HEALTH CARE FOR OLDER AMERICANS: THE "ALTERNATIVES" ISSUE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

PART 8—WASHINGTON, D.C.

Standards in Home Care and the Home Care Services Act

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MONDAY, APRIL 17, 1978

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

The committee met at 9 a.m., pursuant to notice, in room S128 of the Capitol, Hon. Pete V. Domenici, presiding.

Present: Senators Domenici, Chiles, and Percy.

Also present: William E. Oriol, staff director; Margaret S. Fayé, minority professional staff member; Kathleen M. Deignan, professional staff member; Alison Case, operations assistant; and Theresa M. Forster, fiscal assistant.

OPENING STATEMENT BY SENATOR PETE V. DOMENICI, PRESIDING

Senator DOMENICI. I apologize for being late. I expect Senator Chiles to be here in a few minutes, and we are going to try very hard to get through as much as we can this morning. There are so many conflicts, with every Senator having two or three hearings scheduled at the same time. We are going to ask the witnesses to be as brief as they can and make their prepared remarks part of the record.

I am sure you all know that the Special Committee on Aging is very concerned about alternative delivery systems of home health care. The need to expand in-home service for the elderly has become increasingly apparent across this country and is beginning to receive attention by Congress, by the agencies who work with our older people, and by the elderly themselves.

HOME CARE SERVICES ACT

We have a number of bills pending in the Congress. I myself have introduced Senate bill 2009, the Home Care Services Act, which would expand the reimbursement of these services under medicare, eliminating many of the restrictions in the current law and regulations.

The response to this bill across the Nation was extremely favorable as to its concept and its effect on the lives of the elderly who wish to remain independent and in their own homes for as long as possible. The bill was endorsed by a number of State agencies on aging, several national organizations, and many individuals.

We asked for recommendations for improving the bill, and the comment received most often recommended that language be included regarding standards and their enforcement in order to insure high

quality care, with the monitoring of agencies to prevent the possibility of fraud and abuse. The staff of this committee has been in contact with many professionals in the field, including those here today who have been in the forefront of the efforts to develop such standards.

The problem of who should develop standards and of how to devise uniform standards without making them unduly restrictive or rigid—which might work a hardship on rural areas without the resources available in urban areas—led the committee to hold this hearing today on standards in home care and the Home Care Services Act.

In the voluntary sector, much has been done through the accreditation process in which all aspects of agency operations are rigorously assessed by teams of their peers. This process, however, is purely voluntary. With the proliferation of the agencies giving some type of home care, from 1,700 programs in 1973 to 3,700 today—450 new agencies each year—we must be increasingly vigilant as to the quality of service rendered. With the number of home aides nearly doubling, to 82,000 today, we must be certain that they are carefully trained for the work they are doing. Moreover, these figures do not include the individual providers used by many States, under title XX in particular. This kind of provider, often hired by the client, is not accountable to any agency—only to the client.

We cannot expect comprehensive home care programs without a change in medicare. This we are attempting to accomplish through S. 2009. I plan to introduce modifications to this bill as a result of the many comments and suggestions I have received, as well as those resulting from this hearing, to make sure that the issue of standards is addressed in legislation.

It is my hope that this hearing can be informal enough to allow for an exchange of opinions between the witnesses, as well as between the Chair and the witnesses. Only as this problem is approached quite frankly and honestly can we perhaps come to a meeting of the minds in regard to standards, and establish and maintain a high quality of care for all older Americans.

Representative William S. Cohen of Maine wanted to be here today, but unfortunately he had a prior commitment. He has been in the forefront of efforts to develop uniform standards for home health care, and was instrumental in securing passage of the legislation, section 18 of Public Law 94–142, which mandated a study of home health services by HEW. His statement will be inserted into the record at this point.

[Representative Cohen's statement follows:]

PREPARED STATEMENT OF HON. WILLIAM S. COHEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. Chairman, I regret not being able to attend your hearing on "Health Care for Older Americans: The 'Alternatives' Issue"—standards in home care and the Home Care Services Act. However, I appreciate the opportunity to submit a statement on an issue to which I have devoted much attention and energy over the past few years—the need for standards in home health care services.

I was the original author of legislation which resulted in the home health study mandated by section 18 of Public Law 94–142. My objective in drafting this bill was to create a set of uniform, enforceable standards of utilization control and quality care. Any provider of services who could meet these standards would then be eligible to participate in the Federal home health programs of medicare and medicaid or related in-home services of title XX.

It seems quite fitting to report to this body on developments in the area of standards for home care services, including the section 18 report, because it was at the joint hearing held by our two respective committees in October 1975, "Proprietary Home Health Care," that I first became interested in the issue.

In recounting the history of Government involvement in the issue of standards for home health care, let me begin with the issuance of the first and only HEW regulations released by former Secretary Matthews' new advanced rulemaking procedure, in August 1975. These regulations would have allowed greater participation in the medicaid program by proprietary and single service home health agencies. As I mentioned, that October our two committees held a joint hearing on the proposed regulations in which the lack of standards by which the quality of care offered by these agencies could be fostered, and fraud and abuse control was underlined.

Next, in February 1976, Senator Chiles held hearings in Florida on fraud and abusive practices in so-called private, nonprofit home health agencies. This hearing made it clear that generalizations about the quality of care provided in proprietary or nonprofit agencies were unfounded. Later that month, testimony was taken by our committee on the need for standards for all providers at our hearing entitled, "Comprehensive Home Health Care: Recommendations for Action."

The following April, Secretary Matthews withdrew the regulations pending further study. Just before and after this withdrawal, informal meetings between HEW and a variety for provider and consumer groups and individuals were held. No followup on the standards issue was taken, although it was widely recognized that this was a key issue to be resolved before steps could be taken to liberalize provider eligibility per se.

Fully 1 year after Matthews issued his first regulations, he released final revised regulations, without standards, saying he would hold hearings to resolve the more controversial issues raised by the originally proposed HEW regulations. At this point, I introduced home health standards legislation on August 26. In September 1976, the hearings were begun at regional offices across the country. By mid-October, a summary report of the hearings was released, but still no recommendations on the issue of standards were made. It was merely said that HEW would study the matter and make some recommendations in a year.

A discussion paper was circulated within HEW in December 1976 which supported using medicare standards as an acceptable minimum standard for all agencies. The paper contended the licensure requirements on top of meeting medicare standards adds little to quality of care or patient safety. To quote: "Since both proprietary and nonproprietary agencies are participating in medicare and medicaid, it seems appropriate that uniform standards should be applied to all agencies that deliver care to the home, including homemaker agencies."

As we entered this new Congress, more and more attention was paid to the matter of fraud and abuse in medicare and medicaid. As the Health Subcommittees of the House began considering this issue in earnest, it appeared that this legislation would be the vehicle to get something moving on home health standards. Congressman Waxman, a member of the Health Subcommitee of the House Interstate and Foreign Commerce Committee, was sympathetic to the goals of my legislation and in April 1977 amended my bill to H.R. 3, the medicare and medicaid antifraud and abuse bill.

During the legislative process, my legislation was somewhat modified, largely to accommodate concerns of the new Carter administration. Among other things, the issue of uniform provider standards was expanded to include a study of:

(1) The scope and definition of services to be offered under Federal programs;
(2) Requirements for eligibility in those programs;
(3) Methods for reimbursement; and
(4) Fraudulent and abusive practices.

While I believe these issues should be addressed, we must not lose sight of the fact that the primary intent of the Cohen/Waxman amendment was to facilitate establishment of a set of specific, enforceable standards to assure high quality home health services. Committee report language in both the House and Senate reiterates the intent of Congress that the Secretary is to come forth with regulatory changes he intends to make and to recommend appropriate statutory changes with respect to quality assurance and administrative efficiency. Furthermore, the standards for quality review should be suitable for application to all home health providers, regardless of sponsorship.

Since the need for such standards is so well documented, I believe that HEW does not need to wait until the full home health study is complete before standards are implemented. I pursued this issue with the Administrator of HEW's Health Care Financing Administration, Robert Derzon, who has been delegated responsibility for this study, when he testified before our Subcommittee on Health and Long-Term Care on February 22. He was reluctant to make any commitment to speed up the standards segment of the section 18 report. Instead, he promised to stick closely to a timetable calling for release of the report in October of this year.

It also became clear at that hearing that a major stumbling block will be the applicability of these standards to service providers operating under title XX. Although section 18 calls for uniform standards between titles 18, 19, and 20 of the Social Security Act, HCFA has no jurisdiction over title XX. Any recommendations for standards under that title would have to clear the Office of Human Development. Conversations my staff has had with those in OHD involved in the section 18 study suggest reluctance within OHD to endorsing Federal standards. This seems to stem from the adverse reception the Office received to child day care standards, the only other set of standards it has released.

Yet, the need for action is acute. Problems accompanying the lack of standards under title XX were highlighted at a hearing our committee held in New York City on February 6, where it was pointed out that needy elderly persons were deprived of the quality care they deserve because untrained aides were delivering health care services.

To complicate these issues, last November HCFA announced that HEW might accept surveys of the Joint Commission on Accreditation of Hospitals in place of those presently required by HEW for participation in Federal home health programs. The call for "deemed status" has been echoed by other organizations of home health providers who would much sooner use their own requirements to make their membership eligible to participate.

Aside from the fact that deeming is contrary to the congressional mandate in section 18 for a uniform set of standards, I would advise extreme caution for a process that would be nothing more than self-certification. To this end, I wrote the Director of HCFA's Bureau of Health Standards and Quality, Dr. Helen Smits, who will oversee the drafting of new survey and certification requirements for all health providers, requesting that any announcement of Federal policy on the subject of deeming be deferred, at least until the section 18 study is complete. I am pleased to report that Dr. Smits was willing to comply with that request.

As I see it, the problems which were presented to us 2½ years ago still exist. The first annual report of the Inspector General's Office released March 31, of this year reported that the largest number of convictions for defrauding medicare and medicaid were among nursing home and home health agencies. In short, the potential for home health care to develop the same reputation which has characterized the nursing home industry is obvious.

I believe that our present standards are inadequate, or at least not enforced, because abuse continues. I see no reason why any provider group should be arbitrarily excluded from participation in our Federal home health care programs merely on the basis of agency sponsorship. Finally, it is time to rationalize the home health programs of titles 18, 19, and 20. Requirements which are necessary in any home health program, despite its source of reimbursement, to assure quality care and control utilization should be uniform. I would suggest as a starting point that such requirements deal with the supervision and training of personnel, or audit and financial disclosure criteria.

We have no reasonable assurance that the public dollars for home health and in-home care services will be well spent until those matters are resolved.

Senator DOMENICI. I am pleased to welcome Michael Suzuki, Deputy Commissioner of Administration for Public Services, Office of Human Development Services, Department of Health, Education, and Welfare. He is here today as a reactor to the panel's testimony, specifically in regard to title XX. He is not here as a spokesman for the administration, and we understand that.

I might say to all of you who are here in attendance, the committee which is holding this hearing is the Special Committee on Aging, and as you know we are not a legislative committee in the sense of drafting the final bill. That will take place in the Finance Committee of the Senate.

Our committee has decided during the last 18 months that we are going to use our resources to get out front of an issue and take an active role in presenting before the Finance Committee our findings on serious issues affecting the elderly in our country.

Our first panel will be a panel of national associations of home care agencies. We have four panelists and Mr. Suzuki as a reactor. I will name the panelists, and as you each begin, you can tell everybody who you are. Florence Moore, executive director, National Council of Homemaker/Home Health Aide Services, Inc.; Joan Caserta, director, Division of Home Health Agencies and Community Health Services, National League for Nursing; John Byrne, president, National Association of Home Health Agencies, and executive director, Visiting Nurse Association; accompanied by Hope Runnels, cochairman, standards committee, National Association of Home Health Agencies, and executive director, Visiting Nurse Association; Ronald Rosenberg, chairman, Home Health Services Association, and vice president for corporate affairs, Homemakers-Upjohn.

We shall start with Florence, and if you will all keep your statements as brief as possible, then we will have time for an exchange of opinions for the remainder of the morning. Written statements will be made part of the record.

Let's get started.

Mrs. MOORE. I am glad Hadley Hall, a member of our board, is present. He will give our testimony.

STATEMENT OF HADLEY D. HALL, EXECUTIVE DIRECTOR, SAN FRANCISCO, CALIF., HOME HEALTH SERVICE; BOARD MEMBER, NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., ACCOMPANIED BY FLORENCE MOORE, EXECUTIVE DIRECTOR, NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

Mr. HALL. I am Hadley Hall, a board member of the National Council for Homemaker-Home Health Aide Services—a national, voluntary section 501(c)(3) membership organization.

The national council started in 1962 with encouragement and support from HEW, with standard setting as a key mandate. The development of a code of standards was a first accomplishment. The standards have grown and been revised. They are now basic standards, not goal standards; that is, they are the floor below which an agency's performance cannot fall and be acceptable.

In 1969, the council was specified as a standard-setting body for homemaker service organized under the work incentive program. The following year the council was again named by the Social and Rehabilitation Service as a standard-setting body for homemaker service for the aged, blind, and disabled.

Recognition brings responsibilities. The Federal requirements are that agencies be in reasonable conformity with the standards, along with support from Government and the field, the council was encouraged to take the next step—accreditation. An accreditation program helps agencies to prove that they are, indeed, in conformity with the standards—not just say, without verification, that they meet standards.

A copy of a document called "Interpretation of Standards" is attached to this testimony.[1] Funds to support the national council programs for accreditation were made available by HEW and recently by the W. K. Kellogg Foundation.

Emphasis Within Standards

In the years that have followed, the council has worked to make the review process more objective and more efficient. We now have an accreditation commission of 12 persons. They come from all over the country. They meet several times a year to make judgment on the conformity with standards of applicant agencies.

We use an index of compliance to check the objectivity of decisions by the commission. Several of the standards are weighted more heavily than others: Those requiring that the agency be responsible for basic orientation and training of the staff; that there be a professional assessment and plan of care, with periodic reassessments; and that the agency give all employees the protection of observing the minimum wage law and taking responsibility for paying social security, Workmen's Compensation, and other required fringe benefits.

A major impact of the standards has been that many States have used them as a model for the development of State standards. Other national organizations recognize these standards. Many local agencies are using the standards as a guide to developing new programs and upgrading existing ones.

The national council is working cooperatively with other organizations to coordinate accrediting processes such as the American Hospital Association, the National League for Nursing, and the National Association of Home Health Agencies.

In 1973, Federal requirements for standards were removed. Under title XX the Federal Government moved away from providing leadership or standards in health and social service programs. This included leaving standard-setting up to the States.

One result of leaving this up to the States is that local governments are setting up homemaker-home health aide workers who are called housekeepers, attendants, chore workers, personal care workers, or homemakers—frequently as self-employed providers. For this new class of worker, the critical protections of training, professional accountability for the patient, and agency responsibility for required wages, social security payments, income taxes, and other employer-paid benefits are abrogated.

Legislation for Basic National Standards

Both Federal and State governments are giving a lot of attention to expanding in-home services now. The council's greatest concern is that they are not paying as much attention to building protections into

[1] See appendix, item 1, p. 821.

those services. S. 2009, while including many needed changes, is a case in point. It does not stress enough the need for standards or provide the resources for their monitoring. We believe that Federal legislation should require that basic national standards be met and verified as being continually met.

In addition, we believe that Federal legislation should recognize and financially support the standards and monitoring programs of national voluntary accreditation programs.

No army of Federal employees can prevent the financial fraud and patient abuse as well as the people who know the providers in their own community.

Thank you, sir.

Senator DOMENICI. Now, just take your last two statements, that we need these standards set nationally, and then what was your last sentence?

Mr. HALL. I don't believe we can hire the army of Federal employees that would be necessary to police the providers, and it would be far more expensive to do that than it would be to support, financially, voluntary standard-setting organizations that are responsible to national standard-setting bodies.

Senator DOMENICI. At first it appeared inconsistent, but it isn't.

Joan, you are next.

STATEMENT OF JOAN E. CASERTA, DIRECTOR, DIVISION OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING, NEW YORK, N.Y., ACCOMPANIED BY LEAH BROCK, CONSULTANT

Ms. CASERTA. We are happy to be here. I am pleased to have Leah Brock with us, consultant for our group, who will respond also.

Our testimony [1] has been submitted for the record and we would like to include attachments [2] as well.

Senator DOMENICI. That will be done.

Ms. CASERTA. The Council of Home Health Agencies and Community Health Services of the National League for Nursing, I suppose, is the current-day generation of the national organization, the Council of Public Health Nursing established in 1902. That organization set forth a mandate that there must be standards in this industry for any service delivered into people's homes and in ambulatory settings so that the accreditation program and standard setting has been growing since the inception of that organization.

"STRUCTURE" VERSUS "OUTCOME" STANDARDS

In 1961, the first sets of industry standards were published and an accreditation program was established by NLN/APHA. We all know accreditation is a voluntary process by which agencies choose to meet standards set by the field. The standards are set by the field of agencies at large. They currently are structure standards in that they get to structure of an organization delivering services.

[1] See p. 793.
[2] See appendix, item 3, p. 829.

Implicit in those standards are processes by which an agency and its employees carry out their job to promote quality. So you can see evolution from 1961 in accreditation programs through the current day 1978 in which agencies go through site visits and peer review by a nine-member panel of experts.

Currently, we realize the weakness in the program of outcome standards for each of the disciplines operating in the organization. We have a proposal in for funding to HEW which would enable us to develop outcome standards that will be added to the existing standards in the program. Several of our distinguished panelists have agreed to participate in that proposal when and if it is funded. I think in the attachments it would be interesting for you to know that we have submitted the background information of the issues involving standards and accreditation and the development of standards which one of our staff people is conducting in Ontario. There is so much interest in standards and in accreditation that Canada has begun to look at home health and community nursing services much in the same way as we, and we are currently conducting workshop sessions there.

You will also note that, in light of your piece of legislation, S. 2009, we have introduced a set of criteria that can be used for the social support system of the home care service. There is a big debate about whether or not the health care services and social support services should be funded together. There is a big debate in Government about whether one piece of health legislation should support those services. This has to be resolved. To keep people home, there must be a combination of both health and social support services. We have learned from experience over the last 6 or 7 years to recognize about 10 or 11 key services that should be provided for to bring those two together. The current conditions for participation could serve as a baseline for those services conditions with expansion in the definitions, the continuing education requirements, and in supervision of the home health aide requirements.

Also, there needs to be an upgrading of the definition of the Administrator and manager of the Agencies which is not stipulated in the current conditions of participation. There needs also be a recognition in those conditions of the marketing performance of an Agency.

Some 2 years ago the social security amendments mandated that Agencies include a capital budget for 2 years. We believe that the same kind of marketing and program requirement plan has to be produced in those Agencies. We understand the concern of Government. We are as concerned, particularly with the fraud and abuse that this industry is susceptible to.

We concur with Hadley Hall's comment about the monitoring by Government and the army of people it takes to do that, so that we strongly believe voluntarily going through a standard-setting and accreditation process which says, "This is what I am going to do and now I am ready to be judged by a group of my peers."

Thank you, sir.

Senator DOMENICI. Thank you very much.

We are pleased to have Senator Percy with us.

Senator Percy, I have told the panel and the people here that there are many conflicts in our schedules today and we are going to try our

best to spend enough time to get all their testimony. I have also explained it was our position on the Special Committee on Aging that we wanted to have this hearing in order to begin to develop the evidence to present legislation to the Finance Committee for improving the home health care system over which they basically have jurisdiction in terms of funding.

The witnesses are genuinely concerned about standards if we do expand the program significantly. They are also concerned about the possibility for fraud and abuse, and you have heard the last witness in that regard.

I would be delighted to yield to you for comment at this point.

Senator PERCY. I am very pleased to be a cosponsor of S. 2009. We are all concerned about the same thing. We are aiming in the same direction, to determine what is the best way to do this. We welcome all of you.

Senator DOMENICI. Thank you, Senator.

I might say, Senator Percy has joined with a number of us—in fact, I think it is almost unanimous on the Special Committee on Aging—in addressing the broad general issue that I might categorize as finding real alternatives to institutional health care. The institutional health delivery system in our country, we think, quite by accident has been given the main thrust as far as the delivery of health services, because that was in existence when we developed the health plans. We are hopeful we can convince the Finance Committee that by adding significant resources and coverage to alternative systems, we are not necessarily adding many dollars. To the contrary, if we have a whole spectrum of services in existence, we are hopeful someone would review this over a 3- or 4-year period and conclude that this might be less costly because of the options available.

Senator PERCY. I don't know of any area where it is not the right and human thing to do. But no work could be more cost effective. Just look at the potential cost now for construction of new hospital beds and maintenance care. Return on investment is tremendous, and that potential is what we are really after. It is financially sound today. It makes a great deal of sense.

