families, and encourages institutional care rather than maintenance in the home and the community.

Nowhere in the health system is the maxim that form follows financing more apparent than in the long-term care sector. Because all the services are funded by differing public money streams and have widely ranging administrative arrangements, eligibility requirements and benefits, services for older people are multiple, parallel, overlapping, noncontinuous, and confusing to older persons, their families, and professionals as well.

What is more, there are few entities at the local level which can effectively pool the various entitlement and categorical program benefits around the individual's needs to insure that they will receive the appropriate type and level of care in the least restrictive and most cost-effective setting.

This problem, obviously, is reaching crisis proportions, as the size of the elderly population, the number of persons needing long-term care services, and the national nursing home bill are growing.

Particularly noteworthy in S. 2809 is the bill's goal to combine, expand and link the noninstitutional services presently covered under medicare/medicaid in title XX into a new title XXI.

While we most certainly continue to support current legislative proposals to reform the medicaid system, which is the chief support

for nursing home care in this country, we favor in the long run the removal of long-term care's focus from medicaid with its welfare standards, the elimination of fragmentation and proliferation of programs in the long-term care field, and the integration and coordination of social and health care at the community level through the creation of a single funding mechanism as proposed in the legislation.

I would now like to describe New York State's long-term home health care program, drawing on our center's experience as one of the most successful models in the State's demonstration to date. Since the prepared statement is already in your hands, I would like to try not to cover exactly the same observations.

New York's long-term home health care program is a single-entry system into a comprehensive range of health and compensatory services in the home and the community for medicaid clients who qualify for placement in an SNF or ICF. These are for persons who need long-term care, but can benefit from services offered in the community as an alternative.

Referred to as "Nursing Home Without Walls" by its legislative sponsor, Senator Tarky Lombardi, Jr., who incidentally is the chairman of the State senate's health committee, the long-term care program was signed into law in late 1977. It became effective on April 1, 1978.

The legislative program, which took 3 years to develop, contrasts sharply with existing patterns of fragmented and highly restrictive medicaid-financed home care in other States. In passing the law, the State legislature was very much concerned with five trends:

One, the alarming escalation in the costs of nursing home care in New York State;

Two, the rapid growth in the elderly population;

Three, the high degree of inappropriate institutionalization;

Four, the blocking of expensive hospital beds by chronically impaired patients needing long-term institutional care; and finally

Five, the poor coordination in existing home care programs. With regard to this last point, it is interesting to note that even with our State's rather well-developed and financed home care system, which I understand represents roughly 80 percent of the medicaid bill expended on home care in this country, we still have problems in assuring adequate in-home support for our older adults in our State.

The following services are provided by long-term home health care programs: nursing; home health aides; personal care; homemaker; housekeeper; physical and occupational therapy and speech and hearing; social services; special counseling; meals; medical supplies and equipment; respiratory therapy; home maintenance and housing improvement; moving assistance; respite care; transportation; and social day care, as well as 24-hour professional coverage.

Many of these services are provided under an 1115 waiver from the Health Care Financing Administration. This makes it possible to custom-tailor a package of services for people with differing patterns of need.

Unlike the other projects on this morning's panel, new community entities were not formed to provide these services, or to perform the required comprehensive assessment. Existing health care pro-

viders are designated as long-term home health care programs through the State's very strong and existing certificate of needs statute.

Their service areas and capacities are set by the Commissioner of Health. Long-term home health care programs may be served by home health agencies, public or voluntary, not-for-profit hospitals or long-term care institutions. There are currently nine long-term home health care programs in operation throughout our State with a certified capacity of 800 persons. One additional program was recently approved by the State and is expected to begin providing services shortly.

In addition to providing direct service delivery and/or arranging for services, long-term home health care programs perform comprehensive assessments. It is important to understand that this assessment is done in conjunction with representatives of the local social service district, and the discharge planner if the client is currently in the hospital or long-term care facility and is seeking care in the community. It also develops a plan of care, coordinates the provision of services, and monitors the quality and appropriateness. At the core of the program is a gatekeeping mechanism which advises medicaid clients of the availability of these services before authorizing placement in a nursing home.

In order to control costs, the individual's service budget may not exceed 75 percent of the average monthly institutional rate for the appropriate level of care in the ICF or SNF. Case management is, as in the other projects on this panel, crucial to the success of the care plan, and the ability to keep costs under control.

At the State level, the responsibility for the program is shared by the department of health and the department of social services, which is the State medicaid agency. The health department reviews the certificate of need applications from individual providers, develops regulations governing individual long-term home health care programs, formulates reimbursement rates, surveys the providers for participation in medicare/medicaid programs as they are, in fact, considered certified home health agencies, and oversees the quality of care provided. The social services department establishes policies and procedures that local social service districts use in relating to the individual long-term home health care programs in the area. The local social service districts participate in the required joint assessment and assure medicaid eligibility for the individuals participating in the program.

Time is very, very short. I would merely like to say that we have had a very limited experience with the program, and many problems, political, bureaucratic, and otherwise, which perhaps we will address later.

The impression that we have thus far is that the program has been able to provide services to people in the community who would otherwise have been institutionalized in SNF's and ICF's for about 50 to 60 percent of the cost of institutional care.

Thank you.

[The prepared statements of the preceding panel follow:]

The Testimony of Joan L. Quinn, R.N., MS., Executive Director of Triage, Inc., Before The Senate Finance Committee Relating to S-2809

Good morning. My name is Joan Quinn and I am the Executive Director of Triage, Inc. It is an honor to have the opportunity to speak before this committee today on S-2809. The prospect of establishing a reimbursement system and a service procurement mechanism that incorporates a comprehensive assessment/reassessment process for the long term care population is not only imminently logical - it is desperately needed for many, many long term care elderly and disabled persons. As you know, a good portion of this population group has the potential to be able to function independently in their respective communities with the provision of home support services. The impact that this independent living option can have upon the morale, dignity and self determination of this group of individuals cannot be overstated. The direction toward which S-2809 points is the moral imperative of personal dignity and self-determination in the delivery of health care for all Americans - in particular those physically and emotionally fragile consumers and their families - which those of us in the fields of health care and public must address.

Throughout the past decade there has been a great deal of concern about the spiralling costs of health care, particularly among the elderly. The current health care system is predisposed toward the provision of institutional care. Thus, effects to control the

costs of care have been largely directed at the limitation and controlling of institutional costs. There has been an ongoing philosophy that increasing the reimbursement eligible options in health care cannot begin to occur until the present high service costs are brought under control. However, the experience of Triage bears out the premise that the high costs for service eligible for reimbursement under the present system cannot be effectively controlled without expanding reimbursement to include less expensive non-institutional health care options and a comprehensive assessment and service coordination process to procure appropriate care that at the same time can control overall health care costs.

"The experience of the Triage research and demonstration project offers important information to this committee in its consideration of S-2809. Since Triage is a Medicare research project and, therefore, contains no means test for eligibility for program participation, I believe its history of development, service utilization and cost bears directly upon the intent of S-2809 to secure health care services for the non-medically indigent long term care population.

The first two years of the Triage project, from 1974 to 1976, constituted the developmental phase of the research and demonstration effort. Funding for project operations during this period came from the State of Connecticut. Services appropriate to

individual Triage client needs were reimbursed through the traditional Medicare and Medicaid systems. Additional services not eligible for Medicare or Medicaid reimbursement were paid on a limited basis through Older Americans Act Title III-A monies. These dollars, allocated to Connecticut, were made available to Triage by the state.

"Throughout this start-up period, services available to Triage clients were determined by the individual's eligibility for Medicare and Medicaid or by the extent to which services appropriate to the client's needs met the reimbursement criteria of these two programs. These barriers were lifted in August of 1975 when the Secretary of the DHEW granted broad and comprehensive waivers to Triage on the use of Medicare Trust Funds for Service Reimbursement. The waivers permitted Triage to reimburse services not normally eligible for Medicare coverage. This represented the service expansion element of the Triage waiver system. Equally important was the technical waiver aspect. Under this component, the coinsurance and deductible requirements of Medicare were waived as were 100 day benefits limitations. Three day prior hospitalization requirements for skilled nursing facility placement and home health care, homebound requirements for home care services, and physician's plan of care requirements for home care service eligibility were also waived.

"The technical and service expansion elements of the waivers granted to the project in 1975 permitted the Triage project to authorize and reimburse services based solely upon appropriateness to client need without the constraints imposed by third party payer limitations.

"When the waivers were granted to Triage, all components were in place to form a true single entry health care delivery model. The two major purposes for which the Triage project had originally been conceived could thus be pursued using a formal research and evaluation methodology.

"In April of 1976, the National Center for Health Services Research (NCHSR) of the DHEW formally awarded a research and demonstration grant to the Connecticut State Department on Aging to conduct a longitudinal study of the health care needs of the elderly in the Central Connecticut Region and to study the cost and effectiveness of the Triage single entry health care delivery model. The Department on Aging, in turn, contracted with Triage, Inc. for operations and with the University of Connecticut Health Center for research evaluation. Connecticut continued to pay for Triage project operations costs through monies appropriate annually by the State's General Assembly. Grant monies from NCHSR paid for research costs incurred by the Triage and the University of Connecticut during the

three year research time period from April 1, 1976 through March 31, 1979.

Triage is based upon the assumption that assessment of client need and the coordination and monitoring of service quality and ongoing client need should be separate from service delivery itself (Quinn, 1979, 1980). Further reimbursement oversight must be a function discrete from the provision of service. The concept of interdisciplinary expert professional teams performing comprehensive assessment, coordination, and monitoring functions is not new. What is new is the direct connection of these functions to the control of reimbursement dollars. Thus, the Triage staff includes masters prepared nurse clinicians, social service coordinators, and claims and reimbursement personnel.

The nurse clinicians and social service coordinators constitute "professional teams". They assess the comprehensive health care needs of the older adult and utilize agency, community, and individual resources to consistently meet these needs over time. Individual clients and the agencies providing services to those clients are monitored by the nurse clinician/social service coordinator teams. The need for service and amounts of a needed service are integrated with individual and familial support systems to assure effective, appropriate service delivery and maximum levels of client functioning. This approach minimizes

induced client dependence. It also maximizes appropriate individual family responsibility while providing necessary support.

"Claims personnel review bills submitted by service providers for conformity to those services authorized by the nurse clinician/social services coordinator teams and submit these claims for payment as approved to the Office of Direct Reimbursement of the Health Care Financing Administration. This reimbursement function can often be critical to the success of a single entry assessment, coordination, and monitoring model. The efficient, carefully controlled claims and reimbursement system that Triage has developed has contributed greatly to the success of the project in both its research and service aspects. With its single funding source and its single entry billing system, Triage has been a dramatic departure from the fragmented system of health care reimbursement of traditional health care programs. Its uniform claims department procedures have made it simpler for providers to bill for services and easier for clients to understand their bills. Under the Triage system, providers have been made more accountable for the services they delivered than was previously the case. Because they have been treated fairly by the claims and reimbursement system and have been paid in a timely fashion, Triage's relationship with its providers has been a good one

that reflected the high quality of services that were delivered to the elderly people that Triage served.

CLIENT CHARACTERISTICS

"To be eligible for Triage, a person must be 65 or over and enrolled in Medicare or 60 or over with a Medicare disability and live in the seven town Central Connecticut region. Clients gained access to the Triage system merely by calling Triage, Inc. or by having someone else call. From the time that the first Triage client was assessed in March of 1974 to the terminus of the NCHSR grant on March 31, 1979, the program professional staff assessed 2,128 older adults who became active clients. On March 30, 1979, the Health Care Financing Administration awarded Triage a new two year grant to continue the research effort from April 1, 1979 through March 31, 1981.

"The number of persons who were active clients at the close of the initial NCHSR grant on March 31, 1979 was 1,404. The 724 who were terminated from the program during this 61 month period constituted an attrition rate of 34%. From this group, 495 persons or 68.4% were terminated from the project due to death. The overall profile of the population served by Triage has been a frail elderly group, predominantly widowed females, who live alone with less than adequate financial resources and limited educational attainment. Only 15.8% of the Triage population had incomes of over

$6000 per year. Those persons over 75 at initial assessment constituted 57.6% of the Triage population as compared to 27.5% of Connecticut's aging population and 27.0% of the nation. At the end of the project's first grant, those persons over 75 constituted 60.3% of our program's active client population. These age characteristics become important when one considers that people over 75 years of age are five times as likely to be institutionalized as those under 75.

"At the time of initial assessment, 72.4% of the Triage group had heart and circulatory problems, 40% had arthritic problems, and 22% had problems of the digestive system. Those persons who were unable to carry out those basic day to day activities required for independent community living (preparing meals, shopping, housework, handling finances, etc.) constituted 66% of the Triage population. This indicates that without the assistance of Triage, this group could continue to live independently in the community only with the greatest of difficulty.

"The ability to carry out basic personal care functions such as bathing, feeding oneself, dressing, and monitoring continence of bowel and blader was intact for 83.1% of the Triage group at initial assessment. Cognitive functioning was intact for 80% of the population. Among those Triage clients who survived through

March 31, 1979, 72% had improved or maintained their ability to perform basic personal care functions and 48% had improved or maintained their ability to carry out the basic community living activities noted earlier.

SERVICE COSTS

"An analysis of the data collected on overall service utilization and service costs for those individuals who became Triage clients during the three year period April 1, 1976 through March 31, 1979 showed that service utilization on a per client day basis decreased slightly over time while costs increased at a modest rate. These cost increases compared favorably with the sharper health care cost increases experienced within the region and the nation." (Hodgson, Quinn, 1980 pp.365-368)

"In the Fiscal Year 1978, the number of institutional days saved, either through admissions that were delayed (19,955) or prevented (61,320), was 81,275. The net number of dollars diverted from institutional care through these days saved, and therefore available for community oriented care was $1,688,329. Triage was also able to use long term care institutions effectively for rehabilitative purposes. Although 7% of the total Triage population could be expected to be placed in a skilled nursing facility on any given day, at least 41% of this group could be expected to return home. Those persons whose health status was so poor

that they would expire in the nursing home constituted 51% of the 7% group.

Those Triage clients who required hospitalization constituted 1.7% of the total Triage population on any given day. Similarly, those persons residing in intermediate care facilities or homes for the aged constituted less than 1% of the Triage active client group.

"Further analysis of services provided to the 1,747 clients who made up the active Triage population in 1978 showed that average service cost per client for the fiscal year was $11.31 per client day. This figure includes all services including institutional and non-institutional care and waivered and non-waivered services. When services for this population were broken down according to typical usage profiles and costs were dropped for those very ill clients who remained in the program for less than a year, the cost per client day dropped significantly to $9.77. This would indicate that the very ill group had much higher per client day cost. The increased cost was due to the high utilization of institutional care that was required to maintain them in the program. Institutional costs, including acute hospital costs, comprised 57% of the total service dollar at any one time and represented services used by 8.7% of the total population. These higher costs, therefore, were not due to significant or inappropriate increases in the use of home

health care or waivered services.

"The cost of the waivered services themselves were not significant cost generators; they were consistently 20% of the total service costs. Utilization and costs for these waivered services were well controlled over time. The ability to effectively coordinate these services resulted in a discernable and distinct pattern of service utilization in which less expensive home care services were used to substitute for the more expensive outpatient or ambulatory care services. The interesting facet to this pattern was that the assessment--reassessment process became a form of health care intervention that, in and of itself, had the impact of reducing total service costs.

OPERATION COSTS

"When the concept of the Triage single entry assessment, coordination, monitoring, and reimbursement model was initially discussed, there was concern that the cost of such an operation would be prohibitive and result in significantly higher total health care costs. The costs of the Triage operation with its professional teams, reimbursement section, and research component was $.92 per client day for 1978 and $.94 per client day for 1977.

"These figures include costs of performing initial

assessments, coordination and monitoring, reassessment, claims and reimbursement, research and development. For Fiscal Year 1978, assessment activities accounted for 10.2% of the operation's costs of $.92 per client day. Coordination and monitoring constituted 44.1% of this cost and reassessment comprised 5.9% of the operation's costs. The claims and reimbursement functions were 27.9% of these costs, while 11.9% of the operation's cost per client day was the result of research and development activity.

"Generally, the cost of Triage operations has been 7.5% of the total project costs.

"The percent of the total cost spent on administrative functions compares favorably to the percent of the total health dollar spent on operation costs by Medicare Part B carriers. According to the DHEW, the operation costs of these carriers comprised between 9.7% and 12.4% of the total health expenditures from 1967 to 1973." (Hodgson, Quinn 1980, p369)

Much emphasis has been placed upon the costs of innovative health care options to the point that cost has become the primary determinate of the feasibility and value of these alternative forms of care.

While it is clear that the costs of care are realistic and critical factors, I believe that this emphasis has put the cart before the horse. The current health care system is a willy/nilly arrangement of

fragmented services with only limited coordination with one another. Energies to control the costs of these services have been focused upon regulatory efforts at federal and state levels. While regulations have limited the costs and quantity of care rendered, they have done so without imposing any rationality upon the health care system itself.

The strength of S-2809 lies not just in its consolidation of non-institutional services under a single reimbursment system. It lies in the establishment of interdisciplinary preadmission screening and assessment teams. PAT's outlined in S-2809 are designed to assess the comprehensive health care needs of Title XXI eligible persons, to determine appropriate types of care, and to assist the individual in securing care that is appropriate to individual need. This concept contrasts sharply with the current system which reviews for appropriateness of care in a post hoc fashion and provides no assurance that care appropriate to individual need is actually received. The PAT function is a highly skilled, highly technical task, which requires knowledge of community and individual resources, a specific knowledge of the consumer's medical and psycho-social need, and an understanding of client values. The PAT must then directly and objectively formulate these elements into a specific plan of care. To be effective, each PAT must, we believe, perform a

function that goes beyond individual case management to systems management and systems oversight. Further, when this function is tied in closely with a reimbursement claims review, the PAT can be an effective control for fraud and abuse. This role is one which Triage performs daily, and has been an unanticipated benefit of the Triage single entry model.

The effectiveness of the PAT's will obviously be enhanced or limited by the type of assessment and reassessment instruments which are used. It is imperative that such instruments have high reliability and validity. They must be comprehensive enough at a minimum to accurately evaluate the medical, functional, psycho-social, environmental and economic needs of the individual consumer. Kraufert et al (1979, p817) note:

"The increasing use of functional status to evaluate alternative methods of treatment and models of service delivery indicate the need for reexamination of several comparative validity issues."

Their work indicates that there is likelihood of agreement between formal assessment devices and the independent, professional judgement of health clinicians in the evaluation of basic mobility and self-help functions (e.g. transfer, dressing, bathing, feeding). The likelihood of similar concordance on mobility items

and more complex activities such as use of public transport, and ability to perform housework and shopping tasks is not great. It is an individual's performance of the more complex tasks that are critical to the ability of that person to live independently in the community. The use of interdisciplinary PAT's in conjunction with a reliable, valid assessment tool will assure the ability of PAT's to accurately and objectively evaluate the individual's health needs, his/her resources and his/her home environment. This is the key to the successful implementation of Title XXI.

Within the scope of benefits offered under S-2809, it must be noted for the record that services such as meals on wheels, transportation, chore and companion services are not covered. These services frequently serve as less expensive substitutes for other forms of care and should not be overlooked within the parameters of this legislation. I would also suggest that provision be made to include short term, goal specific counseling services. Such services can be used to facilitate an individual's adjustment to the community and mediate supporter stress to prevent supporter burn out.

Respite care services should be expanded to include short term placement in a skilled nursing or intermediate care facility. Such an option may prove

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necessary when manpower shortages prevent 24 hour live in coverage. It is also often less expensive than 24 hour home health aide coverage.

The data collection procedures associated with the assessments and screenings of the PAT's are an important function in developing a rational, controllable non-institutional long term care service program. I would recommend that functional status be included as a data category. I also think it imperative to integrate this data base with sources of service payment and fiscal intermediary reimbursement activity.

The establishment of a statement lead agency to coordinate the designation of local PAT's is important in beginning to define clearly the roles of state and local governments in the provision of long term care to the elderly and disabled population. I suggest that the legislation include wording to establish a formal Long Term Care Planning Group to facilitate ongoing statewide PAT activities, to define state agency roles and to see that a formal statewide long term care plan is instituted in a manner consonant with Title XXI. Membership should permit individuals with a demonstrated long term care expertise who are not associated with state government to participate.

The composition of preadmission screening and assessment teams that is contained in S-2809 is important in assuring an interdisciplinary review function. To enhance the efficiency and effectiveness of the roles of all the PAT members, I suggest that physician's

responsibility specify only that he/she shall certify the "plan of medical care". Requiring physicians to certify the non-medical plan of care is likely to prove as cumbersome and inefficient as it has within the current Medicare system.

Finally, it has been our experience at Triage that whenever possible, payment for home care benefits should be determined on a per hour basis rather than a per visit basis. This provides a greater ability to control for the cost of care and limits potential abuse. It will also tie costs more accurately to the data collection procedures mentioned earlier permitting effective health care planning.

Mr. Chairman, I believe that the experience of Triage indicates that the non-institutional long care service delivery system described in S-2809 is feasible. The population served by Triage, Inc. includes chronically disabled elderly persons which this legislation addresses. Interdisciplinary professional assessment teams which can accurately determine client needs and mobilize consumers and community resources in the provision of care is the correct way to go in initiating health care reform. These functions, as they have been performed by Triage, Inc., have included a claims review and reimbursement process. The cost of these functions at Triage, Inc. compares favorably with the costs of the

fiscal intermediaries within the traditional system. The Triage experience indicates that concepts embodied in Title XXI can, in fact, lead to a humane, consumer centered health care delivery system that has the capacity to control costs in a rationale fashion. We also believe it is the moral thing to do.

My experience as a nurse, my experience as Executive Director of Triage confirms daily that there are too many people wasting away in institutions, and too many families and individuals enduring unnecessary suffering in the community because they cannot receive services appropriate to their needs. For us to delay in bringing about changes in health care delivery will result in the exacerbation of this problem and a continued lack of effective control over health costs.

Legislation such as S-2809 represents a bold attempt at reforming the complicated long term care system. The experience of Triage would indicate that the Title XXI concept can work successfully. Thank you.

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Testimony on behalf of:

Wisconsin Community Care Organization
Wisconsin Department of Health and Social Services

Presented by:

Elizabeth Benson
Madison, Wisconsin

Mr. Chairman. I appreciate the opportunity to appear before you today to discuss the development of comprehensive community-based long term care systems in this country, and in particular, the enactment of S. 2809, TitleXXI of the Social Security Act.

During the last five years the State of Wisconsin, in an effort to create a system of community based long term care developed and ran a research and demonstration program called the Wisconsin Community Care Organization. The CCO project was a demonstration of the concept that long term care for the elderly and disabled in their own homes, or in another community setting, can be an effective alternative to otherwise unnecessary institutional care. The CCO's objective was to test and demonstrate whether eligible clients could be maintained in the community through CCO intervention with greater satisfaction, and at a cost equal to or below the cost of institutional care which might otherwise be required.

Managed through the Wisconsin Department of Health and Social Services and supported by grant funds from the W.K. Kellogg Foundation and a Title XIX waiver from the U.S. Departmeent of Health and Human Services, the CCO operated in three locally administered demonstration sites, the largest of which was Milwaukee County. The CCO project recognized the importance of having an adequate supply of in-home services tailored to the functionally disabled, and by virtue of its Medicaid waiver could assure it. It recognized equally the importance of targeting those services toward appropriate individuals, and of organizing, delivering, managing and monitoring them over time.

Although organized somewhat differently in each county, all three CCO sites established formal organizational links with the myriad of local groups making up the spectrum of home care: groups including health and social services providers, area agencies on aging, elected officials, health systems agencies, hospitals, nursing homes, physicians, advocacy groups, etc.

Each CCO is a local system providing a single point of entry for its clients to community based long term care. Its central function is to organize and manage all services and resources eligible clients require to function in the community. The CCOs take responsibility for developing and implementing individualized service plans which address their clients' daily living problems. CCO service coordinators assess client needs, plan service, purchase or otherwise arrange for the services, monitor their delivery and regularly reassess clients' progress and needs. Each CCO retains and/or enlists family, community, volunteer and professional assistance when establishing an individual's plan of care. Except where they are unable to participate, CCO clients work with service coordinators to help develop their own case plans, and to choose service providers.

CCOs are <u>not</u> direct service providers; rather they purchase needed services from various public and private organizations. CCO purchase contracts specify service standards and allowable unit prices with each provider. Services are then purchased by the CCO <u>by unit</u> as they are needed by individual clients. Each CCO services as the Medicaid fiscal intermediary for the State of Wisconsin for project services. It orders specific services, processes the bills for those services and makes payments to individual providers. Initially funded by the State on a cost reimbursement, fee for service basis, each site is now reimbursed on a per client per day rate based on actual operating experience and on projected changed in caseload, service range and national economic trends. This "modified

capitation" method pays Milwaukee County $8.58 per client per day; LaCrosse County (the CCO's medium sized site) at $7.84 per client per day, and Barron County (the CCO's rural site) at $5.21 per client per day.

The CCO was evaluated by the Faye McBeath Institute on Aging and Adult Life of the University of Wisconsin-Madison. Research needs required the project to define and target its client population, to assess and monitor clients consistently and accurately, to measure them over time according to externally validated norms, and to establish and maintain equivalent experimental and control groups.

Experimental research outcomes focus principally on comparisons of cost and lengths of institutional stay between experimental and control groups. Of the Data we believe those for Milwaukee to be the most reliable because of the large size of the sample and because potential clients were randomly assigned to experimental and control groups at point of intake and then tracked over an 18 month period. Data reported for Milwaukee are based on 223 experimental and 104 control subjects.

With this as a backdrop, the project's cost-effectiveness data are very encouraging. Total monthly cost to the regular (unwaivered) Medical Assistance program was substantially less forCCO clients than for control clients — $197.87 to $325.42. Further analysis reveals that CCO clients showed specific savings in out-patient medical services, hospital costs, nursing home costs, home health care and drug costs when compared to control clients.

To obtain the total Medicaid expenditure piccture, CCO direct service, coordination and administration costs need to be added to the regular program costs. When this is done the total Medicaid bill for the CCO is $4.62 per client per month

(or 15 cents per client per day) more for the CCO than without it. (It should be noted, however, that even this figure is slightly overestimated since the Faye McBeath Institute tells us that research costs have not been backed out of the CCO total.)

Analysis of the cost difference between experimental and control clients indicates that cost savings are largely due to lower numbers of days of nursing home or hospital utilization among the CCO client group. During the experimental period, CCO clients spent a mean number of 29.19 days in nursing homes, compared to 37.83 days for control subjects. It is interesting to note that while the CCO did not prevent nursing home care, it clearly forestalled it, and assured a shorter length of stay once a person had been admitted. Considering that the CCO had no mandatory preadmission screening mechanism and thus no authority to intervene in decisions which sent potential community care clients to nursing homes, it is significant that it nonethelesss reported a systematic decrease in the length of nursing home stays. Had the project had a prescreening mechanism we anticipate it would have shown much more impressive figures in this outcome category.

In terms of hospital days there is a very important difference. CCO clients received an average of 2.95 days of hospitalization, compared with 14.26 days for randomly assigned control subjects. At the cost of hospitalization this is not an insignificant difference. Important questions remain regarding the total public cost of the program. Analysis of Medicare (Title XVIII) data for the same experimental and control clients would likely yield important information showing that CCO clients spent fewer total public dollars than control subjects, this in view of the substantial decrease in hospital lengths of stay leading to corresponding decreases in Medicare expenditures.

Other project outcomes briefly noted include:

- Adequate preplanning and start up periods are necessary to deal with organizational, administrative and political complexities at the local level. (It took the CCO's first site almost a year from selection before it was able to accept its first client.)
- A single, flexible source of funding for home care services is able to substantially reduce the complexities introduced by fragmentation of current programs. The CCO's Title XIX waiver represented the project's chief means of assuring local cooperation. Had it been combined with a mechanism for controlling access to nursing home care (preadmission screening) the CCO would have been even more effective.
- Establishing a strong and consistent definition of the targeted population based on functional disability rather than exclusively on age, diagnostic and financial criteria, will go a long way toward assuring a more equitable distribution of long term care services to those who need them.
- Direct services most frequently utilized by CCO clients were transportation, nutrition, home maintenance and personal care. In addition to these and other direct services, all CCO clients were a part of a coordinated system of care, which greatly simplifyed their access to required services. It is this coordinated system of care which is associated most directly with the project's positive experimental outcomes.

In view of our experience in Wisconsin with the Community Care Organization, as well as of outcomes from similar efforts, we strongly support the efforts being made to establish a comprehensive system of non-institutional long term care services through the enactment of Title XXI. Title XXI's importance lies partially in its recognition of the need to assure an adequate supply of in-home services for chronically impaired individuals. Its equally critical contribution is its proposed preadmission screening assessment team which recognizes that targeting clients and managing community based long term care are as important to its success as is providing more services.

More specifically, we are pleased to see that Title XXI attempts to minimize the maddening fragmentation which currently exists by combining certain services into one Title. We support the development and use of a statewide uniform preadmission assessment mechanism, particularly one which focuses attention on functioning levels, rather than exclusively on age, or acute diagnostic information. As a companion to this we are also pleased to see that Title XXI legitimizes

non-medical services such as personal and household care, and specifically adds adult day services and respite care to the constellation of potential resources. Our experience in Wisconsin, and indeed that of other states, has demonstrated that greater independence for the chronically disabled can often be achieved through accessibility to a rather simple set of services and supports both for the disabled person and for his or her family.

Although we in Wisconsin are as concerned as members of the Senate and other citizens about the cost implications of any new entitlement program, we are nevertheless pleased to see that Title XXI attempts to develop a system which recognizes that long term care needs are not measured in any accurate fashion by financial eligibility. Data from the CCO's LaCrosse site, the only one to serve a private paying clientele, showed them to be older than the rest of the caseload on the average and similarly severely disabled. While little further analysis hasbeen done on this population, at the very least they show themselves to be equally in need of accessible, quality community long term care services as those who cannot pay.

While I may be in the minority of those testifying before you today, let me enthusiastically support the development of a national long term care data base. Anyone who has attempted to do research in long term care is only too well acquainted with the frustration associated with trying to answer the simple question, "how much does it cost?". Long term care is not a field that will diminish in size due to growth in the older population. As this nation reaches it demographic day of reckoning it will be of the utmost important for us to be able to grasp its dimensions by having equivalent units of analysis for planning and budgeting purposes.

A number of critical issues appear less clearly accounted for in Title XXI than

those which I have just mentioned.

I remain concerned that presumptive eligibility for those over 65 could develop into an administrative and managerial nightmare. Preadmission screening and assessment, which will be required for each individual, will assure that some measure of targeting the population will take place. Nevertheless, as one who has had to be concerned about the validity and reliability of assessment methodology and execution in the past, I would caution that targeting must mean something more than a subjective description of a potential client if we are to have a better national record of avoiding inappropriate institutionalization. Fortunately, there are a number of research efforts which address assessment methodology and outcomes. I would urge the Committee to be sensitive to these and to support what is likely to be more sophisticated and effective future work aimed at more correctly identifying those who need help the most.

