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HOME HEALTH SERVICES IN THE UNITED STATES:

A WORKING PAPER ON CURRENT STATUS

(Together with Recommendations
and
A Summary of Proceedings from a Conference:
"In-Home Services: Toward a National Policy,"
Columbia, Md., June 1972)

PREPARED BY THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

JULY 1973

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(Prepared by Brahna Trager, Home Health Consultant)

PREFACE

"We must provide the older adult with better opportunities for choice than is presented to him at the present time. One of the messages that has come through to me, quite loud and clear, from older adults is: 'We want to be put in a position where we can make our own decisions relative to our own lives. We don't want other persons making these decisions for us.' So it seems to me that it is important for us to provide older adults with a variety of choices."

—Dr. Arthur Flemming, Chairman of the 1971 White House Conference on Aging and now U.S. Commissioner of Aging, in his closing address to the Conference: "In-Home Services: Toward a National Policy."

Perhaps the need for the "choices" mentioned by Dr. Flemming are nowhere more vital than in the health care resources available to older Americans.

And yet it has become commonplace to observe that the elderly of our Nation are especially hard-hit by overreliance upon institutions—hospitals, as well as nursing homes—and intensive "crisis" treatment rather than sustained treatment to maintain health or keep chronic illnesses in check.

Clearly, in-home health services would play a major role in any comprehensive system capable of providing the options that older persons, as well as members of other age groups, should have.

For that reason, the Senate Special Committee on Aging last year published a report, written by Miss Brahna Trager, on *Home Health Services in the United States*. An authority of long-standing in this area, Miss Trager concluded that home health service agencies in the United States are laboring under serious difficulties, including restrictive Medicare policies.

Miss Trager, asked by this committee to update last year's findings, has written the following brief report.

Unfortunately, she must conclude that the difficulties still exist. In fact, the number of home health agencies in the United States has actually declined within the past year, and Medicare still causes serious problems for present or potential providers of in-health services.

In direct response to the regrettable situation described in this committee's home health report last year, a group of specialists in the field of home health care convened at Columbia, Md., for a conference on in-home health services. The recommendations, printed in part 2 of this report along with a summary of the proceedings, should have challenged the Federal Government and private resources to awaken to the desperate need for broader and better in-home services.

Furthermore, the Columbia conference participants made a vital point worthy of national note. They emphatically declared that they did not consider in-home services an "alternative" method of care. The community, rather than the institution, was seen as the primary site of care, and the array of services provided in the community are intended to make appropriate choices possible rather than to substitute one method of care, necessarily, for another.

The Columbia recommendations and Miss Trager's latest findings are worthy of careful attention at a time when considerable lip service is paid to the concept of "alternatives to institutionalization."

To help the Committee on Aging to arrive at its own findings and recommendations, the following report is therefore printed as a working paper and source book of helpful information.

FRANK CHURCH,
Chairman, Special Committee on Aging.

EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly.

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PART 1

HOME HEALTH SERVICES IN THE UNITED STATES: CURRENT STATUS

(By Brahna Trager[1])

Concern about inadequacies in health care throughout the United States can be expressed in either of two major ways.

One is the dollars and cents concern. As medical costs rise, so does discussion about methods to reduce those costs.

Another approach to reform is followed by those who are disturbed by the "human" aspects of the problem. They see individual persons who face inconvenience at the least and outright denial of services at the worst.

Starting from these basic concerns—the "dollar" facts and the "human" facts, there is a curious similarity in the conclusions which are becoming increasingly evident: *An approach must be made to the delivery of health care which is more rational and which meets the needs where they exist with appropriate measures of care, including those services that can be delivered effectively in the home.*

Incongruities in the present health delivery system are focussing more and more on stimulating alternatives to traditional health care.

A recent General Accounting Office report[2] typified the growing criticism of present practices by saying:

> There is a consensus among health care authorities that about 25 percent of the patient population are treated in facilities which are excessive to their needs. The health care system is oriented primarily toward treatment of the acute phase of illness and does not offer a complete spectrum of health care by providing available alternatives to acute care, financing for the alternatives, and educating physicians and patients in acceptive alternatives.

Noninstitutional alternatives referred to in the GAO report stress aggressive approaches to prevention, treatment in "the most appropriate, least costly facilities," and "alternative medical care delivery systems that result in less use of hospitals."

Among these "alternative" delivery systems, home care is described:

> Home care advocates have long cited this method of health care delivery as a mechanism for reducing hospital costs.

[1] Miss Trager was the author of a report, *Home Health Services in the United States*, published in April 1972 by the Senate Special Committee on Aging.

[2] "GAO Report." Study of Health Facilities Construction Costs. Report to the Congress by the Comptroller General of the United States. Nov. 20, 1972, ch. I, p. 10.

> Home care can be viewed as meritorious by itself in that it provides the most appropriate care to the patient at the level which best fits his needs. Patients on home care also pay a good deal less than the rate they would have to pay in a general hospital, and there is a growing sentiment among medical economists that a well-conceived home care program could make unnecessary the construction of a substantial number of new general hospital beds. One source estimated that a home care program with a caseload of 50 patients could be an adequate substitute for construction of an equivalent number of hospital beds occupied by patients who require home care but not hospital care.

In the report "Home Health Services in the United States",[3] home health services of "good quality" are described:

> 'Home health services of good quality' describes an array of services which may be brought into teh 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 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.* (Author's emphasis.)

It was pointed out in the same report that such services were limited in their availability; many communities had not developed home health programs at all; many offered only those services required as a condition for certification by the Medicare insurance system; those which participated in the Federal insurance system (Titles XVIII and XIX, Social Security Act) had experienced serious difficulty in providing services because the requirements of the system with respect to eligibility for home health service were unrealistic and interpreted in a variety of approaches by claims reviewers in various areas; paper work, retroactive denials, delays in claims approval had driven many community service programs from the field, had forced them to reduce staff and services, or had resulted in refusal to serve recipients when the third party payor was the insurance system.

During the period since the report was issued, the situation as described has continued. The number of "certified" home health agencies at the end of 1972 is reported to be 2,221; the figure given as of 1970 was 2,350, and as of December 1971, 2,256. The situation with respect to Medicare expenditures still indicates a marked increase in hospitalization (an estimated 9.4 in 1972 over 1971) with no significant increase in expenditures for home health services or the percentage of over-all expenditures for home health services. (See exhibit C, appendix 1, page 54.) Agencies also report a steady attrition of staffs and services because of fiscal problems, many, but not all, of them related to the insurance system.

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[3] *Home Health Services in the United States*, a report, April 1972, U.S. Senate Special Committee on Aging, p. 5, prepared by Brahna Trager, Home Health Consultant.

The situation remains one in which new home health services cannot be developed in communities or areas where they are not now available because no funding mechanism exists for their development. Agencies which have already been organized are unable to expand the area of services which would make them effective as "alternative" community care systems without funding assistance. Agencies and communities have been forced to conclude that however desirable home health services might be and however effective they might be in reducing the cost of inappropriate institutional care they cannot exist entirely on the basis of third party reimbursement. They cannot maintain their present status nor can they expand when much of that third party reimbursement is bound up in a frustrating and expensive set of paper procedures.[4] Fee-for-service by which full cost may be reimbursed from the "private sector" is not reliable as a financial base either for program development or expansion, and reimbursement from the private sector does not solve the problem for that part of the population which has the greatest need for the services.

It has been demonstrated that however much communities might see the need for the development of home health services, funding from voluntary sources cannot be secured in any significant amounts because equally imperative pressures from other areas of the community draw on available funds. In any case, a community system which intends to meet the needs which have become evident for those inappropriately institutionalized, or for those who are at home whose disability is limiting, cannot rely upon casual, or charitable, or sporadic funding sources. Just as the "bricks and mortar" approach was developed with hospital funding, so must the community network which will provide home care and ambulatory care be seriously tackled with the idea of building an important component of the health care system.

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[4] Fiscal Intermediaries and home health agencies, excerpt from American Hospital Association, Minutes, Committee on Home Health Services Assembly of outpatient and home care institutions, meeting of June 27, 1972:

"Some home health agencies continue to experience many difficulties with the fiscal intermediary process. Some of the committee question whether the administrative structure for claims review which has evolved under Medicare is not overly cumbersome, expensive and inadequate.

* * * * * * *

"Some fiscal intermediaries are paying only a part of the prescribed treatment and are thus reversing physician-ordered treatment which the agency had carried out. Some intermediaries ask for medical information in addition to what is sent in on claim forms. Variations between different Blue Cross Plans in their determination on home health agency claims persist as a major problem. Many plans lack professionally trained and experienced claims reviewers. Miss Brown stated that when intermediary operations are reviewed a prime area of interest is the intermediary's rate of claims denied, i.e. billings vs. non-payments. This is seen as being an indication of the adequacy of the intermediary's administrative controls when in fact, the intermediary may have educated the agencies about what are covered services so the agencies are billing only for covered services. The chairman was advised by the Blue Cross Plan in Denver that she must have some claims denied. She questioned the need to file claims knowing they would be ineligible for payment, in order to increase denial rate. The committee would like information on the number of retrocative denials of claims which are reversed after rehearings.

* * * * * * *

"The Secretary has brought the problems agencies were having with intermediaries to the attention of the Medicare Division of Blue Cross Association, since BCA is the prime contractor for the plans. There was staff recognition that too little attention had been paid to helping plans do a better job with home health agency claims review. Written materials, educational programs for the Plans and use of personnel from Plans with good experience in home health agency claims review as consultants to other Plans were identified as ways of improving the situation."

In the immediate future there does not appear to be action which will improve the present situation. Among the major recent legislative (H.R. 1, P.L. 92–603) and regulatory changes:

(SEC. 203)

1. Medicare premiums will be increased.

(SEC. 204)

2. Increased individual financial participation will be required for the Part B (Supplementary Medical Insurance) deductibles.

(SEC. 208)

3. The medically indigent will be subject to monthly premium charges under Medicaid.

FED. REGISTER, SEC. 222.46; FED. REGISTER, VOL. 35, No. 230, Nov. 26, 1970; ELIMINATED

4. Homemaker/home health aide services, an important component of non-institutional community care will not, as previously provided, be maintained as one of the special services which must be provided by the Social and Rehabilitation Services. They will become "optional".

The stipulation that quality must be assured through the requirement that such programs meet those of national standard setting organizations has disappeared.[5]

(P.L. 92–603; SECTIONS 213, 228)

5. The "assurance" of payment section (section 228) and "limitation on liability" section (section 213) will place an additional financial and administrative burden on agencies whose existence is already threatened by financial and administrative problems related to titles XVIII and XIX. (See exhibit D, appendix 1, page 55, for comment.)

6. The requirement that entry into the home health service benefit via the 3 days of hospitalization has been retained in the insurance system.

The contradictions in this approach are immediately apparent: It is an approach which expects to reduce costs by increasing premiums. It is an approach which penalizes those sectors of the population whose need for medical care is the greatest. It is an approach based upon the expectation that financial penalties imposed upon the most vulnerable population groups will deter utilization of health facilities when such deterrent action can only

[5] "Dr. Weinstein stated his opinion that the only criteria for controlling abuses should be (1) medical necessity as attested to by physician orders, (2) responsible agency administration, and (3) utilization review." Harry Weinstein, M.D., M.E.D., Director of Mt. Zion Home Care Program, San Francisco. Minutes, committee on Home Health Services, Assembly of outpatient and home care institutions, AHA, meeting of June 27, 1972.

increase need; reducing utilization of health care in times of need can only produce more serious need. It is an approach which suggests the use of alternative patterns of care without offering the possibility that such alternative care can be made available. It suggests culpability in a number of groups: Physicians, institutions, providers of such "alternative" care as is available; consumers. In fact the delivery system itself is the culprit; all other groups have been forced to make use, appropriately or inappropriately, of what was available in time of need, and there is very good evidence that large numbers in the population are going without care because what they need is not available at all.

THE COLUMBIA CONFERENCE

On May 31, 1972, at Columbia, Maryland, a group of specialists in the field of home health care convened for a conference entitled: "In-Home Services—Toward a National Policy".[6] The title "In-Home Services" was intended to broaden the approach to care in the community, extending it beyond the very limited, narrowly interpreted "health related services" which has become a minimal approach to care. The "In-Home Services" approach emphasizes the development of an array of services which could provide care in a continuous, coordinated fashion offering to both professional and consumer a broad enough range of options so that viable care in the community could be made available for individuals at all three levels of need when it is indicated, desirable or preferred.

During the course of this conference, a significant approach was made to the problem of developing a community network of services which does not eliminate the need for institutional care but which is effectively coordinated with all health and social resources to provide the kind of "appropriateness" that has been referred to in the General Accounting Office report.

The conference group did not confine itself only to the rights and the problems of providers of care. It recognized the fact that the absence of community resources for non-institutional care does not in fact deprive members of the American population of their personal rights and deprives ethical providers of the opportunity to select not only the most effective method of care but one which is adapted to the preference of the individual.

In-home services, as described in the recommendations of the Columbia conference, suggest an administrative framework, a well-developed, linked set of services, coordinated with existing institutions and resources, with a funding base which allows for constant and reliable delivery of good quality care in the community and in the personal environment. Such services could make maximum use of ambulatory care facilities, family care centers, neighborhood care centers, private physicians, health maintenance organizations, a real possibility. In fact, the organized components of a well-developed in-home services system could then make of the community itself a "health

[6] See part II of this report for a summary of proceedings and the full text of the recommendations.

maintenance organization", and since the under-one-roof pattern of HMO's will not, in the foreseeable future, become available to the whole population, such an approach to community care seems to offer the most practical method of reversing both dollar costs and human costs in the present institutionally oriented delivery pattern.

Members of the conference were quite clear about the fact that they do not consider in-home services an "alternative" method of care since the community rather than the institution is seen as the primary site of care (see also exhibit F, appendix 1, page 66) and the array of services provided in the community are intended to make appropriate choices possible rather than to substitute one method of care for another.

Although it is possible and even probable that after initial developmental costs have been incurred community centered care might show cost savings, there was no intention on the part of the conference to eliminate appropriate optional use of, nor was there any intention to substitute a "cheaper" method of care for one which was more expensive. Savings would be those involved in making the best use of the whole range of needed services.

The preamble to the conference's recommendations clearly states the objectives which should include in-home services as a part of our national policy in the range of services to which the population is entitled. This preamble and its recommendations might be said to represent a bill of rights for consumers and providers.

> It is the right of every individual to live his life in circumstances which enable him to make the fullest use of his capacities. This right is protected when the society in which he lives provides these safeguards which ensure his basic economic security in a decent environment and the services which are necessary to promote his physical, mental and emotional health. These services are only effective when they are available in a comprehensive system which includes all of the skills and facilities essential to the promotion and maintenance of optimum health.
>
> In-home services are a major component in this system. They ensure appropriate utilization of all other components in the system; they utilize the home and the family as a valuable resource; they prevent the unnecessary displacement of persons which occurs when services are lacking; they guarantee the right of the individual to remain in the place of his choice. In the absence of in-home services, no system may be considered either comprehensive or effective. They must, therefore, be an integral part of this system and top national priority must be given to the development of a rational system of comprehensive in-home services for the whole population.

In 1972, also, the Committee on Community Health Care of the American Medical Association submitted a report on home health care (see exhibit E, appendix 1, p. 58) which takes much the same approach as that expressed in the General Accounting Office report and

in the recommendations of the Columbia conference with respect to home health care:

> The changing age composition of the U.S. population and the proportionate increase in long-term illness and disability have resulted in the medical profession's increased recognition of the neeed for examining and improving traditional methods of delivering health care services.
>
> Over the past half century, the increase in prevalence of such chronic diseases as hypertensive and arteriosclerotic heart disease, cerebrovascular disease, arthritis, neurological disorders, malignancies, and pulmonary disorders has expanded demand for long-term medical and supportive care.
>
> * * * * * * *
>
> Home care is of benefit for many categories of patients—the acutely ill, the convalescent, and those recovering from surgery. 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." A 1972 report, Home Health Services in the United States, prepared for the U.S. Senate Special Committee on Aging verifies the fact that many patients in nursing homes could better utilize home care services.
>
> * * * * * * *
>
> The benefits of effective home health care programs can be summarized as follows:
>
> 1. Patients prefer care that can be provided in the normalcy of their home environment.
> 2. Home-bound people can be taught to live in a relatively independent status.
> 3. The need for initial admission or readmission to inpatient institutions can be diminished.
> 4. For the necessary institutional admission, unnecessary days can be eliminated through early discharge to home care.
> 5. Unnecessary capital construction costs for inpatient facilities can be decreased.
> 6. The efficiency of the practicing physician can be increased by expanding the team approach. The physician can care for a greater number of patients through a home care program because he does not have to assemble and coordinate individually the services needed for his patients in their home settings.
> 7. Home care staff can readily interpret medical orders, explain treatment regimes, and offer reassurance and support.
> 8. Home care staff can identify day-to-day problems and thus help to reduce the possibility of emergency situations arising.

The report stresses the need for recommendation of these benefits by the practicing phyisican, the need for concern and leadership in the community medical society and the role of institutional medical staffs in recognizing "the important community problems and needs

of patients and the utilization patterns of care that can most appropriately answer those needs." (See exhibit F, appendix 1, page 66.)

Throughout the year in regional conferences concerned with comprehensive health planning, health care delivery, home health services and homemaker services, across the country, the need for in-home health services has been repeatedly stressed and the hardship which the absence of such services imposes on large sections of the population have been repeatedly described.

At one of these conferences the following comments were made:

> It would be very difficult at this time to point to any major public effort which has been made to support the development and expansion of in-home services with hard cash. There has been no move comparable to the funding of our many excellent and expensive acute care facilities. Prior to the implementation of titles XVIII and XIX, there were some very good but limited project grants directed to the development of home health agencies. There were limted funds made available for the training of paraprofessionals, many of whom could not be placed in employment because there were no jobs available for them. There are some funded "homemaker" programs in public welfare departments. A few communities have succeeded in establishing good to excellent networks of services through the consortium approach. In general, however, it would be accurate to say that our services have been left to generate themselves and to become self-sustaining.
>
> I do not need to say to this group that the self-generating, self-sustaining approach has not been successful, and I know there is no need, here, to stress the problems which have arisen out of the administration of the Federal insurance system as it relates to services in the home. It is focussed on two important segments of our population, but however important they are, that system leaves a large portion of the population uncovered. There is no way to defend this absence of concern because it is indefensible.
>
> We cannot therefore truthfully say that "in-home" services are not available because they are not *accepted.* We can only say that they cannot be *accepted* if they are not *available.* We cannot expect the user or the provider to "accept" what he has not known or to "utilize" what is not realistic in terms of the needs that exist.
>
> . . . There is now a growing belief that the institutional pattern of services is not effective. It is not only the cost in dollars which concerns us. There is emerging a set of new concerns. We are hearing about dissatisfaction with "the quality of life". We are seeing developments which stress the importance of individual life styles. We are facing the fact that children do not invariably have well-heeled families to provide all of their needs. We are facing the fact that our rapidly growing population of older persons do not have the "families" to care for them which we liked to believe they had. We are hearing young physicians talk about new traditions which

they intend to establish as a part of their professional responsibilities. It was a nurse at Columbia who suggested that entry into the in-home services system need not invariably be through physician or nursing services but through the need of *any* service which promotes health in its broadest sense. It was a social worker who said "health care is ancillary to social functioning." In a group which included representatives from every field and from every organization—voluntary, proprietary, consumer—related to the fields of human services, there was general agreement concerning the "right of every individual to receive good care in the place of his choice" and the "responsibility of society to meet his needs."

There is also a broad concern with our present delivery system. The current interest in health maintenance organizations does not grow out of cost considerations alone. We are looking at them as a possible method to provide an organized continuum of services which makes maximum use of facilities and resources because they are all tied together and must be appropriately used if they are to sustain themselves. We are hearing about ambulatory care facilities which are a socially organized and potentially effective effort to replicate the services which were available in the days when people considered the institution last. We are hearing more about family centered care. The realization is growing that care in the community for the mentally ill, the massively disabled, the mentally retarded, the alcoholic, the drug addicted can be more effectively provided when concern with personal ties and attachments are included in therapeutic considerations.

We are also, at long last, coming to the conclusion that health care for the whole population and a minimally decent standard of living for the whole population may, in the long run, be the best cost savers of all.