[The prepared statement of Joan E. Caserta follows:]

PREPARED STATEMENT OF JOAN E. CASERTA

I speak today on behalf of the Council of Home Health Agencies and Community Health Services of the National League for Nursing. The council, hereafter known as CHHA/CHS, is a membership organization of some 1,500 agencies which deliver ambulatory and home-based care to individuals for the restoration and maintenance of their optimum health, as well as the prevention of further illness or debilitation. We are pleased to discuss with the Senate Special Committee on Aging the issue of standards for these home care agencies which render services reimbursable under titles XVIII, XIX, and XX of the Social Security Act.

In 1961, the National League for Nursing developed and published the first edition of "Criteria for Evaluating the Administration of a Public Health Nursing Service." Close on its heels came the preliminary phase of a joint accreditation program of community nursing services cosponsored by NLN's then Council of Public Health Nursing and the American Public Health Association. This preliminary phase included a self-study, during which public health nursing agencies which participated developed a written report in response to the criteria guide. To digress for clarity, we define "criteria" as "variables that are used as

indicators of quality performance," the level of expected performance on each of these variables is the standard. Information and evidences of performance were stated in terms of absolute criteria or standards which the agencies met or did not meet in the area of (1) community health public identification; (2) organization and administration; (3) program development; (4) staffing; and (5) strategic future plans for the agency in light of its stated purpose for being.

In 1968, this accreditation program grew to involve an on-site visit to the agency by a peer team of visitors, as well as the self-study report, followed by the collective judgment of a peer board of review to grant or not grant accreditation.

We understand accreditation as a "process by which an agency or organization evaluates and recognizes a program of service as meeting certain predetermined qualifications or standards." The NLN/APHA accreditation program and process are illustrated and defined further in attachment 1.[1]

With the inception of the medicare program, public health nursing agencies began to evolve into multiservice home health agencies, a term coined by that piece of legislation. As the agencies changed, so that accreditation program changed. In 1970, the first representatives from health disciplines other than nursing were added to the Accreditation Standards Committee and, in 1973, the entire name of the program was changed to the NLN/APHA Accreditation Program for Home Health Agencies and Community Nursing Services.

Since that time, standards have been continually reviewed and updated to keep pace with changing industry and the complexities of organizations offering these services. In 1976, a conflict of interest and disclosure standard were adopted and, in 1977, an entire revision of the standards regarding financial management and control was initiated and is continuing today. These standards will ultimately be reviewed with all agencies at an open meeting of CHHA/CHS, at which time final modification and adoption will come from the field. This is the process that has been used over the years since the program's inception. In addition, the program is currently testing a weighting schema which will quantitatively determine the degree to which an agency meets the criteria. Work with this schema will give us the data to identify those standards which are most crucial in the demonstration of quality.

So you can see that we believe that the application of standards is absolutely necessary if we are to make final judgments about the quality of home care and if we are to be accountable to the client as well as third party payors of service.

For the committee's edification today, we were asked to address certain issues relating to standards for the home care industry, as well as issues directly relating to the functioning of the industry as a whole.

CONDITIONS OF PARTICIPATION: HOME HEALTH AGENCIES

Foremost among these issues is the adequacy of current conditions of participation or Federal standards for home health agencies, as stated in HIRM subpart L, revision 8 (November 1973). CHHA/CHS believes these conditions are minimal for the accountability of any agency participating in the program. We believe further that these baseline conditions can be expanded to apply to those home health agencies which offer title XIX and XX services as well. In addition, we would recommend that where agencies offer home care services covered by title III of the Older Americans Act, that conditions not be different for agencies which deliver these services.

We hereby recommend the following changes in the current Federal conditions or standards:

"405.1202 (a) Administrator, Home Health Agency. A person also *is employed full-time for the purpose of organizing and managing the agencies programs and services*, and who . . . ."

Definitions of home health aide, homemaker, chore, and family care worker, etc., would have to be added here as expansions for title XIX and XX programs in particular. Such definitions as have been developed in Texas by the Visiting Nurse Association of Dallas seen in attachment 2[2] would apply.

"405.1204 Certification by State Agency. (b) *Add (1)* 'Following initial certification by the State agency, a home health agency which voluntarily applies to and meets the standards of the NLN/APHA accreditation program may be deemed as being in substantial compliance with the conditions. Such voluntary accreditation decisions will be subject to validation and periodic review by the Secretary and/or his designee.' "

[1] Retained in committee files.
[2] Retained in committee files.

A comparison of the existing federal conditions and the NLN/APHA standards can be analyzed in attachment 3.[1]

Conditions of noncompliance as discussed in section 405.1207 shall apply to the accreditation process as well.

QUALITY CONTROL

Certification and accreditation are both mechanisms of quality control in a home health agency. We believe that quality control programs must have the following components:

(1) The identification and vesting of administrative authority in an individual unit within the agency—with responsibility for ongoing agency, program, and service evaluation.

(2) Ongoing surveillance by agency management in all areas of operations with explicit attention to those factors which insure quality services. Factors such as

—The employment of qualified practitioner of health care. Individuals who meet those standards developed by their professional and/or national associations.

—Use of the prudent buyer concept in purchase of manpower and materials.

—Utilization of personnel to their highest level of performance.

—Development of pragmatic flexible but firm policies.

(3) The development of measurable program and/or service objectives. Objectives stated in patient population aggregates.

(4) Implementation of concurrent and retrospective multidisciplinary patient care audits through ongoing uniform clinical record review systems. This includes identification and periodic study of special problem cases.

(5) Development of process task for peer review audits by disciplines operating within the agency.

(6) Conducting of routine consumer evaluation of services provided, including needs met and unmet as perceived by the patient.

(7) Development of productivity and performance criteria and standards for all personnel.

(8) Routine correlation of findings from all the foregoing processes with concommitant changes, as appropriate, in agency programs, policies, practices, procedures, and manpower.

CERTIFICATE OF NEED

We believe that all newly established agencies and all proposals for extension of services should be subject to a certificate of need review. We believe that objective criteria should continue to be developed and validated to eliminate the possibility of a "certificate of need in name only." Following up on this belief, CHHA/CHS developed a formula for an estimate of home health needs. This formula is not yet validated because we have been unsuccessful in obtaining funding to do so. The formula is being used by many health systems agencies and several home health agencies. We are encouraging anyone who is using it to provide us with feedback on their experience as a beginning step toward validation of the formula. We recommend that this formula be reviewed in conjunction with existing formulas, e.g., those of the Western Pennsylvania Health Planning Association and the Kentucky Comprehensive Health Planning Council.

The CHHA/CHS formula is based upon current knowledge of population trends and utilization of home health within the mix of the seven services now being provided and funded: nursing, physical therapy, home health aide, speech pathology, occupational therapy, medical social work, medical supplies and equipment. No attempt is made to include homemaker and chore service, etc. The formula has to be adjusted and expanded to do so.

24-HOUR SERVICE

Historically, public health nursing and home health agencies were organized to provide a temporary intermittent health service to people in their own homes. When patients or families needed more hours of service than we were staffed to provide, patients were referred to another community agency or to an institution. In other words, we were telling the family that if the patient needed care at times during which we were not equipped to provide it, perhaps the patient shouldn't be cared for at home.

[1] See appendix, item 3, p. 829.

This is no longer true today. Many home health agencies and community nursing services today are available and providing services 7 days a week and during a 24-hour period, and that movement is growing. CHHA/CHS believes that home care services of good quality must be available 24 hours a day to meet patient needs and to facilitate their maximum independence at home in their own environment.

SINGLE SERVICE AGENCIES

During 1973–74, a membership group of CHHA/CHS developed a proposed model for the delivery of home health services. In the introduction of that model, the group stated its basic premise that the availability of a broad scope of home health services to all segments of the population must be increased while, at the same time, maximizing manpower utilization, providing quality assurance, and promoting cost containment.

Ladies and gentlemen, we submit that home health services are an array of services which promote, restore, or maintain health or minimize the effects of illness and disability. Single service agencies cannot, by their very nature, meet those goals. The organizational model of services as seen in attachment 4 [1] has been used by community groups, health planning bodies, and the insurance industry to foster the availability of comprehensive, cost-effective home health services.

CHHA/CHS encourages all agencies to broaden their patient base so they are not dependent on one reimbursement source only. However, home health agencies are faced with the dilemma of inadequate reimbursement for services rendered as demonstrated by decreasing voluntary dollars, medicaid reimbursement below cost, reluctance of private insurance companies to cover home health benefits.

Until we have a national health insurance scheme with universal coverage—one in which home health care is a legitimate part of the delivery system—agencies will continue to render service under reimbursement plans that foster and support a financially sound base.

Single reimbursement source agencies are symptoms of this dilemma.

In closing, we congratulate you, Senator Domenici, for your bill S. 2009. As we wrote to you last August, Mr. Domenici, many of the changes proposed in your bill have long been needed to interrelate the health services needed by persons at home with the social support services needed to keep them there instead of within institutions. We think the issue of standards is especially important in light of S. 2009 and the possibility of serious congressional discussion of a national health insurance program.

We appreciate this opportunity to share our thoughts with you.

Senator DOMENICI. John Byrne, president of the National Association of Home Health Agencies, and Hope Runnels, executive director of the Visiting Nurse Association, Portland, Oreg.

Mr. BYRNE. I have asked Hope Runnels to make the presentation this morning.

STATEMENT OF HOPE RUNNELS, COCHAIRMAN, STANDARDS COMMITTEE, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, AND EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION, PORTLAND, OREG., ACCOMPANIED BY JOHN BYRNE, PRESIDENT, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, ST. LOUIS, MO.

Ms. RUNNELS. I am Hope Runnels, executive director of the Visiting Nurse Association of Portland, Oreg. I am here speaking for the National Association of Home Health Agencies which we call NAHHA. We are grateful to the Senate Special Committee on Aging for convening this hearing and for your willingness to spend this time with us discussing the home health agencies. It certainly exemplifies the concern that you have displayed throughout this series of hearings.

[1] See appendix, item 3, p. 847.

and in the legislation you have introduced, for the millions of older Americans—and other Americans, as well—whose health needs can be met without institutionalization if alternative services are available in sufficient quantity and quality.

The issue of promoting quality care by home health agencies is one that has concerned NAHHA for some time. We believe that it can best be addressed—initially, at least—by prescribing uniform standards for all such agencies that wish to participate in federally supported health services programs.

Committee on Standards

To this end, NAHHA created a committee on standards nearly 2 years ago which set about drafting a set of standards for our member agencies. In the process, we examined standards that have been developed by various private organizations for home health agencies, and for other kinds of health services entities. Over time, we became increasingly dissatisfied with the approach of drafting our own standards, for two separate, but related, reasons.

First, it seemed unlikely that agencies which did not belong to NAHHA would adhere to standards developed by an organization in which they did not participate, yet it was evident that home health agency standards, to be of any real value, would have to be applied to all federally recognized agencies.

Second, of the approximately 2,300 home health agencies certified under the medicare program, probably less than half belong to one or more of the several organized professional groups concerned with standards. Therefore, it was clearly not feasible to seek to cover the field by obtaining HEW approval of the different sets of standards developed by these groups and enforced by them on a voluntary basis. Moreover, such an approach would obviously have departed from the principle of uniform standards for all agencies, which are believed to be an important goal.

Accordingly, we concluded that the only effective way to deal with the problem was to suggest that the requirements established by HEW for reimbursement under the medicare program, known as the conditions of participations, be amended to embody an acceptable set of standards. These medicare conditions are the one common denominator for nearly all agencies, since they are applied to agencies participating in State medicaid programs as well. They also could be expanded to cover providers of home health and homemaker services under title XX programs. They would thus have the virtue of being uniform for all agencies and, if properly constructed, they could be applied with equal force to both a small rural agency and one with a multimillion-dollar budget in a metropolitan area.

Having decided on this approach to the problem, we analyzed the conditions of participation, using the survey form approved for the purpose of reviewing home health agencies and certifying their eligibility to participate in medicare and medicaid. At the outset, we were faced with a fundamental question: What do we mean by standards?

A variety of definitions is available, but the one we felt best described the ends we were seeking is contained in "A Discursive Dictionary of Health Care," published by the Subcommittee on Health

and the Environment of the House Interstate and Foreign Commerce Committee February 1976. The definition given there states, in part, on page 155:

> Standards: generally, a measure set by competent authority as the rule for measuring quantity of quality. Conformity with standards is usually a condition of licensure, accreditation, or payment for services. Standards may be defined in relation to: The actual or predicted efforts of care; the performance or credentials of professional personnel; and the physical plant, governance, and administration of facilities and programs.

Note the emphasis in that definition on measurement. We believe very strongly that something purporting to be a standard fails if it does not give sufficient specific guidance so that a surveyor can assess levels of performance.

Deficiencies in Medicare Conditions of Participation

We then turned to an analysis of the present conditions of participation. We found that while they are sound in many respects, they are deficient to the extent that they merely describe what a home health agency must be, without setting out adequate standards for what it should be doing. Moreover, the conditions are muddled in some places, with separate concepts lumped together. Finally, there are areas in which substantive changes should be made—in a few cases necessitating statutory changes in the Social Security Act—and there are matters not covered which should be included.

Our preliminary conclusions are contained in a document [1] I have supplied to the committee, which is in two parts, which sets out our comments side by side with appropriate sections of the conditions of participation. We need to expand somewhat on these comments to provide a better statement of the reasons for our recommended changes, but I hope that this information will be helpful to the committee, even in its present state.

Here are a few samples of our critique:

First, planning and evaluation. The conditions of participation requirements for institutional planning are limited essentially to the preparation of an annual operating budget and a capital expenditures budget. There is a conspicuous lack of any requirement for the preparation of an overall plan which sets out the particular population to be served in a particular geographic area with services of a stated frequency and availability through specified resources of personnel, finances, equipment, and physical facilities.

In addition, there should be required a program plan which gives the details of how services are to be provided. Coupled with the planning should be a process of written evaluation to determine the extent to which planned objectives are being met and the levels of performance reached in doing so. In this connection, it would be advisable to have surveyors monitor a sample of home visits to assess the patient care being rendered.

Planning and evaluation requirements are of particular significance for use by health planning agencies in the certificate-of-need process to determine whether a need for proposed or existing services exists. A number of States currently cover home health agencies under their

[1] See app., item 5, p. 857.

certificate-of-need laws, and the extension of Health Planning Act authorities recently approved by the House Interstate and Foreign Commerce Committee would extend such coverage to all States.

Second, agency auspices. The present conditions recognize a distinction only as between nonprofit and proprietary—or for-profit—agencies. Information acquired at hearings of this and other committees of Congress has shown that in many instances this is a distinction without a difference. Some agencies organized ostensibly as nonprofit entities function more as individual entrepreneurships, with benefits for those in control that are clearly excessive. It may be that the development of adequate standards applicable to all agencies, regardless of their profit status, will obviate the need for such distinctions, but in the meantime they should be clarified.

Clarification of Non-Profit Agency Status

One indication of genuine nonprofit status is a disinterested board of directors, drawn from the community, to which agency administrators are answerable. Conversely, a board controlled by those having a direct interest in the agency's operations raises doubts about nonprofit status.

Another indicator would be the provision of services on a charitable basis, and the receipt of charitable contributions from voluntary organizations in the community.

Third, supervision. The current conditions require only that skilled nursing or other therapeutic services be provided under the supervision and direction of a physician or a registered nurse. Under this provision, the physician or nurse may be supervising the activities of 1 or 100 persons working under them. Some more measurable ratio should be provided of supervisor to staff personnel. In addition, the duties of supervision need to be spelled out more precisely.

Formal Training for Home Health Aides

Fourth, home health aides. The conditions now provide for the selection of home health aides "on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job." This is less than adequate. There should be a formal training program mandated for home health aides who, after all, most often work without direct supervision in the patient's own home.

These are only a few of the changes we believe are needed in the conditions of participation before they can serve as meaningful comprehensive standards for home health agencies. Others may disagree with the specifics of our recommendations, but we hope that there can be broad agreement on the approach we suggest of establishing the conditions of participation as uniform standards to promote high-quality patient care services by responsibly administered home health agencies. We recognize that these will be minimum standards; once they are established, there will be adequate opportunity for private accrediting organizations to set their own higher standards for those of their members who wish to attain the distinction of demonstrating

a higher level of performance. For now, however, let us take the first step.

NAHHA stands ready to assist in every way possible in the urgent needed process of converting the conditions of participation into adequate standards.

Senator DOMENICI. Thank you very much.

I want to recognize Senator Chiles of Florida. I don't think I have to tell anyone in this room of his genuine abiding interest in this area. He has participated in many hearings, and we are most appreciative that you are here.

Senator CHILES. Thank you, Mr. Chairman.

Senator DOMENICI. If you have some comments to make, please do so.

STATEMENT BY SENATOR LAWTON CHILES

Senator CHILES. Represented at this hearing this morning are four major national associations of home care agencies—all with a strong interest in the development of uniform standards for all forms of home care.

As a matter of fact, there are five associations. The Assembly of Outpatient and Home Care Institutions of the American Hospital Association, representing hospital-based home care agencies, has also worked with the committee and will submit testimony on home care standards.

The mere existence of five national organizations representing home care agencies attests to the growth of home care services during recent years.

This is growth that I know my good friend Pete Domenici and I both welcome, as we are both well aware of thousands of older Americans who still do not have access to competent, quality support for independent living.

At the same time, however, I know we are both concerned with just that—insuring the competence and quality of any services delivered in the home or other independent settings.

"MAJOR PROBLEMS LOOMING"

I took testimony at earlier hearings which makes it clear that this is not always the case, even now. There are indications of major problems looming in home care services supported by title XX and medicaid. Home attendants—underpaid, undertrained, overworked, and unsupervised—recently were the subject of extensive publicity in New York City. I received testimony last May which indicated that similar problems may be occurring in more than 25 States in title XX programs alone. Allegations included instances of patient abuse and fiscal irresponsibility.

We are all familiar with revelations of what can happen with the medicare program too—as complicated accounting arrangements mask inappropriate expenditures of home health funds.

We enter a challenging new era when we increase our support for services delivered in the home. I think many of us have decided that is how we should generally move.

But the very fact of services delivered in isolated settings, where adequate protections are difficult to apply, gives us added responsibility to insure thoughtful and careful program development.

That is why we are having this hearing on standards in home care. Our witnesses have all given a great deal of thought to this issue.

This week I am introducing a bill which would amend the Older Americans Act to encourage the development of coordinated systems of community home care. One feature of the bill is designed to encourage States to develop standards for all forms of home care.

I am not sure that the question of setting, monitoring, and enforcing standards is one that the Federal Government can take on in isolation, and I look forward to your comments this morning.

Senator DOMENICI. Our next witness is Ronald Rosenberg, chairman of the Home Health Services Association, and vice president for planning and development, Homemakers-Upjohn.

STATEMENT OF RONALD E. ROSENBERG, WASHINGTON, D.C., CHAIRMAN, HOME HEALTH SERVICES ASSOCIATION; VICE PRESIDENT FOR PLANNING AND DEVELOPMENT, HOMEMAKERS-UPJOHN CO., ACCOMPANIED BY BERKELEY BENNETT, PRESIDENT, HOME HEALTH SERVICES ASSOCIATION

Mr. ROSENBERG. Thank you, and good morning. Thank you for the opportunity to appear before this group and discuss what we feel is an important issue. I am accompanied by Berkeley Bennett who is president of our association.

Mr. Chairman, the Home Health Services Association was formed in recent weeks primarily to encourage and promote greater quality, efficiency, reliability, and safety in the delivery of home health care services and to improve the services of home health providers to the general public. Home Health Services Association members are national home health care provider groups representing over 500 tax-paying home health offices.

"STANDARDS . . . ARE NEEDED NOW"

Standards for home health care service delivery are needed now to guarantee the quality of care. Every panelist has spoken to that issue. The only Federal program that has established standards for home health is medicare. Unfortunately, these standards are not patient outcome oriented—they apply only to providers in the medicare program. Through complexities and interpretations in the social security amendments, medicaid providers, by regulation, must be medicare certified.

Neither title XX social services nor the Older Americans Act programs require that providers meet any such standards. Therefore, the only standards which apply to home health care in the private sector are those established by the licensure laws that exist in 20 States. In 30 States, there is no protection of the public because home health agencies are not required to be licensed.

The Home Health Services Association believes that standards for home health care providers ought to encompass three aspects of qual-

ity: The functional status and potential of the patient, the training and experience of the care givers, and the level of supervision of individual cases.

First, let's consider the patient. The patient care plan established by the agency to implement the physician's plan of treatment must take into account much more than the diagnosis.

Care must be aimed at assisting the patient to function at full potential, given his diagnosis and current capacity. The care plan must be developed in concert with the patient and family and should concentrate on providing the appropriate level of care. If patients are respected and if the agency properly assesses and monitors the patient, the patient ought to be able to reach his full potential. Currently there are no standards for patients' rights; there are no standards governing the agencies' patient assessment.

Second in the quality structure is delivery. The well-being of the patient is actually in the hands of the person giving the one-on-one care. In the home health field the actual care is given generally by a home health aide. If the home health aide is not trained or experienced, then the patient is not receiving quality care. There are no standards governing the training, experience, and proficiency of home health aides.