Copayments are attractive both practically and politically. Clearly they encourage an individual to remain literally invested in his or her care. Let me also at least mention that enacting such a system will require that it be administered, which will in turn require that public employees will need to be hired to administer it. In further analysis I would think the Committee would wish to see projected cost-benefit data which reflect the projected income from the copayment system compared to the cost of running it. Further, I would urge the Committee to consider an equal copayment system for institutional long term care. I would not like to see a fiscal disincentive built into an individual's pursuit of community care when he compared it to institutional services.

Similarly we would support the use of a tax credit for care of a dependent. We believe, however, that it ought to apply to all those covered by the program, not just those over 65 years of age. Further, we would urge that it be on

par with tax credits for child care which are currently a part of the Internal Revenue Code.

As everyone here knows fiscal incentives usually create the most effective means for modified behavior. Accordingly I would urge a careful review of Title XXI's proposed funding mechanism. Particularly with respect to Medicaid I see no strong incentive for states to alter current behavior (extensive use of hospital or long term care beds) when doing so will not reward them in any tangible (which is to say monetary) way. If Title XXI is to be funded through a Trust Fund, and therefore capped, and Title XIX is still to pay for institutional long term care according to its traditional sum sufficient system, I see problems in changing behavior substantially. The proposed funding mechanism of HR 6194, the Pepper-Waxman bill, because it increases the federal match for community based services over institutional services, demonstrates a more direct and I suspect more effective incentive for changing behavior.

My final concern relates to the case management/ service coordination link which the CCO project has shown to be critical in assuring decreasing time in hospitals and nursing homes. Title XXI must strengthen this link over that presently proposed. While supplying individuals with a list of qualified service providers or referring them directly may prove adequate in some cases, the more disabled the individual the more assistance he or she wll need. I would urge reconsideration of the case management link, especially in view of information pointing to its importance in the system of care.

The CCO project has demonstrated that we can do a much better job in this country to provide comfortable, safe and normal environments for people with chronic disabilities, and that we can do it in a cost-effective way. But in order to address community based long term care systematically there is a need to significantly restructure current programs, a restructuring that can only take

place ultimately through the political system — through the enactment of legislation like Title XXI.

Those of us in Wisconsin who have been so deeply involved in the development of community long term care systems in the past five years look forward to the future of Title XXI, and remain eager to assist the Committee and its staff as you address the many issues yet to be resolved in assuring its enactment.

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WRITTEN TESTIMONY - TITLE XXI LEGISLATION

SENATE FINANCE COMMITTEE

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August 27, 1980

SUMMARY

1. ACCESS, the operational component of the Monroe County Long Term Care Program, Inc., has been providing assessment and case management services to Monroe County residents at risk of institutional placement since December 15, 1977. In that period, 8,862 patients were assessed; 41% were Medicaid eligible and 59% were not eligible for Medicaid. Of the total assessed group, 65% were discharged to or remained in a community setting while the remaining 35% were admitted to a long term care facility.

2. According to the federal evaluator, the ACCESS program has been associated with a reduced rate of growth of long term care expenditures in Monroe County compared to 6 other counties in New York State.

3. Long term care is a system with 3 interdependent components; hospital, nursing home, and home care. Attempts to intervene in the long term care system requires a consideration of the impact on all three components.

4. As suggested under Title XXI, a single entry point for a unified home care program will reduce existing fragmentation between and duplication among the home care provisions of Titles XVIII, XIX, and XX. This will benefit consumers, providers and regulators alike.

5. To the extent the co-payment provisions of Title XXI provide third party reimbursement for previously uncovered groups of patients who could appropriately remain at home, their use of nursing home beds could be reduced. To the extent that these previously uncovered groups of patients chose to remain at home with Title XXI reimbursed services and avoid institutional placement, backed-up hospital patients may be transfered to appropriate long term care settings in a more timely manner, thus reducing government expenditures in the most expensive long term care setting, the acute hospital.

INTRODUCTION

The purpose of this testimony is to provide the Senate Finance Committee with the benefit of the experience of the Monroe County Long Term Care Program, Inc. Title XXI supports the development of non-institutional long term care services for the elderly and disabled; a field in which the Monroe County Long Term Care Program, Inc. has been active since 1975. We hope that our comments will be helpful to the Committee in its review of the proposed legislation.

The format of this paper is as follows:

I. OVERVIEW OF THE ACCESS PROGRAM

II. A. UTILIZATION

B. OPERATIONAL

C. COST ISSUES

III. GENERAL COMMENTS ABOUT TITLE XXI.

I. OVERVIEW OF THE ACCESS PROGRAM.

A. Funding Sources

Monroe County Long Term Care Program, Inc. is a not-for-profit, community based organization governed by a Board of Directors whose members are equally representative of consumers, providers and public offcials. ACCESS is funded under Sections 1115 and 222 of the Social Security Act and operates through contracts and memorandums of understanding with New York State and Monroe County Social Service and Health Departments. Additional funding is provided by the Administration on Aging.

B. Patient Assessment and Case Management Process

ACCESS is a patient assessment and case management service provided to all Monroe County residents, 18 years of age or older who are at risk of long term institutional placement. Assessments are completed by professional evaluators who represent the fields of medicine, nursing, social service, financial counseling and occupational therapy. The

patient assessment information is reviewed by the ACCESS case manager, who then assists in the development of an individualized care plan for each client. Implementation of the care plan will require either assistance in seeking admission to a long term care facility or assistance in coordinating services needed to remain at home. Case managers provide ongoing assistance by monitoring care plans on a continuous basis. Assessment services are provided without charge to all potential long term care clients. Reimbursement for ongoing services, either at home or in an institution, is based on the client's medical/financial eligibility. If the person is eligible for Medicaid then ACCESS has the authority to certify the medical necessity and to approve payment for long term care services. If the client is not Medicaid-eligible, ACCESS will coordinate and monitor the care plan, but payment for ongoing services will be dependent upon the client's personal resources and/or insurance coverage.

C. Objectives

The ACCESS assessment and case management system is designed to operationalize the goal of making long term care services most appropriate, cost effective, and acceptable to the clients.

The objectives are:

1. To encourage persons needing long term care to choose home care in preference to institutionalization when it is an appropriate alternative and is less costly.
2. To provide coordination and continuity of case management for long term care clients.

3. To improve long term care assessment and review procedures.
4. To collect data about the needs, service utilization, and appropriateness of placement of persons requiring long term care to facilitate planning and evaluation.
5. To minimize inappropriate utilization of long term care resources.
6. To reduce the number of Monroe County residents who are in acute hospital beds beyond medical necessity awaiting long term care placement.
7. To reduce Monroe County residents' occupancy of long term care institutions by appropriate use of non-institutional alternatives.
8. To reduce the per person rate of increase of Medicaid expenditures for individuals needing long term care (including both expenditures for long term care and for alternate care days in acute hospitals awaiting long term care) below the rate that would have occurred had Monroe County Long Term Care Program, Inc. not existed.

II. A. UTILIZATION

One of the major objectives of the ACCESS program is to encourage the use of services in the home as an alternative to institutional placement when appropriate and less costly. In order to evaluate the effect of this program, the New York State Department of Social Services, the Monroe County Department of Social Services, and the Monroe County Long Term Care Program, Inc. have been monitoring changes in utilization patterns of ACCESS clients in the three major long term care settings: the acute hospital, the nursing home, and at home.

1. The Acute Hospital

A major problem in Monroe County and many other communities is the back-up of long term care patients in hospital. These patients no longer need acute care but remain in the acute hospital because nursing homes will not accept them and home care is not a viable alternative. In New York City, for example, 2,000 elderly patients are "backed-up" in acute hospitals at a cost of $50 million a year to the Medicaid and Medicare programs.[1]

Preliminary findings in Monroe County indicate that the back-up of hospital clients has continued to increase. However, since the onset of the ACCESS program, the increase in the non-Medicaid group exceeds the increase in the Medicaid eligible group (25% to 17%). "Because ACCESS has greater control over the placement of Medicaid long term care clients, this is a positive finding for the program, particularly since some of ACCESS' success in this area is most likely offset by the reluctance of nursing homes to accept Medicaid patients due to low reimbursement rates."[2]

The ACCESS program's influence may also be seen by comparing the percentage of skilled nursing level clients discharged home with those admitted to a skilled nursing facility. ACCESS data indicate that 79% of the non-Medicaid group and only 51% of the Medicaid group are admitted to a nursing home upon discharge from the hospital. Conversely, only 21% of the non-Medicaid group returns home while 49% of the Medicaid eligible group returns home.[3]

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1 - Vladeck, Bruce C., "Caring for the Old". New York Times, May 19, 1980.

2 - MACRO Systems, "Second Year Evaluation Report on MCLTCP, Inc., p. IV-58.

3 - Covering the period 12/15/77 to 7/31/80, for skilled nursing level groups.

The reasons why the Medicaid group has a higher rate of clients entering into home care from the acute hospitals are:

a. The Medicaid client has third party reimbursement for a wide range of home care services while the non-Medicaid client has limited, if any, outside support for home services.

b. Most nursing homes have admission policies that favor non-Medicaid patients who will pay rates in excess of established Medicaid levels.

An encouraging note is that when 1978, 1979, and 1980 figures are compared, the percent of ACCESS clients choosing home care has steadily increased for both Medicaid and non-Medicaid groups.

2. The Nursing Home

A reduction in the number of residents in long term care facilities is an objective of the ACCESS program. After nearly 3 years of experience it seems fairly certain that reducing the number of residents in nursing homes is not an attainable objective. Emphasis should be focused instead toward more appropriate utilization of existing beds, namely prioritizing admission on the basis of need rather than payment.

While ACCESS is able to prioritize nursing home beds for the Medicaid group on the basis of need, the non-Medicaid group is able to bypass the ACCESS pre-admission needs assessment process and receive first choice of the available bed supply because they will pay a higher rate. This has become a severe problem since many of the non-Medicaid patients enter the nursing home without pre-admission assessment and then shortly after deplete their resources and become Medicaid eligible. These non-Medicaid admissions have effectively circumvented the community-wide placement system which prioritizes admission on the basis of need.

A major step to address this situation would be to include, on an equal basis, the non-Medicaid group as well as the Medicaid group in the same community wide pre-admission assessment and placement system.

3. At Home.

Medicaid expenditures for services in the home have risen dramatically (87%) in Monroe County since the ACCESS program began.[4] Not only are more people returning home from the hospital, but more people who are assessed at home are also choosing to remain at home. From December 15, 1977 to July 31, 1980, 84% of non-Medicaid skilled nursing level clients and 92% of the Medicaid eligible skilled nursing level clients who were assessed at home remained at home. Conversely, 16% of the non-Medicaid group and only 8% of the Medicaid group entered a skilled nursing facility. Once again, the non-Medicaid group is admitted to nursing homes at a higher rate than the Medicaid eligible group. The pattern can be partially attributed to the preferential treatment given to non-Medicaid patients by nursing homes and to the fact that the non-Medicaid patient has no viable third party payer for home care services.

B. OPERATIONAL ISSUES

The planning phase for the program took 30 months. After the start-up date (December 15, 1977) it took another year to fully implement the ACCESS model in Monroe County. Many barriers have existed since the inception of the program. Some of the major ones are listed below.

1. LEGISLATIVE/REGULATORY

a. Medicaid spend down requirements create a disincentive to stay in the community. The living allowance is small compared to institutional allowances and expenses. This also reduces the effectiveness of discharge planning in nursing homes.

b. There is no incentive (from a Federal Financial Participation angle) to spend Title XIX dollars in home care as opposed to nursing home care. What would be helpful would be a higher level of FFP (i.e. 75%) for home care reimbursement for Medicaid clients who had needs that would qualify them for nursing home admission.

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4 - Ibid. p. IV-23.

c. There is no recognized method to prioritize, on the basis of need alone, Medicaid and non-Medicaid patients waiting for institutional admission.

d. While hospitals are covered for non-reimbursable Medicaid related days, nursing homes must absorb these costs. Therefore, nursing homes will not accept clients with an uncertain Medicaid eligibility status and the clients remain in the acute hospital until eligibility for Medicaid is approved.

e. Prior approval by ACCESS for admission to long term care facilities is not required for all seeking placement. This allows nursing homes to selectively admit low care, private pay patients from the community and pass over hospital based Medicaid clients.

2. BUREAUCRATIC/ADMINISTRATIVE

a. Overcoming the systematic resistance to change by more established community health care groups takes an inordinate amount of time and effort.

b. Lower Medicaid rates of payment for nursing home and home nursing services create a disincentive to serve Medicaid clients. Medicaid patients represent heavy care, and more paperwork.

c. There is an undersupply of suitable housing arrangements for persons who could be discharged from a hospital or nursing home as well as for persons from the community who otherwise would enter a nursing home.

3. COST ISSUES

a. Overall Program Impact

One of the major objectives of the ACCESS program is to address the problem of spiraling long term care expenditures under the Medicaid program. The program attempts to accomplish this objective by minimizing unnecessary hospital days, reducing Medicaid nursing home use, and substituting the use of appropriate but less costly services in the home.

The Medicaid expenditures for Monroe County over a 10 month pre and 10 month post ACCESS period were compared with 6 other counties in New York State. The preliminary findings indicated that Monroe County experienced the lowest percent increase in average Medicaid expenditures per eligible recipient. There was a 6% increase in Monroe County compared to an average 18% increase in the comparison counties.

TABLE 1

Percent Changes in Average Monthly Medicaid Expenditure and Beneficiaries[a]

County	Beneficiaries %	Total Expenditures %	Cost Per Beneficiary %
Erie	0	+27	+26
Broome	-1	+16	+17
Onondaga	+5	+24	+18
Suffolk	+3	+21	+17
Albany	+8	+23	+14
Westchester	+8	+23	+14
Average	+4	+22	+18
(Post ACCESS Averages)	(10,218)	($4,314,661)	($433)
Monroe	+9	+15	+6
(Post ACCESS Totals)	(10,005)	($4,030,497)	($401)

[a]Eggert, Gerald M., Bowlyow, Joyce E., Nichols, Carol W., "Gaining Control of the Long Term Care System: First Returns From the ACCESS Experiment", The Gerontologist, Volume 20, No. 3, June, 1980.

Barbara Blum, Commissioner of the New York State Department of Social Services indicated to Governor Carey and the New York State Legislature that: "It can be said with confidence, according to the federally funded evaluator, that the program has been associated with positive changes in long term care, such as curtailed rates of increase in Medicaid expenditures in Monroe County."

b. Pre-admission and Ongoing Assessment Costs

Pre-admission assessments take place in both hospital and community settings. Assessments that occur as a part of the discharge planning procedures in acute hospitals are reimbursed at a flat rate of $35.00 per assessment. This rate includes all nursing, social service, and medical components. To date 4,766 assessments have been completed in the 8 hospitals in Monroe County. Assessments for persons residing in the community are completed by community health nurses, physicians and other professionals as required. Each assessment component is reimbursed according to a fee schedule established by the New York State Health Department. The average cost of 4,096 assessments completed on the community group has been $43.41 per client.

Periodic reassessments are available every 120 days to all ACCESS clients who remain in independent living settings. The reassessment procedure involves a recertification of the medical necessity for services in addition to an update of the care plan. Since the reassessment service was initiated in June, 1979 a total of 1,200 have been completed at an average of $32.00 per reassessment.

Table 2 provides a detailed breakdown of the types of services available, their unit costs, and the total amount expended through July 31, 1980.

TABLE 2

Assessment Costs

	Number	Unit Cost	Total Cost
1. Pre-admission Assessment Services			
a. Clients assessed in the Hospital[a]	4,766	$35.00	$166,810.00
b. Clients assessed in the Community[b]			
1. Nursing review	4,096	27.00	110,592.00
2. Alternate Care Plan Preparation	1,000	25.00	25,000.00
3. Financial Consult	730	31.25	22,813.00
4. Social Worker Consult	146	17.00	2,482.00
5. Home Environment Consult	18	17.00	306.00
6. Comprehensive Medical Work-up	6	40.00	240.00
7. Routine Physician Review	1,365	12.00	16,383.00
Total Cost Per Community Assessment	--	$43.41	$177,816.00
2. Reassessment Services (Offered every 120 days to home care clients)[c]	1,200	$32.00	$38,400.00
TOTAL COST			$383,026.00

[a]Hospital assessment rate of $35.00 includes nurse, social worker and physician assessment and home care plan.
[b]All community clients receive a mandatory nursing review. Additional assessment services are ordered as needed.
[c]Periodic reassessments are available every 120 days to all home clients.

c. Case Management Costs

From 12/15/77 through 7/31/80, a total of $1,201,920 has been expended for case management activities on an assessed population base of 8,862 clients. Assuming an active patient census of 2,100 clients per month at home, the annual case management cost per client is estimated to be $222.

d. Administrative Costs

Administrative costs include planning and development and the costs of the evaluator under contract to the New York State Department of Social Services. The expenditures for 60 months of planning and development are estimated to be $1,100,000 while the evaluation costs for 36 months have totaled an additional $265,000

e. Total On-going Administrative Costs

Excluding start up costs of approximately $550,000 the total ongoing administrative costs have equalled $2,374,000 for a 31 month operational period.

This total cost figure includes four components:

1.	Assessment Services	$383,000	16.1%
2.	Case Management Services	$1,200,000	50.5%
3.	Planning and Development	$526,000	22.2%
4.	Evaluation Activities	$265,000	11.2%

f. Medicaid Home Care Costs

From 12/15/77 through 7/31/80 1,050 Medicaid eligible clients who were assessed at the skilled nursing level of care returned to the community or remained at home. Care plans were developed for this group at an average daily cost of $28.10 which is 62% of the equivalent skilled nursing facility cost of $45.00 per day. The average daily cost may be broken down as follows:

1.	Nursing Services	$1.01/day	3.6%
2.	Personal Care and Home Health Aide	23.18/day	82.5%
3.	Durable medical equipment and disposable supplies	.76/day	2.7%
4.	All other institutional services including day care, 1115 waivered services, drugs, and physician/clinic visits	3.15/day	11.2%
		$28.10/day	100%

III. GENERAL COMMENTS ABOUT TITLE XXI

On the basis of experience with the ACCESS model there are several issues that the proposed Title XXI addresses.

A. Uniform eligibility and need determination conducted by a single agency should reduce the fragmentation that currently exists between Titles XVIII, XIX and XX. By combining these three components, clients will benefit by being able to turn to one source for all long term care services; providers will benefit by a single source of service authorization, regulations and claims processing; regulatory agencies will enforce a single set of eligibility criteria, a single set of standards, and common reimbursement and auditing procedures.

B. To the extent that the Title XXI assessment procedure becomes a prerequisite for admission to a nursing home for both Medicaid and non-Medicaid patients, and placement decisions are made on the basis of need, the excessive demand placed on nursing home beds by non-Medicaid patients may be abated.

C. The co-payment provisions have the potential to provide third party reimbursement to a large number of patients who could stay home but for whom no source of third party reimbursement currently exists.

These individuals comprise the group of non-Medicaid patients who enter nursing homes from either hospitals or the community. The difference in proportions entering nursing homes, i.e. the greater proportion of non-Medicaid clients, is the potential group of individuals upon whom Title XXI could impact to reduce nursing home utilization.

D. If all potential nursing home patients can be subject to pre-admission assessment, and if some financial mechanism can be developed to enable current non-Medicaid clients to receive reimbursement for services at home (as suggested in B and C above), then the potentially open nursing home beds could be used to provide a place into which backed-up hospital patients could be appropriately moved. These moves could reduce the numbers of patients inappropriately using the most expensive component of the long term care system; the acute hospital.

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$240 Million Waste Charged in Care for the Elderly

More than $240 million in Medicare and Medicaid funds is being wasted this year in New York State, monitors who oversee federally financed health care said yesterday. They charged that $200-a-day hospital care was being provided for elderly patients who should be looked after in $50-a-day nursing homes.

According to the monitoring group, the New York Statewide Professional Standards Review Council, 4,424 elderly patients who are well enough to be discharged from hospitals — 1,660 of them in New York City — wait an average of 10 weeks before nursing homes accept them. This, the council said, wastes an average of $150 a day in Medicare and Medicaid funds.

"Over $240 million a year is being wasted on more than 328,000 tax-supported patient hospital days — money desperately needed for other health care needs throughout the state," said Dr. Howard B. Goldstein, the council's chairman.

The council represents 11 local organizations of physicians in the state whose task it is to insure that federally financed health care is medically necessary and appropriately carried out. It said it had based its estimate of the waste on a survey of patients in 289 hospitals on Feb. 28, accounting for virtually all of the state's 78,136 hospital beds.

The survey found, the council said, that 4,424 elderly patients who should not be hospitalized were virtual captives in their beds because they could not find a nursing home that would take them.

Dr. Goldstein called the "inappropriate care" an "incredible waste" of taxpayers money that was 12 percent worse than an indestical survey showed in 1979. Another council member described it as an "explosive problem" that will take an "astronomical leap" in the 1980's as the volume of elderly patients increases.

The council chairman said that the major cause of the problem was the refusal of nursing homes to accept patients from hospitals until they receive assurances that their nursing care will be covered by either Medicaid for the poor or Medicare for the elderly. He said that because of red tape it often takes two or three months to obtain such assurances.

The council has asked Governor Carey and the Legislature to declare that all Medicaid applicants to be "presumed eligible" for coverage so that nursing homes will accept Medicaid patient immediately, with the state guaranteeing the cost of the average 3 percent who ultimately are rejected as ineligible.

While Medicaid is state-administered, Medicare is a Federal program and would require Congressional action for any change.

N.Y. Times - 5/21/80

SUMMARY STATEMENT
Dennis L. Kodner
August 27, 1980

New York's Long Term Home Health Care Program (LTHHCP) is a single entry system into a comprehensive range of health and compensatory services in the home and the community for Medicaid clients who qualify for placement in an SNF or ICF. The goal of the program is to provide aged and disabled persons who need long term care with an alternative to institutional care. The services provided by the program include: nursing, home health aide, personal care, homemaker, housekeeper, physical and occupational therapy, speech and hearing, social services, nutritional counseling and meals, respiratory therapy, medical supplies and equipment, home maintenance and housing improvement, moving assistance, respite care, transportation and social day care, as well as 24-hour coverage. The law became effective April 1, 1980 and operates with a section 1115 waiver from the Health Care Financing Administration on a demonstration basis.

Existing health providers are designated as LTHHCP's through the State's Certificate of Need program. Their service areas and capacities are set by the Department of Health. LTHHCP's may be certified home health agencies or public or voluntary, non-profit hospitals or long term care facilities. There are nine (9) LTHHCP's in operation throughout the state. Individual programs perform comprehensive assessments (with a representative of the local Social Service District and discharge planner if the client is currently in the hospital or long term care facility), develops a plan of care, directly delivers and/or arranges services, coordinates care, and monitors their quality and appropriateness. At the core of the program is a "gatekeeping" mechanism which advises Medicaid recipients of the availability of LTHHC before authorizing placement in a nursing home. In order to control costs, careful case management is instituted and the individual's service budget may not exceed 75% of the average monthly institutional rate for the appropriate level of care.

Although the program is too new to draw any final conclusions, certain tentative observations can be made. First, LTHHCP services appear less costly for most people than institutional care. Second, it is believed that the backlog of hospital patients will not be much affected by the program. This is because the LTHHCP does not presently cover private pay and Medicare patients applying to SNF's and ICF's. It is generally known that long term care facilities prefer these patients because of existing Medicaid reimbursement.

The LTHHCP experienced considerable difficulty in the start-up phase. The implementation of the program has pointed up the very real difficulties in organizing and providing comprehensive, community-based long term care services. Cumbersome program design, lack of community information, unsuccessful discharge planning, "turf" problems, interagency pressures, inadequate client housing, and the need for "seed" funds were some of the problems encountered.

Because existing long term care services are funded by differing funding streams and have widely ranging administrative arrangements, eligibility requirements and benefits, services for older people are multiple, parallel, overlapping, noncontinuous and confusing. More often than not, it is easier to be institutionalized than to arrange for an appropriate package of services in the community. S.2809 speaks directly to these problems. It would eliminate much of the existing fragmentation, preven unwarranted institutional placement, expand the availability of community services and control costs. The bill, which incorporates many of the elements of the LTHHCP and other long term care demonstration projects, represents a creative, far-reaching approach to one of our society's most trying problems.

Dennis L. Kodner
Director, Planning & Community Services
Metropolitan Jewish Geriatric Center
Brooklyn, New York

on behalf of

Metropolitan Jewish Geriatric Center

Mr. Chairman and members of the Committee, my name is Dennis L. Kodner. I am Director of Planning and Community Services of Metropolitan Jewish Geriatric Center (MJGC), Brooklyn, New York. The Center is one of the largest multi-level long term care institutions in the nation, providing services to over 1,000 older people in a wide range of institutional and community-based settings in a number of urban neighborhoods comprising almost one-third of New York City's elderly population. Our present continuum of care consists of skilled nursing and intermediate care facilities, day hospital, hospice, senior center, transportation for the elderly and handicapped, Institute for the Study of Aging and Long Term Care and "Nursing Home Without Walls." The "Nursing Home Without Walls" -- one of our most recent outreach efforts -- is part of a larger State-sponsored initiative, called the Long Term Home Health Care Program (LTHHCP), which has generated considerable interest among policy-makers and planners because of its potential to rationalize health services for the elderly

It is a great pleasure and privilege for me to testify before you today on S.2809. In doing so, I speak on behalf of an organization which -- as you know -- not only provides long term institutional care, but has also pioneered in the planning, development and delivery of the kind of non-institutional services and coordinating structures proposed in your legislaton. Therefore, we believe we have a unique perspective on the legislation before this Committee.

In our view, S.2809 represents a well thought-out approach to restructuring the financing and provision of long term care services -- one which addresses most, if not all, of the major shortcomings in our present delivery system. We believe that the legislation sets forth a sound framework for change -- a national health policy for the elderly -- which will be the impetus for many discussions to come on this most improtant social and health issue.

Needless to say, S.2809 goes to the heart of the problem of long term care in this country. As expressed so succinctly by Senator Packwood on the floor of the Senate, health care for the elderly is a hopeless maze of services, facilities and regulations that fail to meet the needs of individuals and their families and encourages institutional care rather than maintenance in the home and the community. Nowhere in the health system is the maxim that form follows financing more apparent than in the long term care sector. Because all the services are funded by differing public money streams and have widely ranging administrative arrangements, eligibility requirements and benefits, services for older people are multiple, parallel, overlapping, non-continuous, and confusing to older persons and professionals alike. What is more, there are few entities on the local level which can effectively pool the various entitlement and categorical program benefits around the individual's needs to ensure that they will receive the appropriate type and level of care in the least restrictive and most cost-effective setting. This problem is reaching crisis proportions, as the size of the

elderly population, the number of people needing long term care services and the national nursing home bill are growing explosively. S.2809, we believe, directly speaks to each of these problems in the way we presently pay for and deliver long term health care services. Particularly noteworthy is the bill's goal to combine and expand the non-institutional services covered under Titles XVIII, XIX and XX into a new Title XXI. While we continue to support legislative measures to reform the Medicaid system -- the present chief support for nurssing home care -- we favor, in the long run, the removal of long term care's focus from Medicaid (with its welfare standards), the elimination of fragmentation and proliferation of programs in the long term care field, and the integration and coordination of social and health care at the community level through the creation of a single funding mechanism as proposed in the legislation.

Before making more detailed commments and suggestions on the bill, I would like to first describe New York State's Long Term Home Health Care Program, drawing from our Center's experience as one of the most successful of the State's nine demonstration sites. We believe quite strongly that this innovative program, like other long term care research and demonstration projects around the country, can make a significant contribution to improving the quality of health care for our nation's aging population andd effectively controlling the costs of that care at the same time.

New York State's Long Term Home Health Care Program (LTHHCP),

referred to as "Nursing Home Without Walls" by its legislative sponsor, Senator Tarky Lombardi, Jr., was signed into law in late 1977 and became effective April 1, 1978. The program is aimed at providing Medicaid clients who are eligible for institutional placement with the option of receiving nursing-home-type services in their place of residence. The legislative program, which took three years to develop, contrasts sharply with existing patterns of fragmented and highly restrictive Medicaid-financed home care in other states. In passing the law, the Legislature was very much concerned with the following state trends:

-- The alarming escalation in the costs of nursing home care.

-- The rapid growth in the elderly population.

-- The high degree of inappropriate institutionalization.

-- The "blocking" of expensive hospital beds by chronically impaired patients needing long term institutional care.

-- The non-coordination in existing home care programs. (With regardd to this point, it should be noted that even with New York's well-developed home health system - the nation's largest user of Medicaid home health

funds - there are problems in assuring adequate in-home support for the elderly).

At the state level, the responsibility for the program is shared by the Department of Health and the Department of Social Services. The Health Department reviews Certificate of Need applications from the individual providers, developes regulations governing individual program operations, formulates reimbursement rates, surveys the providers for participation in both the Medicare and Medicaid programs and oversees the quality of care provided. The Social Services Department --the Medicaid Agency -- establishes policies and procedures which local Social Service Districts follow once programs are operational on the local level.

At the present time, there are nine demonstration projects participating in the "Nursing Home Without Walls" program. These sites, called Long Term Home Health Care Programs, may be certified home health agencies, public or voluntary, not-for-profit long term care facilities, or hospitals. Prospective providers must receive approval to operate the program from the Department of Health under the State's Certificate of Need law. In considering requests to approve applications to participate in the program, the Health Department considers the demographic characteristics and long term care needs of the proposed service area and the adequacy of staffing, service arrangements, policies and procedures, quality assurance mechanisms, and emergency coverage.

A Long Term Home Health Care Program must offer, either directly or through formal arrangements with other community agencies and private vendors, the following services: nursing, home health aide, personal care and homemaker services, physical and occupational therapies, speech and hearing services, social work, nutritional services, and medical supplies and equipment. A waiver obtained from the Health Care Financing Administration (HCFA) under Section 1115 of the Social Security Act enables the program to deliver these and other services not normally covered under the State's Medical Assistance Plan, including home maintenance tasks, moving assistance, housing improvements, meals and nutritional counseling, respiratory therapy, respite care, day care, and social services. Needless to say, the availability of such wide-ranging services permits a "custom tailoring" of service packages for clients with differing patterns of need.

The scope of Long Term Home Health Care Programs go far beyond the scope of traditional home care providers. They assist in the assessment and subsequent re-assessments, develop the plan of care, deliver and/or arrange services, coordinate care, and monitor the quality and appropriateness of services. When all of these functions are taken together, these organizations represent a new type of community-wide system for providing the aged and disabled with an integrated package of services. Case management is at the core of the LTHHCP model.

In order to intervene in the nursing home admissions process and prevent unwanted and inappropriate institutionalization, local Social Service Districts are required to offer the LTHHCP option to all Medicaid-eligible clients considering SNF or ICF placement who live in an area served by the LTHHCP. Thus, the "Nursing Home Without Walls" program represents a single entry point for the Medicaid population into a comprehensive range of health and related services in the community. Referred to as the "gatekeeping" function, this mechanism is used to screen out those persons applying for admission to a long term care facility who would benefit most from community care.

