HEALTH CARE FOR OLDER AMERICANS: THE "ALTERNATIVES" ISSUE

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BEFORE THE

SPECIAL COMMITTEE ON AGING

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Health Care for Older Americans: The "Alternatives" Issue:

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Part 2. Washington, D.C., May 17, 1977.
Part 3. Washington, D.C., June 15, 1977.
Part 4. Cleveland, Ohio, July 6, 1977.
Part 5. Washington, D.C., September 21, 1977.
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HEALTH CARE FOR OLDER AMERICANS: THE "ALTERNATIVES" ISSUE

WEDNESDAY, JUNE 15, 1977

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

The committee met, pursuant to call, at 9:45 a.m., in room 1318, Dirksen Senate Office Building, Hon. Lawton Chiles presiding.

Present: Senators Chiles and Domenici.

Also present: William E. Oriol, staff director; Kathleen M. Deignan, professional staff member; Caroleen L. Silver, minority staff director; Margaret S. Fayé, minority professional staff member; Patricia G. Oriol, chief clerk; and Alison Case, assistant chief clerk.

OPENING STATEMENT BY SENATOR LAWTON CHILES, PRESIDING

Senator CHILES. Today, the Senate Committee on Aging is seeking information which will help Congress and the administration to make a comprehensive long-term care system for the elderly a reality.

The committee has watched the development of noninstitutional services over the years. We have found that even though many communities have established innovative programs, and even though we have attempted to provide some funding for new development and innovative actions in home health, homemaker, and other in-home and community services, new development has encountered major obstacles.

We are still experimenting with adult day services and hospital geriatric outpatient services. We know that such programs can provide appropriate, and certainly more acceptable, alternatives for many elderly; but we have not provided incentives for their widespread development.

For several years the number of certified home health agencies offering skilled nursing care and therapy services in the home decreased. There has been a slight increase in their numbers since 1975, when Congress passed the Home Health Demonstration Act, but again, that development has been slow in too many areas.

Support for home health and other in-home services under medicare and medicaid has increased only slightly since 1973; it is still only 1 percent of total expenditures. These funds are shoring up our most costly institutions at the expense of the alternatives.

We know that our older Americans are over-hospitalized and too often inappropriately placed in nursing homes—at great cost to our health system. We must find ways to provide more acceptable care—more appropriate for the need, and less costly.

15 Percent Hospital Overutilization

I know that the administration agrees with me. Secretary Califano recently told the Senate Finance Committee that as many as 15 percent of the people in our Nation's acute care hospitals alone do not need to be there. He said that they would be better cared for at home, in nursing facilities, or on an outpatient basis, and estimated that this overemphasis on hospital care is now costing the Nation $7 million per day just for operating costs. He cited the reversal of this system as a major area for hospital cost savings.

We also know that many elderly are placed in nursing homes simply because inadequate community services which could make it possible for them to remain in their own homes are not available. We must find ways to make these alternatives readily available to all older Americans, and we must find a way to do it which will guarantee a quality of service and a standard of care which will meet the real needs of the people we are trying to serve.

"Need To Move Quickly"

I think we need to move quickly, and I hope this distinguished panel of witnesses agrees with me. But we also have questions to resolve on how this move can be made without making ourselves vulnerable to a system which could quickly become out of control. We know, for example, that there is a great deal of interest in home health as a profit-making venture, and we know that there are some alarming shortcomings in accountability.

I think now is the right time to discuss these and other issues. We know that President Carter is committed to tackling these problems, and we want to see his administration go in the right direction to obtain, not only cost containment for health care, but satisfaction and confidence from the people who should be served.

The committee will watch and work with the witnesses here today, and all others who can help. I certainly welcome you here today.

Senator Domenici, who has been a leader in trying to provide a framework for alternatives in home health care, sits with us today and I am delighted to have him. Do you have an opening statement, Senator Domenici?

STATEMENT BY SENATOR PETE V. DOMENICI

Senator Domenici. Thank you, Mr. Chairman. I have a very brief statement. I look forward to hearing the witnesses.

I am pleased that we are able to complete our series of hearings today, Mr. Chairman, on health care for older Americans, focusing on the alternatives issue. I am delighted that we have the administration witnesses with us. This is the first hearing at which we have had an opportunity to discuss major reorganization changes in HEW and how they will have an impact on care for the elderly.

In our first two hearings a month ago, witnesses testified as to the fragmentation of the implementation of the various alternatives to home health care. Each resource for home services has different eligibility standards and regulations. This includes titles XVIII, XIX,

and XX of the Social Security Act, and title III of the Older Americans Act.

There was almost a plea by the various agencies involved in home care services that there be uniform standards, and even one source of funding, in order that expansion of these necessary services could proceed without the current waste of time and money in the determination of not only who should pay the bill, but also when, and even if. There have been retroactive denials which have only served to put out of business agencies who could not afford to absorb the cost, which were initially deemed appropriate but were later denied by social security.

We also want to make sure that HEW is aware of and carries out the legislative intent of Congress when addressing these programs. For example, recent elimination of the certificate of need for home health programs was clearly against the intent of Congress and should be corrected.

Furthermore, Mr. Chairman, the role of nonprofit and profit agencies should be made clear and, regardless of what agency is providing services, the same high quality of standards should be required for all, with an ongoing monitoring of performance by State and/or Federal agencies.

Thank You, Mr. Chairman.

Senator CHILES. The distinguished chairman of this committee, Senator Frank Church, who certainly over the years has had such a great interest in this question, has submitted a statement for the record. Without objection, it will be inserted into the record at this time.

[The statement of Senator Church follows:]

STATEMENT OF SENATOR FRANK CHURCH, CHAIRMAN

Today, the Senate Committee on Aging begins a third day of hearings on noninstitutional health care for older Americans.

Such care may be given in the home, by nurses, or by others trained to perform services which help older persons maintain their independence despite one or more disabilities. Or it may be provided at adult day centers or outpatient clinics where persons with chronic conditions can receive precisely the care they need for a few hours a day before returning to their homes at night.

We've heard a great deal about these so-called "alternatives to institutionalization" since the White House Conference on Aging in 1971, and we've done a few things about them, as well.

We have made home health and in-home services a priority item under the Older Americans Act.

We have enacted a law for startup and expansion funds for home health agencies, and I'm glad to say—as sponsor of that legislation—that during the past fiscal year, 46 communities received assistance, with more expected this year. In view of need, this is only a beginning.

And we have seen other progress as well: There is greater use of title XX social service funds for in-home services and other forms of care out of the institution; there is a growing effort to provide

services to help maintain independent living in what is called assisted housing; and, most of all, there is a growing demand by older persons themselves for the help they need to stay out of institutions while they—and their families—take care of their own needs as best they can.

In other words, the right kind of help can be good for the Nation by reducing our present high commitment of funds for institutional care, and it can be good for individual older persons who, most of all, want to stay in their own homes or apartments for as long as they can, despite long-term or temporary illness.

"Situation Urgent"

The urgency of the situation has been expressed by studies which document needless institutionalization of one kind or another. Just a few days before this hearing, for example, I learned of a recent survey by the Medical Social Review Committee of the Idaho Department of Health and Welfare which found that from 15 to 25 percent of the elderly in my own home State were in nursing homes unnecessarily. And most of them were there because other levels of care were not available.

You can be certain I'll work with the Idaho Health Department to help change this picture; and you can be sure that I will urge the Federal administration to take steps needed to change this picture in Idaho and in the rest of the United States.

I am confident that the Department of Health, Education, and Welfare witnesses we have called today recognize the same need and want positive and early action to deal with it.

As I stated during our earlier hearings, the root of the problem is, of course, restrictive medicare and medicaid policies on home health care and other in-home services. I introduced legislation last year to ease some of these restrictions, and I will consider reintroduction this year, as soon as I examine what we learn today.

Even though we know the need is great, I'm not sure we know the best ways to provide these services, the best ways to organize them, and how to achieve our goals within realistic costs. I hope that we will receive very useful information in this area today, as well.

We have to develop community based systems in which there is a role for institutions and a role for other forms of assistance, based on what people need, when they need it, provided in the most appropriate setting. In order to do this, we must achieve a mix of what are now strictly defined "health" services and "social" services. Achieving this mix at the local level is one of the most challenging problems we now face.

But it is a challenge which must be faced by the Congress and executive branch together, and so I look forward with special interest to today's testimony.

Senator Chiles. Our first witness today will be Mr. Robert Derzon, Administrator, Health Care Financing Administration, Department of Health, Education, and Welfare. We are delighted to have you here, Mr. Derzon.

STATEMENT OF ROBERT DERZON, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. ROBERT BUTLER, DIRECTOR, NATIONAL INSTITUTE ON AGING, NATIONAL INSTITUTES OF HEALTH; AND DONALD REILLY, DEPUTY COMMISSIONER, ADMINISTRATION ON AGING, OFFICE OF HUMAN DEVELOPMENT

Mr. DERZON. Thank you, Mr. Chairman. We submitted to the committee yesterday a more detailed statement.

Senator CHILES. Your full detailed statement will be placed in the record.[1]

Mr. DERZON. Thank you, sir.

I would like to take this opportunity to summarize that statement, but first to express my pleasure in being here. This is my second official congressional hearing. I was sworn in 2 weeks ago, and though I appeared before Senator Domenici earlier this year on another matter, I am delighted to see him and meet with you.

This hearing presents me, early in my experience in the Federal Government, with an opportunity to look into and to learn more about the entire area of long-term care and how it is being handled in the Department of HEW. Today, along with others here—I will introduce them in a moment—we are indeed trying to represent all of HEW, and not simply speaking of the Health Care Financing Administration.

It also has been advantageous for me because it has been my first opportunity to meet with the many components of HEW who are involved in concerns in the long-term care area. I suppose in some ways those many parties are a demonstration of one of our problems; namely, the organization of this activity within the Department.

"LACK OF CLEAR FOCUS IN HEW"

I have learned in the few weeks that I have been here that this is a complicated subject on which the Department's leadership—that is, the new leadership—has not yet adopted clearcut positions. I hope that the lack of clear focus can be resolved in the next several months and that we will emerge with a set of recommendations for your consideration.

This hearing also offers us, firsthand, the opportunity to learn your concerns, and I trust you will share those with us. I have already noted a couple of problems that apparently have come up in recent months. As you know, and Senator Domenici just expressed, both the statutory authorities and funding sources for the Department's activities relating to the alternatives to institutionalization are scattered throughout HEW. We believe, therefore, it would be most helpful today to have the departmental representatives share this testimony.

[1] See page 286.

On my right is Dr. Robert Butler, Director of the National Institute on Aging, National Institutes of Health, and author of an absolutely superb book on the problem; and on my left is Donald Reilly, Deputy Commissioner, Administration on Aging, which is now a component of the Human Development Administration within HEW. Other Department experts are here in the room and will be available, and I will probably need their help because there is so much I don't know about this subject.

The fact that the authority and funding in this area exists in different parts of the Department has caused considerable problems of coordination in the past. This Administration, which took over in January, has not addressed all of those organizational issues. We have taken, however, some steps in that direction. The organization of the Health Care Financing Administration brought five components together that were concerned with long-term care. Together, over the next several months, we will be looking at how these components that have been brought into the health care financing system can be integrated effectively.

At the present time, the most the Department has accomplished is to begin the assignment of personnel into the Health Care Financing Administration and to very broad divisions of activity. These personnel will be assigned informally on June 19, which is sort of the birthday of the new agency.

Additionally, title XX programs have been placed in the Office of Human Development, where the Administration on Aging was already located. I think the significance of that is that we now have roughly three large agencies of HEW, points for activities, in the long-term care field—one in health, one in health care financing, and one in human development.

What is needed now is greater organizational coordination and particularly overall departmental policy development, which the Department is working on, with a brief summary on planning in which the principles of HEW are discussed, so that in a sort of a preliminary way, we might get at the general problems of long-term care, how we can establish better coordination, and how we can proceed to the study. That work has just begun in the Department.

We are currently conducting demonstration projects on alternatives to institutionalization. The results of these projects will, I think, give us information that is currently lacking, about the effectiveness and the cost of some of the various alternatives. I would say to you that we have already studied a great deal about alternatives, but we have not systematically, in my view, compiled that information in a way that is meaningful to policymakers, so that we can go on to another stage, which is to make decisions about how to implement policy on that which we know.

One of the advantages of the new Health Care Financing Administration is it pulls together much of the research activity in this area. We also expect, out of the current demonstration projects, to have additional information that would be useful on the whole issue of alternatives, and many of those demonstration projects will begin to yield results this year.

"Alternatives to institutionalization" must be considered in terms of the most appropriate care for the individual patient. As you know, many considerations enter into that decision. A primary factor is

the medical condition of the patient and what type of treatment or level of care is required. Also, the patient's physician must be assured of the reliability and effectiveness of the chosen alternative. Perhaps most importantly, impact on the total family situation must be examined. Adequate financial and other resources, emotional demands, and disruption of family relationships, are a few of the pertinent factors. Often, and I think unfortunately, a final consideration is whether reimbursement under private insurance, medicaid or medicare, is available. We will talk about that in just a few minutes because I want to say a few words about that issue.

"Alternatives in Long-Term Care"

Rather than regard any specific form of care as an "alternative to institutionalization," we would prefer to think of the many forms of care—both noninstitutional and institutional—in the continuum of care. These are the alternatives that we think about as we view this problem, so that home health care, adult day care, homemaker care, foster home care, and nursing home care, are all alternatives in long-term care. These are all in the string of those alternatives. The type of care selected for an individual should be based on the specific needs and, within reason, the desires of the patient and his family.

Home health services, day care, or other in-home services cannot be viewed as acceptable alternatives to all institutionalization. I think those of us who have worked in this field—I from the outside world—recognize that there are going to be patients who will require institutionalization in sound, well-managed institutions which are priced reasonably, with good care being given. We believe that these institutions represent a last resort, and we would like to find ways to defer institutionalization wherever possible, to intervene before institutionalization takes place, and provide care in the continuum in an appropriate sequence.

Now with respect to funding sources, our prepared statement goes into that in some detail, and I won't go over that. I think all of you know a great deal more about that than I do. We do have, in my view, funding sources that get in the way of trying to achieve for a single individual the services he needs. I am not sure I can tell you what I think we ought to do about that today, but I do think that is a very germane issue, and a very real part of the problem.

"Medicare . . . Unduly Restrictive"

Let me talk briefly about the limitations of medicare and medicaid. In recent years, medicare policies have been subject to intense and often heated debate about whether present law could be interpreted more liberally to allow coverage and reimbursement for more home health services. Many individuals, including, I suspect, many members of this Senate, have argued that medicare coverage of home health services is unduly restrictive and that it does not relate services to the needs of patients as they progress through their illnesses. I must tell you, as a person who has been on the outside world, I share that view from time to time.

It has often been proposed that the medicare law be amended to provide coverage for a broadened range of services, including maintenance services in the home setting. On the other hand, others believe that a medical insurance program, designed to cover the expenses associated with acute illnesses, is not the appropriate mechanism for addressing what may be primarily the social health needs of patients with long-term-care disabilities.

Existing data are not adequate to determine whether increased utilization of home care would decrease or increase medicare program costs, a problem that has precluded a consensus of expert opinion on whether medicare's home health benefit needs change. In other words, it is the lack of being able to determine whether there are cost savings or cost increases. In our view, this has contributed to a delay in effective policymaking. The national public hearings conducted by the Department last fall highlighted these problems, and I would hope that you and the members of the staff have had the same opportunity I had recently to read that report.

Limitations in the medicaid program are somewhat different. One obstacle to provision of home health care under medicaid in some States is that home health agencies think that reimbursement rates are inadequate and do not meet their costs of operation. In addition, some States have imposed restrictions on coverage and availability similar to those in medicare. As a result, many agencies accept only a small percentage of medicaid patients or limit their services to medicare patients only.

Coverage of therapy services is another difficulty under the medicaid program because it differs among the States. Lack of such coverage on an in-home basis may require people to seek institutionalization simply to obtain the services. There are not as many requirements for skilled services, so there is a belief that some patients who have not been able to receive those services in the home—receive that care in the institution.

We recognize that there are major unresolved issues and policy implications surrounding the financing of alternatives to institutionalization. I wish to assure you that these hearings have been of enormous value to me in focusing my personal attention on that problem.

Medicare-Onlys and 100-Percenters

We were asked to comment on the medicare only home health agencies in Florida and elsewhere. Our prepared statement is somewhat more complete in this, but I would point out that title XVIII—medicare—prohibits proprietary home health agencies from participating in the medicare program unless the State has a licensure law governing home health agencies. I believe it is New York State that allows no proprietary institutions to be licensed in their State. I could be wrong about that, but I believe that was in some of the briefing materials I read.

Medicare regulations stipulate that proprietary agencies must directly provide skilled nursing services and at least one other therapeutic service. This is a more stringent standard than that required for nonprofit organizations.

When medicare and medicaid were first implemented, most services rendered in the home were provided by nonprofit or voluntary visiting

nurses associations or public health departments. With the advent of Federal funding of home health, coupled with restrictions on proprietary agency participation, a new kind of provider came into existence, known as "private not-for-profit."

Because medicare reimburses on a cost basis while medicaid often reimburses, in many States, on a basis that provides a lower return, agencies have found it to their economic advantage to serve only medicare patients. That same problem has existed from time to time in the nursing home fields when there were different rates between medicare and medicaid. These agencies have become known as "100 percenters." All of their revenues are derived from medicare reimbursement.

Priority for Reimbursement Analysis

Possibly medicare, with its full cost reimbursement system, has been too generous, or States have been too restrictive, with their medicaid reimbursement—or both. Analysis of reimbursement practices will be a high priority task under the new Health Care Financing Administration and I believe that we will increase our efforts to address these problems in reimbursement, and fortunately, for the first time, we will be able to address them for both programs, so that we can begin to develop, where possible, where the law permits, uniform reimbursement policy for both programs. That is one of our goals and one of my personal goals. I believe we must increase our efforts to develop and implement methods of paying for services that induce providers to furnish services of an acceptable quality at an economical cost, or at least at a reasonable cost.

As the committee is well aware, many of the so-called "not-for-profit" agencies have been able, through excessive salaries and fees, and through manipulation of capital values, to capture the equivalent of profits—in many cases, extraordinary profits.

As you know, we strongly support enactment and enforcement of Federal legislation aimed at halting any abusive and fraudulent practices. In our programs, we have been supportive of both the Clinical Laboratory Improvement Act, which strengthens our ability to deal with laboratories in the fraud abuse area, and H.R. 3 which deals with most fraud and abuse efforts in hospitals, nursing homes, home care agencies, and the like.

I should point out that we are taking steps in our reorganization of the Health Care Financing Agency, and also in HEW, to set up two new mechanisms to deal with fraud and abuse. One, of course, is the Inspector General, which has assembled many of the good audit resources. We have assembled in the one unit all of those individuals both in medicare and medicaid. In other parts of HEW, we have been dealing in monitoring the programs and have put those together in this new organization. We think this action will help strengthen our ability to examine our providers' books, our contractors' activities, and so forth.

Now a question was asked concerning research and demonstration projects. We have a list of those projects and if they were not submitted to you, we will submit them.[1]

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

HEW Reorganization

Now just a few words about the HEW reorganization and that will close my presentation. On March 8, Secretary Califano announced a major reorganization of HEW. For the first time the medicare, medicaid, and quality assurance activities of the Department will be consolidated into one organization; namely, the organization which I now represent, the Health Care Financing Administration. This reorganization in itself does not solve statutory and regulatory differences, but I believe that it genuinely improves medicare and medicaid's ability to formulate compatible policy and to reduce the intergovernmental dispersion of expertise and to concentrate the study of health care programs for the aged.

As I pointed out a little earlier, I believe we are down to three principal agencies with responsibility for long-term care. I think if we could knit them together and put together the units, agencies, and divisions that exist within each of those in a cohesive fashion we will have a better chance to come to grips with the problems that we have been so long concerned with.

We believe that the consolidation of previously separate medicare, medicaid, and quality assurance activities should greatly assist coordination and resolution of major issues relating to the Department's home health policies. The ongoing research efforts and capacity building grant program in the Public Health Service will also contribute to this resolution.

The reorganization also has a direct bearing on the capacity of the Office of Human Development and the Administration on Aging to improve the in-home services provided to older Americans. Mr. Reilly would like to comment on that. Placement of the Public Services Administration, which does administer the services programs within the Office of Human Development, should strengthen the Federal level ties between the Administration on Aging and the Public Services Administration.

We would be happy to address in greater detail questions on behalf of this reorganization and we wish in closing to reiterate our personal commitments in HEW to meeting the needs and finally to provide quality services to individuals served by our programs and, I might add, to emphasize the use of alternatives to meet that commitment.

I thank you for the opportunity to make this opening statement. That completes my statement.

Senator Chiles. Thank you, Mr. Derzon. Your prepared statement will be entered into the record now.

[The prepared statement of Mr. Derzon follows:]

PREPARED STATEMENT OF ROBERT DERZON

Mr. Chairman, since taking on my new duties, this is one of the first opportunities I have had to accept an invitation to testify before a congressional committee. It is indeed a privilege to appear before you today to present testimony on alternatives to institutionalization, including home health, other in-home services, and day care in more formal settings. As you know, both the statutory authorities and funding sources for our activities relating to these alternatives are scattered throughout the Department. Therefore, we believe it would be most helpful to you to have a panel of Department representatives testify. With me today are Dr. Robert Butler, Director of the National Institute

on Aging, National Institute of Health; and Donald Reilly, Deputy Commissioner, Administration on Aging.

The scope of your committee's examination of the alternatives issue is quite broad. While we will limit our written testimony to a brief discussion of the issues raised in your April 22 letter to Secretary Califano, we do welcome a discussion of any other concerns which you may have.

It should be stated at the outset that alternatives to institutionalization must be considered in terms of the most appropriate care for the individual patient. Many considerations enter into a decision concerning such alternatives. A primary factor is the medical condition of the patient and what type of treatment or level care is required. Also, the patient's physician must be assured of the reliability and effectiveness of the chosen alternative. Perhaps most important, impact on the total family situation must be examined; adequate financial and other resources, emotional demands, and disruption of family relationships are a few of the pertinent factors. Often a final consideration is whether reimbursement under private insurance, medicaid, or medicare is available.

Rather than regard any specific form of care as an alternative to institutionalization, we would prefer to think of the many forms of care—both noninstitutional and institutional—in the continuum of care as "alternatives in long-term care." Thus, home health care, adult day care, homemaker care, foster home care, and nursing home care are all alternatives in long-term care, and the type of care selected for an individual should be based on the specific needs and desires of the patient and his family.