Third, the quality of service is dependent upon the level of supervision of individual cases. While medicare standards mandate that nonprofessional personnel be supervised by professionals, there is no standard governing case supervision. A supervisor could get so concerned with personnel management that he might not have time to actually manage the patient and his care plan.

Patient Accountability Missing in Government Standards

In each of these aspects of quality care, the meaningful standards are those established by agencies themselves in order to provide accountability to their patients. Most of the standards established by the Government assure proper accountability by the agency to its funding source.

In the private sector, Mr. Chairman, we are answerable to our patients.

The Home Health Services Association believes that this country must move rapidly to adopt, implement, and enforce industrywide standards for the delivery of home health services and for the individuals who provide such in-home services.

At the very least, Home Health Services Association believes that existing medicare standards ought to apply to all home health providers. As you know, the medicare law allows proprietary home health providers to participate in the medicare program only if they are licensed by individual States. Since the majority of States have not enacted home health agency licensure laws, proprietary providers—as well as nonprofit—are delivering health care to a large segment of the population without a license.

At the time of passage of the medicare and medicaid laws in 1966, the Congress stated in its respective committee reports:

> . . . Organizations providing home care on a profit basis are presently nonexistent. However, the language of the bill permits covering such agencies if they come into being, are licensed, and meet the high standards which the present nonprofit agencies offering organized care meet.

It seems apparent from this statement that the Congress fully expected States to enact home health licensure laws as the need arose. After all, the States license virtually every other segment of health as well as beauticians and barbers in the interest of the health and safety of their State residents. Nevertheless, the majority of the States still have not acted.

Why? In great part because of unspecified fears of the effect of the profit motive on an agency's actual delivery of care. Proprietaries who urge States to enact such laws are not asking for special treatment; to the contrary, they are asking for fair and equal treatment under the law. They are asking to be regulated and bound to perform within specified standards.

States Slow to Act on Licensure

Still, the States have been slow to act, and the net result has been that thousands of people are not receiving home health care because nonprofit agencies serving medicare in States without licensing laws simply lack the manpower to meet the need.

In its discussion paper following the national public hearings on home health care in the fall of 1976, HEW stated:

> Since both proprietary and nonproprietary agencies are participating in medicare and medicaid, it seems appropriate that uniform standards should be applied to all agencies that deliver care to the home, including homemaker agencies—

Adding that—

> the suitability of any provider may be more dependent on ability to comply with quality standards than on financial organization.

For these reasons, Mr. Chairman, we believe that your home health bill, S. 2009, should be revised to include a change in section 1861(o) that would put all agencies on the same footing. This action would immediately make services available to literally hundreds of thousands desperately in need of in-home care. There is a vast unmet need in this country: A need to keep people in their home surroundings; a need to keep costs down; and a need for people to care for the elderly. Coupled with implementation of industrywide standards, this 1861(o) change would end discrimination against a class of providers—nowhere else in the medicare program is anyone singled out—and make home health care services more accessible and more available to those in need. All providers should be equal under the law and answerable to a single set of standards.

Senator Domenici. I wonder if Mr. Suzuki would like to give some reactions at this point.

STATEMENT OF MICHAEL SUZUKI, DEPUTY COMMISSIONER, ADMINISTRATION FOR PUBLIC SERVICES, OFFICE OF HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Suzuki. I appreciate the opportunity to come and hear the testimony that has been presented and to hear the concern this committee has expressed for title XX—the only program I can speak to specifically.

The title XX program is an interesting program in that, under Federal law, the 50 States and the District of Columbia can define their services program.

This, however, has created a problem in that States have come up with more than 1,300 definitions for services, many of which are not comparable. So we really have had to invent a new language in order to accommodate all of the ways that, for example, homemaker service has been described. We have done this.

Title XX—$300 Million for Homemaker Services

In the area of homemaker services, our estimates are that more than $300 million in title XX money is being spent annually. Such sums naturally keep raising the question of standards, and this is a question we have great concern about.

Here I would like to read off to you our top 10 services—in terms of title XX money spent by the States. Using the titles the States use, they are: (1) Day care services for children; (2) foster care services for children; (3) protective services for children; (4) education and training services; (5) counseling services; (6) chore services; (7) homemaker services; (8) health-related services; (9) employment services; and (10) residential care and treatment services.

The reason I wanted to share with you the major services funded under title XX is that the question of standards applies not only in the instance of homemaker services, but in terms of a wide range of services.

When the question comes up of what role the Federal Government should play regarding standards, I have to be very direct and point out that the only service the title XX law says we have the authority to deal with in terms of standards is day care for children. Although this authority has a long history, HEW is currently preparing a report on what the Federal role should be on these standards.

I want to put our dilemma into perspective. Not only are we concerned about chore services and homemaker services for the elderly, but we are offering such activities as the placement of children away from their own homes, and we have no authority to articulate standards in terms of the residential care and treatment these children will receive.

While this is an issue we don't want to ignore, nevertheless from our perspective—and this perspective covers a multitude of programs—whenever we raise the question of Federal standards, the question that invariably surfaces is: What is the proper Federal role?

We are examining in exquisite detail—with an investment of more dollars than I like to think about—the Federal day care standards upon which Congress has declared a moratorium three times. Some of the issues that concerned Congress were the appropriateness of the standards and the costs involved. In certain instances, when Federal funds are expended for services, the State government must develop standards in relation to such areas of activity carried out under title XX.

Today, four national associations discussed their views on this subject. Two of them called for voluntary, national standards, with voluntary accreditation. The other two advocated the use of the medicare conditions of participation. I have no answer as to which approach would be the best.

One of the places where standards are particularly needed is in the area of homemaker services, because here the client is caught in a real one-on-one situation. Thus, for this service, a system of protection needs to be built in—perhaps by licensure, perhaps by accreditation, perhaps by Federal standards.

"An Army of Monitors"

But again, it is all too easy for us to talk about Federal standards. Then the question arises as to whether an "army of monitors" is needed.

Senator Domenici. Do you agree with the statement made that a reasonable interpretation of the laws that exist would have contemplated State licensures for home health providers? If so, why? What would be your thinking that only 20 States have licensure laws and 30 don't?

Mr. Suzuki. That goes to the medicare and medicaid side.

Senator Domenici. Do you have any opinion on that?

Mr. Suzuki. One thing I would like to point out here gets back to the range of service definitions and to the series of services permitted under title XX. It deals with something that was discussed today: Home health aides and homemakers. When we began to talk about home health aides and homemakers, we looked at the wide range of services they could provide; that is, all the way from the extreme side—meaning the medical model of a specific health-related activity—to the middle ground—perhaps of a broad-gaged homemaker service which relates to personal care, personal services, and also the management of the home.

Another major service that States have undertaken is something called chore service. Perhaps in the extreme, some of the activities that fall under this rubric are definable. But there is a distinct blurring of definitions as you go across the list. As adopted by many States, chore services relate less to a personal kind of care than to some kind of assistance around the home. So, from our perspective, a proposal to bring together this whole range of services, including activities called chore services, is very complicated.

And when we talk about "conditions of participation" under medicare, my technical question becomes: Do we try to bring in this kind of activity under that umbrella?

Senator Domenici. Thank you very much.

Senator Chiles.

Senator Chiles. No questions.

Senator Domenici. Mr. Hall.

Mr. Hall. There is a misconception on this chore and homemaker situation. The patients are all the same. In California, for example, a chore worker can do bowel and bladder care, and it says so in their State regulations.

What we have is a set of bureaucratic words, if you will, that have developed because one program has failed to take care of the needs. When medicare and medicaid failed to deal with the chronically ill, long-term patient, title XX and title III of the Older Americans Act had to come into being in order to deal with the patients who were left out. We play a game of words. They are all the same people.

I cannot tell you, as the executive of an agency in business for 20 years, the difference between a chore worker, attendant, home health

aide, and all these others. There isn't any. What we have got is a mechanism to somehow deny care.

$180 Million in California for Title XX Homemaker-Chore Services

The second point I would like to underscore is that though there may not be any standard requirement in these programs—title XX, for example—the fact is that in California we will spend $180 million on homemaker-chore services this year under title XX, which are State and Federal funds. Eighty percent of that money is going to people delivering these services without minimum wage, without social security, income tax withholding, workers' compensation, or any other benefits—in violation of known Federal labor law or State labor law—because they control effective hiring and firing, the tasks assigned and the wages.

I cannot accept that there is nobody who has responsibility for this situation. That has got to be somebody's responsibility.

Last, through Federal regulations, published in the Federal Register, standards were required until 1973. It was done then. If it could have been done then, why can't it be done now?

I certainly don't mean this personally in terms of Mike Suzuki. We have worked well together for a long time, but there has been a history in HEW to deny and ignore these problems.

Senator Domenici. Did you want to comment on that?

Ms. Caserta. Absolutely. I refer to the definitions of the whole social support system that I addressed earlier, in which Texas, California, and New York are employing, I would think, a dozen different kinds of workers. These are called different kinds of workers who have functions that are so mixed up.

So, we not only deny care to people, but we abuse and overutilize these categories of workers. I could not agree more fully that there needs to be a concrete acceptance of a national definition of a chore worker.

There is also something that has not been addressed; I think that there is the need for a system of assessment, a national assessment strategy in agencies. There are several mechanisms that have been tested. I think you are familiar with the PACE tool. It has its problems in that it takes much too long. There needs to be some tailoring of that tool. That has not really been addressed. So I offer it to you for another piece of the package.

Senator Domenici. Senator Chiles.

Senator Chiles. In the 20 States that are licensing, Mr. Rosenberg, how many proprietary agencies are licensed—what percentage?

Mr. Rosenberg. A small percentage at this time. Most of these licensure laws have been enacted in the last few years. The percentage of them, I would not begin to guess. I would probably say in those States, maybe 50 to 60 agencies at this present time—more in Florida than in other places.

Licensure many times is defined or centered around the type of care that is provided. For instance, if you provide only intermittent care, which is usually meant to be 2 hours or less, then a license is required.

If you provide care that is around the clock—that is, longer than 2 hours—then many times a license is not provided. It is a system that varies in the 20 States. That is why our recommendation is that one set of standards, one set of regulations for all providers, be applied nationally.

Senator CHILES. That seems strange, that there is only a small percentage of proprietary agencies that meet the licensing requirements. Did they fail to meet the standards?

Mr. ROSENBERG. I am not sure that is the problem. I think the problem is the development of the proprietaries. The most recent rapid development has been really within the last 2 years. Homemakers-Upjohn is one of the older and larger ones. We have been in business for approximately 8 years, but the rapid development has only been within the last 1 to 2 years in many States. I think you will see in the future more activity toward licensure.

Ms. CASERTA. The licensure issue raises another one which has to do with rural and urban distribution of services—I think you might agree with that—in terms of what counties are still uncovered in the country where agencies will establish themselves. That is why there is a crying need also for national recognition for a need formula to establish an agency and for incorporation in health planning.

We are concerned—and I know in your opening comments you mentioned your concern—about the rural health system, and you will find that licensed proprietary agencies are not established in rural areas, and those are still largely uncovered.

Senator CHILES. How is that going? Proprietary agencies don't want to go into rural areas, primarily because there is not enough profit. A change in national standards as opposed to State licensing—the agency couldn't do anything about that.

Mr. ROSENBERG. Neither have the existing agencies who have been in business for 50 to 60 years in some places. Neither have they in many instances gone into rural areas.

Another problem that exists under licensure laws is that proprietaries cannot become licensed because of restricted certificate-of-need laws. At the present time there is no known formula that we know of to determine how many home health agencies are needed in a community. Everybody has a pet formula that they would love to try, but there has not been one formula, yet, out of HEW or anywhere else.

If a proprietary agency is going to become licensed in a State, it must get a certificate of need. If it can't get a certificate of need because there are already existing agencies, even though that agency may decide it won't provide services under titles XVIII or XIX but just wants to become licensed, it will be turned down for licensure if it is unable to get a certificate of need.

One of the things that is needed—and I hope HEW will address this some time in the future—is national standards. How many home agencies are required in a community? What is the number? Is it even?

Senator CHILES. Are you saying there should not be a requirement for a certificate of need?

Mr. ROSENBERG. At the present time; yes, sir.

Senator CHILES. There should not be that requirement?

Mr. ROSENBERG. Yes, sir, at the present time.

Senator CHILES. I held hearings in Florida a few years ago. One of the great problems there was the overabundance of home health agencies—not only overabundance, but what was happening because of the overabundance. They were paying doctors and nurses. They were overreferring and overtreating, and it convinced me if you didn't have a certificate of need, you would have overutilization tremendously, as we did there.

Mr. ROSENBERG. I am not sure in our findings so far that we have found that certificate of need regulates or controls overutilization. I am not sure that it controls pricing structure at this point in time. I think what is needed are strong regulations that are enforced. I am not sure certificate of need can do those things. There has been no demonstrated proof that it has.

Mrs. MOORE. On the subject of rural-urban, homemaker services started solely under voluntary agency auspices.

PUBLIC AGENCIES IN RURAL AREAS

I think it is interesting that our statistics in 1976–77, indicate that now 51.5 percent of all the agencies are under public auspices, and we find States like North Dakota and Iowa—rural States—have homemaker services in each county. This is because it is being done under public auspices. We find that increasingly the health departments, the social service departments, and in some instances the offices on aging, are working cooperatively to make these programs a reality.

Another point. I would like to be able to send from my office, for inclusion in the hearing record, a definition of chore services[1] which the national council has developed.

Third, it might be of interest to you that this year the national council has a contract with the Public Health Service to develop a new training manual for homemaker-home health aides. When this is completed, it should be of great use in the conditions of participation for the training of this paraprofessional level of worker. We hope it will be used that way, and I think that that is the Public Health Service's intent. We agree that there is a desperate need for a common approach to training of homemaker-home health aides across the country if for no other reason that they are, in terms of volume of service given, becoming the chief care givers in the home.

Senator PERCY. I would like to ask you to address yourself to a problem many volunteer home health service agencies have. If there is to be a viable substitute for—an institution does operate, presumably, 7 days a week, 24 hours a day. Some voluntary home services operate on an 8-hour day, 5 days per week basis, and we have certain Federal programs that are nutrition centers—essentially one meal, 5 days a week. It provides a limited service, but a much-needed service.

Our meals-on-wheels are home delivered meals. 5 days per week, essentially. Some communities have gone beyond that. Could you comment on how, if we are to have a viable substitute, what should be done or can be done about the 24-hour day, 7 days a week needs of those who are confined in their homes or prefer to stay in their homes but might have to be institutionalized because they can't be dependent on 8 hours a day, 5 ways a week?

Mr. BYRNE. I think that relates to one of our first areas of encouragement. It is easy to slip in this universal needs and not define terms.

[1] See appendix, item 2, p. 825.

In some previous public testimony, the voluntary sector has been taken to task by certain interest groups as to not having adequate services.

I am not defending the fact that we don't. I look at VNA affairs, St. Louis—although I have been there 5½ years, I can see great increases in services in staff. We are doing it the same way we did 5 or 10 years ago.

I think what we need to do more effectively is to do what John referred to. There is not only the need but you do have to evaluate the availability of staff. What do we mean? Some of the testimony gets confused as to 24-hour service. Are we really talking about, for instance, VNA of the District of Columbia sending a nurse out at 2 a.m. into 21st and Constitution to change a catheter, or are we talking about, because of need, the temporary homemaker or sitter who would be available around the clock for a brief period? These are things that we have to concern ourselves with in better planning. This is why we are encouraging that conditions be used as a monitor to establish what you are really in business for.

I think this is fairly common. Most businesses, at least—if they don't know what business they are in, they won't stay in long because they won't make a profit. In the voluntary sector we need a challenge as to demonstrate why we are in business, whether we have been around for 67 years or 6 months. If we are using public dollars, we should be ready to show why we are there, and then that we meet the services that are appropriate. We hear constantly home care services are cheaper than institutional care. It is a fallacious concept. It depends on what you are comparing and for how long. What is the length of stay and composition of what you are going to render? That gets back to the needs for planning. Within that the marketing ability to do something that is cost effective and the appropriate use of human resources, client, patient, and staff. These are some of the things we recommend be addressed.

Mr. ROSENBERG. One of the foundations for the proprietary industry, especially for the company I am associated with—Homemakers-Upjohn—was that we fill the void, in our early days, and we still do, and that our services were available and are available after 5 in the evening. They are available on weekends. We have found many, many of the people that we care for need services when some of the traditional agencies that have been available have not provided services during any hours, but only from 9 to 5, Monday through Friday.

We provide a large number of hours of service, particularly at those times after 5, on weekends when family members may not be present, and all that is needed is someone to be there. There is a need and there is a void in many parts of the country for these services.

Senator DOMENICI. Could I just narrow the issue for a minute and discuss this question of standards? I will then try to ask a few questions about what appears to me to be the need for pooling of resources. and for the flexibility of pooling resources at the local level.

NATIONAL COMMISSION ON HOME CARE SERVICES

Would the establishment of a national commission on home care services, with the freedom to set the standards, accreditation process, and the power to withhold funds for nonconforming agencies be one

way of approaching this field? Representative Cohen suggested this possibility in legislation he introduced in August 1976. If that seems possible, what would the makeup of that commission be? What language, in regard to standards, would you want included in legislation such as S. 2009? Does anyone want to address that?

Mr. HALL. I would support it, Senator. The only danger that I see is that it would be a little like in the Inspector General's Office in HEW which has not moved on two flagrant cases of fraud and abuse in the home health field exposed over a year ago, documented in chapter and verse, followed up with letters asking for reports on what has happened. It was laid out in detail.

Senator DOMENICI. In California?

Mr. HALL. Yes; the two happen to be in California. Still, so far as I can tell, nothing has been done either by the Inspector General's office, the Attorney General's office, or the attorney general's office, State of California. If the commission is going to set standards and then not be able to get the bad guys out, I don't think we are any further ahead, but the concept is appropriate and right.

Mr. ROSENBERG. I would agree that a commission could be useful, if it provides a representation that is varied, as varied as this group, and not be set in a vacuum. I would agree it would be helpful.

Ms. RUNNELS. I would hope we would have a voice in the standard setting. I think it is important. NAHHA would certainly endorse the concept of a commission.

Mrs. MOORE. I would like to endorse it, too. As I was thinking earlier this morning, we needed an ongoing vehicle of the kind we have today. It seems to me we need the voluntary sector, the providers, and consumers on the commission. It should be carefully established.

Mr. BYRNE. I think within that, just like the certificate of need, we are not starting de novo. We have lots of experience. We have lots of problems, but we are not starting without any knowledge. This does not necessarily have to be 10 years getting started. We have too much at risk going in with $2 billion or so that is being spent on home services to disregard this for a long time.

Ms. CASERTA. You said two things. You said setting standards by a national commission, and accreditation. Are you mixing those kinds of processes?

Senator DOMENICI. No.

Ms. CASERTA. Would you see setting standards as a major focus for such a commission?

Senator DOMENICI. Yes; I would. If I did not make that clear, it is basically what I was talking about.

EFFECT OF STANDARDS ON SERVICE COST

Senator PERCY. Let me ask one other question. What effect might uniform standards have on cost—national standards? There is some school of thought, obviously, that says all regulations, standards, rules, and regulations are costly. Another school of thought that says the lack of uniformity and lack of standards in home health really contributes to cost unnecessarily. You know more about it than we do. What is your feeling about it?

Senator DOMENICI. Let me say, Senator Percy, I think that Mr. Suzuki addressed that issue when he was speaking of day care, that we had an exact example in Congress. The States thought they were doing a reasonably good job and a simple standard was proposed from Congress that had to do with the number of adults for the number of children.

That cost was quickly estimated and a hue and cry arose from the States that they were going to get less coverage out of money they were spending. As a result, they got a moratorium. It almost caused a major bill to be vetoed. I think Chuck asked a good question. In this area it would be more difficult to measure at this stage.

Mr. BYRNE. I think, again, it is the chicken and the egg. It seems to me the role of Government is to be concerned with the common good, and if all men were interested in everyone else's good we would not have the need for laws. We have had enough testimony to show we have severe problems and the people who are getting hurt are those who have been taxpayers, or may currently be taxpayers, but are not recipients. It is a matter of where you are coming from now. We have hosts of evidence that we can't leave the thing alone and expect to get the value for the taxpayer and the benefits to the client.

Mr. ROSENBERG. That is a question that needs careful study. This system could be priced right out with overregulation, maybe, and overstandardization. It could be delivering the highest possible quality that nobody could afford, either the private consumer or the Federal Government. Somewhere in this there has to be a middle ground. I think that should be one of the charges to this commission that every standard not only be patient-effective and good for the patient, but also be very cost-effective. It must always look at—not only is the Federal Government or a third party payer going to pick up the price tab or somebody, but there are a lot of people out there who will be paying their own way and they deserve a fair chance and a fair shot.

ENFORCEMENT

Senator CHILES. That is the difficulty I see in how you are going to do that with a uniform set of standards, and you have not said who is going to enforce the standards. Is this commission going to enforce them? Is the Federal Government going to enforce them? Who will be the enforcing agency?

Senator DOMENICI. My question would enforce it only by the mechanism of withholding funds. That was included in the question I asked.