The need for institutional care is first determined by using the State's existing screening device, the DMS-1 form. (Admission to the program is only open to persons who would otherwise qualify for institutional placement). Once this is done and the client decides that in-home care is preferable to institutional placement, a comprehensive assessment is performed jointly by the LTHHCP and the local Social Service District to determine the person's needs, suitability of home environment, and overall potential to remain in the community. The whole range of individual needs and resources are considered in this process -- health status, functional ability, psycho-social factors, financial situtation, and living arrangements. If the person is hospitalized or already in an extended care facility and wishes to return to the community, the facility Discharge Planner is also involved. The patient's personal physician is consulted in

either case. This assessment is conducted every 120 days to ensure that there is a continued need for the program and that the care plan is up-dated to meet the person's changing needs. The individual assessment is translated into a list of required services, including the frequency of delivery. A budget is then drawn up to reflect the monthly cost of care. The monthly cost of care is not supposed to be more than the State-mandated ceiling for Long Term Home Health Care as approved in that Social Service District. If it does, the patient cannot participate or continue in the program and institutional care is considered more appropriate. As a result of recent amendments to the law, the patient's budget is now annualized to increase access to the LTHHCP and to provide growth in the program statewide. In the past, the strict application of this budget cap on a monthly basis was responsible for a significant percentage of patients being rejected by the program because of the cost of meeting their immediate service needs.

When the "Nursing Home Without Walls" Program was being developed, the policy-makers were aware of the cost implications associated with the potential "add on" demand for non-institutional care. In order to safeguard against inappropriate use of LTHHCP services and to ensure that costs do not exceed care in an institutional setting, the following elements were built into the program:

-- A Financial Cap: The cost of a patient's LTHHCP service package cannot exceed 75% of the average

adjusted Medicaid reimbursement rate for the equivalent level of institutional care in the area in which the program operates. However, in certain instances, this ceiling can be increased by 10% where here are minor fluctuations in need. Moreover, if the monthly budget is not entirely used, a credit is issued to the patient's "account" which can be spent at a later date, if necessary. In the case of large, one-time expenses (e.g., arcitectural modifications, major medical equipment purchases, etc.), the cost can be pro-rated over several months.

-- System of Planning, Providing, Coordinating, and Monitoring Services: As pointed out earlier, the case management system, which is one of the hallmarks of the LTHHCP, means that the individual programs always have an eye on the patient. Working closely with local Social Service Districts, they develop and up-date assessments, supervise the delivery of direct services and services provided by vendor organizations, monitor the appropriateness and quality of care, and act as advocate and "broker" for the patient and his family.

In summary, the "Nursing Home Without Walls" model is a single entry system of comprehensive health and compensatory services in the home and the community for Medicaid clients who

qualify for placement in an SNF or ICF. It functions as part of a larger "gatekeeping" mechanism for persons seeking facility admission and incorporates multi-disciplinary assessment, case management and cost control elements.

Please allow me to summarize the utilization of the "Nursing Home Without Walls" Program for the 12 month period ending November, 1979. This and other project information are found in the report to the Governor and Legislature dated February 1, 1980. I am enclosing a copy of the report with this testimony. A more detailed evaluation is being prepared by an outside organization and will be made available in September, 1982. We also wish to present an overview of our institution's experience with the program, having been the most successful demonstration site to date.

PROGRAM CHARACTERISTICS

Program Census: As of November 30, 1979, there were nine operational LTHHCP's. A total of 220 patients were served during the first year of operation, which represented only 20.7 percent of the statewide program's total capacity. Metropolitan Jewish Geriatric Center's LTHHCP, operational only seven months during the study period, had obtained an unduplicated count of 94 patients or 94% of the program's approved capacity. Metropolitan's LTHHCP patients constituted almost half of the persons served on the statewide program during this period.

It should be noted that there does not appear to be a direct correlation between the census and the length of program operation. Moreover, it should be evident that programs throughout the state have had varied experiences and successes in attracting patients. It would appear that the enthusiasm and cooperation of other community agencies have varied from area to area and have, in some way, contributed to differences in growth patterns.

Visits: During the first year, 13,863 service visits were made to LTHHCP patients. Services were distributed as follows: nursing (97%); home health aide (57%); Physical Therapy (21%); Occupational Therapy (12%); Respiratory Therapy (7%); Speech Pathology (7%); Medical Social Work (14%); and Personal Care (4%). None of the major expanded services -- home maintenance, moving assistance, housing improvement, nutritional counseling, social day care, congregate meals, etc. -- were provided, as the reimbursement mechanism for these services was not in place.

Patient Admissions: Of the 223 patients referred during the period April 1, 1979 through November 30, 1979, 206 or 92% were not admitted to the LTHHCP. Resaons for failure of these patients to enter the LTHHCP are as follows: too much care needed (37%); cost exceeds 75% cap (15%); family wants other placement (9%); not Medicaid eligible (8%); family unable to provide care (8%); unsuitable home setting (6%); patient not interested in LTHHCP

(6%); patient does qualify for SNF/ICF care (2%); moved out of catchment area (2%); and, other reasons (5%). Of interest is that about one-quarter of all reasons for rejections relate to family or home setting difficulties.

PATIENT CHARACTERISTICS

Age: The mean age for all patients in the program during the first year was 75 and ages ranged from 34 - 104. Eighty-three (83) percent of the patients served were over 65 years of age.

Sex: Three times as many females as males were served by the program. Females represented about 74% of the entire patient population.

Diagnosis: In terms of primary diagnosis, diseases of the circulatory system (44%); musculoskeletal system and connective tissue (18%); repiratory system (8%); malignant neoplasms (7%); diseases of the nervous
system (7%); and, diabetes (6%) were the most prevalent conditions.

Living Arrangements: Data indicate that 45% lived alone; 51% lived with a spouse or other relative; and, 4% lived with other responsible adults. It is interesting to note that 52% of the New York City patients lived alone as compared to 39% of the Upstate patients.

Source of Referral: 51% of all patients were referred from hospitals; 45% were referred from community sources, including family, friends. physicians or other community agencies; and, 4% came from SNF's and ICF's.

Level of Care: Patients with DMS-1 scores of 60 - 179 are technically eligbile for ICF placement. Persons with scores of 180 and over are eligible for SNF care. DMS-1 scores ranged from 61 to 753. Thirty-seven (37) percent of the patients were eligible for ICF placement; sixty-three (63) percent, for SNF placement.

Change in Patient Status: Although patient experience in the LTHHCP was somewhat limited during the program's first year of operation, available data indicates that the DMS-1 scores in 46% of the cases decreased between the initial assessment and the first 120-day re-assessment. Overall, improvement in patient status was translated into decreased monthly budgets.

Patient Discharge: During the first year of the program, 37% of admitted cases were discharged. Reasons for discharge included: admitted to hospital (53%); died (12%); improved (9%); no longer eligible (5%); and, request to leave program (7%).

FINANCIAL AND OTHER CHARACTERISTICS

Based upon actual monthly service costs for LTHHCP patients during the program's first year, the projected cost to the

government for Medicaid eligible patients in the community -- even with supplemental assistance -- appears to be less, on the average, than the total cost of care for such patients within an institutional setting.

The following are two examples from the State report which illustrate the potential impact of government subsidies on the total cost of care for a typical patient with a monthly budget of service costs at the average cost for all patients in the program statewide. The amount of government subsidies provided in each example is then compared to the amount which would be required to maintain that individual in an institution.

Examples:

Cattaraugus County (Upstate)

Example 1 - A LTTHCP patient requiring SNF level care, who lives alone and is an SSI recipient.

LTHHCP Costs:

Average monthly LTHHCP Service Budget for SNF Level Patient	$ 630.00
+ Average Monthly SSI Benefit	+ 181.00
+ Average Monthly Value of Food Stamps	+ 60.00
Government Cost	$ 871.00

Institutional Costs:

Average Monthly SNF Cost	$ 1,368.00
- Amount of SNF Cost Reduced by Patient's Contribution Towards Care	- 61.50
Government Cost	$ 1,306.50

New York City

Example 2 - A LTHHCP patient requireing ICF level care, who lives alone and is an SSI recipient.

LTHHCP Costs:

Average Monthly LTHHCP Service Budget for an ICF Level Patient	$ 529.00
+ Average monthly ICF Cost	+ 181.00
+ Average monthly Public Assistance Supplement	+ 17.00
+ Average monthly Value of Food Stamps	+ 60.00
Government Cost	$ 787.00

Institutional Costs:

Average monthly ICF Costs:	$ 1,116.00
- Amount of ICF Cost Reduced by Patient's Required Contribution Towards Care	- 61.50
Government Cost	$ 1,054.50

A summary of these costs are as follows:

	LTHHCP Cost/Mo.	Institutional Cost/Mo.	Difference (Savings)
Example 1	$ 871.00	$ 1,306.50	$ 435.00
Example 2	$ 787.00	$ 1,054.50	$ 267.00

Administrative tools at the State and local levels are now being refined to accurately track all expenditures to allow for more valid data and conclusions. In the case of Metropolitan Jewish Geriatric Center, for example, it is known that 3200 days of care were provided during the project's first year at a total cost of $95,000. We estimate that, through our program, we have saved the public about $72,000 in health care costs. It would have cost roughly double to provide a comparable level of institutional care to our patients.

With regard to the impact of "Nursing Home Without Walls" on the clients receiving community-based services, it is not known at the present time whether there is a significant difference between LTHHCP patients and persons in institutions. Measures of patient satisfaction and outcome as well as morbidity and mortality will have to determine these differences, if any.

However, based upon our direct involvement in both nursing home and in-home care, it is our impression that LTHHCP patients are generally more positive about their lives, have a better morale and feel more independent than patients placed in nursing home-type facilities.

In terms of the program's overall impact on reducing the number of older persons who are waiting in hospital beds when acute care is no longer necessary, we cannot be sure that it has any siognificant result at the present time. Since the Long Term Home Health Care Program does not cover private pay individuals applying to nursing homes and long term care facilities prefer Medicare and private pay patients because of existing Medicaid reimbursement policies, we do not believe that the backlog of hospital patients requiring alternate level of care placement will be much affected by "Nursing Home Without Walls." It is interesting to note that this is also the case for ACCESS, another long term care demonstration project in Monroe County, New York.

As indicated earlier, all of the Long Term Home Health Care Program sites have experienced difficulty in the implementation and start-up of the project. We were surprised that this process took so long. The reasons for this problem may be of interest to the Committee on Finance in considering the impact of S.2809 on

local communities, the long term care system and the existing government structure:

-- The "Nursing Home Without Walls" Program, by design, was overly bureaucratic. Because of the various layers of monitoring and control, it used to take several weeks for a person to progress from initial assessment to final approval to participation, and even longer if the individual was Medicaid-eligible, but did not have the appropriate documentation. Because of this time lag, a number of clients were either placed in long term care facilities or received care in more costly and less appropriate home care settings. However, as a result of recent legislative changes, this process will be greatly simplified and shortened.

-- Discharge planners and families choose the "path of least resistance" in developing an appropriate plan of care for persons in the hospital who require long term care. Because of the various pressures to discharge, the lack of information regarding the possibilities and availability of home care, and the bewildering array of in-home programs in New York, patients are

frequently institutionalized or placed in more expensive and less desirable home care programs when care in an LTHHCP may be more appropriate and cost-effective.

-- Because of the new thrust of the Long Term Home Health Care Programs in the communities served, relationships at the local level among agencies in most pilot areas of the state have been complicated and subject to pressure. Moreover, political agendas on the part of individuals and agencies on the State and local levels and the desire to protect "turf" was responsible, in large part, for the project's slower than anticipated growth.

-- For the elderly, more than any other group, housing is essential to other aspects of living such as the maintenance of health and independence. Unfortunately, one of the principal barriers to entry of clients into the LTHHCP has been the lack of appropriate living arrangements. People have been forced to enter a long term care facility or remain in a hospital bed because they did not have a suitable place to live, even though they could have been

supported in the community by "Nursing Home Without Walls." One of the recommendations of the State report on the LTHHCP is to examine the feasibility of combining the provision of a housing component with the delivery of in-home services.

-- It was assumed from the beginning that the reimbursement system would provide the funds needed for designated Long Term Home Health Care Programs, either existing entities or new ones, to perform the mandated functions and achieve approved capacity. What we have learned is that significant start-up costs are associated with the program for which reimbursement is not available (e.g., early engagement of staff, marketing, outreach, etc.). The demonstration sites that were the most successful in gearing up for the program and providing services to patients were the very same organizations that employed their own funds for developmental activities.

Before I comment more specifically on S.2809, I would like to summarize those factors -- based upon our Center's experience -- that we believe contribute to a successful community-based long term care program:

1. The early identification of persons in the community who may need our services and their prompt referral for assessment and service delivery is a critical aspect of our model. Therefore, strong, workable links must be developed with agencies and institutions serving the elderly. A major focus of these efforts should be the hospital. It should be the job of community-based long term care programs to work closely with hospital discharge planners so that they no longer view discharges from the acute care setting as "separations" from the hospital, but rather as "intakes" into the community.

2. The community should be involved in the planning process and continue to participate, at least in an advisory capacity, in the on-going operation of the program. Community advisory boards or similar mechanisms -- consisting of both consumer and provider representatives -- are valuable in educating the service area population about the services provided and help to solidify inter-agency relationships so vital to the functioning of the program.

3. As pointed out earlier, "seed" money is required to initiate the program and hire key staff during the developmental phase.

4. The program must be marketed to increase the entire community's awareness of the available services. This means designing and launching a full-scale publicity campaign, including brochures, posters, radio spot announcements, media coverage, and training for professional personnel of referring agencies. Much of these costs are not now covered under existing Medicare and Medicaid reimbursement for home health services.

5. An outreach program should be implemented. This is important, since many elderly people in need of long term care are isolated and are not knowledgable enough about the system to seek services on their own.

6. A capable, hard-working professional and supoort staff must be assembled. They must be self-starters with considerable "hands on" experience in working with the elderly. Moreover, they must be skilled in assessment, case management, and advocacy. Critical is the ability to withstand the confusion, ambiguity and strain of functioning in an extremely difficult professional and interpersonal environment.

While we strongly support S.2809, we would like to make a few detailed observations and suggestions:

FIRST, we would like to raise some questions about the scope of benefits in section 2102. We feel that the definitions for "adult day services" and "respite care services" must be modified. While we are generally pleased with the definition of adult day services, the existing language does not permit skilled nursing facilities to provide this type of care. You are, of course, aware that such services are already provided in SNF's in many states, including New York. We hope that this is an oversight and that the definition will be corrected. The term "respite care services," as presently defined, does not include temporary relief in an institutional setting. There is no reason why this model should not be included. We also feel that additional services should be added, including home maintenance tasks, housing improvement and moving assistance, nutritional counseling, congregate meals, transportation and other support provided in recognized congregate dwellings. The availability of these services will help communities to meet the complex and multi-faceted needs of the frail elderly population. Frankly, we do not believe that this will put the program in fiscal peril, as the Preadmission Assessment and Screening Team's broad assessment and case management functions and the bill's cost-sharing provisions will help prevent inappropriate utilization of these supports.

SECOND, the assessment and screening in section 2104 should not be limited to an evaluation of the individual's health and functional status. We already know that the traditional medical focus can lead to inaccurate placement decisions. This factor alone cannot provide us with sufficient information to determine a person's potential to remain in the community with an appropriate mix of services. Therefore, in order to determine the types and frequency of services, the multi-disciplinary assessment should be expanded to include a review of social, psychological, familial, economic and environmental factors.

THIRD, the frequency of re-assessments should be uniform and not be left to the individual Preadmission and Assessment Screening Teams (PAT's), especially since the entire program will be evaluated during the legislation's demonstration phase.

FOURTH, if an individual is presently in a hospital when the facility makes a referral to the PAT, the discharge planner should be involved as part of the team in the assessment and the development of the plan of care. This is a provision in the law establishing New York State's Long Term Home Health Care Program. This direct link to acute hospitals -- though difficult to establish and maintain -- is in our view critical because of the major barrier these institutions present to current and future

system integration and coordination. Since a large part of our nation's hospital population is suffering from chronic conditions which often require long term health care, we must re-examine the entire concept of discharge planning. It is our feeling that assessment and screening should be performed hand-in-hand with discharge planning in the hospital, and that the discharge planner can play an important role in this process.

FIFTH, we are concerned about the provisions which prohibit home health agencies, except in rural areas, from being designated as a PAT. As a result of this section of the bill, we see immediate problems with the implementation of the program in many communuities throughout the country. This would, for example, effectively remove all of New York's Long Term Home Health Care Programs from consideration. All of us are aware that there are simply too few providers who would be able to carry out the assessment, screening, plan development and case management functions described in the bill. Home health agencies are among the small number of organizations nationwide with the capacity to perform these responsibilities. While local communities should be given the option as to which entities should be designated as a PAT, we should not be moving exclusively in the direction of creating new bureaucracies. This would be costly, further fragment the long term care system, and

add to the heavy load of federal regulations. With regard to the other agencies and institutions which may qualify for PAT designation, we are opposed to the use of Professional Standards Review Organizations (PSRO's), Area Agencies on Aging (AAA's), hospitals and local Departments of Health. In the case of PSRO's, they are responsible for determining the medical necessity, appropriateness and quality of nursing home services. As medical/fiscal control agencies, PSRO's would be put in the position of being asked to make determinations on the suitability of community care using medical criteria, when social need and other interrelated factors may be more overwhelming considerations. AAA's, on the other hand, are the planning and coordinating bodies established by the Older American's Act to serve as catalysts and facilitators in the development of comprehensive aging services on the local level. Their policy, leadership and advocacy roles would be diluted by the assumption of PAT responsibilities. And, finally, the focus of hospitals and local Departments of Health would be medical and acute in nature, thus making it difficult -- if not impossible -- to expand the scope of community-based long term care to include important social and environmental concerns.

SIXTH, the case management system as envisioned in S.2809 requires strengthening. In this regard, we must question

sections 2104 (b)(1)(D) and (E). While it makes sense for older adults and their families to be involved in the development of the care plan and to be consulted about available options, it is unreasonable to expect them to act as their own "brokers," particularly when they are frail, vulnerable and under stress. Moreover, we do not believe that physicians know enough about long term care and opportunities for community-based services to make appropriate recommendations to their patients. In short, the PAT should perform the entire case management function, including the referral for service. This is far easier to manage and monitor than the approach described in the legislation. Indeed, it is better for the client and the family.

SEVENTH, the idea of cost sharing, as presented in the legislation, is particularly appealing, especially because of the fears of the excessive costs of a comprehensive long term care system and the concern to ration non-institutional services with a sensitivity to informal family supports. Therefore, we must make sure that the approach outlined in section 2105 is an effective compromise between the need to foster access by removing financial burdens, on the one hand, and the desire to promote an appropriate balance between institutional, non-institutional and family care.

EIGHTH, we must congratulate the authors on their recognition of the role of families in caring for their dependent aged members by providing for a tax credit. As you know, one of the greatest myths in American society is that children do not provide help to their older parents when the need arises. Public policy has shown relatively little interest in supporting and strengthening the family's natural caring functions. Indications are that many older people can avoid institutional placement if they have relatives to care for them with adequate financial resources. However, we do feel that consideration should be given to increasing the amount of the tax credit.

NINTH, it should be clearly recognized that we will never be able to legislate-away nursing homes. There will always be a need for long term care institutions for those older persons who are too impaired to be maintained safely, comfortably and effectively in the community. We must never lose sight of this and must, therefore, continue to work together in developing policies which encourage the best quality of life possible in these facilities.

As final recommendations, we would urge you to consider the following:

-- A National Council on Non-Institutional Long Term Care Services should be established to advise, consult with and make recommendations to the Secretary of Health and Human Services with respect to the development of national long term care policy; the implementation and administration of Title XXI; and, the evaluation of non-institutional care for the organization, delivery and distribution of long term care services.

-- A high-level Division of Non-Institutional Long Term Care Services should be created in the Department of Health and Human Services to coordinate, support and provide technical assistance for the delivery of non-institutional services.

-- Each PAT should be required to organize an Advisory Committee with representatives from consumers and service providers in the area served as well as the AAA, PSRO and Health Systems Agency. This would provide a measure of local accountability and encourage more effective integration of the PAT's work with the community and its existing institutions and agencies.

-- Some consideration should be given to whether limits should be set on the size of an area a PAT could realistically serve.

In conclusion, we think that S.2809 is a creative, far-reaching approach to one of our society's most trying problems. While some parts of the bill require re-thinking, it still stands as a significant accomplishment.

Clearly, we must move in the direction the legislation proposes now. The longer we delay, the more difficult it will be to reverse the financial and human consequences of our present long term care system. Can we really afford to wait?

Metropolitan Jewish Geriatric Center appreciates the opportunity to offer our views on these very important issues and we look forward to working with you toward passage of this legislation.

I would be delighted to answer any questions the Committee may have at this time. Thank you.

Senator MATSUNAGA. Thank you very much, Mr. Kodner.

Are there any questions?

Senator PACKWOOD. I have one of Ms. Benson.

On page 1 you made reference to a medicare waiver. What kind of a waiver did you get?

Ms. BENSON. Excuse me, Senator, but it was a medicaid waiver. It may be a typo.

Senator PACKWOOD. What was it you got?

Ms. BENSON. It was called an 1115 waiver under the authority of the, then Secretary of HEW, now HHS, to create a waiver. We had a very broad waiver, partially, I think, because it was one of the first that the Department granted, and it was granted to us in December of 1974.

Specifically, it waived what generally is waived in programs like this, the statewideness provision, which meant that we could experiment within various sections of our State. Then it waived the whole services section of our State plan.

Wisconsin, like New York and I suspect Oregon, has a very generous medicaid program. We participate now in all mandatory, obviously, and all voluntary portions of medicaid.

In addition, we wanted to have the flexibility, basically, to use medical assistance as a counterpoint to institutional care. So the actual language is the section that controls the amount of services, their duration, and scope.

Chiefly, we use the money for case management, and for a whole series of direct services that I briefly mentioned, such as transportation, nutrition, and some skilled services. In the skilled level, they were mainly adjuncts to existing services available through medicare and medicaid.

Senator PACKWOOD. I was curious because I noticed that Mr. Putman could not get a waiver for children under 21, who were handicapped, for medicaid payments because they were living at home, and they had to be hospitalized. Obviously, your waiver is unrelated to that altogether.

Ms. BENSON. Yes. I guess, perhaps appreciating the efforts that Mr. Putman put in, it was not a simple process, nor was it a simple process for those colleagues who are at the table with me, who also have medicaid and medicare waivers. It is somewhat lengthy.

As I said, our waiver was extremely broad. It did not explicitly describe the services that we would provide. It said that we could provide services as we needed.

Senator PACKWOOD. Mr. Chairman, I have no other questions. I will say once more that these seven witnesses have given us more information than we could have obtained in days and days of reading or other hearings. This gives us the base that we need to go. I could not be more pleased.

Senator MATSUNAGA. I concur fully with your assessment of the quality of the testimony received today, Senator Packwood.

Senator Bradley.

Senator BRADLEY. Yes, Mr. Chairman, I would like to ask Ms. Benson a question.

You said that you purchase services from providers in the community. Is that right?

Ms. BENSON. Yes.

Senator BRADLEY. That assumes certain market forces at work. The problem with home care is that the people receiving the services—the purchasers—don't always have the money to purchase. What we are proposing is to assist them with some of the money required to pay for these services.

What I am curious about is whether there were enough providers in the community already, or did the number of providers increase in response to the increased demand—and the increased funding—your program brought forth?

Ms. BENSON. Obviously, in a community the size of Milwaukee, not only are there many, many providers, but the potential for providers is extremely great. I suspect that that is true in most large metropolitan areas in the country.

We did have some increase of services in a couple of places, ironically enough, in our medium size county, in LaCrosse County, some actual creation of new services. But in that particular instance they were expansions of existing entities.

One thing that we did with medicaid, too, that is not allowable under the traditional medicaid program, we did allow and encourage certain individual family members to care for other members of the family, which currently is only allowable under title XX.

In general, we found that we expanded services. We did not create a new class of services.

Senator BRADLEY. The reason that I asked the question was to learn whether there were people in the community who are presently providing services who simply jumped onto this revenue stream, or did the existence of the revenue stream and your willingness to purchase from providers generate new providers?

Ms. BENSON. Probably a little bit of both. Needless to say one of the most attractive features of the project for the local level is that it represented potentially unbridled use of medical assistance. They were thrilled. They thought, oh, this is going to resolve all of our problems.

It became considerably more complicated than that because we had all these research requirements that required us to target the program to certain populations, and go through a series of things. In other words, we created a system.

The way in which we control the program through a unit pricing purchase system, I would say, was the most difficult thing initially to sell to the community. Ultimately, we at the State level simply made it a given service. We did not give them an option to have it any other way.

Consequently, what we were not doing, as I indicated briefly, was making available $50,000 to create a new homemaker service. We said, "We will pay you," as an example, "$4.25 per unit." They said, "You cannot do it. We cannot hire people. We need to have more capital." We said, "Well, we think you can," and they could. We even found that to be the case in our rural county.

I should add that, again, you cannot exactly replicate a lot of these things. You can't pick them up and put them in a number of other States.

Even though we demonstrated it in a rural county, our State, in comparison to many others, is very service rich, so there might be more of a base in which to operate there.

Senator BRADLEY. I have a question which goes, I think, to the core of the cost issue: There is a group of people out there today who are not in institutions, and do not have access to home health care but are getting along, for better or worse. Along comes a program which says, "We are going to facilitate the use of home health care."

One of the determinations we have to make about cost is, does this mean an explosion of demand for home care because funding has been made available?

I think Ms. Benson's answer was instructive. But I am interested in what you two gentlemen have to say.

Mr. KODNER. It is my impression, if we can believe some of the estimates that upward of 30 percent of all people in long-term care institutions don't need to be there, and could be more adequately cared for in the community——

Senator BRADLEY. Is this your own finding?

Mr. KODNER. No. This is my reflections on several of the studies that have been done.

Senator BRADLEY. Who did the studies?

Mr. KODNER. I cannot recall all the researchers' names. But the Congressional Budget Office has done a study. Hill, Shanas, Brody and others have also prepared various estimates.

Senator BRADLEY. Speak from your personal experience on that.

Mr. KODNER. In terms of our institution, it is hard to generalize. We are in a part of New York City which has a severe shortage of nursing home beds and as a result, we never have any problem with occupancy.

The people in our institution are there because they could not get services in other facilities in the community, since many discriminate against clients who are on medicaid.

As a result, we have become the institution in our area, in addition to other very large nonprofit providers of last resort because the other facilities will not take them. So I cannot say that there is a large number of people in institutions that don't need to be there.

I would say, however, based on our experience in looking at institutions in general, that there is a percentage of people that can do quite well in the community. About 5 percent of all the people in our long-term home health care program, for example, come from our own facility. We have discharged them.

Luckily enough, they had families who were able to get them an apartment, or we worked very hard to find them living arrangements in the community and get them the income subsidization for that housing, which is an extremely important factor.

However, it is also our feeling that there is a large number of people in the communities we serve that might be equal to the number who don't need to be in institutions and are there now. These people might, in fact, be placed in institutions to fill beds if we emptied them out. That is the difficulty of making estimates for the need and demand for long-term care institutions. That is the dilemma.

Senator BRADLEY. We are not dealing with long-term care in institutions. We are dealing with long-term care at home.

Mr. KODNER. But overall, when we talk about a long-term care system, we have to see it as a continuum of care. We have to look at the noninstitutional services and how they are linked to the institution, to the nursing home, to the ICF, and to the hospital.

When we talk about cost savings, we have to look at the entire system, and how money is saved. If we are going to be emptying out people from nursing homes, there might very well be, even with gatekeeping mechanisms, people coming into those institutions to fill those beds, and there might not be very significant cost savings there.

Senator BRADLEY. But the population that I am talking about is the population that is not now in nursing homes, not now institutionalized, but at home making out one way or another, making do with what they have.

My question is, once title XXI home care becomes available to supplement their own personal resources, will that then lead to an explosion in demand, and knock the cost estimates of this program much higher than we expected? What can you give us from your experience as guidelines to determine whether this is likely or to determine ways to keep those costs down?

Mr. EGGERT. Senator, I would like to make a couple of comments.

I think that if the nursing home situation stays the way it is, basically fully occupied, and if the people stay in the hospitals, and nothing is done to attempt to reduce those two populations, then opening up or expanding the home care situation, as title XXI would do, would increase costs.

I don't know that there is anyone who could say how much it would increase, or how what proportion of the people in the community would then become eligible, or would seek services. But it clearly would increase the numbers of people in the community who would be receiving government supported services, and in that manner it would increase costs.

I think the point that both of us are trying to make is that there are instances where there is overutilization in other parts of the system, such as acute hospitals. The trick of the thing is to try to reduce costs there, and to trade off those cost savings to pay for your expanded services.

Unless you are able to do that in one fell swoop, title XXI is going to increase costs because there will be more people receiving services. That is in the short run.

In the long run, in the next 5 to 10 years, one has to figure, if you did not put more money into home services, how many more nursing home beds would you have to build. That is the other issue. Conversely, if you don't build nursing home beds, you are going to end up building hospital beds, and that is much more expensive.

Senator BRADLEY. Because of the demographics.

Mr. EGGERT. Because of the demographics. In the long run, increasing home care and holding the line on the numbers of beds in hospitals and nursing homes may be the least expensive thing to do, provided that home care services can be programed at less expense than nursing home services, which I think can be done.

In the near term, one has to reduce the excessive utilization of hospitals by people who should not be there, and trade off those

cost savings for your expanded home care services. Otherwise, you are going to increase costs.

Ms. BENSON. I think that this gets to something that concerns me in the bill, and that is the presumptive eligibility of certain classes, particularly people over the age of 65. I have a great deal of concern about that.

I think that, in fact, demographically and in every other way, yes, if you put title XXI in as it is now—and I realize that there is going to be a lot more work on the bill—clearly there will be an increase in cost for all the reasons that were stated here in the short run.

I think there are a number of longer range strategies that could be employed. However, relating to the program itself specifically, it seems to me that the preadmission screening, or whatever mechanism is ultimately used, can take advantage of assessment methodology and research that has been done to attempt to target the population more specifically than simply age related. In other words, get away to a certain extent from the total categorical approach.

Senator BRADLEY. Do you believe that private paying patients should be eligible for it?

Ms. BENSON. Do I believe they should be?

Senator BRADLEY. Yes.

Ms. BENSON. I like that feature, Senator. I happen to believe that there is a great deal of need, although I think there has been a great deal less solid research to really identify that need.

Senator BRADLEY. Do you agree that it will lessen the use of nursing home and acute care?

Ms. BENSON. I have opinions and biases just like everybody else. I know the state-of-the-art as far as the research goes. I think you are seeing the state-of-the-art here at your table in terms of things that have actually been done. There are, obviously, some other examples.

The point I wanted to make is that there are things that exist. There is research that has been done. There are ways to target populations, and one way that has shown some validity and reliability over time is looking at people according to their functioning level. This does not exclude other assessments.

I don't want to get into any argument with any of my colleagues back here about looking at familial and environmental resources. But the nice thing about a functional level is that it also allows you to look at people who are under the age of 65. It is how they live. It is not a diagnostic category, although you don't exclude diagnosis.

The point simply is that there are things that do exist in the field to target people effectively. Many professionals are aware of them.

