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HOME HEALTH SERVICES IN THE UNITED STATES

A REPORT

TO THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

APRIL 1972

Printed for the use of the Special Committee on Aging

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(Prepared by Brahna Trager, Home Health Consultant)

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PREFACE

Much attention has been given—in the months before and after the 1971 White House Conference on Aging—to the need for developing "Alternatives to Institutionalization."

Certainly, home health services—when well organized and related to other components of an overall health delivery system—should rank high as a satisfactory alternative.

Who, as a person in need of limited but essential services, would not rather remain in his familiar living quarters if assured that such services were available and attractive?

Who, as a public official appalled by mounting costs of institutional care, would not welcome services that enable patients to remain at home when it is appropriate for them to do so?

In terms of personal preference on the part of most patients and in terms of public policy, therefore, the arguments for development of home health care networks—providing a *range* of services to deal with temporary or chronic illnesses causing varying degrees of disability—seem irresistible.

And yet, as the report which follows makes all too clear:

—Despite lipservice to the need for home health services, Medicare and Medicaid have actually fashioned serious roadblocks to the development of such services.

—At a time when the "alternatives to institutionalization" psychology is becoming more and more ingrained, the number of home health service agencies is actually *declining*, and many more seem to be in deepening financial jeopardy.

—Less than 1 percent of Medicare expenditures now go to home health care, and even that small portion appears to be declining.

Surely, these facts point to a fundamental conflict between what is said to be public policy and what actually exists in the health delivery nonsystem.

But partially because of confusion and partially because of public unconcern, home health services are vanishing amidst a flurry of paradoxical Federal regulations, widespread pronouncements about overreliance on institutional care, and a search for a miracle cure to the ills of the health industry in the United States today.

This is hardly a promising trend at a time when the Nation is about to make major decisions on health care policy, including the question of national health insurance of one kind or another.

The question is: Will home health services become a major component in a rational and responsive health care system, or will its shortcomings of today become even worse tomorrow, in a health care system grown still more costly and less helpful to people in need of service?

Fortunately, the answer to the question can be positive, if the emergency of the present situation is fully understood.

The Senate Committee on Aging is, of course, concerned primarily about the effects of the present inadequacies upon the elderly. But as is so often the case, action to help older Americans will also help other Americans.

The report which follows documents the shortcomings in public policy in the home health field. But it does more than this. It also points the way to an action program that can help remedy these deficiencies.

Immediate and long-term approaches are needed. The report makes these major recommendations:

—Medicare and Medicaid regulations must be interpreted and applied so as to promote, rather than restrict, home health services.

—Home health planning must be based primarily on the professional judgments of those familiar with consumer needs, rather than remote decisionmakers far removed from the problems.

—Institutionalization as a condition for home health care must be eliminated, as well as requirements for co-insurance payments.

—Costly and confusing redtape must be eliminated in providing home health services, including, in particular, the practices of prior authorization and retroactive denials.

—Proposals for national health care legislation must include provision for comprehensive home health services.

—A national approach to the provision of adequate coverage of the population by home health services is essential.

These are the action steps that can and must be taken now to bring home health services to the frontlines in the battle for decent medical care in this country. For too long these vital services have been pushed to the sidelines. Their potential has not been realized. And this neglect of these services has caused us all to suffer in one way or another. The most unfortunate victim has been the consumer who needs these services.

Let this report serve as a call to action for all concerned with the health care crisis in this country. There is no need to wait any longer to act. And there is every reason to act now before a bad situation becomes even worse.

To the author of this report, Brahna Trager, the committee extends its sincere appreciation for her efforts. We are fortunate to have had a person of her distinguished standing in the field as our consultant in this undertaking. And we are most grateful, too, to those who have contributed the informative materials in the appendixes in this document.

FRANK CHURCH,
Chairman, Special Committee on Aging,
EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly.

CONTENTS

Page

PART 1

The home—An American tradition 1
The population "at risk" 2

PART 2

The potential of home health services 5
Home health services of good quality 5
Patterns of intensity in home health services 6
1. Concentrated or "intensive" services 6
2. Intermediate services 7
3. "Basic" services 7

PART 3

The availability of home health services in the United States 9
Home health agencies 10
Limitations in the Medicare system 10
The definition of a "home health agency" 14
The use of institutions 20
The problem of "return" 20
"Coordinated" home care programs 21
Hospital-based home care programs 22
Community-based home care programs closely linked to hospitals 22

PART 4

Basic components of home health services 25
Nursing services 25
Homemaker-home health aide services 27
Social services 32
Physical therapy, occupational therapy, and speech therapy 34
The potential of home health services in health maintenance organizations and ambulatory care facilities 34
Health maintenance organization 34
Ambulatory care facilities 35
Cost saving 36

PART 5

European home health services 39

PART 6

Manpower 43

PART 7

Summary 45
Conclusions 46

PART 8

Recommendations 49

APPENDIXES

Page

Appendix 1.—Responses of National Organizations:
- Item 1. Letter and material from Kenneth Williamson, deputy director, American Hospital Association — 51
- Item 2. Statement by Donald R. Hayes, M.D., Home Health Care and Service — 54
- Item 3. Statement of the National League for Nursing Department of Home Health Agencies and Community Health Services — 54
- Item 4. American Nurses' Association Statement on Home Health Agencies — 57
- Item 5. Statement of the National Association of Home Health Agencies — 58
- Item 6. Statement by the National Council for Homemaker-Home Health Aide Services, Inc — 61
- Item 7. Statement by the American Home Economics Association — 64
- Item 8. Letter and material from American Speech and Hearing Association, to Miss Brahna Trager — 68
- Item 9. Statement by the American Physical Therapy Association — 74
- Item 10. Statement from the American Occupational Therapy Association, March 14, 1972 — 74

Appendix 2.—Excerpts from statement by Senator Alan Cranston, in support of S. 3355, Congressional Record, September 9, 1970 — 76

Appendix 3.—Excerpts from reports of functioning home health service programs:
- Item 1. Excerpts from report by Blue Cross of Greater Philadelphia — 82
- Item 2. Excerpts from Home Care Following Hospitalization, Associated Hospital Service of New York — 112
- Item 3. Excerpts from the 10th Annual Report of the Home Care Association, Rochester, N.Y., May 11, 1971 — 115
- Item 4. Excerpts from Homemaker-Home Health Aide Services in New Jersey Annual Report — 118
- Item 5. Excerpts from report by San Francisco Home Health Service — 118

Appendix 4:
- Item 1. Letter from Mary L. Whitacre, M.D., health commissioner, Marietta, Ohio, to Thomas M. Tierney, director, Bureau of Health Insurance, Social Security Administration, Baltimore, Md — 122
- Item 2. Letter from Francis J. Charlton, M.D., San Francisco, to Raphael B. Reider, M.D., February 18, 1972 — 124
- Item 3. Letter from Marilyn Taylor, R.N., home care coordinator, Visiting Nurse Service, Battle Creek, Mich., to President Richard M. Nixon, December 30, 1971 — 129
- Item 4. Letter from Mrs. Helen L. Goodwin, R.N., executive director, the Greater Lansing Visiting Nurse Association, to Mr. Charles E. Chamberlain, Washington, D.C., January 27, 1972 — 130
- Item 5. Proposed legislation submitted by the California Association of the Home Health Agencies — 132

Appendix 5.—Athens Community Council on Aging: A model for a communitywide home services and training program — 134

Appendix 6.—Widespread Home Health Care Named A State Necessity, from Age in Action, West Virginia Commission on Aging, November-December 1971 — 147

HOME HEALTH SERVICES IN THE UNITED STATES

(By Brahna Trager*)

PART 1

THE HOME—AN AMERICAN TRADITION

The word "home", the concept of "home life" has a special importance to Americans. Our advertising leans heavily upon it. Pictures of happy families together, of white-haired grandmothers and grandfathers "at home", have a deep appeal. The "preservation of family life" is a phrase commonly used to strengthen the acceptance of new community programs and to protect those which already exist. Institutions frequently use the word as a euphemism to soften the grimmer aspects of institutional living. "Homes" for aged; nursing "homes", convalescent "homes", children's "homes" are terms applied to make more palatable a way of life generally unacceptable to a people which has culturally and historically guarded the right to a personal way of life, and guarded it fiercely. We hear a great deal about the breakdown of family life, and it is true that the generations in families do not remain together as they once did. Increased longevity has brought about a situation in which large numbers of people live alone. That is, they live "alone" statistically. It is rare, however, to find acceptance of institutional life, with all that it means in terms of exclusion from the community, conformity to institutional rules, separation from an environment that is personal, as an adequate substitute for a personal environment, unless that environment is deteriorated or degraded because the community offers nothing to support life there. Even then, it is more often than not, difficult to persuade the individual away from what has seemed to be his own shelter, the extension of himself, and into an institutional bed.

In one area, the traditional regard for the individual's personal choices about his way of life seems to be disappearing. The field of health care, in recent years has become increasingly institutionalized. The family physician at the bedside of the patient in his own home is a vanishing phenomenon. The hospital with its complex of highly specialized treatment facilities has become the safe, the effective and the most convenient place for the treatment of acute illness; the long-term institution has begun to replace a personal environment.

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The effectiveness of medical care has meant that disability and chronic disease are prevalent in our population, and that those who are so afflicted are our problems today. That they are our "problems" rather than a reason for just pride is less a reflection on medical care than on our ability to create in our communities services which will provide our "saved" population with a decent way of life in terms of our own traditions.

We offer the disabled, the chronically ill of all ages but especially in our aging population one of two choices: helpless isolation "at home" or the sterility of an institution.

THE POPULATION "AT RISK"

To say that we are "confronted" with an aging population implies that longevity itself is a problem in American life. We appear to consider it a problem in spite of the fact that we have recently seen a White House Conference on Aging attended by at least 3,400 delegates, many of them from this population, actively working to improve the quality of life for persons of all ages, conference speakers as well as participants in the special interest sessions. We are surrounded in our daily lives by "aging" persons working in their accustomed way, living much as they have always lived, functioning to the limit of their capacities which are often considerable. The physician, the attorney, the plumber, the electrician, the legislator may have acquired, as he passed the 45-year mark, certain of the chronic disabilities which are associated with aging.[1] If he has had access to good health care, has been able to buy those services which he cannot undertake to perform for himself; and can afford to relax in a decent living environment, he is not a "problem". He may in fact be a leader, a full participant in community life and a genial attender of conferences, since, along with his limitations in activity he may have acquired over the years a good deal of wisdom, information and skill which in other cultures are considered the basis upon which the future may be built. As the orthopedist said to the man whose X-rays looked pretty bad: "It's fortunate we don't walk on our X-rays."

Those who have worked with less fortunately placed older persons can testify to the fact that many of them now in the depersonalizing atmosphere of institutions or isolated in their homes might also be able to function with greater effectiveness and satisfaction if they, too, had access to health care of good quality and had the essential compensatory services available to them.

In 1970 our aging population (65 or over) had reached 20,049,592—almost 10 percent of our total population, and the rate of growth in this age group had increased by 21.1 percent in the decade between the 1960 and 1970 census years as compared with a rate of 12.5 percent in the under 65 age group. The population of those aged 45 and over now accounts for almost one-third of our total population.

---

[1] In the age range 45–64, causes of limitation in activity were heart disease 19% and arthritis and rheumatism 16.9%. These increased to 21.9 and 20.2 respectively in the age group 65 years and over. National Center for Health Statistics *Chronic Conditions and Limitations of Activity and Mobility* July 1965-June 1967. USPHS Dept. of HEW p. 9.

Growth in the older age group (75+) occurred at a faster rate. About one-fourth of the population (five million persons) aged 65 and over live alone or with non-relatives;[2] and those in this age range who live with relatives could reasonably be assumed to be living primarily with spouses, siblings or other family members in approximately the same age range. The day of the extended family in which the generations live together is disappearing, destroyed by economic pressures which attract young families either *to* the city and away from the farm, or *away* from the city to the suburbs, in either case limited by the absence of adequate housing, financial security, and community interest in their ability to maintain older family members in the multi-generation family. There is a substantial number of persons in the older age range who no longer have relatives living. There are also many older persons in the situation described in a recent Senate Committee on Aging report, in which the question is asked:

> Can we realistically expect the grandparent generation to assume the responsibility—financial and physical—for the great grandparent generation? A 1962 national survey found that among the noninstitutional population 65 and over, 32 percent were great grandparents. That proportion is higher now.[3]

Although the health status in the aging population does not fit a common stereotype of age as a condition invariably associated with debility, senility, isolation and unhappiness, chronic illness is prevalent in the older persons. About 80 percent of those who are 65 and older are afflicted with one or more chronic conditions,[4] but in the non-institutionalized population in this age group 82.25 percent have no limitation in mobility in spite of the presence of chronic disease; 12 percent have some limitation in mobility; and of non-institutionalized persons 5.75 percent are housebound.[5] There are, however about five percent of older persons confined to institutions.[6]

The use of long-term institutions as an appropriate resource for this latter group has been questioned: ". . . major medical organizations are burdened with patients they should not have, and, as a last resort, move them into quasi-medical nursing institutions—that is, nursing homes which 25–50 percent of the patients do not require."[7]

A study done in Florida and published in June of 1971 showed that "85 percent of all nursing home residents would prefer to be at home. Physicians associated with the nursing homes said that nearly 20 percent of the patients did not belong in institutions. Registered

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[2] Facts and Figures on Older Americans. The Older Population Revisited. First results of the U.S. Census. U.S. Dept. of HEW. SRS. A.A.

[3] A Pre-White House Conference on Aging, Summary of Developments and Data. A Report of the Special Committee on Aging, U.S. Senate, together with minority and supplemental views. November 1971. p. 25.

[4] John B. Martin, Special Assistant to the President for Aging. in: Press release, January 4, 1971.

[5] Facts on Aging, A. A. Publication No. 146. Reprint from May 1970.

[6] John B. Martin, Special Assistant to the President for Aging. Statement to the Senior Citizens Roundup, Albuquerque, N.M., June 16, 1970.

[7] Special Committee on Aging. *Alternatives to Nursing Home Care: A Proposal.* Prepared by staff specialists at the Levinson Gerontological Policy Institute. Brandeis University, Waltham, Massachusetts. October, 1971. p. 2.

nurses felt that fully 30 percent of these nursing home patients should have been at home." [8]

The term "at risk" when it is applied to the aging population refers to the presence of chronic disease, which is characterized by considerable fluctuation; a condition in which optimum health and mobility can at times be affected. The absence of effective preventive and therapeutic services, of compensatory supports, the use of inappropriate resources for care, do in fact with depressing frequency produce debility, senility, deterioration, isolation—the discouraging and so often unnecessary stereotype of old age. The risk is greatest when poverty, bad housing, poor nutrition are present, as they are in the case of almost five million older Americans [9] and is compounded for those who are poor and near poor and who are also alone. Nearly six out of every ten in the older age group who live alone or with non-relatives are classified as poor or near poor.[10]

The movement into these groups by the well aged is a "risk". The cost in dollars of caring for the end product of neglect is a "risk". The waste in human terms in a culture that in almost all respects is comfort loving, life loving and, in general, generous in its ideals is a great "risk".

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[8] State of Florida Department of Health and Rehabilitation Services, *Community Care for the Elderly*, June 1971.

[9] Pre-White House Conference on Aging. Summary of Developments and Data. A Report of the Special Committee on Aging. U.S. Senate. November 1971. p. 6.

[10] Ibid. p. 7.

PART 2

THE POTENTIAL OF HOME HEALTH SERVICES

Home Health Services—a complex of services which may be brought, when and as needed, into the home—have had a very low priority in the United States. References to such services in proposals to meet growing health and social needs in our population are frequently consigned to the "et cetera" sections. Support for the development of viable home health services has been minimal and in such government funding as has been available home health services have been limited, with regulatory conditions so narrow as to make the product negligible in terms of meeting real need.

Such concepts as *preference*—the right of the individual to remain in his own home as a matter of choice; *appropriateness*—the selection of the home as the most appropriate place for care, when it *is* appropriate (as against an inappropriate institutional choice or the absence of service); *economy*—the use of a less costly service which may be preferable; concern about the growing costs of institutional care; and the proliferation of institutional facilities (many of them poor in quality, "one way" facilities with no possibility of rehabilitation or return, the best of them frequently used as the only solution rather than the solution of choice); the growing emphasis upon the necessity for increased use of ambulatory services, should include, but rarely do, a forthright approach to the development of home health services of good quality.

HOME HEALTH SERVICES OF GOOD QUALITY

"Home Health Services of good quality" describes an array of services which may be brought into the home singly or in combination in order to achieve and sustain an optimum state of health, activity, and independence for individuals of all ages who require such services because of acute illness, exacerbations of chronic illness, long term or permanent limitations due to chronic illness and disability. They are an essential component of any system of comprehensive health care and the absence of such services excludes the possibility of the most appropriate use of all other health resources.

Such services are therapeutic and preventive. They are flexibly adapted to meet current need; that is, the selection of those services which are provided at any given time may change as individual needs change [1] or they may be effectively maintained in a given combination

[1] ". . . *the first and most important objective of home care is to meet the need of the individual.* I do not deny the value of another, although secondary, objective, namely, to free precious hospital beds for use by people who need them . . . If we place major emphasis on the desire to free hospital beds then we may easily get into a situation where we use home care as a cheap substitute for good hospital care and this would be a disaster." Goldmann, Franz. *Medical Care Programs and Home Care.* In Public Health Nursing of the Sick at Home. Department of Public Health Nursing. National League for Nursing. New York. 1953.

for long periods of time. They may be provided permanently, when they are necessary either therapeutically or to supplement or replace functional limitations which may increase or which are permanent.

Coordination of the services is an inherent aspect of their quality. Whether the needed combination of services is provided from a single source or is assembled from a variety of sources, they must be provided in a context which ensures firm relationships among the various components of care in order to form a smoothly functioning network of total care.

Continuity of the services is also an inherent aspect of their quality. In the well organized community, home health services are a part of the continuum of care included in the total range. Interruption or change is planned and is not imposed by conditions unrelated to individual need. "Planning" in this sense involves assessment, followed by selection of the most appropriate services planned, change in the "level" of in-home services, selection of alternative method of care, interruption or discontinuance of services because they are not currently needed. The movement through the continuum may begin at any point in the range, and move flexibly through or between components of the comprehensive health care system. (See Diagram A, p. 8.)

PATTERNS OF INTENSITY IN HOME HEALTH SERVICES

The utilization of Home Health Services in combinations of varying intensity are often described as "levels" of care:

1. Concentrated or "Intensive" Service

The most concentrated or "intensive" service is considered effective "for selected patients who otherwise would require admission to hospitals or other health care institutions. It can be equally valid for patients admitted to hospitals or other health care institutions who no longer need instant availability of full diagnostic and therapeutic resources of the institution, but do require multiple professional, diagnostic, therapeutic and supportive services under professional supervision and coordination on an intermittent basis. Patients usually need the intensive level of home care for a relatively short period of time." [2]

Such concentrated services usually involve the provision in the home of a complex which may include visits by the physician several times a week, daily nursing visits, frequent physical therapy and occupational therapy treatment, social services, nutrition services, drugs and medical supplies, the provision of equipment, such as hospital beds, wheelchairs and commodes, portable diagnostic equipment, homemaker-home health aide services, transportation (usually to therapeutic or diagnostic treatment which cannot be provided in the home), and "all other diagnostic and therapeutic services which can be safely delivered in the patient's home." [3]

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[2] American Hospital Association. Governing Council of the Assembly of Outpatient and Home Care Institutions. *Resolution on Ameriplan* April 6–7, 1971.

[3] Ibid.

2. Intermediate Service

A less concentrated array of home health services, an "intermediate" level, is most often applicable to those whose needs require services which correspond to care necessary during convalescence from acute illness or because of temporary disability related to chronic illness. Such services are often utilized for the establishment of therapeutic regimes which will accelerate the return to optimum function. They include, in addition to care given by the physician, nursing visits which may involve specific treatment as well as observation; they may also include physical therapy, occupational therapy, speech therapy and they frequently require utilization of substantial homemaker-home health aide services to support and maintain personal hygiene, adequate nutrition, and an environment which is conducive to health. Services at this level may vary considerably in intensity and duration. In general this level of care, though of longer duration, is not usually required over extended periods of time.

3. "Basic" Services

These services are described in various ways. The term "preventive" is broadly used as it is applied in Public Health, to prevent disease or disability (to promote health); to arrest disease or disability; to support those who, because of increasing disease or disability, will require appropriate home delivered services in order to avoid or delay institutionalization. The term "minimal" is sometimes applied. Such services are not "minimal" in terms of their importance. They have the greatest potential for utilization by large sections of the population. They are also sometimes described as "custodial". The largest numbers within the population for whom they could be useful are not candidates for "custodial" care, however, in the sense that they have lost the capacity to function without substantial supportive services such as those provided in an institutional setting. (The absence of such services does, however, frequently provide "custodial" candidates.)

Basic services involve a simple combination: [4] health supervision or the establishment and maintenance of an open channel to health care as needed and the provision of those services which support or maintain activities of daily living or which supplement limited function by substituting selected services for those which cannot be performed independently.

The usual combination in addition to medical supervision, includes home nursing visits, access to social services, and the services of homemaker-home health aides.

Basic services may adequately maintain individuals in their homes at effective levels of health and function over long periods of time or permanently without recourse to more concentrated care or to institutionalization.

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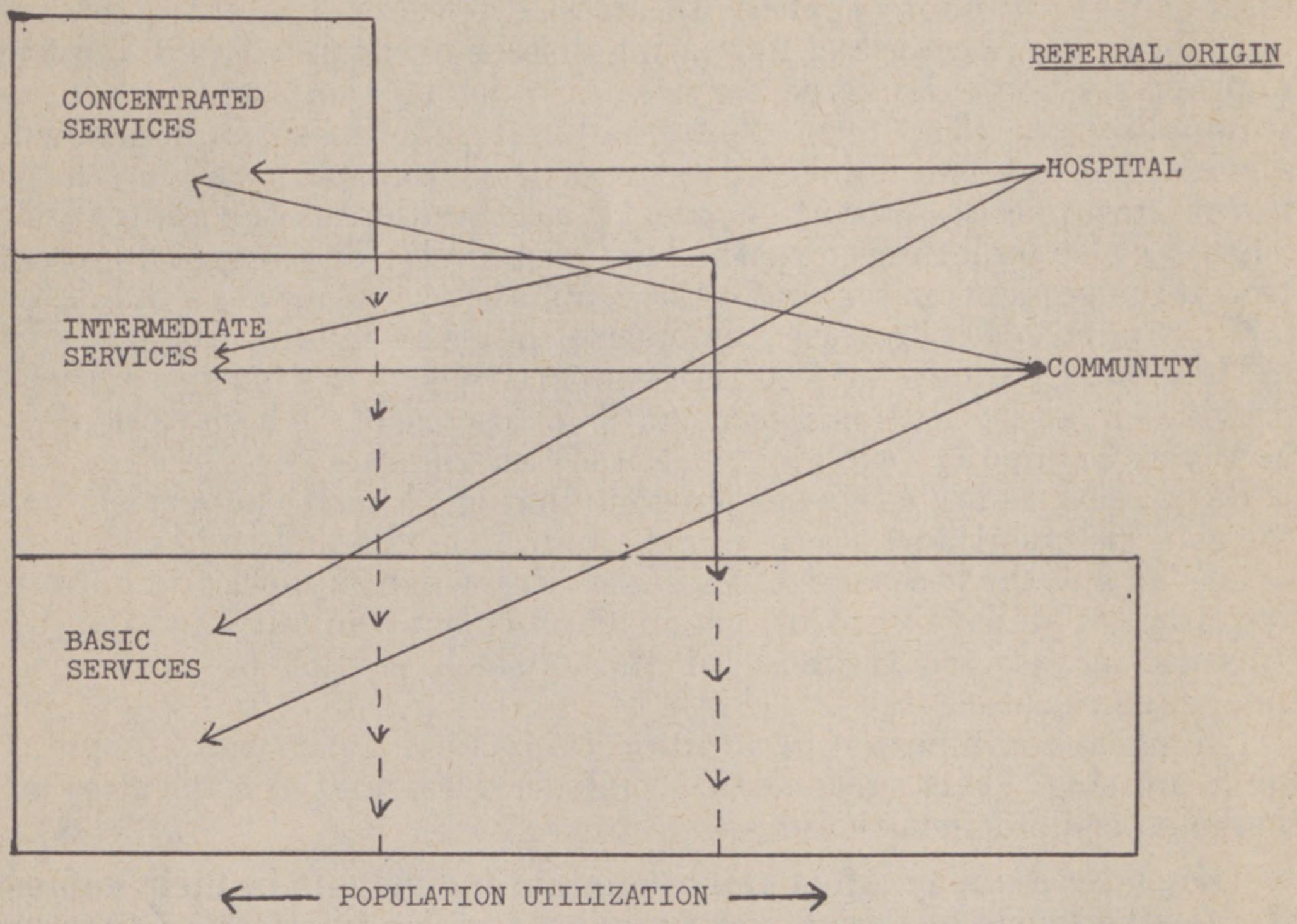
[4] "For the patient with long-term or chronic illness medical care becomes a way of life—and all too often results in his institutionalization. Although the home is not appropriate for all chronically ill patients in all stages of their illness, it can provide a desirable setting for more patients far more often than at present. Home care need not be elaborate in order to meet the requirements of thousands of patients now receiving care in hospitals or chronic disease facilities" American Hospital Association *Statement of the Role and Responsibilities of Hospitals in Home Care*— See Appendix 1, item 2, p. 52.

Such services are most effective when chronic disease limits but does not totally disable, when mobility has been affected so that full physical functioning in the essential activities of daily living is not possible for short or long periods of time. Individuals with multiple diagnostic problems who might, on paper, appear to require institutional care, are very frequently able to continue to live normally in their own homes, to participate in community life, to continue to work, when such basic services are available to them.

". . . Home Care programs . . . serve the patient who is already in his own home and needs care but does not require hospital or other institutional care; they also serve the institutional patient who is ready for discharge and now needs only . . . services of the sort that can feasibly be provided at home . . . (they) are diverse and flexible. They are not restricted to any one group of patients, but are community wide in their reach. All age groups, all disease entities and stages of illness, all economic levels are accepted when . . . indications . . . dictate . . . care at home as the treatment of choice." [5]

DIAGRAM A.

"LEVELS" OF HOME HEALTH SERVICE *



*Source: Ryder, Claire, M.D., Chief of Home Health Branch, Community Health Service, Health Services and Mental Health Administration, DHEW.

[5] Ryder, Claire F. M.D. and Stitt, Pauline G. M.D. *Physician Involvement in Home Care* Inquiry. Volume IV Number 3. Special Issue: Home Care. October, 1967. Blue Cross Association. Chicago, Illinois. Pp. 41–42.

PART 3

THE AVAILABILITY OF HOME HEALTH SERVICES IN THE UNITED STATES

The availability of comprehensive home health services in the United States could substantially affect the appropriate utilization of all health care resources. Such comprehensive services are not available at the present time.

The potential of broad community based home health programs capable of serving large population groups with varying and fluctuating needs has barely been demonstrated. Hospital-based programs are also in short supply and are not being developed in proportion to need. Focused upon short-term concentrated care, they do not have available in the community those services which can be extended to meet long-range need. Home health services, where they do exist are underfinanced, limited in their capacity to cover the population in need, frequently lacking in essential components which might make them an effective resource.

They are diminishing in numbers.
They are curtailing their services.
They are narrowing their coverage to selected population groups.
They are reducing the duration of the care they offer.

The available supply of services includes an assortment of limited agencies: small home nursing programs which depend upon one or two nurses and a few hours of physical therapy or social service—an occasional home health aide—the *minimal* qualification of "skilled nursing plus one" required for certification in Medicare legislation. Such agencies are unable to provide coverage or to meet valid home care need. Homemaker-home health aide programs which should supply the essential basic supports when family members are not capable of supplementing care—or when there are no family members—are rare. They are limited in their ability to meet population demand either for short- or long-term care.

There are geographic areas of the country and large sections of the population which do not have home health services of any kind available. Services are fragmented, geared to special groups, underfinanced, diminishing as the need increases.

This situation does not provide a community resource which can be described as "Home health services of good quality." The auspices under which the services are provided do not determine their quality. Whether they are hospital based, community-based, or exist in an assembly of community agencies, each offering the components of home health care, the essential features which are described in "good quality" are that *all* of the needed services must be available to all of the population. They must be available in a supply which is adequate for the population. They must be coordinated, whether they are under a single roof or housed and administered separately. They

must provide a network which continuously provides services for as long as they are needed.

Home health services and "home health agencies" are not considered synonymous terms. The first is a concept which is based upon clearly defined standards of excellence, as any health care institution of good quality must be. The second is a legislative title which includes only selected and expedient elements of home health services.

HOME HEALTH AGENCIES

The title "Home Health Agency" originated in the Home Health Services section of title XVIII—Federal Health Insurance for the Aged (Medicare).

It has been said that Medicare is not a "program". It is, rather, a mechanism for payment; for reimbursement of the costs of services specified as benefits in the insurance system which covers a selected section of the population.

Nevertheless, the home health regulations of the Medicare insurance system, which governs the expenditure of the insurance funds have had a good deal of influence on the conception of home health services and have had a considerable effect upon the providers of such services and the methods by which the services are provided.

Institutional services can readily be defined and understood. The needed array of home health services which are comprehensive and which must be flexibly utilized is less readily defined.

LIMITATIONS IN THE MEDICARE SYSTEM

As they are applied to the target population—the aged (title XVIII parts A and B) and the indigent sick (Title XIX) the features of the system which limit their utilization are these:

- **Home health services in the Federal Medicare insurance system are focussed upon acute or short term illness.**

  The insurance system limits the number of visits (100 for part A as a post-hospital service and 100 under the supplementary program for those who can afford co-insurance). Since the number of visits includes those provided by all personnel in the home health agency this in effect allows short-term service and imposes upon providers an approach which is limited to acute care.

- **The definition of the eligible consumer of home health services is inherently contradictory as it is applied to the needs of the insured group.**

The eligible consumer of home health services is described in the regulations as follows:

> An individual does not have to be bedridden to be considered as confined to his home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort.
>
> . . . Some examples of homebound patients which are also illustrative of the factors to be taken into account in determining whether a homebound condition exists would be:

> (1) a beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk; (2) a beneficiary who is blind or senile and requires the assistance of another person in leaving his place of residence; (3) a beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and, therefore, requires the assistance of another individual in leaving his place of residence; (4) a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, his actions may be restricted by his physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; and (5) a patient with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity.[1]

In interpreting these regulations considerable emphasis is placed upon the condition that the patient must not be "custodial". On the other hand the severity of limitations, which are indicated in the examples, would appear to apply to the patient who needed considerable service in order to be maintained at home.

- **Services which are reimbursable are not those which are most needed by the majority of the insured group.**

The definition of the eligible consumer as one who is severely limited but not custodial does not appear to "fit" with the services which are permissible in the system. The requirement that they be "part-time and intermittent" must either be applied to a patient who is reasonably able to sustain himself in the intervals or who has others available to do so. The patient must be sick enough to require "skilled" professional services but not so sick that he requires too many visits, visits which are concentrated numerically, or supportive services which the system limits sharply.[2]

The regulations which govern the part-time intermittent services of a home health aide are an illustration:

> While the primary need of the patient for home health aide services furnished in the course of a particular visit may be for personal care services furnished by the aide, the home health aide may also perform certain household services which are designated to the home health aide in order to prevent or postpone the patient's institutionalization. . . . If these household services are *incidental* and do not *substantially* increase the time spent by the home health aide the cost of the entire visit would be reimbursable. Housekeeping services which would materially increase the amount of time required to be spent by the home health aide to make

[1] *Health Insurance for the Aged*—Home Health Agency Manual, P. 16c, Section 208.4, U.S. Department of Health, Education and Welfare, Social Security Administration, HIM–11 (6–66), Reprint Date 5–71.

[2] Trager, Brahna, *Home Health Services and Health Insurance*—Medical Care, Vol. 9, No. 1, Jan.–Feb. 1971.

74–331 O—72——2

> the visit above the amount of time necessitated by care for the patient are not reimbursable.[3] [*Italics supplied*]

The focus on "personal care duties" and the emphasis upon the fact that housekeeping services should not "substantially" increase the amount of time required in the home by the home health aide are extremely difficult to apply. The assumption that "others" in the home are available to provide the essential supportive services of daily living is not generally applicable to the age and living arrangements of the insured group. It is far more likely that the patient who lives alone or with an elderly spouse will be able to achieve his "personal care" services independently, than that he will be able to maintain a decent environment; get the laundry in; or carry groceries in the "intermittent" periods when services are not provided.

- **The definitions of the nature of the services which are reimbursable are susceptible to a wide variety of interpretations.**

  Definitions which apply to the quality of the services which are reimbursable are extremely difficult to rationalize. The term "skilled nursing",[4] for example, has been interpreted to apply to the task itself rather than the assumption that a qualified professional person will apply her skills in all aspects of the service that she renders and that her judgment of the nature of the services required is the essential professional function. This same approach is common in regulations with respect to physical therapy services related to restoration with an additional requirement not compatible with the philosophy of any therapeutic approach:

  > "there must be a medically appropriate expectation that the patient's condition will improve *significantly* in a reasonably (and generally predictable) period of time".[5] The return to an optimum degree of function which is the goal of therapeutic services in other situations, and particularly in this age group, does not prevail. [Italics supplied]

  In practice many patients are undergoing an occupational therapy regimen at the time they are discharged from the hospital or extended care facility and returned to their homes for completion of the treatment program there. Under present law, (Medicare), one of three things must happen: 1) the patient must be retained in the hospital, at an additional cost, until the treatment is completed, or, 2) he must be sent home and the needed treatment halted, or 3) some subterfuge must be found, such as instituting one of the pres-

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[3] Nurses . . . "have a long history of monitoring their activities . . . better utilization has been promoted . . . nursing staff . . . in consultation with the patient's physician, is in the best position to determine the need for care at home. Such a crucial matter should not be left to the judgment of intermediaries, no matter how well intentioned," American Nurses' Association. See appendix 1, item 4, p. 57.

[4] See appendix 4, item 4, p. 130—Reimbursement was retroactively denied for nursing visits made to teach a family member to make a dying patient more comfortable on the score that these were "activities of daily living."

[5] *Health Insurance for the Aged*—Home Health Agency Manual, p. 15–16, section 205.4, U.S. Dept. Health, Education, and Welfare, S.S. Admin. HIM–11 (6–66), Reprint date 5–71.

ently required three types of service even if not needed, in order to complete the treatment at home.[6]

- **The complexities of administration and reimbursement have placed many agencies in financial jeopardy.**

Preparation of claims, approval of reimbursement, computation of visits in the overlapping A and B system have placed considerable pressure on the administration of home health agencies, many of them inadequately prepared to meet these demands.

The processes by which claims are submitted, interpretations made, lengthy correspondence initiated over details of wording and differences in visit counts place an enormous burden on providers. The paper contest over whose judgment shall prevail—the qualified professionals in an agency which must meet exacting standards who is looking at the patient, his illness and his environment, or the fiscal intermediary with the paper who is trying to fit the words to the regulations—would be ridiculous if it were not so tragically wasteful. Larger agencies watch their administrative costs go up. Smaller agencies watch their services go under.

- **The difficulties in establishing and maintaining services have substantially limited the range of services offered by providers. A limited range reduces the usefulness of the services.**

Coordinated home care programs which provide a broad range of services have demonstrated what must be self-evident: the availability of a variety of professional and supportive services in a home health agency encourages utilization, even when the majority of patients treated do not require all of them. Since the necessity to select differing combinations at different stages in care always exists, physicians will not be encouraged to utilize home health services if they are not comprehensive and if the patient must be rehospitalized because services which could reasonably be delivered in the home are not available.

Reimbursement from the insurance system is allowed only for selected services. The relevance of the use of varying combinations with different degrees of intensity according to patient need is an aspect of quality care. The regulations as they are interpreted and applied do not recognize this aspect.

Home health agencies which offer a reasonable array of services must look for the support of their development to their own efforts and to the communities in which they are placed. This support has not been available and the pressure of need for unreimbursed service in the population has strained resources and inhibited development toward comprehensive services.

- **The system has a very strong institutional bias. Entry into the home health services entitlement (Part A) is by way of an institution (a three-day period of hospitalization unless the insured is able to pay for supplementary insurance).**

In both an acute hospital and an extended care facility the system reimburses the provider for all services. Regulations do not limit the skills of professional personnel nor the number and frequency of

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[6] See appendix 1, item 10, p. 74, American Occupational Therapy Association *Statement on Home Health Care.*

visits. They do not exclude the provision and preparation of food or any of the maintenance services essential to a hygienic environment. Given a choice between full and coordinated services in the institution and the relative insecurity of limited home delivered services which are restricted in the provision of professional care and which view all other supportive services very narrowly, consideration for the relative safety of the patient must encourage utilization of the institution. The home might be a more appropriate choice, but unless equal safety can be insured through the provision of adequate professional care and supportive services to compensate for those which the patient can neither provide for himself nor secure from other sources, it cannot be in the patient's interest to treat him there.

- **Utilization of home health services in the Medicare insurance system has remained at less than 1 percent of insurance expenditures and appears to be diminishing. Institutional utilization and expenditures are increasing.**

Increased expenditures for institutional care in the health insurance system reflect both increased costs and increased utilization. Expenditures for home health services in the period 1969–1971 have decreased.[7]

> Retroactive denial of payments combined with under use is resulting in such serious financial difficulties for providers of home health care that such provider resources are diminishing steadily.[8]

There has been a decrease in the number of home health agencies participating in the Medicare insurance system: there were 2,350 participating home health agencies in June of 1970 and in June of 1971, there were 2,256 participating home health agencies.[9]

For these reasons (and others related to the absence of concerted efforts to develop services), contraction of services and personnel have created a prevailing attitude that home health services are not generally available and therefore do not serve a useful purpose.

THE DEFINITION OF A "HOME HEALTH AGENCY"

The Medicare insurance system defines a "Home Health Agency" (one which is eligible for certification and consequently for reimbursement of services by the Medicare insurance system) as a public or private agency (or subdivision of such an organization), which, in addition to requirements for sound administration, adequate records, professional supervision, assessment and review, has as its primary function the provision of skilled nursing service and at least one additional therapeutic service (i.e. physical, speech or occupational therapy, medical social services or home health aide services).

In January 1969, there were approximately 2,161 certified home health agencies in the United States.[10] The majority of them were

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[7] See Table A, p. 16.
[8] See appendix, p. 50, American Hospital Association.
[9] Office of Research and Statistics, Social Security Administration.
[10] See Table C–1, p. 17.

voluntary or public agencies which offered services in the home prior to passage of the Medicare insurance legislation; they were not a substantially new resource for those in need of home health services.

Many of these agencies, those which were primarily engaged in providing home nursing, added, or contracted for an additional service in order to achieve certification. Others providing services which were broader in range were able to receive reimbursement for that portion of their care which fit the conditions of the Medicare insurance system. Those which were established as new agencies in anticipation of sustaining their services through Federal Medicare Insurance reimbursement have had the most difficulty; it is not possible to sustain a home health agency which will provide the care required by those in need when the source of reimbursement is limited to the Medicare insurance system.

Certified home health agencies deliver their services under a variety of auspices:

As of December 1971, the largest number of certified providers 1,303 were the official health agencies. Visiting Nurse Associations made up the next largest with 550 agencies certified; 217 of the 243 hospital-based home care programs were certified as providers. The remaining agencies were distributed among a variety of auspices, public, voluntary and proprietary.[11]

The range of services provided by these agencies is limited. More than half fall into the group "skilled nursing plus one"—the minimum required for certification. Another 26 percent provide two services in addition to nursing. Only 4 percent provide five services in addition to nursing. The second service most frequently offered is physical therapy. The third most frequently offered is home health aide services.

Services are more numerous in urban areas which, prior to passage of the Medicare Insurance legislation, offered bedside nursing services through the official health agencies (departments of Public Health) or through well established Visiting Nurse Associations. The distribution of services in rural areas is thin and in some sections of the country there are no services available.

The number of agencies and the number of services offered provide no real indication of their utility as a practical home health resource. Half of the agencies have fewer than three full time nurses available. The additional services offered are, many of them, only minimally available: physical therapy, nutrition, home health aide services may be available, as are nurses, on an hourly basis, or from one or two employees. "When an agency's services are too limited, one of two things can occur: (1) it can restrict intake to the few conditions it is equipped to serve; or (2) it may accept patients without having the staffing versatility to meet those patients' needs."[12]

Home health services are not generally available to the population in the age group 45–65: a population which should be protected as far as possible from arriving on the Medicare health insurance doorstep in poor condition and consequently slated to be over-utilizers of health

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[11] See table C–2, p. 18.

[12] Ryder, Claire F.M.D.; Stitt Pauline G.M.D.; and Elkin, William F.M.S. *Home Health Services—Past, Present, Future.* Vol. 59, No. 9, American Journal of Public Health, September 1969, see table B, C–3, pp. 16-18.

care thereafter. In this group are persons who are disabled but not sufficiently disabled to be eligible for public assistance although they might be made to become eligible; in this group are "medically indigent" persons who are not sufficiently indigent to meet public assistance criteria but who could be reduced to sufficient indigence given the right conditions for deterioration.

The Medicare insurance system has paid for a great deal of good quality care, *mostly institutional.* It has been a resource for older persons during periods of *acute illness* who need no longer fear that there will be no help "when illness strikes" a realistic fear well developed in pre-Medicare days by advertising.

TABLE A.—*Medicare reimbursements for home health services and inpatient hospitalization, 1969–71*

Year	Reimbursements in millions of dollars	
	Home health [1]	Hospitalization
1969	78. 8	4, 039. 5
1970	67. 4	4, 425. 8
1971 [2]	49. 5	4, 538. 5

[1] Includes parts A and B.
[2] Estimated on the basis of data through Oct. 6, 1971.

SOURCE: Social Security Bulletin, January 1972; vol. 35, No. 1. Department of Health, Education, and Welfare.

TABLE B.—*Home health agencies providing specified numbers of services in addition to nursing service, January 1969*

Services in addition to nursing	Number	Percent
5	96	44
4	130	6. 0
3	205	9. 5
2	574	26. 6
1	1, 155	53. 5
Unknown	24	----------
Total	2, 184	100. 0

TABLE C–1.—*Number and percent of certified home health agencies providing selected services, by type of agency, January 1969*

Type of agency	Number of agencies	Physical therapy		Occupational therapy		Speech therapy		Medical social service		Home health aide		Nutrition guidance	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All agencies	[1] 2,161	1,571	72.7	352	16.3	477	22.1	432	20.0	1,042	48.2	393	18.2
Visiting Nurse Association	541	461	85.2	112	20.7	140	25.9	78	14.4	245	45.3	45	8.3
Combined government and voluntary	107	85	79.4	25	23.4	36	33.6	18	16.8	54	50.5	22	20.6
Official health	1,294	830	64.1	129	10.0	193	14.9	214	16.5	589	45.5	203	15.7
Hospital based	172	154	89.5	62	36.0	82	47.7	98	57.0	126	73.2	104	60.5
Rehabilitation facility based	12	12	100.0	11	91.7	10	83.3	7	58.3	5	41.7	3	25.0
Extended care facility based	15	12	80.0	5	33.3	7	46.7	5	33.3	11	73.3	9	60.0
Proprietary	20	17	85.0	8	40.0	9	45.0	12	60.0	12	60.0	7	35.0

[1] Based on 2,161 of the 2,184 certified agencies for which data were available.

SOURCE OF BASIC DATA: Social Security Administration (type of agency and services provided from application form SSA–1515).

SOURCE: Ryder, Claire F.M.D.; Stitt, Pauline G.M.D.; Elkin, William F.M.S., *Home Health Services—Past, Present, Future*, American Journal of Public Health, Vol. 59, September 1969.

TABLE C–2.—*Number and percentage distribution of participating home health agencies by type of agency as of December 1971*

Type of agency	Number	Percentage distribution
Total	2, 256	100. 0
Official health	1, 303	57. 8
Visiting nurse association	550	24. 4
Combined Government and voluntary	60	2. 7
Hospital based	217	9. 6
Other nonofficial	80	3. 5
Extended care facility based	8	. 4
Rehabilitation facility based	11	. 5
Miscellaneous	61	2. 6
Proprietary	46	2. 0

SOURCE: Social Security Administration, Office of Research and Statistics.

TABLE C–3.—*Number and percent of participating home health agencies providing selected services as of December 1971*

Selected services [1]	Number	Percent of all agencies
All agencies	2, 256	100. 0
Physical therapy	1, 664	73. 8
Occupational therapy	447	19. 8
Speech therapy	636	28. 2
Medical social service	494	21. 9
Home health aide	1, 357	60. 2
Other services	514	22. 8

[1] All participating agencies must offer nursing services to qualify under the program.

SOURCE: Social Security Administration, Office of Research and Statistics.

Within the age group which Medicare is intended to serve (age 65 and over), the Medicare regulations tend to place an impossible financial responsibility on providers. The Medicare insurance program allows reimbursement for the acute or relatively short-term phases of illness (post hospital 100 visits in part A and an equal number in part B when the recipient has the funds to participate in costs of the service) but leaves the provider with the alternatives of terminating service for the long-term service need (which is the commonest need in this age group), finding the funds for continued service, suggesting another period of hospitalization as a means of entry into home health services or avoiding acceptance of such individuals unless there is clear evidence that the need and the Medicare payments will terminate at the same time—a difficult assessment in individuals whose chronic illness may prove unpredictable.

It has been demonstrated that home health services cannot survive on the support of Medicare payments, even if present problems such as the high costs of paper work required by these programs (and the

destructive practices of retroactive denial of payment on the one hand, "prior approval" policies arriving long after the need is over, on the other) were eliminated.

"It has been demonstrated" means, of course, that many home health services have tried to stay afloat and have failed. Some have closed shop. Many have sharply reduced the range of services that make for a useful and constructive resource to physicians, to individuals and families, to communities. Most have tended to offer only those services which can be readily provided and readily reimbursed and have been forced to ignore services which might be "key" services in making a home care plan feasible. Some have refused to accept for care any referral in which third party reimbursement is Medicare reimbursement. Others have narrowed their acceptance criteria and have accepted for service only those for whom payment of the full unit cost can be made. There is a tendency to reject recipients insured under Part B because Medicare pays only 80 percent reimbursement. Certain categories are avoided: long-term care; care in which the "laying on of hands" (evidence that the care is "health related") cannot be clearly demonstrated. Care policies have been adopted which are not necessarily related to patient need.

Agencies which had previously emphasized the relevance of care plans to the needs of individual patients have begun to make routine use of the language of regulations and to make plans which fit that language. (A common one is the refusal to assign a home health aide for less than four hours even when only two hours are needed by an elderly gentleman in a one room apartment; a half hour for his "personal care"; a half hour for a bit of cleaning; a half hour alternately to market, wash two shirts and two sets of underwear; prepare a casserole meal that will last two days. If he is on Medicare he might like the home health aide to come to him for short periods but often; his visits get used up by the requirement that nursing visits must be made at intervals which neither he, nor the doctor, nor the home health service may consider appropriate.[13] Hospitalization and the nursing visits are his entree into home health care, without which he would be compelled to enter a nursing home for as long as the law allows, which in his case, since he has lived for years in this neighborhood might not be for very long—since nursing home patients for a variety of reasons do not have long lives.)

Home health services find it difficult to stay "afloat" economically when they attempt to offer the services that are needed in a way that makes sense for the consumer.

Although Medicare is described as a funding device, the policies which govern the expenditure of Medicare insurance funds have done a great deal to influence and mold the health delivery system. Policies which stress institutional care and which replace the broad concept of home health services with a set of complicated isolated services labeled "health related," are not going to open the possibility of appropriate choice.