These concerns stress, as never before, the necessity for home-centered services. It does not require any great amount of intelligence to understand that the health maintenance organization will be in the same position in the future as the private physician is in today if it must rely for care at home upon a few nursing visits plus an hour or two of "one other service". If it has not been possible to keep people out of institutional beds by providing these limited services in the past it will be equally impossible in the future. Ambulatory care services will not serve a real purpose unless those who could use them effectively are found and helped to reach and use them. Real "health" and "social welfare" objectives are those which insist upon a decent environment, access to health care which is both preventive and therapeutic, good nutrition, psycho-social support, the availability of special skills to meet special needs, and assistance which enables individuals to participate as fully as possible in community life, in recreation and in appropriate occupations.

None of our visions about new approaches which stress appropriate use of facilities and resources, or which look

> hopefully to humanized individual care for those members of the population who really belong in their homes and in their communities, are going to become at all possible through magical processes. Without the same careful planning, without the same development and organization of services, without the same precise approach to the best, the most effective methods that we find in our major medical institutions, in-home services will continue to be the least used and the least useful of community resources.[7]

In spite of this increased verbal interest, the necessary impetus toward implementation of a national policy with respect to home health services is still absent. "It has been said that delay is the worst form of denial." [See exhibit F, appendix 1, page 66.]

This delay and this denial has begun to significantly affect our national economy in terms of dollars. It more significantly, however, affects the health, the personal freedom and to a serious extent the future well-being of the whole population.

The implementation of the recommendations of the Columbia conference, therefore, become less and less an option and more and more a necessity.

EXHIBITS
(See appendix 1)

A. Bed-Disability Days Per Person Per Year By Family Income. July 1965–June 1967.
B. Days of Disability Per Person Per Year By Sex and Age, 1969.
C. Medicare Reimbursements For Home Health Services And Inpatient Hospitalization, 1969–72.
D. Memorandum from Helen L. Rawlinson, Director Home Care Department, Blue Cross of Greater Philadelphia, January 19, 1973.
E. Report of the Council on Medical Service, *Home Health Care*, AMA, 1973.
F. Memorandum from Helen L. Rawlinson, February 20, 1973.
G. *Fact Sheet*, National Association of Home Health Agencies.
H. Study of health facilities construction costs, enclosure C, Chapter 3, Home Care, Comptroller General of the United States. Nov. 20, 1972.

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[7] *In-Home Services—Present and Future,* Brahna Trager, presented at the Conferences: "In-Home Services—Strategies for Community Planning," International Hotel, Los Angeles, July 24–25, and Hilton Inn, San Francisco, July 26–27, 1972.

PART 2

SUMMARY [1] OF PROCEEDINGS AND TEXT OF RECOMMENDATIONS

Conference on "In-Home Services: Toward A National Policy," Columbia, Md., May 31–June 2, 1972

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[1] The report which follows was prepared for the Department of Health, Education, and Welfare and was released for publication as part of this working paper. The official status of the report is described in the following letter:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
Rockville, Md., June 19, 1973.

Mr. WILLIAM ORIOL,
Staff Director,
U.S. Senate Committee on Aging.

DEAR MR. ORIOL: I am pleased to release the manuscript prepared by Ms. Brahna Trager entitled "In-Home Services: Toward a National Policy," a report of the Columbia, Maryland meeting on In-Home Services held May 30–31, June 1, 1972, for publication as a committee document.

It is suggested that the foreword or preface carry the following: "This conference was attended by those in leadership roles in Home Health Services throughout the country, who, acting as a committee, evolved a series of ideas and recommendations which were put together by Ms. Trager into these proceedings under Purchase Order PLD–11046–72, HSMHA, DHEW. While much of the material will be extremely helpful to the Government in future program planning and implementation, the report does not necessarily reflect the policy or views within HSMHA today. This should and does not detract from the proceedings which we are pleased to publish."

Sincerely yours,

EDWARD L. KELLY,
Acting Director.

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I. FRONTISPIECE

It is the right of every individual to live his life in circumstances which enable him to make the fullest use of his capabilities. This right is protected when the society in which he lives provides those safeguards which ensure his basic economic security in a decent environment and the services which are necessary to promote his physical, mental and emotional health. These services are only effective when they are available in a comprehensive system which includes all of the skills and facilities essential to the promotion and maintenance of optimum health.

In-home services are a major component in this system. They ensure appropriate utilization of all other components in the system; they utilize the home and the family as a valuable resource; they prevent the unnecessary displacement of persons which occurs when services are lacking; they guarantee the right of the individual to remain in the place of his choice. In the absence of in-home services, no system may be considered either comprehensive or effective. They must, therefore, be an integral part of this system and top national priority must be given to the development of a rational system of comprehensive in-home services for the whole population.

(Preamble—"In-Home Services—Toward a National Policy," The Columbia conference, May 31–June 2, 1972, Columbia, Md.)

II. INTRODUCTORY STATEMENT

"In-Home Services—Toward a National Policy" describes the central focus of a conference which took place May 31, June 1 and 2, 1972 in Columbia, Md. The conference was sponsored by the Home Health Branch, Division of Health Resources, Community Service, HSMHA, in the Department of Health, Education, and Welfare.

Participant representatives from 20 national organizations, 11 State and local organizations, the Office of the Administrator of HSMHA, the Special Committee on Aging of the U.S. Senate, the White House Conference on Aging, the General Accounting Office, 13 Federal programs and regional office staff came together in a working conference to formulate a national policy and to plan strategy for its implementation.

The term "working conference" is an apt description. It was a conference devoted almost entirely to the deliberations of working groups. Presentations by speakers were sharply centered on the subject at hand and the environment encouraged discussions which continued

during meals and in the informal sessions after the close of the working day.

The diversity of representation, all of it knowledgeable, encouraged and supported the broadest view of in-home services and the need for such services in our population. The result is a statement which ignores established boundaries and compartmentalized interests. It recognizes "The right of every individual to live a full life in the place of his choice" and stresses *in-home services as* "a major component . . . in a comprehensive system which includes all of the skills and facilities essential to the promotion and maintenance of optimum health."

III. THE NEED FOR A NATIONAL POLICY

The use of the phrase "a national policy" as it relates to in-home services bears some resemblence to the established definition of a public health problem. Public concern and public action are necessary in relation to service needs when those needs have been demonstrated to be general, in the sense that they are evidenced in significant numbers of the population, when they are dangerously evident and unmet, when the remedy is specific and when measures to meet them cannot be effectively undertaken by sporadic or voluntary efforts.

The need for in-home services has become increasingly apparent in recent years. There has been accumulated evidence that institutional facilities are being inappropriately used. The rights of individuals to choose where they will be cared for, and of concerned helping professionals to select the most effective method of care, have been limited because the available choice oftentimes is: Care in an institution or no care at all. "Alternatives" to institutional care, usually defined as high quality services provided in the home, are so limited that they do not at present constitute a practical resource. Hopeful beginnings in the development of needed services have been frustrated and defeated in the absence of the support which is essential to development, extension and continuity of such services. The result has been a dismal situation for the sick, the disabled, the crisis ridden sections of the population; young and old, economically disadvantaged and economically secure.

The statement made to participants in the Columbia conference summarized the situation:

> Expressions of interest in the potential of in-home services have been increasing in all areas of our health and welfare systems. They are stressed as an "alternative to institutional care" in health programs, and as an essential component in ambulatory care systems. They are cited as the means of producing a way out of the mental hospital—or of offering the possibility of a more normal way of life for the mentally ill who are still in the community. They are described as key services in preventing family disintegration in periods of family crisis, where the physical and psychological health of children is threatened. They are considered a valuable resource in the development of health patterns of family life

for the economically and culturally deprived. They are repeatedly referred to as the most needed services for the aging population, for the chronically ill, for the disabled. They are beginning to be considered an important therapeutic supplement to community treatment services for special problem groups—in drug addiction and alcohol abuse.

These expressions of interest have produced a variety of approaches, many of them underlining or demonstrating the potential value of such services. *But—they have not yet produced a national policy.*

In the absence of such a policy, the stimulus for the real development of needed services also is lacking. Without a policy, without a legislative and financial base, broad community in-home services for the whole population cannot be developed and the potential of such services cannot be realized.

IV. "IN-HOME SERVICES"

The term "in-home-service" reflects the changes which have been taking place in philosophy, in concepts, in approaches to the development and organization of home delivered services. It represents a natural progression from the "whole patient" to the "whole person"; from the category to the group; from concern with the individual "agency" to concern with effective relationships between agencies; from comprehensiveness within the individual service to comprehensiveness within a network of community services.

In broadening the base, responsibilities are also broadened. "High quality" agencies are diminished in their effectiveness if concern for quality does not extend beyond the agency to related concerns: to the environment in which the services are delivered; to what has happened *before* a specific set of services has been delivered; to what is needed from sources outside the specific service area *during* the period when services are being delivered, and to what will happen *after* the recipient of services has moved from the aegis of the specific service area. They are diminished in their effectiveness if their concern does not extend to those who are relegated to the "not appropriate for service" category because of limitations within the service area and/or limitations in what the community is providing. In a narrow context, such terms as "assessment," "care plan," "evaluation" are a comfort; they are apt to encourage the acceptance of a static situation with respect to what is being provided—even excellently provided—rather than to what could and should be provided.

The broadening of perspectives inherent in the new title, the increased concept of responsibility is supported by some of the most sophisticated theory in the world.

The terms "community planning for comprehensive care," "progressive patient care," the carefully developed schema of the "stages of prevention," the concept of "levels of care" have become common verbal coinage. Well developed theory concerning human psychosocial needs, and concerning all aspects of community organization, is an accepted part of the armenentarium of every professional in the field. Theory is not lacking.

There is also a comparable sophistication in available skills. In medical skill, in nursing skill, in social services, in rehabilitation, in the organization of institutional services to meet the most complex needs, there is ample evidence of a traditional competence. In the delivery of services, and most particularly in what should almost be a garden variety of service delivery—that which is provided in the home—a common place—the implementation of theory and skill in effective service programs has not been achieved in the United States.

This retardation in the development of an essential community resource may be attributed primarily to the absence or insufficiency of financial support. Since community institutions are rarely self generating and only infrequently self supporting, the money problem has undoubtedly been central in the very slow development of community in-home services. Unlike other community institutions, in-home services have been poorly understood. In the absence of a clear view of what is needed and for whom, those services which have been developed have been fragmented in their scope and provided only to meet that part of community need which has appeared to be most pressing. The efficiency of institutions—the under-one-roof provision of services—has been reassuring and attractive in a culture which places efficiency high on the scale of what is most desirable.

There is, however, another standard of desirability which must be equally influential. If services are to be efficient they must also be effective. The growing concern about the effectiveness of institutionalization on most individuals are not desirable. The effects of institutional care on children were observed in England during World War II. At its best such care, it was discovered, produced children who were physically healthy but lacking in emotional capacities—those of developing deep relationships, of learning to love or to understand the quality and durability of love and concern for others. This discovery has had a profound effect on child care theory in most countries in the western world and has stimulated a strong system of in-home services for the childhood population as an alternative to institutional care—except in the United States where the result has been a rather haphazard combination of juvenile halls and poorly supported foster homes. The effects of institutional care upon adults have also been observed—both at home and abroad. In the United States we are hearing new language: "sensory deprivation," "depersonalization" are terms used to describe the effects of isolation from a personal environment, from accustomed social communication from participation in a viable way of life in the community as opposed to the artificial life of the institution.

The value of institutional care cannot be questioned. When there is need for complex facilities and skills, there can be no substitute for the modern hospital. Institutions such as extended care facilities, rehabilitation centers, nursing homes of good quality, hospitals for the mentally ill, and (more questionably) child-care institutions, serve their purpose with excellent effect when they have been selected as the most appropriate resource to meet clearly defined need. The absence of an equally effective complex of services, which can be delivered in the home when institutional care is *not* appropriate, creates a situation in which there is no opportunity for appropriate choice. Inefficient use

of institutional resources is the inevitable result. Appropriateness and the economic use of community resources are desirable objectives. They become pejorative terms when they are applied without reference to the preferences of the individuals. We may be, as a culture, attracted by efficiency, but we are also the culture which has strongly adhered to the concepts of personal right, of personal independence, of that "freedom-of-choice" which is almost a cliche in our modern approach to the development of national institutions.

The approach to services provided in the home, which is implied by the term "in-home services," is intended to include all of the care and all supportive services which make care in the home practical and effective when it is the appropriate and accepted environment for such care.

The statement made to the participants in the Columbia conference defined such services as follows:

> The term "in-home services" is used as an inclusive term in order to broaden the concept of such services. It is meant to describe an array of services which can be brought into the home, singly or in combination, and which can be adapted to meet the needs of persons in all age groups, in all diagnostic categories and in all economic and psychosocial situations when such services can be used therapeutically, or to prevent or arrest illness and disability, to supplement limited function and to protect and support those whose capacities for optimum development, function and participation in family and community life are threatened. In this context, many services which have been considered innovative possibilities but not yet developed, are included. The concept is not tied to existing payment sources, to regulations which limit the scope and duration of services, or to auspices. It is intended to describe a community-wide, coordinated network of services, a complex which can be considered a community institution and an essential component of the health and welfare system.

V. THE CONFERENCE OPENS

Keynote address: Carroll Witten, M.D., president, board of aldermen, mayor pro tem, city of Louisville, Ky.

In regard to home care programs, there is a fragmentation of services. We lack home-health care national policy. In measuring the effectiveness of our Nation, we have failed. Recall the Brahna Trager report (released in April, 1972), part 2, "The Potential of Home Health Services":

> 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.

Agencies providing home health services are diminishing in numbers. Again, "the available supply of services includes an assortment of limited agencies: small home nursing programs (with) . . . the

minimal qualifications of 'skilled nursing plus one' required for certification in Medicare legislation."

Persently only 4 percent of the agencies provide for services in addition to nursing. We are truly warehousing human needs. There is no one at home to look after the patient. We should get more and adequate home health services.

The American Medical Association will not accept all the blame. The Federal, State and local governments should share part of it and initiate bold programs.

We Americans are crisis-oriented toward receiving health services (look at our hospitals). It is old fashioned to be sick at home. In sudden illness (although for thousands we know what is required), people prefer to remain institution-oriented. If the hospital stay of one out of twenty patents could be reduced one day, we could save $20 million a year. Reduction of institutional care means an increase in money-saving.

There are 30,000 homemaker-health aides—a large pool for employment. In one institution 20 percent of the patients do not belong there. Eighty-five percent of our hospital residents prefer to be at home but we have locked the door to their home!

The solution: Home-health services, defined, are:

(1) *Intensive*—doctor daily and nursing services; nutrition for short periods.

(2) *Intermediate*—chronic illness, physical therapy.

(3) *Basic (or preventive)*—to delay or avoid institutional services; help in activities of daily living; open channel to health care.

Here, are the alternatives to the institutional approach (compare Trager report* recommendations, pp. 49–50).

Summary: Why favor home health care?

(1) People get well *faster* in familiar surroundings.

(2) Home health care is less expensive than hospital care. Therefore, we could keep down rising cost of health care.

(3) Home care can relieve hospital bed shortage and even the need for construction of additional hospitals.

Conclusion: We need leadership at Federal and private sector level. We must provide example of workable programs. Compare the Philadelphia program (good, but can be improved). Home health care is a community concern and must be on a par with hospitals.

LEGISLATIVE PROPOSALS REGARDING HOME HEALTH CARE

(Address by David Affeldt, Chief Counsel, U.S. Senate Special Committee on Aging.)

A few weeks ago, Brahna Trager—a nationally known home health consultant—prepared a hard-hitting report on the status of home health services in the United States for the Committee on Aging.

Her basic theme was brief, and blunt. And in a nutshell, it could be summed up this way: Despite the strong support oftentimes expressed

*See footnote 1, p. 1.

for home health and other related services, many serious roadblocks still exist.

It is rather ironic that at a time when the "alternatives to institutionalization" psychology is gaining further momentum, the number of home health service agencies participating in Medicare is actually declining. However, the number dropped from 2,350 in 1970 to about 2,250 in 1972.

What are the reasons for this alarming trend? Well, a key factor is the problem of retroactive denial of payments, which has not only caused hardships for elderly Medicare patients but for home health agencies as well.

Additionally, the complexities of administration and reimbursement have placed many agencies in financial jeopardy. As a result, the larger agencies watch helplessly as their administrative costs shoot upwards, while smaller agencies watch their services go under.

Health Care Becoming Increasingly Institutionalized

Another major theme developed in the report is that our health care system is becoming increasing institutionalized. The family physician at the bedside of a patient in his own home is largely a relic of yesteryear—a vanishing phenomenon.

Moreover, as I am sure you are well aware, home health services have, to a very large degree, had a very low priority in the United States. Less than 1 percent of Medicare expenditures, for example, now go to home health care. And even that small proportion appears to be declining.

Today, as in the past, support for the development of viable home health services has fallen far short of the need. Our funding policies have been limited. And regulatory conditions have been so narrowly defined to make the end product negligible in terms of meeting the real need.

Equally significant, the range of services provided by home health agencies is limited. More than half fall into the category of "skilled nursing plus one," which is the minimum requirement for certification under Medicare. Only about 4 percent provide about five services in addition to nursing.

The Challenge

Despite Brahna's sober assessment of the existing situation, her basic message was not pessimistic. Instead, it was one of a challenge to develop a national policy to bring home health services to the forefront in the battle for decent medical care in our Nation.

And it seems to me that we have two key forces to aid in this objective.

First, most older Americans would prefer to remain in their own homes, rather than be prematurely institutionalized. A classic example of this strong feeling was revealed in a recent study in Florida, which found that 85 percent of all nursing home residents would prefer to be at home. Many of them undoubtedly could remain at home if they were provided with appropriate services. Another important revelation from this study was that nearly 20 percent of these patients—ac-

cording to the physicians associated with the nursing homes—did not belong in institutions.

Second, besides being a more appropriate form of care in many cases, home health care is substantially cheaper than institutionalization. And remember this: If we could shave one hospital day off the Medicare national average, we could possibly provide a savings amounting to approximately $300 million.

Recommendations

These are compelling reasons for initiating action now to meet the immediate and long-range needs in the field of home health care. In her report, Brahna provided an excellent blueprint for action to achieve this goal. In fact, her proposals will serve as a springboard for my discussion with you today.

Now I would like to outline some of these recommendations, which the committee hopes to incorporate in a comprehensive legislative package. At the outset, I wish to emphasize that our proposals will focus on the elderly population because we are the Committee on Aging. However, many of these measures would be applicable for all age groups.

We are now in the process of preparing appropriate memoranda for legislative counsel to draft this proposal. And we also welcome your suggestions for perfecting this omnibus program.

100 Visit Limitation

One of our key proposals will deal with the number of reimbursable visits under Medicare. As I am sure most of you are aware, Medicare limits the number to 100 under Part A as a posthospital service and also 100 under Part B, Supplementary Medical Insurance.

At present, we are considering a three-prong approach to improve the existing law:

1. The number of reimbursable visits would be increased from 100 to 200.
2. For persons who require further care, there would be a "lifetime reserve"—similar to the lifetime reserve for hospitalization—of 50 visits.
3. Further care could be authorized, where appropriate, upon the certification of a utilization review committee.

Elimination of Three-Day Hospitalization Requirement

Another measure would deal with the existing requirement that a patient must be hospitalized for 3 days to be eligible for home health services under Part A. Our proposal would eliminate this requirement.

Today many patients are unnecessarily institutionalized for the sole purpose to become eligible for home health care. The net impact is that this is an improper use of institutionalization.

And it can create a ping-pong effect where a patient goes to a hospital for 3 days to be eligible for home health care. Then he returns for another 3 days after exhausting his home health benefits.

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Protection Against Retroactive Denial of Payments

Earlier, I discussed the problem of retroactive denial of payments. A year ago, Senator Church—Chairman of the Committee on Aging—introduced legislation, S. 1827, to help remedy this situation.

Under this proposal, the Secretary of HEW would be authorized to designate certain periods after hospitalization during which a patient would be presumed to require home health care. This measure was incorporated in H.R. 1, which passed the House of Representatives last June. We are also considering broadening this measure to cover other forms of care. And I will have more to say about that in just a moment.

Expansion of Home Health Services Under Medicare

Another important recommendation of the Trager report called for the expansion of home health and other related services under Medicare. This has been a major concern of the Committee on Aging. In fact, our former Chairman, Senator Harrison Williams, has introduced a bill (S. 882) to broaden Medicare coverage to include services performed by a household aide.

We are considering a number of other proposals to expand the concept to include a full range of needed services.