Senator CHILES. Who looks into the home and sees what is happening, whether these standards are working—who monitors the process?

Mr. SUZUKI. Hadley Hall referred to some concerns on specific issues. One of HEW's concerns is whether or not to establish national standards. Could we expect somehow, even with our regional operations, to get to the community level and monitor the offending or inadequate service? Perhaps to develop such standards would create a cumbersome mechanism. Yet national standards do not necessarily have to be enforced by Federal bureaucrats. In the day care standards, even where there are national standards, we expect State and local government to enforce these standards.

Senator DOMENICI. There was a suggestion made in someone's testimony that we have a local board of directors to act as a peer review mechanism. As I understand it, that is your testimony.

Mr. HALL. Voluntary agencies usually have a board of directors.

Ms. RUNNELS. If I may say, I think those of us who have been in this business for a long time do enforce our own standards. I would like to think that we are responsible enough to see to it that the quality of supervision insures the delivery of safe care to patients. We have United Ways who have been looking at us for years to be sure that we measure up to the standards that are important for that community. And our prices are competitive with other agencies. So I think that it is very possible to enforce standards without having to send out armies of Federal inspectors to be sure we are indeed providing services that are safe.

Mrs. MOORE. We think this point about the board of directors is so important that in our accreditation program, if the agency is not a voluntary one, that is, if it is a public or proprietary agency, we require that they have an advisory committee representative of the community. We think that is one of the factors that should be held to regardless of the auspice.

Mr. HALL. I would like to address Senator Percy's question regarding the cost of these things. No. 1, the two famous cases, in which you participated in the hearings, Senator, took 12 auditors 60 man-days in a van at one of the contractors to establish what everyone knew was going on. I hate to think of what we have spent in that monitoring. That cost would have paid for all of the agencies to have been accredited by all of the groups and would have put a stop to it much faster.

No. 2, I think there are three things that can be done very easily and very cheaply. First, is that whoever pays the bill should send a copy of that bill to the consumer. I don't know whether you know it or not, but an agency can bill medicare and the patient never sees it, never knows what those charges were.

Now, if we went to Macy's or some place else and they just sent the bill to the Government and the Goverment paid it, it would be a funny thing. But we do that in medicare and medicaid and title XX. The consumer never sees what has been billed. That is wrong.

In our agency, we have been sending the bills to the recipients. So, second, you would be amazed at some of the things that come out, both in terms of our quality and our services. The argument that these people are too old and too senile to know the difference does not hold water. We have been doing it for 20 years.

The third aspect of the cost containment thing is, if there were prospective budgeting, with the billing controlled by a simple list of employees—names, social security number, and function—there are computer programs all over the United States that can match those so that if you have a person who is listed as a nurse, who never shows up as having made a nursing visit, the computer could pick that up and say OK, what is it, a wife or daughter or somebody who isn't there.

The prospective budgeting process, the actual audit process, and the billing process, can be set up so that even the simple rural agencies

can do this by hand and it can be put into a system. One key punch operator could handle a whole city, and I am not sure two key punch operators could not handle the whole State of California.

We have not turned our attention, in the Government, to using some of the technology that is available to us. I think a copy of every bill for every hospital stay, for every drug, ought to go to the patient. I think we might find that constituents would be writing you and saying: "Senator, I did not get what they said I got."

Senator PERCY. I think there is no better argument. Could I ask one last question? This discussion has been fine for us and it is in tune with what we want to hear, but always the purpose of a public hearing is to bring better education. I have found in the 3 years I spent writing the book "Growing Old in the Country of the Young," a lot of people never knew of these services. I bet there are a lot of citizens in Portland, Oreg., who don't know how many services are being provided. Would you mind, Ms. Runnels, running through what services are available in Portland in home health care that any citizen would be eligible for or those who are just eligible at certain income levels?

AGENCY SERVICES

Ms. RUNNELS. The income level has nothing to do with it in my own particular agency. The services we provide are nursing, physical therapy, occupational therapy, speech therapy, medical social service, home health aides, and nutrition consultation.

Senator PERCY. That is available on what sort of a basis?

Ms. RUNNELS. It has to be medically indicated and we have to have authorization from the physician; that is the criteria. If this is what the patient needs, it is part of his plan of treatment, then this is what he gets.

Senator PERCY. Are there other cities represented here that could expand that list?

Mr. ROSENBERG. I am not sure I can expand the list much, except entry into the proprietary market or into the proprietary home health agency usually does not have some of the limitations that were just mentioned, such as the physician care or physician authorization that may be necessary.

I would like to go back, if I may, for two comments, Senator, on what you said. In the proprietary market the consumer or the client or the patient, whatever terminology you would like to use in the private portion of the market—not where the proprietary agency is providing services under titles XX and XVIII—that patient does sign a time slip every week for services rendered. There are some flaws in that system. Usually, the patient is asked for an evaluation of services that happens at the same time the patient also receives a bill weekly to be paid. There are some checks. It is an interesting point, Senator Chiles, in Florida where for many years we were delivering services nonlicensed, not certified, nonmedicare services.

The first question asked to us in the private-paying market when we went into a hospital to talk about our program was, "How much will it cost my patient? How much per hour is the service?" Now, we are medicare-certified and providing services under medicare. I

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imagine that in all of our offices down there we could probably count the times on one hand that we have ever been asked how much does this service cost. It is just of no interest because somebody else is now paying for it.

Ms. CASERTA. May I add to that list of services, which I know in my home city of White Plains and the surrounding counties of New York, there are available meals-on-wheels, transportation, chore, physician services at home, and homemaker.

Mrs. MOORE. Friendly visitor, escort, and transportation.

Ms. RUNNELS. I was not trying to speak for the whole community, and all these services are available. One thing I would like to say in relation to looking at the conditions of participation. One of the recommendations that we are making is that agencies would show cause why they would not be providing all of the services which are allowable for reimbursement by medicare, rather than the current conditions which only require that there be nursing and one other service. We think this range of services should be available to those patients who need it and we feel this is an important addition.

Mrs. MOORE. I thought of another important service that I don't think was mentioned, telephone reassurance service—one person calling another person. I think perhaps it was Hope who mentioned need for assessment and reassessment. One of the ways to tell whether a service is a good one or not is whether they do assessment and reassessment and use a combination of some of these services.

For instance, maybe you need homemaker service Tuesday and Thursday, and telephone reassurance every other day, or you may need meals on wheels every day or intermittently, you may need transportation or escort service. And a way to tell if it is a good service—do they pay attention to getting the mix and match of services that people need and change them as needs change.

I heard Hadley testify several years ago when he said while his costs per hour had gone up, his cost per case had stayed the same. One reason was they were making better use of the less costly services, where appropriate, for the people served.

RESTRAINING COSTS

Senator CHILES. On that point—how do we generate any mechanism that would hold costs? Have you tried to hold those costs at some level by mixing the services? The biggest problem we have now is there is no mechanism to cause any restraint. The sky is the limit.

Mr. HALL. In San Francisco in 1976, for example, none of the proprietary agencies made a referral to meals-on-wheels. That community knew that. Yet those agencies that were 100 percenters, in one title or another, were allowed to continue.

It is impossible for them to have a number of patients and not use other community services. My impression about day health is that during 1975 and 1976, under the section 222 projects, not a single proprietary organization was referred for day health services. That appears to be an impossibility. They have a very large caseload. I don't know how you set it up on a national scale to monitor that kind of thing. I think it has to be done at the local level.

Senator CHILES. I don't see how that sets a mechanism on trying to hold prices down. Whether it is a voluntary agency—a proprietary agency, whatever it is—from the national funding level up here as we are trying to appropriate the money, as we are trying to write those programs, how do we try to put some cost restraints into those programs?

Ms. CASERTA. There are two States, California and New York, that legislated utilization review within home health agencies. Now, utilization review, not in the current context of that definition, but a review on a case-by-case basis of the mix and match of services in that case.

Not the length of stay, but what kind of professionals or support systems are being used—to what level, to what degree, what was needed, what was provided, was it overutilized, was it underutilized. To quote from a prior statement, "Was it a Cadillac instead of a Ford that was sent to an agency?" That process used in that way is one way.

Senator PERCY. Mr. Chairman, I have to leave, but I want to thank all of you for the tremendous help you have provided.

EFFICIENCY INCENTIVES

Mr. ROSENBERG. I have one comment. I think the present reimbursement system in many ways is unfair—unfair to the Federal Government and unfair to the taxpayer. There appear to be no rewards or no incentives for efficiency, for doing things in a more businesslike manner, and I put that in quotes. Many of the programs today reimburse on a cost-plus basis. It is almost whatever it costs you to deliver the service, you are going to get reimbursed for. That does not work in the private market. People shop for the service. I think there has to be something done with that reimbursement system.

Senator DOMENICI. That is not a problem exclusive to the home health delivery system, it is a problem with the entire health care system. How many of the private insurance carriers include home health care as an item covered by their insurance policies?

Mr. HALL. Very few.

Ms. RUNNELS. It depends on the particular policy and the group with which it is written. We are seeing, particularly under major medical coverage, more and more of home health benefits being included in these policies.

Mr. BYRNE. I think if you were to look at a typical agency where, if you compared its income base vis-a-vis a hospital base where you are running a ratio of, say, 30, or 35 percent medicare and the hospital with x percent of medicaid, the rest then falls into the Blue Cross or other reimbursement. This is not at all remotely the case in organized home care if you are looking at the medicare-certified agency, which is the 2,400 number you are dealing with. They have 2, 3 percent of health insurance, including Blue Cross participation, at the present time. It is very inadequate. It is very splintered, too, because in commercial insurances you will have some coverage for perhaps a registered nurse or a therapist, but it is very slow—or private duty will be included more often than anything.

Mr. ROSENBERG. Many companies today offer a home health care benefit. The problem is not many people are willing to buy a home

health care benefit or ask for that kind of coverage. I imagine in union demands, home health care benefits for a worker in a union factory is way down. More important is an eyeglass benefit or prescription benefit.

I think the home health care industry has a responsibility to sell the benefits of these programs so more and more people would ask for the coverage. But there is a lot of it available. It is just not being asked for by the people who purchase health insurance.

Mr. HALL. One of the real problems is we have done quite a bit of this. They—the insurance companies—unfortunately have followed the medicare model so they have all the restrictions built in that the medicare model has, so very few people qualify, to be honest.

Senator DOMENICI. Let me ask Mr. Suzuki a question. It seems to me that at the hearing that Senator Chiles and I attended here in Washington, a year and a half or 2 years ago, we were discussing the problem that has evolved because medicare had its genesis in the social security law and is an entitlement program. Since then, there has been an evolution of home health care, a program for health delivery for the poor. Medicaid is not an entitlement program to the same extent. Then we introduced title XX, in which specific kinds of activities are paid for with Federal and State funds. Thus, we have these three programs running independently, when, as a matter of fact, they should be very much related in the community.

It seems to me we were told that HEW was going to try a demonstration in which they would try to pool, without violating the law, the various moneys to see if we could demonstrate a much more effective delivery system without the difficulties being generated by what I just described. I know every time we try something like that, it has a bad time. It looks like we can't mix medicare with medicaid, and there are all kinds of reasons. Is anything occurring, such as I described? Has it been tried anywhere, and what do you think about that approach?

Mr. SUZUKI. I am not sure of the testimony to which you referred. Also, I know of no specific efforts in which title XX is currently involved. Something in medicaid and medicare may be going on, but I would not normally be involved in that unless some kind of research or demonstration project involving title XX was going on. But there is an issue that is being addressed. The Secretary has several task forces and planning mechanisms that are looking at how programs need to fit together, particularly with so much emphasis on deinstitutionalization through community-based services. Specific task forces under Secretary Califano are bringing titles XVIII, XIX, and XX and Older Americans Act staff together to examine the funding of these programs.

Again, each of these laws has its own specific, idiosyncratic "glitches." This creates difficulties because title XX is looked at, not in terms of health services, but in terms of social services.

Senator DOMENICI. It is even difficult for you to invent a word to describe it.

HEW IN "POOR POSITION" ON TITLE XX HOME ATTENDANTS

Senator CHILES. I want to ask Mr. Suzuki a question, if I could. In some testimony that we took earlier in the committee, we talked about, as we mentioned here, some emerging problems in the home

attendant-individual provider services under title XX. Especially we talked about some of the funds being expended in the States utilizing individual providers—New York and others. What is the Department doing to try to get a handle on that?

Mr. SUZUKI. We have struggled with home attendants. There is a statement in title XX which, in a sense, enjoins the Secretary from defining anything in terms of what is or is not a service. This clearly leaves HEW in a poor position, legally, to really attack this issue. I think our language goes to the language of the law and goes to the capacity of States to contract with organizations—proprietary, first of all—public agencies, nonprofits, and individuals. And in many services, this is done; day care, for example.

Senator CHILES. There are some arm's-length transactions between families and individuals. This is needed for two reasons. No. 1 is protection of the family, and No. 2 is protection of Government. We have situations we were hearing about in previous testimony where you just have outright fraud and you have people who are terrorized as individuals. They don't know how to fire this person who is providing this service. Who is checking that? I don't see anything in the law that prohibits HEW from setting some check on that.

Mr. SUZUKI. In response to the home health care issue, Secretary Califano and Under Secretary Champion identified seven major areas and asked the Inspector General and our program units to go out and make what were called service delivery assessments.

My own staff were involved in, first, family planning in relation to teenagers—one of the seven major areas. Then, in a service delivery assessment of home health delivery mechanisms. As I mentioned before, title XX is not a health program; but, because of the homemaker aspects in title XX, we participated in the assessment. We are now in the middle of this specific assessment.

The seven areas selected by the Secretary and the Under Secretary are viewed as critical areas of concern in terms of delivery, and the Inspector General is directing this project. Also involved are our program staff in multiple regions. At this time, a report on the assessment has not come in.

I believe that part of the reason why home health delivery was spotlighted by HEW is because of the kind of concern you expressed. We are aware of it; obviously, States are aware of it too.

Senator CHILES. We had testimony that 26 States are engaged in these services under title XX. Is that about what you have, or are there more than that?

Mr. SUZUKI. In terms of individual providers I would not be surprised. Obviously States would certainly argue against our saying that certain services could not be individually provided. I think you are suggesting that would be better than monitoring.

Senator CHILES. In some cases, it might make sense to have individual providers. There seems to be a desperate need for some control on those services and on who is going to be the provider. I don't think you can say, because there is nothing in the law that prohibits this, we are going to give a blank check.

Mr. SUZUKI. We are under criticism now. But we have said again and again, in every instance, no one complains when major contracts are written between a title XX agency and a major concern—whether nonprofit, home health agency, or a homemaker.

We have a set of regulations we have worked on; we are trying to refine them, which requires defining the conditions by which an individual provider operates. We are catching continuous flack from States because they see that as busy work—paperwork—and an attempt to overview from the Federal perspective. Again, we are now in a position to say that, even if an individual provider is involved, specific things have to be written out.

It does not have to be a formal contract, but there must be some document that governs the delivery of services. This is an area in which we have been working with the States. We have been visiting States. And the States tend to feel that what we are asking for means added paperwork for them in terms of spelling out the provisions for individual providers. The experience of some of these individual providers obviously is of concern. However, that is the one area in which we probably will be able to make some headway—that conditions of the service being rendered by the individual provider are spelled out for reimbursement as well as what is to be covered.

Mr. HALL. These people are employees. There is proof of the employer. If the Government is trying to determine what the hours are, what the tasks are, what effective hiring and firing is, that is proof that the Government is the employer. That is the test of the labor code.

Mrs. MOORE. We haven't exact statistics, but we know there are about 82,000 homemaker-home health aides today working for an agency where the agency is accountable, whether proprietary, public, or voluntary. We estimate there are at least as many of these individual providers now and I think it is the fastest growing form of homemaker-home health aid service. Where the service is delivered by an agency, the proprietary and not-for-profit volunteers are the fastest growing agencies.

Senator DOMENICI. Did you have a comment you wanted to make?

Ms. BROCK. In relation to the earlier discussion on private insurance, we would like to submit for the record, as soon as it is completed, a study conducted by the Council of Home Health Agencies and Community Health Services, which shows the distribution of income for voluntary home health agencies.

Senator DOMENICI. How long will it be before you have that?

Ms. BROCK. A matter of a few weeks.

Senator DOMENICI. We will be glad to receive it.

Let me thank all of you and assure you that your detailed statements will be made a part of the record. I do hope that as we move in the Senate in this area—and I know I am speaking for Senator Church, our chairman—that we are going to attempt to take very strong positions and urge that the Finance Committee devote serious attention to the problem we are talking about here today in its broadest sense.

Our committee will work toward this end. I certainly urge that you, as informed people representing broad-based involvement, continue your genuine interest as these kinds of hearings are held by the committees with legislative jurisdiction. I want to thank you and all of those in attendance for being with us this morning. It would be helpful if the panelists would submit for the record, at their earliest

convenience, statistics on your agency membership, commenting on what proportion of your agency membership provides a full range of services; that is, how many of your agencies provide homemaker-home health aid, chore services, as well as medicare-reimbursed home health care.[1] We would like to have that so, as we analyze your suggestions, we are able to relate them to what your principal involvement is.

If there is nothing further, we are going to close this part of our hearings on home health care. I regret to tell you I am not optimistic that we will get major legislation in this field this year. As you know, the shopping list of legislative mandates in the Senate is growing and time is running out.

I do hope we will continue to keep the pressure on to try to do a better job legislatively with this particular part of the health delivery system. I appreciate Senator Church's calling the hearing. He could not be here today, since he is the principal floor manager on the Panama Canal bill.

Thank you very much.

[Whereupon, at 11:10 a.m., the hearing adjourned.]

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[1] See appendix, items 2 and 4, pp. 825 and 855.

APPENDIX

MATERIAL SUPPLIED BY WITNESSES

ITEM 1. INTERPRETATION OF STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, SUBMITTED BY HADLEY D. HALL,[1] NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., NEW YORK, N.Y.

INTRODUCTION

To protect consumers, providers, and those who pay for homemaker-home health aide services, the National Council for Homemaker-Home Health Aide Services developed a program of basic standards through which an agency could measure its conformity with the components needed to deliver satisfactory homemaker-home health aide service. These standards were developed by community leaders, agency administrators, and professional staff of the council. The standards apply to any agency operating under any auspice which provides homemaker-home health aide service. Only those agencies which employ and pay their homemaker-home health aides may apply to the national council for assessment of the conformity to standards of their homemaker-home health aide service. Applicant agencies use a self-study document in which the standards and the criteria for demonstrating conformity with them are detailed. Need for a less detailed document exists; hence this paper, in which the nucleus of each standard is discussed briefly. No one standard stands alone; all are interrelated.

STANDARDS

I. The agency shall have legal authorization to operate

An agency is required to have one of several types of legal authorization to operate—a certificate of incorporation, a charter, a license or a relevant portion of a State law. In its broadest sense, this document should outline the purposes for which the agency is organized. In many instances, homemaker-home health aide service will be defined specifically in the agency's legal document.

II. There shall be an appropriate duly constituted authority in which ultimate responsibility and accountability are lodged

Those responsible for governing the agency should be identified and there should be participation by members of the community served. In a voluntary agency, traditionally this has been a function of the board of directors. However, to insure that representatives of the community served may assist in agency planning and direction, some voluntary agencies have developed advisory committees in addition to their boards of directors. All governmental units shall have boards or advisory committees to fulfill this function; and proprietary agencies shall have advisory committees or boards drawn from the local service area to insure that representatives of the community served will have the opportunity to participate in policy formulation and planning for agency services.

Bylaws are the rules adopted legally by an organization to assist it in the performance and regulation of its affairs and would ordinarily include such subjects as rotation of board membership and specific duties of officers. Policies and procedures which could result in restricting the governing bodies and the administration in discharging their legal responsibilities should not be included in this document. Bylaws are the means with which to facilitate the exercise of effective organization and functioning of the agency.

[1] See statement, p. 789.

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

The agency board and staff components, as well as the individuals served should reflect the type of ethnic and racial groups included in the agency's service area. Generally, this will be a mixed group. However, if the agency is organized to serve a specific age, patient, or sectarian group, this group might be the only one represented on the board and committees.

Documents such as the bylaws, personnel policies, job descriptions, and publicity materials developed by the agency should include a statement of the agency's nondiscrimination policies. In most instances the efforts to include representation from the community served will involve an outreach program to assure that all ethnic and racial groups are on its policymaking bodies and on its staff, and that the agency's homemaker-home health aide service is available to all who need it.

IV. There shall be designated responsibility for the planning and provision of financial support to maintain at least the current level of service on a continuing basis

Fiscal preparedness of an agency should be reflected in clear, comprehensive fiscal planning and procedures, documented through the preparation of an annual budget.

Agencies have a fundamental obligation to secure broad financial support for the agency's service programs. Planning to secure adequate funding for homemaker-home health aide service should be an ongoing process. The individuals responsible for this planning should be thoroughly familiar with Federal, State, and local policies in terms of funding for service, including third-party contracts.