I would be concerned about a bill that, in fact, would give the message that all people over the age of 65 are presumptively eligible. I think it will create an administrative nightmare for the Department of Health and Human Services. I think that it could potentially create a fiscal nightmare for Members of Congress.

Senator BRADLEY. Let me just ask one more question of each of you, and it goes to the screening panels.

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What do you think their qualifications should be; how large should the team be; and do you feel that paraprofessionals could be involved in this process?

Mr. EGGERT. I would like to answer first.

Our assessments are done from two sources. When they are done in the hospital as part of the discharge planning, we have the opportunity to use nurses, social workers, and the attending physician as an important part of the team since they have the responsibility for discharge planning.

When an assessment is done in the community, we use a certified public health nurse as the lead person. We also use the person's private physician to review the assessment and to give us his or her recommendations.

In the community, as an add-on type of assessment on a need basis, we have available a financial consultant. Many older people have no idea what benefits they are eligible for and have really no idea of what to do with their resources.

We have an occupational therapist who does an in-home architectural review to make sure that if a person is going to return home, if we are providing equipment they can use it in the home, such as a wheelchair.

We also have social work consultants who work with the family and the individual on a short-term basis.

Senator BRADLEY. Can you think of any provision that we could put in this bill that would prevent the title XXI eligibility determination from being a replay of the disability question, where the people deciding whether a person is disabled get down to the decision and they say, "He is disabled, so we will give it to him." Couldn't it easily become, "He needs some help at home, so we will give him the home health care." Professional responsibility could be severely tested by the charitable instinct combined with Government funding.

Mr. EGGERT. The fact of the matter is that people are assessing other people who have obvious needs. These people do have needs.

Senator BRADLEY. Is it your experience that your people can say no.

Mr. EGGERT. Our people say no when they feel it necessary. What we do is tailor the service package to the needs. If the client or the family wants an excessive amount of services, we don't approve payment. There is a fair hearing procedure that we go through. There are legal safeguards built into medicare and medicaid to take care of that. But, we say no.

I guess the other issue is the review process. We review all the assessments that are done internally by our supervisors. On the basis of what the assessed need is, we then compare what we have prescribed as far as the service package.

Where we think that the service package is more than is merited, then we renegotiate, and we either don't pay for it or we work out the situation with the client, the family and the assessor so they receive fewer services.

It is a manageable situation, it just involves the degree to which you are going to review it.

Mr. KODNER. In our program, where there is a 75-percent cap on the cost of care in the community versus the comparable institu-

tional care, and where the local social service district is part of the joint assessment team, I think that we have a significant number of people screened out either because their service needs, when translated into a working budget on a monthly basis exceeded the 75-percent cap, or we have found that in 24 percent of the cases of people who were screened, they were not admitted into the program because they did not have adequate housing. So we have self-screened out that.

With these controls——

Senator BRADLEY. You said that you use 80 percent of all the funds.

Mr. KODNER. In New York State we use, I think, 80 percent of all the national medicaid dollars for home care. I think that that is it.

Senator BRADLEY. You attribute that to your tough screening?

Mr. KODNER. No.

You have to understand that in New York State there are three home care programs now financed under medicaid, and that is part of the problem. We have the certified home health care agencies, which we call the conditional home health care agencies. We have the home attendance program. Then we have this new thing called, long-term home health care.

I think that it is the State's policy intention to find a way to amalgamate everything and bring them under control. This is the only form of home care in the State where there is a cap on the program, and where the local social service district is involved in the assessment.

It is not an open-ended system. I think that that is why we have it in New York State. We are trying to see the light at the end of the tunnel.

Ms. BENSON. I believe that it is called, maximizing the Federal dollar. [General laughter.]

Senator BRADLEY. Or something.

Ms. BENSON. The initial question is, what sort of makeup should be on the assessment team? In our urban area, I would say that we are very similar to what both of these gentlemen who are from more urbanized areas would say. We have a more professional team, as much as anything, because I think they need to be competitive with the crazy world out there in their area.

We do have, in general, a nurse or social worker, although we rely very heavily, as I indicated before, on pretested assessment methodology both to target our population and to eliminate people who do not require service.

Again, some of these things are special due to the fact that this was a demonstration project, and we were attempting to set up a research data base. Those things are not generally applicable in existing service systems. Perhaps they ought to be more so.

Senator BRADLEY. Do you think that this team should make decisions on nursing homes as well as home health care?

Ms. BENSON. I am and always have been very intrigued with that factor in the access program. I think that it is a very solid approach, and also the triage program. I think making decisions is one thing.

The key point to me, and I know that it is shared by other individuals on this panel, is that if you don't have any way of

controlling access to nursing homes, then you may accomplish some things, and I think that our data show that we have accomplished some things, but I think they probably show that we accomplished them in the face of great odds with very little authority to intervene in the system.

It is very clear to me that many people continue to go on their way to nursing homes regardless of anything that we may have done. So I feel very, very strongly about that. Whether you add on the whole payment component and a series of other responsibilities, I think, will depend very much on the relative sophistication of the State and what its particular problem is, frankly.

The point that I wanted to make, though, is that in our more rural areas, we have used paraprofessionals, and we have found them to be, when they are trained and using good assessment methodology and under supervision, to be very adequate.

I think that it is unrealistic to suggest that you can, as I believe was in some of the testimony earlier, find not only a high powered, but I should add high priced assessment.

I think that one of the things that is interesting about our assessment experience, and I believe that it is paralleled by the access project, is that contrary to things that I hear of assessments costing $500 or $600, ours have been quite a bit lower.

I believe yours have been as well, have they not, per unit cost?

Again, these data are hard to report accurately out of context, but we have found that in some cases an initial assessment will cost between $25 and $80, which is certainly different than $500 or $600 that we hear in other places.

Senator BRADLEY. Thank you, Mr. Chairman. I have found this very helpful, too. These individuals have a wealth of experience out in the community working on the delivery of home care services, and I am sure that we will be calling on them for more assistance.

I hope you will be willing to give us the benefit of your experience as we have further questions.

Senator MATSUNAGA. Ms. Benson, under your program, once a person is placed on in-home services, is there a mechanism to evaluate the continued need and frequency for these services?

Ms. BENSON. Yes, there is, Senator. It is part of the case management system. People are reviewed initially every 30 days, but then as they are in the system, we really don't review them systematically, that is to say, a whole thorough assessment any more than 120 days.

I don't mean to indicate that assessments are not available, or that they are not involved with them. It becomes a situation that is partially, I think, common sense, but also built into good practice.

The point is that a person coming out of a hospital generally needs more assistance, more care, more help in putting together a service package and monitoring it. Over time, many individuals stabilize.

The fact remains, as you know in this population, particularly the older population, people experience acute episodes within chronic disabilities, so consequently people go in and out of various locations of care.

Senator MATSUNAGA. You all seem to have such wonderful programs. What specific provisions of S. 2809 will improve your programs, other than of course additional Federal dollars?

Mr. EGGERT. If this bill will give more control over admissions into nursing homes—the irony about this is that it took about 4 years to understand what kind of a situation we are in. The issue is not who goes home. The issue is who goes to nursing homes. That is the issue.

We have restricted the number of nursing home beds that we build by certificate of need, and we have restricted the number of beds to a number that is clearly less than the potential need or the actual need. There have been estimates made that for every person in a nursing home, there are two to three people in the community who meet the same medical necessity requirements.

With unfettered admissions, it is in the nursing homes' best interest, and one cannot fault them for acting that way, to try to admit people who have the lowest care needs, yet who meet the minimum standards because, basically, they expend less staff resources.

So they continue to do that in the face of the fact that people who are very severely disabled are in acute hospitals for excessive periods of time. That is the issue.

If this bill can provide a little more systematic and, let us say, uniform admission policies and procedures into nursing homes, I think you can reduce the number of admissions from the non-medicaid population, and those beds potentially could be used for people in hospitals. That is your potential cost reduction.

Clearly you are going to expand home services by having more people at home.

The secondary approach is that if you can reduce the fragmentation and the duplication among titles XVIII, XIX, and XX, and the different eligibility requirements, you are going to reduce the administrative costs. Consumers are going to understand a little better how they can get services.

Potentially, providers are going to be better off because there is going to be a uniform rate. Now there are three different rates for the same service from three different types of agencies. It will make it a lot cleaner from that perspective.

Those are the advantages that I see.

Senator MATSUNAGA. Mr. Kodner.

Mr. KODNER. I think that Gerry said it very clearly.

Senator MATSUNAGA. Do you have anything to add, Ms. Benson?

Ms. BENSON. I agree. The only thing that I would like to add, which I may be the only person who says it for today, I am thrilled that it includes the development of a long-term care data base. I think that that will be very nice.

Those of us here have struggled to try to create some sort of uniformity among any kind of cost or units, the different eligibilities, the different standards, the different this and that. It is frustrating, to put it gently.

Obviously, as the demographic day of reckoning approaches, I think we need to have much greater capacity to project and to budget. The development of a data base will in fact allow us to get a much better handle on that.

Senator MATSUNAGA. Thank you again. I wish to join my colleagues in expressing the deep appreciation of the committee for your contributions today.

I wish to announce that the record will remain open until September 12, 1980, for written statements. If you have additional written statements, or if any in the audience here would like to submit written statements, the committee will accept any written statements for the record up until September 12.

Thank you very much.

The subcommittee stands in recess subject to the call of the Chair.

[Whereupon, at 11:35 a.m., the subcommittee recessed, subject to the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF SENATOR HENRY BELLMON
PREPARED FOR SUBMISSION TO THE HEALTH SUBCOMMITTEE
OF THE SENATE FINANCE COMMITTEE

MR. CHAIRMAN, I WISH TO COMMEND SENATORS PACKWOOD, BRADLEY AND THEIR STAFFS FOR THEIR EFFORTS TO REMOVE THE INSTITUTIONAL BIAS FROM OUR SYSTEM FOR FINANCING LONG-TERM CARE. I AM SURE S. 2809 WILL BE THE SUBJECT OF MANY COMMENTS DURING THIS AND SUBSEQUENT HEARINGS. THIS BILL IS A CREATIVE FIRST STEP IN THE DEVELOPMENT OF A MORE RATIONAL SYSTEM FOR THE DELIVERY OF SERVICES TO THE ELDERLY, DISABLED AND HANDICAPPED.

MY COMMENTS MAY BE VIEWED BY SOME AS PAROCHIAL BECAUSE I WILL DESCRIBE A PROGRAM WHICH IS UNIQUE TO MY HOME STATE, OKLAHOMA. I BELIEVE OKLAHOMA'S PROGRAM CAN AND SHOULD SERVE AS A MODEL FOR BOTH THE DELIVERY OF NON-INSTITUTIONAL SERVICES AND THEIR INTEGRATION WITH INSTITUTIONAL SERVICES. I DO NOT KNOW WHETHER OTHER STATES COULD REPLICATE OR WOULD WISH TO REPLICATE OKLAHOMA'S NON-TECHNICAL MEDICAL CARE (NTMC) PROGRAM FULLY. I DO KNOW THAT THIS PROGRAM HAS WELL SERVED THE PEOPLE OF OKLAHOMA, ALLOWING MANY OF OUR AGED, DISABLED AND HANDICAPPED TO REMAIN IN THE FAMILIAR SURROUNDINGS OF THEIR OWN HOMES AT MINIMAL COST TO THE FEDERAL AND STATE TREASURIES. I WILL FIRST DESCRIBE THE NTMC PROGRAM AND THEN OUTLINE FOR YOU WHAT I CONSIDER TO BE THOSE PROGRAM ELEMENTS WHICH ARE ESSENTIAL FOR ITS SUCCESS.

SINCE THE 1950'S, THE STATE OF OKLAHOMA HAS OPERATED A PROGRAM IN WHICH INDIVIDUALS ARE PROVIDED PERSONAL CARE SERVICES IN THEIR OWN HOMES. THIS PROGRAM WAS KNOWN ORIGINALLY AS NURSING CARE IN THE RECIPIENTS OWN HOME. THE PASSAGE OF MEDICAID IN 1965 OFFERED OKLAHOMA AN OPPORTUNITY

TO OBTAIN FEDERAL FUNDS FOR ITS PRE-EXISTING PROGRAM. BUT HEW REFUSED TO SHARE IN THE COSTS OF THE OKLAHOMA PROGRAM AND DEVISED REGULATIONS THAT WOULD COVER A STATE'S PERSONAL CARE SERVICES ONLY IF THE STATE ARRANGED FOR NURSING SUPERVISION OF SERVICES DELIVERED. OKLAHOMA ALTERED ITS PROGRAM TO COMPLY WITH THE REGULATION. IN ADDITION, A TRAINING PROGRAM FOR PROVIDERS WAS DEVELOPED. THE NAME OF THE NEW PROGRAM WAS CHANGED TO NON-TECHNICAL MEDICAL CARE (NTMC). IT WAS IMPLEMENTED IN 1970 AND DECLARED ELIGIBLE FOR FEDERAL MEDICAID FUNDS AT THAT TIME.

SINCE 1970, NTMC HAS GROWN INTO OKLAHOMA'S PRINCIPAL IN-HOME SERVICES PROGRAM. EXPENDITURES HAVE RISEN FROM UNDER THREE MILLION DOLLARS WITH 5,400 RECIPIENTS IN 1971 TO ALMOST FOURTEEN MILLION DOLLARS WITH 8,000 RECIPIENTS IN 1979. THE GROWTH OF THE NTMC HAS CONFIRMED THE BASIC PREMISE OF THE PROGRAM -- THAT PERSONAL CARE, RATHER THAN SKILLED CARE, IS THE APPROPRIATE LEVEL OF IN-HOME SERVICE AND THAT PERSONAL CARE CAN BE PROVIDED TO MORE PEOPLE BY RELYING ON INDIVIDUALS RATHER THAN AGENCIES TO DELIVER SERVICES.

NTMC'S PRIMARY OBJECTIVE IS TO HELP PEOPLE FUNCTION IN THEIR OWN HOMES. THE PROGRAM REFLECTS THE BELIEF THAT "AN INDIVIDUAL WITH FAILING HEALTH AND MENTAL ABILITY CAN REMAIN IN HIS OWN FAMILIAR ENVIRONMENT IF THERE CAN BE MADE AVAILABLE A QUALIFIED PERSON TRAINED TO MEET THE INDIVIDUAL'S ESSENTIAL DAILY NEEDS."

NTMC IS DEFINED AS A LEVEL OF NURSING CARE BELOW THAT PROVIDED IN NURSING HOMES. SERVICES INCLUDE DIET MONITORING, PERSONAL CARE, LIGHT HOUSEKEEPING, AND REHABILITATIVE-REMOTIVATION ACTIVITIES. SKILLED CARE SUCH AS PHYSICAL THERAPY AND SKILLED NURSING IS NOT PART OF THE NTMC SERVICE.

CARE IS PROVIDED BY INDIVIDUALS WHO ARE EMPLOYED BY NTMC RECIPIENTS. OFTEN A PROVIDER IS A FRIEND OR NEIGHBOR OF THE RECIPIENT. NEARLY 50 PERCENT OF ALL PROVIDERS ARE 46 TO 65 YEARS OF AGE. GENERALLY THEY ARE FEMALE WITH LIMITED EDUCATIONAL BACKGROUNDS AND OCCUPATIONAL TRAINING.

THE STATE OFFERS A 20-HOUR TRAINING PROGRAM FOR NTMC PROVIDERS. THE PROGRAM OF INSTRUCTION INCLUDES 12 HOURS ON BASIC NURSING CARE PROCEDURES, 2 HOURS ON NUTRITION AND MEAL PREPARATION, 2 HOURS ON REHABILITATIVE SKILLS, 2 HOURS ON DIVERSIONAL ACTIVITIES AND 2 HOURS ON HOMEMAKING CHORES. NURSES TEACH THE COURSE IN TEN WEEKLY SESSIONS OF TWO HOURS EACH. A TEACHING MANUAL DEVELOPED BY THE NURSING STAFF SERVES BOTH AS A TEACHING TOOL AND REFERENCE SOURCE FOR THE PROVIDERS.

REGISTERED NURSES EMPLOYED BY THE OKLAHOMA DEPARTMENT OF HUMAN SERVICES ARE RESPONSIBLE FOR MANAGING PATIENT CARE PLANS AND ENSURING THE QUALITY AND APPROPRIATENESS OF CARE. ONCE AN INDIVIDUAL HAS BEEN APPROVED FOR NTMC, THE CASEWORKER AND NURSE ASSIST THE RECIPIENT IN LOCATING A PROVIDER. LISTS OF NTMC PROVIDERS ARE MAINTAINED AT THE COUNTY SOCIAL SERVICE OFFICES, TO BE USED IF A RECIPIENT CANNOT LOCATE A FRIEND OR NEIGHBOR TO PROVIDE CARE. FOLLOWING REVIEW OF THE CASE BY A SOCIAL WORKER AND A PHYSICIAN, THE NURSE VISITS THE RECIPIENT IN HIS OR HER HOME AND DRAWS UP A PLAN OF CARE, INCORPORATING THE PHYSICIAN'S ORDERS AND HER OWN ASSESSMENT. IF POSSIBLE, THE NURSE REVIEWS THE CARE PLAN WITH THE PROVIDER AND THE RECIPIENT SIMULTANEOUSLY.

THE NURSE MAKES A MINIMUM OF TWO VISITS PER MONTH TO EVALUATE AND ASSIST THE NTMC PROVIDER AND TO ASSESS THE PATIENT'S HEALTH STATUS. IF THE RECIPIENT'S CONDITION CHANGES ENOUGH TO AFFECT THE APPROPRIATENESS OF NTMC SERVICES, THE NURSE (EITHER ON HER OWN OR IN RESPONSE TO OBSER-

VATIONS OF THE SOCIAL WORKER, PHYSICIAN, OR PROVIDER) REPORTS THE CHANGE TO THE MEDICAID PROGRAM WITH A RECOMMENDATION. A FORMAL EVALUATION OF EACH RECIPIENT'S CONDITION IS PERFORMED ANNUALLY, CONSISTENT WITH FEDERAL REQUIREMENTS.

EACH NURSE SUPERVISES AN AVERAGE OF 80 TO 100 PATIENTS. NURSES ARE ON CALL FOR EMERGENCIES AND HAVE RESPONSIBILITY FOR ORGANIZING PROPER TRAINING OF PROVIDERS. NURSES OFFER IN-SERVICE PROGRAMS ON VARIOUS ILLNESSES AS A SUPPLEMENT TO THE BASIC TRAINING PROGRAM. IF A PROVIDER CHOOSES NOT TO ATTEND THE FORMAL TRAINING SESSIONS, THE NURSE WILL INSTRUCT THE PROVIDER IN THE RECIPIENT'S HOME.

IN GENERAL, PROVIDERS ARE TAUGHT TO OBSERVE PHYSICAL AND BEHAVIORAL CHANGES IN THE RECIPIENTS AND TO CONTACT THE NURSE SHOULD THE NEED ARISE. IF A PATIENT NEEDS SKILLED CARE, THE SERVICES CAN BE PROVIDED BY A PUBLIC HEALTH NURSE OR HOME HEALTH AGENCY. THE AVAILABILITY OF SERVICES FROM THESE PROVIDERS, HOWEVER, IS EXTREMELY LIMITED IN OKLAHOMA. IN CERTAIN SITUATIONS THE NURSE AND ATTENDING PHYSICIAN INSTRUCT THE NTMC PROVIDER ON THE DELIVERY OF LOW-LEVEL SKILLED CARE (E.G., GIVING INJECTIONS OR BASIC THERAPY). UNDER UNUSUAL CIRCUMSTANCES, SUPERVISING NURSES WILL PROVIDE LIMITED SKILLED SERVICES. IN GENERAL, HOWEVER, SKILLED CARE IS NOT DELIVERED IN THE HOME, AND A PATIENT NEEDING THAT CARE IS ENCOURAGED TO ENTER A NURSING HOME.

IF A PATIENT UNDER NTMC IS DISSATISFIED WITH HIS PROVIDER AND NO SOLUTION CAN BE FOUND TO THE PROBLEM, THE PATIENT CAN DISMISS HIS PROVIDER. THE SUPERVISORY NURSES MEDIATE WHEN SUCH PROBLEMS ARISE. SOMETIMES THEY ARE SUCCESSFUL IN RESOLVING MISUNDERSTANDINGS AND AT OTHER TIMES THEY ARE NOT. SHOULD A PATIENT FIRE HIS PROVIDER AND LACK A SUITABLE REPLACEMENT, THE NURSE WILL PROVIDE THE PATIENT WITH A LIST OF POTENTIAL AIDES KEPT AT THE COUNTY OFFICE FROM WHICH A NEW PROVIDER CAN BE CHOSEN.

THE OKLAHOMA HUMAN SERVICES COMMISSION WHICH SETS THE RATES FOR ALL PROVIDERS OF DHS SERVICES IN 1971 SET A FLAT PER DIEM FOR NTMC PROVIDERS OF $3.00 PER VISIT FOR ONE PERSON PLUS $1.50 FOR AN ADDITIONAL PERSON UNDER THE SAME ROOF. THE FLAT FEE HAS BEEN REVISED UPWARD PERIODICALLY TO THE PRESENT $10.65 PER VISIT FOR ONE PERSON PLUS $5.33 FOR AN ADDITIONAL PERSON UNDER THE SAME ROOF. PAYMENT IS LIMITED TO ONE VISIT PER DAY PER RECIPIENT AND PROVIDERS CARE FOR A MAXIMUM OF TWO INDIVIDUALS SIMULTANEOUSLY. PAYMENT IS ON A PER-VISIT BASIS. CONSEQUENTLY, NO FORMAL RELATIONSHIP EXISTS BETWEEN THE FLAT FEE AND THE ACTUAL NUMBER OF HOURS WORKED, ALTHOUGH 4 HOURS PER VISIT ARE RECOMMENDED BY THE NTMC STAFF.

OFFICIALS PREFER USING THE FLAT STIPEND TO RATES PER SERVICE OR PER HOUR, BECAUSE THE STIPEND IS LESS COSTLY AND REQUIRES LESS MONITORING. RATES ARE SET AT THE LEVEL NECESSARY TO ATTRACT AN ADEQUATE SUPPLY OF PROVIDERS AND ARE RAISED IN RESPONSE TO COMPLAINTS FROM PROVIDERS AND NURSE SUPERVISORS. RATES ALSO REFLECT DHS'S PERCEPTION THAT NTMC IS BASICALLY A VOLUNTEER PROGRAM. THE MAJORITY OF PROVIDERS ARE FRIENDS AND NEIGHBORS WHO, OFFICIALS FIND, OFTEN NEED LITTLE INDUCEMENT TO BECOME NTMC PROVIDERS.

THE AVERAGE MONTHLY PER CAPITA COST OF THIS PROGRAM IS A LITTLE LESS THAN $275. THIS INCLUDES THE COSTS OF RECRUITING, TRAINING, AND MONITORING PROVIDERS AS WELL AS PAYING FOR THEIR SERVICES. THIS PER CAPITA COST IS 41% OF THE TOTAL MONTHLY <u>NURSING HOME PER DIEM</u>.

I BELIEVE OKLAHOMA HAS PUT TOGETHER A SYSTEM OF HOME CARE THAT MEETS THE NEEDS OF ITS CITIZENS WITHOUT PLACING A GREAT FINANCIAL BURDEN ON THE PUBLIC. THIS SYSTEM IS CHARACTERIZED BY THE FOLLOWING ELEMENTS:

1. SINGLE INTAKE AND EVALUATION POINT FOR ALL PEOPLE REQUIRING LONG-TERM CARE SERVICES WHETHER THOSE SERVICES BE INSTITUTIONAL OR NOT;
2. RELATIVELY FEW, SIMPLE REGULATIONS;
3. COMPREHENSIVE ASSESSMENT OF PATIENTS' NEEDS WHICH LEADS BOTH TO THE DEVELOPMENT OF A PLAN OF CARE AND TO A DECISION ON THE MOST APPROPRIATE SITE FOR THE DELIVERY OF THAT CARE;
4. IDENTICAL CRITERIA FOR ADMISSION TO BOTH INSTITUTIONAL AND NON-INSTITUTIONAL CARE;
5. CAPACITY TO IDENTIFY, TRAIN, REIMBURSE, AND MONITOR LOCAL COMMUNITY-BASED PROVIDERS OF IN-HOME CARE;
6. COST CONTROL MECHANISMS WHICH KEEP THE TOTAL PER CAPITA SERVICE AND ADMINISTRATIVE COSTS WELL BELOW 50% OF NURSING HOME PER DIEM COSTS -- EVEN IN OKLAHOMA WHICH HAS NURSING HOME RATES WELL BELOW THE NATIONAL AVERAGE; AND
7. RELIANCE AT ALL POINTS IN THIS SYSTEM ON PERSONNEL HAVING LIMITED PROFESSIONAL EDUCATION OR TRAINING. EXPERIENCE HAS PROVEN, HOWEVER, THAT THESE PEOPLE ARE MORE THAN ABLE TO PERFORM THEIR ASSIGNED DUTIES.

I BELIEVE EVERY LONG-TERM CARE SYSTEM SHOULD BE CHARACTERIZED BY THESE SEVEN ELEMENTS IF THAT SYSTEM IS TO SERVE THOSE IN NEED BOTH EFFICIENTLY AND EFFECTIVELY.

MR. CHAIRMAN, I URGE THE COMMITTEE TO LOOK CAREFULLY AT THE OKLAHOMA EXPERIENCE AS IT SEEKS TO IMPROVE POLICIES FOR HOME CARE OF ELDERLY AND DISABLED PEOPLE.

State of New Jersey

DEPARTMENT OF HUMAN SERVICES

P. O. BOX 1237 TRENTON, N. J. 08625

September 15, 1980

Mr. Jeff Lewis
Legislative Assistant
1321 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Lewis:

I regret that a representative from the Department of Human Services, State of New Jersey, was unable to testify before the U.S. Senate Subcommittee on Health, Committee on Finance, on August 27, 1980, regarding S. 2809.

However, because of our interest in community-based home health services, we have enclosed some comments expressing our views on the bill. We request that our comments be considered and included in the Committee Report of the public hearing on S. 2809.

Thank you.

Sincerely,

Gerald Reilly
Deputy Commissioner

GR:MW:b
Attachment

Statement on S. 2809, Comprehensive Community Based Noninstitutional Long-Term Care Services for the Elderly and Disabled

The State of New Jersey is committed to the implementation of a needs oriented long-term care delivery system. We envision a system that addresses the needs of the elderly, disabled, mentally retarded, handicapped and the mentally ill. The system will make available to those groups the services that will allow them to continue functioning in the least restrictive appropriate environment. The system must provide a continuum of care ranging from a skilled nursing facility at one end to independent community living at the other. We wholeheartedly support the long-term care concept embodied in S. 2809 as a significant step designed to make such a system a reality.

Although unintentional, the current health care system is biased in favor of institutional rather than community-based care. In FY 1979, there were about 25,000 elderly (65 +) residing in nursing homes in New Jersey. Among those residents, about 22,000 were in intermediate care facilities, 16,600 were level A patients and 5,400 were level B. In 1977 a study conducted by the Urban Health Institute for the New Jersey Medicaid program found that 35 percent of level B intermediate care residents could have received appropriate care in the community if adequate social and medical services had been available. In FY 1979, about 5,400 aged residents in intermediate care facilities were level IV(B) patients. If 1,900 (35 percent) of those patients had been treated in the community, the critical shortage of nursing home beds in New Jersey could have been reduced by 50 percent.

We commend the leadership role the members of the Sub-Committee on Health have displayed in developing this proposed Federal long-term care legislation. S. 2809 is one of more comprehensive approaches toward the development of an effective long-term care policy we have seen at the Federal level. This bill is the first major effort that attempts to combine the myriad of existing programs for the elderly and disabled under a single title. If the bill becomes law, it will help to eliminate service fragmentation, eligibility disparity and the provision of inappropriate services that is so prevalent under existing programs. Under the provisions of this bill,

individuals applying or referred for services will be evaluated on the basis of their health needs rather than on the basis of program needs. We are pleased to note that S. 2809 equalizes eligibility standards, enabling persons in need of long-term care to receive it in the appropriate setting.

The return of the community and the family as the focal point for the provision of health and social services is a philosophy that we in health and social care fields can appreciate and support. Public hearings and surveys show that when confronted with the need for long-term health care and social services, individuals, to an overwhelming degree, preferred to remain at home, or in the community, instead of entering an institution.

Current research shows that although elderly persons live apart from their children, family ties are usually maintained. Contrary to the conventional belief that the caring function of the extended family has shifted to social welfare institutions of the larger society, an extended family helping network still exist. With complete Federal funding of an S. 2809 concept of community services, the relative-helping networks will be supported rather than replaced by costly and inappropriate institutional care.

The concept of care contained in S. 2809 is an excellent beginning toward a needed modification of the distinctly medical model of long-term care. The system promoted by this bill would allow individuals to receive service at an earlier stage of need, for instance, "when they are unable to be left alone during day time hours, but do not require institutionalization."

S. 2809 incorporates some of the core functions necessary for the efficient and effective administration of a long-term care system. These functions include:

a. A comprehensive needs assessment to identify the client needs and provider resources so that a comprehensive solution can be planned.

b. Case management to plan for care, arrange for services, monitor the administration of care and conduct reassessments.

c. The provision of a wide range of home health services under a single funding source.

Probably the most important aspect of the bill is the requirement that no individual may receive long-term care benefits under titles XVIII, XIX or XX unless that individual has been screened and assessed and a plan of care established.

We recognize S. 2809 as an important breakthrough for the development of a needs-oriented Federal long-term care policy. It is our belief that this bill contains some excellent concepts and ideas that will prove to be the nucleus for establishing a new model for long-term care.

As the concepts embodied in S. 2809 are further developed, we have certain concerns and questions that if resolved, we think, would strengthen the bill.

First, it is difficult to project the number of individuals that will require services under S. 2809.
In New Jersey during FY 1979, about 40,500 individuals received home health care, skilled nursing care and intermediate care services under the Medicaid program. During CY 1979, Medicare costs for New Jersey residents were about $38 million for home health and skilled nursing care. We recognize that once benefits becomes available, more people will come forward to use the services. Since we cannot project what that number may be, we cannot project what it would cost to implement S. 2809 in New Jersey.

Second, S. 2809 would reduce states' FY 1980 title XX funds.
Title XX provides that the state and its citizens may decide on the services to be supported under the title and the amount of funds to be allocated for each service. Also, title XX permits states to make changes as necessary to achieve the goals adopted under the plan. If a states' title XX grant is reduced by the amount spent on S. 2809 covered services during FY 1980, it may be very difficult for states to maintain the flexibility of title XX.

A reduction of FY 1980 title XX funds could penalize states that allocated a larger portion of these funds for S. 2809 services. When considered in light of the fact that title XX allocations have not kept up with inflation, it is

easy to recognize such a reduction could result in further reductions in very vital services to children and families. To preclude further cuts in those vital services, title XX allocations should not be reduced.

Third, S. 2809 does not include some services critical to the maintenance of the elderly and disabled in the community setting.
Although S. 2809 provides many community-based home health services, coverage of other services are needed. Some of those critical services are: (a) transportation; (b) legal; (c) meals-on-wheels; and (d) recreation and socialization.