Today the limited Medicare coverage of home health services diminishes the possibility of appropriate choice. Moreover, the concept of "skilled" nursing services has become firmly entrenched in Medicare. As a result, home health services have focused to a substantial degree upon acute cases.

Ideally speaking, we would like to develop an array of services which would establish as a minimum requirement skilled nursing plus four, instead of skilled nursing plus one. These therapeutic and supportive services should be sufficiently flexible to cover the three levels of care mentioned in the Trager report: Intensive, intermediate, and basic. And examples of these services would include nursing, environmental support (homemaker-home health), the various therapies (physical, speech, and occupational), and other levels of appropriate care.

Manpower Requirements

A key problem in the field of homemaker-home health services is the serious manpower shortage.

At the White House Conference on Aging, the delegates called for 300,000 homemaker-home health aides as a minimum requirement. According to Miss Trager, development of these services should achieve a ratio of at least one homemaker-home health aide for each 1,500 persons, and with good geographic distribution.

To meet these demands, we are considering proposals to beef up our present training efforts by providing new or increased funding to:

—Home health agencies;
—Nursing schools;
—State departments of health;
—The Older Americans Act; and
—Other appropriate institutions and agencies.

Other Proposals

The Trager report also suggests a number of other far-reaching actions, which we hope to translate into legislation. In the interest of time, I shall discuss these measures very briefly.

—The establishment of a program to develop home health and homemaker services in areas where none currently exist.

Moreover, funding would be available to "add on" to services to bring existing agencies up to our proposed minimum requirement of skilled nursing plus four.

—A demonstration program to simplify administrative procedures and eliminate red tape for homemaker-home health agencies.

—A merger of Parts A and B of Medicare.

—Congruent eligibility age for Social Security and Medicare.

Finally, we are considering a proposal not mentioned in the Trager report, but one which we believe has a great deal of merit. This measure would establish an eligibility age for Medicare which would coincide with the eligibility age for Social Security.

This is crucial, we strongly believe, because many Social Security recipients are without hospital or medical insurance—particularly those who have received actuarially reduced benefits. And this is likely to become even more intense as pressures for earlier retirement continue to mount.

Even when the Social Security beneficiary becomes eligible at age 65, this may still become a problem—especially if the wife is 2 or 3 years younger than her husband.

Conclusion

In conclusion, these are some of the proposals that the committee plans to incorporate into a legislative package to implement the recommendations of the Trager report. Quite clearly, this will not be the final word on what ultimately emerges. We expect to make perfecting changes. We will probably add new proposals. And we may even change the basic thrust of these measures.

In any event, we welcome your suggestions and counsel. And hopefully, we can submit a legislative package within a few weeks which has the strong support of organizations in the field of aging.

VI. THE WORKING CONFERENCE

Consolidation of discussion at the end of the first day:

The definition of a national policy with respect to in-home services is difficult in the absence of national policy in the broader areas of health care and social welfare. Nevertheless it is necessary to develop such a policy which must then become an important consideration in all legislation, in planning and development of broader systems.

Basic to such a definition are the fundamental principles:

The *right* of the individual to good care and

The *obligation* of society to provide the means to achieve it.

Our concern in the establishment of policy must therefore be broadened. It must describe a pattern of care based on individual needs. It

must include prevention of disease, promotion of health, rehabilitation in its broadest sense and must eliminate artificial restrictions which limits access to and availability of care. It must eliminate the schism between "health" and "social welfare" and between physical health and mental health. It must include all population groups. It must establish the principle that the system must be available to everyone.

Although the home as a natural site of care has been largely ignored in our service system in favor of extensive development of institutional facilities, it remains an important resource. It must not be considered an "alternative" to institutional care. This concept must be reversed so that the institution becomes the "alternative" to care in the home. We must switch our thinking and our approach. The home is the "vital coordinating link" in the planning of services for the individual. The home and family provide support which is essential to personal security. To the extent that this resource is ignored we deprive the care system of a part of its capability. The absence of in-home services "excludes the possibility of the most appropriate use of all other resources."

The problem of moving in-home services into the mainstream of community services is a difficult one but it must be dealt with. A "blue print" for a rational system of in-home services must be developed.

Impediments to the development and utilization of such services have been attributed to a number of factors.

- The absence of a rational funding mechanism.
- A relatively unsophisticated approach to community planning and service administration.
- The absence of developed relationships to community services and institutions which would ensure continuity.
- The absence or spotty development of the range of services needed for a rational in-home service system.
- Community apathy, variously attributed to the lack of "outreach," the absence of a coordinated system which can be a single resource for the prospective user of services, and frustration when the need for services cannot be met.
- The narrowness of the present approach to service which focuses only upon acute care and virtually ignores all other aspects of need.
- Emphasis on the provision of reimbursable or profit producing services.
- Competition and duplication within existing services.
- The reluctance of community services and institutions to share information, to coordinate efforts, to eliminate fragmentation and duplication, to build needed services. (This reluctance is attributed to the present competitive environment which is imposed by the absence of a rational approach to the support of needed services and to the planning of such services.)
- The "problem" of the physician: This is variously described as indifference, frustration because of his difficulty in putting together a needed service package from a variety of sources.
- The problem of the physician's "unwillingness" to make additional home visits: A misconception which must be tackled with

respect to home health services since an available multidisciplinary team would, in fact, increase and extend his resources.

- The dependence of other professionals upon the physician for the "brand" or "stamp" of professional approval.
- The "brake" imposed upon other professionals by this system with a corresponding absence of professional "egalitarianism" which could enable appropriate professionals to assume "team" leadership based upon the changing need.

The broad approach to these and other problems, which inhibit the development and maintenance of a rational system of in-home services, will involve:

- A national mandate which supports the development and maintenance of this system as essential to the population. Such a mandate must incorporate the provision of in-home services to the population in all communities and in all areas.
- The development of a concept of the "system" which can be generally understood and accepted.
- Careful scrutiny of every piece of legislation related to the provision of services and unified efforts to include in-home services in all of them.
- Recognition of the fact that while fragmented funding such as that provided by Medicare, by insurance benefits, by labor health and welfare plans, and by possible funding sources in Federal, State and local programs, must be utilized to the maximum, a broader financial base must be provided.

More immediate and specific action will be essential in developing the system. Such action must involve consumers, planners, providers, payors, and politics. Home health services and allied programs must work hand in hand with community health planning and other planning structures, so that they are familiar with the concept and the need and are prepared to develop and support effective proposals for in-home services.

Effective community structures must be developed which will:

- provide for efficient centralized administration;
- coordinate services;
- maintain continuity between all services;
- eliminate duplication;
- provide mechanism for collecting information concerning community need;
- involve the consumer at all levels of planning, both in program and policy, and as an individual participant in the planning of care for himself and his family;
- provide the community with an effective center of information; concerning sources and availability of services—one is data, the other is information;
- provide for patient outreach and follow-up;

Activities which are immediately necessary involve the coordination of those services which are presently available so that they will present a "base" for the building of the in-home services system. This will involve forging effective linkage between existing home health services, acute care institutions, long-term care institutions, rehabilitation facilities, outpatient services, public and voluntary social serv-

ices and all other resources which can be pulled together to provide the coordinated continuum of care which is needed.

VII. QUOTES FROM THE WORKING GROUPS

(The content of the following sections reflects the flavor of discussion in the working groups which led to the development of the statement of policy; recommendations concerning service principles, service needs and structure; strategies for implementation. Quotations are drawn verbatim from the discussion.)

What Is Policy?

THE "RIGHT" TO HEALTH CARE

"National policy"—a large concept—was developed in all working groups along very much the same lines, the broadest consideration related to the concept of human rights: Are there basic needs which exist in the whole population? Is the need for health care one of these? *The conclusion that the population is entitled to health care was general.*)

"If health care is a right in any population what are the implications? Who is responsible for the personal health care of that population? Society must provide the means to meet those needs" . . .

"Health care is ancillary to social functioning."

"In our society we have traditionally accepted responsibility for those who have been unable to care for themselves."

"Every individual must have the right and opportunity to live a full life. We must provide all services which are necessary to keep the individual in the mainstream of his society."

"Policy involves the avoidance of the displacement of the individual because of the absence of facilities."

"This is more than a problem of services for the aging. It involves the problem of comprehensive care for the whole population."

"If in-home services are not understood, if they are not developed, they may be ignored when the health care system 'shakes down'. We must have a national policy concerning this segment of the system."

"It is perfectly logical to talk about the direction of care from the home. That is where the need for care begins."

"There are more people, served or unserved, in need of services in their own homes than there are in institutions."

"In-home services have been considered something which is intended to take the place of hospital care. A comprehensive system makes use of all modalities. Such a system must make the full range of in-home services available. It must include case-finding and extend to long term care."

"Home health care is the vital, coordinating link. It is more than an alternative. In-home services could become the assessor of the total health care plan."

"If there are 16 services needed as a part of the in-home system, all of these services must be available."

"The decision about what is 'appropriate' depends upon the individual choice of the person who's getting the service. A coordinated

'team' is only qualified to decide what's appropriate when the 'user' of services and the family are members of the team."

PLANNING

"What we need are comprehensive systems of care based on *individual* needs for the prevention of disease and the promotion of health; without artifical limitations—and for the whole population."

"Our present system deals only with the narrowest part of home care. It is concerned with the period *after* acute care and *before* the long pull. Because it is tied to providers and to a constricted payment mechanism it deals with what is profitable. People return to institutions because there is nothing in the community to maintain them there."

"The system must be planned so that there is mandatory linkage between all of the needed services and this includes institutional services and services in the home which are not included in the present system of home care. They have been frozen at the minimum level in the present system. They must be expanded and accepted as a part of the continuum."

"The planning process should be limited. It should not go on ad infinitum."

"In-home services should be an integral part of a coordinated delivery system. In order to utilize this system every community should have an identified administrative structure."

"Program designs should not be constructed simply to follow funding sources. They must be coordinated and not parallel or duplicating."

"The concept of a consortium—linking services together and adding to the base services."

"Let's emphasize the concept of a *network* of services to include all of the services needed to maintain people in the community. We are less concerned with agencies—which may be multiple—we are talking about a system of services."

"The way to make the system available to everyone is to start planning at the community level."

"The in-home facility can be the focus of all out-of-hospital services."

"How can in-home services become an institution? The hospital becomes an institution because:

- It provides an array of services which are readily accessible from professionals and others as needed.
- It is supported financially.
- It is demanded by the consumer.
- Its services are accepted by reimbursement sources (insurance)."

"An institution must have relationships with other institutions. These factors can be applied to in-home services. They could become a part of this continuum."

"In addition to regional and rural planning, emphasis should be placed upon combining duplicating services in urban areas."

"What is needed is a combination of providers, consumers, payors and politics."

"If the consumer doesn't demand comprehensive planning we won't have it."

"Unless the consumer is involved at all levels of decisionmaking the system will not be responsive to need."

BARRIERS TO ACCEPTANCE

Physicians—"they don't accept in-home services readily. They have not had much opportunity to use the services."

"The usual scapegoats are physicians. This is not true."

"One of the misconceptions—that the physician will have to make more home visits if these services were developed—is not valid."

Providers—"there is resistance to exchange of meaningful information—to contribute to the continuity of care. They limit services to funding sources."

Health and professional facilities—"they are not interested in cooperative action."

Public acceptance—"the exposure has been limited. Union members decide what they want in their insurance package. Others get what the present services provide. Very little."

SERVICES

"We need a new professional approach. Professional assessment has become inflexible. Administrative mechanisms defeat professional flexibility when it comes to care in the home. The assessment methods should consider the change in need and the role as 'team leader' of the best person to meet that need. This is not necessarily the physician."

"Professional leadership means any or all the disciplines. At any point in time, depending on need, there can be a different professional leader."

"One of the major problems is having to fund through catastrophic insurance."

"We don't have real social legislation."

"Half the personnel in rehabilitation centers are doing the job over again because the gains are lost when there are no services in the home—there is nothing to support the therapy that's been provided in the institution."

"A coordinated 'team' is only qualified to decide what's 'best' when the patient and his family are members of the 'team'."

"Services must be focused on prevention—on case finding—and maintenance. We are oriented now to crisis care."

"Professional judgment must be more clearly defined."

"We must remove the 'brake' on the other professionals in the team without removing the responsibility of the physician in health care."

"We are talking about all of the modalities—the institutions and other community facilities are a part of the rational service system. The ability to move from one to the other is what's needed."

FUNDING

"It should be required that funding for all programs be coordinated and not parallel or duplicating."

"Funds must be made to flow to where the need for developing service is. This means redirecting funds from existing programs into in-home services."

"Services follow dollars."

"There is always a lag between legislation and the funding ability to reimburse the new services that you know have to come."

"You can't ask communities to develop services for which there is no funding."

"We are always seeking the cheapest, the lowest level of care. Everyone is working their way down."

"What we have now is nickel and dime programs."

"The minimum becomes the maximum and funds get frozen at that level."

"There is no funding for the organization of services—to support coordination."

"There must be funding—for development, for maintenance, for growth in these services."

"We need a rational funding mechanism."

VIII. THE CONCLUSIONS—CONFERENCE RECOMMENDATIONS

"Toward a National Policy"

PREAMBLE

It is the right of every individual to live his life in circumstances which enable him to make the fullest use of his capacities. This right is protected when the society in which he lives provides those safeguards which ensure his basic economic security in a decent environment and the services which are necessary to promote his physical, mental and emotional health. These services are only effective when they are available in a comprehensive system which includes all of the skills and facilities essential to the promotion and maintenance of optimum health.

In-home services are a major component in this system. They ensure appropriate utilization of all other components in the system; they utilize the home and the family as a valuable resource; they prevent the unnecessary displacement of persons which occurs when services are lacking; they guarantee the right of the individual to remain in the place of his choice. In the absence of in-home services, no system may be considered either comprehensive or effective. They must, therefore, be an integral part of this system and top national priority must be given to the development of a rational system of comprehensive in-home services for the whole population.

A national policy must provide:

—that in-home services which are comprehensive will be available, accessible, and acceptable to every member of the population who needs them.

—that they will be available without restrictions as to diagnosis, race, religion, or ethnic origin, age or sex.

—that they will be based on the needs of the consumer rather than the provider.

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—that they will be provided without financial barriers.
—that they will be provided in circumstances which guarantee high quality.
—that they will be provided without barriers between health and social services, but as a coordinated blend which promotes and supports optimum health in the broadest sense.
—that they will be based upon a philosophy which recognizes the right of the individual to participate with professionals in making decisions about the place, type, and extent of care and services he needs and receives.

IMPLEMENTATION

This policy must be implemented through action at all levels of government and in all public and private efforts.

LEGISLATIVE RECOMMENDATIONS

It was recommended:
—that Federal policy require significant provision for the inclusion of comprehensive in-home services in all legislation directed at the establishment of a health security system.
—that voluntary and commercial insurance plans be required to cover comprehensive in-home services.

It was recommended that Federal funds be made available:
—for the development of in-home services in areas which do not have them.
—to expand existing service programs in both range * of services provided and capacity to serve the population in need.
—to coordinate services.
—to maintain services through funding on a reimbursement formula which would provide for growth and economic stability.
—for training in order to implement expanded services—training to be directed at all types of manpower and to include training focused upon the organization, administration and provision of in-house services.

At the national level it is also recommended:
—that a National Advisory Commission on IHS be established with representation from consumers and providers—with consumer representation in the majority.
—that the National Advisory Commission should provide leadership in the development of standards and policies to insure:
the quality of IHS
national organization and administration of IHS
economy in the provision of services
effective delivery of IHS
coordination with all other IHS health and social service systems.

*The range of comprehensive in-home services to include: Home health services, homemaker-home health aide services, home maintenance services, social services, meals-on-wheels, transportation, telephone reassurance, friendly visitors, services which make possible meaningful participation in community and family life.

—that comprehensive health planning agencies should be charged with the responsibility for developing programs of comprehensive in-home services.

—that funds be provided for the development of:

- legislative models for use at the Federal, State and local levels for inclusion of in-home service.
- systems models directed at organization and coordination of services.
- a massive educational process directed at consumers, legislators, providers, payors and professionals involved in the delivery of services which describe comprehensive in-home services, stress their value and provide guidelines for the development and integration of such services in order to establish integrated and effective services for the population.*

—that funds be provided for:

- development, maintenance and expansion of training programs to meet the health manpower needs of an accelerated program of in-home health services.
- development of broadly based training programs, including professional schools.
- State health department educational efforts for technical and operational improvement of agency personnel.
- emerging community college programs and other educational facilities in order to establish a reliable manpower pool and to provide all individuals engaged in the delivery of human services with understanding of the content and value of in-home services and to develop skills which will support the effective organization and delivery of such services.

At State, regional and local levels.

It is recommended:

—that planning for in-home services be assumed as a responsibility in comprehensive health planning agencies and in all other groups involved in planning delivery systems of health and social services.

—that planning be directed to elimination of duplication and unnecessary construction of facilities for institutional care.

—that all planning should support legislation and systems designed to blend social and health services.

—that planning for in-home service should be accomplished by a consortium of total community involvement, consisting of consumers of service, third-party payers, providers, planners, labor, industry, and government.

—that planning must include recognition of the need in every community (or area) for an effective administrative and care faciliting mechanism (a "community based continuum").

Effective administration must:

- Assure the receipt of appropriate care for the individual and his family.

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*It was recommended that a synopsis of the report "Home Health Services in the United States," prepared for the Special Committee on Aging of the United States Senate (No. 74–331, April 1972) be supplied to other provider groups.

- Provide for "outreach" activities in order to assure that all individuals in need of services are found and provided with appropriate services.
- Provide for a sufficiently wide range of in-home services to meet the need appropriately.
- Assure proper utilization of services through direct delivery or arrangement with existing community services.
- Provide for the continuum of services through the development of strong linkage between all services, through established systems of communication within planning areas, through the development of contracts and agreements and through other similar arrangements.
- Establish quality performance standards as seen by both provider and consumer (user *).
- Assure that services be organized, developed, provided and maintained by qualified interdisciplinary personnel in qualified service systems. ("Qualified" service standards to be established by the appropriate national standard-setting organizations.)
- Assure that an evaluation component is present in every in-home service system.
- Identify unmet community service needs and take responsibility for initiating plans to meet these needs.
- Provide for a program of continuing community education concerning the function and value of in-home services.
- Assure effective financial management and accountability through development and use of functional budget practices and cost analysis.
- Make available reliable information concerning costs and statistics.
- Assure full participation by users of service in all decisions and plans for care.

—For research and development in such areas as:

a. Average length of stay by diagnostic categories in the three levels of home care.

b. Prepayment and capitalization plans for home health.

c. Regionalization of home health services.

d. Management in incentive programs within home health agencies.

e. Viable patterns of service for rural areas, for complex urban centers and for the new systems of service which are being developed.

—To broaden the scope of Hill-Burton to include funding for construction, renovation, and modernization of facilities furnishing coordinated home health services.

It was recommended that Federal health care funds be denied to communities without coordinated home health services.

It was recommended that the Home Health Branch, DHR, Community Health Services of DHEW be strengthened in order to provide effective leadership, consultation and research to explore with appro-

*It was suggested that the term "patient" does not accurately describe the individual who uses "in-home services" and that the term "user" be substituted. The terms "user" and "consumer" were referred to throughout the discussions.

priate personnel such areas as the comprehensive health planning process at the national, State and local levels, the functions of the regional medical programs and similar programs, in order to develop a coordinated approach to the development of in-home services within those programs.

Legislative recommendations related to the Medicare-Medicaid insurance system:

It was recommended that:

- Medicare coverage with respect to home health services be expanded to include at least "skilled nursing plus four" additional services in order to provide therapeutic, supportive, and environmental services at the three levels of care (intensive, intermediate, and basic). (Home health agencies would be required to have available at least this range of services a condition for participation.)
- Parts A (Hospital Insurance) and B (Supplementary Medical Insurance) of Medicare be merged and the deductible and coinsurance features for in-home services be eliminated.
- Present Federal legislation and regulations be revised to remove barriers such as 3-day hospital stays as a requirement for admission to home health services.
- Payment for 10 in-home health services visits for covered conditions be guaranteed at the start of care.
- Home health coverage, with respect to the number of reimbursable visits, be increased two-fold with an added life time reserve of 50 visits on the recommendation of the utilization committee.
- Eligibility for home health services be changed to permit entry on the basis of need for *any* service, or for any combination of home health services.
- The practice of retroactive denials be eliminated.
- Congruent eligibility ages for Medicare and Social Security be established. (The expanded home health benefits under Medicare would not be available to people on early retirement unless there is congruent eligibility.)