In summary, home health services, day care, or other in-home services cannot be viewed as viable alternatives to all institutionalization. We believe these forms of care should be available and utilized appropriately—preventing or delaying institutionalization, speeding transfer to home from the institution, and providing needed care as indicated on a continuum.

Funding Sources

At the present time, there are separate funding authorities for various services provided to people in noninstitutional settings. Each program has a different responsibility, and often the criteria for eligibility as established by law are not the same. This makes it very difficult to foster relationships between programs that permit and encourage coordination. Appendix 1 [item 1, p. 307], summarizes the benefits in titles XVIII, XIX, XX and parts of the Older American's Act and illustrates the disparities in coverage for home health services. Patients often encounter problems because of a lack of consistency in definitions.

In addition to the programs outlined in appendix 1 [item 1, p. 307], programs such as health maintenance organizations (HMO) and the community health centers (CHC) help reduce the amount of institutional care or shorten stays in institutions. These programs have the potential of reducing health care costs and improving the quality of care because preventive ambulatory care may be more appropriate for a particular condition. The HMO program integrates the concept of prepayment for care as an additional financial incentive to providers for utilizing the less costly forms of preventive and ambulatory care, and avoiding more expensive forms of care in hospitals and other institutions. Community health centers provide other services including transportation and outreach to locate and treat elderly individuals before critical stages are reached which would require institutional care.

Limitations of Medicare and Medicaid Policies

In recent years, medicare policies have been subject to intense and often heated scrutiny about whether present law could be interpreted more liberally to allow coverage and reimbursement for more home health services. Under medicare, home health services include skilled nursing care, physical, occupational or speech therapy, medical-social services under the direction of a physician, part-time or intermittent services of a home health aide, to the extent permitted in regulations, and medical equipment and supplies delivered to a patient in his residence on a visiting basis. Medicare home health services are provided to individuals who are confined to their home and under the care of a physician. The physician sets up and periodically reviews a plan for home care which is provided by a participating home health agency. The patient must need part-time skilled nursing care or physical or speech therapy.

Many individuals have argued that medicare coverage of home health services is unduly restrictive, and that it does not relate services to the needs of patients as they progress through their illnesses. It has often been proposed that the medicare law be amended to provide coverage for a broad range of services, including maintenance services in the home setting. This would enable patients to remain at home and allow earlier transfer from institutions. On the other hand, many others believe that a medical insurance program, designed to cover the expenses associated with acute illnesses, is not the appropriate mechanism for addressing what may be primarily the social health needs of patients with long-term care disabilities.

Existing data are inadequate to determine whether increased utilization of home care would decrease or increase program costs, a problem that has precluded a consensus of expert opinion on whether medicare's home health benefit needs change. The national public hearings conducted by the Department last fall highlighted these problems. Many witnesses advocated a number of medicare changes including removing the 3-day prior hospitalization requirement, eliminating the "skilled" care requirement, and modifying both the "homebound" and the "part-time or intermittent" requirements. Others opposed such changes. There has also been much debate among Department staff on these issues. The new administration has not yet had the opportunity to carefully scrutinize and resolve various issues relating to these recommended policy and legislative changes.

Limitations in medicaid are somewhat different. One obstacle to provision of home health care under medicaid in some States is that home health agencies think that reimbursement rates are inadequate and do not meet their costs of operation. In addition, some States have imposed restrictions on coverage and availability similar to those in medicare. As a result, many agencies accept only a small percentage of medicaid patients or limit their services to medicare patients only.

Coverage of therapy services is another difficulty under the medicaid program. Therapy for occupational speech or hearing problems is provided and covered differently among the States. As a consequence, the lack of these and other in-home or community services in a particular State may require people to seek institutionalization simply to obtain the services.

The Commissioner of the Medical Services Administration issued an information memorandum in January 1976 to all State medicaid agencies in order to describe two methods of reimbursing for services in alternative care settings and suggested methods of reimbursing for services to the chronically ill in these settings and to explain medicaid's short- and long-range strategy for developing alternative settings for care of the chronically ill and impaired.

We recognize that there are major unresolved issues and policy implications surrounding the financing of alternatives to institutionalization. I wish to assure the chairman that these hearings have been helpful in focusing our attention on the issues.

PROBLEMS

The committee also asked the Department to address the significance of the rise of medicare-only home health agencies in Florida and elsewhere.

With the enactment of title XVIII (medicare) in 1965, a home health agency was defined as "a public agency or private organization, or a subdivision of such agency or organization . . . except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law . . . " This means that proprietary home health agencies cannot participate in the medicare program unless the State has a licensure law governing home health agencies. In addition, under medicare regulations, proprietary agencies must directly provide skilled nursing services and at least one other therapeutic service. This is a more stringent standard than that required for nonprofit agencies.

When medicare and medicaid were first implemented, most services rendered in the home were provided by nonprofit or voluntary visiting nurses associations (VNA's) or public health departments. With the advent of Federal funding of home health, coupled with restrictions on proprietary agency participation care, a new kind of provider came into existence known as "private not-for-profit."

Because medicare reimburses on a cost basis while medicaid reimburses, in many States, on a basis that provides a lower return per unit of service rendered, agencies have found it to their economic advantage to serve only medicare patients. These agencies have become known as "100 percenters." All of their revenues are derived from medicare reimbursement.

The operational patterns of these 100 percenters are viewed by many as symptomatic of something amiss in the way we pay for the services. Possibly medicare, with its full cost reimbursement system, has been too generous, or States have been too restrictive with their medicaid reimbursement—or both. Analysis of reimbursement practices will be a high priority task under the new HCFA organization. I believe we must increase our efforts to develop and implement methods of paying for services that induce providers to furnish services of an acceptable quality at an economical cost.

As the committee is well aware, many of the so-called not-for-profit agencies have been able, through excessive salaries and fees and through manipulation of capital values, to capture the equivalent of profits—in many cases, extraordinary profits.

As you know, we strongly support enactment and enforcement of Federal legislation aimed at halting any abusive and fraudulent practices. Our testimony on H.R. 3 supports and reflects this position. We wish to commend the contributions of this committee in the joint congressional hearings held earlier this session on home health fraud and abuse.

Research and Demonstration Projects

The committee has also expressed interest in various research and demonstrations conducted and funded under various statutory authorities of the Department. Within the Public Health Service, the National Center for Health Services Research in the Health Resources Administration, and the National Institute on Aging in the National Institutes of Health and initiatives relevant to developing more community services for the aged. The Health Resources Administration experimental efforts have focused on a number of adult day care and homemaker demonstrations. The programs can be broadly grouped into two types: those two previously uncovered services, day care and home care, for ill elderly hospitalized patients, and those providing health and social services to clients who are maintaining residents in their own home. A summary of the early findings and brief description of the funded demonstrations can be found in appendix 1 [item 2, p. 308].

The new National Institute on Aging supports research in the ultimate alternative to institutionalization—prevention of disease and disability. The long range aim of such research is to develop new knowledge which would make institutionalization less necessary through improving the health care of the aged and reducing the incidence of diseases that force people into nursing homes in the first place. Such knowledge about the causation of disease would help make true prevention possible and perhaps render other alternatives to institutionalization, such as home care, less necessary as well. This in turn would lead to a reduction in the escalating costs of health care.

Appropriate support of the families which choose to care for their older members at home is also a priority area of research for the National Institute on Aging. The National Institute on Aging seeks to improve our understanding of the changes in behavior of the aged and in family life-style patterns that can enable the family to meet the social and emotional needs of its aged member at home. Such understanding can also provide the basis for a counseling program to assist the family in resolving problems, such as interpersonal conflict and grief, that it may otherwise find overwhelming.

Several other jointly funded (Administration on Aging and Medical Services Administration) projects relate to alternatives in long-term care. The major focus of these projects is day hospital and day treatment services. Several of these projects are designed to restructure the organization or delivery of health services in that they meet special needs of the elderly by maintaining them in the community as long as medically, socially, and economically feasible to prevent premature or inappropriate institutionalization. If it would be useful to the committee, we can provide a summary of these projects for the record.

The Health Revenue Sharing and Health Services Act of 1975 authorized grants for (1) initial expansion and establishment of home health agencies, (2) expanding services available through existing agencies, and (3) compensating personnel during the period of initial operation or agency expansion.

Responsibility for administration of the home health grant program is located within the Bureau of Community Health Services of the Health Services Administration. In September 1976, 56 grants were announced through the regional offices; 16 are for the development of new home health agencies and 40 for expansion of existing agencies. Totaling $3 million, these grants have been awarded in areas with a relatively large population of older persons who are poor.

Agencies receiving grant awards are required to make their services available to all residents of the catchment area and to provide services directly. Grants are awarded for a period of up to 17 months to provide sufficient time for the applicant to achieve an operational level to support the continued provision of home health services in the area. We anticipate that agencies receiving awards will secure sufficient funding from other sources to continue providing home health services after the grant support is no longer available. Since these projects have been funded for only a short period of time, we do not yet have findings to present to the committee.

Role of the Public Health Service in Developing Alternatives

We anticipate that the Public Health Service would play a major role in the following probable future activities relating to home health care:

—Improvement of program planning, development, management, and coordination of home health activities in collaboration with the Health Care Financing Administration. This is pursuant to our longer range goals of deemphasizing institutional, inpatient care settings and emphasizing ambulatory, outpatient, and home care.

—Review the use of home health services as a supplemental service provided under PHS health service delivery projects (e.g., community health centers, community mental health centers, etc.) to determine whether expansion of effort in this area is necessary, feasible, and whether it will support capacity building in rural areas and decrease barriers to access.

—Development of a continuum of care and patient assessment instruments which will encourage proper utilization of health services as well as long-term institutionalization according to the level of patient need.

—Determine what contribution the planning activities within the health systems agencies can make to the coordination of home health services at the community level.

—Determine how health manpower training and education programs can be utilized to educate providers (both professional and paraprofessionals) regarding the purpose and significance of home health services.

In addition to those efforts cited above, we expect that the Public Health Service will be involved in policy development for a range of other Department activities which will improve delivery of home health services.

Role of Public Services Administration and Administration on Aging

The Public Services Administration of HEW's Office of Human Development administers title XX of the Social Security Act—the Federal-State social services program. This program provides $2.7 billion to States to assist in achieving five goals, including helping the eligible population maintain or achieve self-sufficiency and preventing or reducing inappropriate institutional care.

Under the title XX program, the Public Services Administration (PSA) will take a strong role in developing alternatives to institutionalization through its activities to:

(1) Encourage the States to develop and expand their out-of-home services;

(2) Encourage the States to develop and expand their in-home services in quality and variety; and

(3) Insure the efficient, fraud-free delivery of both in-home and out-of-home services.

Specifically, one of PSA's major tools in this effort is to identify States which have developed innovative and replicable models for services, and then to share information about these projects with all States by working through regional offices.

The Office of Human Development is interested in research and demonstration initiatives in areas related to the development of alternatives to institutionalization under the scope of title XX. We especially see a need for research on improving methods of matching services to clients so that the proper level of care

will be given to each person, and experimentation on types of adult day care which should be offered to aged and disabled persons. Results of such research should enable PSA to offer greater leadership to States in their search for suitable alternatives to institutionalization.

The Administration on Aging, operating in the Office of HEW's Assistant Secretary for Human Development, administers Older Americans Act programs which support home care services for the elderly. The Older Americans Act authorizes two basic formula grant programs: (1) Title III, authorizing grants for State and community programs on aging, and (2) title VII, the nutrition program for the elderly. Over $25 million will be used for home services in fiscal year 1977 under title III, representing 16 percent of the total expenditures under that title. The title VII nutrition program supports home delivered meals, although its primary objective is providing opportunities for older persons to have meals in congregate settings. By the end of this year, 60,000 meals a day will be delivered to persons in their own homes under this program.

In addition to these direct expenditures for in-home services, the Older Americans Act sets up area agencies on aging which coordinate other resources that can be used for home services for older persons. In Massachusetts, as an example, nonprofit home care corporations have become area agencies on aging. These agencies are especially alert to the need for in-home services and serve as funding magnets and administrative resources for local aging-related programs. There are 545 area agencies across the country now in place and functioning as advocates, planners, developers, coordinators, and funders of services designed to assist older persons to live semi-independently in their own homes.

The Administration on Aging and its State and area agencies on aging are actively involved in using the authorities and resources available to encourage the development, coordination, and expansion of home services. For example, the Administration on Aging has entered into three interagency agreements designed to facilitate coordinated delivery of home services nationwide. Those agreements are with the Medical Services Administration (medicaid), the Public Services Administration (title XX), and the Public Health Service.

One activity that AoA has undertaken to support those agreements has been to encourage State and area agencies on aging to develop similar agreements with their counterparts at the State and local levels. Currently, there are 13 State-level agreements with medicaid, 52 with title XX, and 27 with PHS.

State and Area Agency Actions

Some examples of activities that State and area agencies on aging have implemented as a result of those agreements follow:

(1) Michigan—the State agency on aging and the State PHS agency have jointly developed standard definitions of home health care. They have also worked together to develop a regulatory mechanism to improve the quality of home health care. In addition, both agencies are working to expand home services within the State.

(2) Minnesota—the State agency on aging and the State public health service agency drafted legislation related to improving quality of homemaker-home health care.

(3) New York—CETA funds were received by the New York State Agency on Aging to develop home health services in nine counties.

(4) In Kentucky, title III moneys were matched with title XX funding to develop a homemaker program. CETA employees were used to augment the services provided through the program.

(5) As a result of a demonstration project funded by the Southwest Area Agency in the State of Washington, the Skamania County commissioners are now funding a $20,000 home health care program for older persons with county funds.

The Administration on Aging is continuing its efforts to increase State and area agency capacity to support the effective and coordinated delivery of home services to older people in a number of ways. The following examples illustrate some of our activities:

(1) AoA is preparing a handbook on homemaker and home health services to provide a basic core of information on "best practice" in the area of homemaker and home health services.

(2) Through an agreement with the Bureau of Labor Statistics, materials on occupational opportunities in working with older people with special emphasis on services in the home were prepared and distributed in the fall of 1976.

(3) In February of this year, AoA transmitted to the State and area agencies on aging materials for improving the quality of homemaker/home health services.

(4) AoA is supporting a research project to determine whether and to what extent economic and service incentive can induce and equip family units to take on home care of the elderly. This project is being conducted by Case Western University.

Using its authority under title III to make grants for model projects, the AoA is supporting a number of interesting efforts involved in the provision of in-home services that are health related or are necessary to maintain older Americans in their own homes. With your permission, Mr. Chairman, I will submit a description of these projects for the record. [See appendix 1, item 3, p. 310.]

Significance of the New Reorganization

On March 8, Secretary Califano announced a major reorganization of the Department of Health, Education, and Welfare. For the first time, the medicare, medicaid, and quality assurance activities of the Department will be consolidated into one organization.

This reorganization in itself does not solve statutory and regulatory differences in eligibility requirements, benefits, individual payment mechanisms, and methods for computing payment, some separate surveyors and different care standards applied to the same providers, etc. Although not easily attained, organizational integration is a primary objective of the Secretary.

The Assistant Secretary for Health will continue to oversee general health policy development. Coordination between HCFA and the Assistant Secretary for Health will need to be carefully planned in order to assure a proper balance of disciplinary perspectives.

Purpose of Reorganization

One purpose of the reorganization is to assist in achieving internal efficiency and economy and to encourage prudent financial management as well as to strengthen our ability to control fraud and abuse in the medicaid and medicare programs. We believe that the consolidation of previously separate medicare, medicaid, and quality assurance activities should greatly assist coordination and resolution of major issues relating to the Department's home health policies. The ongoing research efforts and capacity building grant program in PHS will also contribute to this resolution. The reorganization also has a direct bearing on the capacity of the Office of Human Development and the Administration on Aging (AoA) to improve on the in-home services provided to older Americans. Placement of the Public Services Administration (PSA), which administers the service program authorized under title XX of the Social Security Act, within the Office of Human Development (OHD) will strengthen the Federal level ties between AoA and PSA. These two agencies have already joined together in an interagency agreement to promote cooperation and collaboration between themselves. State level cooperative agreements between agencies on aging and title XX (social services) agencies are required before State plans are approved. Need for such cooperation was emphasized by Congress in the 1975 amendments to the Older Americans Act, and we believe that the recent HEW reorganization will aid in maintaining a close working relationship between AoA and PSA. I would be happy to address in greater detail any questions you may have concerning the reorganization.

We wish to reiterate our commitment to meeting the needs and providing quality services to individuals served by our programs. The Department wishes to thank the committee for the opportunity to appear before you today. We welcome any questions which you may have.

Senator Chiles. You stated in the early part of your statement that in several months you would be offering recommendations. Do you know how many months that will be?

Mr. Derzon. No. Those words were chosen with care, Senator. I don't know. I think the most important thing that HEW could do is to assemble the information it has right now and offer a program that will give direction and leadership to the alternatives. I don't think it is in my position to do that right now. I would ask Dr. Butler, who

has been watching this for a long time and is a part of the inside, if he will make a comment about that.

Dr. BUTLER. I think you are quite correct that the Department does not yet appear to have a consistent, well-thought-out set of policies with respect to alternatives. We have to work toward correcting this lack by assigning responsibility and demanding accountability in such a way that when progress is made or needs to be made, we know where to turn.

Mr. DERZON. As I see it, Senator Chiles, we have another couple of steps to go in reorganization.

Senator CHILES. Sometimes we have to put ourselves under some time restraints or we will never quite get there. These problems hurt your head and they are not going to get any easier to solve.

TIMETABLE FOR LONG-TERM CARE PLANS

Mr. DERZON. We recognize that. We will be happy to submit to you a timetable of a plan.

Senator CHILES. We would be glad to have that.

Mr. DERZON. That would be good for us because it will push us along.

Senator CHILES. Thank you, sir.

In your statement you made the distinction between alternatives to institutionalization and alternatives in long-term care. I hope that this will become the official terminology for HEW, because it makes a very important point. Would this be the case, or is this the case?

Mr. DERZON. We would like to go in that direction, yes, sir.

Senator CHILES. You also talk of a continuum of care. This may seem like a rhetorical question, especially when addressed to someone who was confirmed only a few days ago, but exactly who in HEW is in charge of developing this continuum? When all is said and done, don't we have a fragmented responsibility for the development of this continuum?

Mr. DERZON. Yes, we do. On an overall basis the Secretary of HEW has responsibility to develop programs that meet that. This is not an easy problem.

Senator CHILES. Isn't that also something that we should do, to clearly set forth what the line of authority is, who is going to be responsible, or how that responsibility will work?

Mr. DERZON. I accept that as an excellent suggestion, because I believe that unless there is responsibility taken in key places in the HEW, we will be no further along in 6 months, or a year, than we are right now.

Senator CHILES. I think so, too. While we hope that the reorganization is going to be very meaningful, unless we can pinpoint this responsibility and accountability, I don't think that chart is going to help us that much either.

Mr. DERZON. We will solve both those kinds of problems.

Senator DOMENICI. Would you yield, Senator Chiles?

Senator CHILES. Yes.

Senator DOMENICI. Let me ask this question. There is a lot of talk about reforming the whole system of delivering health care as it pertains to Government responsibility. I guess that is frequently

referred to as the national health insurance, or whatever words you want to use. Now, obviously, in the area that we are talking about today, there is a rather glaring need to do something as soon as possible to eliminate the inconsistencies, the fragmentation, the kinds of things that we have been talking about.

Now my question is, is there any motivation to try to do some curative work, as soon as possible, on the present system, or are we waiting around for a total package that will deal with health services delivery?

A Mistake To Wait for National Health Insurance

Mr. Derzon. I think it would be a great mistake, Senator, to wait around until a national health insurance bill was drawn and accepted, passed enthusiastically, and put in place. Any insurance system, on a national basis, is going to have to be built on much of what exists—built on the existing hospitals, existing physicians, existing home health agencies, and so forth. We are not suddenly going to get a new set of providers. We may have a different arrangement with them under national health insurance.

I think there are steps that have to be taken along the way. One of those major steps, of course, in our view, is cost containment. We believe that we have to get into managed costs, and that is one of the reasons the Secretary is so anxious to push a cost containment program through. Senator Talmadge has a little different approach to the problem, but nevertheless, there is concern that we now come to grips with the cost.

We have been working hard over the years to build, to develop strategies, to have adequate manpower. Now it appears that on the physician front, at least, and on some of the other fronts, that we may have gotten ourselves ready, and in fact, it is possible we may even have too many physicians in some parts of the country. We should be working now on systematic ways to deliver services so that when the financing machinery becomes more uniform, or more central, or more rational, that we get bound to a system that works.

Senator Chiles. Speaking of costs, your existing data is inadequate to determine right now whether utilization of home health care would decrease or increase total cost. Are we likely to arrive at this kind of determination from the limited kind of research that has already been conducted or still underway? What will satisfy you, or what will answer that question for you and for us, as to whether home health care effectively reduces cost or increases cost?

Mr. Derzon. That group behind me ought to be smiling, because I asked them that question yesterday, when will we know the answer to that question? I must tell you that I cannot answer that question because I have not seen the extent of the work that is being done. There has been enough work done, I think, to make some broad calls on that problem.

The question, I think, is now to first measure within one of our programs the alternative cost, and second, try to make a rational judgment about what happens to those people who have not been availing themselves of service; what will they do when suddenly these services become available, and under what ground rules would you want to apply controls, so that not every family gave up responsibility for the care of their own at home. I cannot tell you, at this point, when we

will have a number that effectively delimits the question you want an answer to, as do I, which is, does it cost more or does it cost less for the same 100,000 people?

Senator CHILES. Well, I understand the problems of those trying to make that determination when we don't know how many people will avail themselves of the services, but from the data that you now have, when you make a broad guess or a broad perspective to that question, we would like to have that information, too.

You mention that the Medical Services Administration memorandum of January 1976 described reimbursement for service in alternative care settings. What is the result of this memorandum and has it encouraged greater use of alternatives?

Mr. DERZON. It is a little early to tell because it depends on data from the States. My information, at this point, is that it is making a difference in some States. The States are amplifying their activities under the medicaid program and looking into more alternatives. We also have some good experiments going on in some States where medicaid and an office of the Administration on Aging are working together in very preliminary stages. I heard about one in Wisconsin, which I cannot remember the actual details of, which seems to be working reasonably well early on with a combination of those social dollars and health dollars.

I would like to ask Mr. Reilly if he would perhaps amplify, if I can, on some of this.

Mr. REILLY. There has been a series of demonstrations that have been funded by a combination of the Public Health Service, the Administration on Aging, and the Medical Services Administration. These demonstrations have put into the field a variety of models ranging from primarily social care to a heavy emphasis on health care, complete with a social care component. Three of these demonstrations have been completed, and we are awaiting the results of the fourth which will be over by the end of this year. Another demonstration, also supported by the Administration on Aging focused on testing the concept of cooperative day care by engaging people at the local level in a cooperative. The results of this project, coupled with the findings of the other demonstrations will enable us by the end of this year to obtain quantification of results and the related cost figures. That, hopefully, will provide a basis for projection of what can be done at what relative cost.