Fourth, S. 2809 should provide a continuum of care services ranging from independent community living to institutionalization.
Benefits under S. 2809 would terminate if an eligible recipient is admitted, as an inpatient, to a medical facility.

The preadmission screening and assessment concept has been demonstrated as an effective and efficient approach to long-term care in demonstration projects in New York State (Monroe County Long-Term Care Program) and Connecticut (Triage Project). Critical functions contributing to the success of the programs are the establishment of a plan of care and case management.

S. 2809 should provide the means to carry out complete case management functions. The bill does not provide benefits for recipients in acute care hospitals or long-term care facilities. In effect, the case manager would lose control and influence when an individual becomes an inpatient in a hospital or nursing home. When an individual is preparing to leave a hospital or nursing home, a plan of care should be prepared. Under S. 2809, it appears that the plan would be prepared by appropriate personnel in the medical facility. When the individual returns to the community that plan of care would be administered by case managers in the community who had no input in preparing the plan. In order to maintain continuity in case planning and management, it is recommended that a complete continuum of care benefits be authorized under S. 2809.

<u>Fifth, S. 2809 should require that before any individual enters a long-term care facility, he/she must be assessed and have a plan of care established.</u>

In its present form, S. 2809 would require that no individual could receive long-term care benefits under titles XVIII, XIX, XX or XXI unless that individual has been assessed and a plan of care established. A large percentage of patients in New Jersey enter nursing homes as private pay patients. Private pay patients are not required to undergo any kind of preadmission assessment.

Experience has shown that, when entering LTCFs, private pay patients are generally less ill than public pay patients. It seems to follow that it costs less to care for less ill patients. Also the rates paid by private pay patients may not be restricted by public rate setting agencies. Therefore, it seems that operators of nursing homes have an incentive to fill empty beds with private pay patients.

In order to help alleviate the shortage of long-term care beds and insure that available beds are used for the most needy, S. 2809 should require that everyone entering a nursing home must be assessed and have a plan of care established.

<u>Sixth, some aspects of S. 2809 requirements pertaining to preadmission screening and assessment teams should be modified:</u>

a. The physician member of the team should not provide general supervision but should be a consultant instead. As Senator Packwood stated, "<u>Title XXI</u> places an increased emphasis on social services which would work to provide a viable alternative to the institutional acute care design of the Medicare and Medicaid system." The continued emphasis upon "supervision" by the physician member of the team is contrary to this philosophy and could add greatly to the cost of the program.

b. Including a physical therapist as a member of each team appears unwarranted. This specialist can be consulted, when necessary, as with the occupational therapist.

c. The inclusion of a volunteer advocate is most desirable but could be very impractical and unrealistic. Volunteers are understandably inconsistent in their availability and commitment. Unfortunately, in our society, individuals must be paid to perform such ongoing responsibilities. However, welcoming an advocate's input would be acceptable.

d. The community service thrust of this legislation would tend to support the social services member of the team as the case manager and coordinator, who would assure its passage through the system to service delivery. It is this person who is most knowledgeable about the community services network and family system. The designation "social services" person should be more clearly defined to include required training and expertise. We recommend that, as a minimum, a social services person should have a Bachelor of Arts in social work and one year of experience as a social worker.

The need to demonstrate the many innovative ideas in S. 2809 is obvious. We support the delayed effective date for the program pending conclusions re rendered on the experiences of the ten demonstrations. New Jersey is most interested in being considered a demonstration state. We could easily adapt our Medicaid medical evaluation teams to the preadmission screening and assessment teams described in the legislation.

The 160 professional staff of physicians, nurses, and social workers based in the sixteen Local Medicaid offices through the state could be the nucleus for demonstrating a PAT structure. With a larger population to assess and link up with services, staff, of course, would have to be increased. However, the current relationships in the local community developed over the ten years of the Medicaid program would enable the staff to quickly adjust to the community services concept.

The medical evaluation teams are already involved in home health and medical day care services authorizations of individuals who choose to remain in the community. This experience could be translated into the new approaches to long-term care defined in S. 2809.

GEORGE R. ARIYOSHI
GOVERNOR OF HAWAII

STATE OF HAWAII
STATE PLANNING AND ADVISORY COUNCIL
ON DEVELOPMENTAL DISABILITIES

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LILY IVY WANG
EXECUTIVE SECRETARY

August 19, 1980

The Honorable Spark M. Matsunaga
United States Senate
362 Russell Bldg.
Washington, D.C. 20510

Dear Senator,

Thank you very much for the information on Senate Bill 2809 dealing with Noninstitutional Long-Term Care Services for the Elderly and Disabled introduced by Senator Bob Packwood on June 10, 1980.

I understand the hearing for this Bill has been scheduled for August 27, 1980. Due to the shortness in time, I will not attempt to give a series of arguments for the Bill except to mention one really strong argument. Most of the people that I have been involved with, in my 20 years in the movement of securing and improving services for the mentally retarded (and now the developmentally disabled) have been strong advocates for the philosophy of a single "locus of responsibility." I have been an avid advocate of this philosophy. A single "locus of responsibility" is cost effective and prevents people from "falling between the cracks," that always occurs in a system of fragmented services and authority.

In my estimation, Senate Bill 2809 provides for the "single locus of responsibility" that we have been advocating for. I see it as a giant step forward in the improving of current services, securing of new services, and enabling cost effective measures on current services.

I support the Senate Bill 2809 and hope that you are successful in having it become law.

Aloha,

Lambert K. Wai
Chairman

LKW/yl

JUL 27 PM 2:33

GEORGE R. ARIYOSHI
GOVERNOR

STATE OF HAWAII
EXECUTIVE OFFICE ON AGING
OFFICE OF THE GOVERNOR
1149 BETHEL STREET, ROOM 311
HONOLULU, HAWAII 96813

TELEPHONE NO.

August 22, 1980

The Honorable Spark M. Matsunaga
United States Senator
362 Russell Building
Washington, D.C. 20510

Dear Sparky,

RE: S. 2809 Noninstitutional Long-Term Care Services, for the Elderly and Disabled.

I read with great interest and excitement the materials which you recently forwarded to me on S. 2809. You have taken a very bold step in co-sponsoring the introduction of this progressive bill, and without any further delay, I want to assure you of our full support. The need for major reform is clearly evident and we will do all we can locally to assist your efforts at the Congressional level.

My interest and enthusiasm for S. 2809 originates from a variety of sources -- 1) the long involvement I have had in Hawaii's aging programs, more recently the discussions with numerous administrators and service providers regarding the mounting difficulties faced by individuals with long term care needs , and participation at various task force meetings on long term care issues; 2)recent participation in the White House Conference on Families in which fragmented programs/funding/piecemeal legislation, as well as the institutional bias of current legislation, were cited as major issues which need to be resolved before we can deliver the needed services in a more systematic manner; 3) current development of issues for the Governor's 1980 Conference on Aging, Hawaii's culminating event in preparation for the 1981 WHCOA Conference wherein alternatives to long term instituionalization will be a major issue area for discussion; and 4) perhaps most important of all, the numerous contacts I have had with families who are grappling with ways to provide care for their aging parents in their homes or in settings which avoid the traumatic effects of full institutionalization.

AN EQUAL OPPORTUNITY EMPLOYER

In brief, you have really struck the core of our major concerns by addressing these issues in a comprehensive manner. This legislation gives us hope and will set the pace for initiating vitally needed support services to enable the elderly to maintain a maximum level of independence. As an amendment to the Social Sercurity Act, it will be a major milestone in the history of providing humane and relevant services to our elderly and disabled.

With respect to specific items in the bill, I have the following comments:

- Section 2102 (4). Consideration should also be given to provide respite services to unrelated individuals who live together. In particular, these would be the single and isolated elderly who have agreed to live together for puporese of combining resources and providing mutual support. In Hawaii, six group homes for adults with limitations in daily activities have been initiated by Catholic Social Services. There are undoubtedly numerous other such arrangements of shared living among unrelated older persons.

- Section 2103. Individuals eligible for services should also include those elderly whose family members consists of children or other relatives who have also reached age 65. We are witnessing today more of these families where both children and parents are in the upper age brackets. Often both generations are faced with chronic impairments and thus limited in their ability to care for themselves, and for each other.

- Section 2104. The preadmission screening and assessment should also include an assessment of the natural supports available to the individual such as family members/friends who function as care givers. Local efforts which have identified multidisciplinary assessment and care plans as key elements to determining appropriate community-based services are: the Health and Community Services Counci's Long Term Care Task Force Report; the Long-Term Care Channelling Demonstration Proposal submitted to HCFA by the Department of Social Services & Housing (funding for this proposal which includes satellite projects at Kuakini Medical Center and Queens Hospital is pending); the recently established Gerontology Program of the Honolulu Medical Group's Research and Evaluation Foundation which uses trained Senior Citizens to conduct the assessment of clients; and H.B. 2142, Relating to Care, introduced by Representative Byron Baker in the past session of the Hawaii Legislature and currently being re-drafted for introduction in the 1981 Session. S.2809's screening and assessment mechanism will further provide needed direction in this area.

As a final note for now, I suggest, if it has not yet been done, that information on S. 2809 be transmitted to Mr. Jerome Waldie, Executive Director, White House Conference on Aging as soon as possible. It is important that information on this bill be disseminated and incorporated in reports and technical papers on major issues which are in the process of being prepared for the 1981 WHCOA.

Again, it is most re-assuring to know that you have co-sponsored this measure. The complexities involved in securing its passage are undoubtedly great. However, please be assured that we will make every effort on this end to promote and support the passage of this important legislation for 1982.

Sincerely yours,

Shineji Kanazawa
Member, Policy Advisory Board for Elderly Affairs &
State Coordinator, 1981 White House Conference on Aging

Honolulu, Hawaii
August 26, 1980

Dear Sparky:

Sorry to be so informal, but lacking a secretary and not being one myself, you might know how it is for me.

I have reviewed S. 2809 carefully and will refer to page numbers and line numbers for my comments as follows:

P. 3 L. 4 & 5 and further throughout A provides the home health agency with the total authority for the individual's care, under the "plan".

P. 3 L. 10 & 11 Will a "care home" or "boarding home" or "group home for the elderly or the elderly handicapped " be considered the individual's residence?

P. 3 L. 13 "under the supervision of" needs a specific definition.

P. 4 L. 17 thru 19 Transportation is crucial in many instances and also may be too expensive for the individual.

P. 6 L. 19 thru 22 In Hawaii, the Rehabilitation Hospital of the Pacific, Queen's Medical Center, the Straub Clinic and Hospital, Kuakini Hospital and no doubt others are primarily for care on a 24-hr. basis, but each has out-patient services for services listed in (D) (i) of same page.

P. 8 L. 19 thru 22 care again under the supervision of a registered nurse is required. This supervision may be the major cost of much of the program. There does not seem to be any differentiation between which type of nurse is to be used for supervision. Practical, associate degree and full degree as well as advanced degree nurses are all registered.

P. 10 L. 23 thru 25 and P. 11 L. 1 There is need for a definition of "consulted". The physician who knows the individual and may well have cared for him/her for many years is limited in this bill to refer (P. 3 L. 3), be consulted with and kept informed and again consulted before the plan is implemented. In addition, the physician may recommend a qualified service provider. Perhaps the physician, if he/she wishes, might serve on the PAT and be fully involved.

P. 12 (D) Individual may contact a provider from the list provided by PAT, but this seems to be the only right the individual has about his/her future care. I believe they should be fully informed about the plan, if capable of understanding it, and should be asked for their approval.

P. 13 L. 7 thru 25 and P. 14 L. 1 & 2 As this is a medical-social services program I recommend that the lead agency be the agency which has been responsible for the medicare and medicaid services, with a close cooperative relationship with the other agencies related to the care of the individual. Few, if any states have a department on aging and the state agency on aging is usually not directly providing health and social services. This agency should be involved and be kept fully informed on data relating to the program and serve in an advocacy position. Neither the state nor the area agencies on aging have staff equipped to serve as the PAT.

P. 14 L. 4 & 5 If the qualifications of the professionals on the PAT team, except for the physician, are equivalent the plan of care should be written by the person most responsible for the type of care the individual needs and certification of the plan of care should be done as a team effort. Provision should be made for including other health care workers when needed, such as physiatrist, speech therapist and possibly at times a rehabilitation engineer. The individual's personal physician should be encouraged to serve on the PAT. More physician interest and involvement is needed for the elderly and such experiences will provide more serious interest and understanding of gerentology.

In addition, home health and social services care should be based on a holistic approach of caring for the individual's body, mind and spirit. It would be advantageous to request a clergyman or layman of the person's faith (if he/she has one) to share in discussing the plan.

P. 14 L. 6 (A) I would recommend that when possible the nurse should be a clinical nurse specialist who, with a Master's degree, would be on an equal basis as the majority of others of the PAT team.

P. 15 Copayments--Individuals receiving Medicaid have always been provided with everything. For those receiving only Medicare and some with other insurance, find it very difficult to pay for the many extras when they are old and not well and wish to remain in their own home or in the home of a relative. I hope that in the demonstration programs an attempt will be made to determine just how much expense there is which is not covered.

P. 17 Payments of Benefits

If you refer to Pages 7 and 8 regarding the services which should be provided the individual, it is easy to see that the provider should be a full time worker in many instances. There are times when retired nurses, nurses' aides, personal care workers and household workers who wish to work part time might be employed on an individual contract basis which would meet the need of the individual needing the care and also the worker at far less cost than a full time employee.

Our experience in Hawaii has been that most federal grant programs for health care have averaged 21-25% employee benefits plus the agencies' indirect cost for administration. I have been able to get some cost figures for you which may be helpful.

Dept. of Social Services and Housing
Homemaker Services
$840 per month plus 20% fringe benefit ($168.00)
This is beginning salary and employees are trained by the Dept. In addition there is 18.8% indirect charge. They pay minimum wages for chore services.

Dept. of Health

Family Health Services	Public Health Nurses
21.4% fringe benefits	21.4% fringe benefits
Indirect Services	
1979 6.5%	7.5%
1980 5.8%	9.3%

St. Francis Hospital Home Health Services

Registered Nurse	$41.50 per visit
Physicial Therapist	45.00 " "
Occupational Therapist	48.00 " "
Speech Therapist	49.00 " "
Medical Social Worker	54.00 " "
Home Health Aide	33.00 " "

Up John Health Care Services

Registered Nurse	12.70 per hr.
Nurse's Aide	7.10 per hr.
Companion	5.90 per hr.

(Does light housekeeping, shopping, & gets meals)

Amount Caring Staff Actually Receives
Nurse about $7.00 per hr.
Nurse's Aide about $4.00 per hr.
Companion about minimum wage, probably.
This agency was very reticent about giving me information.

This program will increase the staff in every state who no doubt will be union members, or if not they will be soon after the program is started which will result in regular wage and benefit increases.

P. 20 L. 8 This indicates that PAT must be contacted and re-assessment done every time there is a need for any change in services--a costly procedure. The plans should always be flexible for the elderly and elderly disabled, for many are not in a stable condition.

P. 28 L. 1 Example: An individual returns home following surgery for broken hip. The physician prescribes physical therapy. Does this person have to go through the inconvenience of the PAT? If so, this seems like costly, wasted effort. In the past medicare has provided this service and the individual through payment of taxes has been entitled to medicare. Perhaps there is room for some cases to be waived on the physician's request.

P. 30 L. 9 thru 12 The same as above, except for the next to last sentence.

P. 33 L. 15 thru 18 I believe credit for the care of an elderly dependent should be at least the same as for that of a minor child. If the dependent is declared to be infirm or frail by the PAT it might well be even higher.

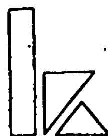
One final recommendation is that some of the demonstration programs should staff their workers from a government employment pool of full and part-time personnel and the others use private agencies and hospital based services, with a careful evaluation mechanism to determine the cost/benefits of each.

Thank you for asking me to share my thoughts with you on this very important legislation. It is an excellent approach. I am working with individuals in a 28 bed care home, in private homes and other long term facilities on a volunteer basis. The experience over the past 6 years has shown me the desirability of maintaining the elderly out of institutions as long as possible. However, it raises some question as to whether it will be a saving from a financial standpoint. I feel certain it will extend the lives of thousands. If this is of help to you, please feel free to use it in any way you wish.

Aloha nui,

Dorothy

Dorothy Devereux
2721 Huapala Street
Honolulu, Hi 96822



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KUAKINI MEDICAL CENTER

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PRESIDENT

MASAICHI TASAKA

August 26, 1980

The Honorable Spark Matsunaga
United States Senator
362 Russell Senate Office Bldg.
Washington, D. C. 20510

Dear Senator Matsunaga:

As you know, Hale Pulama Mau and our proposed Pulama Mau Project to the Health Care Financing Administration (HCFA) emphasizes family and community involvement so that the elderly can live in their environment as long as physically and economically possible. We are aware and experiencing the problem of institutionalization because of the rapidly increasing number of those over 75 years of age. We know that many families have coped and are coping with the care of their elderly parents and relatives with little or no home health services, homemaker, adult day care and respite services. Title XXI will be filling a great gap in services to families so that they can prevent, postpone or delay institutionalization. The amendment is indeed timely and I strongly support the concept of preadmission screening and assessment team.

The emphasis on health and social services for the frail and vulnerable elderly in their homes, be in their natural or surrogate family settings, is the recognition that institutionalization is not only costly but also dehumanizing. Payment for services as proposed in Title XXI will be a significant improvement and will definitely encourage health and social care in the elderly's natural environment.

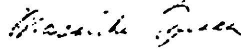
It is my hope that the serious problem of fragmentation of services to the elderly will be resolved organizationally as proposed under Title XXI because caretakers who are either children or relatives are referred to one agency to another -- indeed, a very discouraging daily experience for those who seek and need help.

I believe that the cost of providing health and social services under Title XXI will be higher than most of us in geriatric care would want to accept because of the anticipated increase in numbers of frail and vulnerable elderly. If we are going to be committed to quality of care and life for our elderly, there is no doubt that the cost will be high.

I am very pleased and encouraged with your timely support of S. 2809 and hope that you will be successful in enacting the amendments to the Social Security Act.

Thank you very much for the opportunity to comment on the proposed amendment.

Sincerely yours,



Masaichi Tasaka
President

NATIONAL ASSOCIATION OF SOCIAL WORKERS INC.

'80 SEP 11 PM 1:49

HAWAII CHAPTER • 250 S. VINEYARD STREET • HONOLULU, HAWAII 96813

TESTIMONY REGARDING S 2809
NONINSTITUTIONAL LONG-TERM CARE SERVICES FOR
ELDERLY AND DISABLED ACT

TO: U.S. Senate Committee On Finance

FROM: Kathi Kreinik, Executive Director
National Association of Social Workers, Inc., Hawaii Chapter

DATE: September 3, 1980

We strongly support the passage of S. 2809 to establish a new title XXI under the Social Security Act which would establish a system of noninstitutional long-term care services.

Our society lacks a comprehensive, coordinated system of health and social services for the elderly and chronically ill and currently there are very few viable alternatives to institutional placement. It is clear that the current Medicaid program is biased towards institutional care and many families cannot afford to pay for alternatives. We need an approach that will encourage independence and self-reliance for our seniors and disabled citizens.

The first White House Conference on Families passed many recommendations to advance the quality of family life, several of which focused on home care support alternatives to institutionalization. Further, the cost of institutionalized care keeps increasing dramatically; expansion of home health services should prove to be much more cost-effective as well as provide persons with alternative care that may be more appropriate to meeting their needs.

We are pleased with the concept of a multidisciplinary team of health professionals and social service workers (PAT) to provide comprehensive medical and social assessments, but we are greatly concerned with the qualifications of the "social services worker" (p. 14, line 7). We recommend that the bill be amended to read, "a qualified professional social worker" and that the qualifications for this worker require a minimum of an M.S.W. (Masters of Social Workers) degree from a school accredited by the Council On Social Work Education. Medical social services should include assessment at time of application for services, case management throughout the delivery of services, counseling the patient and family, and discharge planning.

Professional social work education includes case management techniques, interviewing, counseling skills, planning and development and a knowledge base of the psychosocial component of human behavior as well as familiarity with resources. Social workers also have a tradition of going out to people's homes to provide services. There is no equivalent training or experience that prepares a person to understand the multiple needs of patients and their families, or that provides the person with knowledge of the complexities of human services systems and the theoretical concepts underlying them as well as trains the person in assessment, counseling and planning skills.

The key to the success of the entire proposed program lies with the PAT team in the accuracy of their assessment and use of appropriate community resources. It is therefore essential that all members be highly qualified to perform these tasks.

We would also recommend that the bill include a specific section regarding mental health services of seniors and disabled persons and their families. Frequently it is the psychosocial component of a person's illness that, if not properly treated, prevents the successful outcome of other treatments.

In Hawaii, a special long-term care task force was formed by the Health & Community Services Council of Hawaii to study the needs of the elderly and disabled population. A series of meetings were held between June, 1978 and July, 1979 and the top priority that emerged was for the need to establish a well financed system of home based services to prevent unnecessary institutionalization. Specifically, the service gaps identified were for congregrate and sheltered housing, respite services, foster care services, counseling for families with long-term care family members, Red Cross nursing courses, outreach assistance and the development of curriculum and recruitment of trainees to expand the utility of outreach services. The study also called for improvement in transportation services, tax rebates or financial incentives to families and the development of a patients' rights code.

In closing, we would recommend that the state of Hawaii be given serious consideration as one of the ten states selected for the three-year demonstration project for two major reasons: 1) a network of agencies and professionals has already been established by the long-term task force and their study clearly identifies community needs, current resources, and the target population, and 2) several innovative programs have already been recently established, such as independent group homes, sheltered housing, foster homes, senior companion programs, home health care, transportation services, etc., but need funding to be able to continue to provide these services.

Respectfully submttted by,

Kathi Kreinik
Executive Director

HERBERT T. MATAYOSHI
MAYOR

WILLIAM TAKABA
EXECUTIVE ON AGING

COUNTY OF HAWAII
OFFICE OF AGING

September 5, 1980

The Honorable Spark M. Matsunaga
U. S. Senator
United States Senate
362 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Matsunaga:

Subject: S. 2809, Amending the Social Security Act

Thank you for the information on S. 2809, amending the Social Security Act to provide for a program of comprehensive community-based non-institutional long-term care services for the elderly and disabled.

The impact of such a program which encourages less dependence on hospitalization and nursing home care, would indeed be significant. Aside from funds provided through the Older Americans Act, past financial allocations in health care have reflected a predominant thrust towards institutionalization. Enclosed for your information is a copy of my testimony to the joint committee on Health, Housing, and Youth and Elderly Affairs, Hawaii State Legislature, regarding the need to fund programs which serve as alternatives to institutional care.

According to the Director of the Hilo Hospital Home Health Service, "The current Medicare program favors institutionalization of the aged and disabled. For example, its narrow definition of "nursing" prohibits comprehensive care. The proposed S. 2809 will meet some of the needs to maintain people in their communities and be provided the long-term comprehensive care services that are necessary."

Thank you again for the information on S. 2809. We strongly support its passage.

Sincerely yours,

William Takaba
Executive on Aging

WT:yy

Encl.

TESTIMONY BY WILLIAM TAKABA
EXECUTIVE ON AGING
OFFICE OF AGING
COUNTY OF HAWAII

March 14, 1980
Hilo, Hawaii

Representative Herbert A. Segawa
Chairman, Committee on Health

Representative Mitsuo Shito
Chairman, Committee on Housing

Representative James Aki
Chairman, Committee on Youth and Elderly Affairs

I am William Takaba, Director of the Hawaii County Office of Aging. I certainly appreciate having this opportunity to present testimony on the needs and concerns of senior citizens of Hawaii County. Since the high cost of interisland travel limits our personal appearances at the State Legislature, your being here is very important to us.

This morning, my testimony focuses on a growing national as well as local concern, especially among our older people: the need to increase efforts in developing programs which prevent unnecessary institutionalization, and programs which serve as alternatives to institutional care. Such programs would be Adult Day Care Centers, Boarding Homes, Care Homes, Congregate and Group Homes, and services such as Health Screening, Chore, and Transportation.

According to Robert C. Benedict, Commissioner of the Federal Administration on Aging, "Every study of institutional care concludes that up to 1/3 of the elderly in institutional settings might be able to live in the community if alternative supports were available. Hospital costs continue to rise at least in part because of extended stays brought about by the lack of adequate protected living arrangements."

Although many people have used $1,600 per month as the general cost for institutional care, our studies indicate that it is closer to $2,000 per month.

The Hawaii Comprehensive Master Plan for the Elderly (Gordon & Associates, December 1974) further reveals that "Financial allocations in health care reflect a predominant thrust towards institutionalization for the elderly rather than preventive and supportive health care programs designed to keep the elderly in independent living arrangements." On this island, we are particularly concerned with the districts of Kona and Kohala where there are no care homes, boarding homes, or day care centers available for the elderly. Because of this, older residents are often displaced to another community when the need for such a service arises. In research coordinated by the Office of Aging, we found that local ordinances, state regulations, and inadequate financial incentives often discourage potential care or boarding home operators from offering their services. The tourist and agricultural industries have lured these people away. Furthermore, funds to develop day care centers outside of Hilo have simply not been available.

We are pleased to see that various bills have been introduced this year that address some of these problems: House Bill No. 2916-80 establishes the adult family boarding home revolving loan fund to make available, financing to owners of resident units desiring to upgrade their units to satisfy the requirements for licensing as adult family boarding homes; House Bill No. 3049-80 provides $500,000 for supplemental payments to the residents of adult family boarding and care homes who do not come within the levels of care I, II, or III; House Bill No. 2479-80 raises the rates of payment to domiciliary care.

These are important bills not only because of the direct benefits they provide operators but also because they indicate a growing recognition of the value of such facilities by our lawmakers; the Office of Aging supports passage of these bills.

We also support House Bill No. 2794-80 which appropriates funds to expand the Small Group Homes approach to housing elderly persons. When it becomes impractical for senior citizens to live alone, but their physical and mental condition does not warrant institutionalization, Small Group Homes provide a needed alternative. It is far less expensive and more beneficial to the older person. Senate Bill No. 2172-80 is equally important in that it amends Chapter 346 in order to facilitate the receipt of federal housing supplements under the Section 8 Housing Assistance Payments program by the elderly, handicapped, or disabled individuals who live in an independent group residence.

The provision of adequate supportive social services to the elderly is also necessary in our efforts to reduce the need for premature institutionalization. Health Screening, Chore, Transportation, and Escort are all very essential services which support the elderly who can and choose to remain at home. We are concerned that the State has not funded a statewide health screening program for the elderly and that transportation and chore services through Title XX and the State has not been funded at an adequate level of maintenance. Finally, although we notice once again that through House Bill No. 2352-80 and Senate Bill No. 2803-80 funds will be appropriated for transportation to the elderly, disabled, handicapped, and disadvantaged

including preschool children. An assessment must be made, however on the amounts actually released, and how much was used for the elderly.

The task of developing a comprehensive alternative care system is of course, no simple matter. Adequate incentives and assistance must be offered to those interested in furnishing these services, and existing regulations must be eased where appropriate. As we continue our efforts to obtain a new Hilo hospital, we must remember that any hospital can only be beneficial to the extent that people who need the services can receive as well as afford it, and those that don't belong in hospitals can depend on less costly alternative arrangements within their communities.

Thank you once again for the opportunity to present testimony on behalf of the Hawaii County Office of Aging.

RICHARD S H WONG
PRESIDENT

DUKE T KAWASAKI
VICE PRESIDENT

JOSEPH T KURODA
MAJORITY LEADER

ANSON CHONG
GEORGE H TOYOFUKU
ASSISTANT MAJORITY LEADERS

NORMAN MIZUGUCHI
MAJORITY FLOOR LEADER

DANTE K CARPENTER
MAMORU YAMASAKI
PATSY K YOUNG
ASST MAJORITY FLOOR LEADERS

CHARLES M CAMPBELL
MAJORITY POLICY LEADER

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PATRICIA SAIKI
W. BUDDY SOARES

EIGHTH DISTRICT
GEORGE H. TOYOFUKU

The Senate
The Tenth Legislature
of the
State of Hawaii

HONOLULU, HAWAII

September 2, 1980

The Honorable Russell Long
Chairman, Finance Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman and Honorable Members of the Finance Committee:

I am Senator Dante K. Carpenter, Chairman of the Hawaii State Senate Health Committee. It is with great pleasure that I submit this testimony in support of S. 2809, "To amend the Social Security Act to provide for a program of comprehensive community-based noninstitutional long-term care services for the elderly and the disabled."

As Chairman of the Hawaii State Senate Health Committee, I am familiar with the need by persons, who are elderly and disabled, for alternative medical and social services. In the past, Hawaii has sought to find alternatives that would be 1) more cost-effective than institutionalization, and 2) to enable a person to live an independent and nearly as normal life. I have heard testimonies

requesting that services be provided to assist patients who can function at home, if these services are provided, and to prevent institutionalization. In Hawaii, like other states, we have patients in institutions who do not need such services, but they are there because no alternatives are available. We are currently in the process of looking at alternatives to long-term care, where medical and social services are available to the elderly and disabled in a home or day hospital setting. Presently, Hawaii does provide nursing services, homemaker chore services, and senior companion services to those elderly in a low-income bracket. These services are limited to a few, usually on Medicaid. I would like to see more home health services and day hospital services established, so more of our elderly and disabled may remain at home, whenever medically feasible. I am also in favor of this bill because it will enable more people to receive such services who are on a fixed income, but who do not qualify for low-income services. This will prevent this group of people from becoming totally dependent upon the federal and state governments in later years, and it will also prevent incomes from being

totally eroded by unnecessary institutionalization.

It will take time and money to establish more services and convert or establish facilities to serve this group of people. In conjunction with this thought, may I suggest that S. 2809 include an appropriation amount to assist those states in need of establishing such facilities and services outlined in this bill.

I would also like to recommend that S. 2809 include a provision to serve eligible recipients under emergency situations. As an example, under this bill all recipients will undergo a PAT. This PAT will assess each recipient under normal conditions. A recipient may be assessed to need only personal care services or adult day services and not respite care. But, what would happen to the recipient if normal conditions were to be altered suddenly? What would happen if the recipient's family member who normally cared for him/her were to be hospitalized? Then the recipient would need respite care. Is there any provision in this bill that would be able to attend immediately to the recipient's em[illegible] needs? Immediately is defined to be within [illegible]ur hour period on a 24-hour

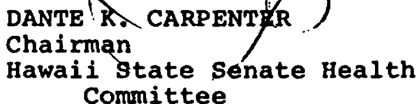
basis.

I sincerely believe that avoiding institutionalization is a step in curbing the high cost of medical bills, as well as humanely enabling people to remain with their loved ones, as long as possible.

I also believe this bill will encourage deinstitutionalization rather than the reverse, which is the prevailing concept. Unlike most bills, that add new services and a new accounting system, this bill diverts the money that would have gone to institutionalization and double accounting is averted.

Thank you for this opportunity to testify before your committee and I urge quick and speedy passage of S. 2809.