To simplify Federal administration of home health services under Medicare:

- It is recommended that action be taken to establish providers appeals for home health agencies.
- Demonstration program must be established to explore effectiveness of audit patterns in relation to fiscal administration, utilization and patient care.
- Policies and standards for professional personnel and related services should only be established by the appropriate professional personnel on an ongoing basis.

A simplified claims processing system must be developed together with a uniform claims form and uniform reporting system which would be applicable to the Federal insurance system and to all other third party payors.

The focus of Medicare coverage must be shifted from the need for skilled professional services to the *needs of the individual.*

All concerned professional organizations should recommend to their governing bodies the adoption of this national policy.

IX. CLOSING ADDRESS

The Administration's Plan for Action

(Remarks by Dr. Arthur Flemming, Chairman, White House Conference on Aging, 1971, and former Secretary of DHEW, at the "In-Home Service—Toward a National Policy" Conference, Columbia, Md., June 2, 1972.)

Thank you very much. I appreciate the opportunity of participating in what seems to me to be a very significant follow-up to the White House Conference on Aging.

I am a staff person on the President's staff with a job description that the President has given me which is fairly specific. He has asked me to continue as Chairman of the White House Conference on Aging during the post conference year of 1972. He has asked me to serve as one of the members of the Cabinet-level Committee on Aging. The committee is chaired by the Secretary of Health, Education, and Welfare—Elliot Richardson. He has also charged me with functioning as an advocate within the Government in the field of aging. The final thing the President has asked me to do is to serve as his representative in an effort to bring about more effective coordination of programs for older adults that cut across departmental lines. In some respects, as I look down the road to the next few months, I think that possibly this could prove to be the most interesting aspect of my assignment.

So it is within the frame of reference of my responsibilities that I will endeavor to address myself to some of the issues that you have been looking at. As I do so, I will be reflecting points of view that have been expressed to me throughout the country by many persons. I decided that when I came on the job, just a year ago on a full-time basis, that I was going to spend a good deal of my time in the field. As a member of the Civil Service Commission and as a Secretary of HEW, I learned that this is a wise thing to do. First of all, if you are in the field, you will pick up ideas that you won't pick up in Washington, and in the second place, if you are in the field, you will learn about things that have happened in Washington that you'll never learn about if you stay in Washington. After all, the people in the field are on the receiving end of what Washington decided to do, and in most cases they are not at all hesitant in giving expression to their convictions.

As we discuss some of the issues that you have been looking at, sometime we refer to alternatives to institutional care. Personally, I do not thnik that this is a very happy choice of words. I like to think in terms of institutional care and services to older adults in their own homes as parallel services for older adults. It seems to me that, in both of these situations, our society must render better services than we are now rendering. We must provide the older adult with better opportunities for choice than is presented to him at the present time. One of the messages that has come through to me, quite loud and clear, from older adults is—"We want to be put in a position where we can make our own decisions relative to our own lives. We don't want other

persons making those decisions for us." So it seems to me that it is very important for us to provide older adults with a variety of choices.

Now, we do have, as you recognize, 900,000 older adults living in institutions. Sometimes I've heard that expressed in this way, "After all, we have only 900,000 living in institutions." And sometimes people will say that it is only 5 percent of the persons 65 years of age and older. I don't like to deal with it in that way—900,000 human beings is a very, very large number of human beings. As the President said in his special message on aging on March 23, "These older men and women require the assistance provided by skilled nursing homes and other long-term care facilities. For them, a dignified existence depends upon the care and concern which are accorded them in such settings."

After all, any policy changes which might enable a larger percentage of older persons to remain in their homes or other places of residence will have very little impact on the lives of the 900,000 persons who are now in these institutions. Furthermore, they will have very little impact on the lives of those who will be moving into these homes today, tomorrow, and the day after tmorrow. Therefore, there isn't any question in my mind but that the quality of care in these homes must continue to be one of our primary concerns.

There is momentum in this area. The President, just a year ago, in his address in the city of Chicago, set forth a policy which has made it very clear he wants to have it implemented. He said there that Medicare and Medicaid funds should not be used for the purpose of subsidizing substandard nursing homes. You may be interested in the fact that that particular sentence was not in the text of the speech that was released to the press prior to the time the President spoke. There was a section of the address that was devoted to nursing homes, but apparently, as he went through that particular section, he decided that it needed to be strengthened; therefore, he added the sentence to which I have referred. He made it very clear to me on the trip back that he expected the executive branch of the Government to do everything possible to implement that particular policy.

You know that that was followed by an eight-point program, which the President announced in New Hampshire in August. The Secretary of HEW has been in the process of implementing that program since then. And I feel that some very significant developments have taken place as a result of the steps that have been taken to implement that eight-point program. For example, it seems to me that the establishment of the office of nursing home affairs in the Department of Hew constitutes a constructive development. I think we are all indebted to the kind of leadership we are receiving from Dr. Marie Callender, who was recruited by the Secretary to head up this particular office.

There is a great deal of work that remains to be done in this whole area of institutional care. I know that those who are participating in this conference recognize this. The President in his special message on aging of March 23, said we must place emphasis, and I now quote him, "on public and private services which can help older persons live dignified, independent lives in their own homes and other places of residence." In reality, this was a reiteration of a statement that he included in his address at the concluding session at the White House

Conference on Aging, when he was referring to the fact that he was going to request an increase for Title III funds, under the Older Americans Act to $100 million for fiscal year 1973. Then he went on to say, "Now let us see what will help people live decent and dignified lives in their own homes, services such as home health aides, homemaker and nutritional services, home delivered meals, and transportation assistance." I am confident that the Secretary of HEW, and the Commissioner of Aging regard that as a directive so far as the utilization of the $100 million is concerned. I believe that this will be reflected in the guidelines which go to the States.

Personally, I believe that helping in the development of a national policy that will make it possible to achieve the kind of objectives that the President has identified is one of the major opportunities confronting us in the field of aging. This is an objective in which the President has a deep-seated personal interest. He recognizes that we can't possibly meet the needs of our older adults by putting emphasis solely on institutional care. He knows that if the kind of objectives that he has set forth are to be achieved, it is going to be necessary for us to work out a national policy in this particular area and to work out ways and means for the implementation of that policy.

What is happening as far as the Older Americans Act is concerned represents momentum in this particular area. As you know, the part of the Act which authorizes appropriations for the programs that are identified under the Act, expires on June 30, of this year. The President, in his special message on aging, stated that he would like to have these authorizations extended on an indefinite basis. Also, the President has proposed some amendments to the Older Americans Act which are designed to bring about a more effective coordination of the delivery of services at the community level. In addition, some members of the Congress have also proposed amendments. At the moment. these amendments are being considered by both the House committee and the Senate committee. I think, however, that the most significant development in this area relates to appropriations. When the President told the delegates to the White House Conference that he was going to ask the Congress to increase the appropriations for title III to $100 million, he did so knowing that as of that particular moment the appropriations for title III for the fiscal year 1972 were around $20 or $22 million. The day after the conference adjourned the Senate was considering a supplemental appropriation bill. Some members of the Senate said, "Well, if we are going to go to $100 million in 1973 why don't we make a real move in that direction in 1972?" So they offered amendments to increase the appropriations for title III in such ways as to bring them up to approximately $42 or $44 million. This was accepted by the House conferees and, of course, became law.

Then, as you also know, a few weeks ago, the Congress passed a law which authorizes the expenditure of funds in the fiscal year 1973 and fiscal year 1974, for grants to States and communities, which they in turn can use for the purpose of supporting programs in the field of nutrition. The amount authorized for 1973 is $100 million, for 1974 it is $150 million. When the President signed the law, he said that he was going to ask for an amendment to his 1973 budget in the amount of $100 million. So, in fiscal year 1973 we will have about $200 million

available for grants to States and communities to support programs which provide service to older persons, with the emphasis on services that will enable them to continue to live in their homes or other places of residence. That's $200 million in 1973 as contrasted with $20 million in the beginning of 1972. This to me represents momentum that has led to significant action. I feel that the spirit created by the White House Conference on Aging has had a good deal to do with the establishment of that momentum.

Now, there is no reason at all why some of the funds that will be made available to the Administration on Aging could not be utilized for the purpose of moving forward in this area of the in-home services. Whether or not it is used in this way depends to a very large degree on the kind of proposals initiated at the community level. This in turn, of course, will depend on the kind of leadership available at the community level. This is one area where we can see some significant developments as the result of grass roots initiative. You are aware that there are now around 150 national organizations which are members of a steering committee chaired by Ellen Winston. The purpose of the steering committee is to stimulate the development of comparable steering committees at the local level. The primary objective of the local committees is to support services that will enable older adults to continue to live in their own homes or in other places of residence. It seems to me that this is a significant development on the part of the private sector. Here again, success will depend to a considerable degree, on the quality of leadership at the local level. Of course, once these committees get under way, they will make vigorous recommendations as to what should be going on in the public sector, at the local level and what kind of support those programs should have at the State and national levels.

I have the feeling that we have really not made as effective use as we could of the adult services title under the Social Security Act. I would certainly like to see us utilizing this title to a much greater extent than we have up to the present time in connection with in-home services.

In the area of nutrition, we have as one of our major resources food stamp and surplus food programs. That resource has been expanded considerably over the past few months until today the benefits are valued at about $2.5 billion a year. It is assumed that around 2.5 million older adults will utilize these benefits during the present fiscal year, in the amount of roughly $350 million. I was talking about this to a group of Governors not long ago, and I was telling them about a project that we are going to launch to locate older adults who are so lost in society that they are totally unaware of the existence of food stamp and surplus food programs. After the meeting, one of the Governors came up to me and he said, "Look, did you ever think of the possibility of utilizing the stamp concept in the field of transportation?" I said, "No, I haven't." He said, "I've talked to Secretary Volpe about this a number of times, and he sees some possibilities in this." Well does it have any possibilities in the area of in-home services? I think it might be worth looking at.

There is another area which is related to your concerns, where there is significant momentum, and that is the area of making it possible for

older adults to continue to be involved in life. Older persons are saying to our society: "We want to continue to be involved in life, we don't want to be put on the shelf." And you will recall that in his address at the White House Conference on Aging, the President put a good deal of emphasis on this area. At that time, he announced, for example, that he was going to ask for a doubling of the appropriations for programs such as foster grandparent programs, senior aide programs, Green Thumb programs. He also announced that he was going to ask for a tripling of the appropriations for the retired senior volunteer program. It seems to me that many of the persons who will be participating in these programs can be trained to play a significant role in the area of in-home services. If this is done, we're accomplishing a number of things. We are contributing to the physical and mental health of those who are trained to participate and they in turn can be a very real help to those older adults who need services in their own homes. For example, it is my understanding that there are 30,000 trained homemaker-health aides in the Nation at the present time, and the need is for 300,000. I think that we have to keep in mind that not all persons who want to be involved are looking for full-time employment or even part-time employment. Many of them want the psychic compensation that comes from being involved in a systematic way in community service activity.

I recognize that we could move much more rapidly in achieving some of our objectives in the area of in-home services if we obtained amendments to the Medicare legislation which would liberalize the use of Medicare funds for such services. This would put an additional burden on the Medicare trust fund but I believe that we can demonstrate that if we are willing to make that kind of investment it would pay tremendous dividends in terms of the overall objectives of the Medicare legislation.

I think it is likewise very important for us to watch the national health insurance legislation from the point of view of in-home services. It seems to me that this country has accepted the fact that the time has come for a national health insurance program. The question is what method is going to be used or what combination of methods are going to be used. This will be one of the major issues confronting the Congress in its next session. Those of us who believe in this concept of in-home services should try to make sure that the legislation that finally emerges from the Congress makes a contribution in the direction of institutionalizing the concept of in-home services.

As I have talked with older adults about national health insurance, I find that they are very unhappy over the fact that proposals pending before the Congress do not come to grips with the issues of long-term care, at any level of care. They are right in identifying that particular weakness.

H.R. 1 has some provisions that can have an impact on the evolution of policy in the field of in-home services, particularly that part which would make it possible for Medicare beneficiaries to join HMO's. Now this, of course, raises another issue: Are the health maintenance organizations going to be established in such a way as to give adequate recognition to in-home services? If that part of H.R. 1 that deals with

health maintenance organizations passes, this whole concept is going to be given quite a shot in the arm.

As some of you know, I did have 10 regional meetings prior to the White House Conference on Aging. Since the White House Conference, I've spent a large part of my time in the field and I am about to have 10 more regional meetings that will really be follow-up meetings to the White House Conference. Let me just summarize the messages: Older adults have said to me that society has put them in an inferior or secondary position. They don't like it. The second thing they've emphasized is that society has been pretty long on promises but short in delivery. Obviously they don't like that. The third is that they want to be in a position where they can make their own decisions relative to their own lives. They want freedom of choice. The fourth is that they want to continue to be involved in life; they don't want to be put on the shelf. The final one, and the one that overrides all the rest, is "We want to be treated with dignity." As I think of these messages, then as I think of the opportunities presented to us in the area of in-home services, it seems to me that if we take advantage of the opportunities that exist in this area we will be responding in a positive and affirmative manner to the messages that I have just identified.

Personally I am grateful for the time and thought that you have put into your deliberations during the last few days, and, as I indicated at the beginning, I look forward to getting the results of those deliberations. I can assure you that my own convictions are such that I will pick up your recommendations and see what I can do as an advocate, particularly within the executive branch of the Government. Thank you.

X. PARTICIPANT ORGANIZATIONS SPEAK

Mr. Richard Schlesinger,
Executive Vice President, Areawide and Local Planning, American Association of Comprehensive Health Planning.

"For those of you who may not know what the association is, I'd better explain, since we are fairly new. The American Association for Comprehensive Health Planning is a new national organization which was just formed last December. It is as the title implies, composed of people who are engaged in, or being trained for comprehensive health planning. . . ."

"The executive committee of the association met last Friday, and had before it a recommendation from the long-range planning committee of the association, which was: 'That the association consider national health planning program and policy development as a significant thrust of its efforts. Special emphasis should be placed on matters that transcend State and community boundaries. Examples might include planning for improvement from the utilization and distribution of health manpower, assessing the impact of national health insurance on the existing and future capabilities of this Nation to respond, and how to harness our Nation's resources into establishing and maintaining a healthy environment for all our population. The

association would assume these community activities under the guidance, participation, and active involvement of its member agencies. Furthermore, all efforts would be made to enlist the resources and experience of other organizations in reaching these objectives. The emphasis of these efforts must be founded on public accountability in achieving tangible and effective results.' That recommendation, from the long-range planning committee, I was informed by telephone, yesterday, was accepted by the executive committee, and will be recommended to the full board at its meeting later in June, and I assume will be adopted. This is a fairly broad statement, obviously, and leaves a great deal of leeway. However, I think that the majority of my colleagues who are involved in the association would generally accept the statement of purpose and goals for comprehensive health planning, the development in our communities and our own States of more rational systems of health care services delivery. From that point of view it seems to me we would all accept the fact of the development of in-home services as the crucial part of what we are aiming to achieve, and a part that largely has been missing."

Miss ALICE GONNERMAN,
Assistant Director,
Division of Ambulatory Care,
American Hospital Association.

"The American Hospital Association really does have a history that it can be proud of in terms of support of home care." ". . . Our official policy statement . . . which came out in 1971, has a number of references to the fact that home care services must be included in any kind of comprehensive care package, and we are interested in the concept of health care corporations which also need to have home care as one of their benefits."

"The American Hospital Association has had a membership category for home care institutions since 1968. In 1969 an Assembly of Outpatient and Home Care Institutions was formed to serve these members."

"This assembly has been meeting with the other national membership organizations for home health agencies to determine in what areas they could work productively together for the benefit of their respective memberships."

Dr. PATRICK STOREY,
American Medical Association,
Professor of Medicine and Community Medicine,
University of Pennsylvania.

(We are) "caught in the cycle of advancing technology which requires management of the sick patient in a facility where expensive equipment and highly skilled personnel are available—which saves and prolongs life—*which means more* prolonged convalescent care for the previously lethally ill, *more* chronic disability, longer life span, *more* aged—which in turn requires *more* home care—and the resurgence of the frontier picture of the physican at the bedside—which is imposible because of the increase in longevity and constant advances in medical technology."

"So we have a dilemma" . . . " a princple in operating which under other circumstances I call Storey's law: i.e. that there are two problems for every solution."

"The AMA has in the past—as part of the image of the American doctor—and does at present—as part of its obeisance to the demands of advanced technology—support completely the concept of need for an elaborate, smoothly functioning, system of home care for the chronically ill, the disabled, the elderly, and the young."

"It pledges its support as an organization, and has consistently urged physicians to recognize their responsibility in this regard to their patients and to their community. It has encouraged physicians to actively seek a leadership role in the development of the home care resources of their communities, and to exploit such resources in the interests of their individual patients."

". . . the last two meetings of AMA's committee on community health care . . . came up with three recommendations: (1) that the AMA council on medical services urge the council on legislation that home health care and homemaker services—as important components of health care delivery systems—be included in AMA's Medicredit and other national health care programs;

(2) sponsor a conference for physicians on home health care;

(3) Review and up-date all present material on home health care."

Mrs. Manuel Bergnes,
Women's Auxiliary of the American Medical Association.

". . . I represent a volunteer group, the women's auxiliary to the AMA. It is an organization . . . with a membership of around 90,000, with component state and county auxiliaries."

"Since the early '50's, the women's auxiliary has actively promoted in-home services, such as: homemaker-home health aide services, home delivered meals, and the volunteer friendly visitors program."

"Some auxiliaries have begun the services themselves, such as: the initial 'meals on wheels' program begun by the San Francisco medical auxiliary; the Knosha, Wis., County Homemaker Service, and the Milwaukee, Wis., meals service. Others have worked actively with other community leaders to begin their services."

"Home centered health care has been a priority project for several years. We've used the slide film, "Home Fires", on the use of the homemaker-home health aid in Illinois in conjunction with the AMA. We've developed a skit on the role of the friendly visitor. This was used in conjunction with the promotion of the volunteer visitors training program and auxiliaries were urged to sponsor the course as well as train their own members to act as volunteers. The telephone reassurance program was also included as an added service for those confined to their home."

"The women's auxiliary continues to work closely with the AMA on any programs needed to be developed for in-home care. With 50 State medical auxiliaries, made up of component county auxiliaries, there is a 90,000 member potential for promotion of whatever comprehensive program that is devised."

Mr. JOHN J. MCMANUS,
Assistant Director,
Department of Community Services,
AFL–CIO.

"Thank you. Probably this is the first time in history that the AMA and the American Hospital Association have *preceded* the AFL–CIO. For an encore I have the following statement. The AFL–CIO is committed to the full implementation of a national health security program. An in-home service program could be of considerable value, and is of critical importance to the preventive and direct service aspects of a full and comprehensive national health security system. The AFL–CIO Community Services Department, of which I am a part, is therefore vitally interested in participating and learning from the conference, and we will be glad to assist in drafting a policy proposal that could be forwarded without commitment to the AFL–CIO for review and further consideration. This ends the gospel for today, but what I wanted to say is that as a professional I am intrigued that it requires a national conference to bring us all together on this very important thing that I felt we'd accepted so very long ago."

MALCOLM U. DANTZLER, M.D., M.P.H.,
Assistant State Health Officer, South Carolina State Board of Health,
Association of State and Territorial Health Officers.

"As you know, State health agencies are very concerned with health services in the home for many, many years. Their efforts in developing home health services were given a major boost in 1965, with the enactment of Medicare and Medicaid. Over 50 percent of home health agencies are now directly affiliated with official health agencies and the remainder have an indirect relationship. The State health officers are strong supporters of home health services and are allocating major segments of their resources to development of home health services. A number of States have established specific bureaus or division of home health services, and many include home health services in their units of nursing, community health services or medical care."

Miss ANN COHLAN,
Blue Cross Association, Federal Programs Contract Operation, Senior Director of Claims Service.

"The Blue Cross Association . . . is . . . a federation of 75 Blue Cross plans across the country. This is one of our strengths, but also one of our weaknesses; that we have 74 autonomous groups or plans in 74 communities or regions in the country that have to respond to regional differences, medical practice, pressures and delivery systems."

"The Blue Cross Association of America, in the past year, has taken a firm position to move into the area of quality control in affecting the delivery and organization of such services as home health."

"The division of research and development is currently staffed with a group of health experts who are looking into HMO development and encouraging Blue Cross plans to get involved in this area. The HMO expert is also looking at home care as part of an HMO

concept, including peer review grouping, as well as other methods of delivery such as home health."