V. The service shall have written personnel policies; a wage scale shall be established for each job category

Each agency should operate under a personnel policy document which pertains to all categories of employees—administrative, professional, clerical, and homemaker-home health aide. The document should describe the terms and conditions of employment which pertain to full-time and part-time personnel. Procedures and administrative policies should be included as addenda to specific job descriptions or be in a separate administrative document. Each category of employment should have a wage scale that takes into account applicable minimum wage laws and wages for comparable jobs in the area served. When an individual is employed by an agency, the employee should be provided with a copy of the personnel policies, the wage scale for the specific position for which he or she was employed and a copy of the job description for that category of employment. Where employees are represented by a labor union, there should be a collective bargaining mechanism leading to a labor contract.

VI. There shall be a written job description for each job category for all staff and volunteer positions which are part of the service

A qualified and competent staff is the basic requirement for an effective service. Job descriptions are the guides which have been developed and that are used in recruiting qualified staff and to guide them in carrying out the functions noted therein. One of the most important elements to be aware of when developing job descriptions is that the responsibilities outlined for a particular position are commensurate with the qualifications of education and experience specified for the position.

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

This standard represents the "heart" of homemaker-home health aide service. Homemaker-home health aide service is a team service which includes both the professional and the homemaker-home health aide personnel in a agency.

Functions of a professional supervisor[2] should include:

[2] See also "Phase I Report of Case Management Study," National Council for Homemaker-Home Health Aide Services, 1976.

(1) In-person (home or office) assessment and periodic reassessment of the need for homemaker-home health aide service.

(2) Development of a plan of care which includes all aspects of service that are required. All clients should have available input from qualified social workers, qualified health professionals, and other professionals as needed.

(3) Providing the homemaker-home health aide with the plan for service delivery and periodic home visits by the supervisor to see that the plan is being carried out and is appropriate.

(4) Individual conferences with the homemaker-home health aide to discuss service and, in the interim times, telephone discussions to maintain contact with the aide.

(5) Maintenance of complete and appropriate records about the service being delivered to the client and complete records about the homemaker-home health aide's performance, which include a formal evaluation on a periodic basis.

(6) Convening of interdisciplinary conferences which include the homemaker-home health aide to discuss the individual's or family's needs.

(7) Plans for the appropriate termination of service.

The homemaker-home health aide has the responsibility for carrying out the tasks outlined in the plan of care, being aware of changes as they may occur in the needs of the individual or family and of reporting these changes to the professional team member.

The professional team member should have qualifications appropriate to the situation. Nursing supervision must be available in situations where personal care is part of a medical plan. Nursing care or consultation must be available where personal care as supportive assistance is provided.[3] Social work supervision or consultation must be available where there are psychological or social problems. The home management skills of the home economist are often needed and should be available where appropriate.

Professional staff members who function in homemaker-home health aide service shall have as a minimum the following qualifications as appropriate:

"* * * a current license to practice as a registered professional nurse, a bachelor's degree in social work, home economics, or closely related helping profession, plus 1 year of related experience."

Individuals employed in the agency before December 31, 1974, who have had at least 5 years of professional experience (i.e., employed and functioned as a professional social worker in a governmental agency), may assume the role of the professional team member if their own supervisors have higher educational qualifications, such as a master's degree in social work, nursing, or home economics.

Appropriate activities for a homemaker-home health aide who has been delegated some supervisory functions are: Administrative supervision of the aide, such as assigning homemaker-home health aides to cases and establishing work schedules; or obtaining basic information for use of the professional charged with case assignment and development of the plan of care. Unless they have the professional background specified in the preceding paragraph, these paraprofessional staff shall not be assigned full responsibility for assessing cases and developing comprehensive plans of care.

The delivery of service may be shared through the development of contractual arrangements. When contractual arrangements are established, the input of the professional person responsible for the assessment of need and case supervision may be provided by either agency, but the agency which employs the homemaker-home health aide must provide the administrative supervision of the homemaker-home health aide. The arrangements between two agencies must be spelled out clearly in a contract.

VIII. There shall be an appropriate process utilized in the selection of homemaker-home health aides

It is essential that an agency have a well-defined recruitment and selection process for homemaker-home health aides. The agency needs to be aware that many individuals applying for homemaker-home health aide positions have never been formally employed before and may not be able to talk easily in an office setting. The interviewer needs to be particularly sensitive to the applicant's attitudes toward and probable ability to get along well with a variety of people from a variety of backgrounds.

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[3] See "Addenda to Standards for Homemaker-Home Health Aides," New York: National Council for Homemaker-Home Health Aide Services, Inc., 1969, pp. 7–10, for differentiation.

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 ongoing in-service training program for homemaker-home health aides

The initial and ongoing training of homemaker-home health aides is an essential component of the standards.

Initial generic training shall be a minimum of 40 hours and be provided prior to or at least within the first 6 months of employment. The 40 hours are to include formal classroom instruction and supervised laboratory instruction in the following areas:

(1) The agency, the community, and the homemaker-home health aide;
(2) The family and the homemaker-home health aide;
(3) Care and maintenance of the home and personal belonging;
(4) Home accident prevention;
(5) Family spending and budgeting;
(6) Food, nutrition, and meals;
(7) The child in the family;
(8) The ill, the disabled, and the aging adult;
(9) Mental health and mental illness;
(10) Personal care and rehabilitative services.

Qualified individuals from a variety of disciplines shall be utilized as instructors in their areas of expertise. Training by health professionals alone, by social workers, or by home economists alone will not suffice. On-the-job training is in addition to the 40 hours of classroom and laboratory training.

In-service programs should be offered on a regularly scheduled ongoing basis, at least quarterly, and all homemaker-home health aides should have the opportunity to attend these meetings. The programs should follow up content areas introduced in the initial generic training and include relevant trends in service. Programs on the agency's policies and procedures are necessary but should not constitute the majority of programs. Opportunity to attend outside seminars and workshops should be made available.

As the number of homemaker-home health aide staff increases, the agency should develop vertical and/or horizontal job opportunities which recognize competence and skill.

X. There shall be a written statement of eligibility criterial for the service

Each agency should have a written statement which outlines the eligibility criteria for service. This statement should be circulated both within and outside the agency. Priorities, based on clients' needs, should be developed for the service. Each individual or family who applies for service, but who cannot meet the criteria, should be assisted in obtaining appropriate services elsewhere.

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 ongoing assessment of community needs and in planning to meet these needs including making appropriate adaptations in the service

The homemaker-home health aide service is an integral part of the human service delivery system in a community; therefore, it should be active in organizations which are working toward meeting community needs. Board and staff members and volunteers should assume the fundamental responsibility for working with others to improve services.

XII. There shall be an ongoing agency program of interpreting the service to the public, both lay and professional

The agency has a responsibility to interpret homemaker-home health aide service as a service which includes professional staff and trained and supervised homemaker-home health aides. Information about the agency and its services shall be made known to the public, both lay and professional. Publicity materials should contain a thorough description of the service as well as specific information concerning fees, eligibility requirements, and the hours the service is offered and any limitations on service.

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 community needs

Annual reviews and periodic in-depth self-studies of the agency's service are required so that its effectiveness and efficiency can be evaluated. Broad partici-

pation from all groups—the board, committees, all levels of staff including the homemaker-home health aides, and consumers of the service should be included in the analysis of the service.

XIV. Reports shall be made to the community, and to the National Council for Homemaker-Home Health Aide Services, as requested

Community relations and public accountability are of major importance to an agency. Development of a narrative, statistical and financial annual report and an audit done by a nonrelated organization are essential to establishing and maintaining communications. Provision of data to the national council is essential to the full development and adequate funding of quality homemaker-home health aide service.

ITEM 2. LETTER AND ENCLOSURES FROM FLORENCE MOORE,[1] EXECUTIVE DIRECTOR, NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., NEW YORK, N.Y., TO SENATOR PETE V. DOMENICI, DATED APRIL 18, 1978

DEAR SENATOR DOMENICI: The National Council for Homemaker-Home Health Aide Services is most grateful to you and to the Senate Committee on Aging for arranging the hearings on standards held Monday, April 17, 1978.

You requested information on our membership statistics. As of the end of 1977 they were as follows:

Agencies:	
Approved/accredited	124
Agency associates	109
Individuals	264
Organizations	41
Total	538

Enclosed are definitions for a number of supplementary services. We would be glad to have them published with our testimony.

Sincerely,

FLORENCE MOORE.

Enclosures.

DEFINITIONS[2] OF VARIOUS IN-HOME SERVICES

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

Telephone reasurrance: A telephone reassurance program provides calls 7 days a week at a prearranged time to ill, disabled, or elderly persons who live alone. The purpose of the calls is to determine each person's condition and to provide community contact over a sustained period of time.

Chore services: A chore service program provides help with minor home repairs, heavy house cleaning, and yard tasks which need to be carried out intermittently to maintain a person safely in his own home. It does not include personal care.

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

Transportation or escort services: Transportation and escort service provide assistance to a person who requires help to get where he needs to go, including, when necessary, an escort to help secure the needed service and to return him safely home.

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[1] See statement of Hadley D. Hall, p. 789.

[2] From "Supplementary Services Guidelines for Services Supplementary to Homemaker-Home Health Aide and Home Health Services." Available from National Council for Homemaker-Health Aide Services.

Policy Statement on Training for Homemaker-Home Health Aides

BACKGROUND TO POLICY STATEMENT

Appropriate training and professional supervision of homemaker-home health aides are required by the National Council for Homemaker-Home Health Aide Services' standards. These standards were developed and adopted by leaders in the field to protect consumers and providers of the service and to ensure that monies spent, public and private, are used effectively. A manual for training homemaker-home health aides was prepared by educators in the field with the help of the Office of Education of the Department of Health, Education, and Welfare. This publication outlines the basic components of the generic training required of aides for agencies applying for approval and accreditation.

A census of classroom training programs for homemaker-home health aides was conducted in 1976 by the National Council. Of the 1,700 agencies surveyed, 1,247 useable responses were coded, computerized and analyzed. Two of the overall impressions, well supported by data, were: (1) Training of homemaker-home health aides lacks uniformity of auspice, and (2) agencies are interested in communicating with others about training homemaker-home health aides.

As new and innovative ways of providing better services and more services are explored and tested by approved/accredited agencies, new resources for the training of aides are under exploration: for example, community colleges, vocational-technical schools, adult education programs, Red Cross and hospital-based programs.

POLICY STATEMENT

Whatever the auspice of the training program, the following guidelines should be observed:

1. Aides who receive training must be screened and sponsored by the agency which will employ them and assume responsibility for their services. In no case should homemaker-home health aides be trained to become independent providers. The moral and legal implications of independently provided paraprofessional services are self-evident.
2. The training of the homemaker-home health aide, both initial and ongoing, is based on a "team concept," in which professionally educated persons assume the responsibility for training the aides as well as the responsibility for case assessment and reassessment. establishing a plan of care (case management) and providing supervision and direction of the aide.
3. Instructors for the course should be familiar with the homemaker-home health aide field and, wherever possible, should have had experience working with an approved homemaker-home health aide service. When possible, instructors should be selected who have had some experience in teaching adults.
4. Field experiences are essential to a good training program. Plans for providing aide trainees with these learning experiences should be worked out jointly by the employing agency and the training resource.
5. The employing agency should have the privilege of monitoring the entire course. The instructors should be given opportunities to observe the aides at work in the homes of the families they serve.

Initial Policy Statement on Supplementary Services, Adopted by the Board of Directors, May 4, 1974

The National Council for Homemaker-Home Health Aide Services, Inc., has formulated this policy statement because it actively supports the development of various in-home services being organized in many communities to meet a broad range of human needs and thus to enable people to remain in their own homes. Many local agencies use various types of non-professional in-home services to supplement the core program of homemaker-home health aide services. The National Council encourages this trend.

Supplementary services are not the professional services rendered in the home but they frequently supplement such services. They are provided by paraprofessionals and/or volunteers under the aegis of a professional health or social service agency that assumes responsibility for evaluating the need for the service and is accountable for the performance of personnel and for the quality of the service delivered.

Supplementary service—those non-professional in-home services other than homemaker-home health aide services—include, but are not limited to, chore services, meals-on-wheels, friendly visitors, telephone reassurance, escort service, shopping services and transportation.

Many families and individuals are able to function with the assistance of a single supplementary service while others may need several services, often in conjunction with homemaker-home health aide services, to maintain or return to independent living. Many different clusters of service are possible and may involve various combinations of professional, paraprofessional and volunteer personnel.

The National Council for Homemaker-Home Health Aide Services believes that supplementary services, like all other services, require guidelines for their orderly and safe delivery.

Supplementary services must be carefully planned so that they are readily available and accessible throughout a geographic area. They should be an integral part of the network of health and social services in a community. The homemaker-home health aide agency may deliver supplementary services or make use of services delivered by others. When more than one agency is involved in the delivery of supplementary services, ultimate responsibility for the coordination of these services to a family or individual must be assumed by a single agency and this responsibility must be clearly delineated.

GUIDELINES FOR AGENCIES WHICH PROVIDE OR COORDINATE IN-HOME SERVICES WHICH ARE SUPPLEMENTARY TO HOMEMAKER-HOME HEALTH AIDE SERVICES

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

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

The following agency administrative policies and procedures are recommended:

1. The parameters of each supplementary service should be clearly defined so that it can be determined when that service is appropriate.
2. The purpose of each supplementary service, and its parameters, should be clearly stated to the community.
3. Each supplementary service should be shown on the agency's organization chart, with policymaking and administrative responsibilities for the activities clearly stated.
4. Those in charge of each supplementary service should be responsible to a professional person who is fully competent to evaluate and coordinate all of the in-home programs needed by the individuals served and responsible for seeing that appropriate service is provided.
5. The responsibilities and functions of the various persons who will carry out the services should be defined in job descriptions and personnel policies.
6. Orientation should be given to all those who will be involved in each supplementary service to: insure understanding of the needs of those to be served; the procedures to be used, the policies to be followed; the purpose and functions of the parent agency and of other resources in the community.
7. Each supplementary service should be carefully analyzed to determine what policies and procedures are needed to safeguard those served and to safeguard the staff members or volunteers providing services. These might include, for instance, general liability insurance including that for a transportation program; or a monitoring system in a telephone reassurance program, to assure that all necessary calls are made and that a carefully worked out emergency plan goes into effect immediately when a reassurance call goes unanswered.
8. Relevant statistics concerning each supplementary service, including indications of unmet needs or duplication of services, should be communicated to the board of the agency and then to appropriate planning and funding groups.
9. Careful financial records should be kept for each supplementary service so that a reasonable estimate can be made of unit costs, such as cost per ride, per meal or per call.
10. Each supplementary service should be evaluated regularly by special committees within the agency and by appropriate community groups.

GUIDELINES TO DEFINING THE PARAMETERS OF CHOICE SERVICES SUPPLEMENTARY TO HOMEMAKER-HOME AIDE SERVICES

The National Council believes that the parameters of chore services should be clearly limited to those skilled or semiskilled tasks which are needed to maintain a person in safety and dignity in his own home.

Chore services fall into three categories: minor home repairs, heavy cleaning, yard and walk maintenance.

Minor home repairs include but are not limited to: replacing window panes, fuses, electric plugs, frayed cords, faucets or faucet washers, hanging screens and storm windows; caulking windows, installing weather stripping around doors; minor painting and repairs to walls, floors, ceilings, stair repair and handrail installation or repair; installing safety rails for tubs and toilets; minor plumbing repairs; furniture repair, minor carpet repair; installation of locks, window locks and hinges.

Heavy cleaning includes but is not limited to: cleaning attics or basements to remove fire hazards; moving heavy furniture; exterior window washing, extensive wall washing, floor care or painting; carrying of water, coal or wood; removing ashes.

Yard and walk maintenance includes: lawn cutting; leaf raking; hedge trimming; minor walkway repairs; snow removal; trash removal.

Chore services in any or all of the three categories may be the only services needed in some instances. In others, they may be provided in addition to homemaker-home health aide services.

ITEM 3. ATTACHMENTS TO STATEMENT SUBMITTED BY JOAN E. CASERTA,[1] NATIONAL LEAGUE FOR NURSING, NEW YORK, N.Y.

nln chha/chs

council of home health agencies and community health services

ATTACHMENT 3

nln/apha accreditation program

Comparison of
Conditions for Medicare Certification
and
NLN/APHA Criteria for accreditaion
of Home Health Agencies

Attached is the comparison of the above done by HEW staff. In addition to the criteria listed, the NLN/APHA Accreditation Program also requires the following evidences:

- consumers of service and representatives of the community participate in agency affairs;
- administrative and fiscal policies and practices assure effective and efficient implementation of the program;
- the agency is coordinated with community and other health facilities and services;
- the agency does an ongoing assessment of current health needs of the community;
- programs are established, reviewed and modified to keep pace with current health needs;
- the agency has specific measurable objectives for each program offered;
- the agency has priorities among and within each program and service offered; and
- if appropriate and feasible, the agency accepts responsibility for participation in the education of health personnel.

April 14, 1978

national league for nursing · ten columbus circle · new york, new york 10019 · 212·582-1022

[1] See statement, p. 791.

COMPARISION OF

CONDITIONS FOR MEDICARE CERTIFICATION	AND	CRITERIA FOR ACCREDITATION OF HOME HEALTH AGENCIES
Compliance with Federal, State and Local Laws. Condition-		Compliance with Federal, State and Local Laws. Condition---
The home health agency and its staff are in compliance with all applicable Federal, State and local laws and regulations. If State or applicable local law provides for the licensure of home health agencies, an agency not subject to licensure must be approved by the licensing authority as meeting the standards established for such licensure. A proprietary organization which is not exempt from Federal income taxation under Section 501 of the Internal Revenue Code of 1954 has to be licensed as a home health agency pursuant to State law. If no State law exists for the licensure of a proprietary home health agency, (see 405.1202(o)) it cannot be certified for participation in the Medicare program. (Reg. 405.1220)		The agency must be legally authorized and have a governing body responsible for its operation. It must (1) submit source of legal authorization to operate, and (2) give the agency's statement of purpose and the source in which it is found, and when it was formulated and when reviewed. The agency must show it is licensed by the State it operates in if that State requires licensure. Administrative responsibilities and relationships are established and clearly defined.
Organization, Services, Administration. Condition-		Organization, Services, Administration. Condition-
Organization, services provided, administrative control and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Administrative and supervisory functions are not delegated to another agency or organization and all services not provided directly are monitored and controlled by the primary agency, including services provided through subunits (see 405.1202(w)) of the parent agency. If an agency has subunits, appropriate administrative records are maintained for each subunit. (Reg. 405.1221)		The agency must: a. Submit its plan of organization currently in effect to show clearly the channels of authority and the relationships of service personnel, program units, or other divisions to one source. b. Delineate the overall responsibilities of all administrative and service personnel. Describe the lines of authority and accountability in relationship to their responsibilities, if different from those shown on the organizational chart.

(a) Services Provided. The Agency provides part-time or intermittent skilled nursing services and at least one other covered therapeutic service (physical, speech, or occupational therapy, medical social services, or home health aide services).

(b) Governing Body. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. The governing body appoints:

(i) a qualified administrator, (see 405.1202(a)
(ii) arranges for professional service (see 405.1222),
(iii) Adopts and periodically reviews written bylaws (see 405.1202(b))or an acceptable equivalent,
(iv) oversees the management and fiscal affairs of the agency.

The name and address of each officer, director, and owner are disclosed to the State Medicare agency with changes reported promptly.

c. Give examples and/or submit administrative documents that illustrate the channels of communication among the governing body or bodies, the administration, and the service personnel.

d. State the ways in which staff in all disciplines and position classficiations have a voice in the agency's administrative policies.

Services Provided. The agency provides part-time or intermittent skilled nursing and at least one other covered therapeutic service and also requires that proprietary agencies provide all services directly and that only the primary agency has authority to accept patients for care. It also includes support elements such as medical supplies and equipment, transportation, laboratory services, etc.

Governing Body. The agency must have a governing body responsible for its operation. It must name and describe the composition and method of operation of the agency's legally constituted governing bodies and/or advisory groups. It must include the following: (1) number and basis for selection of members, (2) tenure or term of office, (3) plan for orientation, (4) frequency of meetings, (5) attendance at meetings, (6) kinds of records kept of activities. The agency must list the overall responsibilities of the governing body and how these responsibilities are fulfilled and give examples of significant action taken by the governing body within recent years which has had effect on the agency's program.

The NLN criteria for the governing body includes all criteria requirements of Title XVIII.

(c) Administrator. The qualified administrator, who may also be the supervising physician (see 405.1202(k)) or registered nurse, (see 405.1202(r)):

(i) organizes and directs the agency's ongoing functions,
(ii) maintains ongoing liaison among the governing body, the group of professional personnel, and the staff,
(iii) employs qualified personnel and ensures adequate staff education and evaluations.
(iv) ensures the accuracy of public information materials and activities, and
(v) implements an effective budgeting and accounting system.

A qualified person is authorized in writing to act in the absence of the administrator.