The "home health agency" is not a provider of comprehensive home health services at the present time; as a potential provider of such

[13] See appendix 4, item 1, p. 122, Federal requirements for nursing visits deemed unnecessary by the physician increased costs by one-fourth.

services it has many advantages. Extended and supported adequately it can offer services to all sections of the population; all age groups; all economic sectors. Whether its components exist under a single administration or are developed separately and coordinated so that utilization and progression are effective it offers the possibility of a system of care which can become a real alternative to institutional care; meeting needs as realistically as a good hospital meets them, or as high quality extended care facilities or nursing homes meet them—expanding the possibility of appropriate choice. This potential effectiveness might be immediately realized by a more realistic approach in the Medicare-Medicaid legislation for the groups affected by that legislation; such a realistic approach would inevitable pave the way for broad coverage in the projected health care systems of the future.[14]

THE USE OF INSTITUTIONS

Institutionalization in extended care facilities, often with a progressive movement into long-term institutions, has affected large numbers of Americans who are clear in their minds, often capable of a good deal of self care, and potentially capable of a good deal more with aggressive measures of rehabilitation. It has cut them off from their communities, their friends, their families, destroyed their privacy—probably man's most precious possession. No normal, healthy, functioning human being likes to visit a hospital, an extended care facility, or a nursing home or, over a long period of time. Pointing the finger and shouting "neglect" at family members and friends increases guilt but does nothing to mitigate the reaction of avoidance which is often more intense the more loved the "inmate" is. Unlike mercy, the quality of pity is much strained. It destroys vital relationships.

In the words of a physician concerned with geriatric patients:

> We are warehousing thousands of functioning human beings because they need some relatively inexpensive health care; they can't change their own bed linen; carry the groceries upstairs; wash their own hair; occasionally need a little help getting in and out of the bathtub and aren't able to take a bus ride to the doctor. The same fragile, but psychologically and socially functioning individual who is lucky enough to have a good doctor, a family and friends or is able to buy a little help for himself doesn't have to give everything up and share a hole in the wall with a stranger and become a vegetable because nobody there is much interested in doing those things for him either. And the worst of it is, there's no return.

THE PROBLEM OF "RETURN"

Institutional care following hospitalization is sometimes the treatment of choice and, provided the institution is a good one, such care accelerates recovery. The return of the individual to his own home becomes a problem when:

- The relationship to his own environment is not carefully guarded, prior to or at the point of admission when plans are being made

[14] See "Recommendations," pp. 49–50.

for his return if such return is at all predictable. Individuals who are on public assistance or who are on marginal incomes must often give up the room or the apartment or even the home in which they have lived because there is no way to maintain it. Interim funds and services extended from the home health agency to institutionalized patients are necessary to support the expectation to return and to maintain the home to which they might reasonably be expected to return.

- The family which may have been available has been overwhelmed either by past care or by the prospect of future care. The assurance that services in the home will be available when the patient returns must be given at the point of admission and throughout the period of institutionalization.
- The individual becomes "institutionalized". He may fear "return" even when he is unhappy in the institution. The poorer institutions do, in fact, increase this fear by reducing independence and ignoring the need for services aimed at restoration. The assurance that care services at home will be available as needed must be specific and based upon reliable facts concerning the kind, duration, and reimbursement sources of home delivered services.
- The physician who might return the patient to his own home is unwilling to do so because he has no way of ensuring patient care there. The availability of a reasonable array of services upon which he can draw for his patient's needs offers him an opportunity to make an appropriate choice which includes return from the institution.

The fact that some institutions are of poor quality is not a reason for the development and utilization of home health services. It is a shame; a reason to improve the quality of institutional care. Good institutions will be an appropriate choice for those who require good institutional care.

The addition to the health care system of good quality home health services provides the services essential to the return from the institution—even the so-called "long-term" institution. It preserves the possibility of choice. It is a continued protection against the danger of assuming that once in, there is no way out.

"COORDINATED" HOME CARE PROGRAMS

All Home Health Agencies and all communities which offer the components of home services consider coordination a key element in the effectiveness of care.

The term "coordinated" as it is applied here has traditionally been included in the title of programs which are either hospital based or which are closely linked to hospital services.

A coordinated home care program is one that is centrally administered and that, through coordinated planning, evaluation, and follow-up procedures, provides for physician-directed medical, nursing, social, and related services to selected patients at home. Home care programs furnish medical, nursing, and rehabilitative services to selected patients in their homes, with a view toward shortening the length of hospital stay, speeding recovery, and bridging a gap in community health services for patients who are too ill or otherwise unable

to visit a physician's office or an outpatient clinic yet do not need hospital care.

There have been two avenues of development in home care during the past 25 years. In one, the hospital extends some of its services into the community to provide home care under medical direction; in the other, a community agency such as the visiting nurse association or the local health department builds upon its existing program of service to provide coordinated home care in collaboration with the hospitals of the community.[15]

Hospital Based Home Care Programs [16]

Described by E. Michael Bluestone, who developed the concept of the hospital-based home-care program as a "hospital without walls", an extension of the hospital into the home which added to the bed capacity of the hospital,[17] hospital based home care programs have been developed in approximately 263 hospitals [18] in the United States. About 82 percent of such programs are based in larger hospitals (100 beds or more) and offer a complex of services . . . about one-half of the programs providing nine to sixteen selected services.

During the year 1969, about 40,000 patients were admitted to 211 hospital home care programs which had been operating for a twelve month period. Over-all the median number of patients admitted to each program for that year was 135. During that same year the median length of stay in the home care programs was 80 days. Hospital based home care programs offering a wider range of services maintained patients in the program for longer periods—the longest (eleven hospitals) providing services to some patients. Almost sixty percent of these programs, queried in 1969, expected to expand their program—planning to add more staff, to add additional services, to include more patients, to increase geographic coverage, to train more homemaker-home health aides. Plans for such expansion were based upon the anticipation of increased reimbursement and additional insurance coverage.

Community Based Programs Closely Linked to Hospitals

"Whether or not the hospital or community agency is the administrator of the home care program, the hospital is a focal point in determining the extent of patient needs. It is within the hospital that arrangements are made for patients potentially in need of home care services." [19]

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[15] *Home Care and The Hospital,* Lorraine Richter, Research Associate, Division of Data Collection and Alice Gonnerman, Assistant Director for Ambulatory Care, Division of Continuing Health Care, American Hospital Association, February 1971.

[16] "In the 1969 annual survey the American Hospital Association's definition of a hospital-based home care program was 'an organized hospital based program that provides medical, nursing and other treatment services to patients in their place of residence'." Richter and Gonnerman.

[17] C. F. Ryder, *Changing Patterns in Home Care,* U.S. Department of HEW PHS publication #1657.

[18] Richter and Gonnerman. Inclusive data concerning admissions and length of stay apply to 243 programs (some federal hospital programs) indicated that questions relating to these figures were not applicable.

[19] *Home Care and the Hospital,* p. 12.

About 216 coordinated home care programs are not hospital based but are so closely linked to in-patient services that they are included by the American Hospital Association in the second group: "to provide coordinated home care in collaboration with the hospitals of the community." [20] Seventy-two of these provide psychiatric foster care and are based in psychiatric institutions.[21]

The importance of the coordinated home care program, whether it is hospital administered (hospital-based) or whether, as a community administered service, it collaborates with or shares services with the hospital, lies in its focus upon the patient in a hospital bed and in its potential usefulness for the patient, the institution and the economy as a means to reduce hospital stay.

The benefits of such programs have been described:

> They offer to the patient, the physician, and the hospital, an alternative to the provision of 'progressive' care—to the hospital-extended care facility-nursing home.
>
> The patient is "at home" and this is a factor which has a tremendous psycho-social effect; it exerts strong influence upon the success of treatment.
>
> They eliminate the "ping-pong" effect of hospital care in which the patient, having received a great deal of care in the hospital goes home and, without the services, deteriorates and must be re-admitted to the hospital, frequently in worse condition.
>
> The physician can care for a greater number of patients at home in the home care program; the coordination of the needed ancillary services at home is the responsibility of the program. He need not individually assemble and coordinate them.
>
> The patient at home has ready and easy access to medical advice. Home care staff identifies problems, foresees them and reduces the possibility of the occurrence of emergency situations.
>
> Home care staff can more readily interpret medical orders, explain treatment regimes, offer reassurance and support.
>
> Where physicians are in short supply, such as urban ghetto areas and areas which do not have ready access to physicians, the system is a tremendous plus to the physician.[22]

Studies of coordinated home care programs have demonstrated that they do in fact shorten hospital stay and that in spite of the costs of the home delivery of an array of services, there is cost saving in the utilization of such services.[23]

Studies which have been made of admissions to hospital based home care programs indicate that increases of admissions to home care are related to the number of services provided by the home care program; longer stays in the home care program are also related to the availability of a broad range of services leading to the conclusion that such programs have a greater capability in the care of sick

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[20] *Home Care and the Hospital*, p. 12.

[21] *Home Care and the Hospital*, p. 14.

[22] Jessimen, Andrew G., M.D., Associate Director of Professional Services, Peter Bent Brigham Hospital, Boston, Massachusetts. Report to the Meeting on Community Health Care of the American Medical Association, Arlington, Va. February 4–5, 1972.

[23] See appendix 3, pp. 82–118.

patients and can provide home care patient days in place of hospital patient days.[24]

Studies which are in process indicate that the anticipated expansion of coordinated home care programs is not occurring.

> Although the benefits for home health services are provided under the Medicare program it is a limited benefit program which fragments reimbursement for coordinated home care services between Parts A and B home health services benefits and Part B out-patient benefits. Medicare benefits are not allowed for several important services which are necessary to properly care for patients of a coordinated home care program which represents an intensive level of care.[25]

Rising costs have restricted the extension of the range of services and their increased utilization. The number of hospitals and community agencies offering such services is not increasing and may be diminishing, in spite of the increasing costs of in-patient care. Coordinated home care programs have been established primarily in or near urban areas. In communities where there are no facilities for long-term care or where such facilities are insufficient (and these are the majority) the "ping-pong" effect still occurs, and the inappproriate use of long-term institutions still, after the investment of the home care program, becomes the only available resource.

The development of increased numbers of such programs is a necessity, and the availability of community services to which such concentrated care programs can refer patients with long-term problems will guarantee the effectiveness of their services.

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[24] Richter and Gonnerman, Table 8.

[25] Blue Cross of Greater Philadelphia, see appendix 3, item 1, p. 84, p. 71e.

PART 4

BASIC COMPONENTS OF HOME HEALTH SERVICES

Components of home delivered health services, which provide a broad base upon which an effective care system can be built and extended, are those of nursing, social work, the "therapies" (Occupational Therapy, Physical Therapy, Speech) and homemaker-home health aide services. These services are applicable to every level of home health care and fulfill essential requirements for prevention, for treatment, and for support of personal, psychosocial and environmental needs in individuals who are acutely or chronically ill or disabled, for short or long periods of time, when the selection of the home as the appropriate site for care is feasible.

Nursing Services

The concept of "skilled" nursing services which has become so firmly entrenched in the Medicare insurance system and which is related almost exclusively to the need for specific bedside tasks requiring narrowly defined nursing "skill" does not offer the possibility of effective home delivery of health care, since such services are focussed primarily upon acute illness—upon illness in specific diagnostic categories: those requiring "therapies". These are not the major needs of the aging population even in periods of acute illness. The "laying on of hands" is not the primary nursing need of patients in institutions, and it is not the primary nursing need of present and potential consumers of effective home health services, although it must be included as one of the elements in nursing care in the home. The application of the public health concept of nursing functions is far more relevant and has, in fact, been the basis upon which our communicable disease control programs, and our preventive and care services to the younger "at risk" population have been built.

These functions include:

Case finding—Searching out those individuals whose health status may constitute a risk to themselves or to the community.

Preventive services.—Providing a necessary link to treatment facilities and establishing patterns of living with demonstration and instruction prescribed by physicians for the return to an optimum state of health.

Assessment and ongoing observation.—Health surveillance which provides for continuing awareness of fluctuations in health status; maintaining an open channel to necessary treatment resources so that services may be adapted to changing needs.

Direct services.—The use of nursing skills to provide needed bedside nursing services or to supervise those who provide such services in the home.

Follow-up.—Identification of individuals who, because of the nature of their disease, disability or physical limitations, are in danger of regressing from an optimum state of health, in order to insure continuity of access to needed treatment services.

This range of nursing services has not been available to the aging population. Historically, home nursing services focussed first upon the nursing care of the indigent sick in their own homes. The development of the concepts of prevention and communicable disease control tended to emphasize services in the home to selected disease categories (those which threatened the health status of the community) and to those sections of the population which were first considered to be "at risk" (services aimed at the prevention of maternal and infant mortality; the elimination of preventable or correctable crippling in children). Nursing services which focussed upon these problems have traditionally been placed in public health departments.

These clear distinctions no longer exist; public health departments have, in many communities, added home nursing of the sick to their services when such services were not available elsewhere; in some communities, Visiting Nurse agencies have merged with the public health department and in some communities the two services have continued to function separately, each with a different emphasis. Whether they provide the range of services under a single auspice or divide their activities, both services see their role in the broad context which has been established in public health.

Its application to the field of chronic disease and disability, and consequently to the older age group has been limited by the failure of funding sources, both government and voluntary, to recognize that nursing services have been faced with a new problem: the increased numbers of older, chronically ill and disabled persons in the population who are entitled to the full range of public health nursing services but who are unable to receive them because there has not been a corresponding increase in nursing personnel to meet this new need and because the approach to the delivery of nursing services to this population has been based upon the misconception that short-term care, directed to acute illness, will meet the need.

Public health departments which have embarked upon programs of home nursing to the older population have found themselves overwhelmed and have been faced with the alternative of sharply limiting such services or of siphoning off the needed services from established programs. Voluntary nursing services—whose primary activity is home nursing—anticipating that the health insurance system would add the necessary income for this new population, have found instead that the program has served to uncover nursing needs which the system will not pay for—services which are essential to the health and safety of the population over sixty-five but which also have important preventive implications for the sick poor of all ages and for the 45–64 age group, in which vulnerability to chronic illness may begin to occur.

In the annual reports of home health agencies for 1970–71, there are repeated references to forced staff reductions and curtailed services—a situation cited as "untenable at a time when the public has been led to expect increased and expanded services." [1]

In the *Yearly Review Survey*, staff cuts in the full time nurse force were reported in 38 percent of reporting agencies. Among official

[1] National League for Nursing, Department of Home Health Agencies and Community Health Services.

agencies, staff cuts were reported by approximately one of every four agencies. Among voluntary agencies, the proportion was twice as high—approximately one of every two agencies. In over 27 percent of the agencies reporting staff curtailment the number of staff nurses employed in April 1971 was at least 30 percent below April 1970 levels with over 7 percent of the agencies experiencing cutbacks of as high as 50 percent or more.[2] Reasons given for cuts were restrictive and retroactive reinterpretation of Medicare regulations coupled with a lag in reimbursement adjustments for previous years, curtailment in Medicaid benefits and reimbursement and reductions in voluntary financial support in voluntary agencies.

These reductions, when they are applied to the total number of professional nurses (15,152) and licensed practical nurses (1,409) employed in Home Health Agencies as of July 1969,[3] represent a "coverage" of the population in need of home nursing services for which the adjective "thin" is an overstatement.

The knowledge that 87 percent of the population resides in counties where there is at least one certified home health agency is not impressive when more than one-half of the agencies have available "less than three but more than two" [4] nurses to provide the primary service of a home health agency.

Homemaker-Home Health Aide Services

In all home health services the supportive care which is essential for the total maintenance of the individual in his environment is provided ideally by paraprofessional personnel. Homemaker-home health aides are carefully selected for personal aptitudes: emotional stability; the capacity to adapt to a variety of differing situations; skills or the capacity to acquire skills; the capacity for observation; discrimination, good sense, judgement; sustained interest in the various aspects of the work; "maturity" as a combination of these rather than as an expression of chronological age. ". . . relationships require compassion, common sense, self-discipline, optimism and a basic knowledge of human behavior . . . The basic training . . . of all individuals employed . . . should be essentially the same. Good orientation, on-going education and professional supervision should help develop the variety of special skills necessary to the purpose of the particular situation." [5]

The title is not intended to describe casual workers, available in the open market to the individual employer. Homemaker-home health aides are always employees of an agency, a service, an administrative

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[2] A sample survey of policies and practices of home health agencies and community health services, conducted annually by the Department of Home Health Agencies and Community Health Services of the National League for Nursing.

[3] Number of Professional and Technical Employees (full time equivalents) in 2,209 Home Health Agencies participating in Medicare as of July 31, 1969. Source: HEW office of Research and Statistics *Health Insurance Statistics*, HI 22, January, 7, 1971 issue.

[4] HHSHMA—Community Health Services Data Center Community Health Services, Community Profile. Data Center Resources Development Branch, June 1971.

[5] National Council for Homemaker-Home Health Aide Services, Inc. *Addenda to Standards* p. 7.

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unit which is responsible for the selection, training, and performance of the worker; in which adequate professional supervision is available, assigned tasks are related to individul skill; protective policies for both consumer and worker are established and maintained, and personnel practices provide workers with acceptable working conditions.

". . . the homemaker-home health aide is one and the same person. The term 'home health aide' may be required for certain funding or legislative purposes; it should not, however, influence the service rendered by the homemaker in the home." [6]

The generic title "homemaker" describes personnel capable of performing the full range of activities necessary to the maintenance of individuals or families in their own homes when long- or short-term illness, disability, psychosocial crises (or combinations of these) require supportive, therapeutic or compensatory services to sustain independent living.

The title "home health aide" is found in Medicare regulations and is intended to describe a somewhat narrower service, sometimes stressed as a service analagous to that of a hospital aide performing functions that are primarily related to the "personal care" of the patient and excluding, when possible, those services which, in the institution, are provided by other personnel. The introduction of the title "home health aide" has occasionally been confusing. It has appeared to reduce the effectiveness of a worker with a range of skills to the performance of a few—in the home a relatively useless assignment—since the home does not have available the variety of ancillary services which are provided by the institution. The combined title has been officially adopted [7] in order to avoid the development of a second group of workers; more important, to avoid a situation which began to prevail following the passage of the Medicare health insurance legislation—in which one paraprofessional—a "home health aide"—was assigned to perform "personal care tasks" and a second paraprofessional—a "homemaker"—was assigned to perform all other functions related to maintenance of the sick at home. The short supply of funded personnel in this paraprofessional category made such a division of labor impressively impractical. Homemaker-home health aides function appropriately in health settings and in social work programs. It is generally agreed that the predominant need is almost invariably health related regardless of age or economic status, and that psychosocial components cannot be separated from health related problems. Training and supervision stress both aspects of the functions of the homemaker-home health aide who is expected to carry out the physician-prescribed therapeutic regime as well as to perform all tasks which are essential to healthful living in a decent environment.

Homemaker-home health aide services, in the developmental years, have been funded entirely from voluntary sources and, as a result, they have not, since the beginnings of such services in the 1920's, had a history of successful growth. In order to recruit, train and adequately supervise such personnel with placement in conditions that protect both worker and consumer, funding from private sources and from fee-for-service were insufficient to stimulate development, although the services have demonstrated their effectiveness in shorten-

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[6] National Council for Homemaker-Home Health Aide Services, Inc. *Addenda to Standards*, p. 7.

[7] Ibid.

ing or preventing institutional care where they have been available. Public welfare programs during the 1930's began to initiate such services and there was limited expansion—usually in protective services for families with children. Amendments to the Social Security Act in 1962, providing 75–25 matching funds for Public Welfare administered homemaker services, increased the volume of employed homemakers from 3000 in 1963 to 5000 in 1965.[8]

Changes in regulations of the Social Security Act with respect to service programs for the aged, blind and disabled, which required all State agencies to provide selected services, including the mandatory provision of homemaker services (to recipients in the categories mentioned) by July of 1973. This has been amended to April 1, 1974. Data on the number of States which include homemaker services in State plans does not include the number of homemakers actually employed. The number of States which include such services in their plans has increased from 16 to 39. The term "homemaker" is used. Adherence to recommended standards of national standard setting organizations such as the National Council of Homemaker-Home Health Aides will be required; the range of skills specified in the standards of the Council combine those specified in Medicare regulations for the "Home Health Aide" [9] with all other services appropriate to promotion of effective home care.

In January 1972, it was estimated that there were approximately 2,850 agencies providing homemaker-home health aide services in the United States: 1,300 serving families with children, 1,200 in health related programs (both public and voluntary); 175 "single service" agencies (i.e. providing supervised homemaker-home health aide services to meet a variety of community needs) and 175 proprietary registries.[10] (See table D, p. 32.)

The estimated total number of homemaker-home health aides employed in these programs is 30,000—as against a total estimated need of 300,000.[11]

In July 1969, 4,061 home health aides were employed in those certified home health agencies which offered the service (an estimated 1,042 agencies); (see table E, p. 32); in June 1970 an estimated 4,276 home health aides were employed in 1,254 certified home health agencies (see table F, p. 32)—an increase of 215 employed home health aides in the one year period. Staff reductions similar to those in nursing staff as a result of continued funding problems have been reported in 1971 in homemaker-home health services.

Experience with Home Help Service in the United Kingdom indicates that with "open availability" of home help service, i.e., to all age groups as needed, approximately two-thirds of the consumers are in the adult population: aging, disabled and chronically ill adults, and the major reason for referral to the service is a health related problem.[12]

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[8] Federal Register Volume 5 Number 230 November 26, 1970 Part II Dept. of HEW; SRS Service Programs for the Aged, Blind and Disabled or Disabled Persons. Section 222.46.

[9] National Council for Homemaker-Home Health Aide Services, N.Y.

[10] Ibid.

[11] Report "White House Conference on Aging," U.S. Government Printing Office. No. O–448–917.

[12] Trager, Brahna, *Home Help Abroad* in Homemaker-Home Health Aide Services, Organization, Administration, Training. In preparation for U.S.P.H.S. publication.

Recruitment and training of personnel for homemaker-home health aide services is relatively simple. This is a category of employment in which temperament and skill-aptitude play a large part; there is a large pool of unemployed and underemployed women (and men as well) who possess the characteristics and interest essential for the work.[13] Didactic training may be relatively short; professional supervision provides a continuous source of on-the-job training. Since trainees are drawn from marginal income groups, both the costs of training and the support of trainees in training must be provided. The personnel produced has been of good quality.

A special project developed in the Kaiser-Permanente group practice program in Portland, Oregon, to provide home care and extended care facilities in the comprehensive system, reported the development of a high degree of technical skill in home health aides utilized in the project. Half of the services provided by professional personnel were provided by aides in this project.[14]

"The use of aides served as an integrating factor in the provision of complex medical services in the home. Since any aide might be providing various kinds of services to a single patient, greater communication was required among various supervising professionals, thereby achieving better coordination of patient care. The patients accepted the services of the home health aide without question and the supervising professionals reported that the aides provided effective service in the field. There were no reports of services detrimental to the patient, as the aides were able to recognize problems and changes in the patient's status as they developed and obtained supervisory help." [15]

Other service programs report similar results, both in the excellence of performance and the wide acceptance by consumers of homemaker-home health aide services. There appears to be a rapid development of rapport and confidence, probably because the homemaker-home health aide is in the home for longer periods than the professional, is integrated into the living routines in the home and has a more natural identification with those she serves.

Homemaker-home health aide training programs were funded and "seed" money for program development was provided prior to implementation of the Medicare health insurance system in anticipation of a greatly increased demand for homemaker-home health aides in certified home health agencies.

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[13] "This vocation is proving a realistic choice for many educationally disadvantaged but capable individuals . . . in some instances this employment has enabled a family to become self supporting . . . thus the community stands to gain doubly from this service as previously unemployed persons become self-sustaining." National Council of Homemaker-Home Health Aide Services. See Appendix 1, item 6, p. 61.

[14] Hurtado, Arnold V. M.D., Greenlick, Merwyn R. Ph.D, and Saward, Ernest W., M.D. *The Organization and Utilization of Home Care and Extended-Care-Facility Services in a Prepaid Comprehensive Group Practice Plan.* Medical Care—January–February 1969, Vol. VII, No. 2.

[15] Hurtado, Arnold V., M.D., Greenlick, Merwyn R., Ph.D., McCabe, Marilyn, B.A., and Saward, Ernest W., M.D. *The Utilization and Cost of Home Care and Extended Care Facility Services in a Comprehensive Group Practice Program.* Medical Care—January–February 1972, Vol. X, No. 1.

These monies—which were made available by United States Public Health Service funded a number of demonstration projects and provided effective program consultation—were essentially short term. A training program funded and directed jointly by the Office of Economic Opportunity-United States Public Health Service focused upon the training of faculty and the ultimate training of 10,000 homemaker-home health aides but did not go beyond the pilot stage, although several State and some local programs did get an effective start as a result of these efforts.

Homemaker-home health aide services cannot develop or expand with voluntary funds, existing third party payments and fees-for-service as the only source of support. Training programs are not being maintained because of cost. More important, job placements following training are not available. Staff curtailments are presently more prevalent in these services than program expansion.

There is a demand for the services which far exceeds the supply. The demand, however, is for those services that are excluded from reimbursement in the Medicare insurance regulations; supportive services and long-term care. This need, which has been accurately described by Morris [16] exists in that section of the population with long-term disability: in "those whose condition is not likely to improve quickly" [17]—an estimated 25–50 percent in "quasimedical nursing institutions", the others in the general population:

> Some 18 million persons, between the ages of 18 and 64, and another 15 million elderly *may* be affected. They have some chronic physical conditions which can limit their freedom of movement or make them dependent functionally in some degree. *But*, only a small percentage of these large totals, perhaps 1½ million adults, require the intervention of any public program beyond that now available. The larger total represents the pool of demand which confronts organized health and welfare services. They suffer from the prolonged consequences of stroke, heart disease, cancer, arthritis, emphysema, industrial and automobile accidents. Except for rehabilitation, which is limited to those who can return to work, the medical system is not designed to meet the long-term needs of such disabled.[18]

The services proposed by Morris are essentially the application to our population of a rational approach to basic care—supportive services coordinated with health and social services to provide in the home what is essential and appropriate to care there—for the long-term as well as the short-term demand, as a part of a comprehensive system.

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[16] Morris, Robert. *Alternatives to Nursing Home Care: A Proposal.* Prepared for use by the Special Committee on Aging, United States Senate, By Staff specialists at the Levinson Gerontological Policy Institute, Brandeis University, Waltham, Massachusetts. October 1971. U.S. Government Printing Office.

[17] Ibid. p. 1.

[18] Ibid. p. 2.

TABLE D.—*Estimated number of homemaker—home health agencies by category:*

Family and Children's Agencies:	
(*a*) Governmental	900
(*b*) Voluntary	400
Health oriented agencies, including mental health:	
(*a*) Governmental	700
(*b*) Voluntary	500
Single service homemaker-home health agencies	175
Proprietary registries	175
Total	2,850

TABLE E.—*Number of professional and technical employees (full-time equivalents) in 2,209 home health agencies participating in Medicare as of July 31, 1969*

Professional and technical employees	Number of employees	Visiting nurse associations	Combination Government and voluntary agencies	Official health agencies	Hospital based agencies	Other
Registered professional nurses	15,152	4,818	1,667	8,091	364	212
Licensed practical nurses	1,409	657	127	283	241	101
Physical therapists	999	232	53	482	145	87
Occupational therapists	146	36	7	32	35	36
Speech therapists	170	32	6	65	36	31
Medical social workers	301	46	9	123	98	25
Home health aides	4,061	1,641	524	1,417	187	292

Source: HEW, SSA, Office of Research and Statistics, *Health Insurance Statistics*, HI22, Jan. 7, 1971 issue.

TABLE F.—*Home health agencies with home health aide service, as of June 28, 1970* [1]

Type of facility	Number of facilities	Number aides
Visiting Nurse Association	300	1,679
Combination Government and voluntary agency	58	489
Official health agency	649	1,570
Rehabilitation facility based program	7	54
Hospital based program	151	233
Extended care facility based program	16	52
Proprietary	24	96
All others	49	104
Total home health agencies with home health aide service	1,254	4,276

[1] Information obtained from Social Security Administration.

SOCIAL SERVICES

At every level of care, social services are necessary to the effective delivery of home health care. The personality of the consumer, his attitudes and those of members of the household; his capacity to adapt to a treatment program at home play an important part in the choice of the home as an appropriate site for care. "Feasibility"

alone is not the decisive factor. The decision that home care is appropriate does not guarantee the success of the plan unless, at all levels and in all phases of care, members of the service program are able to understand and utilize psycho-social strengths and compensate for the attitudinal problems which inevitably arise.

In assessment, in the selection of the home as appropriate for care, in the establishment of treatment plans, these factors are considered when competent social work skills are available.

Social workers must play an important part in the selection, training and recruitment of homemaker-home health aides. Unless there is careful assessment of temperament in the selection of trainees, there is considerable danger that the homemaker-home health aide who is not temperamentally suitable may retard rather than support the home care plan.

Professional skill is essential as interpersonal relationships develop, particularly between the homemaker-home health aide and the individual (and his family). The homemaker-home health aide is in the home more frequently and for longer periods than any other member of the home health staff. Her relationship to the consumer and his family is necessarily an intimate one and as such can influence the situation in a variety of ways; she in turn is affected by the situation in the home and the attitudes of those in the home toward her and her services. The availability of professional skill in the evaluation of these changing relationships, enlarges understanding in the consumer, the homemaker-home health aide, and in other members of the home health staff. Social workers serve as advocates for the consumer and his family—assisting them to make maximum use of resources in the community, and at times representing the consumer's view, his own estimate of his own best interests or his own personal choices in policy decisions of the services.

Many homemaker-home health aide services are administered and/or supervised by professional social workers; those in public welfare departments almost invariably provide such supervision, using other components in contractual or consultative arrangements. Voluntary services are also frequently administered and/or supervised by social workers.

Certified home health agencies offered social services in 20 percent of all of the agencies in 1969[19] but only 301 workers (full-time equivalent) were employed.[20] Slightly more than half of the hospital based home care programs offer social services; 10 percent of those which are not hospital based but which collaborate with hospitals offer social services. Public health agencies occasionally utilize the consultative services of a public health social worker.

Social workers who have health care orientation are in short supply. Schools of social work are beginning to emphasize the health care field in training. An important deterrent to the development of interest in the field is the shortage of employment opportunities.

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[19] Social Security Administration. *Number and Percent of Certified Home Health Agencies providing selected services by type of Agency, January 1969.*

[20] HEW, SSA, Office of Research and Statistics, Health Insurance Statistics HI 22, January 7, 1971 issue—*Number of Professional and Technical Employees (full-time equivalents) in 2,209 Home Health Agencies Participating in Medicare as of July 31, 1969.*

The requirement that social services must be available in all services and at every level of home health care would do a great deal to increase the effectiveness and utilization of the services.

Physical Therapy, Occupational Therapy, and Speech Therapy

Physical therapy takes first place in the series designated as appropriate after nursing service in the Medicare regulations. It is also most frequently indicated as the second service which certified home health agencies offer.

Of the total of professional personnel employed in home health agencies only 999 "full time equivalent" physical therapists are involved—about 4.2 percent of the professional personnel who were employed in home health agencies in 1969.[21] This represents a considerable thinning of the services. Federal regulations, which restrict duration, limit supervision of regimes and delegate a good deal of the essential services to "others" may inhibit utilization.

"Data from the National Institute of Neurological Diseases and Stroke indicate that at least 20 percent of those citizens with stroke have an associate impairment of language" [22] although speech therapy is included as a reimbursable service in the Medicare system, regulations restrict its use.

While it is true that aspects of many of the therapies—physical therapy, occupational therapy, and speech—are readily taught, it is also true that of all treatment modalities, the therapies are the most difficult to sustain without considerable encouragement and motivation; they are the first to "wander away" technically from established procedures when the responsibility is left with "others"; the maintenance of effective regimes, which, on a daily basis seem uninteresting, is the most important in the return to optimum function in virtually all chronic disease diagnostic categories. The enormous investment which institutions make in the return to function of the stroke patient; the substantial provision of initial services to those whose limitations fall into one of the largest categories in the aging population—diseases of the bones and joints—are frequently lost when the institutional effort is no longer available, because aggressive measures are not available or sustained in the home.

The development and maintenance of most of the simplest independent human functions involve mobility—physical mobility, mobility in fine movement and mobility in communication. Their presence or absence make the difference between home and institution. Their presence requires the initiation and the continuation of aggressive therapy measures in home health care.

THE POTENTIAL OF HOME HEALTH SERVICES IN HEALTH MAINTENANCE ORGANIZATIONS AND AMBULATORY CARE FACILITIES

Health Maintenance Organization

There is considerable emphasis upon the Health Maintenance Organization as one of the preferred methods for the provision of

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[21] HEW, SSA, Office of Research and Statistics, *Health Insurance Statistics*, HI22, January 7, 1971 issue.

[22] See Appendix 1, item 8, p. 68.

health care. Such organizations will not necessarily deliver the covered population from problems related to the increased need for home health services.

If the home health services are the same in definition, scope, and duration as those which are presently available, there is no reason to believe that the situation will improve and there could be some reason to be apprehensive about costs of institutional services in the future of such organizations. Proposals for these, as well as for other systems of health care delivery tend to consider home health services as they are presently defined and delivered in the Medicare context.

Better use might be made of such services as they are presently defined when they are attached to or available to a Health Maintenance Organization, simply because such an organization will be in a better position to utilize all of its resources to maximum effect in a coordinated system of care. This use will have its major value only for the short-term patient who does not require the full array of services which are defined in a home health program of good quality.

If, however, the definition and provision of home health services is considerably broadened to include prevention, an effective array of services, and the possibility of extension to serve long-term need, the health maintenance organization has many built-in features which will insure maximum utilization and maximum benefit to the consumer. The availability of high quality home health services to the physician in the organization will encourage the choice of such services when they are appropriate and will discourage the choice of less appropriate care. Economy, which is essential in the choice of services when the total funds available are fixed, will encourage the utilization of alternatives to institutional care.

Flexibility, coordination, continuity and economy within a system which can provide acute hospital, extended care, ambulatory care and home health service become possible when all are of good quality and all are equally available. Capitation cost must, however, provide for a home health system which is a reliable resource.

Ambulatory Care Facilities

The combination of ambulatory care with home health services offers the possibility of a community organized replacement for a pattern of care which has disappeared. The home as the site of service and the neighborhood as the supporting environment belong to a period wherein the family physician utilizing the family and the neighborhood resources thought of the institution last, rather than first. Neighborhood health centers, family care centers, outpatient departments and other types of ambulatory group care with their linked therapeutic services can extend services into the home as an alternative to extension into the hospital in situations of acute illness or mobility limitation which are not severe enough to require institutional care or in situations where the linked therapeutic services are needed to add the necessary treatment services to a home health plan.

"Ambulatory" in this sense requires that the services of the center must be made available; special transportation services, physician home calls, and the appropriate array of home health services can provide care which utilizes the institutional bed only when it is

most essential. Many neighborhood health centers use paraprofessional personnel to extend their services into the home; still others are linked to public health or visiting nurse associations for home care. An innovative model in Denver links neighborhood health centers to a chain of district units staffed to provide physician services and home health services as well as traditional public health services to the neighborhood. Special transportation is available in all levels of care.

Very few ambulatory care centers, including hospital out-patient departments, have available to them the needed array of home health services; their usefulness has not been adequately demonstrated to private groups; the Office of Economic Opportunity financed neighborhood health centers are limited in their financial ability to develop services in the home or to utilize them when they are available in the community. Funding, availability and education could increase the potential of the combination of ambulatory care and home health services, and provide patterns of care which are innovative and practical.

COST SAVING

There is evidence that the utilization of home health services can reduce inappropriate institutional care. Studies which have examined costs have been done in a Health Maintenance Organization, in insurance programs which offer home health services as an insurance benefit, in hospital based home care programs. Reports focus primarily on the release of hospital beds as a result of early discharge to home health services which are less expensive.

The release of hospital beds as a result of early discharge is an important consideration in cost saving at a time when hospital costs have become a major cause of concern in the health care economy. Savings of hospital bed days ranging from one day to an average of 19.2 days is no small item in this economy.

"If the stay in the hospital of one patient in twenty was shortened by *one day*—at a daily cost of $70.00 the total hospital cost to the American people would be reduced by almost *100 million dollars*." [23]

The prevention of inappropriate institutionalization is however, a larger factor in the computation of costs.

The annual report for the calendar year 1970 of the Home Care Association of Rochester, N.Y., a coordinated, comprehensive service, indicates "a total of 42 hospital beds released, with a total of 1,554 patients admitted to the service, 653 of whom would have required hospitalization." [24]

The Rochester report underlines this factor. Almost *one-half* of the patients admitted to the home health service *would have* required hospitalization. Utilization data from programs serving non-hospitalized patients support the conclusion that home health services are utilized by an aging population which, in most respects has problems similar to those of institutionalized populations: the majority are affected with multiple major diagnostic problems. The level of home health service hours utilized were equivalent to one or two days of

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[23] See Appendix 1, item 5, p. 60.

[24] Tenth Annual Report, Home Care Association, 311 Alexander St., Rochester, N.Y., May 11, 1971.

hospital care per month, over relatively short periods of time—(average figures, however including service plans which provided extended periods of care).[25]

The Associated Hospital Service of New York reports that "aggregate hospital stays for the first 5,000 cases admitted to home care was reduced by more than 113,000 days." [26]

The "Early Hospital Discharge Program" of the Denver Department of Health and Hospitals reports that admission to the Home Care Agency of 292 patients dismissed on an early discharge basis reduced an average of 19.2 hospital days per patient. (5,629 hospital days for the total group.) [27]

In a special project designed to link a home health service to the extended care facility and hospital in a health maintenance organization program in Portland, it was reported that the average length of stay in the acute hospital was reduced from 5.4 days to 4.9 days and the use of the acute hospital was only 87 percent of the "expected for the over 65 population and 74 percent of the expected for the Medicare population." (These results are based on the combined use of the extended care facility and the home care program.) [28]

Blue Cross of Greater Philadelphia in a study of coordinated home care reported on an analysis of 3,940 cases admitted to four hospital home care departments between November 1961 and July 1970. "An average of one and one-half percent of the patients discharged from the medical, surgical and pediatric departments of these hospitals were transferred to home care service an average of 12.9 days earlier than would have been likely without the availability of the . . . service. This resulted in 6.6 additional beds being available throughout the report period for care of more acutely ill patients *at no additional cost to the community*".[29] [Emphasis supplied]

All reports emphasize that home health services utilized were substantially less costly than hospital care.

The cost of developing home health services which are available to the total population at risk can be substantially offset by reductions in the use of institutions of all kinds—acute hospital beds, extended care facilities, psychiatric beds and the current overdevelopment and overuse of nursing home beds—costs which are substantial in economic terms but which are far more significant in terms of the alteration in the approach to the American way of life which the institutional bias in our present system is effecting. In economic terms the cost of developing new services and the upgrading of services which are not now adequate will be possible when public policy concerning the delivery of health care has been radically altered to include a positive approach to home health services—an alteration which will

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[25] See Appendix 3, items 4–5, pps. 118–121.

[26] Excerpts From Home Care Following Hospitalization, Associated Hospital Service of New York, 80 Lexington Ave., New York, N.Y. SVN–1965.

[27] Department of Health and Hospitals, City and County of Denver, *Savings to Medicare Program as a result of early Hospital Discharge Program 1/1/70–12/31/70.*

[28] *The Utilization and Cost of Home Care and Extended Care Facility Services in a Comprehensive, Prepaid Group Practice Program.* Medical Care, Vol. 10, No. 1, January–February 1972. (See footnote 15, p. 30.)

[29] *Coordinated Home Care an Effective Alternative for Patients, Physicians, Hospitals Blue Cross.*

Blue Cross of Greater Philadelphia. Home Care Department. February, 1972. Introduction.

produce the determination to develop such services and the funds and personnel which are necessary for analysis of the population which could feasibly use such services and the need of that population for home health care as a component of comprehensive services.

Discussing the difficulties of arriving at cost comparisons of home health care vs. the previous kinds of care, the director of an Athens (Ga.) project said:

"We're dealing with people who—until this service came along—simply died at home." [30]

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[30] Cook, Thomas, Executive Director, Athens Community Council on Aging, Inc., Athens, Georgia, see Appendix 5, p. 134.

PART 5

EUROPEAN HOME HEALTH SERVICES

Home health services in the United States are not the product of the current Medicare insurance system. Home health care has been provided in this country since 1796. Public health nursing services and the services of the many high quality visiting nurse associations, and homemaker-home health aide services producing care for the sick in their own homes, have a long history and are a part of the American tradition. In contrast with European programs, however, services in the United States have not been developed, supported or extended as a matter of public policy, and this situation is paradoxical in the face of our attachment to ideals of personal independence and personal choice.

Home-delivered services to the sick and disabled in Western Europe also have a long history. (Early services date back to the late 18th century).

Unlike those in the United States, such services have grown steadily: in volume, in scope, and in coverage—almost, but not quite—keeping pace with need. (The unevenness is not usually related to unwillingness to fund the services, but is due to diminished pools of health manpower).

Home health services utilized in most European systems are similar to those which we consider comprehensive here: physicians, nurses, social workers, the allied professions and "home helps" working in teams to provide flexibly planned services in the home. Almost all of the European countries have a strong anti-institutional bias. Home health services are therefore one of the most important and firmly based institutions in the array of available services.

The basic service in almost all European programs is the "home help." Usually well trained and supervised, the home help functions as the extension of the professional team into the home. The basic functions of the home help resemble those which we describe here in our homemaker-home health aide. They often include as well certain activities which in the United States are either retained within the professional purview or which have been assigned to an intermediate worker: the vocational nurse, the social work assistant, the physical therapy aide, the nutrition aide, the mental health aide, the community aide.

It is expected that home helps will perform all tasks [1] which are essential to the maintenance of a decent environment; those which we

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[1] "We expect home helps to do *whatever is needed*. They are sent in to help. This means unlimited service except for those tasks which cannot be safely undertaken. It is far better to give unlimited service . . . at home (including medical care and supportive services), than to put them in hospital or nursing homes." The care of incontinent bedfast patients is considered a normal part of the home help's assignment in England. Miss E. Carnegie-Arbuthnot, Organizer. Interview with B. Trager, London, June 1969.

frequently describe as the functions of the housewife—the family homemaker; (these include some interesting cultural variations: almost all continental home helps are taught flower arrangement; rural home helps must garden and tend cattle when necessary) in addition to those more closely related to care of the sick. Nutrition, food preparation and a very fundamental psychology are very heavily stressed. The latter is aimed at the careful preservation of the integrity, dignity, and personal independence of the consumer of services.

The term "consumer of services" is apt since the services are available to and used by all sectors of the population and there is no relationship between utilization and poverty.

The two countries which offer the largest volume and broadest range of services—Sweden and the United Kingdom—have been strongly affected by the growth of aging populations in the development of their services. Sweden's population over 65 makes up more than 13.5 percent of its total population (an increase of 50 percent over the past twenty years.) An increase to 16 percent by the year 1980 is anticipated. Although a number of group living approaches (communal housing, villages, homes and nursing homes for aging persons) have been developed, the Swedish system acknowledges the natural desire of most people to remain in their own homes.

> In my country we now find it natural for various reasons—humanitarian, labor-economic, and social economic—that nobody should stay in an institution if his social or medical problems can be solved in other ways.
>
> No old person should live in an old age home just because he has nowhere else to live, lacks furniture, or cannot clothe, clean or cook for himself. Lodgings can be provided, furniture can be bought, and home help can be found. Thus the individual's independence, a very precious thing in human existence, is saved—and always at a lower price than the cost of institutional care.
>
> No one acutely or chronically ill should have to stay in a hospital if ambulant medical treatment or day hospital care could be used, often in combination with home help. [2]

The home help services which are very available, were utilized for longer or shorter periods by 11 percent of the aging population in 1969 (in a given week). The services are combined with mobile services which compensate for a wide variety of limitations: Meals-on-wheels; home delivery of frozen and other foods; physical therapy units; chiropody; coiffeurs; mobile libraries; "patrols"—units which carry equipment and provide heavy janitorial work-specialized transportation, and travel to specially developed group and recreation centers.

Almost 60,000 home helps are employed in the program, the majority of them serving older persons. The ratio of home helps to population is approximately one to less than one thousand. Rural areas have begun to be a problem in Sweden because of migration of younger families to suburban communities, leaving large and sparsely settled sections in which the inhabitants are mostly older persons. Special experimental programs have been developed in which regional multi-

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[2] M. Nordstrom, Membre du Parlement, Conseillère à la Direction Nationale de la prévoyance sociale, Stockholm. *Les Services Sociaux d' Assistance Ménagère et Familiale en Suede.* Publié dans Revue Internationale du Travaille, Octobre, 1963.

purpose centers are being established with specialized transportation facilities as well as the traditional home help program.[3]

The other program of major volume is that which exists in the United Kingdom. Approximately 69,000 home helps were employed in 1969 by the Ministry of Health and these workers are expected also to provide a very wide range of services which include personal care but which do not include some of the services which are conventionally considered closer to nursing.

It is impressive in England to note that the types of patients cared for at home would, in the United States, be considered institutional candidates. Home help service is not limited to "intermittent part-time care". The home help frequently makes more than one visit in the day and full-time service is not excluded from the entitlement.

In addition to the assignment of the home help there are also mobile services such as meals on wheels and the "Blitzclean" service similar to the janitorial services provided in Sweden. A very flexible in-and-out approach to institutional care has been adopted in England, with families relieved of the responsibility for older family members during vacation periods, when institutional care is offered, day care, weekend care in institutions, and the establishment of centers which are recreational and supervisory and frequently also provide meals.

The line between health services and social welfare is less distinct in many European programs than in the United States, probably because of the relatively well developed entitlements to public services in both areas. The poor and aged sick are not treated as categorically as they are here. Home help services are firmly linked to both the health system and the social welfare system and our difficulties about what is or is not "health related" are in general not a problem in their services.

In the Western European countries virtually all training of home helps and home help directors (usually nurses or social workers) is funded by the government; most trainees are provided salaries or stipends during training; the administration of all service programs is usually government funded with, in some countries, incentive payments to increase the quality of direction, and the funding of the services themselves is subsidized by the government either in part or totally.

All Scandinavian countries provide free services to pensioners (this is not public assistance but a pension entitlement) and they provide for fee payments based on a sliding scale in the remaining population. Some fees for services are charged in most countries but are usually charged only to the economically stable families who can afford them.

In general, countries which provide services to the aging population do not limit the duration of such services. They are considered long-term services and are intended to maintain the individual in his own home for as long as this is feasible.

Coverage is very good in all countries since the services are established by statute and only in rural areas where geographic difficulties have occurred is a thin coverage encountered. Most countries are attempting to solve this problem in a variety of ways. France

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[3] Socialstyreisen—The National Board of Health and Welfare. Stockholm, Sweden. Byrainspektőr M. Herlin. January 3, 1971.

bases its rural program in agricultural family systems or cooperatives and the efforts in rural Sweden have already been described.

The range in population ratio in the Western European countries is from approximately one home help per 760 in Denmark to one home help to 2,000 population in France. The ratio in France is considered inadequate—most of the countries which participate in the International Association consider that a ratio of more than one to 1,500 population constitutes inadequate services.[4] The ratio in the United States at the present time is less than one to 7,000 population, with the cluster mostly in urban areas of the Eastern seaboard.