Respectfully submitted,



DANTE K. CARPENTER
Chairman
Hawaii State Senate Health Committee

DKC:sb

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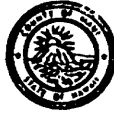
HANNIBAL TAVARES
Mayor
TELEPHONE 244-7855



OFFICE OF THE MAYOR
COUNTY OF MAUI
WAILUKU, MAUI, HAWAII 96793

September 8, 1980

Honorable Spark M. Matsunaga
United States Senator
362 Russell Building
Washington, D. C. 20510

Dear Senator Matsunaga:

Thank you for forwarding us a copy of Bill S.2809 of the 96th Congress, 2nd Session, relative to Non-institutional Long-Term Care Services for the Elderly and the Disabled.

We have reviewed the subject Bill, and find the provisos of said Bill to be highly beneficial for its intended target populations, the elderly and the disabled.

The County of Maui endorses the concept of Bill S.2809, and thanks you in advance for your concern and efforts in behalf of the elderly and disabled of Maui County and the State of Hawaii.

Sincerely,

Hannibal Tavares

HANNIBAL TAVARES
Mayor, County of Maui

HT:lm

GEORGE R. ARIYOSHI
GOVERNOR

RENJI GOTO
DIRECTOR

TELEPHONE NO.
[illegible]

STATE OF HAWAII
EXECUTIVE OFFICE ON AGING
OFFICE OF THE GOVERNOR
1149 BETHEL STREET, ROOM 307
HONOLULU, HAWAII 96813

September 10, 1980

The Honorable Spark M. Matsunaga
United States Senate
362 Russell Bldg.
Washington, D. C. 20510

Dear Senator Matsunaga:

The Executive Office on Aging was pleased to have an opportunity to review S. 2809 which we received from your office. As you know, the development of noninstitutional long term care services in Hawaii has long been an interest of mine.

The bill represents an extraordinarily comprehensive approach to community based care for the elderly and disabled and would be eagerly received in our State. The need for homemaker services and day care is a constant topic of discussion among those of us who are planning and coordianting programs for the elderly. Only yesterday we received a request from Molokai requesting assistance in setting up a Day Care program. As always, there is no payment source other than Title XX for those unable to pay privately although most of the prospective participants are eligible for Title XIX.

The Executive Office on Aging commends your efforts to advocate in behalf of the elderly. In discussing the merits of the bill with interested members of our community and Dr. Satoru Izutsu of our Policy Advisory Board, several points were raised:

1. Regarding the PAT, there is some concern as to whether the physician should be the team "leader" rather than just a member of the assessment. Two immediate deterrents would be the high cost of maintaining a physician in this supervisory capacity and the difficulty recruiting for such a person. Particularly since geriatricians are in short supply everywhere.

2. The tax credit eligibility discussed on page 33, Sec. 44D (a), should conform to allowable expenses for child care which permits the deduction of a percentage of total expenses with an upper limit on the amount that can be deducted.

Thank you for the opportunity to comment on this much needed legislation. Please let us know if we can be of further assistance.

Sincerely,

Renji Goto
Director

ET:rs

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

EXECUTIVE COUNCIL
LANE KIRKLAND
PRESIDENT
THOMAS R. DONAHUE
SECRETARY-TREASURER

815 SIXTEENTH STREET, N.W.
WASHINGTON, D.C. 20006
(202) 637-5000

August 18, 1980

Honorable Herman E. Talmadge, Chairman
Subcommittee on Health
Committee on Finance
United States Senate
Washington, D. C.

Dear Mr. Chairman:

The AFL-CIO strongly supports S. 2809, the Comprehensive Based Noninstitutional Long-Term Care for the Elderly and Disabled Act.

Home health services have great promise to change present reliance on institutionalization of aged and disabled patients and thereby reduce the overall cost of health care. More than that, they could build a community oriented system of service to individuals in their own homes. They could become a major element in an overall strategy of preventive health care.

To date, however, home care programs have many problems. The most serious is that they are underfunded and the financing of home care is fragmented between Medicare, Medicaid and Title XX social services. Other problems are that there are few organized systems to effect patient entry to home care. There is a lack of coordination with other health and social service programs. Different and often conflicting eligibility criteria make it almost impossible to piece together a total home care package to suit the needs of the individual patient. There is little program monitoring, a lack of emphasis on the preventive aspects of home care, an absence of professional standards and a vague and undefined role for family members.

Enactment of S. 2809 would go a long way in resolving these problems. We, therefore, urge enactment of the bill at the earliest feasible time.

Sincerely yours,

Ray Denison, Director
Department of Legislation

cc: Michael Stern

1156 15TH STREET · N.W. WASHINGTON, D.C. 20005 · TEL. 202 466-2070

AMERICAN
PHYSICAL THERAPY
ASSOCIATION

STATEMENT OF THE AMERICAN PHYSICAL
THERAPY ASSOCIATION

S. 2809

The APTA commends Senator Packwood and his cosponsors for their efforts to confront the serious problem of the failure of our health care delivery system to offer adequate non-institutional long-term care services to the elderly and disabled. S. 2809 contains several good ideas, notably the preadmission screening and assessment, but needs substantial reworking.

S. 2809 would create a new title under the Social Security Act to provide services to the elderly and disabled that are not covered under Title XVIII. One of the difficulties with dealing with Title XVIII at present is the overlapping between Part A and Part B. Rather than create a separate overlapping title, it seems more practical to expand Part B of Title XVIII.

S. 2809 requires that a beneficiary undergo a preadmission screening and assessment before home health services (Title XVIII) are reimbursable. It is unclear from the present state of S. 2809 what, if any, effect it would have on the reimbursable services provided by independently practicing practitioners under Title XVIII.

The APTA reads the proposed Section 2106 Payment of Benefits with much trepidation. Aside from our belief that fee schedules are inappropriate for professional services, we are convinced that the Health Care Financing Administration has been incapable of fairly and competently administering such a system. Independently practicing physical therapists who provide services to Medicare beneficiaries under arrangement with providers are covered by a reimbursement procedure commonly called salary equivalency. This procedure reimburses these providers for physical therapy services under guidelines that are supposed to equate the costs of the services to the cost of the same services if provided by the provider using salaried personnel. Presently the reimbursement guidelines are based on 1975 data updated in October 1978 using an inflation factor derived in April 1978. Thus, providers are being reimbursed in August 1980 based on economic conditions which existed

2½ years ago. Indicators from other branches of government show that inflation has caused the costs of most services to increase in the last 2½ years. In fact, it would be difficult to point to any other group of workers who have not had any compensation increase in 2½ years.

If the reimbursement structure of S. 2809 is implemented, it must be amended to instruct HCFA to annually update the fee schedules. If the schedules are not updated annually, then services provided should be reimbursed on a usual, customary, and reasonable basis until such a time as the fee schedules are updated.

It is unclear from Section 2104(d)(1) whether reimbursement for the Preadmission Assessment Team shall be governed by the fee schedules or by a separately negotiated rate. In any case, developing a system of negotiation but giving one of the parties authority to make the final decision if negotiations stall is unreasonable. Only one party would have any incentive to negotiate in good faith.

The APTA looks forward to working with the subcommittee in the future to solve the problems addressed by S. 2809. If we can be of any assistance, please call on us. Thank you for the opportunity to comment on this legislation.

Testimony of

Barbara B. Blum

Commissioner

New York State Department of Social Services

Development of a long term care system capable of appropriately and adequately serving the needs of the growing numbers of elderly and disabled during a period of increasing fiscal constraint is a challenge which must be met during the next decade. Hope of meeting this challenge rests, to a large extent, upon our ability to expand home care and community-based service options thereby restoring balance to the present institutionally focused system. It is critical, if this goal is to be achieved, that the utmost attention be paid to the ability of proposals to serve the needs of the long term care population most effectively.

To meet these needs attention must be focused on the total context of the individual, the family unit and the community. The ability to maintain people in the community must bring together a broad mix of services including financial assistance, adequate housing, health care and support services to the family unit. These services must be provided with appropriate assessments and plans of care and an adequate system of financing. In all of these areas, the basic goal must be to reinforce the strength of the family unit and to use most effectively existing resources in the community.

It is important therefore, that concerted efforts be made to insure inclusion in any proposal of features such as required comprehensive assessments, formalized plans of care, case management, incentives and support for families caring for relatives at home and general enrichment of non-medical support services. It is equally important that a maximum degree of program flexibility and state administrative authority be preserved if community-based care is to be responsive to diverse regional needs.

Examination of proposals designed to improve the long term care system must be built upon a foundation of clear definition of the population to be served and understanding of the needs of that population. Addressing these needs in the most efficient and economical way must remain central to analyses of legislative alternatives. Finally, thought must be given to the most effective means of reinforcing weakened traditional networks of support.

The development of S.2809 is an important step toward focusing public discussion on these important issues. It is important, however, that enthusiasm for the basic intent underlying development of the new title not allow a less than thorough examination of the proposal's ability to ensure that the long term care needs of the elderly and disabled are adequately provided for in the years to come.

Any discussion of the future of the long term care system must begin with an acknowledgement of an expanding service population. Both the number and proportion of elderly people in our society are growing rapidly. The number of Americans 65 and older increased from 4 million in 1900 to 24 million in 1979. By the year 2030, it is projected that there will be 55 million elderly, more than twice as many as today.

The effect of these shifts in the population upon the long term care system will be accentuated by changes in the characteristics of the elderly population. Among the elderly, 38 percent are 75 and over and more than nine percent are 85 and over. By the year 2000, 45 percent of the elderly will be in the 75 and over category. Thus, there are rising numbers of older and frail elderly and striking increases in the number of older persons living along.

This older more dependent elderly population can rely less readily on the support traditionally offered by family, friends and community. Increased mobility and changes in family relationships aggravated by the high cost of caring for relatives at home, have created an elderly population with few support resources.

The costs of institutional long term care have also reflected the increasing demands of this growing population. The total costs of providing care in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF) have nearly doubled in New York over the last five years. In 1975, SNF expenditures totaled $865 million. By 1979, this figure had risen to over $1 billion. ICF expenditures over the same period rose from $116 million to $246 million. New York must now face the need for from 8,000 - 12,000 additional long term care beds by 1990 at an estimated cost of up to $280 million. These costs become even more staggering when consideration is given to the cost of maintaining a growing number of people in acute care hospital beds due to the increased scarcity of suitable long term care placements.

Recent efforts to reduce unnecessary institutional placement and resulting high health care costs have created additional complex problems. As a result, many elderly and non elderly disabled have been returned to the community without adequate prior planning for their ongoing needs. This has created a greatly increased burden upon a limited community-based service system.

While the costs of providing care for the expanding long term care population in institutions already strains the capacity of health care programs, few attempts have been made to limit such expenditures through expansion of community-based care. Such efforts are, in fact, constrained by current federal program and funding structures.

There are a total of four federal titles which provide reimbursement for long term care services for the elderly and disabled. Title XVII (Medicare), Title XIX (Medicaid) and Title XX of the Social Security Act and Title III of the Older Americans Act. Title XIX and especially Title XVIII are limited programmatically to the provision of medically necessary services and are more readily accessible for the funding of institutional care. Title III, though a potential source of funding for community-based support services, is not targeted at low income elderly and disabled with long term care needs. Title XX,an extremely flexible source of non-medical support services, is also a very limited one, and, therefore, is most often used for other purposes.

The impact of these funding constraints is intensified by policies which prohibit reimbursement for families caring for elderly and disabled relatives at home and the lack of such support services as transportation, homemaker/housekeeper or occasional day care. Many families, willing to care for relatives at home, are forced by the absence of such support services to seek institutional placements.

Creation of a Title XXI has several apparent advantages. A new title would draw attention to the frequently ignored needs of the adult long term care population. It would also provide a vehicle for consolidation and expansion of reimbursable services and might allow for an integrated program of medical and non-medical support services currently difficult to arrange. A new title could also expand eligibility beyond the limitations of the Title XIX population.

Along with these advantages, however, there are potential disadvantages to the creation of a new title which must be acknowledged. Establishment of a new title, with its own peculiar requirements, standards and definitions would be a continuation of the trend toward categorical funding, a trend

which could ultimately lead to reduced flexibility and corresponding reductions in program responsiveness. A new title, given the current economic climate, would also be vulnerable to expenditure caps and might, in the final analysis, result in less federal funding available to states for provision of long term care. An additional consequence of a new title might be to increase competition among service groups for limited available resources. All of these considerations deserve serious consideration before a new title is created.

In addition to this basic issue, a number of concerns, germaine to any proposal designed to expand non-institutional care,must be addressed.

In terms of the scope of benefits, the expansion of reimbursable services and the inclusion of such services as homemaker/home health aide, respite care and adult day care in a service package is a positive statement. The proposal does not, however, include case management among reimbursable services. In light of the fragmented 'system' of adult care services in the community, failure to provide for case management must be considered a major deficiency. Transportation, a service vital to the frail elderly and others receiving care at home, is also too narrowly defined in the proposal.

Concern must also be expressed about overly restrictive definitions of adult day services and respite services. Specification of the number of permissable days of respite care, for example, is a matter more appropriately dealt with in state regulation than in statute. More flexible definition of these services is needed.

Another area in which S.2809 moves in the direction of a more complete system of long term care services is program eligibility. Though these sections require clarification, they appear to expand eligibility beyond the Title XIX eligible population. The proposal, however, fails to address

the issue raised by different eligibility criteria and policies for client financial participation for Title III benefits. In addition, continued eligibility for benefits under Title III, Title XIX and Title XX is unclear. The relationship of all titles must be examined carefully and a rational, coordinated approach developed.

S.2809 contains detailed discussion of assessment procedures required under Title XXI and other titles. Required comprehensive assessments and development of a formal plan of care, both vital to a community-based system, are specifically discussed. The important principle of reimbursement for the costs of assessment is also clearly provided although regional rather than statewide rates might prove a more effective means of ensuring a responsive program.

Examination of the proposed preadmission screening and assessment teams (PATs), however, reveals a number of serious difficulties. The organization of PATs, required supervision by a physician, mandatory inclusion of a registered nurse or nurse practioner, and a physical therapist,and the exclusion of home health care workers,implies a continuation of the present medical provider orientation of long term care services. Such an approach may be neither necessary nor cost effective. A more flexible approach along with appropriate utilization review should be encouraged.

Despite this medical orientation there is no discussion of the relationship between PATs and the recipient's own physician which is of particular importance over time. Nor is there discussion of the ongoing role of PATs in insuring appropriate service provision. The proposal also fails to establish links with either social service agencies or the mental health system. Failure to include a mental health component is a serious deficiency of the proposal. Appropriate linkages to the mental

health system are essential for many elderly in need of psychiatric services and emotional support in addition to provision for their physical needs.

Perhaps most importantly, the assessment procedure defined in S.2809 is dependent upon the existence of a home care delivery system which simply does not exist. Without case management there is little chance that people in need of care will be able to negotiate a service package in keeping with the plan designed by the PAT. Rather than assemblying a team of professionals with expertise in areas which may or may not relate to an individual recipient's needs, a single case manager could be assigned who would arrange for a comprehensive assessment by appropriate professionals, determine family resources and needs, secure required services and review the progress of the recipient. In general, the preferable approach would be to require that states develop and submit for approval, statewide assessment plans responsive to their problems and needs.

Several financing issues implicit in Title XXI must also be addressed. It is important to emphasize that an appropriate financing structure must assure increased federal participation in the financing of non medical, non institutional care. This will not be realized through a simple shifting of resources from one title to another. In addition, it is essential that such funding not result in inequitable redistribution of resources among states.

Requiring that recipients and their families contribute to the cost of care may, in some instances, be an appropriate part of efforts to tap traditional supports. The system of copayments suggested in S.2809, is, however, too narrow a treatment of this issue. Such mechanisms as expanded tax incentives must be used to encourage families to take an active and

supportive role in the maintenance of the elderly and disabled at home. Though S.2809 begins to move away from the current disincentives to family care, a more complete exploration of ways to maximize family involvement must be undertaken. New York would welcome the opportunity to participate in a national effort to explore this issue.

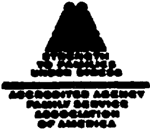
Another concern related to the structure of financing in Title XXI is rate setting. Existing practice and relationships between the states and the federal government in this area should be maintained.

The last section of the bill discusses the structure of Title XXI demonstration projects. The provision that non-demonstration project states adhere to Title XVIII standards for provision of long term care is a potential source of difficulties. Care must be exercised to assure that standards no stricter than existing standards are applied.

In conclusion, the New York State Department of Social Services strongly supports the goal of expanded community based services implicit is S.2809. Such features of the proposal as the requirement of comprehensive needs assessment, mandatory development of individualized plans of care and enrichment of available non-medical supports are all essential to the development of a non-institutional care system. Of special importance is the focus on supportive services for families caring for elderly and disabled persons at home.

There are, however, a number of issues which must be addressed. Failure to provide reimbursement for case management services and to incorporate case management into the assessment procedures is a major concern as is the financing of the title itself. Issues of state authority and potential loss of program flexibility must also be examined.

Finally, it must be acknowledge that a well developed system of community based services does not yet exist. The development of this system and of appropriate mechanisms to link the individual to needed services remains an important challenge and will be accomplished only through maximum coordination of all health and social service programs. Meeting this challenge will require commitment of resources, careful experimentation and full examination of proposals for change. Discussion of S.2809 is an important part of this process.



HOME AIDE SERVICE
FAMILY SERVICE OF BUTLER COUNTY
111 Buckeye Street • Hamilton, Ohio 45011 • Phone 868-9222

IRMA SANDAGE, ACSW
Executive Director

PAT MOLONEY
Project Director

COMMENTS ON TITLE XXI - SOCIAL SECURITY ACT

Those of us in the field of long-term community based care heartily applaud the efforts toward development of a comprehensive system of noninstitutional chronic care for the elderly. Such a system is long overdue.

S.2809 is a good beginning. There are several areas about which we would like to comment:

A. Assessment

1) The pre-admission screening assessment team is to determine need for services, taking into consideration health, social and environmental factors, but those who may be designated as PATs come only from the health field. Our experience indicates that those designated as potential PATs have very limited experience, knowledge or education in assessing social and environmental needs.

2) The Professional Assessment Teams might provide a valuable entry into the system by determining the level of care needed and referring to the proper service provider. As the bill now stands, all professional responsibility lies in their hands, thus creating an entire new level of bureaucracy and stripping provider agencies all of decision and control. VERY FEW AGENCIES WOULD CONTINUE TO PROVIDE SERVICES WITHOUT THIS ELEMENT. THOSE WHO DID CONTINUE TO PROVIDE SERVICES WOULD BE LITTLE MORE THAN EMPLOYMENT AGENCIES LEADING INEVITABLY TO LOWER QUALITY AND LESS SERVICE.

Supported By United Way of Hamilton, Fairfield & Vicinity & of Oxford, Also Supported by A Title XV Contract With the Butler County Department of Welfare And Aid for Independent Living Money From The Ohio Commission On Aging.

3) It is specified that assessments shall be made by "trained" personnel. The word "trained can mean anything from a highly skilled professional to someone who has had a one day workshop, unless it is further defined. We would like to suggest substitution of the word "professional" for "trained" with some indication of the fields the professional should represent, such as nursing, rehabilitation, home economics, psychology, or social work.

B. Standards

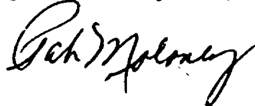
1) Standards are left up to the individual states. In theory this may sound like self-determination, state rights etc. In reality, very few states have adequately enforced standards in the field of home care up to now.

2) The field of home care allows for a great deal more opportunity for abuse and fraud than we see in the area of institutional care. It is essential that standards be a part of the system from the very beginning with monitoring and evaluation an integral part of the delivery system. This is absolutely essential for the protection of the client as well as the taxpayer.

C. Family

No place is there any mention of the role of family in the long-term care of their elderly members. It would be a tremendous mistake for agencies to take over the role entirely of either assessment of need or provision of services. Many families are quite willing and capable of providing both if they have some financial and moral support to know that they are doing the "right thing".

Prepared By: Pat Moloney, Project Director



NATIONAL HOMECARING COUNCIL
(FORMERLY)

NATIONAL COUNCIL
for Homemaker-Home Health Aide Services, Inc.
A non-profit national standard-setting organization

67 Irving Place, New York, N.Y. 10003 (212) 674-4990

September 10, 1980

Mr. Michael Stern, Staff Director
Senate Committee on Finance
Room 2227 Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Stern:

The National HomeCaring Council, formerly the National Council for Homemaker-Home Health Aide Services, Inc., hereby submits comments to you on S.2809, the "Noninstitutional Long-Term Care Services for the Elderly and Disabled Act."

Membership

The National Council is comprised of 610 dues-paying members and associates, of which 255 are agencies providing homemaker-home health aide services in 45 states and in several Canadian provinces; 48 are organizations; and 307 are individuals (1979 year-end figures). Programs from all auspices - voluntary nonprofit, public, and proprietary - are included in the Council's membership. Written and visual materials, conferences, and other services are available to and used by many organizations, including nonmember agencies providing homemaker-home health aide services in the United States and Canada.

General Comments

The National Council would like to congratulate the sponsors of this landmark legislation: Senators Packwood, Bradley, Nelson, Heinz, Matsunaga, Cohen, Cochran, Javitz, and Williams. If enacted, S.2809 would take giant strides toward expanding home care options for persons with long-term needs whil eliminating administrative fragmentation and duplication at the federal level.

The Council has long maintained that such a comprehensive, coordinated system must be forged to weld the disparate funding sources for in-home care. As early as 1975, the Council has gone on record to

OFFICERS
President: Mrs Robert O. Bonnell, Jr., Baltimore, MD
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Executive Director: Mrs. Florence Moore

advocate legislation which would provide comprehensive homemaker-home health aide services to meet both immediate crises and long-term needs for all individuals and families who require such care, including the very young and very old. (See Appendix A.) S.2809 proposes a model which is broader than the Council's envisioned model in some areas, but narrower in others. The following are some concerns which the Council has identified in S.2809.

Section 2102 - Scope of Benefits

The legislation authorizes comprehensively-defined homemaker-home health aide services as one of four designated in-home services. The National Council would like to support use of this comprehensive definition, which recognizes the need for both personal care and environmental assistance in maintaining elderly and disabled persons adequately in a home setting.

However, unlike the "home health" services agency, which must be "certified or licensed by the state," the homemaker-home health aide service provider would be left free to operate in a buyer beware market. The National Council urges that delivery of homemaker-home health aide services be authorized solely by agencies meeting basic national standards for these services, such as those set by the National HomeCaring Council. (See Appendix B.)

It is critical that consumers of homemaker-home health aide services be protected by such safeguards as professional supervision of the paraprofessional homemaker-home health aide, professional case assessment to ascertain what services are needed, plan of care determination, and ongoing case reassessment as changing client needs dictate. The Council believes all of these functions to be the appropriate responsibility of the provider agency and urges that standards be mandated to insure their adherence.

Equally important to insure good quality homemaker-home health aide service delivery are standards of training for the paraprofessional homemaker-home health aide. The Department of Health and Human Services should require all aides to complete an approved program of training in a variety of areas, including personal care tasks, environmental assistance, nutrition and diet, and the like. We strongly urge the Department to endorse for this purpose a comprehensive training curriculum1/ which was developed recently by the National HomeCaring Council, in cooperation with the American Red Cross, the American Home Economics Association, the National League for Nursing and other national agencies, voluntary and governmental, under a grant from HHS' Public Health Service. This HHS curriculum should be recognized not only under Title XXI law but also under all other Titles of Federal law which authorize the delivery of home care services.

As a necessary corollary to sound standards, an effective monitoring system must

1/ Public Health Service, D/HEW. A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide.

be required. The Department should mandate states to develop monitoring units which are responsible for determining not only an agency's adherence to standards of good practice, but also its fiscal integrity. The home care field has already been the object of fraud and abuse by unscrupulous entrepreneurs, phenomena which have been well documented by Congressional committees.[2]

One appalling finding of the Senate Special Committee on Aging was that certain fraudulent providers were involved in home care contracts under Titles XVIII, XIX, and XX simultaneously, using the different loopholes in each program to their personal aggrandizement. Suspension of a provider from one program provided no insurance that he would not resurface in another program or in another state. The National HomeCaring Council hopes that, at the very least, the administrative coordination inherent in Title XXI - coupled with a strong standards and monitoring component - will prevent the kind of fraud and abuse the field has witnessed in the past.

Section 2103 - Eligibility for Benefits

The National Council realizes that this legislation is specifically targeted to elderly and disabled individuals who require noninstitutional long-term care. However, we believe it contrary to the comprehensive focus of the bill to exclude families with children in cases where they, too, require long-term care. Protective services situations - for example, cases wherein real or potential abuse has been identified - exist among both elderly populations and among families with young children. To reimburse one group through Title XXI and the other through Title XX is to perpetuate the fragmentation and administrative chaos which characterize our home care system today.

Moreover, aging groups are increasingly calling for age-integrated policies and programs, and this bill should not fall into a categorical mold which places a stigma on the service recipient. Similarly, Title XXI should be open to persons of all economic strata, with fee structures determined accordingly, so that private-pay clients do not find themselves in a separate "buyer beware" market when they seek in-home care.

Section 2104 - Preadmission Screening and Assessment

(b)(1): The bill currently authorizes PAT services for all eligible individuals

2/ U.S. Senate/Special Committee on Aging (in cooperation with U.S. House of Representatives Ways and Means Committee, Subcommittee on Health and Oversight). Medicare and Medicaid Frauds, Parts 8 and 9. Washington, DC: U.S. Government Printing Office, 1977.

who are referred by a physician or by a social or health organization. The Council recommends that self-referrals also be permitted. For individuals who do not have a private physician to refer them, the self-referral option will eliminate unnecessary and costly bureaucratic overhead.

(b)(1)ABC: Although the Council believes that "an initial screening to determine the need for and appropriateness of any long-term care" is an appropriate responsibility of the PAT, preparation of a plan of care and ongoing case assessment are viewed as inappropriate PAT responsibilities. In the first place, a good home care provider offers a comprehensive team service which includes as part of its professional package case assessment to ascertain the specific services required, plan of care determination, and case reassessment. Were it not to provide such holistic care, the provider agency would function merely as a "registry," supplying workers on demand with no control over the parameters of the job. Secondly, assuming that the provider agency were liable for the paraprofessional homemaker-home health aides, there are major legal as well as professional problems inherent in supervising a worker whose tasks have been determined by an outside unit.

Finally, the National Council does not believe that a centralized PAT structure could be responsive to changing client needs (the reassessment component) in the same way that a provider agency could. Elderly and disabled persons often require dramatic changes in the plan of care over a period of time, and the Council does not see the need for the time-consuming bureaucratic intervention of a PAT in this process.

(b)(1)(D,E): The PAT is authorized to supply "a list of all providers of services in the area who are qualified to provide services under this Title..." Because the term "qualified" is not defined, the PAT is essentially given the latitude to refer vulnerable consumers to agencies which may or may not provide adequate care. The Council advises that PATs refer only to homemaker-home health aide agencies which have demonstrated conformity (i.e., approved or accredited status) with recognized standards of national organizations such as the National HomeCaring Council.

General Comments: It is unclear who is to perform eligibility determinations for Title XXI clients. If PATs are to assume that responsibility, which appears to be a logical role for them, it should be so stated in this section.

(c)(1): The state-level agencies who are named to designate statewide PATs do not include a department of social services. This seems incomprehensible in light of the comprehensive, social and health focus of S.2809. Similarly, the list of organizations which may be designated as PATs reflects a strong health bias. At the very least, social services units should be listed as potential PATs.

The Council is extremely concerned about this component of the bill because it implies continued reliance upon a medical model to deal with comprehensive, long-term care problems. Without social service involvement, the use of health professionals will perpetuate an acute care system which is not consonant with the long-term, chronic care needs of the eligible consumer population. The Council would be pleased to offer guidance in shifting the focus to one which is truly comprehensive in scope.

Section 2112 - Administrative Provisions

This bill does not clarify how acute care cases will fit into this new system, if at all. It is not clear whether the more immediate needs of such persons could be met through the process set forth in S.2809, primarily because the bureaucratic intervention of the PAT probably would delay service initiation.

Conclusion

In closing, the National HomeCaring Council would like to thank the Senate Finance Committee for its attention to these comments on S.2809. We feel strongly that the time has never been more crucial for a coordinated, comprehensive home care program in this nation to meet the long-term care needs of the elderly, disabled and families with children. We hope that you will call upon us to work with you as you continue to forge strong and effective legislation to accomplish this goal.

Sincerely,

(Mrs.) Florence Moore
Executive Director

FM:g
enclosures

NATIONAL COUNCIL
for Homemaker-Home Health Aide Services, Inc.
67 Irving Place · 6th Floor · New York, N.Y. 10003 · (212) 674-4990

APPENDIX A

Revised Draft
1/31/75

A BILL

To provide for homemaker-home health aide services to all individuals and families in need of such care

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Comprehensive Homemaker-Home Health Aide Services Act of 1975."

Sec. 1 Title XI of the Social Security Act is amended by adding the following new sections:

FINDINGS AND PURPOSE

Sec. 1140. (a) The Congress finds that--

(1) Many individuals and families in the United States need homemaker-home health aide services at some time in their lives for a temporary or extended period when their home life is disrupted by illness, disability or social disadvantage, or when the family (or individuals within the family or individuals living alone) are in danger of physical, social or emotional breakdown because of disorganization or stress with which they are unable to cope effectively, or when a family or individual needs help to gain or maintain self-sufficiency;

(2) homemaker-home health aide services meet both immediate crises and long-term needs and help to prevent family breakdown and to maintain individuals and families in their own homes. They are an adjunct to other preventive, rehabilitative, and treatment services and prevent or reduce inappropriate institutional care;

(3) most persons, including the very young and the very old, prefer and should have the right to choose to remain in their own homes when suffering from illness or disability or to be enabled to return to their own homes as quickly as possible after specialized out-of-home treatment;

(4) Care in the home, through the services of a well-trained and competently-supervised homemaker-home health aide, is usually more economical, and more beneficial to the person than maintaining that person in a foster home, an institution or a hospital;

(5) such care in the home should be available to all individuals and families who need it, through: both public and private insurance programs and health maintenance organizations; programs to aid the financially needy; and payment by those who are able to pay part or all of the cost of such care;

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(6) many individuals and families can be helped to improve their level of functioning and self-sufficiency through the teaching programs of homemaker-home health aide services;

(7) all individuals and families who need homemaker-home health aide services should have such services available promptly and of assured quality in the community where they live;

(8) employment as homemaker-home health aides offers satisfying employment and career opportunities to persons who might otherwise need or continue to need public support.

(b) It is the purpose of the Act to--

(1) provide for the development of homemaker-home health aide programs adequate to serve all who need such care;

(2) provide for homemaker-home health aide services in sufficient quantity on a State-wide basis on all political subdivisions;

(3) prevent unnecessary care of individuals in foster homes, institutions or hospitals;

(4) provide for basic standards essential to quality care and the enforcement thereof;

(5) provide training in the home which will make it possible for individuals and families to remain in their own homes and to become as self-sufficient as their capabilities permit.

DEFINITIONS

Sec. 1141. For purposes of this Act--

(a) The term "homemaker-home health aide service" means the care and services provided in the home to an individual or family whose home life is disrupted by illness, disability, social disadvantage or other problems or when a family or individual needs help to gain or maintain independent functioning and self-sufficiency. Individual services to be performed include, among others: care for children during the absence or incapacity of the parent; performing or helping to perform essential household duties; insuring proper nutrition; maintaining a clean and hygienic environment; providing personal care as prescribed by health professionals to persons who are ill, aged, blind or disabled; teaching independent self-care through demonstration and practical suggestions; teaching how to care for children, the value of and how to prepare nutritious meals, how to budget, how to market and how to organize a household; providing emotional support and understanding; observing individual and family functioning so as to assist the professional members of the team to make an adequate plan of care.