Administrator. The governing body delegates to a qualified health professional from a profession involved in implementing the agency's programs, the authority and responsibility to:

--plan, administer, and coordinate the services and programs of the agency,

--participate in the deliberations and decisions made on policies guiding services and programs, utilizing the advice and counsel of other health professionals in the agency.

The qualifications of the administrator should be those established by the profession.

The NLN avers its requirements exceed those required by Title XVIII.

A qualified person is authorized in writing to act in the absence of the administrator.

CERTIFICATION

(d) Supervising Physician or Registered Nurse. The skilled nursing and other therapeutic services provided are under the supervision (see 405.1202(y)) and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse (see 405.1202(q)). This person or similarly qualified alternate, is available at all times during operating hours and participates in all activities relevant to the professional services provided, including the qualifications and assignment of personnel.

ACCREDITATION

Supervising Physician or Registered Nurse. Health care services are directed and/or coordinated by a health professional from a discipline providing agency services. The qualifications for a supervising physician and registered nurse are those enunciated by their respective health professional organizations and are in keeping with the responsibilities assigned within the agency. For all professional personnel, the agency must provide ongoing supervision, peer review, or consultation by a co-professional qualified for this function.

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CERTIFICATION

(e) Personnel Policies. Personnel practices
d patient care are supported by appropriate,
itten personnel policies. Personnel records
clude qualifications, licensure, performance
aluations, and health examinations and are kept
rrent.

ACCREDITATION

Personnel Policies. Personnel practices and patient care are supported by written personnel policies. Personnel policies delineate the conditions of employment and the respective obligations between the employer and employee for all salaried, hourly, or contract personnel. The agency is an equal opportunity employer and has a program of affirmative action.

CERTIFICATION

(f) Personnel Under Hourly or Per Visit Contract. such personnel are utilized by the home health ency, there is a written contract between such rsonnel and the agency clearly designating:

(i) that patients are accepted for care only by the primary home health agency,
(ii) the services to be provided,
(iii) the necessity to conform to all applicable agency policies including personnel qualifications, the responsibility for participating in developing plans of treatment.
(iv) the manner in which services will be controlled, coordinated, and evaluated by the primary agency,
(v) the procedures for submitting clinical and progress notes, (see 405.1202(d) and (n)) scheduling of visits, periodic patient evaluation and
(vi) the procedures for determining charges and reimbursement.

(g) Coordination of Patient Services. All personnel viding services maintain liaison to assure that ir efforts effectively complement one another and port the objectives outlined in the plan of treatment.

(i) The clinical record or minutes of case conferences establish that effective interchange, reporting and coordinated patient evaluation does occur.

(ii) A written summary report (see 405.1202(x)) for each patient is sent to the attending

ACCREDITATION

Personnel Under Hourly or Per Visit Contract. Personnel policies delineate the conditions of employment and the respective obligations between the employer and employee for all salaried, hourly, or contract personnel. The agency is an equal opportunity employer and has a program of affirmative action.

In assigning responsibility, there must be a written description for the basis of assigning personnel with different degrees of preparation and experience to service and related activities, whether they be full-time, part-time, or on a contract basis.

Coordination of Patient Services. Conferences of workers providing services to a patient/family are held (for evaluation, reevaluation, and planning of total care). A professional nurse has the responsibility for coordinating the agency plan for patient care. The records must show the type of conferences, frequency of meetings, participants, and provisions for recording the results. Service records are maintained for planning and improving all services to individuals, families, and groups. The service records should outline clearly the contents such as updated medical records, plan for total care, progress notes reflecting current status of the patient, reasons for terminating any services, plans for discharge and continuing care, etc.

The NLN requires that a written summary report for each patient be sent to the attending physician every 60 days.

CERTIFICATION

(h) Services Under Arrangements. Services provided
ar arrangement with another public or nonprofit
ency (see 405.1202(p) and (e)) must be subject to
ritten contract conforming with the requirements
cified in 405.1221(f).

up of Professional Personnel, Condition -

group of professional personnel, which includes at least
practicing physician and one registered nurse (preferably
ublic health nurse), and with appropriate representation
m other professional disciplines, establishes and
ually reviews the agency's policies governing scope of
vices offered, admission and discharge policies, medical
ervision and plans of treatment, emergency care, clinical
cords, personnel qualifications, and program evaluation.

least one member of the group is neither an owner (405.1221)
employee of the agency. (Reg. 405.1222)

(a) Advisory and Evaluation Function. The group of
fessional personnel meets frequently enough to advise the
ncy on professional issues, participate in the evaluation of
agency's program and assist the agency in maintaining
ison with other health care providers in the community
rmation program.

meetings are documented by dated minutes.

ACCREDITATION

The NLN requires that the agency establish and annually review its policies governing the scope of services offered, admission and discharge policies, medical supervision and plan of treatment, emergency care, clinical records, personnel qualifications, and program evaluation.

Services Under Arrangements. Delineate the overall responsibilities of administrative and service personnel, whether full-time, part-time, or under contract. Describe the lines of authority and accountability in relationship to their responsibilities, if different from those shown on the organizational chart.

The assignment of responsibility provides for appropriate utilization of every employee, whether full-time, part-time, or contract employees.

Group of Professional Personnel.
Programs are established, reviewed, and modified to keep pace with current health needs. This is done by a group of professional personnel, including at least one practicing physician and one registered nurse, with appropriate representatiion from other professional disciplines.

The NLN does require that at least one member of the group is neither an owner nor an employee of the agency.

Meetings are documented by dated minutes.

CERTIFICATION

ceptance of Patients, Plan of Treatment, Medical
upervision. Condition -

atients are accepted for treatment on the basis of
reasonable expectation that the patient's medical,
ursing and social needs can be met adequately by the
gency in the patient's place of residence. Care
llows a written plan of treatment established and
eriodically reviewed by a physician, and care continues
nder the general supervision of a physician (Reg. 405.1223)

(a) Plan of Treatment. The plan of treatment
eveloped in consultation with the agency staff covers
l pertinent diagnoses, including:

(i) mental status,
(ii) types of services and equipment required,
(iii) frequency of visits,
(iv) prognosis
(v) rehabilitation potential,
(vi) functional limitations,
(vii) activities permitted.

ACCREDITATION

Acceptance of Patients, Plan of Treatment, Medical Supervision.

The agency has written policies outlining the major areas of policy in which the scope and also limitations of services are defined, including the major provisions in each group of policies and, specifically, including the conditions for admitting, continuing, and discharging clients, also eligiblity, source of medical direction, practice policies and procedures for each professional service, its assistants and/or aides. The agency will state who is involved in the formulation, review and approval of each group of policies. The written policies should reflect professional standards or existing State laws for each service; protect families and patients and relate to quality of care; and protect the service staff and the agency.

Plan of Treatment. Service records are maintained for planning and improving all services to individuals, families, and groups. Included in the service record are updated medical records, plan for total care, current status of patient, need for continued service with professional reappraisal at regular intervals, plans for terminating services or discharge with continuing care.

(viii) nutritional requirements,
(ix) medications and treatments,
(x) any safety measures to protect against injury,
(xi) instructions for timely discharge or referral, and
(xii) any other appropriate items.

If a physician refers a patient under a plan of treatment which cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency and duration. The therapist and other agency personnel participate in developing the plan of treatment.

(b) Periodic Review of Plan of Treatment. The total plan of treatment is reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of treatment.

Periodic Review of Plan of Treatment. The NLN does require a review of the total plan of treatment by a physician and the HHA personnel as often as the patients' condition warrants, and at least once every 60 days.

(c) Conformance with Physician's Orders:

(i) Drugs and treatments are administered by agency staff only as ordered by the physician.

(ii) The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature.

Conformance with Physicians' Orders. The NLN requires that the patients' record contain updated medical orders, including all drugs and treatments administered by agency staff, and only as ordered by a physician. The nurse/therapist immediately records and signs oral orders and obtains the physicians' countersignature within a reasonable time.

CERTIFICATION

(iii) Agency staff check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contra-indicated medication, and reports any problems to the physician.

Skilled Nursing Service. Condition-

The home health agency provides skilled nursing service by or under the supervision of a registered nurse and in accordance with the plan of treatment. (Reg.405.1224)

(a) Duties of the Registered Nurse. The registered nurse:

(i) makes the initial evaluation visit,
(ii) regularly reevaluates the patient's nursing needs,
(iii) initiates the plan of treatment and necessary revisions,
(iv) provides those services requiring substantial specialized nursing skill
(v) initiates appropriate preventive and rehabilatative nursing procedures,
(vi) prepares clinical and progress notes,
(vii) coordinates services,
(viii) informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related needs, participates in inservice programs, and supervises and teaches other nursing personnel.

(b) Duties of the qualified Licensed Practical Nurse see 405.1202 (1)). The qualified licensed practical nurse:

(i) provides services in accordance with agency policies
(ii) prepares clinical and progress notes,
(iii) assists the physician and/or registered nurse in performing specialized procedures,
(iv) prepares equipment and materials for treatments observing aseptic technique as required; and

ACCREDITATION

The agency staff is responsible for checking all medicines given a patient for identifying possible ineffective drug therapy or adverse reactions, side effects, drug allergies, etc. It requires that any problems be reported to the physician.

Skilled Nursing Service

The service staff inclues professional personnel who meet the standards for employment of their respective professional organizations. Professional nurses have the responsibility for planning, providing, and supervising the nursing care to patients and families. The nursing service, including practical nurses and aides, is directed by a public health nurse whose qualifications are in keeping with the responsibilities assigned, whether director of the overall agency or of the nursing service department.

Duties of the Registered Nurse. The service staff includes professional personnel who meet the standards for employment of their respective professional organizations. The agency must have written policies outlining the major areas of policy in which the scope and also limitations of services are defined. The agency must have job descriptions for each classification, showing functions and required academic/experience qualifications included with the self-study report.

Duties of the Qualified Licensed Practical Nurse. The service staff includes professional personnel who meet the standards for employment of their respective professional organizations. The agency must have written policies outlining the major areas of policy in which the scope and also limitations of services are defined. The agency must have job descriptions for each classification, showing functions and required academic/experience qualifications included with the self-study report.

CERTIFICATION

Therapy Services. Condition -

Any therapy services offered by the agency directly or under arrangement are given by or under the supervision of a qualified therapist in accordance with the plan of treatment. The qualified therapist (see 405.1202(f) (i) and (u)): (Reg. 405.1225)

(i) assists the physician in evaluating level of function,
(ii) helps develop the plan of treatment (revising as necessary),
(iii) prepares clinical and progress notes,
(iv) advises and consults with the family and other agency personnel, and
(v) participates in inservice programs.

(a) Supervision of Physical Therapist Assistant (see 405.1202(j) and Occupational Therapy Assistant (see 405.1202(g). Services provided by a qualified physical therapist assistant, or occupational therapy assistant may be furnished under the supervision of a

ACCREDITATION

Therapy Services

The agency provides orientation and inservice education for each discipline and each classification of worker. The agency makes continuing education opportunities available to all workers, whether they be full-time, part-time, or on a contract basis. The agency must maintain plans for orientation, ongoing education, preparation of staff for new programs, etc.; plans for financing, staff participation, consultant services, resources, etc.

Supervision of Physical Therapist Assistant and Occupational Therapy Assistant. Each employee has ongoing professional or technical supervision to promote individual development and performance. This may be provided by agency employed, qualified personnel or by contract. Job descriptions for each classification, showing functions and required academic/experience qualifications are included with the self-study report.

ualified physical or occupational therapist.
physical therapist assistant or occupational
therapy assistant:

(i) performs services planned, delegated and supervised by the therapist,
(ii) assists in preparing clinical notes and progress reports, and
(iii) participates in educating the patient and family and
(iv) inservice programs.

(b) Supervision of Speech Therapy Services. Speech therapy services are provided only by or under supervision a qualified speech pathologist or audiologist.

edical Social Services. Condition -

edical social services, when provided, are given by a qualified social worker (see 405.1202(t)) or by a qualified social work assistant (see 405.1202(s)) under the supervision of a qualified social worker, and in accordance with the plan of treatment. The social worker: (Reg. 405.1226)

(i) assists the physician and other team members in understanding the significant social and emotional factors related to the health problems,
(ii) participates in the development of the plan of treatment,
(iii) prepares clinical and progress notes,
(iv) works with the family,
(v) utilizes appropriate community resources.
(vi) participates in discharge planning and inservice programs, and
(vii) acts as a consultant to other agency personnel.

Supervision of Speech [illegible]. For all professional personnel the agency provides ongoing supervision, peer review, or consultation by a co-professional qualified for this function. Each employee has ongoing professional or technical supervision to promote individual development and performance. Job descriptions for each classification, showing functions and required academic/experience qualifications are included with the self-study report. The agency provides orientation and inservice education for each discipline and each classification of worker.

A physical therapist assistant or occupational therapy assistant assists in preparing clinical notes and progress reports, and participates in educating the patient and family.

Medical Social Services

For all professional personnel, the agency provides ongoing supervision, peer review, or consultation by a co-professional qualified for this function. Each employee has ongoing professional or technical supervision to promote individual development and performance. Job descriptions for each classification, showing functions and required academic/experience qualifications are included with the self-study report. The agency provides orientation and inservice education for each discipline and each classification of worker.

CERTIFICATION

Home Health Aide Services. Condition -

Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. Aides are carefully trained in assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, maintaining a clean, healthful, and pleasant environment, changes in patient's condition that should be reported, work of the agency and the health team ethics and confidentiality, and recordkeeping.

They are closely supervised to assure their competence in providing care. (Reg. 405.1227)

(a) Assignment and Duties of the Home Health Aide. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or therapist as appropriate. Duties include:

(i) the performance of simple procedures as an extension of therapy services,
(ii) personal care,
(iii) ambulation and exercise,
(iv) household services essential to health care at home.
(v) assistance with medications that are ordinarily self-administered,
(vi) reporting changes in the patient's conditions and needs, and,
(vii) completing appropriate records.

(b) Supervision. The registered nurse, or appropriate professional staff member, if other services are provided, makes a supervisory visit

ACCREDITATION

Home Health Aide Services

The service staff includes professional personnel who meet the standards for employment of their respective professional organizations. Staff may in addition include other appropriate personnel such as aides or assistants.

Assignment and Duties of the Home Health Aide. Each employee has ongoing professional or technical supervision to promote individual development and performance. Job descriptions for each classification, showing functions and required academic/experience qualifications are included with the self-study report. The NLN states that written instructions are prepared by a registered nurse and the duties of the home health aide are outlined in the professional requirements of the job which exceed the requirements of Title XVIII.

Supervision. Each employee has ongoing professional or technical supervision to promote individual development and performance.

CERTIFICATION

to the patient's residence at least every 2 weeks, either when the aide is present to observe and assist, or when the aide is absent to assess relationships and determine whether goals are being met.

Clinical Records. Condition -

A clinical record is maintained in accordance with accepted professional standards and contains: (Reg. 405.1228)

(i) pertinent past and current findings,
(ii) plan of treatment,
(iii) appropriate identifying information,
(iv) name of physician,
(v) drug, dietary, treatment and activity orders,
(vi) signed and dated clinical and progress notes (clinical notes are written the day service is rendered and incorporated no less often than weekly).
(vii) copies of summary reports sent to the physician, and
(viii) a discharge summary.

(a) Retention of Records. Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies call for retention even if the agency discontinues operation

If a patient is transferred to another health facility, a copy of the record or abstract accompanies the patient.

(b) Protection of Records. Clinical record information is safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and conditions for release of information. Patient's written consent is required for release of information not authorized by law.

ACCREDITATION

Clinical Records.

Service records are maintained for planning and improving all services to individuals, families, and groups.

Retention of Records. The agency's policy with regard to retention of records is consistent with applicable State and local laws.

Protection of Records. The NLN requires patients' written consent before releasing information not authorized by law.

CERTIFICATION

Evaluation Condition -

The home health agency has written policies requiring an overall evaluation of the agency's total program at least once a year by: (Reg.405.1229).

(i) the group of professional personnel (or a committee of this group), agency staff and consumers, or by
(ii) professional people outside the agency working in conjunction with consumers.

The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.

Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

(a) Policy and Administrative Review. As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation. The data to be considered may include but are not limited to: number of patients receiving each service offered, number

ACCREDITATION

Evaluation.

The agency has established procedures for program evaluation. The agency will list individuals (by title, not name) and/or groups responsible for program evaluation. It will describe the formal and/or informal procedures used in evaluating the programs of the agency. The agency will list the kinds of data used in the evaluation procedure and explain how they are used to determine the objectives attained. It will explain by example how findings are interpreted to others and how they are used. A written description will be made of any recent changes or innovations that have occurred in the evaluation process.

Policy and Administrative Review. Staff patterns, policies, and practices are evaluated in relation to fulfilling the purposes of the agency. The review will describe the factors considered in establishing the types and numbers of personnel utilized. Agency practices will be discussed to insure that needed services for patients and families are continued or adjusted in a planned way during periods of change.

CERTIFICATION

of patient visits, reasons for discharge, breakdown by diagnosis, sources of referral, number of patients not accepted, with reasons, and total staff days for each service offered.

ACCREDITATION

The agency conducts or participates in a planned evaluation of its organization and administration. All health disciplines providing services and other agency staff are involved in this evaluation process. The evaluation should describe briefly or include the overall agency plan for total evaluation. It should give the dates when the agency last evaluated its organizational structure and annotate any changes resulting from this evaluation. The evaluation should also describe the methods used to evaluate the administrative practices of the agency.

CERTIFICATION

(b) Clinical Record Review. At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct as well as services under arrangement).

There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of treatment and apprppriateness of continuation of care.

ACCREDITATION

Clinical Record Review. The agency maintains an established mechanism for ongoing review of the quality of service rendered by each discipline.

ATTACHMENT 4

PROPOSED MODEL FOR THE DELIVERY OF HOME HEALTH SERVICES

CHHA/CHS

COUNCIL OF HOME HEALTH AGENCIES
AND COMMUNITY HEALTH SERVICES

PROPOSED MODEL FOR THE DELIVERY OF HOME HEALTH SERVICES

INTRODUCTION

Home health care services in the United States continue to be so limited in scope and geographic availability that large segments of the population are denied access to such services as a viable choice for meeting their health care needs.

The purpose of this document is to set forth a model plan for increasing the availability of a broad scope of home health services to all segments of the population and at the same time maximize manpower utilization, provide quality assurance, and promote cost containment.

BACKGROUND

Home health services of good quality are an essential part of the health care system. Such services, appropriately articulated with other health and social services—institutional and ambulatory—provide a more economical and desirable way of meeting many of the health care needs of society, both preventive and curative.

Home health services may be defined as an array of health care services provided to individuals and families in their places of residence or in ambulatory care settings for purposes of preventing disease and promoting, maintaining or restoring health or minimizing the effects of illness and disability. Services appropriate to the needs of the individual and his family are planned, coordinated and made available by an organized health agency—through the use of agency employed staff, contractual arrangements or a combination of administrative patterns. Medical services are primarily provided by the individual's

private or clinic physician although in some instances agencies will employ or contract for physician's services.

These services must be available to the total population and must include all service components necessary to ensure the health and safety of those for whom such services are appropriate.

There are over 2,000 agencies in this country currently providing home health services. However, there is great unevenness in the amount and variety of services available. In addition, there are some extensive, sparsely populated areas where services are minimal or absent.

The Council of Home Health Agencies and Community Health Services of the National League for Nursing[1] is committed to the promotion of ways and means by which communities throughout the country can be assisted in the development of comprehensive home health services. The organizational model proposed in this document is intended for use by community groups, health planning bodies, the insurance industry, and those developing legislative proposals as a new approach to the organization of home health agencies which will foster the availability of comprehensive home health services.

SERVICE COMPONENTS

Essential Home Health Services

The following services are considered essential and hence eligible for insurance coverage. Those denoted with an asterisk* would usually be arranged for by the home health agency and facilitated by the availability of patient transportation services:

Basic Essential (in alphabetical order)

Home Health Aide—Homemaker
Medical Supplies and Equipment (expendable and durable)
Nursing
Nutrition
Occupational Therapy
Physical Therapy

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[1] The Council of Home Health Agencies and Community Health Services of the National League for Nursing is the national spokesman for over 1,400 official and voluntary home health and community health agencies.

Speech Pathology Services
Social Work

Other Essential (in alphabetical order)

Audiological services*
Dental services*
Home delivered meals
Housekeeping services
Information and referral services
Laboratory services*
Ophthalmological services*
Patient transportation and escort services
Physicians services*
Podiatry services*
Prescription drugs
Prosthetic/orthotic services*
Respiratory therapy services
X-ray services*

Desirable Home Health Services

The following environmental/social support services are highly desirable and should be made available to augment home health care services through agency–community planning and development:

Barber/cosmetology services
Handyman services
Heavy cleaning services
Legal and protective services
Pastoral services
Personal contact services
Recreation services
Translation services

ORGANIZATIONAL MODEL

Two classifications of home health programs are proposed in the Model based upon the magnitude of the population served, the geography covered, services offered either directly or by arrangement, administrative structure, and numbers and kinds of staff employed either directly or by contract. These agencies would be community-based, certified to provide home health care and could also be involved in community-based services other than "care of the sick."