> The description of the British system published in 1948 in a Swedish journal stimulated lively discussion among the officials, the social workers and the professors of home help training . . . We were not even certain that they (the aged) really needed help in their own homes at a time when . . . homes for the aged were comfortable, modern apartments were being built for pensioners and when we believed that the majority of older people wanted to care for themselves . . . or to be cared for by their families or their friends. In fact it was doubtful that we could recruit personnel for this kind of work because of a lack of employment . . .
>
> Now, fifteen years after our first tentative approaches, home help for aging and invalids is so well distributed in our country, with its population of 7.7 million, that in 1965 we were able to provide (home help) service to approximately 144,443 aged and incapacitated persons (a total of 17,175,680 hours of service). Close to 8 percent of our aged population received the service. In each municipality . . . aged and incapacitated persons were helped either by specialized home helps reserved for the aged or by home helps with diplomas working full time.[5]
>
> The creation of the first home help service for aged persons is about a dozen years old. The experience has been such a positive one that no one can pretend any longer that it is a temporary activity, a palliative dictated by crowded hospices, boarding homes or hospitals, since the development witnesses to the responsibility and to the growing respect which society owes to the individual and to his liberty.[6]

It must be obvious that the investment in home delivered services is not dictated entirely by cultural attitudes in the European system. The strong support of these services is evidently based upon the realization that it is an economical as well as a rational approach, since there have been no reversals in the steady growth of such services either because of dissatisfaction with their effectiveness or for reasons of economy.

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[4] Trager, Brahna. *Home Help Abroad* in "Homemaker Home Health Aide Services."

[5] M. Nordstrom, Délegué Chef de Division au Ministère des Affaires Social Suédoises, *Le Service Suédoise d'Aide Aux Veillards à Domicile,* Saltsjobaden 12 23 Septembre 1966.

[6] Ibid.

PART 6

MANPOWER

Planning for the development and expansion of health care services which have not previously been available inevitably raises questions about manpower for implementation. This is not a question of major importance in planning for home health services. Many basic services—nursing, the "therapies" (physical therapy, occupational therapy; speech therapy), homemaker-home health aide services and social services have manpower pools available for first steps in development and expansion. They could produce sufficient manpower in a relatively short time *provided job opportunities could make entry into the field attractive* and, at least in the paraprofessional field, funded training facilities could be made available.

It is estimated that, given a more flexible interpretation of reimbursement for nursing services in the present system, staff cutbacks in nursing could be reversed, The manpower situation could also be greatly improved with the application of new patterns of utilization of available nurses using different levels of personnel for services requiring different skills. This effort can only become possible when tight funding is replaced by incentive and demonstration funds to implement plans for innovative use of personnel which are already available. With these changes, additional nursing personnel will still be necessary. It is estimated that nursing personnel for full implementation of comprehensive home health services could be available within a three year period.[1]

Physical therapy services would be adequate for fuller utilization of a more flexible use of the Medicare health insurance system at the present time. Additional professional and paraprofessional personnel can be made available almost as quickly as it is needed.[2] This situation is not as true of speech therapists. There are 8,160 qualified therapists in the United States. Home health agencies have not been able to fully utilize such services because of limitations in the Medicare regulations. Expansion of services would require increased funds for the training of personnel.[3]

In the paraprofessional field there is an enormous potential in home health for those in the reservoir of unskilled, unemployed or underemployed individuals who could be trained quickly and at relatively low cost. They can be capable of performing tasks which are currently accepted as within the range of the professional. They can be helped to move with on-the-job and supplemental training into

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[1] National League for Nursing. Interview with Miss Leah Hoenig 3/13/72.
[2] American Physical Therapy Association Statement before the Senate Finance Committee, February 7, 1972, p. 4.
[3] See Appendix 1, item 8, p. 72.

74-331 O—72——4

work of considerable skill. This will increase the effective use of all health care professionals and at the same time provide members of our poor and near poor population with work that is interesting, and decently paid.

The resurrection and expansion of training programs piloted by the Office of Economic Opportunity and the United States Public Health Service, implementing training patterns developed to upgrade para-professionals, could come very close to producing the ratio of home-maker-home health aides to the aging population, provided job opportunities are available as an end goal.[4]

Innovative approaches to training such as that which has been demonstrated and abandoned in Kansas [5] could be extended.

Probably more than any other health care institution, home health services could be brought into the field quickly and effectively; the availability of manpower will not be a major barrier.

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[4] "At a minimum, homemaker-home health aide agencies should have available 300,000 homemaker-home health aides or one homemaker-home health aide per every one thousand persons in our total population. For older persons, the ratio should be approximately one per 100 as a minimum." *1971 White House Conference on Aging Report to the Delegates*, December 1971, p. 76.

[5] A regional training program adapted to rural areas at Kansas State University which was discontinued because of lack of funding.

PART 7

SUMMARY

Although aging itself does not fit a stereotype which is frequently patterned on the end product of neglect, large numbers of Americans who are afflicted with chronic illness and disability are not receiving preventive and therapeutic services which could maintain them within their own homes as participants in community life. A significant number have been inappropriately cut off from their personal environment and inappropriately placed in institutions which have proliferated alarmingly throughout the country.

The term home health services is broadly applied in quality health care. Such services have application in physical illness, in short- or long-term disability, in emotional illness of short or long duration, in crises which threaten the normal pattern of living and which require treatment and/or support to prevent disintegration of individual and family life. The goal of home health services is to provide services which support personal choice whenever it is feasible and to maintain a way of life which is as closely related to normal life within the community as possible.

Home health services are not considered a substitute for institutional care. They frequently offer an alternative to such care. Adequate home health services should be considered an essential institution in the same sense as a hospital, an extended care facility or a nursing home are institutions.

A review of home health services available in the United States must lead to the conclusion that they do not constitute a valid resource for the population which could make appropriate use of them.

They are in short supply; they do not offer the comprehensive range of services required; they are limited in their capacity to provide for any significant volume of the population in need; they have no geographic coverage. Where they do exist the services are fragmented and are decreasing rather than expanding.

The present system of Medicare health insurance has not stimulated development of home health services in any appreciable way and may, in fact, have depressed such development by opening up to the providers of home health services a caseload which requires a broader range of services and more appropriate services than those which are reimbursed. It has considerably influenced the concept of the services as limited in scope and application. The home health services defined in the Medicare insurance system do not fit the population they are intended to serve—the adult population which requires more than the "nursing plus one" which has, by default, been imposed as the standard. Application of the regulations has been narrow and inflexible and subject to wide, and sometimes quixotic interpretation. The services have been hedged in by a costly paper structure. They have been overcontrolled and underutilized. Services which are reimbursed by

the Medicare insurance system when they are provided in an institution, are not similarly reimbursed when they are provided in the home and this has been a factor in inappropriate use of institutional beds.

There is no reason to assume that placement of home health services in health maintenance organizations or their coordination with ambulatory centers will make any appreciable difference either in meeting need or encouraging utilization if the services which are offered are defined and reimbursed as they are in the present system. The support of a broader range of services adapted to the home as the site of care services and more realistically directed to long term need could, however, make an appreciable difference, enabling appropriate choice when that choice is available. There is evidence to support the conclusion that utilization of home health services is increased in proportion to increase in the range of services available. There is also evidence that appropriate use of home health services can reduce utilization of institutional beds and that overall costs of care may also be reduced. Costs in human terms where choice, personal identity and integration with family and community life are protected and preserved must be implicit in any consideration of "cost".

European programs have demonstrated the economy and effectiveness of very broadly based systems of home health services which include many features not incorporated in the United States conception of home health care. These include flexible use of institutional facilities (for day care, weekends, vacations), and full mobility of both services and consumer, bringing services to the home and the consumer to the services by means of special transportation. The base of the European programs is the home help whose services to the aging, chronically ill and disabled population are virtually unlimited in volume and duration. Services are developed, and supported or subsidized, with government funding; all training programs are government funded and trainees are supported during the period of training.

Home health services in the United States have been unable to sustain or extend their programs with funds presently available from voluntary, third party or fee-for-service sources at any of the three levels of care which are essential to a comprehensive system. Funds which were available for development, training, leadership and consultation from the Department of Health, Education and Welfare are no longer available, and there has been no new development in the field.

CONCLUSIONS

If significant numbers of our aging population are not to be forced to match the stereotype of aging which is the end product of inappropriate care and neglect, health care must include provision for a comprehensive system of home health services. Such a system must include an appropriate range of services at all three levels of care.

Some relief from the present inappropriate use of institutional beds might be achieved with a more realistic application of the home health services regulations in the Medicare insurance system.

Comprehensive home health systems must be understood to include preventive services and effective measures to meet the need of chronically ill and disabled persons for a system of health oriented, supportive services in the home over long periods, or permanently.

Professional manpower could be made available for expanded service.

Homemaker-home health aide services are broad base services and are essential to all levels of care but most particularly to the third level which must be utilized by the largest section of the population. Development of such services should achieve a ratio of at least one homemaker-home health aide to 1,500 population with good geographic coverage.

Unless national health insurance proposals provide for home health services which ignore the present "nursing plus one" definition and expand the concept to include the full range of needed services, adding innovative methods to ensure full use of ambulatory care, they will not fulfill the expectation that national health insurance will improve the health status of older persons.

If comprehensive home health services are to be developed supported and expanded, they must be publicly viewed as an important health care institution, as all other traditional health care institutions are viewed.

PART 8

RECOMMENDATIONS

Both immediate and long term approaches to the provision of adequate home health services are necessary:

1. The interpretation and application of present regulations in the Medicare system must be changed in order to stimulate, rather than restrict, utilization of home health services by allowing *full* implementation of the regulations as they are presently stated. Fuller use of more concentrated services, more flexible approaches to the supportive services of professional and paraprofessional staff must be reimbursed and encouraged.

The establishment and maintenance of home health plans must be based upon the *professional judgment* of personnel in certified agencies rather than upon the judgments of individuals who are remote from the consumer.

2. Changes in the system must be made which eliminate entry into home health services through an institutional bed in part A and which will eliminate co-insurance payment for home health services in part B.

3. A revision of the paper structure presently used in submitting claims, approving service plans, and authorizing payment, must be made in order to reduce administrative costs and stimulate prompt payment. Administrative policies which require prior authorization and allow retroactive denial of claims for services rendered in good faith must be eliminated in order to encourage referral to home health services and to support acceptance of such referrals by home health agencies.

4. A national approach to the provision of adequate coverage of the population by home health services must be made by:

a. Funding the developmental phases of home health services as an *essential health care institution* through mechanisms similar to those utilized in the development of institutional beds (i.e. grants for construction and modernization of hospital and medical facilities). Emphasis on innovative approaches to regional facilities for rural and sparsely populated areas must be included.

b. Funding the expansion of personnel and of the range of services presently provided in existing agencies by incentive grants to "nursing-plus-one" agencies. Financial support must be provided for reasonable periods of time, for an additive approach to the service range in such agencies to at least six of the required services in order to establish in such agencies services which offer a reasonable alternative to institutional care.

c. Amendment of the present Medicare legislation or introduction of new legislation, providing for basic health care and supportive maintenance services to those individuals who require such services for long periods or permanently

when they can be safely and appropriately maintained in their own homes.

d. Funding the development and maintenance of training programs for professional and paraprofessional personnel which is focused upon the organization, administration, and provision of services in the home utilizing existing training facilities and providing for the development of additional facilities for training (with attention to regional facilities in rural or sparsely populated areas). In view of the marginal status of potential paraprofessional workers, support stipends will be an essential component of such training facilities.

e. The re-establishment and adequate staffing at the Federal level of a corps of personnel qualified to provide leadership and consultation in the home-health field, with funds allocated to: the development of training curricula: research and demonstration emphasizing innovative methods of delivery of home health services; and at reasonable intervals a survey of the field to assess present and future needs and make reliably based recommendations.

5. All proposals for the provision of national health care services must carefully consider the components of a comprehensive home health system and include provision for these components. Such proposals must recognize the potential of home health services in the long-term care of patients included in the system.

APPENDIXES

Appendix 1

RESPONSES OF NATIONAL ORGANIZATIONS

ITEM 1. LETTER AND MATERIAL FROM KENNETH WILLIAMSON, DEPUTY DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

FEBRUARY 28, 1972.

DEAR SENATOR CHURCH: As requested, this statement on home health services is provided for inclusion in the report your Senate Committee on Aging is preparing on this subject.

The American Hospital Association has, for at least fifteen years, actively supported the concept of home health care on an organized, coordinated basis as an essential element of comprehensive health care. It has encouraged hospitals to develop home care programs where needed. Enclosed is a copy of the Association's Statement on the Role and Responsibilities of Hospitals in Home Care.

The home health benefit under Medicare as it is now administered consists mainly of nursing services in the home rather than fulfilling the concept we have endorsed—a coordinated multi-disciplinary health service provided the patient in his home. Interpretations of the benefit promulgated by the Social Security Administration during recent years have the effect of so severely restricting the benefit that few patients appear to qualify. Also, as with certain other Medicare benefits, there is lack of uniformity in the interpretation of the definition of home health care as a covered service among intermediaries and even among the regional offices of the Bureau of Health Insurance.

Retroactive denials of payments and restrictive rulings on coverage of home health services have had adverse effects on the ability of hospitals to develop and maintain home health services as well as on physician referrals to such services. There is also a lack of consumer belief in the reality of this benefit.

The resultant underuse of home health services has been adequately documented by published reports of the Bureau of Health Insurance. For example, only one per cent of 1967 reimbursements was for home health services and only .6% of the beneficiaries received the service. The conclusion reached in this report, dated December 1971, is that "there has been very little use of the post hospital alternatives—extended care facilities and home health services."

It is the conclusion of this Association that both legislative and administrative changes are needed if home health benefits are to provide a truly available alternative to long-term institutional care.

1. The provision of home health services under Part A and Part B, especially with respect to deductibles and co-payments under Part B, has led to excessive administrative costs, and has often left providers with uncollectable debts. Retroactive denial of payments combined with underuse is resulting in such serious financial difficulties for providers of home health care that such provider resources are diminishing steadily. Authority to provide needed home health benefits to Medicare beneficiaries in a uniform manner could be accomplished by combining Parts A and B as this Association has previously recommended.

2. The present Medicare administrative guidelines and interpretations of the Social Security Administration should be restudied with the objective of removing unnecessary restrictions that have the effect of denying home health benefits to those who are appropriate candidates for home health care.

Thank you for the opportunity of submitting the comments of this Association on this important Medicare benefit—home health services.

Sincerely,

KENNETH WILLIAMSON,
Deputy Director.

STATEMENT ON THE ROLE AND RESPONSIBILITIES OF HOSPITALS IN HOME CARE

[Approved by the American Hospital Association, May 7–8, 1964]

INTRODUCTION

The American Hospital Association and its member hospitals recognize home care as an essential component of comprehensive patient care; they accept their responsibility to foster the availability of home care services of high quality. This responsibility must be fulfilled at the community level and requires the active participation of the Association's member hospitals.

The goal of the Association is "to assure each patient adequate care at the right place, at the right time, and at a cost the Nation, each community, and its citizens can afford." [1] In certain situations and for certain patients, home care is the mode of patient care that best fulfills this goal.

Hospitals have long accepted the responsibility to try new approaches to better care and to seek methods of controlling costs, but in the past their attention has focused primarily on inhospital services. Home care is no longer a new concept. It is now time to put home care into wide use, permitting its further development through flexible planning, experimentation, sharing of knowledge and experiences, and evaluation of methods and accomplishments. The knowledge thus gained will permit the practical realization of home care as an essential component of health services.

DEFINITION OF HOME CARE

In its broadest sense, home care is the provision of health care and/or supportive services to the sick or disabled person in his place of residence. It may be provided in a wide range of patterns of organization and service. At one end of the range is the simplest form, nursing service under physician direction. At the other end is the coordinated home care program, which fulfills the concept of comprehensive patient care. It has been described, in an Association publication which goes on to explain in detail the terms used in this definition, as a program "that is centrally administered and that, through coordinated planning, evaluation, and follow-up procedures, provides for physician-directed medical, nursing, social, and related services to selected patients at home." [2]

The coordinated program is the ideal. In many communities, it is a practical ultimate objective for programs that begin modestly. In others, particularly in very small communities or in large areas with low population density, the practical objective must remain more limited. Whatever their organization or scope, the essential requirements for all home care programs are high quality of service and proper selection of patients.

SELECTION OF PATIENTS FOR HOME CARE

Successful operation of a home care program demands selection of patients in accordance with their needs and with the availability of services. The earlier concept that coordinated home care programs should admit only patients with long-term illness requiring multiple services is changing as a result of experimental programs extended to a variety of other types of patients. Patients who are convalescing from an illness, those who usually receive treatment on an outpatient basis but are temporarily unable to do so, and certain patients with terminal illnesses are being successfully cared for through coordinated home care programs.

For the convalescent patient, home care may be superior to in-hospital care if the home is suitable and if he no longer needs continuous professional attention or use of equipment that cannot practically be provided outside of the hospital.

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[1] Background Statement on Role of Hospitals in Long-Term Care, American Hospital Association, September 1962.

[2] Hospitals and Coordinated Home Care Programs, American Hospital Association, 1966.

For the patient with long-term or chronic illness, medical care becomes a way of life—and all too often results in his institutionalization. Although the home is not appropriate for all chronically ill patients in all stages of their illness, it can provide a desirable setting for far more patients far more often than at present. Home care need not be elaborate in order to meet the requirements of thousands of patients now receiving care in hospitals or chronic disease facilities.

THE HOSPITAL'S ROLE IN HOME CARE

Whether the hospital or some other community agency will provide the administrative structure, the hospital has a key role to play in helping to stimulate development of home care, in fact-finding to determine the extent of need, in identifying the desirable and appropriate scope of service, and in helping to secure stable financing.

Another basic function of the hospital is to develop and maintain an effective mechanism for identification of patients potentially suitable for home care and for their prompt referral to the program. Eligibility for home care should not be related to the patient's financial condition—many patients who can pay for the services are either unaware of the service or are denied access to home care. Involvement of at least the medical and nursing staff is necessary for successful performance of this function.

The hospital must also back up the home care program by assuring that the patient will be immediately admitted—or readmitted—to the hospital if a change in his condition requires hospitalization. The fear of both patient and family that he will need hospital care and not receive it promptly is an important psychological barrier to their acceptance of home care. Technical services and equipment usually available only in hospitals should be made available to the patient, either by bringing him to the hospital for these services or by taking them to the home, as circumstances dictate.

When the hospital is also the administrative agency for the home care program, its role expands to include the direct provision of professional and related services to the patient at home. Nursing, social services, physical therapy, occupational therapy, and, in some programs, physician services are among these. As the coordinating organization, the hospital seeks the involvement of other community resources, both of manpower and of financing.

THE HOSPITAL'S RESPONSIBILITIES IN HOME CARE

The responsibilities of the hospital also vary in relation to its degree of involvement in the administration of the program. Whatever the auspices or administrative structure of the program, the hospital must assure that the planning is patient-centered. This requires close cooperation and coordination among the several health care and related services that may be called upon to share in this responsibility.

The hospital also has a basic responsibility to the community to assure that services are of acceptable quality, are used efficiently, and are available to patients who can pay the full cost of the service as well as to those who cannot.

When the hospital administers the program directly, its responsibility for the quality of all services, including those rendered by other agencies, and for their proper utilization is necessarily greater because it is directly accountable for all aspects of the program. As the administrative agency, it must recruit competent personnel and provide for their orientation, training, and supervision. It must obtain adequate financing; maintain records—administrative, financial, and medical; and establish and maintain effective communication with other community agencies, both those that participate directly and those that have a legitimate interest in all services to the community.

CONCLUSION

No longer can a hospital's service program be defined in terms of inpatient care alone. The hospital is assuming its proper responsibility to assure a continuum of acute, rehabilitative, long-term, diagnostic, and preventive health care to the patient wherever he may be. The extension of hospital service to the patient in his home is both a natural development and a feasible one when his needs can be met there and the home is suitable.

Home care programs are desirable primarily for the benefit of patients; they advance the goal of adequate care at the right time, at the right place, and at the most economical cost. In addition, the hospital itself benefits from participating in a program that extends needed services beyond its own walls. Its inpatient beds are utilized more efficiently thereby and in some instances construction of additional beds can be avoided. Furthermore, the home care program provides concrete evidence that the hospital is no longer concerned only with the care of the acutely ill today; it is concerned with the health of the whole community.

ITEM 2. STATEMENT BY DONALD R. HAYES, M.D.; HOME HEALTH CARE AND SERVICE

(Donald R. Hayes, M.D., Chairman, Committee on Community Health Care, Council on Medical Service, American Medical Association)

The AMA defines home health care as any arrangement for providing, under medical supervision, needed health care and supportive services to a sick or disabled person in his home surroundings.

The medical profession has long endorsed the concept of home health care. In December 1960, the AMA House of Delegates recommended that "physicians be urged to participate in organized home care programs for any patient who can benefit from the program and to promote such programs in their communities." Since that time AMA has produced several reports and publications designed to assist the physician in the development and effective utilization of such services in his practice.

It has been demonstrated that careful and appropriate instruction to the recently discharged hospital patient and his family enhances a smooth convalescence and leads to a minimum of home care follow-up.

The AMA stresses that leadership by physicians is essential to the efficient and successful provision of home care services. In the past the AMA has stimulated and encouraged cooperative action by state medical and health groups for developing home care programs in their communities through regional workshops on home care. The current concern in hospital costs and utilization has made physicians increasingly aware of the value of home care as an alternative mode of patient care. As a result the AMA continues to maintain continuing liaison with national health and medical groups concerned with effective home care programs. It also maintains an ongoing interest in the evaluation of existing coordinated home care programs regarding their proper support by medical care insurance, with a view toward stimulating development and extension of such programs.

Obviously, the needs of the aging population for home health services is increasing and will continue to increase. Difficulties experienced by existing home health care programs include a shortage of qualified and trained health personnel and problems in adequate reimbursement. To meet this expanding need the AMA recommends that further research and development be undertaken to evaluate the effectiveness and appropriateness of the utilization of the services provided by home health agencies in the community so as to ensure optimum patient care.

ITEM 3. STATEMENT OF THE NATIONAL LEAGUE FOR NURSING, DEPARTMENT OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES

I. NEEDS OF THE AGING POPULATION FOR HOME HEALTH SERVICES

In the past three years there has been a net increase of over 1,000,000 people in the United States 65 years of age and over which now comprise approximately 10% of our population. The 95% of the elderly who live at home could be helped to maintain themselves in reasonably good health through provision of home health services including assessment of health, health teaching and guidance, prevention of illness, services necessary to maintain or restore health and rehabilitation, health maintenance and long-term care when disability occurs.

There are many elderly people who have slim prospects for total recovery, but who have the need for part-time intermittent nursing observation, preventive and restorative services. Changes in the patient's physical or emotional condition may alternate between an acute and stable state, requiring observation, change in regimen and medication.

II. PROBLEMS EXPERIENCED BY EXISTING SERVICES AND PROGRAMS OF ALL TYPES

While it was expected that Medicare would through Social Security assure home care to individuals 65 and over, what has occurred is that increasingly the regulations have interpreted this care to be restricted to a period of acute illness and only certain types of care.

The focus has thus been on care of illness at a critical stage rather than the more universal need for services which will prevent illness and maintain people at their highest level of health in their homes and communities. Unfortunately Medicare has perpetuated the problems created by voluntary health insurance programs that traditionally have given the highest priority to hospitalization as a covered cost—an emphasis which has increased both the utilization and costs of hospitals. Under Medicare the financial incentive is for hospitalization even though care in the home would be more appropriate in the case of countless patients. Thus, the total reimbursements for home health services under Medicare have *decreased* from $79 million in 1969 to $50 million in 1971 while hospitalization reimbursements *increased* from $4 billion to $4.5 billion in 1971. See below:

MEDICARE REIMBURSEMENTS FOR HOME HEALTH SERVICES AND INPATIENT HOSPITALIZATION, 1969–71

[In millions of dollars]

	Reimbursements	
	Home health [1]	Hospitalization
Year:		
1969	$78.8	$4,042.8
1970	67.5	4,433.1
1972 [2]	49.5	4,508.8

[1] Includes pts. A and B.
[2] Estimated on the basis of data through Nov. 3 and 4, 1971.

Source: Social Security Bulletin, February 1972; vol. 35, No. 2, DHEW.

To meet the anticipated need or service provided for in the Federal legislation of 1965, primarily Medicare, Visiting Nurse Associations and nursing units of health departments (home health agencies) were encouraged to and expanded operations for the delivery of services in the home as follows:

1. Employed additional professional and ancillary staff to provide and administer service.
2. Added office staff to meet the need for
   (*a*) substantiation, documentation and transcription of records
   (*b*) development of new account and billing systems
3. Purchased additional equipment for both patient care and office use
4. Extended staff time needed
   (*a*) to interpret to patients, their families, physicians, and health welfare organizations, the continuous modifications in Medicare benefits
   (*b*) to mediate between beneficiaries and SSA regarding conflicting information given about Medicare benefits
   (*c*) to interpret home health services to fiscal intermediaries
   (*d*) to assist with audits imposed by various governmental audits

Since the enactment of amendments to Social Security which legislated Medicare with an expectation of increase in financial support from Federal funds, the percentage of support from United Funds and other private sources decreased for Visiting Nurse Associations. In 1969, as the definition of reimbursable services became restrictive by the Social Security Administration, the agencies began to experience acute financial difficulties. In 1970–71 the situation reached crisis

proportions. With expensive operations set up, the cutback in Medicare reimbursement, often applied retroactively, forced many community nursing organizations to reduce staff and limit the services they offer. During this period when many agencies are faced with a fight for their actual existence, at the same time there is a greater demand and need for services in the home.

The regulations of Social Security have been arbitrary. There is no requirement in the law for consultation from those knowledgeable in the delivery of home health care. There is wide variation in the skill and expertise of the fiscal intermediary offices and *great* diversity in their interpretation and administration of the regulations.

In many areas there have been very limited medical understanding for the necessity for continuity of care from the institutional setting to the home. This lack has also led to over-utilization of hospitals and under-utilization of home health services. There is great disparity in this aspect from state to state. In the first 18 months after the implementation of Medicare, the "Home Health Starts of Care per 1000 Medicare Beneficiaries" ranged from 35.2 in one state to 3.2 in another. The national figure was 15.5. The "Percent of Home Health Starts of Care to Hospital Admissions" for the United States as a whole was 5.1 with a state's range from 1.0 to 14.8.

Medicaid programs also vary greatly from state to state in the benefits they provide for the aged and in each state's standard for eligibility.

Home health services are a part of the programs of three major administrative units of the Department of Health, Education, and Welfare. They are the Social Security Administration, the Social and Rehabilitation Service and the Health Services and Mental Health Administration. There is little coordination among the three programs and no provision for obtaining consultation from non-Federal organizations and agencies in the field of home health services. This further compounds administrative costs as professional and business staff of agencies struggle with these variables.

Home health agencies and community health services—many of them now barely existing today, cannot continue to provide needed services without financing.

III. SUGGESTIONS FOR MEETING NEED BY INCREASING THE SCOPE AND EXPANDING THE COVERAGE OF COMMUNITY HEALTH SERVICES IN THE HOME

To decrease costs and at the same time provide needed care for people, we suggest that program efforts be directed toward *increased utilization of home health agency* services. Home health agency reimbursement accounts for only about 1% of the total Medicare expenditures.

The need is great for redirection of the health care system from the narrow concept of "medical care in institutions during periods of acute illness" to one of "health care which includes improvement and maintenance of health, prevention of diseases, curative and rehabilitative services." In the restructure necessitated by this change in focus it would be wasteful to encourage the development of agencies or services which parallel or compete in communities with existing agencies who provide quality services. We have seen the results of funding which encouraged the establishment of agencies whose services duplicated those provided by existing community agencies. Failure of the new agencies to coordinate with the existing community agencies by contract or similar mechanisms has led to overlapping, increase in administrative costs, confusion for communities, with insufficient evidence that the new independent services lead to improved care for people.

To assure quality care, we recommend that home health agency programs meet NLN–APHA accreditation of community health service standards including requirement for utilization review process in the agency.

We recommend that procedures be developed for advance approval for home health benefits. However, we strongly urge that the advance approval standards be sufficiently flexible to permit coverage for patients who continue to need skilled nursing, physical therapy, or speech therapy services beyond the period initially approved.

We urge provision for the most effective use of existing health care resources and the elimination of duplication of health care resources. To avoid the existing duplicating and fragmentation that now exists at the Federal level in the case of health care programs under Medicare and Medicaid, we recommend a

single organizational unit for the administration and coordination of national health services. Such a unit might be a Department of Health—at the Federal level—and it should make provision for consultation from community health agencies and other providers. Such a coordinated service should develop procedures to avoid the present expensive duplication of cost finding and audit mechanisms.

Community health service agencies have expertise and the capability to provide comprehensive home health services—case finding, prevention of disease, health education, and restorative and maintenance care—but cannot do so without fiscal support. These agencies have for decades focused on the patient and his environment with services more comprehensive than therapy for a period of acute illness. Present Federal program curbs on the provision of comprehensive health services for the elderly in their homes and communities should be withdrawn and the focus changed from illness care to health care.

ITEM 4. AMERICAN NURSES' ASSOCIATION STATEMENT ON HOME HEALTH AGENCIES

The American Nurses' Association is the professional organization of registered nurses in the United States. Its purposes are to foster high standards of nursing practice and to promote the professional and educational advancement of nurses to the end that all people may have better nursing care.

Home health agencies providing nursing services have existed in the United States for nearly one hundred years. However, not all communities have had such services available. Originally, the agencies were established under voluntary auspices, with boards of directors composed of citizens of the community. Their services were offered to all regardless of age, sex, race or ability to pay. Originally, their financial support came from client's fees, from endowments and from Community Chest and United Fund monies. For a period, two national insurance companies paid for home nursing care for certain of their policy holders. Only recently have health insurance programs included coverage for home health services.

During the period when health insurance for the aged under the Social Security System was being debated in the Congress, the ANA vigorously urged that home health services be included as a benefit in any program that was enacted. It contended that nursing care on a part/time basis in cases of acute illness was often more appropriate than hospitalization, that individuals with chronic illness could be maintained in their own homes, rehabilitation measures undertaken in familiar surroundings, and serious breakdown avoided. When Medicare was enacted, the Association was pleased that home care services were included in the program.

However, we have been concerned, in the years since the initiation of Medicare, about the limitations placed on home health services. For example, under Title XVIII, Part A, an individual was only eligible for care at home after a three day stay in a hospital. This requirement was set by law, was rigid and did not allow for an assessment, based on medical and nursing judgment, about where an individual's health care needs could best be met. Health insurance in this country has tended to encourage the use of the most expensive facilities for the provision of care. The requirement of three days hospitalization prior to eligibility for home care services perpetuates this practice. Therefore, we believe such a requirement should be removed from the law so that, when appropriate, care can be provided at home. The decision about the appropriateness of care at home should be determined by an individual's physician and the home care agency responsible for providing home care services.

Another concern is that home health benefits have been over-controlled. Intermediaries have made arbitrary and questionable decisions with respect to the nursing care they will approve for payment. To be sure their decisions are based on regulations of the Social Security Administration that are perhaps interpreted rigidly. For example, crutch walking taught by a nurse is not paid for but is paid for if taught by a physical therapist. This is unreasonable in view of the fact that nurses have the competence and have been filling this teaching role for a long time. The Social Security regulations regarding the skilled nursing services that will be paid for focus on the technical and procedure type of nursing care.

They do not take into account that a client's needs, and those of his family, are met as well through counseling, teaching, emotional support and through assessing, observing and reporting progress or lack of it.

Public health and visiting nurse agencies providing home health services have a long history of monitoring their activities. Unnecessary visiting by nursing staff has been discouraged and better utilization of the nursing team, which includes licensed practical nurses, home health aides and homemakers has been promoted. Nursing supervision of staff in these agencies is of high caliber. Case conferences on patient needs and evaluation of the care provided is a long established practice. It is our opinion that the nursing staff in the home health agency, in consultation with the patient's physician, is in the best position to determine the need for care at home. Such a crucial matter should not be left to the judgment of intermediaries, no matter how well intentioned.

Less than one percent of medicare expenditures has been used to pay for home health services. There is, therefore, some justification in believing the agencies are not given to over visiting for the sake of the Medicare dollar. Yet denial of payment after services have been rendered has occurred and this creates difficulties for the agency and frustration for the patient, both of whom must go through appeal procedures in an attempt to collect payment.

We trust that in the event a national health insurance is enacted ample provisions will be made for home health services. In the meantime, we recommend removal of the limitations placed on these services.

ITEM 5. STATEMENT OF THE NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Home Health Services for the Aged

STATEMENT OF NEEDS

It is generally recognized that the majority of the nation's aged population is economically deprived and, to a large extent, medically indigent. Existing programs for home health services are limited in scope and coverage for payment of services is inadequate.

The home health agencies experience considerable difficulty in their attempts to secure financing for preventive and maintenance services to the aged in their homes.

Preventive services are needed at both primary and secondary levels of care. At the primary level, certain basic services are essential. For example, nutritional services are important to assure an adequate and appropriate diet upon which good health is dependent. However, good dental health predetermines, to a large extent, the ability of the patient to eat the foods necessary for a balanced diet. Assuming that provisions are made for good nutritional and dental services, the degree to which the patient can benefit by these services is contingent upon the ability to market and to prepare the food. Consequently, many aged need assistance with grocery shopping and meal preparation. The ability to ambulate and perform these duties requires functional feet. As one ages, the need for podiatry services increases, and the ability to pay for such services decreases. The goal should be to keep people functional, mobile and healthy, as long as is consistent with the individual's physical and mental condition. It is commonly recognized that eyesight changes with the aging process. The need for on-going eye examinations and updating of prescriptions for glasses is too obvious to require detailed discussion. Coverage for primary preventive services for the aged is practically non-existent and is an area where agencies experience problems on a daily basis.

At a secondary level of prevention, adequate home health services could prevent repeated hospitalizations and could prevent placement in long term care facilities. Many of the aged are afflicted with multiple chronic disease processes. Observation and evaluation of the patient's condition at regular intervals could permit early identification of problems and correction before an acute exacerbation of the disease forces the patient into a hospital. Also, it is possible that with the necessary supportive services, the patient could be maintained in his home, thus avoiding institutionalization for the rest of his life. The so-called "custodial" care of an aged individual falls into the categories of secondary

prevention and maintenance at a given level of illness. These services are essential for keeping aged ill persons in their homes, and money now being expended for long term institutional care should be channeled to home care services. It is our opinion that these services can be provided at a savings to the American public and that this is the more humane approach to a way of living for the aged. The incentives for remaining self-sustaining are much greater in the home environment.

We would recommend that homemaker-home health aide services be provided to enable the aged to remain in their homes. We urge that payment be assured for these services and that payment be assured for professional nurse supervision of the personal care when a physical or mental disability is the cause for the inability of the aged to maintain themselves independently. Only the professional nurse is capable of identifying early symptoms of deterioration and therefore of obtaining early medical intervention. Conversely, the professional nurse can evaluate the patient's progress and make decisions about the necessity for continuing supportive services.

We urge that payment for drugs and medical equipment be provided for the care of the patient in his home, when needed.

We urge that money be made available to employ "handy men" to make the home suitable for the handicapped. Many patients could be kept in their homes if ramps could be built for wheel chairs, doors widened and safety devices installed.

Another tangible need of the aged is transportation. If aged people are to be maintained in their homes, money must be available for transportation to facilities which provide basic health services, i.e., medical, dental, podiatry, hearing centers, rehabilitation centers and the optometrist or ophthalmologist.

RECOMMENDATIONS

If a Federal Insurance Plan is developed which encompasses all of the needs listed, there are some basic facts which must be recognized.

The problems of what is needed for the individual, where the services can be obtained and how to get them, poses severe problems for the American public. We recommend that—

(1) Local centers be established to screen, plan and co-ordinate health services to the aged. A qualified home health agency could provide these services and costly overlap, duplication and gaps in services could be eliminated.

(2) Equal benefits by way of coverage of payment of services be provided for institutional and non-institutional health care services.

(3) Criteria for eligibility for coverage be simplified.

(4) Criteria for claim procedures for providers of care be simplified.

(5) Reimbursement formulae be simplified.

(6) Utilization review committees determine benefit eligibility and be accountable to the national health insurance carriers.

(7) Fiscal intermediaries be limited to financial accountability.

(8) Health maintenance services be covered in the broadest context including a safe hygiene environment.

(9) Preventive services be covered and include health surveillance and education to maintain physical and emotional well-being.

(10) Supportive services be covered, i.e., home health aides, homemakers, podiatrists, dentists, optometrists, equipment and supplies, prescription drugs, laboratory services, transportation and carpentry.

It is time for this country to stop the emphasis on illness and rewards for illness as perpetuated by the present system. It is time to reward wellness and to provide coverage for preventive and health maintenance programs.

What is Home Health Care?

Home Health Care can be defined as a coordinated system of individualized health care delivered to patients in their homes by professional and allied health personnel under the direction of a physician. These services are organized and provided so that the patient is either restored to full health or achieves maximal rehabilitation with the least possible disruption to his usual pattern of daily living.

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Home health services include intermittent nursing care, physical therapy, occupational therapy, speech therapy, social service, home health aide, housekeeping services, laboratory investigation, medical equipment and supplies as ordered by the physician.

There are two basic reasons why home health care is not playing a larger and more important role in the delivery of health care services . . . one, the general public does not understand the use of home care, and two, the reluctance of private and public insurers to include home health services on a broad basis as a benefit of insurance policies.

Proper Recognition and Support

In the past, lack of recognition and understanding of home care services has retarded the Home Health Agency's capacities to function properly and at full potential.

The reluctance of private insurance companies to recognize the Home Health Agency's role and capabilities results in limited coverage for this type of care while the costs of institutional care continue to rise.

Funds allocated by Federal and State Governments lack long-term commitment to solve the problems that exist. Short-term commitments that stimulate initial planning efforts are prevalent. But with no real follow-up, support of these efforts has often not reached fruition. Valuable time, talent, and financial resources are wasted with no real benefits to the patients.

Today's crisis in health care financing demands that the patient be placed at the appropriate level of care. The American Hospital Association estimates that 6% of patients currently hospitalized could be adequately cared for with intermittent home health services at a drastically reduced per diem cost.

Home care is not a substitute for hospital, extended care or nursing home care. Home care is a part of the health care continuum which, if used properly, will complement the others—meeting the patient's needs in a setting which uses the resources of family, neighbors and friends.

Advantages of Home Health Services

It is the position of this Association that full utilization of comprehensive high quality home health services can have the following advantages:

Reduce the length of hospitalization by making early discharge possible.
Diminish the need for readmission to hospitals.
Prevent many admissions to nursing homes.
Provide a more economical alternative to institutional care.
Increase the efficiency and extend the coverage of the practicing physician.
Decrease capital construction costs by releasing hospital and institutional beds.
Provide patient care in the normalcy of the home environment.
Teach home bound people to live independently.

HOME CARE LESSENS THE COSTS OF ILLNESS

Here are some dramatic examples of how home care reduces costs:

(a) If the stay in the hospital of one patient in twenty was shortened by only *one day*—at daily cost of $70—the total hospital cost to the American people would be reduced by almost *100 million dollars*.

(b) During 1970 in Denver, Colorado, a total of 11,019 total hospital days were saved by using home care services. At Denver's $95 per day hospital rate, this is a total saving in excess of over one million dollars.

(c) Because of the shortening of hospital stays for 5,000 Blue Cross patients in New York, costs were reduced by an estimated total of $3,648,174.

(d) H.E.W. states that just a one-day reduction in hospital stays of Medicare beneficiaries in 1968 would have cut program costs by $315,000,000.

(e) Kaiser Research Foundation—Portland, Oregon, lists the following 1968 per diem comparison:

Home Care Services	$5.25
Extended Care Services	39.08
Hospital Care Services	76.62

(f) Home care is approximately 3½ times *less* expensive than hospital care, according to the varied cost studies researched by NAHHA.

NEED FOR STANDARDS

We recognize the need to establish standards for home care and to encourage agencies to work toward meeting such standards. The Joint Commission for Accreditation of Hospitals is currently establishing task forces to establish standards for home care and a program for accreditation of home health agencies. In order to prevent duplication of effort, our National Association will work with the Joint Commission on development of standards. Two of the Board Members have accepted an invitation to work on the task forces.

In summary, we believe:

(a) Home health care should be a integral part of any health care system.

(b) Home care can drastically reduce the cost of illness.

(c) Patients need and want home care—a primary deterrent to patient demand for home care is the lack of public and private insurance coverage for home health services.

(d) The advantages of home health services are real, important and unduplicated.

(e) Home care is not an "add-on" service, but is an alternative service.

(f) Home care coverage must be broadened beyond the present governmental and public insurance plans if any real effect is to be made on the cost of health care.

ITEM 6. STATEMENT BY THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

INTRODUCTION

The National Council for Homemaker-Home Health Aide Services is a nonprofit, tax-exempt membership* organization whose purpose is the development of quality homemaker-home health aide services as an integral part of health and/or welfare services delivered in the home.

The particular focus of this statement will be on the usefulness of the service in helping to meet health needs.

DEFINITION OF SERVICE

Homemaker-home health aide service helps families to remain together in their own homes when a health and/or social problem strikes or helps individuals to return to their homes after specialized care. The homemaker-home health aide, as a member of the health and/or welfare team providing service in the home, carries out assigned tasks in the family's place of residence working under the supervision of a professional person who also assesses the need for the service and implements the plan of care.

RECENT DEVELOPMENTS

In developing this statement we wish to draw attention to several recent pertinent developments.

1. In the January 1969 and in the November 1970 isues of the *Federal Register*, the National Council for Homemaker-Home Health Aide Services was named by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, as a national standard-setting body for homemaker-home health aide services. Partly in response to this designation and with the active support and assistance of its members and other relevant national organizations, the Council has developed and is implementing a national approval program which offers agencies throughout the country, whether under voluntary, governmental or proprietary auspices, help in assuring the quality of their homemaker-home health aide services.

2. The National Council was invited by Dr. Arthur Flemming, Chairman, of the 1971 White House Conference on Aging, to plan a Special Concerns Session on Homemaker-Home Health Aide Services at this important decennial meeting. This session was held December 1, 1971. An account of this Special Concerns Session appears in the White House Conference on Aging report. Most other

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*The Council's membership consists of over 300 agencies which provide homemaker-home health aide services: 50 health and welfare organizations, both state and national; 200 individuals; and several business and industrial corporations which support development of the service.

sessions of the Conference also stressed the need for the development and funding of this service to help the aging remain in or return to their own homes rather than be placed in costly institutions.

President Nixon, at the closing session of the Conference, specifically stated: "We can give special emphasis to services that will help people live decent and dignified lives in their own homes, services such as home-health aides, homemaker ad nutritional services, home-delivered meals, transportation assistance."

3. At its clinical Convention held in Boston in 1970, the American Medical Association adopted a resolution supporting the development of homemaker-home health aide services as a part of a medical care plan, and specifically endorsed the leadership of the National Council for Homemaker-Home Health Aide Services, Inc.

NEED FOR HOME HEALTH SERVICE, INCLUDING HOMEMAKER-HOME HEALTH AIDE SERVICE

Home health service, simply stated, is the provision of health care to the patient in his place of residence. It may be provided through a wide range of services and organization patterns and delivered under a variety of auspices. Homemaker-home health aide service is one of the basic home health services.

Health service delivered in the home is not a new idea. Recently, however, much more attention is being paid to this form of health care, and with good reason. Frequently it is not only the form of care strongly preferred by the patient and his or her family, but it is also the most appropriate plan for care. In addition, in many instances it is the least costly form of service to the patient and/or the community. The National Council has urged in testimony before the Committee on Ways and Means of the House of Representatives that strong emphasis be placed on provisions for financing home health service in national health insurance legislation as an integral part of a continuum of health services, and that homemaker-home health aide services be specified as one of the covered services.

PRESENT SERVICE IS INSTITUTION ORIENTED

Over the last few decades as medical services have become much more specialized and complex, perhaps it was a natural development that health care for the aged and disabled became almost synonymous with institutional care. For example, less than one percent of the national Medicare expenditures were being used to provide home health care, according to the *Second Annual Report—Operation of Medicare Program*, dated January 20, 1969. And Federal regulations relating to home health service, one of the covered benefits under Medicare, have consistently been tightened so that now far too few can qualify for the service under Medicare. Yet the National Council hears consistently from doctors, nurses, social workers, social service departments of hospitals, visiting nurse services, public welfare and public health departments, homemaker-home health aide agencies, and many other organizations that a service urgently needed to help people remain in or return to their own homes is homemaker-home health aide service. In fact, this need is so pressing that proprietary concerns have recognized it and are rapidly springing up throughout the country to make the service available on a profit making basis.

Two cases illustrate the role of the homemaker-home health aide in home health care situations . . . A homemaker-home health aide was assigned to care for a frail, worn mother, 79, crippled with arthritis and her daughter, 56, terminally ill with cancer. In the two days a week the homemaker-home health aide was with them, she helped with meals, did the laundry, shopped and gave some personal care to both women under the supervision of the public health nurse. Besides preventing institutionalization, the lightening of physical burdens meant an easing of emotional tensions between mother and daughter. Equally important, said the caseworker, was the "tremendous mental lift" the homemaker gave the family. Both mother and daughter told the nurse and caseworker, "You've sent us an angel."

. . . And in another situation . . . when a husband, aged 80 visited his wife of the same age in the hospital and heard that she had been discharged, he went to the floor nurse with tears in his eyes and said, "What am I going to do? I am not able to take care of her." His wife was completely bedridden as the result of a fractured hip. They lived with his wife's sister who was an amputee. The nurse referred them to the Home Health Agency Coordinator, and homemaker-home health aide service was planned.

After several months, the homemaker-home health aide was no longer needed. The sister had gone to a nursing home, a niece was able to help with some of the housework, and the wife was able to manage her own personal care. The aged couple had been able to stay together in their own home.

MEASURES OF NEED

One home health agency operated for the last ten years in Rochester, New York, reports more visits by homemaker-home health aides than by any of the other 16 home health services provided. In 1969 there were 21,625 visits by these homemaker-home health aides. This agency only serves patients who would have been in the hospital, otherwise, and its administrator estimates the program saves the community over $1,000,000 each year. Blue Cross subscribers pay $2.67 per family and $1.27 per individual per year for this home health care coverage, including homemaker-home health aide service. Despite the need demonstrated by this agency in this one community, it is estimated that there are only 30,000 homemaker-home health aides in the entire United States serving all categories of social and health needs: the ill, aged, disabled, children and others with social and/or health problems. At a minimum, homemaker-home health aide agencies should have available 300,000 homemaker-home health aides.

A major reason that homemaker-home health aide service is so underdeveloped is a lack of adequate financing. In a report[1] prepared by the Welfare Federation of Cleveland in September 1971, it is stated that, "What has come through to the Committee loud and clear is that here we have a situation where (1) *home health care is a needed part of the health delivery system;* (2) *personnel has the knowledge and skill to provide good care at home and can be successfully recruited for this purpose;* (3) *services are in demand, and are used where costs are fully or partially covered; and where* (4) *the real key to the solution of the problem is more adequate financing.*"

WHAT CAN BE DONE REGARDING FUNDING OF SERVICE

It is essential that the narrow definitions and restrictive coverage plaguing the present home health service aspects of the Medicare program be eliminated. Far from providing the promised help to the nation's aged, Medicare has been to many a source of frustration and dashed hopes that needed care would now be available where they needed it, when they needed it.

National health insurance funding should provide for home health service, not only as an alternative to hospital and nursing home care—although this is very important—but it must also provide home health service for the neediest group of all, the chronically ill and aged. In England, with a population markedly below that of the United States, some 71,000 home-helps (homemaker-home health aides) are employed in the health system primarily providing service to the older chronically ill patients. Such care should be available *whether or not* a patient has been in the hospital, if it is to serve the patient and community to its optimum extent from the standpoint of efficient service at a lower cost.

In a paper entitled "Home Health Service and Health Insurance,"[2] Miss Brahna Trager states: "Home care becomes unreliable if the regulatory and funding conditions in the insurance program do not provide for the necessary continuity of health supervision and a secure environment which is supportive of optimum health. Without these as a reliable base home care becomes an unstable resource. The institution which will assume the necessary responsibility becomes the alternative."