In addition, we are providing assistance to several organizations to develop a range of models for providing supportive, phycho-social services for the frail and chronically ill elderly. We expect that by the end of this year we will have a number of these models funded. Efforts are being made to support these models jointly with other Federal programs. We are also closely following the section 222, Social Security Act demonstrations that focus more heavily on the medical and rehabilitative day care center models.

These demonstrations should also help in the rational development of the continuum-of-care concept. The same older person will have different problems at different times, and these models are designed to put into the field tests of different packages of services which can meet the neels of the same older person at different times. So there is a two-way thrust to this set of demonstrations.

Cost Questions Frustrating

Senator Domenici. Mr. Chairman, might I ask a question on this? I have been frustrated, as has the chairman, with the issue that arises any time an amendment or a bill is offered that provides an alternative. Someone punches in a computer in the Finance Committee or over in your outfit and says, "That is fine, but it is going to cost $750 million." We are at a point where we cannot offer any leadership because we don't know. We can just say generally that if there is more home health service there ought to be less of something else, and we cannot ever prove that. I have arrived at the point where I don't think we will.

Let me ask you this question. Has any thought been given to picking a State in the United States that might be deemed kind of typical of the United States and seeing if we could develop within that State a willingness to try all of these programs under one umbrella for a couple of years and see if the interchangeability of funds and programs might be the kind of model we are looking for?

Mr. Reilly. We should first do this evaluation on the current set of demonstrations. Your suggestion could be a logical next step, depending on how the data shapes up.

Senator Domenici. What are we going to get from this demonstration you are talking about?

Mr. Reilly. It will be turning up data in terms of the relative costs of each of these kinds of models—the heavy health component model on one end of the spectrum, the primarily custodial day care model component on the other end, and two or three in between. One has tried to add a housing component.

Senator Domenici. Do I understand you are going to do all of this theoretically, or are they being tried?

Mr. Reilly. Some of these are being tried right now. Some have been going on for a couple of years. They are in various locations around the country. By the end of this year, the data will be put together and analyzed in terms of trying to find out what the projected costs are going to be if these single models are multiplied on a large scale basis such as a statewide demonstration or national program.

Senator Chiles. Are you referring to your appendix, which lists these model projects funded by the Administration on Aging for in-home services—National Council for Homemaker-Home Health Aide Services, Inc.; Indian Home Health Services, Carson City?

Mr. Reilly. No, that is a different set. That is a group that is jointly funded with the Public Health Service.

My apologies for not knowing the appendixes here. I just came back from leave yesterday and came directly to the hearing. Some of them are section 222 experiments. For example, the rehabilitation center in New York is one of the projects. One of them is On Lok in San Francisco. Those are the two that come to mind where different packages of services have been put together and are running on a demonstration basis now.

Demonstrations Proposed

Mr. Derzon. I would like to mention, Senator Domenici, in the discussions we have had, in a very preliminary fashion in HEW, a sug-

gestion has been made that we take perhaps 10 regions of the country—not necessarily full States, although perhaps a State could be used for that purpose; demonstrations could be considered for the region and all of the funds would be pooled together and a new unit assembled to operate in this area. A serious set of proposals are being thought through, about the way in which we could, in a very large scale, demonstrate the advantages and perhaps some of the problems of doing this kind of assembly.

Senator CHILES. Your discussion of medicaid makes no reference at all to a problem that was discussed in our earlier hearings; that is under title XIX and title XX, funds are now being used—some millions of dollars are being involved for older persons in need of home services to make their own personal arrangement for individual providers or home attendants.

We have had accusations of abuse and waste. I am not sure whether we are sitting on a scandal here or not. Twenty-six of the fifty States and the District of Columbia are utilizing title XX alone to reimburse these individual providers for homemaker and chore services to the elderly. Has the Department made an investigation of the extent of homemaker and chore services being provided under title XX and medicaid in the States?

In California alone last year more money was spent for the homemaker and chore services under title XX than was spent for home care under medicare programs in the entire United States. Eighty percent of those people—of the elderly receiving services—were getting them from individual providers. Do we have any idea what the dollar commitment of that is?

Mr. DERZON. I cannot answer for title XX. I cannot tell you, but I would be happy to provide to you a full response on the question of the issue that came up at a previous hearing. I am not personally familiar with what did come at that hearing or if problems were identified. I will see to it that we respond, not only to your request, but also to the problem.

FAMILY MEMBERS PAID FOR CARE?

Senator CHILES. We would like to know how many States are paying these funds to family members. In a most recent survey of 26 States done for the committee, only 1 of the States which used individual providers did not allow the provider to be a family member. It seems to me there are no guidelines on that if you could even have a family member that could be the provider. This is just an open ticket here and we are not sure what kinds of services are being provided or what kind of check there is over these services. We need to see that this is not just a blank check.

Mr. DERZON. Senator, is it the view of the members of the committee that family members should serve from time to time as home health aides, or that they should not, or that we should demonstrate to try it?

Senator CHILES. I think it would be the view of the committee that you would really wonder about the accountability of a program that simply had no control over the use of family members.

Mr. DERZON. I agree with that.

Senator CHILES. The program is left wide open. The people that are seeking these services—are they really qualified to pick? Are they

not going to be victimized in many instances by people if there is not some group acting as a clearinghouse for the providers of this service or exercising some control over the quality of service? Many people that would be in need of service, not only elderly, could well be victimized. In addition to that, you could have a scheme set up of people seeking services and providing funds to their family members where the services are not needed. The only way this program is going to work is to have some kind of accountability, and it looks like we have none now.

Mr. DERZON. In some cases.

Senator CHILES. I don't say we prohibit it.

Mr. DERZON. You just want controls.

Senator CHILES. That might be the way, but I would like to feel like some truly independent or nonprofit agency or governmental agency had made a determination that this was the way to go, rather than think that it is just a provision—that you just fill out the form, they send you the money, and that is the way it goes.

Mr. DERZON. If I may say something on this point, too. The idea of a family member, under well controlled circumstances, perhaps taking care of another family member and being compensated in some way, is an interesting idea. The trouble with what happens is that one way or another, interesting ideas get defeated, because we don't put the controls and kinds of safeguards into it. I would like to try a little of this. It would seem to me that we want to be very, very careful about how we develop it.

Senator CHILES. I am glad you say in your full statement that my investigation of the medicare-only home health care agencies has helped you to decide that analysis of reimbursement practices will be a high priority task under your new organization. Now what comes next as far as the medicare-only agencies are concerned?

NEXT STEP FOR MEDICARE-ONLYS

Mr. DERZON. Although I have not had a chance to fully explore this with Mr. Tierney, my view of that problem would be that the first thing we ought to do is get our house in order on our reimbursement policies. We should not allow for excessive payments, but for appropriate payments. I believe it would appear that our cost formula is either not fully adequate to safeguard against these occurrences or we did not successfully administer them.

In my view, we have enough protection from the laws. We have to assure ourselves that we can manage reasonable costs. We are managing reasonable costs in the medicare program and in many, many areas. In fact, it limits in some areas. To me it seems to be not a statutory problem but more a regulatory problem.

Now the question of what to do about these private not-for-profit groups is something I have not had much time to think about. It would be my general view that, first of all, we don't like providers who only serve one group of beneficiaries. You see problems behind that; if we have providers who only serve medicaid, or only serve medicare, and don't serve the whole group of patients in the community, that is suspicious.

There is a reason for that; I think it automatically creates discrimination of one sort or another. My view of that is the basis on which we want to look. It is possible to establish rules, as has been done in HMO's, and so forth, to prevent imbalances.

Senator CHILES. Should there be certificates of need for these providers?

Mr. DERZON. My own view of this is that home health agencies are clearly a part of the health care system and ought to be part of the planning process. I have some general questions about that because in some States a certificate of need works very well, and in some States it works rather badly. They should be a part of the planning process. Where a certificate of need is well developed, I think they ought to be a part of it. Where a certificate of need is still under development, I am not so sure.

Senator CHILES. Well, the congressional intent seems to specify that the establishment of new home health services be contingent upon acquisition of a certificate of need, and yet HEW has exempted the home health care agencies.

Mr. DERZON. I noted that in your opening comments, and I put it down on my list of things to do when I get back to HEW today.

COMPETITION BETWEEN AGENCIES

Senator CHILES. One of the concerns that I found in some hearings that I held in Florida was the fact that there was competition between many of these facilities and many of the agencies of the home health providers. They actually had what I think amounted to runners in the hospital. We found instances in which they paid bonuses or fees to people who were able to refer patients to them. Now, it is one thing to say you are making information available to a patient, but when a patient had as many as three or four people calling on him or his loved ones while still hospitalized, it is a different matter. What we have is the hawking of services by these particular agencies, with nurses, the nurses' station, and other attendants involved. The admitting office of the hospital in some instances was a shareholder and some of the doctors were shareholders in those services.

When you get into that kind of situation, that is not just making the information available. You can bet those people are going to go to that facility whether they need to or not. In many instances they were told: "Now you are going to have so many days here and you don't have to pay for that. That is all provided, so you ought to go in." So, under those circumstances, all of the days were being utilized for many of those patients.

Mr. DERZON. Yes; that is one of the problems of the standard benefits, before you clean up, or we clean up, some of these problems. Having worked as a hospital director for a number of years, I can tell you that those practices that exist from time to time, unscrupulous practices in my view, practices that can be sound——

Senator CHILES. You know, we call that ambulance chasing when a lawyer does it, and we try to disbar him when we catch him doing it. Yet, we found there were no constraints about it being done. Trips to the Bahamas, and other prizes, were being given by outfits on the basis of who could send them the most business.

Mr. DERZON. Yes; the rules of the game in this case ought to be crystal clear. There are practices that are unacceptable, and the ones you have outlined, in my view, are unacceptable. These patients are in institutions, they are sick, they cannot easily make judgments, they can be victimized. One of the problems we have right now is that we do not have, in my view, adequate controls or protections for the individual patient.

Senator DOMENICI. Mr. Chairman, could I change the direction just for a moment?

Senator CHILES. Yes.

$2.6 BILLION FOR OVERUTILIZATION

Senator DOMENICI. I certainly don't intend to hold you to an explanation of one of the Secretary's contentions, but I would like to field this issue with you. Secretary Califano, in his testimony on May 11, said that as many as 100,000 of the 700,000 people in the Nation's acute care hospitals—in his words—do not need to be there and could be better cared for at home, et cetera. He said that this extra cost amounted to approximately $2.6 billion a year. Now I assume that he has shared this observation and this concern with you in your new position.

Mr. DERZON. Yes, sir.

Senator DOMENICI. Is that a fair assumption?

Mr. DERZON. Yes, he did.

Senator DOMENICI. Now do you know how much of that $2.6 billion is being paid for by either medicare or medicaid?

Mr. DERZON. Yes; in a general way I do. Probably 40 percent of hospital revenues come out of these public programs or thereabouts.

Senator DOMENICI. So 40 percent of $2.6 billion would be your estimate for this committee?

Mr. DERZON. Yes, sir. I would like to go back and get a more perfect figure for it, but that would be in the general neighborhood.

Senator DOMENICI. What I am wondering is, how do we know that 100,000 of them don't need to be there?

Mr. DERZON. Well, that was an estimate that I do not have the details on. Most of the figures that the Secretary has used have come out of the offices of HEW where this information developed. I think that information reflects a couple of things. There are still some ongoing weaknesses in utilization review, which I think is gradually improving as we strengthen the PSRO activity, and as hospital bills continue to shorten the length of stay. So part of that number clearly is in there.

There are also imbalances in the country where there are ample acute care facilities, but a lack of long-term care institutional facilities. In New York City, when I was there, although I don't know whether it is still true, there were patients in acute settings that ought to be not in acute settings, but should be in an institution.

Senator DOMENICI. Let me just interrupt. I didn't hear the testimony of Secretary Califano, but it would seem to me that the next question we have to have answered is HEW's. Why are they there? Not from the standpoint of pointing an accusatory finger, but giving us reasons why. If the estimate is good, why are they there? The whys ought to lead us, if they are credible responses, to some solutions that are either

regulatory or the result of substantive law. Could you do that for us—give us HEW's analysis of why these 100,000 are there?

Mr. DERZON. Yes, sir.

Senator DOMENICI. And detail for the committee your position as to why they are there.

Mr. DERZON. Yes. I think we could also help by telling you what I think we could do about it.

Senator DOMENICI. The next question would be suggestions for ameliorating the situation, and we would appreciate having your observations on that.

I suspect that the Secretary was talking in this particular set of hearings about hospital care costs. One dimension is to talk of it in terms of containment; the other is to talk of it in the terms I am talking of it here. Have we promoted it by our laws in some way that we ought to know about it?

Mr. DERZON. There are many aspects to this question, and Dr. Butler, who has looked at that problem very carefully, might want to say more about it. By and large, the public programs have put a premium on covering the costs of in-patient hospitalization. One can argue, in a general way, and I think accurately, that that kind of coverage has tended to push people into the most acute care facilities in our communities. We have been more ginger about extending those settings, but now generally coverage is improving; ambulatory care service coverage is improving, and some home care, and the like. So, in a sense, public policy has dictated a certain concentration of patients, and I think has created this problem.

I want to make one other point about this because one of the logical questions is that if we could save that $2.6 billion, and in fact 40 percent of it from public programs, could we not use that money more effectively for alternatives, including home care services? One thing you should remember about that, I think—I do remember—is the fact that most of our institutions are on cost reimbursement, so that fewer patients with the same expenditures in the hospital simply raise the per diem cost to the hospital and do not save the public programs money.

If the formula is changed so that we are not on a strict cost reimbursement system, and so that fewer patients in the institution do in fact reduce the costs, and therefore those costs can be traded, we have accomplished something. I do want to mention that little caveat, because on the surface, it seems like it would be easy to make that change in dollar flow. I don't think it is quite as easy as I would wish or perhaps you would.

Senator DOMENICI. Dr. Butler, do you have a comment?

Dr. BUTLER. I very much appreciate Mr. Derzon's emphasis on a responsible economic program. Among the kinds of observations which have been made so far, one might think of another; namely, that about 20 percent of all medicare expenditures, on the average, are utilized in the last year of life in an older person's last illness.

6 MILLION CARED FOR BY FAMILY

We talk about family care. Something like over 6 million older people are automatically receiving some measure of assistance within

families. There is a very important data base about family care of older people which we have to understand better. It seems to me we put the cart before the horse. We should be talking about alternatives to family and self-care rather than alternatives to institutionalization. We should be supporting the family, the No. 1 caretaker in the United States, through a variety of innovative and cost-effective techniques, facilities, and services. As Mr. Derzon was, I think, quite properly emphasizing, expensive, in-patient care should come about as a last resort.

There are some immediate, time-targeted applications of what we already know, and there are some long-term goals like well trained health providers. Unfortunately, in the United States, we have not given adequate attention to the proper training of people in clinical gerontology, geriatric nursing, or geriatric medicine, so we often don't have effective diagnosis and proper placement of people. Because of such inadequate patient assessment, people may be put into certain tracks of care which are extraordinarily expensive to our Government and extremely painful and anguishing to the people and the families affected. Avoiding such inappropriate care requires improving the health professional's understanding of the conditions of the aged, which in turn depends upon research, increased consensus on the proper methods of diagnosis and treatment of disease, and better training in the health care needs of the aged.

Senator DOMENICI. I understand that. Let me just interrupt for a minute.

Dr. BUTLER. Sure.

Senator DOMENICI. I think you both are making excellent points. I think the whole cost reimbursement system has no incentive for providing the home services—quite to the contrary, it is the opposite. They are living with it. If you were a hospital administrator, you lived with it, and I am sure occasionally you didn't like it. It is very burdensome and it is not the most cost-effective program.

DRUG RESTRICTIONS RAISE HOSPITAL COSTS

Let me just give you an example, and ask you how we would ever find an answer to this. I am convinced that even with the PSRO-type review that some conscientious doctors keep patients in hospitals for this simple reason—I will give you one—because the drugs are provided there. The drugs that are provided there are paid for if they happen to be a medicare or medicaid patient, whereas if we let them out, even with an attending daughter, son, or spouse who is willing to go get the drugs, they will keep them 3 or 4 extra days because they are expensive drugs. Now I know doctors are burdened by that. I have had them tell me, "There is no alternative; it is going to be $150 worth of drugs. They are poor and we are going to keep them there."

They will not tell the PSRO review about this, but I don't think they will catch that either in questioning the professional man's competence. How will we ever find out how much that kind of thing is contributing to the retentions of a person in a hospital?

Dr. BUTLER. The monitoring of the cost of nursing homes is extremely difficult. Our own agency is looking at the nursing home population from a research point of view. What concerns us deeply,

for example, is although older people make up 10 percent of the population, they consume 25 percent of the drugs, frequently including drugs that they should not receive. We need knowledge of drugs and age to avoid inappropriate prescription. Before we can properly tackle the question of regulation or how to monitor the dispensation of medications, we must better understand how drugs are utilized by the body, drug toxicity, and mechanisms of effective action of drugs.

Mr. DERZON. I think the way I would answer your question with respect to the acute care hospital, which is what I think you are particularly concerned about—the answer to that is to make the benefit the same for outpatients as well as for inpatients.

Senator DOMENICI. Well, I agree with that also. But if we have to justify it on the basis that it would probably save money or cost no more, then we have a difficult time. Is that correct?

Mr. DERZON. Yes; we do, and yet a problem like that perhaps ought to be measured. I do think that it is a measurable problem. Even though it is a subtle problem, I think that probably it could be measured. In medicaid it is not a problem.

Senator DOMENICI. That is right.

Mr. DERZON. Medicaid covers drugs on both sides. With medicare, if you change the benefit it may well be that there would be additional costs because outpatient recipients are high users of the prescription medicines. However, there may be enough significant gains to get rid of that abuse.

Senator DOMENICI. Mr. Chairman, I raised that issue not because I think that among the problems that it is a major one, or the only one, but I think it is symbolic of the problem in the delivery system. The choice is not what is needed but, rather, what is available and will be paid for in whole or in part by a provider. I just believe that that is why we are getting, not the best care, but the wrong kind of care, and paying money for the wrong things. I don't know how we get to it other than looking at the whole program, and if we have to do that we are going to be waiting around for years.

I am hopeful that we can evolve out five or six major problems and try some flexibility. That, it seems to me, would be the only approach and, in my opinion, it is not going to come out of these demonstrations that you are running. They are too selective and they are not field demonstrations in the sense that will convince anyone. They are going to convince you all that you are going to have more information than you had when you started, but unless someone suggests a consolidation or a flexibility or some such thing between eight or nine programs and tries it, I don't see how we are going to ever prove it.

Mr. DERZON. I would like to respond on both points, first on the drug example, which is an excellent example of the perverseness of the reimbursement system. The things that happen, people's behavior, is affected by the way money flows. I think that is an example and we could supply some others for you which you are all too familiar with.

On the second point, with respect to demonstrations, I am not viewing them quite as harshly as I think perhaps you are, sir. I think the demonstrations that I have seen, at least the outlines of them, are important. One of the problems in our public programs is we have not researched them to learn from the experiences out there.

One of the reasons I came to Washington was I thought there was an opportunity to aggregate some of this research effort and learn what is assembled, what we have already learned, and to learn some more. Also, the demonstrations are important because they give some illustrations of what we will have to do broadly, on a national basis, in order to develop manpower, in order to develop the right formation of services, the right kind of planning. We are all concerned about the problem of cost and we will be working hard at demonstrations that come to grips with the cost issues.

Senator DOMENICI. Thank you, Mr. Chairman.

FRANCHISING OF IN-HOME SERVICES

Senator CHILES. I want to go back just briefly to the subject that I was on before, that there is increasing evidence of franchising of home health care services. As I understand it, it is practiced consistently—corporate soliciting of physicians and others promising to help set up home health care agencies for a percentage of the take. In one instance the total siphoned-off cost was 30 percent of the funds the home health care agency received from medicaid. The physician was told he could pay himself a large salary, he could write off a car and take vacations at the expense of the company, and he could have the tax-free retirement benefits set up by the home health care agency.

Whether the agency is set up for a profit or not, it is questionable that Congress intended 30 percent of medicaid funds to come off the top for franchising fees. Is the Department investigating this practice and has the Department any plans for treatment of franchising? Are you going to allow that to continue?

Mr. DERZON. Senator, I am not intimately familiar with the franchising issue. This one is news to me and I will get back and get at this. This whole business of percentage arrangements between physicians and other providers, I think, is being addressed to some extent in H.R. 3. I have to check that legislation.

We ought to prohibit any percentage arrangement, anyway, for anything. They are all perverse, and we ought to have broad authority to do that, and we ought to have very strict language in the law that maintains the separation between those who order things and those who deliver things. I don't know enough about the law, I am not a lawyer, but I am with you on this, entirely. I think we have bad practices and that ought to be stopped.

Senator DOMENICI [presiding]. The chairman will be back shortly. Let me just follow up on the last question that Senator Chiles put to you. As you check into that situation you are going to find another anomaly; you are going to find that in spite of all that he has described, it will be contended that they are performing the service cheaper than their counterpart. So as you look at it, some investigation has to be made as to how they can do that. Even with the 30 percent off the top that he has described, the testimony before the committee would have the two systems flowing side by side—the one he describes and the true, not-for-profit visiting nurse type. You find that the cost per visit is cheaper even with all of this that you have described as perverse.

Mr. DERZON. Has the quality of this been excellent?

Senator DOMENICI. It has something to do with how it is monitored in terms of what they are doing at the actual delivery point or how many visits are prescribed for a period of time. Then the strange thing is that in all of them there is a doctor that does all the prescribing in all events, which complicates it very much in terms of who is doing what to whom in the system.

Mr. DERZON. I would say, Senator on this point, that there are a lot of ways to skin the cat in health care, and some people skin it in a way that results in terrible care. It seems to me that the issue here is not whether one can produce a lower cost than the other, because we don't buy an entirely competitive basis in the health field. You have to buy on a reasonable cost basis, looking at the costs that have been incurred in the system. There are unreasonable costs, or costs that have no relationship to service, and it seems to me we should not be paying for them. We will pay some people more for their services than others, because, in our view, they may be providing excellent quality.

Senator DOMENICI. I didn't raise the issue because I was saying we ought to make it totally cost conscious or competitive. I think your observation is correct.

Dr. Butler, do you have any comments on the questions or the general subject we have been discussing today that you would like to make for the record?