(b) The term "homemaker-home health aide" means a trained, supervised person who works as a member of a team composed of professional and allied workers providing health and social services.

(c) The term "supervision" refers to the periodic assessment of an individual's or family's needs to determine the appropriate kinds of service and to the direction given to the homemaker-home health aide by a home economist, nurse, social worker or other member of the professional team responsible for determining and carrying out the plan of service.

(d) The term "provider of the service" means a homemaker-home health aide service agency, or the homemaker-home health aide program of a family or child welfare service, organization serving the aged, local public social services department, visiting nurse association, local public health department, or similar organizations, or by a proprietary agency.

(e) The term "certified" means that the provider of the service has been certified as meeting basic standards set by a responsible national voluntary non-profit agency, such as the National Council for Homemaker-Home Health Aide Services, Inc.

(f) The term "Secretary" means the Secretary of Health, Education, and Welfare.

SCOPE OF BENEFITS

Sec. 1142. (a) The benefits provided to an individual or family under this Act shall include full or part-time care and services whether rendered on a daytime, nighttime, weekend, emergency, or full 24-hour-care basis.

(b) Persons who have been found to be in financial need under regulations prescribed by the Secretary of Health, Education, and Welfare shall receive the benefits of the service without cost to them. The basis of payment to the agency providing services shall be the full reasonable cost of the care and services in accordance with regulations prescribed by the Secretary.

(c) Payment for or by persons not meeting the criteria in (b) above shall be made on a sliding fee schedule in terms of full reasonable cost.

(d) The homemaker-home health aide services for which payment must be made in full or in part from public funds shall be provided through a public agency providing other health and/or welfare services. The service may be provided directly by such agency or through purchase of service. Any agency whether public, non-profit voluntary, or proprietary must be certified as meeting the basic standards set by a responsible national voluntary non-profit agency, such as the National Council for Homemaker-Home Health Aide Services, Inc.

(e) Payment for needed homemaker-home health aide services, as defined above, shall not be conditional upon the individual's or family's receipt of any other health or welfare service.

REPORT

Sec. 1143. The Secretary shall submit annually to the President and to the Congress a full report on the program under this Act, including recommendations for any improvement therein.

EFFECTIVE DATE

Sec. 1144. This Act shall apply with respect to care and services furnished on or after October 1, 1975.

1/31/75
National Council for Homemaker-
Home Health Aide Services, Inc.

NATIONAL COUNCIL
for Homemaker-Home Health Aide Services, Inc.
A non-profit national standard-setting organization
67 Irving Place, New York, N.Y. 10003 (212) 674-4990

POLICY STATEMENT
by
The Board of Directors of the
National Council for Homemaker-Home Health Aide Services
on
Safeguards for Delivery of Homemaker-Home Health Aide Services

Homemaker-home health aide services should be efficient, effective and given with safeguards to protect the people served. Therefore, any agency -- governmental, voluntary non-profit or proprietary -- which provides homemaker-home health aide services should meet basic standards, established by a national voluntary not-for-profit standard-setting body. The standard-setting body determines through objective review whether an agency meets basic standards.

Adherence to basic standards requires that homemaker-home health aide services, under whatever auspices,

1. be provided by a team composed of both professionals and homemaker-home health aides. The homemaker-home health aides are to be employed and paid by the agency; the agency must provide training, and professional supervision;

2. be soundly administered, including maintenance of sound statistical and cost data;

3. insure that appropriate services are given as needed, but only for the period required, as determined by professional evaluation and continuing reassessment of the individual's or family's needs;

4. be described accurately and adequately to the public. Information as to the availability and quality of service shall be readily accessible to those to be served.

The above principles are equally [illegible] when the services are delivered directly to an individual or family and when the services are purchased on their behalf from another agency.

Communities provide homemaker-home health aide services in various ways. Whatever the system, the interest of those served must be protected. Government, voluntary non-profit and proprietary agencies all have responsibility to work actively toward comprehensive, quality homemaker-home health aide service in each community.

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BASIC NATIONAL STANDARDS
for
Homemaker-Home Health Aide Services

I. The Agency Shall Have Legal Authorization to Operate.

II. There Shall Be An Appropriate Duly Constituted Authority In Which Ultimate Responsibility and Accountability are Lodged.

III. There Shall Be No Discriminatory Practices Based On Race, Color Or National Origin: And The Agency Either Must Have Or Be Working Toward An Integrated Board, Advisory Committee, Homemaker-Home Health Aide Services Staff, And Clientele.

IV. There Shall Be Designated Responsibility For The Planning And Provision Of Financial Support To At Least Maintain The Current Level of Service On A Continuing Basis.

V. The Service Shall Have Written Personnel Policies; A Wage Scale Shall Be Established For Each Job Category.

VI. There Shall Be A Written Job Description For Each Job Category For All Staff And Volunteer Positions Which Are Part Of The Service.

VII. Every Individual And/Or Family Served Shall Be Provided With These Two Essential Components Of the Service:
   A. Service Of A Homemaker-Home Health Aide And Supervisor
   B. Service Of A Professional Person Responsible For Assessment And Implementation Of A Plan Of Care.

VIII. There Shall Be An Appropriate Process Utilized In The Selection Of Homemaker-Home Health Aides.

IX. There Shall Be: A) Initial Generic Training For Homemaker-Home Health Aides Such As Outlined In the National Council For Homemaker Services' Training Manual; B) An On-Going In-Service Training Program For Homemaker-Home Health Aides.

X. There Shall Be A Written Statement Of Eligibility Criteria For The Service.

XI. The Service, As An Integral Part Of The Community's Health And Welfare Delivery System, Shall Work Toward Assuming An Active Role In An On-Going Assessment Of Community Needs And In Planning To Meet These Needs Including Making Appropriate Adaptations In The Service.

XII. There Shall Be An On-Going Agency Program Of Interpreting The Service To The Public, Both Lay and Professional.

XIII. The Governing Authority Shall Evaluate Through Regular Systematic Review All Aspects Of Its Organization And Activities In Relation To The Service's Purpose(s) And To The Community Needs.

XIV. Reports Shall Be Made To The Community, And To The National Council for Homemaker-Home Health Aide Services, As Requested.

Write:

National Council for Homemaker-Home Health Aide Services, Inc.
67 Irving Place · 6th Floor · New York, N.Y. 10003 (212) 674-4990

SAMMY K. GRIFFIN, *President*
CHARLES W. HULL, JR., *Managing Director*

THE NATIONAL FEDERATION
OF LICENSED PRACTICAL NURSES, INC.
888 SEVENTH AVENUE, 18TH FLOOR
NEW YORK, NEW YORK 10019
(212) CI 6-6629

September 2, 1980

Senator Herman Talmadge
Senate Finance Committee
U. S. Senate
Washington, D. C. 20510

Dear Senator Talmadge:

The National Federation of Licensed Practical Nurses shares with the Senate Finance Committee a great interest in improving the quality and kind of health care delivery in the United States.

There are more than 600,000 LPNs in the U. S. who work in various settings and situations. The new and expanding role of nurses -- especially LPNs -- is finding more and more participation in noninstitutional settings. While it remains true that most LPNs work in hospitals and nursing homes, a great many are now expanding into areas within the community. As the second largest group of health providers, we have a keen interest not only in delivering health care, but in helping the community formulate policy and law.

We hope that when hearings continue on S.2809, you will consider testimony of LPNs in making what we believe are some important changes in the present proposal.

We look forward to working with you in the months to come and we stand by ready to assist in any way we can.

Sincerely,

Sammy K. Griffin
President

SKG:cdd

NFLPN: The Professional Organization for Licensed Practical/Vocational Nurses in the United States

NATIONAL RETIRED TEACHERS ASSOCIATION | AMERICAN ASSOCIATION OF RETIRED PERSONS

STATEMENT

of the

NATIONAL RETIRED TEACHERS ASSOCIATION

and the

AMERICAN ASSOCIATION OF RETIRED PERSONS

before the

COMMITTEE ON FINANCE

U.S. SENATE

on

S. 2809

THE NONINSTITUTIONAL LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED ACT

August 27, 1980

Mildred Moore, President, NRTA
Olaf J Kaasa, President, AARP
Cyril F Brickfield, Executive Director
National Headquarters: 1909 K Street, N.W., Washington D.C. 20049 (202) 872-4700

Our Associations would like to offer the following brief comments on the bill, S. 2809. We have long been involved in legislative and public policy efforts to provide for a program of comprehensive, community based noninstitutional long-term services for the elderly. The comments offered herein are therefore a reflection of our priority concern that home health care services and community-based long-term care become an equally viable option to institutional care - quite an inadequate response to the long-term care needs of older Americans.

There is at present a strong statutory bias in the long-term care area toward institutional or nursing home care (most clearly reflected in the massive Medicaid program). At the same time there is no real continuum of long-term care services being provided to our elderly citizens. Moreover, the coordination of home- and community-based alternatives to institutional care has been at the very best disappointing. This situation has been exacerbated by the tendency to assess (and subsequently provide) medical services separately from other needed social services.

S. 2809 would provide the elderly with a much needed continuum of in-home health and social services as an alternative to costly institutional care. This is an area which has been largely forgotten in all major national

health insurance proposals, whether comprehensive and universal in nature or merely catastrophic in the protection they purport to offer. Our Associations are firmly convinced of the immediate need to address legislatively this nation's long-term care dilemma. S. 2809 is in close concert with this goal.

Section-by-Section Comments

The scope of entitled benefits (Section 2102) seems to us too limited. While we strongly support the priority use of limited resources to provide home health, homemaker-home health aide, adult day care and respite care services to the aged and disabled, the absence of nonmedical social services could seriously compromise the effectiveness of S. 2809. A full continuum of medical and social services is clearly needed. It seems to us inadvisable to provide reimbursement for more costly home health services when nonmedical aid and assistance would more than suffice. This point reflects a larger concern of ours - the need for an oversight function incorporating both institutional and noninstitutional services within a single program (or Social Security title). Still, we strongly support the

requirement that the home health agency be licensed in those States requiring such a procedure. We oppose the dismantling of those minimal quality of care standards that have been painstakingly established in the area of home health care, and contrary to the recommendation of the Committee on Finance in its bill HR 934 (Medicare-Medicaid Amendments of 1980), we believe that all home health agencies should be licensed by the State(s) in which they operate. There is some question, though, as to the specific licensing, cerification and/or inspection of care requirements for providers of homemaker-home health aide services, adult day services or respite care services contained within S. 2809. Concerning the delivery of respite care services in particular, we would note that many individuals may not require medical care and that a neighbor or nearby family friend may be in the best position to offer such services. As presently constructed, this legislation seems to preclude this from happening.

Section 2103 details eligibility criteria for the Title XXI program. We are especially pleased to see that certification of eligibility is to be made by the Secretary of Health & Human Services (HHS).

As we have stated, it is particularly significant that the Preadmission Assessment and Screening Team (PAT) be given "gatekeeping" authority over the payment of benefits and

the provision of (long-term care) services. We contend, that while the physician should certify and generally supervise the medical plan of care, this authority should not necessarily extend to the total plan of care. At the same time we are encouraged by the fact that a "social or health organization" may also refer eligible individuals to PAT screening and that periodic reassessments are to be undertaken (albeit, at the discretion of the PAT).

After the designation by the Governor of each State of the lead agency for Title XXI, we are told that the lead agency is to designate at least one PAT for each unit of general purpose local government in the State (e.g., local PSRO's, HMO's, department of health or rural health clinic). We wonder, though, whether the size or even the composition of the PAT, should not vary according to the size of the local area or its population. Regarding the composition of the PAT we are curious as to the rationale for deciding on these three mandatory and three optional components. Clearly, the PAT must be "under the general supervision of a physician" charged with certifying the medical "plan of care." But, in addition to a registered nurse (or nurse practitioner) and social services worker, why has the participation of a physical therapist been mandated? Moreover, who determines whether the participation of a mental health professional, a rehabilitation specialist, a senior advocate or an occupational therapist is "necessary"? The designated "lead agency"? And how is a "senior citizen

advocate" defined? What specific role would such an individual play on the PAT?

Section 2105 deals with applicable copayments by Title XXI eligibles. For all but respite care services a 10 percent (of the reimbursable amount) copayment would be required for visits in excess of 50 per calendar year. It is unclear, however, whether any reimbursement, even with substantial copayments, is to be allowed for respite care services beyond the minimal entitlement of 14 days of such care per year. We would also question whether the scope of benefits would be altered to reflect home health benefit expansions such as those contained in the bill HR 934 (e.g., elimination of the 100 visit limit under Parts A and B of Medicare for home health services), should this legislation be enacted by the Congress. On balance we support the stepwise approach this legislation represents and in particular the setting of ceilings on copayment liability in accordance to the "available" income of the individual. It should provide access of the non-poor elderly to community based long-term care services and avoid a significant degree of needless institutionalization.

The amount payable for these services is to be determined on the basis of a schedule of fees negotiated in each State (or area of a State) by the Secretary in cooperation with the appropriate State agencies. One question regarding these jointly developed fee schedules is how this payment system interfaces with the recently promulgated (Section 223) home health agency cost limits. This remains unclear.

The use of carriers for the purpose of administering benefits is also of concern to us. We would hope that in light of the experience with Medicare Part B carriers this Committee and the Congress would seriously consider the development and use of special regional Title 21 carriers who may develop expertise in this area and achieve significant economies of scale in claims processing. The least acceptable approach to us would be the "piggy-backing" of this new function on top of what is already in many instances an unmanageable caseload for many (Part B) Medicare carriers.

Section 2111 indicates that the Secretary will issue regulations which will facilitate the coordination of all Title XVIII, XIX and XX regulations. Yet, despite the role of the PAT team, we believe that insufficient attention has been paid to the need for effective case management. Merely providing an elderly individual a list of service providers is quite frequently inadequate. More attention needs to be paid to the establishment of effective and on-going case management.

Section 7 of S. 2809 would amend the Internal Revenue Code (Section 44) to allow a new tax credit of $100 for each taxable year for the care of an elderly dependent. Our Associations have long supported provisions such as this as a means of providing the family the support needed to avoid costly institutionalization. However, we believe

that a $100 tax credit is an insufficient incentive. It is a marginal improvement over the present situation which finds favorable tax treatment (deductibility) available only when an elderly person is institutionalized. We would recommend increasing such a credit to at least $250 per calendar year and scaling it to the magnitude of individual documented expenses. Furthermore, when cost estimates from the Congressional Budget Office (CBO) are available, we would be most interested in knowing the relative estimated revenue losses of a $100 tax credit versus a $250 or $500 credit. We would also like some clarification as to whether this Section (7) would become effective independent of the three-year noninstitutional long-term care services demonstration program.

Conclusion

These abbreviated remarks are merely the broad outlines of our Associations' intitial thoughts on S. 2809, the "Noninstitutional Long-Term Care Services for the Elderly and Disabled Act." Like many other groups calling the attention of the Congress to this problem, we believe the level of inappropriate institutionalization - especially among private pay patients - can best be addressed in the near term through and expanded range of community-based LTC alternatives. In fact, to the extent that private pay patients with relatively low care needs can be served through an expanded and coordinated array of community based health and social services significant cost savings to the States and Federal

Government can be realized by moving the many Medicaid patients presently in acute care hospitals to a more appropriate level of care, i.e. previously unavailble nursing home beds. Our Associations support S. 2809 as an effective first step in addressing this problem.

September 10, 1980

Mr. Michael Stern, Staff Director
Committee on Finance
Room 2227, Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Stern:

The North Central Florida Health Planning Council and its Long-Term Care Subcommittee are pleased to present the enclosed testimony and related information for your consideration. This material is based on work the Council recently completed in the area of long-term care. We believe it will be useful to the Subcommittee on Health as it considers Comprehensive Community Based Noninstitutional Long-Term Care for the Elderly and Disabled (S. 2809).

Enclosed are:

1. Written testimony summarizing the major problem areas identified by the Council;
2. An assessment of long-term care needs in one of the counties in our health service area; and,*
3. A copy of the draft section on long-term care which will be included in the Council's 1981 Health Systems Plan.*

I hope you find this material useful. Should you have any questions or comments, please do not hesitate to contact Carol Brady, Director of Health Plan Development, at the number below.

Sincerely,

J.B. White CB

J.B. White, Ph.D.
Chairman
Long-Term Care Subcommittee

JBW:mam

Enclosures

*These items were made a part of the official files of the subcommittee.

NORTH CENTRAL FLORIDA HEALTH PLANNING COUNCIL, INC.
2002 N.W. 13th St Gainesville, Florida 32601 Suite 103
(904) 377-4404 Philip J Hughey, Executive Director
Equal Opportunity Employer M/F

North Central Florida Health Planning Council, Inc.
Testimony on Long Term Care
Presented To
United States Senate
Committee on Finance
Subcommittee on Health
September 9, 1980

In January, 1980, the North Central Florida Health Planning Council, Inc. a health systems agency serving 16 counties, established a special subcommittee to investigate long term care and the needs of the elderly in north central Florida. This subcommittee included health care providers, consumers, nursing home administrators and representatives of senior citizens organizations. The subcommittee was charged with determining the needs for services and identifying problems which could be addressed by the Council in its Health Systems Plan.

As part of its study, the subcommittee heard presentations from a variety of persons involved with long term care. These included nursing home operators, licensure officials, representatives from community care programs, members of the Professional Standards Review Organization (PSRO) and Nursing Home Ombudsman Committee, and the chairman of a statewide planning committee.

Based on these presentations and subsequent investigation, the subcommittee identified four major problem areas:

1. The lack of a continuum of long term care services;
2. The inadequacy of Medicaid reimbursement and government funding for community-based alternatives;
3. The availability of long term care services; and,
4. Quality of care.

The first two problem areas are particularly pertinent to the Senate's consideration of S.2809, Comprehensive Community Based Noninstitutional Long Term Care for the Elderly and Disabled.

The elderly require a comprehensive range of services from residential facilities to health care and community support services. Ideally, elderly persons should be able to move with ease between different levels of services based on their needs. Currently, however, when this range of services is available in an area, it is offered by a variety of separate public and private agencies. These agencies usually have different eligibility requirements and sources of reimbursement. Coordination between programs is generally informal. Because of this, the elderly have difficulty finding and receiving services most appropriate to their needs. Specific problems identified by the subcommittee include:

1. The institutional bias of Medicaid.

Although the development of community support services is receiving increased attention, this emphasis is not reflected in major government support programs. For example, a person living in a

congregate living facility receives about $250 per month in State support, while the same person placed as an Intermediate II patient in a nursing home receives more than $600 monthly under Medicaid. Recent legislation has increased monthly state payments to $350, however, a substantial discrepancy remains. Additionally, income eligibility under the Medicaid program is substantially higher for institutional patients. A Medicaid client living in the community has an income limit of $228 per month, while the cap for nursing home residents is $556 per month.

Finally, Florida provides major support for nursing home care. In 1978, $109 million dollars, 38 percent of the total Medicaid budget, was spent on nursing home care. In contrast, $3.4 million dollars was alloted by the State for community support services.

2. Gaps in services.

A comprehensive range of services is available in few areas. Many times it is difficult to find sponsoring organizations or to raise local funds which are required as match for many federal and state programs. Additionally, current programs may not appropriately meet the needs of residents. A major gap identified in the Marion County Study conducted by the subcommittee is a lack of services between congregate living and nursing home care. Elderly residents who are independent but require supervision and limited medical care have difficulty receiving services. Congregate living

facilities cannot provide medical care and few nursing homes except Intermediate patients because of low reimbursement.

3. Lack of coordination between programs.

Since services for the elderly are offered by a variety of independent agencies, coordination between groups is an important component in developing a continuum of care. In general, however, there is a lack of coordination and awareness of the services offered by various agencies. There is no organization which channels the elderly into services. Florida does not have a pre-admission screening program for nursing home patients. Referrals between agencies are frequently limited to problem clients.

4. Provider referral patterns.

Since many community support programs have developed only recently, there is still a tendency on the part of physicians, hospitals and community agencies to think of nursing homes as the primary placement for long term care. More information and education about community services is needed to insure all alternatives are considered for patients.

Additionally, community support services are seldom offered as an alternative <u>before</u> a situation becomes critical. The majority of elderly residents in north central Florida are living with families in the community. Yet, services such as respite care

and adult day care are only offered when families have exhausted their resources and see insitutional placement as the only alternative. Again, Florida has no pre-admission screening program for nursing home patients.

5. Separation of medical and social support programs.

Long term care services have been artificially separated into medical and social programs. Few elderly are free from medical/physical problems, yet studies have shown placement in a medical facility, such as a nursing home, is often due to social problems and the availability of government support rather than medical condition. Separation of funding for social and medical programs, with their inherent differences and eligibility requirements, creates an obstacle to the development of a continuum of care.

In an effort to address these problems and to contribute to the development of a continuum of long term care services, the subcommittee recommends the following:

1. The establishment of pre-admission screening programs for nursing home patients.

   A mechanism must be developed which will channel the elderly into the services most appropriate to their needs. To be effective, a pre-admission screening program must include both private pay and government funded patients.

2. The development of an alternatives budget to finance community programs.

   Florida and other states should eliminate low levels of nursing home care (for example, Intermediate II) and use these funds to finance community based alternatives. This will contribute to long-range cost savings by reducing inappropriate institutional placements, freeing up nursing home beds for patients who require this level of care.

It is important to recognize that a continuum of care will never materialize as long as we allow persons with the same level of activity limitation to be served in the community and in nursing homes. The state and federal governments hold the purse strings effecting long term care. These financing mechanisms have a profound impact on the shape of long term care services. A continuum of care will only be developed if a comprehensive, coordinated approach is used in the funding of these important services.

September 2, 1980

Mr. Michael Stern, Staff Director
Senate Committee on Finance
Room 2227, Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Stern:

The Ohio Council of Homemaker-Home Health Aide Services, Inc., with a membership of over 300 persons from public, private, large, small, urban and rural homemaker-aide agencies across Ohio, appreciates the opportunity to comment on S. 2809, the new Title XXI bill.

We support the plan as an effort to broaden and expand much needed in-home services for the feeble elderly and for the disabled of all ages. We know from experience that many can be and would prefer to be cared for in their own homes rather than in institutions.

However, we are concerned about the following provisions. First, the proposed bill will create a new bureaucracy, Preadmission Assessment Teams (PATs), which will be costly, undermine or duplicate the professional functions of existing services, and could not possibly be responsive to the daily crises of the ill and disabled. We believe that the PATs should confine themselves to establishing the person's need for care and the level of care appropriate to those needs. The person should then be referred to a home care agency which, by certification, approval or accreditation by a state or national body, is known to have adequate standards of service. The service agency should have the responsibility for developing an individualized plan for care after consultation with the individual in need, family members, and the physician. The plan should be reassessed at regular intervals and at any point a change in the individual's condition requires attention.

The role of the staff on the reassessment teams would be limited to establishing the need for care and to monitoring the appropriateness of the service given. Unless adequate standards for care are required in the federal legislation and a system for monitoring by state officials outlined, we believe that this home care program will be marred by serious fraud and abuse. Not only is there a great potential in home care for agencies and individuals to misrepresent what care is being provided, there is also the potential for actual abuse and neglect of the individual in need by untrained and/or unprincipled persons. Standards and the enforcement of standards are absolutely essential to any home care system. The states have failed in this role so far so we believe the federal government must take some responsibility in this area. The least expensive way would be to recognize accreditation or approval by selected national agencies, and certification by state health departments and give the state the option to set or recognize other standards.

An additional problem is that many states like Ohio have excellent written standards in its Welfare Department for homemaker-aide service but don't have the staff to monitor them and award contracts without regard to the standards. Unless an active, effective monitoring system is required in each state, standards will remain a farce.

We believe that an effective monitoring system should look at the client rather than merely at written records and impose heavy penalities on agencies or persons violating conditions of safe or appropriate care. Every attempt should be made to eliminate recording requirements which now result in one hour of paper work for each hour visit. This increases the cost of home care and leaves less time for meeting the needs of the client. The reliance on the written word has certainly not even slowed fraud and abuse. We believe that

insisting that agencies and services meet standards before they are eligible to participate in the home care program and then monitoring care by home visits to a random sample of clients with clearly defined and enforced penalities for violations would be more effective and less expensive.

Our State Council supports the provisions in the bill which include social and environmental factors, as well as health in the pre-admission review. We know from experience how important the social and environmental factors are to the individual's mental and physical health. We are concerned, however, that the designated PATs are traditional health agencies which have not always had a pattern of considering the broad needs of individuals. We see no requirement that social workers be involved nor do we see social work or counseling as one of the services offered. We understand that it can be included under Medicare but the limitations are so great as to make it insignificant. If the bill is to achieve its broad goals, we believe that social services will have to have a larger and mandated role. Otherwise we will be continuing our narrow and inadequate home health care program.

The Council supports the addition of adult day care and respite care to services covered and would hope that the same concern for standards prevail in these areas.

We also support limited tax credits for families caring for dependent elderly but believe this should also be extended to families of the developmentally disabled. We have witnessed the financial burden lasting many years created by care for developmentally disabled at home and know this is a major factor in considering institutionalization.

We also support the system of payments based on income after a specified number of free visits. We would hope that this would help bring some degree of reality to the overwhelming problem of health funding. Perhaps it could be extended to other areas of health care.

In summary, we believe that this bill is a commendable and pioneering approach to the care of the chronically ill or disabled and feeble aged in our country. However, unless it requires adequate standards of service and separates the eligibility determination and monitoring roles of the PATs from actual case management or service provision, we are concerned that it will only add more inadequate and dangerous service to an already troubled field.

Sincerely,

Ann Mootz
Legislative Chairman
Ohio Council of Homemaker-
Home Health Aide Services

AM:rs

STATEMENT

of

PANEL ON BLINDNESS AND DISABILITY

Representing:

American Foundation for the Blind
Association for Retarded Citizens
Epilepsy Foundation of America
National Association of Private Residential Facilities for the Mentally Retarded
National Association of State Mental Retardation Program Directors
National Easter Seal Society
National Rehabilitation Association
National Society for Autistic Children
Paralyzed Veterans of America
United Cerebral Palsy Associations, Inc.

REGARDING

S. 2809

NONINSTITUTIONAL LONG-TERM CARE SERVICES
FOR THE ELDERLY AND DISABLED ACT

Presented to

THE SUBCOMMITTEE ON HEALTH

of

THE SENATE FINANCE COMMITTEE

U.S. SENATE

Friday

September 12, 1980

INTRODUCTION

The ten organizations represented by this statement were hopeful when we learned about the introduction of S. 2809, a bill we believed would finally recognize and begin to deal with the long-term care crisis currently facing our country, especially as it relates to the specific needs of the non-elderly, disabled population. Earlier this year, our organizations were invited to present informal preliminary comments on the bill to the staff of individual Senators. We appreciated and took advantage of that opportunity and are pleased that several of our suggestions were incorporated into S. 2809 as it was introduced. However, we are still not satisfied with the overall tone of the bill and have problems with many of its provisions.

S. 2809 is primarily designed to serve the elderly through a medically oriented, acute care system. This is not to say that there are not major improvements embodied in S. 2809, there are. However, unless we can truly and finally shake the health oriented system of services and recognize the uniqueness of the non-elderly disabled population with social/developmental needs, then we question the need for a new Title XXI and corresponding bureaucracy. Why not modify our existing medical programs, Medicaid and Medicare?

Partly because there has never been a national policy on disability, benefits for this population have evolved and continue to evolve in a questionable manner, i.e. as add-ons, afterthoughts or tagged

inappropriately with benefits for some other population in need. With this haphazard mushrooming of programs or pieces of programs for disabled people comes an equal number of inappropriate definitions, limitations and restrictions. Such is the case with S. 2809, a bill primarily for the elderly with medical needs.

It is also important to realize that the blossoming, in recent years, of budget, appropriations and authorizing committees, subcommittees and special committees has made it impossible for organizations concerned with disability issues to reach, interact and help educate all of the significant members and staff of Congress. Thus, the development of programs for disabled individuals continues to suffer due to lack of in-depth knowledge of their specific needs and trends in the field of disabilities.

Our statement is intended to reflect certain of these needs and trends in an effort to continue a process which will result in S. 2809, in its final form, being truly responsive to the unique needs of chronically disabled people of all ages. Our comments on S. 2809 are presented in the order in which the various provisions appear in the legislation.

PURPOSE OF TITLE

The purpose statement in S. 2809 omits two references that are critical if many of the less articulate elderly as well as the non-elderly disabled are to be recognized as equally eligible recipients under this Title:

1. There is no mention of developmental or psychological services; and
2. There is no recognition that for many persons with disabilities now institutionalized, a major thrust should be to return these individuals to the community and terminate their current institutional status.

Our organizations strongly suggest that the wording of the purpose statement be changed to read "...noninstitutional medical, social, psychological and developmental services..." and "...to ensure that such individuals are assisted in remaining or becoming functionally independent in their own communities, and therefore avoid or terminate unnecessary placements of such individuals in institutional facilities."

SCOPE OF BENEFITS

Our organizations believe there should be no set limits on the amount, duration or scope of the services available under this Title for individuals determined to be eligible for and in specific need of such services. It is generally recognized that such arbitrary limitations are self-defeating and create notches and gaps in services that act as barriers to the development of an individual's independence. One needs only to study the history of programs such as the Supplemental Security Income program (Title XVI of the Social Security Act) with its arbitrary Substantial Gainful Activity (SGA) level (now modified by P.L. 96-265) and the Early and Periodic Screening,

Diagnosis and Treatment (EPSDT) program (under Title XIX of the Social Security Act) which allows the states to set multiple limitations on amount, duration and scope of services to predict the outcome of similar limits proposed under S. 2809.

It makes sense that benefits should be phased out smoothly as the need for such benefits subsides, and that individuals should not be penalized at some arbitrarily established moment as they progress toward functional independence.

Such limitations bear no relationship to an individual's development or need for services. Rather, they are based on immediate economic concerns and suspicions of fraud and abuse. They are short-sighted and do not recognize the real pay-off or savings which can occur if individuals are allowed to progress as far as possible toward an independent functional level. Indeed, they reflect a surprising lack of concern about individual recipients.

Our organizations recommend the removal of all limits on the amount, duration and scope of benefits provided under Title XXI in exchange for a gradual reduction in services based on the needs of individual recipients. This would require the elimination of the 14 day or 336 hour limitation on respite care (Section 2102(a)(4)) and of the 50 visit limit on home health, homemaker-home health aide and adult day services after which copayments are charged (Section 2105 (a)(1), (2), and (3)). (We support copayments which are based on level of income as described on page 13 of this statement.)

Our specific suggestions relative to particular services are the following:

1. Under Section 2102(b)(1)(A)(iv) add the words "including those drugs and biologicals necessary to control an impairment," immediately after "medical supplies." The words "(other than drugs and biologicals)" should be omitted.

Precedent for this change has been established in P.L. 96-265. Both the hearing record and committee reports explain the need for such coverage. As a prerequisite to the development of functional competencies, individuals with certain disabilities such as epilepsy must establish seizure control through the use of drugs and biologicals.