"We need the same kind of feedback we will get from this group as we need in most communities, the reaction of the various home health agencies and institutions, to the local Blue Cross plan so that it will recognize that such a benefit is needed."

Miss HELEN RAWLINSON,
Director, Home Care Department,
Blue Cross of Greater Philadelphia.

"Blue Cross of Greater Philadelphia has been directly engaged in the promotion of home care services since 1956 when we granted a substantial sum of money to a member hospital to assist it to establish the first hospital based home care program in southeastern Pennsylvania."

"Since 1960 full time staff has been responsible for encouraging greater availability and use of the intensive level of coordinated home care. In addition to a comprehensive benefit program we provide consultation and administrative assistance to hospitals and other community health agencies interested in planning and implementing service programs to provide this level of home health care. In 1969 we extended our home care program to selected patients referred directly from hospitals to community home health agencies—the intermediate level of home health services. This benefit is available to patients of all ages when continuing care is planned through participating hospitals home care departments."

"All of our participating coordinated home care programs are hospital based. This is to say the hospital has the same responsibility for home care patients as it does for patients of its inpatient or outpatient services."

"We endorse Miss Trager's statement in the report on 'Home Health Services in the United States' that home health services . . . 'are an essential component of any system of comprehensive health care and the absence of such service excludes the possibility of the most appropriate use of all other health resources.' However, we do not believe the establishment and acceptance of home care as an essential component of the health care system will be accomplished simply by making dollars available. Providers, financers, and consumers of health and health related services must work together to plan, develop and implement programs and procedures which will encourage appropriate utilization of our total health care resources and will also guarantee the availability of needed services to all at a cost our society can support. Implicit in this is the enforcement of reasonable, constructive, and effective controls which will promote a high quality of care delivered economically and consistently. Our home care benefit program, claims administration and reimbursement policies are designed to support these objectives."

"We sense a considerable need for increased innovation which will lead to new and better methods of patient care planning and the delivery of health and social services at the lowest acceptable organizational level of the health care and human delivery systems. We

believe both the voluntary and official agencies which pay for these services have a great responsibility to carry out their trusteeship in a manner which will contribute to the achievement of the essential goals I have mentioned. Therefore, we will continue our endeavors in support of the appropriate and effective development and use of in-home services."

Mr. WILLIAM REINERTSON,
Associate Director,
Health Insurance Council.

"The Health Insurance Association of America, on behalf of its 300 plus members, believes that a major thrust in the improvement of health care delivery systems should be to shift the emphasis from high cost in-patient hospital care to a more accessible ambulatory home care type. To achieve this goal, we feel, requires the expansion of present major medical and basic hospital contracts. The home care relations committee of HIAA is presently preparing guidelines, with the help of many of the provider organizations. Today I am here to learn, as are the Blue Cross people, and we support the need for a national policy."

Mr. LOWELL NORLING,
National Consumer Health Council.

"Primarily we are a grass roots organization, having just organized in October of 1969, and we do have some active participants. Basically, our organization is set up around health centers but it has extended out into many areas. I feel that our organization must have a voice, primarily so that poor people and people whose voice can't be heard, will be heard. It is an organization dealing with all ethnic groups. Retroactive denial is one of the real problems that we have run across. One of the things we are interested in is getting home care to the people who need it, at the time that they need it, and also so that they won't be denied because of Government regulations."

Miss MARGARET LEWIS,
President,
National Association of Home Health Agencies.

"The National Association of Home Health Agencies may be a very new title to many of you in the audience. We are only a year and a half old. The assoication was formed because many of us felt that home health services in terms of the health care system and also because we felt that we needed a single purpose organization. One sole aim was to promote home health care. Of course, we would hope that in the process of promoting it we did not neglect the other aspects of care that were important for patients but we did feel that we were on the low part of the totem pole."

"We are encouraging all of our State associations and our regional representatives on our board to conduct seminars and workshops in their areas not only to promote home health care in their communities, but also hopefully to sharpen the skills of the agencies in terms of administration, accountability, and all the other things which are important in any business administration."

"An example of what we've done in the first year: For one of our board meetings we came to Washington, D.C.; we spent 4 days in which we contacted every legislator with whom we could make a contact. We had a hearing with Senator Long's staff members and with Senator Mills' staff members. We have had a formal protest on the regulations which have been so difficult for us to live with. . . . We have also tried to meet . . . with all of the professions which are engaged in home health care. One of the concepts which we had when we began this organization was that it should be representative of all the disciplines who are engaged in the delivery of services."

"We have had an ongoing communication with HSMHA, Social Security Administration, with legislators, and private agencies, and we are hoping of course to eventually get involved with the labor groups."

Mrs. Helen Burr,
Consultant on National Organizations,
National Council on Aging.

". . . one of the great consumers of in-home services are those who are most needy, the aging, of course. Our organization started first as a committee in 1950 and then was incorporated as a council in 1960. The National Council on Aging is a membership organization of individuals; local, regional, and Federal organizations interested in programs on the aging, in delivery of services, in the consumer input into the services to be given. However, it does not itself give direct services. It does work on a planning and coordinating level with other organizations and it does publish and disseminate information, presently has a number of publications and a bibliography of library references that comes out periodically."

"We feel that we have a vested interest in the support of this kind of conference and the establishment of a national policy for in-home services for obvious reasons."

Mr. Berkeley Bennett,
Executive Vice President,
National Council of Health Care Services.

"The National Council of Health Care Services is made up of a select group of owned or managed companies, including hospitals, nursing homes, clinics, home health care agencies and pharmacies. They are involved in a broad range of health care services. They are all taxpaying companies, and as a condition for membership in the National Council, any companies owning hospitals or nursing homes must be accredited by the joint commission. Consequently, we are as involved and interested in standards in the home health service area as anyone possibly could be. I do feel that all of our members are interested in in-home services, they are interested in the whole concept of the continuum of care."

"We are interested in legislation that would deal with the difficulties with Medicare and Medicaid restrictions and also relate to coverage in HMO's and national health insurance. I believe now is an appropriate time for a group of this type to really get involved in convincing people that home health care and homemaker services are not add-on benefits, but that they are alternatives."

"There is a need to put the patient in the proper level of care. I don't look at it strictly from the viewpoint of getting the patient out of the hospital or the nursing home into home health care, but the other way around; I like to think of keeping them out of the hospital or the nursing home. I will add the significant factor that 20 to 30 percent of patients who are in nursing homes don't need to be there. One problem is that a lot of those people don't have any other place to go."

"We are very interested in the conference, we want to contribute, and we look forward to a really increased interest on the part of the legislature, on the part of Congress, and on the part of our agencies."

Mrs. Florence Moore.

Executive Director, National Council for Homemaker-Home Health Aide Services, Inc.

"The purpose of the National Council for Homemaker-Home Health Aide Services is to promote the development of quality homemaker-home health aide services throughout the country. It is a membership organization, incorporated 10 years ago, under the name, National Council for Homemaker Services, and about a year ago the membership voted to change the name to the National Council for Homemaker-Home Health Aide Services. This symbolizes the fact that this service is equally useful in the health and in the welfare fields."

"I am very pleased to tell you that in 1971 the board of directors . . . gave top priority to the development of an accreditations system for homemaker-home health aide services. That program has been developed, approved by the board of directors, and is now being implemented. At our annual meeting in April of this year, we gave out first certificates to agencies who were in substantial conformity with the standards that the National Council has developed. I think you should know that the standards were based on a code of standards developed in 1965, and both the code of standards and the standards subsequent to that code and the current standards being used for accreditation purposes were developed by groups very broadly representative of health and welfare interests at the national, State, and local level.

"When you hear statistics like Dr. Whitten gave us earlier, about the fact that we have 30,000 homemaker-home health aides and we need 300,000 homemaker-home health aides, you know we have a long way to go in this field. I'd like to just say though that I think that we are on our way. We estimate that during the last 6 years, when the last national survey of this field was done, we have had something like a 400 percent increase in the units of homemaker-home health aide service. This includes a large number of one and two homemaker-home health aid agencies, but nevertheless that is a substantial increase. It does mean that although some of these agencies are small, there is an administrative base there and they can expand from these bases."

"I would perhaps just close by saying that . . . I really liked the first speaker's reference to the 'untapped potential.' It's just beginning to have its potential felt and understood. It does seem to me, though, that if we come up with something in this meeting, there is one

thing that is absolutely imperative in terms of it being implemented and developed, and that is that we've got to work at this thing together. Individually, I can't really promote homemaker-home health aide services. Individually, perhaps you can't do a whole lot in terms of home health care, but together we can really move a mountain."

MRS. KATHERINE ELLICKSON,
National Council for Senior Citizens.

"The last speaker gave the same tone I wanted to give to it, the matter of how we implement what we do here. The National Council of Senior Citizens has 3 million members, organized in 3,000 local groups throughout the country. Many of these are union members still, or were for many years while they were working. While they are all senior citizens now, they are not interested in programs just for themselves, but also for their families, so that there is no limitation in the kinds of comprehensive home health services that they want. Now these people whom I have the responsibility of representing are the veterans of three catastrophic events: first, the great depression, which kept many of them in poverty or injured them physically; then, World War I and World War II. Part of our program is to get the Nation to accept more responsibility for assuring that these people have the kind of life, including health care, which they are entitled to, and which they cannot provide from their own depleted resources. . . . A national convention of the organization will be held next week, and I said to Nelson Cruikshank, the president of the organization, when he asked me to represent us here, what would the convention do about home health services? He said, that depends on what report you can bring us as to what is going to happen, and I do hope that there can be a focus from this conference what will enable me to say, 'Well this is what we hope can be accomplished', and that it will therefore deserve the attention of this national convention. Obviously, the National Council of Senior Citizens has to deal with many other problems besides this one, and they tend to focus on those where action can result from their efforts. They are still supporting changes in the Medicare regulations and in the legislation that would bring some of the kinds of improvements that have been talked about. Particularly, the matter of removing the restriction to the original illness, and preventing retroactive denials. The National Council of Senior Citizens, like the AFL–CIO, believes in a comprehensive national health service."

"In addition, we lobby for things like the nutrition bill (Administration on Aging) that was passed, which provides us $100 million, rising to $200 million, for meals for people, including the aged, which are provided in schools and churches, and in some cases to meals on wheels. The National Council of Senior Citizens, is strongly supporting the 20 percent increase in basic Social Security benefits which has now been sponsored by 55 members of the Senate. In the field of home health services the National Council brought over Dr. Lionel Cosins, who is a British expert in this field, and he testified in favor of comprehensive home health services before the Senate Finance Committee and also gave many lectures on the subject. So there is no question of where we stand on this, and of the awareness of our organization of

the need for great expansion in this field. However, may I say that I think we need to consider home health services, not nesessarily as an economy, because we have to be prepared to invest the necessary funds in this area. True, you can get savings on hospital bills or nursing home bills, but you also need a great deal more financial investment in the home health services."

"Our State and local groups take part in a great variety of activities. This is not a highly centralized organization. This is important to know so that when you want cooperation at the local level, from some of these senior citizens' groups, it will be necessary to contact the appropriate group locally, which may or may not carry the name that identifies it as one of our affiliates. I would hope you would include these groups in your planning, because some of these senior citizens do have time to take part in trying to get support for necessary steps. They have tended, these local groups especially, to do home visiting, to work for free or low fares on buses, and to get homestead exemptions in tax measures, so that the aged can stay in their homes, or pay low rent."

"May I close on the sense of urgency. The people I represent can't wait 10 and 20 years for something to be developed. For these senior citizens, veterans, and in many cases victims of the past, time is urgent. We hope increasingly they can be beneficiaries rather than victims of our health system."

Mr. PETER MEEK,
Executive Director,
National Health Council.

"I was asked to talk for a minute or two about what the National Council has done in the field of services in the home, and as I listen to a recital, one after another of our member agencies, has been at this podium, so I could practically say you have heard it from either our member agencies or organizations with which we are involved or who could be members in the Health Council."

After describing the function and organization of the National Health Council, Mr. Meek told of his experiences with previous attempts to develop services in the home. He emphasized the importance of the steering committee at the White House Conference on Aging and the implications of the new Kennedy bill and the HMO's. He concluded by cautioning against efforts to "re-invent the wheel" and pointed out the importance of constructive planning and joint action.

DR. DOROTHY MCMULLEN,
National League for Nursing.

"The National League for Nursing has six councils on nursing service and nursing education, one of which is the council of home health agencies and community health services. It is a descendant of the National Organization of Public Health Nursing which was originally founded in 1911. The council has in its membership over 1,400 home health and community health agencies and includes the majority of the large community health agencies across the country. These agencies provide services to people in their homes, in schools, ambulatory centers, and other community services such as senior centers, and other

neighborhood health centers. In the interest of improving the quality of community health services, the NLN and the American Public Health Association co-sponsored a national accreditation program for community health agencies. The criteria are more comprehensive than those required for certification under Medicare. A staff of experts is employed to administer this voluntary accreditation program, which aims to help agencies to evaluate and improve their policies and practices. The staff also provides consultation services through field visits, meetings of the council, correspondence and phone calls, and includes program evaluation and development, extension of services, continuity of care from hospital to home, administrative practices, budget and finance, personnel policy, in-service education, board participation, the agency's role in comprehensive health planning, and related areas."

"This year testimony has been given to the Senate Committee on Finance, and in November to the Committee on Ways and Means at the House of Representatives. It is prepared currently to testify on HMO's before the House Committee on Public Health and Environment."

"In 1969, a multidisciplinary advisory committee of the council was formed, which includes the following organizations: The American Speech and Hearing Association, the AMA, ANA, the American Occupational Therapies Association, American Physical Therapy Association, National Council of Hearing and Speech Agencies, the National Association of Social Workers, and the National Council for Homemaker Services. The councils and staffs of the NLN are much concerned with the need to improve and increase the care of people in their homes and on an ambulatory basis."

WORKING CONFERENCE

"IN-HOME SERVICES—TOWARD A NATIONAL POLICY"

URBAN LIFE CENTER, COLUMBIA, MD.

May 31, June 1 and 2, 1972,

To: Conference participants.
From: Program coordinator.
Subject: Background information.

The attached materials are suggested as a working basis for the deliberations of the conference. They should be considered only as a framework on which can be built the understandings and experience of all participants.

The Need for a National Policy

Expressions of interest in the potential of in-home services have been increasing in all areas of our health and welfare systems. They are stressed as an "alternative to institutional care" in health programs, and as an essential component in ambulatory care systems. They are cited as the means of producing a way out of the mental hospital—or of offering the possibility of a more normal way of life for the mentally ill who are still in the community. They are described as key services in preventing family disintegration in periods of family crisis, where the physical and psychological health of children is threatened. They are considered a valuable resource in the development of health patterns of family life for the economically and culturally deprived. They are repeatedly referred to as the most needed services for the aging population, for the chronically ill, for the disabled. They are beginning to be considered an important therapeutic supplement to community treatment services for special problem groups—in drug addiction and alcohol abuse.

These expressions of interest have produced a variety of approaches, many of them underlining or demonstrating the potential value of such services. *But—they have not yet produced a national policy.*

In the absence of such a policy, the stimulus for the real development of needed services also is lacking. Without a policy, without a legislative and financial base, broad community in-home services for the whole population cannot be developed and the potential of such services cannot be realized.

Definition of In-Home Services

The term "in-home services" is used as an inclusive term in order to broaden the concept of such services. It is meant to describe an array of services which can be brought into the home, singly or in combination, and which can be adapted to meet the needs of persons in all age groups, in all diagnostic categories and in all economic and psychosocial situations when such services can be used therapeutically, or to prevent or arrest illness and disability, to supplement limited function and to protect and support those whose capacities for optimum development, function and participation in family and community life are threatened. In this context, many services which have been minimally demonstrated in the United States, or which have been considered innovative possibilities but not yet developed, are included. The concept is not tied to existing payment sources, to regulations which limit the scope and duration of services, or to auspices. It is intended to describe a community-wide, coordinated network of services, a complex which can be considered a community institution and an essential component of the health and welfare system.

Purposes of the Conference

Conference participants represent organizations and agencies whose interest in the development of effective in-home services has been expressed and who are aware of the need for such services as a part of our community institutions. From the varied experience of the participants, it is hoped that the conference deliberations will produce:

1. A clear statement of a proposed national policy concerning in-home services in the United States.
2. A proposed strategy for the implementation of this national policy, including proposals and recommendations for immediate and long-term action.

More specifically, participants will be asked to work toward these goals through the tasks of:

1. Identifying conceptual, attitudinal, and operational barriers to optimal development and utilization of in-home services of several types including:
   a. Administrative.
   b. Legislative.
   c. Professional.
   d. Economic.
2. Establishing immediate and long-term objectives to overcome such barriers.
3. Preparing recommendations for specific action (short and long-term) to achieve the established objectives at:
   a. National.
   b. State.
   c. Local levels.

The Conference—Before and After

The status of home health services today has been fully identified in the report to the Special Committee on Aging by Brahna Trager. To conserve time in the discussions for a forward look, it is expected that all participants will be familiar with its content and thus be able to be involved more readily in planning for a national policy and strategy statement.

It is presently planned to video-tape the general sessions of the meeting, to edit them, and to provide this audio-visual tool to the regional offices for their use at State and local levels. In addition, written proceedings are to be prepared and will be widely distributed to all interested persons.

Finally, as an evaluative procedure, participants will be contacted, 3 months, 6 months, and 1 year following the conference to learn what steps have been taken or are planned by the represented organizations to implement the findings and recommendations of the "Expert" Meeting.

CONFERENCE AGENDA

Wednesday, May 31

9–9:30 a.m.: Registration and coffee.
9:30–11:30 a.m.: First general session.
Greetings: Dr. Paul Batalden, Director, Community Health Service.
Keynote address: Carroll Witten, M.D., president, board of aldermen, mayor pro tem, city of Louisville, Ky.
Legislative proposal: Mr. David Affeldt and Mr. Kenneth Dameron, staff of Senate Special Committee on Aging.
Goals of conference: Claire F. Ryder, M.D., M.P.H., Chief, Home Health Branch.
11:30–12 noon: Small group discussions—Session I.
12–1:30 p.m.: Lunch—continuation of Session I.
1:30–4:30 p.m.: Small group discussions—Session II.
6–8 p.m.: Social hour and dinner.
8–10 p.m.: Meeting of chairpersons, recorders, and staff—Session A (all other participants free for evening).

Thursday, June 1*

8–9 a.m.: Breakfast.
9–12 noon: Small group discussions—Session III.
12–1:30 p.m.: Lunch.
1:30–4:30 p.m.: Small group discussions—Session IV.

*All sessions to be held at the Urban Life Center, Columbia, Md.

4:30–6 p.m.: Meeting of chairpersons, recorders and staff—Session B.
6–8 p.m.: Social hour and dinner.
8–10 p.m.: Second general session—agreements and disagreements—chairperson: Dr. Claire Ryder.

FRIDAY, JUNE 2 *

8–9 a.m.: Breakfast.
9–12 noon: Third general session:
Conference summary: Dr. George Pickett, director, San Mateo Public Health and Welfare Department.
Reactor panel: Legislative point of view: Mr. Affeldt and Mr. Dameron; Professional viewpoint: Dr. Patrick Storey, representing the American Medical Association; the people speak: Mrs. Katherine Ellickson, representing the National Council for Senior Citizens.
Closing address: The Administration's Plan for Action: Mr. Arthur Flemming, Chairman, White House Conference on Aging, 1971.