Dr. BUTLER. Yes. I might comment again on the fact that it is painful to be forced to see us buy bad care. I often find myself troubled about how we can provide effective monitoring among the States, the municipalities, and the Federal Government. Perhaps I might just briefly comment on how certain types of research may make a contribution.

It would be marvelous if we could prevent many of the diseases which make it necessary for people to receive any kind of care. In many respects home care simply relocates people who are already damaged in one way or another. We spoke about drugs because we don't have an adequate knowledge basis. Physicians are not trained in pharmacology that relates to age. Drugs are often given inappropriately.

A person may fall, particularly an older woman with softening of the bones, and wind up with a broken hip and, therefore, very sadly receive unnecessary institutionalization which is a great expense to all. We have senile brain disease and multiinfarct dimentia. These two major conditions alone probably account for up to 60 percent of all the patients who are in our American nursing homes. If we can find new knowledge that is preventative of these conditions, we will be developing the ultimate cost containment and the ultimate service. We don't simply want to move people around from one location to another.

FAMILY STRAINS

With respect to family, we have to understand the painful processes that families go through. In many respects, American families have been given a bad name. American families, as well as families in other

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countries, have gone to great lengths to take care of older family members. That is true particularly of women, who live 8 years longer than men. They tend, when they marry, to marry men 3 years older, so they face an average of 11 years of widowhood. They often care for their husbands, and they grow weary and, at times, resentful. We have to provide them with social supports. We also need to teach all family members how to provide care for their older members.

This applies to very simple things: How to handle emphysema, for example, and make it possible for a person to get his breath more effectively. We also have to help people go through the process of dying. The English experience, with local institutions such as hospices, is that a dying person can be cared for at no more than two-thirds the cost of being institutionalized in a community hospital in what I assure you are much more humane circumstances.

I would like to make one final point which is the need for training so that we can be assured that we get proper placement to begin with, perhaps 20 to 40 percent of the people need not even go to nursing homes but could be in less expensive circumstances—home care, et cetera. To have properly trained people to make those decisions is something we have not really worked on adequately in the legislative authority so far.

Senator DOMENICI. Mr. Reilly, did you have anything to say—any observations?

Mr. REILLY. I welcome the continued attention of the committee in this area. You have held hearings on more than one occasion, you found that there is progress, but the progress is limited. That is an indication of the difficulty of the area. The continued attention of the committee just helps us keep our attention on trying to deal with these very difficult problems.

Senator DOMENICI. We have one question that has sort of an urgency tone to it. It is our understanding that the Bureau of Health Insurance—BHI—is now in the process of notifying all States that advanced medicare certification of new home health agencies is being discontinued. The committee's question is, "Is this true? If so, why was this action taken?"

Mr. DERZON. Senator, I do not know about this. We will file with you, in the next day, information about that point, because it would appear that there is a critical element.

Senator DOMENICI. We have a number of written questions that we are going to submit to you, Mr. Derzon, for response in the record as soon as you can get them to us.

Now we will stand in recess for just a moment while I confer and talk with the chairman and see what he wants to do next.

Mr. DERZON. Thank you, sir.

Senator DOMENICI. Let me just say we have no further questions. The chairman indicated we would adjourn the hearing. We will convene at a future date. We have completed the hearings on this phase of health care for the aged.

We thank you very much.

Mr. DERZON. Thank you.

[Whereupon, at 11:06 a.m., the committee adjourned.]

APPENDIXES

Appendix 1

MATERIAL SUPPLIED BY ROBERT DERZON[1]

ITEM 1. SUMMARY OF LEGISLATION AND REGULATIONS

Legislation	Coverage	Eligibility	Providers	Regulations
Title XVIII of the Social Security Act (medicare).	Under sec. 1812, program payment can be made for visits to home-bound beneficiaries under a physician's plan of treatment for part-time or intermittent nursing care, physical, occupational, or speech therapy, medical social services, part-time or intermittent services of a home-health aide, medical supplies, medical appliances and outpatient services arranged by a home-health agency and a hospital, skilled nursing facility, or rehabilitation center. Under sec. 1812(a)(3) up to 100 pt. A visits per benefit period can be made, but beneficiary must have been an inpatient in a hospital for at least 3 days or have received covered services in a skilled nursing facility for a period not exceeding 1 yr from the date the home health plan is implemented. Sec. 1832(a)(1)(A) provides for 100 pt. B visits per calendar year and and is related to a sec. 1835(a)(2)(A) requirement similar to the pt. A benefit.	Pt. A requirements: 1. Age 65 or disabled. 2. 3-day stay in participating hospital. 3. For further treatment of condition treated in hospital or SNF. 4. Need for part-time skilled nursing, physical therapy, or speech therapy. 5. Homebound. 6. Physician determines need for care and establishes plan of treatment within 14 days after discharge from hospital or SNF. Pt. B requirements: 1. Age 65 or disabled. 2. Need for part-time skilled nursing care, physical therapy, or speech therapy. 3. Physician determines need and establishes plan of treatment. 4. Homebound. 5. Home health agency participating in medicare.	Home health agencies must be in compliance with Federal, State and local laws. Conditions of participation range from the type of services (e.g., an HHA must include part-time intermittent skilled nursing services and one other specific service), to administration and professional personnel requirements.	Subpart II—Reg. No. 5—Condition of participation. Pt. A intermediary manual, secs. 3120–3129.

[1] See statement, p. 281.

Legislation	Coverage	Eligibility	Providers	Regulations
Title XIX of the Social Security Act (medicaid).	Under sec. 1905(a)(7) home health care services are mandated.	All "categorically" needy individuals over age 21, all "categorically needy" individuals under 21, if the State covers them for skilled nursing facility care; and all "medically needy" individuals eligible for skilled nursing facility services.	Home health agencies must be medicare certified or be medical rehabilitation centers meeting the standards in the regulations.	45 CFR 249.10(b)(7)(III) defines the required services as: nursing services, home health aides, and medical supplies, equipment, and appliances; and may make available: physical therapy, occupational therapy and speech pathology/hearing therapy.
Title XX of the Social Security Act (social services).	No section of the legislation mandates inclusion of home health services.	All "categorically" needy eligible individuals plus medicaid eligible, and income eligible.	Social service agencies at the State and local level.	Regulations do not require any specific home health service to be included in the State plan but at least one type of home-based service is included in all State plans, and home-based services may include a wide array of services such as homemakers, chore services, home health aide, and home management.
Titles III and VII of Older Americans Act of 1965.	Under the Area Planning and Social Services (title III) allotment to the States, home services must be one of four priorities.	Title III.—No set age limits are established under these provisions of the act, however, the act generally applies to the age group 60 plus. Title VII.—Those persons who are aged 60 and over and their spouses regardless of age are eligible to participate in the title VII programs.	Each State agency on aging must divide entire State into planning and service areas and designate area agencies on aging for coordination of services. There are presently 521 area agencies covering 90 percent of the Nation's persons aged 60 and over.	Title III—45 CFR Part 903—Grants for State and Community program on aging. Title VII—45 CFR Part 909—Nutrition program for the elderly.

ITEM 2. FINDINGS FROM RESEARCH ON ALTERNATIVES IN LONG-TERM CARE

On the basis of National Center for Health Services Research and Division of Long-Term Care studies thus far completed, we can reach the following conclusions with respect to adult day care:

—Roughly 200 adult day care programs are presently operating in this country. They are funded by a variety of local and national sources, including grants from a local model cities demonstration agency, county revenue sharing funds, Administration on Aging demonstration grants, title XX funds, and medicaid.

—The programs operating can be broadly grouped into two types; Model I, health oriented adult day care programs are strongly oriented toward providing rehabilitative physical and other therapeutic and health care services to a group of rather severely disabled patients; model II, multipurpose adult day care programs are those which are more socially or psychologically oriented and serve individuals who require social interaction, recreation, nutrition, and supervision, and are not so disabled.

—Adult day care is cheaper on a period-of-care basis than nursing home care, despite the fact that day care costs more per day than nursing home care. This remains true even when the expenses of living at home are added to the cost of day care. The reason is that day care is attended only part-time, 2 to 5 days per week, while nursing home care is provided round-the-clock, 7 days a week. Figures from a study of 10 adult day care centers compared to published data for nursing homes show that the third-party payor could save between 37 and 60 percent of the cost of nursing home care per year if

patients could be cared for in adult day care rather than nursing homes. These savings go up as frequency of attendance in day care goes down. When the comparison is made on the basis of total life-support costs (day care plus living at home versus full-time nursing home care), the total savings in day care drops to between 12 and 35 percent, again depending upon frequency of attendance.

—The day care programs studied showed a tendency on average to rely upon more skilled staffs than nursing homes.

What we do not yet know and are in the process of conducting research to find out is:

—What are the costs of homemaker/home health aide services?

—Do patients fare as well or better in adult day care (or with homemaker services) as in nursing homes?

—Would day care or homemaker services be used as substitutes for nursing home care or would they instead be used as added services? If used as a substitute, day care, we have reason to think, would be cheaper. If used as added benefits, however, coverage of day care and homemaker services could actually increase overall expenditures.

—If day care and homemaker services are used as additional services, and thereby suggest increased overall expenditures, could they be justified in terms of improved health status of those served?

The National Center for Health Services Research hopes to answer these questions through analysis of the data provided by the section 222 day care/homemaker demonstrations and experiments. The results should be available late next year. A brief summary of these demonstrations is presented below.

Six demonstrations and experiments were funded by competitive procurement in June 1974 for day care and homemaker services to the following contractors who were established health service providers:

DAY CARE

(1) The Burke Rehabilitation Center, White Plains, N.Y.
(2) St. Camillus, Syracuse, N.Y.

HOMEMAKER SERVICE

(1) Inter-City Home Health Association, Los Angeles, Calif.
(2) Homemaker Home Health Service of Rhode Island, Providence, R.I.

HOMEMAKER AND DAY CARE SERVICE

(1) San Francisco Home Health Service, San Francisco, Calif.
(2) Lexington-Fayette County Health Department, Lexington, Ky.

All demonstrations and experiments were conducted in accordance with a uniform research design protocol. A single contract for overall evaluation was awarded in June 1974 to the Medicus Systems Corp., Chicago, Ill.

Approximately 1,800 patients were enrolled and randomized to "a comparison" and "expanded benefit" groups. The "expanded benefit" group received 12 months' entitlement to presently uncovered health-oriented day care and homemaker services in addition to existing covered medicare services. Homemaker services cover, where appropriate, assistance in personal care, services to maintain a safe and healthy environment, and services to enable a patient to carry out the prescribed care plan.

Day care services are composed of basic and ancillary services. All participants receive basic (routine) services comprising transportation to and from home, nursing service, personal care service, podiatry services, social services, patient activities, meals, and nutritional counselling. Ancillary services, by physician prescription, include physical therapy, occupational therapy, speech therapy, and sight/hearing examinations.

The "control" group did not receive entitlement to the day care and homemaker services, but were eligible for medicare benefits.

All patients were referred to the demonstrations by existing community sources, e.g., hospitals, physicians, and health-related agencies. Referrals for homemaker services required hospitalization no more than 14 days preceding (posthospital). Referrals for day care could be either posthospital, or not posthospital.

The demonstrations produced data on patients' physical functioning, well-being, costs, and health care utilization patterns. The utilization patterns include both the modes of care in the expanded benefits package, and utilization of traditional services outside of the demonstrations. With delivery of services now completed, the final phase of data collection and reporting has begun. Underway are detailed descriptions of the services, characteristics of the population served, and their experiences. These should be completed by September 30, 1977, and followed thereafter by analyses of effectiveness, costs, and policy implications.

Other current research on alternatives in long-term care warrants mention here. One of these is an evaluation of a day hospital service in the department of rehabilitation medicine in a large municipal hospital in New York City. The day hospital mode of providing intensive rehabilitation treatment will be compared to the traditional inpatient mode of providing such services. The two major hypotheses to be tested are that (1) the day hospital mode of treatment will cost less than the inpatient mode and (2) the outcomes of treatment for patients in the experimental day hospital group will be equal to, or better than, the outcomes for patients in the inpatient control group. These outcomes will be measured in terms of the patients' mobility and their need for physical assistance in performing basic activities of daily living (bathing, dressing, etc.), of daily living (cooking, shopping, telephoning, etc.), and their psychological well-being.

The second of these projects is an evaluation of a home care project being conducted by the State department on aging in central Connecticut. Project Triage is a model for single entry into the full spectrum of health and social services for the elderly in which services are provided to each individual based on an assessment of needs by a nurse clinician/social worker team. Reimbursement is provided by medicare for a comprehensive package of experimental services including medical, dental, home health, homemaker, chore, counseling, meals, transportation, institutional, etc., in addition to the already covered benefits.

The research grant is testing the hypotheses that Triage is more effective (in terms of the outcome of care), less costly, and less dependent on institutional care and services than is the existing system. Three hundred of the total Triage client population constitute the experimental group and will be reassessed at 6-month intervals for a 2-year period. The first 6-month reassessment cycle is now in progress. There are 153 individuals in the comparison group drawn from a population outside the Triage area and matched on multiple variables with the experimental group. Their reassessment schedule parallels that of the experimental group. Preliminary data analysis will begin after the completion of this initial reassessment.

ITEM 3. MODEL PROJECTS FUNDED BY AoA FOR IN-HOME SERVICES

National Council for Homemaker-Home Health Aide Services, Inc.—Through this project States will be aided in developing and maintaining in-home services of good quality through professional consultation and technical assistance.

Indian Home Health Services (Carson City, Nev.).—The grantee has undertaken to demonstrate that availability of in-home services provided by Indians will permit some institutionalized elderly Indians to return to their communities, and that per capita cost for health care can be reduced through this strategy.

Papago Tribe of Sells, Ariz.—In order to reduce nursing home placement and to free younger tribal members who must quit jobs or school to care for the physically disabled elderly, the Papagos have developed a homemaker program and chore service.

Model Rural Project for Homemaker Service Program (Lubbock, Tex.).—The project is designed to train, employ, and place homemakers to provide services to rural elderly living in remote areas. The grantee is now in the process of negotiating with a home health agency to continue the program when Federal funding has terminated.

Home Aide Catalyst Project (Cocoa, Fla.).—This project has trained, placed, and provided supervision for homemakers to provide for the needs of eligible homebound elderly. Comprehensive Employment Training Act (CETA) funds supported the training aspects of the program.

The following projects demonstrate the use of direct home services, combined with other alternatives and supportive services, to enable older persons to remain in their own communities for as long as possible. Thus these projects offer home services together with a variety of other benefits.

On Lok Senior Health Services Model Project (San Francisco, Calif.).—The program began as a 5-day week, day-care service for impaired elderly persons and was designed to accommodate the cultural and language needs of Filipino, Chinese, and Italian residents of the area. As it developed, it expanded its scope to make available a full spectrum of services including in-home meal delivery and in-home supportive services, as well as a 7-day week, center-based day care program.

Gila River Indian Community Older Americans Program (Sacaton, Ariz.).—Outreach/organization aides arrange for home-delivered meals, transportation to congregate meal sites, and interpreter services to obtain needed supportive services. AoA funding has now ended. The program is being continued under title XX.

Project HEAL (Tucson, Ariz.).—This project developed a comprehensive array of services, including in-home health care, day care, home-delivered meals, recreation and socialization, transportation, and advocacy services. Medicaid resources have made it possible to continue the project. Title XX after care providers have become qualified as providers of service for reimbursement.

Community-Based Program for Frail Elderly Requiring Mental and Physical Health Services (New York, N.Y.).—The grantee is demonstrating in a current grant a new and innovative mechanism to deliver a coordinated program of mental/physical health services and social support to the high-risk elderly in urban areas. Outreach, on-site mental and physical diagnostic screening, and case-finding are integral to the program's operation.

ITEM 4. RESEARCH AND DEMONSTRATION PROJECTS

Research and Experimental Authority With Regard to Alternatives to Institutionalization

Section 222 of the Social Security Amendments of 1972 provides authority for research, experiments, and demonstration projects related to health care reimbursement and financing policy in a number of areas, including day care, intermediate care, and homemaker services. As such, it offers one mechanism to study a variety of alternatives to institutionalization as an aid to making decisions in this area.

Within the Health Resources Administration, the National Center for Health Services Research and the Division of Long Term Care are currently supporting three efforts using the section 222 waiver authority:

(1) *Homemaker and Day Care Demonstration Experiments.*—The primary objective of the Homemaker Experiments is to determine whether homemaker service would provide a suitable alternative to the post-hospital benefits covered under the Medicare program. Day care services are being tested as an alternative benefit to services currently provided under Medicare Part B and Medicaid. This project involves six demonstration contractors and one overall evaluation contractor. The demonstration sites are at Syracuse, New York; White Plains, New York; Lexington, Kentucky; Providence, Rhode Island; Los Angeles, California; and San Francisco, California.

(2) *Triage—Coordinated Delivery of Services to the Elderly.*—The Triage project provides for a single-entry system involving the assessment of client needs, and the coordination and development of services to the elderly in a seven-town region of central Connecticut. Where needed services do not exist, Triage, Inc., works to develop such services in the seven-town region. The primary objective of the experiment is to determine whether the availability of a full spectrum of coordinated health and health-related services for the impaired elderly will result in better health outcomes and lower total life support costs than under the existing health care system.

(3) *Day Hospital Services in Rehabilitation Medicine—Albert Einstein.*—The primary objective of the Albert Einstein project is to determine whether a service (inpatient rehabilitation) traditionally given on an inpatient basis can, for certain selected cases, be provided in a day hospital setting at lower cost with no sacrifice in quality of care. Specifically, the experiment proposes to provide coverage of transportation and home training costs to offer maximum assurance of the patient's regular attendance at the day hospital treatment program. The

experiment will be conducted at the Bronx Municipal Hospital Center, New York City Health and Hospitals Corporation, which will provide day hospital rehabilitation services.

DIVISION OF LONG-TERM CARE, RESEARCH AND DEMONSTRATION BRANCH

CONTRACT NO.: HRA 106-74-172

Project period: June 28, 1974 to January 27, 1977.

Title: "Experiments and Demonstrations Authorized Under P.L. 92-603, Section 222(b)—Homemaker and Day Care."

Project directors, Dr. Philip Weiler and Mr. Larry S. Pickard. Project officer, Eileen Lester.

Funding: Fiscal year 1975, $241,951; fiscal year 1976, $26,000.

Institution: Lexington-Fayette County Health Department, 330 Waller Avenue, Lexington, Ky., Telephone: 606/278-5411.

Summary.—The specific objectives in this contract are for the contractor to demonstrate, experimentally, provision of two services, namely, Homemaker Services and Day Care Services, in order to: (1) determine the cost of providing each of these services; (2) compare cost of providing the two new services and the currently covered benefits (Skilled Nursing Facility Care and Home Health Services) under Medicare; and (3) determine and compare the extent to which the new services (as defined) will enable an eligible individual to reach and maintain his highest level of performance or will prevent or retard institutionalization as compared to the effectiveness of benefits currently provided.

Progress to date.—This Demonstration has been operational since May 1975. It is located in a public health agency serving the city of Lexington and Fayette County. Patients eligible to receive homemaker services has been referred by five general hospitals. Referral of patients for health-oriented day care services has come from physicians, hospitals, other health care providers, and social welfare agencies. After assessment by a team (physician, public health nurse, medical social worker) and development of a care plan based on need, the patients are randomized into a Control Group and into an Expanded Benefit Group. Both groups are entitled to receive the currently covered Medicare benefits and the Expanded Benefit Group is eligible to receive, in addition, either homemaker and/or day care services. This project is also evaluating the costs and the benefits of providing day care services to a sample of individuals eligible for Medicaid benefits. Reassessments are performed on participants in both the Control and Expanded Benefit Group at quarterly intervals for a period of one year. Data will be evaluated by a separate contractor.

CONTRACT NO.: HRA 106-74-173

Project period: June 28, 1974 to January 27, 1977.

Title: "Experiments and Demonstrations Authorized under Public Law 92-603, Section 222(b)—Homemaker and Day Care.

Project director, Mr. Hadley Dale Hall. Project officer: Eileen Lester.

Funding: Fiscal year 1975, $771,704; fiscal year 1976, $118,000.

Institution: San Francisco Home Health Service. 2940 16th Street, Suite 301, San Francisco, California 94103; Telephone: 415/864-6470.

Summary.—The specific objectives of this contract are for the Contractor to demonstrate, experimentally, provision of two services, namely, Homemaker Services and Day Care Services, in order to:

(1) Determine the cost of providing each of these services; (2) compare the cost of providing the two new services and the currently covered benefits (Skilled Nursing Facility Care and Home Health Services) provided under the Medicare program to its beneficiaries; and (3) determine and compare the extent to which the new services (as defined) will enable an eligible individual to reach and maintain his highest level of performance or will prevent or retard institutionalization as compared to the effectiveness of benefits currently provided.

Progress to Date.—This demonstration became operational in May 1975. It is located in the San Francisco Home Health Services, a non-profit agency providing comprehensive in-home services including homemaker-home health aide services. Homemaker services under the Demonstration are provided by the agency. Health-oriented day care services are provided to Demonstration participants by three community health providers. Two of these are located in hospitals,

one at Mount Zion Hospital and Medical Center and one at Ralph K. Davies Medical Center. The third day care center is located in the Garden Hospital Jerd Sullivan Rehabilitation Center. Referrals to this Demonstration have come from a number of sources. All homemaker referrals have come from San Francisco general hospitals. Referrals to the day care centers have been both post-hospital and from community health and social agencies. This Demonstration has had two assessment teams of physicians, public health nurses and medical social workers augmented by physician therapists, occupational therapists, and a nutritionist. The same research protocol has been followed in this Demonstration as in the other homemaker and day care projects. After assessment participants have been randomized into a control and into an expanded benefit group. In addition to a homemaker sample and a day care sample, this project has a sub-sample of patients who have received both homemaker and day care services. When intake was closed on March 31, 1976, this Demonstration had a study sample of over 1,000 patients. All patients are receiving quarterly reassessments and a new care plan based on needs is developed by the Team after each assessment. As in the other "222" Demonstrations data is being collected and analyzed by a separate Evaluation Contractor.

CONTRACT NO.: HRA 106–74–174

Project period: June 28, 1974 to January 27, 1977.

Title: "Experiments and Demonstrations Authorized under P.L. 92–603, Section 222(b)—Day Care."

Project director: Mr. Nitin H. Mehta. Project officer: Eileen Lester.

Funding: Fiscal year 1975, $179,000; fiscal year 1976, $30,000.

Institution: St. Camillus Skilled Nursing Facility, 813 Fay Road, Syracuse, New York 13219; Telephone: 315/488–2951.