2. Under Section 2102(b)(3) the words "intermediate care facility, hospital" should be omitted. Hospitals and ICF's are institutions. Services provided in these facilities are or should be part of the package for which authorization already exists under Title XIX. All references to hospitals, Skilled Nursing Facilities and ICF's as providers should be omitted.*

Residents or inpatients of such institutions should be eligible only for "inreach" services by community agencies as part of the process of easing and hastening the individual's transition to non-

* This does not, of course, refer to outpatient and clinic services which are housed in a hospital or medical center. It may be advisable to amend Title XIX to assure eligibility of persons defined in Section 2103 for such outpatient services.

institutional status. Community-based services should be provided to individuals residing in normal community dwellings, i.e. single family homes, apartments, condominiums, and so forth. Specifically, unrelated disabled individuals who are living together in a small group living arrangement in the community should be eligible for Title XXI services.

While it is appropriate for multipurpose senior centers, rehabilitation centers, centers or agencies for the handicapped or other such non-residential facilities licensed by the state to be recognized as providers of adult day services, it is inappropriate to encourage the incorporation of such services in institutional environments.

3. Under Section 2102(4), the words "...because of the absence of..." should be deleted and replaced with the words "<u>to provide relief to</u>."

"Respite care services" represent one component of a family/caregiver support system that provides temporary relief for primary caregivers. To be appropriate and meaningful, respite care services under S. 2809 should not be tied to the absence of a caregiver but rather to the need of the caregiver for time away from the dependent individual. It is clear that a critical factor in the continued support and care of a handicapped individual within a home environment is the availability of respite services which allows the primary caregiver time away from the constant responsibilities of caring for the handicapped person.

The medical bias of S. 2809 again emerges in the requirement that respite care services be provided under the supervision of a registered nurse who is employed by a certified home health agency,

homemaker-home health aide agency or local public health department. Such a requirement is not only unnecessary but completely inappropriate when respite care services are provided for elderly and disabled individuals with little or no need of medical services. This requirement, if enacted, would promote the idea that all disabled people are sick and in need of medical services. It would waste a great deal of money by requiring the services of a professionally trained registered nurse where none were needed.

Our organizations vehemently oppose the categorical across-the-board mandate or authority for use of any medical personnel, in either a supervisory or direct care role, or as a referral source. Such models inflate costs and can result in less than optimal use of resources. Such personnel should be required only where it is medically necessary.

4. In our opinion, case management services should be included under Section 2102 of S. 2809. While we recognize that there will be an understandable tendency to emphasize "hard," hands-on services, we believe that it is absolutely critical that availability of case management services be required as a condition of participation under Title XXI. Otherwise, it will be nearly impossible to exercise reasonable control over the cost, appropriateness and quality of services rendered to elderly and non-elderly disabled persons in the community. The accessing and orchestration of such services on behalf

of this population -- many of whom will require a changing array of services over time -- will be an essential determinant of the success or failure of the proposed program.

The term "case management services," as defined by the Federal government in P.L. 95-602, means such services as will assist eligible individuals in gaining access to needed social, medical, educational, and other services; and such term includes:

(a) follow-along services which ensure, through a continuing relationship, lifelong if necessary, between an agency or provider and a person with a disability and the person's immediate relatives or guardians, that the changing needs of the person and the family are recognized and appropriately met; and

(b) coordination services which provide to persons with frailties or disabilities support, assistance in obtaining access to (and coordination of) other services, information on programs and services, and monitoring of the person's progress.

During the August 27, 1980, hearing on S. 2809, the Subcommittee heard from the State of Virginia about the need for strong follow-up services and from the State of New Hampshire about the 400 people who, through the use of interdisciplinary, preadmission screening and assessment teams, were appropriately denied long-term care institutional placements and then lost, i.e. their whereabouts is unknown to the teams and the agencies responsible for screening and assessment.

Once again we want to stress the need for a national policy on long-term care and a system of services organized in a continuum through which individuals can move as their level of care needs change. We want to stop the government from, as one witness put it, "...snipping segments out of human lives." Government must deal not with pieces of an individual but with the whole individual. Case management embodies these concepts.

5. To provide a basic core of services in the community-based service continuum, S. 2809 should include under Section 2102 one additional service, i.e. psycho-social counseling and supervision.

This term includes social supervision and assistance for individuals of limited mental capacity who require such supervision and assistance to maintain residence in the community. For instance, a mentally retarded adult might require intermittent but systematically provided "judgement" of another adult to facilitate daily living.

For many disabled individuals, the appropriate consumption of medications is the primary factor in whether or not they are allowed to remain in or return to the community. Such individuals may require supervision from a responsible adult to ensure that medication is taken on time and in the proper dosage.

The term "psycho-social counseling and supervision" also includes counseling with a professionally trained service provider on a one-on-one or small group basis around a specific individual problem.

Such counseling is designed to assist the individual in alleviating psychological symptoms or in strengthening his/her ability to cope with external and/or internal stress, or merely to cope with what appears to non-disabled persons as ordinary demands of adult living.

ELIGIBILITY FOR BENEFITS

Our organizations are extremely pleased with the definition of eligible individuals especially as it relates to persons no longer eligible for benefits under Title II, XVI, XVIII or XIX of the Social Security Act but for whom the loss of benefits under S. 2809 would seriously jeopardize the individual's ability to continue to live in a noninstitutional community residence.

PREADMISSION SCREENING AND ASSESSMENT

Our organizations support the use of an interdisciplinary team to screen, assess and formulate plans of care for eligible individuals. We suggest that such a team be comprised, at a minimum, of a physician, a psychologist and a social worker. In this way the health, mental health and social care needs of each individual will be addressed. Each team must also have the capacity for retaining additional specialists on an as-needed basis. For example, where the history of an individual indicates the possibility of mental retardation, a qualified mental retardation professional (QMRP) should be a required member of the team. If an individual appears to be suffering from a mental illness, a professional from the mental health field should be required.

One of the unique characteristics of persons with substantial, chronic health-related conditions is that they require a wide spectrum of health, habilitation, rehabilitation and social services. As a consequence, there is a growing recognition that the task of pinpointing a client's needs and developing a balanced array of services to address them requires the involvement of personnel from several disciplines, working together as a team.

Our organizations feel it is not necessary or appropriate to place primary responsibility for the team and approval of the plan of care on the physician. A physician should never make final decisions for non-medical components of a plan of care. The entire team should certify the final plan of care which may or may not include provisions of a medical nature.

We strongly support the idea of a lead agency working in cooperation with other agencies for purposes of this Title. We suggest that an agency of major import has been ommitted -- the states' department on mental health.

It is clear that S. 2809 as written omits mental health services. Our organizations find this omission deplorable. A large proportion of persons currently institutionalized or in danger of institutionalization because of the lack of appropriate community-based services are mentally ill or senile or suffer from emotional disturbances. Many elderly, physically disabled and mentally retarded persons, as well as those with a primary diagnosis of mental illness, require

mental health services. To deny these vital services automatically creates a barrier to the effectiveness of any long-term care program.

There are three areas under Section 2104 which, in our opinion, need to be clarified. First, in Section 2104(c)(1) it is stated that the lead agency and the cooperating agencies shall work to coordinate the designation of at least one preadmission screening and assessment team to serve each unit of general purpose local government. Our organizations assumed that this does not mean that a Professional Screening and Assessment Team (PAT) is required to be located in every unit of general purpose local government but rather that a PAT must be assigned and available to each unit. Clarifying language on this matter would be helpful.

Second, the same Section further states that such a PAT may be a Professional Standards Review Organization, an area office on aging, a center for the handicapped and so forth. Obviously, none of these agencies is in and of itself a PAT but must designate or sponsor a Professional Screening and Assessment Team. Perhaps these agencies should be referred to as Professional Screening and Assessment Sponsors (PAS's). We also suggest that community mental health centers be listed as among eligible PAS's.

Third, Section 2104(c)(3) calls for a statewide uniform assessment instrument. We hope this does not mean there will be an attempt to mandate a particular assessment instrument for use nationwide. Our organizations recognize the tremendous need for basic data and

support the development of guidelines for a basic data set designed to help both the states and the Federal government in their planning and cost accounting efforts. We believe this to be the intent of Section 2104(c)(3) but feel further clarification is required. Data gathering should be a planned by-product of assessment, not vice versa.

In our opinion the establishment of any screening, assessment and referral mechanism must address three fundamental concerns, i.e. the accessibility and ease of intake for the client, the incorporation of appropriate client involvement in the screening, assessment and referral processes, and the avoidance of conflict of interest situations for the professionals conducting the assessments and making the referrals. We ask the Committee to provide additional language in S. 2809 clarifying its intent relative to each of these concerns.

COPAYMENTS BY ELIGIBLE INDIVIDUALS

In recent years, our organizations have often testified for and otherwise supported the concept of copayments for benefits. Such copayments, however, would be required only after an individual's countable income has reached a certain level. We feel it is unrealistic and unfair, if not ridiculous, to begin charging copayments for services when an individual's income is zero or even $200 a month.

Since the purpose of S. 2809 is to provide community-based services in a manner which avoids unnecessary institutional placement and since an individual who is in the community must have sufficient

income protected to cover basic living costs, we recommend that no deductible or copayment be required of persons whose cash income (including government benefits) is less that 133 1/3% of the SSI level. More specifically, we would require that the state plan provide that no person having less than 133 1/3% of the federal level (about $317 at present) would be subject to such charges. In addition, states should be permitted to omit such charges for persons having less than 133 1/3% of the state's own supplemented level for an individual living alone. It should be noted that under present Title XIX rules a person who is not SSI eligible (or not medically indigent in a state having such a program) but who has an income less than three times the federal SSI benefit (i.e. less than $714 as of late 1980) may become eligible for Medicaid coverage by entering a nursing home and that such coverage will include all basic living costs (board and lodging) as well as nursing, medications etc.

For maximum effectiveness, S. 2809 must also contain individual financial incentives aimed at getting people out of nursing homes and other institutional environments. Therefore, S. 2809 should not only protect a level of income which is sufficient to allow an eligible individual to pay his/her other expenses, incurred when living in the community, i.e. expenses not covered by Title XXI, but also Title XIX should be amended to prohibit states from using resource tests more stringent than SSI.

By requiring copayments of individuals with low levels of income

and limiting free visits to 50 visits a year, S. 2809 penalizes those most in need. The severely handicapped may require two "visits" a day, in the morning and again at night. Thus, these individuals would be served through Title XXI for 25 days before copayments were required. These individuals are also those most likely to have little or no income. Thus, a double penalty is imposed.

Those eligible individuals with the most money and fewest service needs would be well served by S. 2809. More severely handicapped people would not. Currently, several Federal and state programs benefiting disabled people do not place limitations on the number of visits; they do not count as income other Federal benefits which are based on low income; they do not require copayments. Many of these programs may have reached their ceilings or have restrictions on covered services and are hence substantially inaccessible to many members of the target population for S. 2809. However, we still question the incentive for chronically disabled individuals in the program proposed in S. 2809, who require ongoing services over many years.

In closing, our organizations must state our grave concerns about about the workability of the financing provisions in S. 2809. Attempting to remove dollars from other previously established programs for certain comparable benefits would be a nightmare. Similar services provided under Title XX Social Services, for example, may be labeled differently in the various states while services with the same label may be vastly different. Pulling dollars from programs already at

their ceilings without some real incentives to the states creates a sense of doom rather than excitement.

The fact that Title XXI would begin on a project basis makes the workability of the financing mechanism even more questionable. Why establish such a complex new bureaucratic structure with such a complicated financing mechanism unless it is coupled with a firm, permanent committment to continuation?

In a similar bill introduced on December 19, 1979, in the House of Representatives, H.R. 6194, the financial incentives are clear - the primary incentive for the states being a higher federal match for community-based services.

Our organizations would be glad to work with the Subcommittee on any of the points mentioned in our statement. The recognition of the need for new approaches to long-term care is indeed heartening, and we are concerned that any new initiatives in this area be based on a thorough knowledge of the field of disabilities and the specific needs of this population, including the disabled population of all ages. For this reason, we are most interested in reviewing the second issue paper to be submitted by Senator Packwood which will examine the problems faced by persons with disabilities and how they are frequently forced to reside in institutions rather than homes. May we offer our data and expertise on these matters especially on the problem of inappropriate placements of these persons in SNF's and ICF's due to an emphasis on deinstitutionalization without adequate community-based residences or services.

The STAMFORD HOSPITAL

A VOLUNTARY NON-PROFIT
COMMUNITY HOSPITAL

A MAJOR AFFILIATE
OF NEW YORK MEDICAL COLLEGE

"AN EQUAL OPPORTUNITY EMPLOYER"

August 26, 1980

Michael Stern
Staff Director
Committee on Finance
Room 2227 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Sir,

I should like to submit the following statement regarding Community-based Non-institutional long-term care for the Elderly and Disabled:

As a professional Social Worker, I support the concept of a community-based non-institutional support system which would provide to elderly citizens the means by which they may, if they so choose, remain in their homes rather than be forced to enter a nursing home.

I strongly urge that these services should be available both to Medicaid recipients and to those who are not Title 19 eligible. Providers should be assured of payment for the full cost of providing out-patient services to Medicaid beneficiaries. All elderly persons would thereby be able to make a choice of remaining at home or being cared for in an extended care facility. Some would undoubtedly choose to enter a nursing facility, but there is no doubt that there are ECF beds being occupied at this time by persons who would be more appropriately and happily situated in their homes in the community.

Thank you for your attention.

Very truly yours,

Carol C. Greenberg,
M.S.W., A.C.S.W.
Director of Social Work

CCG:BD

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VISITING NURSE ASSOCIATION OF BROWARD COUNTY

900 N.W. FIFTH AVENUE
FORT LAUDERDALE, FLORIDA 33311

NURSING OFFICE 525-1551 BUSINESS OFFICE 525-5081

COMMENT ON S. 2809

12 September 1980

SUBMITTED TO

THE SENATE FINANCE COMMITTEE'S

SUBCOMMITTEE ON HEALTH

BY

VISITING NURSE ASSOCIATION OF BROWARD COUNTY, INC.

(Dorothy J. Deegan, B.S.N. - Executive Director)

A UNITED WAY AGENCY

INTRODUCTION

The Visiting Nurse Association of Broward County, Inc. charted in 1952 and serving this community under various fundings, including Medicare, Medicaid and Title XX, would like to comment on the proposed Title XXI, S.2809.

After dealing with trying to meet the health needs of this community regardless of race, creed, sex, age or inability to pay, we congratulate the Senate in their attempt to address these basic needs in a coordinated manner.

We, however, see many problems which need to be addressed before any finalization should be done.

We will delineate them, as we see them, as follows:

A. Eligibility

1. Medicare eligibility is fairly well set at the present time according to age (65 years) or 24 months after becoming eligible for disability under Social Security.

2. Medicaid eligibility is set at the State level without regard to regional differences. The State of Florida is not unique in having rural areas and highly metropolitan areas where the cost of living varies very greatly.

3. Title XX eligibility is set at the State level where the eligibility limit have not changed for over 7 years regardless of the inflation rate. Our agency has a Title XX Homemaker Program where 27 clients lost their service because of the Social Security increase in July 1980. One was $3.50 a month over this eligibility level. Thankfully, we found another source of funding to care for them.

Questions we would like to see answered:

1. What percentage of those persons over the age of 65 cannot afford private care? The large number of proprietary agencies in Broward County who seem to be very busy not only during the tourist season, but year-round, seem to belie the fact that all over the age of 65 are medically indigent. Why set Medicare eligibility only on age and not on a reasonable income level which could be set on a sliding scale?
2. How does a person under 65 years receive care for the 24-month waiting period before Medicare eligibility? At present he receives care in the VNA under private pay on a sliding scale based on his need for care and the cost of the visit supplemented by charitable monies under United Way. He may apply for Medicaid but that takes around 4 to 6 months for processing.
3. Do you plan on taking away State's rights on Titles XIX and XX for setting eligibility?
4. What is the definition of the paragraph (4)(B) Section 2103. as regards "income is not sufficient to allow him to provide for himself a reasonable equivalent of the services? We are having enough problems at present with definitions of reasonable costs. Caps at present are set on visit costs and the great tendency seems to be in this area to rise to the top of the cost allowable.

B. Preadmission Screening and Assessment

1. Make-up of the PAT. The generalizations of the team frighten me. HOME HEALTH CARE IS A SPECIALTY.

a. Physician: This can be any physician from a general family practitioner to a radiologist. Could not a Masters Degree in Public Health requirement be put on this physician so that he might have an idea of what a low income home looks like?

b. Registered nurse: Could not the basic requirement be a B.S. in Nursing with at least 2 years in home health care? Can you expect a 2-year graduate with no experience to know anything about Community Health?

c. Social Services Worker: Not even a Masters in Social Work? No experience except in counseling in a nice air-conditioned office? In the six years I have been in Broward County, how many discharge planners in the social service departments of the Hospitals have had to be taught what constitutes safe and adequate home care by our Educational Coordinator? At least two dozens.

d. A certified licensed physical and occupational therapist: They are specialists and should be able to adapt to home care for their specialty.

e. A Volunteer: A senior citizen who sees himself as a very potential occupant of a nursing home and who would never put someone into an institution no matter the cost or circumstances?

2. Cost

a) The correctly qualified persons would be costly to obtain, but without correct qualifications their decisions could most likely be very inappropriate and increase costs unnecessarily.

b) How many PAT's would be needed in an area such as Broward County with close to 30% of its total population of 1,000,000 to do all the referrals and case management necessary?

c) Who controls the quality of decisions made by the PAT? How many persons are going to be needed to assume correct regulation of the individual PAT, who are they? and how much will this cost? Who pays this cost?

3. Power and possibility of abuse

a) There is already a struggle for power and control between two groups in Broward and so far with political clout the tail is succeeding in wagging the dog over a matter of case management.

b) With the power and control in one group, the possibility of abuse is very great.

I have become cynical in watching abuse which has occurred with the proliferation of home health agencies and the fight waged in every quarter to obtain the Federal dollar. Senator Chiles' hearings have certainly uncovered much of this abuse and so far I do not feel that the approach as presented by a PAT would relieve the situation.

4. Assessment and re-assessment

a) How soon after referral can an initial assessment be made? We can assess the total needs, financial, social and physicial within 24 hours after referral following

good Community Health concepts with referral to the appropriate community reasources for assistance and continuing teaching toward independence if possible.

b) With a case load as heavy as this area would demand is it feasible to do a complete reassessment in 30 days?

Provider

a) Does the provider of services answer to the PAT not only for service given, but the quality of that service and the cost of the service?

b) What is the provider's relationship to the patient's physician? What happens if the patient's physician and PAT disagree?

c) Does the provider have any rights as far as length of service, kind of service or do they merely furnish warm bodies?

d) If in the judgement of the provider, service needs to be changed, either lengthened, shortened or inappropriate, who has the final decision? To whom does the provider appeal for the decision?

Physician

a) What happens to the privileged and private relationship between the patient and his physician when the PAT determines the plan of care?

b) Does the private physician lose his rights to practice and treat his patient as he deems fit?

c) Is he going to be inundated with more papers to sign?

Patient

This may be the last phase of my comments, but to all in the VNA, this is our reason for existence. Without the needs of the patient to be considered, we have no reason for being and yet in only a few places in S.2809 do I see any mention of the patient's right to determine his own care.

He is categorized as a Senior Citizen over 65 years or eligible according to disability and financial status. He is referred by a physician, social or health organization not self referral.

How much consideration will be given to his desire for either home or institutional care?
Will he be refused any care if his decision, no matter how inappropriate, is for home care instead of institutional care? The VNA serves patients, who for various reasons refuse institutional care even though they need a sheltered situation for their own safety and well being. The patient does have the right to determine his own life style unless declared legally incompetent.

These are only a few of the questions we would like to have considered for clarification on the Bill S.2809 before any implementation.

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TESTIMONY SUBMITTED FOR THE RECORD
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

RE: S-2809 - "COMPREHENSIVE COMMUNITY-BASED NONINSTITUTIONAL LONG-TERM CARE FOR THE ELDERLY AND DISABLED"

FIRSTLY, A COMMENT MUST BE MADE TO THE HONORABLE HERMAN E. TALMADGE'S COMMENT (PRESS RELEASE #H-42, JULY 28, 1980.)

> "WE MUST CAREFULLY EXAMINE THE BARRIERS WHICH EXIST IN THE MEDICARE AND MEDICAID PROGRAM WHICH CAN RESULT IN PLACING PEOPLE WHO CAN LIVE AT HOME INTO NURSING HOMES."

IN THE EARLY YEARS OF MEDICARE, 60'S AND 70'S, IT WAS RELATIVELY EASY TO ADMIT PATIENTS TO NURSING HOMES. IN SOME CASES, PATIENTS WHO REALLY DID NOT BELONG IN NURSING HOMES WERE ADMITTED TO THEM. WITH THE ADVENT OF COST CONTAINMENT AND NEW MEDICARE REGULATIONS, IN THE 80'S, IT IS DIFFICULT TO PLACE PATIENTS IN NURSING HOMES AND GET ANY, OR EVEN A PART OF THE STAY COVERED BY MEDICARE. A NUMBER OF NURSING HOMES WILL NOT TAKE MEDICARE PATIENTS AT ALL, OR WILL TAKE ONLY A LIMITED NUMBER, AND MAINLY RELY ON PRIVATE PAY PATIENTS. PATIENTS MUST MEET A MUCH MORE COMPLEX SET OF RULES AND REGULATIONS, BE ACUTE OR INTERMEDIATE LEVEL OF CARE, AND SUBJECT TO REVIEW BY THE PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO). THIS IS A MAJOR REASON FOR A SIGNIFICANT DROP IN MEDICARE NURSING HOME PATIENTS FROM 1968 UNTIL TODAY.

THE DIRECT RESULT OF THE ABOVE IS THAT PATIENTS ARE POSSIBLY HELD IN ACUTE CARE HOSPITALS DUE TO LACK OF FUNDS OR RESOURCES TO PLACE THEM IN A NURSING HOME; THE PATIENT GOES HOME WITH INADEQUATE HOME CARE; OR THE PATIENT GOES TO LIVE WITH A RELATIVE OR FRIEND. IT IS THEREFORE SUGGESTED THAT THE PROBLEM IS NOT NECESSARILY PLACING PATIENTS IN NURSING HOMES UNNECESSARILY, BUT INSTEAD HAVING PATIENTS

AT HOME OR SIMILAR ENVIRONS WITH INAPPROPRIATE OR INADEQUATE CARE AND SERVICES, WITH LITTLE, IF ANY, RESOURCES TO DO OTHERWISE.

"DURING 1979, CONNECTICUT'S THIRTY-SIX GENERAL HOSPITALS COMPLETED A SURVEY OF EXTENDED HOSPITAL STAYS DUE TO PROBLEMS OF PLACING PATIENTS IN SKILLED NURSING FACILITIES. FROM JUNE TO DECEMBER, THE EXTRA DAYS OF HOSPITALIZATION ROSE FROM 4,035 TO 6,034 DAYS. THE PLACEMENT PROBLEMS WERE MOST PRONOUNCED IN NORTHWESTERN AND SOUTHWESTERN CONNECTICUT, ALTHOUGH MOST OF THE STATE EXHIBITED SOME DEGREE OF PLACEMENT PROBLEMS. THE EXTENDED STAYS REPRESENTED A YEARLY COST OF $8.7 MILLION FOR INPATIENT STAYS. THESE COSTS INVOLVE PATIENTS, MOSTLY ELDERLY, WHO MEDICALLY NO LONGER REQUIRE HOSPITAL CARE, BUT WHO NEVERTHELESS REMAIN IN THE HOSPITAL BECAUSE THERE ARE NO NURSING HOME BEDS AVAILABLE TO WHICH THEY COULD BE TRANSFERRED, OR BECAUSE THEY HAVE NOT YET BEEN CERTIFIED BY THE STATE AS ELIGIBLE FOR MEDICAID ASSISTANCE FOR NURSING HOME CARE. IF THE SHORTAGE COULD BE ELIMINATED, AND THE CERTIFICATION PROCESS EXPEDITED, AS MUCH AS 72.4% OR $6.3 MILLION OF THE $8.7 MILLION COULD LIKELY BE SAVED. THIS SAVINGS REPRESENTS THE DIFFERENCES BETWEEN HOSPITAL RATES COMPARED TO NURSING HOME RATES." **

COMMENTS FROM: MARLENE COSTILLA, REGION V REPRESENTATIVE, N.A.Q.A.P.
BOARD OF DIRECTORS

SEE ATTACHMENT #1

COMMENTS FROM: ELIZABETH STEWART, SECRETARY, N.A.Q.A.P.

SEE ATTACHMENT #2

** LYNCH, JOHN T., M.P.H., "EXTENTED HOSPITAL STAYS: A GROWING PROBLEM" CONNECTICUT MEDICINE, JULY, 1980 - VOL. 44, NO.7

A COMPREHENSIVE COMMUNITY BASED CARE PROGRAM FOR THE ELDERLY, PROVIDING NONINSTITUTIONAL, LONG-TERM CARE MUST PROVIDE FOR THE MOVEMENT OF PATIENTS IN ACUTE CARE FACILITIES; NEEDING LOWER LEVEL OF CARE, TO SUCH ALTERNATIVES. IN CASES OF LACK OF FUNDS FOR NURSING HOME CARE, HOME CARE MUST BE THE ALTERNATIVE. THE NEED FOR THIS TYPE OF PROGRAM CAN BE ATTESTED TO BY MANY AGENCIES, ORGANIZATIONS, AND THE ELDERLY THEMSELVES.

THE DEGREE OF NEED VARIES WITH COMMUNITY TO COMMUNITY, BASED UPON NUMBERS OF ELDERLY, INCOME, PRESENT FACILITIES, AND OTHER TANGENT FACTORS. IT IS FEARED BY MANY THAT FEDERAL INTERVENTION WITH FUNDING, PROGRAMS, ETC. WOULD BE FILLED WITH RED TAPE AND BUREAUCRATIC REGULATIONS AND WOULD RESULT IN SIMILAR DEFICIENCIES AS NOW NOW ARE FOUND IN MEDICARE AND MEDICAID. HOW THIS CAN BE ALLEVIATED IS A COLOSSAL QUESTION, BUT THE NEED FOR SUCH CARE IS PRESENT, IMPERATIVE, AND FAST BECOMING A DISGRACE IN MEETING THE REQUIREMENTS OF OUR ELDERLY IN THE UNITED STATES.

RESPECTFULLY SUBMITTED,

ROBERT L. HARNER, R.N., C.M.P.A., M.B.A.
PRESIDENT, N.A.Q.A.P.

ATTACHMENTS

ALTERNATES TO LONGTERM INSTITUTIONAL CARE

The Medicare plan has not been designed to cover the cost of long-term care for the elderly and chronically ill patient. It is my understanding that Medicare is the primary source of payment for only about 1% of the nursing home residents who have been institutionalized for more than 30 days. In some instances, state-operated, but partly federally financed, programs of Medicaid and public assistance have been used to fund longterm care. In most cases, the patient and his family are the primary source of financing longterm care.

There is an absence of consistency among different states' policies and services which are eligible for reimbursement by Medicaid. Many elderly persons are not eligible for any type of aid due to resources which they have accumulated over the years. These resources are soon exhausted when the patient is required to pay all of his own expenses. Many elderly persons are institutionalized who could function in their own home with minimal assistance. If not in their own home, at least in a setting perferable to a Nursing Home.

My suggestion for an alternate to longterm institutional care is derived from my own experience with my aged mother over the past eight months. My eighty year old mother fractured her hip in January of 1980. She was hospitalized as an in-patient in an acute care facility for nineteen days, then transferred to a Skilled Nursing Facility. When her level of care was no longer classified as skilled, she was transferred to the Nursing Home Section of the facility. I should specify that the determining factor as to whether she still required skilled nursing appeared to be that she was no longer eligible for reimbursement by Medicare guidelines. From my personal observation, there appeared to be no difference in the level of nursing care rendered other than it took longer to have her call light answered due to limited staffing of personnel on the Nursing Home side. At this time, all expenses were to be absorbed by the patient and family with no Medicare reimbursement other than for treatments by the physical therapist which were partially covered. The charges were in access of $800.00 per month plus medications. She shared a small bedroom with another lady, a retired disabled schoolteacher, who also paid over $750.00 per month. For the next three or four months, this level of care was necessary, however in later months, we started to seek alternate means of receiving the care or assistance she required. From my observation, many of the patients in the Nursing Home appeared to be capable of residing in their own home or apartment with minimal supervision or assistance. After checking around, we found that, elderly persons must be able to ambulate independently before they would be considered for residence in a Senior Citizen Housing Development or private Retirement Village. There appears to be no readily available housing or assistance for elderly persons who do not qualify for Medicaid assistance and are limited in their ambulatory status. Many residents of Nursing Homes are mentally alert, minimally disabled, and able to care for many of their own needs. Some require assistance with housework, food preparation, bathing, administering medications, shopping and travel. We were fortunate in that we have been able to hire a housekeeper for less than the monthly Nursing Home charge thereby enabling my mother to reside in her own home in familiar surroundings, near her friends and business ties. Many are not this fortunate.

From my own observation, my suggestion for an alternate to Nursing Home care would be a roommate type of system whereby persons of like disabilities, mental status and personalities were grouped together in one house with seperate bedrooms and a central living and dining room. Government regulations should not be as stringent on this type of living arrangement however there should be some reimbursement for home health services necessary to the patient's well being. Routine household expenses, food, utilities, insurance etc., could be shared

by the residents on a pro rata basis. One manager or coordinator could be responsible for administering the financial arrangements, personnel staffing, etc., for several "homes". In ordinary circumstances, one nurse could assist with the medical needs of several homes. Each residence or home could be staffed with a housekeeper-cook on a full-time basis, live in status, with part time personnel available for week end coverage. There should be a central recreational area whereby the elderly persons could be transported by van, to play bingo, dominos, quilt, knit or just visit several afternoons a week. Transportation could be arranged for shopping, doctor visits etc.

A system such as this, probably would not cost the individual patient or resident as much as the charge rendered by a Nursing Home and should afford the elderly a means whereby they may reside in a private home without being subjected to the daily viewing of other elderly persons who are mentally incompacitated, incontinent or terminal. The residents would be encouraged to assume as much of the responsibility for their own activities of daily living as possible and perhaps even assist their "roommates" in areas of self care.

Services of a qualified Social Worker should be available on a regular or routinely scheduled basis for assessing the social and emotional adjustment to the home situation. Transfers could be arranged to another setting as appropriate after discussion with the resident, coordinator and Social Worker.

The coordinator should be aware of which services are reimbursed through governmental agencies such as equipment rental, services of the VNA and other home health agencies.

The quality of services rendered could be assessed by an individual delegated that responsibility or by a representative of the State Health Department. If private owned homes were not available, homes could be leased or constructed to meet the needs of the residents. All "homes" should be one level with doors which will accomadate wheelchairs, stool extensions and showers.

Oftentimes after acute care hospitalization, the patient could be released to his own "home" instead of a Nursing Home or Skilled Nursing Facility, since in many instances, only minimal assistance is required. "

Marlene Costilla

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