We submit that allowing institutional care to continue to be the primary focus for health care is unsatisfactory either in terms of human costs or in terms of financial costs to families and/or to the community. This concept applies to mental and emotional illness as well as to physical illness.

Home health services, including homemaker-home health aide service, should be a part of all forms of health delivery systems, including health maintenance organizations, community and hospital-based health service programs, and any other existing or proposed health delivery systems. Homemaker-home health aide service as an integral part of home health care is provided currently as part of

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[1] "Report of the Exploratory Committee on Public Health Nursing and Related Home Care Programs."

[2] Home Health Services and Health Insurance, *Medical Care,* Volume IX, No. 1, January–February 1971.

the Harvard Community Health Plan (HMO), the Kaiser Permanente Program (HMO), Visiting Nurses Services, Homemaker-Home Health Aide Agencies, Public Health Departments, Mental Hospitals and many others. Its value has been proved over and over in these services around the country. It must also be a vital part of any new, national, comprehensive health insurance program.

OTHER IMPORTANT POINTS

There are several other points which must not be overlooked:

1. Professional personnel is in short supply, and it is expensive. Paraprofessional or allied professional help must be utilized where and when appropriate from the standpoint of safe and effective care. Homemaker-home health aide service is an exemplary utilization of the less expensively prepared individual;

2. All forms of social and health service, including homemaker-home health aide services, must meet basic standards of quality. The Council strongly endorses the concept of assuring quality services through utilization review and other standard-setting mechanisms, such as nationally recognized voluntary self-regulating programs including that established by the National Council for Homemaker-Home Health Aide Services;

3. To meet established national standards, homemaker-home health aides must be carefully selected, trained and supervised, but they do not require an extensive educational background. Therefore, this vocation is proving to be a realistic choice for many educationally disadvantaged but capable individuals. As this service begins to expand consideration should be given to the development of training centers on a local or regional basis located at facilities such as Community Colleges, since it might prove difficult for individual agencies to provide sufficient training for a rapidly increasing number of homemaker-home health aides. Guidelines and materials would need to be made available to assist these training centers in developing a curriculum to meet the national standards for training of homemaker-home health aides.

Often homemaker-home health aides are middle-aged or older women and men. In many communities, homemaker-home health aides are recruited directly from families whose only source of available income has been public welfare. In some instances, this source of employment has enabled the family to become self-supporting; in others, a minor amount of subsidization is still required. Growing numbers of agencies are developing career ladders and are providing job mobility for many such individuals. Many homemaker-home health aide agencies have part-time positions available which enable mothers to work during the hours their own children are in school. Thus, the community stands to gain doubly from this service as previously unemployed individuals become self-sustaining.

4. Homemaker-home health aide services enable the "breadwinner" to retain or return to his or her job, knowing that the ill or dependent member(s) of the family is well cared for. Some 24 voluntary homemaker-home health aide agencies in New Jersey report, among other statistics, that in 1970, their services prevented 2,435 instances of absenteeism from work.

SUMMARY

Homemaker-home health aide services are needed by rich and poor alike and must be available when and where they are needed. The community as a whole stands to gain from a physically and mentally healthy population as well as the individuals and families concerned. However, until there is a secure and adequate funding base, such as can be provided through National Health Insurance, or until the regulations of existing programs such as Medicare and Medicaid are appropriate to home health service needs, agencies will not have the fiscal security needed to develop the quantity and quality of services required throughout the nation, even for those who can afford to pay for the service.

ITEM 7. STATEMENT BY THE AMERICAN HOME ECONOMICS ASSOCIATION

The American Home Economics Association is vitally interested in the home-related aspects of home health services. And it is because the home-related aspects are so interwoven with the health-related aspects, that logic has properly dicated the joining of these two aspects into one recognized service, namely,

homemaker-home health aide services. Whether the home health or the homemaker aspect is emphasized when rendering services to individuals depends on the professional orientation of the supervisory agency.

PROFESSIONAL OBSCURANTISM

One of the major problems confronting the future delivery of service which meets the whole needs of individuals is that of overcoming over-professionalism and its tendency to narrow the focus and limit the services rendered. This tendency towards over-specialization and limitation of service is accented by restrictions on funding, whether source of funding is through health, welfare, education or labor agencies. Yet, where the broader concept has been permitted, the result has been most favorable. For example, a home nursing service which utilized women trained as homemakers was very pleased with the quality of service that these homemakers offered. The health supervisor was able to direct their work with respect to the health situation; in addition, the homemakers were able to contribute extras from their understanding of home-related aspects of the health situation. This came from their training and knowledge of housing, food preparation, nutrition, home management, personal family relations, etc.

Likewise when home health training was added to the homemaker's role, it enhanced the capability and feeling of competency of the women who otherwise felt apprehensive about working in homes with a health problem.

Home economics professionals are uniquely well qualified to work with the related professionals in developing the field of homemaker-home health service. It is our observation that this service should cut across and utilize the several professional areas involved. The omission of any one tends to limit appreciably the quality of the service rendered.

INADEQUATE NUMBER OF PROGRAMS AND PERSONNEL

No program that we know of even begins to meet the needs of the aging population for homemaker-home health services. A research study published in the April, 1966 issue of the *Journal of Home Economics* was undertaken to estimate the demand for homemaker services. It developed a rough estimate of one homemaker for 100 hospital admissions, or about one per 1000 population of that county. Thus, the estimated need of over 200,000 homemakers nationally is conservative, for it is not based on meeting the needs of the non-hospitalized aged. Yet, no community meets this minimum standard or even comes close to it. Using the yellow pages as a simple criterion, it is noteworthy that this direction in most cities does not even include such a service in its index. In those cities which do, the staff is often much too small and is restricted as to the type of service offered.

LIMITED CONCEPT OF SERVICE

The concept of homemaker/home health aide is not new in this country and it is an accepted service in England, Scandanavia and many European countries. There may be several reasons why its potential value has not been recognized in this country, each of which presents a problem area to be reckoned with in providing adequate home health services for the aged:

(1) Social Welfare agencies generally have given priority to welfare recipients and have not solicited its use by those who are able and willing to pay. Thus those who can pay a part of the cost and those able to pay full costs are excluded from the services, since they are not welfare recipients. This is particularly important to the low income but non-welfare aged.

(2) Health agencies have tended to limit the service and view it as an extension of a nursing service which is primarily concerned with the patient's physical problem. Health agencies have been reluctant to include as health related the food buying, meal preparation, home management, household care and family relations problems of the family. The funding of home health service often specifically excludes the rendering of any service other than that directly related to the patient's physical problem. This leads to the third problem.

(3) Categorical care, that is, the limitation of service to specific categories of persons, tends to fracture the service into segments of what is really a total living concern for the patient. Specifically, home care when viewed in the context of the problems of the aged or the disabled, the blind, mentally retarded, the welfare client, etc. tends to focus on that category and not on the patient and his family. Admittedly, the home health problems of the aged are some-

what different from those of a younger family confronted with a terminal illness, with a family needing extended care for the return of a family member from a mental institution, or the family with a physically handicapped homemaker. Yet, the sameness of the problems of housing, equipment, buying food, meal preparation, nutrition, dressing and personal care, transportation, time and money management, family relations, consumer education, and helping the family relate to the world of forms, credit cards, invoices, appointments, schedules of bureaucratic government and private institutions demands a service which has as its focus the meeting of the whole needs of the home resident. Such fractionization of services prevents a community from combining services into the most economical unit. Also, it may mean that the patient is served by and often confused by more than one agency. For persons living in the highly metropolitan, densely populated areas, specialized services may be offered economically. However, this is not possible in the vast areas of rural America or even in the suburbs.

(4) "Momism" or "Anyone can do it" or "It just takes common sense and willingness to work"—Such attitudes prevail in the top administration of many educational, health, welfare and manpower programs. Home services tend to be taken for granted by family members and assumed to be "free". Also, there is no greater reward to the indigenous homemaker for giving excellent rather than poor home care. The work ethic, which is more applicable to the marketplace, is peculiarly not so readily applicable to the homemaker's role. Thus, the importance of training, professional and occupational orientation, and wage scales with fringe benefits is not readily recognized.

(5) Domestic "hangup"—The tendency to identify the work of a homemaker with that of a maid, cook or housekeeper has discouraged people from entering the field, retarded the development of a distinctive occupational title, and lowered the dignity of this worthy profession. The standards recently announced by the National Council for Homemaker-Home Health Aide Services, Inc. hopefully will gain national approval and thereby meet this problem.

(6) Third party buyers of services have been slow to recognize the bargain inherent in home health services. Instead, the fear of building into insurance or government programs a service for which there is lacking actuarial experience has been allowed to overshadow the obvious cost saving benefit of home over institutionalized care. The orientation of the HMO concept such as is described by Representative Bill Roy in the November 11, 1971 Congressional Record (H10974) with his introduction of H.R. 11728, should bring into proper focus the value of homemaker-home health aide in the delivery of health services.

(7) Commitment—perhaps the greatest need is for a positive commitment to launch a program that will make the services of competent, trustworthy and professional homemaker-home health aides, working under the supervision of professional agency personnel, available to all persons in need regardless of their age, color, religion, sex or income.

The recommendations of the Homemaker-Home Health Aide Special Concerns Session, as published in the 1971 White House Conference on Aging report, if implemented, will bring this about.

ECONOMIC ASPECTS HAVE BEEN UNDEVELOPED

The commitment to develop and provide a service must be accompanied by economic measures needed to launch this new service. Can it be sold to the nation as a franchise operation? Is franchising the most efficient method of bringing into being such a new service? Will this produce desirable results? How can the government health and welfare agencies launch a significant new program such as this? What funding systems would be required to develop home health care? And, more basically, if home health care is so advantageous to the patient and economical to the agency purchasing such service, what is it that has inhibited its growth? These and other questions need the benefit of serious research, more specifically:

1. Cost data are needed not only on the operations of home health care but on alternative methods of providing equivalent service to people.

2. Experiments are needed which will generate data useful in assessing the merits of utilizing home health services in lieu of institutional care.

3. Experimentation with new and different methods of financing should be explored as recommended by the Special Concerns section of the White House Conference on Aging Report (p. 124). Historically, services have been priced so low

that the revenue has been insufficient to provide full and adequate service. Furthermore, most welfare oriented agencies have limited their service concept to their own clients, thus denying service to those who would be willing to pay all or part of the cost. This is especially important for the middle-class aged who could pay partially for the cost of the service.

4. What are the investment requirements to launch a new service in a community? And over how many years must this front-end cost be amortized? Investment capital is used to establish a motel service, hamburger or fried chicken outlets across the nation. Likewise, investment capital is needed to launch homemaker service even if launched by a government agency. How, under government auspices, is it possible to support an advertising and public education program? Can such costs be assessed as a fixed portion of the costs of operations, as is often done commercially?

MATCHING MONEY GRANTS ARE NOT SUFFICIENT

Federal funds for homemaker-home health aide service are available under Social Welfare on a three to one matching basis. These funds are unlimited so that it may properly be asked why states do not make more use of this subsidy, particularly in light of the evidence that home health care is less costly than institutional care. One state welfare director answered this by saying that he was convinced his state could save many times its cost in reduced payments for institutional care by using homemaker-home health aides but, it had never been possible to get sufficient funds to launch homemaker-home health aide programs and furthermore it did not appear that it would be possible in the near future.

Funds have also been available under Title III of the Older Americans Act for developing homemaker-home health aide services. However, these require matching. At least two homemaker-home health aide projects in one state collapsed because of: (1) the matching requirements, (2) failure to develop realistic fee schedules, and (3) dedication to provide service to those most needy—thus generating no income.

Implementation grants with assurance of funding for at least a five year period are needed. Such implementation grants should provide for advertising, promotion, training, supervision, and subsidization of newly launched programs.

MYOPIC VIEW OF MANPOWER

Manpower is customarily measured in terms of prevailing occupations and numbers of persons in the labor force. Unemployment statistics evoke greater public concern than do situation reports on persons not in the labor force. That is, there is a proper national concern over the labor force, but an inadequate concern over that population group not counted among the labor force.

Nonparticipation in the labor force by 42 million females in 1971 is the reservoir of latent talent which can be utilized for homemaker-home health aide service. (Table A–28, Jan. 1972, *Employment and Earnings*, USDL) Less than half of the females 16 years old and older are in the labor force. School and family responsibilities are legitimate reasons for the younger women not participating in the labor force. But for those over 45, when child bearing challenges are less time consuming, "home responsibilities" was given most frequently as the reason for non participation in the labor force. It increased with age: 40% of those 45–54 years of age; 44% for those 55–59 years; 55% for the 60–64 year olds and 76% for those 65 and over in years. Since home making is not a full time job, it would appear that many of these women are eligible for part time if not full time employment. It is pathetic that among those who "do not want work now", a large proportion gave as their reason for not seeking work "think they cannot get job". (Table A–30, *Ibid*)

Homemaker-home health aide service could tap this reservoir of manpower not presently in the labor force and thereby have several desirable effects:

(1) It could relieve the pressure on the limited supply of professionals in the current health system.

(2) It would extend the availability, accessibility, and continuity of health care services by reducing the communications and transportation gap between the patient and the physician. For example, most (77%) of the homemakers trained in Kansas had drivers' licenses and were able to provide transportation for the elderly. Furthermore, with their being present at the doctor's office or hospital they were able to assist the elderly in more effective follow-up home care.

(3) Home care would better utilize the nation's capital outlay in homes and not require additional capital outlay for the construction of new facilities.

(4) The money flow would increase the gross national product and increase the tax base to support worthy programs.

(5) Home care would bring a sense of participation and awareness on the part of the mature women who now is not fully occupied at home but who could gain a sense of self-worth and dignity by working and develop a better appreciation for how others in America live through serving them as a homemaker.

VOLUNTEERISM

The magic of volunteer support may be tarnished when applied seriously in the area of homemaker-home health aide service. Some of the work of the aides is equivalent to friendly visiting, baby sitting, reading to the blind, helping with shopping. But much of it is hard work! While we support volunteer efforts, we question whether it can offer a viable solution to the need for the development of wage-paying community service.

TRAINING—THE DEVELOPMENT OF

Probably the greatest danger which lies in the immediate future of homemaker-home health aide service is the possibility of its rapid acceptance, this could come quickly with its incorporation in medicare, medicaid or other health programs which will then make such a great demand that there will be created "*instant homemakers*". It is our conviction that training programs should be instituted immediately in anticipation of the forthcoming demand. Training is necessary because of the technological changes that have taken place with which the older women are not familiar. Secondly, women find training necessary to prepare them to manage the homes of other people, even though they may have managed their own homes well. Thirdly, the trainees need to become aware of specialized problems which have not been part of their own life experiences. They must learn to be able to organize the work and get it done within a limited time, but yet be flexible. And finally, training is necessary because one of the valuable services of a homemaker is to work herself out of a job by having educated the patient or client to serve himself. This is perhaps the most distinguishing feature between the role of the homemaker and that of a domestic. The domestic hopes to continue in the job forever, whereas the homemaker wishes to work out of a job and leave the patient self-sufficient.

The American Home Economics Association has among its membership many members in schools, departments and colleges of home economics who would be anxious, able and willing to assist in the training of homemaker-home health aides and in the supervision of their work.

In summary, we see the need :

(1) To implement immediately training centers throughout the nation.

(2) for R&D grants on the economic and manpower problems,

(3) for strict adherence to the standards published by the National Council for Homemaker-Home Health Aide Services, Inc., and

(4) for grants to states to initiate services.

ITEM 8. LETTER AND MATERIAL FROM AMERICAN SPEECH AND HEARING ASSOCIATION, TO MISS BRAHNA TRAGER

DEAR MISS TRAGER: In a statement prepared for the White House Conference on Aging the American Speech and Hearing Association described the communications problems of the aged and significant issues regarding the delivery of hearing, speech and language services to elderly citizens. A copy of that statement is enclosed with this letter for your information and for inclusion in the special report on home health services now being prepared by your office. We hope this letter will be included in that report as well.

According to national health surveys, it is conservatively estimated that between 13 and 25 percent of the population over age 65 have a bilateral hearing loss of a magnitude sufficient to seriously restrict understanding of speech and, thus, seriously restrict social efficiency. An estimated 90,000 individuals over age 65 are speech handicapped and, according to a United States national health

survey, this number is expected to exceed 148,000 by 1980. Data from the National Institute of Neurological Diseases and Stroke reveal that at least 20 percent of those citizens with stroke have an associated impairmen of langauge. The National Institute of Neurological Diseases and Stroke estimates there are over 600,000 adult Americans with severe language impairment (aphasia).

Data are not available on the prevelance of communicative disorders of those aged Americans who, because of poor health or other reasons, are confined to their places of residence. One can safely assume that the occurrence of communicative disorders in the home-bound aged population is *no less* than the occurrency of communicative disorders in the general aged population. Indeed, the incidence may be *higher* because those debilitating diseases of the aged that result in confinement to the home (e.g., cancer and stroke) are often accompanied by communicative disorders.

There are very few home health agencies known to the American Speech and Hearing Association that maintain full-time staff speech pathologists and/or audiologists. Although many such agencies have consultative services available to them on a part-time contract basis, the extent to which speech, hearing and language services are being provided to the communicatively handicapped homebound aged is not known.

Current policies of the Medicare program are restrictive so that rehabilitative services are often denied those who need them most, i.e., elderly, indigent, homebound individuals. Under the Medicare program, speech, hearing and language services are available to the home-bound aged citizen only when all the following conditions are met:

1. The individual has had prior hospitalization.
2. The services are provided through a home health agency.
3. The services are related to a health condition that required prior hospitalization.

When all the above conditions are met, rehabilitative services (including occupational therapy, physical therapy, nursing, and speech and hearing services) are generally limited to a total of 100 visits during the 12 months immediately following hospitalization.

If the patient does meet the above criteria, but fails to meet the definition under Medicare of what constitutes "home-bound" (primarily physically nonambulatory), speech, hearing and language services are obtainable under Medicare only through out-patient departments of participating hospitals.

These restrictions may be better appreciated if the following three hypothetical examples are considered:

1. If a patient is hospitalized for cancer of the larynx, subsequently undergoes a laryngectomy, and then is discharged to his home, Medicare will provide speech therapy only if he returns to the hospital as an out-patient. If the hospital where the surgery was performed does not provide out-patient speech therapy, the Medicare program will not pay for needed speech therapy even though it may be available in the community from other resources such as community speech and hearing centers, university clinics, or private practitioners. This comes about because only the hospital or extended care facility is defined under the Medicare program as a "primary provider."

2. If a patient is hospitalized for stroke and at the time of discharge from the hospital to his home is still handicapped by an impairment of language and further, he is unable to leave his home because of residual paralysis, he would be unable to obtain speech and language therapy unless a home health agency in that community is able to provide therapy. This would maintain even though rehabilitative services were available to him from other clinical services programs in the community that maintain home-bound programs, e.g., community speech and hearing clinics, rehabilitation centers, and private practitioners.

3. If an elderly patient is diagnosed as having a medical disorder sufficient to require him to stay at home but not sufficiently severe to require hospitalization, and it is determined that home-bound rehabilitative services would improve his health or at least maintain it at the current level, he would be ineligible for rehabilitative services under Medicare because hospitalization was not required. Preventive health services are thereby ruled out under current Medicare provisions.

The American Speech and Hearing Association supports the concept that a national health care program for the aged must incorporate a delivery system

that will assure the distribution of all those health services needed to the home-bound as well as those able to leave their homes. It is our opinion that any national health care program should include a system for preventive care. The American Speech and Hearing Association, therefore, urges that Medicare benefits be expanded to permit greater utilization of all rehabilitative services to the home-bound aged. Those benefits should include speech, hearing and language services by qualified speech pathologists and audiologists upon referral of physicians or *other* health related professionals associated with home health agencies or with any *other* agencies with which the aged citizen comes in contact. It is essential that all community resources be utilized fully in providing care to the aged whether that care is provided in the home or in an out-patient facility. Therefore, we believe that extensions of Medicare programming or new programming for the aged should permit direct participation by appropriately accredited agencies and appropriately qualified individuals to provide services to the aged at home. Further, we urge that rehabilitation centers, community speech and hearing centers, private practitioners and other such health facilities be qualified as primary providers in order to fully utilize existing professional manpower.

For services in speech, hearing and langauge the Medicare regulations already define qualified individuals as those speech pathologists and audiologists who hold the Certificate of Clinical Competence of the American Speech and Hearing Association or its equivalent. The American Speech and Hearing Association also maintains a voluntary national accrediting program for clinical service programs in speech and hearing.

The American Speech and Hearing Association thanks the United States Senate's Special Committte on Aging for this opportunity to express its concerns for the many thousands of elderly speech and hearing handicapped Americans it serves.

(Enclosure.)

Communication Problems of the Aging: A Position Paper[1]

Disorders of communication are an important concern as related to health, education and welfare. Communication includes hearing, language comprehension and usage, and speech. Disorders of communication would include hearing, speech, language, vision, reading, writing and various combinations of these factors. The complexity of communicative impairment is further compounded when the impairment occurs secondary to, in association with, or as a result of, other conditions.

"In general, various kinds and degrees of hearing and speech problems may be associated with a variety of other conditions: all levels of mental subnormality, emotional stability, psychotic states, cerebral palsy and various forms of brain injury or disturbances of the central nervous system, problems of anatomic development, and various degrees of social deprivation or behavioral maladjustment" (3, p. 7).

The effects of communication impairment may profoundly affect the occupation, health and psychosocial adjustment of the communicatively impaired adult. Thus, it is the responsibility of a total health care program to provide evaluation, treatment and management of communicative impairments in the adult.

INCIDENCE OF HEARING, SPEECH, LANGUAGE IMPAIRMENTS IN THE AGING POPULATION

Hearing

According to National Health Surveys, it is conservatively estimated that between 13 and 25 percent of the population over age 65 have a bilateral hearing loss of a magnitude sufficient to seriously restrict understanding of speech, and, thus, seriously restrict social efficiency. Via census translation, there are currently over two and one-half million elderly American citizens who have a significant bilateral impairment. The number will increase as the population grows and longevity becomes greater. According to census projections for 1980, over three million of the nation's aged population will have bilateral hearing impairments.

Hearing loss as a result of aging (presbycusis) is not a condition that necessarily exists alone. It may be superimposed on other kinds of hearing loss. For example, damaged hearing due to noise is now recognized as a disabling possibility in many industries and trades. There is an increasing probability that

[1] Prepared by the American Speech and Hearing Association.

tomorrow's aged, having been exposed to today's noise levels, will present hearing disorders in even greater numbers than previously predicted.

The problem of dysacusis (auditory discrimination deficit resulting in distortion of audible speech) must also be taken into account when citing the incidence of hearing impairment. In a report prepared by the Subcommittee on Human Communication and Its Disorders, National Advisory Neurological Diseases and Stroke Council, the following is stated:

"The prevalence of dysacusis, or the garbling of audible speech, has not been studied systematically on a large enough population to allow any generalizations regarding its occurrence in the population at large. Methods of determining dysacusis involve tests for speech discrimination which have not been rigorously administered on a mass scale. Thus, only three comments can be made at this time. First, dysacusis is often a concomitant of loss in sensitivity. Second, it can also either occur independently thereof or it may appear in conjunction with a threshold deficit too mild to be handicapping by itself. Lastly, a great many elderly persons exhibit a combination of dysacusis and a characteristic high frequency loss in sensitivity. If we include this composite presbycusic malady in our tabulation, the prevalence of handicapping hearing impairment is probably at least as high as one in four among persons over sixty" (2, p. 15).

Speech

According to a U.S. National Health Survey, an estimated 90,000 individuals over age 65 are speech handicapped. By 1980, this number is expected to exceed 148,000. Cancer is a prevalent condition among the elderly. Cancer can require and necessitate the removal of the larynx, resulting in total loss of voice. Cancer may also necessitate removal of the lungs and/or of maxillofacial structures important to the production of speech. In addition, deterioration of articulation proficiency and voice impairments often result from diseases of, or impairment to, the central or peripheral nervous system as well as a result of severe hearing impairment.

Language

At the present time, there are no definitive data posting the incidence of language disorders in the aging population. Vascular lesions, cerebral trauma or tumors are prevalent conditions among the elderly. Often a significant reduction in language function (aphasia) is a result of such conditions. According to the National Institute of Neurological Diseases and Stroke, an estimated 600,000 adult Americans have aphasia (2, p. 16). The inability to comprehend and use linguistic symbols as a result of neurological impairment will significantly reduce the individual's ability to listen, read, write, and/or talk. Loss of the ability to communicate effectively can produce severe concomitant social, emotional and vocational handicaps.

PROVIDERS OF SPEECH, HEARING AND LANGUAGE SERVICES

Definition of Speech Pathology and Audiology

Speech pathology and audiology is the professional discipline basically concerned with the systems, structures, and functions that make human communication possible; with the causes and effects of delay, maldevelopment or disturbance in human communication; and with the identification, evaluation, and rehabilitaiton of individuals with speech, hearing and language disorders.

Speech pathology and audiology is thus both a discipline and a profession. As a discipline, it is concerned with the basic scientific study of the processes of individual communication, with special reference to speech, hearing and language. It encourages research on disorders of human communication. It aims to provide a fund of substantive knowledge as a basis for the practice of the discipline. It therefore concerns itself with the development and evaluation of clinical tation of individuals with speech, hearing and language disorders.

As a profession, its practitioners provide professional services for persons whose educational, vocational, personal and social functioning and adjustment are impaired by disorders of speech, hearing or language. The diagnostic and therapeutic services needed by persons with such disorders are made available through a variety of clinical settings, rehabilitation centers, programs of special pupil services in schools, and private practice facilities.

Descriptions of the duties of the Speech Pathologist and Audiologist are presented in the *Dictionary of Occupational Titles* (1) as follows:

"Speech Pathologist (profess. & kin.) 079.103. Diagnoses treats and performs research related to speech and language problem: Diagnoses speech and language disorders by evaluating etiology. Treats language and speech impairments such as aphasia, stuttering and articulatory problems of organic and nonorganic etiology. Plans, directs and conducts remedial programs designed to restore or improve communication efficiency. Provides counseling and guidance to speech and language handicapped individuals. May act as consultant for educational, medical, and other professional groups. May teach or direct scientific projects concerned with investigation of biophysical and biosocial phenomena associated with voice, speech and language. May conduct research related to development of diagnostic and remedial techniques or procedures, or design of apparatus. May be employed in university, hospital, public school, or community or governmental organization, or may engage in private practice. See Audiologist for one who specializes in diagnosis and treatment of auditory and language problems.

"Audiologist (profess. & kin.) 079.108. Specializes in diagnostic evaluation, habilitative and rehabilitative services, and research related to hearing: Determines range, nature, and degree of hearing function related to patient's auditory efficiency (communication needs), using electroacoustic instrumentation, such as pure-tone and speech audiometers, and galvanic skin response equipment. Coordinates audiometric results with other diagnostic data, such as educational, medical, social and behavioral information. Differentiates between organic and nonorganic hearing disabilities through the evaluation of total response pattern and use of such acoustic tests as Stenger and delayed speech feedback. Plans, directs, and conducts or participated in habilitative and rehabilitative programs including counseling, guidance, auditory, training, speech reading and speech conservation. May conduct research in physiology, pathology, biophysics, and psychophysics of auditory systems. May design and develop clinical and research procedures and apparatus. May act as consultant to educational, medical and other professional groups. May teach art and science of audiology and direct scientific projects. May specialize in fields such as industrial audiology, geriatric audiology, pediatric audiology, and research audiology. See Speech Pathologist for one who specializes in diagnosis and treatment of speech and language problems.

The American Speech and Hearing Association

The American Speech and Hearing Association (ASHA) has a membership of almost 13,000 and is the national professional organization to which most speech, hearing and language specialists belong. The basic qualifications for entrance into the profession have been established by ASHA and include the completion of work for a Master's degree. The American Speech and Hearing Association further recognizes the completion of academic and experience requirements for clinical competency by awarding a certificate attesting to the holder's fulfillment of the requirements. The American Speech and Hearing Association has been recognized by both the National Commission on Accrediting and the U.S. Office of Education as the national organization responsible for accrediting university programs offering graduate education in speech pathology and audiology.

At the present time, there are 8,160 individuals who hold the Certificate of Clinical Competence in Speech Pathology and 1,627 who hold the Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association. Relative to total manpower, the number of speech pathologists and audiologists who hold the Certificate of Clinical Competence in the United States averages approximately 5.0 per 100,000 population.

Qualifications for Providers of Speech and Hearing Services

Services by speech pathologists and audiologists are presented under Medicaid, Regulation Section 249.10. Services for individuals with speech, hearing and language disorders are defined as those diagnostic, screening, preventive, or corrective services provided by or under the supervision of a speech pathologist or audiologist in the practice of his profession. A speech pathologist or audiologist is defined in the regulations as one who has been granted the appropriate Certificate of Clinical Competence by the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience necessary for such a certificate, or who has completed the academic program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate (4).

SIGNIFICANT ISSUES FOR THE DELIVERY OF HEARING, SPEECH AND LANGUAGE SERVICES

The delivery of hearing, speech, and language services to the elderly consumer is recognized as an integral part of a comprehensive health care system. In order for these services to be rendered efficiently and effectively to the communicatively impaired elderly consumer, the resolution of certain issues is mandated.

Issue 1: Manpower Development

A significant problem exists in manpower development to provide personnel qualified to render hearing, speech and language services to the elderly consumer. The growth of the population, as well as the continuous increase in average longevity, will result in an increased number of aged consumers having communicative impairments. Since additional personnel must be trained to meet the demand for delivery of services a substantial increase in funds to graduate education programs in Speech Pathology and Audiology is vitally needed.

Issue 2: Manpower Training

Increasing the number of qualified personnel to render hearing, speech and language services is not the sole solution in meeting manpower needs. Emphasis must be placed upon the training of personnel in type as well as number. The aging process produces special psychological, physiological and social problems that mitigate against the direct application of evaluation, treatment and management procedures appropriate for a younger population. Personnel must be trained to render services as needed for the communicatively impaired geriatric individual. Thus, substantially increased financial support is necessary for the training programs to develop curricula and train personnel to serve the needs of the communicatively impaired adult.

Issue 3: Research

A dearth of research data exists in relationship to the plethora of research needs. Hearing, speech and language services have long been directed to the younger populations. Comprehensive information concerning the special problems of the aged in evaluation and treatment of communication impairments is not available to the speech pathologist, language pathologist, and audiologist. A report by the National Institute of Neurological Diseases and Stroke (2) lists fifty-four areas of research needs in audition and its disorders alone.

In another federally sponsored report entitled *Human Communications: The Public Health Aspects of Hearing, Language and Speech Disorders*, the following is essential for comprehensive community health program development:

"Further investigation is required into the identification, evaluation, treatment, of communicative disorders of the aged. Multidisciplined studies of the medical, social and psychological aspects of aging are necessary for specification of the meaning of habilitation in geriatrics and for the development of a philosophy regarding communicative disorders of the aged (3, p. 24).

Issue 4: Education

Information concerning communicative disorders is necessary for both consumers and public health personnel. One result of Project FIND (5) was the discovery that many aged individuals were not aware of available services or their entitlements to service. All too often agencies wait for the aging to seek them out. Thus, hearing, speech and language services are often not delivered because the consumer does not know they exist rather than through a lack of need.

The National Institute of Neurological Diseases and Stroke's report strongly emphasizes the informational need of public health officers regarding services rendered to the communicatively impaired.

"The broad subject of communicative disorders, their problems and handling, should be an integral part of every education program in public health and hygiene. (Just as acquaintance with public health measures should be part of the education and training of every student of communicative disorders.) This education may be of three general types: (1) Education in public health measures for the specialist in communication, (2) education in the communicative sciences for public health officers, and (3) short-course programs to acquaint service personnel with the public health aspects of communicative disorders" (3, p. 24).

Issue 5: Regulations

In a comprehensive health care program, delivery of services to the consumer need not (and should not) be unduly restricted by administrative barriers. Provisions must allow for *comprehensive* delivery. Regulations for delivery service should provide for multiple entry points into the health care program and direct reimbursement to the provider for services rendered. In addition, provisions for service to the communicatively handicapped geriatric should be standardized among states so that service delivery is not determined solely by accident of geography.

ITEM 9. STATEMENT BY THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Position on Priorities in the Health Care System

In concern for the health of the American people, health care is second in priority only to an environment that contributes positively to human health.

Within health care, the American Physical Therapy Association advocates certain priorities which, if adopted by appropriate policy-making bodies, would promote the right of all persons to have equal access to and equal availability of high quality health care services.

These priorities are directed to principles and mechanisms which should pervade all elements of the health care system in the United States.

The health care system should utilize existing public and private services, facilities, and agencies in ways that will economically make comprehensive health care available and accessible to all people.

Alternatives to existing methods and organizations for delivering health care should be encouraged when they demonstrate reasonable predictability of contributing to the availability and accessibility of comprehensive health care.

Preventive health care services and public education in personal health care should be made an integral part of the health care system.

The health care system should be accountable to the public and should include effective mechanisms for peer review, multidisciplinary review, and consumer participation in policy and audit of the system.

A sufficient number and variety of health care personnel should be educated to meet continuing health care needs, and encouragement should be given to all health care personnel to provide services in areas of the nation where comprehensive health care may not be available.

The availability of health screening, preventive and early care, and timely referral for more extended care should be expanded by recognizing and enhancing the existing competencies of a variety of health care personnel.

Methods of financing the health care system should take optimum advantage of both public and private funding mechanisms to support the full scope of health care and to remove inequitable barriers to receiving necessary health care services.

ITEM 10. STATEMENT FROM THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, MARCH 14, 1972

Occupational therapy is the art and science of directing man's engagement in selected activities in such a way as to promote and maintain his health, diminish dysfunction and pathology, and enhance his capacity to adapt and to function with increasing satisfaction to self and others. The occupational therapist is concerned with the effects of activity upon the whole person, how the individual responds to the environment in life tasks and adapts his behavior in social relationships and all the meaningful activity he undertakes.

For more than 50 years, trained occupational therapists have helped speed recovery for the aged and have made a unique contribution to the care of the aged who are homebound. Occupational therapists provide services for a wide range of illnesses, injuries and disabilities, and they function at all levels of care—in the hospital, nursing home, extended care facility, office, clinic and home.

Adjustment to the home environment and independent of function in the home are primary occupational therapy goals. The independent functioning of the older

person in the home can make the difference between a family member remaining at home to provide continuing care for that person or becoming a part of the labor force outside the home.

It has long been recognized that patients recovering from acute illnesses and receiving restorative care require occupational therapy as an integral part of their rehabilitation regime. Thus, in the hospital the services of the occupational therapist who treats the partial paralysis of a stroke patient by designing and fabricating a special arm or leg splint, for example, are provided under the Medicare law.

However, when the hospital patient is discharged, any needed home health services by an occupational therapist can only be provided, under the present Medicare law, if the patient also needs skilled nursing care or physical therapy or speech therapy.

This is a critical error in the law, interfering with local professional judgment in providing health care to Medicare patients. The physician should be free to choose whatever recognized form of treatment he feels will meet the patients' needs most effectively. Interposing artificial requirements that certain treatment forms must first be instituted before the desired and needed type may be provided interferes with patient care and leads to higher costs rather than savings. In many cases occupational therapy logically comes later in the individual's treatment, translating skills relearned into functional ability.

In practice many patients are undergoing an occupational therapy regimen at the time they are discharged from the hospital or extended care facility and returned to their homes for completion of the treatment program there. Under present law, one of three things must happen: 1) the patient must be retained in the hospital, at additional cost, until the treatment is completed, or 2) he must be sent home and the needed treatment halted, or 3) some subterfuge must be found, such as instituting one of the presently required three types of service even if not needed, in order to complete the treatment at home.

This problem has repeatedly been brought to the attention of Congressional committees concerned with the Medicare law, but as of this date, no changes have been recommended.

Chronic illnesses without prior hospitalization are not covered by the Medicare program. Thus the chronically-ill homebound older housewife who might benefit from instruction by an occupational therapist in special techniques of preparing meals and managing a home from a wheelchair cannot receive this service under Medicare. Nor can the patient over 65 who is losing his sight obtain help and advice in the arrangement of his room or household from an occupational therapist with Medicare reimbursement. These are but two examples among many that might be cited.

To overcome this deficiency in the Medicare program, attention should be given to providing consultation services by occupational therapists to the staff members of home health agencies, extended care facilities and nursing homes. By such consultation the staff members could be instructed in providing this type of assistance to chronically ill persons.

Governing boards of health agencies and facilities as well as the utilization review committees for insurance and government programs should include representatives of occupational therapy. In this way, their expertise could be effectively utilized both in program management and in decisions involving individual cases.

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Appendix 2

EXCERPTS FROM STATEMENT BY SENATOR ALAN CRANSTON, IN SUPPORT OF S. 3355, CONGRESSIONAL RECORD, SEPTEMBER 9, 1970

During committee consideration of S. 3355, I also introduced a number of amendments which give full recognition to the important role home health care can and should play in the Nation's medical care system. I was very pleased that all were accepted by the members of the committee.

These amendments, first, include home health care programs as an integral part of regional medical programs; second, place research and demonstration projects in home health care on an equal priority with those health care methods highlighted as eligible for grants awarded for research and development in health services delivery; and third, assure that in planning for the delivery of health services at both the State and area level, full consideration be given to the potential of home health care services to meet health needs.

Because of the importance which I attach to home health care as a means of solving a number of deficiencies in our health care system. I would like to speak extensively about the history of this medical technique and the unrealized opportunities it offers for many, many sick and disabled persons with no alternative to becoming institutionalized to receive health care.

Mr. President, among various systems of health care delivery developed and improved upon within the past few years, one of the most promising yet least perfected and recognized is the system of home health care. Although home health care is certainly not a novel program—in the United States, the first organized program was established in 1796—several more recent developments have created a demand that these programs provide highly sophisticated, efficient, medical services as a complementary system to the impatient and outpatient services generally thought of as the basic health delivery system.

These recent developments include medical advances which have made it possible to save many lives that in previous decades would have been lost to disease and accidents. In addition, the average lifespan has vastly increased due to improved medical techniques and increased knowledge in the treatment and prevention of disease. The result has been a much larger population, with a higher proportion of elderly individuals who are particularly subject to chronic illness, and an increase in the number of individuals of all ages who are temporarily or permanently disabled. Many of these individuals are not ill to the extent that an acute care hospital bed or full-time institutional care is needed. But they are not ambulatory enough to utilize outpatient facilities, and physician-directed medical care is essential to their recovery.

A second major development in recent years has been the sharp increase in the cost of hospital care, due partly to the expense of acquiring and staffing the new equipment and services modern medicine has produced and partly to increased operating costs and increased construction and renovation costs. Unfortunately, the cost of delivery hospital care has increased at a higher rate than the overall cost of living. These higher hospital expenses are included in overhead costs and transferred to the patent in the daily charge for his hospital bed. Thus, the hospitalized convalescent or chronically ill patient share is the burden of the cost of expensive acute care even though he is not utilizing it.

A third factor encouraging the development of home health care service has been the increase in the utilization of hospital beds. The growth of third party private insurance plans and the enactment of medicare has made hospitalization possible for many who in previous years were unable to afford it when they needed it. At the same time, most of these insurance plans provide reimbursement only for services performed during hospitalization, which restriction has served to increase hospital utilization substantially. As a result, many hospitals, particularly in urban areas, are operating at 95 percent capacity. Accordingly, communities and hospitals have been pressed to find methods of relieving the hospital overcrowding and to insure the availability of the necessary number

of beds for emergency situations. The result has been the establishment of a number of hospital-based home health care agencies, as well as agencies affiliated with one or more hospitals.

Currently, some of the major private third-party insurance plans include in their coverage the cost of posthospitalization home health care services, and in a few cases include prehospitalization services. Among prepaid group practice plans, Kaiser Permanente in Oregon pioneered in demonstrating the efficacy of including home care programs among the services provided its membership. Home health care services are now included in the benefits provided by about one-fourth of the prepaid group practices in the United States.

Congress at an early date recognized the potential of home health care services to meet these new demands on the health care delivery system. In adopting the medicare act, title 18 of the Social Security Act, Congress in 1965 included home health care service as a reimburseable service under both part A, "Hospital Insurance Benefits for the Aged," and part B, "Supplementary Medical Insurance Benefits for the Aged." These provisions made it economically feasible for individuals over 65 to utilize home health care services and at the same time provided some assurance to those wishing to develop such services in the community that there would be a demand from patients with financial ability to pay for the services so that investment in home health care systems would be economically viable. At the same time, Congress provided, through special appropriations in 1966 and 1967, seed money to foster the establishment of home health care agencies which could meet the certification requirements of medicare.

These relatively recent developments have changed the concept of home health care and have brought about the creation of new patterns of delivering that care. Whereas originally, home health care was limited to the provision of a single service—such as a visiting nurse, or a homemaker aide—today the emphasis is on providing multiple services.

Special impetus to the development of a more complex home health care agency was provided by medicare through requirements that only those agencies providing nursing plus one other service—either physical therapy, occupational therapy, speech therapy, medical social services, or home health aid services—could be certified for medicare participation. However, of the over 2,100 certified home health agencies only 78 provide the full range of services suggested but not required by the certification requirements. And over half of the agencies are at the minimum level, limiting their services to a nurse plus only one of the five other services.

I wish to note that as with any developing new field, there have been some problems and deficiencies in home health care systems. Many existing agencies were hurriedly established in 1966 and 1967 following the enactment of medicare. Consequently, they were not properly planned and failed to develop close relationships with other medical services in the community. Recent concerns have been expressed by the Social Security Administration about abuses in the home health programs, and an instructional release has been issued to their carriers and intermediaries emphasizing the legislative requirements governing reimbursement for home health care services. The intent of these provisions is to permit the reimbursement for home health services only where such services are determined by the physician to be essential to the patient's recovery and are a less expensive alternative to institutional care.

I strongly endorse the principle and requirement in the Social Security Act that any treatment program carried out by home health agencies must initially be prescribed by a physician after a visit to the homesite and should be actively monitored by a physician through continued personal, direct contact with the patient.

An important home care milestone is the development in a few communities of a comprehensive pattern of home health service—called the coordinated home care program. This type of program holds a tremendous potential for meeting many of the deficiencies of existing health delivery systems. These programs coordinate a wide range of home services around the needs of an individual patient as prescribed by his physician; they are centrally administered; and operate on a team concept in providing multidisciplinary services which can include medical, dental, nursing, social, educational, or other related services.

Ideally, such a coordinated home care program has relationships with other services in the community, such as hospitals—to assure immediate availability of hospital inpatient services when needed—laboratory and radiology services,

occupational and physical therapy services, psychological services, educational services, and many, many others. Under these circumstances, the program becomes a full partner in the community system of health and social services and provides those types of services which can both be provided most efficiently in a home situation and at the same time be closely coordinated with more complex systems for the provision of necessary services beyond the scope of the home health care program. Unfortunately, the number of home care agencies which have developed this comprehensive, coordinated approach is still very small.

Despite the progress I have outlined, much still needs to be done in this increasingly important field:

First. The distribution of home care agencies throughout the country is very uneven. Fifty-four percent of the counties in the country have no home health care coverage. Many of these are rural or sparsely populated counties, but among them are 99 counties with populations over 50,000. In these 99 counties there are many hospitals, extended care facilities, mental health centers, a few rehabilitation centers, but not a single home health care agency. Moreover, only five States have home health care agencies available for 100 percent of the population and only another 13 States have these services available for 90 to 99 percent of their population. Seven have them available for 75 to 90 percent. Seventeen States have these services available for 50 to 75 percent of their population, and eight have these services available for less than 50 percent of their population. Thus, there is an obvious need to develop these home health care programs in many areas of the United States.

Second. At the same time, new methods of administration of home health services need to be developed. Each community has its own needs, and each pattern of home health care has its particular utility depending on the circumstances of the patient and the circumstances of the health delivery system and other related systems of the community. In some communities, the services may be hospital-based or multihospital-based; in others they may be organized independently of any existing medical agency; in still others they might come under the auspices of a single agency or a multiagency council. A rural community may have a very limited base of health services on which a home health care program can be built, while an urban community may have such a wealth of programs that its challenge may lie in utilizing them fully or in overcoming entrenched but outmoded attitudes of providing services. Many communities have found it difficult to break into long standing medical care patterns traditionally around institutional care. Many existing home health care agencies were established without adequate community planning and support and as a result or inadequate to the particular needs of that community. Thus, considerable study is still necessary to develop further the various methods and scope of delivery of home health care services and to determine means of matching particular models to a particular community's needs and resources.

Third. There is a need for adapting treatment procedures for additional diseases to the home health care delivery method. Significant opportunities exist for treatment at home in the area of the premature infant, the mentally ill, the chronically ill, especially in the area of renal or respiratory diseases, and the spinal cord injured. The child of working parents who becomes ill may require a parent to stay home from work to supervise him. Home care services offer responsible care for such a child without jeopardizing the parent's job career or financial stability. Home health care can be provided the terminal patient, giving him the psychological boost of familiar surroundings and warm loving attention so essential to maintaining his spirits. Finally, a great potential exists in the provision of home health care services prior to hospitalization, particularly in the case of elective surgery, where the first days of hospitalization may be devoted to undergoing a battery of tests which could be provided at home at considerably less expense.

Fourth, Experiments and demonstrations in the innovative use of allied health personnel in home health care programs need to be developed. Opportunities also exist for the development of programs to train the nonprofessional health aide as an extension of the professional worker in the home setting. A special potential for expanding health manpower resources offered by home care programs is the opportunity they provide to utilize on a part-time basis the professional who is unable to meet the rigid schedule of a full-time job in an institutional setting.

Fifth. Studies need to be undertaken in the area of cost effectiveness to develop a formula which could determine with reasonable precision the moment

where the transfer of a patient to or from a hospital or other medical facility would be most economical, as well as medically productive, both for the institution and the patient and his family. These studies need not be confined to the more complex home health care systems. Indeed, the recent report of the staff to the Senate Committee on Finance on "Medicare and Medicaid, Problems, Issues and Alternatives," recommended consideration of extending medicare benefits to include homemaker costs in home health coverage as an alternative to more costly institutional care. The report stated:

"Many physicians and a number of health insurers have pointed out the pressure for continued hospitalization of a patient for several days more than medically necessary because of the lack of someone to assist the patient at home with food preparation, routine cleaning, etc., during the first week or two following discharge from the hospital. During that period, the patient gradually recovers capacity for independent living and ability to meet his routine living needs. In the absence of assistance at home during that recuperative period, physicians are understandably reluctant to discharge patients and patients are reluctant to go home. The present alternative to continued hospitalization is to discharge the patient to an extended care facility or skilled nursing home, which, while less costly than hospital care, is still quite expensive and often encompasses more care than those patients need." (S. Rept. No. 744, 90th Cong., 1st Sess. Nov. 14, 1969).)

Sixth. To encourage greater utilization of home health care services, there is a need to find means of giving recognition and visibility to home care programs, both in the medical community and in the consumer's community. A study undertaken in 1964 under the direction of Dr. Roger Egeberg, now Assistant Secretary for Health and Scientific Affairs in the Department of Health, Education, and Welfare, showed that 7 percent of hospital patients were medically suited for home health care. Yet currently only 2½ percent of hospital patients are being discharged to home health care programs. This discrepancy is due to the fact that many individuals in communities are unaware of the availability of home care services and many doctors also are equally unaware of the extent of the availability of such services, or are unaccustomed to utilizing the services effectively, if at all. Fuller exposure of the medical student to home care programs should be included in his medical school training so that he can learn early in his career the value of such services in the treatment of his patients.