Summary.—The specific objective of this contract is for the Contractor to demonstrate, experimentally, provision of health-oriented day care service in order to: (1) determine the cost of providing such service; (2) compare the cost of providing day care services and the currently covered Medicare benefits; and (3) determine and compare the extent to which the day care service (as defined) will enable an eligible individual to reach and maintain his highest level of performance or will prevent or retard institutionalization as compared to the effectiveness of benefits currently provided.

Progress to date.—This Demonstration became operational in June 1975. This project is located in a non-profit skilled nursing facility having 125 beds which, in addition to its inpatient services, has an organized outpatient service department. Patients eligible to receive health-oriented day care services have been referred by the acute general hospitals serving the Syracuse community. After referral an Assessment Team of physician(s), a public health nurse, and a medical social worker, determine the patients' functional status using an assessment instrument and following research protocol developed for the Demonstrations. After assessment and development of a care plan based on need, the patients were randomized into a Control Group and an Expanded Benefit Group. Both groups are eligible to receive currently covered Medicare benefits and in addition, the Expanded Benefit Group has entitlement in health-oriented day care services for a period of one year. Reassessments of participants in both the Control and Expanded Benefit Groups are done quarterly for a period of one year. Data will be evaluated by a separate Evaluation Contractor. The final report of the Demonstration should be available in the Fall of 1977.

CONTRACT NO.: HRA 106–74–175

Project period: June 28, 1974 to January 27, 1977.

Title: "Experiments and Demonstrations Authorized Under P.L. 92–603, Section 222(b)—Day Care."

Project directors: Ms. Charlotte M. Hamill and Mr. Robert Oliver. Project officer: Eileen Lester.

Funding: Fiscal year 1975, $296,213 and fiscal year 1976, $6,000.

Institution: Burke Rehabilitation Center, 785 Mamaroneck Avenue, White Plains, New York 10605: Telephone: 914/948–0050.

Summary.—The specific objective of this contract is for the Contractor to demonstrate, experimentally, provision of health-oriented day care service in order to: (1) determine the cost of providing such service; (2) compare the cost of providing day care services and the currently covered Medicare benefits; and (3)

determine and compare the extent to which the day care service (as defined) will enable an eligible individual to reach and maintain his highest level of performance or will prevent or retard institutionalization as compared to the effectiveness of benefits currently provided.

Progress to date.—This Demonstration became operational in June 1975. The day care project is located in a separate building on the grounds of the Burke Rehabilitation Center, an inpatient comprehensive rehabilitation facility. It also established in 1972, a day hospital program to demonstrate the value of on-going therapeutic rehabilitation services to patients who did not require 24-hour inpatient care. Referral sources for this Demonstration project have been non-hospital community based health and social welfare agencies. All eligible referrals have been assessed by a team of a physician, nurse, and medical social worker. After assessment of the patients' current functional status and a care plan has been developed based on need, the patients have been randomized into a Control Group and an Expanded Benefit Group. Both groups of patients have entitlement to Medicare, Part B benefits and the participants in the Expanded Benefit Group also have entitlement to health-oriented day care services for a period of one year. Reassessments are done quarterly and the data will be evaluated by a separate Evaluation Contractor.

CONTRACT NO.: HRA 106-74-176

Project period: June 28, 1974–January 27, 1977.

Title: "Experiments and Demonstrations Authorized under P.L. 92-603, Section 222(b)—Homemaker Services."

Project director: Mr. Edmond Perregaux, Jr. Project officer: Eileen Lester.

Funding: Fiscal year 1975, $135,969 and Fiscal year 1976, $2,000.

Institution: Homemaker-Home Health Aide Services of Rhode Island, 265 Melrose Street, Providence, Rhode Island 02907; Telephone: 401/781-8520.

Summary.—The specific objective of this contract is for the Contractor to demonstrate, experimentally, provision of Homemaker Services in order to: (1) determine the cost of providing such services; (2) compare the cost of providing Homemaker Services and the currently covered Medicare Part A services (skilled nursing facility care and home health services); and (3) determine and compare the extent to which the Homemaker Services (as defined) will enable an eligible individual to reach and maintain his highest level of performance or will prevent or retard institutionalization as compared to the effectiveness of benefits currently provided.

Progress to date.—This Demonstration project differs organizationally from the other three similar 222(b) demonstration projects testing the effectiveness of homemaker service for post-hospital discharged patients. The assessment team (physician, public health nurse, and medical social worker) are employed by Miriam Hospital which has a Research Unit to handle demonstration projects. This team will assess all patients and prepare care plans for them. The contractor, Homemaker Home Health Aide Services of Rhode Island, will be responsible for all administrative and fiscal data and will provide the homemaker service to the patients randomized into the Expanded Benefit Group. The Demonstration became operational in September 1975. All patients referred for homemaker services were in-patients at Miriam Hospitals and judged by their physicians to need continuing care after being discharged from the hospital. After assessment by the team and development of a care plan reflecting the individual patients' needs for homemaker and/or other available services, the participants were randomized into a Control Group and into an Expanded Benefit Group. Both groups were eligible to receive the covered Medicare benefits with the Expanded Benefit Group entitled for a one-year period to receive homemaker service if this was approved by the patient's physician. Quarterly reassessments following the research protocol developed for all the homemaker demonstrations are being done. The data regarding the participants' functional status, utilization and cost of services, as well as outcomes from care are being evaluated by a separate Evaluation Contractor.

CONTRACT NO.: HRA 106-74-177

Project period: June 28, 1974 to January 27, 1977.

Title: "Experiments and Demonstrations Authorized under P.L. 92-603, Section 222(b)—Homemaker Services".

Project director: Mr. Robert Desrochers. Project officer: Eileen Lester.

Funding: Fiscal year 1975, $212,788 and fiscal year 1976, $25,000.

Institution: Inter-City Home Health Association, 970 North Virgil Avenue, Suite 100, Los Angeles, California 90029; Telephone: 213/666-5551.

Summary.—The specific objective of this contract is for the Contractor to demonstrate, experimentally, provision of Homemaker Services in order to: (1) determine the cost of providing such services; (2) compare the cost of providing Homemaker Services and the currently covered under Medicare Part A services (skilled nursing facility care and home health services); and (3) determine and compare the extent to which the Homemaker Services (as defined) will enable an eligible individual to reach and maintain his highest level of performance or will prevent or retard institutionalization as compared to the effectiveness of benefits currently provided.

Progress to date.—This Demonstration became operational in August 1975. Patients considered eligible for homemaker service are referred from a selected group of general acute care hospitals located in the Los Angeles community. The project has a team of a physician, public health nurse, and medical social worker who assess the functional status of all patients referred by the hospitals, and after developing care plans based on the need for continuing care, the patients are randomly assigned to a Control Group and to an Expanded Benefit Group. The Control Group is eligible to receive the post-hospital Medicare, Part A, continuing care benefits of skilled nursing facility care and/or home health services. The hospital discharge planners make arrangements for patients assigned to the Control Group to receive the necessary continuing care services. The Expanded Benefit patient has entitlement to homemaker services depending upon his need for a period of one year in addition to the covered Medicare, Part A benefits. Homemaker services under the Demonstration are provided to the eligible participants by a separate Homemaker Service Unit established within the contractor's organization. Data on the functional status, outcomes from the treatment received, costs and utilization of services by both the Control Group and Expanded Benefit Group participants will be collected and analyzed by a separate evaluation contractor.

GRANT NO.: HS 02563 (HS 01673)

Project period March 1, 1975 to March 31, 1980.

Title: "Triage: Coordinated Delivery of Services to the Elderly."

Principal investigator: Charles E. Odell, Commissioner. Project officer: Jean L. Bainter. Coproject officer: K. Mary Straub.

Funding: fiscal year 1975, $164,427; fiscal year 1976, $308,017; and fiscal year 1977, $427,440.

Institution: State Department on Aging, 90 Washington Street, Hartford, Connecticut 06115; Telephone: 203/566-2480.

Summary.—This research project is designed to investigate a model system of health care for the elderly. The system, called Triage, provides for the assessment of health status, and the prescription, organization, delivery, and financing of appropriate, comprehensive services. It is perceived as an effective and economic alternative to the existing system in which care is fragmented and, at times, prescribed according to financial considerations rather than health status or appropriateness. The research will be conducted in two parts—I, an analysis of the ability of Triage to reach its pre-determined goals, and II, a description of the operation and organization of Triage. Part I is a comparative analysis of Triage and the "existing" system. These are posted, in a cost-effectiveness sense, as alternatives, and the research directed towards testing a series of hypotheses derived from the major goals Triage is designed to reach. The hypotheses are that Triage will be more effective, less costly, and less dependent on institutionalization than the alternative. For research purposes, effectiveness is defined in terms of the outcome of care, costs as total life support expenditures, and institutionalization as days in a long-term or acute care facility. The samples are a group of Triage clients and a matched comparison group drawn from an alternative setting. Data, which will be collected for the duration of the experimental phase will be analyzed both statistically and in the context of the cost-effectiveness model. Part II is a descriptive study of the operation and organization of Triage as a system. It addresses the development and setting of Triage, its organization and costs, the population it serves—their socio-demographic characteristics and changes in health and other factors over time, the services it prescribes and their costs, and the providers it uses and their relation to the system.

CONTRACT NO.: HS 01938

Project period. June 30, 1975 to August 31, 1976.
Title: "Evaluating Information and Referral Services for the Homebound."
Principal investigator: Robert J. Newcomer, Ph.D. Project officer: Eileen Lester.
Funding: Fiscal year 1975, $24,003.
Institution: County of San Diego, Office of Senior Citizens Affairs, 1955 Fourth Avenue, San Diego, California 92101.
Summary.—The objective of this project is to compare the relative effectiveness of telephone and peer contact information and service brokerage systems in meeting the supportive service needs of homebound dysfunctional older persons. Essentially, it will provide an evaluation of five ongoing Administration on Aging funded programs that provide information and referral and in-home supportive services to aged persons.
Progress to date.—The research activities became operational in September 1975 and should be completed by the end of August 1976. A final report summarizing the research activities and the findings should be available in the fall.

GRANT NO.: HS 02580

Project period: June 30, 1976–June 29, 1977.
Title: "Adult Day Care Conference."
Principal investigator: Theodore H. Koff. Project officer: Mrs. Edith Robins.
Funding: Fiscal year 1975, $28,147 and fiscal year 1976, $15,000.
Institution: University of Arizona, Tucson, Arizona.
Summary.—This project will convene an invitational conference to develop a research strategy on Day Care based on a compilation of available knowledge relating to the health components of all models of Day Care ranging from the strongly health-oriented to the social model. The research strategy will incorporate such Day Care elements as costs, reimbursement patterns, existing regulations, staffing, patient mix, program size, admission criteria, assessment tools, and transportation.

GRANT NO.: HS 02510

Project period: July 1, 1976–June 30, 1979
Title: "An Empirical Basis for Nursing Home Meal Service."
Principal investigator: Todd R. Risley, Ph. D. Project officer: K. Mary Straub.
Funding: Fiscal year 1975, $71,974.
Institution: Department of Human Development, University of Kansas, Lawrence, Kansas 66045.
Summary.—The purpose of this project is to determine factors which affect nursing home residents' consumption of foods. The specific objectives are: (1) identify the proportion of variance in nursing home residents' food consumption that may be accounted for by the foods themselves; (2) by the conditions of meal services, and; (3) to use this information to provide practical recommendations which will assure reliable and independent consumption of food to meet the Recommended Dietary Allowance of Nutrients. The procedures to be followed include: obtaining reliable measures of the food consumption of the residents in a nursing home around the clock for two three-week menu cycles; analyzing the data and determining the nutrient intake of each resident; choosing new food items high in nutrient consumption, correlating food nutrient with food consumption; investigating the effects of meal service ecology and staff interaction with residents and evaluating the practical effects which menus constructed from empirical data on food and nutrient consumption can have on the nutrient consumption of nursing home residents. The study will be conducted in two 100 bed proprietary skilled nursing homes in Lawrence, Kansas.

GRANT NO.: HS 02627

Project period: April 1, 1977 to March 31, 1979.
Title: "The Family and Long-Term Care."
Principal investigator: Arthur C. Hollister, M.D. Project officer: Jean L. Bainter.
Funding: Fiscal year 1977, $124,565.
Institution: California State Department of Health, 2151 Berkeley Way, Berkeley, California 94704; Telephone: 415/843–7900, Ext. 391.

Summary.—The broad objectives of this study focus on two major aspects of long-term care: (1) the role of family structure and functioning as determinants of subsequent placement of chronically ill or disabled members in a long-term care institution; and (2) the role of the family in the provision of long-term home care for the disabled.

The first objective will be approached utilizing data available from a longitudinal study of health and ways of living conducted among Alameda County adults over the period 1965–1974. These data will permit analyses of various aspects of family structure, such as size, age and sex composition of disabled members. Additionally, other analyses on the impact of chronic illness and disability on family health, stability, happiness and psychological well-being are also contemplated.

The second objective involves the development and application of a survey instrument for the study of the long-term care needs and problems of disabled persons living at home. This instrument will be employed in a study of 150 households drawn from a sample of disabled persons identified from the longitudinal study. The new study will examine the full range of problems associated with home care including needs for personal care services and for social interaction.

Appendix 2

RESPONSES TO HEALTH CARE FINANCING ADMINISTRATION TESTIMONY [1]

ITEM 1. LETTER FROM STAFF DIRECTOR, SENATE COMMITTEE ON AGING, TO REPRESENTATIVES OF NATIONAL AGING ORGANIZATIONS TRANSMITTING TESTIMONY OF MR. ROBERT DERZON, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, AT JUNE 15, 1977 HEARING

JUNE 17, 1977.

As a followup to the committee's invitation to you to submit written testimony for our hearing record on "Health Care for Older Americans: The 'Alternatives' Issue," we thought you would be interested in this statement from the new Director of the Health Care Financing Administration, who testified on June 15. I'm also enclosing excerpts from the HEW Secretary's recent testimony before the Ways and Means Committee on hospital cost containment.

During questioning, Mr. Derzon readily acknowledged that the hearings had caused him to focus his attention on the many issues discussed at the hearings in which you participated.

When asked by Senator Chiles who at HEW "is in charge" of the continuum of care mentioned in his statement, he said that it is clear at the moment that no one is, but that this issue should receive early and sensitive attention.

He also said that he would look into many other matters raised by Senators Chiles and Domenici.

His frankness and concern were very welcome. We intend to work closely with him and other HEW representatives on followup activities in the near future.

In the meantime, if you wish to submit an addendum to your earlier testimony, based on Mr. Derzon's comments, we'd be glad to have it by July 8.

And thanks once again for all your help.

Sincerely,

STAFF DIRECTOR.

ITEM 2. LETTER FROM CONSTANCE HOLLERAN, DEPUTY EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS DIVISION, AMERICAN NURSES' ASSOCIATION, INC.; TO WILLIAM E. ORIOL, DATED JULY 5, 1977

DEAR MR. ORIOL: Thank you for sharing Mr. Derzon's testimony of June 15, 1977.

It is really very heartening to see the openness and interest expressed in that statement.

We agree with him that alternatives to institutional care cannot always be utilized. The best interest of the patient may only be able to be met in certain situations, by a period of institutional care. If that is the case, of course, we feel that the quality of that care must be higher than is often the case now. Staffing in some nursing homes, as we have indicated time and time again, is often disgracefully inadequate.

As we mentioned in our testimony, we do feel there needs to be overall coordination and monitoring of the various home care services, and we do suggest that professional nurses are best able to do this. The concern is that all health needs be considered continuously. There are major changes needed in the medicare law, and we hope these can be faced up to soon.

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[1] See additional testimony and statements in hearing records of May 16 and 17, 1977, "Health Care for Older Americans. The 'Alternatives' Issue," parts 1 and 2.

The creation of HCFA causes us some concern about a potential overemphasis on cost factors at the expense of people's health needs. We do hope the policy direction and joint planning of PHS and HCFA will in fact occur.

We appreciate the diligence of the Special Committee on Aging in its constant effort to improve health care and other services for the elderly. We want to help in any way possible.

Sincerely yours,

CONSTANCE HOLLERAN.

ITEM 3. LETTER FROM PETER W. HUGHES, LEGISLATIVE COUNSEL, NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS; TO WILLIAM E. ORIOL, DATED JULY 6, 1977

DEAR BILL: Thank you for providing us with an opportunity to include a statement in the hearing record on "Health Care for Older Americans: The 'Alternatives' Issue." We also appreciate your sending us a copy of Robert Derzon's testimony.

It appears to us that two central tasks must be addressed at this time. The first is to develop greater continuity among existing services and programs. The second is to broaden the continuum of available health care resources in the area of long-term care.

Related to these tasks is the overriding need to develop some mechanism to ensure that eligible recipients receive the proper mix of services to which they are entitled. Mr. Derzon illustrated the current morass associated with the provision of home health services. The great amount of disparity in the various home health programs is a source of confusion to professionals and lay persons alike. Thus, while efforts are made to increase coordination and broaden the benefit package, steps must also be taken to guarantee that older patients will be provided with sufficient guidance to enable them to obtain services commensurate with their needs.

Our associations' Federal and State legislative objectives for 1977 outline the spectrum of services required to satisfy patient needs. As a priority item, we have identified the necessity of developing a long-term care services program which provides a complete continuum of coordinated nonsocial services through a community network.

A related legislative remedy pertains to a liberalization and classification of the conditions of eligibility for home health care under medicare. Present restrictions should be removed with respect to reimbursement for home health care, in-patient and out-patient mental health services, day hospital care, and care provided by physician extenders and other paraprofessionals in primary care facilities such as rural clinics and community mental health centers.

We would also like to see a greater degree of elderly consumer representation on the governing and policy making boards of the various entities which comprise this spectrum of services. A related consideration is the need to develop geriatric-oriented training programs for the different categories of health personnel that provide these services.

While all of these items are of paramount importance, it should be recognized that a central issue at this juncture is the control of health care costs. Our associations have taken the lead in supporting the administration's Hospital Cost Containment Act. Although caps on hospital costs represent only an interim measure, we firmly believe that this is the only legislative proposal to date which merits serious consideration.

We fully agree with the proposition that the aged require a broader array of health and social need related services. We are cognizant, however, that such an expansion is unlikely in the context of a rapid rate of inflation in the health care sector. It would be helpful, at this point, if other individuals and groups which share an interest in the aged would join forces to support cost containment initiatives. Doing so would increase the likelihood that other highly sought-after objectives might be attained.

Finally, we are pleased to see that there is a greater recognition of the need to have concrete data on the costs and consequences of various forms of out-of-institution health care. It has long been argued that nursing home care is more expensive than the different types of non-institutional care. If it turns out that this is not always the case, then proponents of this view will be placed in a some-

what weaker position in advancing their cause. The various on-going studies should be most beneficial in providing policymakers with the information needed to design a network of services that meets patients' needs while still being fiscally responsible.

As usual, your hearings on this important subject were both thorough and timely. Again, we appreciate the opportunity to play a role in them.

Sincerely,

PETER W. HUGHES.

ITEM 4. LETTER FROM STANLEY J. BRODY, PROFESSOR, DEPARTMENT OF RESEARCH MEDICINE, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA., TO WILLIAM E. ORIOL, DATED JULY 6, 1977

DEAR BILL: In response to your letter of 16 June 1977, in re the submission of an addendum to earlier testimony, may I make the following observations:

The testimony by Robert Derzon, Administrator, Health Care Financing Administration, discusses home care and long term care under medicare in the single dimension of cost. While cost is a major consideration, I would submit it is not the first question and certainly not the only question. The issue that should be initially considered by policymakers, whether administrative or legislative, is what is the most effective and acceptable spectrum of long term support services which maximizes the level of functioning of the elderly. Services, whether in the community or in institutions should be examined and developed in keeping with their appropriateness to achieving this goal as Mr. Derzon points out in his introductory statement.

The tunnel vision of a cost centered approach forecloses considerations of what is best for the individual, the family, and the community. The limited focus of Mr. Derzon's testimony on medicare is reinforced by the Federal Register of June 28, 1977, in which the Long Term Care Unit is removed from the Public Health Service to the Health Care Financing Administration. Program effectiveness and costs are interrelated but arise from different perspectives. A sound policy decision should consider the priority of the program first and then modify that judgment by the availability of fiscal resources. The abolishment of the Office of Long Term Care and its transfer to HCFA raises serious questions affecting the welfare of the frail elderly. The contents of Mr. Derzon's opening statement must be reconciled with his discussion of medicare before a clear policy emerges which can be evaluated by the aged and those interested in their welfare.

Sincerely,

STANLEY J. BRODY.

ITEM 5. LETTER FROM PETER D. ARCHEY, EXECUTIVE DIRECTOR, BERKS COUNTY OFFICE OF THE AGING, READING, PA.; TO WILLIAM E. ORIOL, DATED JULY 7, 1977

DEAR MR. ORIOL: Thank you very much for sending the copies of testimony by Secretary Califano and Mr. Derzon with your letter of June 16. I am pleased to have the opportunity to add comments, as you offered in your letter.

My additional comments on Mr. Derzon's paper are as follows:

(1) A service system is needed which includes a host of options and service alternatives which provide the right service, at the right time, at the right cost, by the right agency. As suggested by Mr. Derzon, the system should not only be talking about alternatives to institutional care but about a continuum of care which truly serves people with the right choice or option for their specific need. Hopefully, the enthusiasm and interest shown by Mr. Derzon at the hearing will result in further attempts to develop this type philosophy and service approach.

(2) As stated at earlier hearings, it is critical at all levels that some unit literally be in charge of the system. Apparently Mr. Derzon is aware of the problem that HEW has considerable fragmentation and significant lack of definition as to responsibility for home care and other service options. His statement that the issue should receive early and sensitive attention is a positive and hopeful sign.

(3) The service system developed with an adequate range of services and options must be a regulated system, well monitored at all levels and based on client need, rather than reimbursement. Mr. Derzon appears to be conscious of this need and supportive of strong program, fiscal, and client monitoring.

I would also like to add some comments on Secretary Califano's comments as follows:

(1) The HEW intent to develop a single reimbursement form which all third party payers could use is a move which should save time and provide more efficient administration.

(2) The statement seems to be discussing a few options and alternatives but does not focus on the necessity for a wide range of services and options, one of which is appropriate hospital in-patient care.

(3) There is little mention of the necessity to provide a sufficient inventory of home care options or alternatives, both as an alternative to hospital care and as the preferred and appropriate choice of service in the community.

(4) The service options should also include outpatient services when appropriate.

(5) Reimbursement must follow the patient/client needs; many options are not funded now. This is especially true of non-medical services.