CONFERENCE PARTICIPANT LIST

NATIONAL

American Association of Comprehensive Health Planning: Mr. Richard Schlesinger, Executive Vice President, Area-Wide and Local Planning, 1010 James Street, Syracuse, N.Y. 13202.
AFL–CIO: Mr. John J. McManus, Assistant Director, Department of Community Service, 815 Sixteenth Street N.W., Washington, D.C. 20006.
American Hospital Association: Miss Alice Gonnerman, Assistant Director, Division of Ambulatory Care, American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill. 60611.
American Medical Association: Dr. Patrick Storey, Professor of Medicine and Community Medicine, University of Pennsylvania, 36th Street and Hamilton Walk, Philadelphia, Pa. 19104.
Women's Auxiliary of the American Medical Association: Mrs. Manuel Bergnes, 1735 West Main Street, Norristown, Pa. 19401.
American Nursing Home Association: Dr. Thomas Bell, American Nursing Home Association, 1025 Connecticut Avenue, N.W., Washington, D.C. 20036.
Association of State and Territorial Health Officers: Malcolm U. Dantzler, M.D., M.P.H., Assistant State Health Officer, South Carolina State Board of Health, Association of State and Territorial Health Officers, 26 Bull Street, Columbia, S.C. 29201.
Blue Cross Association: Miss Ann Cohlan, Blue Cross Association, Federal Programs Contract Operation, Senior Director of Claims Service, 840 North Lake Shore Drive, Chicago, Ill. 60611.
Group Health Association of America: Mr. Jeffrey Cohelan, Executive Director, Group Health Association of America, 1717 Massachusetts Avenue N.W., Washington, D.C. 20036.
Health Insurance Council: Mr. William Reinertson, Associate Director, Health Insurance Council, 750 Third Avenue, New York, N.Y. 10017.
National Association of Home Health Agencies: Miss Margaret Lewis, President, National Association of Home Health Agencies, 659 Cherokee Street, Denver, Colo. 80204.
National Association of Neighborhood Health Centers: Dr. James Shepperd, Vice President, 924 Nineteenth Street N.W., Washington, D.C. 20036.
National Consumer Health Council: Mr. Lowell Norling, National Consumer Health Council, Palo Alto, Calif.
National Council on Aging: Mrs. Helen Burr, National Council on Aging, Consultant on National Organizations, 1828 L Street N.W., Suite 504, Washington, D.C. 20036.
National Council of Health Care Services: Mr. Berkeley Bennett, Executive Vice President, National Council of Health Care Services, 407 N Street S.W., Washington, D.C. 20024.
National Council for Homemaker-Home Health Aide Services, Inc.: Mrs. Florence Moore, Executive Director, National Council for Homemaker-Home Health Aide Services, Inc., 1740 Broadway, New York, N.Y. 10019.

National Council for Senior Citizens: Mrs. Katherine Ellickson, National Council for Senior Citizens, 1511 K Street N.W., Washington, D.C. 20005.

National Health Council: Mr. Peter Meek, Executive Director, National Health Council, 1740 Broadway, New York, N.Y. 10019.

National League for Nursing: Dr. Dorothy McMullen, National League for Nursing, 10 Columbus Circle, New York, N.Y. 10019.

United Way of America: Mr. John Tierney, Director of Health Affairs, United Way of America, 801 North Fairfax Street, Alexandria, Va. 22313.

STATE AND LOCAL

Mr. James Bergman, Director of Program Development, State Council on Aging, 141 Milk Street, Boston, Mass. 02109.

Mr. Richard Brown, Executive Director, Home Health Services of Louisiana, Inc., 2115 Caronochet Street, New Orlean, La. 70115.

Mr. Thomas Cook, Executive Director, Athens Community Council on Aging, 230 South Hull Street, Athens, Ga. 30601.

Professor Lester Davis, Chairman, Department of Human Resources, Westchester Community College, 75 Grasslands Road, Valhalla, N.Y.

Mrs. Shirley DeMott, Director, Home Health Services, West Nebraska General Hospital, 4021 Avenue B, Scottsbluff, Nebr. 63961.

Mr. Alan Fite, Executive Director, Nassau-Suffolk Home Care Council, 1200 Stewart Avenue, Garden City, N.Y. 11530.

Miss Jean Keating, Southeastern Kentucky Regional Demonstration, Inc., P.O. Box 4238, 1718 Alexandria Drive, Lexington, Ky. 40504.

Mr. Edward Lindsey, State Communities Aid Association, Buffalo Office—810 Genesse Biulding, Buffalo, N.Y. 14202.

Miss Helen Rawlinson, Director, Home Care Department, Blue Cross of Greater Philadelphia, 1333 Chestnut Street, Philadelphia, Pa. 19107.

Dr. Hugh Rohrer, Director, City Health Department, 2116 North Sheridan Road, Peoria, Ill. 61640.

Mrs. Dorothy Watts White, Administrator, Home Care Administration, 311 Alexander Street, Rochester, N.Y. 14604.

FEDERAL

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Office of the Administrator: Mrs. Ruth Knee.

Community Health Service: Office of the director, Donald P. Conwell, M.D.; Division of Health Resources, Paul D. Pedersen, M.D.; Division of Medical Care Standards, Mrs. Mary Frances Hilton.

Comprehensive Health Planning Service: Mr. James Williams.

Maternal and Child Health Service: Dr. Alice Chenoweth.

National Center for Health Statistics: Mrs. Gloria Hollis.

National Institutes of Mental Health: Miss Dorothy Collard, R.N.

Regional Medical Programs Service: Mr. Walter C. Levi.

National Institutes of Health, Bureau of Health Manpower Education, Miss Geri Piper.

Social Rehabilitation Service, Administration on Aging, Mrs. Stephanie Stevens; Community Services Administration, Mr. James Burr; Medical Services Administration, Mr. Joseph Manas.

Social Security Administration, Bureau of Health Insurance, Mr. Bruce Edemy; Bureau of Health Insurance, Miss Sue Jenkins.

Office of Child Development, Home Start, Dr. Ann O'Keefe; Health Start, Mrs. Olive Burner.

Veterans Administration, Extended Care Services, Dr. William Klein.

Senate Special Committee on Aging, Mr. David Affeldt and Mr. Kenneth Dameron.

General Accounting Office, Mr. Allen Elliot.

Regional Office, Community Health Service, Region III, Miss Marie Herold; Community Health Service, Region VII, Miss Helen Epp; Community Health Service, Region IX, Miss Esther Gilbertson.

Conference staff, Home Health Branch, Division of Health Resources, Community Health Service, Claire F. Ryder, M.D., M.P.H.; William E. Cox; Miss

Nina Lee; Miss Marcile Backs; Mrs. Melver Hodgson; Miss Cybthia M. Palank; Special Assistant, Mr. Hector Sanchez.

PROGRAM PARTICIPANTS

Dr. Paul Batalden—Speaker, Director, Community Health Service, Health services and Mental Health Administration, Rockville, Md.

Frank Ellis, M.D.—Conference Summarizer, Regional Health Director, Region V, Chicago, Ill.

Mr. Arthur Flemming—Speaker, Chairman, White House Conference on Aging, 1971.

Miss Brahna Trager—Special Consultant for Conference, San Geronimo, Calif.

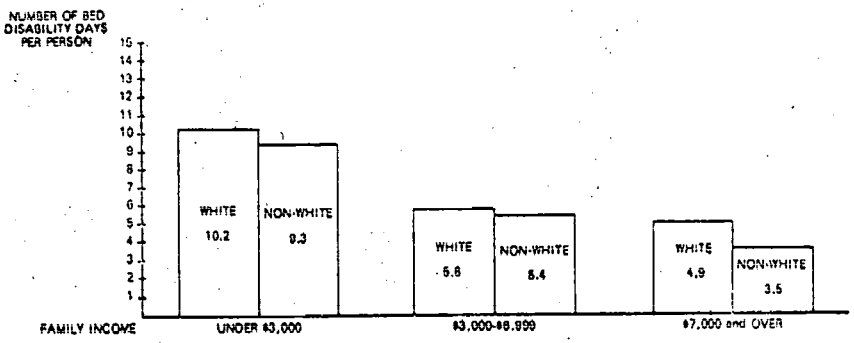
Carroll Witten, M.D.—Speaker, President, Board of Aldermen, Mayor Pro Tem, City of Louisville, Louisville, Ky. 40205.

APPENDIX 1

(Exhibits submitted by Brahna Trager)

EXHIBIT A

Chart 5 — Bed-Disability Days Per Person Per Year By Family Income, July 1965-June 1967



Source: Table 8

EXHIBIT B

TABLE 9.—DAYS OF DISABILITY PER PERSON PER YEAR BY SEX AND AGE, 1969

Sex and age	Days of disability per person per year		
	Restricted-activity	Bed-disability	Work-loss [1]
Both sexes—all ages	14.8	6.1	5.2
Under 17 years	9.8	4.7	
17 to 24 years	9	4	3.6
25 to 44 years	12.8	5.1	4.8
45 to 64 years	20	7.6	6.3
65 years and over	33.5	12.9	5.8
Male—all ages	13.4	5.3	5.1
Under 17 years	9.6	4.4	
17 to 24 years	8	2.7	3.6
25 to 44 years	10.8	3.8	4.5
45 to 64 years	19.1	7.4	6.5
65 years and over	30.9	11.9	6.7
Female—all ages	16	6.8	5.2
Under 17 years	10	5	
17 to 24 years	9.8	5.1	3.7
25 to 44 years	14.6	6.2	5.4
45 to 64 years	20.9	7.7	6.1
65 years and over	35.5	13.7	4

[1] Work loss reported for currently employed persons aged 17 years and over.

Source: 14.

EXHIBIT C

MEDICARE REIMBURSEMENTS FOR HOME HEALTH SERVICES AND INPATIENT HOSPITALIZATION, 1969–72

[In millions of dollars]

Year	Reimbursements	
	Home health [1]	Hospitalization
1969	79.7	4,088.6
1970	68.7	4,514.7
1971	56.6	5,026.0
1972 [2]	58.5	5,550.6

[1] Includes pts. A and B.
[2] Estimated on the basis of claims received through Dec. 7, 1972 (first 6 months multiplied by 2).

Source: Monthly Benefit Statistics, Feb. 15, 1972; No. 1—1973, DHEW/SSA/Office of Research and Statistics.

1971 medicare reimbursements

	Thousands
Hospital insurance	$5,234,630
Inpatient hospital	5,026,025
Home health	40,771
Extended care facility	167,834
Medical insurance	[1] 1,956,423
Physicians	1,748,270
Home health	15,824
Outpatient hospital	104,778
Independent laboratory	12,398
All other	75,062
Total	7,191,053

[1] Includes some reimbursables for which type of service is unknown.
Source: (Same as above.)
Home Health (pts. A and B) reimbursements for 1971, total $56,595 (in thousands) or 0.787 percent of the total Medicare reimbursement for services in 1971.
Prepared by Department of Home Health Agencies and Community Health Services, NLN, Feb. 20, 1973.

EXHIBIT D

To: D. Ann Cohlan, senior director, Federal Programs—Health Care Services, Blue Cross Association.

From: Helen L. Rawlinson, director home care department, Blue Cross of Greater Philadelphia.

Date: January 19, 1973.

Copy to: Howard W. Baker, M.D., vice president, Blue Cross of Greater Philadelphia.

Subject: Social Security Act—1972 Amendments (P.L. 92-603). Section 213—Limitation on Liability of Beneficiary and Provider Where Services Furnished Are Not Medically Necessary or not of a Covered Level of Care; Section 228—Assurance of Payment for Skilled Nursing Care Facility and Home Health Services.

I have studied the sections of the amendments noted above and various statements of criteria and procedures that have been drafted regarding their implementation. It is clear that the Congress included these amendments to authorize administrative procedures that would help to resolve problems and inequities experienced previously in the administration of the Medicare program. I am concerned, however, because enforcement of these sections of the law in relation to home health services will significantly increase both providers' and intermediaries' costs. It is particularly important to recognize that procedures required for enforcement will inevitably reduce the productivity of provider professional personnel, which is in short supply. Therefore, the following comments and suggestions are submitted for your consideration with the hope you will bring the recommendations to the attention of appropriate officials.

SECTION 213—LIMITATION ON LIABILITY OF BENEFICIARY AND PROVIDER

Effective enforcement of this amendment will require documentation that the provider advised the beneficiary the services supplied were, in the provider's judgment, considered to be not covered and the beneficiary accepted the services regardless of this fact. This requirement will result in severe problems for home health providers and, more important, for their patients.

Such mandatory documentation has serious implications that will impact not only on home health providers' administrative procedures and costs, but also on the quality of care they can provide. Nurses and therapists establish care plans based on professional judgments related to the physician's therapeutic plan and the medical goals established for the patient; also on the patient's nursing and/or therapy needs and the type of services and frequency of visits required to achieve the medically desired results. Unlike services provided in an institutional environment where patient care plans are carried out under circumstances and in an atmosphere that does not require patients to make decisions regarding their willingness or ability to assume financial responsibility for each service provided, the unit of service and cost under a home health plan is a visit to the patient's home. Therefore, the home health agency staff would be obliged to discuss with every patient who is a potential Medicare beneficiary each non-covered visit and to obtain the patient's acceptance or rejection of the service to document the beneficiary's liability and the agency's exercise of "due care". It should also be noted that it is not always possible to know in advance of a visit whether a covered or non-covered level of care will be provided because of the frequent fluctuations in the physical status of older persons with chronic or long term illnesses.

An average of 45 percent to 50 percent of all visits provided by home health agencies in the five county southeastern Pennsylvania area to persons over 65 years of age are now determined by providers to be for a non-covered level of care by Medicare definitions, and Medicare billings are not submitted to the intermediary for such visits. Notwithstanding the lack of Medicare coverage, home health agencies make every possible effort to provide services they deter-

mine their patients to need. If the patient can pay for all or part of the cost of non-covered visits, he is billed. If the agency concludes, often without discussing the issue with the patient, that he is financially unable to pay for the services provided, no bill is submitted and the agency seeks financial support for such costs from charitable and other sources. The provider's primary concern is to meet the patient's needs and voluntary HHA providers try to avoid patients declining their services because of financial considerations. This amendment would force HHA providers to discuss the payment status of all non-covered visits with patients who are financially able to pay either part of the visit charge or the total charge, and to obtain a signed statement from such patients accepting the non-covered services provided. Although patients for whom the provider voluntarily assumes liability do not represent a problem under the amendment, full pay and especially the part pay patients will present serious problems, complicated by the fact that patient care plans often call for covered visits to be interspersed with visits that by Medicare definitions represent a non-covered level of care. As noted previously, visits are made on the basis of professional judgments related to patients' medical needs. Professional nurses and therapists should not be obliged to discuss the medical implications of the need for non-covered visits with patients to obtain documentation of the beneficiary's acceptance of non-covered services when to do so would not be in the best interest of the patient.

It is apparent this amendment, although intended to protect beneficiaries from unreasonable financial obligations resulting from unpredictable and/or improper decisions and/or actions on the part of responsible Government agencies and fiscal intermediaries, may instead create an unanticipated and unintended situation in relation to proper and full use of home health services as an alternative to more costly institutional care. At the same time, it offers precious little prospect of serving a significantly useful purpose in connection with home health services because (1) the problem it is intended to deal with is not prevalent in the home health field; (2) judging from experience over the past five and one-half years, its enforcement, because of the necessary documentation required, will escalate administrative costs of home health providers and intermediaries while adversely affecting the quality of care and patient's willingness to accept needed services, and (3) it will interfere with the professional management of patient care and the delivery of medical services.

SUGGESTIONS AND RECOMMENDATIONS

1. We suggest the rulings regarding procedures for implementation of Sec. 213 applicable to home health providers be written independently of procedures for institutional providers and after consultation with persons experienced in the area of home health administration.

2. We recommend that procedures promulgated for enforcement of Sec. 213 in relation to home health providers be implemented at the discretion of intermediaries or BHI regional offices. Implementation would be required only and during the period a provider is determined to be functioning unsatisfactorily in exercising "due care" in (1) making consistent and accurate decisions regarding covered levels of care, and (2) advising beneficiaries appropriately of the financial obligations they incur upon acceptance of the home health services provided.

SECTION 228—ASSURANCE OF PAYMENT FOR HOME HEALTH SERVICES

I am concerned that this section, which applies to Part A home health claims only, will create unreasonable and unnecessary problems in processing home health claims and provider and intermediary costs will be significantly increased. Again, the documentation required for effective enforcement by intermediaries will lessen the productivity of the provider's professional staff because of the duplication of time and effort in writing clinical records that will be required. This view is shared by all local home health providers who have discussed the matter with me.

If it were conceded that an assurance of payment procedure would serve a useful purpose, it is impossible to rationalize its application to Part A claims only since eligibility for Part A home health coverage can usually be determined with more confidence than eligibility for Part B coverage. This is due to the fact that Part A benefits are allowable only after beneficiaries have been treated in a

hospital or skilled nursing facility for at least 3 days and no more than 14 days prior to establishment of the home health plan or treatment. Therefore, these patients' conditions and their need for home health services are documented and easier to assess than is generally the case with beneficiaries eligible only for Part B coverage.

The number of Part B home health claims is almost equal to the number of Part A claims. Therefore, the assurance of payment amendment will, at the most, apply to only about one-half of all home health claims and these represent the least controversial in terms of coverage eligibility.

This amendment represents little value if providers have been adequately instructed by their intermediary regarding the rules and regulations governing covered and non-covered services. There is little, if any, justification for mandatory implementation of this amendment.

Therefore, we strongly urge that, if permissible under the law, guidelines pertaining to Sec. 228 specify that implementation of assurance of payment be voluntary on the part of providers and/or intermediaries as now is the case with periodic interim payment provisions. That is to say, the assurance of payment procedures for home health services need not be implemented unless requested by the home health provider.

EXHIBIT E

REPORT OF THE COUNCIL ON MEDICAL SERVICE

American Medical Association Report: C (C–73)[1]

Subject: Home health care.
Presented by: William B. Hildebrand, M.D.
Referred to: Reference Committee D (G. E. Collentine, Jr., M.D., chairman).

The Committee on Community Health Care reviewed the AMA position on home health care and prepared this report, which consolidates information previously contained in several different publications. The report includes discussion on:

1. Background.
2. Patterns and Levels of Care.
3. Homemaker-Home Health Aide Services.
4. Financing of Home Health Care.
   A. Private Insurance Programs.
   B. Federal Programs.
5. Benefits of Home Care Services.
6. The Role of the Practicing Physician.
7. The Role of the Medical Society.
8. The Role of the Institution Medical Staff.

The American Medical Association defines home health care as: Any arrangement for providing, under medical supervision, needed health care and supportive services to a sick or a disabled person in his home surroundings. The provision of nursing care, social work, therapies (such as diet, occupational, physical, psychological, and speech), vocational and social services, and homemaker-home health aide services may be included as basic components of home health care. The provision of these needed services to the patient at home constitutes a logical extension of the physician's therapeutic responsibility. At the physician's request and under his medical direction, personnel who provide these home health care services operate as a team in assessing and developing the home care plan.

1. Background

The changing age composition of the U.S. population and the proportionate increase in long-term illness and disability have resulted in the medical profession's increased recognition of the need for examining and improving traditional methods of delivering health care services.

Over the past half century, the increase in prevalence of such chronic diseases as hypertensive and arteriosclerotic heart disease, cerebrovascular disease, arthritis, neurological disorders, malignancies, and pulmonary disorders has expanded demand for long-term medical and supportive care. Many of these diseases, after a dramatic acute phase, are followed by long periods of convalescence, rehabilitation, and supportive care often punctuated by additional acute episodes. Other medical problems have a less acute onset phase that requires definitive diagnosis followed by a long course of definitive therapy. Congenital defects (in structure or metabolism) and disabilities resulting from accidents also contribute their share of long-term care problems.

Such diseases or disabilities present difficult problems of medical, social, and economic significance. The long periods of time involved in treatment and rehabilitation, with the resulting social and financial burdens placed on the individual, the family, and society in general, necessitate that physicians become concerned with optimal methods by which needed services and facilities can be furnished to the patient.

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[1] Past House Action: C–70: 146, 176–117; A–67: 63–65: A–62: 118–119; C–61: 170, 182; C–60: 155, 157, 163–164.

Obviously, during the acute phase of illness the complex and costly services of the general hospital are often necessary. In the period of continued disability, however, hospital stay on a continuous basis frequently is neither necessary nor desirable. The patient may be moved from the hospital to a skilled nursing home. At any time when part-time services are needed, the patient may well benefit from the provision of medical and other needed services at home. In addition to those patients who are referred from an institution, many patients are ill in their own homes, and they may need the same kind of services. Although not currently needing an institutional setting, they need home care as preventive and therapeutic measure. Home care is of benefit for many categories of patients—the acutely ill, the convalescent, and those recovering from surgery. 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." A 1972 report, Home Health Services in the United States, prepared for the U.S. Senate Special Committee on Aging, verifies the fact that many patients in nursing homes could better utilize home care services.

2. Patterns and Levels of Home Care

Home care services are available from a variety of sources. They may be provided through: (1) A single service agency such as a homemaker-home health aide services program or a meals-on-wheels program; (2) a multiple-service agency that arranges for two or more types of services, such as home nursing care, physical therapy, and homemaker-home health aide, or (3) a coordinated home care program that arranges for a wide range of home services designated to meet the patient's individual needs through one centralized administration. The coordinated home care program also is responsible for planning, evaluation, and follow-up procedures to provide physician-directed medical, nursing, social, and related services to selected patients at home.