Underutilization of home health care services is also caused to some extent by the limitations of private third-party insurance plans in including such services in their coverage. In those cases where it is covered, it usually is reimbursable only following hospitalization. And even where covered in private third party insurance plans and in medicare there is considerable under-utilization of the services. A study of medicare beneficiaries who were hospitalized during 1 year, indicated that the rate of utilization of home health care per State ranged from 3.2 individuals per 1,000 hospitalized to 37.8 per 1,000, with the individual State average being 13.2 individuals per 1,000 hospitalized.

When the expensive daily costs of hospital care are considered, this wide differential in the use of home health care services indicates that considerable savings might have been realized had home health care services been fully utilized. For example, a Blue Cross study of some 2,500 Blue Cross, medicare, and other patients in Philadelphia indicated that by utilizing home care services for these patients, some 33,000 hospital days were saved. For each patient the saving represented an average of 13 days of inpatient hospital care, and the cost of home health care on the average was roughly one-half that of the same care provided in a hospital.

Underutilization of home care services following hospital treatment can also be attributed to a lack of adequate hospital patient-discharge planning due partly to inertia in changing established patterns of care and partly to the lack of financial motive for the hospital, the physician, and the family. The hospital, if not operating at capacity, loses revenue; the physician's reimbursable services are not covered as fully as in the case of a hospitalized patient; and the family may find home care more expensive in terms both of utilization of their own time, and financially in that only limited coverage or none may be available—for example, after the initial benefits are used up in the case of medicare, reimbursement is limited to 80 percent of the costs.

In sum the potential for improvement and development of home health care programs is almost unlimited. Experience and recent research findings have shown that home health care programs can accelerate the rate of recovery from illness, can prevent or postpone disability, can reduce the time of hospitalization, can prevent rehospitalization, and can achieve these results at lower cost than the same services provided in an institutional setting. Benefits to the patient are considerable, economically in terms of reduced cost of care and psychologically in terms of a comfortable recovery in a noninstitutional, familiar, home environment. The amendments made to S. 3355 will encourage the development of new and the improvement of existing home health care agencies and services.

The amendments to title IX of the Public Health Service Act—sections 102 (b) and 104(a) of the bill—are intended to emphasize that home health care is an important method of care to be utilized in regional medical programs. The critical diseases which are the major concern of regional medical programs are particuarly appropriate for home care treatment. Three instances applicable to RMP are described in an article "Home Health Service—Past, Present, Future," in the September 1969 issue of the American Journal of Public Health, as follows:

"1. In one community, program evaluation had revealed that not a single patient with terminal cancer had been admitted to the home although many cancer patients had remained in hospitals until death. The following year, a concerted effort by hospital and home care staffs resulted in home care for selected patients with terminal cancer. Patient and family response was encouraging. The patients were more at ease and required fewer sedatives and drugs for pain; the families were better able to cope with grief. In general, these terminal patients were better off, both physically and mentally, in the home setting.

"2. Growing concern in the health field over the restricted number of patients who can receive intermittent renal dialysis in hospital centers suggests the need for dialysis at home. The development of a portable dialysis unit, and evidence that continuing intermittent renal dialysis can be carried on at home . . . makes utilization of home care programs particularly pertinent to treatment of kidney disease. (The Veterans' Administration is already carrying out home dialysis in ten areas.)

"3. St. Luke's Hospital in New York City has instituted a home health nursing program for outpatients with heart disease. The addition of public health nursing visits as follow-up to the outpatient cardiac program has reduced the rate of hospitalization for congestive heart failure. The staff feels that an anticipatory home care program based in a community hospital 'has great potential both for improving the health status of patients with chronic illness and for bringing the hospital closer to its community.' "

These examples, I believe, are clear evidence of the need to include home health care programs as an integral part of procedures utilized in regional medical programs.

An amendment to section 304(a) of the Public Health Service Act—section 203(2) of the bill—would place research in home health care in its proper perspective as a full member of a comprehensive health care delivery system. There is a continuing need for research in this special means of health care delivery to, first, find better methods of delivering home health care; second, find additional medical fields in which home health care can be utilized; third, develop innovative uses of new types of allied health professionals; and fourth, undertake studies to enable the doctor to determine the most effective way of caring for the individual patient—home care or institutional care—and when the transition should occur. This amendment would give research in home health care the same priority as research in other modes of health services delivery.

The amendments to section 314(a) and (b) of the Public Health Service Act—sections 220(d) and 230(b) of the bill—would encourage the utilization of home health care services in the community and would encourage the development of additional agencies and programs by identifying home health care as a service that should be included in health services planning at both the State and areawide level. To meet community needs adequately, home health agencies must be planned and developed with the full cooperation and counsel of the areawide comprehensive health planning agency (314(b)). This participation would be assured by these amendments in S. 3355.

I also feel special efforts should be made by the 314(a) and 314(b) agencies to seek representation on their advisory councils of representatives of substantial home health care programs to insure that this kind of service is given full consideration in the planning of community and State health services.

Furthermore, in the development of State plans for the utilization of section 314(d) formula money. I believe that each State should be strongly encouraged to devote a portion of its funds to encourage the establishment of home health services and to the support of one or more individuals whose function would be to provide guidance and counsel to existing home health care agencies in methods of improving their utilization within the community and meeting the specific health needs of the community. Section 1902(a)(24) of the Social Security Act requires that each State provide consultative services to home health agencies, among other types of facilities, to assist them in qualifying for reimbursement under the provisions of medicaid. Thus a nucleus already exists for these additional counseling functions.

Greater emphasis must also be placed in the allocation of section 314(e) funds on the establishment of home health agencies or the provision of home health services. In particular, I recommend to the Secretary of Health, Education, and Welfare that in granting funds for the establishment of comprehensive health care programs, such programs in all cases include the delivery of home health care services. Currently, I understand, 33 primary health care projects are being funded by section 314(e) grants. Of these 33 projects funded for the purpose of providing comprehensive health care to a select group or to a community, 12 fail to mention the provision of home health care services; eight plan to refer cases which require home care to other existing agencies, in many instances, the Visiting Nurse Association; and only 13 include home health care services as a component of their program. My proposal would insure that in all these projects, due consideration would be given to the feasibility of including home health care services among those provided by the program.

Considerable opportunity exists in the Hill-Burton program—support of hospital and other health facilities construction—for encouraging such facilities to utilize both prehospitalization and posthospitalization home health care services. In awarding of grants or other forms of support for these facilities, recipients should be encouraged to provide such services either directly or through arrangements with an existing home health care agency.

As a member of the Health Subcommittee of the Labor and Public Welfare Committee over the past 20 months since I entered the Senate, I have become greatly concerned about the impending crisis in our total health delivery system—if a system it is—and about the need to prod the medical community to move far faster in adjusting to today's needs, yesterday's means of caring for the sick, rehabilitating the disabled, and preventing injury and disease. I believe that S. 3355 can provide some of that necessary impetus by giving home health care the full recognition it requires as an important functioning part of a health care delivery system suited to today's needs and by encouraging full utilization of these services in plans for improving the delivery of comprehensive and specialized health services in our communities.

Mr. President, at the same time, as chairman of the Subcommittee on Veterans Affairs of the Labor and Public Welfare Committee and in line with my particular interest in the Veterans' Administration medical program, I plan to introduce amendments to section 612(a) and (f) of title 38, United States Code, which will give impetus to the provision of home health care services as part of the outpatient medical services provided a veteran for a service-connected disability, before, after, and independent of hospitalization. These same home health care services would also be made available to a veteran eligible for hospitalization and treatment even though his injury or illness is not service connected.

These new authorities would enable the Veterans' Administration more efficiently to perform its vital function of providing first quality modern health care for our veterans.

Appendix 3

EXCERPTS FROM REPORTS OF FUNCTIONING HOME HEALTH SERVICE PROGRAMS

ITEM 1. EXCERPTS FROM REPORT BY BLUE CROSS OF GREATER PHILADELPHIA

Coordinated Home Care an Effective Alternative

[By Helen L. Rawlinson]

This report documents a decade of experience which has demonstrated that a skillfully administered array of professionally coordinated nursing, therapeutic and ancillary medical services represents a concentrated level of patient care which is valuable to patients, physicians, hospitals and Blue Cross. Patients generally respond more rapidly and fully to care at home, physicians' services can be expanded to more patients when this level of home care service is available to their patients (more than 800 private physicians have used the service), hospitals can increase the use of existing facilities and enlarge their services to the community without a corresponding capital investment, and Blue Cross subscribers can be provided a broader range of benefits for medically required health care services without a related increase in subscription rates.

An average of one and one half percent of patients discharged from medical, surgical and pediatric departments of the participating hospitals included in this report were transferred to home care service an average of 12.9 days earlier than would have been likely without the availability of the coordinated home care service. This resulted in 6.6 additional hospital beds being available throughout the report period for care of more acutely ill patients at no additional cost to the community. Expressed in other terms, the value of the inpatient days saved on 3,940 home care cases amounted to $2,495,267. The net value after deducting the cost of providing services to patients and the related administrative costs amounted to $1,298,381 or $330 per case.

In 1958, Pennsylvania Insurance Commissioner Smith held hearings in connection with a request by Blue Cross for subscription rate increases. Evidence developed in the hearings indicated the alarming escalation of hospital costs was due in part to the use of inpatient services for patients whose medical needs did not require around-the-clock nursing care and supervision nor the instant availability of hospital services. In his adjudication Commissioner Smith directed Blue Cross to undertake initiatives to reduce inappropriate utilization of hospital facilities, including the exploration of benefit programs which would provide acceptable alternatives to inpatient care. One of several actions taken by Blue Cross pursuant to this directive was an indepth study of coordinated home care. Available literature was studied. Physicians, nurses, and administrators of visiting nurse organizations and hospitals operating home care programs were interviewed, home care programs in distant cities were visited and home care related workshops and sessions of professional organizations were attended. These activities led to the following conclusions.

1. The concept of coordinated home care was endorsed by all professional organizations concerned with the provision of health care, by the American Hospital Association and the Public Health Service.

2. Home care, both single service (VNA) and multiple services (coordinated home care), was used mostly for elderly, chronically ill, indigent or medically indigent persons and female patients outnumbered male patients fifty to sixty percent.

3. Hospitals were not prepared to organize home care programs and thus to assume additional responsibility for long-term care of patients out of the hospital without assurance that reimbursement would be available to cover the costs of such care.

4. Physicians did not refer private patients to "organized" home care programs in which the home care department medical director and his "team" of allied health professionals assumed responsibility for the medical management of patients. Therefore, the organized hospital home care programs were used for medically indigent patients almost exclusively.

5. Innovative work in some programs suggested that departures from traditional administrative patterns and service programs might stimulate private physicians and their patients to use home care.

6. Coordinated home care represents a level of care appropriate for patients of all ages, and without regard to sex, diagnosis, and the patient's financial status. However, such services were not generally available.

7. Convincing data was not available from existing programs to demonstrate a reduction in the use of inpatient facilities resulting from the use of coordinated home care but there were some cases which indicated that this might be anticipated.

8. Utilization controls applicable to the use of home care services were almost nonexistant.

9. The appropriate use of professionally coordinated home care services would probably result in an improved quality of medically required continuity of care.

10. If skillfully administered and appropriately used, coordinated home care could contribute to fuller use of existing services and facilities and possibly lessen the cost of individual episodes of illness.

11. Coordinated home care appeared to represent a valid level of health care which hospitals, other community health agencies and Blue Cross should investigate cooperatively through the development of pilot programs. For if home care potentially offered an alternative to unnecessary hospitalization or other institutional care it would be essential for the provider and financing sectors to work together to develop a medically acceptable service with appropriate financial support.

PROGRAM DEVELOPMENT

In preparing the Program Plan special care was taken to develop administrative and reimbursement principles which would apply effectively to the operation of a coordinated home care service administered by any general hospital or other community agency. Decisions which were made regarding the following issues are reflected in the Home Care Program Plan included with this report:

1. How to structure and administer a home care service which would be most acceptable and useful to private physicians and their patients?

2. How to develop and implement patient care planning activities which would encourage the timely transfer of patients to appropriate levels of care?

3. The range of services which should and could be delivered to patients in their homes.

4. What methods of coordinating the delivery of home care services to patients and keeping the responsible physician informed regarding his patient's condition would be most effective and efficient?

5. Personnel required to adminster the home care service and to coordinate patient services.

6. The uses and design of home care medical record forms.

7. Utilization controls which would assure appropriate use of home care services.

8. How to monitor the quality of patient care provided through the home care service?

9. Development of effective functional relationships between the home care department and other departments of the hospital and participating community organizations.

10. Administrative and professional policies for the admission of patients and delivery of services.

11. Blue Cross benefits to be allowed and how third party financing could stimulate appropriate and optimum use of home care within the context of an insurable risk.

12. Statistical and financial record systems which would produce reliable medical, cost and actuarial data efficiently.

All hospitals participating in the Blue Cross Home Care Program have used the Program Plan when organizing their home care departments. The participating hospitals include a metropolitan medical center which serves an older urban

population, a pediatric hospital, general hospitals located in affluent and less privileged suburban communities, hospitals associated with university medical schools, and a general hospital which serves an area severely depressed financially and socially. All of the hospitals, except one, purchase nursing and therapeutic services from community home health agencies and provide directly the hospital ancillary medical services such as laboratory, X-ray, electrocardiogram, and other special diagnostic treatment services, medical supplies and equipment, medications, and all other services of the hospital as feasible.

Blue Cross home care benefits include all medical and related services ordered by the responsible physician which would be covered if the subscriber were an inpatient, including nursing and therapeutic services on a visiting basis, all ancillary medical services supplied by the hospital and medically required patient transportation between hospital and home provided by commercial carriers. These benefits are allowed for treatment of the condition for which the patient was hospitalized or would be hospitalized if coordinated home care services were not available. Benefits are not provided in cases of normal obstetrical deliveries or for food, housing, homemakers, home health aides or for supplementary diet assistance.

Blue Cross reimbursement to participating hospitals for covered home care services includes the cost of nursing, therapeutic and related ancillary medical services plus a proportionate share of the direct and indirect administrative costs incurred by the hospital in operating the home care department. Various reimbursement methods have been used. Experience indicates that payment for direct patient services according to a negotiated schedule of charges plus semi-annual settlements for approved administrative costs is the most efficient and mutually satisfactory method.

EXPERIENCE ANALYSIS

An analysis of 3,940 home care cases is presented in a series of tables which are a part of this report. These cases represent all admissions to four hospital home care departments between November 1961 and July 1970. The hospitals included are most similar organizationally and administratively and with one exception had been in operation more than five years. However, the hospitals present considerably different characteristics in terms of size and the population served. The number of medical, surgical, and pediatric beds in the smallest hospital has averaged about two hundred during the report period, the largest about seven hundred. The other two hospitals averaged about four hundred beds. One hospital is located in a predominately industrial suburban community with a younger population. One is situated on the boundary of a depressed urban area and a more stable and moderately prosperous suburban community. Another hospital is a division of an urban medical center which serves an older population with a varying financial and social characteristics. The fourth hospital serves a generally affluent suburban community.

UTILIZATION EXPERIENCE

The goal is establishing a coordinated home care service is dichotomous—the quality of continuing care must be maintained, if not improved, and the cost of medically required care should be lowered through the timely use of an acceptable alternative to more costly institutional care.

HOME CARE ADMISSIONS

The synergistic values achieved by participating hospitals and Blue Cross were disturbed when the medicare benefit program emphasized transfer of patients to extended care facilities as the primary alternative to unnecessary inpatient hospital care. Although benefits for "home health services" are provided under the medicare program it is a limited benefit program which fragments reimbursement for coordinated home care services between Part A and Part B "home health services" benefits and Part B outpatient benefits. Medicare benefits are not allowed for several important services which are necessary to properly care for patients of a coordinated home care program, which represented an intensive level of home care.

The impact of medicare benefits for extended care facility services on the previously steady growth of coordinated home care utilization is shown in Exhibit 11 which charts home care admissions and transfers to extended care facilities.

Medicare benefits for "home health services" also produced a temporary increase in the number of patients referred to community home health agencies. This intermediate level of home care which represents an additional service in the continuum of patient care was rarely included in Blue Cross or commercial health insurance benefit schedules prior to 1966. As medicare rulings became more restrictive, the number of referrals to community home health agencies declined. In 1969 Blue Cross extended its home care benefit program to include nursing and physical therapy visits when this level of continuing care was medically necessary and was planned through the participating hospital home care departments. Again the number of referrals to community home health agencies increased.

The fact that the medicare statute does not recognize the special characteristics of coordinated home care presents problems in the promotion and development of this level of care which offers an effective alternative to institutional health care. The experience of Hospital D presented in this report reflects this influence.

AGE AND SEX OF HOME CARE PATIENTS

The census records of both hospital home care services and community home health agencies generally indicate that women represent a substantial majority of home care patients. A different experience is demonstrated in Table III. In the 65 and over age group during the four years 1966–1970 (1,254 cases) female patients outnumbered male patients by 56.4%, however, among the patients under 65 years of age who were admitted during the same period (1,392 cases) male patients outnumbered female patients by 19%. In the hospital which serves a younger population, male patients represented 52% of the total home care census; in the hospitals serving older populations, female patients (56%) outnumbered male patients (43%).

The average age of all home care patients was 61 years. It is important to note, however, that 51% of the patients were under 65 years of age. This experience was consistent during the four years before and after implementation of the medicare program. Patients under 22 years of age accounted for 6% of the cases, 12% were between 22 and 45, and 33% of all patients were between 46 and 65 years of age. During the periods before and after medicare 49% of the home care patients were 65 years of age or older (Table IV).

The use of coordinated home care for male patients in 47% of the cases and for patients under 65 years of age in 51% of the cases suggests that health care planners, legislators, financing agencies and health care providers should take a new view of the patient universe which can be served by coordinated home care services. It also indicates that providers of home care services should evaluate their service programs to see if they are prepared to meet the scope of health care services required by non-geriatric and male patients.

PRIOR HOSPITALIZATION LENGTH OF STAY

The period of hospitalization which precedes transfer of patients to home care service is influenced by several factors: the traditional patterns of medical practice, hospital administrative policies and practices, patient care planning procedures used in the hospital, or the absence of such procedures, the size of the institution, the patient's clinical status, his socio-economic situation, the availability of supportive services in the community, to name a few. Numerous studies have demonstrated that substantial numbers of patients are hospitalized inappropriately or remain in hospitals longer than medically necessary. Not all such patients need coordinated home care either. The problems of patient care planning must be studied carefully to identify procedures which can be applied effectively to all patients. Although a great amount of attention has been given to this problem in the planning and operation of the hospital home care departments, results have been uneven and, to some extent, disappointing. Nevertheless, it should be remembered that patients who require this intensive level of coordinated home care generally have a very serious illness which usually requires prolonged care, or have experienced an unusual recovery from serious

illness. For this reason arbitrary parameters are not appropriate and are often misleading when applied to home care patients or potential home care patients.

The average period of hospitalization prior to home care admission averaged 31 days, the median was 27 days. Within reimbursement categories, the average ranged from 20 to 48 days and the median from 19 to 37 days. It is significant that 39% of all home care patients were hospitalized 21 days or less, 349 patients (9%) were hospitalized less than 10 days, 1,171 patients (30%) were hospitalized between 10 and 21 days. Direct admissions, instances of hospitalization being avoided through use of coordinated home care services, accounted for 151 cases (4%) (Table V). The prevalence of certain diagnoses affects the period of hospitalization before transfer to home care service. This influence is evident when the distribution of diagnoses (Table VII) is compared to the periods of hospitalization shown in Table V. However, the distribution of diagnoses is much less variable. The possibility that non-medical considerations influenced the length of time patients were hospitalized prior to admission to the home care service must be acknowledged.

HOME CARE LENGTH OF STAY

Only the intensive level of coordinated home care is represented in the cases included in this study. This is to say that the responsible physician determined the medical status of his patient to require centralized professional coordination of a range of services provided through the hospital home care department. When this level of care is no longer necessary, patients are either discharged, transferred to continuing care by a community home health agency, or other appropriate arrangements are made for the needed level of continuing care.

The average home care length of stay for all patients was 39 days, the median was 26 days. Blue Cross subscriber patients remained on home care service an average of 31 days (median 24 days) medicare patients averaged 47 days (median 30 days) and all other patients used an average of 38 days (median 27 days) per case. (Table VI.)

DIAGNOSES

Coordinated home care was used in the treatment of all classifications of disease (Table VIII). Variations in the frequency home care was used for patients experiencing different diagnoses reflect to some degree characteristics of the population served by the hospital, particularly age, sex and social factors. For example, a higher percentage of injuries, exclusive of fractures, were treated in the hospital which serves a relatively younger population in an industrial community. Patients with strokes and other circulatory illness represented a higher percentage of the patients in the hospital which serves an older population. Other variations can be identified with different characteristics of the hospital medical staffs. For example, a physician in one hospital transferred his patients with hip fractures to home care as promptly following surgery as possible while in another hospital orthopedic surgeons did not use home care at all for his fractures.

Although the four most prevalent diagnoses, heart, cancer, fractures, and circulatory conditions other than cardiovascular accidents, accounted for 58% of all cases, it is important to resist the tendancy to associate coordinated home care with a limited number of disease categories. Such identification tends to interfere with the use of this level of care for all patients for whom it is appropriate which, in turn, diminishes its potential value and usefulness.

PATIENT SITUATION ON DISCHARGE FROM HOME CARE

The majority of home care patients do not require an organized program of health care services following discharge from the coordinated home care service. Continuing medical supervision was the only care needed by 70% of the patients discharged. (Table VIII.) Three percent of the patients were transferred to continuing care by community home health agencies, 4% expired while on home care, 2% were transferred to nursing homes or extended care facilities.

Readmission to the hospital occurred in 19% of the cases. The number of cases readmitted to the hospital due to acute exacerbations is misleading because until 1969 all patients readmitted to the hospital were counted as in

the acute exacerbation category unless the medical record indicated that readmission was part of the therapeutic plan. During the two years ending June 30, 1970 the reasons causing readmission were analyzed more accurately and it was determined that of the total unplanned readmissions, 43% were caused by expected physical deterioration due to the disease process and 16% were caused by superimposed illnesses with diagnoses unrelated to the original home care diagnosis. Upon adjusting the readmission experience according to this analysis, the readmission figure shown in Table VIII would appear as follows: Admitted to hospital due to—

	Percent
Acute exacerbation	6
Planned	5
Disease progression	6
Unrelated diagnosis	2

HOME CARE SERVICES PROVIDED TO PATIENTS

Twenty-one different medical and related services were provided to home care patients. The number and percentage of all patients who used each service are listed in Table X. The following tabulation indicates the percentage of patients who received each service and the corresponding percentages of usage within the three payment categories.

HOME CARE SERVICES PROVIDED TO ALL PATIENTS, 1966–70

[In percent]

Home care services	All cases	Blue Cross cases	Other cases	Medicare cases
Nursing	97.0	98.0	98.0	96.0
Laboratory procedures	48.0	57.0	46.0	44.0
Medications	42.0	78.0	64.0	10.0
Medical equipment	42.0	38.0	33.0	50.0
Medical supplies	38.0	32.0	44.0	38.0
Physical therapy	23.0	15.0	19.0	30.0
Laboratory technician	22.0	31.0	16.0	21.0
Electrocardiogram	13.0	15.0	15.0	10.0
X-ray (diagnostic)	4.0	4.0	5.0	4.0
Oxygen	4.0	4.0	4.0	4.0
Inhalation therapy	3.0	4.0	3.0	3.0
Speech therapy	2.0	.8	1.0	2.0
Home health aide	1.0	.1	.7	3.0
Occupational therapy	.7	.3	1.0	.6
Outpatient Department visits	.6	.7	.3	.2
Operating room	.6	1.0	1.0	.07
Clinic visits	.4	.6	.4	.3
Other	.3	.4	.4	.2
X-ray (therapeutic)	.2	.1	.4	----------
Patient transportation	.2	.4	.3	----------
Social service	.0007	----------	----------	.2

The level of illness of coordinated home care patients usually presents a need for medication therapy. The lack of medicare benefits for medications, which are covered when supplied as an inpatient service, interferes with the ability of the professionals responsible for coordination and delivery of services to supervise the prescribed medication regimen. This is of special concern at a time when the physical, mental and financial capabilities of patients to be personally responsible for observing medication orders are usually impaired. When the medicare home care patient elects to obtain ordered medications privately, rather than to have them supplied through the home care department, the coordinator of patient services is unable to exercise effective control over this important aspect of the patient's treatment. This is an example of the potential influence of financing arrangements on the quality of patient care.

When the scope of home care services provided is considered with the high percentage of patients (70%) who require only continuing medical supervision following discharge from coordinated home care, the comparatively short duration of home care services (27 days median) and the full range of diagnoses treated, the dynamic character and the therapeutic values of this intensive level of coordinated home care are evident.

FINANCIAL EXPERIENCE

Express related to providing home care services are detailed in Tables XI, XII, XIII and XIV. Expenses include the costs of direct patient services, the administrative costs of coordinating the direct patient services and administering the home care department and the related overhead costs.

The average per diem costs, including all direct and indirect expenses, during the period 1962 through 1965 was $6.30, the average per diem cost during the period 1966 through 1970 was $8.73, an increase of 38.6% for home care compared to an average increase of 78.9% for inpatient hospital care during the same periods.

Direct patient services represented 57.8% of total costs, direct and indirect administrative costs represented 42.2% of total costs. Financial experience is expressed in terms of per diem and per case costs in this report because these cost units reflect the continuous character of a coordinated home care service. Although some patients are not visited by a nurse or therapist every day their care is under continuing professional supervision and patients are supplied with all ancillary medical services needed for their daily care. The cost of professional coordinating services are included in direct administrative costs.

VALUE OF COORDINATED HOME CARE

The financial value of coordinated home care service can be expressed in various ways. The most common is to estimate the number of days patients would have remained hospitalized if home care services were not provided. Such estimates are usually based on the physician's opinion when he referred his patient to the coordinated home care service. These are of questionable reliability for various reasons, the most significant being that physicians have no sure knowledge at the time of referral what patients' continuing responses to treatment and their illnesses will be. The only reasonably reliable guide to the potential affect of coordinated home care on the use of inpatient service is obtained from an objective professional analysis of the home care medical record following discharge of patients from home care service. The professional analysis should take into consideration the services ordered and provided and the patient's progress. The estimated number of inpatient days saved due to use of coordinated home care service shown in Table XV were based on such an analysis of each patient's medical record. An estimated average of 12.9 inpatient days were saved on each home care case, a total of 50,800 inpatient days. At this rate 6.6 additional hospital beds were made available throughout the report period without a corresponding capital investment.

The monetary value of the estimated inpatient days saved (Table XVI) is based on the average inpatient per diem cost in each hospital during each of the report years multiplied by the number of estimated days saved during the corresponding years. The result is a gross value of $2,495,267.

The direct and indirect cost of providing home care services was $1,196,886 which leaves an estimated net value of $1,298,381 or $330 per home care case. During the year ending June 30, 1970, the estimated net value per case was $473, a figure which does not appear in the tables included with this report.

CONCLUSION

Blue Cross objectives in supporting coordinated home care have been substantially realized through the nine hospitals which have participated in the home care program. There has been no concentrated effort to encourage all hospitals to establish home care programs. Hospitals which have indicated an interest have been encouraged and assisted to develop home care services and this experience has provided a variety of opportunities to test and refine the Program Plan and administrative methods. In all situations the basic concepts have been applicable to the solution of special problems.

Private physicians, more than 800, have used the hospital home care departments for their patients who, with few exceptions, have indicated they preferred coordinated home care to continued hospitalization.

Hospitals and community home health agencies have developed new cooperative relationships, service programs and the professional skills of community home health agencies have been expanded and upgraded.

Levels of patient care have been more appropriately defined and experience has demonstrated that it is feasible and desirable to provide an intensive level of care to patients in their own homes when medical and environmental conditions are suitable. This has lead to broader recognition and use of the intermediate level of nursing and therapeutic services which community home health agencies have provided traditionally. It is estimated that five percent of all hospitalized patients could be transferred to coordinated home care earlier in their illnesses with a corresponding reduction in the use of inpatient facilities.

Coordinated home care has been used for the continuing care of patients with all types of illnesses and in 4% of the cases, hospitalization was avoided or delayed through use of the hospital home care departments.

PHYSICIAN COMMENTS

This report would be incomplete if the views of physicians who have used coordinated home care for their patients were not mentioned.

One hundred and fifty-eight randomly selected physician responses to a questionnaire were reviewed. Three questions were asked: (1) Was the home care department able to provide all the services you considered necessary for your patient? (2) What medical considerations influenced you to transfer your patient to the home care service? (3) How many times did you see the patient during the home care period? Space was provided for additional comments. All but three physicians stated that the home care service provided all needed services, two did not answer the question and one replied negatively. A wide variety of medical considerations which prompted use of coordinated home care was given, the majority indicated that the availability of professionally coordinated nursing and ancillary hospital services which would meet their patients' needs at home prompted use of the home care service. Physicians saw their patients at home or in private offices as the medical situation warranted. Generally the physicians did not have to see patients as frequently as they would have been obliged to see them without the home care service. As one physician put it, "The home care department saves me inestimable house calls."

Considering the well known fact that physicians weary of filling out forms, it was surprising that 115 responses had additional comments noted. For example:

"I was able to obtain pertinent information regarding my patient's condition and vital signs, and to get necessary lab work at home."

"A great service to the patient and hospital."

"The value of this service is unlimited and it should be expanded. M.D.'s need more information regarding details of the service on a regular basis."

The final comment is included here as a tribute to the dedicated directors of all the participating home care departments, as it was intended by the responding physician for the director who assisted in the care of his patient. The physician's comment—"How does one describe a masterpiece?"

Dr. Cecil G. Sheps, Director, Health Service Research Center and Professor of Social Medicine at the University of North Carolina, stated the following in a paper delivered in September, 1970:

"As central as hosiptals are to the provision of health services, most of them are characterized by important deficiencies in term of their functional connection with the chronic care system and with ambulatory care. Both of these linkages need to be developed much more strongly as continuous programs.

"Beginnings are being made. In various parts of the country, general hospitals have merged with or developed extended care facilities and rehabilitation programs, in addition, of course, to the more substantial, though still very inadequate, development of home care programs."

BLUE CROSS OF GREATER PHILADELPHIA COORDINATED HOME CARE STUDY 1962–70

TABLE I.—HOME CARE CASES DISTRIBUTION BY SOURCE OF PAYMENT, 1962–70

	A		B		C		D		Total 1962–70		Total 1962–65		Total 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Source of payment:														
Blue Cross, Philadelphia	416	32	800	48	285	32	30	44	1,531	39	780	60	751	28
Blue Cross, other	24	2			2	1			29	1	2		24	1
Self-pay	251	19	87	5	135	15	10	15	483	12	185	14	298	11
Insurance, including Blue Cross major	104	8	106	6	45	5	14	21	269	7	77	6	192	7
service, free care	43	3	38	2	10	1			91	2	79	6	12	1
Pennsylvania medical assistance	185	14	261	16	38	4	5	7	489	12	227	18	262	10
Medicare	336	25	578	35	483	54	9	13	1,406	36			1,406	53
More than 1 of above	−11	−1	−39	−2	−20	−2			−70	−2	−18	−1	−52	−2
Open cases from previous year	−31	−2	−166	−10	−88	−9			−285	−7	−38	−3	−247	−9
Admissions this year	1,317	100	1,665	100	890	100	68	100	3,940	100	1,294	100	2,646	100

HOME CARE ADMISSIONS
EXHIBIT II

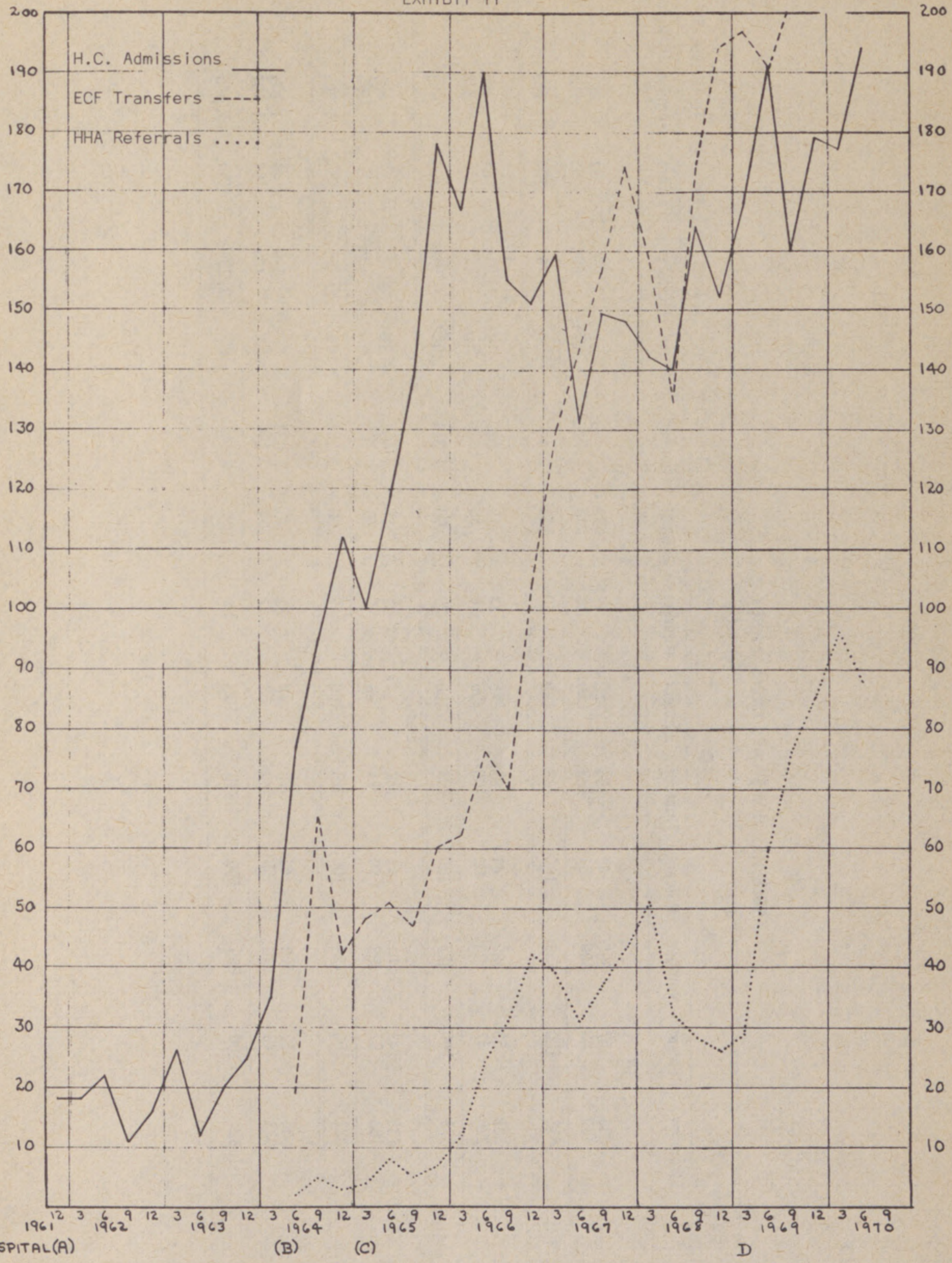


TABLE III.—HOME CARE CASES BY SEX

	A		B		C		D		Total, 1962–70		Total, 1962–65		Total, 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blue Cross cases:														
Male	236	57	368	49	135	50	17	57	756	51	355	47	401	57
Female	180	43	390	51	133	50	13	43	716	49	408	53	308	43
Total	416	100	758	100	268	100	30	100	1,472	100	763	100	709	100
Other cases except medicare:														
Male	309	53	180	44	87	45	13	45	589	49	234	44	355	52
Female	270	47	233	56	106	55	16	55	625	51	297	56	328	48
Total	579	100	413	100	193	100	29	100	1,214	100	531	100	683	100
Medicare cases:														
Male	139	43	201	41	148	34	1	11	489	39	----	----	489	39
Female	183	57	293	59	281	66	8	89	765	61	----	----	765	61
Total	322	100	494	100	429	100	9	100	1,254	100	----	----	1,254	100
All cases:														
Male	684	52	749	45	370	42	31	46	1,834	47	589	46	1,245	47
Female	633	48	916	55	520	58	37	54	2,106	53	705	54	1,401	53
Total	1,317	100	1,665	100	890	100	68	100	3,940	100	1,294	100	2,646	100

TABLE IV.—HOME CARE CASES, AGE DISTRIBUTION

	A		B		C		D		Total 1962–70		Total 1962–65		Total 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blue Cross cases:														
Under 22 years	44	11	17	2	35	13	----	----	96	7	36	5	60	8
22 to 45 years	101	24	93	12	43	16	8	27	245	17	110	14	135	19
46 to 64 years	198	48	406	54	145	54	22	73	771	52	264	35	507	72
65 and over	73	17	242	32	45	17	----	----	360	24	353	46	7	1
Total cases	416	100	758	100	268	100	30	100	1,472	100	763	100	709	100
Average age	50	----	59	----	52	----	53	----	55	----	60	----	50	----
Median age	51	----	57	----	55	----	57	----	55	----	62	----	54	----
Other cases except medicare:														
Under 22 years	84	14	28	7	23	12	7	24	142	12	38	7	104	15
22 to 45 years	140	24	58	14	34	18	6	21	238	19	72	14	166	24
46 to 64 years	228	39	181	44	97	50	16	55	522	43	143	27	379	55
65 and over	139	23	146	35	39	20	----	----	324	26	278	52	34	6
Total cases	591	100	413	100	193	100	29	100	1,226	100	531	100	683	100
Average	50	----	56	----	53	----	41	----	52	----	60	----	46	----
Median age	49	----	55	----	54	----	45	----	51	----	64	----	52	----
Medicare cases: 65 years and over	310	100	494	100	429	100	9	100	1,242	100	----	----	1,254	100
Average age	75	----	74	----	75	----	73	----	76	----	----	----	76	----
Median age	74	----	73	----	74	----	75	----	74	----	----	----	74	----
All cases:														
Under 22 years	128	10	45	3	58	7	7	10	238	6	74	6	164	6
22 to 45 years	241	18	151	9	77	9	14	21	483	12	182	14	301	11
46 to 64 years	426	32	587	35	242	27	38	56	1,293	33	407	31	886	34
65 and over	522	40	882	53	513	57	9	13	1,926	49	631	49	1,295	49
Total cases	1,317	100	1,665	100	890	100	68	100	3,940	100	1,294	100	2,646	100
Average age	56	----	63	----	63	----	51	----	61	----	60	----	61	----
Median age	58	----	65	----	67	----	56	----	63	----	62	----	63	----

TABLE V.—HOME CARE CASES, INPATIENT DAYS PRIOR TO HOME CARE ADMISSION

Inpatient days	A		B		C		D		Total 1962–70		Total 1962–65		Total 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blue Cross cases:														
Under 10 days	69	17	34	4	41	15	2	7	146	10	73	10	73	10
10 to 21	176	42	225	30	79	29	9	31	489	33	267	34	222	32
22 to 28	98	24	149	20	40	15	7	23	294	20	144	19	150	21
29 to 35	38	9	141	19	19	7	4	13	202	14	110	14	92	13
36 to 42	15	4	72	9	27	10	3	10	117	8	60	8	57	8
43 to 56	10	2	71	9	12	5	1	3	94	6	44	6	50	7
Over 56 days	8	2	66	9	10	4	3	10	87	6	43	6	44	6
Direct admissions	2				40	15	1	3	43	3	22	3	21	3
Total cases	416	100	758	100	268	100	30	100	1,472	100	763	100	709	100
Average days	20		30		24		27		26		26		27	
Median days	19		28		21		23		24		21		24	
Other cases except medicare:														
Under 10 days	89	15	27	7	12	6	4	14	132	11	52	10	80	12
10 to 21	225	39	75	18	47	24	10	34	357	29	160	30	197	28
22 to 28	119	21	60	15	29	15	6	21	214	18	90	16	124	18
29 to 35	53	9	64	15	25	13	2	7	144	12	65	12	79	12
36 to 42	25	4	35	8	17	9	4	14	81	7	36	7	45	7
43 to 56	21	4	41	10	22	12	1	3	85	7	41	8	44	6
Over 56 days	27	5	111	27	20	10	2	7	160	13	78	15	82	12
Direct admissions	20	3			21	11			41	3	9	2	32	5
Total cases	579	100	413	100	193	100	29	100	1,214	100	531	100	683	100
Average days	23		48		34		26		33		35		32	
Median days	21		37		27		22		27		33		26	
Medicare cases:														
Under 10 days	40	12	7	1	24	6			71	6			71	6
10 to 21 days	127	39	86	17	108	25	4	45	325	26			325	26
22 to 28 days	60	19	72	15	79	18	2	22	213	17			213	17
29 to 35 days	28	9	92	19	67	16	1	11	188	15			188	15
36 to 42 days	15	5	60	12	54	12	2	22	131	10			131	10
43 to 56 days	11	3	68	14	44	10			123	10			123	10
Over 56 days	3	1	109	22	24	6			136	11			136	11
Direct admissions	38	12			29	7			67	5			67	5
Total cases	322	100	494	100	429	100	9	100	1,254	100			1,254	100
Average days	20		47		29		25		34				34	
Median days	21		34		28		26		29				29	

All cases:														
Under 10 days	198	15	68	4	77	9	6	9	349	9	125	10	224	8
10 to 21 days	528	40	386	23	234	26	23	35	1,171	30	427	33	744	28
22 to 28	277	21	281	17	148	17	15	22	721	18	234	18	487	18
29 to 35 days	119	9	297	18	111	12	7	10	534	14	175	14	359	14
36 to 42	55	4	167	10	98	11	9	13	329	8	96	7	233	9
43 to 56 days	42	3	180	11	78	9	2	3	302	7	85	7	217	8
Over 56 days	38	3	286	17	54	6	5	7	383	10	121	9	262	10
Direct admissions	60	5	----------		90	10	1	1	151	4	31	2	120	5
Total cases	1,317	100	1,665	100	890	100	68	100	3,940	100	1,294	100	2,646	100
Average days	22	----------	40	----------	30	----------	26	----------	31	----------	27	----------	31	----------
Median days	20	----------	35	----------	26	----------	23	----------	27	----------	26	----------	27	----------

TABLE VI.—HOME CARE CASES, NUMBER OF HOME CARE PATIENT DAYS

Patient days	A		A		C		D		Total 1962–70		Total 1962–65		Total 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blue Cross cases:														
10 or less	98	24.0	96	13	64	24	7	22	265	18	107	14	158	22
11 to 20	145	35.0	122	16	49	18	6	22	322	22	137	18	185	26
21 to 30	128	31.0	188	25	67	25	10	34	393	26	212	27	181	26
31 to 60	43	10.0	283	36	75	28	7	22	408	28	236	31	172	24
61 to 90	7	2.0	82	11	19	7	----	----	108	7	70	9	38	5
91 to 120	----	----	21	3	7	3	----	----	28	2	17	2	11	2
121 to 150	1	----	7	1	5	2	----	----	13	1	4	1	9	1
151 to 180	----	----	----	----	----	----	----	----	----	----	----	----	----	----
Over 180	----	----	----	----	----	----	----	----	----	----	----	----	----	----
Open cases from previous report per	−6	−2	−41	−5	−17	−6	----	----	−64	−4	−19	−2	−45	−6
Cases transferred to other permanent source	----	----	----	----	−1	−1	----	----	−1	----	----	----	----	----
Total	416	100.0	758	100	268	100	30	100	1,472	100	763	100	709	100
Average days	18	----	37	----	33	----	23	----	31	----	32	----	29	----
Median days	15	----	29	----	25	----	21	----	24	----	25	----	22	----
Other cases except medicare:														
10 or less	196	34.0	48	12	45	23	6	21	295	24	100	19	195	29
11 to 20	183	32.0	75	18	36	19	13	45	307	25	95	18	212	31
21 to 30	119	20.0	69	17	40	20	3	10	231	19	117	22	114	17
31 to 60	75	13.0	138	33	59	30	6	21	278	23	121	23	157	23
61 to 90	15	3.0	70	17	28	15	1	3	114	9	54	10	60	9
91 to 120	7	1.0	48	12	5	3	----	----	60	5	37	7	23	3
121 to 150	1	----	16	4	6	3	----	----	23	2	13	2	10	1
151 to 180	1	----	17	4	6	3	----	----	24	2	19	4	5	1
Over 180	----	----	7	2	3	2	----	----	10	1	7	1	3	1
Open cases from previous report per	−15	−3.0	−61	−15	−15	−8	----	----	−91	−7	−19	−4	−72	−11
Cases transferred to other permanent source	−3	----	−14	−4	−20	−10	----	----	−37	−3	−13	−2	−24	−4
Total	579	100.0	413	100	193	100	29	100	1,214	100	531	100	683	100
Average days	19	----	62	----	45	----	22	----	38	----	44	----	56	----
Median days	17	----	56	----	28	----	18	----	27	----	39	----	25	----

Medicare cases:														
10 or less	80	25.0	64	13	70	16	2	22	216	17			216	17
11 to 20	122	37.0	94	19	59	14	3	34	278	23			278	23
21 to 30	67	20.0	89	18	64	15	2	22	222	18			222	18
31 to 60	45	14.0	186	38	147	35	2	22	380	30			380	30
61 to 90	16	5.0	70	14	69	16			155	12			155	12
91 to 120	4	1.0	28	6	40	9			72	6			72	6
121 to 150	2	1.0	15	3	13	3			30	2			30	2
151 to 180	2	1.0	2	0	8	2			12	1			12	1
Over 180	2	1.0	12	2	13	3			27	2			27	
Open cases from previous report per	−17	−5.0	−65	−13	−54	−13			−136	−11			−136	−11
Cases transferred to other permanent source	−1		−1						−2				−2	
Total	322	100.0	494	100	429	100	9	100	1,254	100			1,254	100
Average days	26		51		58		19		47				47	
Median days	17		34		36		23		30				30	
All cases:														
10 or less	374	28.0	208	13	179	20	15	22	776	20	207	16	569	22
11 to 20	450	34.0	291	17	144	16	22	33	907	23	232	18	675	26
21 to 30	314	24.0	346	22	171	18	15	22	846	21	329	25	517	19
31 to 60	163	12.0	607	36	281	32	15	22	1,066	26	357	28	709	27
61 to 90	38	3.0	222	13	116	13	1	1	377	10	124	10	253	9
91 to 120	11	1.0	97	6	52	6			160	4	54	4	106	4
121 to 150	4	.5	38	2	24	3			66	2	17	1	49	2
151 to 180	3	.5	19	1	14	2			36	1	19	1	17	1
Over 180	2	.5	19	1	16	2			37	1	7	1	30	1
Open cases from previous report per	−38	−3.0	−150	−9	−86	−10			−274	−7	−38	−3	−236	−9
Cases transferred to other permanent source	−4	−.5	−32	−2	−21	−2			−57	−1	−14	−1	−43	−2
Total	1,317	100.0	1,665	100	890	100	68	100	3,940	100	1,294	100	2,646	100
Average days	21		48		49		22		39		37		39	
Median days	17		34		30		18		26		31		26	