(6) As listed in our comments on Mr. Derzon's statement, a service system, including the hospital option, must be publicly regulated. There is obvious need for HEW to quickly and forcefully decide on how the various pieces of legislation relate and how regulation should be done and by whom. This includes the fragmentation now between regulating medicare, medicaid, title XX, health systems agencies, professional standards review organizations, etc.

(7) All changes introduced and any system development should focus on a person needing service on a local level, entering and moving appropriately through the service system. This client based, local focus is often missing in program and funding development. The end product or the bottom line is the service delivery to the individual client in a local community. This also should be the basis of monitoring and evaluation and is an obvious reason why some local body has to be responsible for insuring that people can enter and move through a service system.

I hope these comments are helpful. I appreciate the opportunity to provide them. My thanks for the opportunity to testify at the hearings and for your kind assistance in providing additional reference material.

Sincerely,

PETER D. ARCHEY.

ITEM 6. LETTER FROM JEROME KAPLAN, PUBLIC INFORMATION CHAIRPERSON, GERONTOLOGICAL SOCIETY, WASHINGTON, D.C.; TO WILLIAM E. ORIOL, DATED JULY 12, 1977

DEAR BILL: I am responding to your letter of June 17, 1977 to Ed Kaskowitz in my capacity as the public information chairperson of the Gerontological Society. This written commentary are my own views. I am, however, sending copies of my letter to our public information committee suggesting they write to you directly on any aspect they wish as it pertains to the testimony of Robert Derzon. I do wish, however, to make the following notations:

The alternatives issue will continue to plague us as long as we use terms like "alternatives" with ambivalence, on the one hand referring to it as a substitute and on the other as an added service. Further, we keep using this term primarily as a release from institutionalization instead of putting the entire concept into the continuum of care module. This is consistently tied in with the point that nursing homes, for example, began their initial great growth in the 1950's and early 1960's due to societal pressure, not governmental decree, and that families in general apparently are not able to cope with the psychological, nor economic nor time demand pressures of an aged ill person in their home.

We are not in an alternatives stage; we are in a continuum of services stage. The more services we provide, the more people who are not in an institution "come out of the woodwork", so to speak, who are in need of them. I had rapproached the alternatives concept for 6 years as the previous editor-in-chief of The Gerontologist but terms fostered by government die hard because of all the governmental resources available to perpetuate them. If there must be an alternatives issue, then it should be one of alternatives to care in one's own home. The perspective then undertakes a radical change.

Tied in with this and of greater import is the administration's focus on cost containment rather than a primacy of focus on the functioning of the aged. Qualified administrators first look at needs of people, then how and to what extent can one meet these needs. To focus on a cost centered approach—when, in

fact, much of the added health care costs are due to governmental directions whether legislative or regulatory—is to push elderly services into a framework of how do we meet the needs of our regulators not those who are to be served. The removal of the Long Term Care Unit from the Public Health Service (Federal Register, June 28, 1977) to the Health Care Financing Administration is a reinforcement of this focus on costs, but not of program. I would strongly urge a reinforcement of the priority of program albeit within the exigencies of fiscal resources, of course.

Mr. Robert Derzon's opening statement and his medicare views do not appear to be synonymous. I am left with a feeling there is no aged policy but the beginnings of a massive bureaucratic effort to contain certain kinds of costs. The program aspects appear to be essentially those undertaken through legislative effort. The administrative view comes close to being one of how can we contain the wishes of Congress.

Sincerely,

JEROME KAPLAN.

ITEM 7. LETTER AND ENCLOSURE FROM HADLEY D. HALL, EXECUTIVE DIRECTOR, SAN FRANCISCO HOME HEALTH SERVICE; TO WILLIAM E. ORIOL, DATED JULY 8, 1977

DEAR BILL: In reviewing the testimonies of Mr. Robert Derzon and Secretary Joseph A. Califano, Jr., it is clear that problems are stated briefly and with precision.

Secretary Califano's presentation of May 11, 1977 is a welcome statement. The only quarrel with his remarks might be that "long term cost containment strategy" cannot be viewed in isolation (or after) "hospital cost containment." That is, alternatives must be available for those currently being institutionalized inappropriately. It is not clear that Secretary Califano understands that with alternatives and hospital cost containment people would be better served at more appropriate costs.

Mr. Derzon's reputation is excellent and of long standing. Although I do not know him well, many local people—for whom I have great respect—are supporters of Mr. Derzon. No person could grasp the details contained in the document in so short a time. Therefore, knowing something of Mr. Derzon's work, reputation and writing, I have concluded that a typical, fragmented, uncoordinated committee—focused on self interests—prepared the testimony.

The fact that Mr. Derzon did not bring with him representatives of the Bureau of Health Insurance or the Social and Rehabilitation Services is curious—especially since the document reiterates untenable positions held by these agencies—positions which prevent in-home health services from being offered to people who are otherwise candidates for institutional care.

The major deficiency in the document is that the funding under title XX (and title III of the Older American Act) for in-home health services is described as something apart from in-home health services funded by medicare and medicaid. In other words, public servants have presented language that seems to justify the continued fragmentation of in-home health services—while deploring this very fact.

Rather than provide justifications for my conclusions—by a paragraph by paragraph review—I am enclosing a copy of a recent speech which attempts to state my major concerns.

Thank you for allowing me to review and comment on these important matters.

Cordially,

H. D. HALL.

[Enclosure.]

ISSUES IN HOMEMAKER-HOME HEALTH AIDE SERVICES

(By Hadley Dale Hall)

We, in the United States, are a big spending, big consuming, and most generous nation of people. We spend more to consume food, oil, housing, medical care and most other goods and services than any society known to historians. An obvious exception is spending for consuming of homemaker-home health aide services. History will record, in the final analysis, that we have not always spent or consumed our resources wisely.

In our early history, we gave enormous land grants to private railroad companies, at the same time we gave modest land grants for institutions of higher learning. When we had more children than space for them in our schools, we built more schools and trained more teachers for the classrooms. As medical knowledge and technology achieved the capacity to alleviate many of our acute and communicable diseases, we built medical schools and hospitals so that our medical professionals could practice their sciences and arts and so that our people could become well. When we recognized that there were large numbers of elderly poor, we enacted social security to insure an income for nearly all workers who had contributed their labor during prior years. When handicapped children were seen and acknowledged, a well-funded program for crippled children's services was established. In all of these situations, a need was recognized and, following the recognition of the need, resources were granted to meet the need.

History will repeat itself. Homemaker-home health aide services are needed—in a very short time, our generous people will supply the resources to meet these needs. We will be big spenders and consumers of homemaker-home health aide services. But, just as history repeats itself in meeting the needs of people, some of the abuses of our generosity may be repeated, also.

If we are to be wise, then, it is appropriate to examine some of the issues related to homemaker-home health aide services, and to plan for an orderly and prudent use of the resources which will be available very soon.

The most critical issue related to homemaker-home health aide services is the absence of a policy for "long-term care." Billions of dollars support a fragmented and uncoordinated system, which encourages the institutionalization of people—too often inappropriately. This situation is the direct result of restrictive, fragmented and uncoordinated funding sources, which exist currently. One only needs to mention medicare, medicaid, title XX, the Older American Act, Hill-Burton, and private insurance policies, among others, to appreciate these facts. The absence of a policy on "long-term care" means we spend billions on horizontal care (care delivered to a person in bed) for about 5 percent of the population, while only a few million dollars are used to prevent, reduce or postpone the need for horizontal care.[1] Of the few millions spent on in-home health services, an unknown (but insignificant) amount is used for homemaker-home health aide services.

Well funded homemaker-home health aide services will not mean that those in the institutional system will rise up and leave their beds, or that those "places" will be needed no longer; but, well funded homemaker-home health aide services will mean that there should be reduced need for institutional care and cost savings.[2]

You will all recognize the last statement as the "cost-effectiveness" argument: "reduce the need for institutional care and save money." This spurious argument is very much in vogue and the argument is applied to many areas. In homemaker-home health aide services, costs are not defined or determined, so that colleagues cannot compare the programs in New York with programs in Los Angeles and Chicago.

No one is opposed to determining cost or to measuring effectiveness. But, there is little agreement about what is included in cost (and compared to what) and effectiveness must be measured against the expensive alternatives.

For example, medicare has required an inadequate, but uniform, cost report, and has a modest data collection system. The medicare cost report identifies and allows inclusion of costs for:

(1) Recruitment and screening of home health aides;

(2) Orientation and in-service training of all staff;

(3) Supervision of patients and home health aides by appropriate professionals:

(4) Actual expenses for clerical, business, accounting and statistical activities;

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[1] For a more complete discussion of purposes of care, levels of care, and expenditures, see: Trager, Brahna: U.S. Congress, Senate: Home Health Services in the United States: A Report to the Special Committee on Aging: Washington, D.C., U.S. Government Printing Office. LaVor, Judith and Callender, Marie: *Medical Care:* October, 1976: vol. XIV, No. 10, "Home Health Cost Effectiveness: What Are We Measuring?", pp. 866–872.

[2] See Meyers, Robert J.: Actuarial Cost Estimates for Hospital Insurance Act of 1965 and Social Security Amendments of 1965. Actuarial Study No. 59, U.S. DHEW: Social Security Administration, January 1965.

(5) Travel time and expense of staff;
(6) Overhead costs; and
(7) Administrative expenses.

In the San Francisco Bay Area, there are 12 home health agencies. Not one has costs for Home health aide services below $10 per hour.

In many States, Medicaid uses the same data and rules for determining costs that are used by medicare; but then pays a maximum amount—sometimes less than 50 percent of cost. How can any program deliver services below cost for very long? They go bankrupt or are dishonest in other ways, as history has taught us repeatedly.

In title XX, we see "competitive bidding" and "contracts," both of which allude to the same cost factors and describe, essentially, the same services—trained and supervised homemakers. These bids are anywhere from $3.25 per hour to over $9 per hour.

The point is: no two funding sources are alike in defining what is included in cost or in what the funding source will pay for services.

The issue of effectiveness must also be addressed. Homemaker-home health aide services have been advanced as alternatives to hospitals, skilled nursing facilities, intermediate care facilities and other institutional providers. As LaVor and Callender point out: ". . . one would expect that the many statements about cost effectiveness would take the differences among these institutions into account. . . . While home care will not always replace a hospital stay, it can shorten it. Other levels of home care must be examined in relation to equivalent levels of institutional care in order to be evaluated fairly" (pp. 870 and 871).

The "cost-effectiveness" argument is a "red herring" if by that we mean the argument is offered to divert us from more important considerations. The "cost-effective" argument has been used historically when deciding if we were going to meet specific needs; but, it has seldom been a determining factor in long term policy formation. The extent of need may have been a factor; cost may have been a consideration; priorities may have been a part of the equation; an immediate political consideration may have played its part; but "cost-effectiveness" as an argument has proved false in health care, education and in war, even though it has always been used.

Highways were not built because they were "cost-effective." Amtrak is not cost effective. Schools were not built because they were "cost-effective." The over-building of hospitals was not financed with our money because they were "cost-effective." They were built because we thought they were needed—we decided they were needed.

Homemaker-home health aide services are going to be funded, too; because we think they are needed; we believe they are humane; and we have already decided that we will not continue to use our resources to build expensive installations of bricks and mortar for the "warehousing" of our loved ones, because that solution has proved ineffective, costly and inhumane.

The facts are clear. The population of the elderly, the disabled and those with chronic conditions is increasing in number and percent of the population—and they will continue to live ever longer. Medical technology has eliminated most of the communicable diseases and many of the acute conditions of these groups. However, we have not reversed the process of aging, eliminated poverty, or prevented the chronically disabling conditions. There is a growing number of people with "long-term care" needs. Those needs are going to be satisfied to a very large extent through homemaker-home health aide services, regardless of cost. Let us design these services so that they will be effective, and humane.

From the foregoing, several issues can be identified:

(1) There is a growing need for "long-term care";

(2) The alternatives to good homemaker-home health aide service are not acceptable, whether they are "cost-effective" or not;

(3) Horizontal care is to be discouraged;

(4) Vertical care is to be encouraged;

(5) The concept of "long-term care" has been identified but has remained imprecise and generally ill-defined—no single accepted definition has developed;

(6) There has been fraud of our generosity by institutions and by providers of homemaker-home health aide services, regardless of the funding source;

(7) There has been recipient abuse; and

(8) The homemaker-home health aides have been treated without dignity and in violation of laws and morality.

This institute and its workshops identify other issues of critical importance:
(1) Organizational structure for providers;
(2) Training and supervision of homemaker-home health aides;
(3) The relationship of the services to the legislative process;
(4) Special service needs and methods to meet those needs in rural areas;
(5) Helping the developmentally disabled; and
(6) Dealing with abused and neglected children and their adult caretakers.
Still other issues can be listed:
(1) The relationship between law and regulations and the programs of service delivery;
(2) The relationship between the many units of Federal, State, regional, and local governments and the providers and recipients;
(3) The issue of accountability—accountability to whom and for what—including fiscal accountability and outcome accountability;
(4) The need, design, implementation, and uses of a data system which allows questions to be answered and services to be expanded and improved;
(5) The issue of "profit-taking" in tax supported human service programs;
(6) Licensing, certification and standards for providers and employees;
(7) The role of volunteers;
(8) The issues of budgeting, prospective budgeting and audits by and for governments and providers; and
(9) Employer-employee issues, including employer paid benefits and collective bargaining agreements.

The list of issues could be expanded. It is not practical in one Institute or presentation to discuss very many of the issues which have been identified. One issue, however, is overriding: How is the homemaker-home health aide to be treated?

The backbone of any system of "long-term care" is the paraprofessional work force. This is true in other countries, in our facilities of "long-term care" and in the facts of the individual circumstances of the patients with "long-term care" needs. Even in acute hospitals, the labor force and labor costs for paraprofessional services are greater than the professional labor force and its costs.

In any system of "long-term care," regardless of where the care is given, certain basic activities must be performed: there must be an hygenic environment (the housekeeping staff who does the cleaning); there must be nutritious food available to the patient (the purchasing and kitchen staff who do the shopping and cooking); clean bed linen and clothing (a staff who does the laundry); the ability to move from place to place (the staff who transports the patient or assures their safety in going from room to room or place to place); and attention to "personal care" (someone to wash a face or touch the person in need of "long-term care"). In other words, "long-term care" requires cleaning, shopping, cooking, laundry, transportation and personal care. Depending upon individual circumstances and place of care, more attention will be needed or given to each activity and the intensity of an activity will vary from day to day. Each activity can, and usually is, performed by paraprofessional personnel. Since this is truly universal, and because the paraprofessional person is the "backbone"—the key personnel—in caring for people at home, we had better be certain that the "backbone"—the key people—are strong, reliable, and competent for the tasks.

We cannot assure a competent, reliable and strong work force with the current employment practices of homemaker-home health aides. Let me share with you the principles by which I believe we should address this issue:

(1) All work is dignified. People who sweep our streets do dignified work; buyers of furs for stores do dignified work; chefs are treated with dignity for their culinary talents; the presser in a laundry is treated with dignity; bus drivers are treated with cautious respect—if not dignity; and the doctor who does a rectal examination is treated with dignity. The homemaker-home health aides also do dignified work when they sweep the floor instead of the street; shop for simple, but nutritious food, or clothing instead of furs; cook a bland meal as part of a diet, instead of a spicy sauce; help a patient ambulate instead of driving a bus; or clean an incontinent patient, instead of giving a diagnosis of the bowel. Too many of our colleagues have an "identification with the aggressor"—an identification with critics who say: "a little housekeeping shouldn't cost so much." Until the leaders of homemaker-home health aide services vigorously challenge the sexist belief that cleaning, shopping, cooking and laundry

are not of great value—that those activities are expected for nothing, or very little—homemaker-home health aide services will not achieve a dignified status;

(2) If homemaker-home health aide services are dignified activities and work, then they must be compensated for the work with dignified earnings. You know that the street sweepers earn over a thousand dollars a month plus several hundred dollars a month in employer paid benefits; you know that fur buyers are paid and on "expense accounts" when they travel from place to place seeking their merchandise; you know that the chefs of restaurants have a month's paid vacation and any number of paid holidays; you know that the presser of starched shirts gets "rest breaks" and increased wages with seniority and greater skill; you know that bus drivers receive medical, major medical and dental insurance, plus a generous retirement benefit for past work; and, comments about the dignified earnings of physicians need not be mentioned. Until the administrators and leaders of homemaker-home health aide services recognize and demand dignified wages, with an appropriate package of employer paid benefits for those who do cleaning, shopping, cooking, laundry, ambulation and personal care, there will be no strong, reliable and competent work force. We cannot treat homemaker-home health aides as casual and unimportant laborers. These workers must have the security of regular earnings increasing wages with skill and knowledge, the same benefits granted to nurses and social workers and the security of retirement without economic eligibility for welfare.

(3) There must be dignified support. The street sweeper is not expected to buy the broom or machinery to sweep the streets; the fur buyer is expected to have too many or too few of an item; the shirt presser in the laundry will have shirts to do over; the chef will have souffles that fall; the bus driver will have accidents; and the doctor will need consultation. The homemaker-home health aides are key employees, working with people who have "long-term care" needs. They must have inservice training, which is meaningful and related to their capacities; they must have the physical tools to do their work. Closely related to dignity and income is the need for dignified support. If a physician or a nurse makes a mistake, their supervisors and colleagues defend and support them. The turnover of nurses' aides in hospitals and nursing homes, and of homemaker-home health aides in in-home health service agencies, is exceedingly high. It is not always caused by a lack of dignified work, or because of a lack of decent pay, it is also caused by lack of dignified support through in-service training programs and a commitment to, and understanding that, most workers can and will do things right, when given a chance. The continued building of the knowledge and skill which enables paraprofessionals to do their best work creates workers who become experts in their field. This is what dignified support means.

(4) Dignity of self respect: "dignified" people do not permit the lack of social recognition to depreciate their self esteem. For people to work with dignity, therefore, they must be acknowledged by the community, properly, in several ways. Respect and dignity mean we assign value to an individual's actions, allowing them to exercise their judgments and powers within those established limits they help to build for themselves. In other words, dignity and respect are not made the work of just one person. They are built up where any group of people contribute to a body of knowledge and experience. In our services, the homemaker-home health aides and their colleagues have tested the ideas and the practices that have the best results. And, in our services, dignity and self respect result when responsibilities and opportunities for participating in decisions are encouraged and made a part of the plans.

(5) Dignified organization: Workers in most fields find their greatest strength in working together to bring about changes or to prevent destructive laws or rules which they know are unfair to them, or unwise or unfair to the community they serve. They try to find, with other groups like themselves, a common ground so they can work together. They try to decide, with groups like their own, how to act together for better understanding. They try to develop methods of action so that the people who do not understand that they, or the people they serve, are being unfairly treated. They develop methods of action so that people will know what is happening and correct the bad and expand the good. They can only take these steps when they understand the value of what they have to offer. Our services are long past the stage when they can be considered casual, unimportant labor. We understand that. And, if we have that conviction, there is every reason to insist that, like everyone else working in the field of health and welfare. wages, working conditions and the standards of our services be given serious, dignified and respectful attention.

ITEM S. LETTER AND ENCLOSURE FROM FLORENCE MOORE, EXECUTIVE DIRECTOR, NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., NEW YORK, N.Y., TO WILLIAM E. ORIOL, DATED JULY 29, 1977

DEAR BILL: Thank you for your letter of July 17 and for the enclosure of Mr. Derzon's statement given at the June 15 hearing. As an addendum to the testimony submitted by the National Council (see copy attached) and in light of Mr. Derzon's statement, the National Council submits the following further comments.

The National Council is in complete agreement with the continuum of care concept articulated by Mr. Derzon. We urge that the Special Committee on Aging recommend that a ranking HEW official be put in charge of implementation of the concept and that coordinating mechanisms to help bring it about be developed by the federal departments and HEW agencies.

We are also in agreement with his main premise which is that the patient should receive the care that is best for him. We agree, too, that the disparity between separate funding authorities is a problem and hence the urgent need for the continuum of care concept and the coordinating mechanisms referred to above. He comments that consistency of definitions would be an aid in achieving quality services. We completely concur and ask that steps be taken immediately to arrive at a consistent definition differential between homemaker-home health aide service (or any aspect of that service, such as personal care) and chore service. The confusion between these two services is causing great difficulty across the nation in terms of clarity and appropriateness of the service being given.

We would draw to Mr. Derzon's attention that in his discussion of Medicaid he did not address the issue of the self-employed provider. This rapidly growing form of in-home service is raising serious question about: accountability, of public funds; safety of service to the consumer; and questionable, if not illegal, personnel practice problems for the self-employed provider. We refer Mr. Derzon to the testimony given at the hearing by Ms. Bloom and Mrs. Kinoy.

We commend the Department for planning to review the reimbursement practices that have allowed so-called not-for-profit agencies to "capture the equivalent of profits—in many cases extraordinary profits."

We wish to comment on Mr. Derzon's statement about the fears regarding the cost of homemaker-home health aide service, if funds were made available for its rapid expansion. Undoubtedly, there would be an increase in cost initially because there is a backlog of need. However, once the service is in place, and assuming it is quality service, the costs should level off and it would begin to save other costs such as nursing home construction and upkeep and corresponding costs in the hospital field, as well as monthly case costs. Furthermore, although it is almost impossible to prove or disprove, undoubtedly there would be other savings through prevention or amelioration of recurrent crises, emotional problems, lack of nutrition and so on. Certainly, an adequate supply of quality homemaker-home health aide services would have incalculable human benefits.

We are greatly encouraged by the potential role of the Public Health Service as spelled out in Derzon's testimony.

The Department will be interested to know that the National Council has found a very substantial interest on the part of the DHEW regional offices and states so in its project funded recently by AoA and referred to in Appendix C in Mr. Derzon's statement. There is much need across the country for aid in developing and maintaining in-home services of good quality through professional consultation and technical assistance.

The anticipated goals which Mr. Derzon and Mr. Califano expect to result from the reorganization within DHEW sound promising. We hope that the reorganization will indeed help to bring about the achievement of these goals.

We are particularly pleased that Mr. Derzon's closing statement referred to the need for quality service. We would add to his comment that quality service is a key way to maintain cost containment in in-home services.

We are most grateful for this additional opportunity to present comments to the Senate Special Committee on Aging.

Sincerely,

MRS. FLORENCE MOORE.

[Enclosure.]

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

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

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

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

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

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

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

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

—Attention must be given to the need for in-home services for the chronically ill and aged in need of long-term care. Only when this segment of our population is receiving the in-home services needed will the pressure to increase the number of costly institutions diminish or be kept to a minimum. Compared with Western European nations, the United States is seriously behind in its development of in-home services for the aged population and for

others. The difference appears to be directly related to the leadership provided by the European governments and to the level of government support for in-home services. Holland, for example, has almost 90,000 persons employed in the home help (homemaker-home health aide) field for a population of over 12 million.