Home care is generally considered to be categorized into three component levels: (1) Concentrated or intensive care; (2) intermediate service; and (3) basic services.

The most concentrated or intensive service is for patients who would ordinarily require admission to inpatient institutions. Some patients require complex professional services on a coordinated and continuing basis for brief periods of time. They do not require full-time resources and can benefit from intensive home health care services.

Intermediate services are those needed on a less intensive basis. Patients requiring intermediate services may have long-term problems or may have been recently discharged from an acute care facility.

Basic services are those that provide an effective level of health care for an individual within that person's home. Basic service should be sufficient to sustain patients adequately so that they can remain relatively independent. Assuming they have stabilized physical conditions, they do not have to return to an inpatient facility for more intensive care.

Home health services, including follow-up, can be provided by many different kinds of private and public agencies, including visiting nurse associations (VNA's), departments of public health, and hospital-based programs. VNA's are voluntary nonprofit groups that deliver nursing services in the home. The public health departments are governmental units that may provide, in addition, a variety of services such as case finding, preventive services, observation, and follow-up. Hospital-based home care programs serve as an extension of hospital services and can provide nursing care plus a variety of other supportive services to noninstitutionalized and post-hospital patients.

Since enactment of the Medicare law, programs that were previously providing nursing care of the sick at home have expanded their functions to include other services, such as physical therapy, homemaker-home health aide services, and social services. Whether a VNA, a public health department, or a hospital-based program, a home health agency certified under Medicare must receive referrals from physicians. It provides services for both noninstitutionalized and the post-hospital patients.

Whatever the organizational mechanism, home care services at any of the described levels should be viewed as an alternative to hospital, nursing home, or other institutional care and as part of a total medical care plan. As such,

home care can enable the patient to remain in, or return to, a home environment that may be psychologically therapeutic and probably result in a cost saving. The patient must want to receive care in the home environment and family relationships should be conducive to care.

Training of the patient in self-care and instruction of family members are of prime importance in achieving maximum effective utlization of available professional health personnel. For example, institutional efforts devoted to careful instruction of a diabetic or a post-coronary patient and his family before the patient goes home provides for continuity of care and reinforcement of the educational process in the setting of the patient's home. Home care will be enhanced by having instructions start in the hospital because they will then be reinforced in the home.

3. Homemaker-Home Health Aide Services

Homemaker-home health aide service programs offer a type of home health care to a variety of patients, Homemaker services originated in the 1920's. Services are provided by homemaker-home health aides who are mature and specially trained persons with skills in both homemaker and personal care. They help maintain and preserve a family environment that is threatened with disruption by illness, death, ignorance, social maladjustment, and other problems. They can assume full or partial responsibility for child or adult care, for household management, and for maintaining a wholesome atmosphere in the home. Their activities are performed under the general supervision of a nurse, social worker, or other appropriate health professional.

Home health aide services is a term that refers to the personal care services for the patient. This term was first used in the Medicare regulations to describe the services eligible for reimbursement under that program. Home health aide services can be broadened to include certain functions of homemaking directed toward maintaining the environment of the patient.

Homemaker-home health aides can perform a number of routine duties: light housekeeping, light laundry, preparation and serving of meals, shopping, simple errands, teaching of household routine and skills to well members of the family, and general supervision of the children of the patient. There is a need for the expansion and extension of this service in new and imaginative ways.

The AMA and its women's auxiliary have long promoted the use of effective homemaker-home health aide services. The AMA supports the appropriate development of homemaker-home health aide services. Physicians and medical societies as well as hospital administrators and other health professionals should appreciate and understand the important role that the homemaker-home health aide can play in the proper operation of a coordinated home care program.

The National Council for Homemaker-Home Health Aide Services, Inc., is a nonprofit, tax-exempt, voluntary membership organization whose purpose is the development of quality homemaker-home health aide services as an integral part of health and welfare services delivered in the home. In 1969, it was named as the national standard-setting body for homemaker-home health aide services for the program administered by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare. In this role, the National Council has developed and is implementing a national approval program that can offer help in assuring the quality of homemaker-home health aide services. The AMA has actively supported the National Council since its beginning and, in November 1970, the AMA urged support and extension of homemaker-home health aide services.

Homemaker-home health aides help a community maintain and improve its physical and mental health by providing high quality homemaker-home health aide services. The medical profession should cooperate with and support individuals and organizations that are capable of delivering these high quality homemaker-home health aide services in communities where they are needed.

4. Financing of Home Health Care

The financing and the cost of home health care services are complex subjects. From the standpoint of coverage and reimbursement, home health services have been almost ignored by most third parties in the past. In recent years, however, home care coverage is more available as a result of patient and provider satisfaction and the recognition by all parties of the potential cost savings. The AMA

believes that home health services should be an integral part of any health insurance program.

The appropriate use of home health care services can reduce unnecessary utilization of institutional services. Earlier discharges from hospitals release more hospital beds and can reduce the costs of hospital stays. The National Association of Home Health Agencies has reported that if the average hospital stay were shortened by one day for only five precent of all hospital patients, the potential cost savings would be about $100 million annually. However, this figure does not include the operating cost of maintaining empty institutional beds that must also be assumed by communities. Also, it must be understood that home care programs may merely shift a portion of the total health care costs from the inpatient category to the outpatient category. This outpatient home care service can normally be provided at a fraction of the inpatient costs and thus an overall savings can be expected. This shift in costs from the inpatient category has usually resulted in out-of-pocket expenses for the patient because the inpatient care was reimbursable whereas home care or ambulatory services are frequently not covered.

A. PRIVATE INSURANCE PROGRAMS

Third party payors, including Blue Cross-Blue Shield and commercial insurance companies, are recognizing that effective utilization of home health care services potentially can result in significant cost savings. As a result, a greater number of health insurance policies are beginning to include coverage of home health care services. Insured home care programs in two areas—Philadelphia, Pennsylvania, and Rochester, New York, have been in operation for several years and have reported significant cost savings.

The Blue Cross of Greater Philadelphia Home Care Program was developed to serve as an effective alternative to institutional care for patient and physician use. Blue Cross of Greater Philadelphia worked with selected member hospitals and community home health agencies in a collaborative effort to develop an administrative mechanism to facilitate coordinated home health care delivery as an alternative to inappropriate and unneeded institutional care. Under this program, Blue Cross subscribers were provided a broader range of benefits. The patients who have made use of the home care have generally accepted the opportunity for care. They have been released from hospitals an average of 13 days earlier than they would have been without the availability of the coordinated home care service. Expressed in the value of inpatient days saved on 3,940 home care cases, this amounted to a gross savings of approximately $2.5 million. Net savings amounted to approximately $1.3 million, or $330 per case after deducting the cost of providing home care services and the related program administrative costs. More than 800 private physicians have participated and referred patients to the home care service. Most of the physicians indicated they preferred coordinated home care to continued hospitalization. Better cooperative relationships, high quality programs, and professional skills have been developed within the participating hospitals and community home health agencies.

The Rochester (New York) Home Care Association Program is also underwritten through the Rochester Blue Cross Program. Home care services are purchased primarily from the VNA and the public health nursing department. Direct social services are also provided in this well organized program that offers continuing care. Patients are referred to the home care program in many ways and from a variety of providers, including practicing physicians, and organizations within the community. The program grew from a total of 141 referrals in 1961 to over 1,500 referrals in 1970.

The national inpatient per diem cost rose from $36 in 1961 to $92 in 1971. In 1961, the Rochester home care cost per day was about $8 and in 1971 it was $16, and it offered approximately a $76 saving over charges for a patient day in the hospital in 1971. The average hospital length of stay for the type of patient served by the program was about 40 days. However, through utilization of home care services a savings of 21 inpatient days per case was realized. For the calendar year 1970, the Rochester Home Care Program achieved a net savings of over $1 million.

Both of these programs illustrate that effective programs of home care services can reduce costly inpatient stays and thus achieve significant savings.

Blue Cross, Blue Shield, and other insurance companies will underwrite almost any service for which the insured group is willing to pay the premium. It must be remembered that labor and management play a large part in determining what goes into an insurance contract.

B. FEDERAL PROGRAMS

Government programs generally provide for reimbursement of home health services to the extent that such coverage is specifically included in the law. Thus in Medicare and Medicaid, in which home health services are identified in the statutes as reimbursable, the service is generally provided. In the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) and the Federal Employees Health Benefits Program (FEHB), home care is normally provided and reimbursed as an adjunct to physician services.

1. Medicare—Title XVIII

Medicare reimburses for home health services under both Parts A and Part B of Title XVIII. After a minimum of 3 days' stay in a hospital or after a discharge from an ECF, Part A pays for up to 100 hospital-related home health visits within a 12-month period. These visits must be ordered by a physician according to a plan established within two weeks after institutional discharge. The home health agency must be a participant in the Medicare program and the patient must be treated for the same condition for which he was hosptialized. Part B of Medicare pays the providing home care agency for up to 100 home health care visits each year when a patient has no prior hospital stay if such services are provided according to a plan of treatment approved by a physician. Part B of Medicare also may be used if the patient's Part A visits have been exhausted.

It should be emphasized that Part A pays reasonable costs of home health services, while Part B pays 80 percent of the reasonable cost of services after the patient has met the overall annual $50 deductible for Part B services.

Medicare cost data for fiscal year 1971 indicate that both the number of claims and the amount paid comprise an extremely small portion of the total expenditures for the program. Home health services accounted for less than 20 percent of the number of claims and less than 1 percent of the dollars paid out under Medicare.

2. Medicaid—Title XIX

Medicaid statutes list services that are eligible for Federal matching, including home health care services. Home health care services are defined in Medicaid regulations to include nursing and therapy services, as well as other services provided through a home health agency under direct supervision of the physician. About 80 percent of the individual State Medicaid programs have included home health services either for the categorically indigent or the medically indigent. As of July 1, 1970, all States were required to provide home health services for eligible individuals entitled to skilled nursing home services. All home health agencies participating in the Medical program must meet Medicare standards.

Unlike Medicare, the Medicaid program does not require payment of reasonable costs or reasonable charges but rather the law states that payments may not be in excess of reasonable charges. There is no minimum payment level set. In general, the method of determining payment levels is a state option.

In the overall Medicaid program, home health expenditures again are a small part, totalling less than a half percent of the dollars paid out.

3. Civilian Health and Medical Program Uniformed Services (CHAMPUS)

The Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) is one of the most comprehensive Federal health programs, and it is administered through a number of private insurance carriers and/or State medical societies. There is no specific listing of home health services in the enabling legislation or in descriptive materials issued by the program. The program attempts, where feasible, to pay for any appropriate legitimate services ordered by the physician for treatment of a patient. Apparently most, if not all, of the individual services provided by home health agencies could be ordered by

a physician and paid for under the program, but each would be paid and reported under the category of the specific individual service such as nursing, speech therapy, physical therapy, etc, rather than as organized home health services. CHAMPUS will pay for home care by registered nurses, and by licensed practical nurses, as well as by other health providers.

4. Federal Employees Health Benefits Program (FEHB)

The Federal Employees Health Benefits Program (FEHB) has no statutory mention of home health service. Enabling legislation, P.L. 86–382, speaks of "general care rendered in the patient's home," "ambulatory patients' benefits," and "other medical supplies and services" but makes no statutory requirement for specific coverage of home health services. Statistical reports on the program do not identify utilization of such services but generally combine all hospital benefits. It is estimated that approximately 95 percent of those enrolled in the high option FEHB program are covered for home nursing, but the patient often pays a deductible or has some other limitation, such as a coinsurance payment. Coverage by the two largest plans—the Blue Cross-Blue Shield and Aetna (the contractor for the other insurance companies)—includes a variety of home health care services.

There are limitations in most of the Federal programs. Some limitations in home health service under the Medicare program are: (1) Focus is on acute or short-term illness; (2) there are inherent contradictory definitions of the eligible home health service patient as applied to the insured group's need; (3) reimbursable services are not necessarily those most needed by the majority of the insured group; (4) definitions of reimbursable services are susceptible to a great degree of interpretations; (5) many agencies have been placed in financial jeopardy by delays in reimbursement resulting from administrative complexities; (6) difficulties are encountered in establishing and maintaining comprehensive services because reimbursement from the insurance system is limited to selected services; (7) strong institutional bias exists with a 3-day hospital stay required prior to entitlement for home health services under Part A, and non-hospital related home health services under Part B are dependent on the individual's paying the insurance premium and 20 percent of the cost of service; (8) cost of home health services under Medicare has remained at less than 1 percent of insurance expenditures and appears to be diminishing while expenses for institutional services are increasing. Similarly, many of these criticisms have been leveled against the State-administered Meidcaid program.

The United States Senate's Special Committee on Aging's 1972 report, Home Health Services in the United States, stated that there were minimal Federal resources allocated for the creation of appropriate home health service programs and that, where there were resources, strict regulations had hampered the success of such programs in meeting the needs for home care. A question might also be raised as to what degree any open-ended need for home health services can realistically be met.

5. Benefits of Home Care Services

The benefits of effective home health care programs can be summarized as follows:

1. Patients prefer care that can be provided in the normalcy of their home environment.
2. Home-bound people can be taught to live in a relatively independent status.
3. The need for initial admission or readmission to inpatient institutions can be diminished.
4. For the necessary institutional admission, unnecessary days can be eliminated through early discharge to home care.
5. Unnecessary capital construction costs for inpatient facilities can be decreased.
6. The efficiency of the practicing physician can be increased by expanding the team approach. The physician can care for a greater number of patients through a home care program because he does not have to assemble and coordinate individually the services needed for his patients in their home settings.

7. Home care staff can readily interpret medical orders, explain treatment regimes, and offer reassurance and support.

8. Home care staff can identify day-to-day problems and thus help to reduce the possibility of emergency situations arising.

6. The Role of the Practicing Physician

Depending upon the needs of the patient, home health care may require many persons and organizations to combine their efforts and form a health care team under physician direction. Leadership by physicians is essential to the efficient and successful provision of home care services. This leadership role can be expressed in many ways. Examples are as a: (1) medical director in a hospital; (2) medical director of a community-based home health agency; (3) member of a board or advisory committee of a home health agency; (4) coordinator of a hospital-based home care program; (5) a member of a home care committee or similar body of a hospital, health center, medical society, etc., or as (6) a private practitioner who makes appropriate use of home health services in his patient care management.

Whatever the role, some suggestions for physicians are:

1. The physician should be aware of the home care services available in his community and the various methods by which they can be developed or improved.

2. The physician should assist in initiating innovative ways in his community that encourage the delivery of more efficient, more economical, and more appropriate care in the natural home setting of the patient.

3. The physician should become familiar with the various financing alternatives that can be used in paying for home health services.

4. When referring patients for home care, the physician should establish a plan of treatment for each patient and should periodically review this plan and the patient's progress with the home health personnel providing the care. Special efforts (or arrangements) may be needed to maintain this communication when a patient is cared for at home because of the separation in time and distance between the different services and personnel involved. The physician may, therefore, wish to support the establishment of coordinated home care programs that can fulfill this role.

5. The physician should ensure that he receives regular reports, observations, and progress notes from the health personnel or home care program providing the services.

7. The Role of the Medical Society

The medical society has a proper concern with the availability and adequacy of health care services for the population in its service area. The medical society, therefore, should stimulate physician interest in and acceptance of home care as an integral part of the overall continuum of care. Along with this, the society should provide community leadership in both improving the coordination of existing home care services and stimulating the development of new services where they are needed.

Adequate community home care services will be dependent not only upon the actions of the local medical society but also upon the sound cooperative planning efforts of many public and private health and service agencies in the community, especially the community health planning agency. In addition to the medical society and its women's auxiliary, other agencies that might properly become involved in the overall community planning for home care include local and State health departments (particularly their bureaus of nursing); local visiting nurse associations or community nursing services; local or State nurse, hospital, and nursing home associations; local or State health professional provider organizations; health financing organizations; chambers of commerce; and other important community business and government leaders.

Medical societies should help to ensure that the community health planning agency has broad representation from all organizations concerned with providing home care. The medical society, in particular, can stimulate the involvement of physicians in these planning activities. Some of the activities that the community planning agency may want to consider in the development of adequate community home care services are:

1. Measure the need for such services in the community by making inpatient population analyses and demographic studies that show who can use

such services and show what significant economic benefit can be reaped by a community.

2. Measure the capability of the community to provide home care from the standpoint of manpower, financial, transportation, and institutional resources, and any other necessary resources.

3. Stimulate the development and use of home health care programs in the community in whatever setting is considered most appropriate.

4. Identify expected sources of income for the program and urge expansion of existing insurance payment mechanisms for appropriate types of home care.

5. Make use of medically and ethically sound promotional and educational material on available home care programs.

6. Provide technical advice and assistance in developing and operating home care programs.

7. Encourage the public to demand insurance coverage for a needed home care alternative.

The medical society should also urge the medical directors in hospitals and other health facilities to develop continuing professional education programs on the utilization of home care services. Communitywide public education programs should be initiated as a means of promoting community acceptance.

The medical society should emphasize the need for medical schools and internship programs to educate medical students, interns, and residents in the value and proper use of home care programs.

The medical society should emphasize in all of its deliberations concerning home care that effective home care programs can offer high quality medical care and can be an extension of the physician's services at very little cost and effort to him.

Each medical society should create a home care committee to coordinate the medical society's activities on the subject of home care.

8. Role of the Institutional Medical Staffs

As an integral part of a health care institution, the organized medical staff should be particularly sensitive not only to that institution's specific needs and goals but also to the important community problems of the needs of the patients and the alternative patterns of care that can most appropriately answer those needs. Because the medical staff's decisions affect the general utilization of institutional beds and services, it is important that the hospital medical staff be fully aware of the value and proper use of home care programs. The medical staff's primary concern is to ensure that all patient care is appropriate and of high quality. These concerns should lead the medical staff to seek active and involved representation on the institution's home care committee. If there is not a home care committee, the medical staff should stimulate its development.

The interests of an institutional home care committee should extend beyond acute inpatient care and they should determine the appropriate and effective use of home care programs for the patients served by the institution. The home care committee should coordinate its efforts with the activities of the medical society, the community planning agency, other appropriate community agencies, and organizations concerned with home care services.

The medical staff and the home care committee should urge the medical director of the institution to develop and offer continuing professional education programs on the use of home care services. The home care committee should ensure that any interns, residents, and other health professional students in the institution are trained in the value and use of the home care program. The committee should also encourage the development of appropriate professional review and evaluation of home care programs. The effective use of the home health care services can only be realized when well designed criteria for selection of patients for home care and standards for evaluating the effectiveness of home care are used.

EXHIBIT F

To: Brahna Trager.
From: Helen L. Rawlinson, Director Home Care Department, Blue Cross of Greater Philadelphia.
Date: February 20, 1973.

Home care, its potential values and the problems that have impaired its growth and utilization were carefully stated and well documented in "Home Health Services in the United States," the report you prepared for the Special Committee on Aging of the United States Senate. Although there is some evidence that more recognition is being given to the need to effectively incorporate home care in the main stream of the health care delivery system, there is precious litle evidence of action in this direction. It has been said that delay is the worst form of denial with respect to enhancing the quality of patient care, and reducing related costs, through expanded and appropriate use of home care services, we have witnessed the validity of this statement. Expressed opinion is generally in favor of home care, but action to establish it as a viable component of the health care delivery system is afforded a priority so low that the resulting delay in effective action threatens the capability of organized providers of home care to maintain even the services they have supplied in the past.

Several reasons for this decline could be stated but, in my view, the three most important causes are:

1. Absence of physician understanding and interest.
2. Emphasis on health services provided in institutional facilities.
3. Isolation of home care providers from the "main stream" of the health care system and the absence of innovation in development, delivery and administration of home care services.

These issues can only be dealt with by casting aside thinking that is circumscribed by historical burdens and moving forward vigorously to replace traditional concepts with decisive action toward new administrative and service patterns that will be responsive to countemporary problems and needs. A prerequisite to change in correction of the erroneous understandings and thinking that associate the financing, administration and delivery of home care services with institutional providers of health care.