TABLE VII.—HOME CARE CASES, CLASSIFICATION OF DISEASE

Disease classification	A		B		C		D		Total 1962–70		Total 1962–65		Total 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blue Cross cases:														
Cancer	42	10.0	83	11	42	16	11	36	178	12	90	12	88	12
Diabetes	43	10.0	45	6	16	6	2	7	106	7	52	7	54	8
C.V.A	12	3.0	34	4	5	2	3	10	54	4	40	5	14	2
Heart	170	41.0	175	23	54	20	2	7	401	28	187	25	214	31
Circulatory, other	11	3.0	107	14	12	4	2	7	132	9	69	9	63	9
Respiratory	2	.5	66	9	7	3	3	10	78	5	49	6	29	4
Digestive	20	5.0	64	8	18	7	3	10	105	7	62	8	43	6
G.U.-gyn	35	8.0	13	2	13	4	1	3	62	4	45	6	17	2
Fractures	24	6.0	50	7	40	15	2	7	116	8	53	7	63	9
Other orthopedic	2	.5	32	4	31	12	----	----	65	4	25	3	40	6
Injuries excluding fractures	13	3.0	----	----	4	1	----	----	17	1	----	----	17	2
Other	42	10.0	89	12	26	10	1	3	158	11	91	12	67	9
Total	416	100.0	758	100	268	100	30	100	1,472	100	763	100	709	100
Other cases except medicare:														
Cancer	65	11.0	41	10	28	15	11	39	145	12	61	11	84	12
Diabetes	74	14.0	31	8	5	3	----	----	110	9	55	10	55	8
C.V.A	13	2.0	36	8	8	4	3	10	60	5	33	6	27	3
Heart	187	32.0	60	15	29	15	2	7	278	23	117	22	161	24
Circulatory, other	14	2.0	68	16	13	7	4	14	99	8	39	7	60	9
Respiratory	1	----	18	4	2	1	----	----	21	2	10	3	11	2
Digestive	43	7.0	26	6	12	6	1	3	82	7	40	8	42	6
G.U.-gyn	33	6.0	6	1	7	4	1	3	47	4	28	5	19	3
Fractures	41	7.0	52	13	51	26	4	14	148	12	61	11	87	13
Other orthopedic	12	2.0	23	7	18	9	----	----	53	4	18	4	35	5
Injuries excluding fractures	35	6.0	1	----	1	1	----	----	37	3	----	----	37	5
Other	61	11.0	51	12	19	9	3	10	134	11	69	13	65	10
Total	579	100.0	413	100	193	100	29	100	1,214	100	531	100	683	100

Medicare cases:														
Cancer	49	15.0	49	10	73	17	2	22	173	14	----	----	173	14
Diabetes	40	12.0	16	3	12	3	----	----	68	5	----	----	68	5
C.V.A	17	5.0	66	13	24	6	----	----	107	9	----	----	107	9
Heart	100	31.0	71	14	72	17	1	11	244	19	----	----	244	19
Circulatory, other	34	11.0	99	20	44	10	----	----	177	14	----	----	177	14
Respiratory	5	2.0	19	4	15	4	----	----	39	3	----	----	39	3
Digestive	21	7.0	19	4	32	7	1	11	73	6	----	----	73	6
G.U.-gyn	20	6.0	11	2	6	1	----	----	37	3	----	----	37	3
Fractures	11	3.0	78	17	88	21	4	45	181	14	----	----	181	14
Other orthopedic	2	.5	16	3	31	7	1	11	50	4	----	----	50	4
Injuries excluding fractures	2	.5	----	----	5	1	----	----	7	1	----	----	7	1
Other	21	7.0	50	10	27	6	----	----	98	8	----	----	98	8
Total	322	100.0	494	100	429	100	9	100	1,254	100	----	----	1,254	100
All cases:														
Cancer	156	12.0	172	10	143	16	24	36	495	13	151	12	344	13
Diabetes	157	12.0	92	6	33	4	2	3	284	7	107	8	177	7
C.V.A	42	3.0	135	8	37	4	6	9	220	6	73	6	147	5
Heart	442	34.0	306	18	155	17	5	7	908	23	304	23	604	23
Circulatory, other	74	5.0	273	16	69	8	6	9	422	11	108	8	314	12
Respiratory	8	1.0	103	6	24	3	3	4	138	4	59	5	79	3
Digestive	84	7.0	109	7	62	7	5	7	260	7	102	8	158	6
G.U.-gyn	88	7.0	30	2	26	3	2	3	146	3	73	6	73	3
Fractures	76	5.0	180	11	179	20	10	15	445	11	114	9	331	13
Other orthopedic	16	1.0	74	4	80	9	1	1	171	3	43	3	128	4
Injuries excluding fractures	59	4.0	1	----	10	1	----	----	61	2	----	----	61	2
Other	124	9.0	190	12	72	8	4	6	390	10	160	12	230	9
Total	1,317	100.0	1,665	100	890	100	68	100	3,940	100	1,294	100	2,646	100

TABLE VIII.—HOME CARE CASES, PATIENT SITUATION AT TERMINATION OF HOME CARE

Patient situation	A		B		C		D		Total, 1962–70		Total, 1962–65		Total, 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blue Cross cases:														
Medical followup	340	84.0	512	72	181	74	18	64	1,051	76	542	77	509	74
Admitted to hospital:														
Acute exacerbation	31	7.0	80	11	25	10	3	11	139	9	79	11	60	9
Planned	16	4.0	48	7	15	6	2	7	81	6	37	5	44	6
Disease progression	2	.5	10	1	4	2	4	14	20	1	----	----	20	3
Unrelated diagnosis	----	----	7	1	3	1	----	----	10	1	----	----	10	1
Admitted to nursing home/ECF	2	.5	5	1	4	2	----	----	11	1	7	1	4	1
Visiting nurse followup	3	1.0	20	3	2	1	----	----	25	2	18	3	7	1
Patient expired	12	3.0	28	4	12	4	1	4	53	4	18	3	35	5
Closed cases	406	100.0	710	100	246	100	28	100	1,390	100	701	100	689	100
Other cases except medicare:														
Medical followup	474	83.0	239	60	140	69	15	56	868	72	356	71	512	73
Admitted to hospital:														
Acute exacerbation	44	7.0	79	20	18	9	3	11	144	12	77	15	67	10
Planned	17	3.0	28	7	16	8	1	4	62	5	18	4	44	6
Disease progression	4	.7	10	3	2	1	5	18	21	2	----	----	21	3
Unrelated diagnosis	3	.6	2	1	----	----	----	----	5	1	----	----	5	1
Admitted to nursing home/ECF	12	2.0	8	2	8	4	1	4	29	2	17	3	12	2
Visiting nurse follow-up	4	.7	9	2	11	5	----	----	24	2	12	2	12	2
Patient expired	16	3.0	21	5	9	4	2	7	48	4	24	5	24	3
Closed cases	574	100.0	396	100	204	100	27	100	1,201	100	504	100	697	100
Medicare cases:														
Medical followup	234	75.0	340	69	237	56	1	50	812	66	----	----	812	66
Admitted to hospital:														
Acute exacerbation	37	12.0	72	15	59	14	----	----	167	14	----	----	167	14
Planned	6	2.0	15	3	11	3	----	----	32	3	----	----	32	3
Disease progression	9	3.0	18	4	14	3	----	----	41	3	----	----	41	3
Unrelated diagnosis	3	1.0	8	2	4	1	----	----	15	1	----	----	15	1
Admitted to nursing home/ECF	6	2.0	8	2	18	4	----	----	33	3	----	----	33	3
Visiting nurse followup	----	----	5	1	47	11	----	----	52	4	----	----	52	4
Patient expired	17	5.0	20	4	35	8	1	50	73	6	----	----	73	6
Closed cases	312	100.0	486	100	425	100	2	100	1,225	100	----	----	1,225	100

All cases:														
Medical followup	1,048	81.0	1,091	69	558	64	34	60	2,731	71	898	75	1,833	70
Admitted to hospital:														
Acute exacerbation	112	9.0	231	15	102	11	6	11	451	11	156	13	295	11
Planned	39	3.0	91	6	42	5	3	5	175	5	55	5	102	5
Disease progression	15	1.0	38	2	20	2	9	16	82	2	----	----	82	3
Unrelated diagnosis	6	.5	17	1	7	1	----	----	30	1	----	----	30	1
Admitted to nursing home/ECF	20	2.0	21	1	30	3	1	2	72	2	24	2	48	2
Visiting nurse followup	7	.5	34	2	60	7	----	----	101	3	30	2	71	3
Patient expired	45	3.0	69	4	56	6	4	6	174	5	42	3	132	5
Closed cases	1,292	100.0	1,592	100	875	100	57	100	3,816	100	1,205	100	2,611	100

TABLE IX.—HOME CARE DAYS AND NURSING VISITS

	A	B	C	D	Total 1962–70	Total 1962–65	Total 1966–70
Blue Cross cases:							
Case admitted	416	758	268	30	1,472	763	709
Total home care patient days	7,601	28,521	8,835	678	45,635	24,875	20,760
Average patient days per case	18.3	37.6	33.0	22.6	31.0	32.6	29.3
Total nursing visits	3,279	6,662	3,088	282	13.311	7,597	5,714
Average number nursing visits per case	7.9	8.8	11.5	9.4	9.0	10.0	8.1
Average number days between nursing visits	2.3	4.3	2.9	2.4	3.4	3.3	3.6
Other cases except medicare:							
Cases admitted	579	413	193	29	1,214	531	683
Total home care patient days	11,293	25,579	9,246	636	46,754	23,597	23,157
Average patient days per case	19.5	61.9	47.9	21.9	38.5	44.4	33.9
Total nursing visits	5,088	4,238	2,761	266	12,353	591,6	6,437
Average number nursing visits per case	8.8	10.3	14.3	9.2	10.2	11.1	9.4
Average number days between nursing visits	2.2	6.0	3.4	2.4	3.8	4.0	3.6
Medicare cases:							
Cases admitted	322	494	429	9	1,254	----------	1,254
Total home care patient days	8,339	25,340	24,302	167	58,148	----------	58,148
Average patient days per case	25.9	51.3	56.6	18.6	46.4	----------	46.4
Total nursing visits	3,298	4,151	8,338	72	15,859	----------	15,859
Average number nursing visits per case	10.2	8.4	19.4	8.0	12.7	----------	12.7
Average number days between nursing visits	2.5	6.1	2.9	2.3	3.7	----------	3.7
All cases:							
Cases admitted	1,317	1,665	890	68	3,940	1,294	2,646
Total home care patient days	27,233	79,440	42,383	1,481	150,537	48,472	102,065
Average patient days per case	20.7	47.7	47.6	21.8	38.2	37.5	38.6
Total nursing visits	11,665	15,051	14,187	620	41,523	13,513	28,010
Average number nursing visits per case	8.9	9.0	15.9	9.1	10.5	10.4	10.6
Average number days between nursing visits	2.3	5.3	3.0	2.4	3.6	3.6	3.9

TABLE X.—DIRECT SERVICES PROVIDED HOME CARE PATIENTS

Services	A		B		C		D		Total 1962–70		Total 1962–65		Total 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blue Cross cases	416		758		268		30		1,472		763		709	
Nursing	414	99	680	90.0	264	99.0	30	100	1,388	94.0	690	90.0	698	98.0
Physical therapy	8	2	216	28.0	48	18.0	5	17	277	19.0	170	22.0	107	15.0
Social service			16	2.0	1	.4			17	1.0	17	2.0		
Speech therapy			8	1.0	5	2.0			13	1.0	7	.9	6	.8
Occupational therapy					1	.4	1	3	2	.1			2	.3
Inhalation therapy			85	11.0					85	6.0	56	7.0	29	4.0
Nutritionist														
Home health aide					1	.4			1	.1			1	.1
Laboratory technician			417	55.0	29	11.0			446	30.0	227	30.0	219	31.0
Drugs and medications	318	76	694	92.0	187	70.0	23	77	1,222	83.0	667	87.0	555	78.0
Laboratory procedures	231	56	425	56.0	99	37.0	13	43	768	52.0	364	48.0	404	57.0
Electrocardiograms	145	35	17	2.0	20	7.0	3	10	185	13.0	82	11.0	103	15.0
X-ray:														
Diagnostic	15	4	22	3.0	31	12.0	1	3	69	5.0	38	5.0	31	4.0
Therapeutic							1	3	1	.1			1	.1
Medical/surgical supplies	168	40	141	19.0	106	40.0	15	50	430	29.0	202	26.0	228	32.0
Medical equipment rental	56	13	400	53.0	93	35.0	6	20	555	38.0	287	38.0	268	38.0
Oxygen	1	.2	47	6.0	7	3.0			55	4.0	27	4.0	28	4.0
OPD/emergency room			3	.4	2	1.0			5	.3			5	.7
Operating room					9	3.0			9	1.0	2	.3	7	1.0
Clinic visits					4	1.0			4	.3			4	.6
Patient transportation					3	1.0			3	.2			3	.4
Other			5	.6	2	.7			7	.5	4	.5	3	.4
Other cases except medicare	579		413		193		29		1,214		531		683	
Nursing	577	99	370	90.0	186	96.0	28	97	1,161	96	493	93.0	668	98
Physical therapy	12	2	188	46.0	62	32.0	7	24	269	22	138	26.0	131	19
Social service			130	31.0					130	11	130	24.0		
Speech therapy			13	3.0	8	4.0	1	3	22	2	12	2.0	10	1
Occupational therapy			4	1.0	3	2.0	2	7	9	.7			9	1
Inhalation therapy			41	10.0					41	3	20	4.0	21	3
Nutritionist														
Home health aide			1	.2	4	2.0			5	.4			5	.7
Laboratory technician			199	48.0	13	7.0			212	17.0	106	20.0	106	16
Drugs and medications	358	62	271	66.0	112	58.0	21	72	762	63.0	328	62	434	64
Laboratory procedures	253	44	205	50.0	53	27.0	3	10	514	42	200	38	314	46
Electrocardiograms	131	23	5	1.0	11	6.0			147	12	43	8	104	15
X-ray:														
Diagnostic	14	2	37	9.0	24	12.0			75	6	42	8	33	5
Therapeutic							3	10	3	.2			3	.4
Medical/surgical supplies	288	50	91	22.0	95	49.0	13	45	487	40	187	35.0	300	4
Medical Equipment rental	63	11	285	69.0	82	42.0	11	38	441	36	218	41.0	223	33
Oxygen	2	.3	33	8.0	3	2.0	2	7	40	3	16	3.0	24	4
OPD/emergency room	1	.2			6	3.0			7	.6	5	.9	2	.3

TABLE X.—DIRECT SERVICES PROVIDED HOME CARE PATIENTS—Continued

Services	A		B		C		D		Total 1962–70		Total 1962–65		Total 1966–70	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Operating room					12	6.0			12	0.9	5	0.9	7	1
Clinic visits					6	3.0			6	.5	3	.6	3	.4
Patient transportation					2	1.0			2	.2			2	.3
Other	1	0.2	1	0.2	1	.5			3	.2			3	.4
Medicare cases:	322		494		429		9		1,254				1,254	
Nursing	322	100	449	91.0	424	99.0	9	100	1,204	96			1,204	96
Physical therapy	4	1	261	53.0	112	26.0	4	44	381	30			381	30
Social service					2	.5			2	.2			2	.2
Speech therapy			20	4.0	5	1.0			25	2			25	2
Occupational therapy			5	1.0	2	.5			7	.6			7	.6
Inhalation therapy			39	8.0					39	3			39	3
Nutritionist														
Home health aide			11	2.0	26	6.0			37	3			37	3
Laboratory technician			242	49.0	23	5.0			265	21.0			265	21
Drugs and medications	49	15	27	5.0	49	11.0			125	10			125	10
Laboratory procedures	174	54	243	49.0	135	31.0	3	33	555	44.0			555	44.0
Electrocardiograms	102	32.0	5	1.0	20	5.0			127	10.0			127	10.0
X-ray:														
Diagnostic	2	.6	1	.2	50	12.0			53	4.0			53	4.0
Therapeutic														
Medical and surgical supplies	164	5	97	20.0	209	49.0	2	22	472	38.0			472	38.0
Medical equipment rental	41	13.0	337	68.0	244	57.0	5	56	627	50.0			627	50.0
Oxygen			28	6.0	20	5.0			48	4.0			48	4.0
OPD/emergency room					3	1.0			3	.2			3	.2
Operating room					1	.2			1	.07			1	.07
Clinic visits					4	.9			4	.3			4	.3
Patient transportation														
Other	1	.3	1	.2	1	.2			3	.2			3	.2
All cases	1,317		1,665		890		68		3,940		1,294		2,646	
Nursing	1,313	99	1,499	90.0	874	98.0	67	99	3,753	95	1,183	91.0	2,570	97
Physical therapy	24	2	665	40.0	222	25.0	16	24	927	24	308	24.0	619	23
Social service			146	9.0	3	.3			149	4	147	11.0	2	
Speech therapy			41	2.0	18	2.0	1	1	60	2	19	1.0	41	2
Occupational therapy			9	.5	6	1.0	3	4	18	.5			18	.7
Inhalation therapy			165	10.0					165	4	76	6.0	89	3
Nutritionist														

Home health aide			12	1.0	31	3.0			43	1			43	1
Laboratory technician			858	52.0	65	7.0			923	23	333	26.0	590	22
Drugs and medications	725	55	992	60.0	348	39.0	44	65	2,109	54	995	77.0	1,114	42
Laboratory procedures	658	50	873	52.0	287	32.0	19	28	1,837	47	564	44.0	1,273	48
Electrocardiograms	378	29	27	2.0	51	6.0	3	4	459	12	125	10.0	334	13
X-ray:														
Diagnostic	30	2	60	4.0	105	12.0	1	1	196	5	80	6.0	116	4
Therapeutic							4	6	4	.1			4	.2
Medical/surgical supplies	620	47	329	20.0	410	46.0	30	44	1,389	35	389	30.0	1,000	38
Medical equipment rental	160	12	1,022	61.0	419	47.0	22	32	1,623	41	505	39.0	1,118	42
Oxygen	3	.2	108	6.0	30	3.0	2	3	143	4	43	3.0	100	4
OPD/emergency room	1	.07	3	.2	11	1.0			15	.4	5	.4	10	.4
Operating room					18	2.0			18	.5	2	.2	16	.6
Clinic visits					14	2.0			14	.4	3	.2	11	.4
Patient transportation					5	1.0			5	.1			5	.2
Other	2	.2	7	.4	4	.4			13	.3	4	.3	9	.3

TABLE XI.—DIRECT PATIENT SERVICES, AVERAGE CHARGE PER CASE

Services	A	B	C	D	1962–70	1962–65	1966–70
Blue Cross cases	416	758	268	30	1,472	763	709
Nursing	$39.70	$57.77	$86.85	$106.99	$58.96	$47.85	$70.92
Physical therapy	.47	17.11	17.17	10.13	12.28	14.02	10.41
Social service		.13	.01		.07	.13	.01
Speech therapy		2.23	.87		1.31	.92	1.73
Occupational thrapy			.18	.80	.05		.10
Inhalation therapy		1.43			.74	.98	.48
Nutritionist							
Home health aide			.50		.09		.19
Laboratory technician		8.04	1.10		4.34	3.97	4.74
Drugs and medications	10.20	44.18	19.89	31.56	29.90	31.92	27.73
Laboratory procedures	8.78	41.49	11.29	17.53	26.26	16.20	37.09
Electrocardiograms	14.63	.93	1.73	3.83	5.01	4.34	5.73
X-ray:							
Diagnostic	1.04	.82	2.95	1.00	1.27	1.17	1.38
Therapeutic				9.60	.20		.41
Medical/surgical supplies	4.46	2.20	6.38	10.40	3.77	2.80	4.81
Medical equipment rental	1.39	20.74	14.60	3.99	13.81	12.36	15.37
Oxygen	.12	1.37	.41		.81	.87	.75
OPD/emergency room			.08		.01		.02
Operating room			.77		.14	.08	.20
Clinic visits			.15		.03		.06
Patient transportation			.34		.06		.12
Otner	.10	.42	.25		.28	.18	.39
Total charges	80.90	198.86	165.52	195.83	159.39	137.79	182.64
Other cases excluding medicare	579	413	193	29	1,214	531	683
Nursing	$46.11	$81.26	$99.72	$106.96	$68.03	$57.74	$76.04
Physical therapy	.32	29.68	37.28	11.76	16.46	19.18	14.35
Social service		2.36			.80	1.83	
Speech therapy		6.13	2.62	.76	2.52	3.89	1.45
Occupational therapy		.59	.85		.34		.60
Inhalation therapy		1.29			.44	.53	.37
Nutritionist							
Home health aide		.46	2.17	2.66	.57		1.01
Laboratory technician		8.10	.82		2.89	3.46	2.45
Drugs and medications	9.15	52.07	14.20	20.55	24.83	31.35	19.76
Laboratory procedures	6.31	37.57	9.58	3.03	17.39	12.59	21.12
Electrocardiograms	8.98	.36	1.37		4.62	3.08	5.82
X-ray:							
Diagnostic	.76	2.22	2.72		1.55	1.65	1.47
Therapeutic				16.76	.40		.71
Medical/surgical supplies	5.05	3.30	9.85	4.57	5.21	3.46	6.57
Medical equipment rental	1.10	41.71	17.78	17.23	17.95	23.20	13.87
Oxygen	.06	2.95	.13	10.65	1.31	.88	1.64
OPD/emergency room			.19		.03		.05
Operating room			.90		.14	.13	.15
Clinic visits	.01		.13		.02	.01	.03
Patient transportation			.17		.03		.05
Other	.06	.02	.12		.05		.09
Total	77.91	270.07	200.60	194.93	165.58	162.98	167.60
Medicare cases	322	494	429	9	1,254		1,254
Nursing	$55.22	$86.80	$159.83	$74.44	$103.59		$103.59
Physical therapy	.21	25.12	34.73	21.33	21.98		21.98
Social service			.01		.01		.01
Speech therapy		14.85	.40		5.99		5.99
Occupational therapy		.56	.30		.32		.32
Inhalation therapy		.89			.35		.35
Nutritionist							
Home health aide		2.75	5.84		3.08		3.08
Laboratory technician		7.70	1.00		3.38		3.38
Drugs and medications	2.08	1.59	3.51		2.36		2.36
Laboratory procedures	9.50	45.62	14.29	17.89	25.43		25.43
Electrocardiograms	10.42	.36	3.11		3.88		3.88
X-ray:							
Diagnostic	.04	.03	3.13		1.09		1.09
Therapeutic							
Medical/surgical supplies	6.41	3.76	13.59	.67	7.78		7.78
Medical equipment rental	1.78	30.43	29.22	18.80	22.58		22.58
Oxygen		2.05	3.79		2.10		2.10
OPD/emergency room			.09		.03		.03
Operating room			.07		.02		.02
Clinic visits			.06		.02		.02

TABLE XI.—DIRECT PATIENT SERVICES, AVERAGE CHARGE PER CASE—Continued

Services	A	B	C	D	1962–70	1962–65	1966–70
Patient transportation		$0.18			$0.07		$0.07
Other	$0.02		$0.15		.06		.06
Total charges	85.68	122.69	273.12	$133.12	204.12		204.12
All cases	1,317	1,665	890	68	3,940	$1,294	2,646
Nursing	$46.35	$72.22	$124.81	$102.67	$76.03	$51.90	$87.84
Physical therapy	.34	22.60	30.00	12.31	16.66	16.14	16.91
Social service		.64	.01		.27	.83	
Speech therapy		6.94	1.02	.32	3.17	2.14	3.67
Occuptational therapy		.31	.38	.35	.22		.33
Inhalation therapy		1.23			.52	.79	.39
Nutritionist							
Home health aide		.93	3.44	1.13	1.19		1.77
Laboratory technician		7.96	.99		3.59	3.76	3.51
Drugs and medications	7.75	33.50	10.76	22.70	19.58	31.68	13.66
Laboratory procedures	7.86	41.74	12.37	11.40	23.27	14.72	27.45
Electrocardiograms	11.11	.63	2.31	1.69	4.54	3.82	4.89
X-ray:							
Diagnostic	.67	.93	2.99	.44	1.30	1.37	1.27
Therapeutic				11.38	.20		.30
Medical and surgical supplies	5.20	2.93	10.60	6.62	5.49	3.07	6.67
Medical equipment rental	1.35	28.82.	22.33	11.60	17.89	16.81	18.42
Oxygen	.06	1.96	1.99	4.54	1.37	.88	1.61
OPD/emergency room			.10		.02		.03
Operating room			.47		.11	.10	.11
Clinic visits	.01		.10		.02	.01	.02
Patient transportation		.05	.14		.05		.07
Other	.06	.20	.18		.15	.11	.17
Total charges	80.76	223.59	224.99	187.15	175.64	148.13	189.09

TABLE XII.—AVERAGE PER DIEM CHARGE

Services	A	B	C	D	1962–70	1962–65	1966–70
Blue Cross cases:							
Number of home care days	7,601	28,521	8,835	678	45,635	24,875	20,760
Nursing	$2.17	$1.55	$2.63	$4.73	$1.91	$1.47	$2.43
Physical therapy	.03	.45	.52	.45	.39	.42	.35
Social service			.005		.005	0.	.01
Speech therapy		.06	.03		.04	.03	.05
Occupational therapy			.01	.04	.005		.01
Inhalation therapy		.04			.02	.03	.01
Nutritionist							
Home health aide			.02		.005		.01
Laboratory technician		.21	.03		.14	.12	.16
Drugs and medications	.55	1.18	.60	1.40	.97	.98	.96
Laboratory procedures	.48	1.10	.34	.78	.84	.50	1.25
Electrocardiograms	.81	.02	.05	.17	.16	.13	.20
X-ray:							
Diagnostic	.06	.02	.09	.04	.04	.04	.04
Therapeutic				.42	.01		.02
Medical/surgical supplies	.25	.06	.19	.46	.12	.09	.16
Medical equipment rental	.07	.55	.44	.18	.44	.38	.51
Oxygen	.01	.04	.01		.03	.03	.03
OPD/emergency room			.005		.005		.01
Operating room			.02		.005	0.	.01
Clinic visits			.01		.005		.01
Patient transportation			.01		.005		.01
Other		.01	.01		.005	.01	.01
Total charges	4.43	5.29	5.02	8.67	5.15	4.23	6.25

TABLE XII.—AVERAGE PER DIEM CHARGE—Continued

Services	A	B	C	D	1962–70	1962–65	1966–70
Other cases excluding medicare:							
Number of home care days	11,293	25,579	9,246	636	46,754	23,597	23,175
Nursing	$2.37	$1.30	$2.08	$4.87	$1.76	$1.29	$2.24
Physical therapy	.02	.48	.78	.54	.43	.42	.43
Social service		.04			.02	.04	
Speech therapy		.10	.05	.03	.07	.09	.04
Occupational therapy		.01	.02		.01		.02
Inhalation therapy		.02			.01	.01	.01
Nutritionist							
Home health aide		.01	.05	.12	.01		.03
Laboratory technician		.13	.02		.08	.08	.08
Drugs and medications	.47	.84	.30	.93	.65	.71	.58
Laboratory procedures	.33	.61	.20	.14	.45	.28	.63
Electrocardiograms	.47	.01	.03		.12	.07	.17
X-ray:							
Diagnostic	.04	.04	.06		.04	.04	.04
Therapeutic				.76	.01		.02
Medical/surgical supplies	.26	.05	.21	.21	.14	.08	.19
Medical equipment rental	.06	.67	.37	.79	.47	.53	.41
Oxygen		.05	0	.49	.03	.02	.05
OPD/emergency room			0		0		0
Operating room			.02		0	0	0
Clinic visits			0		0	0	0
Patient transportation			0		0	0	0
Other			0		0	0	0
Total charges	4.02	4.36	4.19	8.89	4.30	3.67	4.94
Medicare cases:							
Number of home care days	8,339	25,340	24,302	167	58,148		58,148
Nursing	$2.13	$1.69	$2.82	$4.01	$2.23		$2.23
Physical therapy	.01	.49	.61	1.15	.47		.47
Social service			0.		0.		0.
Speech therapy		.29	.01		.13		.13
Occupational therapy		.01	.01		.01		.01
Inhalation therapy		.02			.01		.01
Nutritionist							
Home health aide		.05	.10		.07		.07
Laboratory technician		.15	.02		.07		.07
Drugs and medications	.08	.03	.06		.05		.05
Laboratory procedures	.37	.90	.25	.96	.55		.55
Electrocardiograms	.40	.01	.05		.08		.08
X-ray:							
Diagnostic	0.	0.	.06		.02		.02
Therapeutic							
Medical/surgical supplies	.25	.07	.24	.04	.17		.17
Medical equipment rental	.07	.59	.59	1.01	.49		.49
Oxygen		.04	.07		.05		.05
OPD/emergency room			0.		0.		0.
Operating room			0.		0.		0.
Clinic visits			0.		0.		0.
Patient transportation		0.			0.		0.
Other	0.		0.		0.		0.
Total charges	3.32	4.34	4.82	7.17	4.40		4.40
All cases:							
Number of home care days	27,233	79,440	42,383	1,481	150,537	48,472	102,065
Nursing	$2.24	$1.51	$2.62	$4.71	$1.99	$1.39	$2.28
Physical therapy	.02	.47	.63	.57	.44	.43	.44
Social service		.01	0.		.01	.02	
Speech therapy		.15	.02	.01	.08	.06	.10
Occupational therapy		.01	.01	.02	.01		.01
Inhalation therapy		.03			.01	.02	.01
Nutritionist							
Home health aide		.02	.07	.05	.03		.05
Laboratory technician		.17	.02		.09	.10	.09
Drugs and medications	.37	.70	.23	1.04	.51	.85	.35
Laboratory procedures	.38	.87	.26	.52	.61	.39	.71
Electrocardiograms	.54	.01	.05	.08	.12	.10	.13
X-ray:							
Diagnostic	.03	.02	.06	.02	.03	.04	.03
Therapeutic				.52	.01		.68
Medical/surgical supplies	.25	.06	.22	.30	.14	.08	.17
Medical equipment rental	.07	.60	.47	.53	.47	.45	.48
Oxygen	0.	.04	.04	.21	.04	.02	.04
OPD/emergency room			0.		0.		0.
Operating room			.01		0.	0.	0.
Clinic visits			0.		0.	0.	0.
Patient transportation		0.	0.		0.	0.	0.
Other	0.	0.	0.		0.	0.	0.
Total charges	3.90	4.69	4.72	8.59	4.60	3.95	4.90

TABLE XIII.—AVERAGE CHARGE FOR EACH SERVICE AS A PERCENTAGE OF TOTAL DIRECT SERVICE CHARGES

Direct services	Hospitals						
	A	B	C	D	1962–70	1962–65	1966–70
Blue Cross Cases:							
Nursing	49.1	29.1	52.5	54.6	37.0	34.7	38.8
Physical therapy	.6	8.6	10.4	5.3	7.7	10.2	5.7
Social service		.1	.1		.1	.1	
Speech therapy		1.1	.5		.8	.7	.9
Occupational therapy			.1	.4	.1		.1
Inhalation therapy		.7			.4	.7	.3
Nutritionist							
Home health aide			.3		.1		.1
Laboratory technician		4.0	.6		2.7	2.9	2.6
Drugs/medications	12.6	22.2	12.0	16.1	18.7	23.2	15.2
Laboratory procedures	10.9	10.9	6.7	9.0	16.5	11.8	10.4
Electrocardiograms	18.1	.5	1.1	2.0	3.1	3.1	3.1
X-ray:							
Diagnostic	1.3	.4	1.7	.5	.8	.8	.8
Therapeutic				4.9	.1		.2
Medical/surgical supplies	5.5	1.1	3.8	5.3	2.4	2.0	2.6
Medical equipment rental	1.7	10.4	8.8	2.0	8.7	9.0	8.4
Oxygen	.1	.7	.3		.5	.6	.4
OPD/emergency room			.1				
Operating room			.5		.1	.1	.1
Clinic visits			.1				
Patient transportation			.2				.1
Other	.1	.2	.2		.2	.1	.2
Total direct service	100.0	100.0	100.0	100.0	100 0	100.0	100.0
Other cases excluding medicare:							
Nursing	59.2	30.1	49.7	54.9	41.1	35.4	45.4
Physical therapy	.4	11.0	18.6	6.0	9.9	11.8	8.6
Social service		.9			.5	1.1	
Speech therapy		2.3	1.3	.4	1.5	2.5	.8
Occupational therapy		.2	.4		.2		.4
Inhalation therapy		.5			.3	.3	.2
Nutritionist							
Home health aide		.2	1.1	1.4	.3		.6
Laboratory technician		3.0	.4		1.7	2.1	1.5
Drugs/medications	11.7	19.3	7.1	10.5	15.0	19.3	11.8
Laboratory procedures	8.1	13.9	4.7	1.6	10.5	7.7	12.6
Electrocardiograms	11.5	.1	.7		2.8	1.9	3.5
X-ray:							
Diagnostic	1.0	.8	1.4		.9	1.0	.8
Therapeutic				8.6	.2		.4
Medical/surgical supplies	6.5	1.2	4.8	2.3	3.1	2.1	3.9
Medical equipment rental	1.4	15.4	8.9	8.8	10.8	14.2	8.3
Oxygen	.1	1.1	.1	5.5	.8	.5	1.0
OPD/emergency room			.1		.1		
Operating room			.4		.1	.1	.1
Clinic visits			.1				
Patient transportation			.1		.1		
Other	.1		.1		.1		.1
Total direct service	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicare cases:							
Nursing	64.4	39.0	58.6	55.9	50.8		50.8
Physical therapy	.2	11.3	12.7	16.0	10.8		10.8
Social service							
Speech therapy		6.6	.1		2.9		2.9
Occupational therapy		.3	.1		.1		.1
Inhalation therapy		.4			.2		.2
Nutritionist							
Home health aide		1.2	2.1		1.5		1.5
Laboratory technician		3.5	.4		1.7		1.7
Drugs/medications	2.4	.7	1.3		1.2		1.2
Laboratory procedures	11.1	20.4	5.3	13.4	12.5		12.5
Electrocardiograms	12.2	.2	1.1		1.9		1.9
X-ray:							
Diagnostic	.1		1.1		.5		.5
Therapeutic							
Medical/surgical supplies	7.5	1.7	5.0	.5	3.8		3.8
Medical equipment rental	2.1	13.7	10.7	14.2	11.1		11.1
Oxygen		.9	1.4		1.0		1.0
OPD/emergency room							
Operating room							
Clinic visits							
Patient transportation		.1					
Other				.1			
Total direct service	100.0	100.0	100.0	100.0	100.0		100.0

TABLE XIII.—AVERAGE CHARGE FOR EACH SERVICE AS A PERCENTAGE OF TOTAL DIRECT SERVICE CHARGES—Continued

Direct services	Hospitals						
	A	B	C	D	1962–70	1962–65	1966–70
All cases:							
Nursing	57.4	32.3	55.5	54.9	43.3	35.0	46.5
Physical therapy	.4	10.1	13.3	6.6	9.5	10.9	8.9
Social service		.3			.2	.6	
Speech therapy		3.1	.5	.2	1.8	1.4	1.9
Occupational therapy		.1	.2	.2	.1		.2
Inhalation therapy		.6			.3	.5	.2
Nutritionist							
Home health aide		.4	1.5	.6	.7		.9
Laboratory technician		3.6	.4		2.0	2.5	1.9
Drugs/medications	9.6	15.0	4.8	12.1	11.1	21.5	7.2
Laboratory procedures	9.7	18.7	5.5	6.1	13.2	9.9	14.6
Electrocardiograms	13.8	.3	1.0	.9	2.7	2.6	2.6
X-ray:							
Diagnostic	.8	.4	1.3	.2	.7	.9	.7
Therapeutic				6.1	.1		.2
Medical/surgical supplies	6.4	1.3	4.7	3.5	3.1	2.1	3.5
Medical equipment rental	1.7	12.8	9.8	6.2	10.2	11.3	9.7
Oxygen	.1	.9	.9	2.4	.8	.6	.9
OPD/emergency room			.1				
Operating room			.2		.1	.1	
Clinic visits			.1				
Pt. transportation			.1				
Other	.1	.1	.1		.1	.1	.1
Total direct service	100.0	100.0	100.0	100.0	100.0	100.0	100.0

TABLE XIV.—DIRECT SERVICE CHARGES AND INDIRECT COSTS[1]

Total expenses	Direct service charges			Indirect costs			All cases				
	Blue Cross cases	Other cases	All cases	Blue Cross cases	Other cases	All cases	Blue Cross cases	Other cases	1962–70	1962–65	1966–70
Hospital:											
A	$33,656	$72,699	$106,355	$24,971	$52,360	$77,331	$58,627	$125,059	$183,686	$66,385	$117,303
B	150,734	221,547	372,281	106,930	178,078	285,008	257,664	399,625	657,289	209,666	447,623
C	44,359	155,884	200,243	31,050	92,790	123,840	75,400	248,674	324,083	29,504	294,575
D [2]	5,875	6,851	12,726	8,406	10,698	19,104	14,281	17,549	31,830	----------	31,830
Total	234,624	456,981	691,605	171,357	333,926	505,283	405,981	790,907	1,196,888	305,555	891,331
Average per case: Hospital:											
A	80.90	80.69	80.70	60.03	58.11	58.72	140.93	138.80	139.48	149.18	134.52
B	198.86	244.26	223.59	141.07	196.34	171.18	339.93	440.60	394.77	299.52	463.86
C	165.52	250.62	224.99	115.86	149.18	139.15	281.38	399.80	364.14	198.02	397.55
D [2]	195.83	180.29	185.15	280.20	281.53	280.94	476.03	461.82	468.09	----------	468.09
Average all cases	159.38	185.16	175.53	116.41	135.30	128.25	275.80	320.46	303.78	236.13	336.86
Average per home care patient day: Hospital:											
A	4.43	3.70	3.90	3.28	2.67	2.84	7.71	6.37	6.74	7.51	6.38
B	5.29	4.35	4.69	3.74	3.50	3.59	9.03	7.85	8.28	6.29	9.71
C	5.02	4.65	4.72	3.51	2.77	2.92	8.53	7.42	7.64	4.69	8.16
D [2]	8.67	8.53	8.59	12.40	13.32	12.90	21.07	21.85	21.59	----------	21.49
Average all cases	5.14	4.36	4.59	3.75	3.18	3.36	8.89	7.54	7.95	6.30	8.73

[1] Unaudited figures.

[2] Indirect costs estimated.

TABLE XV.—ESTIMATED NUMBER OF INPATIENT DAYS SAVED DUE TO USE OF HOME CARE SERVICE

	A	B	C	D	1962–70	1962–65	1966–70
Estimated members of inpatient days saved:							
Blue Cross cases	5,122	7,528	3,592	369	16,611	6,953	9,658
Other cases excluding medicare	7,661	7,322	3,253	296	18,532	9,311	9,221
Medicare cases	3,994	6,197	5,364	102	15,657	----------	15,657
All cases	16,777	21,047	12,209	767	50,800	16,264	34,536
Estimated average days saved per case:							
Blue Cross cases	12.3	9.93	13.4	12.3	11.3	9.1	13.6
Other cases excluding medicare	13.2	17.73	16.9	10.2	15.3	17.5	13.5
Medicare cases	12.4	12.54	12.5	11.3	12.5	----------	12.5
All cases	12.7	12.64	13.7	11.3	12.9	12.6	13.1
Number of hospital beds made available due to estimated inpatient days saved	5.6	9.1	6.5	1.5	6.6	5.3	7.4

TABLE XVI.—VALUE OF ESTIMATED INPATIENT DAYS SAVED BASED ON AVERAGE PER DIEM COSTS

	A	B	C	D	1962–70	1962–65	1966–70
Blue Cross cases	$175,679	$378,044	$210,156	$32,103	$795,982	$219,960	$576,022
Other cases	276,214	327,050	304,488	8,874	916,626	299,981	616,645
Medicare cases	185,891	365,417	205,599	25,752	782,659	----------	782,659
All cases	637,784	1,070,511	720,243	66,729	2,495,267	519,941	1,975,326
Less home care service charges and indirect costs [1]	183,688	657,289	324,079	31,830	1,196,886	305,555	891,331
Estimated net value	454,096	413,222	396,162	34,899	1,298,381	214,386	1,083,995
Estimated net value per case	345	248	445	513	330	166	410

[1] Unaudited figures.

TABLE XVII.—BLUE CROSS EXPERIENCE

	A	B	C	D	1962–70	1962–65	1966–70
Value of estimated inpatient days saved	$175,679	$378,044	$210,156	$32,103	$795,982	$219,960	$576,022
Less home care service charges and indirect costs [1]	58,627	257,664	75,408	14,281	405,980	163,331	242,649
Estimated net value	117,052	120,380	134,748	17,822	390,002	56,629	333,373
Estimated net value per case	281	159	529	594	265	74	470

[1] Unaudited figures.

ITEM 2. EXCERPTS FROM: HOME CARE FOLLOWING HOSPITALIZATION, ASSOCIATED HOSPITAL SERVICE OF NEW YORK

INTRODUCTION

Pre-planned post-hospital Home Care sponsored by Associated Hospital Service of New York has gained wide acceptance among patients, their families, attending physicians and participating Home Care hospitals.

This Greater New York area program was started in 1960, following a five-year study conducted by Associated Hospital Service of New York in the provision of pre-planned post hospital visit-nurse care at home.

This study showed that remarkable improvement in patient health and well-being resulted from use of pre-arranged visiting nurse care for hospital patients carefully selected by their own physicians. It also showed that these patients' hospital stays were shortened and their over-all costs of illness reduced.

In addition, the study led to understanding of the kind of structure, standards and controls which would be needed for an effective permanent program of post hospital care at home for large numbers of patients.

Associated Hospital Service of New York designed such a program and then requested changes in the New York State Insurance Law to permit coverage by Blue Cross of the Home Care services now provided. The Law was changed in 1959. The first participating hospital started Home Care one year later.

The continuing goal of the Home Care program is to provide outstanding and highly individualized post-hospital care at home for many thousands of patients. Progress toward that goal is summarized in this report.

The report includes data on the entire group of Home Care patients and more detailed information about experience gained in the first five thousand cases.

The aggregate hospital stays for these first 5,000 cases were reduced by more than 113,000 days, and illness costs were reduced by over $3.6 million dollars. This amount includes patient savings of $2.1 million dollars and Blue Cross savings of $1.5 million dollars.

The Home Care program offered by a participating hospital develops at a controlled pace; full use is attained in from two to three years. Experience to date confirms earlier estimates that at least ten percent of any general hospital's medical, surgical, and pediatric patients are at one time or another candidates for Home Care instead of continued hospital confinement.

For the 5,000 cases, combined hospital and home care averaged 90 days at a per diem cost of $10.24. The average per diem Blue Cross payment for the in-hospital portion of the combined care was $31.28; for Home Care portion, $3.05. The combined care costs were higher for older age groups.

The older the age group, the higher the costs of both in-hospital and Home Care.

5,000 CASES: BLUE CROSS PAYMENTS FOR IN-HOSPITAL AND HOME CARE, BY AGE GROUP

Age group in years	Number of cases	Average per case payment		
		In-hospital care	Home care	Combined care
Total	5,000	$717.08	$204.69	$921.77
Per diem average:				
Under 12	148	569.03	136.84	705.87
13 to 19	100	640.73	147.10	787.83
20 to 34	180	624.49	166.23	790.72
35 to 49	747	624.24	193.45	817.69
50 to 64	1,866	723.10	211.94	935.04
65 to 74	1,374	760.89	214.09	974.98
75 and over	576	795.47	214.73	1,010.20
Not given	9	602.34	83.10	685.44

For the 5,000 cases, combined hospital and home care averaged 90 days at a per diem cost of $10.24. The average per diem Blue Cross payment for the in-hospital portion of the combined care was $31.28; for Home Care portion $3.05. The combined care costs were higher for the older age groups. The older the age group, the higher the costs both in-hospital and Home Care.

PATIENT AND FAMILY REACTIONS

In considering patient and family reactions to Home Care, it should be realized that the program is designed to provide high quality individualized care to selected patients, that use of Home Care is voluntary, and that it is available only when recommended by the attending physicians.

The first reaction to Home Care by patients and their families is satisfaction because it shortens hospital confinement while providing continuity of care under direct supervision of the attending physicians.

When Home Care ends. Blue Cross requests patient and family appraisals of the service. In the 2,000-case group, 1,720 (85 percent) replied. Those not replying either could not be located, or used Home Care again at a later date, or had died. Of those replying, 1,708 evaluations were favorable, with strong and common emphasis on the feelings of security that Home Care gave to patients and families. The individualized Home Care approach seems to be highly prized by patients and families.

Frequently mentioned points pertaining to overall satisfaction with Home Care include: belief that recovery or improvement is hastened; gratification with the earlier return to the home; comfort in the observed close working relationship between public health nurse and attending physician; the conviction that

much has been learned about self-care or the care of a family member; elimination of the need for family members to visit the patient in the hospital; saving of Blue Cross coverage for later use; reduction in costs of care; and freeing a hospital bed for other sick people. Much praise and many blessings are bestowed upon the hospitals, the physicians, the public health nurses and Blue Cross.

Patient and family judgments are important in evaluating Home Care; favorable appraisals indicate that patients and their families make personal assessments of professional competence. It seems logical to assume that unless patients and families were favorably impressed as to competence, they would not express feelings of security with such unanimity and enthusiasm.

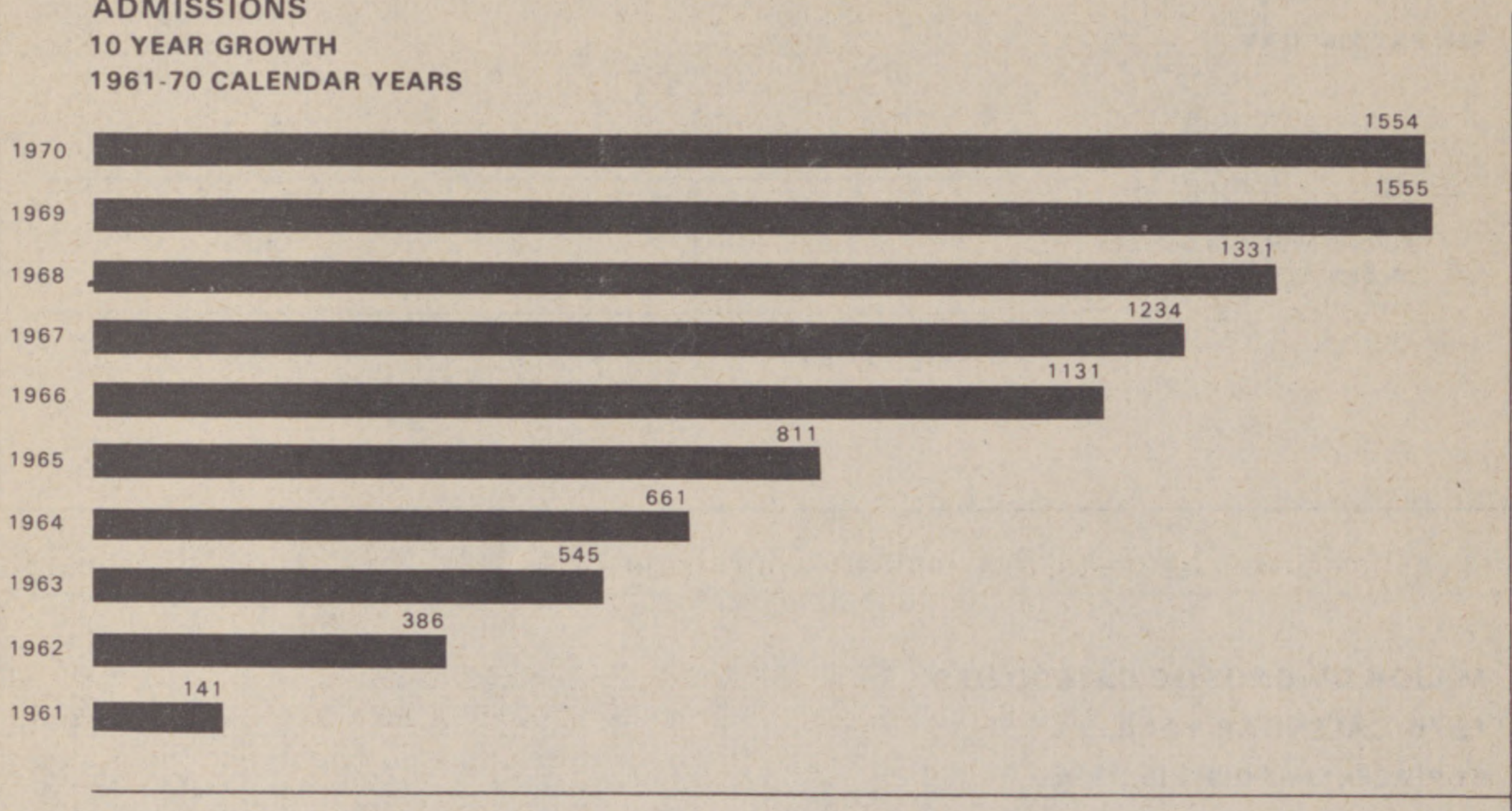
Nevertheless, overwhelmingly favorable patient and family response in no way lessens professional obligation for evaluation of the quality of care provided under Home Care and work toward ever higher performance standards.