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

ITEM 9. ADDITIONAL MATERIAL[1] SUBMITTED BY MARIE-LOUISE ANSAK, EXECUTIVE DIRECTOR, ON LOK SENIOR HEALTH SERVICES, SAN FRANCISCO, CALIF.

Since detailed documentation on On Lok Senior Health Services' experience with the development of a community-based "alternative" has already been submitted, we would like to take this opportunity to summarize some of our experiences and add some additional comments, particularly in support of Mr. Robert Derzon's testimony.

On Lok Senior Health Services was started in 1972 and was the outgrowth of the community's concern about its frail elderly. Due to cultural alienation, the Chinese, Filipino, and Italian elderly of this district, when disabled, faced a very special type of isolation in a nursing home far removed from the home. It was for this reason and the general suspicion of western medical institutions that the community searched for an "alternative." Over the years, it has become quite clear that On Lok's success with its participants is due mainly to the community's understanding of its elderly and its willingness to start and support an organization in its midst. On Lok grew "organically" developing new services or approaches as the need arose. Today, On Lok is well on its way (provided funding continues to be available) in its development of a "continuum of care" including social day health maintenance, day health services, in-home care, sheltered housing, respite care, and "hospice care" somewhat further down the line.

Perhaps the most important lesson On Lok has learned is the fact that its success is based on its flexibility, the recognition that only a system of "social health care" under the leadership of a multi-disciplinary team can start to solve the problems of the elderly.

There is no "alternative" to 24-hour nursing care. There comes a time when even the best coordinated and most flexible services no longer meet the average older person's needs at home. We have, however, found that for those On Lok participants who have the full range of the services offered (including sheltered housing), the period during which they might have to be institutionalized is sharply reduced.

We are convinced that different types of "community care systems" could be developed as "alternatives" which would provide a continuum of care, preferably in the neighborhood where the elderly live. On Lok has demonstrated one such model which has been flexible and able to respond to the "continuum of need" of the elderly. The frail elderly's problems cover their social, physical and mental existence and are inter-related and inter-dependent. Only a bureaucracy involved with the "mystique" and economics of technological medicine has difficulties in seeing a connection between a fourth floor rooming house, a man with a crippling stroke and portable meals. If it were understood and accepted as part of the total health problem, it would not be necessary to involve four different funding sources to provide "health" care (title XX for home chore services, title XIX for medical care, OAA titles III and VII for transportation and meals). Left after all this is the need for funds to cover coordination of services to this old man. Without coordination, the client is confused and gets too little or too much.

Coordination of services to the individual is crucial but so is coordination of funding sources. Without it, a program like On Lok's is doomed. On Lok has been developed under demonstration, model and pilot project grants. Its continued operation will depend on appropriate legislation which will permit the payment of comprehensive social health services. Only the State of California

[1] Also see "Health Care for Older Americans: The 'Alternatives Issue,'" part 1, appendix 2, item 2, p. 71.

has thus far made a modest move toward this by introducing AB 1611, a bill which, if enacted, will permit the development and reimbursement under Medi-Cal of day health services.

On the Federal level, the bill of the Hon. Barber B. Conable Jr., the Medicare Longterm Care Act of 1977, would allow for a type of funding needed for a community-based long term care organization such as On Lok.

The runaway cost of medical care is a rather universal topic and has been addressed in your committee by both Messrs. Califano and Derzon. Unfortunately, it seems hardly destined for a change until the medical profession is either willing or forced to change its methods. Particularly, the elderly are in urgent need of a shift towards a holistic health approach with emphasis on prevention and maintenance. Today, most of the seniors are still faced with fragmented, crisis-oriented and institution-based care.

We have found that individuals under the care of On Lok were able to maintain themselves in the community without the frequent acute hospitalizations. Frequently, On Lok staff has to intervene with a private physician to avoid hospitalization or unwanted elective surgery. However, it is the physician who makes the final decision and patients intimidated and without support and knowledge are reluctant to contradict and lose his service.

It would be important to force physicians to involve themselves more meaningfully with other members of the health team. At On Lok, we have a multi-disciplinary intake and assessment team composed of social workers, nurses, the medical director, physical and occupational therapists, and the dietitian. The discussions are lively, and contrary to trends in hospitals, the medical director is willing to concede.

On Lok has been able to demonstrate that community-based, longterm care can be provided at reasonable costs. Under the present arrangement with Medi-Cal, we are reimbursed a comprehensive daily rate which includes all services offered at the present time (intake and assessment as well as regular re-assessment by a multi-disciplinary team, transportation, meals, social services, nursing and medical care, physical, speech occupational and recreational therapies personal care, etc.). The $25.15 daily rate is paid only for those days the participants attend the center but includes services offered in the home such as portable meals, chore services, etc., on all the other days. This arrangement has worked out very well for our program and provided all participants (including those on medicare) would be paid the same rate, On Lok would be self-supporting.

Much discussion has also centered around the need for more research in the field of alternatives. Much has already been done, but unfortunately, again without general overall plan. On Lok's experience in one example. In 1972, the Administration on Aging decided to experiment with both the day care centers and day hospital concept. On Lok received a three-year research and demonstration grant. In 1974, an impatient HEW contracted with the Trans Century Corporation for an "evaluation" of day care in the U.S.A. On Lok was barely on its feet when this research team came to spend three days with us in San Francisco and then produced the report which has been the basis for many "definitive" statements about day care. Unfortunately, On Lok was (like most of the other "studied" programs) still in an embryonic stage and almost incapable of providing accurate data.

If more research should be needed, it is important to allow for sufficient scope, time and support to come up with definite figures. Otherwise, we would like to join those who question the need for more evaluation and point to all the experience that has been gathered in England and over the past few years in the United States. Could it be that we are demanding for research in order to avoid the real issue which calls for a re-organization of priorities?

Appendix 3

STATEMENT OF SAMUEL W. BROWN, JR., DIRECTOR, ACTION

I share with you a deep concern over the isolation, abandonment, and neglect that many older persons face in institutional settings. I strongly believe in home care services as a viable and less costly alternative, but only if these services offer an opportunity for companionship, community life, and social support. Otherwise home care itself would only perpetuate isolation and loneliness comparable to institutional settings.

Home care must be viewed in more than cost terms. It should provide an enriching experience for older persons, encompassing a full range of health, nutrition, social, and community support services (including housing and transportation).

For too long our society has failed to respond to the needs of older persons with chronic illness and other limitations, who with some assistance would be able to lead semi-independent, if not independent lives in a home environment. What is lacking is a strong governmentwide commitment to bring programs together to prevent the shunning and institutionalizing of millions of older people. It is estimated that as many as 40 percent of the elderly living in institutional settings are forced to do so because they lack acceptable alternatives—alternatives which provide care, and companionship. The evidence clearly points to the tragic effects of institutionalized living: deepening isolation, loss of privacy, forfeiture of rights, deprivation of family relations, and higher mortality rates.

I feel that this kind of treatment is unconscionable and unacceptable. When we talk about older Americans, we are talking about a generation of Americans who have worked hard, who have sustained this country through a depression and two world wars, and who brought the abundance of today's living to the rest of us. While many of us enjoy the fruits of their labors, older Americans once again struggle; this time their plight is compounded by inflation, isolation, and indifference.

I believe these hearings offer a serious opportunity to develop a plan of action designed to preserve the right that every older person has to live a decent and dignified life.

Through the senior companion program, ACTION is committed to this basic human right. Authorized under title II of the 1973 Domestic Volunteers Service Act, it is a grants program operated through local projects sponsored by public or private nonprofit organizations. The program, which is only 3-years old, has provided low income older persons with the opportunity to be of service to those in greater need.

First of all, it has created a cadre of advocates dedicated to protecting the rights of older Americans—and improving community support and services for the elderly.

Second, it has enabled many older people served under the program to remain in their own homes or communities, and avoid the tragedy of needless institutionalization, isolation, and despair.

Third, it has helped to prepare institutionalizzed or hospitalized persons to return to productive lives outside the institution.

Fourth, it has created an enriching experience for the participants by utilizing their skills and talents and sensitivity in assisting other older persons.

Initially, 18 projects were funded in mid-1974. Currently, there are 2,600 senior companions in 48 projects in the United States and Puerto Rico, sponsored by civic, church, government, and social agencies. They receive a nominal stipend of $1,600 a year and provide assistance to 6,000 recipients. Over 60 percent of the senior companions are serving frail elderly in private homes. For 20 hours a week, the companions are frequently the only source of continuing care available to lonely and isolated older persons strapped by physical and finacial burdens.

Senior companion projects are also effectively coordinating their efforts with AOA title VII and other supportive programs for older Americans at the local level. In fact, they serve as catalysts and advocates for older persons. Senior companions have been instrumental in providing personal care and friendship and in organizing services for physically handicapped and frail elderly (such as home health care and title VII nutrition services). This timely involvement has meant for many the opportunity to remain in their homes and communities—and escape the debilitating effects of institutional life.

Senior companions are helping to prevent needless institutionalization and to alleviate feelings of isolation. Thousands of elderly now have less fear of being alone, and the senior companions serving them are happier and healthier because they are providing this service. ACTION is deeply committed to this program as an alternative to institutionalization of older persons—an alternative which is based on what I believe to be essential ingredients to physical and emotional health ; namely, caring and companionship.

Appendix 4

MATERIAL RELATIVE TO ACTION ON ADULT DAY CARE IN THE ASSEMBLY OF THE CALIFORNIA LEGISLATURE

ITEM 1. LETTER FROM SENATOR LAWTON CHILES TO HON. FRED W. CHEL, CHAIRMAN, ASSEMBLY SPECIAL SUBCOMMITTEE ON AGING, SACRAMENTO, CALIF., DATED MAY 19, 1977

DEAR MR. CHAIRMAN: It has come to my attention that your subcommittee has made an especially persuasive case for making adult day health care a Medi-Cal benefit. As you can see from the enclosed statements by Senator Church and by me on May 16, I have opened hearings investigating the so-called alternatives to institutional care in preparation for issuance of a report summing up present Federal policies related to that subject. In fact, we had hoped to have your consultant, Thomas A. Porter, as a witness at those hearings; but we chose a date which was inconvenient for him and for you.

In lieu of direct testimony, I would very much appreciate a written presentation summing up the reasons for the development of the legislative package now receiving attention from the California Legislature. I would also welcome selected excerpts from your excellent hearing on "Adult Day Health Services; Pilot Project or Permanent Program?" Much that was said on October 8 is of direct relevance to our inquiry and forthcoming report.

If at all possible, we would like to have this material by June 3 to assure inclusion in our hearing record.

With appreciation and best wishes,

Sincerely,

LAWTON CHILES.

ITEM 2. LETTER AND ENCLOSURES FROM FRED CHEL, CHAIRMAN, ASSEMBLY SPECIAL SUBCOMMITTEE ON AGING, SACRAMENTO, CALIF.; TO SENATOR LAWTON CHILES, DATED JULY 14, 1977

DEAR SENATOR CHILES: Unfortunately we have not been able to respond to your request for information by June 3. The subcommittee staff has been occupied with developing amendments to and guiding public support of the very bills in which you are interested (AB 1610, AB 1611, AB 1612, and AJR 22).

We are encouraged by the Assembly's favorable reception of these proposals. The roll call vote thus far is as follows:

AB 1610: Assembly Health Committee—do pass, 10–0; Assembly Ways and Means Committee—do pass, 17–0; Assembly Third Reading—passed, 77–0; Senate Health & Welfare—do pass as amended, 6–0; Senate Finance—do pass, 8–0; Senate Third Reading—passed, 31–0. Signed by Governor, June 30, 1977, chapter 211.

AB 1611: Assembly Health Committee—do pass as amended, 10–0; Assembly Ways and Means—do pass as amended, 18–0; Assembly Third Reading—passed, 76–0. In Senate and not assigned to committee as yet.

AB 1612: Assembly Health Committee—do pass, 11–0; Assembly Ways and Means Committee—do pass, 18–0; Assembly Third Reading—passed, 74–0. In Senate and not assigned to committee as yet.

AJR 22: Assembly Health Committee—be adopted, 11–0; Assembly Rules Committee—be adopted. 5–0; Assembly Third Reading—adopted, 74–0. Senate Rules Committee.

I believe these proposals have been accepted so readily because the reasons for their introduction are clearly recognized and reliably documented. Briefly, (1) there is an unnecessary over-reliance on nursing homes where quality of care continues to be a concern, (2) adult day health care is humane and effective

health care, (3) adult day health care is a better investment of public health care funds, (4) adult day health care is an optional form of long-term care which a substantial number of citizens of California know about and want.

Since the initiation of State legislative hearings in 1971 on nursing homes and alternatives, there has been a growing movement in California which has led to the inevitable introduction of these much needed and long awaited legislative proposals. A step-by-step explanation of this process can be seen in the background document attached to this letter.

We have extrapolated portions of testimony presented at the October 8 hearing, "Adult Day Health Care—Pilot Project or Permanent Program?" which the committee found to be persuasive.

Sincerely,

FRED W. CHEL.

[Enclosures.]

BRIEF EXPLANATION OF THE ALTERNATIVE HEALTH CARE BILLS

Assembly Bill 1610: Under current law the State and a county may share the cost of providing preventive health programs of scheduled visits by public health nurses to senior centers, housing projects, and nutrition sites serving low-income elderly. The preventive health services provided includes hearing and vision testing, glaucoma screening, blood pressure readings, food and mouth examinations, a medical history, nutritional and medications review, counseling, health education, and referral to proper treatment based on the diagnosed condition.

Through the early intervention of these services chronic conditions have been successfully detected in older persons and consequently major medical crisis, costly hospitalization and placement in nursing homes has been avoided.

AB 1610 authorizes, in addition to counties, city health agencies to participate in the public health nursing services to the elderly program.

Assembly Bill 1611:[1] (a) Establishes a new health facility licensing category for adult day health care centers and a special permit for licensed health facilities who wish to provide this service.

(b) Establishes adult day health care as a Medi-Cal program.

"Adult day health care" means an organized day program of therapeutic, social, and health activities and services provided to elderly persons with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care. Provided on a short-term basis, adult day health care serves as a transition from a health facility or home health program to personal independence.

Provided on a long-term basis, it serves as an option to institutionalization in long-term care facilities, when 24-hour skilled nursing care is not medically necessary or viewed as desirable by the recipient or his family."

Guidelines for the special provisions of this bill are:

(a) Adult day health care centers must be a community-based service with heavy community involvement.

(b) The centers must be accessible to the low-income elderly.

(c) Growth of this program should be planned and controlled. Centers should be where needed, but only where needed.

Innovative aspects of the legislation are:

—A county plan is required to be developed by an adult day health planning council, which is appointed by the board of supervisors. Membership mandates a majority of senior citizen representatives, and representatives from aging and health programs.

—The county plan will provide the State with recommendations regarding location of facilities and individual prospective providers.

—The State will have approval and disapproval power of the plan and individual provider applications.

—No license, special permit, or Medi-Cal certification can be obtained in any other way. All *must* follow above procedures.

—Medi-Cal certification, a license, and special permit are for 12 months only.

—All providers *must* meet Medi-Cal program regulations and cannot refuse Medi-Cal participants who meet the eligibility criteria of the act.

—Every provider must have a governing body. Fifty percent of this governing body must be composed of participants in the program, relatives of participants and community representatives.

—No one may serve on the governing body who has a financial interest in the center.

[1] Signed by the Governor September 24, 1977. California State law, chapter 1066.

—Before renewal of the license, special permit, or Medi-Cal certification, department of health will conduct an on-site financial, management, medical, and licensing review.
—Ongoing monitoring program and fiscal controls are established.

BENEFITS OF THE ADULT DAY HEALTH CARE PROGRAM

(1) Adult day health care is cost-effective; two persons can be served in this program for the cost of one in a skilled nursing facility ($260 versus $668).
(2) Adult day health care provision of services in a group setting is more cost-effective per unit of service than similar services provided on an individual basis by a home health agency.
(3) Adult day health care treats medical, psycho-social, and supportive needs of the chronically ill elderly in one setting. Ambulatory and transportation problems making obtaining needed services from different service sites difficult and often impossible for persons who cannot use public transit and have no transportation available. Adult day health care makes services available and accessible.
(4) Adult day health care works to preserve family relationships and provides help to family members who are trying to keep the ill family member with them in their own home and community. Institutionalization disrupts family relationships and eliminates family responsibility.
(5) Adult day health care works to promote independence in the participant by providing needed therapies to restore the participant to his/her maximum functional ability.
(6) Adult day health care services fill an important gap in health care delivery. There is now nothing between independence, with home and family care, total dependence and institutionalization. A number of persons (estimates range from 25 percent to 40 percent) could be maintained in their homes and communities and not institutionalized if these services were available.

Assembly Bill 1612:[1] It is the intent of the committee to make adult day health services accessible in the community where older persons live and to encourage and help community organizations to provide these services to their older neighbors. Since there is a time lag of several months until a sufficient number of medical eligible older persons become participants of the adult day health care program enabling it to operate on Medi-cal reimbursement, startup funds are needed for initial operating expense of the program.

AB 1612 appropriates $100,000 to the department of health to be used as grants to match the funds raised by the community organizations for an adult day health care program.

Resolution—AJR 22:[2] Urges the President and Congress to amend title XVIII (Medicare) of the Social Security Act to cover adult day health care as medicare benefit.

EXCERPTS FROM INTERIM HEARING OF THE CALIFORNIA ASSEMBLY SPECIAL SUBCOMMITTEE ON AGING, ENTITLED "ADULT DAY HEALTH SERVICES: PILOT PROJECT OR PERMANENT PROGRAM?" HELD OCTOBER 8, 1976, IN LONG BEACH, CALIF.

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Chairman CHEL. Thank you. Miss Kahn, would you proceed and introduce the next witness.

Ms. KAHN. Next will be Ann Burk whose husband uses the program.

Mrs. ANN BURK. If I cry you'll just have to forgive me because this is a very emotional thing with me. I couldn't possibly keep my husband home if I didn't have this center. I was very glad to have found it two months ago.

Chairman CHEL. Drink some water and take it easy.

Mrs. BURK. Thank you. My husband gets kindness there and love and attention and all kinds of things from people who understand geriatric problems. When he comes home, he feels very good. Now I tried to get Dial-a-Ride for him, and I was told recently that I would have to wait five months and it seems to me that more people would use this program who are all alone, who don't have anybody to take them.

There are days when I have to do two things and I have to run around among my neighbors and ask them if they would please take my husband down or pick him up that day because there are sometimes conflicting things that I have to do. How can I take him down there when I have to be someplace else the same time. My husband needs constant care, I don't ever leave him alone,

[1] Signed by the Governor September 24, 1977. California State law, chapter 1065.
[2] Signed by the Governor September 24, 1977.

ever. I think, and I want to reiterate that if we had more Dial-a-Ride, more people would use it and they need it. I know I need it. This gives me—as I tried to explain to my husband—this gives me a few hours away from him and he's with other people who are kind and considerate and then I'm not quite as agitated as I might get. I take a lot of valium so that I can understand and try as much as I can. So I think we really need more people. Thank you.

Chairman CHEL. Mrs. Burk, I wonder if you might, certainly personally, and the committee has no intention of prying into your own life, on the other hand it's for informational purposes—is your husband under some kind of disability?

Mrs. BURK. Yes, he is.

Chairman CHEL. And what you are telling us is that he is benefitting by the programs offered by the Senior Day Center?

Mrs. BURK. Yes. Very much so, I think.

Chairman CHEL. And in connection with his disability is it a matter of the daily attendance there of particular benefit rather than periodic?

Mrs. BURK. He goes four times a week. Every day that they are open he goes and if it would be open five times a week he would be going five times a week.

Chairman CHEL. Assuming for a moment that the absence of the services offered which we will be exploring further, would you be able to maintain your husband at home?

Mrs. BURK. No. In fact I'd already been told that I'm under so much tension that I'm going to go off my rocker myself, if I didn't have this to help me.

Chairman CHEL. Thank you.

Mrs. BURK. And I want to keep my husband home with me as long as possible. As long as I feel that I can do it, and this is really helping him.

Chairman CHEL. I appreciate your being here. Miss Kahn.

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Chairman CHEL. Thank you. We have next Miss Julie Bronson, Deputy Public Guardian of the Los Angeles County Public Guardian's office. Proceed, Miss Bronson.

Miss JULIE BRONSON. I am Julie Bronson with the Los Angeles County Public Guardian's office. The Los Angeles Public Guardian's office is responsible for approximately 2700 persons who have been placed under conservatorship by the courts pursuant to State law.

There are two types of conservatorships in California. The Lanterman-Petris-Short Act program, which is authorized by the Welfare and Institutions Code, provides conservatorship services for persons with a mental disorder who cannot meet their basic needs of food, clothing or shelter and are unwilling or incapable of accepting voluntary treatment. The Probate Code provides conservatorships for persons unable to care for their personal needs or property due to a mental or physical disability.

More than 90 percent of the approximately 2700 persons for whom the Los Angeles Public Guardian is currently responsible are being cared for in various types of institutions, including State hospitals, skilled nursing facilities and residential care facilities.

This high rate of institutionalization of conservatees has not only been of great concern to our office but also from time to time has subjected the Public Guardian's office to criticism. The problem, of course, is that in most cases we have no choice. Many persons are institutionalized due to the lack of community alternatives that prevent institutionalization by maximizing independent living. If institutional placement is made not because the person needs institutional care, but because the kinds of assistance he needs are not available, then the human and financial cost is difficult to justify. The absence of community alternatives such as Adult Day Health Care for persons of low income and moderate means, forces us to institutionalize many persons who would be happier and in all probability healthier if they could remain in a residential with appropriate support services.

I am sure that all the medical, social and emotional advantages of alternatives to institutionalization are all known to you and do not need to be reiterated here today. However, I do want to focus your attention on one of the negative aspects of institutionalization—patient neglect and abuse.

Our experience in attempting to locate skilled nursing and residential care facilities which provide responsible levels of care under current Medicare and Medi-Cal rates, has in many cases been extremely disappointing. Not only are a substantial number of the out-of-home care institutions dehumanizing, but also the level of care they provide is grossly inadequate. In far too many instances

in recent years, the discovery of neglect and/or patient abuse in skilled nursing facilities and board and care homes, has forced our office to relocate patients and relocation, as you well know, presents a risk of its own to the elderly and the ill.

Specifically, for the million or more people across the Nation residing in institutions, the care ranges from excellent to negligible. The standards for long-term care facilities have not been enforced consistently. Recently there has been growing disenchantment with the current inadequacy of institutionalization. At the same time present exposures of the horrors and scandals and frauds are becoming increasingly frequent in newspapers, magazines, radio, T.V. and in Congress.