PROPOSED HOME HEALTH AGENCY PROGRAM MODEL

BASIC ESSENTIAL SERVICES

HOME HEALTH PROGRAM I		HOME HEALTH PROGRAM II
Nursing and at least two direct services of the following:	PROVIDED DIRECTLY BY AGENCY	Nursing
Home Health Aide-Homemaker Medical Supplies and Equipment Nutrition Services Occupational Therapy Physical Therapy Social Work Speech Pathology Services	PROVIDED DIRECTLY BY AGENCY OR BY CONTRACT	Home Health Aide-Homemaker Occupational Therapy Physical Therapy Social Work Speech Pathology Services

OTHER ESSENTIAL SERVICES WHICH MAY BE PROVIDED DIRECTLY OR BY ARRANGEMENT

Audiological Services*	Laboratory Services	Physician Services*
Dental Services*	Medical Supplies and Equipment†	Podiatry Services*
Home Delivered Meals*	Nutrition†	Prescription Drugs
Housekeeping Services	Ophthalmological Services	Prosthetic/Orthotic Services*
Information and Referral Services	Patient Transportation and Escort Services	Respiratory Therapy X-ray Services*

*These services may be arranged for by the agency and facilitated by the availability of transportation.
†Required for Home Health Program I; incorporated into Home Health Program II if feasible.

DESIRABLE ENVIRONMENTAL-SOCIAL SUPPORT SERVICES—SOME MAY BE DEVELOPED AS VOLUNTEER SERVICES

Barber-Cosmetology	Heavy Cleaning Services	Pastoral Services	Recreational Services
Handyman Services	Legal and Protective Services	Personal Contact Services (Friendly Visitor, etc.)	Translation Services

ASSUMPTIONS BASIC TO THE PROPOSED MODEL

The following assumptions are basic to the organizational model as proposed:

1. The home health care services provided will be adapted to meet the health needs of individuals and families of all age groups, in all diagnostic categories, and in all economic situations without regard to race, color, creed, or national origin.

2. The program will include the basic essential home health services as identified on pp. 2-3 and, as feasible, the "other essential" home health services as well as appropriate environmental/support services.

3. The geographic boundaries selected will not be in conflict with area-wide regional health planning.

4. All geographic areas will have service available based upon validation of need.

5. The agencies providing home health services will be certified for this purpose by appropriate bodies and maintain standards as established by the National League for Nursing, the American Public Health Association and other national standard-setting bodies, as appropriate.

6. Overlapping and duplication of services will be avoided and new agencies will not be developed in areas where there is a home health program with capacity to meet the needs for services as described in the proposed Model. Health programs serving a defined population, *i.e.,* hospital-based home care programs, health maintenance organizations, and neighborhood health centers, will contract for home health services with the programs described in the Model.

7. Insurance coverage and other payment mechanisms for health care will include the essential home health services as previously identified.

HOME HEALTH PROGRAM I

Home Health Program I will be conducted by an agency which would:

1. Serve a defined population base and geographic area such as a state, or group of counties, a large county, a large city.

2. Be accredited or in the process of being accredited by NLN/APHA.

3. Limit staff travel for direct service with consideration for terrain, use of sub-stations, numbers and kind of specialized staff, and transportation facilities.

4. Offer all basic essential services listed in the "Proposed Home Health Agency Program Model" on pp. 4-5 as a minimal program package either directly or by arrangement, with the exception that nursing, and at least two other services, *must* be offered directly. In addition, the full range of identified *essential* and *desirable* services should be incorporated into the service program as feasible in the community.

5. Ensure the availability of the number and kinds of staff needed to supply the range of services offered to the base population.

6. Be willing to extend selected direct patient care services and consultant services to Home Health Program II agencies through arrangement.

7. Be capable of and willing to offer administrative management and centralized services to neighboring Home Health Program II agencies. These may include, but are not necessarily limited to, billing, statistical, accounting, costing and purchasing services; centralized inservice education; patient record and utilization review systems.

HOME HEALTH PROGRAM II

Agencies which qualify as a Home Health Program II would:

1. Serve a defined population base and geographic area such as small county, small city, town, health area.

2. Provide nursing service directly and, in addition, provide directly or by arrangement (contracts) Homemaker/Home Health Aide service, Occupational Therapy, Physical Therapy, Social Work, and Speech Pathology services. In addition, the full range of identified *essential* and *desirable* services should be incorporated into the service program as feasible in the community.

3. Employ a direct service staff of at least five full-time nurses (or part-time equivalent) plus one full-time director/supervisor (or equivalent). Although staff may be deployed on a wide geographic basis, necessary provisions would be made for regular on-site contact to agency headquarters on the part of field staff. This staffing pattern is proposed with the understanding that, in sparsely populated areas, modification may be necessary.

4. Contract with a neighboring Home Health Program I agency for direct patient care and consultant services not available to the agency locally.

5. Contract with a neighboring Home Health Program I agency for administrative management and centralized services not available locally, as are required to maintain quality administrative practices.

ITEM 4. LETTER AND ENCLOSURE FROM JOAN E. CASERTA, NATIONAL LEAGUE FOR NURSING, NEW YORK, N.Y., TO SENATOR PETE V. DOMENICI, DATED APRIL 25, 1978

DEAR SENATOR DOMENICI: In behalf of the members of the Council of Home Health Agencies and Community Health Services, we thank you for the opportunity to present our views last week on the issue of standards in home care. You are to be congratulated on your keen insight, knowledge, and understanding of the home health industry and the problems confronting the industry.

At the hearing you asked for a breakdown of the services provided by our member agencies. At this time we do not have up-to-date figures, but will conduct a survey this summer to gain a profile of the groups. Historical data from the National Center for Health Statistics reveal that in 1975 services provided by home health agencies were as follows:

Type of service:	*Percent providing service*
Nursing	100
Physical therapy	75
Speech pathology	35
Occupational therapy	25
Medical social work	25
Home health aide	70

We are enclosing CHHA/CHS's position statements on the issues of certificate of need and licensure which are for your review and which we would like entered into the record of the hearings. As soon as our tabulation on the distribution of income and expenditure for voluntary home health agencies is completed, we will forward it to you for inclusion in the record.

Thank you again. We look forward to continuing work with you and your very able staff.

Sincerely,

JOAN E. CASERTA.

Enclosures.

POSITION ON LICENSURE OF HOME HEALTH AGENCIES

Two processes are required by law to protect consumers of home health agencies and to assure title 18 and 19 that the minimum standards required by the law are in effect.

One process is certification by a State of nonprofit entitles; the other is licensure, an option each State may elect in order to certify profitmaking entities.

Each process is required annually. Each is able to permit provisional approval until agency practices can be brought into compliance. Each tests compliance with the Federal law. Both may be withheld or withdrawn for noncompliance.

Certification by each State is approved by regional HEW offices and ultimately by the Secretary. States may require higher standards, but not lower than required by the law.

Licensure in each State is not approved by regional HEW. Licensure can be a function of department of institutions, department of licenses, or other arrangement within the States.

There is no evidence that licensure has enriched or reinforced certification. Rather, it may have had the negative effect of decreasing emphasis on much needed improvements in the certification process. It has also increased costs, both in time and paperwork.

CHHA/CHS promotes the certification requirement for home health as a uniform national test of legal compliance for home health agencies. CHHA/CHS will continue to work for the improvement of sanctions and upgrading of provisions in the certification process.

If licensure remains the only federally acceptable method for certifying a profitmaking home health agency, CHHA/CHS will support State licensure for all home health agencies equally when based on a certificate of need requirement (national standard).

CHHA/CHS will continue supporting the position of a federally required certificate of need based on national standards rather than a State option.

In new Federal legislation CHHA/CHS recommends that certification be expanded to protect both the people and the government purchasing so that additional layers of bureaucracy are not needed.

POSITION STATEMENT ON CERTIFICATE OF NEED

Introduction

Home health services are rapidly gaining recognition as a vital, integral part of the health care system by the Federal Government, consumers, insurance companies, and other providers of services.

In the coming years, we can anticipate an accelerated growth in the number and kinds of agencies offering home health services. We predict as well that the kinds and amounts of services being offered will change. Thus, the industry is faced with two alternatives: The expansion can be left to chance with the possible end result of costly fragmentation, duplication of services in some areas, and no service in other areas; or, the expansion can be accomplished in a planned, rational, and orderly fashion based on community need. We believe the latter is the only feasible approach.

To achieve this, we are proposing that all newly established home health agencies and all proposals for geographical extension of services or for establishment of satellite offices of existing agencies be subject to a certificate of need review.

We have defined a home health agency as an overall organization offering a program of home health services in homes and/or other community settings to people of all ages. Such services include: physician service, nurse service, physical therapy, occupational therapy, speech pathology, home health aide/homemaker service; medical social work, nutrition, laboratory service, and medical supplies and equipment.

We hereby make a distinction between an agency which offers a home health program, including the above services and an agency which offers a home management program (meals-on-wheels, transportation, chore service, etc.). One agency may offer both programs. In this paper, however, we are addressing ourselves solely to a home health program.

Rationale for Needs Criteria

The establishment of baseline criteria sets is essential to enable:

(1) Health planners to more effectively identify the mix of health needs not currently being met;

(2) Consumers to make educated decisions about the appropriate facility to meet their felt needs;

(3) Health providers to develop and implement service modalities based on factual data in concert with recognized community groups.

The Council of Home Health Agencies and Community Health Services is very sensitive to the political pressures involved when an agency tries to establish itself where another agency or other agencies exist. Objective criteria should eliminate these pressures and should prevent a certificate of need in name only, being used to protect the turf of existing agencies or allowing for the establishment of new agencies where need does not exist.

Developing Criteria

In developing the criteria, the following types of information will be needed:

Population characteristics.—For both community and catchment area, each of the following in relation to morbidity rate: Age; income level; ethnicity (including language); usual living arrangements; education; general survey of industry in area; employment status and reasons (e.g., temporary industry layoff); infant mortality: and resources for reimbursement.

Provider profiles.—Institutional health facilities (hospitals, SNF's, ECF's, etc.) for both community and catchment area: Number of beds by type of service (med-surg., etc.); number of admissions; and number of discharges by diagnosis and disposition.

Noninstitutional health facilities.—(HMO's, home health agencies, rehabilitation centers, etc.) for both community and catchment area: Services being provided; and composition of case load being served.

Other providers.—For both community and catchment area: Number of physicians by specialty; and number of surgeons by specialty.

Patient assessment.—Levels of care provided in community; ratio of visits per patient by discipline; ratio of visits per patient by diagnosis; and outcome measures.

The criteria which are eventually developed must take into account the following: The number of patients to be served with and without prior hospitalization; projections of the population mix 5 years hence; projections of the impact of new health care providers (surgicenters, HMO's, etc.) 5 years hence; how to en-

courage provision of service to rural areas and/or to traditionally underserved population segments; and how to distinguish between need for additional services or additional agencies.

Determining Need

The data will be used to determine indices. The indices must be measured against national indices for population at risk utilizing home health services. Then the indices will be used to develop criteria. Such criteria will have to be tested for validity and finally valid criteria will establish national standards against which local communities can measure their needs.

It would appear, then, that in determining need, the following is the logical sequence:

Information (or data or facts)→Indices (or guidelines)→Criteria (tested for validity)→Standards (for determining need)

ITEM 5. LETTER AND ENCLOSURE FROM JOHN P. BYRNE,[1] PRESIDENT, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, ST. LOUIS, MO., TO KATHLEEN DEIGNAN, STAFF MEMBER, SENATE SPECIAL COMMITTEE ON AGING, DATED APRIL 10, 1978

DEAR KATHY: Our association of home health agencies has been grappling with the problem of standards for agencies and services provided from them for the past couple of years. As you may recall in my testimony as president of NAHHA before the HEW regional hearing in Chicago in October 1977, I stated, and still believe, that the most critical issue facing home health agencies and the appropriate expansion of services rests with the issues of effective standards.

In the fall of 1975, when NAHHA held its fifth annual meeting here in St. Louis, the membership directed its board to pursue the issue of standards and the development of an adequate approach to them. Following that, during the succeeding year, a small ad hoc committee met several times to review what had been done to date in the home health care field with regard to standards or a summary of them as criteria performance. Based upon this review and a great deal of study, a draft of standards statements was prepared and submitted to the membership at the Philadelphia meeting in October 1976. It was intended to be only a reflection of what was the attempt of the board to address the issue. The board and its ad hoc committee received the endorsement of the membership to continue this work, as indeed we did during the remainder of that year and the first 6 or 7 months of 1977.

I might note that although a fair amount of time elapsed, our limited resources permitted only infrequent meetings of this ad hoc committee over these 18 or 24 months. As the work of the ad hoc committee continued, it became relatively apparent that we were dealing with a large number of word changes from what others had done, but not a great deal of substantive new developments resulted from the work. Another concern that we had was that in reviewing the accreditation and standards processes of other national organizations, we found that only a small number of home health agencies were in fact inclined toward participating in these efforts.

Keeping this in mind and also seeing the rather minimal results from the efforts of the ad hoc committee in terms of a "spanking new" approach and some substantive progress in this area, it was decided during October 1977 that we change the thrust of the ad hoc committee and begin to study the conditions of participation, which are in fact a universal set of regulations effecting all home health agencies receiving title XVIII funds.

As a result of this new direction, the ad hoc committee was slightly revamped and has met twice during 1978 to study the conditions. As a result of these meetings, we are enclosing a copy of the conditions and their definitions with a commentary wherever we felt necessary to illustrate weaknesses in the conditions, as well as actual oversights. It is our judgment that if these areas are strengthened, the conditions of participation can provide the framework applicable to all title XVIII and, for that matter, title XX agencies who are charged with the responsibility of providing services under Federal dollars support.

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[1] See statement of Hope Runnels, p. 796.

We do not mean to imply by the submission enclosed to think that the work on this is nearly done. We are merely trying to point out what we feel are the areas that a combined effort by HEW and home health agencies could complete, whereby we truly would have effective standards in this area of health delivery.

It is our hope to meet with officials from HCFA or any other appropriate administrative unit within DHEW to review this matter and attempt to obtain their endorsement to proceed with a further development in this regard. We are indeed prepared as a national body to work to whatever extent possible in the completion of this work which we feel is so very vital to the success of home care in the future.

We look forward to discussing this matter with you at the time of the committee hearing on April 17, 1978.

Sincerely,

JOHN P. BYRNE.

Enclosure.

HOME HEALTH AGENCY SURVEY REPORT (Form OMB No. 72-R0735)	NAHHA Standards Committee Remarks
I. Compliance with Federal, State and Local Laws. Condition-(405.1220) The home health agency and its staff are in compliance with all applicable Federal, State and local laws and regulations. If State or applicable local law provides for the licensure of home health agencies, an agency not subject to licensure must be approved by the licensing authority as meeting the standards established for such licensure. A proprietary organization which is not exempt from Federal income taxation under Section 501 of the Internal Revenue Code of 1954 has to be licensed as a home health agency pursuant to State law. If no State law exists for the licensure of a proprietary home health agency (see 405.1202 (o) it cannot be certified for participation in the Medicare program	Private, non-profit status is not well defined.
II. Organization, Services, Administration. Condition-(405.1221) Organization, services provided, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Administrative and supervisory functions are not delegated to another agency or organization and all services not provided directly are monitored and controlled by the primary agency, including services provided through subunits (see 405.1202 (w)) of the parent agency. If an agency has subunits, appropriate administrative records are maintained for each subunit.	Requirement that administrative supervisory functions cannot be delegated to another agency or organization requires clarification when both agencies are certified as home health agencies; e.g., a certified agency contracts for all services but one with another certified agency. Both have a responsibility for supervision of all their employees. This provides duality of supervision and increases costs. Clarification of administrative supervision and clinical supervision is needed.
If the agency has subunits, list each by name and address.	The definition of subunit is interpreted differently by the various surveyors. This causes hardship in rural public health agencies-criteria should be spelled out. Crux of the problem is who is held accountable and by what means in order to assure quality of care.
(a) Services Provided. The agency provides part-time or intermittent skilled nursing services and at least one other covered therapeutic service (physical, speech, or occupational therapy, medical social services, or home health aide services).	Recommend that agencies be required to provide a full range of therapeutic services or show cause for not doing so.

HOME HEALTH AGENCY SURVEY REPORT (Form OMB No. 72-R0735)

NAHHA Standards Committee Remarks

Services provided directly and/or under arrangement

A. Skilled Nursing
B. Physical Therapy
C. Speech Therapy
D. Occupational Therapy
E. Medical Social Services
F. Home Health Aide

(b) Governing Body. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. The governing body appoints:
(i) a qualified administrator, (see 405.1202(a))
(ii)arranges for professional service (see 405.1222),
(iii)Adopts and periodically reviews written bylaws (see 405.1202(b)) or an acceptable equivalent, and
(iv)oversees the management and fiscal affairs of the agency.

The name and address of each officer, director, and owner are disclosed to the State Medicare agency with changes reported promptly.

Clarify "arranges for professional services". Recommend a restudy because of the differing types of home health care providers; e.g., the governing bodies of public health home health agencies are the county elected officials. If this is an attempt to assure accountability and legal responsibility, these issues should be confronted in a more direct manner; e.g., who is the governing body in a sole proprietorship or partnership? Who is the governing body of a hospital home health agency when it is responsible to the Board of Trustees and a University?

(c) Administrator. The qualified administrator, who may also be the supervising physician (see 405.1202 (k)) or registered nurse (see 405.1202 (r)):
(i) organizes and directs the agency's ongoing functions,
(ii)maintains ongoing liaison among the governing body, the group of professional personnel, and the staff,
(iii)employs qualified personnel and ensures adequate staff education and evaluations.
(iv)ensures the accuracy of public information materials and activities, and
(v) implements an effective budgeting and accounting system.

A qualified person is authorized in writing to act in the absence of the administrator.

Administrator (405.1221(c))-- eliminate "who may also be the supervising physician or registered nurse". Recommend improved definition of functions of the administrator along more commonly accepted lines; i.e., planning, organizing, evaluating, and so forth as found in chief executive officer's job descriptions in health institutions.

HOME HEALTH AGENCY SURVEY REPORT (form OMB No. 72-R0735)

NAHHA Standards Committee Remarks

(d) Supervising Physician or Registered Nurse. The skilled nursing and other therapeutic services provided are under the supervision (see 405.1202 (y)) and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse (see 405.1202(q)). This person or similarly qualified alternate, is available at all times during operating hours and participates in all activities relevant to the professional services provided, including the qualification and assignments of personnel.

(e) Personnel Policies. Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications, licensure, performance evaluations, and health examinations and are kept current

Delete "patient care". There should be written job descriptions, performance evaluations, and evidence of licensure or certification.

(f) Personnel Under Hourly or Per Visit Contract. If such personnel are utilized by the home health agency, there is a written contract between such personnel and the agency clearly designating:

(i) that patients are accepted for care only by the primary home health agency,

(ii) the services to be provided,

(iii) the necessity to conform to all applicable agency policies including personnel qualifications, the responsibility for participating in developing plans of treatment,

(iv) the manner in which services will be controlled, coordinated, and evaluated by the primary agency,

(v) the procedures for submitting clinical and progress notes, (see 405.1202 (d) and (n)) scheduling of visits, periodic patient evaluation, and

(vi) the procedures for determining charges and reimbursement.

Delete "Hourly or Per Visit" and bring (h) Services Under Arrangement in closer relationship to (f). Suggest(a) Services under individual arrangement and(b) Services under group arrangement.

HOME HEALTH AGENCY SURVEY REPORT (Form OMB No. 72-R0735)

NAHHA Standards Committee Remarks

(g) Coordination of Patient Services. All personnel providing services maintain liaison to assure that their efforts effectively complement one another and support the objectives outlined in the plan of treatment.

(i) The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordinated patient evaluation does occur.

(ii) A written summary report (see 405.1202(x)) for each patient is sent to the attending physician at least every 60 days.

Suggest changing to 90 days.

(h) Services Under Arrangements. Services provided under arrangement with another agency (see 405.1202(p) and (c)) must be subject to a written contract conforming with the requirements specified in 405.1221(f).

See (f).

(i) Standard: Institutional planning. The home health agency under the direction of the governing body, prepares an overall plan and budget which provides for an annual operating budget and a capital expenditure plan.

Should be a new condition developed as a Condition on Planning for Home Health Agencies.

(1) Annual operating budget. There is an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense).

(2) Capital expenditure plan.

(i) There is a capital expenditure plan for at least a three year period (including the year to which the operating budget described in paragraph (i)(1) of this section is applicable), which includes and identifies in detail the anticipated expenditure in excess of $100,000. In determining if a single capital expenditure exceeds $100,000, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures

directly or indirectly related to capital expenditures such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions which are separated in time but are components of an overall plan or patient care objective are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds.

(ii)If the anticipated source of such financing is in any part, the anticipated reimbursement from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Health Insurance for the Aged and Disabled) or title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act the plan states:

(a) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform to current standards, criteria, or plans developed pursuant to the Public Health Service Act or the Mental Retardation Facilities, and Community Mental Health Centers Construction Act of 1963, to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

(b) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval pursuant to section 1122 of the Social Security Act (42 U.S.C. 1320a-1) and implementing regulations.