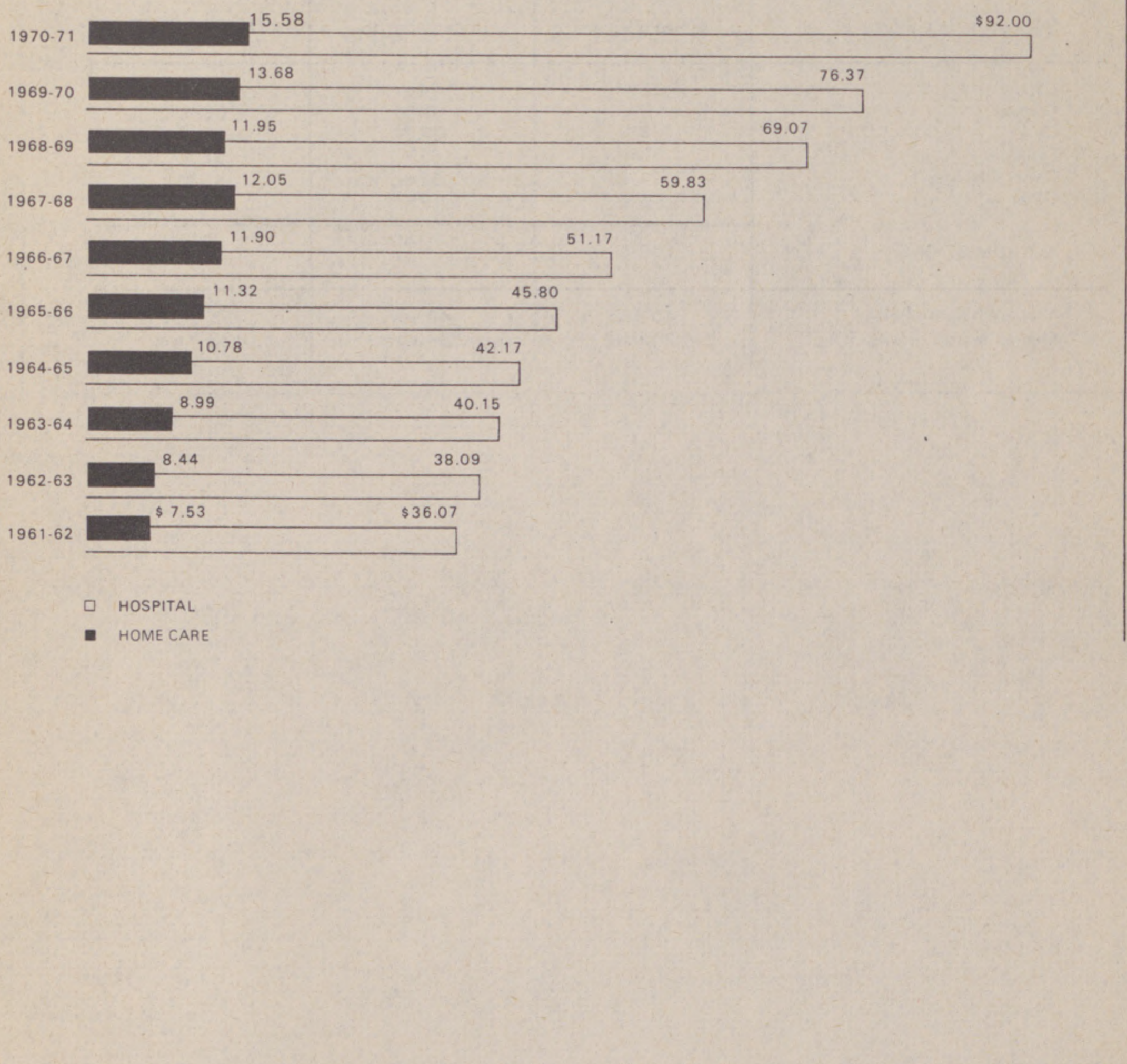
PHYSICIAN REACTIONS

In these 2,000 cases 1,606 (80 percent) of the attending physicians responded to Blue Cross requests for medical appraisals of Home Care. It is significant that among Home Care patients are physicians themselves and members of their families.

Physicians approve of Home Care because it is voluntary and because they are responsible for the final selection and continuing management of their patients.

ITEM 3. EXCERPTS FROM THE 10TH ANNUAL REPORT OF THE HOME CARE ASSOCIATION, ROCHESTER, N.Y., MAY 11, 1971





AVERAGE COST OF CARE
FISCAL YEARS
PER PATIENT DAY

	1968-69	1969-70	1970-71
Home Care Administration	$ 1.72	$ 1.80	$ 2.01
Purchased Health Services	9.95	11.58	13.22
Medical Social Casework	.28	.30	.35
	$11.95	$13.68	$15.58

MAJOR DIAGNOSTIC CATEGORIES
1970 CALENDAR YEAR
BY PERCENTAGE DISTRIBUTION

Diagnostic Category	All Admissions	Under age 65	Over age 65
Cancer	22%	54%	46%
Cardiac	15%	32%	68%
CVA	8%	32%	68%
Orthopedic	32%	62%	38%
General Surgery	7%	57%	43%
Other	16%	49%	51%
ALL ADMISSIONS	100%		
Average length of stay	40 days	44 days	36 days
Median length of stay	31 days	34 days	29 days

HOME CARE ASSOCIATION

ESTIMATED SAVINGS RESULTING FROM HOME CARE

CALENDAR YEAR 1970

Total Patients Admitted	1554
(1) Total Patients who would have received hospital care as an alternative to Home Care	653
Patient days hospital care saved by Home Care, average per patient	21
Total hospital patient days saved	13,713
Average hospital cost per day in Monroe County	$ 92.00
Average Home Care cost per day	$ 15.10
Net savings per day	$ 76.90
Total savings per year	$1,054,529.70
(2) Total hospital beds released	42

(1) Estimated from a 1970 survey of physicians who reported that 42% of 297 patients studied would have required an average of 21 additional hospital days care. This figure is conservative since 83% of responding physicians agreed that further hospitalization would have been required but 57% of these physicians declined to estimate the number of days.

(2) Based on approximately 90% utilization, i.e., 325 patient days per hospital bed per year.

ITEM 4. EXCERPTS FROM HOMEMAKER-HOME HEALTH AIDE SERVICES IN NEW JERSEY ANNUAL REPORT

HI-LITES OF 1970

New Jersey's twenty-four homemaker agencies received 14,211 applications for service.

9380 patients received, 1,362,677 hours of service this year.

80 percent of the patients accepted for service this year were female.

The Placement of a homemaker-home health aide prevented hospitalization for 2465 persons in 1970.

65 percent of the patients were sixty-five years of age or older; 23 percent were between 19 and 49; 11 percent were between 50 and 64; one percent were younger than 19.

2435 instances of employment absenteeism were prevented by the placement of a homemaker-home health aide.

1334 homemaker-home health aides were employed in December 1970.

25 training courses were held and 443 new homemakers trained.

Hospital discharge was facilitated for 2228 persons because of the availability of a homemaker-home health aide.

TOTAL PATIENTS SERVED AND HOURS OF SERVICE BY DIAGNOSIS

Diagnosis	Number of patients	Percentage	Number of hours	Percentage
Heart and circulatory	2,721	29	434,350	32
Bones	1,111	12	177,384	13
Cancer	896	10	105,674	8
Accidents and injuries	747	8	103,959	8
Nervous system	548	6	97,122	7
Pregnancy	561	6	28,115	2
Aging	487	5	115,093	8
Digestive system	492	5	47,333	3
Genitourinary	342	4	37,805	3
Respiratory	296	3	29,663	2
Neuropsychiatric	244	2	31,197	2
Infectious diseases	79	1	8,774	1
Other	856	9	146,208	11
Total	9,380	100	1,362,677	100

Average hours per patient 145.

ITEM 5. EXCERPTS FROM REPORT BY SAN FRANCISCO HOME HEALTH SERVICE

The following data is drawn from statistical compilations during a study period [1] in an agency which has provided in-home services (the range of personal care, rehabilitation in activities of daily living, environmental maintenance, assistance in reaching medical resources, and assistance in planning health care and allied services) to older individuals. Data has been gathered over a ten year period during which approximately 10,000 referrals were received.[2] Services are provided in approximately 700 households per month in an urban community well supplied with medical resources: [3]

More than 70 percent of the persons admitted were aged 65 and over; one-fourth were 80 or over.

Two-thirds were persons living alone.

Of those having other persons in the household, in 39 percent of the cases there were other ill persons in the home.

[1] 1957–1966.
[2] See tabulations.
[3] Refers to basic level of care.

Most patients served had marginal incomes; over 70 percent had categorical aid or Social Security as their principal source of income.

Almost two-thirds had multiple diagnoses. The most frequently reported were heart conditions (28 percent), arthritis (21 percent), orthopedic conditions (19 percent), neoplasms (15 percent), and cerebral vascular accidents and their residuals (14 percent).

In a given admission, approximately one-half of the group used in-home services for less than six months. One-third were still receiving services a year after admission (Table 2).

One-third of the patients studied averaged less than ten hours' homemaker/aide service a month; one-third required 10 to 19 hours; the other one-third, 20 hours or more (Table 3).

Over a period of time, intermittent service was provided to one-third of the study group; these persons had other admissions to agency service during the ten-year period, either before or after the study admission.

The individual who is fairly typical of the candidates for home health services under Title XVIII usually lives alone in a small apartment, a rooming house, or, less frequently, a single dwelling. He rarely has assistance available from family or relatives. He is able to get along with part-time assistance, usually averaging less than 20 hours per month (often in larger volume during the first weeks of illness and tapering off with convalescence) *provided* that such assistance is realistically geared to his circumstances. This means that he is provided with planned care during those hours, in that amount, and of the kind that he particularly needs while he is too ill to maintain himself. Plans may change from day to day during his period of illness and recovery.

Virtually all plans for service *include* maintenance of bathroom and food preparation areas and preparation of linens for laundry. Almost invariably food shopping is essential, either in the pattern of providing a supply of food which can be prepared ahead and used by the patient in the absence of assistance or, where refrigeration and storage are limited (as is often the case), on a more frequent basis.

The provision of limited household maintenance and food are so inextricably bound up with bathing, bed-changing, assistance with ambulation and retraining that "costing them out" of the reimbursable charge becomes difficult and unrealistic (as is surveillance which shifts eligibility on the basis of how many visits outside the home are made by the patient for treatment in any given week). Neither does it appear to be feasible in these predominantly single unit dwellings to provide one subspecialist for personal care and another subspecialist for the maintenance and support services that are essential to most older patients during periods of illness.

TABULATIONS

Data given is drawn from a study of case characteristics and service patterns based upon a single admission (ignoring later admissions during a study year) during two years following admission to service. Patients studied were admitted 8/64 to 7/65. Over the ten-year period 1957–1966 this agency received 9411 referrals for service and accepted 3024 for in-home services.

The study group consisted of 359 patients admitted to service in the year August, 1964, to July, 1965; information was recorded for the two years after admission. (Length of service and hourly data given are based on this single admission, although 25 of the patients were readmitted during the year.) The age, living arrangement, income source and diagnoses reported at admission were similar to those of 3024 admissions to agency service over a ten-year period. (Table 1)

TABLE 1.—CHARACTERISTICS OF PATIENTS SERVED BY SAN FRANCISCO HOME HEALTH SERVICE COMPARISON OF 1964–65 STUDY GROUP AND ALL ADMISSIONS, 1957–66

Patient characteristics	1964–65 study group		All 1957–66 admissions	
	Number	Percent	Number	Percent
Total patients admitted	[1] 359	100.0	[2] 3,024	100.0
Sex, age at admission:				
Male	67	18.6	639	20.9
Under 65	18	4.0	186	6.1
65–79	21	5.8	264	8.7
80 and over	28	7.8	186	6.1
Not stated			3	([3])
Female	292	81.3	2,385	78.6
Under 65	82	22.8	710	23.4
65–79	141	39.2	1,144	37.6
80 and over	64	17.9	511	16.9
Not stated	5	1.4	20	.7
Living arrangement:				
Person living alone	245	68.0	1,806	59.8
Person living with others	114	32.0	1,218	40.2
Percent of persons living with others where there are other ill persons in household		38.6		37.9
Principal source of income: Categorical aid	200	55.6	1,403	46.5
Not categorical aid	159	44.4	1,621	53.4
Social security	57	15.9	549	18.1
Pension, disability insurance	32	9.0	239	8.0
Wages or other	70	19.3	832	27.3
Diagnoses most often reported: [1]				
Arthritis	77	21.4	452	14.9
Heart conditions	101	28.0	799	26.2
Neoplasms	52	14.5	374	12.4
Cerebral vascular accidents and residuals	49	13.6	321	10.6
Orthopedic	69	19.2	470	15.5

[1] First admission during study period only.
[2] Each admission counted separately; total referrals for period, 9,411.
[3] Less than .01.
[4] Same patient may be counted under more than one diagnosis.

TABLE 2.—SAN FRANCISCO HOME HEALTH SERVICE, HM/HHA SERVICE PROVIDED DURING 2 YEARS FOLLOWING ADMISSION PATIENTS ADMITTED AUGUST 1964 TO JULY 1965[1]

Diagnosis age at admission	Length of service in 2 years following admission									
	Total	Under 6 months	6 to 11 months	12 to 23 months	24 months or more	Total	Under 6 months	6 to 11 months	12 to 23 months	24 months or more
All diagnoses	359	181	63	61	54	100	50.0	17.5	17.0	15.0
Arthritis	77	32	12	16	17	100	41.6	15.6	20.8	22.0
Under 65	12	8	4			100	([2])	([2])	([2])	([2])
65 and over	65	24	18	16	17	100	37.0	12.3	24.6	26.2
Heart	1_1	51	18	17	15	100	50.5	17.8	16.8	148
Under 65	18	10	4	2	2	100	([2])	([2])	([2])	([2])
65 and over	81	39	14	15	13	100	48.1	17.3	18.5	16.1
Not stated	2	2				100				
Neoplasms	52	38	6	5	3	100	73.0	11.6	9.6	5.8
Under 65	27	22	4	1		100	81.5	14.8	3.7	
65 and over	23	14	2	4	3	100	([2])	([2])	([2])	([2])
Not stated	2	2				100	([2])			
CVA and residuals	49	25	7	8	9	100	51.0	14.3	16.3	18.3
Under 65	11	6	2	1	2	100	([2])	([2])	([2])	([2])
65 and over	38	19	5	7	7	100	50.0	13.2	18.4	18.4
Orthopedic	69	33	13	14	9	100	47.9	18.8	20.3	13.0
Under 65	22	12	5	4	1	100	([2])	([2])	([2])	([2])
65 and over	46	20	8	10	8	100	43.5	17.4	21.7	17.4

[1] 1st admission during year only.
[2] Percents not computed for fewer than 25.
Note: Diagnostic groups include patients with this diagnosis as 1 of 3 possible recorded conditions; the same person may be shown under more than 1 group: arthritis, ICD 720–727; heart, ICD 410–443; neoplasms, ICD 140–205, 210–236 (or mention of colostomy, mastectomy); CVA, ICD 330–334, 352; orthopedic, ICD 730–738, 740–749 (excluding muscular dystrophy), 758; fracture or absence of limb.

TABLE 3.—SAN FRANCISCO HOME HEALTH SERVICE, HM/HHA SERVICE PROVIDED DURING 2 YEARS FOLLOWING ADMISSION, PATIENTS ADMITTED AUGUST 1964 TO JULY 1965 [1]

Diagnosis, age at admission	Average monthly hours in 2 years following admission							
	Total	Under 10 hours	10 to 19 hours	20 hours or more	Total	Under 10 hours	10 to 19 hours	20 hours or more
All diagnoses	359	121	121	117	100	33.8	33.8	32.6
Arthritis	77	24	22	31	100	31.1	28.5	40.5
Under 65	12	6	2	4	100	(2)	(2)	(2)
65 and over	65	18	20	27	100	27.6	30.7	41.5
Heart	101	34	33	34	100	33.6	32.6	33.6
Under 65	18	6	8	4	100	(2)	(2)	(2)
65 and over	81	27	25	29	100	33.3	30.8	35.8
Not stated	2	1	---	1	100	(2)	---	(2)
Neoplasms	52	17	13	22	100	32.7	25.0	42.4
Under 65	27	8	7	12	100	29.6	26.0	44.5
65 and over	23	7	6	10	100	(2)	(2)	(2)
Not stated	2	2	---	---	100	(2)	---	---
CVA and residuals	49	13	20	16	100	26.6	40.8	32.7
Under 65	11	4	5	2	100	(2)	(2)	(2)
65 and over	38	9	15	14	100	23.7	39.4	36.8
Orthopedic	69	19	22	28	100	27.6	31.9	40.5
Under 65	22	8	5	9	100	(2)	(2)	(2)
65 and over	46	11	17	18	100	23.9	37.0	39.0
Not stated	1	---	---	1	100	(2)	---	(2)

[1] 1st admission during year only.
[2] Percents not computed for fewer than 25.

Note: Diagnostic groups include patients with this diagnosis as 1 of 3 possible recorded conditions; the same person may be shown under more than 1 group: Arthitis, ICD 720–727; Heart, ICD 410–443; Neoplasms, ICD 140–205, 210–239 (or mention of colostomy, mastectomy); CVA, ICD 330–334, 352; Orthopedic, ICD 730–738, 740–749 (excluding muscular dystrophy), 758; Fractures or absence of limbs.

Appendix 4

ITEM 1. LETTER FROM MARY L. WHITACRE, M.D., HEALTH COMMISSIONER, MARIETTA, OHIO, TO THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION, BALTIMORE, MD.

JANUARY 9, 1970.

DEAR SIR: I am enclosing a copy of a recent study I have made concerning the recent Social Security regulations which affect two Home Health Agencies which are operated out of the Marietta City Health Department. I am the Director of these agencies and I run them as efficiently and economically as possible to give the greatest amount of service to the patients involved.. I am quite concerned with the amount of money the Federal Government is spending with no appreciable return to the patient or to the taxpayer.

I do general practice in association with my father in Chesterhill, a village of 400 people. I am also part-time Health Commissioner for the city of Marietta. In our general practice my father and I charge $5.00 for a house call within the village limits. In my Home Nursing Services it costs $7.00 to send out a nurse to make a home nursing visit. This cost is going up 25% in 1970 due to the reasons stated on the enclosed study. This means a home nursing visit is going to cost $8.75.

Secretary Finch recently announced that the monthly rate of Medicare Part B—Co-Insurance would be raised from $4.00 to $5.25 per month due to the rising costs of doctors' fees and other services of the program. I take this as a personal insult. I have practiced medicine for 14 years and never in my life have I come across such an obvious waste of money and inefficient, un-coordinated operations as that of the total Medicare program.

I realize that all this added cost is re-imbursable to my Nursing program but to spend $18,000,000 and get nothing in return is more than I can stomach. It's hard earned taxpaying citizens' money they are squandering and I don't like it. I've always felt that the elected officials in Washington had a contract with us home folks. As proof of that contract I received my income tax bill every 3 months. I'm a "naive hill country gal" who feels that the politicians in Washington should fulfill their part of the contract and spend my money wisely or I won't send my money. I may get a needed long vacation at federal expense if I persist in this delusion. So I am asking you and the politicians and super geniuses in Washington to justify the need of these recent (maybe old) regulations.

(Enclosure.)

THE COMMUNICATION GAP IN GOVERNMENT OR ONE HAND DOESN'T KNOW WHAT THE OTHER HAND IS DOING

In an attempt to reduce costs and make Home Nursing Services more efficient Social Security has recommended and put into effect the following.

1. Reduce the number of patients eligibile for Home Nursing Services making the eligibility requirements more stringent.

2. Require a full page of information to be submitted on each patient being served in the Home Health Agency every 2 months.

(This information will be reviewed by a physician or physicians at the intermediary's office. It will be his decision as to whether the patients are or are not eligible and then our agency is notified.)

3. Raised from 1 to 2 number of supervisory visits per month the nurse makes with the Home Health Aide on each patient the Home Health Aide serves.

The following statistics are based on the actual number of patients served in November, 1969 in the 2 Home Nursing Services I now run. I have calculated the expense that these regulations will cost my Home Nursing agencies.

Additional cost to program for this added call—

Month of November, 1969

County Home Nursing Service
Total number of patients—15
Number of patients seen by Home Health Aide—8

[Time in hours]

Location	Round trip (miles)	Number patients	Traveltime	Visit time ½ hour per patient	Writeup	Time per 2 weeks
New Matamoras	64	4	2	2	2	6
Little Hocking	60	1	2	½	½	3
Rinard Mills	64	1	2	½	½	3
Williamstown	10	1	½	½	½	1½
Devola	10	1	½	½	½	1½
Total	208	8	7	4	4	15

City Home Nursing Service—Month of November, 1969—
Total number of patients—45.
Number of patients seen by Home Health Aide—16.

Location	Round trip mileage	Travel time	Visit time	Write-up	Total time every 2 weeks
Marietta	2 miles per pt. (16 x 2)	20 minutes	½ hour per pt	½ hour per pt	
Do		(20 minutes) x 16 pts.	(16 x ½ hour)	(16 x ½ hour)	
Total	32 miles	5 hours	8 hours	8 hours	21 hours.

Total number of nurse hours and travel time: 36 hrs.

The total number of nursing hours spent is 36 but realistically I feel it will take 40 hours, which is 1 week's time. She previously was spending 1 week out of 4 making supervisor visits but now she spends 2 weeks out of 4.

Previously the nurse made Home Nursing visits 3 weeks and a supervisor visits 1 week. Now with the new regulation she will spend 2 weeks making Home Nursing visits and 2 weeks making supervisor visits, therefore I have to hire a registered nurse to make the nursing visits for the week the Supervisor Nurse is making supervisor visits.

52 weeks÷4=13 weeks; 13 weeks=¼ time employee;
Annual nurse's salary=$6,000.

¼ time nurse's salary	$1,500
12% PERS and Workmen's Comp	180
Total	1,680

Now this additional nurse will be paid travel also. The average travel pay per month for our supervisor nurse is $17.000 per month. The additional nurse will need ¼ of this (as she works 1 week out), which is:
$4.50 travel pay per week×13 weeks=$58.50
We pay 10 cents a mile for travel therefore added travel costs are:

City miles=32 times 10 cents times 12 months	$38.40
County miles=208 times 10 cents times 12 months	249.60
Total	288.00

The added cost for the required clerical work (the 1 page of patient information to be made out and mailed to the intermediary every 2 months—and we have a total of 60 patients) is:

¼ time clerk for City Home Nursing Service.
¼ time clerk for County Home Nursing Service.
½ time clerk.
Annual clerk's salary=$4,218.00.

½ time clerk's salary	$2,109.00
Plus 12% PERS and Workmen's Comp	253.08
Total	2,362.08

Total actual cost added to the Home Nursing program for the forthcoming year is:

Annual additional travel pay for Supervising Nurse making supervisory visits	$288.00
Annual additional ¼ R.N. salary plus Pers., Workmen's Compensation	1,680.00
Annual additional travel pay for ¼ time nurse	58.50
Annual additional clerk salary plus Pers., Workmen's Compensation	2,362.08
Total	4,388.58

The county program is only 9 months old and the number of patients served in 1970 will double and may triple. The city program is 2½ years old and will probably increase by 10% this year.

The total budget for both county and city programs for 1970 before this additional cost was:

1970 city budget	$23,530
1970 county budget	13,000
Total	36,530

Social Security in an attempt to reduce the cost and make the program more efficient has added one-fourth of the total budget to the cost.

The cost of the physician and clerk hired by the intermediary to review the forms to determine eligibility or ineligibility of each new patient admitted and then notify the agency, I won't even attempt to estimate but this is not an insignificant item.

Our Home Health agency is one of the smallest ones in the state of Ohio. There are over 100 such agencies in the state. Just projecting take $9,000 x 100 agencies which equals $900,000. To go one step further assume that in the other 49 states there are 2,000 Home Health agencies (I am figuring that Ohio is a big state and am assuming that there are not 100 Home Health agencies in each of the 49 states.) If I take 49 x 100 which would give an estimated 4,900 Home Health agencies in the other 49 states which figure I know is too high. Therefore I am estimating that there are 2,000 Home Health agencies in 50 states.

Now $900,000—100 agencies =$18,000,000.00 for 2,000 agencies.

In our agency these regulations have not reduced the cost. They have not resulted in more effective, efficient service. The total end results are that an additional cost of 25% of our total budget has been added to the program and that fewer people over 65 will be eligible for the service.

ITEM 2. LETTER FROM FRANCIS J. CHARLTON, M.D., TO RAPHAEL B. REIDER, M.D., SAN FRANCISCO, CALIF., FEBRUARY 18, 1972

AGING AND CHRONIC ILLNESS COMMITTEE

DEAR DR. REIDER: First, my congratulations to you on becoming the chairman of the Committee. You have probably heard by this time about my breaking my leg on the last day of 1971. I had decided to beg off being chairman for a second year, even prior to that time, because of certain personal and professional problems, which prevented my devoting sufficient attention to the work of the Committee, and which therefore resulted in my neglecting certain things which I should have done as chairman of the Committee during the year. This is not

to say that I am anything but pleased and enthusiastic with the accomplishments of the Committee during the year, and with some positive contributions that I did manage to make. Most of the history and work of the Committee, as well as reference to unfinished business, will be found in the minutes and the letters on file at Society headquarters. This letter to you will be accompanied by other papers and documents, which will come in two packages. One will be a folder of communications between Blue Cross, ———— Home Health Service, and me, and I'll summarize my action and thoughts up to the end of the year. You may feel that I took the easy way out, and may wish to reopen those negotiations. If you do decide this, I shall be very glad to help in any way that I can as a member of the Committee, and as one who now has a considerable understanding of the disagreement between the ———— Home Health Service and their fiscal intermediary, Blue Cross. The second package consists of an envelope full of items received during the year—requests, complaints, and so forth—arranged in chronological order and about which I shall make some running commentary, which will help you to decide which items you simply wish to file at Society headquarters, and which you feel that the Committee should do something about.

If you will now direct your attention to the manilla folder labelled number 1, SFHHS vs. Blue Cross, and read over the seven numbered letters in the front of the folder, starting with that dated July 29, 1971, to me from Blue Cross, and finishing with the Dec. 27, 1971, letter from HHS to me, you will see that Blue Cross rejected some claims from the Home Health Agency, that they could not reach an agreement, and requested the assistance of our Committee. In addition to the letters there were several phone calls, in which I was told, among other things, that it would take perhaps several months to prepare the nine cases to be presented. This prediction was correct in that we did not receive the protocols until Nov. 8, 1971, together with the letter from Blue Cross to me, dated Nov. 5, 1971, in which Mr. A——— proposed that I review the summaries and then have a preliminary meeting with him and other representatives of Blue Cross. He thought that this perhaps would eliminate the need of a special review by the whole Committee. You will note in document 5, my letter to Mr. A———, dated Nov. 15, 1971, that I spent one and one-half hours reviewing two of the nine cases, and that upon finding that controversy seemed to revolve around Blue Cross' use of meaningless form letters, rather than clear explanations of their position, that my patience was finally exhausted, which resulted in a somewhat petulant quality in my letter. Nevertheless, I think it was a good letter and that what I said needed saying, in as much as Blue Cross, Mutual of Omaha, and SSA need very much to be reminded from time to time that it is not only unrealistic but also rude for them to demand of the "vendor" detailed reports and meaningful explanations of services delivered and bills presented, when they themselves communicate almost exclusively by such barbaric means as the odious form letter. Mr. A——— having apparently been vaporized, promoted, or put out to pasture, the next letter from Blue Cross on Dec. 8, 1971, from Mr. B——— made some important references to intermediary letters number 395, and number 71–10.

The next items in the folder, after a final letter from HHS, are these two important documents, which I recommend that you read in order to fully understand the heart of the dispute. They may be summarized as follows: Intermediary letter number 395 goes into some detail as to what was considered skilled nursing care in August of 1969, and the principle that in order to be covered for Medicare payment for home health services, the patient had to be certified as needing skilled nursing care on an intermittent basis or physical or speech therapy. The later document headed "Part A Intermediary Letter 71–10" does not really change or refute anything in the prior document, but does enlarge the explanation somewhat and makes the important point that "while many denials flow from the guidelines set out in Intermediary Letter 395, many others are unrelated to these guidelines and are based on other factors." (See second paragraph of 71–10). Careful reading of the last three paragraphs of Mr. B's——— letter of Dec. 8, will reveal that Blue Cross was planning to come to the table with a closed mind, and that we were going to be used to support their position, or were to be ignored if we disagreed with their position. This is a very revealing document and should not be misplaced.* Letter number 7 from

*Excerpts from the Fiscal Intermediary to the Chairman of the Chronic Disease Committee regarding these cases.

HHS to me, dated Dec. 27, 1971, concludes with the statement that they would like to meet with our Committee to clarify differences between the law, the regulations, and the interpretation of those regulations. You of course should make your own decision, but the idea of a meeting sometime between representatives of HHS, Blue Cross, our Committee and SSA of HEW to discuss the principles involved might help to clear the air, particularly if all participants were provided with an agenda which included such items as pointlessness of review by a Medical Society Committee which is impotent at the outset by the rules of the game.

This letter being quite long enough, I'll close it and discuss the other items mentioned above in a supplementary letter.

BLUE CROSS,
San Francisco, Calif., July 29, 1971.

FRANCIS J. CHARLTON, M.D.,
Chairman, Aging and Chronic Disease Committee, San Francisco Medical Society, San Francisco, Calif.

DEAR DR. CHARLTON: We have met with the ———— Home Health Agency to resolve Medicare cases where skilled nursing services, plus home health services, have been provided over an extended period of time. We were unable to arrive at a reasonable solution as the question related to the interpretation of medical fact based upon usual and customary practices in the community.

The Aging and Chronic Disease Committee in the past has assisted us and home health agencies by reviewing such questions and furnishing us with a recommendation. We would appreciate your Committee assisting us again. There are nine cases, however, the medical information which requires review is not voluminous and the resolution of a few of the cases will probably set the pattern with regard to the balance. We can prepare these cases in the usual manner, including a summary of the medical facts for Committee members and a statement of the questions which are raised under the Medicare Program. We will furnish the Committee with three sets of the full medical information and additional sets can be made available upon request. We will furnish the summary information to the Home Health Agency so that they know what information has been presented in case they wish to supplement that information.

Very truly yours,

RALPH THOMAS,
Assistant Director, Medical Utilization Review.

San Francisco, Calif., August 4, 1971.

Mr. RALPH THOMAS,
Assistant Director, Medical Utilization Review, Blue Cross,
Oakland, Calif.

DEAR MR. THOMAS: We are pleased that you have arranged to have the Aging and Chronic Disease Committee of the San Francisco Medical Society review the nine cases we discussed on July 20, 1971.

We assume that the summaries of medical information you have agreed to send will include a copy of the "questions raised under the Medicare Program" which you plan to send to Dr. Charlton's committee.

We also hope that there soon will be clarification from either Blue Cross or Social Security regarding the subject of "reasonableness", which you mentioned at our meeting.

Sincerely,

————,
Director of Nursing.

BLUE CROSS,
San Francisco, Calif., August 17, 1971.

Director of Nursing, San Francisco Home Health Service,
San Francisco, Calif.

DEAR ————: Thank you for your letter of August 4, 1971. If the Aging and Chronic Disease Committee is able to review your cases, the information which we will send to you and to that Committee will include "the questions raised under the Medicare Program" for your review.

I believe that the review by the Committee will clarify the subject of "reasonableness". This is an area of medical interpretation which should stay in the

community and be interpreted by physicians in the community wherever possible. Interpretations from Blue Cross of the Social Security Administration may, in an effort to clarify a point, be more restrictive than would otherwise be necessary when there is an individual interpretation of medical facts made by representatives of the medical community.

Very truly yours,

RALPH THOMAS,
Assistant Director, Medical Utilization Review.

San Francisco, Calif., September 16, 1971.

MR. RALPH THOMAS,
Assistant Director,
Medical Utilization Review,
Blue Cross, Oakland, Calif.

DEAR MR. THOMAS: Since we have not yet received notice that the Aging and Chronic Illness Committee of the San Francisco Medical Society either will or will not review our disputed Medicare cases, I would like to know when action is to be taken. It is my understanding that the committee meets on the last Friday of the month and considerable time has elapsed since our agreement and your letter of August 17, 1971.

These patients were all homebound, under definitive medical care and required skilled nursing, with Home Health Aide care as an integral part of the medical plan of treatment. In terms of the types of medical problems and treatment here, we fail to understand the rationale of discontinuing payments for successful care plans as not being "reasonable." helping the physician to keep the patient relatively stable than it would be logical if, once the cardiac has been stabilized on digitalis, that medication were discontinued.

Sincerely,

———,
Director of Nursing.

SAN FRANCISCO MEDICAL SOCIETY,
San Francisco, Calif., November 15, 1971.

MR. DONALD W. BOWDEN, JR.,
Manager Medical Review,
Blue Cross Medicare Fiscal Intermediary,
Oakland, Calif.

DEAR MR. BROWN: I have this morning reviewed two of the nine cases referred to in your letter of Nov. 5, 1971. Forty-five minutes time spent on each file revealed to me that your denials were reasonable based on the clarifications so well presented in HEW Intermediary Letter No. 71–10, dated Nov. 1971. It is equally clear to me that the long impasse and many needless letters between your organization and the HHS resulted from failure to properly and promptly cite the appropriate regulations, but rather to resort to that most offensive weapon, the irrelevant form letter. When HHS finally persuaded you to submit "specific reasons for denial of coverage" they received a comprehensive letter from Mrs. H——— which quoted amply from your medical consultant's comments but, unfortunately, did not refer to the principles in I.L. NO. 71–10, which, had they been used, might well have ended the appeal.

Because, in my opinion, the members of my committee appear to be better acquainted with the law and with pertinent documents than is the fiscal intermediary, I am forced to ask the following questions:

Do you see the proposed conference, which will require from four to eight hours preparation on the part of each member of my committee involved, as a court of appeal in which your opinion will be binding? If so, I shall be willing to review the other cases and in due time to submit them to a subcommittee for deliberation. If such is not the case, then I cannot impose upon the committee members to the extent of asking them to spend the many hours necessary to become thoroughly acquainted with each case. In the latter event it would be better and more honest to inform the appealing agency that it is without further recourse or at least that this committee lacks the authority necessary to make it a valid court of appeal.

Sincerely yours,

FRANCIS J. CHARLTON, M.D.,
Chairman, Chronic Illness and Aging Committee.

BLUE CROSS,
San Francisco, Calif., December 8, 1971.

FRANCIS J. CHARLTON, M.D.,
Chairman, Chronic Illness and Aging Committee, San Francisco Medical Society, San Francisco, Calif.

DEAR DR. CHARLTON: Thank you for your letter of November 15, 1971 regarding the cases from ———— Home Health Services submitted for the Committee's review. We share your concern about the time involved in reviewing cases such as these and endeavor to submit, for the Society's review, those cases where Blue Cross, as a Medicare Fiscal Intermediary, is of the opinion that the comments and opinions of the Committee would allow a more favorable decision for the beneficiary.

Your comments concerning the method of notifying the provider as to the exact reason for the denial are well taken. Blue Cross recognizes the need to effectively communicate at all levels and devotes considerable time to an ongoing training program for providers of services. We believe that the understanding of the Medicare levels of care and their application to an individual case is essential, although the use of exact denial reasons is used occasionally for additional educational value.

Intermediary Letter #395 was issued by the Bureau of Health Insurance in August of 1969. The instructions contained in Intermediary Letter #395 were those in effect at the time the services were rendered to those Medicare beneficiaris whos files you have. Those instructions were released to all Home Health Agencies in December of 1969. Just prior to the release of these instructions. Blue Cross added a Licensed Public Health Nurse to its staff to devote full time to the education and problems of Home Health Agencies. In January of 1970, there was a meeting in Los Angeles under the auspices of the Bureau of Health Insurance, to discuss covered levels of care under Home Health Medicare benefits.

During April of 1971, Blue Cross conducted four Home Health Workshops that were devoted to Home Health benefits under Medicare as they are outlined in the Medicare Law and pertinent Medicare Regulations and Intermediary Letters. These items were again covered at a State-wide workshop in Los Angeles on June 30th of this year. The June 30th meeting covered all items contained in Intermediary Letter #71–10, which had been issued in May of 1971.

In addition to these general meetings to discuss Medicare Home Health benefits, numerous personal meetings were held with the Home Health Services to discuss and answer questions pertaining to the Medicare Law, Regulations and Intermediary Letter #395 and #71–10.

Blue Cross views the education of all providers as an important function and will continue to schedule workshops in utilization review and Medicare levels of care throughout 1972. As before, such meetings will focus on Medicare issues.

It is agreed that, at this point, the nine cases referred to your Committee for review have been reviewed extensively within Blue Cross. As with all claims where a denial action is necessary, the claim has also been reviewed by one of Blue Cross' Medical Consultants. Each review has resulted in a determination that the care provided each patient did not meet Medicare coverage criteria.

Contractually, Blue Cross must apply those coverage exclusions in the Medicare Law, Regulations and instructions, such as Intermediary Letters #395 and #71–10. Blue Cross' Medical Review policies and procedures consider all available medical information in review of those Medicare claims that are reviewed medically.

In the nine cases referred to your Committee for review, we are of the opinion that all information has been carefully evaluated and a fair and just decision has been reached on each case. In reply to your specific question, we cannot consider the opinion of your Committee as binding. The appealing agency will be notified.

We do, however, feel that with your Committee's excellent understanding of the Medicare Law and Regulations, the Committee's recommendation on each case would, in all likelihood, have been the same as our decision.

We appreciate your time spent in the review of these particular cases, and look forward to a continued working relationship in the future with you and your Committee.

Sincerely,

RICHARD D. KLINE,
Medical Review Department Manager.

San Francisco, Calif., December 27, 1971.

FRANCIS J. CHARLTON, M.D.,
Chairman, Chronoic Illness and Aging Committee, San Francisco Medical Society, San Francisco, Calif.

DEAR MR. CHARLTON: Thank you for sending us a copy of your letter of November 15, 1971 to Mr. Donald Bowden of Blue Cross. Since we had understood that we would be invited to the meeting and review of the records, we were somewhat surprised that you had spent considerable time reviewing some of these records yourself.

Your statements to Mr. Bowden regarding the specific denial reasons demonstrate an excellent grasp of some of our complaints to Blue Cross. The other major complaint, however, is that Intermediary Letter 71–10 was not published at the time these patients received services and we were demanding reasons which related to the Medicare Law (89–79) or to the two Federal publications which enumerate the required standards of care provided and the conditions under which a licensed Home Health Agency can expect Medicare reimbursement (conditions of participation—HIM–2 and Home Health Agency Manual—HIM–11).

Some of the nine cases you received were, indeed, appealed due to an irrelevant denial reason which did not relate to the regulations, cited above, which we were privy to at that time. The majority, however, are examples which clearly indicate a care plan requiring the skills of a professional nurse to assess the patient's condition between physician examinations and to continue a care plan (utilizing a Home Health Aide) which was an integral part of the physician's plan of treatment.

The Medicare Law includes 100 visits under the Supplementary Benefits so that visits need not be linked to a hospital. This seems to indicate that the intent of Congress was to meet some of the needs of the chronically ill elderly in " . . . the prevention and/or postponement of institutionalization." The current interpretation by our fiscal intermediary is that care is to be related only to acute episodes and must cease once relative stability is reached.

We would very much like to meet with you or a subcommittee to clarify the differences between the Law, the regulations, and the interpretations of the regulations which severely restrict the physician in providing therapeutic care to his patients.

Sincerely,

Director of Nursing.

ITEM 3. LETTER FROM MARILYN TAYLOR, R.N., HOME CARE COORDINATOR, VISITING NURSE SERVICE, BATTLE CREEK, MICH., TO PRESIDENT RICHARD M. NIXON, DECEMBER 30, 1971

President RICHARD M. NIXON,
The White House.

DEAR PRESIDENT NIXON: I request you take time to read this so that you may know the real situation as it relates to health services available to our over 65 years of age citizen.

I am a registered nurse, have been involved with visiting nurse agencies in one capacity or another off and on for the past 30 years. I am presently serving as agency co-ordinator to five acute care hospitals in our area. We have recently instituted a Co-ordinated Home Care program. I work closely with a nurse co-ordinator in each of these hospitals and we assist families and patients with discharge planning. This planning may result in a transfer to a nursing home, either skilled or basic, a rehabilitation center, and in many cases it logically is to their own home with the assistance and support of the visiting nurse to carry out their nursing needs.

In our area we are fortunate to have the team of Health Professionals to effectively deliver the needed services to patients in their homes. Unfortunately, the rigid restrictions of Medicare guidelines regarding eligibility are hampering our efforts and when we cannot recover payment for such services, the only alternative is to cut services.

The specific case for which we recently were denied payment and prompted me to write this letter goes like this. On August 3, 1971 we received a referral on a 79 year old Mr. B from one of our local acute care hospitals. Mr. B was suffering from cancer of the stomach and his surgeon felt nothing more could be done surgically as he was in the terminal stage of his illness. This man needed a daily enema and on many days it was necessary for the nurse to manually remove the feces from the rectum. His disease naturally, interfered with normal digestion and his diet consisted mostly of dairy products as this was the only type of food he could tolerate. Mr. B was to be discharged to his home with his 81 year old wife if the nurse could go in daily to supervise and support Mrs. B and give the enema. Without this daily evacuation Mr. B was extremely uncomfortable and developed severe abdominal distention.

We accepted the referral and assisted with the arrangements to allow Mr. B. to go home. We had a nurse visit daily (including Saturdays and Sundays) from August 3, 1971 through August 23, 1971. Mrs. B was not able to perform the procedure and there were no other family members we could teach. On August 24, 1971 Mr. B was readmitted to the hospital where he died the following day.

It certainly goes without my saying that this elderly man was more content in his home for these last days than in a hospital. Our charge was $12.00 per visit. Currently in our area, the average cost per day in the hospitals is $110.00. So, from a pure economic view it was a charge of $252.00 for 21 visits by the visiting nurse as compared to $3310.00 for the same period in the hospital.

I have discussed this case with our Medicare representatives in Detroit. I have furnished them with additional information documenting the needs of this patient. We were notified December 23, 1971 that after reconsideration they were maintaining their original position. In other words we have not been able to collect for even one visit to this man.

Now, I might add I am familiar with the regulation that forced them to take this stand. They clearly state they will not pay for cleansing enemas to a so-called basic care patient. Again and again much needed services are denied because of this unfair, unreal, unworkable definition of skilled and basic care. Believe me, Mr. President, the situation is deteriorating daily for the ill over 65 citizen of our great country. There is no way you could know what is happening to these senior citizens unless you personally and other of our elected officials begin to listen to those of us attempting to live within the regulations and still deliver the needed services.

Care of the sick at home is without question the most economical. Reimbursement to Home Health Agencies represents only 1.5% of total paid out under Medicare benefits. It is inconceivable that such agencies must continue to be denied repayment for services by a professional nurse, such as cited in this letter when the alternatives are much more costly and in many cases less satisfactory.

Your personal attention to this matter would be greatly appreciated by citizens throughout our country.

ITEM 4. LETTER FROM MRS. HELEN L. GOODWIN, R.N., EXECUTIVE DIRECTOR, THE GREATER LANSING VISITING NURSE ASSOCIATION, TO MR. CHARLES E. CHAMBERLAIN, WASHINGTON, D.C., JANUARY 27, 1972

DEAR MR. CHAMBERLAIN: The Secretary of H.E.W.'s Committee to Study Extended Role for Nurses "has arrived at certain conclusions and recommends some broad courses of action as guides to all who seek and have responsibility for achieving improvement in the availability and effectiveness of health care for the American people."

This statement from the report of the Committee to Secretary Richardson would seem to indicate a concern for meeting needs of people wherever and at whatever level is necessary. It is one thing to give lip service to an idea but quite another to actually implement it at the grass roots. This is where the billions of dollars spent in formulating "Ivory Tower" concepts fail to result in improved health care of services to people.

We talk about the health care delivery system—the need for innovation to improve the system—to provide the care wherever and whenever needed with a humanitarian approach and yet what is actually happening at the service level is denial of necessary care.

Interpretation of covered care is based on procedure only and inconsistent even then. Knowledge, judgment, assessment skills though considered fundamental to a physician are apparently less fundamental to the nurse. The physician is reimbursed for such skills, the hospital is reimbursed for its care to a terminally ill patient and yet a community agency caring for the patient and exercising assessment and judgmental skills is not reimbursed. What a paradox that the very service designed to maintain the patient in the community whenever possible and to lessen the high cost of medical care is the service, offered on a non profit basis, that is being forced out of business by the restrictive interpretation of covered care (about 1%+ of the cost of Medicare and Medicaid is attributable to Home Care services).

We must somehow help our leadership, our law-makers, our communities to understand what is happening to patient care on the community level before it is too late.

Examples from several agencies of denial of coverage by fiscal intermediary:

Patient I:

Diagnosis: Congestive Heart Failure, Arthritis, Old Hip Fracture.
Physician's Orders: Observation of symptoms and side effects relative to change in medical regime—increase or decrease in edema, respiratory difficulty, vital signs, etc. Techniques to reduce edema. Report to physician.
Reimbursement denied: No specific procedures involved for the ten nursing visits. *If the doctor had made the visits or the patient hospitalized would reimbursement also have been denied?*

Patient II:

Diagnoses: Terminal Carcinoma of the esophagus (Cobalt therapy), Mild Diabetes.
Physician's Orders: Check for fecal impaction—relieve as necessary. Observation and assessment of patient—report to physician. Support to patient and family during terminal stages of illness.
Five nursing care visits made: Admitted to hospital—Expired. Reimbursement denied. *If the doctor had made the visits would reimbursement have been denied? Was the hospital denied?*

Patient III:

Diagnoses: Hypertension—Cerebral Vascular Accident, Urinary Retention.
Physician's Orders: Teach care of patient to housekeeper—vital signs, force fluids, catheter care, intake and output, etc. Supervise care.
Patient expired: Six visits—Reimbursement being questioned.

Patient IV:

Diagnoses: Cerebral Vascular Accident—Behavioral Changes, Urinary Retention
Physician's Orders: Check for impaction—Manual removal (enemas not effective). Catheterization as necessary—Observe for signs of retention.
Patient admitted to hospital: Expired.
Reimbursement denied.

Patient V.—Age 66:

Diagnoses: Sarcoma—(Terminal), Old Cerebral Vascular Accident with left hemiplegia, Rheumatic Heart Disease Arteriosclerotic Heart Disease.

This 90 pound woman was rapidly deteriorating as evidenced by continued rapid weight loss, dehydration, increased pain, poor to no appetite, beginning incontinence. She needed constant care and medication.

The VNA's purpose of four visits was to teach her husband and an auxiliary person *how to provide skillful care to a dying patient.* She was under close medical care.

This service as provided was referred to by the fiscal intermediary as "Activities of daily living" and four teaching visits were rejected.