There is little comparability between economic forces related to institutional and physician services and home health services. Except for a history of casual utilization controls in providing prolonged periods of health supervision and maintenance levels of care, home health agencies have enforced extraordinary economy in their operation. They have in no way contributed to the escalation of health care costs. Nevertheless, they have had to absorb the problems of increasing costs, especially salary costs which they have been obliged to meet to compete with institutional providers for qualified professional personnel. More recently they have had to incur substantial increases in administrative costs to comply with Medicare provider certification and reimbursement regulations. Concurrently, charitable and local government financial support has been reduced drastically on the assumption that Medicare cost reimbursement would eliminate the deficits previously covered by these sources of financial support. This has not been the case, however, because Medicare coverage of home health services is defined narrowly while voluntary (nonprofit) agencies have continued to try to provide the services their patients need regardless of the availability of Medicare or other third party reimbursement. More recently, rulings of the Economic Stabilization Program have compounded home health agencies' financial problems by ruling out the possibility of obtaining reimbursement of their costs related to providing covered services to Medicare beneficiaries. Many agencies, as a result, have depleted their modest endowment funds that were accumulated from gifts over the years and others have had to reduce their services to patients. Many are facing total financial insolvency. Therefore, the future of home

health services is dependent on correction of the unreasonable raises of the agencies financial instability.

Assuming adequate financial resources can be made available, providers of home health services could take initiatives through cooperation and structural relationships with physicians and institutional providers to deal with some of the most acute deficiencies of our health care system—providing care, under medical direction, to individuals in their places of residence when institutional care is not medically required, assessing individuals' health needs, and assisting those who require active medical treatment and/or institutional care to reach promptly the appropriate sources of needed care. For example: Professionally qualified and supervised home health agency personnel could be regularly assigned as an on-site primary care resource in housing complexes for the aging and in other areas where an aging population is concentrated. These practitioners would provide primary care screening, health education and maintenance services, morbidity care and access to supportive services required incident to illness of either an acute or chronic nature. They would provide a continuance of medically directed care following hospitalization or other institutional care.

A program as described would contribute significantly to resolution of the problems associated with the absence of primary care in the community while relieving the need for physicians to make time-consuming visits to patients' homes. The proper use of qualified home health agency professional personnel could be one of the most effective steps toward building a primary care system. Home health agencies would provide in the community setting needed and appropriate levels of health and related services as hospitals provide the required levels of care in an institutional setting.

Implementation of this concept would require home health agencies to expand their staffs to include clinicians and practitioners in nursing and the allied health professions. To accomplish the objectives, new relationships with physicians and health care institutions would have to be achieved; new administrative concepts and practices would have to be developed; there would have to be relief from inappropriate and unreasonable financial restraints; financial support would have to be provided for well conceived and managed demonstration projects; and logical thinking would have to prevail among planners and persons formulating reimbursement policies. Home health services would become an integral part of the organizational infrastructure of the health care delivery system.

As stated so well in the Senate Committee Report of April 1972, "They (home health services) are an essential component of any system of comprehensive health care and the absence (or the failure to use appropriately) such services excludes the possibility of the most appropriate use of all other health resources." In an article in the March 1971 issue of "Inquiry", Anne R. Somers wrote, "The guiding principle of the Swedish planners is that 'care should be provided at the lowest acceptable organizational level of the medical care system'."

In terms of the needs of the aging, it is not an "alternative" service that is needed, but a whole new organization of services that will assure accessibility and effectiveness when they are required and delivered where they are needed. A system that would provide ready availability of services, coordination of services under professional supervision, channels to other levels of care, and helpful counseling. Such a system would be an alternative to the bewildering fragmentation and the inaccessibility of entry to the system that now prevails.

EXHIBIT G

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

FACT SHEET

N.A.H.H.A.

The National Association of Home Health Agencies believes that: The inclusion of in-home health services as an integral part of a rational health system should result in a reversal of a trend toward institutionalization, increased consumer satisfaction and moderation of rising costs.

DEFINITION

In-home health services are the activities and services provided to individuals and families in their places of residence for the purpose of promoting, maintaining or restoring health, or minimizing the effects of illness and disability.

ADVANTAGES

Home care produces greater results in relieving human misery. Various studies have revealed that:

1. 84–90 percent of the patients preferred home health care to institutionalization.
2. 84–95 percent of physicians felt that home care could satisfactorily meet the needs of their patients.
3. Home care was the service of choice.
4. Home care enables patients to retain independence.

Home care extends services to residents of ghetto, rural and suburban areas. It increases efficiency in utilization of manpower.

COST

In-home health services lessens the cost of illness:

1. Home care is 3½ times less expensive *per case* than hospitalization.
2. Home care is 4–5 times less expensive *per day* than skilled nursing home care. (E.C.F.)

In-home health services reduces the high health care costs:

1. Home care saves community funds.
2. Reduces the length of hospitalization.
3. Decreases hospital re-admissions.
4. Makes many nursing home admissions unnecessary.
5. Reduces capital construction costs of new institutional beds.[1]

In-home care insures that given amounts of money will accomplish more:

1. Maximizes each individual's potential for self-care.
2. Extends the efficiency and coverage of practicing physicians.
3. Home environment is more conducive to patient learning than the hospital.

QUALIFIED PROVIDERS

In-home health services must be furnished by only organizations that meet the following qualifications:

- Primarily engaged in providing in-home health services.
- Have a readily identifiable governing body accountable for the management of the agency.

[1] New Jersey in 1970 saved Medicare an estimated $3.5 million through selective and proper use of home health services, extended care services, and hospitals.

- Have established policies, reviewed and approved by a committee of health professionals and consumers.
- Provide health services under the direct supervision of appropriate health care personnel.
- Maintain appropriate clinical records.
- Conduct periodic peer reviews and utilization reviews.
- Establish policies and procedures for systematic evaluation and revision of their programs.

SUMMARY

In the past, price has been the least important consideration in health care purchases. However, we must solve the current dilemma of too many people requiring care, not enough manpower, (doctors, nurses, etc.) and not enough money. The home must be re-established as to the center of care so that resources will go where they can do the most good for *all;* the taxpayer, the poor, the elderly, the children, the handicapped, and the disadvantaged. Greater utilization of in-home health services will help develop a high quality health care delivery system that uses the institution as the last alternative.

EXHIBIT H

EXCERPT FROM STUDY OF HEALTH FACILITIES

CONSTRUCTION COSTS

(General Accounting Office, Nov. 20, 1972)

CHAPTER 3—HOME CARE

Home care, in the broadest sense, 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 through a broad range of service and organizational patterns from nursing service under physician direction to a coordinated home care program which is centrally administered, planned, and evaluated to provide for physician-directed medical, nursing, social, and related services to selected patients at home. Coordinated home care should include visiting nurse, home aide, and laboratory services; physical therapy; drugs; and sick room equipment and supplies. The purpose of such programs is to shorten the length of hospital stay, to speed recovery, and to bridge the 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 areas of development in home care during the past 25 years, the hospital-based service and the community-based service. In the one area the hospital extends some of its services into the community; in the other a community agency, such as the visiting nurse association or the local health department, builds on its program of service to provide coordinated home care. One study found that the hospital-based programs tend to specialize in relatively dynamic conditions which required a good deal of medical management, while community-based programs tend toward more static chronic conditions which require rehabilitation more than therapeutic services. Whether or not the hospital or community agency is the administrator of the home care program, the hospital and the physician are the focal points in determining the extent of patient needs. It is within the hospital that arrangements are made for patients potentially in need of home care. The physician plays the major role in identifying and appraising need, establishing a care plan, delivering services, reappraising the care, and discharging the patient.

Under earlier concepts of home care, only patients with long-term illnesses requiring multiple services were considered acceptable. A study of organized home care in New York City and adjoining counties found that the home health care population was (1) predominantly in the upper age bracket and (2) predominantly chronically ill or permanently disabled with little or no expectation of ultimate recovery or significant improvement. However, there has been some change in the earlier concept and patients who are convalescing from illnesses, those who usually receive treatment on an outpatient basis but are temporarily unable to do so, and certain patients with terminal illnesses can now be successfully cared for through coordinated home care programs. Other studies of small community home care programs disclosed that, although home care programs are primarily involved with aged and chronically ill patients, often home care is used intermittenly only for one short period in the course of a patient's illness.

Though home care has a longstanding history, growth has been slow. The familiar prototype of hospital-centered organized home care was established at the Montefiore Hospital in New York City in 1947, but by 1966 PHS had identified fewer than 70 home care programs. The implementation of the Medicare law (42 U.S.C. 1395) provided a sudden stimulus toward implementation of this system of medical care. Under Parts A and B of Medicare, reimbursement is possible for home health services provided to eligible beneficiaries. By early

1967, 1,800 home care providers had been certified under Medicare with about 10 percent under hospital auspices. The number of certified providers under Medicare had increased to 2,256 as of December 1971.

The AHA annual survey of registered hospitals for 1970 disclosed that 523, or 8 percent of the reporting hospitals, had home care departments. A special study of 547 hospitals reporting home care programs in 1969 disclosed, however, that only about half these hospitals actually administered programs. Hospitals reporting programs not administered by them usually referred patients to community program.

A substantial majority of patients with long-term illnesses could best be treated at home with suitable supervision and assistance and environmental adaptations. Analysis of general hospital use shows that from 20 to 30 percent of the extended-stay patients have been retained because of social rather than medical reasons, and surveys of nursing homes show that many patients do not need the continuous nursing services of the facility but could be adequately cared for in home settings if some type of nursing and related care were available.

Home care advocates have long cited this method of health care delivery as a mechanism for reducing hospital costs. Home care can be viewed as meritorions by itself in that it provides the most appropriate care to the patient at the level which best fits his needs. Patients on home care also pay a good deal less than the rate they would have to pay in a general hospital, and there is a growing sentiment among medical economists that a well-conceived home care program could make unnecessary the construction of a substantial number of new general hospital beds. One source estimated that a home care program with a caseload of 50 patients could be an adequate substitute for construction of an equivalent number of hospital beds occupied by patients who require home care but not hospital care.

A study by the Rochester, New York, Regional Hospital Council in 1966 indicated that 5.2 percent of the acute patient days could be eliminated by transfer of patients to an adequate home health program. A cost-effectiveness analysis of health care facilities prepared by the Health Economics Branch of the Bureau of Health Services of PHS, to be conservative, cut this rate in half and projected that in 1970 about 5.8 million hospital days, equivalent to about 20,000 beds, could be saved. Our study noted similar examples, as follows:

—A Blue Cross plan in New York initiated a home care program in March 1960. By 1967 there were 27 community nursing service agencies and 40 member hospitals providing preplanned, coordinated services at home. From March 1960 to May 1967, there were 15,261 registered home care cases. A study of the first 5,000 closed cases disclosed that the average number of inpatient days was about 23 while about 85 percent of the hospital stays were shortened by 1 to 4 weeks, or an average of about 23 days. According to the study, the home care program reduced the inpatient stay for the 5,000 patients by 50 percent.

—In February 1960 a Michigan Blue Cross plan also undertook a 1-year demonstration project for home care, involving 300 cases. These 300 cases showed an average of 27 days of hospitalization prior to home care and an estimated 20 hospital days saved per case. The results of the program were so impressive that the program was subsequently adopted on a permanent basis and, as of January 1972, there were 78 hospitals participating in the program. During the period January 1963 through December 1969, there were about 9,800 discharged cases with an average of 16.3 days of inpatient hospital days saved per case. A representative of the plan advised us that these cases and days saved are applicable only to non-Medicare patients. Data was not available for Medicare at the time of our contact.

—A Pennsylvania Blue Cross plan initiated a home care program in November 1961. An analysis of 3,940 admissions to four participating hospitals' home care departments between November 1961 and July 1970 showed that patients were transferred from the hospitals' medical, surgical, and pediatric departments to the home care department an average of 12.9 days earlier than would have been likely without available home care. This amounted to a reduction of about 30 percent in inpatient days and resulted in 6.6 additional beds being made available without a corresponding capital investment. Blue Cross concluded that its objectives in supporting home care had been substantially realized. These objectives included improvement in the continuum of patient care and promotion of more economical use of existing hospital and other health care facilities through an acceptable alternative method of delivering care.

—One specialty hospital, an institution for treating crippled children, has also demonstrated that home care could save inpatient days. The average length of stay at the institute has been reduced—from 49 days in 1962 to about 19 days in 1971. The reduction is due to many factors, including changes in treatment procedures and a waiting list for admission, but also to a change in the attitude of the doctors who recognize that the home is the best treatment place for the patient. One specific item which contributed to the reduction is a special program instituted in June 1969 to train mothers of patients who had spinal fusions for scoliosis to care for the patients at home. A limited test comparing patients admitted prior to the training program with patients admitted after showed a reduction in length of stay of about 5 days. In addition, the program has significantly reduced the readmission of scoliosis patients for treatment of pressure sores from body casts. Because of the decrease in average length of stay the hospital was able to admit 966 patients in 1971 compared with 366 admissions in 1962.

—Another study, sponsored by HEW, to determine potential benefits of home care, was conducted by a health research center located in Portland, Oregon. The study concerned the integration of home health services into a prepaid comprehensive group practice plan. However, the services were added to a medical care system with a history of very low hospital use and the study concluded that there was very little reduction in acute hospital days attributable to home care services. A Kaiser-Permanente representative advised us that the benefits of home care are considered to be more social than economic.

The significance of the benefits of home care programs can be illustrated by the potential savings in days of hospital care on a national basis for diagnoses for which home care is applicable. Heart disease, cancer, and stroke are always numerically important diseases among patients on home care, along with diseases of the nervous and digestive systems, diabetes, and injuries. We noted that these types of diseases accounted for an estimated 136 million inpatient days of care for 1970. We recognize that not all patients with a particular diagnosis are candidates for home care. However, since our study noted that acute inpatient days were reduced from 5 to 50 percent for patients in home care programs, we believe that additional bed use possible through even a 5-percent reduction in acute inpatient days should help reduce the need to construct new acute beds.

Home care programs have been found to result in lower costs to patients, third-party payers, and the community as a whole. Home care costs are offset by the shortening of the hospital stays and an apparent reduction in the frequency and duration of home care patient readmission. We found specific data on the cost benefits of home care to be sketchy but noted several examples which demonstrate this point. Home care programs use various measurements in reporting costs, such as cost per visit, cost per day, or total costs per case. In the Michigan Blue Cross home care program, the average cost per day for home care in 1967 was $3.96 compared with an average cost of inpatient care of $51.34. The average number of acute hospital days saved at the $51.34 per day rate due to home care resulted in a savings of about $550 per home care case. The Pennsylvania Blue Cross coordinated home care study for the period November 1961 through July 1970 disclosed an average cost per patient day of $7.95. The value of the inpatient days saved from the home care program for this period was estimated at $1.3 million, or $330 per case. While the national average of hospital expenditures per patient day was rising from $38.91 in 1963 to $70.03 in 1969, the per day cost of the various home care programs noted in our study ranged between $3 and $8.

A more significant example of the costs of home care as opposed to inpatient care is in the area of renal dialysis. Renal dialysis is a process of artificially cleansing the body's blood when the kidney becomes incapable of doing so. This can be done by means of an artificial kidney machine. In most cases when the kidney is totally nonfunctional, treatment is required three times weekly.

Inpatient renal dialysis programs are costly to operate in terms of space, equipment, and manpower. For example, in 1971 the cost to construct a unit capable of handling at least 10 patients simultaneously was estimated at $275,000. Moreover, a study of dialysis services and facilities in the Philadelphia-South Jersey metropolitan area showed that the annual cost to operate a dialysis bed ranged between about $13,000 and $64,000 per bed depending on the extent and

use of the program, the number of dialyses performed, and professional personnel required.

Technology, however, has produced an artificial kidney which can be used in the home for long-term treatment of chronic kidney disorders. Home dialysis has the advantage of being cheaper for the patient through the elimination of both hospital costs and professional manpower. The average annual cost of home dialysis to 413 Veterans Administration (VA) patients in fiscal year 1971 was about $9,000 per patient. A person with a totally nonfunctional kidney is required to have three treatments weekly. The cost of each treatment at the VA hospital was about $160. Thus, the annual inpatient program cost for a chronic patient could total $25,000, or a difference of $16,000.

These statistics are further borne out by data from a Florida hospital. The hospital reported that for fiscal year 1970 the average charge per inpatient treatment was about $113. About the same time the average charge for home dialysis for the Florida Division of Vocational Rehabilitation was about $30, representing a savings of as much as $13,000 per year to a patient.

With improvements in, and simplification of, home dialysis equipment, home dialysis is preferred for those patients who can manage such a program. Hospital facilities are thus made available to teach patients being prepared for home dialysis and for backup care of home dialysis patients and for other patients not suitable for home programs.

Since home care has the apparent advantages of reducing the need for expensive acute hospital beds and a lower cost of operation, why has the health care delivery system failed to jump at an opportunity that can save money? Though strongly endorsed, organized home care has not taken hold. We identified numerous explanations for this paradox, but the most common was lack of third-party reimbursement of one aspect or the other of the care provided. For example, although the Michigan Blue Cross plan has a home care program which has been demonstrated to save acute inpatient days, the actual number of patients which use the program is small, less than 1 percent of acute admission in participating hospitals. One reason for this limited use is that Michigan Blue Shield does not pay for physician services in a home care program. A representative of Michigan Blue Shield advised us that this lack of coverage has merely been a matter of priorities. Other types of coverage in their insurance package have been considered more important.

Another example of the reimbursement problem is the experience of a New Mexico hospital. The hospital instituted a home care program several years ago but had to drop it because those individuals that needed the care could not afford a $10 charge per visit and health insurance was not available. The administrator advised us that the demand for home care still exists.

In addition, when home care is offered as a benefit in an insurance program, it is often offered on the basis of providing entitlement to a number of days of home care in exchange for one inpatient day. Therefore patients who anticipate readmission to the hospital may be reluctant to forego hospital benefits.

Coverage of home care by insurance has been somewhat extended by its inclusion as a Medicare benefit. However, this coverage is limited to persons over age 65, and, although a large percentage of home care patients are over age 65, there remains a large group of persons under 65 who could benefit from home care. Moreover, the Social Security Administration (SSA) reported in 1967 that less than 1 percent of the persons ever enrolled for Medicare had used home care services. This is due, in part, to the stringent requirements governing the receipt of care under the program. We found that several authorities have attributed the lack of home care programs to the complex requirements of such a program, such as the degree of organization and inflexible application of definitions.

The physician is most important in instituting home care. A study of 83 physicians by research staff of Pennsylvania State University, in conjunction with a Pennsylvania hospital, found that among users and nonusers alike there was a generally favorable attitude toward home care. Other studies indicate, however, that some physicians are highly resistant to home care. For example, a survey of organized home care by the Columbia University School of Public Health and Administrative Medicine found that there are some physicians who will not permit their patients to even be told of the existence of such programs.

Several reasons for the physician's attitude were reported in studies by the Blue Cross Association and in a study by a task force on health facilities by the

American Institute of Architects, as well as by various hospital officials. These include:

1. Preference for the convenience of the hospital or clinic.
2. The physician's method of treatment does not often require an organized home care program.
3. Physicians are unaware of the existence and value of home care.
4. Home care is seen as a disrupting influence on the doctor-patient relationship.
5. Physicians see home care as primarily a social welfare program.

There are also indications of resistance to home care by hospital administrators because of low occupancy in some hospitals and time and staffing problems. We were advised that low occupancy in hospitals is a problem that seriously affects use of any type of outpatient service. Other problems affecting home care include:

1. The fact that home care is restricted to those discharged from acute care.
2. The physical condition of the home and the family situation.
3. The process of care may be disorganized.

After a decade of experience, home care programs have been found to effect a reduction in the length of acute inpatient stays for specific ages and diagnostic categories of patients. Columbia University's study of the many problems restricting home care programs concluded that home care is a valuable health care resource and suggested to various authorities, including the different levels of government, that:

1. Community-based home health agencies enlarge their scope and become multiservice, health-related home care agencies.
2. It is time to penalize hospitals which relegate home care program offices to some inaccessible and invisible location in the hospital.
3. Medical staffs be prohibited from barring patients from access to home care services
4. Additional education of family members in how to care for the sick and aged at home is needed.
5. Because much unnecessary institutional placement of the aged results from lack of relatives or others to help with simple activities of daily living, local governments study tax incentives to encourage families to care for the aged sick at home or in small, group-living arrangements.
6. Medicare provide for approved, multiservice, home health agencies to accept patients directly in lieu of unnecessary hospital or ECF admission.

Over 11 percent of the population are limited in their activities due to chronic conditions. In addition, science and technology are causing the average age of population to increase and thereby are also increasing the proportion of the population susceptible to chronic illness. The AHA Report of a Conference on Care of Chronically Ill Adults concluded that the high cost of hospital care, changing housing and family patterns, the inability of the medical profession to deal effectively with chronic diseases, and a significant increase in the number of old people should stimulate the growth of various forms of community care.

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