(c) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it has been so presented.

(3) Preparation of plan and budget. The overall plan and budget is prepared under the direction of the governing body of the home health agency by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff.

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NAHHA Standards Committee Remarks

Overall Plan and Budget prepared by representatives of:
1. governing body
2. administrative staff
3. medical staff or patient advisory group

Composition of committee:

Name	Title
_____	_____

(4) Annual review of plan and budget. The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (j)(3) of this section under the direction of the governing body of the agency.

III. Group of Professional Personnel.Condition-(405.1222)
A group of professional personnel, which includes at least one practicing physician and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, personnel qualifications, and program evaluations.

Can be mis-interpreted. Causes confusion in roles of ultimate authority. The group of professional personnel; e.g., VNA Board is utlimate authority. What is the role of the professional personnel group? How do they interrelate? Is personnel the terminology-should it be professional advisors?

At least one member of the group is neither an owner (405.1221(b)) nor employee of the agency.

Describe committee.

List professional background and community representation (if any) where applicable.

(a) Advisory and Evaluation Function. The group of professional personnel meets frequently enough to advise the agency on professional issues, participate in the evaluation of the agency's program and assist the agency in maintaining liaison with other health care providers in the community information program.

Its meetings are documented by dated minutes.

Note dates of last two meetings.

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IV. Acceptance of Patients, Plan of Treatment, Medical Supervision. Condition-(405.1223)
Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of treatment established and periodically reviewed by a physician, and care continues under the general supervision of a physician.

Change title to Patient Care Services. What is encompassed by social needs? Suggest new language "on the basis that the patient's health and social needs can be met with a provision that exceptions can be granted where patients are awaiting hospitalization or nursing home placement. Delete second sentence and place under subsection on plan of treatment. Add a new requirement-written policies reflect admission and discharge policies. Definition of "place of residence" does not cover patients in day care centers and hospice programs.

Written policies reflect admission criteria:

(a) Plan of Treatment. The plan of treatment developed in consultation with the agency staff covers all pertinent diagnoses, including:
(i) mental status,
(ii) types of services and equipment required,
(iii) frequency of visits,
(iv) prognosis,
(v) rehabilitation potential,
(vi) functional limitations,
(vii) activities permitted,
(viii) nutritional requirements,
(ix) medications and treatments,
(x) any safety meansures to protect against injury,
(xi) instructions for timely discharge or referral, and
(xii) any other appropriate items. (Examples: laboratory procedures and any contra-indications or precautions to be observed).

Explanation should read-"medical orders are initiated by the physician. Based on the diagnosis, medical orders, and other relevant factors, a patient care plan is developed by appropriate agency personnel and is endorsed by the physician." Eliminate (i) through rest of paragraph.

If a physician refera a patient under a plan of treatment which cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.

Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration.

The therapist and other agency personnel participate in developing the plan of treatment.

HOME HEALTH AGENCY SURVEY REPORT (Form OMB No. 72-R0735)	NAHHA Standards Committee Remarks
(b) Periodic Review of Plan of Treatment. The total plan of treatment is reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of treatment.	Change review of Plan of Treatment from 60 days to 90 days.
(c) Conformance with Physician's Orders: (i) Drugs and treatments are administered by agency staff only as ordered by the physician. (ii)The nurse or therapist immediately records and signs oral orders and obtains the physician's counter-signature. (iii)Agency staff check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contra-indicated medication, and reports any problems to the physician.	Agency staff makes a "reasonable effort" to [illegible] all medications. Add new statement (iv) Decisions to decrease visits may be made by the care given.
V. Skilled Nursing Service. Condition-(405.1224) The home health agency provides skilled nursing service by or under the supervision of a registered nurse and in accordance with the plan of treatment.	Change to read "skilled health service", delete nursing.
(a) Duties of the Registered Nurse. The registered nurse: (i) makes the initial evaluation visit, (ii)regularly reevaluates the patient's nursing needs, (iii)initiates the plan of treatment and necessary revisions, (iv)provides those services requiring substantial specialized nursing skill, (v) initiates appropriate preventive and rehabilitative nursing procedures, (vi)prepares clinical and progress notes, (vii)coordinates services, and (viii)informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nurse and related needs, participates in inservice programs, and supervises and teaches other nursing personnel.	(ii) Change to "health" needs. (iv) Change to "those services requiring specialized knowledge, judgment, and skill". (vi)Documents clinical care given in patient's care record. (viii) Separate out last two functions to read: (ix) supervises nursing personnel, (x) teaches nursing personnel.

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(b) Duties of the Qualified Licensed Practical Nurse (see 405.1202(l)). The qualified licensed practical nurse:
(i) provides services in accordance with agency policies,
(ii) prepares clinical and progress notes,
(iii) assists the physician and/or registered nurse in performing specialized procedures,
(iv)prepares equipment and materials for treatments observing aseptic technique as required, and
(v) assists the patient in learning appropriate self-care techniques.

Change to Duties of the Licensed Practical Nurse and add provides services in accordance with agency policies and in compliance with the State Nurse Practice Act, thus eliminating (iii), (iv), and (v) and add reports changes and conditions to registered nurse.

VI. Therapy Services. Condition-(405.1225)
Any therapy services offered by the agency directly or under arrangement are given by or under the supervision of a qualified therapist in accordance with the plan of treatment. The qualified therapist (see 405.1202 (f) (i) and (u)):
(i) assists the physician in evaluating level of function,
(ii)helps develop the plan of treatment (revising as necessary),
(iii)prepares clinical and progress notes,
(iv) advises and consults with the family and other agency personnel, and
(v) participates in inservice programs.

(a) Supervision of Physical Therapist Assistant (see 405.1202(j)) and Occupational Therapy Assistant (see 405.102(g)).
Services provided by a qualified physical therapist assistant, or occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapist assistant or occupational therapy assistant:
(i)performs services planned, delegated and supervised by the therapist,
(ii)assists in preparing clinical notes and progress reports, and
(iii)participates in educating the patient and family, and
(iv)inservice programs

Put physical therapy assistants and occupational therapy assistants under respective therapy classifications.

No. Physical Therapists_____
No. Physical Therapist Assistants_____
No. Occupational Therapists_____
No. Occupational Therapist Assistants_____

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(b) Supervison of Speech Therapy Services. Speech therapy services are provided only by or under supervision of a qualified speech pathologist of audiologist.

VII. Medical Social Services. Condition-(405.1226)
Medical social services, when provided, are given by a qualified social worker (see 405.1202(t)) or by a qualified social work assistant (see 405.1202(s)) under the supervision of a qualified social worker, and in accordance with the plan of treatment.
The social worker:
(i) assists the physician and other team members in understanding the significant social and emotional factors related to the health problems,
(ii)participates in the development of the plan of treatment,
(iii)prepares clinical and progress notes,
(iv)works with the family,
(v) utilizes appropriate community resources,
(vi)participates in discharge planning and inservice programs, and
(vii)acts as a consultant to other agency personnel.

Suggest addition of: Evauates the social and emotional factors impacting on the health problems and does direct intervention as indicated.

No. Social Workers_____
No. Social Work Assistants_____

VIII. Home Health Aide Services. Condition-(405.1227)
Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. Aides are carefully trained in assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process, and pleasant environment, changes in patient's condition that should be reported, work of the agency and the health team, ethics and confidentiality, and recordkeeping.

Change to: Home health aides are recruited and selected on the basis of successful completion of a formal training program administered by an educational institution or a training program approved by the State surveyors.

They are closely supervised to assure their competence in providing care.

HOME HEALTH AGENCY SURVEY REPORT (Form OMB 72-R0735)	NAHHA Standards Committee Remarks
(a) Assignment and Duties of the Home Health Aide. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or therapist as appropriate. Duties include: (i) the performance of simple procedures as an extension of therapy services, (ii)personal care, (iii)ambulation and exercise, (iv)household services essential to health care at home, (v) assistance with medications that are ordinarily self-administered, (vi)reporting changes in the patient's conditions and needs, and (vii)completing appropriate records.	
(b) Supervision. The registered nurse, or appropriate professional staff member, if other services are provided, makes a supervisory visit to the patient's residence at least every two weeks, either when the aide is present to observe and assist, or when the aide is absent to assess relationships and determine whether goals are being met.	Suggest new language: "Makes a supervisory visit to the patient's residence within the first two weeks of service to evaluate the home health aide's performance when the aide is newly employed. Makes a supervisory visit to evaluate the patient's progress at periodic intervals at a minimum of once a month. Makes a visit to the patient's residence to supervise the aide's performance on a regularly scheduled basis at a minimum of once every three months."
IX. Clinical Records. Condition-(405.1228) A clinical record is maintained in accordance with accepted professional standards and contains: (i) pertinent past and current findings, (ii)plan of treatment, (iii)appropriate identifying information, (iv)name of physician, (v)drug, dietary, treatment and activity orders, (vi)signed and dated clinical and progress notes (clinical notes are written the day service is rendered and incorporated no less often than weekly), (vii)copies of summary reports sent to the physician, and (viii)a discharge summary.	Suggested addition: "A clinical record is developed by the care giver and is maintained in accordance with accepted professional standards and agency policy and contains (then list (i) through (viii))"and add Patient outcome expectation"(vi) clinical notes are prepared by the care giver on the date care is given and are signed and dated no less than on a weekly basis."

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(a) Retention of Records. Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies call for retention even if the agency discontinues operation.

Clarify length of time for retention of records when they are microfilmed.

If a patient is transferred to another health facility, a copy of the record or abstract accompanies the patient.

Perhaps the last paragraph should specify that the transfer is from one home health agency to another home health agency. Home health agencies do not transfer patients from their service to other institutions. Physicians do this.

(b) Protection of Records. Clinical record information is safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and conditions for release of information. Patient's written consent is required for release of information not authorized by law.

X. Evaluation. Condition-(405.1229)
The home health agency has written policies requiring an overall evaluation of the agency's total program once a year by:
(i) the group of professional personnel (or a committee of this group), agency staff and consumers, or by
(ii) professional people outside the agency working in conjunction with consumers.

Suggest new language: There shall be an evaluation process based on the goals and objectives of the agency. There shall be a review at least once a year of the goals and objectives, accomplished in relation to the goals and objectives for the ensuing year.

The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.

These shall be reviewed by the professional advisory committee. Evaluation must track the purpose of the agency, services performed (qualitative and quantitative), objectives for staff, fiscal operations, use of equipment and supplies, and development of resources for all of the aforegoing.

Results of the evaluation are report to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

Describe the evaluation procedure:

HOME HEALTH AGENCY SURVEY REPORT (Form OMB 72-R0735)

NAHHA Standards Committee Remark

(a) Policy and Administrative Review. As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation. The data to be considered may include but are not limited to: number of patients receiving each service offered, number of patient visits, reasons for discharge, breakdown by diagnosis, sources of referral, number of patients not accepted, with reasons, and total staff days for each service offered.

Describe the data collected and the way it is used:

(b)Clinical Record Review. At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct as well as services under arrangement).

There is a continuing review of clinical records for each 60-day period that a patient receives home health services to detemine adequacy of the plan of treatment and appropriateness of continuation of care.

Describe how the sample was selected:

Suggest provision of: Review of records where service was denied.

Amplify to include Utilization Review for both under and over utilization. (Note: Surveyor's manual specifies smaple review guidelines. Why in one instance is it 10% sample of the visits when in all other samples reference is made to patients, cases, or records?)

SUGGESTED NEW CONDITIONS

1. Planning.

Develop a condition requiring a plan and a conscious planning process in each agency. Such a plan should encompass as a minimum a program plan, a budget plan, a staffing and equipment plan, and a statement of goals and objectives. Criteria are available to justify the staffing plan for all levels of personnel.

2. Supervision.

Perhaps some adaptation of the definition contained in the book Public Health Administration by R. Freeman (Holmes, 1960) would strengthen this part of the Conditions of Participation. We would suggest the addition of a coordination function to this definition. The current Conditions do not distinguish between supervision of patient care (case management) and supervision of employee (line management).

3. Fiscal Responsibility.

Suggest a requirement for a uniform methodology for cost reporting by home health agencies.

Suggest a Condition covering the prudent buying concept.

4. Physical Therapists, Occupational Therapists, and Speech Therapists.

Recommend that the A.P.T.A., A.O.T., and A.S.H.A. be consulted for updating of those sections of the Conditions.

CONDITIONS OF PARTICIPATION DEFINITIONS (405.1202)	NAHHA Standards Committee Remarks
As used in this subpart, the following definitions apply:	
(a) Administrator, home health agency. A person who: 1. Is a licensed physician; or 2. Is a registered nurse; or 3. Has training and experience in health service administration and at least one year of supervisory or administrative experience in home health care or related health programs.	Delete (1) and (2) so that (3) becomes the body of the definition.
(b) Bylaws or equivalent. A set of rules adopted by a home health agency for governing the agency's operation.	Bylaws govern a corporation or organization, but not an agency operation. Needs clarification.
(c) Branch office. A location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.	Definition is vague in relation to sub-unit. Interpretation varies among surveyors state by state. (Sub-unit is found in Item (w))
(d) Clinical note. A dated written notation by a member of the health team of a contact with a patient containing a description of signs and symptoms, treatment and/or drug given, the patient's reaction, and any changes in physical or emotional condition.	A dated notation by the care-giver for each patient care encounter which contains a descrip- of signs and symptoms, treatment...
(e) Nonprofit agency. An agency exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954.	No changes.
(f) Occupational therapist. A person who: 1. Is a graduate of an occupational therapy curriculum accreditated jointly by the Council on Medical Education of the American Medical Association and the American Occupation Therapy Association; or	Confer with occupational therapy association regarding current eligibility.

GONDITIONS OF PARTICIPATION DEFINITIONS (405.1202)	NAHHA Standards Committee Remarks
2. Is eligible for the National Registration Examination of the American Occupational Therapy Association; or 3. Has two years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapist for December 31, 1977.	
(g) Occupational therapy assistant. A person who: 1. Meets the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association; or 2. Has two years of appropriate experience as an occupational therapy assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapy assistant after December 31, 1977.	Confirm with an occupational therapy association regarding current required eligibility.
(h) Parent home health agency. The agency that develops and maintains administrative controls of subunits and/or branch offices.	No changes.
(i) Physical therapist. A person who is licensed as a physical therapist by the State in which practicing, and the American Physical Therapy Association or 1. Has graduated from a physical therapy curriculum approved by (ii) The Council on Medical Education and Hospitals of the American Medical Association,or (iii) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or 2. Prior to January 1, 1966, (i) Was admitted to membership by the American Physical Therapy Association, or (ii) Was admitted to registration by the American Registry of	Confer with A.P.T.A. for current requirements.

CONDITIONS OF PARTICIPATION DEFINITIONS (405.1202)

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Physical Therapists, or (iii) Has graduated from a physical therapy curriculum in a four-year college or university approved by a State department of education; or

3. Has 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977, or
4. Was licensed or registered prior to January 1, 1968, and prior to January 1, 1976, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or
5. If trained outside the United States, (i) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy. (ii)Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy. (iii) Has 1 year of experience under the supervision of an active member of the American Physical Therapy Association, and (iv) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(j) Physical therapist assistant. A person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and

Confer with A.P.T.A. regarding current requirements.

1. Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or
2. Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such

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determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualifications as a physical therapist assistant after December 31, 1977.	
(k) Physician. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which such function or action is performed.	No change.
(l) Practical (vocational) nurse. A person who is licensed as a practical (vocational) nurse by the State in which practicing.	No change.
(m) Primary home health agency. The agency that is responsible for the service rendered to patients and for implementation of the plan of treatment.	No change.
(n) Progress note. A dated, written notation by a member of the health team summarizing facts about care and the patient's response during a given period of time.	A dated, written notation by the care-giver summarizing facts...
(o) Proprietary agency. A private profit-making agency licensed by the State.	No change.
(p) Public agency. An agency operated by a State or local government.	No change.
(q) Public health nurse. A registered nurse who has completed a baccalaureate degree program approved by the National League for Nursing for public health nursing preparation or post-registered nurse study which includes content approved by the National League for Nursing for public health nursing preparation.	Confirm with A.N.A. regarding current requirements for community health nursing.
(r) Registered nurse. A graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing.	No change.
(s) Social work assistant. A person who:	

CONDITIONS OF PARTICIPATION DEFINITIONS (405.1202)	NAHHA Standards Committee Remarks
1. Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least 1 year of social work experience in a health care setting; or 2. Has 2 years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a social work assistant after December 31, 1977.	
(t) Social worker. A person who has a master's degree from a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.	Confirm with A.C.S.W. regarding the current requirements in the field.
(u) Speech pathologist or audiologist. A person who: 1. Meets the education and experience requirements for a Certificate of Clinical Competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association; or 2. Meets the educational requirement for certification and is in the process of accumulating the supervised experience required for certification.	Confirm with A.S.H.A. regarding the current requirements.
(v) Subdivision. A component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department which independently meets the conditions of participation for hom health agencies. A subdivision which has subunits and/or branches is regarded as a parent agency.	No change.
(w) Subunit. A semi-autonomous organization which serves patients in a geographic area different from that of the parent agency. The subunit by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision, and services on a	Needs clarification in relation to branch (c).

CONDITIONS OF PARTICIPATION DEFINITIONS (405.1202)	NAHHA Standards Committee Remarks
daily basis with the parent agency and must, therefore, independently meet the conditions of participation for home health agencies	
(x) Summary report. A compilation of the pertinent factors from the clinical notes and progress notes regarding a patient which is submitted as a summary report to the patient's physician.	Needs clarification in relation to discharge summary.
(y) Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Unless otherwise provided in this subpart, the supervisor must be on the premises if the person does not meet qualifications for assistants specified in the definitions in this section.	

See comments for suggestion new conditions. Definitions need to be developed for planning, standard, and fiscal (see Discursive Dictionary).

ITEM 6. LETTER AND ENCLOSURE FROM FLORENCE MOORE, EXECUTIVE DIRECTOR, NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., TO MARGARET S. FAYÉ, MINORITY STAFF, SENATE SPECIAL COMMITTEE ON AGING, DATED MAY 4, 1978

DEAR PEG: This comes further to my letter of April 18 to Senator Domenici with additional information.

Of the 124 National Council approved/accredited programs at the end of 1977, 19 of them were certified for medicare participation. We do not know how many of the agency associates are medicare certified.

The homemaker-home health aide services provided by agencies fall generally into four categories:

(1) Substitute and/or supplementary mother/child care;
(2) Care of the aged and/or disabled;
(3) Personal care and rehabilitation; and
(4) Helping to raise the quality of individual and/or family life, including protective services.

The National Council's goal and objectives for 1978 are attached. (The goal doesn't change, some of the objectives will.)

It occurred to me that if you are including the definition of the various supplementary services in the hearing publication, it would be useful also to include a definition of homemaker-home health aide services. Of course, it should not be attributed to the supplementary services guidelines, but it can be attributed to this organization.

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

Sincerely,

FLORENCE MOORE.

[Enclosure.]

GOAL AND OBJECTIVES APPROVED BY BOARD OF DIRECTORS, OCTOBER 26, 1977

GOAL

Availability of quality homemaker-home health aide services in all sections of the nation to help individuals and families in all economic brackets when there are disruptions due to illness, disability, social and other problems or where there is need to help enhance the quality of daily life.

OBJECTIVES

Establish and help assure implementation of basic standards for the service through provision of a current code of standards, guides for meeting the standards and operation of a national agency accreditation program including the current approval program.

Shape and implement the National Council's policies and programs by bringing together representatives of voluntary and governmental health and social services, professional and lay leadership, business, labor and the general public to serve on National Council committees and the board of directors.

Interpret the service to legislators and government agencies through testimony, letters and personal contacts and keep member agencies informed of major legislative and regulatory developments.

Provide technical assistance to agencies, communities, organizations and individuals through institutes, manuals and consultation specifically geared to organizing new or expanded services and to strengthening the administrative and management capabilities of agencies providing the service.

Provide technical assistance (as above) by expanding services and benefits to members and associates.

Interpret the need for quality homemaker-home health aide services to the general public and to special groups and to develop technical materials and publish studies about various uses of the service.

Coordinate homemaker-home health aide services with other health and social services in cooperation with other national agencies, both voluntary and governmental.

Act as an information and referral service to those seeking homemaker-home health aide service.

Seek new ways of using homemaker-home health aide services and develop new methods of carrying them out, with special attention to such groups as the physically disabled, emotionally or mentally disturbed and mentally retarded.

Promote needed research, collect basic data about the field.

Develop uniform reporting and accounting procedures.

Develop a sound funding base for the National Council sufficient to underwrite its basic ongoing operating costs and seek project support.

Provide liaison between the homemaker-home health aide service field in the United States and the International Council of Homehelp Services in such ways as representation on the International Council's official bodies, participation in international meetings and the fostering of associate and individual memberships in ICHHS from the United States.

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