Patient VI.—Age 91:

Diagnoses—Carcinoma of breast: Metastasis to lungs and skin.

This frail, debilitated lady, with draining area on breast needing careful dressing changes, and several other growths on chest and back that were inflammed and painful, was admitted for care on Medicare B. She needed assistance with hygiene of skin, mouth and particular care to draining and painful

areas. She had poor vision due to glaucoma and was extremely feeble so was for the most part bed bound.

She lived alone and the Visiting Nurse made one visit to teach her to care for herself and encourage hiring an auxiliary person. This one visit was billed to Medicare and documentation of service was requested even for the one visit.

Several additional visits were made due to her increasing needs and she was advised that Medicare would not cover the nursing care she needed and a financial investigation was done showing she could pay $10.00 per visit without cutting into her savings. She became angry with the nurse and said it should be paid for by Medicare and refused to let the nurse return. She died a few weeks later. Telephone persuasion by the supervisor was to no avail. If Medicare would not pay she would do without.

Retroactive denial of reimbursement after services have been offered in good faith that they will be covered (according to criteria in the Home Care Manual) is devastating to an Agency who has incurred the liability and must somehow contend with the budget deficit.

We sincerely hope these concerns of Home Health Agencies in Michigan will be helpful to you in your deliberations in the coming year as you consider health care needs of people.

ITEM 5. PROPOSED LEGISLATION SUBMITTED BY THE CALIFORNIA ASSOCIATION OF THE HOME HEALTH AGENCIES

HOME HEALTH SERVICES

1. A home health agency is a qualified provider:

a. if it is an agency or organization or a subdivision of such an agency or organization;

b. if it is primarily engaged in providing therapeutic services in the homes of patients who are under the care of a physician;

c. if the services are provided under the direct professional supervision of trained health care personnel in accordance with a plan of treatment which has as its objectives, restoration to health, full or partial rehabilitation, the initiation and maintenance of a treatment program for the patient in the home which will be safe and feasible.

Home health services must be directly related to the health problem for which the patient is under the physician's care and include all services which might be provided singly or in combination in an institution or out-patient facility if they can be offered effectively in the home. Such services shall be provided on an intermittent basis but may, in exceptional circumstances, become a full time treatment regime for brief periods, if care of the patient is served. Home Health Services shall not be used as a substitute for appropriate out-patient services or institutional care.

2. A home health agency shall:

a. have written policies developed and reviewed from time to time by a group of professional personnel associated with the agency, including one or more physicians and one or more registered professional nurses, and representatives of consumers to govern the services which it furnishes, and provide for supervision of such services by a physician or a registered professional nurse. Operational matters, related to professional activities, shall be handled by an appropriate subcommittee of the governing group;

b. maintain adequate clinical records on all patients;

c. meet all applicable requirements of the law of the State in which it furnishes services;

d. have written policies and procedures, which provide for a systematic evaluation of its program at appropriate intervals in order to assure the appropriate utilization of services;

e. provide a planned program of continuous in-service training for all of its staff.

FUNDS FOR THE DEVELOPMENT AND EXTENSION OF HOME HEALTH SERVICES

The government has appropriated some funds for the training of home health personnel. These funds have been insufficient in amount and too narrow in scope to help us solve the problems or meet the existing needs of home health care.

Institutions are offered many financial programs that assist with construction of facilities, purchase of equipment, training of personnel, and expansion of service programs as well as direct grants and guaranteed loans. None of these devices is currently available to Home Health Services and financial support should be offered.

Sec. 1. The development of new home health agencies

Grants-in-aid for the development of new home health agencies as defined in Section ——, shall be made available in accordance with the following requirements:

a. Development funds shall be provided in grants for periods of from one to three years.

b. Preference shall be given to communities or areas where such services are not sufficiently available.

c. Funds may be provided to a public or private, non-profit agency which has a governing body on which there is substantial representation of qualified health and social welfare professionals as well as representation from consumer groups.

d. The agency must present plans which provide for on-going community services upon termination of the grant.

e. Plans must include provision by the agency, directly or through arrangements, of all elements of professional and supportive personnel and services considered essential to home care.

f. Agencies established by such grants must demonstrate effective liaison and planning activities with existing health care facilities and resources in the community.

Sec. 2. Funds for the expansion of existing home health agencies

Funds for the expansion of existing home health agencies shall be made available to home health agencies as defined in Section — in order to add new areas of service or to increase the range and effectiveness of services in the home. Such funds shall be provided to add personnel in new areas of competence or to purchase equipment essential to diagnosis or treatment in the home or to increase the effectiveness of services through the provision of mobile equipment. The following provisions shall apply to such funds:

a. Funds to develop new services may be made available for periods of one to three years.

b. New services may be funded when evidence indicates a need.

c. Preference in the funding of new services shall be given to agencies when similar services are not provided elsewhere in the community.

d. Funds for expansion may not be provided to subsidize or expand case load or geographic coverage.

Sec. 3. Funds for the training of home health personnel

Section 1. Home health training facilities which provide approved training to professional and non-professional personnel in the field of home health care may be provided:

a. As an extension of the training curriculum in an existing educational facility.

b. As an organized training program attached to a health care facility or a home health agency.

Section 2. Training facilities for home health personnel must be closely linked to home health agencies and must demonstrate that training is realistically linked to home health service needs. It is highly desirable that basic training be in "traditional" school settings and existing institutions wherever possible.

Section 3. Training subsidies may be made available for faculty, facilities, equipment and for maintenance of trainees when it has been demonstrated that employment will be available for trainees upon completion of training.

Section 4. Grants for curriculum planning and the training of faculty may be made to a training facility or to a qualified home health agency or to a non-profit health or educational facility as sponsor or coordinator of planning and implementation of training programs.

Appendix 5

ATHENS COMMUNITY COUNCIL ON AGING: A MODEL FOR A COMMUNITY-WIDE HOME SERVICES AND TRAINING PROGRAM, ATHENS CLARKE COUNTY, GEORGIA

I. Introduction

The Athens Community Council on Aging (ACCA), a private-non-profit association of service agencies, civic groups and churches, in philosophy, accepts the worth and dignity of all citizens, and feels a major responsibility to assist older citizens in pursuing a worthwhile, meaningful, healthy, dignified and to the degree possible, independent life and life-style befitting our older citizens. It is with a sense of urgency that the ACCA has attempted to develop a multiple services system to provide assistance for our older citizens some of whom, for too long, have been a major neglected group who in their declining, and to considerable degree, helpless conditions, are deserving of more than mere existence.

The ACCA accepts the fact of the increasing population of older citizens, now over 10 percent of the total population. The acute need for coordinated assistance programs or specific services of such programs, by a majority of older citizens cannot be questioned in light of recent Congressional Hearings, research and experiences by agencies such as ACCA.

The only real questions remaining to be answered are: (1) What is the magnitude of specific service needs? (2) Can priorities be determined among these needs and what are they? (3) In terms of organization and finance, how will the priority services be provided?

It is from this base and background that the ACCA is attempting to become a MODEL for the organization and delivery of services to older citizens and an integral linkage between them and other needed services located not only in the Athens area, but throughout Georgia. The following section provides a brief overview of current operations of the ACCA.

II. Comprehensive Home Care and Community Services for Older Adults, Blind or Disabled Persons

PURPOSE AND BENEFICIARIES

The purpose of this service is to provide a range of interlocking services, coordinated and inter-linked with other public and private services, to maintain, strengthen, improve and safeguard home and family life, especially where older adults are involved. Primary beneficiaries will be those individuals in the service area who demonstrate a need for Homemaker/Home Health Aide and the related services listed below. Secondary beneficiaries will be those able-bodied, mature adults, primarily from the MNA, who will receive specialized training and full or part-time employment.

SUMMARY OF PROGRAM SCOPE AND CONTENT

The following components comprise the currently funded expanded services (under Titles XVI & IV–A of the Social Security Act, and the CDA) aimed toward maintaining older adults in their own homes or chosen residence as self-directing, active participants in the community:

Home management, home maintenance and personal care service to those individuals who are determined by the agency to need this service. Homemaker/Home Health Aides will be trained and supervised by professionals under recommended standards set by such recognized organizations as The National Council for Homemaker-Home Health Aide Service (of which the agency is a member).

AUXILIARY HOME SERVICES

Handyman service assists in small minor repairs to eliminate hazards and promote safety and well-being for those unable to do or have done such maintenance. Assistance in moving to better housing. Chore services, such as housework, lawn care, shopping, errands, etc. not requiring a trained Homemaker/Home Health Aide, will be provided eligible persons who because of frailty cannot do for themselves. Loan of wheel-chairs, walkers, sick-room supplies, etc. for those who need them on a temporary basis or have no other way to secure these items for self-care in the home are provided on request.

INFORMATION, REFERRAL AND FOLLOW-THROUGH

This service provides a community-wide source of information and counsel to all aged, blind or disabled and their families without regard to any eligibility requirements. A Telephone "Life-line" is the central point for incoming inquiries and for outgoing "Telephone Reassurance" calls to isolated, homebound persons. Assessment of requests and interpretation of need will be made in reacting to these requests. Referral to the appropriate resource in the agency or community follows. Community Service Aides assist with necessary home visits, escort service to needed services and with follow-through to determine if the individual received adequate care.

COMMUNITY AND VOLUNTEER SERVICES

Staff organizational and coordination assistance will be rendered to established and new groups of older adults in the community. Program services related to consumer protection, money management, improved opportunities for social and community participation, and information essential to providing individuals with alternatives for independent living in times of stress or illness, are arranged for both individuals and groups. Transportation assistance is also provided when available. Staff coordination of Volunteers is made for nursing home visits, residential home visits, transportation and delivery of hot meals and commodities. Location of isolated, needy, frail elderly is a function of "Finder" staff personnel.

HOME DELIVERED MEALS

The agency prepares or secures nutritious meals and delivers one or more hot meal daily to the home of eligible persons who are unable to obtain or prepare nourishing meals.

DAY CARE SERVICES

Day care services will be provided during the day to eligible persons in protective settings for purposes of personal care and to promote the social, health, and emotional well-being of clients through opportunities for companionship, self-education and other satisfying leisure time activities.

TIME TABLE

Expanded services under the provisions of Title XVI were not activated until the sixth month of the current project year. Thus a number of objectives will not be reached until well into the next project year. It is anticipated that three Day Care units will be operational by the beginning of the third project year. Staffing for positions indicated should be nearly complete by that time. Training and Upgrading will occur on a continuing schedule and new Aides will be trained and placed as vacancies occur, services demand and resources dictate.

SOURCES OF FUNDING

Major funding for the project is provided through a contract with the Georgia Department of Family and Children Services under Title XVI of the Social Security Act entitled "Service Programs for Aged, Blind & Disabled" with provision for Title IV–A of the same act where families with dependent children qualify for Homemaker services. This contract is made possible through matching "Donor" funds from Model Cities. The Agency also will receive about $8,200 through the United Fund which with local in-kind is used as matching for a small grant under Title III of the Older Americans Act through the Georgia Commission on Aging

which offers additional technical support in the development of the range of services offered by the Council on Aging. Contributed consultant services through the University of Georgia School of Social Work and the Institute of Community and Area Development are utilized for matching purposes.

The above resources provide a mix of both categorical and noncategorical services to assure that persons in both the MNA and the entire Athens residential area may receive the care they need based upon their individual circumstances. Fees for services will have a negligible part with the more generous provisions of Title XVI and will be employed when unallowable expenditures are not otherwise covered under other resources.

Continuation of support from Model Cities, the Georgia Dept. of Family and Children Services, the Georgia Commission on Aging and an increase in community input is an indication of the recognition of the needs of older citizens and confidence in the planning and implementation capacity of the agency as well as the future for these services which have been now written into the State plan. (Underwriting of Homemaker provisions becomes mandatory for States in 1974) the ACCA, through this project is developing models for training and day care guidelines under Title XVI.

Summary Statement of Objectives

As the ACCA developed its proposal for expanded services under Title XVI the following objectives were identified as important to the long range development of an adequate service delivery system for the community:

1. To determine what is a reasonable cost per unit of service for each category. Based on this experience it is hoped a mechanism for third party payments from both public and private sources will be developed. It is recognized that these services will be mandated by 1974 for public assistance recipients and demands from private sources will be increasing.
2. To develop and provide homemaker/home health aide and related home services according to accepted and established standards as set forth by such organizations as the National Council on Homemaker/Home Health Aide Service.
3. To design, implement and refine a model training of homemaker/home health aides related to Georgia and rural America adaptable to potential operations of a similar nature, including pre-service and in-service classes of varying sizes.
4. To develop a model service operation manual to use as a guide for other potential home services in the State.
5. To increase the number of career opportunities for individuals in all helping professions.
6. To measure the extent to which the promotion of jobs for older adults (50 and over) can be effective in the home service field.
7. To evaluate the impact of home services in the total needs of the community.
8. To enlist, coordinate and bring to bear appropriate existing resources and services within the community which would reinforce the home services.
9. To document and test existing guidelines for eligibility for delivery of home services.

Background: Athens Community Council on Aging

The Athens Community Council on Aging was formally organized on January 9, 1967 as a private-non-profit association of service agencies, civic groups and churches. Through the five years of its existence the Council on Aging has depended largely upon the local church community including the Ministerial Alliance, the churches themselves and Church Women United for resources, direction, and volunteer services. The Council was initially begun with a mix of local and Title III funds administered through the Georgia Commission on Aging, under the Older Americans Act of 1965. Concerned individuals and representatives of the above mentioned groups and agencies created the Council to develop "more effective means of providing services for older adults in the Athens area" as well as to promote means whereby our older adults can find challenging and meaningful ways to become involved in the life of the community and to serve throughout the rich retirement years.

The Athens Community Council on Aging has conducted community surveys to determine the needs of the aging, what services are available to meet such needs, what additional services should be developed, and what resources are available to support needed services. It has served as the community planner for new and improved programs and activities essential to the health and well-being of older adults. It has sought to coordinate existing services to promote efficient and wise use of community resources. The council on Aging operates and generates needed

service programs not otherwise available either on a demonstration or continuing basis.

In 1969, the present Director, Thomas C. Cook, Jr., arrived during the third year of the Council's operation. The Board was reorganized and its programs and activities were strengthened. At the time the Council was going through a survival crisis involving fiscal and operational difficulties, but the people of the Athens and Clarke County area rallied to the support of the Council and community support has been building ever since. In late 1969, the Athens Council on Aging together with the Athens Model Cities designed a program which would meet the needs of older persons living in their own homes and which would strengthen family life by providing Homemaker/Home Health Aide services, starting with elderly persons in the Model Cities area.

Funding from Title III money through the Georgia Commission on Aging, in addition to the supplemental Model Cities Grant, indicated a concern that the needs of older Georgians be met in both opportunities to be employed and served. (Typically, 75% of the clients are elderly.) The Georgia Commission on Aging has given staff time to assist in developing and initiating the project. The project has demonstrated the potential for becoming a model service entity which can be duplicated in similar cities or areas in the State.

Five training sessions have been completed. The aides trained in these programs have been unable to meet the increasing requests for service that have come to the agency. (See p. 145, service growth record.) Since funds for this project are largely generated by Model Cities Funds, the service has been predominately to the Model Cities geographic area, in terms of both employment and service. Expanded services to the entire service area of the ACCA is one objective now made possible with Title XVI Social Security Funds. Aging and all its related problems is not one peculiar to one geographic area, and there is a compelling need to expand home services to the total community.

Cooperation with the Georgia Commission on Aging, Model Cities Department of the City of Athens and local and State department of Health and Welfare has enabled us to provide what has been described as a model service to promote older people being able to remain in their own homes as long as possible.

In 1972, the Council on Aging together with Model Cities as donor of matching funds was able to initiate the first Title XVI service program for aged, blind and disabled in the State of Georgia. This meant that services were multiplied through the matching quality of Model Cities funds and services were not only increased to this target area, but have spilled over into the entire city and county where demonstrated need exists for such services.

Increased visibility, increased support through these city resources plus the inclusion of the Council on Aging into the Athens-Clarke County Community Chest is indicative of the broad support for its many programs which have proved to be a success in meeting the needs of older adults. This creative combination of resources, programs and commitment as evidenced by the plans being generated through a joint committee of the Athens Community Council on Aging and the Christian College of Georgia to promote a learning service center and the broadened scope of direct services including Homemaker/Home Health Aide services; information, referral and follow-through, "telephone lifeline", broader community planning for elderly, the involvement of the University of Georgia's Council on Gerontology, the increasing number of clubs and organizations for older people and now our proposed Day Care for Elderly soon to become operational, gives tangible evidence of the concern of a city for its older citizens and the quality and range of alternatives they may choose.

We believe that the motto of the Athens Community Council on Aging has real meaning for people in our town "Making Life More Meaningful for Older Adults—Building a Brighter Future for All".

The work of our local Council on Aging, including its board of membership and staff and the involvement and backing of the city Fathers and community at large, has reached a point of national recognition and inclusion in such publications as "Recommendations for Developing Retired Senior Volunteer Programs", etc. The Council on Aging will soon be submitting a proposal for our own local Retired Senior Volunteer Program which will interlink with the Athens Voluntary Action Center, which also is backed and sponsored by both the Council on Aging and the Christian College of Georgia.

Athens, Georgia cares for its older citizens, not only that they be cared for when they are unable to contribute actively in the way they always have to the life of the community, but also that they have dignity and become involved meaningfully in the life of the city in which they live.

Home Services

DEFINITION

Why do we need Home Services and what do we mean by this term? It has often been emphasized that home life is the highest and finest product of civilization. In every field of social work, and now in the medical field, the emphasis on maintaining persons in their own home is receiving more and more attention. Not only is the home the place where people can live with greatest peace of mind, but it is axiomatic that it is the most economical for the community. The recent national concern for Health Maintenance Organizations (HMO) reinforces the prevention and primary level of this service.

We have, therefore, initiated in our community a flexible program available to individuals, agencies, physicians and others which will provide services in a variety of ways designed to maintain people in their own homes. Our agency administers a program with a two-pronged approach—one developed to cope with social needs of a family, and the other focused to meet the supportive health maintenance needs necessary to maintain an individual in his home.

WHO NEEDS THESE SERVICES?

The types of problems are many and varied that a service such as we are developing may help solve the following life situations illustrate both the acute needs and the scope of services required.

PREVENTION

Mrs. Y, age 80 years, with only partial vision, is unable to prepare adequate meals for herself. To prevent physical breakdown meals should be prepared for her. With some rehabilitation help she could be taught to deal with her partial vision and keep herself and her home.

Mr. G., age 70, is physically fit but since retirement has been unable to find a role for himself. He is depressed and needs some outside stimulation. Referral to an activities center should be arranged.

A mother of one child has just had her second. This five weeks old baby has had to be admitted to a hospital for lack of proper care and nourishment. This happened with her first child as well. The doctor on the case indicated that all this woman needed was some instruction on how one feeds a newborn and how one gives a baby the tender, loving care that is so essential to proper growth and development. A teaching homemaker visiting this family once or twice a week might very well have prevented a costly stay in the hospital.

PRESERVATION OF HOME LIFE

An older woman with terminal cancer is anxious to return to her home and her husband. They live alone in a small apartment. Medically, there is no reason for her to remain at the hospital. Her husband, although anxious to have her home, fears that he will be unable to care for her alone. After investigation by a social worker it was decided that they could have gotten along very well with the help of an aide two to three hours a week and a nurse's visit once a week.

A young mother about to have a new baby needs someone to care for her other children while she is in the hospital. Her husband is employed but if he is unable to find help at home, he will have to stay at home and care for his children.

A mother in a one parent home needs to be hospitalized for surgery. If help is not available to care for her children they will have to be placed with foster parents.

UTILIZATION OF HOME SERVICES

An older woman has been hospitalized with a cracked pelvis. She is able to leave the hospital earlier with daily home help involving 4 hours of service each day. She is able to walk with a walker and take care of her personal needs, but needs daily help with meal preparation, laundry, shopping and housekeeping.

An elderly male stroke patient can be returned to his home setting earlier if his elderly wife can have help. There is need for physical therapy as well as assistance with personal care of the patient. With an aide to assist 4 hours a day, 5 days a week, the patient can be maintained at home.

Mrs. H. A.: October 27, 1970–current

Age 84. Owns her own home but has no near relatives. A distant cousin lives nearby and can check on her occasionally but cannot assume responsibility for her. Mrs. A. is mobile and can care for her bodily needs but cannot adequately care for her home alone. Recently she reached the point where she would not cook for herself. Her nutrition was so poor the caseworker put her in the hospital to build her hemoglobin up.

Homemaker Health Aide Service increased Mrs. A's time to 4 hours, 3 times a week. The aide cleans house, shops, does laundry, and sees that Mrs. A. has a hot nutritious meal before she leaves. Oh the two days a week that the aide doesn't go in, Hot Meals deliver a noon day meal.

Mrs. A. has been kept out of a nursing home and living in her own home for over a year due to this help. She is in better health now than she had been for a long time.

Mrs. D. M.: February 2, 1971–current

Mrs. M. is 83 years old. She is alert mentally and had physically remained active and able to care for her own needs until a broken hip and a kidney infection put her in a wheel chair.

She lives with a single daughter in a low rent project. Her only income is a combination of Social Security and D.F.C.S.

A married daughter was driving across town to share in her care. Both daughters reported their jobs were in jeopardy because they were losing so much time from work. They refused to consider a nursing home and the single daughter had decided to quit work altogether and apply for welfare. Homemaker Health Aide Service provides an aide 8 hours a day to care for Mrs. M. and to see that her meals are prepared. Both family members have been kept on the job for over a year as a result of the service.

Mr. E. T.: November 19, 1971–current—Age 29

Mr. T. has 4 children, ages 3–8.

Mr. T. wife deserted him and the children and left him in a serious situation. He had no one to help him except an elderly mother who was an invalid. Mr. T. was trying to work an evening shift and keep the children in school. Ho ever, the invalid mother could not continue to sleep away from her own home to be with the children at night. Homemaker Health Aide goes in daily, takes the children to and from school and cares for the house. Mr. T. has been able to remain on the day shift and is slowly getting his and the children's life back in order.

Mr. & Mrs. L.: November 16, 1970–current—ages 40 and 28

Both Mr. and Mrs. L. were blind. They had a baby 3 months old at the beginning of service. A teen age son was of great help but needed to be in school. This couple did many things for themselves but with the advent of a baby some things were difficult. Homemaker Health Aide Service went in and bathed the baby, arranged the food situation to help her prepare what food she could. The Aides always prepared a meal on the day they were there and prepared Mrs. L. for the next days meals. This couple has remained independent in their own home and the son has been able to continue school.

Mrs. P. B.: January 1972–current

Mrs. B. has 2 children which she supports. Her husband is in prison. She used the Day Nursery for the 3 year old but the nursery refuses to care for a child who is on medication. Since this child has suspected cepter fibrosis she is often out ill. The mother's job was in jeopardy and the oldest child, a son, was missing much time from school in an effort to keep the mother working. Homemaker Health Aide Service goes in intermittently when the child is ill. The mother has been kept on the job and the boys grades have improved as he is no longer required to be out of school to help.

Mr. C. W.: December 10, 1970–current—age 71

Mr. W. is semi-invalid with a heart condition who has rapidly deteriorated mentally. His wife wants very much to keep him at home as long as possible. Homemaker Health Aide Service goes in to help her with her duties and sit for her to get out occasionally. A male aide goes in twice weekly to give Mr. W. a

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bath and care for other personal needs. Mr. W. is one of several clients in similar condition who would of necessity be in a mental hospital if Homemaker Health Aide Service did not serve them.

Mrs. M. H.: December 11, 1970–current

Age 85. Lived independently in a low rent project on an income of $110.00 SS and D.F.C.S. She had a daughter who lived across town on a very limited income and in very crowded conditions. She is willing to help but does not have the means. Mrs. H. was able to care for herself and remain active with one day a week service from Homemaker Health Aide Service. On December 19, 1971 she broke her arm and was forced to move in with her daughter. She kept contact with this office by telephone. Eventually she became severely depressed at living under such conditions.

She was allowed to return home on condition that the Homemaker Health Aide Service would go in daily to help her. She has since become more able to care for herself and now only needs 4 hours instead of 8 hours a day. She is very happy to be living independently again.

Studies in Rochester, Syracuse and Binghamton in New York State have shown that about 20% of the patients in hospitals and nursing homes could have been cared for at less expensive levels of care, many of them in home settings. The Coordinated Home Care Program in Rochester, New York has demonstrated that its use can save an average of 21 patient days of hospital care per patient admitted to the program. This resulted in a saving of $890,000 in 1970.

HOW WE HOPE TO MEET THE PROBLEM

We proposed that a Home Services Program be set up along the lines suggested in the chart, p. 144. This expanded program, now in its fifth month of development, is under the supervision and direction of the Board of Directors of the Athens Community Council on Aging. The Executive Director is responsible for carrying out the policies of the board and services.

The Chart shows the functions we plan to carry out. The director is directly responsible for all programs and their evaluation. There are six defined services:

1. Community and Volunteer Services

This agency has rendered catalytic services for the older adult since its inception. Its service in this area has been less than desirable due to lack of staff time. Some of the activities in which the staff has been involved in the last year are:

Organizing of groups and activities.
Cooperation with University of Georgia Human Services Disciplines.
Workshops on activities.
Sponsoring seminars on Aging.
Stimulation of existing agencies to initiate or improve services to elderly.
Cooperation on Pre-White House Conference on Aging 1971.
Joint Planning with Christian College of Georgia for "National Institute for Life Enrichment"—a learning service center for older adults and practitioners.
Comprehensive Health Planning (with NEGAPDCO).

These activities are not complete. With additional staff the services in this area could be greatly enhanced. A full-time coordinator and a field worker have been hired to concentrate on this program. This coordinator with the assistance of the Volunteer Committee, recruits and trains volunteers that assist in all functions of the agency program. Volunteers are used in a number of different ways and are assured of a good experience personally in addition to rendering valuable and needed services, with staff assistance when needed. A major effort is made to effectively use this volunteer assistance.

2. Field Service

Since the future for home services is one of expansion and growth, the homemaker/home health aide service should be in a free standing position. The future for third party payments for aide service is bright. This can be documented by the fact that a large commercial pharmaceutical company, UpJohn Inc., has purchased a franchise operation formerly known as Homemakers, Inc., and plans to operate offices across the nation. At this time they are operating more than 100 offices and by 1974, when homemaker services become mandatory in all States, 400 offices will be opened. They plan to deliver aide service to the homes of our country on a fee for service basis. It was the conclusion of this company,

following a study in 1969–70, that the future delivery of health service in the United States would include home services as an acceptable level of care and that this would be included in our future health insurance packages.

With this as background it is wise to base fees for the field service on the costs that are incurred for placing the aide in the field (wages plus fringe benefits) plus administration. This fee should not include the training costs nor any expensive professional or para-professional overhead that the agency has on its staff.

Fees must be realistic and competitive. The commercial firms will use the existing training facilities, graduates, schools, agencies, hospitals, and place the person in the field. Their fees will be based on costs, plus administration, which will include a margin for profit. If the non-profit voluntary sector is to take advantage of third party payments, they must be in a position to present their costs on the same basis the commercial agency does and take advantage of not having to plan for a margin for profit. In this manner the non-profit organization should be a force to reckon with.

At this time there are 50 trained homemaker/home health aides functioning in Athens-Clark County. These aides have provided home services predominantly for people needing assistance in the Model Cities Area. In the first 18 months of operation, the needs of the elderly have been so great and acute that the staff has had to concentrate its efforts in meeting the most urgent needs. However, there are many gaps in service that have been identified and should be met in other areas, e.g., child care. The aides have served in emergency situations in homes with children where mothers have been unable to care for their families, but due to lack of an adequate number of aides, the most urgent requests are the only ones that have been served. We are now in the process of modifying our staff pattern to include one full-time placement assistant to coordinate and place these aides. A registered nurse is being hired to coordinate health services. Her responsibilities will include the three functions of health training for aides, the supervision of health services, and the provision of direct skilled nursing to day care clients.

3. Auxiliary Home Services

The third program area being developed is Auxiliary Home Services. During these first months of operation the need for teaching home management, child rearing practices and budgeting has been documented. The agency has four field counselors and four community service aides on the staff. We are augmenting our staff with several home maintenance aides and two handyman drivers.

Within this function, a Telephone Life Line Service has been initiated. This is an answering and phoning service which eventually will operate on a 24 hour basis. The types of functions that can be performed in this area are:

Daily phone contact with older persons living alone.
Information and referral.
Emergency life line or "Hot line".
Answering service for other related agencies.

To further this type of service two persons will be hired to cover the phone outside the regular working hours. These could be handicapped or elderly persons.

There should be some flexibility for growth and change allowed in this function. It can be expected that the field counselors and community service aides will listen to the residents they are serving, and where needs are identified, provision can be made to meet the needs as they are brought to the staff and board's attention.

The agency has acquired three vehicles for service use: a 12 passenger van, and two 9 passenger station wagons for client and staff mobility and the delivery of meals and equipment to homes.

4. Training and Upgrading

Training of homemaker/home health aides has been a function of this agency. Five courses have been conducted by professional staff personnel with nurses, social workers, and home economists on a contractural and consultant basis. These courses will be continued intermittently to train the additional personnel needed to expand and replenish the field service.

A training manual for the course is being developed that can be used locally or with equal effectiveness in surrounding counties. (It is wise to recruit and train in areas where the service will be used and needed.) The Athens Community Council on Aging's aide service has had experience in training of aides and could, with adequate financial support complete the development of such a manual and

transport the course to other communities. While some material is already available from other States, our experiences have shown that a tailoring of coarse materials to fit the characteristics of the area of service (here, basically non-metropolitan urban with rural fringes) is a must.

In addition, there should be additional training developed for any personnel who might be upgraded to the positions that will become available in the Auxiliary Home Service. If upgrading is not possible, training must be developed for new personnel who may be coming into the agency to fill vacant positions. In-service training on a monthly basis for all staff is another area that must be developed.

A full-time coordinator of training has been hired to develop and conduct training whenever needed. There is a budget for consultants for training to be used by the coordinator to meet the needs of expanded training.

5. Day Care

Identified early in the project as a needed service for more effective care of many individuals now receiving individual care in the home, is day care. Because of this and in response to requests from model neighborhood residents to include day care, it was added to the proposal now funded through the Title XVI program under contract between the ACCA and the Georgia Department of Family and Children Services. At present, a pilot unit adjacent to the offices of the ACCA is being furnished in an extensively remodeled old home. A variety of services and activities is being developed, including nutrition, health, recreational, educational and social services. Projections of plans include two additional units, one to be placed in East Athens and one in West Athens. These will be operated as satellite units sharing certain staff services with the central day center. We are hopeful that a modular unit can emerge and be reproducible in other areas as we gain experience.

6. Nutrition Services (Home delivered meals)

Inserted in the project out of demonstrated need and as a means whereby a greater number of clients could be served, hot meals delivered to the client's home are now a most effective function of the ACCA. Expansion of this program will accelerate when our demonstration kitchen is completed. Located in the pilot Day Care Center, the kitchen will serve as preparation point for both day care meals and to dispatch volunteers and staff personnel with nutritious meals to those unable to prepare them at home or where an aide is needed only for nutrition service and can be released for serving another client. We are utilizing the surplus meals of the College Avenue Day Center for Children and the Pattie Hillsman School. These meals are purchased for a nominal fee, packaged in insulated containers and delivered hot to the client. Additional meals and special diets are prepared by staff daily and on holidays when school cafeterias are closed. At present we are serving from 40–50 clients one meal a day, five days a week.

The six functions described above are the major direct services that the agency delivers. These are the cost centers identified for functional budgeting.

Functional Budgeting

All services in the field of social welfare should consider the advisability of being able to tell what each service costs. (Cost accounting has been a must with the business community for years.) It is imperative that the social welfare field consider it a must at this time. For the first time in its history, third party payments will be available for the services. The cost of service must then be a true cost (including administration) as well as being a realistic one. It follows, then, that if we are to charge for aide service we must know the cost of placing that aide in the field plus per unit costs of administration. It is not realistic to include in this cost the costs of training the aide, nor the cost of all the social services and medical services that may also be part of the agencies program.

To functionalize one program, is to know what the various services are that an agency delivers. When these are identified and defined the number of cost centers will correspond to the number of services identified.

Upon identifying the cost centers, the professional and para-professional staffs of the agency must keep a time sheet if they are working in more than one of the identified services. Based on these time sheets, the salaries of the personnel are charged to each of the cost centers. All other costs that can be charged to the specific centers should be so charged. All other costs are placed in management or administration.

Any income that the agency derives should also be placed in the proper cost center. As one instance, if the agency is reimbursed for training costs, such income should be placed in that cost center.

When income and expense items have been placed in the proper cost centers, the amount that has been allocated to administration or management must be prorated to all the service cost centers. The percentage figure that is used for proration is the percentage of personnel time that has gone into each cost center. The net balance figure for each cost center is the operational surplus or deficit for that cost center.

DEVELOPMENT AND EVALUATION

The agency recently hired a full-time coordinator for evaluation of existing functions, and to be involved in the development of the expanded services and evaluations of all components of the agency. The staff of this department is a direct responsibility of the executive director. Clerical or secretarial assistance is provided plus a budget for consultants.

STAFFING PATTERN

The Board of Directors of the Athens Community Council on Aging, Inc. sets policy and procedures for the agency. They hire the Executive Director to implement and carry out the policies and procedures approved by the Board.

The Executive Director is responsible for hiring all other staff. The Director may delegate responsibility for portions of the agency program. Those functions that will be a direct supervisory responsibility of the Director are: General Administration, Development, Evaluation, Technical Services, Volunteer and Community Services, and Training and Upgrading.

The Supervisor of Home Services is responsible for directing, coordinating and supervising the Field Service and Auxiliary Home Services. The Supervisor of Home Services is directly responsible to the Executive Director. Since Training and Community and Volunteers Services may provide staff to the Home Services, the personnel of these three areas in particular have to cooperate and meet in staff conferences on a regular basis.

WHY A VOLUNTARY AGENCY?

1. It is a free agent to purchase services wherever and whenever the need arise.
2. With no political ties, it is able to serve the total community and not be totally subject to administrative or legislative restrictions.
3. In a report prepared by the Michigan Hospital Service (Blue Cross) in 1964 concerning their participation in home care programs, the following statement was made:

"From the Blue Cross standpoint, it is preferred that in communities where there is more than one hospital, community-wide planning be done to make the service available to all Blue Cross subscribers of the area in need of such service, rather than to those discharged from only one of the hospitals."

4. A voluntary agency may administer a fee schedule of payments from its clients with ease.
5. Policy direction in a voluntary agency with a representative board, including the professions and interested public, can be more viable and more readily adjust to changing situations.
6. A voluntary agency is more likely to marshall the full support it needs from patient, physician, welfare agencies and insurance carriers.
7. Public agencies generally have a greatly restricted clientele, whereas the private agency may utilize public and private resources to open services to all.

Our older citizens are not in the habit of asking for services. They comprise a silent 10% of the population when it comes to speaking up for personal services. They have largely been schooled not to ask because they, as a group, never had their needs adequately met. Now we have National policy directed toward meeting their needs, hence, we must find, develop, and extend new services to this vulnerable segment of our society.

These services must be comprehensive (in the specialized sense that the package of services must be indigenous to the needs of the older population) and cover a wide range from those needed by the self-directing to the totally dependent person—e.g. pre-retirement, retirement, life enrichment activities, health maintenance, home health aides, homemaker services, prescriptive hospital and nursing care, and finally institutional care, when, and only when it is the only alternative.

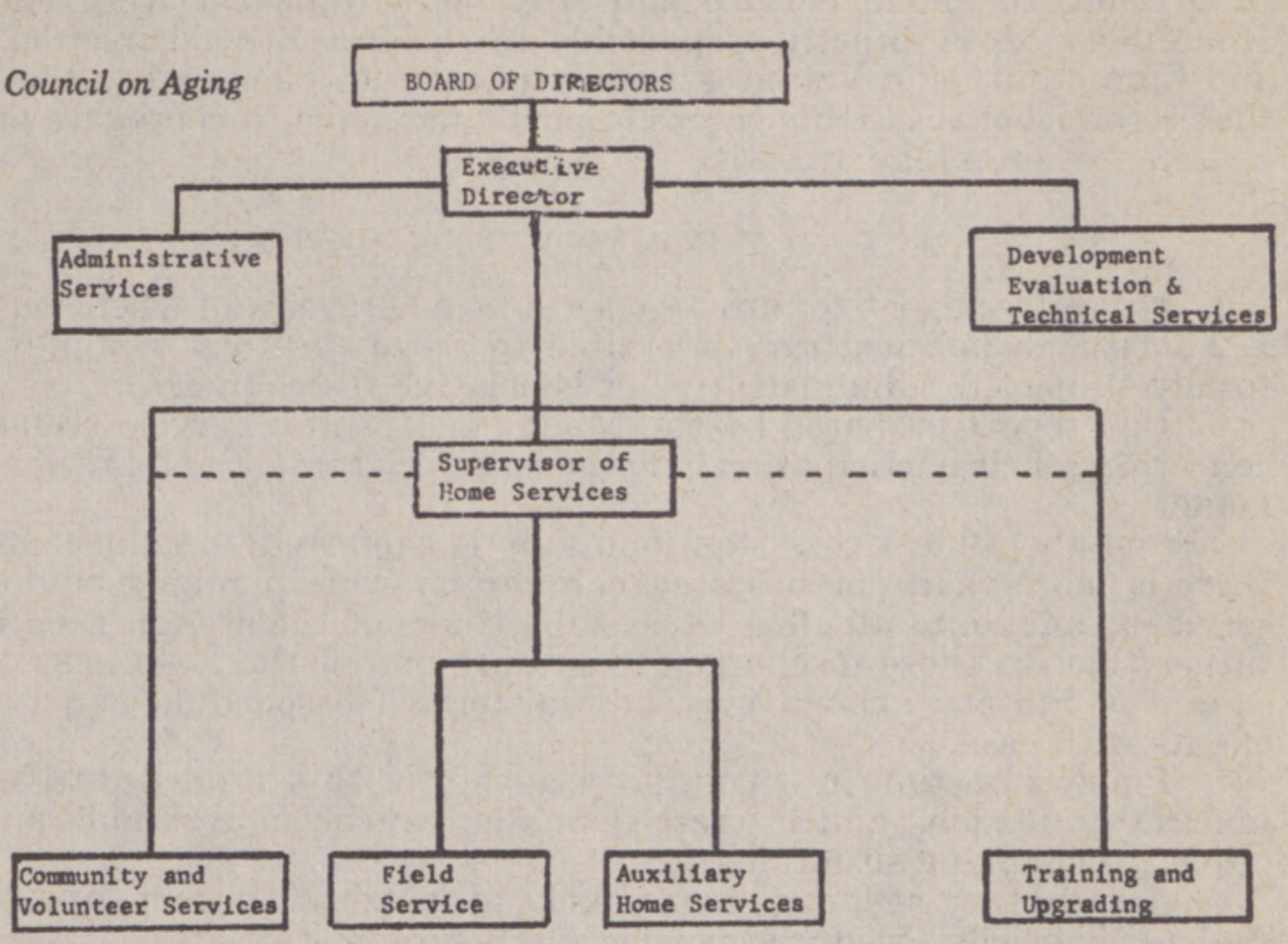
The model currently being developed by the Athens Community Council on Aging seeks to provide "barrier free" services to the extent now possible with the mix of resources and programs available to it. What is most important is that services are now being provided where once (not long ago) none such existed.

Measurement of effectiveness, cost/benefit ratio etc. is not done easily. What we do know is that many elderly persons are alive and well cared for where once they just died unattended for lack of appropriate help—institutional or otherwise. They were invisible to the community.

PLANNING VS. DELIVERY?

One of the new combinations possible because of new re-formulation of health and social services is the possibility of testing new original patterns for the planning and delivery of social and health services. In the past, it has been considered a policy guideline to separate out operational and planning services because of the tendency for operations to swamp the planning function. It is now possible to experiment with "vertical linkage" whereby the various services of prevention and rehabilitation of aged can be brought into the administrative purview of one agency which would necessarily have a planning function in order to maintain interlinkage of services and would have the capacity of assuming the role of planning advocate for developmental and remedial services for the aged. Specifically, this unites the traditional planning function of the Athens Community Council on Aging with the operating responsibility of the direct service agency. Organizational differentiation along the vertical axis will involve a management-resource allocation system that will be attuned to the needs of the older population and therefore, perhaps be better prepared to contribute to full scale community planning since it will represent sources of need and data whose absence has led to an inevitable distortion of community planning.

Athens Community Council on Aging



STAFF MEMBERS IN EACH SERVICE

Administrative Services
Assistant for Administrative Services
Fiscal Manager
Secretary
Clerk-Typist

Development, Evaluation & Technical Services
Administrative Ass't for Development & Evaluation
Clercial staff
Consultants

Community & Volunteer Services
Coordinator

Field Service
Assistant for Field Service
30 full time Aides
30 part time Aides

Auxiliary Home Services
4 Field Counselors
4 Community Service Aides
2 Telephone Life Line Staff
2 Home Maintenance Aides
1 Driver
1 Handyman

Training and Upgrading
Supervisor & Coordinator
Consultants

HOMEMAKER/HEALTH AIDE SERVICE—SUMMARY OF PATIENT/CLIENT FILES

Month	Number of clients	Visits per week	Hours per week
December 1970	75	191	401
Inactivated	−13	−58	−27
December balance	62	133	374
January 1971	62	133	374
Gains	14	27	115
Total	76	160	489
Inactivated	−6	−17	−86
January net	70	143	403
February 1971	70	143	403
Gains	8	28	123
Total	78	171	526
Inactivated	−5	−13	−38
February net	73	158	488
March 1971	73	158	488
Gains	8	24	97
Total	81	182	585
Inactivated	−2	−3	−9
March net	79	179	576
April 1971	79	179	576
Gains	15	34	167
Total	94	213	743
Inactivated	−2	−10	−50
April net	92	203	693
May 1971	92	203	693
Gains	10	32	139
Total	102	235	832
Inactivated	−1	−5	−40
May net	101	230	792
June 1971	101	230	792
Gains	8	34	107
Total	109	264	899
Inactivated	−2	−10	−50
June net	107	254	849
July 1971	107	254	849
Gains	1	2	4
Total	108	256	853
Inactivated	−5	−12	−35
July net	103	244	818
August 1971	103	244	818
Gains	11	40	81
Total	114	284	899
Inactivated	−12	−33	−112
August net	102	251	787
September 1971	102	251	787
Gains	4	14	41
Total	106	265	828
Inactivated	−1	−2	−6
September net	105	263	822
October 1971	105	263	822
Gains	22	57	187
Total	127	320	1,009
Inactivated	−3	−10	−25
October net	124	310	984
November 1971	124	310	984
Gains	11	25	95
Total	135	335	1,079
Inactivated	−14	−40	−125
November net	121	295	954
December 1971	121	295	954
Gains	16	48	136
Total	137	343	1,090
Inactivated	−3	−11	−32
December net	134	332	1,058
January 1972	134	332	1,058
Gains	28	84	320
Total	162	416	1,378
Inactivated	−2	−8	−32
January net	160	408	1,346
February 1972	160	408	1,346
Gains	18	63	230
Total	178	471	1,576
Inactivated	−1	−2	−8
February net	177	469	1,568

Note: In addition to homemaker health aide service: Community Service aides—260 clients received 918 hours of service for the month of March 1972. This represents assistance with doctors' appointments, paying bills, grocery shopping, and etc.

SEPTEMBER 1971—CLIENTS SERVED BY SOCIAL SERVICE WORKERS ("COMMUNITY SERVICE AIDES")

Beadie Alexander	93
Ruby Howard	83
Viola Galloway	73
Visits for month of September 1971	249

OCTOBER 1971—SERVICES RENDERED BY SOCIAL SERVICE WORKERS

Beadie Alexander	97
Ruby Howard	102
Viola Galloway	72
Services rendered for clients in October 1971	271

NOVEMBER 1971—SERVICES RENDERED BY SOCIAL SERVICE WORKERS

	Clients	Services
Beadie Alexander	32	45
	34	62
Viola Galloway	19	28
	30	43
Ruby C. Howard	24	35
	28	32
Joe L. Sorrells	7	13
	3	3
Total	177	261

DECEMBER 1971—SERVICES RENDERED BY SOCIAL SERVICE WORKERS

Beadie Alexander	87	113
Viola Galloway	45	77
Ruby C. Howard	52	103
Joe L. Sorrells	47	47
Total	231	340

JANUARY 1972—SERVICES RENDERED BY SOCIAL SERVICE WORKERS

Beadie Alexander	77	102
Viola Galloway	49	86
Ruby C. Howard	44	108
Joe L. Sorrells	102	136
Total	272	432

FEBRUARY 1972—SERVICES RENDERED BY SOCIAL SERVICE WORKERS

Beadie Alexander	62	122
Viola Galloway	44	90
Joe Lanier Sorrells	70	141
Myrtice Strickland	36	67
Ruby Howard	48	102
Total	260	522

Appendix 6

WIDESPREAD HOME HEALTH CARE NAMED A STATE NECESSITY

[From *Age in Action,* West Virginia Commission on Aging, November-December, 1971]

Dr. N. H. Dyer, Director, West Virginia Department of Health and member, West Virginia Commission on Aging, feels that " *** the most neglected area of health service is home care.

"If adequate health services to patients in their home could be made available, we will have helped greatly in meeting some of the real needs the elderly face in dealing with their health problems," he wrote in the November 25, 1971, *State of the State's Health.*

Thousands of the State's senior citizens spoke out in more than 300 Older Americans Community Forums, naming their main needs as adequate income, health care and transportation.

The regional White House Conferences on Aging and the State Conference emphasized the need for improved health care for the elderly.

One of West Virginia's proposals on health care states: "Fewer than 25 percent of our counties have home health services, yet such care is essential if older men and women are to remain in their homes. These services should be extended throughout the State, and physicians should be encouraged to make referrals. Without home health care, our people are being deprived of services covered in large part by Medicare."

In 1966, legislation was passed authorizing health departments to provide home health services. Sixteen home health agencies in local health departments were certified to provide care to patients covered by Medicare in 21 counties. "Seed money" for this effort was available from the Public Health Service.

However, due to financial problems and lack of patient referrals, two home health agencies are discontinuing the program. These agencies offered services in an eight-county area. There are presently 11 home health agencies in local health departments serving 11 counties.

Many people working with the elderly have misconceptions about the health of older persons, Dr. Dyer feels. The aged enjoy reasonably good health—only 5 percent are in health care facilities and 14 percent of the noninstitutionalized elderly are totally unable to work or keep house due to a chronic condition.

"This may look like a rosy picture," he continued, "but when several variables are added, the picture becomes out-of-focus. One variable of significance is that those 65 and over are the fastest growing poverty-stricken age group in our society. Other factors influence the health care problems of the elderly: (1) Are services available to meet the needs of the 14 percent who live in the community, but who have major health problems that prevent functioning within their normal limits? (2) Are there services available to maintain the relatively healthy aging who are able to function with few or no limitations? All too often, the answers to these questions are a qualified 'no.' "

In general, he wrote, the aging need health services that are comprehensive, coordinated and continuous. Comprehensive service is a total range of service that is available and accessible to meet all known needs of the older person and his family. Coordinated service is a service that is assembled into an appropriate package for each individual and is available to fit the needs of the individual and his family. Continuity of service is a service that is provided without interruption.

The need for this type of service is reflected in another of the State's proposals for the White House Conference on Aging: "We need a coordinated health service system at the Federal, State, and local levels which would provide both long-term and short-term care for the physically and mentally ill aged * * *. Such a health system would stress, (among other things) home health care as a necessary means of helping older people stay out of institutions and would involve home health aides, homemakers, and volunteers."

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