As problems come to the attention of the Public Guardian's office, we have actively worked with other county agencies, especially the Department of Health Services and the Department of Public Social Services in seeking solutions. But making existing programs more effective is not enough. As I mentioned earlier, the Public Guardian's office is often forced to institutionalize a person because of the lack of alternatives.

But going one step further and developing alternatives to institutionalization will result in solutions that are better, not only for the person but also governmental budgets. Adult Day Health Care of older persons is one such service. Such a program would not only provide supervision and personal care services, but also aid in solving the difficulties of daily living. Many people in nursing homes, board and care homes, and similar institutions could live in the community if they had simple services to assist them.

Obviously, alternatives to institutionalization, such as Day Care cannot entirely replace institutionalization. Hospitalization may be precipitated by an acute illness. However, the availability of community support services may shorten hospital or nursing home days.

In response to all the growing pressure, increased attention has been given to the development and utilization of Day Health Care as a cost-effective approach to prevent or delay the need for institutionalization and for using day care as a service designed to reduce length of stay in both short-term and long-term care facilities.

Unfortunately, under the current Federal and State reimbursement programs, the primary focus is on institution care. This must be changed in California.

At the same time, day care programs have been demonstrated to be less costly than institutionalization. Yet, unless some form of long-term reimbursement is provided for adult day health care, the seeding of day health care programs will rarely result in ongoing activity.

The development of alternatives to institutionalization can mean the difference between an individual remaining in the community or entering an institution. Ideally, all of us as individuals should be able to remain in the community as long as we wish and as long as it is medically feasible. We, not the service providers, should have the freedom of choice. Each decision concerning institutionalization must be based on the individual's needs and the alternatives should be as attractive, therapeutic and cost-effective as possible.

Chairman CHEL. Thank you, very much. Next on the panel we have Dr. Lawrence Feigenbaum and Marie-Louise Ansak. I wonder if both of them might come forward. You're all seated. I wonder if you might identify yourselves for the record, and your affiliation.

Dr. LAWRENCE Z. FEIGENBAUM. I'm Lawrence Z. Feigenbaum, M.D., Director of Ambulatory Services and Associate Chief of Medicine, Mt. Zion Hospital and Medical Center, San Francisco and Associate Clinical Professor of Medicine, the University of California, School of Medicine, San Francisco. Did you want me to go ahead with the testimony?

Chairman CHEL. I would appreciate that, yes.

Dr. FEIGENBAUM. My testimony stems from a background of 18 years as a practicing internist in San Francisco, five years as full-time Director of Ambulatory Services at Mount Zion Hospital and as Medical Director of Mount Zion's Geriatric Day Health Program.

Each of us is growing older daily and will be facing the problems of the aged in this country. These include illness, isolation, becoming poor due to inflation, and facing immense difficulty in obtaining appropriate health care. I doubt if any one of us looks forward to the possibility of entering a nursing home some day and yet the legislation as it stands today will undoubtedly force some of us against our will to enter one unless some better health legislation is developed. It is legislative bodies such as yours which have the enviable opportunity of

doing something to improve this intolerable situation. It is rare that we have the opportunity to develop a truly vital and fulfilling human service and at the same time provide cost savings to the government. I believe that Adult Day Health services can do just this. Although it sounds unlikely, we have a great deal of data to support this statement.

Adult Day Health Programs are directed to the approximately 15% of the elderly whose course is likely to lead them into a nursing home. With this service they have a support system which allows them to remain in their own home. The Day Health Centers provide transportation, group and individualized physical therapy, occupational therapy, nursing care, speech therapy and social services. All patients receive a hot, nutritious meal (usually their major source of nutrients for the day) and participate in social programs and recreational activities. This incorporates the advantages of Home Health Services, namely keeping the patient in his own home, but in addition and most importantly provides the patient with the opportunity to be with other people and participate in a program which often restores their interest in life. The effect that this has had on the health of these patients has been at times dramatic and almost always beneficial, despite serious underlying illness. It has been repeatedly shown that the disabling diseases of the aged are aggravated more by isolation and loneliness than by any other factor. Geriatric studies have shown decrease in morbidity and mortality rates in the elderly when isolation is minimized. Weiler, et al., in *Medical Care*, August 1976, published their results on an Adult Day Health Program, and on composite analysis this clearly revealed that the group receiving day health services improved in level of physical functioning while the control group regressed. Their study also showed significant improvement in the individual's ability to maintain him or herself in their present setting.

How am I able to suggest that such a program would not cost the state additional money? As you know, our present system has built into it incentives to use the most costly services rather than emphasizing those modalities that may do as well or better at less cost. Medicaid nationally is spending approximately four billion dollars per year on nursing home care. Studies have shown that between 20–40% of the people in nursing homes could be treated better at less expense if other alternatives were available. As this distinguished committee knows, the State of California is paying approximately $600 per month for many Medi-Cal patients totaling approximately $350 million per year for nursing home care. I certainly do not have to tell this committee about the inadequacies—really the shocking deficiencies—of most nursing homes. What a great value to society as well as cost savings to the state if roughly 30% of the patients who are presently entering nursing homes were permitted to remain in their own homes if relatively inexpensive support systems were available to them. Although the data on financing is not final, it appears that an average cost of Day Health Care services is approximately $250–300/month (less than half that of an inferior nursing home). This figure is based on the fact that our programs and the others I am aware of have shown that the average need for Day Health Services is only 2½ days per week in order to keep most patients functioning well. Our daily costs are approximately $25/day; thus the total cost is less than $300 per month. Even adding the costs of room and board, the total is no greater than the cost to Medi-Cal for 7 day/week nursing home care. In addition, if there is a family available, the patient receives the personal attention that is often missing in nursing homes.

Allow me to tell you of one case history that is not unusual. Mr. L. U., an 83-year-old San Francisco-born, ex-salesman, sustained a fracture of his left elbow. He lived alone and following the fracture was managing very poorly, becoming more and more severely depressed and it seemed likely that he would soon require a nursing home. He was admitted to the Geriatric Day Health Care Program following which his improvement was striking. He became interested in the activities and the other people in the program and truly "came to life." As a consequence he followed medical directions in a way that he had not been able to do before, was able to return to his apartment, his fracture healed well, and the full use of his arm returned. Subsequent to this, he had another fall and fractured his hip at which time he required hospitalization. Ordinarily this serious fracture in a depressed man living alone would have been the beginning of the end for him, but even in the convalescent period he attended the Day Health Care Center which decreased his depression and clearly shortened the period of both hospitalization and time needed in a skilled nursing facility. Mr. U. was able to be discharged to a board and care residence, covered by SSI payments, and continues obtaining physical therapy in the Day Health Center. He has healed

well, is walking and is again active and his spirits are excellent. The likelihood is that without this service he would have been relegated to a nursing home for the rest of his life. The other day he said, "This is the only family I have. The staff gives me something to look forward to."

As you are probably aware, the medical profession has not always been as ready to accept new programs as it should have been. It is of particular interest that the need for this kind of program is so clear to physicians that we had absolutely no criticism or objection to the original development of this demonstration program at Mount Zion Hospital, and now there is significant enthusiasm. In addition, those physicians and other health professionals who have been in any way involved with this program have been uniformly positive about its values. Dr. David Rabin, my colleague who has had a great deal of experience at the On Lok Day Center in San Francisco, strongly concerns that patients have a better medical outcome and improved quality of life with this type of treatment. We both have noted salutary effects on patients' families who are less burdened as the family obtain some respite and see their parent or spouse again take an interest in life and improve in health.

I, for one, can say that my involvement in geriatric day health care services has been the single most gratifying experience of my professional career. I would strongly urge this committee to recommend legislation that would permit Medi-Cal reimbursement for adult day health care services which I firmly believe in the long run will help reverse the expensive and disspiriting trend of unnecessarily shunting many of our elderly citizens into nursing homes. I am certain that members of the California Association for Adult Day Health Services would be able to provide you with any information you need in view of their combined expertise and I personally would like to offer my services in any way I can be of help.

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Chairman CHEL. Does your Center offer any services in addition to normal medical health type?

Dr. FEIGENBAUM. As part of this program and even as a physician, I can say at least as important to its success are—there is a major emphasis on recreational activities, socialization. We have outings with the patients. The Conservatory of Music on a regular basis sends musicians over and we have programs. There are poetry readings. There are body movement programs, but these are a group of people who are clearly a very sick group and who need modalities of care, such as physical therapy, speech therapy, the occupational therapy. Many of them have been receiving those before, and I think the additional ingredient of being part of a group again and coming to life and having something to look forward to and the recreation that goes with it is an awfully important part of it. We do have patients who were attending strictly recreational social centers where the staff felt they could not cope. They were so anxious about the patient who might have fainting spells. The patient who has certain physical disabilities that they just don't feel they can cope with. This kind of environment does emphasize the seriously ill but includes other than medical modality only.

Chairman CHEL. What is the average number of clients that you serve at your Center?

Dr. FEIGENBAUM. We are serving about 35 to 40 per day, and the average need we have found even for this group of quite sick people is about 2½ days per week averages out. There are some people who can manage with one day a week, some with two, some do come five days. We are not a 7 day a week operation.

Chairman CHEL. Does your Center either provide or cooperate with other facilities in terms of any kind of home care?

Dr. FEIGENBAUM. Yes, our hospital was, if I may brag a bit, the pioneer in the West for home care services. Our program is over 20 years old. We really were the model that was used for a lot of the legislation and other.

Chairman CHEL. The home care services to which you refer, does that entail more than visiting nurse?

Dr. FEIGENBAUM. The home care services are those people who literally cannot leave their home and there the nurse, the therapist, the chore services, whatever is needed, has to go to the home. One of the advantages, one of the things that we have that we think is useful is that there is an easy flow from one to the other. We have many of our patients in Day Health Care who are home care patients but, as they have improved and we can provide the transportation, now can get

out and that additional, being part of a group again, has had an immense value. On the other hand, old people's health is not a static thing. You can't define it today and know it is going to be that way next week.

That patient who is coming in today to Day Care Program, next week may just have an intercurrent infection or some other aggravation of their condition and may then need our home health services. On the other hand, others of the patients will get well enough that we want them to leave and go to just a day care program—not a day health program.

Chairman CHEL. In your geographical area—San Francisco and suroundings, are you aware of any kind of a continuing program by way of outreach or otherwise to determine whether or not people are institutionalized and ought not to be there?

Dr. FEIGENBAUM. I cannot give you any data about the nursing home facilities in our area in terms of a survey of that sort. That kind of study has been done. It was done by Dr. Robert Morris in the East, part of the Levinson Gerontological Institute and in their studies, it was in the neighborhood of 40% of the patients.

Chairman CHEL. You mentioned this in your presentation. That's why I am asking.

Dr. FEIGENBAUM. No, we have not—I don't know whether there are any other data that someone else may have. I don't have any data on the situation. I dare say—I know from my own subjective action to that is, I know that there are patients who, because they are alone in an apartment and are ill and are on Medi-Cal, because there are no other adequate provisions for that patient, such as day care, have gone to nursing homes. I am certain there are many patients in nursing homes who do not have to be there. On the other hand, don't misunderstand me, there are many people obviously—nursing homes are required, there is no doubt about that.

Chairman CHEL. What I am wondering is, as a physician and mixing obviously among your colleagues in the medical community, has there been any concern or any attempt at all to try to increase discharge out of institutions?

Dr. FEIGENBAUM. Once they get into nursing homes, they aren't easily discharged, because my experience, and I must say close to 20 years, it is a shock to me how many people who for supposedly a relatively short period of convalescense, once there, they know that this is the beginning of the end. They know they are being rejected. Whether that's true or not, that certainly is their perception and they go down hill. I don't see a lot of room for patients that are already there to empty them. Now, there are undoubtedly—we have had some patients who were in nursing homes and I know that Dr. Rabin and I have talked—he has seen patients also who were so unhappy in nursing homes that fortunately had not deteriorated so much. They were still able to benefit and very much come alive with this kind of program. I can't give you numbers on that, Assemblyman Chel, I am sorry.

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Mr. J. MEL MERCHANT. I am J. Mel Merchant, health care consultant in the Medical Services Administration, Department of Health, Education, and Welfare. I hold a master's degree in hospital administration from the Medical College of Virginia. My professional experience includes assistant administrator positions in several hospitals and as Director of the American Hospital Association, Region III Office in Washington, D.C.

Public policy, as the dominating influence on governmental action at all levels, is demanding appropriate steps to curb the ever-increasing cost of medical care, especially medical care offered under public assistance programs. In meeting the fundamental accountability to the public, the Medical Services Administration of HEW continues to search for methods to hopefully reduce or at least contain the costs of medical care without sacrificing the quality or quantity of care which has been determined medically necessary.

The Medical Services Administration is keenly aware of our national statistics which indicate that approximately 20 percent of Medicaid recipients are age 65 or older and annually consume approximately 40 percent of the total Medicaid budget. This is for long-term nursing care. Consequently, cost containment efforts are focused on this area.

From studies done in many states, by state agencies, universities and others, we receive documentation in the form of research and demonstration proposals that many aged Medicaid eligible individuals are "residing" in long-term care facilities solely because no other alternative is available. We also receive documentation in the form of research and demonstration proposals that there are

many aged individuals still residing at home who are potential candidates for Medicaid-sponsored, long-term care unless alternatives are developed.

The Medical Services Administration convened a conference of specialists in health and social sciences in 1971 to study health and access problems of elderly. Of the recommendations made by conference participants, the Medical Services Administration and the Administration on Aging felt that Day Health Care Services offered the most potential for helping elderly persons remain in their communities. In 1972, four grants were awarded to study this concept. On Lok Senior Health Services of San Francisco was selected as one of the grantees.

It was a privilege to be appointed consultant to the On Lok Board and Project Director. Since the beginning we have worked closely with the California Health Department so that they might have the benefit of our knowledge and experience at On Lok and other Day Health Care Programs. Members of your State Assembly became interested in the On Lok experience and have been very supportive to On Lok's cause, its survival, and its replication.

Even though the M.S.A. worked closely with the Prepaid Health Section of the State Health Department, it was with limited success until Dr. Jerome Lackner was appointed State Health Director and Dr. Ruth Von Behren was appointed as On Lok Project Monitor. At that time, we became encouraged that Day Health Care Services might become a Medi-Cal covered service. My personal and professional observation is that Dr. Von Behren exhibits a thorough knowledge of the problems of the elderly and a full understanding of how Day Health Care Services can provide high quality health care to these persons and help them remain a part of the community they call home.

Dr. Von Behren has involved important divisions of the Health Department in the On Lok Project. These include Medi-Cal benefits, licensing and certification, rate setting and utilization review and control.

This kind of involvement is vital to both the Department of Health and to projects like On Lok because it prepares each for the time that Day Health Care becomes a permanent service in our health care system.

It is encouraging to the Medical Services Administration that the State Legislature has moved to conduct hearings on Day Health Care. We have continued to support On Lok beyond the usual grant period and have acted to assist the State Health Department to increase the number of sites through our Research and Demonstration program with the hope that the State of California would move to help the Department of HEW now firmly establish this greatly-needed service. Although we may be unable to continue funding Day Health Care sites beyond their current project life, we stand ready to provide consultation to the State as you move toward implementing Day Health Care as a Medi-Cal benefit.

In January 1976, we published Information Memorandum 76-3, a guideline for states, where we advise State Medicaid agencies how they can implement Day Health Care services and receive federal matching for those services. We believe that we have provided maximum support to help—now we need to hear from you and what your plans for the future are. I believe that many members of your State Legislature are genuinely interested in doing the maximum for your elderly. We would encourage you to proceed with legislation, but not without utilizing available controls. Perhaps a task force of representatives of the legislative committee staff, State Health Department, California Association for Adult Day Health Care Services, State Commission on Aging, and the State Department of Aging could serve to help develop legislative language and possible regulations. The State can control this service through your certificate of need and Medi-Cal certification programs once you have regulations and standards. By vesting the authority and responsibility for implementing this service in competent, sensible persons who have sufficient decisionmaking authority, you will strengthen the insurance that qualfied providers will be operating Day Health Care Programs.

Thank you.

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Ms. RUTH VON BEHREN. I'm Ruth Von Behren. I'm the Project Director for Adult Day Health Services in the Department of Health.

I am very pleased and very honored to be here today. I am pleased because the existence of this hearing demonstrates that the California Legislature is vitally interested in the problems and needs of our impaired senior citizens here. This interest has also been demonstrated by legislative action during the past session with the passage of Assembly Bills 2578 and 1810. I want to thank you, as representatives of the Legislature, and particularly to thank Speaker McCarthy, for your efforts in behalf of this program.

I am honored to be here to speak to you about our adult day health services demonstration program. For the past 15 months this program has been my responsibility. Since I am the only person in the Department of Health working exclusively with this program, anything and everything that involves adult day health services ends up on my desk. In response to your letter, I have chosen today to give my presentation about one aspect of my work; that is my function as Chairperson of the Adult Day Health Care Work Group. I would like to talk to you about this group, what it is, why it came into existence and its accomplishments.

Definitions.—The Adult Day Health Care Work Group is composed of representatives from the Department on Aging, the Commission on Aging, Department of Finance and various programs in the Department of Health. We now have representatives from Licensing, Social Services, Rates and Fees, Budget, Medi-Cal and Chronic Diseases. At one point a student from your subcommittee staff was an active participant in this group—that's Gretchen Bostwick.

Reason for Group.—The formal establishment of this group was an outcome of several informal meetings held by Alternative Health Systems Division in November and January. The intent was to share information about our program and to seek advice from other persons whose job responsibilities involved either a programmatic or regulatory role in this program. As you have heard, adult day health services is a program that cuts across traditional categories and organizational lines. Therefore, Alternative Health Systems Division felt the establishment of an inter-departmental group was essential. A memo was issued by Dr. Lackner, Director of Health on January 23, to all Deputy Directors, establishing the Adult Day Health Care Work Group.

The charge given to the Adult Day Health Care Work Group was:

(1) Clearly define the goals and objectives of state-funded day health care.

(2) Establish criteria for future Alternative Health Systems Division contracts with adult day health care demonstration projects.

(3) Develop licensing standards appropriate to the special circumstances of the adult day health care situation as the basis for future regulations.

(4) Develop recommendations for departmental positions on proposed and pending state and federal legislation on day health care services.

(5) Advise on the development of a standard assessment instrument for the effectiveness of day health care services.

(6) Devise and propose a coordinated approach to funding of such projects.

(7) Advise on a rate-making methodology for comprehensive day services funded by the state.

ACCOMPLISHMENTS

(1) *Information gathering and sharing.*—Since adult day health care was an entirely new concept to most members, program knowledge was the first essential. We met that need in two ways: (1) visits to various centers, (2) collection and analysis of program, legislation and regulations from other states. This is an on-going function and we try to serve as a focal point for information regarding adult day health services.

(2) *Development of a proposal/informational package which is sent to all interested persons.*—This package includes criteria and guidelines for our demonstration program. To date this information has been sent to 31 interested persons. A sub-committee of the work group also reviews proposals and makes recommendations to Alternative Health Systems Division. We have now 10 proposals in various stages, two of which we hope to contract with shortly.

(3) *Advised on the on-going development of an assessment instrument.*—Department of Health has a contract with a consultant who is developing this instrument and collecting data as part of the On-Lok evaluation. He has met with the group several times.

(4) *In process—development of program parameters, eligibility criteria and legislative language.*—We have identified the basic set of services which are appropriate for Title XIX funding. All individual services are now being paid for by Medi-Cal to various providers such as nursing homes, home health agencies and out-patient clinics. What is new about adult day health is the package. It is a new combination of existing services.

Eligibility criteria is vitally important and undergoing continual revisions. The Adult Day Health Care Work Group has also identified key elements that should be included in enabling legislation for a permanent Medi-Cal program. Actual legislation needed is minor, far more important is the development of regulations. A brief summary of the group's conclusions are:

(a) Legislation should mandate a cross-section community advisory board for all centers.

(b) Licensing should be as a clinic sub-category or as a "special service" offered by a clinic or in-patient facility. In the light of AB 1815 a waiver from Medi-Cal is needed so the multi-purpose center, under community care facility licensing could be reimbursed for their health services.

(c) Regulations should mandate—

(1) The composition of the Board of Directors.

(2) Separate and identifiable administration and staff, particularly important when adult day health care is part of an in-patient facility.

(3) Professional requirements for staff.

(4) Evaluation method.

(5) Utilization review.

This concludes my statement.

ITEM 3. LETTER FROM LEO T. McCARTHY, SPEAKER OF THE ASSEMBLY, CALIFORNIA LEGISLATURE; TO SENATOR LAWTON CHILES, DATED JULY 1, 1977

DEAR SENATOR CHILES: In response to your inquiry, I am indeed encouraged by the U.S. Senate's Special Committee on Aging's focus on "Health Care for Older Americans: The 'Alternatives' Issue."

The subject of your committee's hearings has been a concern of mine for a long time. Fortunately, my position as an elected official in State government has given me the opportunity to act on these matters in California.

As the first chairman of the Assembly Special Subcommittee on Aging, I directed our efforts at assessing and improving the quality of care in nursing homes. It was through a statewide series of hearings on "Nursing Homes and Alternatives" that I was convinced of the unnecessary over-reliance on this form of long-term health care. One of the outcomes of the hearings was the enactment of AB 1810 which allows for demonstration projects in adult day health care. Based on the evidence of these adult day health care projects, legislation (AB 1611, AB 1612, and AJR 22) has been introduced to make adult day health care a permanent medicaid program in California.

I am happy to report all these bills have passed the Assembly without a single vote of opposition. It is apparent that at least the California Assembly is convinced we must shift our health policy in new directions to provide optional forms of long-term care for our older citizens.

The intent language of AB 1611, the major adult day health care bill, while focusing primarily on adult day health care, states the long-range policy goal of the Assembly in the following:

"Include the services of adult day health centers as a benefit under the Medi-Cal Act, which shall be an initial and integral part in the development of an overall plan for a coordinated, comprehensive continuum of optional long-term care services based upon appropriate need."

In order to achieve this "continuum" policy objective, I feel for efficiency and fiscal reasons we must have a solid base of data on the most effective method of delivery of necessary health and social services to our older citizens. Any continuum of care must include an access process, and provision for movement within the system based on the appropriate need and personal preference of the older person. I would emphasize that the quality nursing home is a vital part of this continuum.

Consequently, I have introduced AB 1741, designed to collect such information through experimental pilot projects utilizing Federal waivers to blend the funding and waive impeding regulations to the greatest extent possible.

We appreciate your committee's involvement in the alternative issue and look forward to working with you on developing a humane and effective optional system of care for our country's older citizens.

Cordially,

LEO T. McCARTHY.

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